Georgia's CAPTA Citizen Review Panels

Annual Report 2010

Child Protective Services Advisory Committee

Children's Justice Act Advisory Committee

Child Fatality Review Panel

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

-Margaret Mead

Executive Summary

Child Abuse Prevention and Treatment Act (CAPTA)

The Child Abuse Prevention and Treatment Act (CAPTA), adopted in 1974, provides guidelines and federal funding to states for child abuse and neglect prevention, assessment, investigation, prosecution and treatment activities. With each reauthorization, most recently in 2010, CAPTA has evolved in response to the child welfare climate, shifting its focus to safety due to concerns over child fatalities in open cases, children languishing in care, and children returned home to unsafe environments, as well as a desire to increase accountability in the child protective services (CPS) system.

CAPTA provides grants to states for the purpose of improving the state's child protection systems. To be eligible for a CAPTA grant, the state is required to submit a state plan every five years as a component of its five-year Child and Family Services Plan (CFSP) that specifies the areas of its CPS system it intends to address with its CAPTA grant. The CAPTA plan must also include detailed information on the state's compliance with CAPTA requirements.

CAPTA Citizen Review Panels

The CAPTA reauthorization of 1996 established citizen review panels (CRP) as a requirement for all states receiving a CAPTA grant. The purpose of CAPTA citizen review panels is to examine the extent to which states are discharging their child protection obligations by examining the policies, procedures and practices of state and local CPS agencies and providing feedback on the effectiveness of the agency's child abuse prevention and treatment strategies in producing the desired child and family outcomes. In addition, CRPs are responsible for reviewing state and local CPS agency compliance with the state's CAPTA plan and any other criteria the panel(s) considers important. CRPs are required to prepare and submit an annual report of activities and recommendations to the child welfare agency.

The CAPTA re-authorization in 2003 expanded CRP-related requirements to include:

- Developing a means for public comment
- Requiring the state's child welfare agency to respond to the CRP annual report

CAPTA CRPs 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. These panels are composed of volunteer members who broadly represent the communities in which they operate and include individuals with expertise in the prevention and treatment of child abuse and neglect.

Georgia's Citizen Review Panels

As a state CAPTA grant recipient, Georgia designated three existing committees to serve as its CAPTA citizen review panels: the Child Protective Services Advisory Committee, the Children's Justice Act Advisory Committee, and the Georgia Child Fatality Review Panel. The mission of Georgia's CAPTA CRPs is to assure that children are protected from maltreatment, and that children and their families are provided the best possible services within the framework of available resources.

Each of Georgia's three CRPs meets all statutory CAPTA requirements:

- Meet a minimum of four times a year
- Include members broadly representative of the communities they represent
- Examine policies, procedures and practices of the state's child protection system and evaluate the extent to which Georgia is meeting its child protection responsibilities and its compliance with CAPTA and the state's five-year CAPTA plan
- Prepare an annual report on activities and recommendations
- Provide for public comment

All three CRPs have a statewide approach to examining systemic issues that impact the effectiveness of the state's child protection system identifying opportunities to reform state systems to improve the processes by which Georgia's child welfare system and communities respond to cases of child abuse and neglect.

Georgia's SFY2010 child welfare statistics *(Source: StateRegionalCountySheetsHB1406_2010)* showed a 6% decline in reports of abuse and neglect from 2009. Of the 75,750 reports received in 2010, 11,979 were screened out; 37,432 were identified as "low-risk" and referred to Diversion (Family Support), Georgia's alternative response system; and 26,339 were considered credible and warranted full investigation by the state's child protective system. These report investigations involved 37,400 children. Of the investigated reports, 7,957 were substantiated for abuse or neglect and resulted in either an open Family Preservation or Foster Care case. 12,796 children received Foster Care services.

The work of Georgia's three CRPs 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 the community can improve its efforts to prevent child maltreatment. The overlapping interests of the three panels address the full child welfare continuum, from prevention and investigation to treatment and prosecution of cases of child abuse and neglect.

Activities of the CRPs are detailed in individual annual reports. (*See Attachments I, II, & III.)* The following section highlights recommendations resulting from their 2010 activities.

CPSAC

Child Protective Services Advisory Committee

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 CRP, the CPSAC is composed of dynamic and committed individuals with diverse backgrounds, expertise and experience 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. Members include an adoptive parent, a former foster child, a child care provider, service providers, a prevention specialist, law enforcement, a maternal and child health specialist, a CASA and an attorney.

The priorities of the CPSAC focus on the prevention/early intervention end of the child welfare continuum. An ongoing interest for this CRP is Georgia's alternative response system, Diversion (Family Support); in 2010, the CPSAC expanded on its previous recommendations for the development of a statewide policy and standard practice model for Diversion. Involvement in the CAPTA PIP Babies Can't Wait (BCW) work group in 2010 prompted the CPSAC to turn its attention to victims of substantiated abuse ages 0-3, and the panel developed several recommendations to address this vulnerable population.

CPSAC Recommendations:

In addition to, and in support of previous recommendations with respect to Diversion, the CPSAC respectfully recommends that the Division:

- Identify and appoint a qualified individual to shepherd the agency through the development and implementation of an effective statewide system
- Establish a work group of internal and external stakeholders, including current Diversion caseworkers, as a body of experts to develop a comprehensive, statewide system
- Enlist the support and guidance of experts from the National Resource Center for Differential Response

With respect to early intervention services for victims of child abuse and neglect ages 0-3:

- Convene stakeholders serving children age birth to three years who are victims of substantiated abuse and neglect to conduct a cross-system programmatic and fiscal analysis of currently funded social and emotional services to identify overlap, gaps and action priorities
- Consult with Zero to Three and other national leaders on early childhood mental health
- Enhance SHINES, the state's child welfare data system, to capture and track screening results for all referrals, service utilization for eligible children, and unmet needs (including social-emotional/ mental health related needs) for children ages 0-3 who did not meet eligibility requirements for BCW enrollment

CJAAC

Children's Justice Act Advisory Committee

The Children's Justice Act Advisory Committee (CJAAC) serves a dual role as both 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 requirement for 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 with making policy and training recommendations for improvement. Its membership is composed of professionals with knowledge and experience relating to the criminal justice system and the 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.

The CJAAC continues to place a high priority on supporting activities and practices that specifically address the handling of cases of child sexual abuse and multi-disciplinary cross-training of child welfare professionals.

CJAAC Recommendations:

Intake: *To improve consistency in the handling of reports of child abuse and neglect*

- Evaluate current handling of reports of child abuse and neglect to identify gaps in service and inconsistencies in practice
- Explore the feasibility of centralizing, or regionalizing, a call center for handling reports of child abuse and neglect

Mandated Reporter Training: *To improve the training of individuals required to report suspected child abuse and neglect by establishing training standards*

- Collaborate to develop and support a web-based mandated reporter training curriculum with multi-disciplinary modules that include a comprehensive evaluation component

Administration of CJA Grant: *To streamline the administration and improve the utilization of the CJA grant*

- Reserve a portion of the total state grant to support "long-term", ongoing projects that remain DHS and task force priorities. Identify and acknowledge priority projects for long-term support so that recipients can enter into commitments as necessary, and provide predictability for the preparation of those contracts to maintain the seamless delivery of activities. These projects would be reviewed and reconfirmed each spring.
- Set aside remainder of state grant for "short-term" projects (6-9 month commitment), which will be allocated based on

recommendations made by the task force after evaluating proposals and approval by the Division. Applications would be solicited between October (post confirmation of state grant amount) and December 31 for consideration.

Multi-Disciplinary Training: *To provide a forum for inter-disciplinary collaboration and improve coordination of training resources*

- Convene a planning committee of stakeholders to develop a comprehensive five-year plan for multi-disciplinary training with respect to the handling of cases of child abuse and neglect, particularly child sexual abuse and child sexual exploitation and maltreatment-related fatalities
- Collaborate with stakeholders in the planning and delivery of a statewide multi-disciplinary conference (as determined in the five-year plan)

In addition, task force recommendations for Children's Justice Act funding allocations in 2010/2011 include:

Long-term, ongoing CJA projects:

- Emory Summer Child Advocacy Program
- Youth Law Conference
- SAAG training
- Multi-disciplinary training for child fatality review teams
- "Finding Words" training
- Crisis Intervention Team training

Short-term CJA projects:

- Data linkage project
- Child sexual abuse training for foster parents
- Advanced courtroom training for CASAs

Future short-term CJA projects proposed:

- Web-based GAL pre-appointment training
- Web-based CAPTA-specific training for SAAGs
- Development of curriculum and training protocol for investigators who interview child witnesses or victims of abuse who have developmental or communications disorders

To improve the administration of the state's CJA grant, the task force also recommends streamlining and standardizing the processing of proposed projects.

CFRP

Child Fatality Review Panel

Georgia's Child Fatality Review Panel (CFRP), a statutory body mandated by the Georgia State Legislature in 1990, is composed of an appointed body of representatives who oversee the process of reviewing child fatalities. Charged with examining the circumstances around child deaths, 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.

In 2010, the CFRP maltreatment committee began a review of Georgia's mandated reporter laws and plans to prepare a proposal to amend the statute for the 2012 legislative session.

One Voice…

Georgia's CAPTA CRPs would like to emphasize the need for the collaborative development of a coordinated and comprehensive public awareness and education plan on child abuse and neglect, incorporating local, regional and statewide components. CRPs recommend that the Division take a leadership role in convening an advisory group of internal and external stakeholders, both public and private, with a special interest and expertise in child abuse and child abuse prevention and charge them with designing a plan for an annual multi-faceted public campaign on:

- What constitutes child abuse and neglect and should be reported
- When and how to report suspected child abuse and neglect
- What to expect after a report is made
- State laws related to child abuse and neglect
- Obligation to report suspected child abuse as a citizen and as a mandated reporter
- Community-based child abuse prevention strategies
- The role and responsibility of the Division as the state's child welfare agency
- The roles and responsibilities of other state agencies, institutions and organizations that also have an interest in the safety, permanency and well-being of children
- National efforts to prevent child abuse and neglect

CAPTA Citizen Review Panel Successes

Georgia's citizen review panels can count many collaborative successes in 2010. As a result of concerns raised by CRPs and other child welfare advocates, the Division reconsidered its position on Diversion policy. A consultant was engaged to review current practice and make recommendations on the development of a statewide policy and a standard practice model. CRPs, along with other stakeholders, were consulted during the review process and have been invited to participate in ongoing dialogue around developing an effective alternative response system.

CRP members were invited to review and provide input on the state's recently revised safety resource policy. Through CAPTA PIP work groups, CRP feedback was incorporated into revised child welfare policy and practice and data system enhancements associated with:

- Appointment of Guardians ad Litem to all children involved in deprivation proceedings
- Incorporation of protocols to identify, for review, cases where "near fatality" occurred
- Referrals of children age 0-3 involved in substantiated cases to early intervention services under part C of the Individuals with Disabilities Education Act

In the case of the last item, CRP members also provided input on the development of a Memorandum of Understanding for CAPTA referrals between the Division of Family and Children Services (DFCS) and the Division of Public Health, the agency responsible for part C services in Georgia.

DFCS, committed to the re-establishment of a multi-disciplinary review process for the review of cases involving child deaths, near fatalities or serious injuries, has consulted with CRPs to identify:

- Committee composition
- Criteria for selection of cases for review
- Protocol for review of cases

A welcome benefit from the establishment of Georgia's citizen review panels has been an increase in the collaboration and coordination of multi-disciplinary advocacy efforts, as Georgia CRP members represent the full continuum of child welfare. This has resulted in a better understanding of some of the challenges facing the Division, internal and external stakeholders, and families as a result of local, state and national policy, economics and priorities.

CAPTA Citizen Review Panel Challenges

Child welfare professionals, state agency personnel and the community-at-large need to be better educated on the role and benefits of CAPTA citizen review panels. Often CRPs are confused with the long-established "citizen panel reviews" – Georgia's foster care review process. The CAPTA CRP website, www.gacrp.com, developed in 2010, will promote the benefits of citizen involvement in improving Georgia's child protection system.

Timeliness and coordination of the exchange of information and communication on changing Division priorities, especially those relevant to CAPTA and the role of CRPs, continues to improve. CRPs will invite state office unit staff to become more involved with the CRP steering committee in 2011.

Individual priorities and activities of Georgia's citizen review panels reflect their unique perspectives and interests in the child welfare system. Collectively, they share a common goal: the safety, permanency and well-being of Georgia's most valuable, and vulnerable, resource – children.

CAPTA citizen review panels would like to express their sincere appreciation for the continued support and willingness of the Division to engage with CRPs on their common objectives to improve both Divisional and community response to Georgia's children and families in crisis.

Respectfully submitted for consideration by

Georgia's CAPTA Citizen Review Panels

"Coming together is a beginning. Keeping together is progress. Working together is success."

-Henry Ford

Attachments

I. Child Protective Services Advisory Committee Annual Report 2010

II. Children's Justice Act Advisory Committee Annual Report 2010

III. Child Fatality Review Panel
- ~ Maltreatment Committee 2010 Summary of Activities
- ~ 2009 Annual Report

Georgia's CAPTA Child Protective Services Advisory Committee

C P S A C

Annual Report 2010

Georgia's CAPTA Child Protective Services Advisory Committee

Annual Report 2010

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.

CPSAC

Members
Karl Lehman, Co-Chair
Arianne Weldon, Co-Chair
Diane Bellem
Angie Burda
Sharon Carlson
Molly Casey
Liz Ferguson
Suzanne Geske
Amy Leverette
John McCraw
DeeDee Mize
Lori Muggridge
Amy Rene
Scott Rhoden
Carole Steele

State Liaisons
Ann Pope
Susan Denney

Coordinator
Deb Farrell

"We must not, in trying to think about how we can make a big difference, ignore the small daily differences we can make, which over time, add up to the big difference we cannot often see."

- Marion Wright Edelman

What we are…

Georgia's Child Protective Services Advisory Committee (CPSAC) 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 CAPTA citizen review 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's priorities lie at the prevention and early intervention end of the child welfare spectrum: public awareness and education on child abuse and neglect, the initial contact families have with the child welfare agency, the quality of the interaction between families and child welfare workers, and the resources available to support families - more specifically, services for families with children ages 0-5.

Who we are…

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. *See Appendix A for list of members.* The newest additions to the panel include a representative from a foster parent advocacy group, a former foster child and advocate for youth in foster care and a former CPS caseworker who currently works with teen parents. Identifying and engaging consumers - parents, foster parents and youth - to serve on the panel remains a challenge, but the CPSAC is considering alternative engagement strategies for incorporating input from these groups into the CRP process.

In 2010, the CPSAC met bi-monthly, exceeding the federally-mandated CAPTA quarterly meeting requirements. Subcommittees met or held conference calls between meetings, as needed.

Our collaborative efforts…

Representatives from CPSAC serve on a joint CAPTA panel steering committee with members from the other two citizen review panels, the Children's Justice Act 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. This forum provides an opportunity for inter-panel collaboration, coordination of panel activities and joint planning with Georgia's child welfare agency. The steering committee meets 2-4 times per year.

CPSAC members, invited in 2009 by the Division to assist in the development a CAPTA Program Improvement Plan (PIP) to improve Georgia's compliance with respect to its obligations as a CAPTA grant recipient, continue to participate in quarterly workgroup meetings to monitor and evaluate the state's progress toward meeting its PIP objectives. A significant achievement in 2010 was the improvement in the referral process of eligible children in substantiated cases to early intervention services mandated under part C of the Individuals with Disabilities Education Act, in collaboration with the Division of Public Health. This included:

- Development of an inter-agency Memorandum of Understanding
- Updated CPS policy
- Clarification of practice expectations
- Enhancements to Georgia's online data collection system, SHINES, to improve the documentation and consistency of referrals to Children 1st, Georgia's Part C "gateway"

CPSAC members had an opportunity to review and comment on the agency's updated safety resource policy. Revised policy went into effect in October 2010 and addressed many of the concerns panel members had with respect to this safety intervention strategy.

CPSAC members contributed to Georgia's Annual Progress and Services Report, providing input on activities related to Georgia's five-year (2010-2014) CAPTA plan.

In the fall of 2009, the Office of Child Fatality Review included several CPSAC members at its two-day retreat to review and update the statewide model child abuse protocol (CAP). The updated CAP was finalized and disseminated for use by local child abuse protocol committees in 2010. During the protocol review, gaps in the prevention component were noted. Subsequently, two opportunities to address these gaps have been identified: 1) utilizing the CAP prevention component as a vehicle to develop and sustain a statewide child abuse prevention plan; and 2) the expansion of the maltreatment-related fatalities component of the Child Fatality Review Panel's "Statewide Child Injury Prevention Plan".

Connecting on a national level…

A CPSAC member and a representative from each of Georgia's other two CRPs attended the national citizen review panel conference in May 2010 in Lexington, KY. Presentations and workshops included topics such as developing and maximizing resources; effective recruiting, training and engaging of new members; youth in foster care; and the results from a national study on the effectiveness of citizen review panels. Several citizen review panel programs were highlighted in a panel discussion. Additionally, representatives from the Children's Bureau and the National Child Welfare Resource Center on Legal and Judicial Issues provided an update on CAPTA reauthorization and recent federal legislative and policy developments. The conference provided an invaluable opportunity for Georgia representatives to network with citizen review panel members from 20 other states and gain insight into the common challenges facing all citizen review panels and their state's child welfare agencies.

At this year's conference, the new national Citizen Review Panel Advisory Board was introduced. This advisory board is composed of representatives from several states. Members include Georgia's CRP Coordinator and representatives from the Children's Bureau and the National Resource Center for Child Protective Services. The purpose of the advisory board is to promote Citizen Review Panels nationwide and the power of the community to end child abuse and neglect, coordinate communications among the panels, and share promising practices to facilitate panel activities.

CPSAC at work in 2010…

Georgia continues to make strides in improving its Child and Family Service Review (CFSR) outcomes. Repeat maltreatment is at an all-time low. Fewer children are in foster care. More children are obtaining permanency. Reports of abuse have declined 21.5% over a five-year period, from 96,511 reports in SFY2006 to 75,750 reports in SFY2010.

Georgia Reports of Suspected Child Abuse & Neglect

	SFY2006		SFY2010		%
	#	%	#	%	Change
Total Reports	**96,511**		**75,750**		**-21.5**
Screened Out	15,152	15.7	11,979	15.8	0.1
Diversion *(Family Support)*	17,565	18.2	34,432	49.4	31.2
Investigated	63,794	66.1	26,339	34.8	-31.3
Substantiated & Opened	*14,477*	*15.0*	*7,957*	*10.5*	-4.5
Substantiated & Closed	*11,099*	*11.5*	*5,487*	*7.3*	-4.2
Unsubstantiated & Opened	*1,255*	*1.3*	*1,058*	*1.4*	0.1
Unsubstantiated & Closed	*36,964*	*38.3*	*11,837*	*15.6*	-22.7

Sources: Georgia DHR DFCS, Child Protective Services Data System (2006-2008), DHS/DFCS Data Analysis & Reporting presentation at G-Force meeting August 27, 2009, "Preserving Families and Maintaining Safe & Thriving Forever Families" and StateRegionalCountySheetsHB1406_2010.

Since 2006, investigations have declined from 66.1% to 34.8% of reports. This decline has been offset by the increasing referral of low-risk reports to Diversion, Georgia's "alternative response" strategy. These trends can be attributed to changes in Georgia's child welfare policy and

practices related to the screening of reports. This trend has been of primary interest to the CPSAC for several years due to concerns about the lack of a statewide policy and a consistent practice model for Diversion.

In 2010, the CPSAC continued its efforts to support and advance earlier recommendations on Georgia's Diversion practice by continuing dialogues with the Division. In recent years, findings from two independent studies commissioned by the agency and a report released by Georgia's Office of the Child Advocate supported CPSAC recommendations for the development of a statewide Diversion policy and implementation of a practice model based on nationally accepted standards for a differential/alternative response system.

CPSAC continues to support its earlier 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
- 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 cases reviewed during regional case review process (PEAS) to be more reflective of Diversion caseloads

2010 Recommendations…

In addition to, and in support of previous recommendations with respect to Diversion, the CPSAC respectfully recommends that the Division:

- *Identify and appoint a qualified individual to shepherd the agency through the development and implementation of an effective statewide system*
- *Establish a work group of internal and external stakeholders, including current Diversion caseworkers, as a body of experts to develop a comprehensive, statewide system*
- *Enlist the support and guidance of experts from the National Resource Center for Differential Response*

The CPSAC also turned its attention to Georgia's most vulnerable population: children ages 0-3. "Children younger than three years of age are the most likely of all children to be involved with child welfare services" (Wulczyn et al, 2005). As a result of its CAPTA PIP, Georgia made several policy and practice changes in 2010 related to the referral of these children to the state agency providing early intervention services under part C of the Individuals with Disabilities Education Act: the Division of Public Health, through its Children 1st and Babies Can't Wait (BCW) programs. Early indications suggest that these changes have resulted in more than 92% of the eligible children being referred as required.

However, in 2010, of the estimated 6,800 children age birth to three years who were victims of substantiated abuse and neglect, only 4% of those referred met eligibility requirements for BCW services. Research continues to confirm that "negative early experiences can impair children's mental health and effect their cognitive, behavioral, social-emotional development" (Cooper et al, 2010). Whether or not children are determined eligible, Georgia has limited mental health providers to deliver empirically-supported interventions that have been used with young children in child welfare.

2010 Recommendations…

- *Convene stakeholders in the needs of children age birth to three years who are victims of substantiated abuse and neglect to conduct a cross-system programmatic and fiscal analysis of currently funded social and emotional services to identify overlap, gaps, and action priorities (Johnson et al, 2005)*
- *Consult with Zero to Three and other national leaders on early childhood mental health*
- *Enhance SHINES, the state's child welfare data system, to capture and track screening results for all referrals, service utilization for eligible children, and unmet needs (including social-emotional/ mental health related needs) for children ages 0-3 who did not meet eligibility requirements for BCW enrollment*

The CPSAC strongly urges that the Department follow the recommendations regarding child welfare and Early Head Start partnerships outlined in the ACF Information Memorandum dated 01.31.2011 to address the unmet mental health needs of children.

Moving forward…

In the fall of 2010, CPSAC members participated in Georgia's fourth annual citizen review panel retreat to develop a platform for 2011. In addition to its continued interest in Diversion, the CPSAC plans to review the handling of reports of child abuse and neglect, including review of:

- Intake policy
- Staff training on the handling of reports of child abuse and neglect
- Disposition of reports by type of reporter
- Criteria for decision-making
- Identification and examination of regional trends
- Impact of Division budget cuts, staffing levels and furlough days

Three subcommittees have been established to examine policy, practice and data associated with the handling of cases at intake.

The CPSAC will also monitor implementation of new protocols with respect to CAPTA and referrals to Children 1st/Babies Can't Wait and its training collaboration with the Division of Public Health, in addition to expanding its examination of services available to support the social-emotional development of children ages 0-6 who are victims of child abuse and neglect.

"In the citizen review process, I find a compelling example of the impact a group of caring and concerned individuals can have on the direction our state takes when making important child and family welfare policies and decisions. Thank you for allowing me to participate in this important work." *- Scott Rhoden, CPSAC Member*

The CPSAC respectfully submits its recommendations for 2010, requests their careful consideration by the Division, and looks forward to ongoing collaboration with the Division that will promote improvements in practice and outcomes for Georgia's children and families.

"Often we set out to make a difference in the lives of others only to discover we have made a difference in our own."

- Ellie Braun-Haley

A special note of thanks to Sheltering Arms for hosting CPSAC meetings in 2010

Child Protective Service Advisory Committee
Members

Diane Bellem Vice President Georgia Training Institute Sheltering Arms Early Education & Family Centers	Dee Dee Mize Executive Director Family T.I.E.S., Inc.
Angie Burda Program Coordinator Clayton County Kinship Care Resource Center	Lori Muggridge Executive Director Ocmulgee CASA
Molly Casey Systems of Care Administrator Multi-Agency Alliance for Children Teen Parent Connection	Scott Rhoden Executive Director Compassion House, Inc.
Sharon Carlson Executive Director Adoption & Foster Parent Association of Georgia	Carole Steele* Preventions Program Coordinator Governor's Office for Children and Families
Liz Ferguson* *(formerly Associate Director of Programs, Prevent Child Abuse Georgia)*	Amy Rene, LCSW* Vice President of Community Programs Hillside, Inc.
Suzanne Geske Executive Director Foster Children's Foundation, Inc.	Arianne Weldon (Co-Chair) Title V Administrator Maternal and Child Health Program Georgia Department of Community Health Division of Public Health
Karl Lehman (Co-Chair)* Executive Director Childkind, Inc.	Ann Pope (State Liaison) Program Director Promoting Safe and Stable Families DHS/DFCS
Amy Leverette, Attorney Ocmulgee Circuit	Susan Denney (State Liaison) Strategic Planning Unit Director DHS/DFCS
Detective John McCraw Special Victims Unit Crimes Against Children Cobb County Police Department	Deb Farrell CAPTA CRP Project Coordinator Care Solutions, Inc.

**Also serve on CAPTA CRP Steering Committee*

Georgia's CAPTA Children's Justice Act Advisory Committee

…Task Force on Children's Justice

Annual Report 2010

C J A A C

Georgia's CAPTA Children's Justice Act Advisory Committee

…Task Force on Children's Justice

Annual Report 2010

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.

CJAAC

Members
Melissa Carter, Co-Chair
Angela Tyner, Co-Chair
Hon. Bill Bartles
LaLaine Briones
Lori Brown
Lisa Ellis
Dr. Jordan Greenbaum
Vale Henson
Cynthia Howell
Diana Johnson
Trish McCann
Julia Neighbors
Stephanie Pearson
Vala Peyton
Paula Sparks

State Liaisons
Ann Pope
Susan Denney

Coordinator
Deb Farrell

"Each time a man stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope…"
- Robert F. Kennedy

What we are…

As a recipient of a Children's Justice Act (CJA) grant, Georgia is 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. The Children's Justice Act Advisory Committee (CJAAC) was established to meet requirements described in the Child Abuse Prevention and Treatment Act (CAPTA), Section 107. The purpose of the CJA task force is to review and evaluate the 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.

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

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 task force was designated by the Department of Human Services (DHS) as a citizen review panel (CRP) in response to the 2003 CAPTA requirement that states must establish citizen review panels (Section 106). The purpose of the CRP is:

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.

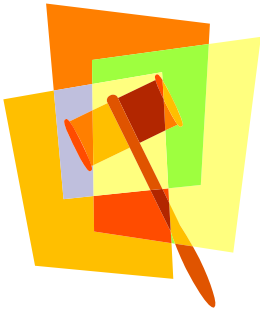
The other two CRPs are the Child Protective Services Advisory Committee and the Child Fatality Review Panel.

Who we are…

As a task force on children's justice, the CJAAC is required to maintain membership representing the following disciplines:

- Judges and attorneys, both civil and criminal, prosecuting and defense
- Law enforcement
- Child protective services
- Child advocates
- Court Appointed Special Advocates (CASA)
- Health and mental health professionals
- Parents and parent groups
- Individuals who specialize in working with children with disabilities

In 2010, to fill vacant positions, the CJAAC successfully recruited Judge Bill Bartles, Henry County Juvenile Court; Lori Brown, specialist in interviewing child victims and witnesses who are disabled; and Dr. Jordan Greenbaum, Medical Director, Children's Healthcare of Atlanta. *See Appendix A for complete list of members.* In 2011, the task force hopes to expand its membership to include a representative from the Department of Education and a Special Assistant Attorneys General (SAAG). Engaging youth and parents in the citizen review panel process has been challenging, and the task force plans to involve these important stakeholders more regularly by using focus groups to solicit their participation in the development of the upcoming three-year assessment required by CJA.



In 2010, task force members met bi-monthly, exceeding the federally-mandated quarterly meeting requirements. Subcommittees met or communicated between meetings as needed.

"For the past several years, I've had the pleasure of serving on the Children's Justice Act Advisory Committee. When we first started, we struggled to even know what our identity as a Citizen Review Panel meant! I'm proud of the progress we've made, as we now have a taskforce comprised of professionals from a variety of disciplines who come together to discuss issues and identify ways we can improve the child welfare system in Georgia. This year, we're committed to seeing the creation of a training registry and the re-development of some form of multi-disciplinary training, because we share the common belief that only through well-trained and well-prepared professionals will we ultimately improve the handling of child abuse and neglect cases and reduce any further trauma to child victims."

-Angela Tyner, Task Force Co-Chair

Our collaborative efforts…

Representatives from the CJAAC serve on a joint CAPTA panel steering committee with members from the other two citizen review panels, the Child Protective Services Advisory Committee and the Child Fatality Review Panel. Representatives from Georgia's child welfare agency are also invited to attend steering committee meetings to provide subject matter expertise. This forum provides an opportunity for inter-panel collaboration, coordination of panel activities and joint planning with Georgia's child welfare agency.

CJAAC members, invited in 2009 to assist in developing a CAPTA Program Improvement Plan (PIP) to improve Georgia's compliance with its obligations as a CAPTA grant recipient, continued to participate in quarterly workgroup meetings in 2010 to monitor and evaluate the state's progress toward meeting its objectives. Of particular interest to task force members was the component of the PIP related to Guardian ad Litem (GAL) appointments. CAPTA requires that all children involved in deprivation proceedings be appointed a GAL. In addition to attaining an enhancement of Georgia's child welfare data system, SHINES, to document GAL appointments, task force members assisted in the identification of several strategies to help improve representation in specific jurisdictions, including:

- Training for judges
- CAPTA grant (with matching dollars from the Committee on Justice for Children) to provide additional resources to targeted jurisdictions identified by the work group in collaboration with the Administrative Offices of the Court
- CAPTA grant to support Court Appointed Special Advocates (CASA) recruitment and training in two targeted judicial circuits to increase the number of CASA volunteers
- Revision to policy and practice to reinforce CAPTA requirement: improving caseworker documentation of appointments, standardizing request by Special Assistant Attorneys General (SAAG) at the 72-hour hearing for appointment of a GAL and defining the working relationship between caseworkers and GALs
- Informal peer discussions with judges in judicial circuits with low GAL representation

In addition to these strategies, the task force has continued to support the investment in the annual Youth Law Conference, which provides role-specific GAL training, with a CJA grant. In 2010, the conference offered a joint training for GALs and SAAGs. The combined result of these strategies has resulted in an increase in the number of GAL appointments; at the writing of this report, more than 96% of deprived children had representation.

Task force members also contributed to the State's Annual Progress and Services Report (APSR), providing input on Georgia's five-year CAPTA plan and Children's Justice Act grant-supported activities.

Connecting on a national level…

A CJAAC member and a representative from each of Georgia's other two CRPs attended the national citizen review panel conference in May 2010 in Lexington, KY. Presentations and workshop topics included developing and maximizing resources; effective recruitment, training and engagement of new members; youth in foster care; and the results of a national study on the effectiveness of citizen review panels. Several state citizen review panel programs were highlighted in a panel discussion that provided Georgia's attendees with ideas to bring back to Georgia. Additionally, representatives from the Children's Bureau and the National Child Welfare Resource Center on Legal and Judicial Issues provided an update on CAPTA reauthorization and recent federal legislative and policy developments with respect to both CAPTA and the Children's Justice Act.

The conference provided an invaluable opportunity for Georgia representatives to network with members of citizen review panels from 20 other states, including several which, like the CJAAC, serve both as a CRP and a task force on children's justice.

At this year's conference, the new national Citizen Review Panel Advisory Board was introduced. This advisory group is composed of representatives from several states. Members include Georgia's CRP Coordinator, the Children's Justice Act Program Specialist from the Children's Bureau and the Director from the National Resource Center for Child Protective Services. The purpose of the advisory board is to promote Citizen Review Panels nationwide and the power of the community to end child abuse and neglect, coordinate communications among the panels and share promising practices to facilitate panel activities. In addition to planning the annual national conference, the advisory board assists in the identification of training opportunities of interest to citizen review panels, including webcasts, teleconferences and webinars.

In 2010, the task force was asked to participate in a panel discussion at the annual Children's Justice Act grantee meeting in Washington, DC, on innovative uses of CJA grants. Melissa Carter gave attendees an overview of the Emory University Summer Child Advocacy Program (ESCAP). The ESCAP program provides law students and students completing a Masters in Social Work an opportunity to gain child welfare experience in a variety of placements, including the Office of the Child Advocate, Juvenile Courts, SAAG offices, Voices for Georgia's Children, CASA, and Atlanta Volunteer Lawyers Association. Several current and past CJA task force members participated in the ESCAP program.

Task force at work in 2010…

The task force agenda in 2010 included:

1. Exploring centralized intake call systems for handling reports of child abuse and neglect
2. Reviewing available mandated reporter training curricula and assessing their consistency with state child welfare policy and Georgia law and their impact on the screening and disposition of reports of child abuse and neglect, particularly cases of child sexual abuse and child sexual exploitation
3. Identifying and supporting new projects and activities to further CJA objectives
4. Improving the coordination of multi-disciplinary training, particularly training on child sexual abuse
5. Reviewing available child sexual abuse training curricula
6. Developing a resource list of multi-disciplinary trainings available, including but not limited to, training on child sexual abuse

1.Centralized Intake

Anecdotal reports of inconsistent handling of reports of child abuse and neglect, particularly child on child sexual abuse and cases assigned to Diversion (Family Support), Georgia's alternative response system, and reports from task force members who personally experienced difficulty making reports of suspected abuse, initiated the CJAAC interest in exploring centralized intake. In Georgia, reports of child abuse and neglect are handled locally in all 159 counties. Dwindling resources, staff turnover and tight operating budgets have given rise to concerns with respect to how efficiently and appropriately these reports are handled.

The lack of a single statewide intake call line that can be publicized presents a major barrier to public involvement in the protection of children. Anecdotal reports to the task force indicated that on Division furlough days, the Prevent Child Abuse Helpline has received calls to report suspected abuse when callers are unable to reach the local county office. The task force has also been told that unsuccessful attempts to reach a local county office due to an unanswered telephone or a full voice mailbox were eventually resolved by making the report directly to a state office contact.

Task force research, assisted by an ESCAP intern, has found that at least 33 states have a statewide toll-free number for reporting alleged child abuse or neglect. Such a system allows direct access to workers with sufficient specialization and expertise

to make crucial early decisions about appropriate responses to reports of child abuse or neglect. The Georgia Department of Human Services (DHS) has been successful in the creation and use of centralized systems for other services, such as the mental health crisis and access line (1-800-715-4225) and the aging services access line (1-866-55AGING). It has been reported that a centralized intake protocol for reports of child abuse is being tested in three Georgia counties in service delivery region 17.

In addition to a central hotline, several states provide multiple options for reporting child abuse and will accept reports by email, online via their website, or by fax.

2010 Recommendations…

- *Evaluate current handling of reports of child abuse and neglect to identify gaps in service and inconsistencies in practice*
- *Explore the feasibility of centralizing, or regionalizing, a call center for handling reports of child abuse and neglect*

2.Mandated Reporter Training

Georgia's citizen review panels have advocated for for the development of web-based mandated reporter training that allows for an evaluation of its effectiveness as a training tool and its impact on the volume and quality of reports. Individuals currently identified by Georgia statute as mandated reporters do not have specific training requirements, and many receive little, if any, training specific to their roles related to child welfare. In recent years, there have been several legislative and policy changes that impact mandated reporting, and trainings developed independently of the state agency are not necessarily up-to-date and reflective of current policy and practice. Currently, there is no mechanism for reviewing and approving curricula on mandated reporting.

The benefit of a web-based system sponsored or co-hosted by the state agency would be the potential to address the concerns previously mentioned as well as to provide information on individuals trained and the saturation levels of mandated reporter training around the state.

2010 Recommendation….

- *Collaborate to develop and support a web-based mandated reporter training curriculum with multi-disciplinary modules that include a comprehensive evaluation component*

3.New Projects and Improved Protocol

The CJAAC's responsibilities as a task force include making recommendations for the utilization and allocation of the state's CJA grant. These recommendations support Georgia's five-year CAPTA plan, CJA objectives and priorities identified in the three-year system assessment completed by the task force in 2009, as well as CJAAC's own ongoing priorities.

Long-term, ongoing CJA projects in 2010 include:

- Emory Summer Child Advocacy Program
- Youth Law Conference
- SAAG training
- Multi-disciplinary training for child fatality review teams
- "Finding Words" training
- Crisis Intervention Team training

Short-term CJA projects in 2010 include:

- Data linkage project
- Child sexual abuse training for foster parents
- Advanced courtroom training for CASAs

Future short-term CJA projects proposed in 2010 include:

- Web-based GAL pre-appointment training
- Web-based CAPTA-specific training for SAAGs
- Development of a curriculum and training protocol for investigators who interview child witnesses or victims of abuse who have developmental or communications disorders

In order to streamline the grant allocation process to more effectively and efficiently utilize this federal funding source, the task force recommends standardizing the process for the administration of CJA funds to ensure the successful and timely fulfillment of grant deliverables.

2010 Recommendations…

- *Reserve a portion of the total state grant to support "long-term", ongoing projects that remain DHS and task force priorities. Identify and acknowledge priority projects for long-term support so that recipients can enter into commitments as necessary, and provide predictability for the preparation of those contracts to maintain the seamless delivery of activities. These projects would be reviewed and reconfirmed each spring.*
- *Set aside remainder of state grant for "short-term" projects (6-9 month commitment), which will be allocated based on recommendations made by the task force after evaluating proposals and approval by DHS. Applications would be solicited between October (post confirmation of state grant amount) and December 31 for consideration.*

Additionally, the task force would like to see priority given to projects and activities proposed by multi-disciplinary collaborations that model a practice the CJA promotes.

4.Multi-Disciplinary Training

The task force continues to support a multi-disciplinary approach to training professionals involved in the handling of child abuse and neglect cases, particularly child sexual abuse and child sexual exploitation, and maltreatment-related fatalities. Budget cuts and travel constraints in recent years have resulted in the suspension of many statewide training opportunities for these individuals. Although they may have been able to avail themselves of some local and regional trainings, the benefits derived from their interaction as a collective body of disciplines with common goals and objectives with highly specialized skills cannot be underestimated.

2010 Recommendations...

- *Convene a planning committee of stakeholders to develop a comprehensive five-year plan for multi-disciplinary training with respect to the handling of cases of child abuse and neglect, particularly child sexual abuse and child sexual exploitation, and maltreatment-related fatalities*
- *Collaborate with stakeholders in the planning and delivery of a statewide multi-disciplinary conference (as determined in the five-year plan)*

"If we don't stand up for children, then we don't stand for much."

- Marian Wright Edelman

5. Child Sexual Abuse Curricula Review

In 2010, the task force completed its review of curricula on child sexual abuse used in Georgia by many of the professional disciplines involved in these cases. Inconsistencies and outdated information and protocols were noted in many of the curricula reviewed. The task force reviewed and had high praise for the section in new caseworker training dealing with child sexual abuse, which incorporates current data and research and nationally-recognized best practices.

In 2011, the task force would like to explore the feasibility of developing a comprehensive curriculum on child sexual abuse and sexual exploitation with multi-disciplinary modules that is reflective of new Georgia laws and updated DFCS policy and practice.

6.Multi-Disciplinary Training Resource Registry

The task force completed its review of training curricula available for professionals handling cases involving child sexual abuse. The challenges faced by the review committee in identifying and obtaining curricula and information on these specialized trainings highlighted the need for a comprehensive resource guide to available trainings. The task force has included this 2010 objective on their agenda for 2011 and will support the development of a comprehensive "registry" of multi-disciplinary training focusing on, but not limited to, child sexual abuse.

Moving forward...

In the fall of 2010, CJAAC members participated in the fourth annual citizen review panel retreat to develop a platform for 2011. In addition to its ongoing interest in facilitating the development of a multi-disciplinary curriculum on child sexual abuse and a resource "registry" for child sexual abuse trainings, the task force will:

- Identify new short-term projects compatible with CJA goals and objectives
- Continue monitoring the impact of new child welfare protocols and case practice, and targeted support strategies on GAL appointments

A committee has been established to begin planning for the next three-year assessment required by CJA, due in 2012. The committee will initiate talks with state and local child welfare leaders, other CRPs and interested stakeholders to identify practice areas to consider for the focus of their assessment.

The CJAAC respectfully submits its recommendations for 2010, requests their careful consideration, and looks forward to ongoing collaboration with the Division that will promote improvements in practice and outcomes for Georgia's children and families.

"There is no trust more sacred than the one the world holds with children. There is no duty more important than ensuring that their rights are respected, that their welfare is protected, that their lives are free from fear and want and that they can grow up in peace."

- Kofi Annan

A special note of thanks to the Prosecuting Attorneys Council and the Georgia Public Defenders Standards Council for hosting CJAAC meetings in 2010

Children's Justice Act Advisory Committee
Members

Hon. Bill Bartles Henry County Juvenile Court *Judge*	Trish McCann, JD* Appellate and Juvenile Advocacy Attorney Georgia Public Defenders Standards Council *Defense Attorney*
Lalaine A. Briones, JD Executive Assistant District Attorney Crimes Against Children Clayton County District Attorney's Office *Prosecuting Attorney*	Julia Neighbors Voices for Children *Advocate*
Lori Brown Director of Forensic Services Crimes Against Children Unit Oconee County Sheriff's Office *Disabilities*	Stephanie L. Pearson, Ph.D. Child and Adolescent Program Director Department of Behavioral Health & Developmental Disabilities *Mental Health Professional*
Melissa D. Carter, JD (Co-Chair)* Executive Director Barton Child Law and Policy Center Emory University School of Law *Advocate*	Vala Peyton Project Manager Adoptive & Foster Parent Association of Georgia *Adoptive Parent*
Lisa Berry Ellis, LCSW Trauma Specialist Morningstar Children & Family Services, Inc. *Mental Health Professional*	Major Paula Sparks Cobb County Police Department Crimes Against Persons Division *Law Enforcement*
Dr. Jordan Greenbaum Medical Director Child Protection Center Children's Healthcare of Atlanta *Health Professional*	Angela Tyner, JD (Co-Chair)* Director of Advocacy & Program Development Georgia CASA *Court Appointed Special Advocate*
Vale Henson Field Program Specialist Department of Family and Children Services *Child Protective Services*	Ann Pope (State Liaison) Program Director Promoting Safe and Stable Families DHS/DFCS
Cynthia D. Howell Chief Executive Officer Children's Advocacy Centers of Georgia *Advocate*	Susan Denney (State Liaison) Strategic Planning Unit Director DHS/DFCS
Diana Johnson, JD Attorney, Private Practice *Guardian ad Litem*	Deb Farrell Care Solutions, Inc. CAPTA CRP Project Coordinator

** Serves on CAPTA CRP Steering Committee*

Georgia's CAPTA Child Fatality Review Panel

Annual Report 2010

C F R P

Georgia's CAPTA Child Fatality Review Panel

Maltreatment Committee

2010 Summary of Activities

In response to Child Abuse Prevention and Treatment Act (CAPTA) requirements, the Child Fatality Review Panel established a CAPTA maltreatment committee to address its obligations as a citizen review panel as it relates to the review of maltreatment-related child deaths.

The annual report prepared by the Child Fatality Review Panel is attached as Appendix A. This comprehensive report identifies many "opportunities for prevention" of maltreatment-related injuries and fatalities. The maltreatment committee has prepared this summary of its activities in 2010.

Respectfully submitted by
J. David Miller

CFRP Maltreatment Committee

Members
J. David Miller, Chair
Rachelle Carnesale
John Carter
Melissa Carter
Lisa Dawson

State Liaisons
Ann Pope
Susan Denney

Coordinator
Deb Farrell

"There is no tragedy in life like the death of a child. Things never get back to the way they were."

Dwight D. Eisenhower

The Georgia Child Fatality Review Panel (Panel) is a statutory body 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.

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

The Panel is supported by staff under the supervision of the Office of the Child Advocate for the Protection of Children (OCA). The Panel and its 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 on their findings and the issues raised by the local committees and the Panel after reviewing state-wide trends. *See Appendix A for summary findings on child deaths.*

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

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. The Panel meets quarterly.

Representatives from the Panel and its maltreatment committee serve on a joint CAPTA panel steering committee with members from the other two citizen review panels. Representatives from Georgia's child welfare agency are also invited to attend steering committee meetings to provide subject matter expertise. This forum provides an opportunity for inter-panel collaboration, coordination of CRP activities and joint planning with Georgia's child welfare agency.

At Work in 2010…

A maltreatment committee member, representing the CFRP, and a representative from each of Georgia's other two CRPs attended the national citizen review panel conference in May 2010 in Lexington, KY. The conference provided an invaluable opportunity for Georgia representatives to network with citizen review panel members from 20 other states.

CFRP members also contributed to the State's Annual Progress and Services Report (APSR) providing input on activities related to Georgia's five-year CAPTA plan.

CFRP and maltreatment committee members participated in the development a CAPTA Program Improvement Plan (PIP) to improve Georgia's compliance with its obligations as a CAPTA grant recipient and continued to participate in quarterly workgroup meetings in 2010 to monitor and evaluate the state's progress toward meeting its objectives. Of particular interest to the CFRP and maltreatment committee was the component of the CAPTA PIP requiring the state to have procedures in place for the disclosure of "fatalities and near fatalities" and the recommendation to re-establish a multi-disciplinary committee to review child deaths, near fatalities and serious injuries.

Looking ahead to 2011…

In the fall of 2010, CFRP members participated in the fourth annual citizen review panel retreat to develop a platform for 2011. In addition to developing a proposed revision to Georgia's mandated reporter statute, the maltreatment committee plans to:

- Continue to advocate for the institutionalization of a multi-disciplinary committee to review maltreatment-related child fatalities, near fatalities and serious injuries
- Work with the Office of Child Fatality Review to develop criteria to identify maltreatment-related fatalities for further review by the maltreatment committee

A special note of thanks to the Prosecuting Attorneys Council for hosting the maltreatment committee meetings in 2010

Georgia Child Fatality Review Panel

2009 ANNUAL REPORT

Appendix A
CFRP

Georgia Child Fatality Review Panel
Annual Report
Calendar Year 2009

Sonny Perdue, Governor
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December 2010

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
- John Carter, Ph.D. Epidemiology Department of Emory University, Rollins School of Public Health
- Katherine Kahn, M.P.H. Maternal and Child Health Program Epidemiologist, Division of Public Health, Department of Community Health
- Jimmy Clanton, Graphic Designer. Georgia Division of Public Health, Department of Community Health

Georgia Child Fatality Review Panel

Dear Governor Perdue and Members of the Georgia General Assembly:

On behalf of the Georgia Child Fatality Review Panel, I present to you the 2009 Abridged Annual Report. This report provides a statistical overview of child deaths that occurred in Georgia during the 2009 calendar year. In accordance with our mission to accurately track the causes of unexpected deaths in Georgia's children and to promote effective prevention measures, the CFR Panel has launched the following initiatives:

In January 2009, the Child Fatality Review Panel transitioned to the National Center for Child Death Review (NCCDR) Case Reporting System, a more comprehensive web-based data tool which assists local committees in providing more thorough scene investigation and agency-specific information.

In July 2009, Georgia was one of five states selected by the Centers for Disease Control and Prevention (CDC) to participate in a three-year pilot project, the Sudden Unexpected Infant Death Case Registry. The purpose of this project is to enhance our understanding of circumstances surrounding unexplained infant deaths. The result of reliable data will ultimately be the development of prevention measures that will reduce such deaths from occurring. As a participant in this project, Georgia has been awarded grant funds which aid in providing vital resources to assist local committees in their diligent efforts to reduce infant mortality.

In October 2009, the Child Fatality Review Panel supported the Office of Vital Records by assisting staff with core functions necessary for accurate reporting of child deaths.

Thank you for your continued support of this vital work. The CFR Panel will continue to honor the memories of children unnecessarily lost by gathering and interpreting data to better equip communities with prevention strategies.

Sincerely,

Velma C. Tilley

Judge Velma C. Tilley, Chair

Georgia Child Fatality Review Panel

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Preface

The year 2010 marks the 20th anniversary of the existence of the Georgia Child Fatality Review Panel. Created through legislation with the ultimate purpose of preventing avoidable child deaths, the Panel is charged with collecting and interpreting local child-specific data. To this end, multi-disciplinary child fatality review committees in every county come together to share information and track the reviewable child deaths in the jurisdiction. Recognizing that Georgia's children are our most valuable resource and our most vulnerable population, the Panel has evolved and adapted to the logistical, economic and strategic challenges that have arisen over time.

Over the last two decades, the Panel has succeeded in dramatically improving the quality and quantity of data received from local committees. Georgia is now well-positioned to move decisively toward proven prevention measures that are data-driven and supported by evidence. However, progress is contingent on the continued momentum built through collaboration between the Panel and its partners in government and the community. As the Panel has seen progress, it has also faced disappointment. We continue to see that the number one cause of death in infants is related to sleep environment, despite the efforts of numerous governmental and private organizations. In the same vein, we continue to experience the greatest loss of young children through motor vehicle accidents. These forms of entirely preventable loss of precious life must become priorities statewide.

In this report, challenges to progress and resulting or needed systems changes are outlined, along with summaries of current data. It will become clear as you examine this report that action is desperately needed to improve capacity at the Office of Vital Records, an anchor for the process of Georgia child death review. To this end, the Panel and its partners are collaborating to determine how best to support a Vital Records system that is facing massive challenges.

For 20 years, the Panel has served as the only complete source for child death review information in Georgia. The Panel is now poised to collaborate and lead in the growing movement for prevention of needless child deaths in Georgia over the next decade. The time is now to provide Georgia's children with the safe, healthy environment they deserve.

Rachelle Carnesale

Rachelle Carnesale, J.D.
Acting Director
OCA/CFR

This report was developed and written by the CFR Division staff:
Arleymah Raheem, Wende Parker, Malaika Shakir
With essential support from Carri Cottengim and Sarah Stocker

History and Progression of Child Fatality Review in Georgia

In 1990, 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 separate child fatality review committees in each county and determine procedures for conducting reviews and completing reports.

Deaths are eligible for review when the child is less than 18 years of age, and when the death meets the criteria for a coroner or medical examiner investigation. Legislation requires that 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: as a result of violence; by suicide; from an unintentional injury (e.g. car crash or fire); suddenly when in apparent good health; from any medical condition when unattended by a physician; in any suspicious or unusual manner, especially if the child is under 16 years of age; after birth but before seven years of age if the death is unexpected or unexplained; while an inmate of a state hospital or a state, county, or city penal institution; or as a result of a death penalty execution.

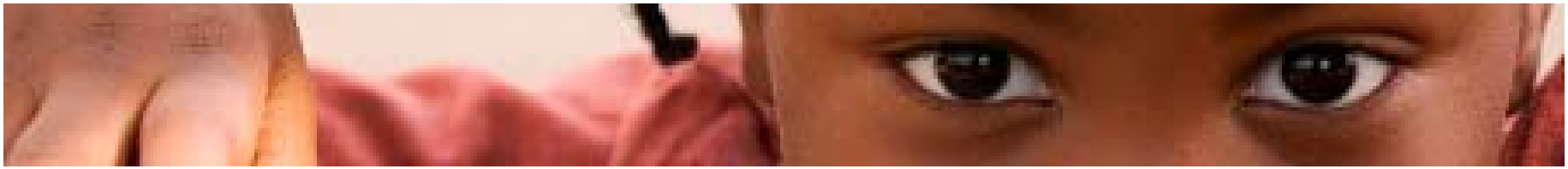
In 1996, researchers from Emory University and Georgia State University conducted an evaluation of the child fatality review process. The evaluation concluded that there were policy, procedure and funding issues that limited the effectiveness of the review process. In 2003, the Panel distributed its first child fatality review

protocol manual to all county committee members. An online reporting system was established for both the child fatality review report and the coroner/medical examiner report. A partnership was established between the Georgia Office of Child Fatality Review and the National Center for Child Death Review. The Georgia Child Fatality Investigation Team (CFIT) program was established through a partnership between CFR, the Department of Family and Children Services, and the Georgia Bureau of Investigation.

In 2004, the Prevention Advocate was added – by policy – to the child fatality review committee membership, the office quarterly newsletter was established and distributed to all members and agency partners, and a sub-committee of the Panel was formed to begin creating the Statewide Child Injury Prevention Plan. In 2006, the child fatality review protocol manual was revised and updated to reflect best practices. 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. In 2008, the Office of Child Fatality Review was merged with the Office of the Child Advocate for the Protection of Children (OCA). Subsequent to the merger, the CFIT program expanded to include a statewide comprehensive training academy. The training academy faculty is comprised of subject matter experts in the fields of law, medicine, law enforcement, and child welfare. Additionally, the Statewide Child Injury Prevention Plan was completed and presented to the Governor's Office and other agency partners.

In 2009, child fatality review committee reports were submitted to a web-based reporting system developed and maintained by the National Center for Child Death Review. The system offers many benefits to staff and county review committees, including the capability for local committees to produce their local data reports in real time. The Child Fatality Review Division of the Office of the Child Advocate was awarded a three-year grant from the Centers for Disease Control and Prevention (CDC) to implement the Sudden Unexplained Infant Death (SUID) Case Registry pilot project.

The child fatality review process in Georgia has evolved and improved over the past twenty years. Due to the intense work and dedication of the CFR staff and partners, the success is evident in the effectiveness of the review committees. In the next few years, we will continue to work on improving data collection and reporting through the CDC SUID Case Registry project, continuing collaboration with the OCA Child Welfare Division staff activities, the Georgia Violent Death Reporting System, and the Office of Vital Records, and seeking out partnerships for prevention and health promotion. These activities will strengthen the position of CFR among agencies and communities, and support our mission of prevention and reduction of child abuse and fatality in our state.



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Clyde L. Reese, III, Esq., Commissioner Sonny Perdue, Governor

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www.dch.georgia.gov

The Office of Vital Records, in the Department of Community Health, Division of Public Health, works diligently to provide accurate records and data concerning vital events to Georgians and other stakeholders in an expeditious and friendly manner. Two of our primary tasks are to record and enter all occurrences of Georgia vital events into the vital records database (more than 200,000 records each year), and prepare certified copies of birth and death records (nearly 318,000 copies each year). The Child Fatality Review Division of the Office of the Child Advocate (OCA/CFR) has been very helpful in providing staff to assist us in completing this work.

In 2009 and 2010, OCA/CFR has been a strong partner in the effort to improve efficiencies in recording death certificates to the vital records electronic database. Death certificates are completed by funeral directors and certifying physicians, except in the case of coroner investigations where the coroner certifies the manner of death. The CFR Division staff has dedicated time to obtaining these necessary records when they were unavailable to us, which also supports their work in comparing CFR reports by committees to vital statistics data. Additionally, we have begun sharing birth certificate data with CFR to assist them in their CDC Sudden Unexplained Infant Death Investigation grant-related data collection activities. We welcome the opportunity to partner with CFR and look forward to a long and collaborative relationship.

Unfortunately, one of the problems with our death information is the lack of ICD-10 coding. The employee who was entering this information retired earlier this year and because NCHS indicated their intentions to assume this responsibility and that particular skill requires several months of training and approximately two years experience to become proficient, we have not attempted to replace her. We hope to work out the kinks in the processing of this data in the upcoming months.

We look forward to enhancing the mutual benefits of our relationship with CFR in the future. As of this date, over 40,000 2010 death records have been entered in our system by funeral homes, county registrars and OVR staff. The advantages of having this data readily available cannot be overrated.

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"The child fatality review process in Georgia has evolved and improved over the past twenty years. Due to the intense work and dedication of the CFR staff and partners, the success is evident in the effectiveness of the review committees. In the next few years, we will continue to work on improving data collection and reporting through the CDC SUID Case Registry project, continuing collaboration with the OCA Child Welfare Division staff activities, the Georgia Violent Death Reporting System, and the Office of Vital Records, and seeking out partnerships for prevention and health promotion. These activities will strengthen the position of CFR among agencies and communities, and support our mission of prevention and reduction of child abuse and fatality in our state."

All 2009 Reviewed Child Deaths

Child fatality review committees utilize a multidisciplinary approach to review all available circumstances surrounding the death, including any relevant history the family has had with public agencies. The resulting information provides a more accurate picture of what happened and helps to create more targeted prevention efforts. Greater knowledge of child deaths leads to more opportunities for the prevention of child deaths. In addition, comprehensive reviews can clarify trends in causes and show patterns of increasing or decreasing deaths.

CFR staff obtained initial records and death notifications from a variety of sources, including coroner/medical examiner reports, Vital Records (VR) death certificates, Georgia Bureau of Investigation (GBI), and Department of Family and Children Services (DFCS). While Vital Records death certificates generally provide a true and valid denominator of all deaths occurring in the state, several issues with VR reporting have resulted in an incomplete file of records for 2009. Therefore, CFR did not have a full and complete denominator of deaths for 2009, and no way to conclusively determine if all the deaths that were reviewed represented all the child deaths that occurred.

However, with the notifications that were received, staff were able to identify those deaths in need of review. CFR staff worked very closely with local CFR committees to ensure that those identified deaths were reviewed within a timely manner, and that the reports detailing the circumstances of death were thorough and accurately submitted to the office. The following data are based on those deaths that were reviewed and reported using the CFR web-based reporting form. The form can be viewed at http://childdeathreview.org/reports/CDRCaseReportForm2-1-11009.pdf.

In 2009, CFR committees reviewed 518 child deaths. Thirty-eight percent of these deaths (199) were among infants younger than 12 months. The following charts show the variation in causes of death between infants and children over the age of one. SUID (Sudden Unexplained Infant Death – usually occurring during sleep) was the leading cause of death among infants (134), followed by medical causes (32). For children over the age of one, unintentional injuries were the leading cause of reviewed deaths (165 – including motor vehicle, drowning, fire, asphyxia, and other circumstances), followed by medical causes (67). The greatest number of infant deaths was due to sleep-related circumstances, while the greatest number of child deaths was due to motor vehicle-related circumstances.

Figure 1 shows the number of all reviewed deaths of infants by cause in 2009 (N=199)

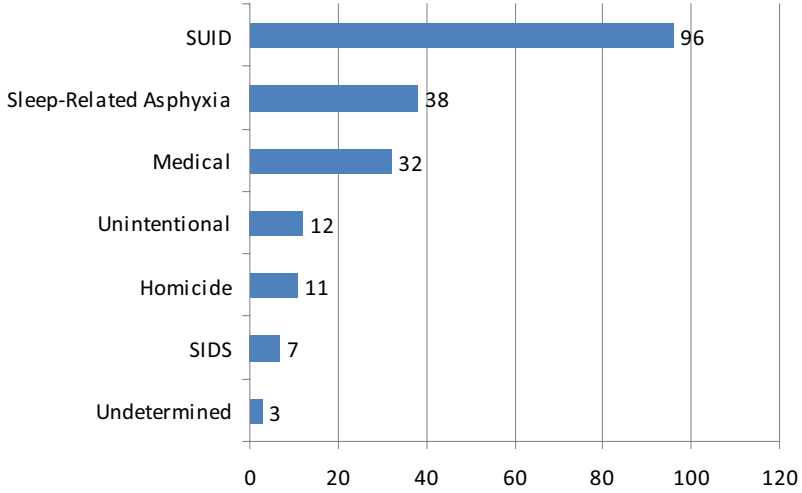
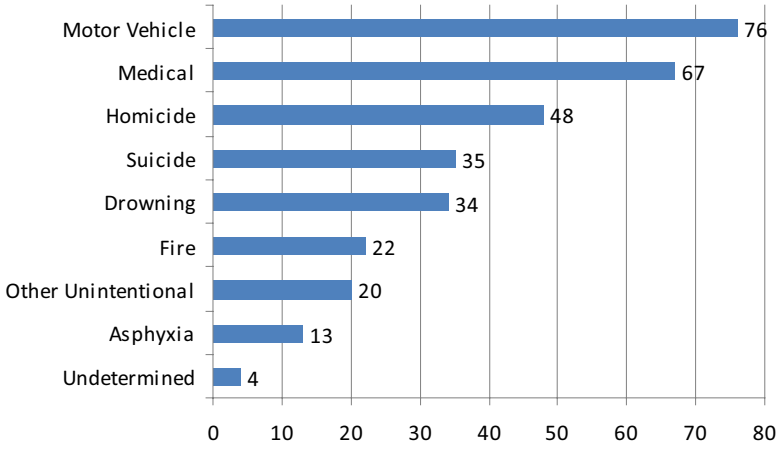


Figure 2 shows the number of all reviewed deaths of children ages 1-17 by cause in 2009 (N=319)



- African-Americans and Whites together were 88% of all reviewed deaths, while Hispanics were nine percent of the total
- Infants were 38% of the reviewed deaths, while older teens (15-17) and toddlers (1-4) together made up 40% of the total
- Consistent with previous years, males were 60% of the total reviewed deaths

The following charts show the race/ethnicity, gender, and age categories of the 518 deaths reviewed. All race categories reported are non-Hispanic, except where otherwise noted. The race/ethnicity of "Hispanic" includes any infant or child reported to be any race plus Hispanic ethnicity.

Figure 3 shows the race/ethnicity of all reviewed deaths in 2009 (N=518)

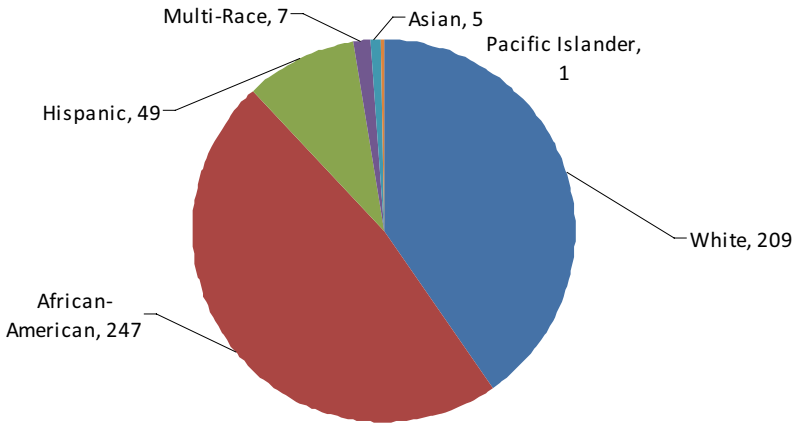


Figure 4 shows the age category of all reviewed deaths in 2009 (N=518)

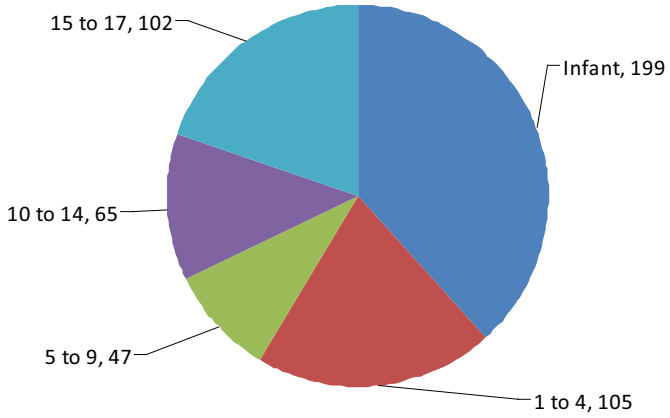
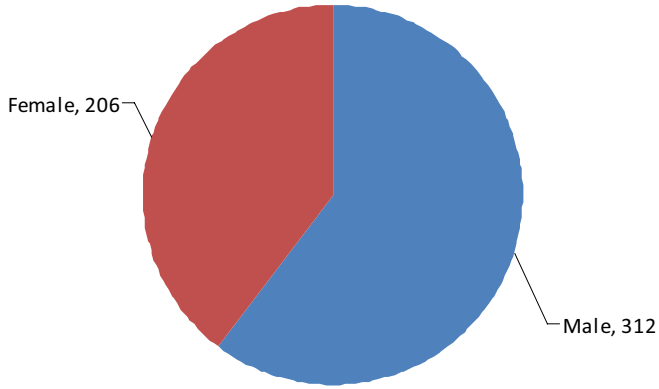


Figure 5 shows the gender of all reviewed deaths in 2009 (N=518)



Spotlight on Maltreatment

In 2006, the Georgia Child Fatality Review Panel was designated to serve as one of Georgia's three Child Abuse Prevention and Treatment Act (CAPTA) citizen review panels. As the recipient of a federal CAPTA grant, Georgia is required to maintain and support three independent citizen review panels whose purpose is to examine the policies, procedures, and practices of State and local agencies. The panels are further required to evaluate the extent to which they are effectively discharging their child protection responsibilities, which includes a review of maltreatment-related child fatalities and near fatalities. Based on their review, CAPTA citizen review panels make recommendations for system improvements in the prevention and treatment of cases of child maltreatment.

The CDC describes child maltreatment as emotional, physical, or sexual abuse (i.e. acts of commission) and/or neglect (i.e. acts of omission) to a child under the age of 18 years by a person in a custodial role to that child (i.e. parent or other caregiver). The CDC and other national organizations have long recognized the need for a consistent definition of child maltreatment. The Child Fatality Review reporting system collects information on maltreatment specific to acts of omission (child neglect) and acts of commission (child abuse). These descriptions of maltreatment, along with consistent data collection and investigation efforts at the local level, can produce a more thorough examination of child death trends for prevention.

Of the 518 child deaths in 2009, CFR committees identified 77 children as victims of maltreatment. This identification was based on a positive response to one or more of the following four variables:

- Child had a history of maltreatment as a victim
- The investigation found evidence of prior abuse
- Child abuse caused or contributed the death
- Child neglect caused or contributed the death

Forty-five child death reviews revealed that the child had history of maltreatment as a victim. In 14 cases, the investigation found evidence of abuse. In 23 cases, child abuse reportedly caused/contributed to the child's death, and in three cases, child neglect reportedly caused/contributed to the child's death (N=26). Because four separate variables were used to determine maltreatment, there was some overlap with the reporting. There were 21 cases where the committees identified two of the four maltreatment variables, and two cases with three maltreatment variables identified. There were no cases where all four maltreatment variables were included in the report.

Of these 77 children with maltreatment identified, 34 were reported as homicide deaths (44%), 12 were medical deaths (16%), eight were suicide deaths (10%), and five were infant sleep-related deaths (six percent). Maltreatment reported by race/ethnicity identified 39 African-Americans (51%), 31 Whites (40%), six Hispanics (eight percent), and one Multi-racial child.

Children ages 0-4 represented 41 of the child deaths with maltreatment identified (53%), and 21 of the child deaths with maltreatment identified (27%) were teens (13-17).

CFR committees were able to identify an additional 179 children where some form of omission or commission occurred and was a contributing cause in the death. Examples of other contributing causes include poor supervision or other negligence. CFR has collected data on child maltreatment for many years, and the capacity to consistently collect the information relies upon the CFR committee approach and that all organizations work together to produce accurate and thorough case information.

Agency Involvement

Committees were asked to report on the number and type of agencies who had involvement with the child or the child's family at any point prior to the death. Involvement was generally defined as having provided services of some type (e.g. mental health, social services, law enforcement, disability services, etc.) to the child or the child's family. In many cases, multiple agencies were providing services to a single family. These represent opportunities for education, prevention, and risk reduction counseling with each agency visit or staff interaction.

- 15 children were receiving services through Children with Special Health Care Needs (CSHCN) for a disability or chronic illness
- 23 children had received mental health services at one time, and 13 of the 23 were currently receiving services at the time of death
- 32 children had an open CPS case at the time of death
- 26 children had prior court involvement for delinquent or criminal history
- 11 children had spent time in juvenile detention prior to their death
- 106 cases reported that a caregiver had received social services (e.g., WIC, food stamps, Medicaid, TANF) in the 12 months prior to death

Opportunities for Prevention

- Of the 11 children with juvenile court history, eight (73%) died from intentional injuries (six homicides and two suicides)
- Of the 32 children with open CPS cases, eight died from sleep-related causes, seven died from intentional injuries (homicide), and five died from medical causes
- Of the 23 with any mental health service history, 13 died from intentional injuries (nine suicides and four homicides), and five died from medical causes
- Of the 15 children receiving CSHCN services, seven (47%) died from medical causes

Death Scene Investigation

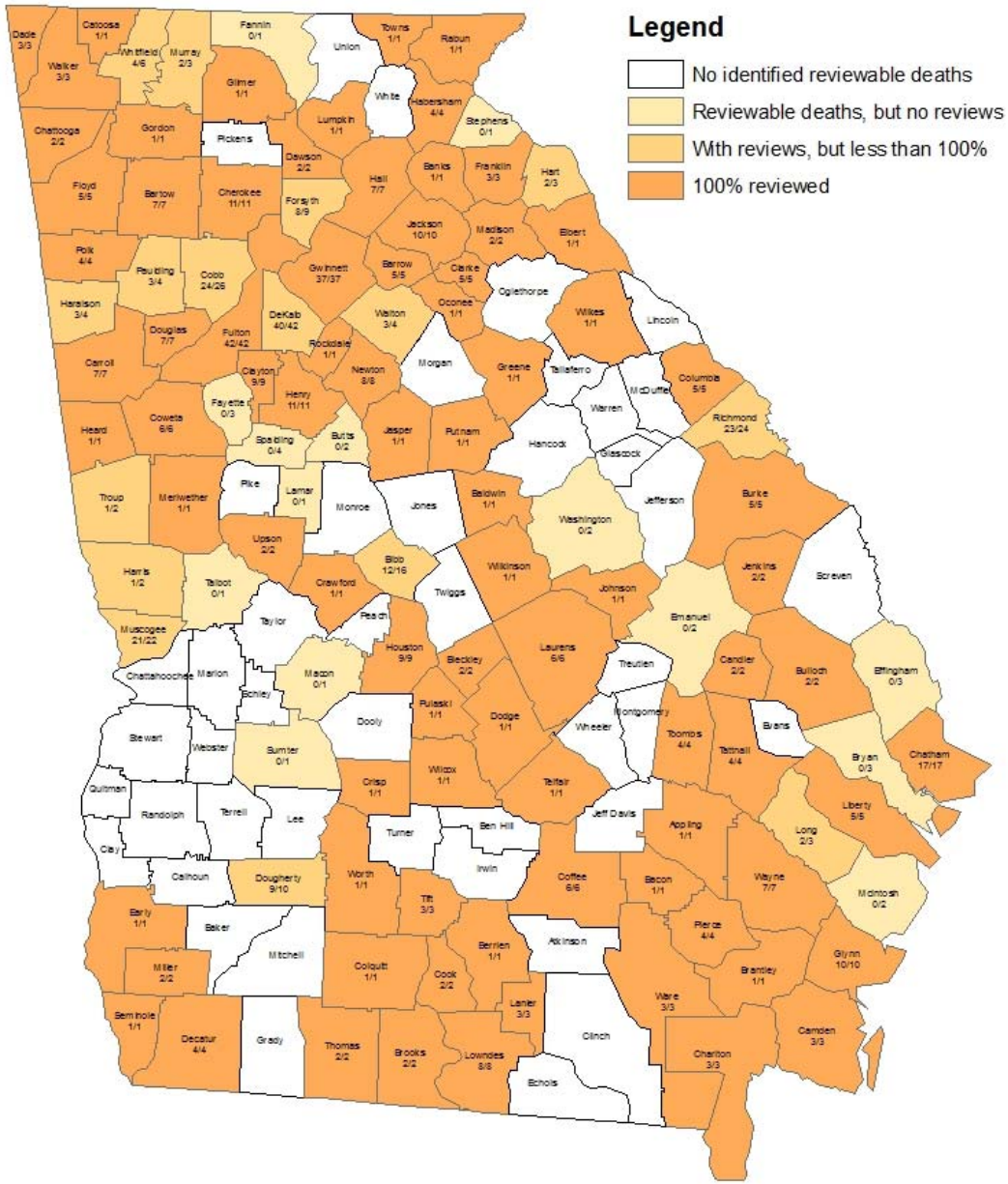
Committees reported that in 54 cases, there were no agencies involved in the death scene investigation. In the remaining 464 cases reviewed, there was at least one agency that participated in the death scene investigation

Agencies Involved	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
0	22	9	7	8	8	54
1	34	19	9	13	19	94
2	62	35	16	18	36	167
3	65	29	13	15	31	153
4	11	10	0	7	7	35
5	5	1	2	4	1	13
6	0	1	0	0	0	1
7	0	1	0	0	0	1

- The average number of agencies involved in death scene investigation (DSI) is just over 2.1, and does not vary by age category

Child Fatality Reviews 2009

Numbers are number reviewed out of number reviewable



Sleep-Related Infant Deaths

A 4-week-old infant was placed on his back and in bed with his parents to sleep for the night. Their bed was very soft and had an egg-crate mattress on top of the queen mattress. Sometime during the night, the father got up and moved to another room. When he awoke later, he discovered that the infant was cold and not moving. EMS was called but the child was already deceased. When his body was sent for autopsy, the cause of death could not be determined due to the history of bed-sharing and possible overlaying. While this family did have some protective factors that could have reduced his risk of death (he was healthy at birth; full-term and normal birthweight; his mother did not have a history of smoking during pregnancy), there were other risk factors for this family: his mother was an older teenager with a high school education, and while his usual sleeping place was a bassinette, he was not placed there on this night.

Definitions

Sudden infant death syndrome (SIDS) is the sudden death of an infant under age one that cannot be explained after a thorough investigation has been conducted, including a complete autopsy, an examination of the death scene, and a review of the clinical history.

Sudden Unexplained Infant Death (SUID) is the sudden and unexpected death of an infant in which the manner and cause of death are not immediately obvious prior to investigation. SUID cases may sometimes appear to be SIDS at first glance, but a thorough and complete investigation reveals other contributing risk factors present.

Sleep-related asphyxia is reported when the circumstances of the death clearly show that the infant experienced suffocation during sleep (e.g. positional asphyxia, wedging, or strangulation). Infant sleep-related asphyxia deaths often occur while bed-sharing with another person.

This category of sleep-related infant deaths captures SIDS, SUID, and sleep-related asphyxia. How are SUID and SIDS different? SUID can be caused by undiagnosed metabolic disorders, possible hypothermia or hyperthermia, undetermined neglect or homicide, undetermined poisoning, or undetermined suffocation. Often the cause is unknown. Research by the Centers for Disease Control and Prevention (CDC) has found that the decline in SIDS since 1999 corresponds to an increase in SUID rates during the same period. This change in the classification of SUID can be explained by changes in how investigations are conducted and how SUID is diagnosed.

When residence location was reported for infant sleep-related deaths (N=124), 53 occurred in suburban counties (43%), 40 occurred in urban counties (32%), and 31 occurred in rural counties (25%)

Spotlight on Maltreatment

Of the 141 sleep-related infant deaths in 2009, five infants were reported to have evidence of maltreatment prior to or at the time of death. Four were reported as SUID and one was a sleep-related asphyxia. Two infants were White, two were African-American, and one was Multiracial.

Figure 6 shows the demographic data for reviewed sleep-related infant deaths, 2009 (N=141)

	SIDS	Asphyxia	SUID	All	%
White Male	1	9	23	33	23.4
White Female	1	9	19	29	20.6
African-American Male	1	13	26	40	28.4
African-American Female	2	3	18	23	16.3
Hispanic Male	1	2	3	6	4.3
Hispanic Female	0	1	4	5	3.5
Other Race Male	1	1	1	3	2.1
Other Race Female	0	0	2	2	1.4
Total	7	38	96	141	100.0

Figure 7 shows the reviewed sleep-related deaths by caregiver age (when known), 2009 (N = 119)

Caregiver Age	SIDS	Asphyxia	SUID	All	%
<20	0	6	12	18	15.1
20-29	3	23	53	79	66.4
30+	1	5	16	22	18.5
Missing/ Unknown	3	4	15	22	--

Smoking during pregnancy was reported for 31 infant sleep-related deaths. In 12 cases, the committees received evidence of prenatal smoking and in 19 cases, there was none.

Although two-thirds of the reviewed infant deaths were with caregivers between 20 and 29 years of age, sleep-related infant deaths are not directly related to a caregiver's or mother's age. Prevention education should target youth and adults of all ages, to ensure that all potential caregivers have the best information before taking on the responsibility of caring for an infant.
Risk Factors for SIDS, SUID, and sleep-related asphyxia include: bed-sharing, prone sleep position, tobacco exposure, and delayed prenatal care. According to the Department of Health and Human Services (DHHS), infants born to mothers who received no prenatal care are three times more likely to be born at low birth weight, and five times more likely to die, than those whose mothers received prenatal care. Georgia PRAMS (Pregnancy Risk Assessment Monitoring System), a statewide surveillance system, show the population estimates for maternal behaviors, including these risk factors. The most recent published PRAMS data are from women who delivered a live-born infant in Georgia between 2004 and 2006.

- PRAMS data show 78% of respondents reported entering prenatal care during their first trimester
  - The highest percentages of women who enter prenatal care during their first trimester are: non-Hispanic White women, women 30-39 years old, women whose highest level of education is completion of college, and women with a household income of $50,000 or higher
  - PRAMS data also show that 76-80% of women reported receiving prenatal care and counseling from an MD or HMO. Only 18-19% received prenatal care and counseling from a health department or hospital clinic. The highest reported barriers to care were appointment availability and cost

Figure 8 shows the reviewed sleep-related deaths by gestational age (when known), 2009 (N=76)

Gestational Age in Weeks	SIDS	Asphyxia	SUID	All
Moderate-Extreme Preterm, <34 weeks	1	3	4	8
Late Preterm, 34-36 weeks	0	1	16	17
Term, 37+ weeks	0	15	36	51
Missing/Unknown	6	19	40	--

- PRAMS data show 51% of respondents reported that their infant sleeps in the same bed with them or someone else
  - The highest percentages of women who report that their infant is bed-sharing are: African-American women, women younger than 20 years old, women whose highest level of education is completion of high school or less, Hispanic women, women with a household income of less than $15,000, non-married women, and women who delivered an infant weighing between 1,500 and 2,499 grams (3lbs 5oz – 5lbs 8 oz)
  - Infant bed-sharing appears to be increasing among women whose race is other than African-American or White, women 40 years or older, and women with a household income between $35,000 and $49,999

Of the 141 sleep-related infant deaths reviewed in 2009, 26 were reportedly low birthweight (<2,500 grams) and 45 were reportedly normal birthweight (>2,500 grams). This information was not provided for 70 of the deaths (50% missing/unknown).

- PRAMS data show 19% of respondents reported smoking a cigarette during the three months before pregnancy
  - The highest percentages of women who report smoking before pregnancy are: non-Hispanic White women, women 29 years or younger, non-married women, and women whose delivery was paid for by Medicaid
  - Pre-pregnancy maternal smoking appears to be increasing among women who delivered an infant weighing less than 1,500 grams (3lbs 5oz)

Figure 9 shows the reviewed sleep-related deaths by bed-sharing (when known), 2009 (N=110)

Sharing Sleep Surface	SIDS	Asphyxia	SUID	All	%
Yes	1	20	65	86	78.2
No	1	9	14	24	21.8
Missing/ Unknown	5	9	17	31	--

Figure 10 shows the reviewed sleep-related deaths by sleeping position when discovered (when known), 2009 (N = 106)

Sleep Position	SIDS	Asphyxia	SUID	All	%
On back	4	2	26	32	30.2
On stomach	0	26	31	57	53.8
On side	0	4	13	17	16.0
Missing/ Unknown	3	6	26	35	--

Opportunities for Prevention:

- Encourage crib use in families and communities. Use a crib that meets current safety standards. The mattress should be firm and fit snuggly in the crib. Cover the mattress with only a tight-fitting crib sheet. Portable cribs and play yard style cribs are also good choices
- Fewer than 20% of women in Georgia seek prenatal care from a health department or hospital. Support private health care providers by encouraging training and providing resources for counseling of new mothers. Support communities and providers by incorporating culturally and linguistically competent values, policies, structures and practices in SIDS/Infant Death-related programs.
- Support public health campaigns to promote healthy habits among parents expecting a child or caring for an infant to prevent child malnutrition (such as Text4Baby.org). Support medical research to better understand and prevent birth defects, premature birth and Sudden Infant Death Syndrome (SIDS) and to promote healthier growth and development

Prevention Success

A product recall was initiated for Amby Baby Motion Hammocks after a county review. A mother placed her infant in the hammock on her back after a feeding. When the mother checked on her infant around 3:00 am, the infant was found face down with her face in the mattress. Soon after this case was submitted, the Consumer Product Safety Commission issued a recall in December 2009. This county review was instrumental in the product recall

All Reviewed Medical Deaths

She was a 17-year-old high school student, and in school on this last day of her life. She had been in the hospital a few months before her death and diagnosed with severe hypertension. She was on four different medications for her high blood pressure. On this fateful day, she was crying and complaining of a severe headache. She asked a classmate to bring her to the school clinic. She admitted that she had not taken her medication that morning. Her blood pressure was extremely high and she became unresponsive. Her mother was contacted and EMS was called. She was transported to the hospital emergency department but they were unable to save her. Her final diagnosis: acute intracerebral hemorrhage – her brain functions had completely stopped. She was pronounced dead on that same day

Definitions

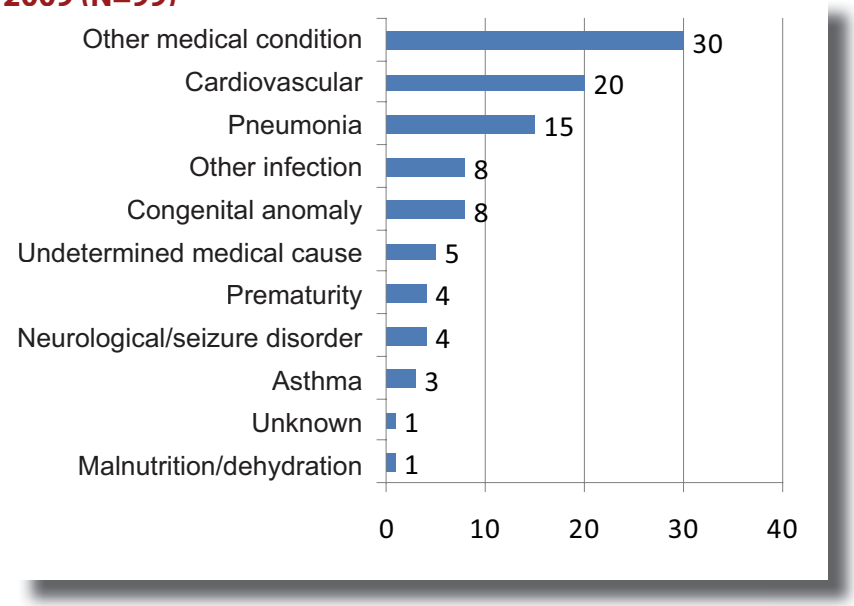
Medical deaths are eligible for review by committees when the death is referred to the coroner or medical examiner and meets CFR eligibility criteria (i.e. unexpected/unexplained/suspicious circumstances). Examples of reviewable medical deaths are those from medical illnesses that do not normally cause death in otherwise healthy children, and can be successfully managed with proper medical care and treatment (i.e. asthma or high blood pressure). However, many medical deaths may not be reviewed by committees if the death occurred in the hospital, or was not reported to the local coroner/medical examiner. [Note: deaths that occur while in hospice care are not considered reviewable by CFR, as they are considered “expected” deaths]

Figure 11 shows the demographic data for reviewed medical deaths, 2009 (N=99)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White	11	5	2	5	7	30
African-American	18	12	9	9	12	60
Hispanic	2	1	0	1	1	5
Multi-racial	1	1	0	0	1	3
Other Race/ Ethnicity	0	0	0	0	1	1
Total	32	19	11	15	22	99

A death due to a natural cause can result from one of many serious health conditions. Congenital anomalies, genetic disorders (such as cystic fibrosis), cancers, heart and cerebral problems, serious infections and respiratory disorders such as asthma can be fatal to children. Many of these conditions are not believed to be preventable in the same way in which accidents, homicides or suicides are preventable. But there are some illnesses, such as asthma, infectious diseases and some genetic disorders, in which under certain circumstances, fatalities can and should be prevented. Treatments for asthma, certain infectious diseases, and other medical conditions are numerous and generally very effective.

Figure 12 shows the causes of medical deaths reviewed in 2009 (N=99)



Spotlight on Maltreatment

There were 12 medical deaths reviewed with maltreatment findings. Six were African-American (50%), five were White (42%), and one was Hispanic. Of the 12 deaths, two were children younger than five years old, three were ages 5-9, and seven were ages 10-17. In all 12 cases, the committee did not determine that the prior abuse directly caused or indirectly contributed to the death. The committee noted in four of the cases, the child had been treated by a physician shortly before the death.

There were 99 medical deaths reviewed by committees in 2009. Of the 99 deaths reviewed, 41 children were reported to have a known physical disability or chronic illness at the time of death. Twenty-one had reported heart or lung disorders (including asthma, lung disease, and heart disease), and seven had reported seizure disorders. Several children had multiple illnesses reported. Thirty-five children had no known disability or chronic illness reported before death. Of these 35, eight deaths were determined to be due to pneumonia. Pneumonia can be caused by a variety of agents including bacteria, viruses, and mycoplasmas, among others. Pneumonia remains an important cause of morbidity and mortality in the United States as both a primary and secondary infection. The “other medical conditions” reported (30) consist of a variety of conditions that are not adequately represented in other named categories, such as necrotizing fasciitis, spontaneous pneumothorax, and pulmonary embolism.

Opportunities for Prevention:

- Regular health exams and tests can help find problems early, when the opportunities for treatment and cure are better
- Remove triggers that may cause asthma or other respiratory health problems. Triggers include smoke, dust mites, cockroaches, pets, and mold
- The most important thing that all people can do to help keep from getting sick is to wash hands, especially after coughing and sneezing, before preparing foods or eating, and after using the restroom. It is estimated that one out of three people do not wash their hands after using the restroom

Prevention Success

Due to an increase in asthma deaths in one community, an asthma prevention coalition was created. The coalition is now working closely with the school system to do research on air quality

Unintentional Injury-Related Deaths

A 14-year-old, accompanied by a teenage friend, lost control of an ATV. The teens crossed the highway, striking a parked car, a mailbox, rocks, and finally a tree. Both children were ejected from the vehicle and killed.

Definitions

Unintentional injury is damage to a person's body via mechanical, thermal, or chemical distribution. These injuries are not deliberate, therefore these injuries (fatal or non-fatal) can be considered preventable. This category includes those injuries where the manner of death was listed as unintentional by CFR committees.

In 2009, unintentional injury-related deaths were reported for 165 children over the age of one (52% of all deaths among children in this age group). While the overall number of reviewed unintentional injury-related (UI) deaths has decreased from previous years, there is an average of 3.4 child deaths each week due to unintentional circumstances such as motor vehicle, drowning, fire, poisoning, firearm, asphyxia, falls, dog bites, and exposure to the elements. UI deaths affect all children, regardless of race, gender, or age, but each year, children ages 1-4 years (i.e. toddlers) are at greatest risk. Deaths to children in this age group were 35% of all UI deaths. Toddlers represented the majority of drowning, fire, exposure, and asphyxia fatalities.

Figure 13 shows the reviewed unintentional injury-related deaths by mechanism of injury and age of victim, 2009 (N=177)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	TOTAL
Motor Vehicle	3	16	17	18	25	79
Drown	1	22	3	3	6	35
Fire	2	12	5	4	1	24
Asphyxia	3	7	3	3	0	16
Weapon	0	1	0	3	4	8
Fall/Crush	1	1	2	1	0	5
Exposure	1	3	0	0	0	4
Poison	1	0	1	0	2	4
Bite	0	1	1	0	0	2

The most common mechanisms of reviewed UI deaths were due to motor vehicle, drowning and fire (138). However, children died from other preventable incidents such as being exposed to space heaters, wedged between furniture, strangulated on high chair straps, firearm incidents, deprivation of oxygen due to the “choking game” and choking on grapes/other objects.

In 2009, the most common mechanisms of reviewed UI deaths were:

Infants	Asphyxia (25%) and Motor Vehicle- Related (25%)
1-4 years	Drowning (35%)
5-9 years	Motor Vehicle-Related (53%)
10-14 years	Motor Vehicle-Related (56%)
15-17 years	Motor Vehicle-Related (66%)

For all ages, males have a significantly higher risk of death than females

Research has shown that children from low-income homes are at increased risk for unintentional injuries (Safe Kids, 2004). Families with lower income may not have the resources to obtain the recommended safety equipment, may live in neighborhoods without safe play areas, or have inadequate supervision for children. When family income was reported (30), 19 families were reported to be living in a low income household (63%). Of those 19 families, 13 (68%) were receiving social services of various types (WIC, TANF, Food Stamps).

Spotlight on Maltreatment

CFR committees reported 15 unintentional injury-related deaths where the investigation revealed history of maltreatment. However, 21% of all unintentional injury-related deaths were associated with some form of maltreatment (child abuse and/or neglect), including poor supervision or other negligence. The majority of those cases involved motor vehicles (65%) or weapons (14%).

Figure 14 shows the reviewed unintentional injury-related deaths by mechanism of injury and race/ethnicity of victim, 2009 (N=177)

	Asphyxia	Bite	Drown	Exposure	Fall/ Crush	Fire	MVC	Poison	Weapon	TOTAL
MALE										
White	6	1	16	2	1	2	18	3	2	51
African-American	3	0	7	1	0	6	24	0	5	46
Hispanic	0	0	5	0	1	4	5	0	0	15
Other Race	0	0	1	0	0	0	0	0	0	1
FEMALE										
White	2	1	4	0	2	1	14	1	0	25
African-American	5	0	0	1	1	10	11	0	0	28
Hispanic	0	0	1	0	0	1	5	0	1	8
Other Race	0	0	1	0	0	0	2	0	0	3

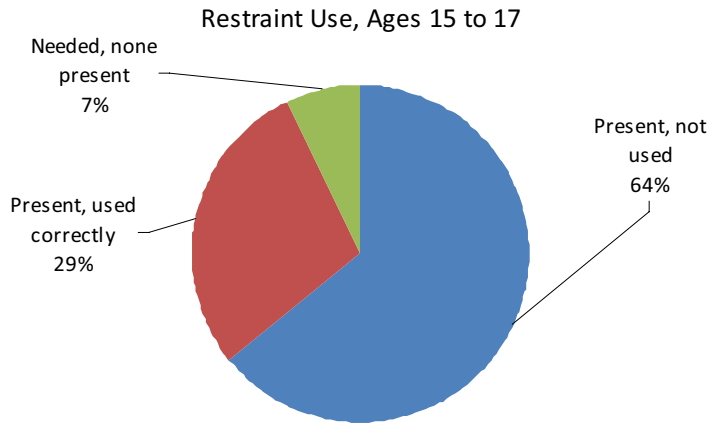
Motor Vehicle-Related Deaths

There were 79 motor vehicle-related deaths reviewed by committees in 2009. Motor vehicle-related deaths accounted for 45% of all unintentional injury-related deaths reviewed in 2009. Thirty percent of the motor vehicle-related deaths were pedestrian fatalities, which continue to be an important issue for all age groups. The number of these reviewed deaths has stayed about the same over the past several years. Prevention initiatives for pedestrian injuries have proven to be great successes in communities across Georgia, and the deaths associated with motor vehicle crashes are declining nationally. However, it remains a prominent focal point for unintentional injury professionals. The momentum must continue in order to see further reductions in motor vehicle-related deaths and injuries in Georgia.

The National Highway Traffic Safety Administration (NHTSA) recommends a booster seat be used until the child reaches a height of four feet nine inches tall or the vehicle seat belt system fits the child properly. CFR committees reported on 11 vehicle occupants ages 5-9 years; five (45%) of these children were riding unrestrained. CFR data variables specifically indicated that the restraint was “present, but not used” or “needed, but none present.”

CDC data indicate that teenagers most at risk for motor vehicle-related injuries and deaths include males, teen drivers with other teen passengers, and newly licensed drivers, particularly during their first year of driving. The data from CFR committees are consistent with this risk analysis. Reported causes of these crashes included driver inexperience, unsafe speeds, pulling out in front of other vehicles, and losing control. There was only one reported case where drugs or alcohol was a cause of the fatality. CFR committees identified 25 children ages 15-17 years who died from motor vehicle-related injuries; 19 were identified as "operators/drivers". Seven had more than two teen/young adult passengers (ages 14-21) riding with them.

Figure 15 shows motor vehicle restraint use for teens ages 15-17 (when known), 2009 (N=14)



Studies have shown that the majority of unintentional injuries occur during evening hours. Of the 155 UI deaths where time of death was known, CFR committees indicated that 55 UI deaths (35%) occurred between 5 and 10 pm

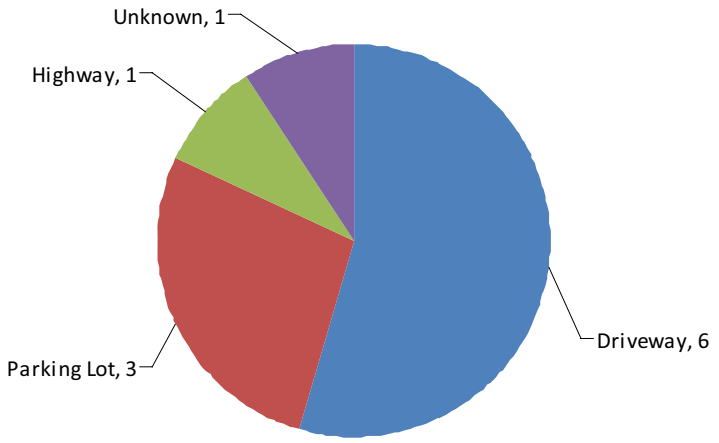
Restraint use has proven to save lives for children and adults of all ages. In Georgia, seat belt use is a primary enforcement law requiring everyone to ride with a seatbelt. Children must be in an approved child safety seat or booster seat until their sixth birthday

For children between the ages of 10-14 years, reported restraint use is very mixed. CFR committees reported 50% of youth to wear their seatbelt correctly, while the other 50% were unrestrained. There were also three deaths related to driving an All-Terrain Vehicle (ATV). All three children were 12-14 years of age. In each of the three cases, the driver reportedly lost control, which is often related to elevated speed or inexperience.

The age of a child can determine their mobility and independence, both of which can affect their risk of being hit by a car. Toddlers are generally less cognizant of surroundings and unknowingly put themselves in risky situations (e.g., playing in unsafe locations). Studies show that adults tend to supervise young males less vigilantly than young females, which can lead to more injuries and deaths. CFR committees reported 21 deaths to toddlers associated with motor vehicle-related injuries. Of these 21 deaths, 11 (52%) were pedestrian-related where the incident occurred outside of the car.

CFR committees reported that of the 10 toddler deaths when supervision was known, seven had adequate supervision at time of death. In 88% of those cases, the mother was the supervisor at the time of death.

Figure 16 shows locations of pedestrian-related fatalities for children ages 1-4 (when known), 2009 (N=11)



Opportunities for Prevention:

- Continue to support the Graduated Licensing of all teen drivers so that experience can be gained over time. Parents should continue to work through driver's education programs with their teen, such as the P.R.I.D.E. program provided by the Governor's Office of Highway Safety (www.ridesafegeorgia.org)
- Young children should be actively supervised at all times. Active supervision of toddlers in and around roadways, parking lots, and driveways is critical for their safety
- Children should ride in a booster seat until the vehicle seat belt system fits them correctly, and they are around four feet nine inches in height
- Parents, caregivers, family members, and friends can be role models. Everyone should wear a seatbelt to teach children and youth how this behavior can save lives

Drowning-Related Deaths

Drowning deaths occur from water-related submersion injuries and asphyxia, and include deaths involving public and private swimming pools, natural open water (e.g., rivers, lakes, oceans, and ponds), bathtubs, and other bodies of water. Drowning is the second leading cause of unintentional injury-related deaths to children over age one. The CDC reports that for every child who dies from drowning, another four children receive emergency care for submersion injuries.

Figure 17 shows the demographic data for reviewed drowning deaths, 2009 (N=35)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	TOTAL
White	0	15	2	1	2	20
African-American	1	2	0	2	2	7
Hispanic	0	4	1	0	1	6
Other Race	0	1	0	0	1	2
Total	1	22	3	3	6	35

Toddlers (children ages 1-4) continue to represent the majority of drowning deaths in Georgia (63%). The majority of toddlers were found in pools (50%) and open bodies of water (41%). Seventy-three percent of the pools had no barriers to prevent accessibility (such as fence or gates). CFR committees reported that children in this age group were supervised mostly by their biological parents (55%). The CDC recommends that active supervision of young children should be "touch supervision", where the supervisor should be able to touch the child at all times. The child should always be in sight of the supervisor. CFR committees also reported that 75% of the supervisors were distracted or absent at the time of death.

Children over age four accounted for 34% of the reviewed drowning deaths. The location of the drowning deaths varied, but the majority occurred in open water.

Figure 18 shows the number of children ages 1-4 with supervision at the time of drowning, 2009 (N=22)

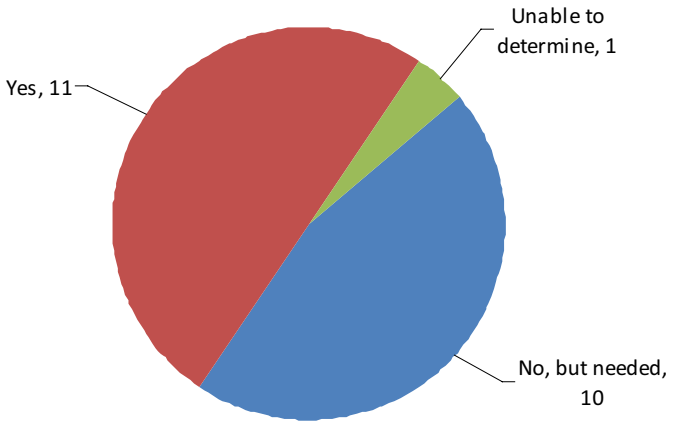
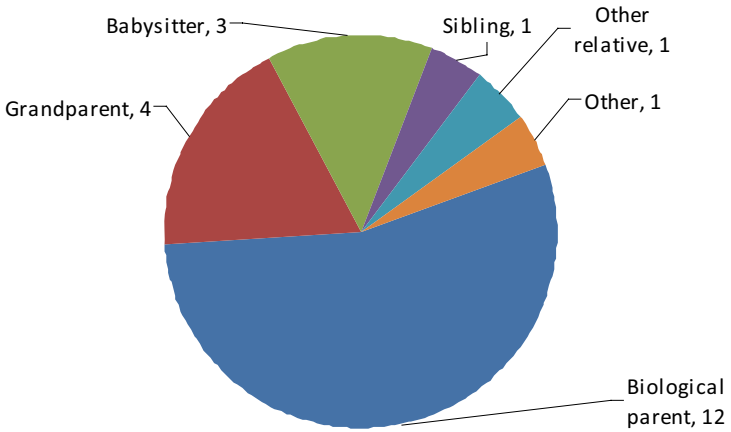
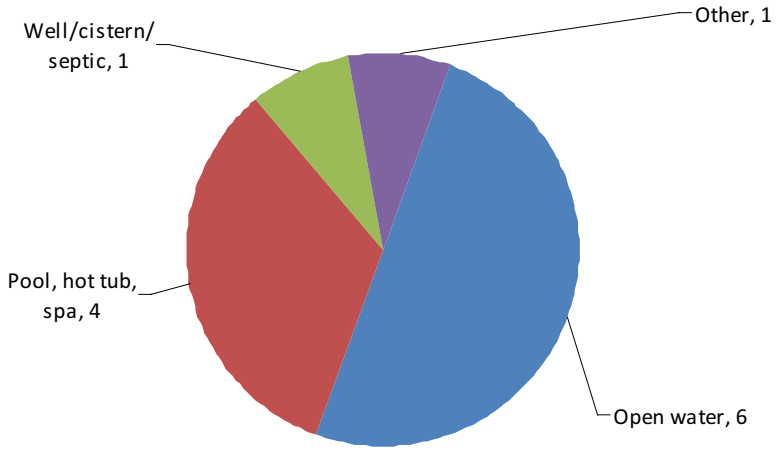


Figure 19 shows the type of supervisors to children ages 1-4 at time of drowning, 2009 (N=22)



CFR committees reported that CPR was initiated in 79% of the drowning deaths before EMS arrived

Figure 20 shows the location of drowning for children ages 5-17, 2009 (N=12)



Opportunities for Prevention:

- Active supervision of children around water is critical and often not practiced by caregivers
- All pools should be protected by a fence at least four feet tall and the pool should be separated from the play area, yard and house
- Older children should always swim with a buddy and should be taught to use extreme caution in open bodies of water. Teens need to be taught to swim and how to assess if the water is safe for swimming

Prevention Success

After a toddler drowned in a nearby public pond, a fence was put up to provide a barrier of accessibility to others

Intentional Injury-Related Deaths

He was an openly gay teen, having problems with classmates and with his family. He was at home with his parents when he said he was going to the basement to do laundry. Shortly after, his parents heard what they thought were firecrackers. His father went to the basement and found him with a self-inflicted gunshot wound to his head.

Definitions

While most child fatalities in Georgia are a result of medical causes or unintentional circumstances, many children also die as a result of intentional injuries. Intentional injuries are those which are deliberately inflicted by oneself (suicide), or by another person (homicide). This also includes a willful, wanton, or reckless disregard for the safety of others during the course of action (for example, a child killed while being disciplined by a parent or caregiver).

In 2009, local committees reviewed 59 child homicides and 35 child suicides. Reviewed child homicides have decreased from 87 in 2007 and 75 in 2008. However, there has been a substantial increase in reviewed child suicides from 19 in 2007 and 20 in 2008.

Mortality rates are higher among males than females in almost all species, including humans, at all ages and even before birth. Research suggests that there are biological as well as social, cultural, environmental, and behavioral reasons for the mortality differences between males and females

Figure 21 shows the demographic data for reviewed intentional injury deaths, 2009 (N=94)

	Suicide	Homicide	All	%
White Male	23	5	28	29.7
White Female	4	6	10	10.6
African-American Male	4	24	28	29.7
African-American Female	1	19	20	21.4
Hispanic Male	2	3	5	5.3
Hispanic Female	1	2	3	3.3
Total	35	59	94	100%

- Two thirds (66%) of all suicide deaths were White males; and 41% of homicide deaths were African-American

Spotlight on Maltreatment

Local committees identified 19 child homicide and eight child suicide cases that were associated with some form of maltreatment (child abuse and/or neglect). Additionally, there were six child homicide cases where prior history of maltreatment involving the parent or caregiver was documented (in these six cases, there was no documented history involving the child).

Homicide

Homicide is the leading cause of injury deaths among infants under one year of age in the United States (15th leading cause of infant mortality from all causes). Males are generally more likely than females to be killed during the first year of life. Moreover, non-Hispanic African-Americans are at higher risk than children of other races to die of an intentional injury during their first year of life. Additionally, while overall homicide levels in the United States have fluctuated minimally in recent years, those involving young victims and perpetrators—particularly young African-American males—have surged. From 2002 to 2007, the number of homicides in the U.S. involving African-American male juveniles as victims rose by 31% and as perpetrators by 43%. Particularly, the number of homicides with firearms among this young population also increased dramatically. In 2009, African-American males accounted for almost half of all reviewed homicides (41%), which is disproportionately high compared to White males (nine percent). African-American females also had a disproportionately high number of reviewed homicides representing 32%, while White females accounted for 10% of all reviewed homicides. It is imperative that all parents, educators, legislators, and community advocates invest in children and families to address this growing epidemic of violence within society.

Figure 22 shows the demographic data for reviewed homicide deaths, 2009 (N=59)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	%
White Male	0	2	2	1	0	5	8.5
White Female	1	4	0	0	1	6	10.2
African-American Male	4	4	1	7	8	24	40.7
African-American Female	5	8	0	1	5	19	32.2
Hispanic Male	0	1	1	0	1	3	5.1
Hispanic Female	1	0	0	0	1	2	3.4
Total	11	19	4	9	16	59	100%

After some decline during the 1990s, the percentage of homicides that involve a gun has increased since 2000, both among young White and African-American offenders. The percentage of gun homicides for young African-American offenders has reached nearly 85%

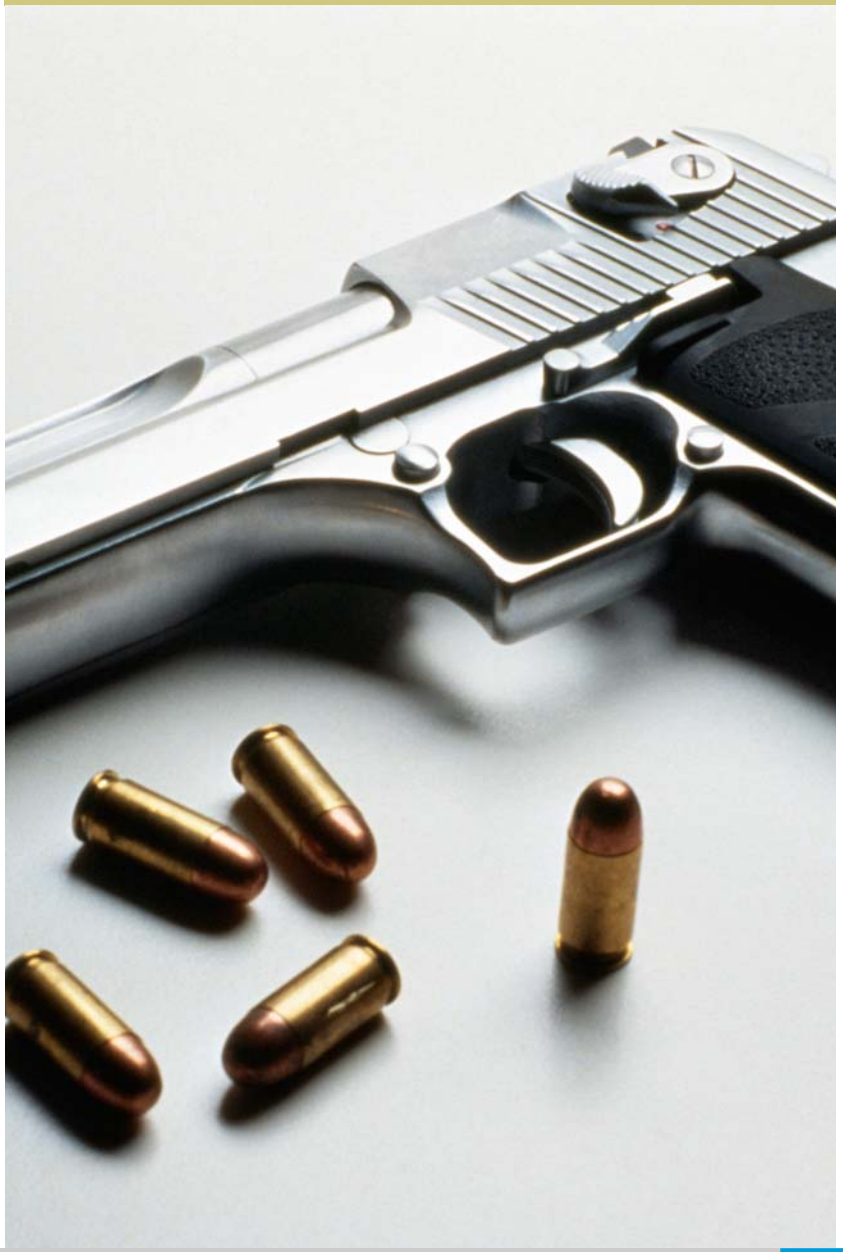
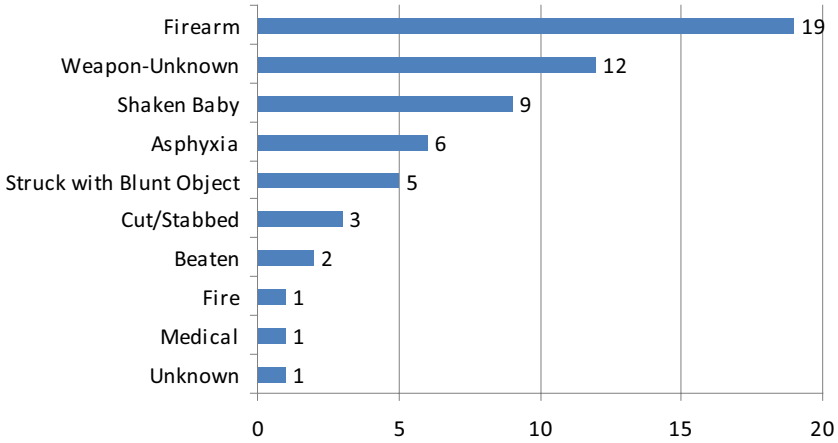
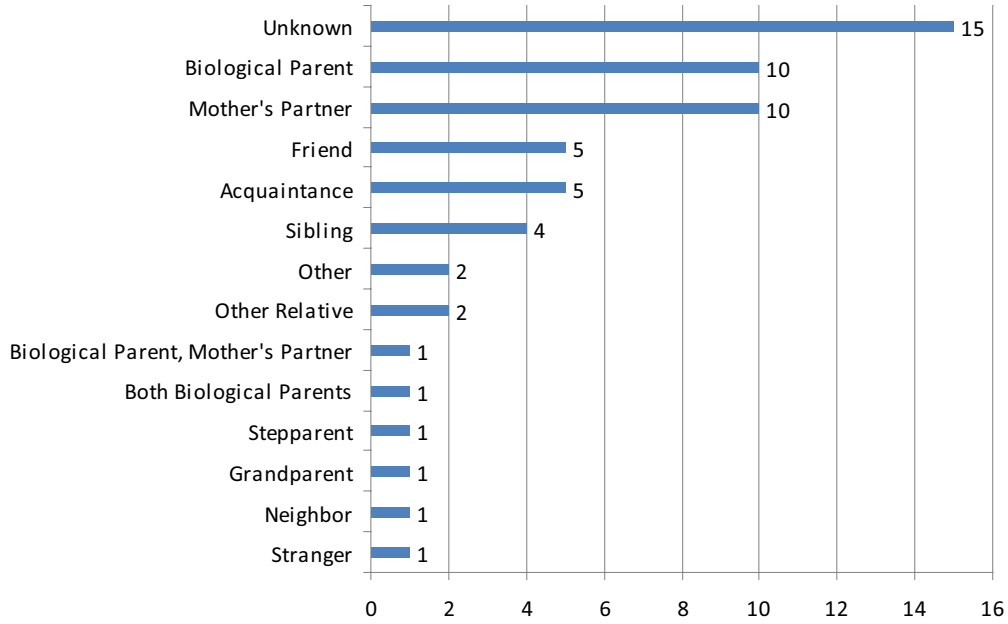


Figure 23 shows reviewed homicide deaths by mechanism, 2009 (N=59)



- In 14 of the 19 firearm-related homicides where weapon type was specified, there were nine handguns, two hunting rifles, one pellet gun, one shotgun, and one assault rifle
- Of the 19 firearm-related homicides, eight involved older teens ages 15-17 (42%), seven were children ages 10-14 (37%), three were young children ages 5-9 (16%), and one was a toddler
- There were eight reported homicides with “head shaking”; three were infants and five were children ages 1-4. Seven of the eight also had documented retinal hemorrhages

Figure 24 shows reviewed homicide deaths by person handling fatal weapon, 2009 (N=59)



- Seven infant homicides were committed by a biological parent (64%), while the majority of toddler homicides (10) were committed by the mother's partner (53%)
- Of the 10 homicide deaths committed by biological parents, two were mothers, seven were fathers, and one was gender unknown. "Other" includes a security guard and a babysitter
- When known, most homicides involving children ages 10-14 (four) and older teens ages 15-17 (five) were committed by friends or acquaintances within the same age cohort, illustrating the growing trend of youth on youth violence

On school days, the risk of violent crime victimization spikes during the after-school hours – the prime time for juvenile crime – while the late evening hours are the most problematic on non-school days, particularly summertime weekends

Homicide occurrence followed no appreciable pattern by time of day based on the 45 cases for which incident data was provided. The times when larger number of homicides occurred by age group was:

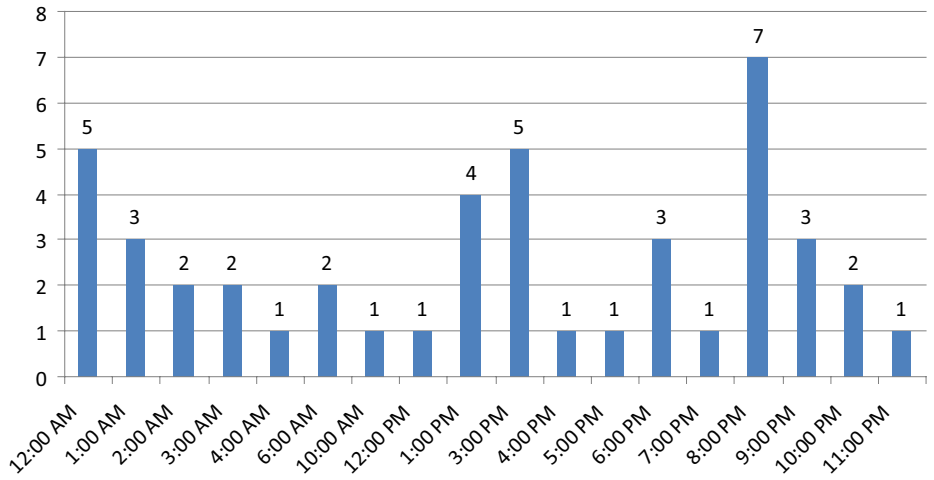
- Ages 15-17: 12midnight (four deaths) and 9pm-11pm (four deaths)
- Ages 10-14: 8pm-10pm (five deaths)

These data demonstrate the importance of ensuring that adolescents and youth are continuously engaged in positive activities throughout the day and some level of supervision is incorporated into their evenings.

Opportunities for Prevention:

- Direct state and federal government spending for after-school youth enrichment and violence prevention programs
- Implement child, parent, and family support networks to provide vital resources for healthy growth and development

Figure 25 shows the reviewed homicides by time of incident (when known), 2009 (N=45)



Suicide Deaths

The longing for approval, admiration, acceptance, and camaraderie accompanies us through every phase of life but is extremely crucial during adolescence. Many youth are overwhelmed by the competing need to feel accepted and embraced by their peers while struggling to cope with familial, educational, communal, and societal challenges they face. This can oftentimes be too much for many youth to handle as they grapple to develop effective coping mechanisms. The CDC reports that 60% of high school students say that they have thought about committing suicide, and nine percent say that they have attempted killing themselves at least once.

Fortunately, many youth display warning signs prior to attempting suicide which can offer a critical window of opportunity for effective intervention strategies. One of the most significant protective factors for youth is a caring relationship with an adult, thus illustrating the importance of parents, educators, and community advocates playing an active role in their lives. By maintaining healthy relationships, youth can develop positive coping strategies that will follow them into adulthood

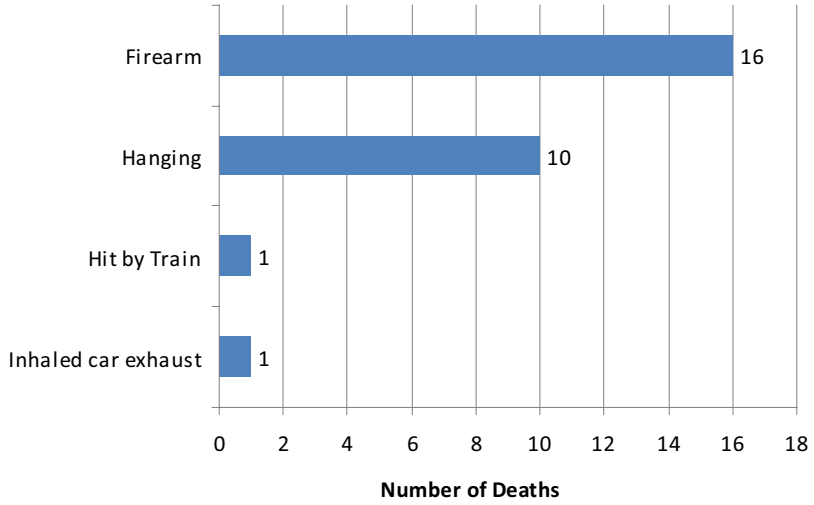
Figure 26 shows the demographic data for reviewed suicide deaths, 2009 (N=35)

	10 to 14	15 to 17	Total	%
White Male	3	20	23	66
White Female	1	3	4	11
African-American Male	1	3	4	11
African-American Female	1	0	1	3
Hispanic Male	2	0	2	6
Hispanic Female	1	0	1	3
Total	9	26	35	100%

Twenty-three of the 35 reviewed suicides (66%) had a “history of acute or cumulative personal crisis”, inclusive of such issues as family discord, school failure, legal problems, and others. There were six cases where the committee reported the child talked of suicide and threatened suicide. In three of those deaths, the committee reported that the child had made at least one suicide attempt prior to their death. Six of the children who committed suicide were currently receiving mental health services. Fourteen of the 35 reviewed suicides were “completely unexpected”.

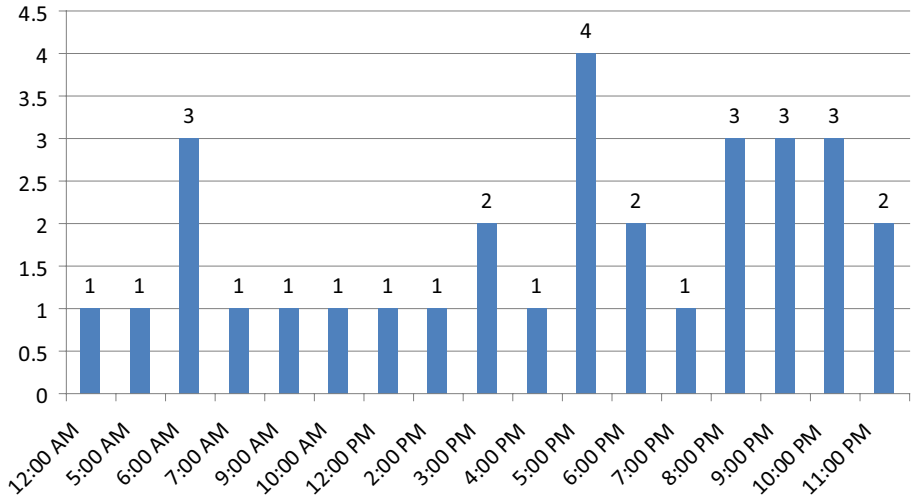
The risk of suicide increases dramatically when children and teens have access to lethal means at home, and nearly 60% of all suicides in the United States are committed with a firearm

Figure 27 shows the reviewed suicide deaths by mechanism of injury, 2009 (N=35)



- Of the 11 suicide deaths where information pertaining to weapon owner was reported, six weapons were owned by the biological parents, three by the victim, and one each by a friend and a stranger
- National data show that young females who attempt suicide are more likely to try overdosing on pills or cutting themselves. Young males are more likely to choose a more lethal method, such as guns or hanging, which is why they are more likely to complete a suicide

Figure 28 shows the reviewed suicide deaths by time of incident (when known), 2009 (N=31)



Suicide occurrence followed no appreciable pattern by time of day based on the 31 cases for which incident data was provided. The times when larger number of suicides occurred by age group was:

- Ages 15-17: 3pm-8pm (eight deaths – 31%)
- Ages 10-14: 3pm-8pm (eight deaths – 89%)

Opportunities for Prevention:

- Increase awareness of suicide warning signs, and promote prompt action when warning signs are recognized among parents, educators, caregivers, and communities
- Support extra-curricular and after-school programs that provide positive activities for children and youth
- Expand Question, Persuade and Refer (QPR), a three-step basic gatekeeper training within schools and community advocacy centers

Prevention Success

An anti-bullying bill was signed into law in 2010, requiring the state Department of Education to develop an anti-bullying policy for all students, kindergarten through 12th grade


Mizuno

Prevention

When CFR committees review a child death, they must also identify the "preventability" of the death. Preventability is 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. The circumstances before the event, during the event, and immediately after the event are all considered in this determination.

Figure 29 shows all reviewed deaths by cause and preventability (when known), 2009 (N=506)

Cause of Death	Probably Not	Probably	Undetermined
Asphyxia	1	14	1
Bite	0	1	1
Drown	4	29	0
Exposure	0	4	0
Fall/Crush	0	4	1
Fire	2	19	2
Homicide	5	49	3
Medical	59	13	25
Motor Vehicle Crash	2	72	3
Poison	0	4	0
SIDS	4	0	3
Suicide	7	16	11
Sleep-Related Asphyxia	1	30	6
SUID	16	51	28
Undetermined	2	1	4
Weapon	1	7	0
Total	104 (21%)	314 (62%)	88 (17%)

Figure 30 shows the services identified by committees as offered or provided to families after a death (when known), 2009

Services Identified					
	Bereavement	Funeral	Mental	Health	Legal
Infant	80	50	20	6	2
1 to 4	50	37	14	6	3
5 to 9	23	17	4	1	1
10 to 14	25	18	9	1	3
15 to 17	33	30	5	1	0
Total	211	152	52	15	9

*78 records had both Bereavement and Funeral indicated

Prevention can often begin with services offered to a family after a death of a child. The education and support from these services can help families consider risk factors and behaviors that may prevent another death from happening in the future. Committees reported these services were offered or provided to families after a death was reviewed.

When prevention initiatives were recommended by committees after completing a child death review, these activities were most often mentioned: media campaigns (58), community safety projects (50), school programs (45), and public forums (19).

Examples of prevention recommendations by CFR committees:

- Coordinate health department, DFCS, and hospitals to provide sleep safety information to all new mothers
- Contact the Department of Transportation when street lights and pedestrian crosswalks are needed
- Provide counseling in schools to help students cope with death and prevent suicides; make students aware of counseling availability
- Develop media campaigns on private pool safety and risk factors; teach proper adult-to-child ratio for subdivision pools
- Encourage parental supervision around pools, vehicles and weapons

Prevention is an ongoing process, and requires the commitment of many individuals, agencies, and organizations. CFR will continue to provide the highest quality data, training, and technical assistance to all of our partners to achieve a reduction in the number of child

deaths each year. In 2007, local CFR committees were asked to develop a specific prevention plan, which would be used to drive all child fatality prevention efforts in their county for the upcoming years. Each committee was asked to outline their strategy, define action steps, and identify resources to help them in their objectives. The prevention plans gave CFR insight into the needs and available resources of the communities. The project also allowed committees to network with each other and identify ways they could share resources while working toward the same goals. The barriers that were commonly identified were lack of funding for personnel and program materials, and lack of awareness or participation in the community.

The CFR Panel and staff are actively working on several prevention projects to respond to these identified barriers. In 2008, the Panel supported the development of the first statewide childhood injury/fatality prevention plan, which uses data and best practice models to educate community members, leaders and professional agency staff. In 2009, staff convened a workgroup of agency representatives – including Injury Prevention, Behavioral Health, DFCS, Safe Kids Georgia, the Governor's Office for Children and Families, and Family Connection Partnership – to generate state and local support for the statewide prevention plan. This Panel workgroup is also creating a "prevention toolkit" for counties to use for developing, sustaining, and evaluating local prevention efforts. This toolkit uses results from a quantitative "readiness assessment" tool, together with the CFR committee prevention plans, to devise strategies specific to the needs and issues of each jurisdiction, and facilitate collaboration and partnerships in the prevention planning process. This collaborative effort is designed to address the specific barriers that each CFR committee faces, and provide targeted resources to reduce them.

The Panel and staff also work with other state agencies and coalitions to address specific prevention strategies, such as the Georgia Infant Safe Sleep Coalition, which is funding a safe sleep social marketing campaign; a Georgia State University/Emory University partnership to review 2005-2008 drowning data, including hospital and EMS records; the Child Injury Prevention & Control Policy Plan Advisory Group for child safety seat policies; and the Metropolitan Atlanta Violence Prevention Partnership. Financial assistance for medical, funeral, crime scene clean-up and mental health counseling expenses can be provided to victims of crime (and their families) through the state's Crime Victims Compensation Program (www.cjcc.ga.gov).

In support of prevention legislation, CFR contributed data and statistics for the hearings on the statewide law to ban hand-held cellphone use while driving, cellphone use for young or novice drivers, and texting while driving. CFR has also contributed a voice to the national policymakers, by submitting a letter of support for the Stillbirth and SUID Prevention, Education and Awareness Act of 2009. This bill would improve the collection of critical data to determine the causes of theses tragic deaths, increase education and awareness about how to prevent these tragedies in the future and expand support services for families who have experienced a stillbirth or SUID loss.

Opportunities for Prevention and Education in Communities:

Healthcare Providers / Hospital Staff

- Rates of medication errors and adverse drug events for hospitalized children were comparable to rates for hospitalized adults in a 2001 study in the Journal of the American Medical Association. However, the rate for potential adverse drug events was three times higher in children and substantially higher still for infants in neonatal intensive care units. But errors also happen when doctors and their patients have problems communicating. For example, a study supported by the Agency for Healthcare Research and Quality (AHRQ) found that doctors often do not do enough to help their patients make informed decisions. Uninvolved and uninformed patients are less likely to accept the doctor's choice of treatment and less likely to do what they need to do to make the treatment work. (www.ahrq.gov)
- Advocate for mandatory youth school physicals
- Advocate for a state-wide campaign for reducing prone sleeping (Back to Sleep)
- Parent pressure makes a difference. For pediatric care, a recent study showed that doctors prescribe antibiotics 65% of the time if they perceive parents expect them, and 12% of the time if they feel parents do not expect them. Parents should not demand antibiotics when a health care provider has determined they are not needed. Parents should talk with their health care provider about antibiotic resistance. (www.cdc.gov)

Parents and Caregivers

- It only takes a second for small children to get into something they shouldn't get into. To prevent injury, be aware of common causes of injury in the home, at school, and on the move
- Store all medicines, household products, personal care products, and other dangerous substances in locked cabinets that are out of reach of small children
- Ensure that everyone caring for a child (including family, friends, neighbors, day care, and schools) has all emergency contact information, knows what to do in case of an emergency, and has appropriate policies in place to handle problems. Determine if caregivers are screened and provided training
- Advocate for residential speed bumps and traffic calming measures in neighborhoods
- Require completion of an ATV driver safety course, use of helmets and restriction of child operators in all ATV operations

Coaches / Athletic Directors

- Encourage girls to participate in sports and athletic activities. Girls who play sports have higher levels of self-esteem, lower levels of depression, more positive body image, and higher states of psychological well being than girls and women who do not play sports
- Treat concussions seriously. A concussion is a brain injury. Concussions are caused by a bump or blow to the head, and can occur even when the blow appears to be minor. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If a child reports any symptoms of concussion or if the symptoms are noticeable, seek medical attention right away