Georgia's
Child Abuse Prevention & Treatment Act
Citizen Review Panel Program

2009 Annual Report

Hand in Hand, Making a Difference

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Georgia's Child Abuse Prevention and Treatment Act (CAPTA)
Citizen Review Panels

2009 Annual Report

Executive Summary

80,833

reports of suspected child abuse and neglect resulting in…

15,433 investigations
9,900 substantiated open cases
2,501 foster care cases opened

Georgia's 2009 child welfare statistics[1] showed an 8% decline in reports of suspected abuse and neglect from 2008. Of the 80,833 reports received, 15,433 were considered credible and warranted full investigation by the state's child protective system. Of the investigated reports, 9,900 were substantiated for abuse or neglect and resulted in either an open Family Preservation or Foster Care case. Of the reports that were considered low-risk but did not warrant an investigation, 40,775 were referred to Family Support (aka "Diversion"), Georgia's alternative response system. In Georgia, the work of its three independent citizen review panels is directed at improving how the child welfare system and the community respond to protect the victims of these reports and support their families, and how we, as a community, can improve our efforts to prevent child maltreatment.

The establishment of citizen review panels for all state Child Protective Services (CPS) systems was mandated by the federal Child Abuse Prevention and Treatment Act (CAPTA) reauthorization of 1996, for all states receiving a CAPTA grant. Georgia designated three existing committees to serve as CAPTA citizen review panels to fulfill this requirement: Child Protective Services Advisory Committee, Children's Justice Act

[1] DHS/DFCS Data Analysis & Reporting presentation at G-Force meeting August 27, 2009, "Preserving Families and Maintaining Safe & Thriving Forever Families"

Advisory Committee, and Georgia Child Fatality Review Panel. The purpose of CAPTA citizen review panels is threefold: 1) to examine the policies, procedures, and practices of state and local child protective service (CPS) agencies; 2) to provide feedback on the effectiveness of the agency's child abuse prevention and treatment strategies in producing the desired child and family outcomes; and 3) to determine whether they (CPS) are effectively discharging their child protection responsibilities. Each of the three existing panels had a child welfare vision and mission that would support meeting these objectives and satisfy the CAPTA requirement.

The mission of Georgia's CAPTA citizen review panels is to assure that children are protected from maltreatment, and children and families are provided the best possible services within the framework of available resources through:

- Evaluating and assessing the child welfare system
- Promoting quality child protective services practice
- Advocating for the strengthening of resources
- Recommending and advocating for policies and procedures that promote the highest practice standards
- Cross-system problem-solving involving both formal and informal support agencies, groups and individuals

The purpose of these panels is to provide opportunities for community members to play an integral role in ensuring that states are meeting their goals of protecting children from child abuse and neglect.

Georgia's **Child Protective Services Advisory Committee (CPSAC)** was established originally as an advisory group to the state's Child Protective Services Unit of the Department of Human Services (DHS), Division of Family and Children Services (Division). Re-configured in 2006 to serve as a CAPTA citizen review panel, the CPSAC is composed of dynamic and committed individuals with diverse backgrounds, expertise and experience along the full child welfare continuum who have a special interest in the

prevention of child abuse and neglect and whose primary concern is the safety and well-being of Georgia's children and youth.

The **Children's Justice Act Advisory Committee (CJAAC)** serves a dual role - both as a CAPTA citizen review panel and a multi-disciplinary task force on children's justice. Established as a result of the 2003 CAPTA re-authorization as a condition of the state's Children's Justice Act (CJA) grant, the CJAAC has an expanded purpose; it is also charged with the review and evaluation of the investigative, administrative and judicial handling of child maltreatment-related cases and making policy and training recommendations for improvement. Its membership is composed of professionals with knowledge and experience relating to the criminal justice system and issues of child physical abuse, child neglect, child sexual abuse and exploitation, and child maltreatment-related fatalities. The task force also provides technical support in the administration of the Children's Justice Act grant, including funding recommendations and administrative oversight.

Georgia's **Child Fatality Review Panel (CFRP)**, a statutory body whose creation was mandated by the Georgia State Legislature in 1990, is composed of an appointed body of representatives that oversees the process of reviewing child fatalities. Its mission includes providing high-quality data, training, technical assistance, investigative support services, and resources to prevent and reduce child abuse and fatalities. In 2008, a CAPTA maltreatment committee was established to specifically address its additional obligations as a CAPTA citizen review panel and maltreatment-related child deaths.

The overlapping interests of these three panels address the full child welfare continuum from prevention and investigation to treatment and prosecution of cases of child abuse and neglect. All three CRPs have a statewide approach to examining systemic issues that impact the effectiveness of the state's child protection system, and identifying opportunities to reform state systems and improving processes by which Georgia's child welfare system and communities respond to cases of child abuse and neglect.

Activities of the panels are detailed in individual annual reports. (*See Attachments I, II, & III.)* The following section highlights recommendations resulting from their activities in 2009.

Child Protective Services Advisory Committee

The priorities of the CPSAC focus on the prevention/early intervention end of the child welfare continuum. In addition to reinforcing its 2007/2008 recommendations, the CPSAC has expanded recommendations with respect to Georgia's Diversion program and a statewide plan for the prevention of child abuse and neglect in 2009 to include:

Diversion:

- Development of training for caseworkers and supervisors to improve intake screening, case management and monitoring/follow up of "diverted" reports/cases
- Engagement of community at-large to ensure availability of adequate supports and services to meet the early intervention needs of children and families in Diversion cases
- Increase in the number of Diversion cases reviewed during regional case review process (PEAS) to be more reflective of the volume and impact of these cases

Prevention:

- Work collaboratively with the Office of Child Fatality Review to expand and enhance the prevention component of Georgia's model child abuse protocol to advance a statewide child abuse prevention plan

Children's Justice Act Advisory Committee

The CJAAC continues to place a high priority on supporting activities and practices that specifically address the handling of cases of child sexual abuse as well as the multi-disciplinary cross-training of child welfare professionals. 2009 recommendations support these priorities and include:

- Development of a comprehensive sexual abuse training curriculum which could be made available to a broad spectrum of disciplines involved in the investigation, treatment and prosecution of these cases using a model similar to the revised DFCS

new caseworker curriculum, based on updated research and victim advocacy, and general enough in nature to encompass the unique needs of the multiple disciplines involved

- Re-establishment of an annual, multi-disciplinary conference or series of workshops that incorporates both foundational and discipline-specific information and resources for coordinated, cross-discipline training and professional development on child abuse and neglect, more specifically on child sexual abuse

In addition, task force recommendations with respect to Children's Justice Act funding allocations in 2009/2010 include:

- Continued support of training priorities identified by the Division, including legal services training, Special Assistant Attorneys General (SAAG) training, and training for crisis and child fatality investigations
- Continued support of multi-disciplinary training on sexual abuse, pre-service training for Guardians ad litem (GAL) and summer internships in child welfare advocacy
- Identifying, encouraging and supporting new projects that meet CJA objectives such as supplemental training for foster parents on fostering child victims of sexual abuse and/or sexually-reactive children, and developing methods for the systematic linkage of existing Georgia data systems related to children in Georgia

Child Fatality Review Panel

The CFRP is charged with examining the circumstances surrounding child fatalities and its recommendations are directed at the prevention of these deaths. 2009 recommendations include:

- Continued expansion and support of local child abuse investigative teams trained in the multi-disciplinary approach to death scene investigations
- Routine training for hospital staff, community medical providers and other categories of mandated reporters on identification of child abuse, injury prevention strategies and how to make a report to DFCS

- Develop public awareness campaign to target risks of co-sleeping, shaken baby, and drowning
- Provide resource referrals and materials to new parents to educate on coping strategies, child development, appropriate discipline, and parent support groups (e.g., "Period of Purple Crying" program, "Better Brains for Babies," and American Academy of Pediatrics "Practicing Safety" training modules)
- Reconstitution of multi-disciplinary, multi-agency team to examine causes and circumstances of deaths, near-fatalities and serious injuries as reported through Child Death and Serious Injury (CDSI) procedure
- Develop mechanism by which "near-fatalities" that result from child maltreatment will be made publicly available so as to enhance system transparency and accountability
- Develop definition of "child maltreatment" that can be consistently applied across contexts and encompass the components of fatal neglect and fatal abuse
- Develop, implement, and evaluate methods for the systematic linkage of existing Georgia data systems related to children in Georgia

The panels recognize that the state has already made some progress in addressing several of their recommendations and look forward to continued open dialogue on CRP priorities to improve both Divisional and community response to Georgia's children and families in crisis.

Respectfully submitted,

Child Protective Services Advisory Committee
Children's Justice Act Advisory Committee
Child Fatality Review Panel

Child Protective Service Advisory Committee

Georgia's Child Abuse Prevention and Treatment Act (CAPTA)
Citizen Review Panel 2009 Annual Report

Child Protective Services Advisory Committee

Annual Report 2009

Vision

Every child will live in a safe and nurturing home,
and every family will have the community-based supports and services they need
to provide safe and nurturing homes for their children.

Mission Statement

To work in partnership with Georgia's child welfare system to ensure
that every effort is made to preserve, support and strengthen families and,
when intervention is necessary to ensure the safety of children, that
they and their families are treated with dignity, respect and care.

"Child abuse casts a shadow the length of a lifetime." ***Herbert Ward***

Georgia's Child Protective Services Advisory Committee (CPSAC), one of the state's three citizen review panels, was established in 2000 in response to Section 106 of CAPTA Title I to solicit input from citizens regarding the activities of the state's Child Protective Services Unit of the Department of Human Services, Division of Family and Children Services (the Division). In 2006, the CPSAC was formally identified as one of Georgia's three required CAPTA citizen panels. The purpose of a CAPTA citizen review panel is threefold: 1) to examine the policies, procedures, and practices of state and local child protective service (CPS) agencies; 2) to provide feedback on the effectiveness of the agency's child abuse prevention and treatment strategies in producing the desired child and family outcomes; and 3) to determine whether they (CPS) are effectively discharging their child protection responsibilities.

The CPSAC is composed of a group of dynamic and committed individuals with diverse backgrounds, expertise and experience along the full child welfare continuum who have a special interest in the prevention of child abuse and neglect and whose primary concern is the safety and well-being of Georgia's children and youth. Efforts continue to expand the base to incorporate additional child welfare disciplines and consumers and to improve engagement of members. In 2009, new members included representatives from law enforcement, a community-based family resource center and Family Connections Partnership. Identifying and engaging consumers - parents, foster parents and youth, to serve on the panel remains a challenge but the CPSAC is committed to identifying opportunities for these groups to contribute. *See Appendix A for list of current members.*

In 2009, members met bi-monthly, exceeding the federally-mandated CAPTA quarterly meeting requirements. In addition, subcommittees met or communicated between meetings, as needed.

Representatives from CPSAC serve on a joint CAPTA panel steering committee with members from the other two citizen review panels, Children's Justice Act Advisory Committee and the Child Fatality Review Panel. Representatives from Georgia's child welfare agency, the Division, are invited to attend steering committee meetings to provide subject matter expertise, as needed. This forum provides an opportunity for inter-panel collaboration, coordination of panel activities and joint planning with Georgia's child welfare agency. This group meets quarterly.

A CPSAC member and representatives from Georgia's other two CRPs attended the national citizen review panel conference in May 2009. Presentations and workshops included topics such as improving transparency in child welfare; effective private/public partnerships; and information on national child welfare data and the Fostering Connections Act. The conference provided an opportunity for Georgia representatives to network with citizen review panel members from other states and gain insight into the common challenges facing all citizen review panels and their state's child welfare agencies.

CPSAC members were invited to participate in a workgroup convened by the Division to assist in the development of a CAPTA Program Improvement Plan (PIP) to improve Georgia's compliance with respect to its obligations as a CAPTA grant recipient. The CAPTA PIP item of particular interest to the CPSAC is:

> *"…provisions and procedures for referral of a child under the age of three who is involved in a substantiated case of child abuse or neglect to early intervention services funded under part C of the Individuals with Disabilities Act*[1]*…"*

A representative from the CPSAC continues to serve on an ongoing CAPTA PIP Babies Can't Wait workgroup, has consulted on the development of the action plan to address the CAPTA deficiency, and will participate in the ongoing monitoring and evaluation of the state's progress toward successful implementation of its CAPTA PIP.

Georgia implemented a policy development and review process in 2009 that included consultation with several stakeholder groups including CRP members. CPSAC members had an opportunity to provide feedback on the new and revised child protective services policy including intake, investigations, independent living, HIPAA and administrative case review. Currently, there is no mechanism to effectively track CRP recommendations and any resulting impact on policy reviewed.

CPSAC members were also provided an opportunity to provide input on Georgia's five-year CAPTA plan. Priorities recommended for consideration in the five-year plan included:

- Improving the intake, assessment, screening, and investigation of reports of abuse and neglect
- Improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers

[1] Child Abuse Prevention and Treatment Act as amended by The Keeping Children and Families Safe Act of 2003

- Developing and facilitating training protocols for individuals mandated to report child abuse or neglect and developing and facilitating research-based strategies for training individuals mandated to report child abuse or neglect
- Developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level.

During 2009, CPSAC continued its examination of Georgia's Diversion program, the non-investigative response to maltreatment reports deemed as "low-risk." In 2007, CPSAC members raised concerns with respect to the handling of reports referred for "Diversion" and established a subcommittee in 2008 to examine and gain a better understanding of this alternate response practice and its potential impact on families and children. The subcommittee reviewed Georgia's child abuse report and disposition statistics, county/regional protocols and national literature on differential response practices and evaluation results, and made several recommendations.

Disposition of Reports of Child Abuse and Neglect

	SFY2009	SFY2008	SFY2007	SFY2006
Total Reports	**80,833**	87,892	92,185	96,511
% of total reports				
Screened Out	**14.6**	17.2	15.6	15.7
Family Support*	**50.4**	45.2	30.0	18.1
Substantiated & Opened	**12.2**	10.7	13.1	15.0
Substantiated & Closed	**6.9**	8.2	10.5	11.5
Unsubstantiated & Opened	**1.5**	1.4	1.7	1.3
Unsubstantiated & Closed	**14.3**	17.4	29.1	38.3

**aka Diversion*

Sources: Georgia DHR DFCS, Child Protective Services Data System (2006-2008) and DHS/DFCS Data Analysis & Reporting presentation at G-Force meeting August 27, 2009, "Preserving Families and Maintaining Safe & Thriving Forever Families"

Although overall reports of child abuse and neglect have declined since 2006, those identified as Family Support, or Diversion, have steadily increased to more than double 2006 levels reinforcing their concerns with respect to the lack of a statewide policy and consistent practice

model. The CPSAC continued its efforts to support and advance these recommendations by continuing dialogues with the Division including participating in meetings with consultants hired

by the Division to assess its Diversion program and aid in the development of policy and practice framework for an effective differential response system. In addition to reiterating some of their ongoing concerns during these discussions with consultants about reported inconsistencies in the handling of these low-risk reports, CPSAC members were provided an opportunity to discuss some of their policy and practice recommendations. A report released in 2009 by the Carl Vinson Institute of Government, University of Georgia, one of the consulting groups hired to prepare a study, supported many of the recommendations made by CPSAC members.

CPSAC continues to support the following 2008 recommendations with respect to Diversion:

- *Development of a statewide policy*
- *Design and implementation of a best practice model*
- *Minimum standards/guidelines for community-based service array*
- *Comprehensive evaluation of its effectiveness as an early intervention strategy*

The CPSAC feels that reports of child abuse and neglect referred to Diversion continue to be such a significant percentage of all report dispositions that the screening of reports and subsequent handling of these cases should be sufficiently comprehensive to guarantee not only the safety of the children in these families but also be expected to improve their well-being. It remains the opinion of the CPSAC that a clearly defined policy, a comprehensive practice model and adequate and equitable access to community-based resources are necessary to ensure the effectiveness of Diversion as an early intervention strategy and has expanded its earlier recommendations.

2009 Recommendations:

- ***Development of training for caseworkers and supervisors to improve intake screening, case management and monitoring/follow up of "diverted" reports/cases***
- ***Engagement of community to ensure availability of adequate supports and services to meet the early intervention needs of children and families in Diversion cases***

- ***Increase in the number of Diversion cases reviewed during regional case review process (PEAS) to be more reflective of the volume and impact of these cases***

In 2006, CPSAC identified the importance of a statewide, coordinated, and comprehensive child abuse prevention plan. The panel reiterated their commitment to the collaborative development of a statewide plan in 2007, and reinforced their early recommendations with additional specificity in 2008 recommendations including:

- *Development of a common "prevention" language*
- *Assessment of Georgia's prevention resources*
- *Collaborative development of a statewide child abuse and neglect prevention plan*
- *Identification of an oversight body to coordinate the development of, promote and monitor such a plan*

During 2009, several CPSAC members were invited by the Office of Child Fatality Review to participate in a review and update of the state's model child abuse protocol (CAP) to provide input on the prevention component of the protocol. It has been recommended that the prevention component of the protocol could be used as a platform to institutionalize a statewide child abuse prevention plan. In addition, the Child Fatality Review Panel has developed a framework for injury prevention that could be supplemented with a stronger child abuse prevention component and incorporated into the CAP for use at the county level in their local prevention efforts. The CPSAC recommends that the Division encourage and support this collaborative approach to development and implementation of a statewide child abuse prevention plan.

2009 Recommendation:

- ***Work collaboratively with the Office of Child Fatality Review to expand and enhance the prevention component of Georgia's model child abuse protocol to advance a statewide child abuse prevention plan***

CPSAC panel members respectfully request that the Division consider their recommendations, continue to provide them with opportunities to participate in planning, and maintain an open dialogue on these ongoing CPSAC priorities.

Moving Forward…

In the fall of 2009, CPSAC members participated in the third annual citizen review panel retreat to develop its platform for 2010. In addition to monitoring the design and development of statewide policy and a practice model for Georgia's differential response system, continuing to advocate for a statewide child abuse prevention plan and enhancement, expansion and evaluation of mandated reporter training, CPSAC will turn its attention to examining the following:

- Impact of budget cuts on staffing and caseloads
- Timeliness of assessments
- Repeat maltreatment
- Service array and accessibility of services to families

The CPSAC respectfully submits its recommendations for 2009, requests their careful consideration by the Division and looks forward to ongoing collaboration with the Division that will promote transparency and improve outcomes for Georgia children and families.

Never doubt that a small, dedicated group of citizens can make a difference. Indeed, it is the only thing that ever has…

~Margaret Mead

"The CPSAC committee strives to support the Division and ensure the well-being of all Georgians. The continued commitment and work of the CPSAC members is admirable and a valuable service to all."

Liz Ferguson, CPSAC Co-Chair

A special note of thanks to Prevent Child Abuse Georgia for hosting CPSAC meetings in 2009.

2009 Membership

Liz Ferguson*, Co-Chair
Associate Director of Programs
Prevent Child Abuse Georgia

Sarah O'Leary, Co-Chair
Public Health Advisor
Centers for Disease Control

Kemberlie Sanderson, Executive Director
Rainbow House Children's Resource Center

Angie Burda, Program Coordinator
Clayton County Kinship Care Resource Center

Diane Bellem, Vice President
Georgia Training Institute, Sheltering Arms Early Education & Family Centers

Sharon Carlson, President
Adoption Foster Parent Association of Georgia

Mary Esposito, Community Programs Director
CHRIS Kids, Inc.

Karl Lehman, Executive Director
Childkind, Inc.

Amy Leverette, Attorney
Ocmulgee Circuit

John McCraw, Detective
Cobb County Police Department

Dee Dee Mize, Executive Director
Family T.I.E.S., Inc.

Lori Muggridge, Executive Director
Ocmulgee CASA

Scott Rhoden, Executive Director
Compassion House

Carole Steele*, Director of Prevention Programs, Governor's Office for Children and Families

Amy Rene*, Community Services
Hillside, Inc.

Arianne Weldon, Director of State Partnership Strategies, Georgia Family Connection Partnership

DHS/DFCS Support and Consultation
Ann D. Pope, State Director
Promoting Safe & Stable Families

Susan W. Denney, DHS/DFCS Strategic Planning Unit Director, Office of the Deputy Director, Programs & Policy

Deb Farrell, Care Solutions, Inc.
CAPTA Citizen Review Panel Project Coordinator

* Members of CAPTA Steering Committee

Children's Justice Act Advisory Committee

A task force on children's justice

Georgia's Child Abuse Prevention and Treatment Act (CAPTA)
Citizen Review Panel 2009 Annual Report

Children's Justice Act Advisory Committee

Annual Report 2009

Vision

All of Georgia's children will receive the best possible protection from all forms of child abuse and neglect from a system of highly trained professionals, who thoroughly investigate alleged abuse and adequately prosecute those who abuse children, while protecting children from repeat maltreatment.

Mission Statement

To identify opportunities to reform state systems and improve processes by which Georgia's child welfare system responds to cases of child abuse and neglect, particularly cases of child sexual abuse and sexual exploitation, and child abuse or neglect-related fatalities; and, in collaboration with the state's child protection agency and its external partners, make policy and training recommendations regarding methods to better handle these cases, with the expectation that it will result in reduced trauma to the child victim and the victim's family while ensuring fairness to the accused.

"...in serving the best interests of children, we serve the best interests of all humanity."

Carol Bellamy

Georgia's Children's Justice Act Advisory Committee (CJAAC) was established by the Department of Human Services (DHS) as a citizen review panel (CRP) in response to the 2003 re-authorization of the Child Abuse Prevention and Treatment Act (CAPTA), Section 106, to satisfy a CAPTA grant recipient requirement. The purpose of the CRP is to: 1) examine the policies, procedures, and practices of state and local child protective service (CPS) agencies; 2) provide feedback on the effectiveness of the agency's child abuse prevention and treatment

strategies in producing the desired child and family outcomes; and 3) determine whether they (CPS) are effectively discharging their child protection responsibilities.

As a recipient of a CAPTA Children's Justice Act grant, Georgia was also required to establish and maintain a multi-disciplinary task force on children's justice composed of professionals with knowledge and experience relating to the criminal justice system and issues of child physical abuse, child neglect, child sexual abuse and exploitation, and child maltreatment-related fatalities (CAPTA, Section 107). The purpose of the task force is to review and evaluate investigative, administrative and judicial handling of these cases and make policy and training recommendations for improvement. The task force also provides technical support for the administration of the Children's Justice Act grant, including funding recommendations, and administrative oversight.

The CJAAC serves a dual role as both a task force on children's justice and one of Georgia's three citizen review panels. The other two panels are the Child Protective Services Advisory Committee and the Child Fatality Review Panel.

In 2009, the task force identified and successfully recruited new members representing law enforcement, health and mental health, and parent attorneys. However, recruitment and retention of a judge and an individual with expertise and experience in the field of child disabilities has been challenging, and the task force has discussed alternate strategies for identifying and engaging individuals from these disciplines. Recommendations are under consideration and it is expected that these positions will be filled in the coming months. The task force also continues its ongoing efforts to identify opportunities for former foster youth and parents to participate. *See Appendix A for a list of members.*

In 2009, task force members met bi-monthly, exceeding the federally-mandated quarterly meeting requirements. Subcommittees met or communicated between meetings, as needed.

Representatives from CJAAC also serve on a joint CAPTA panel steering committee with members from the other two panels, Child Protective Services Advisory Committee and the Child Fatality Review Panel. Representatives from Georgia's child welfare agency are invited to

attend steering committee meetings to provide subject matter expertise, as needed. This forum provides an opportunity for inter-panel collaboration, coordination of panel activities and joint planning with Georgia's child welfare agency. This group meets quarterly.

A CJAAC member and representatives from Georgia's other two CRPs attended the national citizen review panel conference in May 2009. Presentations and workshops included topics such as improving transparency in child welfare; effective private/public partnerships; and information on national child welfare data and the Fostering Connections Act. The conference provided an opportunity for Georgia representatives to network with citizen review panel members from other states, including some that also serve a dual role as the CJAAC in Georgia does, and gain insight into the common challenges facing all citizen review panels and their state's child welfare agencies.

At Work in 2009…

In its role as a CRP and task force on children's justice, the CJAAC had an opportunity to contribute to or collaborate on several child welfare-related activities initiated by DHS/DFCS during 2009. These included:

- CAPTA Program Improvement Plan (PIP)
- Georgia's five-year CAPTA plan
- Child Protective Services policy review

<u>CAPTA PIP</u>

CJAAC members were invited to participate in a workgroup convened by Georgia's child welfare agency, Division of Family and Children Services (DFCS), to assist in the development of a CAPTA PIP to improve Georgia's compliance with respect to its obligations as a CAPTA grant recipient. The compliance item of particular interest to the task force is the following CAPTA requirement:

> *"…provisions and procedures requiring that in every case involving an abused or neglected child which results in a judicial proceeding, a guardian ad litem who has received training appropriate to the role, and who may be an attorney or a court appointed special advocate who has received*

training appropriate to that role (or both), shall be appointed to represent the child in such proceedings—

I. to obtain first-hand, a clear understanding of the situation and needs of the child; and

II. to make recommendations to the court concerning the best interests of the child;"[1]

A representative from the CJAAC continues to serve on the CAPTA PIP Guardian ad Litem (GAL) workgroup, has consulted on the development of the action plan to address the CAPTA deficiency, and will participate in the ongoing monitoring and evaluation of the state's progress toward successful implementation - 100% representation for all children.

Georgia's Five-Year CAPTA Plan

Task force members were also provided an opportunity to contribute to the development of Georgia's five-year CAPTA plan and support activities identified in the plan that address the following:

- Improving intake, assessment, screening and investigation of reports of child abuse and neglect
- Improving the use of multi-disciplinary team and inter-agency protocols to enhance investigations
- Improving legal preparation and representation
- Updating child and family data system (SHINES)
- Developing and facilitating mandated reporter training and reporting protocols

These CAPTA priorities are consistent with task force objectives and influenced recommendations identified in this report.

Child Protective Services Policy Review

Georgia implemented a policy development and review process in 2009 that included consultation with several stakeholder groups including CRPs. CJAAC members had an opportunity to provide feedback on the new and revised child protective services policy including intake, investigations, independent living, HIPAA and administrative case review.

[1] Child Abuse Prevention and Treatment Act as amended by The Keeping Children and Families Safe Act of 2003

Currently, there is no mechanism to effectively track CRP recommendations and any resulting impact on policy reviewed.

The CJAAC also undertook the review and examination of several issues related more specifically to their role as a task force on children's justice. In 2009, these included:

- Three year assessment of the state's system for the handling of child abuse and neglect cases
- Comprehensive review of training curricula on child sexual abuse
- Children's Justice Act funding allocations

Children's Justice Act Three Year Assessment

In 2009, the task force was required (CAPTA, Section 107) to conduct a comprehensive review and evaluation of law, policy and the investigative, administrative and judicial handling of cases of child abuse and neglect and make training and policy recommendations in each of the following three categories:

1. Investigative, administrative and judicial handling of cases of child abuse and neglect, particularly child sexual abuse and exploitation, as well as cases involving suspected child maltreatment related fatalities and cases involving a potential combination of jurisdictions (such as inter state or federal/state), in a manner which reduces the additional trauma to the child victim and the victims' family and which also ensures procedural fairness to the accused

2. Experimental, model and demonstration programs for testing innovative approaches and techniques which may improve the prompt and successful resolutions of civil and criminal court proceedings or enhance the effectiveness of judicial and administrative action in child abuse and neglect cases, particularly child sexual abuse and exploitation cases, including the enhancement of performance of court-appointed attorneys and guardians ad litem for children, which also ensures procedural fairness to the accused

3. Reform of state laws, ordinances, regulations, protocols and procedures to provide comprehensive protection for children from abuse, particularly sexual abuse and exploitation, while ensuring fairness to all affected persons

An assessment instrument (copy attached as Appendix B) was developed by the task force and responses solicited from a broad range of individuals and professionals involved in the handling of these cases including state, regional and county leadership, supervisors, caseworkers, judges, law enforcement, medical, mental health, Guardians ad Litem (GAL), Special Assistant Attorneys General (SAAG), Court-Appointed Special Advocates (CASA), parent advocates, prosecutors, and foster parents. Respondents were primarily solicited by CRP members and through their professional affiliation networks. The task force focused its assessment in three areas:

1. The handling of cases of child abuse and neglect, by both DFCS and its collaborative partners,
2. Multi-disciplinary training on child sexual abuse, and
3. Mandated reporting.

More than 525 individuals participated in the web-based task force survey, with an 85% completion rate.

Results of the Assessment: DFCS handling of cases of child abuse and neglect…
While most respondents indicated that DFCS ***handling of reports of suspected abuse*** as more than adequate or adequate, many respondents described DFCS ***screening of reports of suspected abuse*** as less than adequate with respect to reports of neglect (32%), physical abuse (24%), and sexual abuse (28%). Although more than half of respondents (58-62%) rated DFCS performance in the handling of child abuse as somewhat or not very effective, caseworkers were described as knowledgeable about the dynamics of child sexual abuse and responsive to the individual needs and concerns of children and families, and supervisory staff were described as experienced and administrators supportive.

Many respondents acknowledged several challenges facing caseworkers that impact their ability to do their job effectively including the size and demands of their caseloads, adequate training and education, caseworker experience and staff turnover. In addition to budget cuts and shrinking resources that impact caseworker ability to meet families' needs, practice challenges include timeliness of mental health assessments, assessment resources in cases of suspected

sexual exploitation of children, engaging and supporting fathers, and resources for children with disabilities who have been victims of abuse.

Results of the Assessment: DFCS working in collaboration with its partners in the investigation, prosecution and disposition of cases of child abuse and neglect…

Seventy-two percent of respondents felt that law enforcement and DFCS worked somewhat effectively to extremely effectively in the investigation of child abuse. Respondent suggestions on how DFCS and law enforcement might work together more effectively included improved communications, more multi-disciplinary training, particularly on child sexual abuse and working with children with disabilities, and consistent use of child abuse protocols.

Although 80% of respondents indicated that prosecutors and DFCS worked effectively together in the criminal prosecution of cases of abuse, 60% of those reported that they felt they were only "somewhat effective." Respondent suggestions on how DFCS and prosecutors could work more effectively together included more multi-disciplinary training with respect to legal issues, better communication, more timely prosecutions and consistent use of child abuse protocols.

Overall, the effectiveness of juvenile court and DFCS collaboration in the disposition of cases of child abuse was rated as effective or very effective in 74% of responses; however, only 58% felt that deprivation cases were resolved in a timely manner. Respondent suggestions on how DFCS and juvenile courts could be more effective included improved communications, consistent appointment of GALs, and better preparation of caseworkers for court.

Results of the Assessment: Multi-disciplinary training…

Several themes have emerged from the task force study with respect to multi-disciplinary training, particularly the need for in-depth training on the dynamics of child sexual abuse, skills for working with children with disabilities who are victims of abuse, and training on commercial sexual exploitation of children. Gaps in training were identified by some respondents suggesting the need to identify core content training for all disciplines on the dynamics of child sexual abuse training. The desire for regular continuing education was also identified. Several responses indicated that additional training and support on child abuse protocols, changing laws and

legislation, and current research would be beneficial.

Results of the Assessment: Mandated reporting…

The survey also included several questions on the screening of reports of suspected child maltreatment, and three more specifically on mandated reporting. Twenty-seven percent of responses indicated that they felt that reporting compliance by mandated reporters was inadequate. Forty-five percent felt that mandated reporter training availability was inadequate. Fifty-eight percent responded that there was a need in their communities for additional mandated reporter training. These results supported previous recommendations from the task force on enhancing mandated reporter training, improving availability, both geographically and frequency, as well as evaluation of its effectiveness. This recommendation was incorporated into the five-year CAPTA plan.

A copy of the assessment instrument, complete results and analysis were included in Georgia's annual CJA grant application for 2009, as required.

Review of Training Curricula on Child Sexual Abuse

Consistent with the task force role to develop, establish, and operate programs designed to improve the investigation and prosecution of child sexual abuse and exploitation cases, in 2009, the task force completed its review of available training curricula for professionals involved in cases of child sexual abuse. Specifically, the objective of the curricula review was to determine the quality of information provided to professionals in the field, consistency between training materials, and the general preparation of professionals to address the complexities of child sexual abuse cases.

Training curricula for the following professionals were chosen for the review: Children's Advocacy Centers, DFCS caseworkers, foster parents, Comprehensive Child and Family Assessment (CCFA) providers, Court Appointed Special Advocates (CASA), GALs, Juvenile Judges, law enforcement, parent attorneys, SAAGs, public defenders, Department of Juvenile Justice (DJJ) officers, citizen panel review members and mental health professionals. From these disciplines, standard training curricula was only available for DFCS caseworkers, foster parents,

CCFA providers, CASA, DJJ and law enforcement for the purpose of the committee review. With the exception of the recently updated DFCS training curricula that includes current research and best practices, curricula generally failed to capture the complexity of child sexual abuse or promote the importance of not further traumatizing victims and did not reflect updated empirically validated information concerning intra-familial sexual abuse. Of note, child advocacy center professionals complete specialized training using nationally recognized models of forensic investigation.[2]

Most significant was the absence of standard training materials for many of the professionals most intrinsically involved in the investigation, prosecution, and recovery process for sexually victimized children including: Juvenile Judges, parent attorneys, GALs, public defenders, SAAGs, and citizen panel review members. Any specialized training for these groups is often only obtained at the discretion of the individual, and trainings offered may lack specificity to their role in these investigations.

Recommendations resulting from the review are as follows:

1. *Develop standard curricula on child sexual abuse - The task force recommends the development of a comprehensive sexual abuse training curriculum which could be made available to a broad spectrum of disciplines involved in the investigation, treatment and prosecution of these cases. The task force recommends using a model similar to the revised DFCS new caseworker curriculum, based on updated research and victim advocacy, and general enough in nature to encompass the unique needs of the multiple disciplines involved.*
2. *Facilitate multi-disciplinary training - As many child welfare professionals do not receive discipline-specific, foundational training on child sexual abuse and need to rely primarily on external sources for training, the task force recommends the re-establishment of an annual, multi-disciplinary conference or series of workshops that incorporates both foundational and discipline-specific information and resources.*

[2] eg. Finding Words, CornerHouse, APSAC Forensic Interview Training

Children's Justice Act Funding Allocations

To further its primary objectives as a task force on children's justice, the task force promotes and supports activities that:

- Build and support a network to promote the best response to child maltreatment
- Strengthen intervention and prosecution in child maltreatment cases
- Promote effective multi-disciplinary approaches to training and education to improve the identification, intervention, and prosecution of child maltreatment
- Encourage advocacy in the field of child welfare
- Reduce trauma to child victims of abuse
- Encourage collaborative efforts between Georgia's child welfare agency and its external partners

In 2009, the task force recommended the allocation of the state's CJA grant for a wide variety of activities aimed at the improvement of the investigative, administrative and judicial handling of cases of child abuse.

These recommendations include:

1. *Continue the support of several training priorities identified by the Division, including legal services training, SAAG training, and training for crisis and child fatality investigations*
2. *Continue to support task force priorities on multi-disciplinary training on sexual abuse, pre-service training for GALs and summer internships in child welfare advocacy*
3. *Expand to provide additional opportunities to grantees to encourage and support new projects that meet CJA objectives including supplemental training for foster parents on fostering child victims of sexual abuse or sexually-reactive children, and to develop, implement, and evaluate methods for the systematic linkage of existing Georgia data systems related to children in Georgia.*

Georgia's 2009 CJA application included allocations for programs and activities recommended for consideration by the task force.

Looking ahead to 2010…

In fall 2009, task members participated in the third annual citizen review panel retreat. Key activities at the retreat included strategic planning, and identification of CAPTA and CJA

priorities, all of which will continue to direct task force activities in 2010. The task force will concentrate its efforts on the following objectives and activities:

1. Improving the intake screening of reports of child sexual abuse
    - Reviewing child welfare legislation, policy and protocol related to the handling of reports of child abuse
    - Exploring the feasibility of a centralized intake system
2. Reviewing mandated reporter curricula, including CPS policy and protocols, and their impact on reports of child abuse and neglect, particularly cases of child sexual abuse
3. Identifying inconsistencies in the training of professionals involved in the investigation, treatment and prosecution of cases of child maltreatment, particularly child sexual abuse
    - Develop recommendations on improving the coordination of multi-disciplinary training on child sexual abuse
    - Explore feasibility for co-sponsorship of an annual multi-disciplinary conference
    - Develop resource list of trainings available on child sexual abuse
4. Encouraging new projects and activities to further CJA objectives
5. Participating in the implementation, support and monitoring of Georgia's CAPTA PIP

The task force respectfully submits its recommendations for 2009 and requests continued commitment by the Division to improving transparency through open dialogue on task force priorities and helping to identify opportunities for the task force to contribute to systems improvement.

"If we don't stand up for children, then we don't stand for much." *Marian Wright Edelman*

"It has been gratifying to see that CAPTA citizen review panels are beginning to make a difference here in Georgia. Serving as both a citizen review panel and a task force on children's justice, and having such diverse representation, has presented the CJAAC interesting collaborative opportunities that have resulted in some positive changes."

Angela Tanzella Tyner
Co-Chair, Children's Justice Act Advisory Committee

A special note of thanks to Georgia Public Defender Standards Council for hosting CJAAC meetings in 2009.

Appendix A

2009 Children's Justice Act Advisory Committee Members

Angela Tanzella Tyner, JD* (Co-Chair)	Director of Advocacy and Program Development, Georgia CASA, Inc.	*CASA*
Trish McCann, JD* (Co-Chair)	Appellate and Juvenile Advocacy Attorney, Georgia Public Defender's Standard Council	*Defense Attorney*
Stephanie Pearson, PhD*	Child and Adolescent Program Director Department of Behavioral Health & Developmental Disabilities	*Mental Health*
Diana Rugh Johnson, JD	Private Practice	*Parent Attorney*
Melissa Carter, JD*	Director, Office of the Child Advocate	*Child Advocate*
Mary Joyce Bacon	Program Manager Child Protection Center Children's Healthcare of Atlanta	*Health Professional*
Beth Locker, JD	Policy Director Voices for Georgia's Children	*Attorney*
Lisa Ellis, LSCW	Clinical Supervisor, Morningstar Treatment Services, Inc.	*Mental Health*
Cynthia Howell	Executive Director Georgia Children's Advocacy Centers	*Child Advocate*
Lauren Bowen, JD	Troup County Juvenile Court	*Attorney Child Advocate*
Laliane Briones, JD	Prosecuting Attorneys Council of Georgia	*Prosecuting Attorney*
Vale Henson	Social Services Field Program Specialist Region IV, Permanency Expediter	*Child Protective Services*
Vala Peyton	Project Manager Adoptive & Foster Parent Association of Georgia	*Foster Parent Advocate*
Paula Sparks	Cobb County Police Department Crimes Against Persons	*Law Enforcement*
DHS /DFCS Support and Coordination		
Ann D. Pope	DHS/DFCS, State Director Promoting Safe and Stable Families	*Child Protective Services*
Susan Denney	DHS/DFCS, Strategic Planning Unit Director, Office of the Deputy Director, Programs and Policy	*Child Protective Services*
Deb Farrell	Care Solutions, Inc.	*CAPTA Project Coordinator*

* Members of CAPTA Steering Committee

Appendix B

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survey title:
GA Children's Justice Act Task Force Survey Edit Title

design survey | collect responses | analyze results

- Edit Survey
- Survey Options
- Print Survey
- Restore Questions

Edit Survey

Preview Survey

To change the **look** of your survey, select a theme below.

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Page #1 Edit Page | Move | Copy | Delete | Add Logic — Show this Page Only

1. Please tell us about your role in the care and protection of Georgia's children.

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* Please identify the geographic area/region that includes the county/counties where you perform the majority of your c work/activities. If your role is not limited to a specific locale and has statewide responsibilities, select "Statewide".

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* Which of the following best describes your involvement or role in Georgia's child welfare system?

If other, please describe:

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* How long have you served in this role?

- Less than 1 YR
- 1-3 YRS
- 3-5 YRS
- 5-10 YRS
-

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* If you serve on any of the following local committees or panels, please indicate which one(s). If you do not particpate o

- Child Abuse Protocol Committee
- Child Fatality Investigation or Review Team
- Multi-Disciplinary Team
- None
- Other

Other (please specify)

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2. REPORTING SUSPECTED CHILD ABUSE

The task force would like your opinion on the reporting of suspected child abuse in your community.

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Based on your experience or knowledge, select the response which you feel best describes each of the following items:

	More than Adequate	Adequate	Less than Adequate	Don't Know
Community awareness of child abuse and neglect	○	○	○	○
Ease of making a report	○	○	○	○
Reporting compliance by mandated reporters	○	○	○	○
Availability of mandated reporter training	○	○	○	○

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If you indicated that community awareness of child abuse and neglect was less than adequate, in what area(s) do you feel additional information would be helpful?

- ☐ How to recognize child neglect
- ☐ How to recognize child abuse
- ☐ How to recognize child sexual abuse
- ☐ When to make a report
- ☐ How to make a report
- ☐ Resources for families to prevent child abuse and neglect

Other (please specify)

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Is there a need for additional mandated reporter training in your community?

- ○ Yes
- ○ No
- ○ Don't Know/Not Sure

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3. DFCS HANDLING OF CASES OF CHILD ABUSE

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Based on your experience with Georgia's child welfare system, indicate which best describes DFCS' handling of each of the following items:

	More than Adequate	Adequate	Less than Adequate	Don't Know
Reports of suspected neglect	○	○	○	○
Reports of suspected physical abuse	○	○	○	○
Reports of suspected sexual abuse	○	○	○	○
Concerns of person making report	○	○	○	○
Response time to reports	○	○	○	○

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OVERALL, how would you rate the effectiveness of DFCS in the intake and screening of reports of suspected abuse?

Extremely Effective	Very Effective	Somewhat Effective	Not Very Effective	Don't Know

How could they be more effective? (Optional)

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Based on your experience with Georgia's child protection agency, indicate which best describes DFCS' investigation and assessment of child abuse reports in each of the following areas:

	More than Adequate	Adequate	Less than Adequate	Don't Know
Use of risk assessment tool				
Timely medical assessments				
Timely mental health assessments				
Assessment resources in cases of suspected sexual abuse				
Assessment resources in cases of suspected commercial exploitation of children				

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OVERALL, how would you rate the effectiveness of DFCS in the investigation and assessment of reports of suspected abuse?

Extremely Effective	Very Effective	Somewhat Effective	Not Very Effective	Don't Know

How could they be more effective? (Optional)

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Based on your experience with Georgia's child protection agency, indicate which best describes DFCS' intervention and treatment in cases of child abuse in each of the following areas:

	More than Adequate	Adequate	Less than Adequate	Don't Know
Engaging and supporting children				
Engaging and supporting parents/caregivers				
Engaging and supporting fathers				
Identification and engagement of other relatives				
Medical resources or services				
Mental health resources or services				
Substance abuse treatment resources or services				
Resources for children				

have been victims of abuse	○	○	○	○
Referral of children ages 0-3 in substantiated cases of abuse to "Babies Can't Wait"	○	○	○	○

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OVERALL, how would you rate the effectiveness of DFCS in its intervention and treatment in cases of abuse?

○ Extremely Effective ○ Very Effective ○ Somewhat Effective ○ Not Very Effective ○ Don't Know

How could they be more effective? (Optional)

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Based on your experience with DFCS staff, indiate whether you agree or disagree with the following statements:

	Agree	Disagree	Don't Know
Caseworkers are well trained	○	○	○
Caseworkers are knowledgeable about the dynamics of child sexual abuse	○	○	○
Caseworkers are responsive to the individual needs and concerns of children and families	○	○	○
Caseworkers are well prepared for court	○	○	○
Supervisory staff are experienced	○	○	○
Administrators are supportive	○	○	○

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What do you feel is the biggest single challenge facing a DFCS caseworker?

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4. LAW ENFORCEMENT INVESTIGATIONS OF CHILD ABUSE REPORTS

If you do not feel that you have enough experience with law enforcement investigations of child abuse to comment, please skip this page and go to page 5.

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Based on your experience or knowledge of law enforcement investigations in cases of suspected child abuse, indicate whether you agree or disagree with the following statements.

	Agree	Disagree	Don't Know/Not Sure
Investigators are knowledgeable about child abuse	○	○	○

Investigators are knowledgeable about sexual abuse	○	○	○
Investigators are knowledgeable about commercial sexual exploitation of children	○	○	○
Investigators are experienced in dealing with volatile youth/family situations	○	○	○
Investigators are knowledgeable about when to refer for a medical evaluation	○	○	○
Investigators have the skills and/or resources to address issues of children with disabilities who are victims	○	○	○

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How effectively do you feel that law enforcement and DFCS work together in the investigation of cases of abuse?

○ Extremely Effective ○ Very Effective ○ Somewhat Effective ○ Not very Effective ○ Don't Know/Not Sure

How could they be more effective?

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OVERALL, do you feel that law enforcement investigators receive sufficient training on child abuse?

○ Yes
○ No
○ Don't Know/Not Sure

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OVERALL, do you feel that law enforcement investigators receive sufficient training on sexual abuse?

○ Yes
○ No
○ Don't Know/Not Sure

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5. CRIMINAL PROSECUTION OF CHILD ABUSE AND NEGLECT

If you do not feel that you have enough experience with the criminal prosecution of child abuse to comment, please skip this page and go to page 6.

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Based on your experience and knowledge of the criminal prosection of child abuse, select the response which you feel best describes the following items.

	More than Adequate	Adequate	Less than Adequate	Don't Know
Coordination between criminal and juvenile courts	○	○	○	○
Timely prosecution	○	○	○	○
Successful prosecution of cases of child abuse	○	○	○	○
Successful prosecution in cases of sexual abuse	○	○	○	○
Successful prosecution in cases of commercial sexual exploitation of children	○	○	○	○

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Based on your experience or knowledge of criminal prosecution of child abuse cases, indicate whether you agree or disagree with the following statements.

	Agree	Disagree	Don't Know/Not Sure
Prosecutors have the skills and/or resources for working with children with disabilities who are victims	○	○	○
Prosecutors have the skills to minimize additional trauma to child victims	○	○	○
Supports and advocacy resources are available for child victims and their families	○	○	○
Cases are prosecuted in a manner that ensures fairness to the accused	○	○	○

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How effectively do you feel that prosecutors and DFCS work together in the criminal prosecution of cases of abuse?

○ Very Effectively ○ Effectively ○ Somewhat Effectively ○ Don't Know/Not Sure

How could they be more effective? (Optional)

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OVERALL, do you feel that prosecutors receive sufficient training on handling cases of child abuse?

○ Yes
○ No
○ Don't Know/Not Sure

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OVERALL, do you feel that prosecutors receive sufficient training on handling cases of sexual abuse?

○ Yes
○ No
○ Don't KNow/Not Sure

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6. JUVENILE COURT HANDLING OF CASES OF CHILD ABUSE

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Based on your experience or knowledge of juvenile court proceedings in deprivation cases, indicate whether you agree or disagree with the following statements.

	Agree	Disagree	Don't Know/Not Sure
Appropriate priority is given to cases of child abuse	○	○	○
Deprivation cases are resolved in a timely manner	○	○	○
GAL/child attorney or CASA is appointed for every child	○	○	○
Consultations with children are age and developmentally appropriate	○	○	○

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How effectively do juvenile courts and DFCS work together in the disposition of cases of child abuse in your community?

○ Very Effective ○ Effective ○ Not Very Effective ○ Don't Know/Not Sure

How could they be more effective? (Optional)

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In general do you feel that each of the following professionals receive sufficient training on child abuse?

	Yes	No	Don't Know/Not Sure
Judges	○	○	○
SAAGs	○	○	○
Guardian ad litem(child attorneys)	○	○	○

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In general, do you feel that the following professionals receive sufficent training on sexual abuse?

	Yes	No	Don't Know/Not Sure
Judges	○	○	○
SAAGs	○	○	○
Guardian ad litem(child attorneys)	○	○	○

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7. TELL US ABOUT YOUR EXPERIENCE AND TRAINING INVOLVING CASES OF CHILD SEXUAL ABUSE.

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* **How frequently do your cases involve sexual abuse?**

- Always
- Frequently
- Occasionally
- Never

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* **Indicate amount of training and education you have received on child sexual abuse.**

	None	1-4 Hours	4-8 Hours	8+ Hours
Mandatory training or education				
Optional training or education				
Ongoing or continuing education training (in past year)				

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* **Do you feel you have had sufficient training to fulfill your role in cases of sexual abuse?**

- Yes
- No

If no, what additional training would be helpful?

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8. ADDITIONAL FEEDBACK REQUESTED...

The Child Abuse Prevention and Treatment Act (CAPTA) requires that every child involved in a deprivation case be represented by a Guardian ad litem.

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In the course of your work, if you are involved in deprivation cases, please indicate how frequently every child is appointed a Guardian ad litem and how they are repesented.

	Always	Most cases	Some cases	Never
Attorney Guardian ad Litem only				
Lay (non-Attorney) Guardian ad Litem (other than CASA) only				
CASA only				
CASA in addition to an Attorney Guardian ad Litem				
Lay Guardian ad Litem in addition to an Attorney				
Child Attorney				

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9. What have we missed?

The goal of this survey is to help the task force identify areas for improvement in Georgia's child welfare practices with respect to the investigation and prosecution of child abuse and neglect cases, and particularly cases involving sexual abuse and child fatalities.

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Please take this opportunity to comment on any issue(s) not addressed in this survey that you feel warrants attention.

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Child Fatality Review Panel

Georgia's Child Abuse Prevention and Treatment Act (CAPTA)
Citizen Review Panel 2009 Annual Report

Child Fatality Review Panel

Georgia CAPTA Citizen Review Panel
2009 Maltreatment Committee Summary Report

History

The Georgia Child Fatality Review Panel (Panel) is a statutory body whose creation was mandated by the Georgia State Legislature in 1990. Since that time, laws governing the membership, organization and functions of the Panel have been amended to reflect changes deemed appropriate by the state legislature and Governor. In 2008, the legislature found that the work of the CFRP would be more efficiently and effectively served by placing the functions of its Panel and staff under the supervision of the Office of the Child Advocate for the Protection of Children (OCA). During 2009, the staff, budget, and all assets of the two agencies were consolidated to allow for integration of all functions and responsibilities, and the unified agency moved to office space shared with the Governor's Office for Children and Families (GOCF), which subsumed the state Children and Youth Coordinating Council and Children's Trust Fund to foster enhanced collaboration between the two agencies.

The membership of the Panel is set forth in state law O.C.G.A. § 19-15-4, and is essentially comprised of the heads of all state agencies which play a significant role in the health and welfare of the children in Georgia, as well as representatives of agencies/offices involved in the investigation, prosecution and prosecution of criminal offenders. In addition to the agency heads identified in the statute, other members are appointed to the Panel by the Governor, with the exception of one appointment by the Lt.

Governor and one by the Speaker of the House of Representatives. The Panel meets quarterly.

The Panel and staff, at the direction of the Panel, review and monitor the work of the 159 county Child Fatality Review Committees (CFRC) and make recommendations based upon their findings and issues raised by both the local committees and the Panel after reviewing state-wide trends. *See Appendix A for summary findings on 2007and 2008 child deaths.*

While Georgia law sets forth the duties and membership of the Panel, there is no statutory provision which mandates that the Panel serve as one of Georgia's citizen review panels (CRP) for purposes of the federal Child Abuse Protection and Treatment Act (CAPTA). However, as the recipient of state CAPTA grant, the state is required to establish and maintain three CRP and may designate existing entities to satisfy this requirement and in 2006, the state Department of Human Services designated the Panel as one of the three citizen review panels to satisfy this obligation as a recipient of a CAPTA grant. The other two Georgia CRPs are the Children's Justice Act Advisory Committee (CJAAC), which also serves and dual role, and the Child Protective Services Advisory Committee (CPSAC).

Section 106 of CAPTA legislation describes the function of CRPs:

> *"… Each panel established pursuant to paragraph (1) shall, by examining the policies, procedures, and practices of State and local agencies and where appropriate, specific cases, evaluate the extent to which State and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with—*
>
> *i. the State plan under subsection (b) of this section;*
>
> *ii. the child protection standards set forth in subsection (b) of this section; and*
>
> *iii. any other criteria that the panel considers important to ensure the protection of children, including—*
>
> *I. a review of the extent to which the State and local child protective services system is coordinated with the foster care and adoption*

programs established under part E of title IV of the Social Security Act [42 U.S.C. 670 et seq.]; and

II. ***a review of child fatalities and near fatalities*** *(as defined in subsection (b)(4) [of this section]). "*[1]

In response to its obligation as a CRP, the Panel established a maltreatment committee in 2008 to specifically address its obligations as a CAPTA citizen review panel as it relates to child maltreatment-related deaths.

2009 Activities and Accomplishments

Three representatives from Panel serve on a joint CAPTA panel steering committee with members from the other two CRPs. Representatives from Georgia's child welfare agency are invited to attend to provide subject matter expertise, as needed. This forum provides an opportunity for inter-panel collaboration, coordination of panel activities and joint planning with Georgia's child welfare agency. This group meets quarterly.

Representatives from each of the CRPs attended the national citizen review panel conference in May 2009. Presentations and workshops included topics such as improving transparency in child welfare; effective private/public partnerships; and information on national child welfare data and the Fostering Connections Act. The conference provided an opportunity for Georgia representatives to network with citizen review panel members from other states and gain insight into the common challenges facing all citizen review panels and their state's child welfare agencies.

Panel members or their proxies were invited to participate in a workgroup convened by the Division in response to assist in the development of a CAPTA Program Improvement Plan (PIP) to improve Georgia's compliance with respect to its obligations as a CAPTA grant recipient. Of particular interest to the Panel is:

[1] Section 106 Child Abuse Prevention and Treatment Act as amended by the Keeping Children and Families Safe Act of 2003

> *"…provisions which allow for public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality"*[2]

During the 2009 legislative session, the Georgia Code was successfully amended by Senate Bill 79 to require public disclosure of "near-fatalities" to satisfy the CAPTA disclosure provision.

Representatives from the Panel continue to serve on the CAPTA PIP public disclosure workgroup, have consulted on the development of the action plan to address the CAPTA deficiency, and will participate in the ongoing monitoring and evaluation of the state's progress toward successful implementation. These representatives have also been consulted and engaged in the re-establishment of an inter-agency, inter-discipline collaborative process to review maltreatment-related child deaths and serious injuries for families with DFCS CPS involvement or children in foster care.

To improve reporting fidelity, the Panel recommended and supported a change in data collection by transitioning to the National Child Death Reporting Tool.

Georgia Code requires the establishment of a child abuse protocol committee in each county. These committees are charged with the development and implementation of a child abuse protocol to improve multi-disciplinary collaboration in the investigation, treatment and prosecution of child abuse and neglect, including child fatalities. In 2009, OCA, with the support and involvement of the Panel, convened and facilitated a meeting of stakeholders for the purpose of updating the State Model Child Abuse Protocol. The model protocol and/or technical assistance by the Panel staff is made available to local child abuse protocol committees to use as a standard for their individual protocols.

Also in 2009, the Panel updated and published its "Framework for Childhood Injury Prevention," a 59-page document available online at the Child Fatality Review Panel's

[2] Child Abuse Prevention and Treatment Act as amended by The Keeping Children and Families Safe Act of 2003

website. This document provides a framework for use by local communities and governmental agencies for planning and collaboration on child injury prevention efforts. The framework focuses on primary prevention, i.e., preventing the injury-causing event, promoting use of evidence-based interventions and targeting injury-related health disparities. The four goals supporting the mission of preventing childhood injuries are (1) Increasing awareness of the social and financial impact of childhood injuries; (2) Promoting use of a systematic planning process that incorporates use of evidence-based intervention; (3) Encouraging collaboration among all child-serving organizations, and (4) Evaluating progress toward its mission and goals at all levels.

Recommendations

Based on the work of the Panel, its staff, and the maltreatment committee, the following CFR recommendations are put forth for consideration:

- Continued expansion and support of local child abuse investigative teams trained in the multi-disciplinary approach to death scene investigations
- Routine training for hospital staff, community medical providers and other categories of mandated reporters on identification of child abuse, injury prevention strategies and how to make a report to DFCS
- Develop public awareness campaign to target risks of co-sleeping, shaken baby, and drowning
- Provide resource referrals and materials to new parents to educate on coping strategies, child development, appropriate discipline, and parent support groups (e.g., “Period of Purple Crying” program, “Better Brains for Babies,” and American Academy of Pediatrics “Practicing Safety” training modules)
- Reconstitution of multi-disciplinary, multi-agency team to examine causes and circumstances of deaths, near-fatalities and serious injuries as reported through Child Death and Serious Injury (CDSI) procedure
- Develop mechanism by which “near-fatalities” that result from child maltreatment will be made publicly available so as to enhance system transparency and accountability

- Develop definition of "child maltreatment" that can be consistently applied across contexts and encompass the components of fatal neglect and fatal abuse
- Develop, implement, and evaluate methods for the systematic linkage of existing Georgia data systems related to children in Georgia

Moving Forward…

In the fall of 2009, Panel members participated in the third annual citizen review panel retreat to develop a platform for 2010. The maltreatment committee will turn its attention to examining the following:

- Reviewing literature and sample of CPS cases, and compare other state statutes to determine current utilization of Georgia's Safe Haven law and the efficacy of any protections.
- Reviewing inconsistencies between deaths identified as maltreatment-related by local child fatality teams and those identified by DFCS
- Developing a process for identifying maltreatment-related child deaths for further review by the maltreatment committee and the Panel
- Expanding and enhancing the "Framework for Childhood Injury Prevention" to incorporate a more comprehensive maltreatment prevention component
- Improving the timeliness and accuracy of the reporting child deaths
- Developing a framework for improving child death investigations involving children with special needs
- Evaluating cases and data to determine risk factors associated with child maltreatment-related fatalities and near-fatalities
- Examination of Georgia's mandated reporting statute and those of other states

Respectfully submitted for consideration,

J. David Miller
Chairman, CAPTA Maltreatment Committee

GEORGIA CHILD FATALITY REVIEW PANEL

Annual Report
Calendar Years 2007-2008

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Mission

The Mission of the Georgia Child Fatality Review Panel is to provide the highest quality child fatality data, training, technical assistance, investigative support services and resources to any entity dedicated to the well being and safety of children in order to prevent and reduce incidents of child abuse and fatality in the state. This 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.

Acknowledgements

The Georgia Child Fatality Review Panel wishes to acknowledge those whose enormous commitment, dedication, and unwavering support to child fatality review have made this report possible. These include:

- All the members who serve on each of the county child fatality review committees and child fatality investigation teams
- John Carter, Ph.D. Epidemiology Department, Rollins School of Public Health, Emory University
- Katherine Kahn, MPH, Maternal and Child Health EpidemiologyDivision of Public Health, Department of Community Health
- Jimmy Clanton, Graphic Designer, Department of Community Health
- All the other public and private agencies that have so willingly collaborated with this office and provided support

GEORGIA CHILD FATALITY REVIEW PANEL

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The Georgia Child Fatality Review Panel is an appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data. Two year appointments are made by the governor except as otherwise noted.

[1]Appointed by the Lieutenant Governor
[2]Appointed by the Speaker of the House of Representatives
[3]Ex-Officio

Georgia Child Fatality Review Panel

Dear Governor and Members of the Georgia General Assembly:

On behalf of the Georgia Child Fatality Review Panel, it is my privilege to present this report providing information on child deaths occurring in Georgia during 2007-2008. As you know, the Panel is charged with the responsibility of gathering this information and providing some analyses and recommendations respecting the reduction and prevention of child fatalities. The information contained in this Report is disturbing, as it is with every report the Panel makes. It is disturbing because it reflects the suffering and death of Georgia's most innocent – most precious – citizens. It is our hope, however, that the information contained in this Report will assist you in your efforts to protect children. We recognize that you will not end this evil with legislation or policy; the problem is complex and demands the attention of everyone. Nevertheless, it is you who provide the leadership in the struggle, and for that we are grateful. Please know that this Panel, local review committees, and numerous participating agencies are following your lead and working tirelessly to end the violent and preventable deaths of Georgia's children.

Edward D. Lukemire
Chairperson,
Georgia Child Fatality Review Panel

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PREFACE

Focusing on Health

Most of my 30+ year career has been dedicated to working to improve the lives of children and families. Child fatality review was a relatively new concept when I accepted the responsibility of directing the program for the State of Georgia. I wondered if delving into the "hows and whys" of child deaths could significantly impact future outcomes. Was it really possible to intervene in ways that would keep kids alive? I have come to know that yes, it is possible to save the lives of numerous children who die every day. Many of the circumstances that steal the lives of children are indeed predictable and preventable.

Over the past years, much of our attention in the child fatality review field has been focused on injury-related deaths; however, a number of child deaths are the result of medical conditions that are also preventable. Risk factors for some of these child deaths include low birth weight, prematurity, obesity, undetected heart conditions, inappropriate drug administration to young children, and lack of accessible health care, to name a few.

The news media has reported on several infectious outbreaks and medical deaths in recent years which require our constant vigilance and attention to maintaining good health. We were informed of the newest influenza outbreak, H1N1, also known as "swine flu". We learned of outbreaks in schools across the country and around the world. Children and young people between the ages of 6 months and 24 years were believed to be at an increased risk for catching H1N1 flu and for developing health problems from it. We were warned about the overweight and obesity epidemic in children, vaccine injuries in infants and young children, a nationwide increase in vaccine-preventable illnesses, and increases in premature births and births to teens.

CFR has reviewed data on all of the deaths related to these medical conditions, including those deaths related to medicines and drug treatments. CFR has also reviewed reports on children dying from obesity-related complications, enlarged or otherwise impaired heart complications, and complications from pneumonia and asthma. Even the benign act of providing medicines to a young child to alleviate their symptoms can trigger a fatal reaction. These are medical conditions that can be identified and treated early, preventing a tragic death. Our data show that many medical deaths in children can be prevented by simple measures – regular health checkups with a trained medical professional, improved health literacy to read and understand dosages, maintaining a normal body weight, and maintaining a clean environment.

It is very important, now more than ever, to maintain the health of children, and be conscious of the signs and symptoms that can indicate a serious illness. CFR is committed to working with county child fatality review committees to increase the review of preventable deaths due to medical causes, and to advocate for messages that encourage parents and caregivers to know the risks and benefits of physical activity, medical treatments, and other health care for children. Prevention is a constant activity, and we, collectively, should promote the message that prevention must be an integral part of parenting and providing care for a child.

Eva Johnson, LCSW

Executive Director

Executive Summary

The Georgia Child Fatality Review Panel (Panel) publishes an annual report chronicling the tragic, preventable deaths of children in Georgia. Child deaths are identified through death certificate data provided by the Office of Vital Records within the Division of Public Health. Local child fatality review committees review only those deaths that are sudden, unexpected, or unexplained ("eligible"), and complete a standardized form detailing the circumstances of the deaths. That information is compiled and used in the Panel's report. The Panel is charged with tracking the numbers and causes of child deaths as well as identifying and recommending prevention strategies that could reduce the number of child deaths.

This year, the Panel is providing a report detailing the circumstances of child deaths occurring during 2007-2008. Because complete Vital Records data for 2008 child deaths were unavailable at the time of this publication, this report focuses on the 1,252 child deaths reviewed by child fatality review committees for the 2007-2008 period. Considering aggregated child death data year to year is useful in revealing recurring patterns and indicating prevention gaps and opportunities. We encourage parents, communities, organizations, and policymakers to use these data to make life-saving decisions for children.

Key Findings

FATAL CHILD ABUSE/NEGLECT

Department of Family and Children Services reported that 60 children in Georgia died as a result of substantiated abuse or neglect in 2007 (2008 data not posted). Those deaths were investigated by DFCS, and did not include deaths that were handled by law enforcement or the courts without DFCS involvement. Forty children died as a result of inadequate supervision or of other forms of parental neglect, and another 20 children died from physical abuse. Of the 60 children, 35 had no current or prior history with Child Protective Services; 25 were from families that had been investigated at some time prior to the child's death.

Child fatality review committees determined that in 2007-2008, 270 child deaths resulted from both confirmed and suspected abuse/neglect - 145 confirmed and 125 suspected. The number of deaths with confirmed abuse/neglect for 2007 alone was 82. Children under the age of five accounted for 84% (226) of the reviewed abuse/neglect-related deaths. Perpetrators were identified in 190 of the 270 abuse/neglect related deaths, as well as relationship of the perpetrator to the child. More than one perpetrator was identified in 44 child abuse/neglect deaths. Sixty-one percent (61%) of perpetrators identified in child abuse/neglect deaths were natural parents. Homicide was the cause of 81 confirmed abuse /neglect deaths.

NATURAL

Child fatality review committees reviewed 452 deaths from natural causes (medical or SIDS/SUID). Two hundred sixty-eight (268) of those deaths were reported as SIDS or SUID. (SUID – Sudden Unexplained Infant Death - is a term used for a death that appears to be SIDS, but has other factors that *could* have contributed to the death.) Committees are required to review all SIDS/SUID deaths, as well as medical deaths that are unexpected or unattended by a physician. Medical deaths reviewed included conditions related to asthma, spinal, or heart-related complications.

UNKNOWN

Child fatality review committees reported 23 deaths due to unknown causes. Eleven of those deaths occurred among infants. An unknown cause of death is reported by review committees when the information gathered from the scene investigation, family circumstances, medical history and autopsy cannot conclusively determine what caused the death of the child.

INJURIES

Child Fatality Review committees reviewed 800 deaths that resulted from injuries in 2007 - 2008, but 14 of those deaths listed an unknown intent. Unknown intent is reported by the review committee when the information gathered from the scene investigation, family circumstances, medical history and autopsy cannot conclusively determine the intentionality of the injury that caused the child's death. Among infant deaths reviewed, there were 169 known injury-related deaths, including deaths from homicides, motor vehicles, and asphyxia. There were 594 deaths in children ages 1-17 resulting from known injuries, either intentional (inflicted) and unintentional (accidental).

Unintentional Injuries

Child fatality review committees reviewed 428 deaths attributed to unintentional injuries among children ages 1-17. Child fatality review data indicated the three leading causes of death related to unintentional injury for this age group as:

- 239 motor vehicle incidents
- 70 drowning incidents
- 27 poison-related incidents

Intentional Injuries
Child fatality review committees reviewed 166 deaths to children ages 1-17 from intentional causes – 127 homicides and 39 suicides.

FIREARM DEATHS
Child fatality review committees reviewed 119 firearm-related deaths. Eighty-two percent (98) were intentional (79 homicides and 19 suicides). The type of firearm was identified in 102 of the 119 reviewed firearm-related deaths. Handguns were most frequently used (87 of the 102 deaths where type of firearm was identified).

PREVENTABILITY
A primary function of the child fatality review process is to identify those deaths believed to be preventable. The issue of preventability was addressed in 1,248 of the 1,252 child deaths reviewed.

Child fatality review committees determined that 84% (1,048) of the 1,252 reviewed child deaths with preventability data were definitely or possibly preventable. Of the 270 reviewed abuse/neglect deaths, 98% were determined to be definitely or possibly preventable.

AGENCY INVOLVEMENT
Child fatality review committees reported that in 176 (65%) of the 270 child abuse/neglect related deaths, the child and/or family had prior involvement with at least one state or local agency. Committees re also asked to determine which of the total deaths reviewed could have been prevented with agency involvement and 16 deaths were identified. While not all of those 16 deaths had findings that identified abuse or neglect, seven of the 16 did have an abuse/neglect determination ("confirmed abuse" for three, "confirmed neglect for two, and "suspected neglect" for two).

Accomplishments, Recommendations, and Goals of the Georgia Child Fatality Review Panel 2009

CFR Accomplishments

1. Continued legislative recognition of county efforts through Senate resolutions for "Coroner of the Year", "County Committee of the Year", and "CFIT Team of the Year
2. Published and distributed an updated "Framework for Childhood Injury Prevention Planning", and convened a multi-disciplinary steering committee to promote the framework statewide
3. Enhanced fatality surveillance and data collection by transitioning to the National Child Death Reporting Tool

a. Convened statewide meeting with stakeholders for the purpose of updating/revising the State Model Child Abuse Protocol

4. Continued partnerships by providing training and collaboration with the Governor's Office of Highway Safety, Georgia Alliance for Drug Endangered Children, Criminal Justice Coordinating Council, Division of Public Health, Georgia Bureau of Investigation, Children's Healthcare of Atlanta, Georgia Coroner's Association, and the Governor's Office for Children and Families
5. Continued support of child abuse and child fatality investigation teams, encouraging a multi-disciplinary approach and offering training and consultation
6. Developed the Georgia Child Abuse Training Academy and offered training to local child abuse teams delivered by subject matter experts
7. Awarded a three-year grant from the CDC to improve local investigations, reviews, and reporting of sudden and unexpected infant deaths
8. Continued administration of the Georgia Infant Safe Sleep Coalition, sponsored by the CFR Panel, said group being awarded a grant by the CJ SIDS Foundation

On-going Legislative Recommendations

1. Recommend, in the interest of improving stakeholder representation and Panel functionality, that three new positions be added to the Panel for inclusion; Governor's Office of Highway Safety, Department of Education, Emergency Medical Services
2. Recommend that three new members be required to participate on the local CFR committees - EMS, Schools, Medical Provider
3. Establish a study committee to address the needs pursuant to the abandonment of infants up to 90 days old, and anonymity for the mother

On-going Agency Recommendations

1. **Division of Public Health:** The Panel recommends that Vital Records provide monthly death certificate reports to the Panel to facilitate a timely review of child deaths in each county
2. **Georgia Coroner Association:** Expand current annual training to include improved death scene investigations for any child death that is suspicious, unexpected, and/or unexplained, and timely autopsy reports
3. **Department of Education:** support infant care training and SIDS risk reduction into middle and high school curricula
4. **Department of Behavioral Health and Developmental Disabilities :** Redirect a portion of crisis funding for children's mental health services to devote more resources to preventive care, especially for those identified as "at risk"

Information Sources and Inconsistencies

This annual report addresses calendar years 2007 and 2008 infant and child fatality review (CFR) data collected by the Georgia Child Fatality Review Panel. This report also includes 2007 death certificate (DC) data collected by the Office of Vital Records and prepared by the Office of Health Information and Policy (OHIP). (Complete death certificate data for 2008 was not available in time for inclusion in this report. A preliminary, incomplete file was provided by Vital Records and was used to identify reviewable 2008 deaths. The 2008 DC list was supplemented by identified deaths from coroners and medical examiners.) Child fatality review reports are the primary source of data for this report.

The death certificates provide the ICD-10 coding (International Classification of Diseases, Revision 10) for the cause of death, and are used (if available) to identify the set of "reviewable" infant and child deaths. For child fatality review purposes, the relevant ICD-10 codes include deaths due to unknown or undetermined causes, SIDS, and any death due to accident or violence. In addition, a medical examiner, coroner, or CFR committee may also determine that a death should be reviewed because of the circumstances of the death (e.g., the child was not under the care of a physician). Accordingly, the total number of reviewed deaths in a county may exceed the number of deaths identified as "reviewable" based on death certificate alone.

Child fatality review reports detail the cause, manner and circumstance of death, supervision at time of death, prior history of abuse or neglect, others identified as causing or contributing to child deaths, and prior agency involvement. Reports also contain information regarding whether a death might have been prevented and what measures might be taken to lessen the likelihood of a similar death occurring in the future.

Although death certificate and child fatality review data do not always agree, the causes of death are generally consistent between the two sources. However, committees often have access to additional information, and may reach a different conclusion regarding the cause and/or manner of death. The system used in the coding of the causes of death on the death certificate, the ordering of reported codes to select the underlying cause, and the collapse of codes into categories all contribute to error in the classification of the death certificate "cause" of death. One of the values of the CFR process is that it provides a check on the death certificate coding of cause.

Processing delays experienced in the Vital Records system as well as data quality issues with the death certificate files complicated the CFR process for 2007 and 2008 child deaths. The DC file was used to identify deaths that are required to be reviewed, and delays in that identification made it more challenging for the county CFR committees to gather information and conduct the reviews. Seventy-two (72) of 612 "reviewable" CY2007 deaths were not reviewed (in contrast, only five were not reviewed in 2004). There were also 32 reviewed deaths that could not be matched to a death certificate. This is a much larger number than usual (compared to 14 in 2004) and may reflect closing the 2007 DC file before all deaths had been entered into the system. No statistics on file links were provided for 2008 reviews since the 2008 death certificate file was incomplete.

Rates were not calculated for 2007-2008 deaths due to the large number of deaths not reviewed. A rate calculated on the reviewed deaths would be inaccurate and skewed. Therefore, the proportion of deaths was presented throughout this report, in order to demonstrate the rate of deaths within the population of all reviewed deaths.

Georgia Child Fatality Investigation Program

The Georgia Child Fatality Investigation Team (CFIT) Program, founded and administered through the Georgia Child Fatality Review Panel, was designed to promote the utilization of best practices in the area of the investigation of suspicious child deaths in Georgia. Recognizing the importance of an immediate and comprehensive response in such cases, experts around the country suggest the utilization of a multi-disciplinary team approach from the inception of such investigations. These teams utilize highly trained representatives from their own district attorney's offices, coroners, and/or medical examiners, local law enforcement agencies, and the Department of Family and Children Services, and immediately respond and share information from the point of the child's death. The original judicial circuits involved in the pilot program include: Lookout Mountain, Middle, Douglas, Dougherty, Stone Mountain, Eastern, Rome, Northeastern, Alcovy, Southern Judicial Circuit, and Tifton. The following judicial circuits enrolled in the program between 2004-2009: Blue Ridge, Bell-Forsyth, Clarke, Rockdale, Gwinnett, Flint, Cobb, Clayton, Macon, Brunswick, Paulding, Towaliga and Coweta.

In 2007, 681 child deaths were reviewed by child fatality review committees. Eighty-seven of those deaths were deemed to be homicides by committees. In 2008, there were 571 child deaths reviewed by child fatality review committees and 75 of those deaths were determined to be homicides by committees. Thus, in both years, at least one child a week was a victim of homicide in Georgia. The quality of investigations in child homicide cases largely determines whether there will be prosecutions in these cases and whether such cases can be successful. In 2009, in an effort to support these investigations and promote a multi-disciplinary approach, the Georgia Child Abuse Training Academy was developed as part of the CFIT Program. The all-volunteer faculty for this program includes Georgia subject matter experts from the fields of medicine, law enforcement, prosecution and child protective services. During 2009, the Academy offered the "Three-Day Basic Child Abuse Training" for teams two times at no cost to participants. Child abuse practitioners from all over Georgia were trained to work on multi-disciplinary teams involving local prosecutors, law enforcement, child protective services, coroners and medical examiners. While earning substantial continuing education credit, trainees had the opportunity to network with other specialists from around the State and to develop relationships with the faculty members for future consultation. Feedback from the training was excellent with trainees indicating on evaluations that they would change aspects of their investigations subsequent to the course.

The CFIT Program Director also acted as Chair of the Georgia Infant Safe Sleep Coalition during 2008 and 2009. This group, involving participants from the public and private realms, seeks to support communities and professionals in the ongoing effort to better educate the public about the hazards of unsafe sleep conditions for infants. Looking at the combined data for 2007 and 2008, there were 373 deaths related to unsafe sleep conditions. Given that these are clearly preventable deaths, the Training Academy will offer courses in 2010 around this subject matter, including pieces on scene investigation and prevention measures.

Finally, in addition to offering training at the local level and through the Training Academy, the CFIT Program continued to offer advice to local jurisdictions upon request. Availing themselves of the case consultation offered through the program, team members received support in many different phases of child abuse and homicide cases, from autopsy to preparation of the indictment. On numerous cases, the program director was able to serve as a liaison and facilitate discussion between the children's hospital, the medical examiner, DFCS and the local law enforcement and prosecution where communication had not yet been established or had broken down. Cases involving fatal and non-fatal physical abuse, neglect, sexual abuse and special needs victims were the focus of investigative support services in 2007-2009. From 2009 forward, participants in the Training Academy will now have easier access to subject matter experts, who serve as faculty, from around the State.

In 2010, in addition to the three-day basic training, the Training Academy will also offer short one-day courses involving topics ranging from scene investigation to techniques for interviewing special needs victims and witnesses. The Children's Justice Act grant supports this work.

When local CFR committees review a child death, they also identify the degree to which that death could have been prevented. They specifically examine the circumstances of the child and the child's family *before* the event, *during* the event, and *immediately after* the event, in an effort to clearly recognize the level of prevention needed to avert a similar death in the future. The review committees define "preventability" based on two criteria: if a death is identified through retrospective analysis to be foreseeable, or is the result of an absence of reasonable intervention.
Of the 1,252 deaths that were reviewed in 2007-08, where the possibility of preventability was reported, the review committees' findings show that 84% of the deaths were considered to be "definitely preventable" or "possibly preventable".

Figure 1: Preventability, All Reviewed Deaths, 2007-2008 (N=1,248)

	Number	Percent
Definitely Preventable	520	41.7%
Possibly Preventable	528	42.3%
Not Preventable	200	16.0%

Figure 1 shows preventability of all reviewed deaths, 2007-2008

Sixty-one percent of unintentional and 71% of intentional injury-related deaths were determined to be "definitely preventable" by the local CFR committees. An additional 33% of unintentional and 23% of intentional injury-related deaths were considered to be "possibly preventable". The committees reported that 513 (65%) of the 784 considered "definitely/ possibly preventable" had at least one risk factor identified prior to the death. The committees also identified 561 (67%) deaths where there had been some community action prior to the death.

Figure 2: Preventability, Unintentional and Intentional Injury Deaths, 2007-2008 (N=761)

	Not at All	Possibly	Definitely
Unintentional Injuries	34	185	341
	6.1%	33.0%	60.9%
Intentional Injuries	14	44	143
	7.0%	21.9%	71.1%

Figure 2 shows preventability for unintentional and intentional injury deaths, 2007-2008

While there are certain circumstances that are unforeseen and not reasonably preventable (i.e.) particular medical situations), many injuries that are reviewed by CFR committees should be considered preventable based on the awareness of risk reduction, safety and prevention messages in the community. It is unlikely that any homicides, suicides, motor vehicle crashes, firearm, or drowning deaths would be considered "not at all preventable". In contrast, 53% of medical deaths were determined to be "not at all preventable". Those deaths were often the result ofunknown risk factors or unidentified hazards in the home.

Figure 3: Preventability by Cause, All Reviewed Deaths, 2007-2008 (N=1,248)

	Not at All	Possibly	Definitely
Medical	98	80	6
SIDS	20	18	0
SUID	29	176	23
Drowning	2	18	54
Fire	0	7	19
Firearm	0	6	14
Motor Vehicle	18	81	154
Other Injury	4	9	17
Poison	2	7	19
Asphyxia	8	57	64
Homicide	8	21	133
Suicide	6	23	10
Unknown Intent	2	6	6
Unknown	3	19	1

Figure 3 shows preventability by cause for all reviewed deaths, 2007-2008

The CFR Panel believes that targeted and data-driven recommendations for prevention can be developed for each community, which could potentially reduce child deaths by a significant percentage. To achieve this, we have developed and promoted Georgia's first Framework for Childhood Injury Prevention Planning (CIPP), which is a tool for policymakers, communities, child health/safety professionals, and parents. This tool provides data on the most significant injuries that require hospitalization, the injuries that lead to deaths, and provides evidence-based programs and policies that are proven to prevent them. Work on the CIPP has involved the enthusiastic efforts of many agencies and organizations, to further education and awareness of prevention and to encourage readiness in communities.

The Panel has also received federal grant funding from the Centers for Disease Control and Prevention (CDC) to strengthen investigations and reviews of those deaths that do not have readily identifiable risk factors – SIDS and SUID. While 81% of the SIDS/SUID deaths were determined to be preventable, there is still a great unknown in the prevention community as to what specific measures can be promoted to make prevention successful. With a three-year grant to support data collection and reporting of infant deaths, we are making efforts to improve the understanding of SIDS/SUID risk factors, which will allow us to design more targeted, data-driven prevention strategies for communities.

Child Deaths in Georgia, 2007

In 2007, Georgia lost 1,850 children ages birth-17 years to deaths due to medical conditions and intentional or unintentional injuries. Previous year information indicated the following:

2004 1,760 deaths
2005 1,723 deaths
2006 1,825 deaths
2007 1,850 deaths

The top three overall causes of death for individuals less than 18 years of age were medical, motor vehicle incidents, and Sudden Infant Death Syndrome (SIDS). The top three causes of death for children have not changed in the past ten years.

Figure 4: Deaths to Children Under Age 18 in Georgia - All Causes Based on Death Certificate, 2007 (N=1,850)

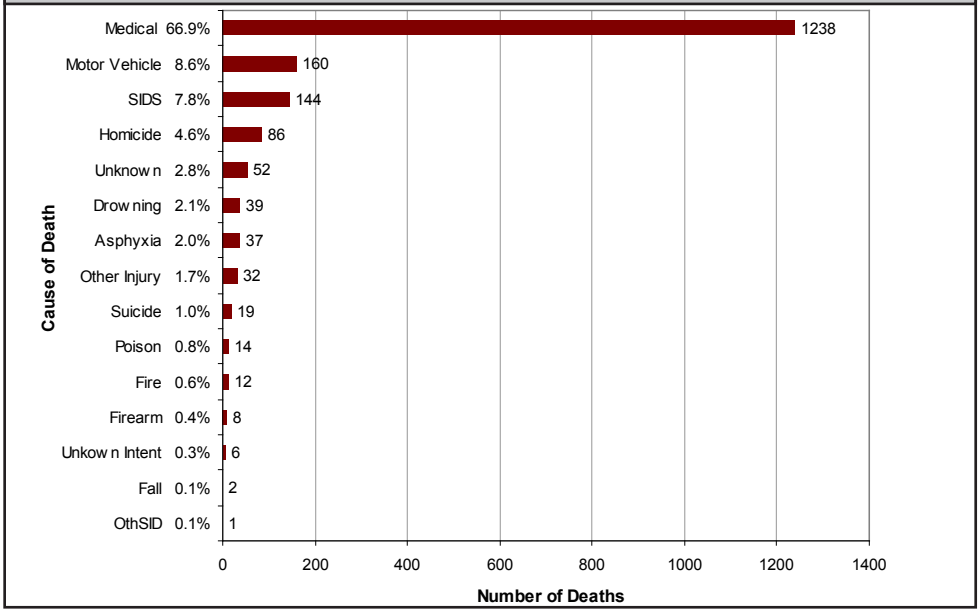


Figure 4 shows all child deaths by cause based on Georgia Vital Records

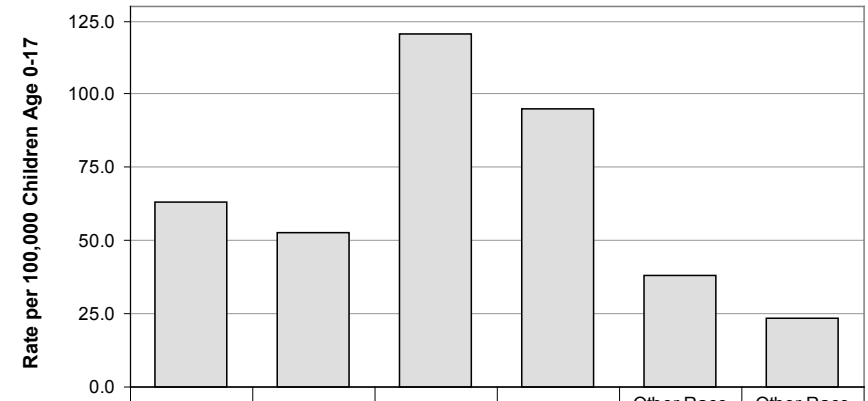
Findings:

- The number of child deaths in 2007 increased from 1,825 in 2006
- Infants accounted for 78% of all medical deaths
- The second leading cause of death overall was motor vehicle incidents with older teenagers representing the majority of those deaths (53%) and 10-14 year olds at 20%

Findings:

- Child deaths occurred disproportionately among African-Americans. The rate for African-American males was 1.9 times higher than that of White males
- Males were more likely to die than females. Within each racial category, the rate for males was higher than for females

Figure 5: All Child Death Rates per 100,000 Children Age 0-17 by Race/Gender Categories, 2007 (N=1,850)



	White Male	White Female	A-A Male	A-A Female	Other Race Male	Other Race Female
Rate	63.4	52.5	120.6	95.2	38.4	23.4
# of Deaths	499	390	521	399	26	15

Figure 5 shows the rate and number of child deaths by race and gender groups

Figure 6: Leading Cause of Death by Age Group, Georgia, 2007 (N=1,850)

	Age Group in Years					
Rank	**<1 1198 (64.8%)**	**1-4 196 (10.6%)**	**5-9 103 (5.6%)**	**10-14 116 (6.3%)**	**15-17 237 (12.8%)**	**All Deaths <18 1850 (100%)**
1	Fetal and Infant Conditions 593 (49.5%)	Drowning 26 (13.3%)	MVC 14 (13.6%) Cancer 14 (13.6%)	MVC 32 (27.6%)	MVC 85 (35.9%)	Fetal & Infant Conditions 596 (32.2%)
2	Birth Defects 194 (16.2%)	MVC 24 (12.2%)	Homicide 9 (8.7%) Other Injury 9 (8.7%)	Major Cardiovascular Diseases 14 (12.1%) Cancer 14 (12.1%)	Homicide 35 (14.8%)	Birth Defects 225 (12.2%)
3	SIDS 144 (12.0%)	Birth Defects 20 (10.2%)	Major Cardiovascular Diseases 7 (6.8%)	Nervous System Diseases 10 (8.6%)	Suicide 16 (6.8%)	MVC 160 (8.6%)
4	Digestive Diseases 39 (3.3%)	Homicide 18 (9.2%)	Nervous System Diseases 6 (5.8%)	Homicide 8 (6.9%)	Nervous System Diseases 14 (5.9%)	SIDS 144 (7.8%)
5	Unknown 33 (2.8%)	Respiratory Diseases 14 (7.1%)	Suffocation 4 (3.9%) Unknown 4 (3.9%)	Respiratory Diseases 6 (5.2%)	Major Cardiovascular Diseases 13 (5.5%)	Homicide 86 (4.6%)

Figure 6 shows the five most common causes of death for each age group, and the percent of all child deaths occurring within each age group

The total number of child fatalities based on death certificate data provides the following information:

Infants

- Sixty-five percent of all child deaths were to infants (less than one year old)
- The second leading cause of death for infants was birth defects such as neural tube defects
- SIDS accounted for 12% of all infant deaths

Ages 1-4 (Early Childhood)

- Eleven percent of all child deaths occurred to children between the ages of one and four
- The majority of medical conditions for this age group included birth defects and respiratory diseases
- Drowning was the leading cause of death for this age group accounting for 13%

Ages 5-9 (Middle Childhood)

- Six percent of all child deaths occurred to children between the ages of five and nine
- Homicide and "other injuries": each accounted for nine of the leading causes of death
- Cancer and motor vehicle-related crashes accounted for the majority of deaths in this age group (each represented 14%)

Ages 10-14 (Early Adolescence)

- Motor vehicle-related crashes accounted for the majority of deaths in this age group (28%))
- Six percent of all child deaths occurred to children between the ages of 10-14
- Leading causes of medical deaths included cardiovascular diseases and cancer

Ages 15-17(Later Adolescence)

- Thirteen percent of all child deaths occurred to children between the ages of 15-17
- Leading causes of medical deaths included cardiovascular and nervous system diseases
- Motor vehicle-related crashes continued to be the leading cause of death for this age group

****Note: 2008 Vital Records Data not available at time of this report****

All 2007-2008 Reviewed Deaths

The purpose of the child fatality review process is to promote effective prevention initiatives by first examining all aspects of children's untimely deaths. These deaths are reviewed by Child Fatality Review Committees which are comprised of local professionals who convene for the purpose of analyzing all circumstances of child deaths. This review process utilizes a multi-faceted approach to providing a comprehensive understanding of the intricacies surrounding each child's death. A child's death is eligible for review when the death is unexpected, unexplained, suspicious, or attributed to unusual circumstances. Child medical deaths are deemed reviewable if unexpected, suspicious, or unattended by a physician (e.g., unexpected heart failure). Child fatality review is a critical component for enhancing our ability to galvanize community efforts toward the reduction of preventable child deaths.

In 2007, 612 of the total 1,850 child deaths met the eligibility criteria for review based on death certificate data (total 2008 death certificate data is unavailable). Committees submitted reports for 88% (540) of those deaths. Committees identified an additional 141 deaths that warranted investigation and review. A total of 681 deaths were reviewed. The distribution of child deaths in Georgia is proportional to the county population as seen below:

- There were 15 counties with ten or more reviewable deaths in 2007. Those counties had over 50% of the child population and accounted for 52% of all reviewable deaths. Those counties reviewed 91% (289) of their 317 reviewable deaths
- There were 105 counties with one to nine reviewable deaths. Those counties reviewed 251 of their 295 reviewable deaths (85%)
- All counties with reviewable deaths reviewed at least one child death. In comparison, there were nine counties that did not review any of their reviewable deaths
- Twelve counties had no child deaths in 2007, and 39 counties had no child deaths that met criteria for review

The top three causes of all reviewed infant and child deaths in Georgia for 2007/2008 combined were motor vehicle-related deaths (20%), sudden unexpected infant death (18%) and medical deaths (15%).

Findings:

- Motor vehicle-related incidents continue to account for the leading cause of reviewed child deaths (20%)
- Homicide deaths accounted for 13% of the total reviewed deaths for 2007-2008 combined. This was .an increase from nine percent in 2006
- Unknown deaths are deaths for which there was no definite cause identified after a review of the scene investigation, clinical history, and/or autopsy findings
- "Other" injury includes accidental blunt head trauma, electrocution, lightning, falls, and heat-related deaths

Figure 7: Causes of Death, All Reviewed Infant/Child Deaths, Georgia, 2007-2008 (N=1,252)

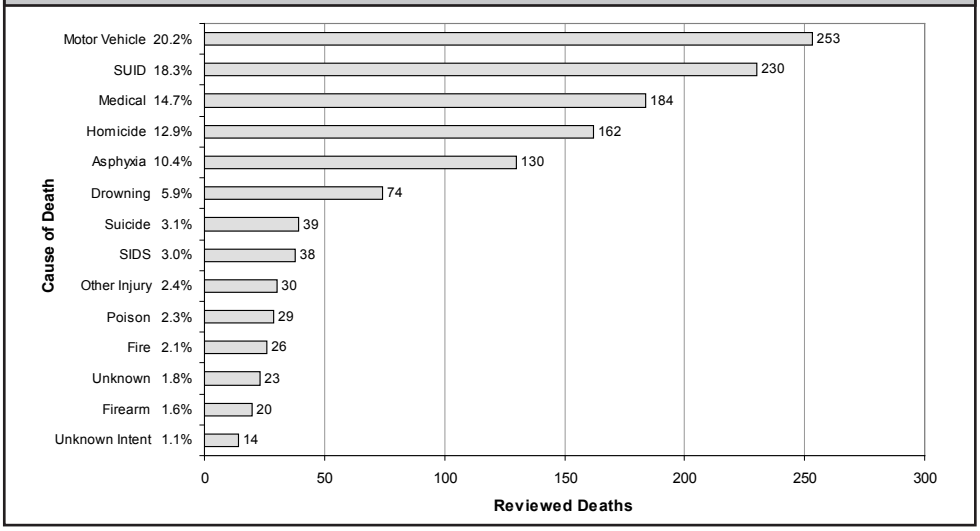


Figure 7 shows the cause of death for all 2007 and 2008 cases reviewed by child fatality review committees. In 2007, 681 deaths were reviewed. In 2008, 571 deaths were reviewed

****Note: Comprehensive reviewability data cannot be reported for 2008. The below cited information is solely based on the number of reports submitted by CFR committees.****

All Reviewed Medical Deaths

Medical deaths are reviewable by child fatality review committees if the death occurs unexpectedly, unattended by a physician, or occurs in a suspicious or unusual manner (for more details on deaths eligible for review, please see Appendix A). Based on these criteria, CFR committees reviewed 102 deaths in 2007 and 82 in 2008. Thirty-eight percent had pre-existing medical conditions with the majority being related to seizures, asthma, and heart complications.

Figure 8: Cause of Death, All Reviewed Medical Deaths by Review Criteria, 2007-2008 (N=184)

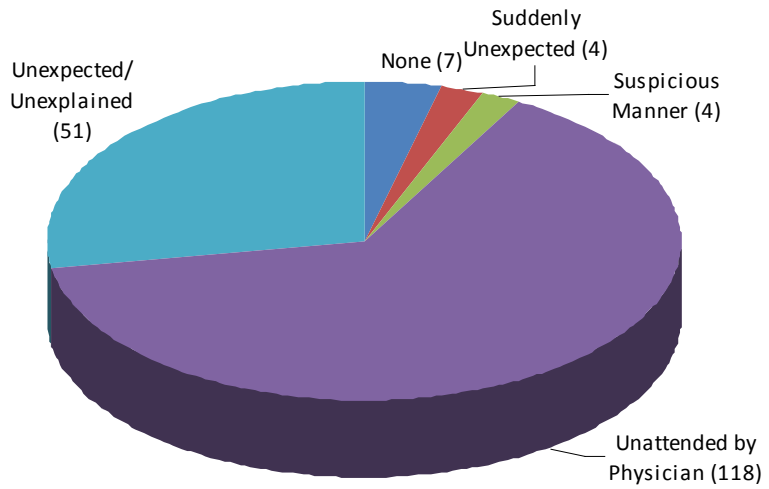


Figure shows medical deaths reviewed based on criteria for review

Findings:

- Twenty-eight percent of the medical deaths were unexpected or unexplained
- Sixty-four percent of medical deaths were unattended by a physician (i.e., a child experienced a death as a result of a medical condition outside of a medical facility/physician's care). Examples included respiratory and heart-related complications

Opportunities for Prevention:

For Parents

- Ensure children have annual check-ups with a health-care provider to check for any illnesses or abnormalities in wellness and development

For Community Leaders and Policy Makers

- Expand school health programs for children, to include having registered nurses in all schools

For Professionals

- Promote expanding physical education in schools and facilitating "new behaviors that promote healthier lifestyles for future generations" (Georgia Nurses Association, 2009)

Facts:

- According to the CDC, "one of seven low-income preschool aged children is obese." Many chronic diseases are affected by obesity including diabetes, heart diseases, and some cancers
- Healthy People 2020-4 proposes to increase the proportion of adolescents who have a wellness check up in the past 12 months

Child had an enlarged heart and asthma and was regularly exposed to cigarette smoke. She died on a hot summer day in a home with no good ventilation or air conditioning

Resources:

Centers for Disease Control and Prevention
www.cdc.gov

Georgia Nurses Association
www.georgianurses.org

Healthy People 2020
www.healthypeople.gov/HP2020/

Child Abuse and Neglect

Each time the life of an innocent child is taken, whether by blatant force or subtle disregard, the painful memory of such a tragic loss leaves an indelible mark on our society. We are continuously confronted with countless accounts of children who were helpless victims of fatal abuse and neglect. Yet this devastating trend continues to grow as more and more children die at the hands of their caregivers leaving survivors to endure the lifelong ramifications.

Every day five children die from abuse and/or neglect in the U.S. According to a study conducted by Every Child Matters Education Fund (ECMEF), child abuse and neglect kills more children in the United States than in any other industrialized nation. The U.S. rate is three times higher than Canada's and 11 times higher than Italy's. The closest to the U.S. rate is France with 1.4 children out of 100,000 dying due to abuse or neglect compared to 2.4 out of 100,000 in America. In these countries, social policies in support of families are much greater and typically include child care, universal health insurance, paid parental leave, visiting nurses, and more—all of which together support prevention of child maltreatment. (ECMEF, 2009)

The U.S. invests modestly in similar preventive measures compared to the needs of the most vulnerable families. This serious social policy lapse creates an environment where preventable child maltreatment fatalities are inevitable (ECMEF, 2009). Instead of spending billions on damage control efforts, it is imperative that we make prevention a national, state, and local priority by investing in our most valuable resource, our children.

What is included in the definition of "abuse and/or neglect"?

In general, child maltreatment is defined as any act or failure to act resulting in the imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse, or exploitation of a child (under the age of 18). Fatal child abuse may involve repeated abuse over a period of time (e.g., battered child syndrome), or it may involve a single, impulsive incident (e.g., suffocating, or shaking a baby). In cases of fatal neglect, the child's death results not from anything the caregiver does, but from a caregiver's *failure to act*. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub).

How does Georgia compare with the U.S. average?

The National Child Abuse and Neglect Data System reported **an estimated 1,760 child maltreatment fatalities in 2007 (**a rate of 2.35 children per 100,000 children in the general population). In 2007, 60 children in Georgia were reported by Department of Human Services to have died as a result of substantiated abuse or neglect which translates to 2.7 per 100,000 children in the general population.

In 2007, child fatality review committees determined 82 children died as a result of confirmed abuse and/or neglect. Committes determined 63 of the identified deaths for 2008 as being a result of confirmed abuse and/or neglect.

Infant died of hyperthermia as a result of being left in the car while his mother went shopping

Figure 9: Reviewed Deaths with Abuse/Neglect Findings, by Age Group, 2007-2008 (N=270)

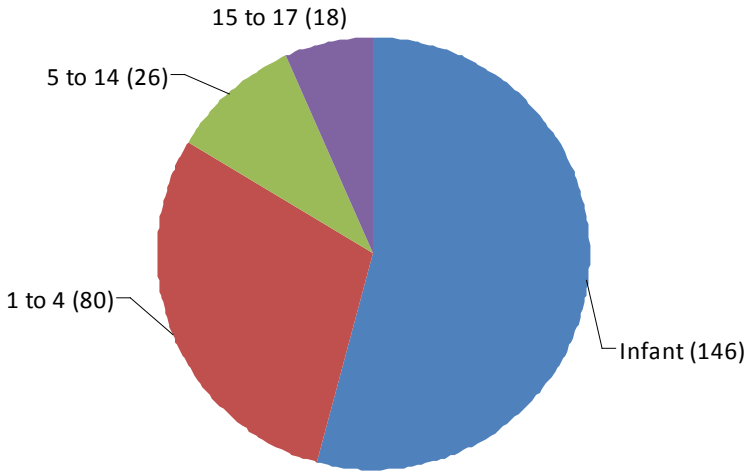


Figure 9 shows the percent of child abuse/neglect deaths for each age group for 2007 -2008 combined

Findings:

- Infants accounted for over half of all maltreatment deaths (54%)
- Children under five years of age comprised over 80% of all abuse/neglect deaths
- The proportion of child abuse/ neglect deaths drastically decreases with age

Facts:

- Males and infants are at greater risk of being victims of abuse or neglect
- Infants and young children are more susceptible to maltreatment because of their limited size, level of dependency, and inability to protect and defend themselves from harm and danger

Figure 10: Cause of Death for Reviewed Deaths with Abuse/ Neglect Findings, 2007-2008 (N=270)

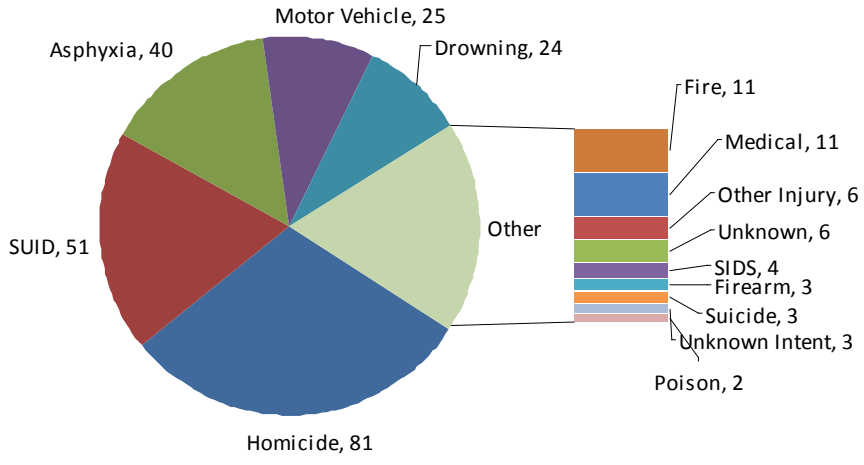


Figure 10 shows the causes of death when child abuse/neglect was suspected or confirmed

Findings:

- Homicide deaths associated with maltreatment findings have increased from 31 deaths in 2006 to 42 deaths in 2007
- Motor vehicle deaths with abuse or neglect findings have declined over recent years from 20 in 2006 to 13 in 2007

Fact:

- Studies have shown that from seven to 27 percent of deaths attributed to unintentional injuries and natural causes actually may have been due to child abuse or neglect

Findings:

- Natural mothers continued to represent the largest category of perpetrators (40%). Mother's significant other as perpetrator has decreased from 13 in 2006 (15%) to seven (6%) for 2007
- Eighty reviewed deaths with abuse/neglect findings had no perpetrator identified

Fact:

- Most fatalities resulting from physical abuse are caused by fathers or other male caretakers

Figure 11: Relationship of Perpetrator for Reviewed Deaths with Abuse/Neglect Findings, 2007-2008 (N=270)

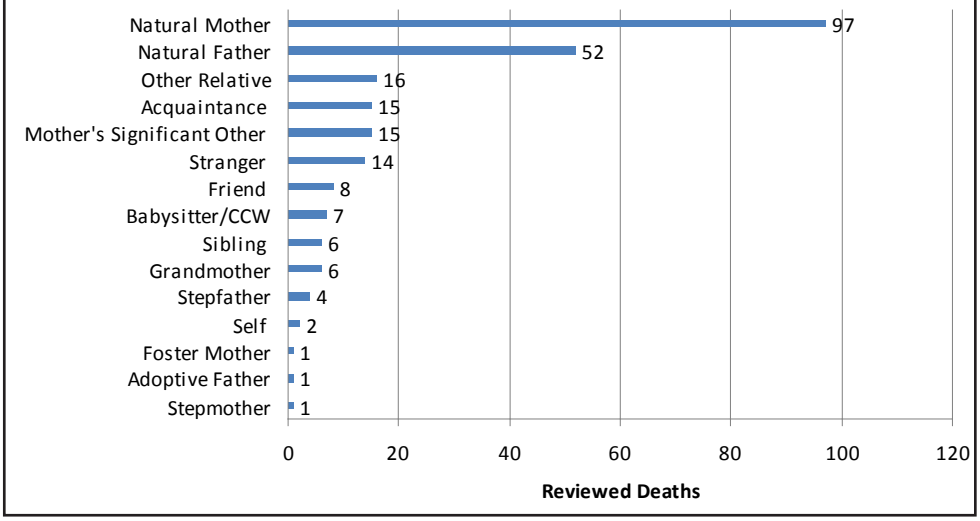


Figure 11 shows the relationship of perpetrators to children in suspected or confirmed child abuse/neglect related deaths. Some child abuse/neglect related deaths involved more than one perpetrator

Opportunities for Prevention:

For Parents

- Participate in classes that teach effective coping strategies, developmental stages of children, and age-appropriate disciplinary practices
- Increase self-awareness to identify personal stressors and child behaviors that elicit anxiety, stress, and anger
- Seek assistance and guidance from family members, friends, community members, and service providers
- Consult with health care practitioners and child care professionals for health tips, advice, and information

For Community Leaders and Policy Makers

- Train hospital emergency room staff to improve their ability to identify child abuse injuries and fatalities and improve reporting to the appropriate agencies
- Provide comprehensive training on the mandated reporting of child abuse and neglect to local human service agencies, hospitals and physicians
- Develop a networking system with neighborhood associations, community centers, and faith-based centers

For Professionals

- Develop media campaigns to enlighten and inform the general public on known fatality-producing behaviors (i.e., violently shaking a child out of frustration)
- Implement crisis nurseries which serve as havens for parents "on the edge" where they can leave their children for a specified period of time, at no charge
- Provide intensive home visiting services to parents of at-risk infants and toddlers
- Learn how to recognize and report child abuse and neglect

Resources:

Department of Human Services
www.dhr.georgia.gov

Every Child Matters Education Fund
www.everychildmatters.org

U.S. Department of Health and Human Services
www.acf.hhs.gov

Prior Agency Involvement

U.S. Department of Health and Human Services has reported an increasing number and rate of fatalities for children. In thousands of these cases, people reported danger facing the child(ren) to authorities. For a variety of reasons - especially child protective agency budget cuts - the response to these warnings failed the child. Now a harsh economy combined with a steadily weakened safety net, and unprecedented slashes in child protection spending threatens to put even more children at risk (Every Child Matters Education Fund, 2009).

Fifty-five percent (684) of the 1,252 reports received for 2007 and 2008 indicated that one or more community agencies had prior involvement with the deceased child and/or his/her family. The duration and degree of community agency involvement varied depending on individual circumstances. Oftentimes, a child or family was involved with multiple agencies.

Figure 12: Proportion of Deaths (No Abuse/Neglect Identified) with Prior Agency Involvement, 2007-2008 (N=982)

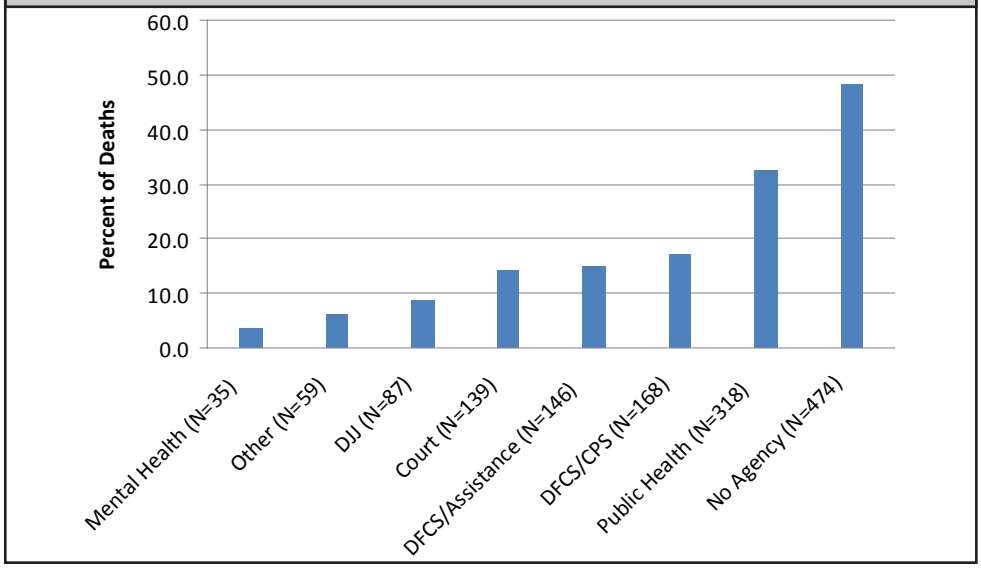


Figure 12 shows prior agency involvement for deceased children and their families with no abuse/neglect findings. A significant number of children and/or their families were involved with more than one agency which exceeds the number of deaths depicted.

Findings:

- Almost half of the deaths without abuse/neglect findings had no prior agency involvement
- Public Health represents the agency most often involved with families (32%) without abuse/neglect findings

Fact:

- Mandated reporters are required to have specialized training for accurate identification of risk factors and signs of abuse/neglect

Findings:

- Sixty-five percent of deaths with abuse/neglect findings had some level of agency involvement (176)
- A higher percentage (26%) of deaths with abuse/neglect findings had prior DFCS/ CPS involvement compared to (17%) of deaths without abuse/neglect findings
- Substantially more deaths (47%) with abuse/neglect findings had prior public health involvement compared to 32% of deaths without abuse/neglect findings

Fact:

- According to ECMEF, a high number of "first responders" to child abuse and neglect, including child protection workers, law enforcement, educators, and health professionals, lack the training and support necessary to effectively protect children

Figure 13: Proportion of Deaths (Abuse/Neglect Identified) with Prior Agency Involvement, 2007-2008 (N=270)

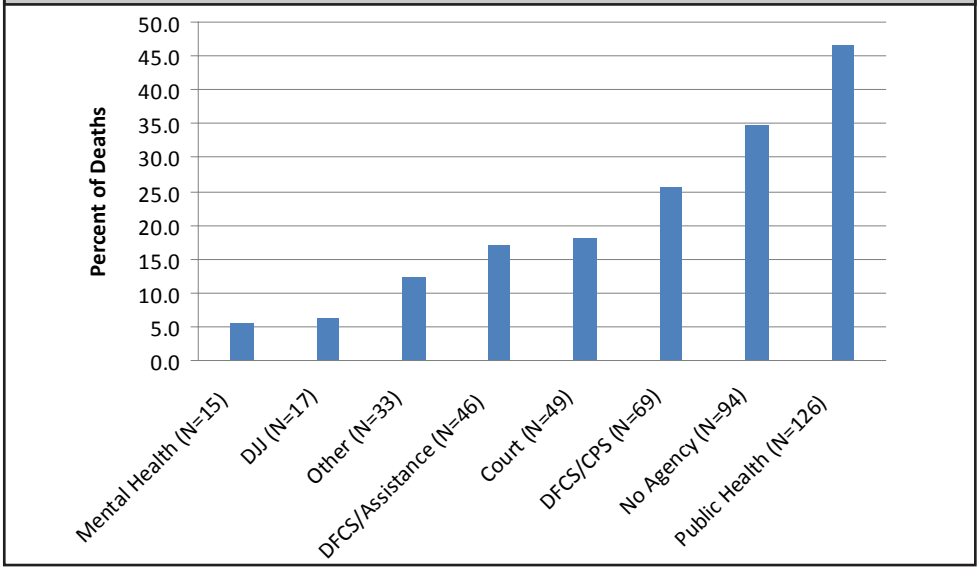


Figure 13 shows prior agency involvement for deceased children and their families with abuse/neglect findings. A significant number of children and/or their families were involved with more than one agency which exceeds the number of deaths depicted.

Opportunities for Prevention:

For community leaders and policy makers

- Engage community members and leaders in collaborative efforts to address child maltreatment
- Encourage policy makers to implement policies that will enhance and expand protective service programs to focus on prevention and early intervention
- Increase public awareness about the importance of reporting child abuse and neglect

For professionals

- Identify the warning signs and indicators of abuse and neglect
- Participate in trainings, seminars, and workshops to learn how to recognize and report child abuse and neglect
- Collaborate with service providers and community advocates to promote child abuse and neglect reporting and prevention initiatives

Sleep-Related – SIDS and SUID

Sleep-related deaths include all deaths to infants that occur while sleeping, but have no identifiable medical cause. They are the leading cause of death for children up to one year of age. According to the Centers for Disease Control and Prevention, more than 4,500 infants die each year with no obvious explanation. Many of these deaths are diagnosed as SIDS (Sudden Infant Death Syndrome). SIDS is defined as the sudden death of an infant less than one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history. Other infant sleep-related deaths appear to be SIDS, but have other factors present that could have contributed to the deaths. These deaths are often diagnosed as SUID (Sudden Unexpected Infant Death). Sleep-related deaths may also result from sleep-related asphyxia (extreme decrease of oxygen in the body accompanied by an increase of carbon dioxide). Examples of sleep-related asphyxia include unintentional overlay by a caregiver, sleeping with head or face covered, or wedging.

The following have been consistently identified across studies as independent risk factors for SIDS and other infant sleep-related deaths: prone sleep position, sleeping on a soft surface, maternal smoking during pregnancy, overheating, late or no prenatal care, young maternal age, preterm birth and/or low birth weight, and male gender. Consistently higher rates are found in African-American and American Indian/Alaska Native children—2 to 3 times the national average.

Although many risk factors have been identified in association with SIDS and other sleep-related deaths, a primary cause has not been determined. Research suggests a complex combination of physiology and environmental stressors that contribute to SIDS. A death should only be determined as SIDS after careful investigation - including an autopsy, a thorough death scene investigation, and an examination of the infant's medical history - so that all other possibilities can be ruled out. The process is expensive, and many counties do not conduct such thorough investigations.

How does Georgia compare to the U.S.?

The U.S. infant mortality rate has remained relatively stable since 2000, around 6.8 per 1,000 live births. Georgia's infant mortality rate was 10.1 deaths per 1,000 live births in 1994, decreasing to 8.5 deaths per 1,000 live births in 2004.

Finding:

- In 2007-2008, there were 268 reviewed sleep-related infant deaths attributed to SIDS or SUID. Of those, 157 were males, and 111 were females. SUID accounted for 230 of the 268 SIDS/SUID deaths reviewed. There were 145 SIDS/SUID deaths reviewed in 2007

Fact:

- The CJ Foundation for SIDS reports that SIDS claims the lives of almost 2,500 infants in the U.S. each year, nearly seven infants every day

Figure 14: Race/Gender Distribution, Reviewed SIDS and SUID Deaths, 2007-2008 (N=268)

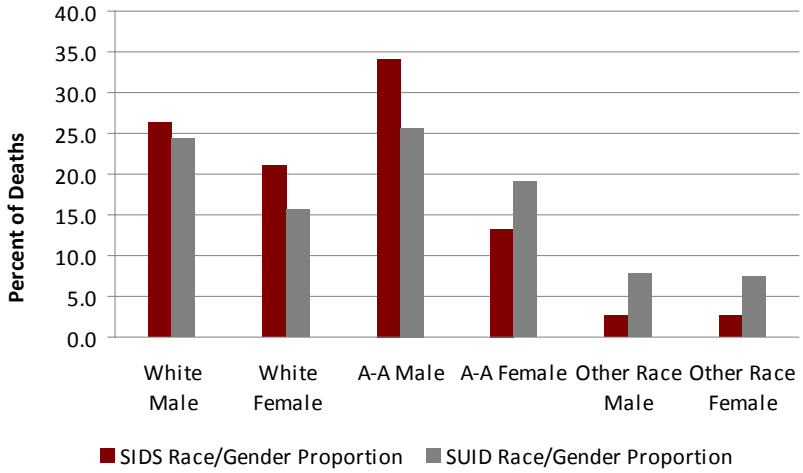


Figure 14 shows the race and gender distribution of reviewed SIDS/SUID deaths

Finding:

- Of the 268 reviewed SIDS/ SUID deaths in 2007-2008, 52% (140) occurred among infants between two months and four months of age, and 85% (228) occurred among infants four months of age or younger

Fact:

- The NIH reports that most SIDS deaths happen when infants are between two months and four months of age

Figure 15: Reviewed SIDS/SUID Deaths by Age in Months, 2007-2008 (N=268)

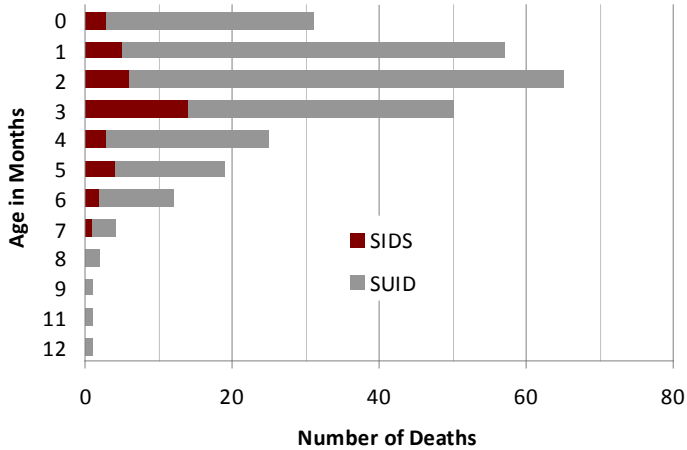


Figure 15 shows the age of reviewed SIDS/SUID deaths

Figure 16: Location Where Found (if known), Reviewed SUID, 2007-2008 (N=223)

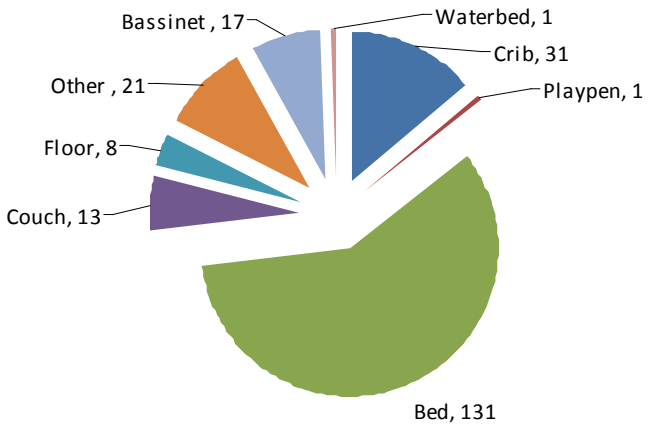


Figure 16 shows the location of death for reviewed SUID deaths

Figure 17: Location Where Found (if known), Reviewed SIDS, 2007-2008 (N=35)

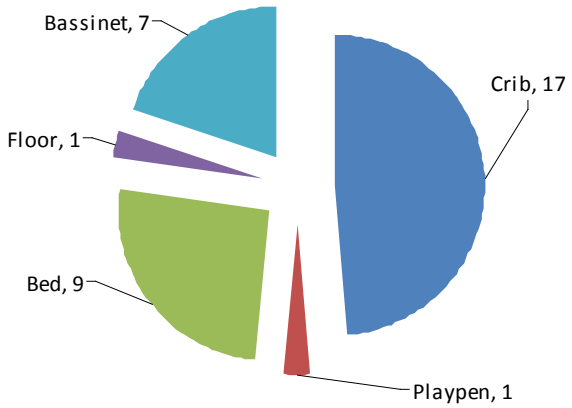


Figure 17 shows the location of death for reviewed SIDS deaths

Findings:

- SUID is more likely than SIDS to be the cause of death when the infant is reported to be sleeping in an unsafe sleeping environment (bed, couch, floor, etc.). Of the 35 reviewed SIDS deaths with location known, 49% occurred while the infant was sleeping in a crib, compared to 14% of the 223 SUID deaths (when location was known)
- Of those infants found in a crib who died of SIDS, eight were White, eight were African-
- American, and one was another race. Of those infants found in a crib who died of SUID, 19 were White, nine were African-American, and three were another race
- Of those infants found in a bed who died of SIDS, three were White and six were African-American. Of those infants found in a bed who died of SUID, 49 were White, 61 were African-American, and 21 were another race

Fact:

- A recent study published in Pediatrics found that prone sleep and unsafe sleep surfaces increase the risk of sudden infant death. Epidemiologic studies also suggest that when an infant's head or face is covered by bedding, or when a sleep surface is shared with others, the risk of dying increases. The inference of a causal role for these risk factors is supported by physiologic studies and by the consistent finding that fewer infants die when risk factors are reduced

Findings:

- Most SIDS deaths (68%) occurred when the infant was positioned on its back during sleep. Most SUID deaths (62%) occurred when the infant was positioned on its stomach or side during sleep
- Of the eight SIDS deaths when the infant was known to be positioned on its stomach or side, four were White males and four were African-American males
- Of the 108 SUID deaths when the infant was known to be positioned on its stomach or side, 28 were White males and 29 were African-American males. In addition, 18 were White females, 16 were African-American females, eight were males of another race, and nine were females of another race

Fact:

- The AAP Task Force on Infant Sleep Position and SIDS has issued recommendations for "back to sleep" along with the assurance that infants will not aspirate while on their backs. They report that there is no evidence that healthy infants are more likely to experience serious or fatal aspiration episodes when they are supine. In fact, in the majority of the very small number of reported cases of death due to aspiration, the infant's position at death, when known, was prone

Three month old infant died while sleeping between both parents in adult-sized bed

Figure 18: Sleeping Position When Discovered (if known), Reviewed SIDS, 2007-2008 (N=25)

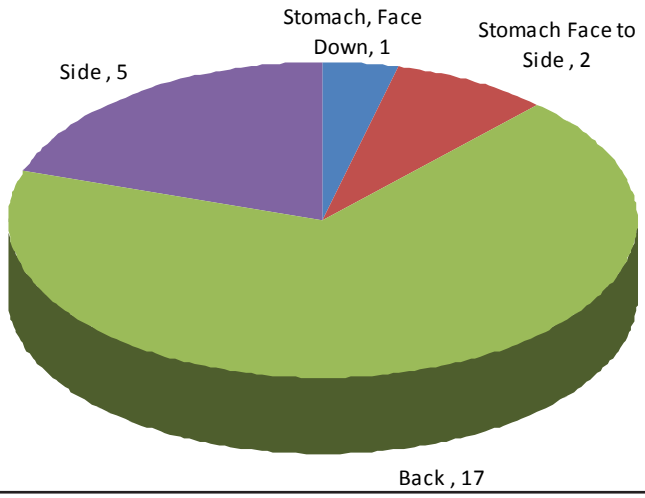


Figure 18 shows sleeping position of reviewed SIDS deaths

Figure 19: Sleeping Position When Discovered (if known), Reviewed SUID, 2007-2008 (N=175)

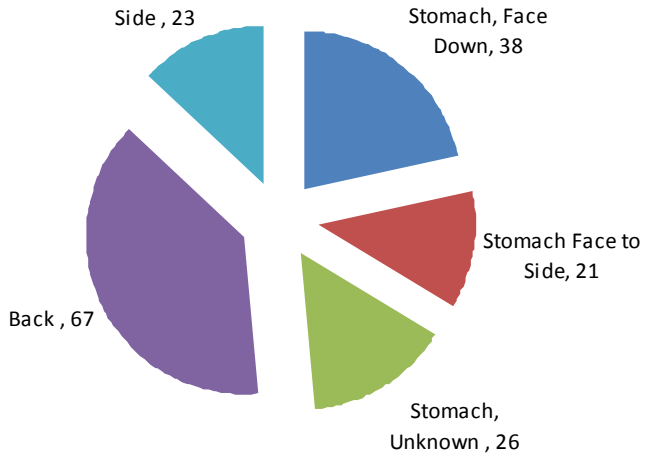


Figure 19 shows sleeping position of reviewed SUID deaths

Opportunities for Prevention

For Parents and Caregivers

- Become aware of, and implement safety measures that caregivers can put in place to reduce the risk of SIDS

For Agencies and Community Leaders

- Continue campaign efforts to inform parents about the importance of back sleeping and of reducing all other risk factors

Resources:

CJ Foundations for SIDS
www.cdc.gov/sids

Georgia Department of Community Health
www.dch.georgia.gov

Figure 20: Reviewed Infant Asphyxia Deaths, by Age in Months, 2007-2008 (N=105)

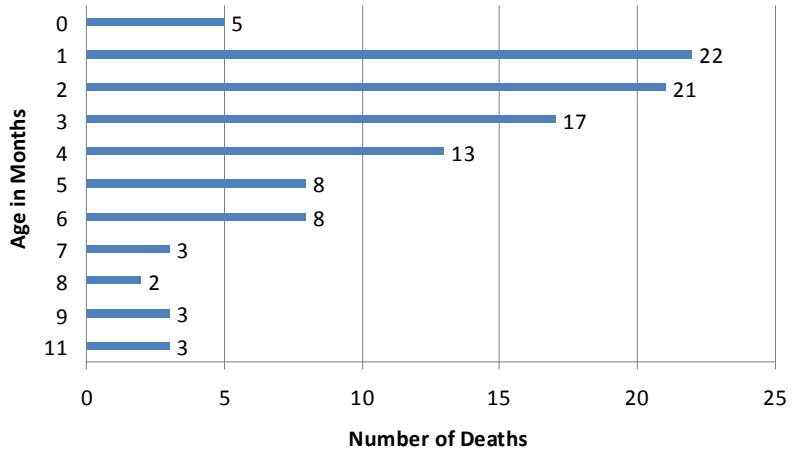


Figure 20 shows age of reviewed infant asphyxia deaths

Finding:

- Sixty-two percent (65) of the infant asphyxia deaths were infants younger than four months of age

Fact:

- Some study findings show that the age of infants most at risk for sleep-related asphyxia is similar to the age of infants most at risk for SIDS

Figure 21: Number of people Sleeping with Infant at Time of Asphyxia Death 2007-2008 (N=90)

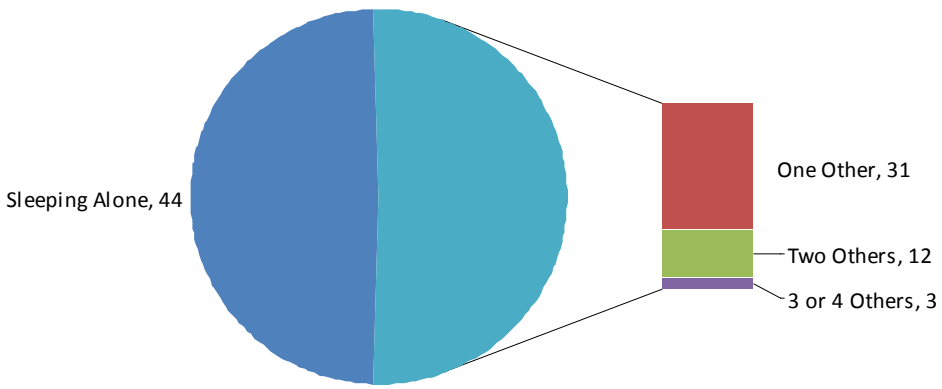


Figure 21 shows number of people sleeping with infant at time of asphyxia deaths

Finding:

- When known, 51% of the sleep-related infant deaths due to asphyxia were sharing a sleep surface with at least one other person

Fact:

- Since 1993, the percentage of infants bed sharing has doubled from six percent to twelve percent. A report by First Candle notes that the increase in bed sharing has occurred in groups not traditionally associated with bed sharing: mothers over 18 years of age, Caucasians and mothers living in the Mid-Atlantic, Mid-West and South. It has been postulated that the Back to Sleep campaign raised parents' concerns about sleep safety, which may have inadvertently resulted in parents' bed sharing out of a desire to keep their infant close and safe while sleeping

Opportunities for Prevention:

For Parents and Caregivers

- If caregivers choose to sleep in the same bed with their infants, care should be taken to avoid using soft sleep surfaces. Quilts, blankets, pillows, comforters, or other similar soft materials should not be placed under the infant
- The bed-sharer should not smoke or use substances such as alcohol or drugs that may impair arousal

Resources:

CJ Foundations for SIDS
www.cdc.gov/sids

Georgia Department of Community Health
www.dch.georgia.gov

Unintentional Injury-Related Deaths

Child fatality review committees across the state identified that unintentional injury-related deaths accounted for 312 deaths in 2007 and 250 in 2008. This type of injury caused more death to children 1-17 years of age than any other reviewed category (medical or intentional injuries). According to the CDC, unintentional injuries are "responsible for more deaths than cancer, congenital abnormalities, homicide, heart disease, suicide and respiratory illnesses combined" for children 1-14 years. Despite this, unintentional injuries have continued to decline on a national front since 1987 (Safe Kids, 2008). More work in the injury prevention community is paramount in order to continue this downward trend.

For 2007-2008 reviewed unintentional injury-related deaths, the leading cause of death by age group was:

< 1 year =	Asphyxia (78%)
1-4 years =	Drowning and Motor Vehicle-Related (36% each)
5-9 years =	Motor Vehicle-Related (50%)
10-14 years =	Motor Vehicle-Related (70%)
15-17 years =	Motor Vehicle-Related (67%)

What is an unintentional injury?

Injury is damage to a person's body via mechanical, thermal, or chemical distribution. The intent of an injury is important to note as well. Unintentional injury is not deliberate therefore these injuries (fatal or non-fatal) are preventable. This category includes those injuries described as unintended regardless of whether the injury was inflicted by oneself or by another person. It does not include deaths whose intent was labeled as unknown, as during certain case review, intent was not able to be determined by CFR committees.

How does Georgia compare to the U.S. average?

The CDC reported for 2006 that the top three causes of unintentional injury-related fatalities for children ages 1-17 in the U.S. were motor vehicle crashes, drowning, and fires/burns. For infants (younger than one), the leading cause was unintentional asphyxia. Georgia's data reflects national data. According to the National Center for Injury Prevention and Control, in 2006, the United States' unintentional injury-related fatality child death rate (birth-17 years) was 10.82 per 100,000, while Georgia's was 11.52.

Child found deceased in bed with her boyfriend. Testing showed child positive for methadone toxicity

Figure 22: Reviewed Unintentional Injury-Related Deaths by Cause, 2007-2008 (N=562)

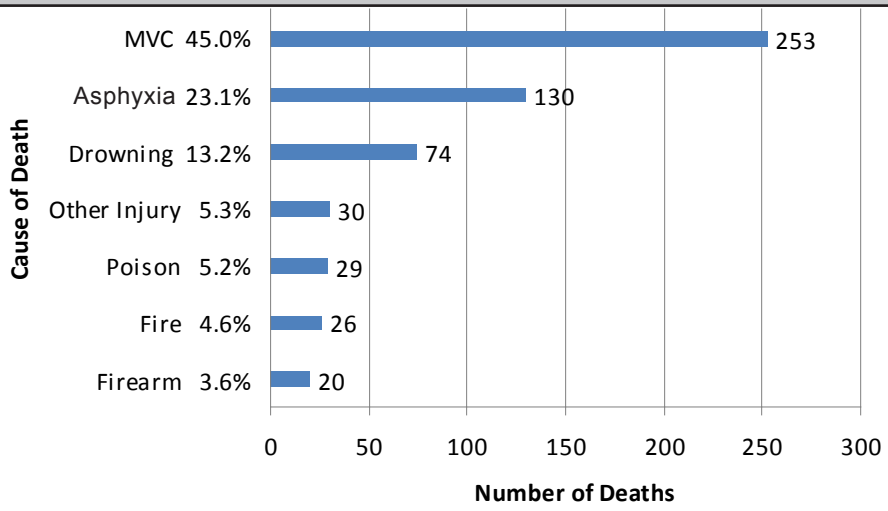


Figure 22 shows unintentional injury-related deaths by mechanism

Findings:

- For 2007-2008, infants younger than one year accounted for most unintentional injury–related deaths. The majority of those deaths were attributed to asphyxia
- Motor vehicle-related deaths accounted for the majority (45%) of reviewed unintentional injury deaths
- Motor vehicle-related, drowning, and asphyxia deaths continued to be the leading causes of unintentional injury-related deaths

Facts:

- Based on the CDC's *2009-2018 Research Agenda*, "unintentional poisoning is considered an emergent health problem and is second only to motor vehicle traffic crashes as a leading cause of unintentional injury death in the United States" for all ages."
- Research shows that injury prevention counseling by pediatricians is very effective
- Unintentional poisonings were the third leading cause of reviewed unintentional deaths in Georgia for 1–17 year olds
- CFR committees reviewed 15 unintentional poisonings in year 2007 alone as compared to seven in 2006, a 114% increase. The majority (73%) of those poisonings occurred in the 15-17 year old age group and were mostly due to drug overdoses including those from prescription medications (methadone, oxycontin, and alprazolam).

Resources:

Centers for Disease Control and Prevention
www.cdc.gov

Children's Safety Network
www.childrenssafetynetwork.org

Motor Vehicle-Related Injury Deaths

The National Highway Traffic and Safety Administration reported overall traffic fatalities reported in 2008 "hit their lowest level since 1961 and that fatalities in the first three months of 2009 had continued to decrease." Motor vehicle-related deaths continued to be a leading cause of deaths for children over age one. Older teenagers represented the largest majority of those deaths and factors associated with those include driving at nighttime, driving to and from school (when a lot of other teens are on the road), having teen passengers in the car, and making simple driving errors and/or speeding. Georgia's child pedestrian-related fatalities continued to rise over the past three years with 26 reviewed in 2007.

What is included in the definition of motor vehicle-related death?

Deaths attributed to motor vehicle-related incidents include the drivers and passengers of a vehicle, and occupants, riders or pedestrians impacted by any other form of transportation (bicycles, ATV, go-carts, motorized scooters, airplanes).

How does GA compare with the U.S. average?

Based on the CDC (2006), across the United States, and in Georgia, motor vehicle-related deaths were the leading causes of death to children ages 1-17 years. According to the National Center for Injury Prevention and Control, the 2006 United States' motor vehicle-related child death rate (birth–17 years) was 5.83 per 100,000 children while the CDC reported Georgia's rate as 6.12 (a reduction from 2005 rates in U.S. and Georgia).

Findings:

- Teenagers ages 15-17 accounted for 46% of the 253 reviewed deaths
- Youth ages 10-14 accounted for 19% of those deaths, which was an increase from 2006 (17%)

Facts:

- Every state has enacted a Graduated Licensing Law (GDL)
- In the Allstate Foundation's 2007 online research survey, the study revealed that 60% of parents do not know what GDL laws are
- Young drivers are at greater risk when driving at night
- Under Georgia's Teenage and Adult Driver Responsibility Act (TADRA), teenage drivers must have 40 hours of supervised driving with a parent or guardian prior to obtaining a Class D license

Figure 23: Reviewed Motor Vehicle-Related Deaths by Age, 2007-2008 (N=253)

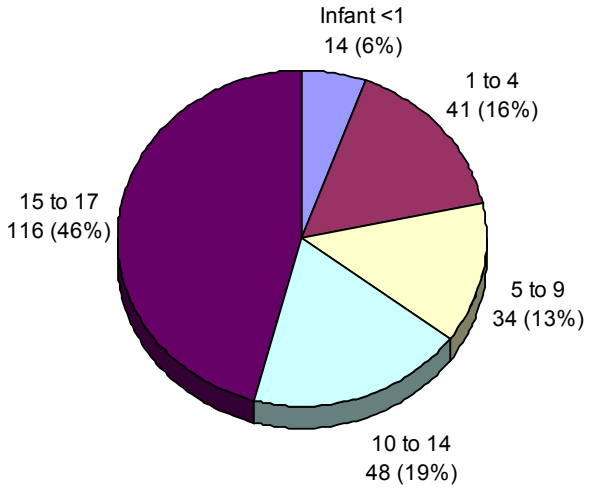
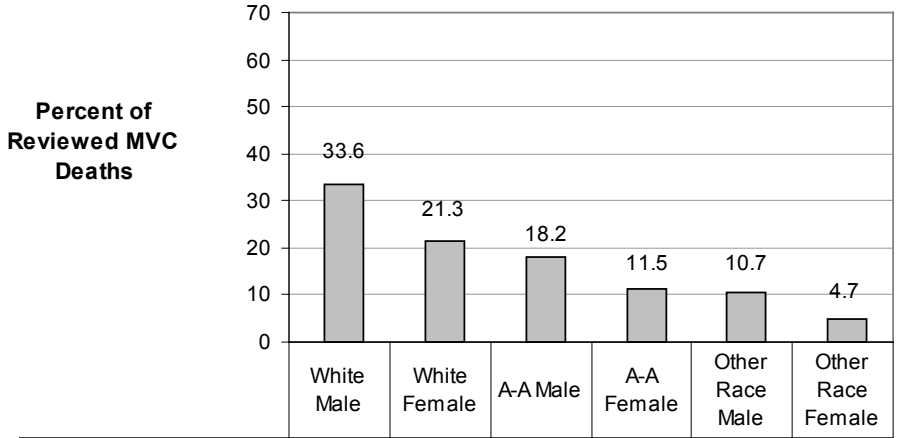


Figure 23 shows the age breakdown of motor vehicle related deaths

Figure 24: Reviewed Motor Vehicle-Related Deaths by Race, Gender and Proportion, 2007-2008 (N=253)



	White Male	White Female	A-A Male	A-A Female	Other Race Male	Other Race Female
# of MVC Death (N=253)	85	54	46	29	27	12
Percent	33.6	21.3	18.2	11.5	10.7	4.7

Figure 24 shows breakdown of motor vehicle deaths by race, gender, and proportion

Findings:

- White children are at a higher risk (55%) than African-American children (30%) of dying in a motor vehicle-related crash
- White males continue to have the highest proportion of deaths
- Males account for the majority of motor vehicle-related deaths (62%)

Facts:

- Georgia is the only state in the nation that exempts an entire class of passenger vehicles – pickup trucks – from safety belt laws
- Eighty percent of teenagers rated their parents as their number one driving influence (Allstate Foundation, 2009)

Figure 25: Reviewed Motor Vehicle-Related Deaths by Restraint Use and Age, 2007-2008 (N=253)

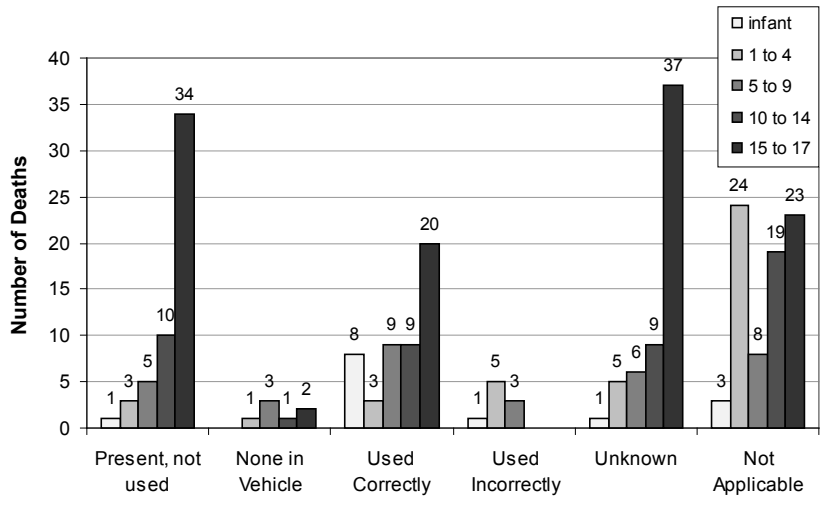


Figure 25 shows restraint use at the time of death. Restraint use was not applicable in some cases (e.g., bicycle, ATV)

Findings:

- CFR committees did not identify the restraint use (unknown) in 23% of cases
- There were 116 reviewed deaths among the 15-17 year old age group; 63% were reported as not wearing their seatbelt (when restraint use was known and applicable)

Facts:

- In 2009, the Georgia legislature passed the "Super Speeder" legislation aimed at helping to reduce traumatic vehicle crashes due to excessive speed
- According to the Governor's Office of Highway Safety, traffic crashes overall cause more than 1,600 fatalities each year, with excessive speed being a primary factor
- Based on the Allstate Foundation's 2009 research study, more than 49% of teens reported texting as a distraction

Finding:

- Of the 73 back seat passengers shown, 23 were 15-17 years of age. Of those teens, 92% were riding unrestrained (when restraint use known and applicable)

Facts:

- Helmet use among children aged 14 and younger is approximately 15% nationwide (Children's Safety Network)
- Safe Kids recommends children under the age of 16 years should never ride or operate ATVs of any size

Figure 26: Motor Vehicle-Related Deaths by Position at Time of Injury, 2007-2008 (N=253)

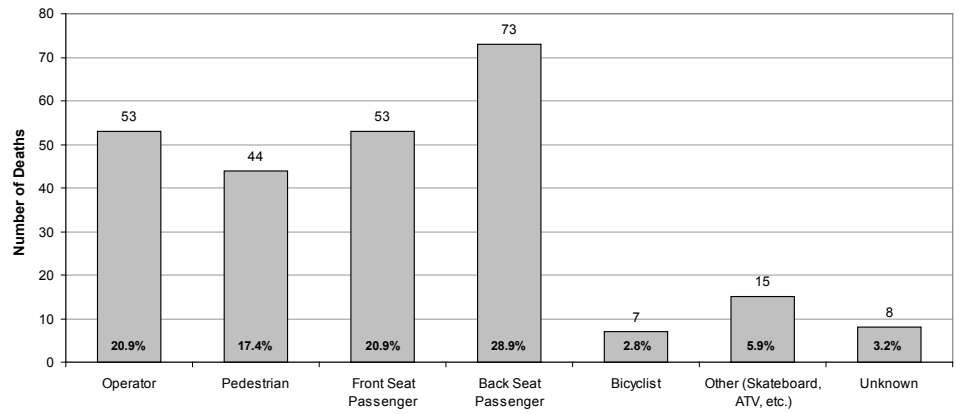


Figure 26 shows the position of the decedent at time of death

Findings:

- Forty-eight percent of pedestrian-related fatalities involved toddlers
- Older teens had the second highest percentage of pedestrian-related deaths
- CFR committees reported 65% of toddler pedestrian deaths to have inadequate supervision (when supervision known)
- Toddler deaths were attributed to being in a roadway unattended or in a driveway

Fact:

- High risk pedestrian areas include locations with a higher number of parked vehicles, higher posted speed limits, no divided highways, and few alternative play areas

Figure 27: Reviewed Motor Vehicle-Related Deaths Involving Pedestrian Decedents by Age and Proportion, 2007-2008 (N=44)

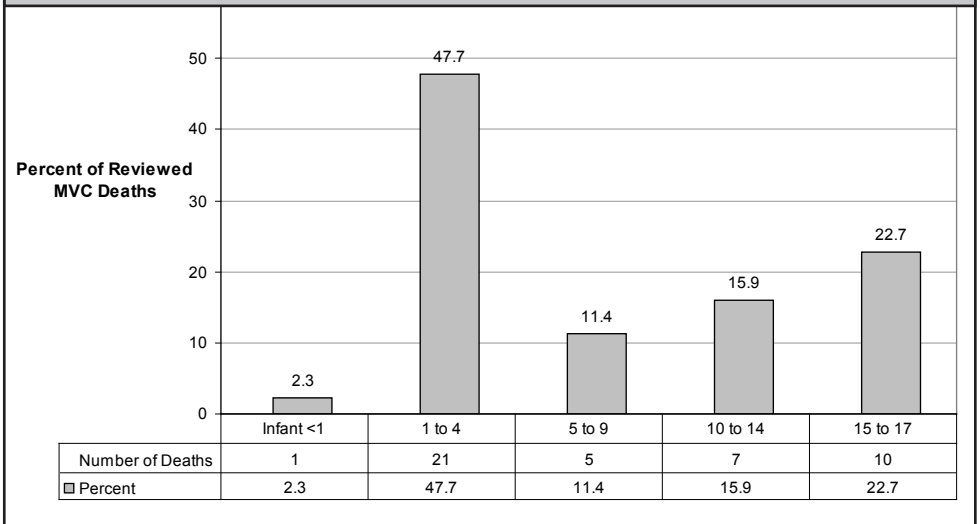


Figure 27 shows pedestrian deaths by age and proportion

Figure 28: Motor Vehicle-Related Death Rates per 100,000 Teens Age 15-17, Three-Year Moving Average, 1994-2007 (Based on OASIS Data)

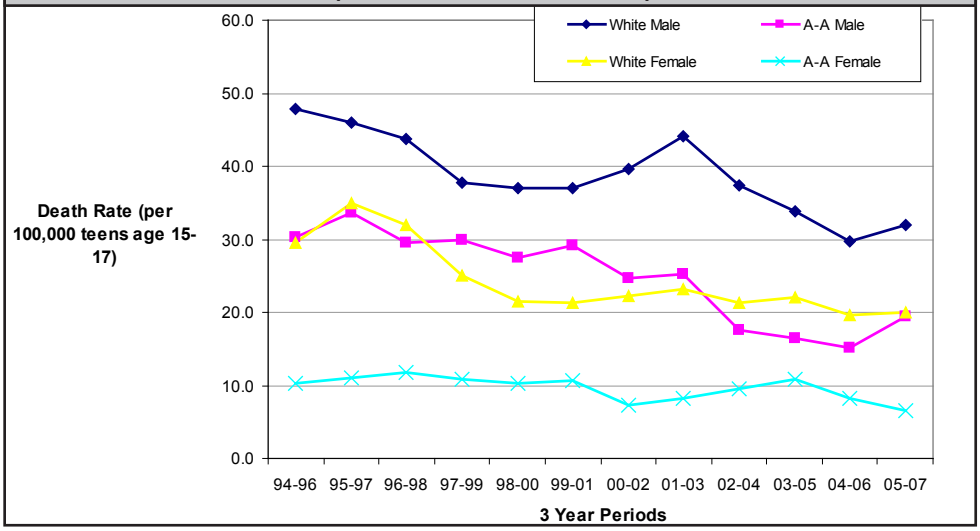


Figure 28 shows motor vehicle-related deaths since 1994

Finding:

- OASIS data shows a slight increase in deaths for males over the past three years

Fact:

- NHTSA reported in 2007 that lap and shoulder belts (when used) reduce the risk of fatal injury by 45%

Toddler was riding tricycle on a private street when a car backed out of a driveway, running over child.

Opportunities for Prevention:

For Parents

- Consider delaying licensing for teens who are not ready to accept the enormous responsibility of driving (i.e., longer learning permit holding period)
- Ensure your toddler's car seat is installed properly according to the manufacturer of the seat and your vehicle by having it checked by a certified child passenger safety technician

For Young Drivers

- Wear a seatbelt every time you ride in a vehicle and enforce that passengers with you do the same
- Do not consume alcohol or ride with someone who has

For Community Leaders and Policy-makers

- Consider attaching penalties for failure to comply with the GDL restrictions
- Support changes to the current child restraint law to increase booster seat use beyond six years of age
- Amend the current safety belt law to require safety belts be mandatory in pick-up trucks

Resources:

AllState Foundation
http://www.allstate.com/foundation/teen-driving/Shifting-Teen-Attitudes.aspx

Children's Safety Network
www.childrenssafetynetwork.org

Safe Kids Worldwide
www.safekids.org

Traffic Safety Facts, 2007
http://www.nhtsa.dot.gov

Young Adult Driver Task Team
Georgia Strategic Highway Safety Plan, 2007-2008
www.gahighwaysafety.org

2009 Governor's Strategic Highway Safety Plan
www.gahighwaysafety.org

Drowning Deaths

Drowning continues to be one of the leading causes of death for children ages 1-17. Drowning is the number one cause of injury-related deaths for children ages one to four in Georgia based on death certificate data and deaths reviewed. CFR committees reviewed 37 drowning deaths in 2007 and 37 in 2008. In 2007, 37% of reviewed drowning deaths were found to have suspected or confirmed abuse or neglect by CFR committees compared to 27% in 2008. Committees also found drowning deaths to be "definitely preventable" in 66% of cases for 2007 and 78% of cases in 2008. CFR committees identified 66% of the children did not have adequate supervision based on death scene investigation reports containing this information.

In 2009, the Health Resources and Services Administration (HRSA) announced new research based on the largest and most comprehensive study of injuries at home - the *"State of Home Safety in America"*. Specific to backyard safety, less than one in ten homes (8%) have a four-sided fence that completely surrounds the pool. Only six percent indicated they make sure the pool has a gate that closes and locks by itself.

What is characterized as a drowning death?
Drowning deaths occur from water-related submersion and asphyxia, and include deaths involving public and private swimming pools, natural open water (rivers, lakes, oceans, and ponds), bathtubs, and other bodies of water. Occasionally, other areas may include drainage ditches and septic tanks.

How does GA compare to the U.S. average?
The CDC continues to report drowning as the second leading cause of death for children ages 1-17, as is the same for Georgia, based on the WISQARS data program. According to the National Center for Injury Prevention and Control, the 2006 United States' drowning child death rate was 1.27 per 100,000 children, while Georgia's rate was 1.62 in 2006.

Finding:

- Toddlers continued to have the majority of drowning deaths (55%)

Fact:

- Multiple strategies are needed to prevent drowning, such as "layers of protection" that include supervision, physical barriers limiting access to bodies of water, alarms, swimming lessons and quick emergency action (e.g., C.P.R. training)

Figure 29: Reviewed Drowning Deaths by Age, 2007-2008 (N=74)

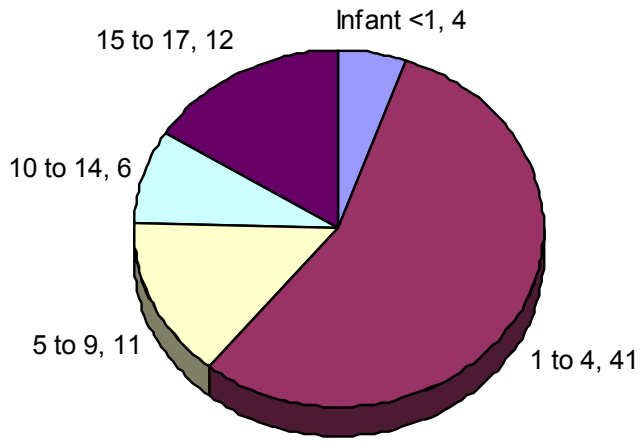
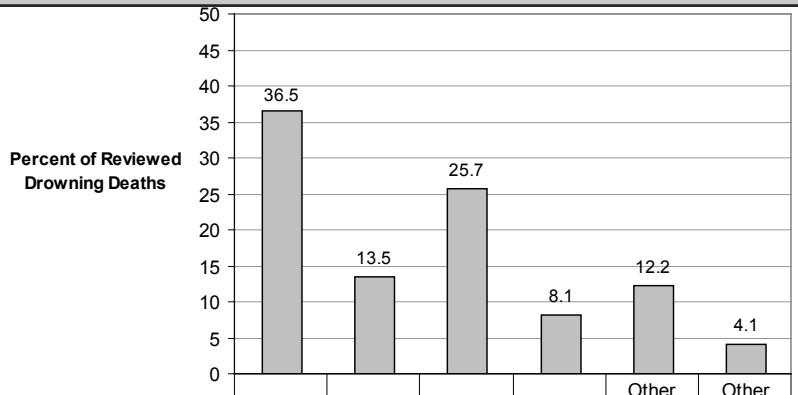


Figure 29 shows drowning deaths by age categories

Figure 30: Reviewed Drowning Deaths by Race, Gender and Proportion, 2007-2008 (N=74)



	White Male	White Female	A-A Male	A-A Female	Other Race Male	Other Race Female
# of Deaths (N=74)	27	10	19	6	9	3
Percent	36.5	13.5	25.7	8.1	12.2	4.1

Figure 30 shows proportion of child drowning deaths by Race and Gender

Finding:

- Overall, males accounted for 74% of all reviewed drowning deaths, with White males comprising 37%

Fact:

- Regardless of race, males (74%) were at greater risk than females (26%) for drowning

Figure 31: Reviewed Deaths Due to Drowning in Natural Bodies of Water and Private Swimming Pools by Month of Occurrence, 2007-2008 (N=54)

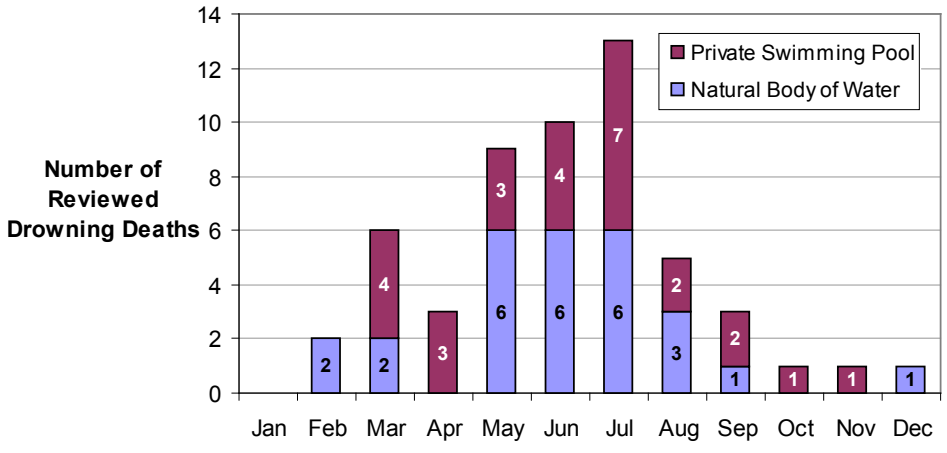


Figure 31 shows the number of deaths by month of occurrence, and location

Findings:

- For children less than five years of age, 51% died in private swimming pools
- Natural bodies of water continued to be the leading location for older teenager deaths

Facts:

- The World Report on Child Injury Prevention has reported drowning as a public health issue calling for "worldwide attention"
- The Consumer Product Safety Commission has reported an overall annual increase in drowning deaths associated with small inflatable pools

Findings:

- The drowning death rates for males overall appears to be declining slightly over the past three years
- The African-American female drowning rate has increased over the past three years, while the White female rate has plateaued

Fact:

- The Home Safety Council recommends "touch supervision" while children are around water. Touch supervision means you are looking at the child and can reach out and touch the child

Resources:

Centers for Disease Control and Prevention
www.cdc.gov

Consumer Product Safety Commission
www.cpsc.gov

Home Safety Council
www.homesafetycouncil.org

National Drowning Prevention Alliance
www.ndpa.org

Mom thought toddler was watching television and she went to take a shower. When she returned, she could not locate child and ultimately found him in the pool outside, face down

Figure 32: Drowning Death Rates per 100,000 Children Age 0-17, Three-Year Moving Average, 1994-2007 (Based on OASIS Data)

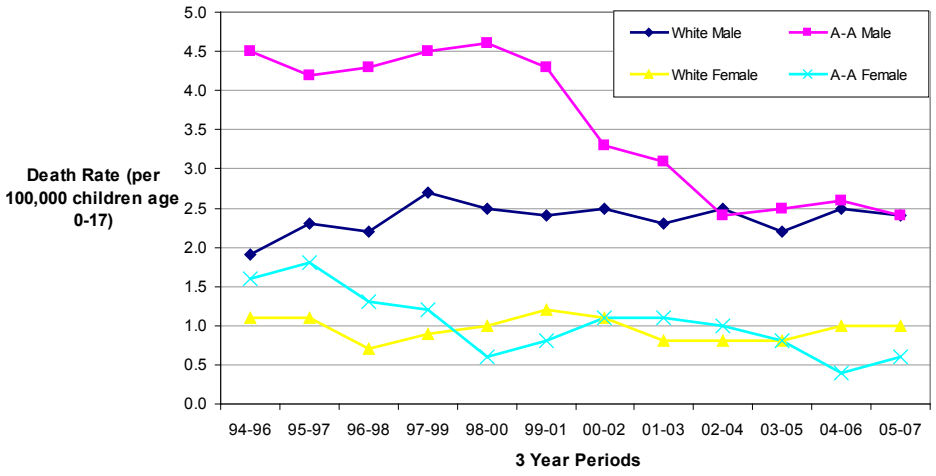


Figure 32 reveals drowning death trends since 1994

Opportunities for Prevention

For parents and caregivers:

- Make sure children always swim with a grown-up. No child or adult should swim alone
- Use layers of protection. No one layer is "foolproof" and multiple layers with "constant supervision" offer the most protection (CPSC, 2006). Layers of protection include:
  - Supervision during non-water and water activities
  - Physical layers limiting access to the pool or spa area and water including fencing, alarms, pool covers
  - Swimming Lessons for all
  - Emergency layer including telephones, CPR, and rescue equipment
  - Other types of water layers, including plans for buckets, bathtubs, ponds/fountains, and toilets

For community leaders and policy makers

- Support a state-wide media campaign with messaging specific to drowning prevention for all ages
- Continue to consider ways to empower, implement, and enforce the local ordinance that require specific isolation fencing for private pools across the state

For professionals

- Support and consider conducting new research pertaining to active adult supervision and drowning prevention surveys for caregivers

Fire-related deaths have continued to remain fewer than in previous years. In 2006, there were 19 fire-related deaths reviewed. The decrease continued with 15 in 2007 and 11 in 2008. The most common structure for fires was wood frame (53%) and the source was more often space heaters (30%) when known. Additionally, there was not a significant difference in the location of fires between urban and rural areas of the state. CFR committees reviewed 52% in urban areas and 48% in rural Georgia. Committees found 73% of fire deaths to be "definitely preventable" and 27% to be "possibly preventable".

What is included in the definition of fire-related death?
A fire-related death is one resulting from fire or burn injuries sustained in a fire, and includes deaths from smoke inhalation.

How does GA compare with the U.S. average?
The United States Fire Administration reported in 2006 that the national fire death rate for all ages was 13.2 deaths per million population while Georgia's was 18.8. Georgia's rate ranks 13th among the states, but lower than all other listed southern states, except North Carolina (15.6). According to the National Center for Injury Prevention and Control, the United States' residential fire-related child death rate was 0.62 per 100,000, while Georgia's was 0.81 in 2006.

Figure 33: Reviewed Fire-Related Deaths by Age, 2007-2008 (N=26)

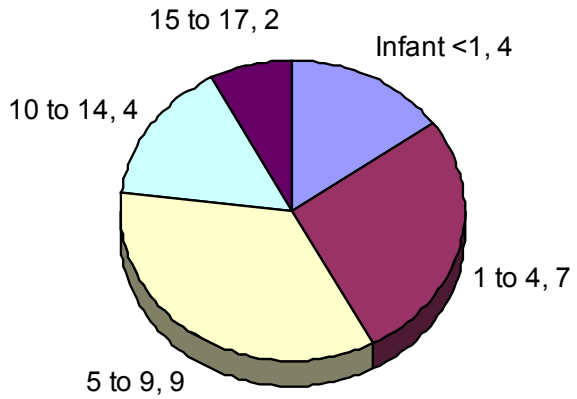


Figure 33 shows fire-related deaths by age and proportion

Finding:

- Reviewed deaths appeared to be more widespread across the age groups than noted in previous years

Facts:

- According to the U.S. Fire Administration (USFA), matches, lighters, and other heat sources are the leading causes of fire deaths for children
- In Georgia, all public and private schools are required to perform monthly fire drills while in session
- In 2007, fire deaths occurred most during the spring months, (March-May with eight), while in 2008, more occurred during winter months, (December-January with six)

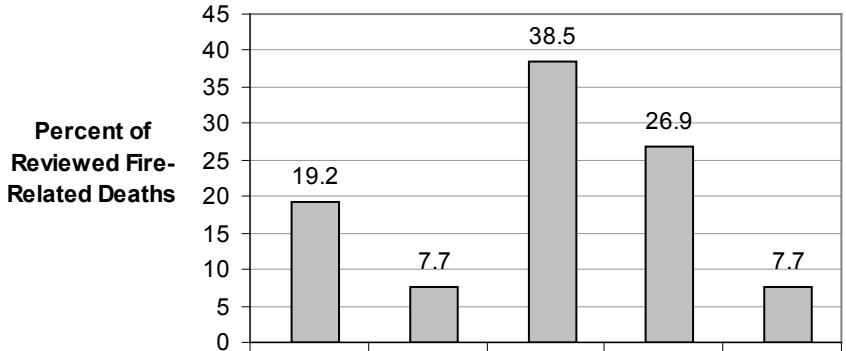
Findings:

- Males accounted for 65% of all reviewed fire-related deaths
- A higher percentage of fire-related deaths occurred among African-American children

Facts:

- According to the USFA, stationary heating units are the leading type of equipment involved in ignition of rural residential heating fires
- Most fatal fires occur at night during sleep

Figure 34: Reviewed Fire-Related Deaths by Race, Gender and Proportion, 2007-2008 (N=26)



	White Male	White Female	A-A Male	A-A Female	Other Race
# of Deaths (N=26)	5	2	10	7	2
Percent	19.2	7.7	38.5	26.9	7.7

Figure 34 shows proportions of fire deaths by Race and Gender

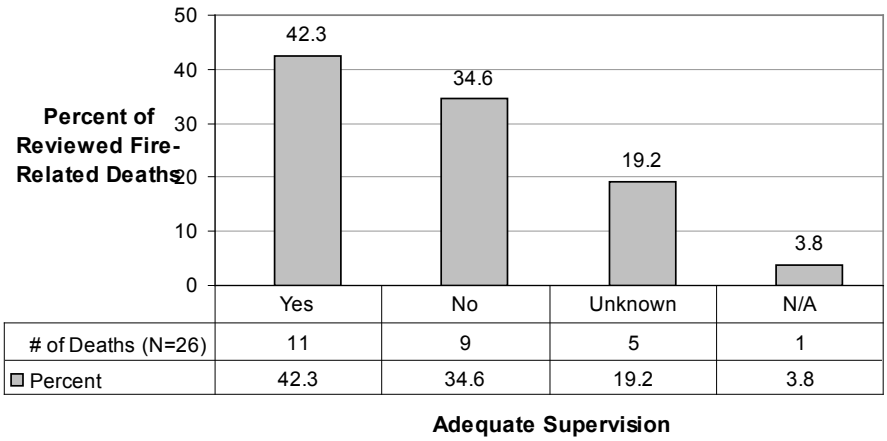
Finding:

- Forty-two percent of children were determined by CFR committees to be supervised adequately at the time of death which may include parents being asleep at time of fire

Facts:

- When both smoke alarms and fire sprinklers are present in a home, the risk of dying is reduced by 82% (USFA, 2008)
- Most home fire deaths are linked to lack of working smoke alarms

Figure 35: Reviewed Fire-Related Deaths by Adequate Supervision and Proportion, 2007-2008 (N=26)



	Yes	No	Unknown	N/A
# of Deaths (N=26)	11	9	5	1
Percent	42.3	34.6	19.2	3.8

Figure 35 shows fire-related deaths by level of supervision

Figure 36: Fire-Related Death Rates per 100,000 Children Age 0-17, Three-Year Moving Average, 1994-2007 (Based on OASIS Data)

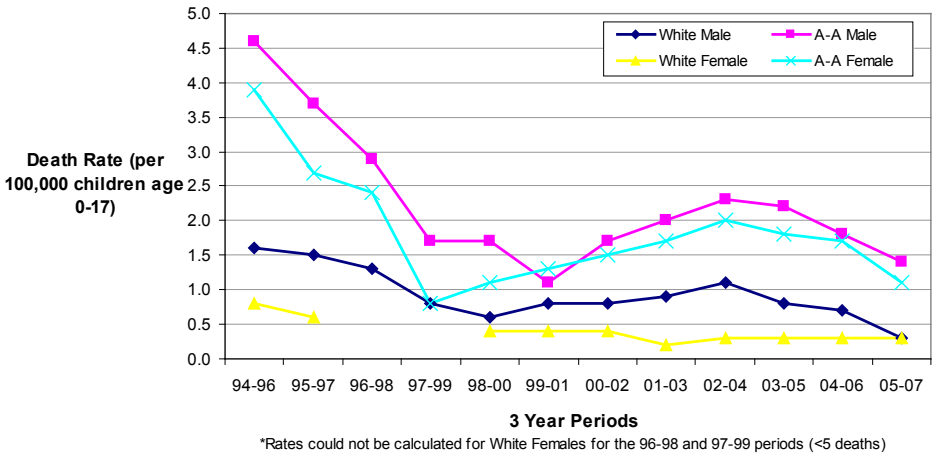


Figure 36 shows fire-related death rates since 1994

Findings:

- Fire deaths have continued to decline over the past five years
- The rate of fire deaths for African-American males and females continued to be higher than for White males and females

Facts:

- The USFA reported that children of all ages set over 35,000 fires annually
- The Home Safety Council's survey revealed respondents overwhelmingly named the kitchen the most dangerous room in the home
- Novelty and toy lighters are "linked to incidents of deaths, injuries, and property loss across the nation" (Home Safety Council, 2008)

Opportunities for Prevention

For Parents

- Never underestimate your child's curiosity about fire, nor their ability to strike matches or start a lighter
- Keep space heaters at least three feet away from anything that can burn
- Practice fire drills at night, since studies have shown that children may not awaken from the smoke alarm sound

For community leaders and policy makers

- Support funding requests for smoke alarm distribution programs

For professionals

- Spread the word about practicing fire drills at home
- Incorporate fire safety prevention messages into all injury prevention programming

Victim at a friend's house when fire broke out. All escaped safely, but decedent returned to house to get a video game.

Resources:

Home Safety Council
www.homesafetycouncil.org

United States Fire Administration
http://www.usfa.dhs.gov/index.shtm

Asphyxia Deaths

Unintentional asphyxia happened more often among infants during 2007 and 2008 than any other age group, occurring mostly during sleep. During 2007 and 2008 combined, there were 130 asphyxia deaths to children ages birth-17. In this section, the emphasis is on children older than age one (n=25), as infant asphyxia is discussed in the sleep-related death section. Toddlers accounted for 44% of asphyxia deaths for children ages 1-17, with objects exerting pressure on the neck area being a primary cause of death in this age group.

What is included in the definition of unintentional-related asphyxia?

Asphyxia occurs when there is an extreme decrease of oxygen in the body, accompanied by an increase of carbon dioxide, and usually caused by an interruption of breathing or suffocation.

How does GA compare with the U.S. average?

According to the National Center for Injury Prevention and Control, the United States' unintentional asphyxia child death rate was 1.54 per 100,000 children, while Georgia's was 1.34 in 2006.

Figure 37: Reviewed Asphyxia Deaths by Cause and Infant vs. Non-Infant, 2007-2008 (N=130)

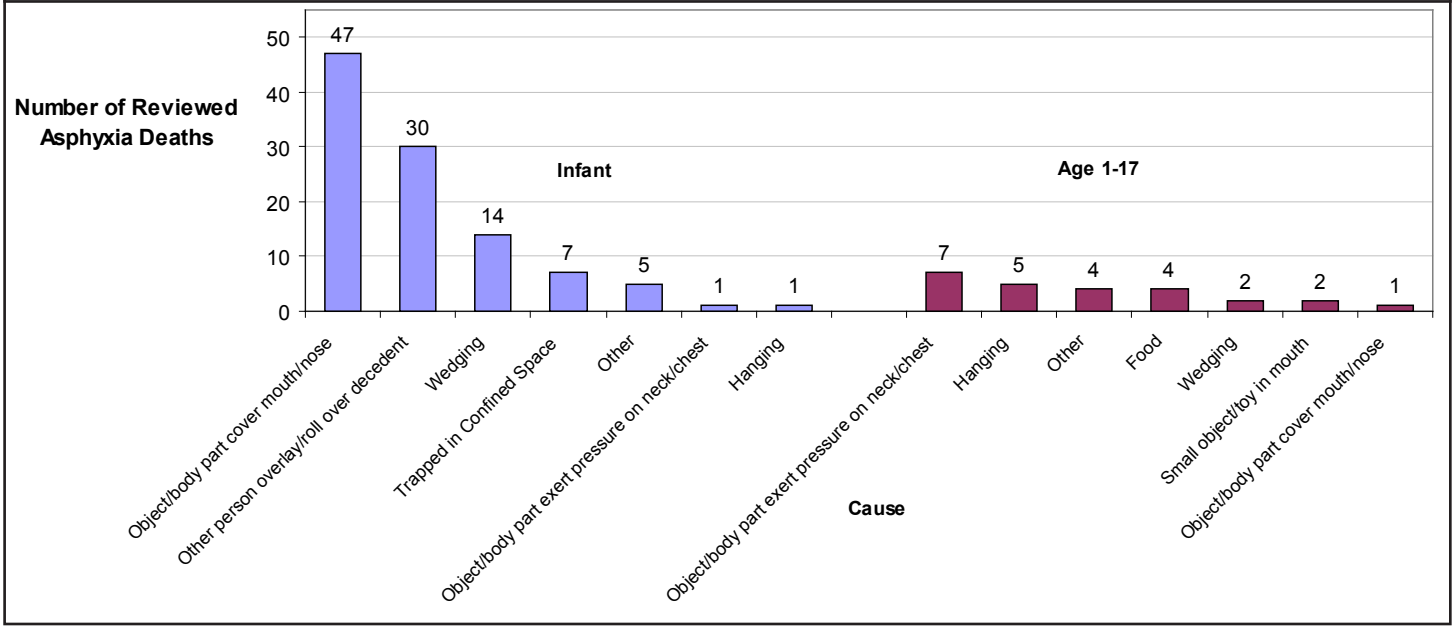


Figure 37 shows asphyxia deaths by cause, separating infant from other ages

Findings:

- During these two years, there were 25 asphyxia deaths for 1-17 year olds, with the majority of the deaths attributed to objects exerting pressure on the neck or covering the mouth/nose area (e.g., dresser fell on child; plastic bag on child's head)
- Unintentional hangings were reported for five children between the ages of five and 17, two of which were associated with either autoeroticism or the "choking game"

Fact:

- Warning signs for youth regarding the choking game include: mention of the choking game (or the game by its other names); bloodshot eyes; marks on the neck; frequent, severe headaches; disorientation after spending time alone; and ropes, scarves, and belts tied to bedroom furniture or doorknobs or found knotted on the floor (CDC, 2008)

Opportunities for Prevention:

For Parents

- Continue to monitor activities of children, especially school age children who are curious about games or activities they may learn about from their peers
- Use active supervision of young children paying attention to risky behaviors that may harm them
- Be able to recognize the warning signs of the choking game
- Learn Cardio-Pulmonary Resuscitation (C.P.R.)

For Community Leaders and Policy Makers

- Take a stand against asphyxiation games and educate your community regarding the warning signs and consequences associated with such activities
- Set an example and learn Cardio-Pulmonary Resuscitation (C.P.R.)

For Professionals

- Implement and complete an official "Games Adolescents Shouldn't Play" Training within your organization to promote awareness
- Medical Examiners and Coroners should be "aware of the choking game as a possible explanation for deaths from self-inflicted strangulation in youth that otherwise might be miscategorized as suicides" (CDC, 2008)
- Conduct research to provide effective interventions aimed at reducing or eliminating the choking-game participation

Resources

Centers for Disease Control and Prevention
MMWR, February 15, 2008, 57 (06); 141-144
www.cdc.gov

National Center for Injury Prevention and Control
www.cdc.gov/ncipc

Games Adolescents Shouldn't Play
www.stop-the-choking-game.com

Child put a rope around his neck and jumped out of a tree after telling his friend he would

Firearm-Related Deaths

During 2007 and 2008, 119 children were killed due to firearms caused by homicide, suicide, or unintentional injury. In Georgia, an African-American teen aged 15-17 is almost twice as likely to be murdered than that of a White teen in the same age group. Across the nation, firearm injuries take a toll on youth.

What is included in the definition of firearms?
A firearm is any weapon that fires a high-velocity projectile, and includes rifles, pistols, revolvers, shotguns, handguns, and BB guns.

How does GA compare with the U.S. average?
According to the National Center for Injury Prevention and Control, the national child death rate due to firearms (all intents) in 2006 was 2.16 per 100,000 children while Georgia's was 1.50 per 100,000. The unintentional firearm child death rate was .62 in the U.S. and .81 in Georgia, per 100,000 children. Georgia continues to be a state with one of the weakest Child Access Prevention Laws across the United States. Georgia's CAP law prohibits persons from intentionally, knowingly, and/or recklessly providing handguns to children under 18 years and hold parents liable when they know a "substantial" risk may occur. (O.C.G.A. 16-11-101.1).

Findings:

- Older teenagers represented the majority of firearm-related deaths (69%)
- African-American males accounted for the largest percentage of the firearm-related deaths (42%)

Fact:

- The Georgia Youth Risk Behavior Survey for 2007 indicated 20% of students reported they had carried a weapon such as a gun, knife, or club on at least one day during the 30 days prior to the survey

Figure 38: Reviewed Firearm-Related Deaths by Age, Race, and Gender, 2007-2008 (N=119)

	White Male	White Female	A-A Male	A-A Female	Other Race Male	Other Race Female
Infant	1	0	0	0	0	0
1 to 4	0	0	3	6	1	0
5 to 9	2	1	2	1	2	0
10 to 14	7	0	5	4	2	0
15 to 17	18	4	40	6	11	3

Figure 38 shows age, race, and gender breakdown of firearm-related deaths

Figure 39: Reviewed Firearm-Related Deaths by Intent 2007-2008 (N=119)

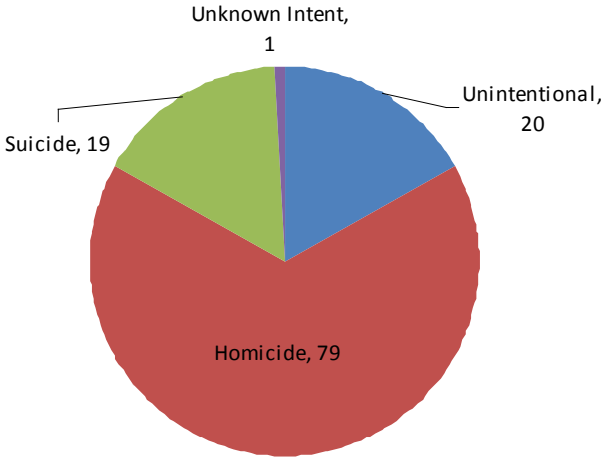


Figure 39 shows reported intention of intention of firearm-related deaths

Findings:

- Sixty-six percent of firearm-related deaths were homicides
- Sixty-eight percent of firearm suicides took place at the decedent's home

Facts:

- The Georgia Department of Natural Resources provides hunting education classes for youth. In Georgia, if you are between ages 12-15, you are allowed to hunt without a hunter education course, as long as you are under direct adult supervision. If you are over age 12, you can hunt unsupervised as long as you have received a hunter's education certificate
- Safe Kids USA reports that unintentional injury firearm-related deaths account for nearly 20% of all firearm related fatalities. In Georgia, they accounted for 17% of all firearm related fatalities for 2007-2008

Figure 40: Reviewed Firearm-Related Deaths by Location of Event 2007-2008 (N=119)

	Unintentional	Homicide	Suicide	Unknown Intent
Decedent's Home	6	19	13	0
Other Home	8	15	3	0
Parking Lot	0	7	0	0
Street	0	15	0	0
Driveway	1	0	1	0
Wooded area	2	4	0	0
Work Place	0	1	0	0
Rural Road	0	1		0
Other	3	17	2	1

Figure 40 shows the reported location of decedent at time of death

Findings:

- "Other" locations included places such as motels, apartments, restaurants, backyards, and shopping malls
- Forty percent of unintentional firearm-related deaths occurred at an "other home" such as a grandparent or friend's house
- Homicides by firearm occurred more in urban counties (60%) than in rural counties (7%)
- Unintentional firearm-related deaths were equally distributed in urban and rural Georgia

Facts:

- Georgia's law does not prohibit the sale of handguns to juveniles under the age of 21 by unlicensed sellers, it only applies to firearm dealers
- People who purchase firearms from unlicensed sellers are not subject to a background check

Finding:

- Handguns were used in 84% of firearm deaths

Fact:

- H.R. 256, The Child Gun Safety and Gun Access Prevention Act of 2007 was introduced into Congress. This legislation specifically calls for a raise in the handgun accessibility age to 21 (from 18)

Figure 41: Reviewed Firearm-Related Deaths by Type of Firearm 2007-2008 (N=119)

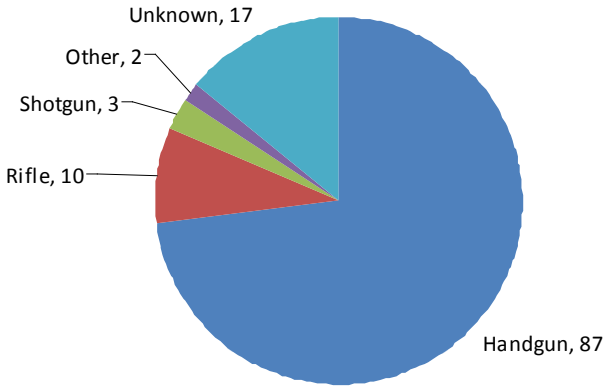


Figure 41 shows type of firearm used in reviewed firearm-related deaths

Resources:

The Brady Campaign
www.bradycampaign.org

Georgia Department of Natural Resources
www.georgiawildlife.dnr.state.ga.us

Safe Kids U.S.A.
www.safekids.org

www.opencongress.org

Hunting accident involving two youth. One youth thought movement in the bushes was a deer and shot his partner

Opportunities for Prevention:

For Parents

- If you must have firearms in the home, store the firearm and ammunition separately and the gun should be locked
- Ensure all youth attend hunting education classes and make sure they know how to properly secure the weapon while traveling back to vehicles and/or coming out of hunting stands
- Make sure children know what to do if they encounter a gun at a neighbors house

For Community Leaders and policy makers

- Support hunting education classes
- Improve the Child Access Prevention Law to increase negligence penalties for inadequate firearm storage
- Introduce legislation specific to requiring a minimum age for youth and rifles or shotgun usage, under parental supervision
- Introduce and support legislation mirroring that of federal law. Require unlicensed sellers of firearms to adhere to the same regulations as firearm dealers and not sell to persons under the age of 21

For professionals

- In order to decrease accessibility to firearms, promote public health awareness and education regarding the need for safe storage of all firearms in the home

Intentional Injury-Related Deaths

Although the majority of child fatalities are attributed to medical causes or are the result of unintentional circumstances, many children die as a result of intentional injuries, commonly at the hands of their loved ones. Intentional injuries resulting in death are those which are purposely inflicted either by oneself (**suicide**), or by another person (**homicide**). It also includes a willful, wanton, or reckless disregard for the safety of others during the course of action (for example, a child killed by a stray bullet). In 2007, local committees reviewed 87 child homicides and 19 child suicides. In 2008, committees reviewed 75 child homicides and 20 child suicides. The number of reviewed homicide deaths increased when compared to 56 in 2006. However, the number of reviewed child suicides decreased from 26 in 2006.

Homicide

The U.S. Census Bureau reports that homicide claims the lives of more teenagers than any other cause other than motor vehicle accidents. The risk for homicide is greater in infancy than in any other period of childhood before age 15. Homicides of infants and young children are most often committed in the home by parents/caregivers using "weapons of opportunity" (e.g., hands, feet, and household objects). The vast majority of perpetrators for infant/child homicide are female, and most often the mother. Certain maternal characteristics have been established as risk factors for infant/child homicide including age, marital status, and education (National Violent Death Reporting System, 2006).

As a society, we have treated violence as a criminal justice issue *after the fact* without prioritizing what can be done to *prevent violence before it occurs*. Prevention requires comprehensive, multi-faceted efforts to address the risk factors associated with violence.

How does Georgia compare with the U.S. average?
According to the National Center for Injury Prevention and Control, the U.S. child homicide rate was 2.45 per 100,000 while Georgia's child homicide rate was 1.94 per 100,000 in 2006. U.S. and Georgia child homicide rates have remained relatively constant over the past two decades. However, in Georgia, the number of reviewed child homicide deaths has steadily increased from 50 homicide deaths in 2005, 56 in 2006, 87 in 2007, and 75 in 2008.

Figure 42: Reviewed Homicide Deaths by Mechanism of Injury, 2007-2008 (N=162)

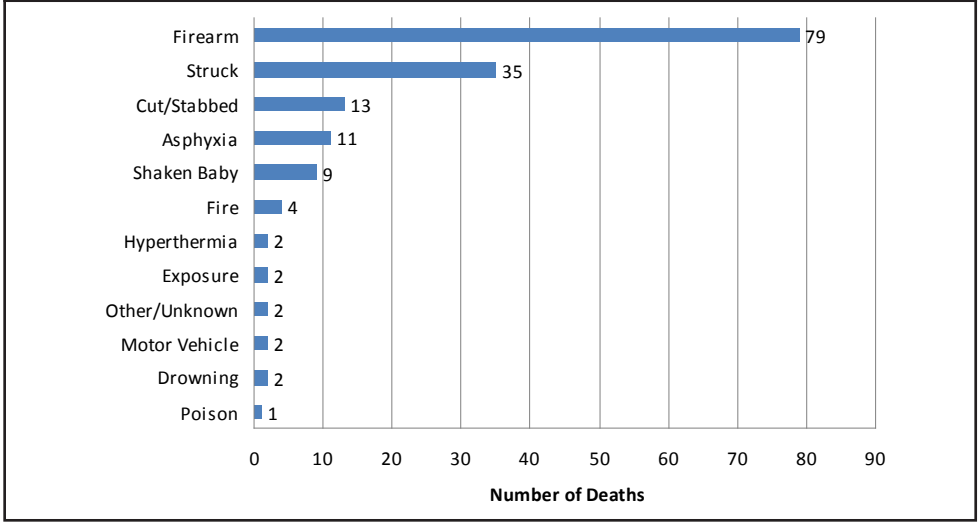


Figure 42 shows the mechanism of injury for the 162 children whose deaths were homicides in 2007-2008

Findings:

- Firearms were leading mechanism of injury accounting for almost half of the 162 homicide deaths for 2007-2008 (49%)
- Thirty-five deaths (22%) were attributed to violent force of impact resulting from being struck by an object or weapon
- The "other" category accounted for deaths in which the cause could not be clearly determined
- There were two "hyperthermia" and two "exposure" deaths for 2007-2008

Fact:

- In the U.S., approximately 37 children die of vehicular hyperthermia every year (since 1998). Studies indicate that these incidents can occur on days with relatively mild (i.e.~ 70 degrees F) temperatures and that vehicles can reach life-threatening temperatures very rapidly (Kids and Cars, 2009).

Findings:

- Older teens ranging in age from 15-17 accounted for the largest percentage (40%) of child homicides reviewed
- Children ages five to nine accounted for seven percent of the total reviewed homicides

Fact:

- Homicide rates for children significantly decrease between children ages five and 14, particularly after reaching school age

Figure 43: Reviewed Homicide Deaths by Age, 2007-2008 (N=162)

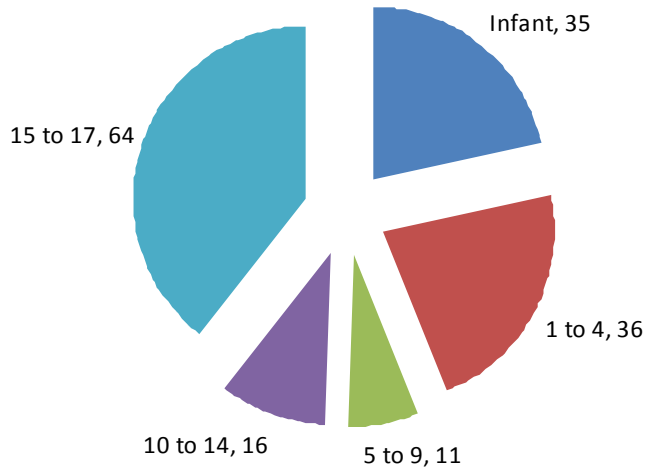


Figure 43 shows the number of deaths by age category for the 162 children whose deaths were homicides in 2007-2008

Findings:

- African-American males continue to be the highest-risk group for homicide representing almost half (43%) of all homicide deaths
- "Other race" females are the lowest-risk group for homicides accounting for four percent of all homicide deaths

Fact:

- Studies indicate a disproportionate rise in the risk of homicide for minority youth

Figure 44: Race/Gender Distribution for Reviewed Homicide Deaths, 2007-2008 (N=162)

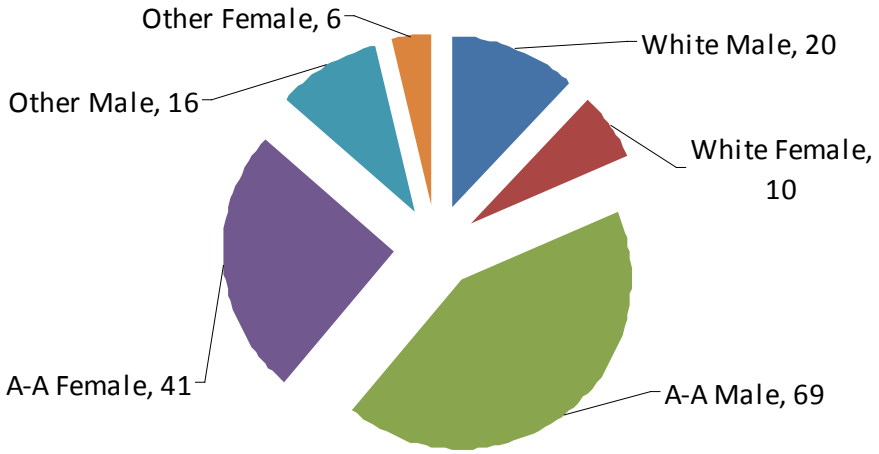


Figure 44 shows race and gender proportions for the 162 children whose deaths were homicides in 2007-2008

Opportunities for Prevention:

For Parents

- Enhance the ability to recognize personal stressors, anxieties, and triggers
- Seek assistance when feeling overwhelmed or stressed
- Reduce access to lethal weapons by securing firearms and other lethal weapons

For community leaders and policy makers

- Create incentives for parents to attain pre and post-natal parent training through programs that provide them with the knowledge and skills to appropriately respond to child-related stressors
- Establish strong, positive community support networks that are comprised of faith-based entities, neighborhood associations, and local service agencies
- Increase public awareness of the warning signs of child maltreatment and encourage community members to report child maltreatment to child protective service agencies

For professionals

- Provide respite care to assist parents and caregivers who are overwrought with stress
- Increase support for violence prevention programs
- Promote firearm safety to ensure that guns are secured and inaccessible to children and youth
- Implement in-school and after-school programs designed to engage children and youth in positive activities
- Link young parents with parent mentors for the purpose of developing and maintaining relationships rooted in modeling impulse control, anger and stress management, and other positive parenting behaviors

Resources:

National Center for Injury Prevention and Control (NCIPC)
http://www.cdc.gov/ncipc/

National Youth Violence Prevention Resource Center
http://www.safeyouth.org/

Urban Networks to Increase Thriving Youth (UNITY)
www.preventioninstitute.org

Father took his three young children deep into the woods where he shot each of them in the head. Moments later, he killed himself.

Suicide Deaths

Children and youth face many tough decisions and difficult life experiences that, at times, seem overwhelming. For many children, difficult, scary or threatening situations, e.g. loss of a loved one, family discord, or peer bullying, can cause so much distress that they try to find ways of escaping the problem. Unfortunately, far too often, they think of taking their own lives as a way of the escaping the pain. Although most youth contemplating suicide are not likely to seek help, they typically display warning signs to their friends, classmates, parents, and/or school personnel, thus heightening the importance of effective intervention strategies to help them face their problems in a healthy, productive way.

Now approaching epidemic proportions, suicide is currently the third leading cause of death among teens in the United States. It results in approximately 4,500 lives lost each year. Additionally, non-lethal suicide attempts and suicide ideation increase the magnitude of this problem. More young people survive suicide attempts than actually die. A nationwide survey of youth in grades 9-12 in public and private schools in the United States found that 15% of students reported seriously considering suicide, 11% reported creating a plan, and seven percent reporting trying to take their own life in the 12 months preceding the survey (CDC, 2009).

How does Georgia compare with the U.S. average?
According to the National Center for Injury Prevention and Control, the U.S. child suicide rate was 1.35 per 100,000 while Georgia's child suicide rate was 0.91 per 100,000 in 2006. In Georgia, reviewed child suicide deaths have fluctuated over the past few years with 20 child suicides in 2005, increasing to 26 child suicides in 2006, and declining to 19 child suicides in 2007.

Findings:

- Firearms accounted for the highest number of child suicide deaths for 2007-2008 (49%)
- Asphyxia and firearms combined account for almost all of the suicide deaths (92%)

Fact:

- Firearms remain the most commonly used method, of suicide among youth regardless of race or gender (American Association of Suicidology)
- According to the CDC, the top three methods used in suicides of young people include firearm (46%), asphyxia (39%), and poisoning (8%). Georgia's data for suicide among youth mirrored the CDC data

Figure 45: Reviewed Suicide Deaths by Method of Death 2007-2008 (N=39)

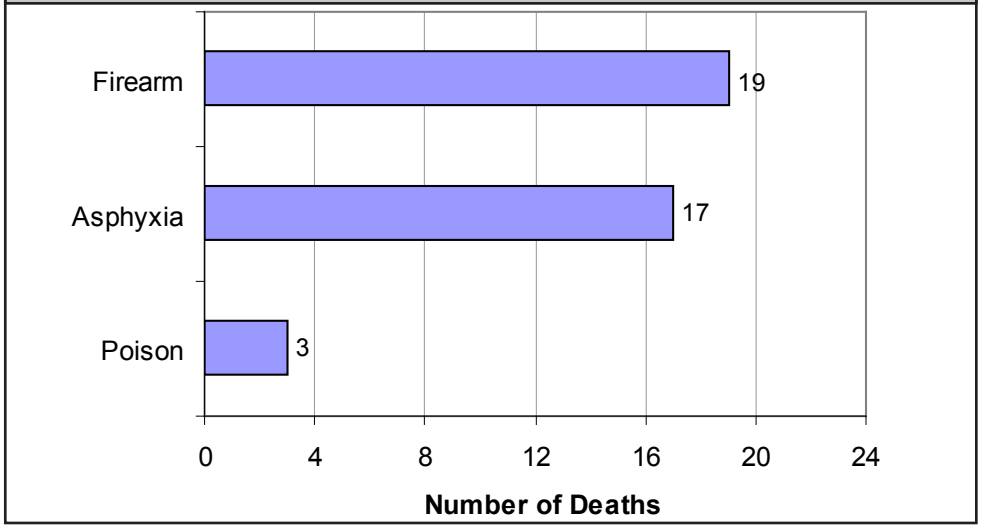


Figure 45 shows the mechanism of death for the 39 children who completed suicide in 2007-2008

Figure 46: Reviewed Suicide Deaths by Age, 2007-2008 (N=39)

Figure 46 shows the age breakdown for the 39 children who completed suicide in 2007-2008

Findings:

- Older teens accounted for 82% of the 39 suicide deaths for 2007-2008
- Seven children (18%) were between the ages of 10-14

Fact:

- Experts estimate that 20-25% of teens admit to thinking about suicide at some time in their lives and for every suicide, there are between five to 45 suicide attempts

Figure 47: Reviewed Suicide Deaths by Race, Gender and Proportion, 2007-2008 (N=39)

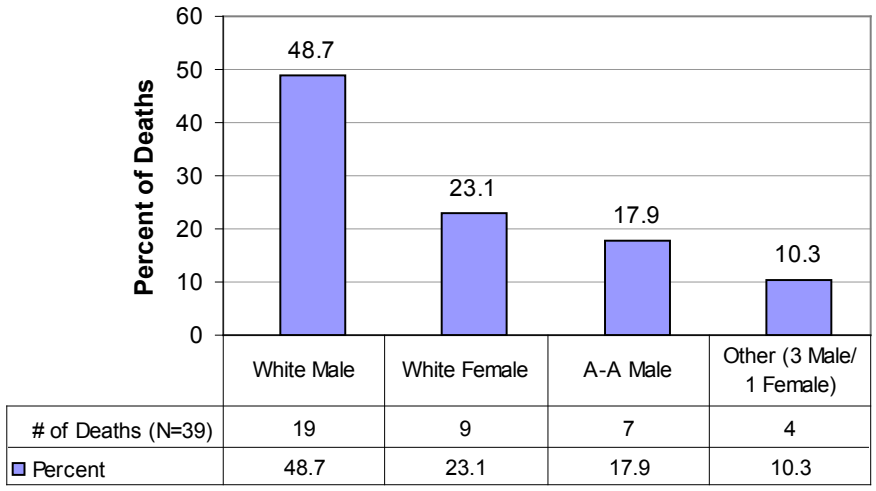


Figure 47 shows the number and proportion of reviewed suicide deaths by race and gender

Findings:

- White males accounted for the highest number of suicides for 2007-2008 (49%)
- There were no reviewed suicides for African-American females

Fact:

- White males are four times more likely to commit suicide than other race/gender groups, but White females are more likely to attempt suicide

Opportunities for Prevention

For Parents

- Recognize the risk factors and warning signs for suicide
- Develop and maintain an open, understanding parent-child relationship that fosters communication and trust
- Closely monitor children for changes in behavior e.g., loss of interest in favorite things
- Seek professional help when signs of depression, anxiety, and suicidal thoughts have been detected

For community leaders and policy makers

- Promote youth suicide campaigns within local communities
- Provide suicide prevention and intervention training for school personnel, service providers, and parents

For professionals

- Provide support services so that youth feel comfortable seeking help coping with stress, depression, and/or suicidal thoughts
- Educate parents about the seriousness of youth suicide and the importance of recognizing behavioral indicators of suicide

Decedent and mother were arguing over grades. Decedent went to his bedroom and mother heard a gunshot. Decedent was found on the floor by mother

Resources:

Center for Disease Control and Prevention (CDC)
www.cdc.gov

National Institute of Mental Health (NIMH)
http://www.nimh.nih.gov

Suicide Prevention Action Network (Georgia)
www.span-ga.org

Suicide Prevention Coalition of Georgia
www.spcgeorgia.org

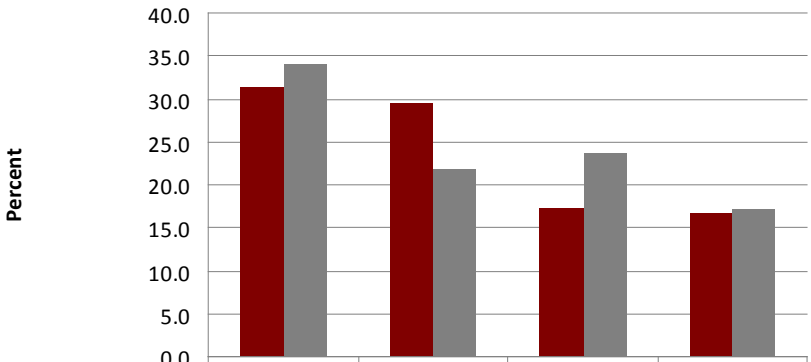
Suicide Prevention Resource Center
www.sprc.org

The National Suicide Hotline
1-800-SUICIDE (1-800-784-2433)

In 2007, Georgia's population was estimated at 9.5 million individuals. Of those, 2.5 million were children younger than 18 years of age (about 26%). Sixty-two percent of those youth were White; 34% were African-American, and five percent were of another race. While Hispanic ethnicity is included in the "race" categories, and is not separated in these data, the U.S. Census Bureau estimated that eight percent of all Georgians were Hispanic or Latino (of any race). Among the total 2007 youth population in Georgia, 152,919 were infants. African-American infants made up 32%, and White infants made up 62% of the total infant population. However, African-American infants and children ages 1-17 were over-represented in the fatality data, more so than their population proportion would suggest.

If the proportion of deaths to children mirrored the proportions of the population, then we could expect White children to make up about 62% of the total child deaths, and African-American children to make up about 33% of the total child deaths. That is not the reality indicated by CFR data.

Figure 48: Deaths to Children Ages 1 to 17 and Percent of Population in Georgia by Race and Gender, 2007 (based on Death Certificates)



	White Male	White Female	A-A Male	A-A Female
% of Population	31.3	29.5	17.3	16.7
% of Deaths	34.0	21.9	23.8	17.0

Figure 48: shows Deaths to Children Ages 1-17 and Percent of Population in Georgia by Race and Gender, 2007 (based on Death Certificates)

Fact:

- Certain medical conditions and injuries affect children disproportionately. For example, rates associated with more severe asthma outcomes (i.e., emergency department visits, hospitalizations and deaths) are notably higher for African-American children than for other groups. According to 2003-2004 data, the rates of asthma-related emergency department visits, hospitalizations and deaths for African-American children exceed those for White children by 260 percent, 250 percent and 500 percent, respectively. In particular, the death rate for African-American children was 9.2 per one million during this period, compared to only 1.3 per one million for White children (*Joint Center for Political and Economic Studies, 2009*)

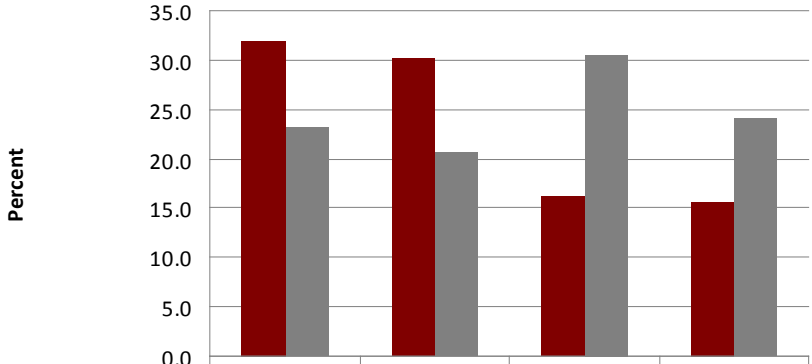
Findings:

- With the exception of White females, the percentage of deaths among each race/gender group was higher than their percentage of the population
- The percentage of deaths among African-American males was 37% higher than their percentage of the population, more than any other race/gender group reported

Findings:

- The percentage of deaths among African-American male infants was 90% higher than their percentage of the population, more than any other race/gender group reported
- While African-American infants made up 32% of the population, their percentage of deaths was 72% higher than their percentage in the population

Figure 49: Deaths to Infants and Percent of Population in Georgia by Race and Gender, 2007 (based on Death Certificates)



	White Male	White Female	A-A Male	A-A Female
% of Population	32.0	30.1	16.1	15.6
% of Deaths	23.1	20.6	30.6	24.0

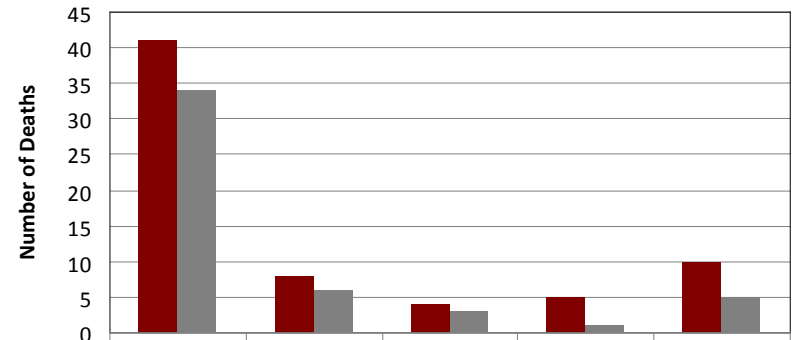
Figure 49 shows deaths to infants by race and gender, (based on Death Certificates)

Facts:

- The infant mortality rate (IMR) for African-Americans in 2006 was 13.7 per 1,000 live births, twice the national average of 6.9 per 1,000 births (*CDC*)
- Children of African-American women are the most likely to be born low-weight. Low-birthweight infants (those born weighing less than five pounds, eight ounces or 2,500 grams) are at increased risk for serious health problems or even death
- Maternal mortality was 3.4 times greater for African-American women compared to White women in 2006, which may be related to the disproportionate IMR and overall health disparities (*CDC*)

Low birthweight is widely used as an indicator of infant health, and has been linked to certain chronic conditions in adulthood, such as hypertension, Type 2 diabetes and heart disease (*March of Dimes 2008*). The high incidence of African-American infants born at low birthweight increases the likelihood of a child having health and learning problems down the road. For instance, a child born at low birthweight is about 50 percent more likely to score below average on measures of both reading and mathematics at age 17. While Hispanic children overall experience low-birthweight rates similar to that of White children, the rate of low-weight births to Puerto Rican women is slightly lower than the rate for African-American women, indicating that this Hispanic population is also at increased risk for associated health problems.

Figure 50: Hispanic Deaths by Age and Gender, 2007 (Based on Death Certificates)



	Infant	Age 1 to 4	Age 5 to 9	Age 10 to 14	Age 15 to 17
Male	41	8	4	5	10
Female	34	6	3	1	5

Figure 50: shows Hispanic Deaths by Age and Sex, 2007 (N = 117)

Findings:

- The number of deaths among Hispanic youth was higher in infancy (75) compared to all other ages from 1-17
- Hispanic females had fewer fatalities at every group compared to Hispanic males

Opportunities for Prevention:

For Parents:

- Seek information on prenatal health and wellness, ideally before becoming pregnant, to ensure overall healthy child development

For Community Leaders and Policymakers:

- Improve health coverage and access to prenatal health care for women. Almost one in every four pregnant Black women and more than one in three pregnant Latina women is uninsured, compared with one in nearly seven pregnant White women. Without coverage, they are less likely to access or afford prenatal care, and may not get the advice, examinations and screenings that could protect the health of both mothers and infants
- Improve health coverage and access for all children. Children without insurance are 60 percent more likely to die than their insured peers, according to a 2009 study from Johns Hopkins University
- Provide diversity training to service providers and community advocates

For Professionals:

- The AAP recommends that health surveillance and research should incorporate resources, such as education, income, and wealth, and the other includes status or rank, a function of relative positions in a hierarchy, such as social class, in addition to other social factors. Only then can effective preventive intervention strategies be developed and implemented during childhood to improve the health of our children

There are a number of factors that may contribute to the racial and ethnic disparities among youth in Georgia, including social, economic, and educational. A collaborative, systemic approach is necessary to address these issues. We must view these deaths not as individual, isolated events, but in a socio-ecological framework that encompasses all areas of a child's life – from family to community to policy. Any successful strategy to reduce disproportionate deaths among infants and youth must include members of families, communities, educators, and policymakers at every level – from inception to program development to evaluation. Successful strategies are not short-term programs; they are long-term paradigm shifts that remain prevalent in our culture for generations.

Resources:

www.CDC.gov/nchs for rates, vital statistics and health disparities

www.Census.gov for demographic and population data

www.childrensdefensefund.org for prevention information

THE HISTORY OF CHILD FATALITY REVIEW IN GEORGIA

1990 - 1993

Legislation established the Statewide Child Fatality Review Panel with responsibilities for compiling statistics on child fatalities and making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols for the investigation of alleged child abuse and neglect cases. Statutory amendments were adapted to:

- Establish a separate child fatality review team in each county and determine procedures for conducting reviews and completing reports
- Require the Panel to:
  - Submit an annual report documenting the prevalence and circumstances of all child fatalities with special emphasis on deaths associated with child abuse
  - Recommend measures to reduce child fatalities to the Governor, the Lieutenant Governor, and the Speaker of the Georgia House of Representatives
  - Establish a protocol for the review of policies, procedures and operations of the Division of Family and Children Services for child abuse cases

1996 - 1998

- The Panel established the Office of Child Fatality Review with a full-time director to administer the activities of the Panel
- Researchers from Emory University and Georgia State University conducted an evaluation of the child fatality review process. The evaluation concluded that there were policy, procedure and funding issues that limited the effectiveness of the review process. Recommendations for improvement were made to the General Assembly
- Statutory amendments were adopted to:
  - Identify agencies required to be represented on child fatality review teams, and establish penalties for non-participation
  - Require that all child deaths be reported to the coroner/medical examiner in each county

1999 - 2001

- Child death investigation teams were initially developed in four judicial circuits as a pilot project, with six additional teams later added. Teams assumed responsibility for conducting death scene investigations of child deaths that met established criteria within their judicial circuit
- Statutory amendments were adopted which resulted in the Code section governing the Child Fatality Review Panel, child fatality review committees, and child abuse protocol committees being completely rewritten. This was an attempt to provide greater clarity and a more comprehensive, concise format
- The Panel's budget was increased

2002 – 2005

- The Panel published and distributed a child fatality review protocol manual to all county committee members
- Statutory amendments were adopted which resulted in the following:
  - Appointment of District Attorneys to serve as chairpersons of local committees in their circuits
  - Authority of the Superior Court Judge on the Panel to issue an order requiring the participation of mandated agencies on local child fatality review committees. Failure to comply would be cause for contempt
  - Authority of the Panel to compel the production of documents or the attendance of witnesses pursuant to a subpoena
  - Director of the Division of Mental Health added as a member of the Panel
- Funding was secured and an on-line reporting system was established for both the child fatality review report and the coroner/medical examiner report
- A collaboration was established between the Office of Child Fatality Review and the National Center for Child Death Review
- The Georgia Child Fatality Investigation Program was established through a partnership between OCFR, DFCS and the Georgia Bureau of Investigation. A director was hired to advance a multi-disciplinary approach to child death investigation through development and training of local teams.
- A Statewide Model Child Abuse Protocol was developed and distributed to all Protocol committee members

- A Prevention Advocate was added, by policy, to all child fatality review committees. Statewide training was conducted for all prevention advocate members
- A quarterly newsletter was created and distributed. The newsletter is sent to all child fatality review members and contains useful information about the process as well as prevention
- Annual awards were established for the Child Fatality Review Coroner of the Year and Child Fatality Review County Committee of the Year. Awards are presented at the annual Child Fatality and Serious Injury Conference sponsored by the Panel, DHR, GBI and the Office of the Child Advocate
- A sub-committee of the Panel was formed to begin working on a Statewide Prevention Plan. The sub-committee also includes outside agencies working in the prevention field

2006-2008

- The Child Fatality Review committee protocol was revised and updated to reflect best practices. The Protocol was presented to all county committee members and is also available online
- The Panel subcommittee on prevention completed the Statewide Child Fatality Prevention Framework. The Framework was presented to the Governor's Office and other agency partners
- An annual award was established for the Outstanding Investigator/Team of the Year for death investigation cases.
- The CFIT Program expanded to address all types of multi-disciplinary child abuse investigations, including sex abuse, physical abuse and neglect as well as homicides
- The Panel added a Prevention Specialist staff position to assist the local efforts in child fatality prevention
- Annual CFR Coroner of the Year and CFR Committee of the Year winners were recognized by the Georgia Senate honoring their work
- The Office of Child Fatality Review merged with the Office of the Child Advocate for the Protection of Children

2009

- Adopted National Child Death Review online reporting form for all child deaths
- Included as one of five states to participate in three-year CDC pilot project to improve investigation, review and reporting of unexpected infant deaths
- Expanded CFIT program to include a child abuse investigation training academy

CRITERIA FOR CHILD DEATH REVIEWS

Child Fatality Review Committees are required to review the deaths of all children under the age of 18 that meet the criteria for a coroner/medical examiner's investigation.

"Eligible" Deaths or Deaths to be Reviewed by Child Fatality Review Committees

The death of a child under the age of 18 must be reviewed when the death is suspicious, unusual, or unexpected. Included in this definition are incidents when a child dies:

1. as a result of violence
2. by suicide
3. by a casualty (i.e., car crash, fire)
4. suddenly when in apparent good health
5. when unattended by a physician
6. in any suspicious or unusual manner, especially if under 16 years of age
7. after birth but before seven years of age if the death is unexpected or unexplained
8. while an inmate of a state hospital or a state, county, or city penal institution
9. as a result of a death penalty execution

Timeframes

If child is resident of the county**, medical examiner or coroner will notify chairperson of child fatality review committee in the child's county of residence within** 48 hours **of receiving report of child death (Code Section 19-15-3).**

If child is not resident of county, medical examiner or coroner of the county of death will notify the medical examiner or coroner in the county of the child's residence within **48 hours** of the death.

Within **7 days**, coroner/medical examiner in county of death will send coroner/medical examiner in county of residence a copy of Form 1 along with any other available documentation regarding the death.

Upon receipt, coroner/medical examiner in county of residence will follow outlined procedures

Medical examiner or coroner reviews the findings regarding cause of death.

If cause of **death meets the criteria** for review pursuant Code Section 45-16-24, medical examiner or coroner will complete Form 1 and forward to the chair of the child fatality review committee for review within **7 days** of child's death.

If cause of death does not meet the criteria for review pursuant to Code Section 45-16-24, the medical examiner/coroner will complete Sections A, B, and J of Form 1 and forward to the chair of the child fatality review committee within **7 days**.

If chair believes death meets the criteria for review, chair will call committee together.

If chair of committee agrees that death does not meet criteria for review, then chairperson signs Section J of Form 1 and forward to the Office of Child Fatality Review.

Committee meets to review report and conduct investigation into the child death within **30 days** of receiving the report.

Committee will complete its investigation within **20 days** after the first meeting following the receipt of the medical examiner or coroner's report.

Committee transmits a copy of its report within **15 days** of completion to the Office of Child Fatality Review.

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.

Total Child Fatalities Based on Death Certificate (N=1,850)

	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Totals
Infant (Age < 1)								
	Drowning				2			2
	Fall				1			1
	Fire		1					1
	Homicide	3	3	9	1			16
	Medical	222	199	295	228	14	6	964
	MVA	2	2		1			5
	Other Injury		1	1	2			4
	OthSID			1				1
	Poison			1				1
	SIDS	36	25	46	37			144
	Suffocation	5	5	6	9			25
	Unknown Intent				1			1
	Unknown	9	11	7	6			33
	Totals	277	247	366	288	14	6	1198
Ages 1 to 4								
	Drowning	12	9	3	2			26
	Fire		1	1	2			4
	Firearm	1		1				2
	Homicide	1		5	12			18
	Medical	24	31	19	18	3	4	99
	MVA	9	3	6	6			24
	Other Injury	2	2	1	1			6
	Poison				2			2
	Suffocation	1		2	2	1		6
	Unknown Intent	1	1		1			3
	Unknown	1	2	2	1			6
	Totals	52	49	40	47	4	4	196
Ages 5 to 14								
	Drowning	4	1			1		6
	Fire	1		4	1			6
	Firearm	3		1				4
	Homicide	5		4	8			17
	Medical	35	23	35	19	2	2	116
	MVA	20	11	7	7		1	46
	Other Injury	4	4		3			11
	Poison	1						1
	Suffocation	1	1	2				4
	Suicide	2					1	3
	Unknown	2	1	1	1			5
	Totals	78	41	54	39	3	4	219
Ages 15 to 17								
	Drowning	1		4				5
	Fall	1						1
	Fire	1						1
	Firearm	1		1				2
	Homicide	8	3	17	6	1		35
	Medical	14	17	16	11	1		59
	MVA	35	23	18	6	2	1	85
	Other Injury	8	1	2				11
	Poison	7	3					10
	Suffocation	1				1		2
	Suicide	10	5	1				16
	Unknown Intent			2				2
	Unknown	5	1		2			8
	Totals	92	53	61	25	5	1	237

Total Reviewed Child Fatalities, 2007 and 2008 Combined

	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Totals
Infant (Age < 1)								
	Drowning	1			2	1		4
	Fire		1		2	1		4
	Homicide	5	4	15	6	3	2	35
	Medical	13	10	24	17	6	5	75
	MVA	2	4	3	3	2		14
	Other Injury	1	2	1	1			5
	Poison		1	1				2
	SIDS	10	8	13	5	1	1	38
	Suffocation	17	22	30	24	7	5	105
	SUID	56	36	59	44	18	17	230
	Unknown Intent	1		1	1	1		4
	Unknown	2	3	3	2		1	11
	Totals	108	91	150	107	40	31	527
Ages 1 to 4								
	Drowning	15	9	7	4	3	3	41
	Fire		1	4	2			7
	Firearm			2		1		3
	Homicide		1	14	18	1	2	36
	Medical	10	7	8	9	4	4	42
	MVA	11	8	7	7	5	3	41
	Other Injury	1	1	2	1	1	1	7
	Poison		1		4		1	6
	Suffocation	5	1	2	2	1		11
	Unknown Intent	2	1	1				4
	Unknown	2	2	3	2			9
	Totals	46	32	50	49	16	14	207
Ages 5 to 14								
	Drowning	7	1	6		3		17
	Fire	4		6	3			13
	Firearm	4		1	1	2		8
	Homicide	6	2	6	10	3		27
	Medical	11	7	14	8	3	2	45
	MVA	30	16	15	11	8	2	82
	Other Injury	2	1	1	2	1	2	9
	Poison		1					1
	Suffocation	3	1	2		1		7
	Suicide	3	1	1		1	1	7
	Unknown Intent	2		2		1		5
	Unknown	1		1	1			3
	Totals	73	30	55	36	23	7	224
Ages 15 to 17								
	Drowning	4		6		2		12
	Fire	1				1		2
	Firearm	2		2	2	2	1	9
	Homicide	9	3	34	7	9	2	64
	Medical	5	3	5	7		2	22
	MVA	42	26	21	8	12	7	116
	Other Injury	6		2		1		9
	Poison	14	3		1	2		20
	Suffocation	3	1	2		1		7
	Suicide	16	8	6		2		32
	Unknown Intent			1				1
	Totals	102	44	79	25	32	12	294

Reviewed Child Fatalities with Abuse/Neglect Findings

	Cause of Death	White Male	White Female	A-A Male	A-A Female	Other Male	Other Female	Totals
Infant (Age < 1)								
	Drowning				1			1
	Fire				2			2
	Homicide	4	4	15	6	3	2	34
	Medical	1		1	4		1	7
	MVA				1			1
	Other Injury	1	1	1				3
	SIDS			4				4
	Suffocation	5	4	16	7	1	2	35
	SUID	8	3	17	14	8	1	51
	Unknown Intent				1	1		2
	Unknown		2	2	1		1	6
	Totals	19	14	56	37	13	7	146
Ages 1 to 4								
	Drowning	6	4	4	3		2	19
	Fire		1	3	2			6
	Firearm					1		1
	Homicide		1	12	17	1	2	33
	Medical			1	1			2
	MVA	4	1	2	2	1	1	11
	OthInjury			1	1			2
	Poison				1			1
	Suffocation	2	1		1			4
	UnkInt	1						1
	Totals	13	8	23	28	3	5	80
Ages 5 to 14								
	Drowning	3				1		4
	Fire			1	1			2
	Firearm				1			1
	Homicide	1	1	1	2	1		6
	Medical		1					1
	MVA	5	1	3				9
	OthInjury						1	1
	Suffocation			1				1
	Suicide			1				1
	Totals	9	3	7	4	2	1	26
Ages 15 to 17								
	Fire					1		1
	Firearm					1		1
	Homicide		1	4		2	1	8
	Medical						1	1
	MVA	2		2				4
	Poison	1						1
	Suicide	1		1				2
	Totals	4	1	7	0	4	2	18

Preventability for Reviewed Deaths with Suspected or Confirmed Abuse or Neglect (N = 270)

	Preventability			
Cause of Death	Not at All	Possibly	Definitely	Missing
Drowning			24	
Fire		1	10	
Firearm			3	
Homicide	4	11	66	
Medical	1	8	2	
MVA	1	2	22	
Other Injury			6	
Poison			2	
SIDS		4		
Suffocation		19	20	1
Suicide		1	2	
SUID		45	6	
Unknown Intent		2	1	
Unknown		6		
Totals	6	99	164	1

Preventability for Reviewed Deaths with No Suspected or Confirmed Abuse or Neglect (N = 982)

	Preventability			
Cause of Death	Not at All	Possibly	Definitely	Missing
Drowning	2	18	30	
Fire		6	9	
Firearm		6	11	
Homicide	4	10	67	
Medical	97	72	4	
MVA	17	79	132	
Other Injury	4	9	11	
Poison	2	7	17	1
SIDS	20	14		
Suffocation	8	38	44	
Suicide	6	22	8	
SUID	29	131	17	2
Unknown Intent	2	4	5	
Unknown	3	13	1	
Totals	194	429	356	3

Map: Number of Reviewable Deaths 2007

APPENDIX D

Appendix E

2007 Child Fatality Reviews, By County, By Age Groups

Appendix E presents county level data for the Child Fatality Review process in 2007. The data are presented for four age groups (infants less than one year old, children from 1 to 4 years of age, children 5 to 14, and teenagers ages 15 to 17). Four numbers are provided for each age group:

Total Deaths: The total number of deaths (all causes) for that age group. This number is generally based on Georgia death certificate data and only includes deaths to Georgia residents under the age of 18. This does include deaths of Georgia residents that occurred in other states and were reported back to Georgia, but it does not include deaths of out-of-state residents that occurred in Georgia. The review committee of the child's county of residence has the responsibility of reviewing deaths. However, the residence determined by the committee may not correspond with the residence reported on the death certificate. If the review committees identified any deaths that occurred to residents of other states and were coded as Georgia residents on the death certificates, then those deaths are not included in the child death statistics presented in this report.

Reviewable Deaths: The number of SIDS/SUIS, unintentional, or violence-related deaths (reviewable deaths) according to the death certificate classifications. Although other deaths due to medical or natural causes may be eligible for review according to OCGA 19-15-3(e), SIDS deaths are explicitly required to be reviewed, and unintentional/violence related deaths should be reviewed as "sudden or unexpected deaths." Thus, this number represents a minimum number of deaths that should be reviewed. This is a subset of total deaths (DTH). The death certificate is not a "perfect" determinant of reviewable deaths. For example, a death certificate may be file with "R99" (undetermined) for the cause of death. The review committee may have autopsy or toxicology information that identifies a specific cause. If that is a medical cause, the review committee may not complete a review.

Reviewable Deaths Reviewed: The number of SIDS, unintentional, or violence related deaths that were reviewed. This number is a measure of how well a county identified and reviewed the minimum number of appropriate deaths. This is a subset of the total "reviewable" deaths. However, there are several sources of error (or inconsistencies) in the county-level tables. The CFR committee may have access to additional information regarding the death and the committee may reach a different conclusion regarding the cause of death.

Total Deaths Reviewed: This is the total number of child deaths in 2007 for which a Child Fatality Review Report was submitted. It includes deaths due to natural causes (other than SIDS) in addition to those deaths that were identified as eligible for review. This reflects the work of the committee within the county of residence identified from the death certificates.

Seventy-Two (72) of 612 "reviewable" CY2007 deaths were not reviewed (in contrast, one hundred fifteen-115 were not reviewed in 2006). There were also 32 reviewed deaths that could not be matched to a death certificate.

All Deaths						All Reviewable Deaths					Reviewable Deaths Reviewed					All Deaths Reviewed				
County	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Appling	2	1			3	1	1			2	1	1			2	1	1			2
Atkinson																				
Bacon				1	1				1	1										
Baker			2		2			2		2			2		2			3		3
Baldwin	6		2	3	11	1		1		2	1		1		2	2		1		3
Banks	2				2															
Barrow	3	2	3	1	9		1	2	1	4		1	2	1	4		1	3	1	5
Bartow	9	3	3	2	17	1	3	2	2	8		3	2	2	7		3	2	2	7
Ben Hill	3	2	1		6	2		1		3	2		1		3	2	1	1		4
Berrien	3				3	1				1						1				1
Bibb	34	6	3	7	50	6	3		3	12	6	2		2	10	8	2	1	3	14
Bleckley	1				1	1				1	1				1	1				1
Brantley	2	1		2	5	1	1		1	3	1	1		1	3	1	1		1	3
Brooks	3	1			4	1	1			2	1	1			2	1	1			2
Bryan	3			3	6	1			3	4				3	3				3	3
Bulloch	5	2	1	1	9		1	1	1	3		1		1	2		1		1	2
Burke	2	1		2	5	1	1		2	4	1	1		2	4	2	1		2	5
Butts	3	1	1	2	7		1	1	1	3		1	1	1	3		1	1	1	3
Calhoun				1	1				1	1				1	1	1			1	2
Camden	6			1	7	1			1	2	1			1	2	2			1	3
Candler	1		1		2															
Carroll	12		2	4	18	2		1	4	7	1		1	3	5	1		1	3	5
Catoosa	6		2	2	10	2		1	1	4	1		1	1	3	1		1	1	3
Charlton	2	1		1	4	1	1		1	3	1	1		1	3	1	1		1	3
Chatham	35	8	6	3	52	5	7	2	3	17	5	7	2	3	17	7	8	3	3	21
Chattahoochee	2				2	1				1										
Chattooga	3		3	1	7	1			1	2	1			1	2	2			1	3
Cherokee	17	3	3	4	27	6		1	4	11	6		1	4	11	8		2	4	14
Clarke	12		5	1	18	3		2	1	6	2		1	1	4	4		2	1	7
Clay																				
Clayton	56	10	13	12	91	10	6	4	10	30	10	6	3	9	28	12	7	5	9	33
Clinch	2				2															
Cobb	70	9	7	11	97	9	5	2	8	24	6	5	2	8	21	12	6	2	9	29

All Deaths						All Reviewable Deaths					Reviewable Deaths Reviewed					All Deaths Reviewed				
Coffee	9	2	4	1	16	1	1	1	1	4	1	1	1	1	4	1	1	2	1	5
Colquitt	7	1			8	1				1	1				1	5				5
Columbia	10	3			13	2	3			5	2	3			5	3	3			6
Cook	2		1		3	1		1		2	1		1		2	1		1		2
Coweta	4	5	4	1	14	1	3	2		6	1	3	2		6	3	3	2		8
Crawford				1	1															
Crisp	3		1		4	1		1		2	1				1	1				1
Dade	1	1			2	1	1			2	1	1			2	1	1			2
Dawson	2			2	4				2	2				1	1				1	1
Decatur	4	1			5	1				1	1				1	1				1
DeKalb	104	13	7	14	138	24	7	4	11	46	22	7	4	8	41	28	8	5	8	49
Dodge	5	1	1		7	2				2	2				2	2	1	1		4
Dooly	4	1			5	1				1	1				1	2				2
Dougherty	20	1	3	3	27	3			2	5	2			1	3	2			1	3
Douglas	17	2	1	4	24	6	1		4	11	4	1		3	8	5	1		3	9
Early	5				5															
Echols																				
Effingham	7	1	3		11			3		3			3		3			3		3
Elbert	3	1		2	6		1		2	3		1		2	3		1		2	3
Emanuel	2	1			3		1			1		1			1		1			1
Evans	2	4	2		8	1	3	1		5	1	3	1		5	1	3	1		5
Fannin	1	2			3															
Fayette	5	1	2	2	10			2	1	3			1	1	2			1	1	2
Floyd	16	5	2	7	30	3	3		5	11	2	3		5	10	6	2	1	6	15
Forsyth	13	2	2	3	20	1	2	1	2	6	1	2	1	2	6	1	2	1	2	6
Franklin	3				3	3				3	3				3	4				4
Fulton	121	14	23	22	180	28	7	9	16	60	26	7	9	14	56	28	8	11	15	62
Gilmer	2		1		3															
Glascock	1				1															
Glynn	14	2	5	2	23	3	2	5	1	11	3	2	5	1	11	5	2	4	2	13
Gordon	5	2	4	1	12	2		2	1	5	2		2	1	5	3	2	2	1	8
Grady	4		1	1	6	2			1	3	2				2	2				2
Greene	1				1															
Gwinnett	75	8	14	16	113	9	4	3	14	30	7	3	3	14	27	9	3	7	14	33
Habersham				2	2				1	1				1	1				1	1

All Deaths						All Reviewable Deaths					Reviewable Deaths Reviewed					All Deaths Reviewed				
Hall	20	2		6	28	2	1		4	7	1	1		2	4	1	1		2	4
Hancock																				
Haralson	3	2		1	6	2	1		1	4	2				2	2				2
Harris	1			1	2				1	1				1	1				1	1
Hart	1		1	2	4			1	1	2										
Heard																				
Henry	29	3	3	10	45	4	1	2	8	15	4	1	2	8	15	6	1	2	9	18
Houston	22	2	3	4	31	3	1	3	2	9	1	1	2	1	5	1	1	2	1	5
Irwin	1	1	1		3															
Jackson	7			1	8	2			1	3	2			1	3	2			1	3
Jasper	4			1	5				1	1				1	1	1			1	2
Jeff Davis			1		1													1		1
Jefferson	1		1	1	3			1	1	2			1	1	2			1	1	2
Jenkins	1				1															
Johnson																				
Jones	8				8	1				1	1				1	1				1
Lamar	2				2															
Lanier	2				2	1				1	1				1	1				1
Laurens	9		1		10	1				1	1				1	1				1
Lee	3	1	1		5			1		1			1		1	1		1		2
Liberty	12	2	3	4	21	2	2	1	3	8	2	2	1	3	8	2	2	1	3	8
Lincoln																				
Long	2		1	1	4			1	1	2			1		1			1		1
Lowndes	30	3	2	1	36	7	2	1	1	11	6	2		1	9	7	2		1	10
Lumpkin	1	1			2	1				1	1				1	1				1
Macon	1			1	2				1	1				1	1				1	1
Madison	1	1		1	3				1	1				1	1				1	1
Marion	1			1	2															
McDuffie	4		1	2	7			1	2	3			1	2	3	2		1	2	5
McIntosh			1	1	2															
Meriwether	3		1		4											1		1		2
Miller			1	1	2			1		1			1		1			1		1
Mitchell	1		1		2															
Monroe	2				2															
Montgomery	1				1	1				1	1				1	2				2

All Deaths						All Reviewable Deaths					Reviewable Deaths Reviewed					All Deaths Reviewed				
Morgan	1	1		1	3												1		1	2
Murray	5	1	2	1	9	1			1	2				1	1	1	1	1	1	4
Muscogee	47	7	5	3	62	9	2	3	2	16	8	2	2	2	14	10	2	4	3	19
Newton	7	5	2	3	17	1	1	1	2	5	1	1	1	1	4	2	2	3	2	9
Oconee	2				2	1				1										
Oglethorpe		1	1		2		1			1		1			1		1			1
Paulding	14	2	3	2	21	5		1	2	8	5		1	2	8	8	1	1	2	12
Peach	9	3	1		13	1	2	1		4	1	2	1		4	2	2	1		5
Pickens	3	2	1	2	8		2	1	2	5		2		2	4	1	2		2	5
Pierce		1		2	3				1	1				1	1		1		1	2
Pike	2	1			3															
Polk	4	1	2	2	9		1	2	1	4			2	1	3			2	1	3
Pulaski				1	1				1	1				1	1				1	1
Putnam	3	2	2		7	1		2		3	1		2		3	1		2		3
Quitman	2				2															
Rabun	1	1		1	3		1		1	2		1		1	2		1		1	2
Randolph																				
Richmond	33	6	4	6	49	5	2	1	4	12	5	2	1	3	11	8	4	4	4	20
Rockdale	8	1	3	1	13	2	1	2	1	6	2		2	1	5	2		3	1	6
Schley			1		1			1		1										
Screven	4			1	5	1				1										
Seminole				1	1				1	1				1	1				1	1
Spalding	5	4	2	2	13		1		1	2		1		1	2		3	2	1	6
Stephens	3	1	3		7		1	3		4		1	3		4	1	1	3		5
Stewart	1		1		2											1				1
Sumter	3		2	1	6	1				1	1				1	1				1
Talbot	3				3															
Taliaferro																				
Tattnall	3		1	1	5				1	1				1	1			1	1	2
Taylor	1				1	1				1	1				1	1				1
Telfair	2	1		1	4	2			1	3	2			1	3	2			1	3
Terrell	2	1		1	4		1			1		1			1		1			1
Thomas	2	2	2	1	7			2	1	3			2	1	3	1		2	1	4
Tift	5		2	4	11	3			4	7	3			3	6	4			3	7
Toombs	4	1	2		7		1			1		1			1	1	1			2

All Deaths						All Reviewable Deaths					Reviewable Deaths Reviewed					All Deaths Reviewed				
Towns																				
Treutlen	1				1															
Troup	9		1	1	11	2			1	3	2				2	2				2
Turner	3			1	4															
Twiggs	2		1		3	1		1		2	1				1	1				1
Union																			1	1
Upson	3		1		4	1		1		2	1		1		2	1		1		2
Walker	5	2	2		9	4		2		6	3		2		5	3	1	2		6
Walton	11	1	2	2	16	5		2	2	9	5		1	2	8	6		1	2	9
Ware	3		1		4															
Warren																				
Washington	4	1			5	1				1	1				1	1	1			2
Wayne	4	1	2		7	1		2		3	1		2		3	2		2		4
Webster	1		1		2			1		1			1		1			1		1
Wheeler	3				3															
White	2				2															
Whitfield	10	2	3	4	19	1		2	3	6	1		2	2	5	2	1	2	2	7
Wilcox		1			1		1			1		1			1		1			1
Wilkes			1		1			1		1			1		1			1		1
Wilkinson	5			1	6				1	1				1	1	1			1	2
Worth	3			1	4	2			1	3	2				2	2				2
Totals	1,198	196	219	237	1,850	234	97	103	178	612	205	92	90	153	540	284	112	121	164	681

GLOSSARY OF TERMS

AA - African American
Asphyxia - the extreme condition caused by lack of oxygen and excess of carbon dioxide in the blood, produced by interference with respiration or insufficient oxygen in the air; suffocation.
Child Abuse and Neglect – an act, or failure to act, on the part of a parent or caretaker that results in serious physical or emotional harm, sexual exploitation, or death of a child.
Child Abuse Protocol Committee - County level representatives from the office of the sheriff, county department of family and children services, office of the district attorney, juvenile court, magistrate court, county board of education, office of the chief of police, office of the chief of police of the largest municipality in county, and office of the coroner or medical examiner. The committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.
Child Fatality Review Report - A standardized form required for collecting data on child fatalities meeting the criteria for review by child fatality review committees.
Child Fatality Review Committee - County level representatives from the office of the coroner or medical examiner, county department of family and children services, public health department, juvenile court, office of the district attorney, law enforcement, and mental health, and prevention advocate.
Drowning Deaths – Deaths that occur from water-related submersion and suffocation.
Eligible Death - Death meeting the criteria for review including death resulting from SIDS, unintentional injuries, intentional injuries, medical conditions when unattended by a physician, or any manner that is suspicious or unusual.
Firearms – any weapon that fires a high-velocity projectile, and includes rifles, pistols, revolvers, shotguns, handguns, and BB guns.
Fire-Related Death – Death resulting from fire or burn-related injuries sustained in a fire, and includes deaths from smoke inhalation.
Form 1 - A standardized form required for collecting data on all child fatalities by coroners or medical examiners.
Georgia Child Fatality Review Panel - An appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data.
Homicide – a death caused by the intentional actions of another person
Injury - refers to any force whether it be physical, chemical (poisoning), thermal (fire), or electrical that resulted in death.
Intentional - refers to the act that resulted in death being one that was deliberate, willful, or planned. It includes homicide and suicide.
Medical Cause - refers to death resulting from a natural cause other than SIDS.
Motor Vehicle-Related Death – incidents that include the occupants of a vehicle, pedestrians struck by motor vehicles, bicycles, and occupants or riders of any other form of transportation (ATV, go-carts, etc.).
Natural Cause - refers to death resulting from an inherent, existing condition. Natural causes include congenital anomalies, diseases of the nervous system, diseases of the respiratory system, other medical causes and SIDS.
"Other" Race - refers to those of Asian, Pacific Islander, or Native American origin.
"Other Injury" as Category of Death - includes deaths from poisoning and falls (unless otherwise indicated).
Perpetrator - person(s) who committed an act that resulted in the death of a child.
Preventable Death - one in which with retrospective analysis it is determined that a reasonable intervention could have prevented the death. Interventions include medical, social, educational, legal, technological, or psychological.
Reviewed Death - death which has been reviewed by a local child fatality review committee and a completed Child Fatality Review Report has been submitted to the Georgia Child Fatality Review Panel.
Risk Factor - refers to persons, things, events, etc. that put an individual at an increased likelihood of dying.
Sleep-Related Infant Death – all deaths to infants that occur while sleeping but have no medical cause. Included are SIDS, SUIDS, and all suffocation/asphyxia deaths related to a sleep environment.
Sudden Infant Death Syndrome (SIDS) - the
sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. In this report, SIDS is not considered a "medical" cause.
Sudden Unexplained Infant Death (SUID) - is a category used by child fatality review committees for deaths that appear to be SIDS but have other risk factors that could have contributed to the infant's death.
Trend - refers to changes occurring in the number and distribution of child deaths. In this report, the actual number of deaths for each cause is relatively small for the purpose of statistical analysis, which causes some uncertainty in estimating the risk of death.
Unintentional - refers to the act that resulted in death being one that was not deliberate, willful, or planned.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