Georgia

CAPTA

Citizen Review Panels

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

2012 Annual Report

Citizen review panel member speaks about their experience…

"Each year I learn more about Georgia's child welfare system. The more time I spend on the citizen review panel, the more I appreciate the complex and systemic issues with which DFCS staff must contend."

Georgia

CAPTA

Citizen Review Panels

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

2012 Annual Report

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Child Abuse Prevention and Treatment Act

Originally enacted in January 1974, the Child Abuse Prevention and Treatment Act (CAPTA) is a key piece of federal legislation addressing child abuse and neglect. CAPTA has been amended several times, most recently in December 2010, and reauthorized through 2015. Although the primary responsibility for addressing the child welfare needs of children and families lies with each state, CAPTA provides federal funding to support child abuse prevention, assessment, investigation, prosecution, and treatment activities for the purpose of improving the state's child protection systems.

The 2010 reauthorization had three "primary" goals:

1. To improve the collection of data;
2. To improve systems for training and supporting individuals who identify, prevent and respond to reports of abuse and neglect; and
3. To improve the coordination between agencies working to address challenges associated with abuse and neglect, such as domestic violence.

Key changes in CAPTA legislation included the addition of new state plan assurances, modifications to the fund allocation formula, and changes in the program areas for which CAPTA funds can be used.

CAPTA State Plan

To be eligible for a CAPTA state grant, a state must comply with specific federal requirements and guidelines related to its child welfare policies, practices and laws. The state is also required to submit a plan that describes which of the fourteen

program areas specified in CAPTA it will address with grant funds to improve its child protective services system. Prior to CAPTA reauthorization in 2010, the CAPTA plan was submitted every five years in conjunction with the state's five-year Child and Family Services Plan (CFSP). Reauthorization of 2010 modified this requirement, stipulating that states must develop new plans and periodically review and revise them to reflect changes in strategies or programs identified in the plan. Georgia completed and submitted a new CAPTA plan in 2011, which was subsequently approved in 2012 by the Children's Bureau.

States are required to submit an annual report describing how CAPTA funds were used to address the purposes and achieve the objectives of the CAPTA grant program identified in their approved state plan. States are also required to submit assurances in the form of a certification signed by the Governor that the state has in effect and is enforcing a state law, or has in effect and is operating a state child welfare program in compliance with its obligations as a CAPTA grant recipient. In addition, the annual report must include notification if there were any:

- Significant changes in how the state proposes to use funds from the state's approved CAPTA plan; or
- Substantive changes to state laws or regulations, including those relating to the prevention of child abuse and neglect that could affect the state's eligibility for the CAPTA state grant.

CAPTA Citizen Review Panels

With each reauthorization, including the most recent 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. The CAPTA reauthorization of 1996 established citizen review panels (CAPTA panels) as a requirement for all states receiving a CAPTA state grant. States were required to establish and maintain a minimum of three CAPTA panels to provide opportunities for community members to play an integral role in ensuring that states are meeting their goals of protecting children from child abuse and neglect.

The purpose of the CAPTA citizen review panels is a) to examine the policies, procedures, and practices of state and local agencies and, where appropriate, specific cases; and, b) to evaluate the extent to which state and local child protection system agencies are effectively meeting their child protection responsibilities in accordance with:

1. The state's CAPTA plan;
2. Child protection standards required by CAPTA; and
3. Any other criteria that the CAPTA panel considers important to ensure the protection of children, including:
   a. A review of the extent to which the state and local child protective services system is coordinated with the foster care and adoption programs established under Title IV Part E of the Social Security Act; and
   b. A review of child fatalities and near fatalities.

CAPTA citizen review panels are required to meet quarterly, provide for public outreach, and prepare an annual report on activities to provide feedback on the effectiveness of the state's child abuse prevention and treatment strategies and to make recommendations for improvements. State child welfare agencies are required to provide access to information CAPTA panels desire to review, to provide administrative support that CAPTA panels need to fulfill their duties, and to respond to the annual reports.

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

Children's Justice Act

Section 107 of CAPTA authorizes grants to states for the purpose of improving the assessment, investigation and prosecution of cases of suspected child abuse and neglect, including cases of child sexual abuse and exploitation, maltreatment-related fatalities, and cases involving children with disabilities or serious health-related problems who are victims of abuse or neglect. As a Children's Justice Act (CJA) grant recipient, Georgia must also submit an annual application that includes a performance report documenting CJA-supported projects, describing proposed activities for the coming year and containing assurances in the form of a certification from the Governor that the state meets all CJA compliance criteria.

Both CAPTA and CJA state grant requirements include the establishment by the recipient states of advisory groups of stakeholders – citizen review panels and a task force on children's justice with specified roles and responsibilities.

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 panels 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 citizen review panels meets all statutory CAPTA requirements:

- Meet a minimum of four times a year
- Include members broadly representative of the community, and where specified, meet the statutory requirements of that group
- 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 CAPTA plan
- Prepare an annual report on activities and recommendations
- Provide for public comment

All three CAPTA citizen review panels have a statewide approach to examining systemic issues

that impact the effectiveness of the state's child protection system. The 2012 activities of Georgia's three CAPTA panels were directed at improving the child welfare system and community response to protecting victims and supporting families. The overlapping interests of the three CAPTA panels address the full child welfare continuum, from prevention and investigation to treatment and prosecution of cases of child abuse and neglect and maltreatment-related fatalities.

CAPTA Panels Networking and Collaboration

At the annual retreat, CAPTA panels reflect on their successes and challenges, identify new opportunities and draft work plans for the coming year. At this year's retreat, a group of experts from the child welfare agency representing the full child welfare spectrum, were invited to meet with the CAPTA panels to provide insight on policy and practice subject matter expertise and help to explore new directions.

Leadership changes in Georgia's child welfare agency in 2011 resulted in renewed collaborative efforts with its partners and internal and external stakeholders increasing system transparency.

Annual meetings with the Department of Human Services (the Department) Commissioner and quarterly meetings with the Director of the Division of Family and Children Services (DFCS) have provided CAPTA panels with opportunities to exchange ideas, and they are frequently consulted or "at the table" when decisions or actions are being contemplated. CAPTA panels are considered partners in the process, their feedback is valued and they have influenced results.

CAPTA panel members met with Georgia's DHS Commissioner, Clyde Reese, and DFCS Director, Ron Scroggy, in May to discuss their annual report and recommendations.

Georgia's CAPTA panels can count many collaborative successes in 2012. As citizen review panel representatives, members contributed to:

- The revision of the state's CAPTA plan and annual report
- The implementation and monitoring of the CAPTA-PIP related to 2010 reauthorization requirements
- Georgia's Annual Progress and Services Report
- Policy revisions related to:
  - Healthcare services plan
  - Mandated reporter training
  - Differential response protocol
  - Intake policy

Georgia's CAPTA panels continue to advocate for the collaborative development of a coordinated and comprehensive public awareness and education plan on the prevention of child abuse and neglect and maltreatment-related fatalities, incorporating local, regional and statewide components.

Activities of each CAPTA panel are detailed in individual annual reports. (*See Attachments I, II, & III.)* The following section highlights their individual 2012 recommendations.

Child Protective Services Advisory Committee

The 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 (the Department), Division of Family and Children Services (DFCS). Reconfigured 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.

In 2012, CPSAC activities focused on two practice areas of concern:

- Service array necessary to support an effective differential response system; and
- Early intervention for children 0-3 involved in substantiated cases of child abuse and neglect, particularly, child welfare workforce training specific to this most vulnerable population.

CPSAC 2012 Recommendations

Recommendations related to service array include:

1. Use of community service supports framework to engage in dialogue with partners, at both the state and local level, to assess community resources, identify gaps and collaborate to develop a shared plan that ensures that sufficient community-based supports are available to meet the needs of families assigned to Family Support, Georgia's differential response track. Active engagement of stakeholders and particularly consultation with consumers for whom differential response is designed are critical to the successful implementation of an effective, statewide system.
2. A reiteration of its 2011 recommendation to enhance the statewide automated system for data collection (SHINES) to include documentation on engagement and service coordination for families who are assigned to Family Support.

Recommendations related to children ages 0-3 include:

1. Conduct a needs assessment to determine unmet service needs and barriers and/or gaps to meeting these needs for children 0-3 and their families
2. Enhance regional quality assurance process to include additional specificity related to the 0-3 population
3. Engage subject matter experts to assess current caseworker training related to 0-3 and enhance training with skills-based training including:
   a. Infant/toddler development
   b. Attachment, bonding and nurturing skills
   c. Current research related to brain development
4. Engage subject matter experts to develop policy related to the 0-3 population in foster care, including:

a. Placement changes – number and frequency
b. Visitation – frequency and quality
c. Parent coaching

5. Review and enhance current training for foster parents to include 0-3 and their special needs.

Children's Justice Act Advisory Committee

The Children's Justice Act Advisory Committee (CJAAC) serves 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 reauthorization requirement for the state's Children's Justice Act (CJA) grant, the CJAAC has an expanded purpose as a task force on children's justice: 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 from required disciplines, 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 maltreatment-related fatalities. CAPTA reauthorization 2010 added two new task force membership requirements – adult former victims of abuse and individuals working with homeless youth. Georgia's CJA task force expects to fulfill these requirements in 2012.

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 funding projects and activities that are multidisciplinary, demonstrate collaboration between the grantee, the Department and other child welfare partners, and support program areas identified in the state's CAPTA plan.

In 2012, CJAAC activities focused its assessment of systems related to the investigative, administrative and judicial handling of child abuse, neglect and exploitation cases and child maltreatment-related fatalities to make training and policy recommendations. The task force concentrated its efforts during the first half of the year on the development and analysis of a survey on investigative, administrative and judicial practices and how prepared disciplines were for effectively addressing cases involving children with special needs. This assessment is required every three years by CJA and the results are used to guide task force activities and support its CJA funding priorities and recommendations.

CJAAC 2012 Recommendations

To meet its CJA mandate to make training recommendations for the improvement of the investigation and assessment of cases of abuse and neglect, the task force reaffirms its priorities and recommends continued CJA investment in multidisciplinary training for professionals involved in the handling of cases of child abuse and neglect. This includes:

1. Specialized forensic interview training, Finding Words, for professionals who interview victims of child abuse and child sexual abuse to

improve investigative results and reduce trauma to victims

2. Review and updating of local Child Abuse Protocols to improve consistency and compliance with 2010 CAPTA reauthorization
3. Legal training for caseworkers to improve their preparation for court
4. Annual cross-training for legal professionals and CASAs involved in juvenile court deprivation matters that includes pre-appointment training for Guardians ad Litem (GALs)
5. Annual training for Special Assistant Attorneys General (SAAGs)
6. Juvenile court and advocacy training for CASA supervisors and volunteers, caseworkers, lawyers and judges to gain a better understanding of courtroom procedures, roles and expectations
7. Training and experience for students interested in the field of child welfare

Additionally, to further its objective to improve outcomes in cases of child abuse and neglect involving children with special needs, the task force recommends that all projects and activities supported with CJA funds be required to include a component addressing the unique needs of these victims from the initial response and investigation through prosecution and judicial disposition.

Child Fatality Review Panel Maltreatment Committee

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 2010, a CAPTA maltreatment committee was established to address its additional obligations as a CAPTA citizen review panel. In 2011, CFRP bylaws were amended to include its role as a CAPTA citizen review panel in the description of its purpose as a statutory body.

The maltreatment committee's work during 2012 continued to emphasize its ongoing priority related to the improvement of data collection, reporting and sharing of information on maltreatment-related child deaths and as a result, support the following recommendations:

2012 Recommendations

1. Strengthen data quality by:
   a. Providing additional training for child fatality review teams to improve the consistency of reports and prevention recommendations particularly for maltreatment-related child deaths
   b. Including multidisciplinary child death review results in SHINES
2. Improve information sharing on maltreatment-related child fatalities such as an annual report of summary findings and actions resulting from 24-hour/multidisciplinary review of child deaths
3. Improve data sharing between the Department and other sources of child and family information to improve the identification of risk

factors for maltreatment-related deaths and opportunities for prevention

One Voice

Priorities and activities of Georgia's citizen review panels reflect their individual mandates and interests, and are as diverse as its citizen members' backgrounds and perspectives. Georgia's CAPTA panels are dedicated to their common concern - the safety, permanency and well-being of Georgia's children.

Georgia's CAPTA panels work plans for 2013 include:

- Review of policy and caseworker practice related to cases involving children ages 0-3
- Review of foster parent training related to cases involving children ages 0-3
- Examination of child welfare workforce morale, job satisfaction and performance
- Review of policy and practice related to youth in foster care including Independent Living Program
- Examination of the reporting and review processes of maltreatment-related child deaths and serious injuries and the subsequent impact of the results of that review process on practice, prevention and community education and awareness
- Review of policy and practice related to child victims with special needs – all ages
- Evaluation of training and projects supported by CJA funding

National Exposure for Georgia

Georgia's CAPTA panels were asked by the national citizen review panel advisory board to consider hosting the 2014 National Citizen Review Panel conference. A committee was formed in the fall of 2012 to explore the feasibility of hosting the conference in Atlanta. A plan was developed and presented to the Director of the Division of Family and Children Services. The Director responded favorably and offered to take the CAPTA panels' proposal to the DHS Commissioner who has endorsed the conference. CAPTA panel members are excited about the opportunity to highlight Georgia's many attributes and look forward to showcasing its successful collaboration with the child welfare agency.

Measuring Success

Since 2006, Georgia CAPTA panels have slowly made progress toward increasing meaningful and productive collaborations with the state's child welfare agency and its many partners. They have tackled some tough issues, such as inconsistencies in the handling of reports of abuse and neglect and the state's Diversion[1] practice. The state has made steady progress toward practice improvement in these areas by establishing an after-hours and weekend central call center with plans for 24/7 implementation and development of a true differential response system for statewide implementation.

The child welfare agency's quarterly data reports on maltreatment-related fatalities are now made available on its website. The report reinforces the

[1] Georgia's differential response practice was initially known as "Diversion."

importance of prevention efforts, such as the Safe Sleep Campaign launched by the Georgia Children's Cabinet, chaired by Georgia's First Lady of Georgia, Sandra Deal.

The child welfare agency is actively engaged in discussions to remove barriers to seamless data sharing among agencies with shared child and family responsibilities to improve the identification of populations at risk for maltreatment and increased risk for child fatality and/or serious injury to identify prevention and early intervention strategies.

Increased access to leadership and staff, frank and open discussions, and consultation regarding child welfare policy and practice changes under consideration, all experienced by CAPTA panels, promote and support system transparency and responsiveness to the concerns of its stakeholders.

Georgia CAPTA citizen review panels would like to express their sincere appreciation to the Department for its continued administrative support, its willingness to engage with CAPTA panels and its ongoing commitment to collaborate with its partners and stakeholders to improve outcomes for children and families.

Respectfully submitted for consideration by
Georgia's CAPTA Citizen Review Panels

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

Prepared by:
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Care Solutions, Inc.
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Citizen review panel member speaks about their experience…

“I have grown in my respect and admiration for the people at the child welfare agency who, day in and day out, grapple with seemingly intractable problems, never losing focus on our shared dream of creating a better world for Georgia’s children.”

Attachment I

CPSAC

Child Protective Services Advisory Committee

2012 Annual Report

CPSAC Members

Liz Ferguson, Co-Chair
Karl Lehman, Co-Chair
Diane Bellem
Molly Casey
Stacy Collins
Rachel Ewald
Sheralyn Hector
Jaime Joseph
Jen King
David Meyers
Amy Michaud
Dee Dee Mize
Lori Muggridge
Mike Patton
Ray Rene
Amy Rene
Scott Rhoden
Carole Steele
Heather Wademan
Kathy Wages
Arianne Weldon

Citizen review panel member speaks about their experience…

“I appreciate that the CAPTA panels are not just a group of people that meet just to satisfy a federal guideline or quota. They put a lot of thought and care in trying to improve the system.”

CPSAC

Child Protective Services Advisory Committee

2012 Annual Report

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

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

Child Abuse Prevention and Treatment Act

The Child Abuse Prevention and Treatment Act (CAPTA) was originally enacted in 1974 to provide federal funding for prevention, assessment, investigation, prosecution and treatment activities to improve states' child protection systems. CAPTA legislation has evolved in response to the child welfare climate, and, in 1996, reauthorization called for increased accountability for state child protection systems. A component of the 1996 reauthorization, Section 106, was the call for establishment of citizen review panels (CAPTA panels) to solicit input from citizens regarding the activities of states' child protective services systems.

CAPTA Citizen Review Panels

As a recipient of a CAPTA state grant, Georgia is required to establish and maintain a minimum of three citizen review panels. In 2000, in response to federal legislation, the Child Protective Services Advisory Committee (CPSAC) was established by the Georgia Department of Human Services, Division of Family and Children Services (the Department) and subsequently designated as one of Georgia's three CAPTA panels[1].

The purpose of CAPTA citizen review panels is: a) to examine the policies, procedures, and practices of state and local agencies and, where appropriate, specific cases; and, b) to evaluate the extent to which state and local child protection system

[1] Georgia's other two CAPTA panels are the Children's Justice Act Advisory Committee and the Child Fatality Review Panel.

agencies are effectively discharging their child protection responsibilities in accordance with:

1. The state's CAPTA plan
2. Child protection standards required by CAPTA
3. Any other criteria that the CRP considers important to ensure the protection of children, including:
    a. A review of the extent to which the state and local child protective services system is coordinated with the foster care and adoption programs established under Title IV Part E of the Social Security Act; and
    b. A review of child fatalities and near fatalities.

Although the priorities of the Georgia CPSAC are rooted in prevention and early intervention, their interests span the full spectrum of family involvement in the child protection system, for all types of families and children of all ages. Of continued interest to the CPSAC is the initial interaction between the child welfare agency and the family when an allegation of child abuse has been made - the decision-making process and subsequent assessment and family engagement.

CPSAC Membership

CAPTA requires that each CAPTA panel be composed of volunteer members who are broadly representative of their communities and include members who have expertise in the prevention and treatment of child abuse and neglect. The diversity of personal and professional backgrounds, and the wide range of experience and expertise of CPSAC members, brings many unique perspectives to their common interest - the safety and well-being of Georgia's families, children and youth.

New members in 2012 included:

- Student from Kennesaw State University School of Social Work
- Licensed trauma-focused therapist
- Maternal and child health coordinator from Public Health
- Founder and Executive Director for a foster care support organization
- Member of the public service faculty at the University of Georgia

The CPSAC includes members from both rural and urban communities, some traveling several hours to attend bi-monthly meetings. Although the size of the state of Georgia presents a challenge when recruiting and engaging members that represent all its geographic areas, most regions are represented on the twenty-member CPSAC. Identifying and engaging consumers - parents, foster parents and youth- remains a challenge, however, recruitment efforts continue to target these groups.

2012 CPSAC Activities

In 2012, the CPSAC held five regular panel meetings, exceeding the federally-mandated CAPTA quarterly meeting requirement. In addition to their regular meetings, work groups met or held conference calls, as needed, to continue working on special projects. The Co-chairs consulted regularly with each other and a contracted Coordinator to monitor work in progress, discuss recent events relevant to panel goals and objectives, identify and

coordinate additional resources and to prepare the agenda for upcoming meetings.

On May 24, 2012, CPSAC and other CAPTA panel members met with Georgia's Department of Human Services Commissioner, Clyde Reese, and the Director of the Division of Family and Children Services, Ron Scroggy, and several members of his leadership team, to discuss the 2011 annual citizen review panel report and recommendations. This annual meeting also provided an opportunity to highlight CPSAC plans for the coming year. CPSAC Co-Chairs also met with Georgia's child welfare Director and other agency representatives on several occasions during the year to continue dialogue on CPSAC and citizen review panel priorities and activities, share concerns and challenges, and identify collaborative opportunities.

In addition to these meetings, agency representatives were invited to share information at CPSAC meetings as subject matter experts. These included a presentation on behalf of the Collaborative Partners Unit on the new logic model for Departmental multidisciplinary review in cases of child death/near fatality/serious injury and another on the 2011 State Trend Report by the Office of Quality Management. A special meeting was held in November 2011 and all citizen review panel members were invited to a presentation on the development and implementation plans for the state's differential response system and new safety response practice.

The Co-Chairs and one other CPSAC member serve on a joint CAPTA panel steering committee with representatives from the other two citizen review panels. The steering committee meets two to four times per year, as needed, to promote inter-panel collaboration, coordination of panel activities and joint planning with Georgia's child welfare agency. In 2012, the steering committee was also instrumental in the development of standards for panel operations, leadership development and recruitment guidelines.

In April 2012, the CPSAC was represented at the eleventh annual national Citizen Review Panel conference in Washington, DC. The 2012 conference was held in conjunction with the national Child Abuse and Neglect conference and the 100th anniversary of the Children's Bureau. The conference provided an invaluable opportunity for peer-to- peer support and exposure to many successful and innovative child welfare agency and CRP partnerships.

Georgia's CAPTA panels maintain a website, www.gacrp.com. In addition to information on CAPTA and citizen review panels, the website is used to post meeting schedules, and inter- and intra-panel communications. It is also used as a depository for shared documents, such as policy for review and work in progress. CAPTA panel annual reports and state responses, and state and national child welfare resources and links are also available on the website.

In addition to regular meetings and workgroup activities, members of the CPSAC:

- Participated in the development of a CAPTA Program Improvement Plan (PIP) addressing state compliance related to new requirements included in the 2010 CAPTA

reauthorization. As stakeholders, they continue to provide oversight and subject-matter expertise in the monitoring of state progress toward completing all tasks and meeting CAPTA-PIP objectives.

- Reviewed and commented on revisions to the CAPTA plan in response to new requirements included in the CAPTA 2010 reauthorization
- Contributed to and reviewed Georgia's 2011 Annual Progress and Services Report
- Reviewed and commented on new and updated child welfare policy and practice guidelines, or were consulted on:
    - Healthcare services plan
    - Mandated reporter training
    - Differential response protocol
    - Intake policy

2012 Results and Recommendations

At their annual retreat in September 2011, CPSAC members decided to focus on two issues during 2012:

1. Service array and community-based resources necessary to support an effective differential response system; and
2. Child welfare policy and practice in cases involving children 0-3 in substantiated cases of child abuse and neglect, particularly, child welfare workforce training specific to this most vulnerable population.

Service Array

For several years, CPSAC reports have included multiple recommendations regarding the development of a statewide differential response system to address their concerns related to a lack of comprehensive policy and inconsistent practice in the response to low-to-moderate risk allegations of child abuse or neglect. The Department responded and continues to make substantial progress toward full implementation of a statewide differential response system that includes improvement in the consistency of response, case work practice and policy.

In 2012, a CPSAC work group conducted review on national guidelines and gathered information on services recommended to support a successful differential response system. It also examined how other states support differential response with community-based partnerships to provide or coordinate core and ancillary services for families. This included:

- Community engagement to ensure availability of adequate supports and services to meet the early intervention needs of children and families
- Minimum standards/guidelines for a community-based service array

Based on this review, the work group developed a framework of community-based supports and services they felt were essential to a successful differential response system that included:

I. EMERGENCY ASSISTANCE

To address immediate family needs such as utilities, rent, and other issues related to housing, including:

a) State/regional/county funding needs assessment and annual budgeting

- *Rental assistance to prevent eviction and/or provide temporary assistance*
- *Security deposits, utility reconnection and temporary assistance*
- *Emergency food and other basic needs*

b) Sources of emergency assistance outside of the state's child welfare budget

- *Food banks*
- *Faith-based programs*
- *Local, state and federal sources of funding such as CBCAP, PSSF, VOCA, private foundations, other grants*

c) Emergency shelters

II. ONGOING CASE MANAGEMENT

To help families identify and utilize community-based supports and services to meet their needs, including:

a) Staffing needs and worker qualifications

- *Annual staffing needs assessment, statewide and county level*
- *Minimum standards for Family Support case managers*
- *Case management when services are not available*
- *Rural vs. urban case management response*

b) Eligibility determination and service navigation assistance

- *Temporary Assistance to Needy families (TANF)*
- *Women, Infant and Children program (WIC)*
- *Disability benefits*
- *Other community-based programs*

c) Parent education and/or coaching to increase parental capacity and protective factors

d) Coordinating and providing assistance to identify and secure specialized services

- *Mental health services*
- *Disability services*
- *Early periodic screening, diagnosis, and treatment*
- *Public health insurance*
- *Substance abuse treatment*
- *Court/custody mediation services*

e) Child support enforcement

f) Mandated school-based services

- *Establishing services*
- *Compliance and enforcement*

g) In-home assistance and support

- *Cooking and nutrition instruction*
- *Cleaning instruction*
- *Appliance repair assistance*

h) Recreational activities, particularly for youth

i) Peer support groups and mentoring

j) Domestic violence victim support

III. EMPLOYMENT SUPPORT

To find, secure and maintain employment, including:

a) Childcare – emergency, long-term and after school

b) Employment training and job skills

c) Transportation

d) Educational supports

Service Array Recommendations

1. The CPSAC recommends that the Department use this framework to engage in dialogue with its partners, at both the state and local level, to assess community resources, identify gaps and collaborate to develop a shared plan that ensures that sufficient community-based support are available to meet the needs of families assigned to Family Support, Georgia's differential response track. Active engagement of stakeholders and particularly consultation with consumers for whom differential response is designed are critical to the successful implementation of an effective, statewide system.

2. Additionally, the CPSAC reiterates its 2011 recommendation to enhance the statewide automated system for data collection (SHINES) to include documentation on engagement and service coordination for families who are assigned to Family Support.

Zero to Three

A continuing interest for the CPSAC is early intervention practice in substantiated cases of abuse and neglect where there are children under the age of three. Of ongoing concern to the CPSAC is the low percentage (4%) of children in substantiated cases who meet the eligibility criteria for early intervention services. In these cases, the caseworker may be solely responsible for determining screening, assessment and service needs. As a result, a work group was formed to develop a plan to examine the state child welfare policy and practice related to children ages 0-3.

The work group prepared a list of questions and divided them into five categories:

- Training
- Staff supervision
- Policy
- Practice
- Overall, including data

During 2012, the work group focused primarily on the staff training component. A representative from the Department's Education and Training unit met with the work group to provide an overview of new caseworker training and highlight the 0-3 content included in the curriculum. The overview of both classroom and web-based training included:

- Keys to Child Welfare Practice
- Child Protective Services Track Training
- Foster Care Track Training
- Adoption Track Training
- Post-Certification Training

Other than CAPTA Babies Can't Wait training for the referral of children under age three in substantiated cases for part C services, a CAPTA requirement, no courses were identified that solely addressed the unique needs of these children and their families. However, several courses included specific references to the 0-3 population such as:

- Child Care – Establishing child care services for families involved with child protective services or in a temporary placement
- Child Development – Understanding "normal" child development

Zero to Three Recommendations

1. Conduct a needs assessment to determine unmet service needs and barriers and/or gaps to meeting these needs for children 0-3 and their families
2. Enhance regional quality assurance process to include additional specificity related to the 0-3 population
3. Engage subject matter experts to assess current caseworker training related to 0-3 and enhance training with skills-based training including:
    a. Infant/toddler development
    b. Attachment, bonding and nurturing skills
    c. Current research related to brain development
4. Engage subject matter experts to develop policy related to the 0-3 population in foster care, including:
    a. Placement changes – number and frequency
    b. Visitation – frequency and quality
    c. Parent coaching

5. Review and enhance current training for foster parents to include 0-3 and their special needs.

Looking Ahead to 2013

At the annual retreat in September 2012, the CPSAC decided it would continue to monitor the state's differential response practice through data trends and regional quality assurance reviews until a statewide policy has been approved and resulting changes fully implemented. They are satisfied that the Department continues to make steady progress toward implementation of recommendations and addressing their concerns related to the "Diversion" practice.

The Zero to Three work group will continue its examination of Georgia's child welfare response to families with children ages 0-3 and expand the scope of its work to include families prior to any involvement with the child welfare agency, those receiving Family Support services and those with children in foster care. This will include a review of:

- Staff training(course review)
- Policy
- Practice
- Service coordination
- Outcomes
- Prevention
- Medicaid/CMO guidelines for funding early childhood mental health services

Several members of the Zero to Three work group are also interested in reviewing the various assessment tools and protocols currently used for children, youth and families involved with child protective and placement services. This review would also extend to the assessment of at-risk families for early intervention supports and services and utilization of assessment tools that are trauma focused.

CPSAC members have expressed concerns related to state budget cuts and the impact on Georgia's child welfare workforce with respect to job satisfaction, job performance and morale. Although furlough days have been eliminated, staff has not had a cost of living increase in many years and often must to do more with less – higher caseloads, added job responsibilities, fewer staff, and shrinking resources.

Because of these concerns, in 2013, the CPSAC plans to examine the following practices related to Georgia's child welfare work force:

- Recruitment, including hiring, staffing and compensation policies
- Training, including professional development
- Supervisory support and staff development

Lastly, media reports rarely accentuate successful outcomes and often sensationalize the failures. In addition to any resulting recommendations from this review, the CPSAC would like to highlight the accomplishments of our child welfare work force and the great work that is done every day to promote and ensure the safety, permanency and well-being of Georgia's children. The CPSAC will explore options to honor individual staff members for exemplary performance and dedication.

The CPSAC requests careful consideration of these recommendations and looks forward to continued collaboration with the Department to promote improvements in practice and outcomes for Georgia's children and families.

Respectfully submitted on behalf of the
Child Protective Services Advisory Committee

Liz Ferguson, CPSAC Co-chair
Karl Lehman, CPSAC Co-chair

A special note of thanks to Sheltering Arms, Atlanta for hosting meetings

Prepared by:
Deb Farrell, CAPTA CRP Coordinator
Care Solutions, Inc.
Atlanta, GA

Attachment II

CJAAC

Children's Justice Act Advisory Committee

2012 Annual Report

Task Force Members

Melissa Carter, Co-Chair
Angela Tyner, Co-Chair
Sandra Barrett
Bill Bartles
LaLaine Briones
Lori Brown
Kathleen Dumistrescu
Lisa Ellis
Nick Gage
Susan Gage
Jordan Greenbaum
Vale Henson
Diana Johnson
Trish McCann
Julia Neighbors
Stephanie Pearson
Mitzie Smith
Kristina Stepanova
Donnie Winokur

Children's Justice Act making a difference…

"After learning more about victims special needs I recognized some signs of a developmental disability in a teen client and requested an evaluation which resulted in a change in her services, case plan and placement."

CJAAC

Children's Justice Act Advisory Committee

2012 Annual Report

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.

The Children's Justice Act

The Children's Justice Act (CJA) provides grants to states to improve the investigation, prosecution and judicial handling of cases of child abuse and neglect, including child sexual abuse and exploitation, in a manner that reduces trauma to the child victim. This includes maltreatment-related child deaths and cases involving children with disabilities and serious health problems who are also victims of abuse and neglect. The source of CJA funds is the Crime Victims Fund, and grants are awarded by the Administration on Children, Youth and Families, US Department of Health and Human Services, as outlined in Section 107 of the Child Abuse Prevention and Treatment Act (CAPTA), as amended by the Keeping Children and Families Safe Act of 2003. CAPTA is the primary federal legislation addressing child abuse and neglect and authorizes funding to states in support of prevention, identification, assessment, investigation and treatment activities.

CJA Task Force

To be eligible for CJA funds, the state must also be eligible for a CAPTA basic state grant and is required to establish and maintain a multi-disciplinary task force on children's justice. The Children's Justice Act Advisory Committee (CJAAC) was established in Georgia to meet this requirement and is composed of representatives from selected disciplines involved in the assessment and investigation of cases of child abuse and neglect. The purpose of the task force is to review and evaluate practice and protocols associated with the investigative, administrative and

judicial handling of cases of child abuse and neglect and to make policy and training recommendations to improve the handling of these cases.

The task force also collaborates with Georgia's child welfare agency on the administration of the CJA funds, including the solicitation and review of proposals and making funding recommendations. To further its primary objectives as a task force on children's justice and meet its mandate, the task force continues to support activities that strengthen the investigation and prosecution of cases of child abuse and maltreatment-related fatalities that:

- Use a multi-disciplinary approach to training and education to improve the identification, intervention, and prosecution of child maltreatment
- Reduce trauma to child victims of abuse
- Encourage and support advocacy in the field of child welfare
- Encourage collaborative efforts between Georgia's child welfare agency and its external partners

In response to a three-year assessment conducted in 2012, the task force has expanded its priorities to include activities that:

- Incorporate components, such as training, practice or system reform, to improve the handling of cases involving children with special needs

CAPTA Citizen Review Panels

In addition to its role as a CJA task force, the CJAAC also serves as one of Georgia's three citizen review panels (CAPTA panels)[1]. The task force was designated by Georgia's Department of Human Services, Division of Family and Children Services (the Department) as a CAPTA panel in response to the 1996 CAPTA amendment requiring that recipients of CAPTA state grants establish and maintain citizen review panels (Section 106). The purpose of CAPTA citizen review panels is a) to provide opportunities for community input and to examine the policies, procedures, and practices of state and local agencies and where appropriate, specific cases; and b) to evaluate the extent to which state and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with:

1. The state's CAPTA plan
2. Child protection standards required by CAPTA
3. Any other criteria that the CRP considers important to ensure the protection of children, including:
   a. A review of the extent to which the state and local child protective services system is coordinated with the foster care and adoption programs established under Title IV Part E of the Social Security Act; and
   b. A review of child fatalities and near fatalities.

The purpose and objectives of a CJA task force and a citizen review panel are complementary and provide unique opportunities to examine and address overlapping interests.

Task Force Membership

The task force has maintained a stable and committed core membership for several years. As a task force on children's justice, the CJAAC is

[1] The other two CAPTA panels are the Child Protective Services Advisory Committee and the Child Fatality Review Panel.

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
- Individual with experience in working with homeless children and youth *(new)*
- Adult former victim *(new)*

Several members satisfy multiple requirements often providing a unique perspective to the work of the task force. One task force member is both the parent of a child with special needs and an expert investigator specializing in forensic interviews with children with special needs. Another member was in foster care as a youth, and is currently a foster and adoptive parent.

CJA task force membership requirements also satisfy CAPTA citizen review panel membership requirements.

In addition to active recruitment by task force members, child welfare agency leadership and a variety of professional and advocacy groups are consulted to identify and engage appropriate candidates. CAPTA 2010 reauthorization added two additional task force membership recommendations: an adult former victim of child abuse and an individual with experience working with homeless children and youth. Efforts to recruit candidates were successful and both positions were filled during 2012.

Currently the task force has vacancies in two positions – superior court judge and foster care youth. In order to identify a suitable candidate for the former position, the task force has decided to direct its recruitment efforts toward recently retired superior court judges[2]. It has been an ongoing challenge to engage youth in the task force. On several occasions, youth have been identified and recruited but have not been able to make the commitment, primarily due to their busy schedules. In addition to its recruitment efforts, the task force will continue to identify opportunities for parents, foster parents and youth in the citizen review panel process.

2012 Task Force Activities

In 2012,the task force held five regularly scheduled meetings, exceeding the federally-mandated quarterly meeting requirements for both a CJA task force and a CAPTA panel. In addition to regular scheduled meetings, conference calls and special meetings were held, to facilitate planning for the three-year assessment required in 2012 by the Children's Justice Act. The Co-chairs consulted regularly with each other and a contracted Coordinator to discuss work in progress, recent events related to panel goals and objectives, recruitment efforts and to identify and coordinate additional resource needs.

On May 24, 2012, the task force and other CAPTA panel members met with Georgia's Department of

[2] Option approved by the Children's Bureau

Human Services Commissioner, Clyde Reese, and the Director of the Division of Family and Children Services, Ron Scroggy, and several members of his leadership team, to discuss the 2011 annual citizen review panel report and recommendations. This annual meeting also provided an opportunity to highlight task force plans for the coming year. The Co-Chairs also met with Georgia's child welfare Director and/or other agency representatives on several occasions during the year to continue dialogue on CJA objectives and task force priorities, and to coordinate activities, share concerns, and identify collaborative opportunities.

In addition to these meetings, task force members were invited to attend a special meeting was held in November 2011 for a presentation to all CAPTA panel members on the development and implementation of the state's differential response system and new safety response practice. In April 2012, task force members met with representatives from the Department to discuss the results of the three-year assessment conducted by the task force[3], new and ongoing objectives and priorities as well as their 2012 CJA funding recommendations.

The Co-Chairs and one other task force member serve on a joint CAPTA panel steering committee with representatives from the other two citizen review panels. The steering committee meets two to four times per year, as needed, to promote inter-panel collaboration, coordination of panel activities and joint planning with Georgia's child welfare agency. In 2012, the steering committee was also instrumental in the development of standards for panel operations, leadership development and recruitment guidelines.

In April 2012, the task force was represented at the eleventh annual national Citizen Review Panel conference in Washington, DC. The 2012 conference was held in conjunction with the national Child Abuse and Neglect conference, the Children's Justice Act annual grantee meeting[4] and the 100th anniversary of the Children's Bureau. As several other states also utilize their CJA task force as one of their CAPTA citizen review panels, the conference provided an invaluable opportunity for peer-to-peer support and exposure to many successful and innovative child welfare agency, CJA and CAPTA panel partnerships.

Georgia's CAPTA panels maintain a website, www.gacrp.com. In addition to public information on CAPTA citizen review panels and the CJA task force, the website is used to post meeting schedules, and inter- and intra-panel communications. It is also used as a depository for shared documents, such as policy for review and work in progress. CAPTA panel annual reports and state responses, and state and national child welfare resources and links are also available on the website.

In addition to regular meetings and activities, members of the task force:

- Participated in the development of a CAPTA Program Improvement Plan (PIP) addressing state compliance related to new requirements included in the 2010 CAPTA reauthorization.

[3] CJA requires that a system assessment be conducted every three years as a condition of the state's CJA grant.

[4] State CJA liaison and task force representative are required to attend annual CJA grantee meeting as a condition of the CJA grant.

As stakeholders, they continue to provide oversight and subject-matter expertise in the monitoring of state progress toward completing all tasks and meeting CAPTA-PIP objectives.

- Reviewed and commented on revisions to the CAPTA plan in response to new requirements included in the CAPTA 2010 reauthorization
- Contributed to and reviewed Georgia's 2011 Annual Progress and Services Report
- Reviewed and commented on new and updated child welfare policy and practice guidelines, or were consulted on:
    - Healthcare services plan
    - Mandated reporter training
    - Differential response protocol
    - Intake policy

2012 Results and Recommendations

Task force activities and recommendations focused on the three-year assessment required by CJA and its ongoing priorities and interests that included:

- Cases of child abuse and neglect involving children with special needs
- Training for professionals involved in the investigation and assessment of cases of child abuse and neglect
- Operationalizing task force funding recommendations
- Information/data sharing

3-Year Assessment: *Children with Special Needs*

Every three years, the task force is required to conduct an assessment of systems related to the investigative, administrative and judicial handling of child abuse, neglect and exploitation cases and child maltreatment-related fatalities and make training and policy recommendations. The results of the assessment would then be used to guide task force priorities including CJA funding recommendations, through 2014.

Areas of interest considered by the task force for the subject of its three-year assessment included:

- Children with special needs
- Sibling groups in foster care
- Fostering Connections: Extension of foster care to age 21 and youth transitioning out of foster care
- New CAPTA requirements in 2010 reauthorization - implications and implementation
- Quality of GAL representation
- Multidisciplinary Team Meetings (MDT)
- Family Team Meetings (FTM)
- Children with special needs

The task force considered several factors in making its decision on the focus of the three-year assessment. It was decided that the focus of the assessment would be cases of child abuse and neglect involving children with special needs because:

- Children with special needs are at higher risk for abuse and neglect.
- It is suspected that their abuse and neglect is under reported.
- They are often the victims of child sexual abuse and sexual exploitation.
- It is often difficult to obtain evidence from these traumatized victims.
- Professionals who come in contact with these children in the course of their work need the skills and tools to interact effectively with these

children to collect accurate information without further traumatizing them in order to protect, advocate or engage them.

Given the unique needs of this special population and the challenges often encountered in these cases, the task force decided to conduct a survey to assess the experience and skill levels of the multi-disciplines involved in the handling of these cases and to identify opportunities for practice improvement.

The task force concentrated its efforts during the first half of the year on the development and analysis of a survey on investigative, administrative and judicial practices and how prepared disciplines were for effectively addressing cases involving children with special needs. *Copy of survey instrument is attached as Appendix A*.[5] Targeted disciplines invited to participate in the online survey included child welfare caseworkers, supervisors and administrators, as well as advocates, service providers, law enforcement, investigators, prosecutors, attorneys and judges.

The following findings or observations based on survey responses helped identify new opportunities for the task force or affirm continued support of several ongoing priorities that are the basis for 2012 recommendations.

1. Lack of training for professionals involved in the investigation, assessment and prosecution of cases to develop skills needed for cases involving children with special needs

   Opportunity: *Support and promote multidisciplinary training to improve specialized interview and engagement skills*
2. Lack of awareness of Child Abuse Protocols regarding child victims with special needs in cases of child abuse, sexual abuse and sexual exploitation

   Opportunity: *Support the review and update of local Child Abuse Protocols, and educate professionals and other stakeholders*
3. Barriers related to information sharing, generally among agencies serving these children and specifically among disciplines investigating, assessing and prosecuting cases of child abuse

   Opportunity: *Promote inter- and intra-agency communication to improve collaborative efforts and outcomes in cases involving children with special needs*
4. Concerns with respect to policies and child welfare practices directed at special needs youth aging out of foster care or in an Independent Living Program

   Opportunity: *Review Independent Living Program policies and practices for children with special needs aging out of the foster care system*
5. Insufficiently trained and prepared placement resources, including foster parents and other temporary placements for crisis stabilization, for children with special needs who are victims of abuse

   Opportunity: *Review policy, practice, and regulations associated with the placement of children with special needs*

[5] Georgia's 2012 CJA Application included a full report on results and actions related to the three-year assessment.

Opportunity: *Promote specialized training to better prepare foster parents to care for children with special needs*

6. Children with special needs who have multiple placements and the impact on their educational stability
   Opportunity: *Review child welfare policies and practices associated with the educational needs of children with special needs*
7. Concerns that children with special needs are not being identified at the time an allegation of child abuse is reported
   Opportunity: *Review intake and response processes to determine if protocol is sufficiently attentive to the special needs of alleged victims*
8. Concerns regarding children with special needs being required to testify in criminal proceedings without special considerations
   Opportunity: *Review legal requirements and consider opportunities to advocate for approaches that would reduce trauma to these victims*

2012 Recommendations

To meet its CJA mandate to make training recommendations for the improvement of the investigation and assessment of cases of abuse and neglect, the task force reaffirms its priorities and recommends continued CJA investment in multidisciplinary training for professionals involved in the handling of cases of child abuse and neglect. This includes recommendations supporting:

1. Specialized forensic interview training, Finding Words, for professionals who interview victims of child abuse and child sexual abuse to improve investigative results and reduce trauma to victims
2. Review and updating of local Child Abuse Protocols to improve consistency and compliance with 2010 CAPTA reauthorization
3. Legal training for caseworkers to improve their preparation for court
4. Annual cross-training for legal professionals and CASAs involved in juvenile court deprivation matters that includes pre-appointment training for Guardians ad Litem (GALs)
5. Annual training for Special Assistant Attorneys General (SAAGs)
6. Juvenile court and advocacy training for CASA supervisors and volunteers, caseworkers, lawyers and judges to gain a better understanding of courtroom procedures, roles and expectations
7. Training and experience for students interested in the field of child welfare

To further its objective to improve outcomes in cases of child abuse and neglect involving children with special needs, the task force recommends that projects supported with CJA funds be required to include a component addressing the unique needs of the victims in these cases from the initial response and investigation through prosecution and judicial disposition.

Looking Ahead to 2013

In fall 2012, task force members participated in the annual citizen review panel retreat. The purpose of the retreat includes strategic planning, identification of new opportunities and confirmation of ongoing

CAPTA and CJA priorities, all of which guide the task force activities and resulting recommendations. To guide its efforts in 2013, the task force reinforced its commitment to 1) ongoing support for long-term projects and activities that support CJA and task force objectives, 2) encouraging inclusion of special needs components in all activities and training supported by CJA funds and, 3) incorporating new opportunities identified in the three-year assessment into their work. These new opportunities include, but are not limited to:

- Review of child welfare agency policies, practices and/or regulations related to cases involving children with special needs, including:
  - Intake protocol and decision-making process when a report is made, including safety considerations when a special needs victim is identified
  - Independent Living Program and children with special needs aging out of the foster care system
  - Placement and permanency decisions when children with special needs are involved
  - Educational needs of children with special needs
  - Foster parent training when caring for children with special needs
- Review legal requirements and approaches to reducing trauma to child victims with special needs who are involved in legal proceedings related to child abuse and neglect

In addition, the task force will continue to advocate and support:

- New projects and activities that demonstrate multi-disciplinary collaboration
- Improving the quality, consistency and penetration of mandated reporter training
- Collaborations to maximize state, federal and local resources
- Development of protocols and agreements for data-sharing among state agencies and holders of other data systems, and evaluation and analysis of shared and integrated data

At the annual retreat, the task force was asked by the Department to support a criminal justice liaison position within the Collaborative Partners Unit of the child welfare agency beginning in the fall of 2012. Responsibilities of this position would include the interface between the child welfare agency and judicial system in the investigation and prosecution of cases of child abuse and neglect, commercial sexual exploitation of children (CSEC), and maltreatment-related child fatalities, near fatalities and serious injuries. This position would also include training and resource development related to CSEC and management of CJA contracts.

The CJA task force requests careful consideration of its 2012 recommendations by the Department and looks forward to continued collaboration with the Department and other partners and stakeholders to promote improvement in practice and outcomes for Georgia's children and families.

Respectfully submitted on behalf of the
Children's Justice Act Advisory Committee

Melissa Carter, Task Force Co-Chair
Angela Tyner, Task Force Co-Chair

A special note of thanks to the Georgia Public Defenders Standards Council for hosting meetings

Prepared by:
Deb Farrell, CAPTA CRP Coordinator
Care Solutions, Inc.
Atlanta, GA

Citizen review panel member speaks about their experience…

“CAPTA panels have worked hard to develop a good partnership/working relationship with the child welfare agency and there seems to be a real openness on the part of the agency to make that happen.”

Attachment III

CFRP

Child Fatality Review Panel

2012 Annual Report

and

Maltreatment Committee
2012 Summary Report

CFRP Members

C. LaTain Kell, Sr., Chairman
J. David Miller, Vice Chair
Vernon Keenan
E.K. May
Peggy Walker
Ron Scroggy
Paul Battles
Kris Sperry
Gloria Butler
Tonya C. Boga
Barbara Lynn Howell
Brenda Fitzgerald
Kathleen Bennett
Paula Sparks
Frank Berry
Beverly Losman
Robertiena Fletcher

Citizen review panel member speaks about their experience…

“I have a clearer picture of the complexities of the child welfare system and appreciation for the courage and tenacity it takes to make changes in the direction and focus of the child protection system statewide.”

CFRP

Child Fatality Review Panel

2012 Annual Report

and

Maltreatment Committee 2012 Summary Report

This summary reflects the 2012 activities, interests and priorities of the CFRP Maltreatment Committee…

J. David Miller
Melissa Carter
John Carter
Lisa Dawson
Liz Ferguson
Kim Washington

In response to Child Abuse Prevention and Treatment Act (CAPTA) requirements, Section 106, Georgia's Child Fatality Review Panel (CFRP) was designated as one of Georgia's three CAPTA citizen review panels (CAPTA panel). In 2010, the CFRP established a maltreatment committee to address its obligations as a CAPTA panel. These obligations include the examination of Georgia's child protection policy and practice and circumstances related to child deaths resulting from abuse and neglect. The CFRP amended its by-laws in 2011 to include its role as a CAPTA citizen review panel.

Georgia's Child Fatality Review Panel

The Georgia Child Fatality Review Panel (CFRP) is a statutory body established in 1990 by the Georgia State Legislature. The purpose of the CFRP[1] is to review the circumstances of child deaths and make statute, regulation or policy recommendations to reduce the risk of child death by:

- Identifying factors that put a child at risk for death
- Collecting and sharing information among state agencies that provide services to children and families or investigate child deaths
- Making suggestions and recommendations to appropriate participating agencies for improving and coordinating services and investigations
- Identifying trends relevant to unexpected and unexplained child death

[1] *Source: http://www.childdeathreview.org/Legislation/GAleg.pdf*

- Investigating the relationship, if any, between child deaths and violence of past or present caregivers
- Reviewing reports from local child fatality review teams
- Providing training and written materials to local review committees to assist them in carrying out their duties
- Developing a protocol for child fatality investigations and revising the protocol, as necessary
- Monitoring the operations of local review committees to determine training needs and service gaps

CAPTA Citizen Review Panels

As the recipient of a Child Abuse Prevention and Treatment Act (CAPTA) state grant, Georgia is required to establish and maintain three citizen review panels (CAPTA panels). Federal legislation allows for the designation of existing groups to serve as CAPTA panels provided they meet CAPTA requirements. In 2006, the CFRP was designated by Georgia's Department of Human Services (the Department) as one of its three citizen review panels.[2]

The purpose of CAPTA citizen review panels is to examine the policies, procedures, and practices of state and local agencies and where appropriate, specific cases, and evaluate the extent to which state and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with:

1. The state's CAPTA plan
2. Child protection standards required by CAPTA
3. Any other criteria that the CAPTA panel considers important to ensure the protection of children, including:
   a. Review of the extent to which the state and local child protective services system is coordinated with the foster care and adoption programs; and
   b. Review of child fatalities and near fatalities.

CFRP Membership

The membership of the CFRP, 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 Georgia's children 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 members, with the exception of one appointment by the Lt. Governor and one by the Speaker of the House of Representatives. The CFRP meets quarterly satisfying the CAPTA meeting requirements.

The CFRP is supported by staff under the supervision of the Office of the Child Advocate for the Protection of Children (OCA). The staff review and monitor the work of the 159 county child fatality review committees, analyze results and develop recommendations based on their findings and the

[2]The other two Georgia CRPs are the Children's Justice Act Advisory Committee and the Child Protective Services Advisory Committee.

issues raised by the local committees and CFRP members.

In response to its obligation as a citizen review panel, the CFRP established a CAPTA maltreatment committee in 2010 to specifically address its obligations as a CAPTA panel as it relates to child maltreatment-related deaths. The maltreatment committee includes members of both the CFRP and child welfare experts and advocates.

The CFRP is statutorily required to prepare an annual report. The Annual Report - Calendar Year 2011 is attached as *Appendix A*. The CFRP report identifies "opportunities for prevention" in all child fatalities, including those resulting from child abuse or neglect.

The CAPTA maltreatment committee has prepared a brief summary of its interests and activities in 2012.

2012 Maltreatment Committee Activities

Representatives from the CFRP and 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 invited to 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, as needed.

On May 24, 2012, the CFRP and other CAPTA panel members met with Georgia's Department of Human Services Commissioner, Clyde Reese, and the Director of the Division of Family and Children Services, Ron Scroggy, and several members of his leadership team, to discuss the 2011 annual citizen review panel report and recommendations. This annual meeting also provided an opportunity to highlight CFRP and maltreatment committee plans for the coming year. Representatives from the CFRP also met with Georgia's child welfare Director and/or other agency representatives on several occasions during the year to continue dialogue on CFRP and citizen review panel objectives and maltreatment committee priorities, and to coordinate activities, share concerns, and identify collaborative opportunities.

In addition to these meetings, CFRP members were invited to attend a special meeting was held in November 2011 for a presentation to all CAPTA panel members on the development and implementation of the state's differential response system and new safety response practice.

Members of the CFRP and maltreatment committee serve on a joint CAPTA panel steering committee with representatives from the other two citizen review panels. The steering committee meets two to four times per year, as needed, to promote inter-panel collaboration, coordination of panel activities and joint planning with Georgia's child welfare agency. In 2012, the steering committee was also instrumental in the development of standards for panel operations, leadership development and recruitment guidelines.

In April 2012, the CFRP was represented at the eleventh annual national Citizen Review Panel

conference in Washington, DC. The 2012 conference was held in conjunction with the national Child Abuse and Neglect conference and the 100th anniversary of the Children's Bureau. As several other states have also designated child death review teams as CAPTA citizen review panels[3], the conference provided an invaluable opportunity for peer-to-peer support and exposure to many successful and innovative child welfare agency, child fatality review and citizen review panel partnerships. The Chair of the Georgia's CAPTA maltreatment committee (and Vice-Chair of the CFRP) has been invited to speak at the National Citizen Review Panel Conference in Jackson Hole, WY, May 22-24, 2013, a reflection of his leadership and meaningful contribution to both the CAPTA citizen review and child death review processes.

Georgia's CAPTA panels maintain a website, www.gacrp.com. In addition to public information on CAPTA citizen review panels, the website is used to post meeting schedules, and inter- and intra-panel communications. It is also used as a depository for shared documents, such as policy for review and work in progress. CAPTA panel annual reports and state responses, and state and national child welfare resources and links are also available on the website.

In addition to regular meetings and activities, representatives of the CFRP had the opportunity to:

- Participate in the development of a CAPTA Program Improvement Plan (PIP) addressing state compliance related to new requirements included in the 2010 CAPTA reauthorization. As stakeholders, they continue to provide oversight and subject-matter expertise in the monitoring of state progress toward completing all tasks and meeting CAPTA-PIP objectives.
- Review and comment on revisions to the CAPTA plan in response to new requirements included in the CAPTA 2010 reauthorization
- Contribute to and review Georgia's 2011 Annual Progress and Services Report
- Review and comment on new and updated child welfare policy and practice guidelines, or were consulted on:
    - Healthcare services plan
    - Mandated reporter training
    - Differential response protocol
    - Intake policy

In February 2012, several CAPTA panel members participated in a webinar sponsored the National Center for the Review and Prevention of Child Death on the *Coordination of Child Death Reviews and Citizen Review Panels*.

During the 2012 legislative session, CFRP and the maltreatment committee members supported changes to Georgia's mandated reporter laws, expanding the definition of a mandated reporter to include such professionals as coaches and volunteers as mandated reporters.

The maltreatment committee's work during 2012 continued to emphasize its ongoing priority related to the improvement of data collection, reporting and

[3] Three states, Oklahoma, Delaware and Michigan use CAPTA citizen review panels to review child fatalities. Ten states, like Georgia, have designated their child death review panels as CAPTA panels.

sharing of information on maltreatment-related child deaths and, as a result, support the following recommendations:

2012 Recommendations

1. Strengthen data quality by:
   - Providing additional training for child fatality review teams to improve the consistency of reports and prevention recommendations particularly for maltreatment-related child deaths
   - Including multidisciplinary child death review results in SHINES
2. Improve information sharing on maltreatment-related child fatalities such as an annual report of summary findings and actions resulting from 24-hour, multidisciplinary review of child deaths
3. Improve data sharing between the Department and other sources of child and family information to improve the identification of risk factors for maltreatment-related deaths and opportunities for prevention

Looking Ahead to 2013

In the fall of 2012, CFRP members participated in the fifth annual citizen review panel retreat to develop a platform for 2013. Plans for the maltreatment committee include:

- Continuing to advocate for the inclusion of additional stakeholders in the multi-disciplinary review of maltreatment-related child fatalities, near fatalities and serious injuries
- Developing a multi-system data framework or matrix to support further review and analysis of maltreatment-related fatalities
- Proposing legislation and/or statewide protocol to require toxicology screens on all infant autopsies
- Review and follow up on prevention recommendations generated through local child fatality reviews and action related to prevention recommendations and their effectiveness

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We respectfully request careful consideration by the Department of the recommendations included in the Child Fatality Review Panel annual report and supplemented by the CAPTA maltreatment committee summary report.

Respectfully submitted on behalf of the
Child Fatality review Panel
and the
CAPTA Maltreatment Committee

C. LaTain Kell
Chairman, Child Fatality Review Panel

J. David Miller
Vice Chair, Child Fatality Review Panel
Chair, CAPTA Maltreatment Committee

Summary prepared by:
Deb Farrell, CAPTA CRP Coordinator
Care Solutions, Inc.
Atlanta, GA

Citizen review panel member speaks about their experience…

“Interacting and networking with the widely diverse and expert members of the CAPTA panel meets a personal professional need to constantly expand professional collaborative opportunities and learn from them.”

Appendix A

GEORGIA CHILD FATALITY REVIEW PANEL

Annual Report - Calendar Year 2011

C. LaTain Kell, Sr.
Chairman

Nathan Deal
Governor

DECEMBER 2012

Georgia Child Fatality Review Panel
Annual Report
Calendar Year 2011

Nathan Deal, Governor

Office of the Child Advocate for the Protection of Children
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December 2012

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 acknowledges the following people and entities whose enormous commitment, dedication, and unwavering support to child fatality review have made this report possible:

- All the members who serve on each of the county child fatality review committees;
- John Carter, Ph.D., Epidemiology Department of Emory University, Rollins School of Public Health;
- Katherine Kahn, M.P.H., Maternal and Child Health Program Epidemiologist, Georgia Department of Public Health;
- All public and private agencies that have so willingly collaborated with The Office of the Child Advocate and provided support; and
- All the public and private entities dedicated to the safety and well-being of children.

We would also like to thank the 2011 Child Fatality Review Committee of the Year and the 2011 CFR Coroner of the Year for their support and dedication to the children of Georgia:

Coroner of the year: Nickie Stockel – Deputy Coroner, Forsyth County
County CFR Committee of the year: Gwinnett County Child Fatality Review Committee

This report was developed and written by staff members of the Office of the Child Advocate: Arleymah Raheem Gray, Malaika Shakir, Tomia White, Crystal Dixon, Ryan Sanford, and Ken Perrin.

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Georgia Child Fatality Review Panel

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

On behalf of the Georgia Child Fatality Review Panel, it is my honor to present to you the 2011 Annual Report. This report summarizes the Panel's analysis of child deaths occurring in Georgia during the past calendar year.

The Panel takes seriously its statutory duty of promoting effective prevention measures and reviewing child deaths in the state with the primary focus on prevention. With the assistance of the Office of the Child Advocate and its talented and capable staff, the Panel has reviewed case files and has analyzed trends for future recommendations.

As in past years, the Panel has continued to focus on preventable child deaths in the areas of 1) unrestrained child passengers, 2) accidental child shootings, 3) child drownings, and 4) co-sleeping deaths. Future programs will continue to emphasize these areas. In addition, child maltreatment-related deaths and accuracy in the reporting of such deaths continue to be a priority with the Panel and with agencies and entities associated with the Panel.

Thank you for your review of this report and for your continuing interest in this critical work. Your ongoing support is essential to the task of reducing the number of preventable child deaths in Georgia in the coming year and in years to come.

We ask for your continued support for funding that is so essential to the work of this Panel and for the accurate collection and analysis of the data that are so vital to its function. With your help, the Child Fatality Review Division of the Office of the Child Advocate will continue its work strengthening the policies and protocols that will reduce child deaths in Georgia.

Sincerely,

Judge Tain Kell, Chair

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Practical Applications For This Report

Suggestions for Data Use:

Child Fatality Review (CFR) data can be very helpful for everyone. It is our hope that as you review the state level data summary, that it will encourage you to seek out opportunities to educate others about the continual need we have to protect our children. CFR data can be broken down to the state, regional, or county levels and be an effective means to educate others. The data can be used for summary reports, overall disposition of child deaths, policy informational briefs, or general education. Education for agency staff, policy makers, and general public can be an important too when you are trying to seek out funding sources, partnerships, and volunteer support. Some of the ways the data in this report can be shared with others:

- Develop talking points for your local media outlets, agency newsletters, or bulletins
- Share specific risk factors with your staff or colleagues who serve children, to raise their awareness of the issues
- Encourage your local leaders to read the report and address any needed policy changes
- Support the education of students by including information on specific risk factors in curricula, and facilitate regular discussions of safety habits
- Realize opportunities for prevention and education are all around you, and many people may not be aware of the trends in child deaths

If you would like the Office of the Child Advocate to prepare specific data for your county or area of expertise, please contact us so we may begin working with you. You are a critical partner in our mission to protect Georgia's children.

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Executive Summary

The Georgia Child Fatality Review Panel publishes a report each year that details the circumstances of death for children under the age of 18 that are deemed reviewable based on established standards in Georgia. Child deaths are identified through death certificates that are filed by the Office of Vital Records of the Department of Public Health. Supplemental notifications are also provided by other agency sources.

The deaths that are eligible for review are deaths that are unexpected, unexplained or are due to suspicious circumstances. The deaths are reviewed on the local level by Child Fatality Review Committees. In accordance with O.C.G.A § 19-15-3 (b), these committees are comprised of the county medical examiner or coroner, the district attorney, a representative of the Division of Family and Children Services, a local law enforcement representative, the sheriff or county police chief, a juvenile court representative, a county board of health representative and a county mental health representative.

Committee members represent agencies that may have been involved in some manner with the deceased child or the family of the deceased child. The expertise of the members of the committee are vital to conducting a thorough investigation of the circumstances surrounding the child's death.

The circumstances of each death are recorded using a standard surveillance form. The staff members of the Office of the Child Advocate along with the Georgia Child Fatality Review Panel use the data collected in this process to identify opportunities for prevention of future child deaths. The Office of the Child Advocate has one full-time staff member who is solely dedicated to prevention of future child deaths. The prevention specialist works with all counties throughout the State of Georgia.

Due to the fact that the Office of Vital Records did not have a complete data set for 2011 deaths available at the time of publication of this report, the information contained in this report is based solely on the 495 deaths that were reviewed by the CFR committees.

All Reviewed Child Deaths

The death of a child is a devastatingly tragic loss not only for families and loved ones but for the broader community as well. Every unfortunate loss leaves behind a story and far too many of these stories tell of mistakes made and opportunities missed. These stories guide us on the path to saving lives by helping us better understand how we can improve as parents, caregivers, policy makers, practitioners, advocates and legislators. In Georgia, local committees are commissioned with the extraordinary task of reviewing each of these child deaths so that we can work collectively to ensure the health and safety of our youngest citizens.

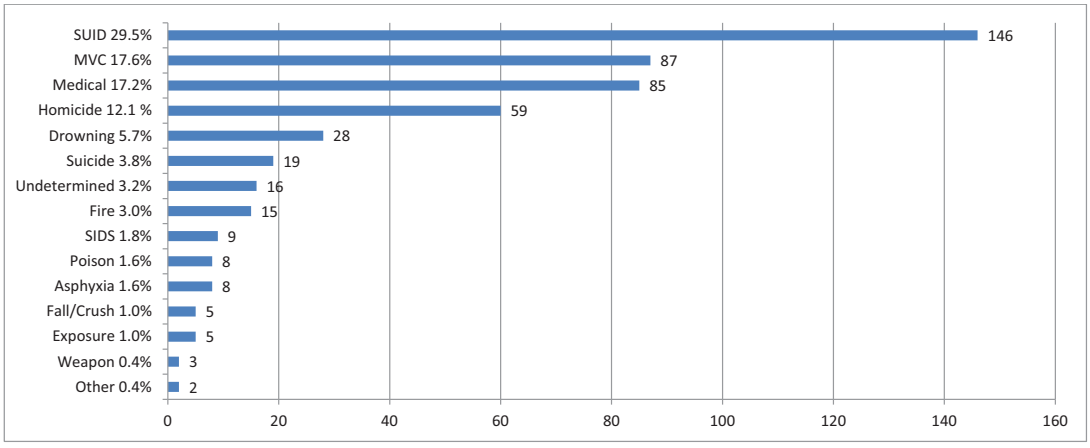
In 2011, Child Fatality Review committees reviewed 495 child deaths which is a significant decline when compared to 594 child deaths reviewed in 2010. These committees are comprised of professionals from various disciplines convening for the purpose of reviewing preventable child deaths. A child's death is eligible for review when the death is sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances. Death notifications are gleaned from a myriad of sources, including reports from county coroner/medical examiner offices, Vital Records (VR), Georgia Bureau of Investigations (GBI), and Department of Family and Children Services (DFCS). This death data is linked with Vital Records data to ensure a comprehensive and accurate account of all deaths. However, the full vital records data file was not available prior to completion of this report.

Figure 1: Demographics of All Reviewed Deaths, 2011 (N=495)

		Number	Percent
Age	Infant	219	44.2
	1 to 4	85	17.2
	5 to 9	44	8.9
	10 to 14	57	11.5
	15 to 17	90	18.2
Race/Ethnicity	White Male	134	27.1
	White Female	85	17.2
	African-American Male	129	26.1
	African-American Female	112	22.6
	Hispanic Male	20	4.0
	Hispanic Female	8	1.6
	Multi-Race Male	3	0.6
	Multi-Race Female	1	0.2
	Asian Male	2	0.4
	Asian Female	1	0.2

Please note that 557 deaths were deemed reviewable based on CFR criteria. However, there are 495 deaths for which a review was conducted and a report was submitted by local CFR committees. The information contained in this report is solely based on data attained from these 495 child death reports.

Figure 2: All Reviewed Deaths by Cause, 2011 (N=495)



- The "Sudden Unexpected Infant Death" (SUID) category is comprised of 116 SUID deaths and 30 sleep-related infant asphyxial deaths (146).
- In 2011, there were eight asphyxial deaths. The "Asphyxia" category represents deaths involving children over the age of one (e.g. choking on food particles)
- The "Other"category represents two tornado-related deaths; the Weapon category represents three unintentional firearm deaths
- Forty percent of all Motor vehicle deaths (MVC) involved older teens ages 15 to 17

- Half of all drowning deaths involved toddlers ages 1 to 4 (14) which is equivalent to all other age categories combined (14)

❖ Please note that the "Asphyxia" category depicted in **figure 2** does not include sleep-related infant asphyxial deaths. These deaths are included in the "SUID" category

Prevention and Preventability

In addition to conducting a thorough review of each death, CFR Committees are also asked to determine if the death was preventable. **Preventability** is defined for CFR Committees as a death in which, with retrospective analysis, it is determined that a reasonable intervention (e.g., medical, educational, social, psychological, legal, or technological) could have prevented the death. In other words, a child's death is preventable **if the community or an individual could reasonably have done something, at any point, that would have changed the circumstances leading up to the death**. Many deaths to children are predictable, understandable, and therefore preventable.

Figure 3: Preventability Determination by Cause of Death, 2011 (N=495)

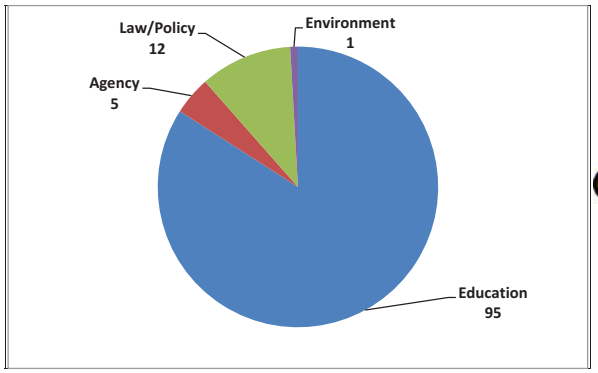
CAUSE	Missing/Blank	No, Probably Not	Yes, Probably	Team could not determine	% Preventable*
All Unintentional	2	18	134	10	88.2
SIDS	--	6	--	2	n/a
Sleep-Related Asphyxia	1	2	21	4	91.3
SUID	6	15	61	26	80.3
Homicide	4	5	48	3	90.6
Suicide	--	3	16	--	84.2
Undetermined	--	4	3	7	n/a
Medical	9	49	17	19	25.8

SIDS = Sudden Infant Death Syndrome
SUID = Sudden Unexplained Infant Death
**% Preventable* calculated excluding "missing/blank" and "team could not determine"*

Based on the retrospective review process, if the committees believe that the death could have been prevented, the committees are also asked to make prevention recommendations to reduce future deaths to children from similar circumstances. Each recommendation can have multiple components, if the committee feels that multiple domains, agencies, or policies could be effective in prevention.

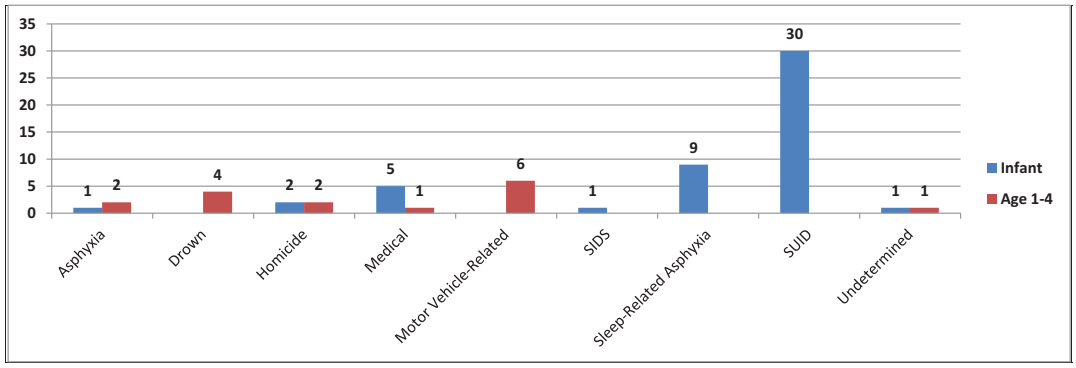
Committees can choose multiple recommendation areas in each death, because there are many ways that prevention efforts can be delivered to parents, caregivers, communities, providers, and policymakers. In 2011, there were 104 deaths (21%) where the committees made a prevention recommendation for at least one area (e.g. education, law/policy, environment, etc). In 391 cases, the committee did not recommend any preventive action.

Figure 4: Prevention Recommendations by Topic, 2011 (N=104)



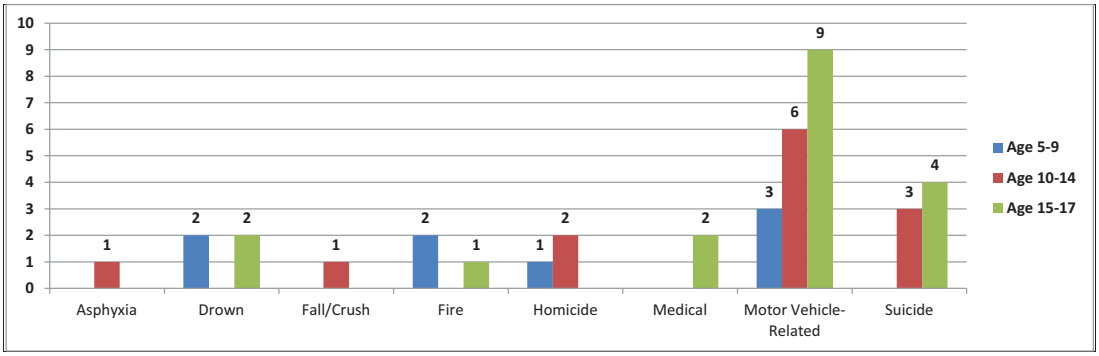
- Of the 227 "education" recommendations reported in 95 deaths, committees most often suggested media campaigns, school programs, parent education, and community safety projects
- Of the 12 "law" recommendations reported in 12 deaths, committees most often identified enforcing existing laws and ordinances
- Of the six "agency" recommendations reported in five deaths, committees most often identified revising policies, creating new programs, and expanding services

Figure 5: Prevention Recommendations for Children Age <5, 2011 (N=65)



CFR Committees most often made prevention recommendations for young children (age <5) in the areas of sleep-related deaths (62%), motor vehicle-related deaths (9%), and medical deaths (9%)

Figure 6: Prevention Recommendations for Children Age >5, 2011 (N=39)



CFR Committees most often made prevention recommendations for older children (age 5-17) in the areas of motor vehicle-related deaths (46%), suicide (18%), and drowning (10%)

PREVENTION RESOURCES FOR PARENTS, CAREGIVERS, AND PROVIDERS

Successful prevention efforts will encompass multiple areas and have overlapping impact. The Office of the Child Advocate suggests using the *Spectrum of Prevention* model, and addressing each of these six areas with prevention programming or policies:

1. Strengthening individual knowledge and skills
2. Promoting community education
3. Educating providers
4. Fostering coalitions and networks
5. Changing organizational practice

6. Influencing policy and legislation

Specific resources will be mentioned in each of the following sections of this report, relating to the singular cause and/or manner of death in each chapter. However, there are several national and state-level resources available that address multiple areas of child injury and fatality, and have materials or trainings available upon request. The Office of the Child Advocate encourages parents, caregivers, providers, and policymakers to utilize these and other resources and incorporate prevention as often as possible.

- Safe Kids USA (www.safekids.org)
- Prevent Child Abuse America (www.preventchildabuse.org)
- National Institute of Child Health and Human Development (www.nichd.nih.gov/sids)
- Suicide Prevention Resource Center (www.sprc.org)
- Centers for Disease Control and Prevention (www.cdc.gov/injury)
- Children's Healthcare of Atlanta, Child Protection Center (www.choa.org/childrens-hospital-services/child-protection-center)

Spotlight on Maltreatment

The Centers for Disease Control and Prevention (CDC) defines child maltreatment as any form of abuse or neglect of a child under the age of 18 by a parent, caregiver, or a person in a custodial role such as a coach or a teacher. The four common forms of abuse are:

- Physical Abuse: the use of intentional physical force, such as hitting, kicking, shaking, burning or other show of force against a child.
- Sexual Abuse: engaging a child in sexual acts including fondling, rape, and exposing a child to other sexual activities.
- Emotional Abuse: engaging in behaviors that harm a child's self-worth or emotional well-being such as name calling, shaming, rejection, withholding love, and threatening.
- Neglect: the failure to meet a child's basic need including housing, food, clothing, education, and access to medical care.

Although many incidents of child abuse and neglect are unreported, in 2011 Child Protective Services identified 681,000 children as victims of maltreatment in the United States. 48.6% of the victims of abuse and neglect were male and 51.1% were female. 1545 of these children died as a result of abuse and neglect.

Neglect was the most common form of maltreatment suffered by children in the United States and more children died as a result of neglect than abuse. 81.6% of the children who died due to abuse and neglect were under the age of 4. 86.5% of the children who died as a result of abuse and neglect were African American (28.2%), Hispanic (17.8%) and White (40.5%).

Of the 495 child deaths in Georgia reviewed in 2011, the CFR Committees identified 76 children as victims of maltreatment (15.3%). This number was identified by a positive response by the CFR Committees to one of these four variables:

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

Among the more frequent causes of death of maltreatment victims identified by the CFR Committees was homicide which represented 29 cases (38.1%) , sleep related infant death which represented 14 cases (18.4%), deaths related to a medical cause which represented 10 cases (13.1%) and deaths involving motor vehicles which represented 7 cases (9.2%).

36 children were White, 31 children were African American and 9 children were Hispanic. Children under the age of 5 represented 47 cases (61.8%) where children were victims of maltreatment. Children in the next three age groups represented between 9-10 cases each for a total of 29 cases (38.2%).

CFR teams identified 47children that had a ***history of maltreatment as a victim***.

In 42 (89.3%) of those 47 cases an act, omission or commission of maltreatment was a direct cause of the child's death. 30 of those 42 were children were under the age of 5. Child abuse was the most frequent cause of death in those 42 cases where an act, omission or commission of maltreatment was a direct cause of the child's death.

The CFR Committees identified an additional 185 cases where some form of act or omission occurred and was a contributing cause of death. Examples of these contributing causes include poor supervision and other forms of negligence

Figure 7: Causes of Death for All Reviewed Maltreatment Deaths, 2011 (N=76)

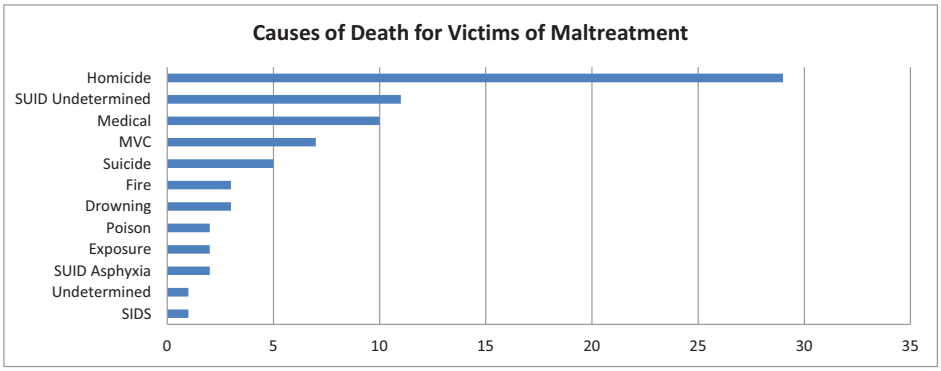


Figure 8: Demographics of All Reviewed Maltreatment Deaths, 2011 (N=76)

		Number	Percent
Age	Infant	29	38.2
	1 – 4	18	23.7
	5 - 9	10	13.2
	10 - 14	9	11.8
	15 - 17	10	13.2
Race/Ethnicity/Gender	White Male	19	25
	White Female	17	22.4
	African-American Male	17	22.4
	African-American Female	14	18.4
	Hispanic Male	4	5.3
	Hispanic Female	5	6.6

Agency Involvement

The CFR Committees were asked to identify the number and type of agencies that provided a service of some kind to the deceased child or the child's family. Child Fatality Review Teams identified 252 cases (50.9%) where a public agency had contact with a deceased child or the child's family. The agencies that had involvement in these cases include but are not limited to mental health, law enforcement, juvenile detention and social services. Each agency visit or staff intervention with a family represents an opportunity for prevention, education and risk reduction counseling for Georgia's families.

- 23 children were receiving services through Children with Special Health Care Needs for a disability or a chronic illness.
- 19 children had received prior mental health services at one time. 10 of these children were receiving mental health services at the time of their death.
- 26 children had an open Child Protective Services case at the time of their death.
- 20 children had a criminal or delinquent history.
- 5 children spent time in juvenile detention prior to their death.
- Child Fatality Review Teams reported that caregivers received some social service assistance (e.g Medicaid, TANF, Food Stamps, WIC) in 246 cases.

Of the 26 cases where there was an open Child Protective Services case:

- There were 5 cases of sleep related infant death. All five of these cases involved African American children.
- 7 children were found to have been the victim of a homicide. 5 of those seven children were Hispanic.

Of the 20 cases where children had a criminal or delinquent history:

- 9 children were the victim of a homicide.
- 5 of these children were between the ages 15-17 and 4 of these children were between the ages 10-14.
- 8 of these 9 children were African American.

Of the 23 children who received services through Children with Special Health Care Needs for a disability or a chronic illness, 15 children died of a medical cause. Examples of the medical conditions identified by CFR teams in these cases are:

- Complications related to a seizure disorder
- Complications related to cerebral palsy
- Complications related to prematurity
- Cardio facial feature disorder
- Hirschstrings disease
- Asthma
- Charge syndrome
- Failure to thrive
- Bacterial pneumonia
- Group B streptococcus sepsis
- Sleep apnea
- Staph infection
- Leukemia

9 of these children were under the age of 5.

11 of these children were African American.

7 of these 11 African American children were under the age of 5.

Medical-Related Deaths

A child medical death is reviewable when the death occurs unexpectedly, unexplained, unattended by a physician, or in a suspicious or unusual manner. Examples of reviewable child 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 seizure disorders).

In 2011, there were 495 child deaths reviewed by the CFR Committees. Out of those 495 child deaths, 85 were medical related, the third largest cause of deaths among children in Georgia.

Figure 9: Demographics of All Reviewed Medical Deaths, 2011

		Number	Percentage
Age	Infant	31	35.6
	1 to 4	16	18.4
	5 to 9	10	11.5
	10 to 14	12	13.8
	15 to 17	16	18.4
Race/Ethnicity/Gender	White Male	17	19.5
	White Female	12	13.8
	African American Male	27	31.0
	African American Female	24	27.6
	Hispanic Male	3	3.4
	Hispanic Female	1	1.1
	Asian Female	1	1.1

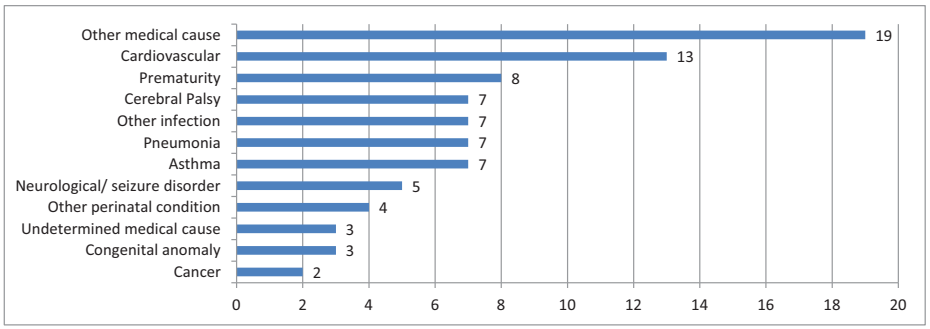
Findings:

- Thirty-six percent of all medical deaths involved infants, almost twice as many deaths in the first year of life than there are in the next 13 years
- Out of 31 infant deaths, 20 had a reported gestational age of less than 39 weeks

Facts:

- According to the March of Dimes, one in eight babies is born prematurely in the United States
- More than half of under-five child deaths are due to diseases that are preventable and treatable through simple, affordable interventions.

Figure 10 : Causes of Medical Related Deaths Reviewed in 2011, (N=85)



Medical related deaths can result from one of many serious health conditions. Examples of these medical conditions are congenital anomalies, cancers, cardiovascular and cerebral problems; respiratory disorders, and neurological disorder.

Many medical related deaths are not believed to be preventable. However, deaths attributed to conditions such as asthma, pneumonia, infectious diseases and some genetic disorders can oftentimes be prevented. There are many treatments for asthma, certain infectious diseases, and other medical conditions and they are generally effective.

In 2011, Twenty-two percent of all medical-related deaths were due to "other medical" causes which include conditions such as charge syndrome, Zellweger syndrome, severe combined immunodeficiency and 4q deletion syndrome.

The American Accreditation Healthcare Commission says that the cause of most infant deaths is associated with prematurity. Death due to prematurity frequently results from a lack of prenatal care.

PREVENTION POINTS:

Prenatal Care is Important!

- Healthy Babies are Worth the Wait is a comprehensive initiative by the March of Dimes to prevent preventable preterm birth, with a focus on reducing elective deliveries before 39 weeks gestation.
- Some birth defects cannot be prevented. However, some conditions may be diagnosed during pregnancy. Such conditions, when recognized, may be prevented or treated while the baby is still in the womb or immediately upon birth.
- Evaluation may include genetic screening of the parents, parental medical histories and childbearing history
- Most state health departments have programs that provide prenatal care to mothers, whether or not they have insurance or able to pay

Sleep-Related Deaths

CFR Committees determine the cause of infant sleep-related deaths by reviewing multiple factors associated with the sleep environment, the infant's medical history, and autopsy findings. A death is determined to be Sudden Infant Death Syndrome (SIDS) when the infant is considered to be in the safest possible sleep environment and no other potential risk factors are identified. A death is determined to be asphyxia when there is evidence of suffocation, wedging, or overlay during sleep. The Sudden Unexplained Infant Death (SUID) cases are determined when there is evidence of an unsafe sleep environment and/or other factors that could possibly have contributed to the death (e.g. bed-sharing, over bundling, prone positioning, or existing health issues).

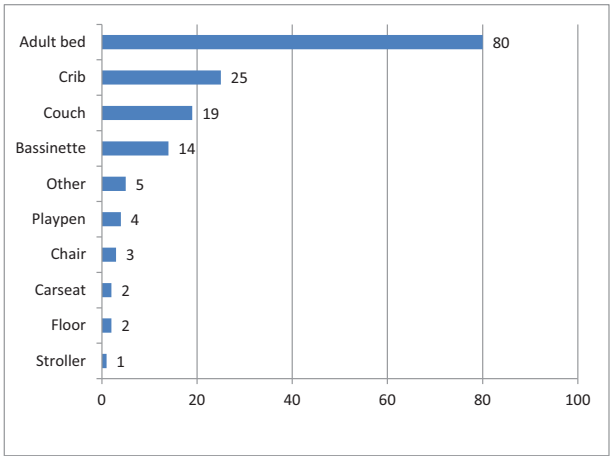
Figure 11: Demographics of All Reviewed Sleep-Related Infant Deaths, 2011 (N=155)

	SIDS		Asphyxia		SUID		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
White Male	2	22.2	6	20.0	25	21.6	33	21.3
White Female	1	11.1	9	30.0	22	19.0	32	20.6
African-American Male	5	55.6	4	13.3	27	23.3	36	23.2
African-America Female			11	36.7	37	31.9	48	31.0
Hispanic Male	1				3	2.6	4	2.6
Hispanic Female					1	0.9	1	0.6
Multi-Race Female					1	0.9	1	0.6
Total	9		30		116		155	

*All Race/Ethnicity/Sex categories are non-Hispanic, except the Hispanic category

- While not indicative of population rates, the race/sex categories with the highest percentage of reviewed infant deaths due to sleep-related circumstances were African-American females (31.0%) and African-American males (23.2%). However, population rates should be considered when determining priority for prevention programs and services.

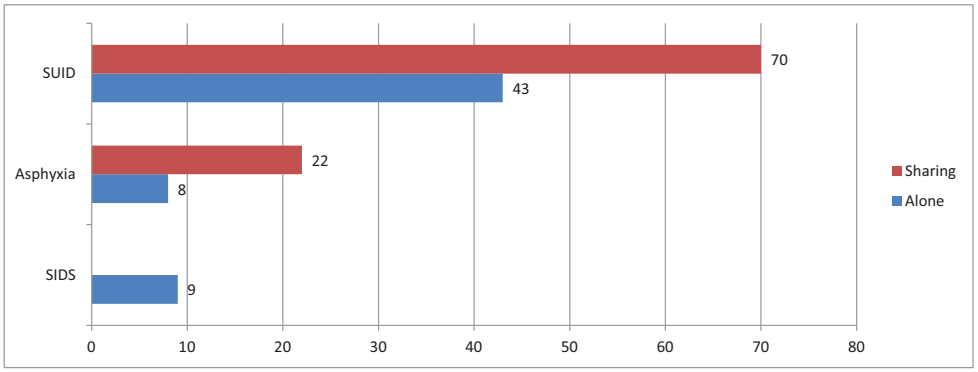
Figure 12: Sleep Location, Sleep-Related Infant Deaths, 2011 (155)



- Of the 155 infant sleep-related deaths reviewed in 2011, just over half of the deaths occurred in an adult bed (52%). The safest place for an infant to sleep is in a safety-approved crib, without blankets, bumper pads, or soft objects that can pose a suffocation hazard

- Twenty-five percent of the deaths occurred in a crib/bassinette; Although a crib or bassinette is a very appropriate sleep location for an infant, there were several incidents where soft or fluffy materials were placed in the crib, or the infant was placed in a prone position, which possibly contributed to the death

Figure 13: Reviewed Sleep-Related Deaths and Bed-Sharing, when known (N=152)



- Of the 70 SUID cases where bedsharing was a factor, 63 were sharing with an adult and 21 were sharing with a child (the total is greater than 70 because in several instances, the infant was sharing a sleep surface with both an adult and a child)
- Of the 22 sleep-related asphyxia cases where bedsharing was a factor, 17 were sharing with an adult and 8 were sharing with a child (the total is greater than 22 because in several instances, the infant was sharing a sleep surface with both an adult and a child)
- Scientific evidence shows that bed-sharing is not safe for children under the age of one. Scientific evidence shows that bed-sharing increases the risk for SIDS, as well as the risk of suffocation. Infants can be overlain by the parent, they can get entrapped between the mattress and the box spring or under the pillow, or they can be suffocated by heavy bedding

Sleeping in a supine position – on the back – is considered the safest position for an infant to sleep until their first birthday. Even when the infant is able to roll over on his own, caregivers are still encouraged to place the infant to sleep on his back. "Tummy time" is encouraged for play, when the infant is supervised by a caregiver, to avoid developing positional plagiocephaly (i.e. "flat head")

- Of the 59 sleep-related deaths where the infant was placed on their back to sleep (supine), 49 deaths (83%) were determined to be SUID, eight were determined to be asphyxia (14%), and two were SIDS (3%)
- Of the 44 sleep-related deaths where the infant was placed on their stomach to sleep (prone), 33 were determined to be SUID (75%), 8 were determined to be asphyxia (18%), and 3 were SIDS (7%)

Prevention Recommendation

The U.S. national campaign to reduce the risk of sudden infant death syndrome has entered a new phase and will now encompass all sleep-related, sudden unexpected infant deaths. The National Institutes of Health (NIH) "Safe to Sleep" campaign recommends placing infants to sleep in their own safe sleep environment and not on an adult bed, without any soft bedding such as blankets or quilts. "Safe to Sleep" also emphasizes breast feeding infants when possible, which has been associated with reduced SIDS risk, and eliminating such risks to infant health as overheating, exposure to tobacco smoke, and a mother's use of alcohol and illicit drugs. (www.nichd.nih.gov/sids)

In addition, the national Text4Baby initiative, launched in 2010, provides free weekly text messages to registered mobile phone users promoting safe and healthy behaviors for pregnant women and infants. This service includes information to reduce sleep-related deaths, such as tobacco cessation, accessing prenatal care, and making sleep arrangements prior to the birth. Text4Baby messages are also available to registered users through the infant's first year.

CFR committees are promoting safe sleep environments for infants in their communities, by educating parents and caregivers to place infants to sleep on their backs, use a firm, tight-fitting mattress, and not add extra padding, blankets, pillows, or comforters in the sleep space.

First Lady's Children's Cabinet

Ensuring all of Georgia's children are educated, healthy, safe, and productive members of society

The First Lady's Children's Cabinet coordinates policies and resources to improve outcomes for children and families. The Cabinet provides unique leadership on child welfare and juvenile justice issues in Georgia by identifying the state's strategic priorities, then developing initiatives in response.

The First Lady of Georgia, Sandra Deal, who is the Chairwoman of the Georgia Children's Cabinet, launched the Safe Sleep Campaign on October 9th, 2012. The First Lady knows the critical importance of educating all parents and caregivers of babies about SIDS and the risk factors that contribute to it. The campaign highlights the actions that can be taken to help prevent SIDS and sleep related deaths.

Helpful resources for safe sleep:

DJJ Information on Safe Sleep: http://www.djjnewsandviews.org/safesleep/

DPH Information on Safe Sleep: http://health.state.ga.us/programs/sids/index.asp

Department of Health and Human Services: http://dfcs.dhs.georgia.gov/news-archives
http://dhs.georgia.gov/sites/dhs.georgia.gov/files/safesleepingrev2.pdf

Office of the Child Advocate: http://oca.georgia.gov/documents/safe-sleep-infants

The safest sleep environment is:

Alone—do not share a bed
Back—place infants to sleep on their backs, not tummy or side
Crib—-use a safety-approved sleep place such as a crib or bassinet

Motor Vehicle Injury-Related Deaths

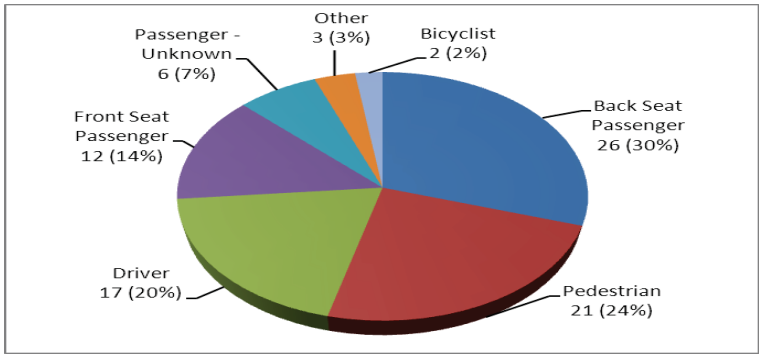
During 2011, motor vehicle related crashes were the second leading cause of all reviewed deaths. Motor vehicle injury-related deaths accounted for a total of 87 out of 161 total reviewed unintentional injury-related deaths. A total of 87 deaths in 2011 is a decrease from the total of 111 deaths that occurred in 2010. According to the National Highway Traffic Safety Administration, young drivers, ages 15 to 20 years old, are especially vulnerable to death and injury on our roadways - traffic crashes are the leading cause of death for teenagers in America.

Figure 14: Demographics of Reviewed Motor Vehicle-Related Deaths, 2011 (N=87)

	Category	Number	%
Age	Infant	4	4.6%
	1 to 4	17	19.5%
	5 to 9	13	14.9%
	10 to 14	19	21.8%
	15 to 17	34	39.1%
Race/Gender	White Male	33	37.9%
	White Female	17	19.5%
	African-American Male	15	17.2%
	African-American Female	15	17.2%
	Hispanic Male	5	5.7%
	Hispanic Female	2	2.3%

- Males represented 53% of all motor vehicle-related crashes.
- In regards to race/gender, the largest number of deaths occurred with white males.
- Teenagers age 15 to 17 had the largest number of deaths

Figure 15: Reviewed Motor Vehicle-Related Deaths by Location at Injury, 2011 (N=87)



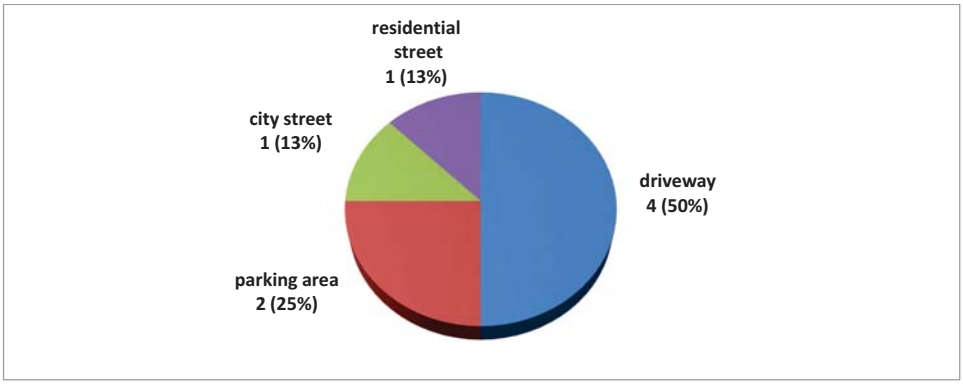
The largest type of Motor Vehicle-Related crashes (26) was as a result of passengers who rode in the back seat of the car. This is not indicating the back seat as a danger zone for passengers. Three out of a total of eight accidents occurred where passengers were not being restrained by a seatbelt between the ages of 10 to 14. Only one out of six known accidents occurred in teens 15 to 17 where the decedent was not restrained. However, one report indicated a child being restrained in a car seat. The accident was caused by a driver in another vehicle.

Information regarding the new Child Passenger Safety Restraint Law in Georgia is documented by Children's Healthcare of Atlanta. "During the 2011 state legislative session, Children's successfully advocated for an increase in the state required age for a child to be restrained in a booster seat when riding in a motor vehicle. On May 9, 2011, Governor Nathan Deal signed the legislation at Scottish Rite.

Effective as of July 1, 2011, all children **under 8 years old** must be properly secured in an approved car seat or booster seat while riding in a car, van, SUV or pickup truck.

A few findings were documented as a result of reviewable deaths reported for 2011. In one accident, a child, between the ages of 1 to 4, was properly restrained in a car seat when the car was hit by another vehicle. The child died in a hospital two days later. Another accident, occurring with a child between ages 5 to 9, found the child in the back seat behind the driver and was not wearing a seatbelt. Ultimately, a strong recommendation is to continue to enforce the restraint law in Georgia to prevent child deaths as a result of motor vehicle related crashes.

Figure 16: Location of Reviewed Motor Vehicle-Related Pedestrian Deaths, Ages 1 to 4, 2011 (N=8)



- A total of eight motor vehicle-related crashes occurred involving pedestrian children ages 1 to 4. The most prevalent location (50 %) was in a driveway.
- Two deaths occurred where the children darted out into the path of a car. One death was a result of the child not being seen by the driver of the car. The other death involved the driver not having time to stop when the child darted out in the path of the vehicle.
- One method of prevention is increasing close adult supervision of children in this age group

PREVENTION POINTS:

Below are a few guidelines for parents regarding child passenger safety. They are recommended by The Committee on Injury, Violence, and Poison Prevention. (www.cdc.gov)

- Use a seat belt on every trip, no matter how short. This sets a good example.
- Make sure children are properly buckled up in a seat belt, booster seat, or car seat, whichever is appropriate for their age, height and weight.
- All children younger than 13 years should ride in the back seat. Airbags can kill young children riding in the front seat. Never place a rear-facing car seat in the front seat or in front of an air bag.
- Place children in the middle of the back seat when possible, because it is the safest spot in the vehicle.

Drowning-Related Deaths

Figure 17: Demographics of Reviewed Drowning Deaths, 2011 (N=28)

	Category	Number	%
	1 to 4	14	50.0%
	5 to 9	7	25.0%
	10 to 14	3	10.7%
	15 to 17	4	14.3%
Race/Gender	White Male	12	42.9%
	White Female	5	17.9%
	African-American Male	6	21.4%
	African-American Female	1	3.6%
	Other Male	3	10.7%
	Other Female	1	3.6%

In general, drowning deaths decreased from a total of 39 in 2010 to 28 deaths in 2011. Fifty percent of all reviewed drowning deaths in 2011 occurred in children ages 1 to 4. All deaths occurred as a result of or due to careless safety measures. In some cases, there were two adults watching a child. But, they both left the child alone in a pool or bathtub for a few minutes. When they returned, the child was found unresponsive in the water.

PREVENTION POINTS:

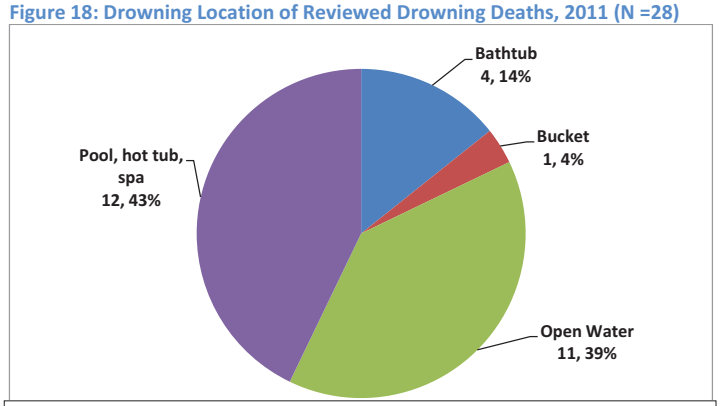
According to the Centers for Disease Control and Prevention, the following prevention tips can be implemented:

Learn life-saving skills. Everyone should know the basics of swimming (floating, moving through the water) and cardiopulmonary resuscitation (CPR).
Fence it off. Install a four–sided isolation fence, with self–closing and self–latching gates, around backyard swimming pools. Fences can help keep children away from the area when they aren't supposed to be swimming. Pool fences should completely separate the house and play area from the pool.

Make life jackets a "must." Make sure kids wear life jackets in and around natural bodies of water, such as lakes or the ocean, even if they know how to swim. Life jackets can be used in and around pools for weaker swimmers too.

Be on the lookout. When kids are in or near water, including bathtubs, closely supervise them at all times. Adults watching kids in or near water should avoid distracting activities like playing cards, reading books, talking on the phone, and using alcohol or drugs.

Figure 18: Drowning Location of Reviewed Drowning Deaths, 2011 (N =28)



- The largest percentage of reviewed drowning deaths occurred in a pool, hot tub or spa
- In general, CFR Committees reported evidence of children being unsupervised and left alone in unattended pools.
- The second highest location of drowning deaths occurred in open water.
- Reports also showed that children were unsupervised while playing with other siblings.
- Two teen deaths were ruled accidental.

Fire-Related Deaths

Nationally, deaths from fires and burns are the third leading cause of fatal home injury. Over one-third (37%) of home fire deaths occur in homes without smoke alarms and smoking is the leading cause of fire deaths (CDC, 2010). All too often, tragic fires occur when young children are left unattended, for even short periods. Even though they have a natural curiosity about fire, children may become frightened and confused in a fire and hide rather than escape to safety. Children are often found hiding in closets or under beds where they feel safe. Therefore, it is imperative that parents and caregivers hold fire drills in the home at least twice a year to let them practice the right things to do in a fire emergency (U.S. Fire Administration, 2009).

In Georgia, Fire-related deaths have fluctuated over the past several years

- 19 deaths in 2006
- 15 deaths in 2007
- 11 deaths in 2008
- 24 deaths in 2009
- 12 deaths in 2010
- 15 deaths in 2011

Figure 19: Demographics of Reviewed Fire-Related Deaths, 2011 (N=15)

	Category	Number	%
Age	Infant	2	13.3%
	1 to 4	4	26.7%
	5 to 9	6	40.0%
	15 to 17	3	20.0%
Race/Gender	White Male	4	26.7%
	White Female	3	20.0%
	African-American Male	5	33.3%
	African-American Female	3	20.0%

- Of the total 15 fire-related deaths, the source of fire originated from a heating stove (4 deaths) space heater (3 deaths), cigarette (1 death), surge protector (1 death), faulty electrical wiring (1 death) and unknown sources (5 deaths)
- Eighty-Seven percent of fire-related deaths occurred in single home structures
- In the majority of cases, it is unknown whether smoke detectors and fire extinguishers were present and operable at the time of incident. This underscores the importance of increased participation of fire scene investigators in the local child fatality review process.

Homicide Deaths

Homicide is one of the leading causes of child deaths. Child homicide victims account for 8% to 14% of all homicide victims. More often than not, most homicides occur by mechanism of injury. These injuries include but not limited to: shaken baby, fire, firearm, drowning, motor vehicle-related, poisoning, asphyxia, inflicted injury (being kicked, struck, stabbed or bitten) or other injury (crushed, heatstroke, etc).

Nationally, homicide accounts for one in five injury-related deaths among infants (less than one year of age). Infants are most likely to be killed by their mother during the first week of life, but thereafter are more likely to be killed by a male (usually their father or stepfather). The risk of infant homicide is highest on the day of birth, and half of all infant homicides occur by the fourth month of life. Homicide risk is greater in the first year of life than in any other year of childhood before age 17.

Research studies of infant death data drawn from multiple agencies (such as police or social service records) indicate the actual rate of deaths attributable to abuse or neglect of infants and children up to four years old is more than twice as high as the official rates reported in death certificate data. Studies have also indicated that a substantial but uncertain number of unreported infant homicide deaths, may occur among very young infants, particularly those infants for whom no birth or death certificates are found, such as those who are born with no trained attendants and not in a clinical setting.

Key risk factors associated with infant homicides include the circumstances surrounding the birth of the child. Among homicides occurring on the first day of life, 95% of the victims were not born in a hospital. Other important maternal risk factors include a second or subsequent infant born to an unmarried teenage mother (19 years of age or younger); no prenatal visit before the sixth month of pregnancy or no prenatal care; a history of maternal mental illness; a mother with 12 or fewer years of education; and premature birth (gestation of less than 28 weeks). Studies suggest that male caretakers (fathers or mother's intimate partners), often acting impulsively, are the perpetrators of the majority of infant homicides. However, there is generally less information (including potential risk factors for infant homicides) on biological fathers than there is on mothers, because of the frequency with which birth certificates are missing paternal data.

Between 1970 and 2000, the official infant homicide rate more than doubled; from 4% to 9% infant deaths per 100,000 children under age one. Between 2000 and 2002, the rate declined to 7% and has since fluctuated between 7% and 8%. The rate was 8% in 2010.

In 2010, for example, the infant homicide rate for boys was 8% for children under age one and 6% for girls. And as for race and ethnicity, African-American infants are substantially more at risk for homicide than are other infants. In 2009, the homicide rate for African-American infants was 17%, while Hispanics and Whites had rates of 6% and 5%, respectively.

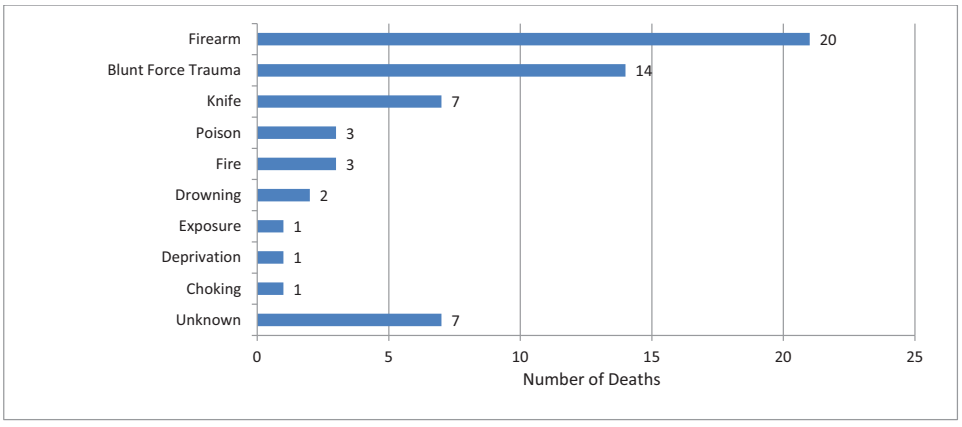
Homicide is the second leading cause of death among teens ages 15 to 19, after unintentional injury. Although other teens are the perpetrators of many of the homicides of teens below age 18, two-thirds of the murderers are eighteen or older.

Males ages 15 to 19 are 6 times more likely to die from homicide (14% and 2% respectively in 2010). As for race, in 2010, the national homicide rate for African-American teens was 52%, more than 22 times higher than the rate for White male teens (2%). Rates for other groups were 18% for Hispanic males, 11% for American Indian males, and 3% for Asian and Pacific Islander males.

Although the rate of homicide increased between 2004 and 2006, to 10.7 deaths per 100,000, it has since decreased. In 2010, the homicide rate was 8%, the lowest it has been since before 1980.

Georgia's homicide story is a vastly different one than previously reported in the past because Georgia's homicide rate has also decreased. In 2011, there were a total of 59 homicides.

Figure 21: Reviewed Homicide Deaths, by Mechanism, 2011 (N = 59)



Infant child deaths were listed at 23%, while children ages 1 to 4 were listed at 28%. For children ranging from ages 5 to 9 was 10% and ages 10 to 14 was 15%. The last remaining group, ages 15 to 17 was 22%.

Out of these deaths, racially, 10% were White males and 10 % were White females. However, African-American males had the highest death rate of 45%, while African-American females came in second with 16%. The Hispanic male death rate was 12%, while Hispanic females were only 5%.

Over 50% of child deaths that occurred were intentional injury related. The intentional injury deaths were by the hands of either both the father and mother, the mother or the father. This type of homicide is known as filicide (killing of your own child by a biological parent). The other injuries occurred by abuse, neglect (E.g., two cases where children drowned because their whereabouts were unknown and they were not being properly supervised), fire (e.g., a case where the mother and father were operating a crystal meth or methamphetamine lab out of their home, which blew up, killing two of their own children), or blunt force trauma. Oftentimes the biological parent themselves are either socially, mentally or emotionally unstable. Consequently, the child killings are a reflection of the parent's overall disposition.

Georgia continues to focus on homicide prevention by criminalizing firearm possession by minors, prosecuting minors as adults in criminal court or holding adults responsible for the actions of minors when there are multiple incidents of serious injuries upon others. However, these prevention methods may only curtail some of the homicidal occurrences. More thorough prevention efforts need to address early signs of potential maltreatment or homicidal tendencies. Georgia is steadily increasing its preventive measures by 1) developing stronger communications with local and regional Department of Family and Children Services units and 2) through each Child Fatality Review Committee, examining possible patterns that stem from various causes such as lack of resources or bare living necessities. Stronger communication with the Department of Family and Children Service units allows the Office of the Child Advocate to intervene in possible issues that may later result in death (such as a parent's psychological well being) Likewise, the Child Fatality Review Committees submit data and reports indicating information that signal common occurrences that may be stopped once the issues are addressed. For example, child dying because of the lack of knowledge of properly strapping a child in a car seat. By focusing on both of these measures, Georgia is able to further ensure the safety of its children.

Suicide Deaths

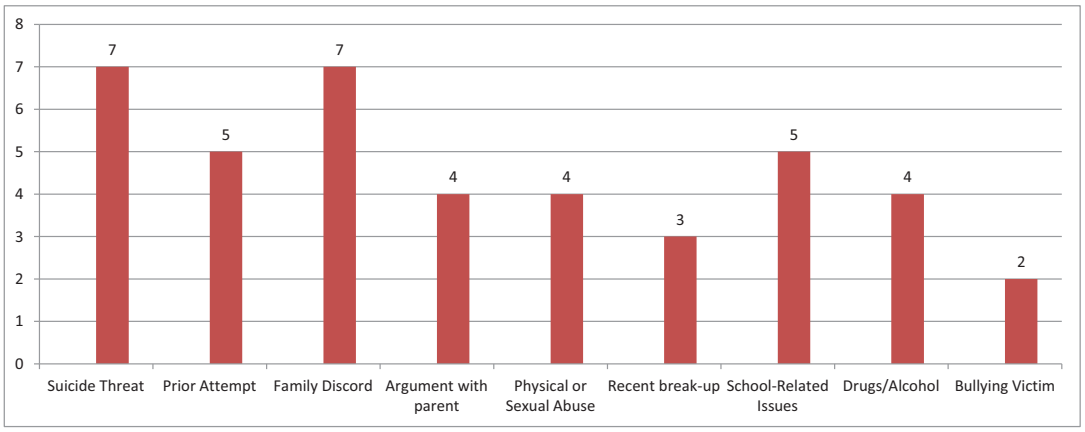
Suicide is the third-leading cause of death for 15 to 24 year-olds, according to the Centers for Disease Control and Prevention (CDC), after accidents and homicide. It is also thought that at least 25 attempts are made for every completed teen suicide. The risk of suicide increases dramatically when kids and teens have access to firearms at home, and nearly 60% of all suicides in the United States are committed with a gun. Therefore, guns kept in the home should be unloaded, locked, and kept out of the reach of children and teens. Overdose using over-the-counter, prescription, and non-prescription medicine is also a very common method for both attempting and completing suicide. It is important for parents and caregivers to carefully monitor all medications in the home and to be aware that teens will "trade" different prescription medications at school and carry them, or store them, in their locker or backpack (CDC, 2010).

Figure 22: Demographics of Reviewed Suicide Deaths, 2011 (N=19)

		Number	Percent
Age	10 to 14	7	36.8
	15 to 17	12	63.2
Race/Ethnicity/Gender	White Male	12	63.2
	White Female	2	10.5
	African-American Male	2	10.5
	African-American Female	2	10.5
	Asian Male	1	5.3

- White males accounted for over half of all reviewed suicide deaths (63%)
- Forty-seven percent of all reviewed suicide deaths involved hanging (9); thirty-seven percent involved firearms (7)
- Nationally, suicide rates differ between boys and girls. Girls think about and attempt suicide about twice as often as boys, and tend to attempt suicide by overdosing on drugs or cutting themselves. Yet boys die by suicide about four times as often as girls, perhaps because they tend to use more lethal methods, such as firearms, hanging or jumping from heights.

Figure 23: Suicide Deaths and Reported Risk Factors, when known, 2011

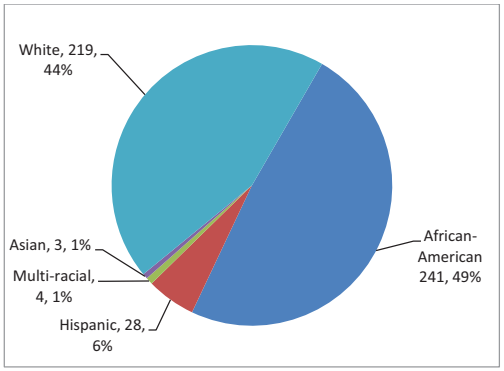


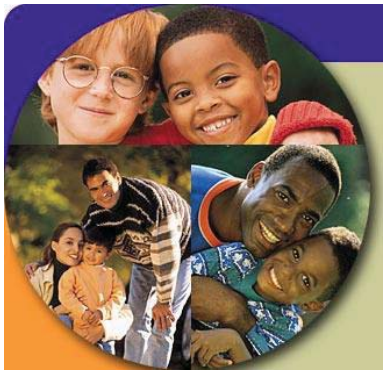
- **Early identification of behavioral indicators and potential risk factors can serve as opportunities for effective prevention (CDC, 2009)**

Disproportionate Deaths

According to the United States Census, the racial makeup of Georgians in 2011 was 63% White, 31% African-American, 9% Hispanic, and 3% Asian. However, the racial makeup of reviewed child fatalities in 2011 did not reflect the general population. African-Americans were disproportionately represented in the reviewed deaths (49%), while proportionally fewer deaths occurred among Whites (44%) and Hispanics (6%), relative to their percentage within the state's population.

Figure 24: Number and Percentage of All Reviewed Deaths by Race/Ethnicity, 2011 (N=495)





According to the Georgia Department of Public Health, Online Analytical Statistical Information System (OASIS), the death rate for African-American infants due to sleep-related circumstances in Georgia was almost twice that of White infants for many years. However, the death rates for other external causes of injury, with the exception of motor vehicle crashes, are nearly identical between African-American children and White children. The death rate for child homicides is five times higher among African-Americans compared to Whites.

Figure 25: Proportion of Reviewed Deaths with Prior Agency Involvement, by Race/Ethnicity and Age, 2011

Proportion of Reviewed Deaths with Prior Agency Involvement, by Race/Ethnicity

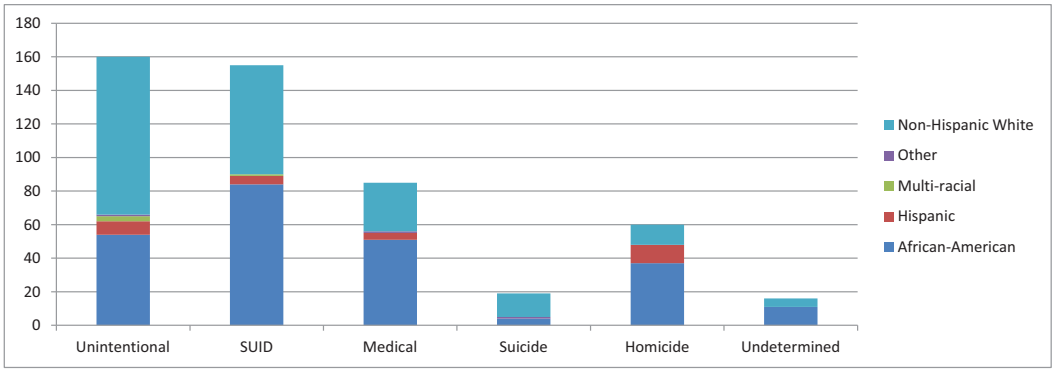
	Number	Percent
White	101	46.1
African-American	140	58.1
Hispanic	17	60.7

Proportion of Reviewed Deaths with Prior Agency Involvement, by Age

Infant	150	68.5
1 to 4	39	45.9
5 to 9	18	40.9
10 to 14	20	35.1
15 to 17	34	37.8

Minorities and infants were more likely to have agency involvement prior to their death.

Figure 26: Causes of Death by Race



It is evident that certain populations bear a disproportionate burden of injury or death. Many state and local agencies are working to identify the causes of the disproportionate deaths and how we can address them. For prevention efforts to be successful, we must consider the unique social and ecological circumstances for all racial and ethnic groups within communities, and tailor prevention programs and services to meet their specific needs. The Office of the Child Advocate remains committed to working with communities through the local CFR committees to develop specific and appropriate prevention plans.

Resources

- Safe Kids USA (www.safekids.org)
- Prevent Child Abuse America (www.preventchildabuse.org)
- National Institute of Child Health and Human Development (www.nichd.nih.gov/sids)
- Suicide Prevention Resource Center (www.sprc.org)
- Centers for Disease Control and Prevention (www.cdc.gov/injury)
- Children's Healthcare of Atlanta, Child Protection Center (www.choa.org/childrens-hospital-services/child-protection-center)
- www.cdc.gov/ViolencePrevention/childmaltreatment/
- www.cdc.gov/ViolencePrevention/pdf/CM_Factsheet2012-a.pdf
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. Child Maltreatment 2011 (www.acf.hhs.gov/sites/default/files/cb/cm11.pdf)
- The American Accreditation Healthcare commission
- March of Dimes (www.marchofdimes.com)
- Healthy Babies are Worth the Wait

- Governor's Office of Highway Safety (www.gahighwaysafety.org)
- Georgia Department of Public Health (www.health.state.ga.us)
- Georgia Traffic Injury Prevention Institute (www.ridesafegeorgia.org)
- Georgia Family Connection Partnership (www.gafcp.org)
- Governor's Office for Children and Families (www.children.georgia.gov)
- Safe Kids Georgia (www.safekidsgeorgia.org)
- Prevent Child Abuse Georgia (www.preventchildabusega.org)

- The National Institutes of Health (NIH) "Safe to Sleep" campaign (www.nichd.nih.gov/sids) Text4Baby
- U.S. Fire Administration (www.usfa.fema.gov)
- Statistics from the National Highway Traffic Safety Administration *(www.nhtsa.gov)*
- Children's Healthcare of Atlanta *(www.choa.org)* documentation for Child Passenger Safety Restraint Law in Georgia
- Prevention Tips from Centers for Disease Control and Prevention *(www.cdc.gov)*
- The American Accreditation Healthcare commission

- Data for 2001-2010: Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2012) http://webappa.cdc.gov/sasweb/ncipc/mortrate10us.html

- National Center for Injury Prevention and Control. (2012). WISQARS online data tool. Data for 2010. Available at: www.cdc.gov/injury/wisgars/fatal injury reports.html

- Overpeck, M.D., Brenner, R. A., Trumble, A. C., Trifilette, L. B., & Berendes, H.W. (1998). Risk factors for infant homicide in the United States. *New England Journal of Medicine*. 339(17). 1211-1216.

- WISQARS. 2012, United States homicide injury deaths and rates per 100,000. Available at: www.cdc.gov/injury.wisgars/fatal injury reports.html

- Crume, T. L., DiGuiseppi, C., Byers, T., Sirotnak, A. P., and Garrett, C.G. (2002). National under ascertainment of child maltreatment fatalities by death certificates, 1990-1998. *Pediatrics*, 110(2). Available at: www.pediatrics.org/cgi/reprint/110/2/e18.pdf

- Overpeck, M. D., Brenner, R. A., Cosgrove, C. Trumble, A. C., Kochanek, K., and Mac Dorman, M (2002). National under ascertainment of sudden unexpected infant deaths associated with deaths of unknown cause. *Pediatrics 109(2*): 274-283.

- Paulozzi, L. & Sells, M. (2002). Variation in homicide risk during infancy- United States, 1989-1998. Morbidity and Mortality Weekly Report, 51 (09): 187-189. Centers for Disease Control and Prevention. Available at**:** www.cdc.gov/mmwr/preview/mmwrhtml/mm5109a3.htm

Reviewable Deaths By County

The following table represents the status of county level reporting compliance for 2011. Please note that the total number of CFR reports does not correspond with the total number of reviewed deaths indicated in this report for a host of reasons. Some committees submitted data online without convening a CFR meeting while others submitted insufficient data to be deemed complete by reporting standards. Also, many committees convened CFR meetings but the data was not submitted online. Some committees were not notified of deaths that occurred within their county and did not have sufficient time to conduct a review at the time of this report. This information is reflected below in the following three categories:

Number of Reviewable Deaths Known

- This is the number of deaths that the Office of the Child Advocate was aware of through a variety of sources (i.e., vital records, Georgia Bureau of Investigations, local medical examiner offices, coroners, and others)

Number of CFR Reports Submitted

- This is the number of completed child death reports submitted via the online reporting system

Number of CFR Reports Not Submitted

- This is the number of reviewable deaths for which a completed report was not submitted via the online reporting system

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Appling	3	1	2
Atkinson	0	0	0
Bacon	0	0	0
Baker	0	0	0
Baldwin	1	1	0
Banks	0	0	0
Barrow	0	0	0
Bartow	3	3	0
Ben Hill	1	1	0
Berrien	1	1	0
Bibb	8	8	0
Bleckley	0	0	0
Brantley	2	2	0
Brooks	0	0	0
Bryan	2	0	2
Bulloch	4	4	0
Burke	2	2	0
Butts	4	3	1
Calhoun	0	0	0
Camden	3	3	0
Candler	1	0	1
Carroll	6	6	0
Catoosa	6	6	0
Charlton	1	1	0
Chatham	12	10	2
Chatooga	5	5	0
Chattahoochee	0	0	0
Cherokee	9	9	0
Clarke	6	6	0

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Clay	0	0	0
Clayton	17	17	0
Clinch	1	1	0
Cobb	17	17	0
Coffee	6	5	1
Colquitt	1	1	0
Columbia	13	13	0
Cook	3	3	0
Coweta	9	9	0
Crawford	0	0	0
Crisp	2	2	0
Dade	1	1	0
Dawson	1	1	0
Decatur	2	2	0
DeKalb	39	36	3
Dodge	1	1	0
Dooly	1	1	0
Dougherty	12	12	0
Douglas	8	8	0
Early	1	1	0
Effingham	9	9	0
Elbert	2	2	0
Emanuel	1	0	1
Evans	1	1	0
Fannin	2	2	0
Fayette	3	3	0
Floyd	11	11	0
Forsyth	6	5	1
Franklin	0	0	0

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Fulton	56	50	6
Gilmer	1	1	0
Glascock	0	0	0
Glynn	7	0	7
Gordon	7	7	0
Grady	1	0	1
Greene	0	0	0
Gwinnett	35	35	0
Habersham	0	0	0
Hall	6	2	4
Hancock	2	2	0
Haralson	1	1	0
Harris	0	0	0
Hart	2	0	2
Heard	2	2	0
Henry	14	12	2
Houston	10	10	0
Irwin	0	0	0
Jackson	1	0	1
Jasper	4	4	0
Jeff Davis	4	2	2
Jefferson	0	0	0
Jenkins	1	1	0
Johnson	0	0	0
Jones	2	2	0
Lamar	0	0	0
Lanier	1	1	0
Laurens	3	1	2
Lee	2	2	0

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Liberty	3	2	1
Lincoln	2	0	2
Long	2	0	2
Lowndes	9	9	0
Lumpkin	1	1	0
Macon	0	0	0
Madison	4	4	0
Marion	0	0	0
McDuffie	2	1	1
McIntosh	5	0	5
Meriwether	0	0	0
Miller	0	0	0
Mitchell	2	2	0
Monroe	4	4	0
Montgomery	0	0	0
Morgan	2	2	0
Murray	6	6	0
Muscogee	14	14	0
Newton	11	9	2
Oconee	1	1	0
Oglethorpe	0	0	0
Paulding	4	4	0
Peach	2	2	0
Pickens	0	0	0
Pierce	1	1	0
Pike	1	0	1
Polk	5	4	1
Pulaski	0	0	0
Putnam	0	0	0

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Quitman	1	1	0
Rabun	2	2	0
Randolph	0	0	0
Richmond	13	12	1
Rockdale	4	4	0
Schley	0	0	0
Screven	0	0	0
Seminole	0	0	0
Spalding	3	3	0
Stephens	1	0	1
Stewart	0	0	0
Sumter	0	0	0
Talbot	0	0	0
Taliaferro	0	0	0
Tattnal	2	0	2
Taylor	0	0	0
Telfair	0	0	0
Terrel	2	2	0
Thomas	1	1	0
Tift	2	2	0
Toombs	2	0	2
Towns	0	0	0
Treutlen	0	0	0
Troup	3	3	0
Turner	1	1	0
Twiggs	0	0	0
Union	2	2	0
Upson	3	3	0
Walker	2	2	0

COUNTY	# OF KNOWN REVIWABLE DEATHS	# OF CFR REPORTS SUBMITTED	# OF CFR REPORTS NOT SUBMITTED
Walton	4	4	0
Ware	3	3	0
Warren	0	0	0
Washington	6	5	1
Wayne	2	2	0
Webster	0	0	0
Wheeler	0	0	0
White	2	2	0
Whitfield	3	3	0
Wilcox	0	0	0
Wilkes	0	0	0
Wilkinson	0	0	0
Worth	1	0	1
Total	557	495	62

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