Georgia CAPTA Panels

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

2013 Annual Report

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

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

…Margaret Mead

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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Originally enacted in January 1974, the Child Abuse Prevention and Treatment Act (CAPTA) is a key piece of federal legislation addressing child abuse and neglect.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 agency, 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.

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 meet their goals of protecting children from child abuse and neglect.

The purpose of CAPTA Panels is to increase system transparency and accountability and provide opportunities for community input by:

a) examining the policies, procedures, and practices of state and local agencies, and, where appropriate, specific cases; and
b) evaluating the extent to which state and local child protection 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 Panels consider important to ensure the protection of children, including:
    a) reviewing 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) reviewing child fatalities and near fatalities.

CAPTA Panels are composed of volunteer members who broadly represent the communities in which they operate and include individuals with expertise in the prevention and treatment of child abuse and neglect. 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 the Panels need to fulfill their duties, and to respond to the annual reports.

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). The 2010 reauthorization modified this requirement, stipulating that states must develop new plans and periodically review and revise them, as needed, to reflect changes in strategies or programs identified in the plan.

Georgia's CAPTA Plan

Georgia completed and submitted a new CAPTA plan in 2012, which was subsequently approved in 2013 by the federal Administration on Children and Families Children's Bureau. Georgia's CAPTA Panels were provided an opportunity to review and comment on the amended CAPTA plan.

Georgia identified five program areas as the focus of its CAPTA plan:

Program Area 1

- The intake, assessment, screening and investigation of reports of child abuse or neglect

Program Area 2

- Creating and improving the use of multidisciplinary teams and interagency, intra-agency, interstate and intrastate protocols to enhance investigations; and improving legal preparation and representation, including:
  - Procedures for appealing and responding to appeals of substantiated reports of child abuse or neglect; and
  - Provisions for the appointment of an individual to represent a child in judicial proceedings.

Program Area 5

- Developing and updating systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange

Program Area 7

- Improving the skills, qualifications and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers

Program Area 13

- Supporting and enhancing interagency collaboration among public health agencies, agencies in the child protective service system, and agencies carrying out private community-based programs:
  - To provide child abuse and neglect prevention and treatment services (including linkages with education systems), and the use of differential response
  - To address the health needs, including mental health needs, of children identified as victims of child abuse or neglect, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports

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.[1] Additionally, 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.

This report on the CAPTA plan is included in the state's Annual Progress and Services Report (APSR).

[1] One of these obligations is establishing and maintaining CAPTA citizen review panels and responding to annual recommendations resulting from their activities included in the CAPTA Panel annual report.

Georgia's Citizen Review Panels (CAPTA Panels)

The mission of Georgia's CAPTA Panels is:

"To ensure that children are protected from maltreatment, and that children and their families are provided the best possible services within the framework of available resources."

In 2006, three existing committees were officially designated to serve as Georgia's CAPTA Panels: the Children's Justice Act Task Force (CJATF), the Child Protective Services Advisory Committee (CPSAC), and the Georgia Child Fatality Review Panel (CFRP). The CJATF serves a dual role as a CAPTA Panel and a task force on children's justice. The CFRP serves as both a CAPTA Panel and a state-legislated body charged with reviewing the circumstances in all child deaths and identifying opportunities for prevention. The CPSAC serves only as a CAPTA Panel.

Each of Georgia's three CAPTA Panels meets all statutory requirements, including:

- Meets a minimum of four times a year
- Includes members broadly representative of the community, and where specified, meeting the statutory requirements of that group, as specified by state or federal legislation
- Examines policies, procedures and practices of the state's child protection system and evaluates the extent to which Georgia is meeting its child protection responsibilities and its compliance with CAPTA and the state's CAPTA plan
- Reports annually on its activities and recommendations
- Provides for public comment

Each with its own unique vision and mission, Georgia's CAPTA Panels have a statewide systemic approach to examining issues that impact the effectiveness of the state's child protection system. Their common goal is to improve the child welfare system and community response to protecting victims and supporting families. This is reinforced by their overlapping interests that 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.

Georgia's CAPTA Panels Working Together in 2013

The co-chairs from each CAPTA Panel serve on a joint steering committee that 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 2013, the steering committee continued its work on developing standards for Panel operations, leadership development and recruitment guidelines, in addition to outlining roles, responsibilities and expectations of the coordinator and the relationship between the CAPTA Panels and the state child welfare agency. These were reviewed at the annual retreat in September 2013 and will be revised based on input from Panel members, formalized and implemented during 2014.

At the annual retreat, CAPTA Panels reflect on their successes and challenges, address unfinished business, identify new opportunities and draft work plans for the coming year. The agenda at the retreat included:

- A presentation and dialogue with the Region IV Child Welfare Specialist on the roles and responsibilities of both CAPTA Panels and the state child welfare agency
- A facilitated discussion between CAPTA Panel members and representatives from the child welfare agency leadership team, including the newly appointed Director of the Federal Regulations, Data & Policy Unit
- A presentation on prevention of child abuse and neglect and prevention of child fatality, near fatality and serious injury

Comments from Panel members on their experience at the annual retreat included:

"I loved the commitment from [DFCS] staff to working in a more collaborative environment and reaching out to the community for input."

"It was enlightening to hear our federal partner speak from the national perspective on its expectations of the child welfare agency regarding its CAPTA Panels."

"I understand our role as a CAPTA Panel and what to expect much more clearly."

During the last session of the day-long retreat, Panels met in their respective groups to identify opportunities and discuss plans for 2014. The results of these discussions are included in the summary of their activities later in this report.

On the national level, members from each of the CAPTA Panels represented Georgia at the 12th National Citizen Review Panel Conference in Jackson Hole, Wyoming. The annual 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. Presentations and breakout sessions included:

- Personal experiences of an adult former foster child
- Mandated reporting and educating the community
- Citizen empowerment
- CAPTA citizen review panels and child death review
- Lessons learned in 13 years with CAPTA citizen review panels
- Recent federal legislative and policy development

Time is set aside at the conference for updates from each state, allowing Panel members to share their successes and their challenges. These updates are often a source of inspiration and support for Panels that may be struggling with implementation and meeting their CAPTA mandate.

Georgia's CAPTA Panels will host the national citizen review panel conference in Atlanta, May 19-21, 2014. Members from all three Georgia CAPTA Panels formed a conference committee in 2013 and began planning for the national conference in earnest. The committee has developed an exciting array of plenaries, workshops and activities for conference participants. In addition to an inspirational keynote speaker, the committee has confirmed both local and nationally recognized experts in child welfare, including the state's federal partners and national resource center representatives, as speakers.

Georgia's CAPTA Panels were able to take advantage of a wide variety of webinar opportunities offered during 2013 by local and national organizations, including the federal Children's Bureau, National Resource Center for Child Protective Services (NRC-CPS), FRIENDS National Resource Center for Community Based Child Abuse Prevention, Missing and Exploited Children's Program, and Children's Healthcare of Atlanta. Of particular interest to Georgia's Panels were webinars relevant to their current work and interests, such as:

- Interviewing Children with Disabilities
- Evidence-based Practice: Resources and Strategies for [CAPTA] Citizen Review Panels
- Mandated Reporting of Child Abuse and Neglect: Looking at the Laws after Penn State
- Coordination of Child Death Reviews and [CAPTA] Citizen Review Panels
- Trauma-Informed Child Welfare
- Child Maltreatment 2011 – Key Findings
- LONGSCAN Findings that Can Change Child Welfare

Georgia's CAPTA Panels maintain a website, www.gacrp.com, to allow public access to information on CAPTA citizen review panels and the CJA task force. In addition, the website is used to post meeting schedules and inter- and intra-panel communications and as a depository for shared documents, such as policy for review and work in progress. CAPTA Panel annual reports and state responses, as well as state and national child welfare resources and links are also available on the website. It is hoped that the website will be further developed to provide an opportunity for public comment.

CAPTA Panels Working with Georgia's Child Welfare Agency

The steering committee, comprised of the co-chairs from each of Georgia's CAPTA Panels, met with the Director of the Division of Family and Children Services (DFCS) and members of the agency's leadership team three times during the year. These meetings provided an opportunity to share concerns, exchange ideas, discuss agency actions related to Panel recommendations and identify new opportunities to work together. At one meeting, concerns were voiced by the vice-chair of the CFRP regarding a preventable child death that resulted from an accidental shooting that could have been prevented with free trigger locks that are available from many participating law

enforcement agencies.[2] This prompted immediate action by the DFCS Director to notify caseworkers to encourage them to utilize this local resource on home visits with families having a gun in the home.[3]

These meetings with DFCS leadership also provided CAPTA Panels with invaluable insight into the challenges facing the agency, including budgetary constraints, staff turnover, implementation of new practices, meeting federal requirements, aging technology, and public opinion fueled by media reports, which in turn influenced the interests and advocacy efforts of the Panels.

A presentation on Georgia's new Safety Response System (SRS) was made to all CAPTA Panel members in February 2013. The SRS Project Director provided an overview of the history, design, and implementation plan for the state's differential response system, including the practice transformation from Diversion[4] to the non-investigative assessment track, Family Support. SRS is being piloted in two counties, Richmond and Sumter, and the statewide implementation plan involves a phased-in approach beginning in September 2013 with Intake, followed by Family Support and Investigation, and then Family Preservation and Foster Care. Full statewide implementation is targeted for June 2017.

In May 2013, as has been the practice for several years, the CAPTA Panels met with agency leadership to review and discuss the Panels' 2012 annual report. The agency responded to the recommendations included in the report, and Panel members had an opportunity to clarify their expectations.

During FFY2013, a new Department of Human Services Commissioner and a new director for the Division of Family and Children Services (DFCS) were appointed. As a result, there was a reorganization of many key positions in the child welfare agency. The CAPTA Panel liaison position was vacated when the Director of Strategic Planning moved out of state and resigned during the summer. This role was assumed by the new Director of the Federal Regulations, Data & Policy Unit, the state officer who is now responsible for CAPTA Panels. Additionally, during 2013 a Criminal Justice Liaison was appointed within the Collaborative Partners Unit to help facilitate communications between the CJA task force and the agency regarding funding recommendations and related activities.

Also during FFY2013, members from CPSAC and CJATF reviewed reports on quality assurance case reviews conducted by the DFCS Office of Quality Management. As Georgia's CAPTA Panels have a statewide, systemic approach to examining policy and practice, they felt these reports, conducted at the regional level on individual case records, would provide them with a valuable, frontline view of child welfare policy and practice in action. Region 4 and Region 6 reports were reviewed and summary observations provided to the Panels. A quality assurance review conducted on the intake after-hours call center pilot was also reviewed, as the Panels had been strong supporters of a centralized call center for reporting child abuse and neglect. The agency has since revisited its regional quality review process, modeled on the federal Child and Family Service Review (CFSR), and has developed a new continuous quality improvement (CQI) process based on a statewide sampling of cases. The Director of the Office of Quality Management Unit has met with CAPTA Panel members to discuss opportunities for CAPTA Panels in the new CQI process.

Two concerns identified in the quality assurance review results were:

- Lack of understanding by community stakeholders of the Safety Response System (SRS)
- Stakeholder frustration experienced by individuals related to the new centralized intake process

Collective Recommendations

1. To ensure the successful implementation of the SRS and centralized intake process, CAPTA Panels recommend the development of a comprehensive communication plan to educate partners and communities on both new practices.

2. Regarding SRS, CAPTA Panels also recommend that the agency ensure that regular

[2] Project Childsafe is sponsored by the National Shooting Sports Foundation.
[3] It has been reported that caseworkers in some counties have distributed trigger locks to families.
[4] Georgia's non-investigative response to low-risk reports was previous known as Diversion.

communications regarding this significant practice change, including the rationale for practice change, its design and implementation and its expected impact on all stakeholders are adequately conveyed to its partners and the community at large, and that regular opportunities to provide feedback be made available. Regular progress reports on the phasing in of SRS, as it rolls out, should also be made available.

3. Regarding the reporting of suspected child abuse and neglect, CAPTA Panels recommend that the DFCS website be enhanced to provide more comprehensive information on the central intake call center and reporting of suspected abuse and neglect, including, but not limited to:
    - Why the change to centralized intake
    - When to report
    - Options for making a report
    - How to be prepared when making a report
    - What to expect after a report is made

4. Recognizing that professionals who are mandated reporters are not typically using the DFCS website as a source of information related to reporting abuse and neglect, efforts should be made to communicate directly with those groups who are the most frequent mandated reporters, such as the medical profession, schools, law enforcement, child care and service providers, on changes to the report and intake process.[5] Steps should also be taken to ensure that local child abuse protocols are revised accordingly.

CAPTA Panel Collaboration

CAPTA Panels were provided an opportunity to contribute to and comment on the 2013 Annual Progress and Services Report (APSR), as they have done since the last Child and Family Service Review (CFSR). Panel members also contributed to the monitoring and quarterly reporting of the state's CAPTA Performance Improvement Plan (PIP) related to new requirements in the 2010 CAPTA reauthorization. In addition, Panel members were involved in the review and update of the state's mandated reporter training for medical professionals addressing the CAPTA requirement that states have a plan of safe care for drug-exposed infants, which was a CAPTA-PIP item. They also provided feedback on the state's comprehensive health care plan for children in foster care.

During 2013, Georgia's child welfare policy manual was updated to ensure compliance with state and federal laws and align with DFCS practice principles and SRS. CAPTA Panels were given the opportunity to review and comment on all revised policies. Specific comments were submitted directly to the DFCS Policy Unit for consideration.

Collective Recommendation

CAPTA Panel members recommend that future policy updates:

- Identify specific changes
- Explain why the change was necessary and the expected results
- Describe if and how the change was vetted with the stakeholders most impacted by the change

CAPTA Panels appreciated the opportunity to participate in the review of the updated policy manual and encourage the engagement of external stakeholders as early in the policy development or revision process as practicable. Panel members look forward to evaluating the impact of these revisions on practice and outcomes.

Georgia's CAPTA Panels on Prevention…

Georgia's CAPTA Panels are united in their continued advocacy for the collaborative development of a coordinated and comprehensive public awareness and education plan that includes effective strategies for the prevention of child abuse and neglect, injuries, and fatalities. The Panels recommend that the child welfare agency take a leadership role in bringing local, regional and statewide partners and resources together to develop and implement a statewide plan.

[5] It is important to distinguish between the previous process for calling to "report" suspected abuse and neglect and the new centralized "intake" for reports of suspected child abuse and neglect.

CJATF

Children's Justice Act Task Force

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

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.

Although the priorities of the task force are rooted in the investigation, prosecution and judicial handling of cases of child abuse and neglect, their interests span the full spectrum of family involvement in the child protection system, for all types of families and children of all ages.

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, particularly child sexual abuse and exploitation, in a manner that limits additional trauma to the child victim. This also includes the handling of child fatality cases where child abuse or neglect is suspected and cases involving children with disabilities or serious health problems who are the 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. As a CJA grant recipient, the state is required to establish and maintain a multi-disciplinary task force on children's justice. Georgia's Children's Justice Act Task Force (CJATF) was established to satisfy 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 that will improve the handling of these cases and result in reduced trauma to the child victim and victim's family while ensuring fairness to the accused.

The purpose and objectives of a CJA task force and a CAPTA 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 CJATF is required to maintain membership representing the following disciplines:

- Judges[6] and attorneys, both civil and criminal, prosecution and defense
- Law enforcement
- Child protective services
- Child advocates
- Court-appointed special advocates (CASA)
- Health and mental health professionals

[6] In Georgia, juvenile court judges may preside over both civil and criminal cases.

- Parents and parent groups
- Individuals who specialize in working with children with disabilities
- Individuals with experience in working with homeless children and youth
- Adult former victims

Beyond the required membership, the Georgia CJATF includes members with experience and expertise in child abuse prevention, education – both in law and social work – and a student studying social work. Several members satisfy multiple requirements, often providing a unique perspective to the work of the task force.

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. The 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. In 2013, a former foster youth was successfully recruited and engaged to satisfy the "adult former victim" requirement. The task force member with experience working with homeless youth and children resigned recently; however, another candidate was identified and invited to join the task force during 2014.

The task force is also interested in supplementing its membership with representation from the Department of Juvenile Justice and a training expert,[7] and continues to identify additional opportunities for parents, foster parents and youth to contribute to both the CJA and CAPTA Panel process. Another priority is the identification of a clinical specialist to fill a position recently vacated by a member with experience working with both victims of sexual abuse and youth perpetrators.

[7] Because CJA funds are primarily used to support multidisciplinary training, the task force is interested in engaging an expert in curriculum development and adult learning.

Task Force 2013 Activities & Recommendations

In 2013, the task force held six regularly-scheduled meetings, exceeding the federally-mandated quarterly meeting requirements for both a CJA task force and a CAPTA Panel. In addition to regular meetings, conference calls and special meetings were held as needed. The co-chairs consulted regularly with each other and the contracted coordinator to discuss work in progress; recent events related to task force goals, objectives and recruitment efforts; and to identify and coordinate additional resource needs.

The task force collaborates with Georgia's child welfare agency on the administration of the CJA funds, including the solicitation and review of proposals and 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 and:

- 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 expanded its priorities to include activities such as training, practice or system reform to improve the handling of cases specifically involving children with special needs. As a result, all activities supported with CJA funding are required to include a component that addresses this priority interest in victims with special needs. The task force also planned to develop specific awareness, education and training objectives to improve the handling of these cases.

Streamlining the solicitation, review, award decision and contracting process to support their annual CJA funding recommendations had been a challenge for the task force. A task force member was identified to lead the solicitation and review process for CJA proposals.

Related activities included consultation and support to facilitate the updating and distribution of the solicitation document, recruitment and management of a review panel, and preparation of summary results and proposed awards.

CJA Funding Recommendations

The task force recommended CJA awards for the following proposals that addressed CJA objectives identified in the 2012 assessment, including the task force priority on cases involving children with special needs:

- ChildFirst Multidisciplinary Forensic Interview Training (Cherokee Child Advocacy Center)
- World Day Conference (Child Advocacy Centers of Georgia)
- Annual Special Assistant Attorneys General (SAAG) Conference* (DHS/DFCS Legal Services Unit)
- Emory Summer Child Advocacy Program (Barton Child Law & Policy Center, Emory University School of Law)
- Child Abuse Protocol Review (Barton Child Law & Policy Center, Emory University School of Law)
- CASA Advocacy Training Project (Georgia CASA)
- Annual Youth Law Conference* (Georgia Association of Council for Children)
- Prosecutor, Child Abuse Protocol, and Guardian Ad Litem Training (Office of the Child Advocate)

**A task force member presented as an expert on Fetal Alcohol Spectrum Disorder (FASD) at both the Annual SAAG Conference and the Youth Law Conference.*

Each of these activities supported the CJA emphasis on multidisciplinary work and collaboration. The task force reaffirmed that these activities would remain priorities in 2014-2015.

Additional consultation with the agency's Criminal Justice Liaison, agency representatives and task force members was required to negotiate and approve final recommendations. Although the Criminal Justice Liaison has greatly helped to facilitate this solicitation, review, and award process, the task force hopes to add efficiencies to the decision-making process as an element of its next assessment, to be conducted in 2014-2015.

The Criminal Justice Liaison's responsibilities related to the commercial sexual exploitation of children (CSEC) include the development and implementation of a DFCS protocol for the handling of suspected CSEC cases. The task force received regular updates on progress to pilot the protocol, including the development of a training plan for all DFCS workers. The Criminal Justice Liaison also has consultation responsibilities with respect to child fatality, near fatality, and serious injury (CDNFSI) cases, including the investigation, assessment and prosecution of these cases. Information relevant to CJA objectives on these cases was also shared regularly with the task force.

In April 2013, the Criminal Justice Liaison and the CJA Coordinator attended the annual CJA grantee meeting in Washington, DC.[8] Presentations and breakout sessions included such topics as:

- Trauma-informed systems and practice
- Applying lessons learned from child fatality review and a preview of results from the national study
- Differential responses and what QIC-DR has learned from three demonstration sites
- Grantee reports on two state projects, Title IV-E waivers and first responder training

The annual grantee meeting also provided an opportunity for facilitated peer networking that included discussions on a variety of topics, including working with youth with disabilities, child sex-trafficking, Fetal Alcohol Spectrum Disorder (FASD,) and an open forum on the required CJA assessment.

Looking Ahead to 2014

The task force will continue its emphasis on victims with special needs and advocate for:

- Increasing awareness of the risk of abuse and neglect and fatalities for children with special needs
- Education on the unique needs of child victims who have special needs

[8] Attendance at the annual CJA grantee meeting is a requirement for all state grant recipients.

- Promoting training to improve the handling of cases involving child victims with special needs

Another activity planned for 2014 is a revision of both the CJA proposal solicitation document and performance reports for CJA grantees.

At the annual retreat, the task force initiated discussions on a focus for its next assessment in 2014. The task force will establish a committee in 2014 to identify a theme and develop and conduct the assessment. The results of this assessment will help to determine task force multidisciplinary and collaborative priorities for 2015-2017.

Children's Justice Act Task Force Members

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Executive Director
Barton Child Law and Policy Center
Emory University School of Law

Angela Tyner, JD (Co-Chair)
Director of Advocacy & Program Development
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Sandra Barrett
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Judge Bill Bartles
Henry County Juvenile Court

Lalaine A. Briones, JD
Domestic Violence, Sexual Assault, & Crimes Against Children
Prosecuting Attorneys' Council of Georgia

Lori Brown, Director of Forensic Services
Crimes Against Children Unit
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Nancy Chandler, CEO
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Nick & Susan Gage
Parents - biological, foster & adoptive

Jordan Greenbaum, MD
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Donnie Winokur
Parent (FASD)

John Tully
DHS/DFCS, Criminal Justice Liaison
System of Care Section

CPSAC

Child Protective Services Advisory Committee

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.

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.

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 CPSAC includes members from both rural and urban communities, some of whom travel several hours to attend bi-monthly meetings. Although the size of the state presents a challenge when recruiting and engaging members that represent all of its geographic areas, most regions are represented on the CPSAC. 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.

CPSAC membership was stable during 2013, although the recent resignation of a therapist specializing in children and youth has left an opening on the 16-member Panel. Recruitment efforts continue to target under-represented groups such as parents, foster parents, and relative caregivers.

CPSAC 2013 Activities & Recommendations

In 2013, the CPSAC held four regularly-scheduled meetings, meeting the federally-mandated quarterly meeting requirements for a CAPTA Panel. In addition to regular meetings, conference calls and special meetings were held as needed. The co-chairs consulted regularly with each other and the contracted coordinator to discuss work in progress; recent events related to Panel goals, objectives, and recruitment efforts; and to identify and coordinate additional resource needs.

At the beginning of the year, CPSAC members identified several issues they were interested in examining more closely. These included policy and practice issues related to relative caregiver placements, particularly those with grandparents; car seat safety and training of caseworkers, transporters and foster parents on proper installation and use; secondary post-traumatic stress; and child welfare worker morale. It is this last interest that became the primary focus of the CPSAC's efforts in 2013.

Additionally, CPSAC members reiterated their interest in continuing the examination of policy and practice related to children ages 0-5, who are at risk or victims of abuse and neglect, and their families. Revision of Georgia's child welfare policy manual in 2013 provided an opportunity for CPSAC members to comment on policies with specific references to this population. Future action by the Panel will include a closer examination to determine whether 2013 policy revisions sufficiently address their practice concerns related to families with children ages 0-5. Members concerned about trauma experienced by children who have endured abuse and neglect conducted some preliminary work on trauma assessments and they are interested in looking further at the Child and Adolescent Needs and Strengths (CANS) assessment tool[9] adapted for the birth to 4 population.

Concern expressed by one CPSAC member regarding car seat safety prompted the Panel to look into policy

[9] Versions of the CANS are currently used in 25 states in child welfare, mental health, juvenile justice, and early intervention applications.

and practice related to transporting children. Review of child welfare policy revealed training on the installation and proper use of car seats was not included in caseworker or transporter training. Review of IMPACT training for foster parents also revealed that training on proper installation and use of car seats was not included.

Recommendations

As every county has local resources[10] that provide free training on the installation and use of car seats, the CPSAC recommends that:

1) Caseworkers and transporters be required to obtain instruction on the proper installation and use of car seats
2) Foster parents also be required to obtain this training

CPSAC members have expressed their concern regarding the impact of budget cuts, changing child welfare priorities, high staff turnover and a negative public perception of the agency on caseworker job satisfaction and morale. Conversations with local and state staff supported what they already knew - caseworkers have a stressful job and work under difficult conditions, and their work is often undervalued. This reinforced the resolve of the Panel to identify opportunities to support, improve and acknowledge the important work that is done by frontline caseworkers, and try to improve public perception of their work.

During 2013, the CPSAC developed a survey to solicit feedback from the Georgia child welfare workforce on job satisfaction. The CPSAC polled other CAPTA citizen review panels through the national listserve, however, no other states reported having conducted a workforce study. Webinars offered by the National Child Welfare Workforce Institute, a 2003 Study of Personal and Organizational Factors Contributing to Employee Retention and Turnover in Child Welfare in Georgia conducted by the University of Georgia, School of Social Work, and a DHS 2010 Employee Satisfaction Survey were used as resources in the development of the Georgia survey.

The survey includes questions regarding training, professional development and career advancement opportunities; supervisory relationships and support; the workplace environment and worker safety; and resources, both services and tools, including technological supports. The survey will be conducted in 2014. A report on results will be included in the 2014 annual report.

The CPSAC agreed that it would continue to monitor implementation of the state's differential response system. The Panel has requested updates from the agency on the pilot counties and the phased statewide rollout during the year and has provided feedback. The Panel is particularly interested in the intake phase and the disposition of maltreatment reports, including screen-outs with prior history and assignment of cases to Family Support when risk is not sufficient to warrant an investigative response and services are voluntary.

Lastly, quarterly child death reports, published by the child welfare agency during 2013, were reviewed by the CPSAC. The Panel applauds the agency's move to increase transparency with respect to circumstances surrounding these cases. However, aggregate data has limited potential for providing insight into maltreatment-related child deaths, particularly those with a long case history, and also makes it difficult to differentiate those that have not had any agency involvement or prior maltreatment history.

Recommendation

It is recommended that the agency supplement these child death reports to include data on the ages of the children involved and include information on history with the child welfare agency to provide additional context for the quarterly reports.

Looking Ahead to 2014

At the annual retreat in September, the CPSAC identified several interests to pursue or follow up in 2014, in addition to continuing its work on caseworker morale, evaluating the effectiveness of SRS as the practice is phased in, and its interest in services for families with children ages 0-5. As an extension of their interest in families with young children who have experienced maltreatment, the Panel would like to explore comprehensive behavioral health or trauma assessments for children whose families are receiving

[10] To locate car seat inspection stations in Georgia visit http://www.gahighwaysafety.org/campaigns/child-safety-seat-fitting-locations/.

Family Support and Family Preservation services. The Panel will consider conducting a review of foster parent training and services for youth, including pregnant and parenting teens. The Panel will also consider additional recommendations related to caseworker training and supervision, and policy specific to the 0-5 population based on its research efforts.

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CFRP

Child Fatality Review Panel & CAPTA Maltreatment Committee

The Georgia Child Fatality Review Panel (CFRP) is a statutory body established in 1990 by the Georgia State Legislature. The CFRP was created to prevent child fatalities through the establishment of an effective review and standardized data collection system designed to:

- Improve response to child fatalities
- Improve understanding of how and why children die
- Influence legislation, policies and programs that affect the health, safety and protection of children

The CFRP mission includes providing high-quality data, training, technical assistance, investigative support services, and resources to prevent and reduce child abuse and fatalities 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 deaths
- 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

The CFRP provides direction and oversight for the local Child Fatality Review (CFR) committees. The purpose of the CFR committees is to provide a confidential forum to determine the cause and circumstances around child deaths. The work of the CFR committees is:

- To accurately identify and uniformly report the cause and manner of every child death
- To identify circumstances surrounding deaths that could prevent future deaths and initiate preventive efforts
- To promote collaboration and coordination among the participating agencies
- To propose needed changes in legislation, policies and procedures

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 as well as 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 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 issues raised by the local committees and CFRP members.

In 2010, a CAPTA Maltreatment Committee was established to address additional obligations of the CFRP as a CAPTA citizen review panel, including its CAPTA Panel obligations related to maltreatment-related deaths. The CAPTA Maltreatment Committee includes members of the CFRP as well as child welfare experts and advocates. 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.

2013 CFRP & CAPTA Maltreatment Committee Activities & Recommendations

The CFRP is statutorily required to prepare an annual report on its activities and findings. The Annual Report - Calendar Year 2012[11] is attached as *Appendix A*. The CFRP report identifies "opportunities for prevention" in all child fatalities, including those resulting from child abuse or neglect. See *Appendix A* for specific recommendations.

The CFRP meets quarterly, satisfying its CAPTA meeting requirements. The CAPTA Maltreatment Committee also meets up to four times each year.

In 2013, CFRP meetings included the review of selected child fatality case records. These reviews helped to identify report inconsistencies and incomplete or overlooked information. The primary purpose of the CFRP is to review the circumstances in all child deaths and identify opportunities for prevention. However, some reports did not indicate that the deaths were preventable when circumstances suggested that they were or that they may have been. In other reports, although a death was identified as preventable, a specific prevention action or activity was not recommended. Also, there were reports where circumstances suggested the likelihood of child welfare involvement or a history of involvement; however, pertinent information was missing, or there was no additional follow up reported. As a result, a number of maltreatment-related deaths may not have been identified as such.

Maltreatment Committee Recommendations

Enhance training for child fatality review teams to:

1) Improve identification of circumstances that indicate the preventability or possible preventability of child deaths
2) Improve identification of circumstances that suggest possible child abuse and neglect or child welfare history
3) Improve prevention recommendations, including specific actions, responsible individual or entity, time frames, accountability, and evaluation of prevention recommendation effectiveness

The CAPTA Maltreatment Committee also supports the CFRP's ongoing priority to improve the overall timeliness and quality of data collection. To this end, it recommends that CFRP be supported with sufficient resources to monitor, evaluate, and report on child deaths, including maltreatment-related deaths, to ensure that it meets its state and federal mandates.

Georgia has several mechanisms for the review of child fatalities, outlined in the table below, that are mandated by state and federal law and child welfare policy.

Convened by	Participants	Review Focus	Objective(s)
Agency Within 24 hours	Internal staffing (DFCS) May involve selected partners	Case specific Maltreatment-related child deaths, primarily with agency history	To determine what happened and the response needed
Agency 45-60 days after child death	CDNFSI Convened by DFCS Multidisciplinary (limited)	Case selection dependent on specified criteria Maltreatment-related child deaths	To review practice for strengths and areas for improvement and identify prevention opportunities
CFRP Within 30 days	Local child fatality review committees Multidisciplinary	Individual examination of the circumstances surrounding all child deaths	To determine manner and cause of death and identify prevention opportunities
CFRP 12-18 months	State Child Fatality Review Panel Multidisciplinary	Evaluation of aggregate data on all child deaths	To make statute, regulation or policy recommendations to reduce the risk of child death

Each mechanism has the potential to identify child welfare policies and state and local practices that may need to be addressed to prevent future fatalities. The only published report on child fatality reviews is based on the annual aggregate findings of reviews by the CFRP. In 83 child deaths reviewed during 2012, it was determined that an abuse or neglect incident was the direct cause or contributing factor in the child's death.[12] Of these 83 children, 60 had a reported history as a

[11] There are plans to revamp and revitalize the annual CFRP report in 2014.

[12] 2012 Georgia CFR Annual Report, January 2013 is attached as *Appendix A*.

victim of maltreatment. The CAPTA Maltreatment Committee continues to feel strongly that there is a need to improve coordination of the evaluation of the findings from these reviews, including data collected from multiple sources on children and families, to better meet the CAPTA mandate. To support the CAPTA Maltreatment Committee's ongoing priority to improve multidisciplinary participation in the review of maltreatment-related child deaths and improve system transparency, it is reiterating several previous recommendations made to the agency.

Maltreatment Committee Recommendations

- Collaboration with and engagement of external stakeholders by the child welfare agency in the CDNFSI multidisciplinary review of individual child deaths
- Reconciliation of the various data sources that document and/or report child deaths to identify collaborative opportunities to improve policy, practice or protocols
- Inter-agency sharing of data and information on children and families[13] to improve collaborative efforts in preventing maltreatment-related child deaths

Looking Ahead to 2014

Georgia's CFRP and CAPTA Maltreatment Committee remain committed to improving the evaluation of maltreatment-related child fatalities. Preliminary results reported from a national study conducted on child fatality reviews in 2012[14] suggest that maltreatment-related fatalities are underestimated, particularly those that may be attributed to neglect. A Michigan study demonstrated a correlation between child death reviews and a reduction in child deaths[15] and that child death reviews resulted in recommendations related to state law, policy and procedures that impacted CPS investigation, assessment and service provision. In 2014, the Maltreatment Committee will consider evaluating the various child fatality review processes to identify ways to coordinate results to improve transparency and system accountability and advocate for and promote effective prevention activities.

During the 2014 Georgia legislative session, the administrative responsibilities for child fatality review were relocated from the Office of the Child Advocate to the Georgia Bureau of Investigations. It is expected that this relocation will result in the identification and realignment of resources to improve coordination of investigations, training of local child fatality review committees, reporting compliance and data collection and evaluation. Members of the CFRP and the Maltreatment Committee will be included in discussions during 2014 and monitor plans to insure a seamless transition.

[13] Data sources include, but are not limited to: DFCS (SHINES), Child Fatality Review/National Child Death Review databases, Department of Public Health, and vital records – all birth and violent death records.

[14] D. Kelly, L. Oppenheimer, Y. Yuan, "Applying Lessons Learned from Child Fatality Reviews to Preventing Fatalities and Near Fatalities", Annual CJA Grantee meeting, April 2013

[15] Palusci, V.J., et al. Effects of a Citizen Review Panel in preventing child maltreatment fatalities. Child Abuse & Neglect (2010), doi:10.1016/j.chiabu.2009.09.018

Child Fatality Review Panel Members

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J. David Miller (Vice Chair)
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Paul Battles
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This report was prepared in consultation with and on behalf of Georgia's CAPTA Panels by

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Appendix A

GEORGIA CHILD FATALITY REVIEW PANEL

Annual Report - Calendar Year 2012

Tain Kell
Panel Chairman

Nathan Deal
Governor

JANUARY 2014

THE CHILD FATALITY REVIEW PANEL MEMBERS

C. LaTain Kell, Panel Chairman – Judge, Cobb County Superior Court

J. David Miller, Panel Vice-Chair – District Attorney, Southern Circuit

Rep. Paul Battles – Georgia House of Representatives

Kathleen Bennett - Central Savannah River Area Economic Opportunity Authority Head Start Program

Dr. Frank Berry – Commissioner, Department of Behavioral Health and Developmental Disabilities

Sen. Gloria Butler – Georgia State Senate

Dr. Brenda Fitzgerald – Commissioner, Department of Public Health

Robertiena Fletcher – Board Chairperson, Department of Human Services

Charles Fuller – Chairperson, Criminal Justice Coordinating Council

Sharon Hill – Director, Division of Family and Children Services

Vernon Keenan – Director, Georgia Bureau of Investigation

Beverly Losman – Director, Safe Kids Georgia

E.K. May – Coroner, Washington County

Paula Sparks – Cobb County Police Department

Dr. Kris Sperry, Chief Medical Examiner, Georgia Bureau of Investigation

Peggy Walker – Judge, Douglas County Juvenile Court

Vacant – Office of the Child Advocate

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 T. Carter, Ph.D., M.P.H., Epidemiology Department, Rollins School of Public Health, Emory University
- Ibaad Jiwani, M.P.H., Injury Prevention Program, Georgia Department of Public Health;
- All the public and private entities dedicated to the safety and well-being of children.

We would also like to thank the 2012 Child Fatality Review Committee of the Year, the 2012 CFR Coroner of the Year, and the 2012 CFR Prevention Committee of the Year for their support and dedication to the children of Georgia:

- CFR Coroner of the Year: Dr. Carol Terry, Gwinnett County
- CFR Committee of the Year: Floyd County
- CFR Prevention Committee of the Year: Cherokee County

This report was developed and written by the Child Fatality Review Division staff members of the Office of the Child Advocate: Arleymah Gray, Malaika Shakir, and Crystal Dixon

LETTER FROM THE CFR PANEL CHAIR

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 2012 Annual Report. This report summarizes the analyses of child deaths occurring in Georgia conducted by the Panel during 2012.

As you can see from the report, the comprehensive data gathered from local review panels in each of the 159 counties in Georgia is utilized to identify trends and focus resources toward prevention of child deaths. Despite some challenges this year, the Office of the Child Advocate and its talented staff has assisted in the compilation of data that fulfill the statutory mandates of the Panel.

This year, trends identified in the available data as continuing areas of emphasis for the Panel include: 1) sleep-related infant deaths, 2) motor vehicle related deaths, 3) homicides and suicides and 4) drownings. Other areas warranting further analysis also include demographic/ racial disproportionality in reviewed deaths, deaths with some prior state or local agency involvement and deaths in which prior maltreatment has been identified. Special emphasis will be devoted to these areas in the coming year.

The Panel continues to refine the scope of data gathered from agencies and local panels in an effort to develop prevention programs, legislation and other recommendations for action. We are also hopeful that you will support the recommendation that funding be appropriated for a study of data collected over the past four years as the Panel believes such a study would prove invaluable to the mission of this body and the State of Georgia.

As one of Georgia's three Citizen Review Panels, mandated by the federal Child Abuse Prevention and Treatment Act (CAPTA), the Panel has made annual recommendations concerning the critical need for better integration of State agency databases. The Governor, Legislature and Panel would be better served if those data bases were integrated, allowing for more complete data for use in analysis, and resulting in more effective recommendations for laws and policies to reduce the serious injuries and deaths of the State's children. Additionally, the Panel has recommended that there be a truly diverse, multidisciplinary review of child deaths/near fatalities/serious injuries of children served by DFACS, whether those children are in the custody of the State, or whether they have merely been receiving services from State agencies.

We appreciate your review of this report and your interest in these essential matters. As always, we ask for your continued support in all areas outlined in this report. The Panel and I look forward to working with you toward our common goal of preventing and reducing child fatalities in Georgia.

Sincerely,

Judge Tain Kell, Chair

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EXECUTIVE SUMMARY

The Child Fatality Review program in Georgia has historically been one of the most comprehensive and well-executed CFR programs in the United States. We have statutory requirements for agencies to share information and for exercising subpoena power when necessary, mandatory agency participation in each county, and a stated HIPAA Privacy Rule exemption from the state Attorney General, which allows for access to a child's medical records when needed for the review process. Our legislation requires child deaths to be reviewed and fully reported by each county committee within three months of the death, which is an important time frame when designing awareness and prevention programs, so our partners can use the momentum from the tragic event to effect change in the community. Many other state CFR programs do not have such comprehensive and detailed requirements, dedicated state funding, or legislative support for such a critical public health surveillance function. There are many benefits to the child fatality review process, including: putting a real time, urgent focus on children; creating a comprehensive portrait of every child; promoting professional interweaving from different systems; building relationships and trust among agencies to drive systems quality improvements; allowing a more rapid identification of and response to every death; drawing bold lines from qualitative and quantitative data to prevention; fostering community response to real community problems; and creating opportunities for professional debriefing.

CFR is often the most complete source for information concerning a child death, more so than any individual state agency, because there are multiple agencies and organizations who are involved. They collaborate to report the circumstances of the event, as well as any precipitating events that may have contributed to the death. This information can be used for trend analysis and prevention recommendations, and creates opportunities to protect other children, today and into the future. In recent years, the CFR program has weathered many challenges, and we are committed to re-energizing our program in order to remain a viable and necessary part of the child safety community in Georgia. One focus of our efforts will be on improving local team reviews – providing more and better trainings, more direct support, and the investigation tools to aid them in doing their work most effectively.

Quality scene investigation is the first tool that CFR uses, and we build our data on investigative findings. We will ensure that Georgia's CFR program provides quality data, verifying the data completeness, accuracy, and integrity at every stage in order to support prevention and the work of our partners. We will encourage the local review teams to maintain an open and honest forum for their meetings, because the review process is not to assign blame but to identify opportunities for prevention. We will work with our partners, collaborating at all stages so that our efforts support each other. We all have the goal to protect children, and we are most effective when we work as a team, encouraging each other, sharing our ideas and resources, and promoting creativity and efficiency at every stage.

ALL REVIEWED

When we think of children, we think of first birthdays, training wheels, spelling bees, dance recitals, and graduations. We don't think about the fact that children die every day and that far too often these deaths could possibly have been prevented. When a child dies, we have an obligation to ask ourselves, was there something that we---as caregivers, as a community, and as a society-- could have done to prevent this tragic occurrence? Did we fail this child in some way? Child Fatality Review helps us answer these tough questions by determining how and why a child died. The answers aid us in developing and implementing effective strategies aimed at saving young lives. This information can serve as a tool for revitalizing our families and communities by ensuring that we learn from these deaths. Until we know how and why a child's death occurred, we cannot effectively prevent future deaths and promote a safe community where our children can grow and thrive. Collectively, we can work together toward enhancing the overall health and safety of our children.

All 159 Georgia counties convene a Child Fatality Review (CFR) Committee which is comprised of local professionals from multiple disciplines. These committees examine the critical aspects of child deaths deemed reviewable by CFR criteria. A death is eligible for review when the child is under age 18, and the death is sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances. Death notifications are obtained from a variety of sources to include coroner/medical examiner reports, death certificates from Vital Records (VR), and death investigation reports from the Georgia Bureau of Investigation (GBI) and Department of Family and Children Services (DFCS). Typically, CFR data are linked with Vital Records data to ensure a comprehensive and accurate depiction of all child deaths in the state of Georgia. However, a complete 2012 Vital Records data file was not available in time for completion of this report. The data included in this report are solely based on deaths reviewed and reported by CFR committees.

In 2012, a total of 516 child deaths were deemed reviewable by preliminary death certificate data. Ninety percent of these deaths were reviewed (464) by local CFR committees. CFR committees are encouraged to consider all documents and reports generated from a child's death, but due to the nature of the review process – using a multidisciplinary forum to determine how and why the child died – there may be instances where the death certificate cause/manner and the CFR-determined cause/manner may not agree. CFR committees are empowered to use their professional expertise and judgment to make those determinations, and are not required to simply re-state the information found in other data sources.

Figure 1: Demographics of All Reviewed Deaths, GA, 2012 (N=464)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	36	16	6	14	32	104
White Female	37	13	6	11	19	86
African-American Male	63	21	18	12	23	137
African-American Female	35	22	8	7	11	83
Hispanic Male	4	8	2	4	5	23
Hispanic Female	6	2	5		2	15
Multi-race Male	4	1		1		6
Multi-race Female				1		1
Other Race Male	3	1			2	6
Other Race Female	2			1		3
Total	190	84	45	51	94	464

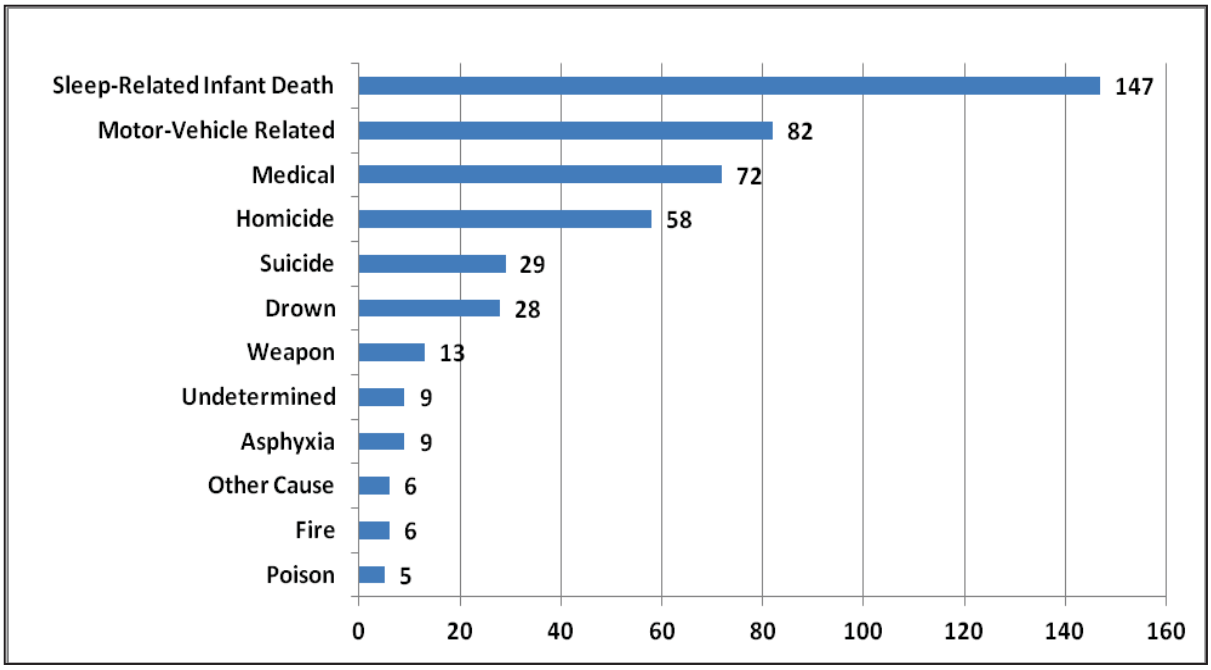
Infants accounted for 41% of all reviewed deaths

African-American children accounted for almost half (48%) of all reviewed deaths

Male children were 59% of reviewed deaths, and females were 41%

Infants, African-Americans, and males are disproportionately represented in the reviewed deaths. Prevention efforts should make special considerations to address these at-risk groups with targeted strategies tailored to their needs

Figure 2: Causes of Reviewed Deaths, GA, 2012 (N=464)



Sleep-related infant deaths (147) accounted for 32% of all reviewed deaths; this category is comprised of 96 sudden unexpected infant (SUID) deaths, six sudden infant death syndrome (SIDS) deaths, 37 sleep-related infant asphyxia deaths, and eight medical deaths with prominent sleep environment risk factors (*see the Sleep-Related Infant Death section for more information*)

"Other Cause" represents one dog bite death, three fall/crush deaths, and two Sudden Unexplained Death in Childhood cases (SUDC – which can resemble SIDS or SUID in circumstances, except that the child is over the age of one)

RACIAL DISPARITIES IN REVIEWED DEATHS

According to the United States Census, the demographic representation of Georgians in 2012 was 63% White, 31% African-American, nine percent Hispanic, and three percent Asian. However, the racial makeup of reviewed child fatalities in 2012 did not reflect that of the general population. African-American children were disproportionately represented in the reviewed deaths (48%), while proportionally fewer child deaths occurred among Whites (41%) and Hispanics (8%), relative to their percentage within the state's population.

According to the GA Department of Public Health, Online Analytical Statistical Information System (OASIS), the death rate for African-American infants due to sleep-related circumstances in Georgia has been 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.

There are no clear reasons why certain populations bear a disproportionate burden of injury or death, but many state and local agencies are working to identify causes of health inequity and how they can be addressed. National research data show that racial and ethnic minorities often receive poorer quality of care compared to Whites, and face more barriers in seeking care – including preventive care, acute treatment, or chronic disease management. Racial and ethnic minorities are also more likely to report poorer quality patient-provider interactions, particularly among those with limited English proficiency.

While the number of deaths among African-American children is disproportionate to the number of African-American children in the general population, without further context, the analysis could imply to a layperson that race is a causal factor when, in fact, it is not. Racial disparities could be an indicator for educational disparities, socioeconomic disparities, or differences in cultural practices; in other words, child deaths could be more common among African-American children simply because a disproportionate number of African-American families live below the poverty level. Poverty is correlated with poor prenatal and postnatal care, drug and alcohol abuse, lack of parenting skills, and other risk factors.

Unfortunately, CFR data on parental education, parental income or other socio-economic status markers are often missing or unknown by the local CFR committees, so that we cannot report on the many areas where disparities may exist. It is certainly possible when the effects of income and socio-economic status are controlled for in analysis, race may have little impact on the rate of childhood morbidity. For prevention efforts to be successful, providers, policymakers, and practitioners 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.

PREVENTION

In addition to conducting a thorough review of each death, Child Fatality Review committees are also asked to determine if the death was preventable. CFR committees determine preventability through a retrospective analysis of factors. **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: Determination of Preventability, GA, 2012 (N=464)

	Missing	No, probably not	Yes, probably	Team could not determine	Percent Preventable *
All Unintentional	3	10	131	5	92.9
Homicide	3	2	50	3	96.2
Suicide	1	8	16	4	66.7
SIDS/SUID	5	20	91	31	82.0
Medical	2	51	7	12	12.1
Sudden Unexplained Death in Childhood (SUDC)			1	1	N/A
Undetermined	1	1	3	2	N/A
All Reviewed Deaths	15	92	299	58	76.5
**% Preventable* calculated excluding "missing/blank" and "team could not determine"*					

Committees determined that 299 of the 464 reviewed deaths could have been prevented. Based on the retrospective review process, if the committees believe that the death could have been prevented, they are also asked to make prevention recommendations that might prevent 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 are asked to make recommendations that impact **environment** (e.g. consumer products or public spaces), **law or policy** (e.g. enforcing or amending laws and ordinances), **agency** (e.g. creating new programs, polices, or services), or **education** (e.g. media campaigns, school programs, or provider education).

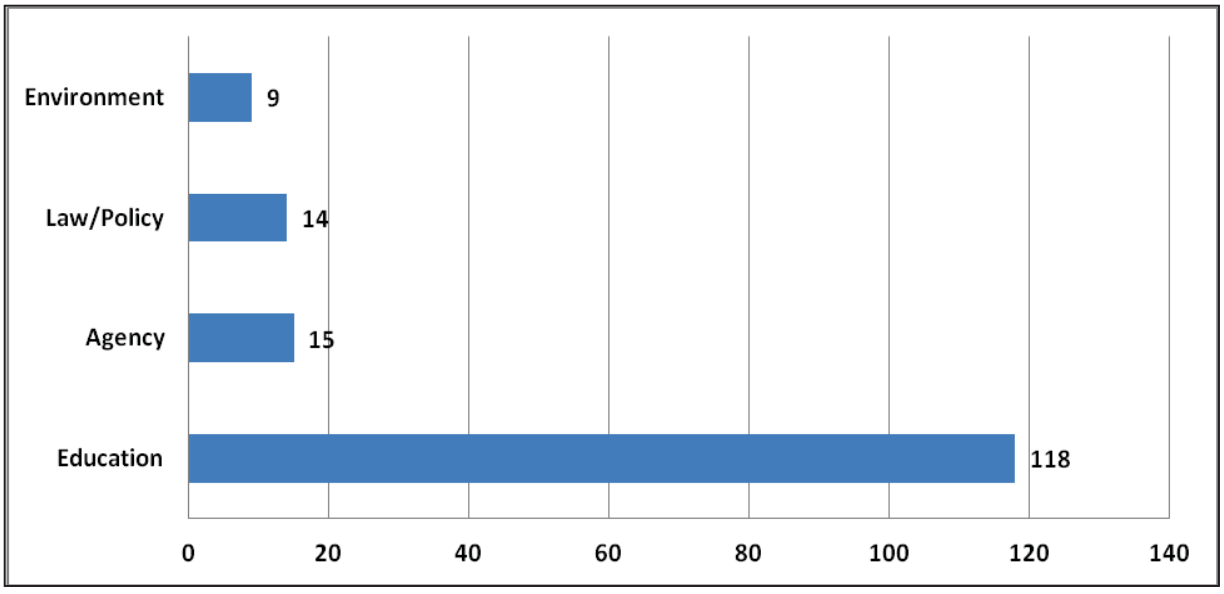
111 deaths were determined to be preventable, and the committee made at least one prevention recommendation (several case reports listed multiple recommendations)

There were an additional 18 deaths where the committee could not determine if the death was preventable (n=14), they found it "not preventable" (n=3), or they did not answer the question (n=1), but they made a recommendation for prevention anyway

There were 188 deaths that were determined to be preventable, but the committee did not make any recommendation for prevention

Committees are also asked to document any current prevention efforts that may address the risk factors identified in the reviewed death, and to classify its current stage of action (e.g. recommendation, planning, or implementation).

Figure 4: Prevention Recommendations Identified by CFR Committees, 2012 (N=156)



Opportunity for Prevention:

There has been a noticeable decline in recent years in prevention recommendations made by local CFR committees. A more focused effort must be made to educate and encourage committee members and chairpersons to engage in the prevention discussion during review meetings, and to document their ideas for prevention that result from those discussions. This may be accomplished through more frequent training opportunities and more comprehensive outreach to committees across the state. It is also important to ensure that all CFR committees are knowledgeable about the prevention resources available at the state and local level that may be able to assist in the planning and implementation of an idea.

PREVENTION PLANNING

Prevention of child deaths remains the primary goal of child fatality review in Georgia. Prevention relies on a broad and inclusive population-based approach, focusing efforts upstream to change the agent and the environment, and creating a user-friendly, easily understood system of policies, programs, and tools that makes it easier to live safely and without injury or death. All members of a society – in every age and income group – can contribute to prevention by promoting protective factors (i.e. strengths, resources, and skills) and reducing risk factors (i.e. barriers, stressors, and dangerous or negligent behaviors).

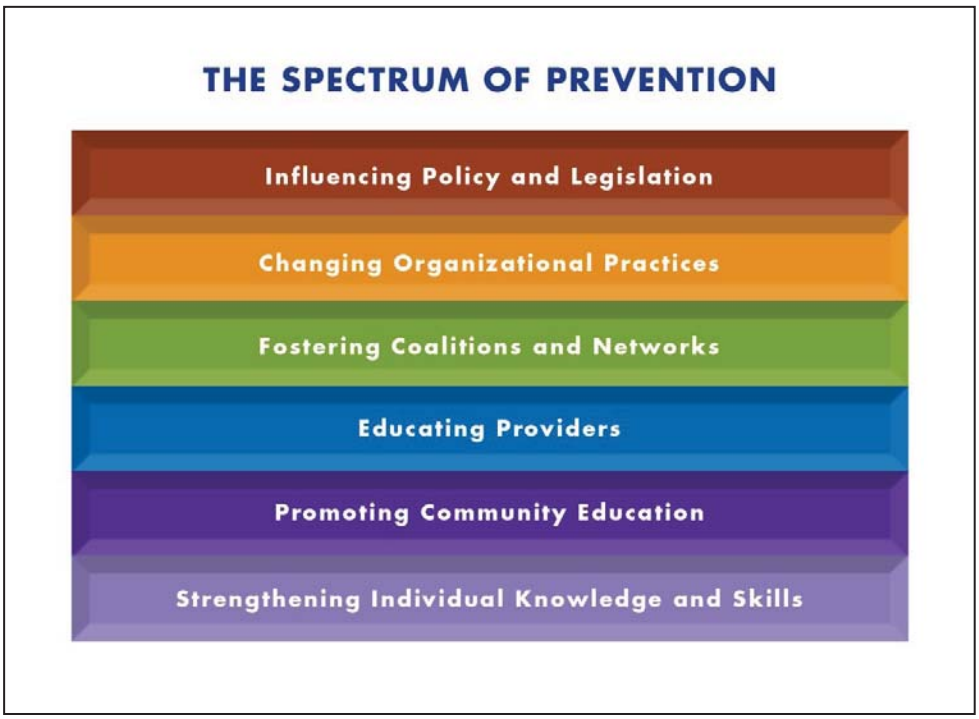
CFR is a great opportunity to mobilize people from across communities. **Committee members who might not traditionally think of themselves as prevention agents actually have a lot to contribute to the design of prevention programs**. For example, law enforcement officers know the causes of motor vehicle crashes, and have ideas on how to avoid them. Prosecutors and social workers have insights into the contributing causes of child abuse and neglect, and have ideas on how to reduce those incidents. Coroners and medical examiners know the general history of the youth who die from suicide, and have ideas on how to prevent future teen suicides. Public health nurses, midwives/doulas, and home visitors have ideas on improving infant safe sleeping habits among families without compromising bonding or breastfeeding practices. Pediatricians, trauma surgeons, and emergency personnel can be recruited to deliver compelling, evidence-based messaging to caregivers and media. These professionals have knowledge and experience, as well as respect and standing in the community, which can increase the chances of a successful prevention initiative.

Identify Modifiable Risk Factors

Extrinsic or Modifiable (*actions or behaviors that can be changed*)	**Intrinsic or Non-modifiable (*characteristics that cannot be changed*)**	**Possibly Modifiable (*situations that may be extremely difficult to change*)**
Actively supervising a child playing near a pool or street	Race and ethnicity	Domestic violence situation
Ability to swim	Age	Poor stress management and coping skills
Ability to access firearms	Sex	Bullying
Position and/or location of a sleeping baby	Number of children	Smoking/tobacco exposure
Wearing a seatbelt in a car	Special-needs child	Income/financial limitations
Wearing a helmet on a bike or motorcycle	Weather conditions	Marital status of a parent or caregiver
Walking on a highway in the dark	Mental illness or chronic health condition of a parent/caregiver or child	Social support system of parent/caregiver

Reviewing the circumstances of each death helps committees focus on the specific factors that caused the death or made the child more susceptible to harm. Once the committee has identified these factors, the committee should decide which factors they believe they can modify or impact. Not all risk factors are easy to impact; some may require long term, systemic change. Thus, the prevention of risk may be simple or it may be complicated and long term.

Once individuals understand the risk factors for their community, they can bring together other interested individuals (i.e. "Stakeholders") and develop an **action plan for prevention**, using the Spectrum of Prevention model (http://www.preventioninstitute.org/component/jlibrary/article/id-105/127.html).



Collect multiple sources of information to know where and how often the types of deaths and related injuries occur. In addition to CFR data, you can obtain morbidity data (www.oasis.state.ga.us) to understand the full extent of the problem. For example, you may have reviewed one suicide, but further analysis of the number of teens who seek services at your local hospital emergency room for suicide attempts will help you to understand the full extent of the risks. For most mechanisms of injury , there are more injuries than deaths, and once you know how many children are injured by a particular cause (and how and why), you can develop better prevention strategies.

Review publicly available data on cost outcomes for interventions. There are a large number of prevention-intervention programs that are proven cost-effective, in that the cost involved to implement the effort is much less than the costs associated with the injury (and subsequent re-injuries, rehabilitation, or lifetime disability). The Children's Safety Network (www.childrenssafetynetwork.org) publishes a summary of costs for various prevention programs, from youth substance abuse and crime to motor vehicle-related issues. These cost data can be instrumental in persuading your elected officials to adopt effective and cost-beneficial prevention programs.

Reach out to local advocates to support your efforts and provide resources. 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. We encourage all parents, caregivers, providers, practitioners, and policymakers to utilize these and other resources and incorporate prevention as often as possible.

Georgia's Framework for Childhood Injury Prevention Planning (www.oca.georgia.gov)

Safe Kids Georgia (www.safekids.org)

Prevent Child Abuse Georgia (www.preventchildabusega.org)

Children's Healthcare of Atlanta, Stephanie V. Blank Center for Safe and Healthy Children (www.choa.org/childrens-hospital-services/child-protection-center)

Georgia DPH Injury Prevention Program (www.health.state.ga.us)

Georgia Governor's Office of Highway Safety (www.gahighwaysafety.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)

REVIEWED DEATHS WITH AGENCY INVOLVEMENT

Per O.C.G.A. § 19-15-4(i) , it is required that the CFR Panel submit an annual report regarding the prevalence and circumstances of child fatalities in the state, recommend measures to reduce such fatalities caused by other than natural causes, and address the following issues: whether the deaths could have been prevented; whether the children were known to any state or local agency; the actions, if any, taken by any state or local agency or court; whether agency or court intervention could have prevented their deaths; whether policy, procedural, regulatory, or statutory changes are called for as a result of these findings; and whether any referral should have been made to a law enforcement agency which was not made.

In 2012, CFR committees reported that 194 of the 464 total deaths reviewed (42%) had some evidence of prior agency involvement. Involvement is defined as the provision of some form of service to the deceased child or the child's family. The agencies that had involvement in these cases include but are not limited to public health, 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.

There were 128 decedents where the child's caregiver(s) had received some type of social service assistance in the past 12 months, such as WIC, TANF, Medicaid, or food stamps

There were 48 decedents with a reported disability or chronic illness; of those 48 decedents, 15 were receiving services through Children with Special Health Care Needs at the time of their death (31%)

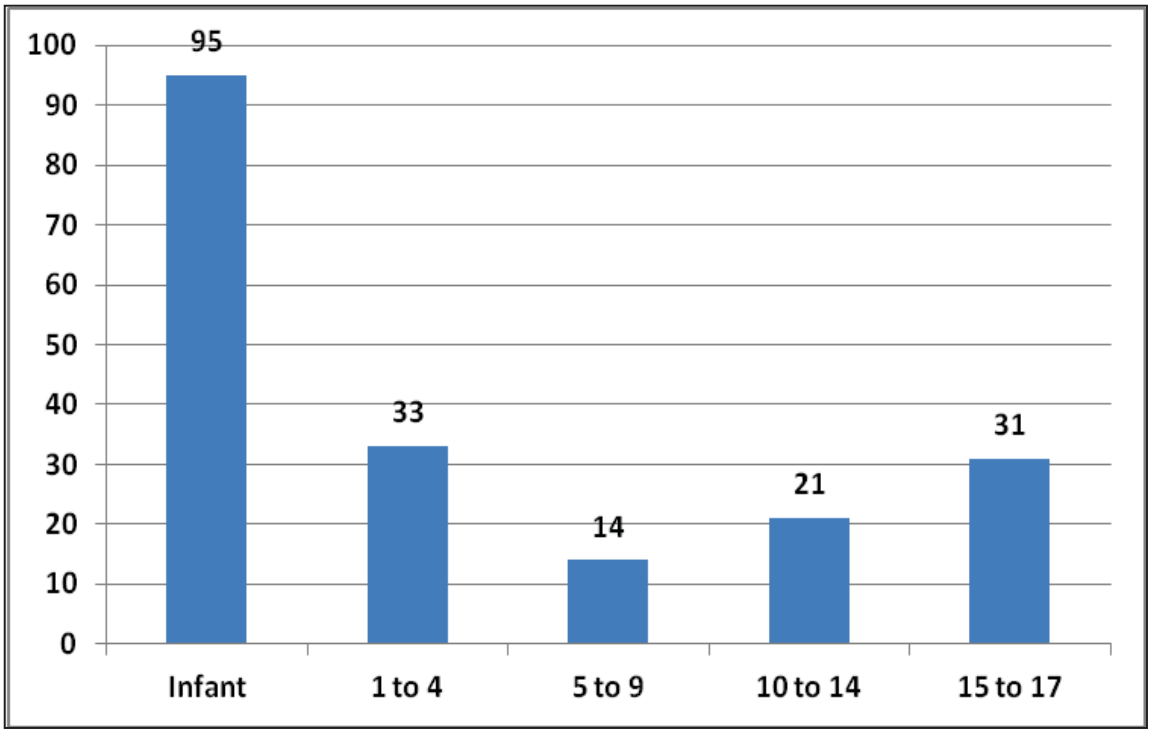
There were 24 decedents who had received mental health services prior to their death; there were 12 decedents who were receiving mental health services at the time of their death

There were 48 decedents with a reported history of child maltreatment. Of those 48 decedents, 37 were identified through CPS records (77%), and the remaining cases of maltreatment were identified through other sources (e.g. autopsy, x-rays, or law enforcement records)

There were 35 decedents that had an open CPS case at the time of death; 15 of those had reported maltreatment history (43%) from either physical, sexual, or emotional abuse, or neglect

There were 20 decedents who had reported delinquent or criminal history, due to assaults, robbery, drugs, or other charges; in eight cases, the child had spent some time in juvenile detention

Figure 5: Age by Cause of Death for Decedents with Prior Agency Involvement, GA, 2012 (N=194)



The demographics of these deaths, where agency involvement was indicated, show that almost half (49%) were infants younger than 12 months of age

Of the 35 decedents with an open CPS case at the time of death, 25 were African-American (71%), and of the 20 decedents where prior criminal history was noted, 12 were African-American (60%)

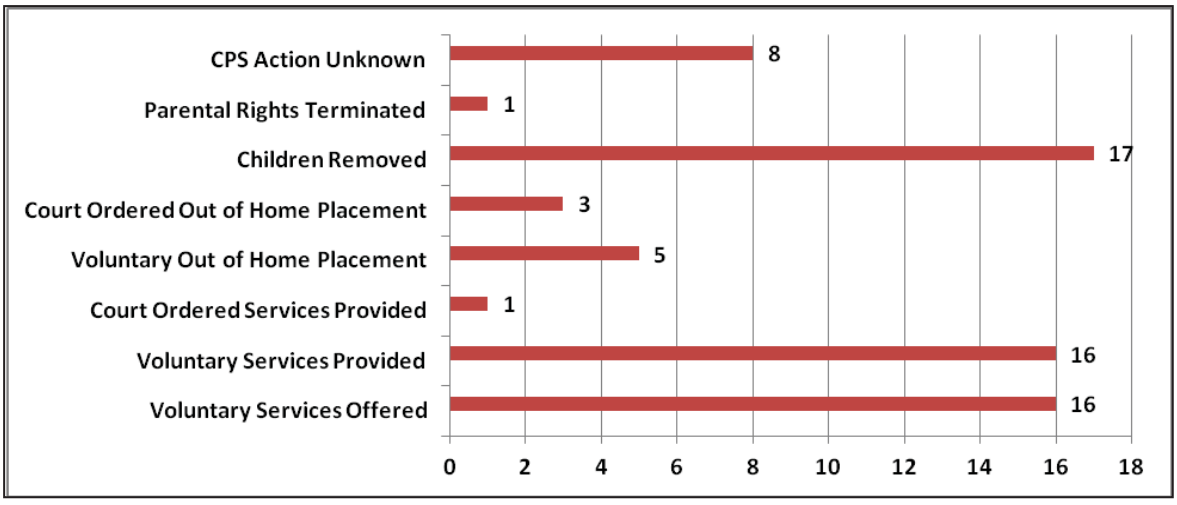
Infants and African-Americans are disproportionately represented among those decedents where agency history was reported

Figure 6: Number of Deaths with Prior Agency Involvement by Cause, GA, 2012 (N=194)

		All Reviewed	Percent
Unintentional	44	147	29.9
Sleep-Related	74	147	50.3
Suicide	13	29	44.8
Homicide	31	58	53.4
Medical	27	72	37.5
Undetermined	5	11	45.5
Total	194	464	41.8

The CFR reporting form asks local review committees to report if any CPS action was taken as a result of the death. Thirteen cases did not have any specific action identified, and an additional eight reported that the committees did not know what action was taken. In 69 cases, there was CPS action reported as a result of the death. Of those 69 cases, two were reported screened out, five were found inconclusive, 11 were unsubstantiated, 40 were substantiated, and there were 11 cases where the committee reported that CPS action was taken, but the specific action was left blank.

Figure 7: Services as a Result of CPS Action, GA, 2012 (N=67)



Opportunities for Prevention:

Of the 194 decedents with prior agency involvement, 75 were due to sleep-related causes (39%). This represents an opportunity for state agencies to address infant sleep safety with every client and family, and highlights the need for a consistent and continuous message about sleep safety with every caregiver (*see the Sleep-Related Deaths section of this report for specific sleep safety recommendations*)

There were 44 deaths (23%) due to intentional injury (homicide and suicide). Agencies need to also routinely engage clients and families in discussions to identify strategies for coping with hardships, and to identify alternatives to violence (*see the Intentional Injury Deaths section of this report for specific injury prevention recommendations*)

Thirty-four of the 69 cases where CPS action was taken as a result of the death were determined to be preventable (49%). CFR committees need to share their prevention recommendations with agency leadership in their communities, so that agencies can respond to these child deaths with targeted prevention programs and policies (*see the Preventability section of this report for specific prevention planning recommendations*)

REVIEWED MALTREATMENT-RELATED DEATHS

The Child Abuse Prevention and Treatment Act (CAPTA) is the key Federal legislation addressing child abuse and neglect. CAPTA was originally enacted in P.L. 93-247 and was most recently amended and reauthorized in December 2010. CAPTA provides Federal funding to States in support of prevention, assessment, investigation, prosecution, and treatment activities and also provides grants to public agencies and nonprofit organizations. In the reauthorization of CAPTA, Congress requires states to establish at least three designated panels: Child Protective Services Advisory Committee (CPSAC); Children's Justice Act Advisory Committee (CJAAC); and Child Fatality Review Panel (CFRP) and mandates that at least one of them review child maltreatment deaths and near deaths. Individual priorities and activities reflect their unique perspective and interest in the child welfare system. Collectively, they share a common goal: the safety, permanency and well-being of Georgia's most valuable, and vulnerable, resource – children.

The Child Fatality Review reporting form captures child maltreatment deaths through several variables. First, the local review committee identifies that the death was directly caused by an act of abuse or neglect, or that abuse/neglect directly contributed to the death. Second, there is a noted history of abuse, if the child was ever a victim of maltreatment or the forensic investigation found evidence of abuse. Third, if the child's caregiver has a history of perpetrating maltreatment. Of the 464 total deaths reviewed, there were 83 deaths with confirmed maltreatment.

In 60 of the 83 maltreatment deaths, the decedent had a reported history as a victim of maltreatment

In 37 of the 83 maltreatment deaths, it was determined that the abuse or neglect incident was the direct cause or contributing factor in the child's death

For 14 decedents, both "reported maltreatment history" and "abuse/neglect as cause" were identified

Figure 8: Demographics for Decedents with Maltreatment, 2012 (N=83)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	6	4	1	3	4	18
White Female	7	4	2	2	3	18
African-American Male	15	6	2	3	3	29
African-American Female		6	3	2	2	13
Other Male (including Hispanic)	2	1	1	1		5

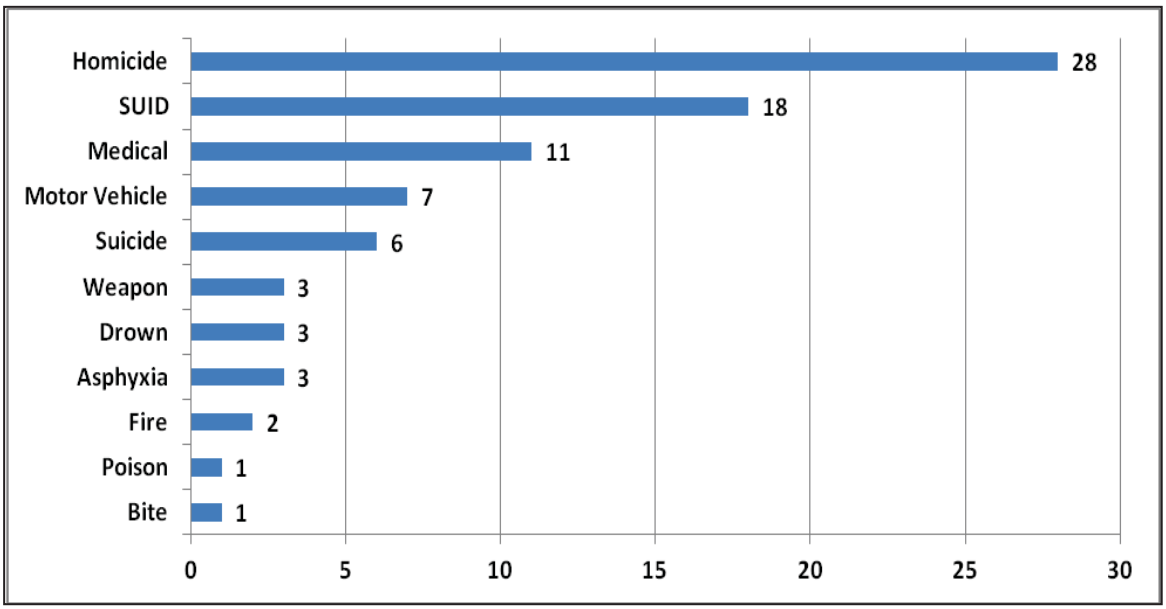
The demographics of these deaths, where maltreatment was indicated, show that slightly more than one-third (36%) were infants younger than 12 months, and 25% were toddlers younger than five years

Half of the deaths occurred among African-Americans (51%), while 43% occurred among non -Hispanic Whites

Infants and African-Americans are disproportionately represented among those decedents where maltreatment was the direct cause or contributing factor in the death

CFR committees are also encouraged to consider other acts that may have been a factor in the death, including poor supervision, other negligence, religious/cultural practices, and medical misadventure. These acts are named in a category of "omission/commission". Reviewing the data from these variables, there were 253 cases (55%) that indicated some act of omission or commission either caused or contributed to the death; of those 253 cases, there were 118 where the act was a direct cause, and for 149, the act was a contributing factor in the death (in 14 cases, the committee reported the act both caused and contributed to the child's death). "Poor/absent supervision" was reported as causing seven deaths and contributing to an additional 60; "Other negligence" caused 16 deaths and contributed to an additional 19 deaths.

Figure 9: Cause of Death for Decedents with Maltreatment, 2012 (N=83)



Of the 83 cases where maltreatment was determined to have directly caused or contributed to the death, 28 were homicide deaths (34%). Sleep-related risk factors (SUID) accounted for 22% of the maltreatment deaths. Unintentional injuries accounted for 24% of the maltreatment-related deaths.

Fifty-nine maltreatment-related deaths were determined to be preventable (71%), but only 19 had a prevention recommendation (*see the Preventability section of this report for specific prevention planning recommendations*)

Resources:

Children's Healthcare of Atlanta, Child Protection Center (www.choa.org/childrens-hospital-services/child-protection-center)

Prevent Child Abuse Georgia (www.preventchildabusega.org)

REVIEWED SLEEP-RELATED INFANT DEATHS

A sudden infant death is a tragic event, especially when the cause of death is not known or understood. There are multiple state and national organizations that are working diligently to find out why these sudden sleep-related deaths happen, and how to best prevent them. These organizations and agencies believe that success in saving infants' lives will be enhanced through strategic partnerships, collaboration and coalition-building. Georgia's First Lady, and her Executive Children's Cabinet, are also working collaboratively to ensure that all state agencies are communicating the message of infant safe sleep.

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 **Sleep-related Asphyxia** when there is forensic evidence of suffocation, wedging, positional asphyxia, or overlay during sleep. The **Sudden Unexplained Infant Death (SUID)** cases are those when the cause of death is truly undetermined, because 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). **Sleep-related Medical deaths** are those when an infant has a serious medical condition, but was also placed in an unsafe sleep environment, which exacerbated the medical issues and led to the death (these deaths are also reported in the Medical section of this report, in order to highlight opportunities for prevention among children with serious medical concerns).

CFR committees reviewed 147 sleep-related infant deaths in 2012

Of those, 48% were African-Americans, and 42% were non-Hispanic Whites; African-American infants continue to be disproportionately affected by sleep-related deaths

Twenty-five sleep-related infant deaths occurred among infants with a disability or chronic illness (17%); six of those 25 also had evidence of maltreatment

Figure 10: Demographics of Reviewed Sleep-Related Infant Deaths, GA, 2012 (N=147)

	SIDS		Sleep-Related Asphyxia		Sleep-Related Medical		SUID (Undetermined)		Total	
	Count	Per-cent	Count	Per-cent	Count	Per-cent	Count	Percent	Count	Per-cent
White Male	1		10	27.0			21	21.9	32	21.8
White Female	2		5	13.5	3		20	20.8	30	20.4
African-American Male	2		14	37.8	1		31	32.3	48	32.7
African-American Female	1		4	10.8	3		15	15.6	23	15.6
Hispanic Male			1	2.7			1	1.0	2	1.4
Hispanic Female			2	5.4			3	3.1	5	3.4
Multiracial Male							3	3.1	3	2.0
Other Male							1	1.0	1	0.7
Other Female					1		1	1.0	2	1.4
Unknown Male			1	2.7					1	0.7
Total	6		37		8		96		147	

The National Institutes of Health "Safe to Sleep" public education campaign (http://www.nichd.nih.gov/sts/) highlights the best practice recommendations developed by the American Academy of Pediatrics (AAP) in November 2011. The most critical recommendations to reduce the risk of sleep-related infant death are:

Always place **baby on back** for every sleep time

Use a **firm sleep surface** covered with fitted sheet

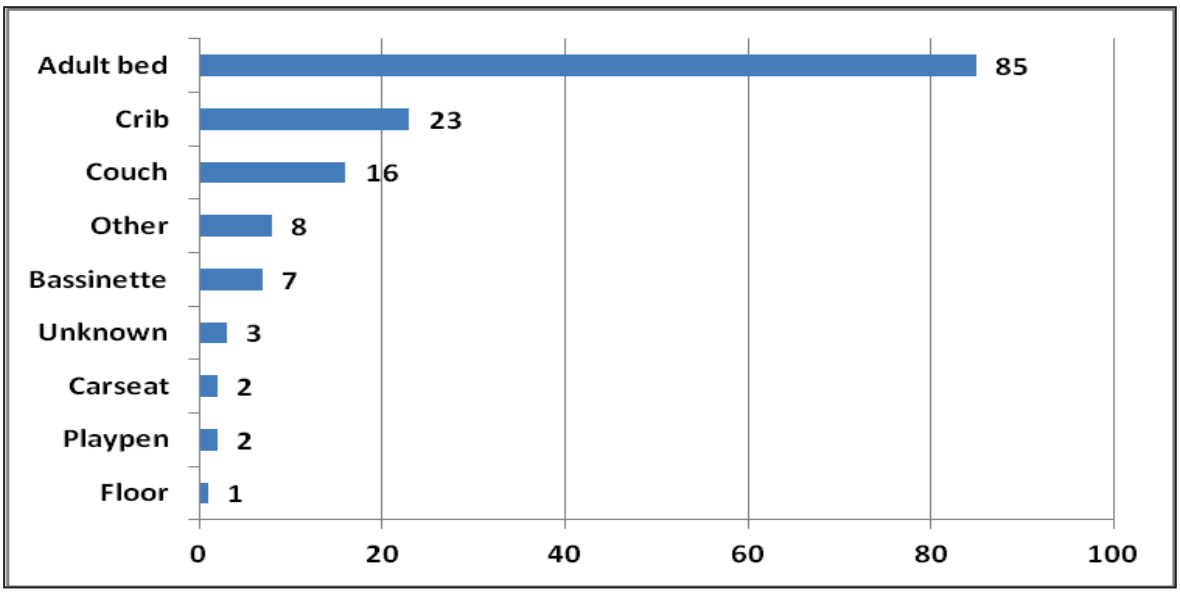
Room sharing without bed sharing

Keep soft objects and loose bedding out of baby's sleep area, including bumpers

Maintain a smoke-free environment for infants

Pregnant women should receive regular prenatal care

Figure 11: Sleep-Related Infant Deaths by Location at Time of Death, GA, 2012 (N=147)

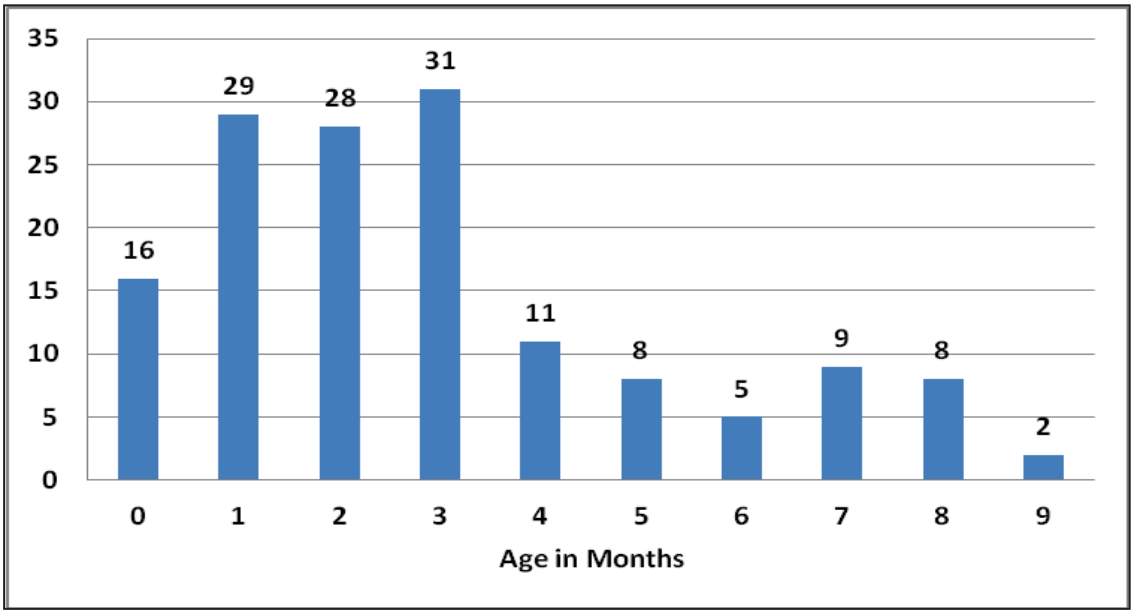


Sleep environment continued to be a critical issue in the reviewed deaths

Most of the deaths occurred in an adult bed (58%), while only 16% occurred in a crib

In 70 cases where the infant was placed to sleep on either an adult bed or a couch (n=101), the infant was sharing the sleep surface with at least one other person

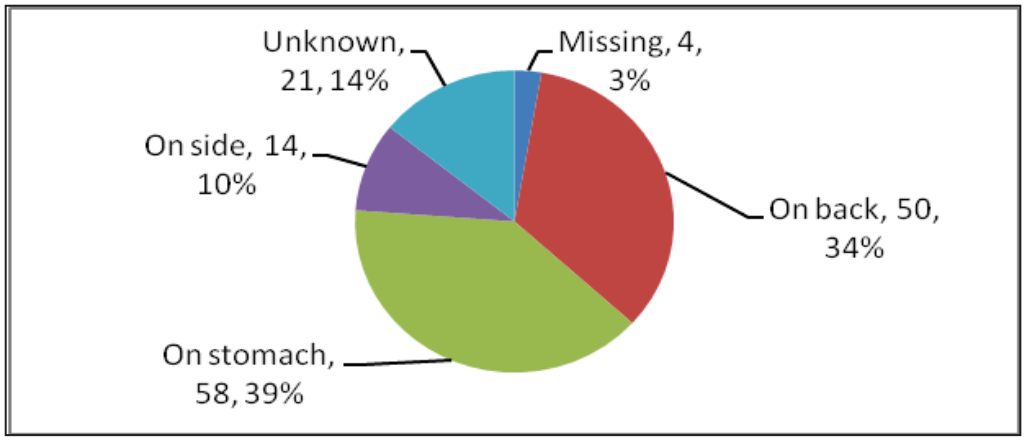
Figure 12: Sleep-Related Infant Deaths by Age in Months, GA, 2012 (N=147)



Almost three-fourths of the reviewed sleep-related deaths occurred among infants younger than four months (71%). This finding highlights the need for primary caregivers and those who may also support in caregiving responsibilities to receive consistent and repetitive messaging about safe sleep environments during the prenatal period and throughout the first four months of the infant's life

There were 80 deaths reviewed where the infant was reported as bed-sharing with at least one other person at the time of death (54%)

Figure 13: Reviewed Sleep-Related Deaths by Position when Found, GA, 2012 (N=147)



Forty-nine percent were reported as sleeping in an unsafe position – on the side or stomach

Of the 50 that were found on their back, 33 were reported as sharing a sleep surface with at least one other person, i.e. bed-sharing (66%)

The Georgia Infant Safe Sleep Coalition (GISSC) – a subcommittee of the CFR Panel with participation from both public and private organizations – endorses these recommendations and actively supports community efforts to implement and sustain risk reduction measures in accordance with the "Safe to Sleep" campaign. The GISSC is committed to reducing the risk of sleep-related death for all infants in Georgia, and to providing targeted prevention messages to all parents and caregivers of infants. There are many areas where prevention can be targeted, from individual caregivers to community programs to institutional policies, and one area of need in Georgia is influencing hospital policy. In order to reduce sleep-related infant deaths in a community, it is critical to provide a consistent and repetitive message about infant sleep safety. A hospital-based program is one avenue to achieve our goal of reducing the risk of injury and death to infants while sleeping, through multiple processes including: 1) providing accurate and consistent infant safe sleep information to hospital personnel including medical, nursing, breastfeeding, child birth education, and nutritional staff; 2) enabling the hospital to implement and model infant safe sleep practices throughout their facility; and 3) providing direction to health care professionals so that safe sleep education for parents is consistent and repetitive.

Cribs for Kids offers a fully developed **Hospital Initiative Toolkit** online at www.cribsforkids.org/hospital-initiative-tools, where all policy templates, organizational charts, and provider letters can be freely downloaded and revised to fit any hospital system. Another valuable resource is "**Model Behavior**", a policy template for hospital nurseries that provides specific language and activities to model safe sleep practices for the Well Baby and Neonatal Nurseries. The policies were developed with significant input from nursing staff, educators, SIDS researchers, trainers and other national healthcare professionals to address the following five key areas: sleep position, bedding/soft materials, crib use/bed sharing, breastfeeding, swaddling, and tobacco exposure. All hospitals in Georgia are urged to incorporate these policies into their existing protocols for NICU and well-baby nurseries. The policy template and information on Continuing Education credits can be found at www.firstcandle.org/professionals/program-highlights/model-behavior-nurses-ce-program/.

Resources:
Governor's Office for Children and Families (www.children.ga.gov)

Georgia Department of Human Services (www.dhs.georgia.gov/safe-sleep)

Safe to Sleep Campaign, National Institutes of Health (www.nichd.nih.gov/sts)

Text 4 Baby (www.text4baby.org)

First Candle (www.firstcandle.org/new-expectant-parents/bedtime-basics-for-babies/)

REVIEWED MEDICAL DEATHS

A medical related death is reviewable when the death occurs unexpectedly, is unexplained, unattended by a physician, or occurs 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, pneumonia, or certain types of infection). Deaths that occur while in hospice care are not considered reviewable by CFR, as they are considered "expected" deaths.

Many medical related reviewed 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 2012, CFR committees reviewed 80 child deaths that were attributed to medical conditions.

Of these 80 deaths, 29 were non-Hispanic Whites (36%), 39 were African-Americans (49%), and six were Hispanic (8%); African-Americans continue to be disproportionately affected by these types of reviewable medical conditions

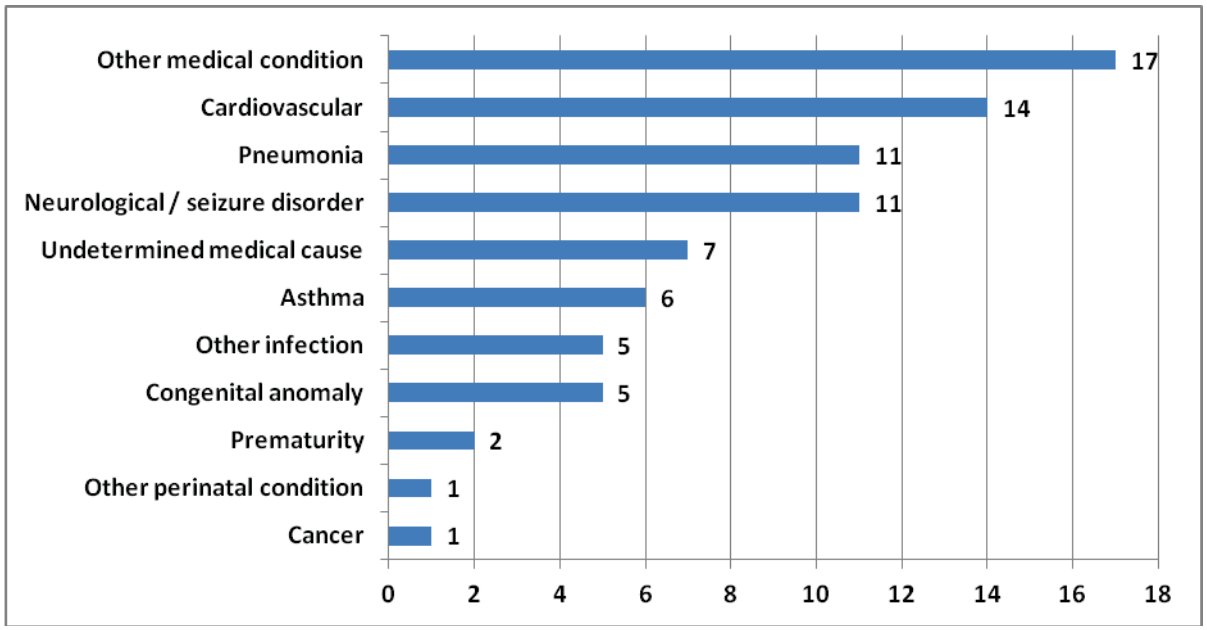
Fifty-six percent of the medical reviewed deaths occurred among young children less than five years of age

Forty-two medical deaths occurred among children with a disability or chronic illness (53%); eight of those 42 also had evidence of maltreatment

Figure 14: Demographics of Reviewed Medical Deaths, GA, 2012 (N=80)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	TOTAL
White Male	1	2	3	2	3	11
White Female	7	2	2	3	4	18
African-American Male	7	5	3	2	1	18
African-American Female	6	7	4	1	3	21
Hispanic Male	1	3			1	5
Hispanic Female			1			1
Multiracial Male	1					1
Multiracial Female				1		1
Other Male		1				1
Other Female	1			1		2
Missing		1				1
	24	21	13	10	12	80

Figure 15: Medical Causes of Reviewed Deaths, GA, 2012 (N=80)



The Cardiovascular and Other Medical Condition categories include several types of medical issues

Cardiovascular and Neurological Disorders were the most frequently reported medical causes for those age 15-17 (eight out of 12); Pneumonia was the most frequently reported medical cause for infants (seven out of 24)

Pneumonia was the single most common medical-reviewable cause of death. Pneumonia and influenza are the 8th leading cause of death in the United States. Worldwide, bacterial pneumonia is the leading cause of death in children under age five (about 1.4 million annually)

In 2012, eight infant sleep-related deaths were reviewed that also had a significant medical condition. The sleep environment was a contributing factor in the death, and the child's medical condition was exacerbated by the unsafe sleep environment. The review committees determined that the child may not have died from the medical condition if their sleep environment had been safer. These eight are also mentioned in the sleep related section.

Risk factors associated with medical deaths in children:

Children with congenital anomalies, genetic disorders, or chronic health conditions
Children who do not receive preventive medical care
Children who are non- compliant with prescribed treatment regimens
Parents and/or caregivers who fail to seek adequate medical attention for their children
Children who live in poverty and are regularly exposed to environmental hazards

Opportunities for Prevention:

The Centers for Disease Control and Prevention (CDC) Advisory Council recommends that all people ages six months and older, unless contraindicated, have a yearly flu shot. Healthy people can usually fight off pneumonia infections. However, people who are sick, including those who are recovering from the flu (influenza) or an upper respiratory illness, have a weakened immune system. This makes it easier for bacteria to grow in their lungs

Remove triggers that may cause asthma or other respiratory health problems such as pneumonia. Triggers include smoke, dust mites, cockroaches, pets, and mold. In most cases, pneumonia can be effectively treated with low cost oral antibiotics, but children can die very quickly from the infection and treatment is needed urgently

Make sure your child has regular visits with a health-care provider to check for any illnesses or abnormalities in their wellness and development. If you feel that your child's diagnosis or treatment was unsatisfactory, seek a second opinion from another health-care provider

School systems should enhance the quality and frequency of youth sports physicals, as well as provide a school-based health center as a medical home for children without a regular primary care provider. This can ensure that more children are fully screened for potentially life-threatening conditions, including cardiovascular or neurological disorders

The most important thing that all people can do to help keep from getting sick is to wash their hands, especially after coughing and sneezing, before preparing foods or eating, and after using the restroom. It is estimated that one out of three people do not wash their hands after using the restroom. By washing hands often, germs are washed away that may have been picked up from other people, from contaminated surfaces, or from animals and animal waste

REVIEWED UNINTENTIONAL INJURY-RELATED DEATHS

In 2012, CFR committees reviewed 147 unintentional injury-related deaths. An unintentional injury-related death may also be called an "accident", but very often the types of circumstances that lead to these deaths are predictable – and therefore, preventable. According to the Centers for Disease Control and Prevention (CDC) 2012 *Vital Signs* report, death rates from unintentional injuries among children and adolescents from birth to age 19 declined by nearly 30 percent from 2000 to 2009. And although rates for most causes of child injuries have been dropping, poisoning death rates did increase, with a 91 percent increase among teens aged 15-19, largely due to prescription drug overdose, and suffocation rates are on the rise, with a 54 percent increase in reported suffocation among infants less than one year old (*see the Sleep-Related Infant Death section of this report for more information on infant suffocations*).

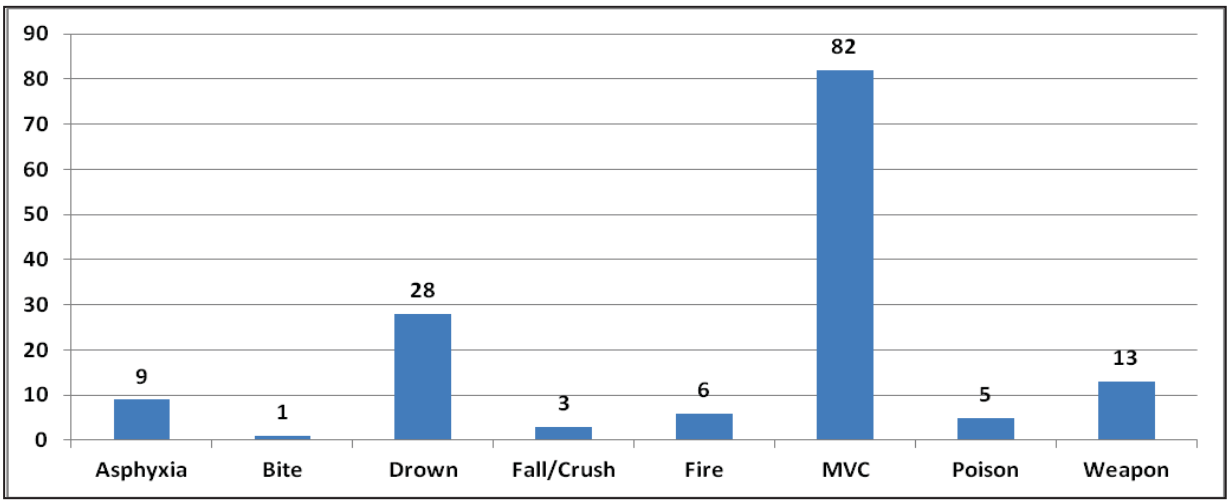
The most common cause of death from unintentional injury for children in the United States is motor vehicle crashes; other leading causes include suffocation, drowning, poisoning, fires, and falls. Across the United States, every four seconds, a child is treated for an injury in the emergency department, and every hour, a child dies as a result of an injury.

Figure 16: Demographics of Reviewed Unintentional Injury-related Deaths, GA, 2012 (N=147)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	3	12	3	8	16	42
White Female		7	3	5	11	26
African-American Male	4	10	12	5	7	38
African-American Female	5	7	4	3	3	22
Hispanic Male		5	1	4	1	11
Hispanic Female		1	4		1	6
Other Male					2	2
Total	12	42	27	25	41	147

Eight unintentional injury deaths occurred among children with a disability or chronic illness; four of those had evidence of maltreatment

Figure 17: Causes of Reviewed Unintentional Injury-related Deaths, GA, 2012 (N=147)



The leading cause of reviewed unintentional injury-related death was due to motor vehicle crashes (56%); drowning accounted for 19% of reviewed unintentional injury-related deaths; More detail on these two leading causes of deaths will be addressed in the next section

These do not include sleep-related infant deaths or intentional suicide deaths by asphyxia

Opportunities for Prevention:

CDC and more than 60 partner organizations have released a National Action Plan on Child Injury Prevention in conjunction with the Vital Signs report. The National Action Plan's overall goals are to: raise awareness about the problem of child injury and the effects on our nation; highlight prevention solutions by uniting stakeholders around a common set of goals and strategies; and mobilize action on a national, coordinated effort to reduce child injury. Georgia has also developed a state child injury prevention plan (CIPP), through a subcommittee of the CFR Panel, which draws from the National Action Plan and provides detail on best practices in prevention using local Georgia resources and organizations. The CIPP can be found on our website at www.oca.georgia.gov.

Resources:

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

Governor's Office of Highway Safety (www.gahighwaysafety.org)

Georgia Department of Public Health (www.health.state.ga.us)

Governor's Office for Children and Families (www.children.georgia.gov)

Safe Kids Georgia (www.safekidsgeorgia.org)

REVIEWED MOTOR VEHICLE-RELATED DEATHS

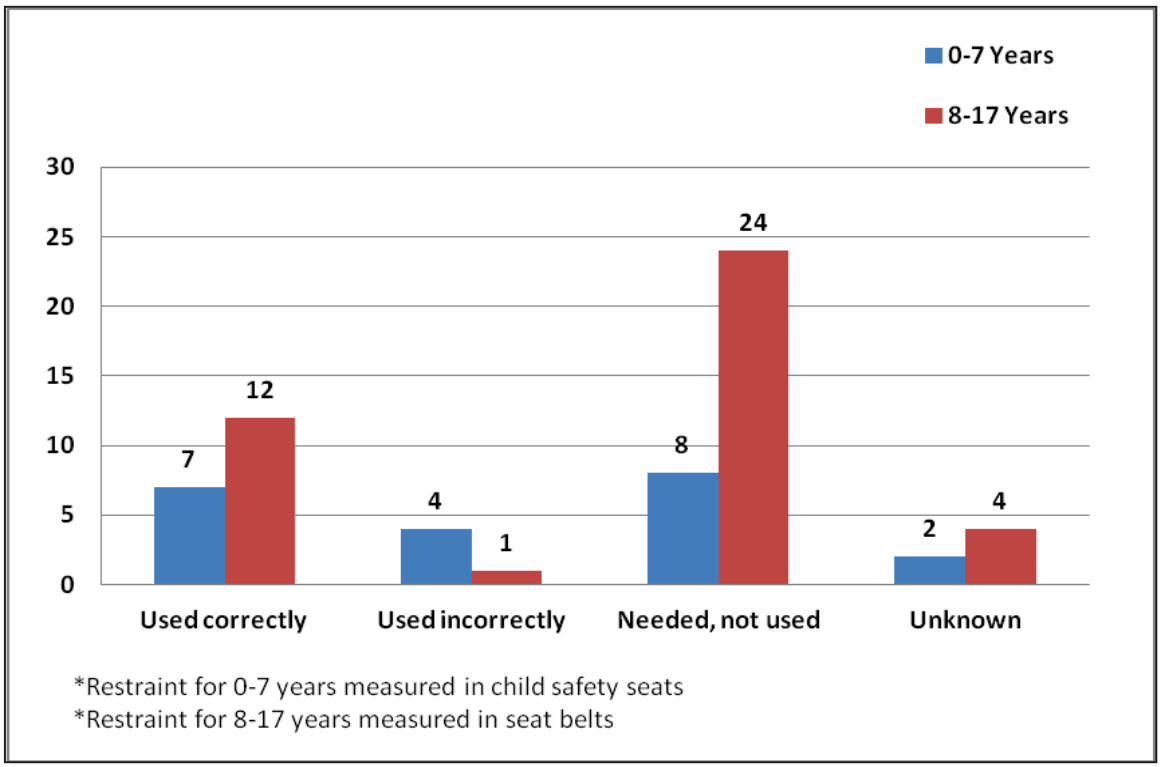
In 2012, CFR committees reviewed 82 deaths due to motor vehicle-related incidents. Sixty-two were passengers or operators of a vehicle, and 20 were pedestrians, bicyclists, or riding an ATV.

Figure 18: Demographics of Reviewed Motor Vehicle-Related Deaths, GA, 2012 (N=82)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	1	2	3	6	10	22
White Female		1	1	1	11	14
African-American Male	2	2	10	3	5	22
African-American Female	3	5	3	2	3	16
Hispanic Male		1	1	2	1	5
Hispanic Female			2		1	3
Total	6	11	20	14	31	82

Motor vehicle crashes are a leading cause of death for young children and teens in the United States. Most deaths are caused by unsafe behaviors and can be prevented. Since motor vehicle crash victims are a diverse group, prevention efforts need to be targeted to each population and specific behaviors common to that population.

Figure 19: Restraint Use by Age among Reviewed Motor Vehicle-Related Deaths, GA, 2012 (N=62)



Lack of appropriate restraint use, such as child safety seats and booster seats, contributes significantly to injuries and deaths among infants and young children. Georgia law requires children under the age of eight to be restrained in an approved child safety seat. Parents and caregivers can visit their local Public Health Department or contact Safe Kids Georgia for more information.

Figure 20: Pedestrian Deaths by Location, GA, 2012 (N=17)

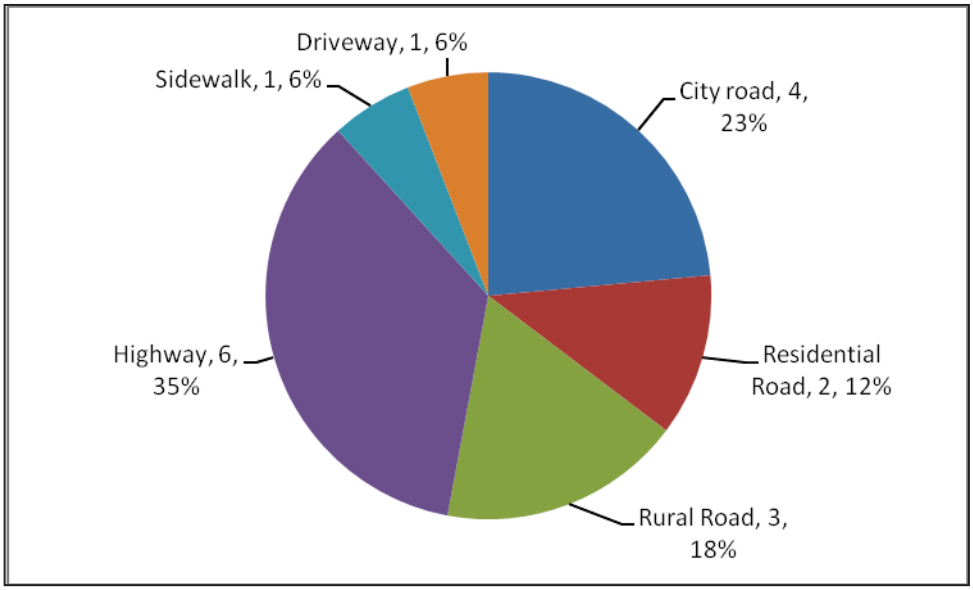


Figure 21: Pedestrian Deaths by Age among Reviewed Motor Vehicle-Related Deaths, GA, 2012 (N=17)

Pedestrian Deaths by Age		
	Number	Percent
Infant	0	0%
1 to 4	3	18%
5 to 9	6	35%
10 to 14	5	29%
15 to 17	3	18%

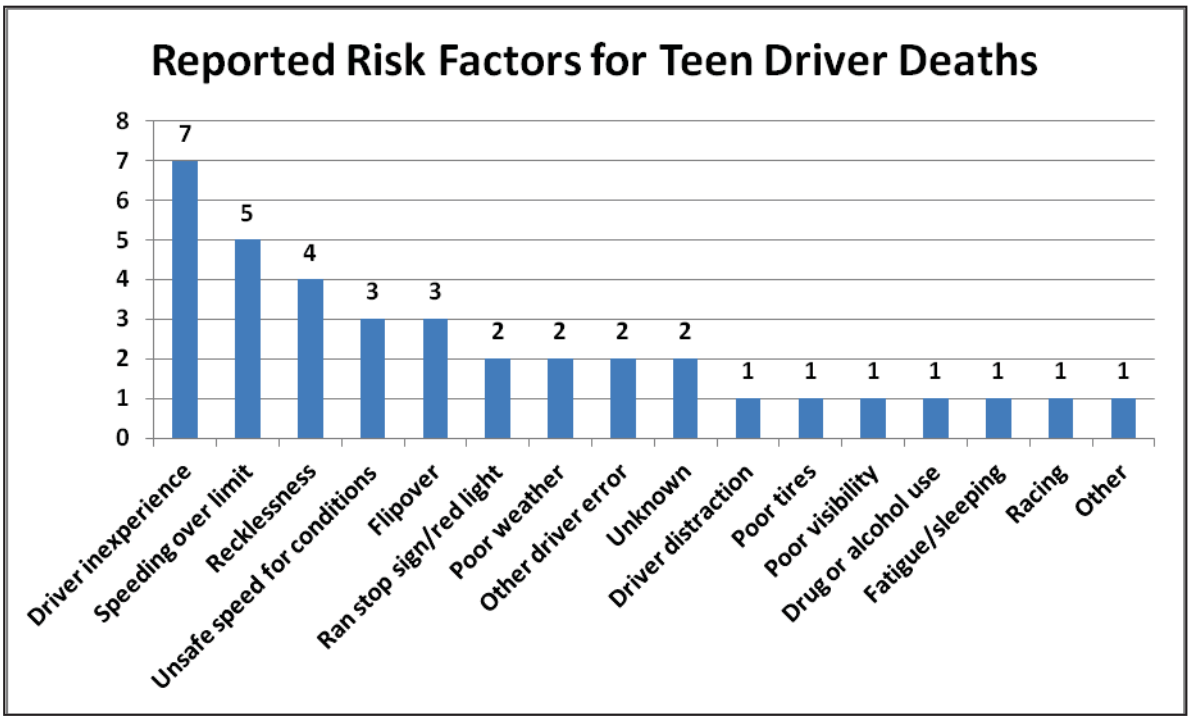
Pedestrian deaths include children who are outside of a vehicle –they may be playing in the driveway, walking, crossing streets, or standing at bus stops. Pedestrian deaths are increasing in suburban communities due in part to the “suburbanization of poverty”. Many suburbs have sprawling and auto-dependent land use patterns, and don't have the kinds of public transit networks or infrastructure that can safely connect families with young children to transportation. Many child injuries and deaths occur while attempting to cross multi-lane roadways to reach bus stops from apartment homes.

Opportunities for Prevention – Pedestrian Fatalities:

Funded by the Federal Safe Routes to School (SRTS) program, Georgia's SRTS program is designed to encourage more primary and middle schools kids (grades K-8) to walk and bike to school safely. The SRTS program provides funding to local governments to improve the walking and bicycling conditions to schools, and support for school-based Safe Routes to School programs through partnerships with the Resource Center. The Safe Routes to School Program is organized around five ideas: Engineering - making the environment safer for walking and bicycling; Encouragement - encouraging kids to walk and bike; Education - teaching kids and parents safe ways to walk and bike; Evaluation - checking to see how many kids are walking and biking as a result of the program; and Enforcement - changing driver, walker and bicyclist behavior as they travel together along the road.

Midblock locations account for more than 70 percent of pedestrian fatalities. Vehicle travel speeds are usually higher at midblock locations, contributing to the higher injury and fatality rates at these locations. More than 80 percent of pedestrians die when hit by vehicles traveling at 40 mph or faster while less than 10 percent die when hit at 20 mph or less. A successful prevention strategy is the pedestrian hybrid beacon (also known as the High intensity Activated crossWalK (or HAWK)). It is a pedestrian-activated warning device located on the roadside or on mast arms over midblock pedestrian crossings. Pedestrian hybrid beacons should only be used in conjunction with a marked crosswalk. In general, they should be used if gaps in traffic are not adequate to permit pedestrians to cross, if vehicle speeds on the major street are too high to permit pedestrians to cross, or if pedestrian delay is excessive. Transit and school locations may be good places to consider using the pedestrian hybrid beacon. Installation of the pedestrian hybrid beacon has been shown to provide up to a 69 percent reduction in pedestrian crashes, and up to a 29 percent reduction in total roadway crashes. Pedestrian crossing islands and medians are also successful prevention measures that can reduce pedestrian fatalities. Medians are a particularly important pedestrian safety countermeasure in areas where pedestrians access a transit stop or other clear origins/destinations across from each other. Providing raised medians or pedestrian refuge areas at marked crosswalks has demonstrated a 46 percent reduction in pedestrian crashes. At unmarked crosswalk locations, medians have demonstrated a 39 percent reduction in pedestrian crashes.

Figure 22: Reported Risk Factors for Teen Driver Deaths, GA, 2012 (N=17)



** The risk factors reported for a child can include multiple factors for each death, therefore the total is greater than the number of teen driver deaths*

Opportunities for Prevention – Teen Driver Fatalities:

Research shows which behaviors contribute to teen-related crashes. Inexperience and immaturity combined with speed, drinking and driving, not wearing seat belts, distracted driving (cell phone use, loud music, other teen passengers, etc.), drowsy driving, nighttime driving, and other drug use aggravate this problem.

According to the National Highway Traffic Safety Administration (NHTSA), among drivers 15-19 years old involved in fatal crashes, 21 percent of the distracted drivers were distracted by the use of cell phones. Sending or receiving a text takes a driver's eyes from the road for an average of 4.6 seconds, the equivalent – at 55 mph – of driving the length of an entire football field, blind. A quarter of teens respond to a text message once or more every time they drive. Twenty percent of teens and 10 percent of parents admit that they have extended multi-message text conversations while driving. Because text messaging requires visual, manual, and cognitive attention from the driver, it is by far the most alarming distraction.

There are several prevention measures to reduce the risk of motor-vehicle injuries and deaths for teen drivers. On any high-speed roadway, the primary safety concerns are crash types related to lane departure, including run-off-road crashes. On high-speed, rural two-lane highways, an increased risk of cross-centerline head-on or cross-centerline sideswipe crashes is a concern because drivers may have

more difficulty staying within the travel lane. Mandatory driver education, graduated licensing laws, and speed reduction techniques are in place in many states, but engineering improvements for roadways can also be implemented. Of all single vehicle crashes in Georgia, more than half were due to roadway departures. One proven countermeasure to address roadway departures is to install "Rumble Strips". Longitudinal rumble strips are milled or raised elements on the pavement intended to alert inattentive drivers through vibration and sound that their vehicles have left the travel lane. Rumble strips are designed primarily to address the subset of driver error crashes caused by distracted, drowsy, or otherwise inattentive drivers who unintentionally drift from their lane. Vertical pavement edges are a recognized detriment to safety, contributing to severe crashes that frequently involve rollovers or head-on collisions. Studies in some states have found that crashes involving edge drop-offs are two to four times more likely to include a fatality than other crashes on similar roads. The Governor's Office of Highway Safety (GOHS) is committed to encouraging a transportation safety culture – safer drivers and passengers, safer vehicles, safer roadways, protected pedestrians, and enhanced emergency medical services – to move Georgia toward zero deaths.

Additional prevention opportunities include maintaining rear-facing child safety seats for children under the age of two, and NHTSA's 4 STEPS FOR KIDS program, which promotes the correct use of child safety seats at different stages in a child's development. When children out-grow forward-facing child safety seats, they need to be restrained in belt-positioning booster seats. This usually occurs when children are about 4 years old and weigh approximately 40 pounds. To ensure children's safety, they should remain in booster seats until they are at least eight years old, unless they are 4'9" tall. Georgia law also requires children under the age of eight to be in the back seat of a vehicle, and a general recommendation that children under the age of 13 be in the back seat.

Resources:

Georgia Governor's Office of Highway Safety (www.gahighwaysafety.org)

Safe Routes to School, Georgia Department of Transportation (www.saferoutesga.org)

Georgia Injury Prevention Program, Department of Public Health (www.health.state.ga.us)

Georgia Traffic Injury Prevention Institute (www.ridesafegeorgia.org)

Safe Kids Georgia (www.safekidsgeorgia.org)

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

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

REVIEWED DROWNING DEATHS

According to the Centers for Disease Control, every day, about ten people die from unintentional drowning. About one in five people who die from drowning are children 14 and younger. For every child who dies from drowning, another five receive emergency department care for nonfatal submersion injuries. Nonfatal drowning injuries can cause severe brain damage that may result in long-term disabilities such as memory problems, learning disabilities, and permanent loss of basic functioning (e.g., permanent vegetative state). Drowning ranks fifth among the leading causes of unintentional injury death in the United States. Most drowning deaths occur at residential pools, especially for children under the age of five.

In 2012, CFR committees reviewed 30 deaths due to drowning.

Figure 23: Demographics of Drowning Deaths, GA, 2012 (N=30)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	
White Male	1	4			2	7
White Female		4	1			5
African-American Male		2	2		1	5
African-American Female	1			1		2
Hispanic Male		3		2		5
Hispanic Female		1	2			3
Multi-race Male				1		1
Other Male					2	2
						30

Reviewed cases in 2012 revealed 47% of children who died from drowning were between the ages of one and four

Twenty of the 30 reviewed drowning deaths were among males (67%)

According to the CDC, the populations most at-risk are males, children ages one to four, and African-Americans. Among children ages one to four, most drownings occur in home swimming pools. The fatal drowning rate of African-American children ages five to 14 is almost three times that of White children in the same age range

Factors such as access to swimming pools, the desire or lack of desire to learn how to swim, and choosing water-related recreational activities may contribute to the differences in drowning rates. The main factors that affect drowning risk are lack of swimming ability, lack of barriers to prevent unsupervised water access, lack of close supervision while swimming, location, failure to wear life jackets, alcohol use by parents/caregivers, and seizure disorders.

Figure 24: Drowning Location of Reviewed Drowning Deaths, 2012 (N=30)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
Open Water		1	1	2	2	6
Pool, Hot tub, Spa		11	4	1	3	19
Bathtub	2	1		1		4
Other		1				1

A pool, hot tub, or spa was the most common location for reviewed drowning deaths. Risk factors that often contribute to drowning deaths among children include a lack of barriers. Barriers such as a pool fence or gate can prevent a child from gaining access to a pool. Forty-seven percent of drowning locations had no barriers to prevent unauthorized access; 13% had a fence, three percent had a gate, and 23% were reported with unknown barriers. However, when a physical barrier was identified by the CFR committee, in 13% of reviewed cases, the fence/gate had a gap or other damage, or the door was unlocked.

Opportunities for Prevention:

Supervise children around water – they should be no more than an arm's length from a watchful caregiver at all times

If your home has a swimming pool, make sure that there is a fence or gate around the area; the fence should be at least four feet high with a locking door

Swimming skills help. Taking part in formal swimming lessons reduces the risk of drowning

among children. However, some research has found that increased swimming ability leads children and adolescents to take greater risks in and around the water

Seconds count—learn Cardiopulmonary resuscitation (CPR). CPR performed by bystanders has been shown to save lives and improve outcomes in drowning victims. The more quickly CPR is started, the better the chance of improved outcomes.

Resources:

Safe Kids Georgia (www.safekidsgeorgia.org)

National Drowning Prevention Alliance (www.ndpa.org)

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

REVIEWED INTENTIONAL INJURY-RELATED DEATHS

In 2012, CFR committees reviewed 58 homicide deaths and 29 suicide deaths. The following sections will provide more detail on the circumstances of these deaths, and opportunities for prevention.

Figure 25: Location of Reviewed Unintentional Injury-related Deaths, GA, 2012 (N=147)

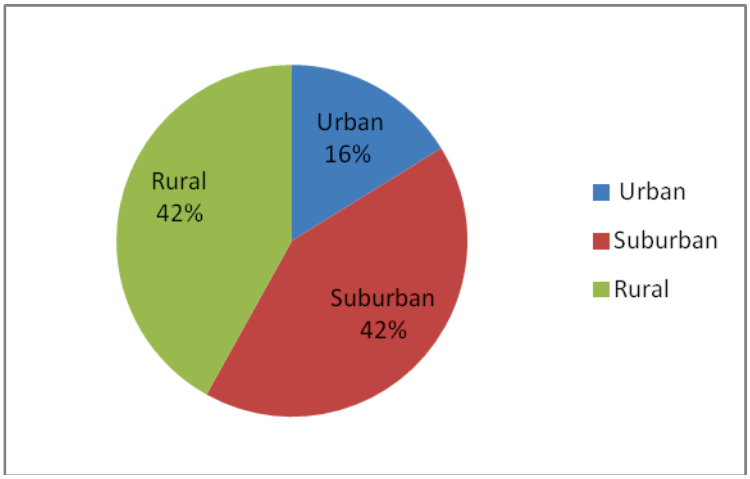
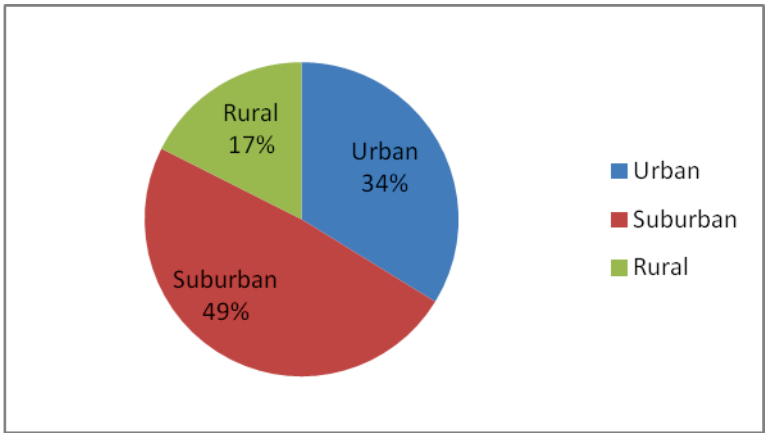


Figure 26: Location of Reviewed Intentional Injury-related Deaths, GA, 2012 (N=87)



Intentional injury-related deaths occurred more often in suburban counties (49%) and somewhat less often in urban counties (34%), while unintentional injury-related deaths occurred most often in rural (42%) and suburban (42%) counties

Prevention efforts need to address the unique social and environmental issues within each region, and consider the available resources and their accessibility to the residents

HOMICIDE DEATHS

According to the Johns Hopkins Urban Health Institute, homicide is the leading cause of death for African-American males between the ages of 15 to 34 in the United States. Risk factors such as gang activity, arguments, revenge, self-defense, robbery, and drug disputes contribute to the high numbers of homicides among teens and young adults. Preventing young people from joining gangs in the first place is crucial to realizing a significant and lasting reduction in youth gang activity. The most common age for youth to join a gang is between 13 and 15, making early prevention efforts critical. Young people join gangs for various reasons, including money, sense of support and belonging, peer status, perceived sense of protection, or to demonstrate an outlaw mentality. Community partnerships can help reinforce and enhance the existing strengths of families and communities to reduce gang-joining, especially when supporting activities such as tutoring, mentoring, life-skills training, case management, parental involvement, and supervised recreation.

Maltreatment contributes to homicides in very young children. Maltreatment includes various forms of abuse, including physical assault, sexual molestation or exploitation, emotional or psychological abuse and neglect. These very young children are particularly vulnerable due to their dependency, small size, and their inability to defend themselves.

Figure 27: Demographics of Reviewed Homicide Deaths, GA, 2012 (N=58)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17
White Male		1			1
White Female	3	4	1	1	2
African-American Male	4	6	2	3	10
African-American Female	2	6		3	4
Hispanic Male	1		1		1
Multi-race Male				1	
Other Male	1				
Total	11	17	4	8	18

Forty-eight percent of reviewed homicide deaths were among children younger than five years

Thirty-one percent of reviewed homicide deaths were among older teens

The perpetrators and circumstances of homicides are different across these age groups, and prevention efforts need to address the unique social and cognitive development of children within each targeted age group

Figure 28: Mechanism of Injury for Reviewed Homicide Deaths, GA, 2012 (N=58)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Asphyxia	2	1	1		1
Drown		1		1	
Missing/ Unknown	1	1			1
Battered Child Syndrome	1	1			
Poison	2				
Weapon	5	13	3	7	16

Of the 58 homicides reviewed in 2012, 44 were committed with a weapon; the weapons most frequently used were a firearm (n=21) and a person's body part (n=13)

In 16 of the 58 reviewed homicides (28%), the perpetrator was the biological parent, step-parent, or adoptive parent; in six cases, the perpetrator was another relative, sibling, or grandparent (10%)

In seven homicides, the perpetrator was a friend, acquaintance, or paramour of the victim (12%)

In nine homicides, the perpetrator is listed as "Other", which includes law enforcement officers, homeowners defending themselves during a robbery, and rival gang members

Opportunities for Prevention:

Youth violence and homicide prevention shouldn't wait for youth who are at risk for committing violent behavior, or of becoming a victim of violence, to seek out help—professionals and community partners should seek them out. Whether it's helping them to stay in school, re-enter society, or manage their anger, the objective is to intervene at a crucial time in the lives of young people and offer them a better path.

Help middle-school truants and students at risk of suspension stay in school and succeed

Help academically qualified students who are financially challenged attend college or technical school

Help youth with repeat offenses to re-enter society from state and county detention programs

Provide alternatives for youth who are arrested for crimes, but not detained

Prevent victims of violence and their friends and relatives from continuing the cycle of violence through retaliation

Nurture civic engagement and revitalize the appearance and the spirit of neighborhoods

Provide affordable, accessible childcare to families in need, including late-night and respite care; educate parents on choosing the right caregivers for their child(ren) when necessary

Resources:

Violent Death Reporting System, Georgia Department of Public Health (www.health.state.ga.us)

Georgia Family Connection Partnership (www.gafcp.org)

Prevent Child Abuse Georgia (www.preventchildabusega.org)

Criminal Justice Coordinating Council (www.cjcc.georgia.gov)

REVIEWED SUICIDE DEATHS

A youth suicide (aged 15-24) occurs every 100 minutes in the United States; according to the CDC, it results in approximately 4,600 lives lost each year. For every completed suicide by youth, it is estimated that 100 to 200 attempts are made. Over 90 percent of people who die by suicide have a mental illness at the time of their death; the most common mental illness is depression. Untreated depression is the number one cause for suicide. Furthermore, many youth die by suicide because depression is triggered by several negative life experiences such as the death of a loved one, divorce or other family discord, being sexually or physically victimized, drug and/or alcohol abuse and bullying (CDC, 2011).

Adolescence can be a tumultuous time for many young people and some experiences can be very confusing and difficult to handle. When faced with difficult experiences, young people can become emotionally distraught rather easily and thus are vulnerable to suicidal thoughts. Fortunately, many youth display warning signs prior to attempting suicide. Therefore, it is imperative that parents, caregivers, teachers, administrators, and counselors are aware of and able to identify these warning signs and seek help for the suicidal youth as quickly as possible.

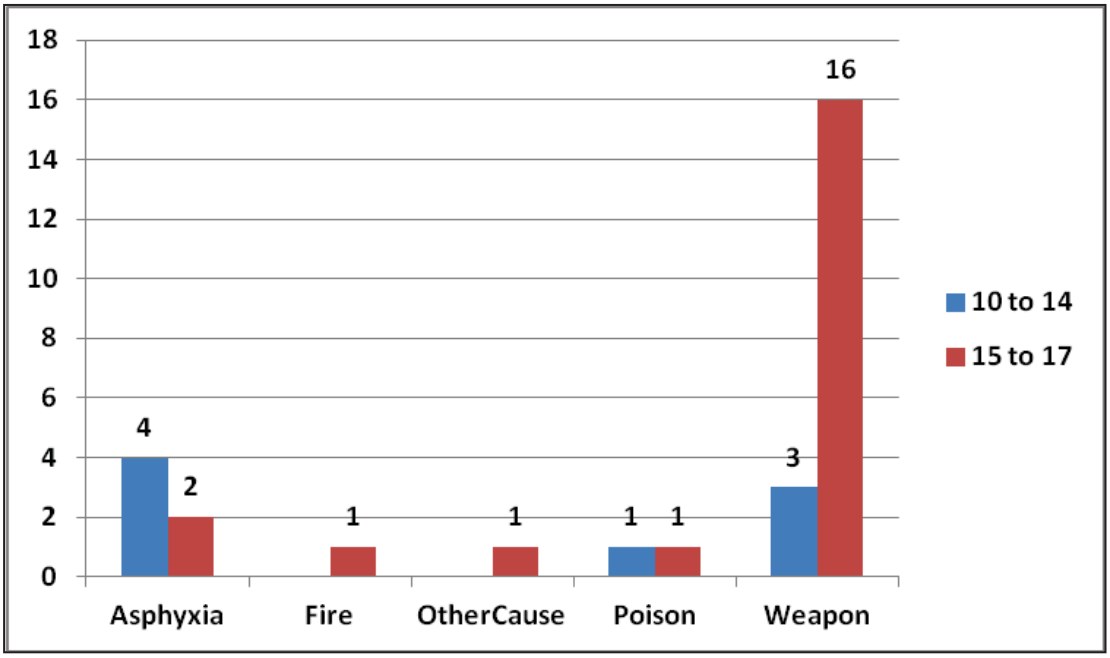
Figure 29: Demographics of Reviewed Suicide Deaths, GA, 2012 (N=29)

	10 to 14	15 to 17
White Male	4	12
White Female	2	2
African-American Male	2	4
Hispanic Male		2
Hispanic Female		1

Although White males accounted for almost half (41%) of all reviewed suicide deaths, the number of suicide deaths among African-American males is steadily increasing

The majority of all suicide deaths involved children ages 15 to 17. Nationally suicide is the fourth leading cause of death among children between 10 and 14 years, and recent national news coverage has reported children as young as 7 attempting suicide (kidsMD, 2012)

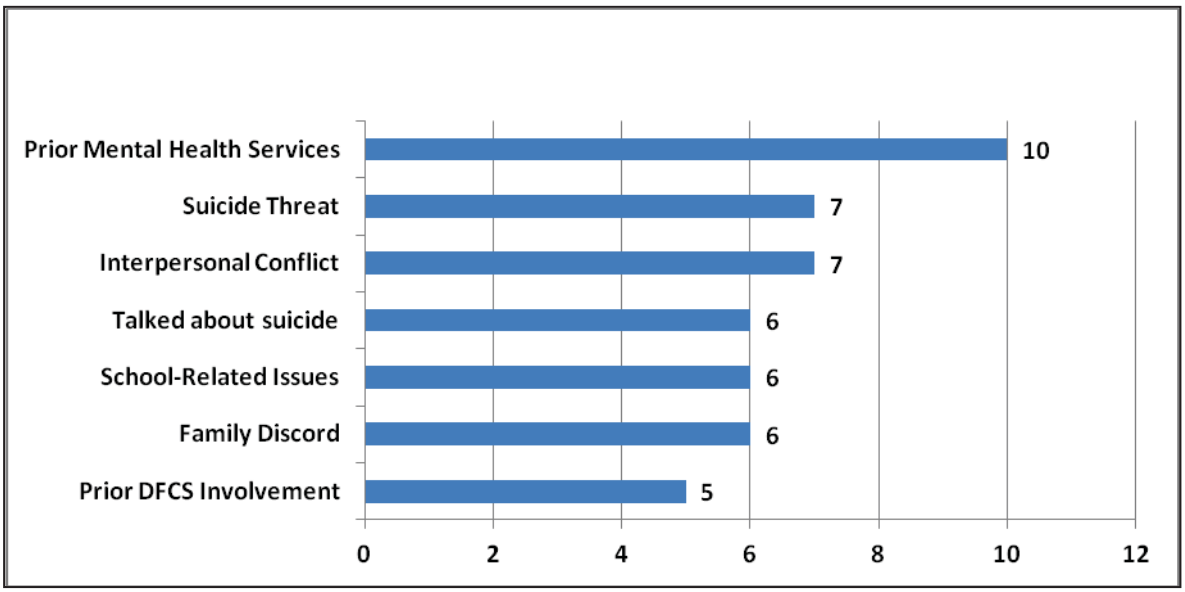
Figure 30: Mechanism of Injury in Reviewed Suicide Deaths, GA, 2012 (N=29)



In Georgia, more than half (62%) of all reviewed suicide deaths resulted from the use of a weapon; all cases within the "weapon" category involved use of a firearm

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

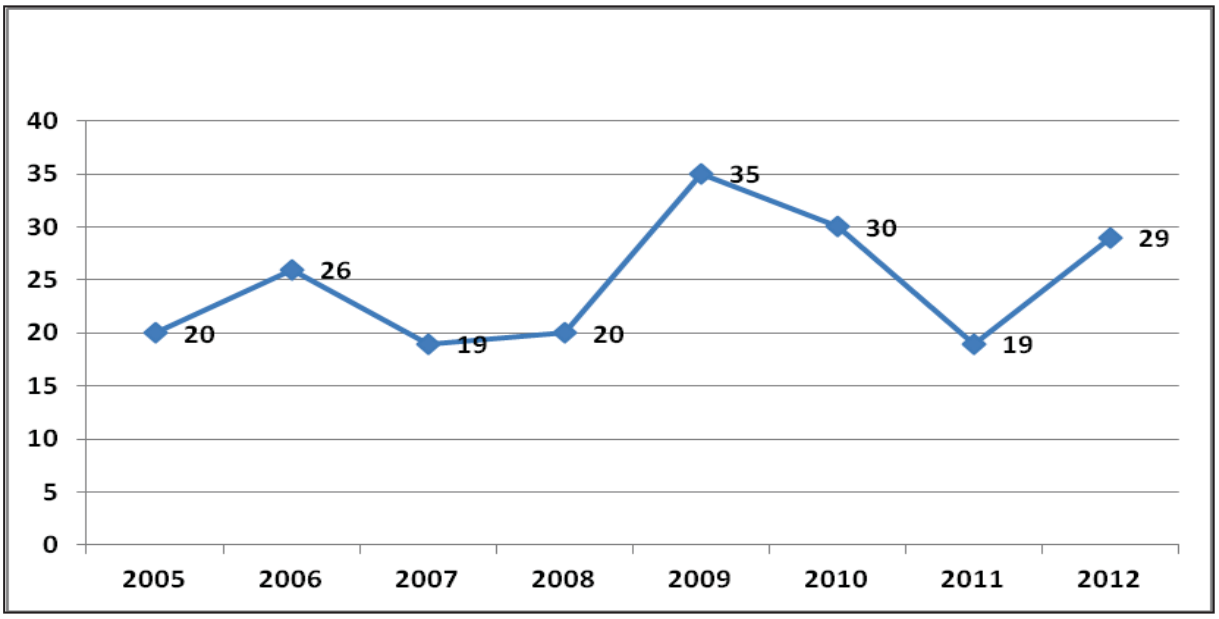
Figure 31: Reported Risk Factors for Reviewed Suicide Deaths, GA, 2012



**The history reported for a child can include multiple actions for each death, therefore the total is greater than the number of suicide deaths*

In a recent study, adolescent groups reported that suicidal thoughts often were the result of too many stressors and not enough support; noting mental illness, peer pressure, negative life experiences, and lack of family support as significant contributors to suicidal thoughts (AAP,2010).

Figure 32: Reviewed Suicide Deaths, GA, 2005-2012



Reviewed suicide deaths have fluctuated in recent years, from a high of 35 in 2009 to a low of 19 in 2011. It is unclear what social or ecological factors are driving these trends, and researchers should investigate the recent rise to identify opportunities for prevention

Opportunities for Prevention:

Increase awareness of suicide warning signs and encourage parents, school personnel, counselors, health care providers and other community agents who interact with youth to take prompt action when these signs are recognized

Increase accessibility and availability of mental health services to children, youth and families

Implement suicide prevention programs in elementary, middle and high schools statewide

Promote family and community connectedness by aiding parents and caregivers in talking with youth for the purpose of listening to and understanding the issues and concerns they face

Aid in reducing the stigma and shame associated with suicide by educating youth on the importance of openly communicating with someone they trust (whether a friend, a parent, a relative, a teacher, a counselor, or a coach) so that they feel supported

Resources:

GA Department of Behavioral Health and Developmental Disabilities (www.dbhdd.georgia.gov)

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

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

The Journal of American Academy of Pediatrics (www.pediatrics.org)

APPENDIX A

CRITERIA FOR CHILD DEATH REVIEWS

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

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

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

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

APPENDIX B

CFR TIMEFRAMES AND RESPONSIBILITIES