Georgia CAPTA Panels

2014 Annual Report

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

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Originally enacted in January 1974, the Child Abuse Prevention and Treatment Act (CAPTA) is a key piece of federal legislation addressing child abuse and neglect.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:
        - 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
        - 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 so that the Panels can fulfill their duties, and to respond to 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 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 most recently revised its CAPTA plan in July 2013.

Although Georgia's CAPTA Panels have been involved in the response to two CAPTA Program Improvement Plans (PIP) the state received, they have had limited involvement in the state's CAPTA Plan. In 2015, members of one of the panels plans to focus its efforts on evaluating the current plan and its effectiveness.

Georgia's Citizen Review Panel (CAPTA Panels) History

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:

- Meeting a minimum of four times a year
- Members who are broadly representative of the community, and where specified, meet the statutory requirements of that group, as specified by state or federal legislation
- Examining 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
- Reporting annually on its activities and recommendations
- Providing 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 goal 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.

National Resources for CAPTA Panels: Training and Peer Networking

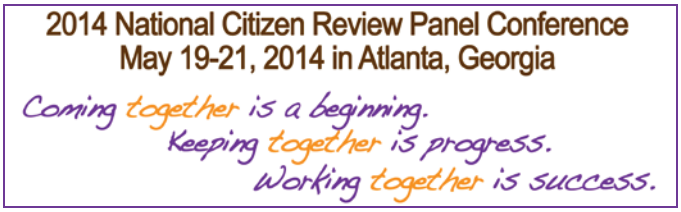
The Children's Bureau continues to support the CAPTA Panels by providing technical assistance, training and networking opportunities. Georgia's CAPTA Panels continued to take advantage of a wide variety of webinar opportunities offered during 2014 by local and national organizations, including the federal Children's Bureau, 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:

- Continuous Quality Improvement
- Interviewing Children with Disabilities II
- Mandated Reporter Training
- The Importance of Prevention in Citizen Review Panel Discussions
- Preventing Child Abuse and Neglect in Children with Developmental Disabilities
- Series on Child Sex Trafficking and Commercial Sexual Exploitation
- Techniques for Interviewing Challenging Clients
- Supporting Victims with Complex Communication Needs

Georgia Panels solicited input from panels in other states on the implementation of centralized intake call systems and maltreatment-related child fatality review. Conversely, Georgia's panels had an opportunity to provide feedback on several issues of interest to other states such as engaging youth on CAPTA Panels, caseworker turnover, and panels serving dual roles as both a CAPTA Panel and as a CJA Task Force.

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.

2014 Highlight: Georgia Hosts National Citizen Review Panel Annual Conference



In May of 2014, Georgia had the pleasure of hosting the National Citizen Review Panel (NCRP) conference in Atlanta at the State Bar of Georgia. NCRP conferences bring together passionate citizen-volunteers from around the country to consider emerging policy and practice issues that present both challenges and opportunities for the child welfare systems and the families they serve. More than 125 individuals from 28 states, including 25 Georgia delegates, attended the conference.

The conference content was developed to strengthen attendees' capacity to improve outcomes for vulnerable children who depend on the state child protective services agencies that CAPTA Panels help hold accountable. Plenary presenters included Howard Davidson, the Director of the American Bar Association Center on Children and the Law; National Council of Juvenile and Family Court Judges, President-Elect Peggy Walker; NCRP Coordinator Blake Jones; and Tracy Fava, the Administration on Children and Families (ACF) Region IV Child Welfare Specialist. In addition, the conference offered a variety of break-out sessions in which attendees could select topics of interest and roundtable opportunities for similarly-situated panels from across the country to consider timely and pressing issues, to share experiences and insights, and to form collaborations that deepen the panels' collective impact.

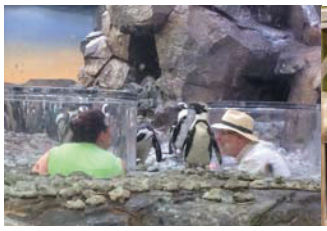
CAPTA Panel Co-Chairs with Dr. Sharon Hill, DFCS Director[1]

The conference opened with greetings from DFCS Director, Dr. Sharon Hill, who talked about the positive changes she has observed as a result of the relationship between Georgia Panels and the child welfare agency during her tenure. Carlis V. Williams, ACF Region IV Administrator, also welcomed out-of-state guests. A highlight of the conference was Keynote Speaker Naomi-Haines Griffith. A well-known storyteller and family systems specialist, Griffith uses humor and her own experiences to challenge and inspire audiences. She kept the audience laughing while motivating everyone in attendance to renew their commitment to working with children and striving to improve the system.

The conference offered a host of other informal networking opportunities, including a welcome

[1] Dr. Hill has since left DFCS and Bobby Cagle was appointed as the DFCS Director in July 2014.

reception, as well as an opportunity to showcase Atlanta with a visit to the Georgia Aquarium and a southern-inspired picnic at Centennial Olympic Park. The Youth Villages Inner Harbor Drum Program provided entertainment during the picnic and captivated the audience with its West African-style therapeutic drumming.



The feedback from the evaluations indicated that Georgia hosted a quality conference, presented a wealth of information to digest and consider, provided a fresh perspective on policy and practice, and raised the bar for future conference-sponsoring panels. A special thank you to Georgia Department of Family and Children Services (DFCS) for their commitment to and support for Georgia hosting the 2014 national conference and to everyone who assisted in making it a renowned success!

Georgia's CAPTA Panels Working Together in 2014

The co-chairs from each CAPTA Panel serve on a joint steering committee that meets several times during the year, as needed, to promote inter-panel collaboration, coordination of Panel activities and joint planning with Georgia's child welfare agency. As questions or concerns arise, often steering committee members are able to provide information, resources or a fresh perspective that can then be taken back and shared with their respective panel members.

In addition to its ongoing work related to developing standards for Panel operations, leadership development and recruitment guidelines, the steering committee continued its advocacy efforts regarding expanding the multidisciplinary review of maltreatment-related fatalities. The steering committee also provided invaluable leadership and resources during the planning and hosting of the national citizen review panel conference.

Each year, at the annual retreat, CAPTA Panels reflect on their successes and challenges, address unfinished business, and identify new opportunities. 2014 accomplishments included:

- DFCS workforce survey conducted
- Improvement in CJA contracting process
- Additional attention on special needs victims
- National recognition resulting from CAPTA Panel conference

Ongoing challenges:

- Lack of early, or consistent, engagement by DFCS on collaborative opportunities
- Understanding of state's CAPTA Plan
- Effective and timely information sharing
- Sustaining relationships due to state and local staff turnover

The highlight of this year's retreat was an open dialogue with a panel of regional and county DFCSdirectors on the current child welfare climate and the challenges they face as directors and supervisors of an overwhelmed and underappreciated workforce, and how CAPTA Panels might support their efforts. Reinforced during this exchange was the Panels' desire to increase advocacy efforts on behalf of DFCS with state legislators and to address the negative public image of the child welfare system and its workers.

Regional and county DFCS staff speak candidly with panel members

During the last session of the day-long retreat, Panels met in their respective groups to discuss and draft work plans for coming year.

CAPTA Panels Working with Georgia's Child Welfare Agency

The steering committee met with the DFCS Directors and members of the agency's leadership team several 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.

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.

When the Governor appointed Bobby Cagle as DFCS Director in July 2014, CAPTA Panels were pleased with his choice of leader for the child welfare agency. Director Cagle is highly regarded by colleagues and returns to DFCS after a successful tenure as Commissioner, Department of Early Care and Learning, and brings with him a wealth of experience, enthusiasm and leadership to Georgia's child welfare system.

CAPTA Panels were invited to review, comment or contribute to:

- 2014 Annual Progress and Services Report
- 2014-2019 Child And Family Services Plan
- Mandated reporter training for educators
- Legislation regarding child fatality review and transfer of operational and administrative responsibility from the Office of the Child Advocate to the Georgia Bureau of Investigations
- External stakeholder survey regarding DFCS activities, services and outcomes
- Updated child welfare policy, including:
    - Adoption Assistance
    - Room Board and Watchful Oversight

The agency's efforts to improve system transparency and willingness to work in partnership with CAPTA Panels and other external partners are to be commended. CAPTA Panels recommend early engagement of stakeholders in any planning or consultative process to ensure effectual stakeholder contribution.

Georgia's CAPTA Panels 2014 Recommendations

Recommendations from each of the CAPTA Panels are articulated in their section of the annual report. In addition to those recommendations, collectively they would like to reinforce and expand on previous recommendations regarding the centralized intake call center.

Centralized Intake Call Center (CICC): Panel members continue to share their concerns related to the centralized statewide system for reporting child abuse and neglect. Although data shared with the panels indicated that the quality and consistency of the agency's assessment and response to allegations had improved, ongoing concern or frustration expressed by stakeholders in making reports overshadows these improvements. In addition to resolving issues identified in DFCS' own evaluation[2] of the CICC, panels reiterate and expand on previous recommendations regarding a campaign to promote awareness and educate partners and communities on the centralized intake call center for reporting.

Recommendation: To enlist the services of a communications and/or media relations expert to facilitate the development and implementation of an effective communications plan to improve the awareness, understanding and effective utilization of the CICC.

For communities, public awareness and education should include:

- When to make a report
- Options for making a report
- How to be prepared when making a report
- What they can expect after a report is made
- Additional resources available to them, such as free online mandated reporter training and the Prevent Child Abuse Georgia Helpline

For partners, who are professionals or resent professional disciplines that are most frequent reporters of child abuse and neglect[3], early engagement during the development, implementation, and evaluation of any policy or practice change that has the potential to impact shared responsibilities, as did the centralized reporting system, is crucial to ensure the changes do not negatively impact performance, and expectations are realistic and have the intended results.

[2] CICC, Quality Assurance Case Review, August 2012

[3] Such as medical professionals, schools, law enforcement, child care and service providers

"The objective of Georgia's CAPTA Panels is to ensure safety and permanency for all children by holding the state's child welfare agency accountable with regard to its child protection responsibilities. However, in doing so, we must also ensure that they have not only our support but the necessary tools and resources to fulfill its obligations. It is only through our combined advocacy efforts that this can be accomplished."

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[4] 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
- Parents and parent groups
- Individuals who specialize in working with children with disabilities

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

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 requirements:

- Individuals with experience in working with homeless children and youth
- Adult former victims

In 2014, all statutory membership requirements were met, however, the individual representing homeless children and youth resigned and the position was vacant. A new member with extensive experience and expertise with homeless youth has since been successfully recruited and will join the task force in 2015.

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

Additionally, based on needs identified in the three-year assessment conducted in 2014, the task force will supplement its membership with representatives from the Department of Juvenile Justice and the Department of Education as work continuing from the assessment will benefit from the experience in their respective fields. Another priority was the identification of an individual with experience working with trafficked and sexual exploited children. Two new members have already been successfully recruited and will join the task force in 2015. The task force continues to identify additional opportunities for parents, foster parents and youth to contribute to both the CJA and CAPTA Panel process.

Task Force 2014 Activities & Recommendations

In 2014, the task force held five regularly-scheduled meetings, exceeding the federally-mandated quarterly meeting requirements for both a CJA task force and a CAPTA Panel. In addition to regular 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.

In April 2014, the Criminal Justice Liaison and the CJA Coordinator attended the annual CJA grantee meeting[5] held in conjunction with the National Child Abuse and Neglect Conference in New Orleans, LA. The first two sessions of the annual meeting included a Joint Leadership Institute with state liaison officers. Sessions included:

- Exploring Transformational Leadership through the Science of the Positive
- The Seven Core Principles of the Science of the Positive

Breakout sessions during the remainder of the second day provided an opportunity for facilitated peer networking.

The task force had several active interests during 2014. Guests were invited to task force meetings to provide additional background and/or insight on various issues including the state child abuse protocol and the centralized intake call center. Other interests during the year included proposed legislation regarding the privatization of Georgia's foster care system, maltreatment-related fatalities in the news and the commercial sexual exploitation of children.

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

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

- Encourage collaborative efforts between Georgia's child welfare agency and its external partners

Streamlining the solicitation, review, award decision and contracting process to support their annual CJA funding recommendations has 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.

In response to a three-year assessment conducted in 2012, the task force expanded its priorities to include activities such as training, and 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.

2014 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)
- Emory Summer Child Advocacy Program (Barton Child Law & Policy Center, Emory University School of Law)
- CASA Advocacy Training Project (Georgia CASA)
- Annual Youth Law Conference (Office of the Child Advocate & Georgia Association of Council for Children)
- Juvenile Code Re-Write Checklist for Judges (Office of the Child Advocate & Georgia Association of Council for Children)
- Child Abuse Protocol Review and Revision (Office of the Child Advocate)
- Local Multidisciplinary Team Training on Victims with Special Needs (The Cottage)

Additional consultation with the agency's Criminal Justice Liaison, agency representatives and task force members was required to negotiate and approve final recommendations. Contracts were successfully executed for all recommended projects. Although the Criminal Justice Liaison has greatly helped to facilitate this solicitation, review, and award process, the task force plans to consider recommendations regarding efficiencies to the decision-making, implementation and monitoring of these awards in 2014-2015.

Each of these projects supported the CJA emphasis on advocacy, multidisciplinary work and collaboration. The task force reaffirmed their ongoing desire to continue supporting these or comparable activities. Additionally, training with an emphasis on children with special needs and commercial sexual exploitation of children will remain a priority.

CJA Three-Year Assessment: Charged with completing a three-year assessment[6], the task force solicited input on a focus for their assessment from members and interested constituent groups, including the child welfare agency. Previous assessments had focused on training for individuals involved in cases of sexual abuse, victims with special needs, mandated reporter training and representation of children in legal proceedings. Because the task force continues to have concerns related to the reporting and handling of reports of incidents of abuse, they made that the focus of their assessment. Their concerns arose from personal experience and anecdotal reports from law enforcement, medical professionals and other frequent mandated reporters regarding how allegations were handled that were not consistent with expectations or published policy.

On a parallel track, DFCS had initiated its own investigation into inconsistencies between various state agencies with child caring responsibilities such as the Departments of Juvenile Justice, Education, Early Care and Learning, as well as agencies responsible for children in temporary care, when special investigations were conducted. When DFCS became aware of the task force interest, they requested that the subject of

[6] Every three years, CJA state grant recipients are required to conduct a comprehensive system assessment to identify opportunities to improve the handling of cases of child abuse and neglect. The task force initiated their assessment in 2014 in order to meet the 2015 CJA application requirement.

the assessment be broadened to include these state agencies and the task force agreed to do so.

The task force assessment committee worked closely with representatives from DFCS Program and Policy Unit to identify specific objectives, sources of information and development of the methodology for evaluation. The purpose of the assessment was to identify inconsistencies in terminology, definitions, policies, practice or training that might explain inconsistencies in how incidents of maltreatment were reported or handled. In addition to reviewing the identified state agencies, the assessment included a review of applicable sections of the Georgia Code, relevant DFCS policy and the state's child abuse protocol.

Attached, as Exhibit A, is a summary report of findings and recommendations resulting from Georgia's Children's Justice Act Task Force Three-Year Assessment: Review of Law and Policy Related to Child Abuse and Neglect Definitions, Reporting and Investigation Report of Results and Recommendations. These recommendations include:

Legislative Recommendations:

1. The task force recommends that Georgia code definitions related to child abuse in 19-7-5 (reporting of child abuse), 19-15-1 (child abuse definitions), 49-5-40 (child abuse definitions) be updated to be consistent with and/or cross-referenced to the definitions in 15-11-2 (Juvenile Code child abuse definitions).[7]

2. The task force recommends that the Georgia code 19-15-2 (protocol committee on child abuse) be updated to reference the appropriate definitions in 15-11-2, to mandate a multi-disciplinary response to child abuse allegations, to require consistent participation (particularly by DFCS and local prosecutors/district attorneys) on child abuse protocol committees (CAPCs) and related multi-disciplinary teams (MDTs), to require that CAPCs meet monthly, and to mandate adherence to local child abuse protocols.

Policy Recommendations:

1. The task force recommends that DHS/DFCS request that DHS/OIG-RCC and other state agencies with any child-caring staff or contractors or oversight of same (DBHDD, DCH, DECAL, DJJ, DOE, DPH) update their policies/regulations to specifically incorporate and/or reference appropriate child abuse definitions in 15-11-2.

2. The task force recommends that DHS/DFCS request that state agencies with any child-caring staff or contractors update their policies/regulations to specifically incorporate/reference 19-7-5 (reporting of child abuse) if they do not already do so (DHS/OIG-RCC, DBHDD, DJJ, DPH).

Child Abuse Protocol Recommendations:

1. The task force recommends that DHS/DFCS request that the Office of the Child Advocate:
   a. Update child abuse definitions in the state's model child abuse protocol to incorporate/reference 15-11-2.
   b. Clarify and communicate its collaborative processes for updating the model protocol, communicating protocol updates, providing training to local child abuse protocol committees, collecting and reviewing local child abuse protocols and annual reports.

The task force will consult with DFCS leadership how to move these recommendations forward and what support might be needed from the task force, the child welfare reform council, and/or the governor's office.

Looking Ahead to 2015

The three-year assessment identified many opportunities that the task force intends to consider and pursue over the next several years. The task force is developing a plan for ongoing activities related to the assessment results that include:

- Establishing an approval mechanism for all mandated reporter training to ensure consistency

[7] Title 15 (Juvenile Code) governs cases brought to Juvenile Court and not all definitions included in that section are appropriate for community and agency reporters of maltreatment; however, definitions in Titles 19 and 49 (and the Child Abuse Protocol) would be better served by adoption of uniform definitions (with a broader standard than in Title 15).

and compliance with child welfare policy, practice and federal and state law
- Requiring approved mandated reporter training for individuals at state agencies with child-caring staff, if not already required
- Reducing the number of times victims are interviewed in the course of an investigation
- Investigating and clarifying the intent of federal privacy legislation, such as HIPPA and FERPA, often cited as the reason for the delay or poor exchange of information
- Improving consultation and communication between law enforcement, medical professionals and the child welfare agency, at both the state and local levels, on policy and practice change related to their mutual responsibilities
- Improving collaboration and communication between all disciplines involved in the investigation, prosecution and judicial handling of cases of abuse and neglect and the child welfare agency, at both the state and local levels, on policy and practice change with the potential to impact their respective responsibilities
- Improving the consistency of feedback to mandated reporters who have made a report
- Challenges related to jurisdiction and follow up on reports involving a more transient or mobile population (inter-county and inter-state)

The task force will continue its support for multidisciplinary training to improve the investigation, prosecution and judicial handling of cases of child abuse and neglect, and in particular, training related to victims with special needs, commercial sexual exploitation of children and maltreatment-related child fatalities.

Children's Justice Act Task Force Members

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Barton Child Law and Policy Center
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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 2014. Recent additions to the panel include a director from a domestic violence shelter in south Georgia and a program director from a kinship care program in metro Atlanta. Recruitment efforts continue to identify and engage a child abuse prevention specialist and individuals from child care and education, in addition to finding opportunities for parents and foster parents to contribute to the panel.

CPSAC 2014 Activities & Recommendations

In 2014, the CPSAC held six regularly-scheduled meetings, exceeding 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 their annual retreat, CPSAC members agreed to focus their efforts in 2014 in addressing the troubling recruitment and retention of child welfare caseworkers. They had ongoing concerns regarding the impact of budget cuts, changing child welfare priorities, high staff turnover, high caseloads and a negative public perception of the agency on caseworker job satisfaction and morale.

Workforce Survey: The CPSAC developed a survey to solicit feedback from the Georgia child welfare workforce on their caseworker 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 2014 DFCS workforce survey conducted by the CPSAC proved to be well-timed. With a state-wide staff turnover rate in excess of 35%, it is critical that State Government, in all of its branches, recognize the danger this presents to the wellbeing of Georgia's children. The results of the CPSAC's 2014 Workforce Survey of Georgia Social Service Caseworkers and Supervisors offers insight into the contributing factors that have had an adverse impact upon sustaining the child welfare workforce.

The summary report is attached as Exhibit B. Its results have found their way into the final reports of the Georgia Child Welfare Reform Council and Georgia

Senate Child Protection Study Committee[8] and have been used by DFCS leadership to support its own advocacy efforts. CPSAC members are most pleased that stakeholders in the state's child welfare system have found this study to be useful.

The survey underscores the need for DFCS to focus upon building a strong workforce equipped to handle the challenging work of child welfare. Planning, communicating, managing its people, plus creating and sustaining an environment that both attracts new talent and keeps those who can make positive contributions to the work of DFCS – should be a priority not just of the DFCS Director but of the Governor and Legislature as well. Panel members are encouraged by the SFY 2016 budget proposal and by the engagement of key legislators with DFCS leadership; clear progress has been made towards insuring sufficient resources will be there to rebuild the child welfare workforce.

First and foremost, it is the recommendation of the panel that leadership utilize the results of the survey and the accompanying analysis. Additionally, the CPSAC makes the following recommendations:

1. Workforce Retention

A. Establish a budgetary plan to increase worker salaries and compensation ranges by a minimum of 11% over three years through a merit based system prior to the implementation of any modification to the existing system of employee evaluation.

B. Develop and implement a five-year plan to improve public perceptions about DFCS employees and their work. The following stakeholder audiences should be engaged in this planning process:
   i. Georgia Legislators: At the local level, insure each legislator has visited the DFCS office in their respective districts within two years. At the state level, insure legislators understand performance standards to which the state is held accountable.
   ii. Website and social media outlets: Use outside experts to manage social media.
   iii. Media outlets: Strategically engage the media directly and through organizations such as the Atlanta Press Club.
   iv. Nontraditional media outlets.
   v. Faith and other community organizations.

C. Utilize regional and/or county focus groups, focusing on specific environmental topics from the workforce survey:
   i. Personal Safety – both at the office and in the field.
   ii. Chaotic work environments
   iii. The juxtaposition of performance expectations/outcomes and concerns over the wellbeing of children served through CPS or Foster Care.
   iv. Service quality and availability.

D. Commit sufficient resources to develop and implement a robust support system for front-line staff, focusing on secondary trauma, grief, and stress reduction. Consider partnerships with local level community stakeholders, organizations, and faith groups in the plan.

2. Evaluate Policy Development and Implementation

A. Utilize worker feedback to insure content of policy is understood and implemented as planned.

B. Insure that feedback from county directors leads to policy change or modification when needed.

3. Utilize Feedback from Local Staff in Strategy Planning

In addition to the recommendations related to the workforce survey, the CPSAC would like DFCS to also consider the following recommendations:

4. Services

It seems clear that a strong social safety network of providers and services, public and private, will be major contributing factor in the success of the state's child welfare agency. The workforce survey did offer a glimpse into social worker frustration at the lack of available services for children and families.

Panel members have observed that in some counties, it appears DFCS is engaged with local stakeholder groups. Representatives from DeKalb County DFCS participate in the development of priorities for their county

[8] Copy of PowerPoint presentation by CPSAC Co-chair to senate committee, attached as Exhibit C.

government's distribution of human service grant funds. Although Cobb County has a well-developed system of distributing funds to the local community, in contrast to Dekalb, Cobb DFCS is not engaged with the county agency that administers the funds.

In the CPSAC's 2012 annual report, recommendations encouraged the development the necessary array of community-based services. The 2013 annual report expanded on its previous recommendations to include:

a. Development of regional stakeholder work groups to inventory and evaluate community and professional service availability and potential public and private funding sources.
b. Utilization of the 2012 service array recommendations as an outline or template for the evaluation.
c. Creation of a regional strategic plan to improve service availability.

The CPSAC continues to s advocate for these recommendations and further recommends that DFCS undertake an evaluation of needed local services as described in the 2012 annual report.

5. Continuous Quality Improvement

We support the multi-level C³ Connected strategy. By using the CQI process, we are confident that thoughtful, thorough engagement of those most affected by the practice will be afforded a voice and the opportunity to buy-in to system change.

Regarding the C³ Continuous Quality Improvement plan, we offer the following recommendations:

a. CQI Teams become an integral part of the development and implementation of any practice model for DFCS.
b. CQI Teams include external community stakeholders (actual stakeholders in service provision and outcomes)
c. CQI Teams are included in a systematic process for strategy development, critique and evaluation and that an avenue of communication for such participation facilitates the flow of information from the local teams to DFCS leadership.

The CPSAC had several other interests they pursued during 2014. These included monitoring the rollout of the state's Safety Response System and its Family Fusion practice for low to moderate risk families, in addition to the evaluation results on the centralized intake call center. Representatives from DFCS units were invited to CPSAC meetings to present information or updates on these areas of interest.

A former caseworker was also invited to speak to the panel on her experience with the child welfare agency and share her insights on the job and the working environment. In her tenure with DFCS she worked in both urban and rural county offices, and in Investigations, Intake and Family Preservation. Overall, she reported that her experience was positive and she spoke highly of her fellow caseworkers. On the plus side, she felt the strengths of the system included training, child welfare policy, and intake decision-making tree. The negatives were high caseloads, low compensation, inexperienced coworkers and the constant pressure and stress of the job. It is the latter that eventually precipitated her resignation. Her testimony only reaffirmed the panel's intention behind the workforce survey.

Other interests during the year included proposed legislation regarding the privatization of Georgia's foster care system and maltreatment-related fatalities in the news, and in particular, how biased media reports in these cases are, not always articulating enough pertinent information on the circumstances surrounding the deaths to adequately inform the public on systems other than the child welfare system that may have shared some responsibility for the failure to protect a child.

Looking Ahead to 2015

At the annual retreat in September, the CPSAC identified several interests to pursue in 2015, including:

- Evaluation of the state's CAPTA Plan
- Ongoing child welfare policy review
- Foster parent recruitment, training and support
- Public image of the child welfare agency and educating the public on DFCS' role and the communities' role in protecting children
- Improvement to the DFCS website and increased use of social media

Child Protective Services Advisory Committee Members

Karl Lehman (Co-Chair)
CEO
Childkind, Inc.

Amy Rene (Co-Chair)
Vice President of Community Programs
Hillside, Inc.

Angela Burda, Program Director
Clayton County Kinship Care Resource Center

Molly Casey, Teen Parent Connection
Multi-Agency Alliance for Children, Inc.

Rachel Ewald, CEO
Foster Care Support Foundation

Michelle Girtman, Executive Director
Battered Women's Shelter, Inc.

Sheralyn Hector
CASA

Jennifer King, Program Operations Director
Georgia CASA

Lori Muggridge, Executive Director
Ocmulgee CASA

Mike Patton, Program Manager
Healthy Grandparents Program
Georgia Regents University

Ray Rene
Technology Development & Operations Manager
Biocure

Scott Rhoden, Executive Director
Compassion House, Inc.

Kathy Wages, Community Liaison
Georgia Family Connection Partnership
UGA Cooperative Extension Family and Consumer Sciences

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.

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.

The CFRP is supported by staff that 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. It is important to note that during 2014, the

administrative responsibility for child fatality review transferred from the Office of the Child Advocate (OCA) to the Georgia Bureau of Investigations (GBI). The transition was successfully completed in July.

Members of the CFRP and the Maltreatment Committee were consulted on legislation related to the transfer and provided input on child fatality priorities, including its CAPTA obligations to the agency leadership. It was anticipated that resources at the disposal of the GBI had the potential to enhance the quality and improve the consistency of reviews, in addition to increasing reporting compliance.

2014 CFRP & CAPTA Maltreatment Committee Activities & Recommendations

The CFRP meets quarterly, satisfying its CAPTA meeting requirements. The CAPTA Maltreatment Committee also met several times each year. The CFRP remains steadfast in its desire and efforts to reduce preventable child deaths resulting from all manner and circumstances and increase public awareness of their shared responsibility to protect Georgia's children. The CFRP is statutorily required to prepare an annual report on its activities and findings. The Annual Report - Calendar Year 2013 is attached as Exhibit D. The CFRP report identifies "opportunities for prevention" in all child fatalities, including those resulting from child abuse or neglect.

Teri Covington, Director of the National Center for the Review and Prevention of Child Deaths was invited to speak to CFRP members during the year and provided invaluable insight on the challenges facing most states in their child death review and prevention efforts. Lack of funding was reported as the biggest challenge in most states, and those with adequate funding for their child death review programs, see better results. She emphasized the need for early notification on deaths and the need for a strong link to vital records for birth and death information, strong data support to improve quality of reviews and reporting, and integration of partners with vested interest to facilitate information and data sharing. She also advocated for providing feedback to local review teams on a regular basis.

Several high profile child deaths that occurred during 2014 resulted in an ongoing dialogue regarding identifying the circumstances surrounding these and other deaths when maltreatment is suspected and missed opportunities that could have possibly changed the outcome. In these most troubling of cases, families are often involved with multiple support systems in the community. Breakdown of any one of these systems can contribute to a child death, however, DFCS is most often cited as having failed in their protection responsibilities.

Confidentiality laws limit the extent of information that can be shared with the public, and as a result, diminishes the opportunity to protect children and prevent future child deaths. CAPTA state grant recipients are required to have established "provisions which allow for public disclosure of the findings or information about a case of child abuse or neglect which has resulted in a child fatality or near fatality"[9]. This is accomplished through an open records request in Georgia. However, to increase agency transparency and public awareness, and eventually, to prevent child deaths, the results of the multiple reviews conducted and actions taken should be made public annually in some aggregate format that protects the confidentiality of the individuals involved.

Recommendation #1: Explore viable options for improving the public disclosure of the circumstances surrounding child fatalities, as intended by CAPTA.

During 2013 and 2014, the review of specific cases and aggregate data collected from child death reviews, suggested that fatalities where maltreatment may have been a contributing factor may have been overlooked or not reported.

Recommendation #2: To ensure that no maltreatment-related death is overlooked and under-reported, provide additional training to child death review teams on child abuse and neglect, including:

- Definitions and terminology
- Indicators (red flags) and standards for comparison
- Resources, including access to child welfare history

Recommendation #3: Review definitions and terminology in Child Death Review Case Reporting System to identify potential inconsistencies with state (Georgia) and local policy or practice that may impact

[9] CAPTA Section 106 b.2.x

the quality and consistency of report and the assessment of data.

The Maltreatment Committee has suggested that state level aggregate data on maltreatment-related deaths is not sufficiently illuminating and has suggested that other options be explored to improve its ability to study maltreatment-related deaths in fulfilling its role as a CAPTA Panel.

Recommendation #4: Explore additional options for enhancing the review of maltreatment-related deaths that will provide insight into the mitigating factors surrounding the death and help to evaluate the effectiveness of relevant child welfare policy and/or practice.

Prevention recommendations remain fairly consistent from year to year. In the 2013 CAPTA Panel annual report, several recommendations were offered related to improving the effectiveness of prevention recommendations at both state and local levels. The Maltreatment Committee would like to reaffirm these for 2014.

Recommendation #5: To improve prevention efforts, provide additional training to child death review teams on developing measurable and actionable recommendations that include:

- Specific tasks, timeframe and entity or individual responsible for taking action
- Objectives and expected results that are measurable
- Identification of additional resource needs or barriers to overcome

Looking Ahead to 2015

Georgia's CFRP and CAPTA Maltreatment Committee will continue to explore collaborative opportunities to increase the effectiveness of our collective prevention efforts.

Child Fatality Review Panel Members

Judge LaTain Kell (Chair)
Cobb County Superior Court

Judge Peggy Walker (Vice Chair)
Douglas County Juvenile Court

Paul Battles
GA Representative

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

Dr. Frank Berry
Department of Behavioral Health & Developmental Disabilities

Gloria Butler
GA Senator

Brenda Fitzgerald
Division of Public Health

Robertiena Fletcher, Board Chairperson
Department of Human Services

Charles Fuller, Chairperson
Criminal Justice Coordinating Council

Bobby Cagle, Director
Department of Family and Children Services

Vernon Keenan
Georgia Bureau of Investigations

Tiffany Sawyer, Prevention Director
Georgia Center for Child Advocacy

E.K. May Jr.
Washington County Coroner

Paula Sparks
Safepath Children's Advocacy Center

Dr. Kris Sperry
GBI Medical Examiner

Ashley Willcott
Office of the Child Advocate

Ashley Wright, District Attorney
Augusta Judicial Circuit

Amy Jacobs, Commissioner
Department of Early Care and Learning

Vacant
Department of Education

CAPTA Maltreatment Committee Members

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Melissa Carter, Executive Director
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Emory University School of Law

Lisa Dawson, MPH, Director
Injury Prevention Program
DPH Division of Health Protection

John Carter, Emeritus Professor
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Judge LaTain Kell
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Beoncia Loveless, Death Investigation Specialist III
GBI Coordinator for the Child Abuse Investigative Support Center

Kim Washington, DV & Prevention Liaison
DHS/DFCS
Safety Management Section

Deb Farrell, Vice President
Care Solutions, Inc.
CAPTA Panel & CJA Task Force Coordinator

On behalf of the members of Georgia's CAPTA Panels, the 2014 annual report is respectfully submitted for review and consideration by the Department of Families and Children Services. CAPTA Panel members look forward to meeting with DFCS Director and members of his leadership team to discuss our work and the resulting recommendations articulated in this report.

We want to express our sincere appreciation to the leadership team at DFCS for supporting our efforts and for affording panel members the respect, transparency, and responsiveness needed to fulfill our mandate as a CAPTA Panel. We look forward to working with Director Cagle in 2015; we especially value the collaborative spirit he brings to our work with the Department.

Respectfully

Melissa D. Carter, JD
Angela Tyner, JD
Children's Justice Act Task Force

Karl Lehman
Amy Rene
Child Protective Services Advisory Committee

Judge LaTain Kell
Judge Peggy Walker
Child Fatality Review Panel

This report was prepared in consultation with and on behalf of Georgia's CAPTA Panels by Deb Farrell, GA CAPTA Panel & CJA Task Force Coordinator, Care Solutions, Inc.

For more information on Georgia's CAPTA Panel program, visit www.gacrp.com.

Exhibits*

Exhibit A:	Georgia Children's Justice Act Task Force 3-Year Assessment: Review of Law and Policy Related to Child Abuse and Neglect Definitions, Reporting and Investigation, Report Results and Recommendations conducted by the Children's Justice Act Task Force
Exhibit B:	2014 Workforce Survey of Georgia Social Services Caseworkers and Supervisors conducted by Child Protective Services Advisory Committee
Exhibit C:	August 19, 2014 presentation to Georgia Senate Child Protection Study Committee on 2014 Workforce Study
Exhibit D:	Georgia Child Fatality Review Panel Report, Annual Report – Calendar Year 2013

**Full size copies of exhibits are available at www.gacrp.com.*

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Exhibit A

Georgia Children's Justice Act Task Force 3-Year Assessment:
Review of Law and Policy Related to Child Abuse and Neglect Definitions, Reporting and Investigation

Report of Results and Recommendations

2014/2015

Introduction

Every three years, as a component of the state's Children's Justice Act (CJA) state grant application, the CJA Task Force is required "to undertake a comprehensive review and evaluation of the investigative, administrative and judicial handling of cases of child abuse and neglect and to make training and policy recommendations" in each of the three CJA categories. This assessment must include a report outlining the review, evaluation and recommendations.

In 2009 and 2012, the Georgia CJA Task Force took a narrow approach to its assessment. In 2009, the assessment focused on CAPTA requirements that intersected with CJA objectives and evaluated mandated reporter training, practice regarding appointment of representation for children in dependency cases, and training for cases involving allegations of child sexual abuse. The assessment conducted in 2012 focused on policy, practice and training related to cases involving children with special needs.

For the current three-year assessment, the Georgia Children's Justice Act (CJA) Task Force decided to address inconsistencies reported in the response to allegations of maltreatment among selected agencies and organizations, including both initial reports, and reports of maltreatment of children in out-of-home care.

Background

In early discussions at its April and June 2014 meetings, task force members had expressed concerns about reported inconsistencies in how various agencies (e.g., education, law enforcement) respond when there is an allegation of child maltreatment. Independently, the Division of Family and Children Services (DCFS) Program and Policy Unit was exploring concerns it had identified during reviews of maltreatment in care allegations that revealed a lack of consistency (language, definitions, standards) between DFCS and other agencies (and facilities monitored by other agencies) that affected outcomes. DCFS was already in the process of researching and addressing some of these concerns as they relate to maltreatment of children in foster care facilities regulated by the Department of Human Services' Office of Residential Child Care and detention facilities operated by the Department of Juvenile Justice (special investigations).

At its August 2014 meeting, the task force heard from DFCS program and policy representatives regarding the DFCS work thus far related to special investigations and the concerns it had identified with the goal being a coordinated and consistent response to maltreatment allegations. More specifically, the task force was interested in how reports are handled; the definitions of maltreatment; the responses to maltreatment reports, including internal investigations and their objective; related agency policies and practices; and the nature and timing of information-sharing with DFCS as the state's child welfare agency, if any. The purpose of the assessment was to identify any important inconsistencies with the child welfare agency's policy and practice and address those in task force training and policy recommendations to inform the use of CJA funds. The task force agreed to collaborate with DFCS and expand on their work in the CJA assessment, and one of the DFCS representatives agreed to participate on the task force's assessment committee.

The task force's assessment committee met to begin framing the plan for the three-year assessment. The group felt that a key to consistent response was mandated reporter training, particularly for the most frequent mandated reporters (school personnel, law enforcement and medical professionals, as well as personnel in facilities that are most often the subject of a special investigation (maltreatment in care). The group noted there is no process for approving such training to ensure it is consistent with federal and state law as well as DFCS policy and practice. Additional discussion about the assessment and specific concerns took place at the task force's annual retreat September 18.

Assessment Method

Policy Review

The assessment committee met several times to flesh out the assessment plan and decided that the assessment would focus on a review of policy to identify inconsistencies in agency definitions, reporting, and investigation of maltreatment allegations, with follow-up regarding practices over the next three-year period. Staff prepared the assessment concept and developed a template for questions to be used by committee members in their reviews of agency policies. Staff met with DFCS policy representatives to review a preliminary draft of the assessment concept and template questions to solicit additional input.

In November, the draft concept and template was emailed to assessment committee members and then to the full task force for review. In December, staff met again with DFCS representatives for a final review of the template. Additionally, committee and task force members signed up to review the policies of specified agencies, as well as DFCS policies, to identify inconsistencies/areas of concern, and DFCS representatives forwarded copies of policies and concerns identified in their research.

Copies of various agency policies/regulations, the state's model Child Abuse Protocol (full and minimum standards versions, as updated in 2014), relevant excerpts from the Georgia Code, DFCS intake policy (as updated in 2014), and DFCS draft investigations policy were posted on a secure website for reviewer access. After incorporating feedback received from task force members and DFCS policy representatives, the template with instructions (attached) was distributed to volunteer reviewers.

Agencies Reviewed

Policies were reviewed for the following agencies:

- DHS – Department of Human Services
  - Division of Family & Children Services (DFCS) - child welfare agency
  - Office of Inspector General Residential Child Care (OIG-RCC) unit – regulates child caring institutions (CCIs), outdoor child caring programs, child placing and adoption agencies (CPAs), children's transition care centers
- DBHDD – Department of Behavioral Health and Developmental Disabilities – oversight of six regional state hospitals and community-based services across the state
- DCH – Department of Community Health – lead agency for Medicaid; oversight of healthcare facilities
- DECAL – Bright from the Start: Georgia Department of Early Care and Learning – oversight of child care providers, GA Pre-K; Head Start Collaboration Office
- DJJ – Department of Juvenile Justice – oversight of youth development campuses and regional youth detention centers
- DOE – Department of Education – state oversight, policy for local boards of education

Exploratory Research

In the meantime, because there is no one statewide agency with law enforcement oversight, staff met with a law enforcement representative (task force member) representing a large metro county police department to discuss response and investigation of maltreatment allegations on the part of law enforcement. Discussions also included law enforcement training and communication with DFCS, locally and on the state level.

Similarly, because there is no one statewide agency with oversight of health care professionals, staff met with representatives of Children's Healthcare of Atlanta and a co-located DFCS representative regarding processes and concerns related to the reporting and investigation of maltreatment allegations in health care settings, specifically hospitals and their satellite clinics.

Assessment Results

Based on the completed templates and other feedback from reviewers as well as additional staff research, a draft summary of the assessment results was compiled and distributed to committee and task forces members for consideration and discussion of potential recommendations.

Again, this assessment included a review of definitions in various sections of the Georgia Code relevant to agencies with oversight of care settings for children under age 18, the state-level policies of those agencies, and the state's model Child Abuse Protocol. This was supplemented with interviews with law enforcement, healthcare, and DFCS representatives. While there were many areas in which law and policy were consistent, the following summary represents inconsistencies identified in this assessment process.

Definitions of Child Maltreatment

Within the Georgia Code there are some inconsistencies in language (highlighted) likely due to the more recent passage of the updated Juvenile Code (Title 15), which was used as the comparison reference. The state's Child Abuse Protocol (model) uses the definitions found in Titles19 and 49 rather than those in the Juvenile Code. Title 19 includes the mandated reporter section (19-7-5).

Term	Juvenile Code (Title 15)	Criminal Code (Title 16)	Domestic Relations (Title 19), Social Services (Title 49), and the Child Abuse Protocol	Education (Title 20) and Law Enforcement (Title 35)
Abuse (child implied) or child abuse	(A) Any non-accidental physical injury or physical injury which is inconsistent with the explanation given for it suffered by a child as the result of the acts or omissions of a person responsible for the care of a child; (B) Emotional abuse; (C) Sexual abuse or sexual exploitation; (D) Prenatal abuse; or (E) The commission of an act of family violence as defined in Code Section 19-13-1 in the presence of a child.	Not specifically defined; defines crimes, including child maltreatment (depriving of sustenance), serious injury (includes sexual abuse of a child under 16), and child molestation (among other sexual offenses)	(A) Physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means; provided, however, physical forms of discipline may be used as long as there is no physical injury to the child; (B) Neglect or exploitation of a child by a parent or caretaker thereof; (C) Sexual abuse of a child; or (D) Sexual exploitation of a child. (in 19-15-1, 19-7-5, and 49-5-40)	Not specifically defined
Sexual abuse	A caregiver or other person responsible for the care of a child employing, using, persuading, inducing, enticing, or coercing any child to engage in any act which involves . . . (specific acts listed)	Defines specific "sexual offenses" (but not labeled sexual abuse) Defines sexual exploitation of children as sexually explicit conduct (actual or simulated), listing the same acts as for sexual abuse in Title 15	A person's employing, using, persuading, inducing, enticing, or coercing any minor who is not that person's spouse to engage in any act which involves . . . (same acts as Title 15)	Not specifically defined
Emotional abuse, neglect, prenatal abuse	Defines these terms	Not separately defined	Do not define these terms	Title 20 references criminal code for crimes (injury/death) and sexual offenses Title 35 references training regarding family violence and sexual offenses (not defined) and trafficking for labor or sexual servitude as defined in Title 16
Sexual exploitation	Conduct by a caregiver or other person responsible for the care of a child who allows, permits, encourages, or requires a child to engage in prostitution (16-6-9) or sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct (16-12-100).	Defines prostitution (in sexual offenses, 16-6-9) and sexually explicit conduct (in sexual exploitation of children, 16-12-100)	Conduct by any person who allows, permits, encourages, or requires that child to engage in prostitution (16-6-9) or sexually explicit conduct for the purpose of . . . (16-12-100)	Title 20 references 16-12-100; Title 35 does not define or reference criminal code

Additionally, there are differences in policy definitions of child maltreatment among the agencies reviewed, ranging from very broad to very specific. Note that DBHDD and DCH definitions apply to adults as well as children. Additionally, in policy, DHS has a maltreatment codes guide with 31 specific categories of maltreatment with definitions; DJJ has a special incident reporting codes guide with 55 specific incident categories with definitions, including categories related to child abuse and neglect.

Term	DHS Intake Policy	DBHDD	DCH	DECAL	DJJ	DOE
Abuse or child abuse	Abuse: Any non-accidental physical injury or physical injury which is inconsistent with the explanation given for it suffered by a child as the result of the acts or omissions of a person responsible for the care of a child (same definition as in Title 15)	Not separately defined	Abuse: Any unjustifiable intentional or grossly negligent act, exploitation or series of acts, or omission of acts which causes injury to a person, including but not limited to verbal abuse, assault or battery, failure to provide treatment or care, or sexual harassment	Defines crimes per criminal code: battery, contributing to the delinquency of a minor, sexual offenses, or attempts at any of these Lists prohibited behaviors, generally including physical or sexual abuse; sexually overt conduct in child's presence; corporal punishment; verbal abuse; inappropriate discipline; and criminal acts in child's presence	Child abuse: An adult causing bodily injury to a youth other than by accidental means. Mistreatment: Violation of DJJ policy, with no injury to youth, including slapping, shoving, kicking, biting and spitting at/on a youth	References crimes per criminal code, including sexual offenses, sexual exploitation Specifies unethical conduct, including child abuse, physical and verbal abuse, cruelty to children, child endangerment, committing with or soliciting from a child a sexual act
Physical abuse	Same definition as abuse, above	Any interaction or physical contact, motion, or action that is directed toward an individual by someone other than another individual (peer), which may cause harm or pain. (Gives examples)	Not separately defined	Not separately defined	Same as child abuse definition above (in incident codes)	Not separately defined
Sexual abuse	Same as Title 15	Any sexual contact between an employee and an individual. An employee encourages or allows sexual contact between individuals, one of whom is not consenting.	Not separately defined	Not separately defined	Same as criminal code definition (in incident codes)	Not separately defined
Sexual exploitation	Same as Title 15	Not defined	Not defined	Not defined	Same as criminal code definition (in incident codes)	Not separately defined

Emotional abuse	Same as Title 15	Psychological abuse: An act by someone other than another individual (peer) that causes or could reasonably be expected to cause emotional distress to an individual. (Gives examples)	Not defined	Not defined	Not defined	Not separately defined
Family violence	References 19-13-1	Not defined	Not defined	Not defined	Not defined	Not defined
Neglect	(A) The failure to provide proper parental care or control, subsistence, education as required by law, or other care or control necessary for a child's physical, mental, or emotional health or morals; (B) The failure to provide a child with adequate supervision necessary for such child's well-being; or (C) The abandonment of a child by his or her parent, guardian, or legal custodian. (same as Title 15)	The failure of an employee or an organization to provide goods, services and/or supervision necessary to avoid physical harm.	The absence or omission of essential services to the degree that it harms or threatens with harm the physical or emotional health of a person	Not defined	Lack of supervision, abandonment, and/or disregard for the child's basic needs for food, shelter, medical care or education that places the child at substantial risk of harm	Not defined
Prenatal abuse	Same as Title 15	Not defined	Not defined	Not defined	Not defined	Not defined
Abandonment	Defined	Not defined	Not defined	Not defined	Not defined	Not defined
Commercial Sexual Exploitation of Children (CSEC)	Defined	Not defined	Not defined	Not defined	Not defined	Not defined

Reporting Child Maltreatment

Each agency reviewed has policy requiring the reporting of child abuse and neglect, with three agencies specifically referring to the mandated reporter law (19-7-5), which defines child abuse and neglect (see previous chart) and requires reports within 24 hours:

> *An oral report shall be made immediately, but in no case later than 24 hours from the time there is reasonable cause to believe a child has been abused, by telephone or otherwise and followed by a report in writing, if requested, to a child welfare agency providing protective services, as designated by the Department of Human Services, or, in the absence of such agency, to an appropriate police authority or district attorney.*

If signed by the governor, HB 268, passed by both houses in 2015, would amend 19-7-5 to mandate that a person required to report child abuse who receives reliable information that child abuse has occurred involving a person who attends to a child as part of their duties as an employee or volunteer in hospital, school, social agency, or similar facility notify the person in charge of such facility and the person receiving the notification shall further make a report of the suspected child abuse without altering the information provided by the reporter. The bill also permits reports to be made by telephone or other oral communication, or by email or fax.

Reporting	DHS OIG-RCC	DBHDD	DCH	DECAL	DJJ	DOE
Reported to agency internally	Serious occurrences/ incidents; child abuse	Deaths and critical incidents	Serious occurrences/ incidents; child abuse	Child abuse, neglect or deprivation; communicable diseases; incidents	Special incidents; child abuse and neglect; sexual abuse	Ethics violations (includes child abuse) to Georgia Professional Standards Commission
Reported to DFCS	Child abuse, neglect, sexual exploitation; some rules & regulations reference 19-7-5; others say state law	Abuse or neglect of child	Child abuse per 19-7-5	Child abuse, neglect or deprivation per 19-7-5	Child abuse and neglect, sexual abuse	Child abuse per 19-7-5
Time frame for reporting to DFCS or law enforcement	24 hours	Not specified, except report immediately to law enforcement if there is immediate danger	24 hours	24 hours	24 hours	24 hours
Required training related to child abuse and neglect, mandated reporting	Requires training in child abuse policies and procedures and reporting requirements for child abuse and sexual exploitation for CCIs and children's transition care centers (not specified for CPAs or outdoor programs)	Not identified in policies related to incidents or personnel	Requires creation of orientation/training on policies and procedures related to child abuse, neglect and exploitation, including reporting requirements	Requires all child care providers/staff to receive initial orientation on reporting requirements for suspected cases of child abuse, neglect or deprivation Not specified for GA Pre-K Federal regulations require staff training that includes identifying and reporting child abuse and neglect in accordance with state laws	Not specified in policies related to special incidents and child abuse or staff development and training	All school personnel who have contact with students are required to have training in the identification and reporting of child abuse and neglect (with annual written updates)

Investigating Child Maltreatment

The reviewed state agencies that regulate facilities providing care for children all investigate incidents that occur on those premises, including incidents involving child maltreatment, with the exception of the Department of Education. The focus of those investigations is incidents, which may be death, injury, abuse, and/or violations of rules and regulations. DFCS focuses primarily on child maltreatment and child safety, while the other agencies that investigate incidents are more focused on violations of policy and regulations. While some of these agencies allow for removing the accused employee from contact with children for the sake of individual/child safety, others do not address this in policy. Additionally, while DJJ has policy related to coordinating investigations of abuse or neglect with DFCS, the other agencies with investigatory responsibilities do not address this.

Investigation	DHS DFCS	DHS OIG-RCC	DBHDD	DCH	DECAL	DJJ	DOE
Focus of investigation	Child maltreatment	Incidents	Incidents	Incidents	Violations of rules and regulations	Incidents and child abuse	Student discipline (local entities) Educator conduct (Georgia Professional Standards Commission)
Who investigates internally	DFCS	DHS OIG	DBHDD Office of Incident Management and Investigations	DCH Office of Inspector General	DECAL	DJJ Office of Investigations	
Provisions for ensuring child safety	Child safety assessed at intake and during investigation; option for child removal	For CCIs and children's transition care centers: must evaluate continued use of any staff member alleged to be involved in abuse; not specified for CPAs and outdoor programs	Broad requirement that providers take action to protect individuals; may remove employee from direct contact	Not specified in rules and regulations	Not specified in rules and regulations	Accused staff member may be placed on "no contact" with youth status	Not specified in policy
Joint investigations	With law enforcement for all serious and/or complex reports of abuse or neglect	Not specified in rules and regulations	Requires cooperation with law enforcement investigation	No specified in rules and regulations	Not specified in rules and regulations	On request from facility, program or office directors, will coordinate with DFCS for investigations of child abuse or neglect	Not specified in policy

Related Topics

Child Abuse Protocol

Georgia's state Child Abuse Protocol was designed to be a model protocol for adaptation by Georgia counties. The protocol defines areas of responsibility, mostly at the county level, without designating the specific agency that may have oversight of county agencies, such as mental health services, public health services, medical services, perhaps taking its cue from the GA Code list of protocol committee designations. As a result, or because they are not directly involved in the investigation of child maltreatment or related incidents, some of the agencies reviewed for this assessment are not party to or referenced in the protocol, including DBHDD, DCH, DECAL and DOE. Additionally, the protocol does not provide for communicating the protocol or providing training on the protocol to local agency staff or health professionals who may have responsibilities under the protocol.

Topic	DHS DFCS	DHS OIG-RCC	DBHDD	DCH	DECAL	DJJ	DOE
Party to or referenced in GA Child Abuse Protocol	Yes	No	No – but includes county mental health organization, mental health providers	No – but includes county public health, doctors/ medical providers	No	Yes	No – but includes county board of education, school districts, and schools

Background Checks

All of the agencies require background checks for agency employees and directors/staff of facilities that provide care and/or education for children. DCH and DOE do not specify whether fingerprint checks must be used; DHS OIG-RCC specifies fingerprint checks only for program directors and CPA foster parents.

Topic	DHS DFCS	DHS OIG-RCC	DBHDD	DCH	DECAL	DJJ	DOE
Criminal background checks	Fingerprint checks required for all applicants selected for employment and for all prospective foster parents and adoptive parents (also required are medical exams, screening in the CPS, Sexual Offenders Registry, Pardons and Parole, and Department of Corrections systems	Criminal background checks required for CCI, outdoor program, CPA and transition care center directors and staff; fingerprint checks required for directors and CPA foster parents (type not specified for others)	Fingerprint checks required for all applicants selected for employment	Background checks required for all facility staff; type not specified except that must be cross-referenced against the state sexual offender registry	Fingerprint check required for all child care and GA Pre-K providers and staff (exception for family or group home staff with no child contact) Head Start must follow state law or administrative requirements	Fingerprint check required for all employees; background check may also include sex offender registry, criminal records, credit history, driver history and military service record For placements and non-parent visits all adults must have background investigations	All persons hired by DOE must agree to undergo drug screening and criminal background investigation (type not specified) The GA Professional Standards Commission indicates all public school employees receive background checks and applicants for educator certificates are checked against a national database for sanctions in other states (website)

Related Concerns Identified in Interviews

Informal discussions with law enforcement, healthcare and DFCS representatives identified additional concerns related to the identification, reporting and investigation of child maltreatment. These issues were not necessarily related to the policy reviews but were included in this summary report because they suggested areas for the CJA Task Force to consider in its recommendations and/or additional research.

Additional issues identified by DFCS representatives:

Reporting
- DJJ does not report minor injuries (rated as a 1 or 2) to DFCS
- While agencies may report maltreatment to DFCS, they do not necessarily provide DFCS with information from their internal reports or investigations, resulting in inappropriate screen-outs or duplication of effort
- Federal FERPA cited as barrier by education agencies from sharing information with DFCS
- DECAL does not require mandated reporter training
- DOE mandated reporter training does not address allegations against a teacher or administrator

Investigation
- DFCS and RCC have differing time frames for response
- Multiple interviews of maltreatment victims due to multiple agency investigations
- Inconsistencies in whether DFCS also investigates DJJ incidents

Child Safety
- DFCS cannot remove a child from a DJJ facility to keep the child safe
- DECAL Childcare and Parent Services does not have oversight on substantiated abuse in child care facilities, which may care for children in subsidized care

Additional issues raised by law enforcement (Gwinnett representative):

Reporting
- Basic police training includes training on the GA code, including crimes against children (including abuse/neglect) and mandated reporting (professional development is self directed based on required hours per year, rather than specific content)
- If law enforcement considers a child to be in danger and there is no other family member who can take physical custody of the child, and DFCS is delayed in getting a caseworker to the scene, they may seek a removal order from the court directly (potential for disagreement with DFCS assessment of safety and removal not being required))
- Facility/school administrators may be reluctant to get police involved
- Concerns related to the length of time it takes to make a report to DFCS and answering questions on the telephone (sends copy of police incident report by mail) [Note that HB 268, if signed by the governor, will allow for fax and email reports.]

Investigation
- Investigates family violence, including child abuse; if child abuse is serious, will investigate; if not serious, refers to DFCS CPS intake (calls and then sends copy of police report by mail)

- Conflict with DFCS response times: police want to complete their investigatory interviews prior to confronting suspect; DFCS interviewing before that time may affect police investigation
- Conflict related to purpose of law enforcement investigations versus the purpose of DFCS investigations which may hinder the police investigation

Other

- Police services vary at the local level – there may be city police, county police, and/or county sheriff's department; some counties only have sheriff's department; in some areas state highway patrol has police duties

Additional issues identified by Children's Healthcare of Atlanta (CHOA) representatives:

Reporting

- General practitioners may not report maltreatment because of their patient relationships and/or not recognizing the maltreatment, possibly due to insufficient training or confidentiality concerns
- Child abuse and neglect training varies with medical schools; some have little training in this area, even for pediatricians
- Difficulties in making reports efficiently via the DFCS call center
- Non-resident or out-of-county children seen in hospitals or clinics: Concerns expressed regarding protocol in handling reports in these situations because of an inability to collect information; additionally, there is confusion regarding county assignment for out-of-county children
- Strength: CHOA policy requires suspected maltreatment be reported to DFCS and/or law enforcement within 24 hours, even if the doctor or care team members do not agree that there is maltreatment

Investigation

- Delays in DFCS assigning reports to caseworkers, resulting in delay of discharge from hospital: per CHOA policy, when a maltreatment report is made, the patient cannot be discharged until cleared by DFCS or law enforcement
- Information reported to call center not shared with caseworkers, resulting in re-reporting of information; compounded problem when there are multiple siblings with different injuries
- Inconsistent feedback on reports/cases

Judicial Handling

- No consistent protocol to provide feedback to the courts regarding impact of judicial decisions on cases, particularly when professionals advised differently in court (and may only be seen in media coverage)

For both law enforcement and healthcare, there is no one statewide oversight body in either area to support communication of requirements, policies, protocols and updates to any of those statewide. For law enforcement, the Peace Officer Standards and Training Council (POSTC), established by state statute, oversees training and certification of peace officers but has no oversight of law enforcement agencies. In the healthcare arena, the Department of Community Health (DCH) oversees the state's Medicaid program and state health benefit plan and regulates healthcare facilities such as hospitals and nursing homes but not private medical practices. The Department of Public Health (DPH) oversees various public health programs as well as county health departments.

Task Force Response - Recommendations & Additional Actions

The CJA Task Force discussed assessment results to identify potential task force recommendations and activities for future action or those requiring further investigation. Formal recommendations are listed below. Additional actions for the task force consideration and action during 2015 are italicized.

Legislative Recommendations

1. The task force recommends that Georgia code definitions related to child abuse in 19-7-5 (reporting of child abuse), 19-15-1 (child abuse definitions), 49-5-40 (child abuse definitions) be updated to be consistent with and/or cross-referenced to the definitions in 15-11-2 (Juvenile Code child abuse definitions).[1]
    a. *The task force will explore this as a legal intern/law student research project.*
    b. *The task force will explore with DFCS taking this recommendation to the child welfare reform council.*
2. The task force recommends that the Georgia code 19-15-2 (protocol committee on child abuse) be updated to reference the appropriate definitions in 15-11-2, to mandate a multi-disciplinary response to child abuse allegations, to require consistent participation (particularly by DFCS and local prosecutors/district attorneys) on child abuse protocol committees (CAPCs) and related multi-disciplinary teams (MDTs), to require that CAPCs meet monthly, and to mandate adherence to local child abuse protocols.
    a. *The task force will research other states' requirements, specifically Tennessee, which requires an MDT in every county, to see how statutory frameworks for protocol committees/MDTs line up with court frameworks.*
    b. *The task force will explore this as a legal intern/law student research project.*
    c. *The task force will explore with DFCS taking this recommendation to the child welfare reform council.*

Policy Recommendations

1. The task force recommends that DHS/DFCS request that DHS/OIG-RCC and other state agencies with any child-caring staff or contractors or oversight of same (DBHDD, DCH, DECAL, DJJ, DOE, DPH) update their policies/regulations to specifically incorporate and/or reference appropriate child abuse definitions in 15-11-2.
2. The task force recommends that DHS/DFCS request that state agencies with any child-caring staff or contractors update their policies/regulations to specifically incorporate/reference 19-7-5 (reporting of child abuse) if they do not already do so (DHS/OIG-RCC, DBHDD, DJJ, DPH).
    a. *The task force will consult with DFCS leadership how to move these recommendations forward and what support might be need from the task force, the child welfare reform council, and/or the governor's office.*

Child Abuse Protocol Recommendations

1. The task force recommends that DHS/DFCS request that the Office of the Child Advocate:
    a. Update child abuse definitions in the state's model child abuse protocol to incorporate/reference 15-11-2.
    b. Clarify and communicate its collaborative processes for updating the model protocol, communicating protocol updates, providing training to local child abuse protocol committees, collecting and reviewing local child abuse protocols and annual reports.

[1] Title 15 (Juvenile Code) governs cases brought to Juvenile Court and not all definitions included in that section are appropriate for community and agency reporters of maltreatment; however, definitions in Titles 19 and 49 (and the Child Abuse Protocol) would be better served by adoption of uniform definitions (broader and with a lower standard than in Title 15).

For future consideration and further development by the task force 2015 – 2018

1. The task force will consult with DFCS and OCA regarding the establishment of a state-level multi-agency committee to develop a state-level multi-agency agreement/protocol (analogous to local child abuse protocols with specified agencies and agency responsibilities) on the reporting, investigation and prosecution of child abuse.
    a. The committee would include all state agencies with any child-caring staff or contractors (or oversight of same) and state agencies/organizations with oversight of those involved in the investigation or prosecution of cases (e.g., the Prosecuting Attorneys Council, District Attorneys' Association, Council of Juvenile Court Judges, Children's Advocacy Centers, Georgia Bureau of Investigation (GBI), Georgia Professional Standards Commission, Peace Officer Standards Training Council).
    b. The agreement would include mandated reporter requirements and time frames; mandated reporting training requirements, standardized mandated reporter training for specific agencies/roles, and DFCS approval of mandated reporter training content; joint investigations and interviewing of child victims to minimize duplication and trauma to child; and communication and information-sharing.

2. The task force will consider recommending that DFCS convene a state-level workgroup with Children's Healthcare of Atlanta, hospitals and other regional medical centers to address reporting and response concerns, particularly response times, out-of-county and non-resident children, communication and feedback.

3. The task force recommends that DFCS convene a state-level law enforcement workgroup to include state-level organizations representing the GBI, highway patrol, county sheriff and city/county police departments to address conflicts in mission related to reporting, response times, investigation/joint investigation, information-sharing and interviewing of child victims.

4. The task force will consider recommending that DFCS take advantage of training opportunities at judges' conferences to provide/arrange for presentations/training/discussion sessions on evidence standards in and judicial handling of child abuse cases, including how to review a forensic interview.
    a. The task force will explore possible role for the Court Improvement Project, in convening a workgroup with DFCS, the Council of Juvenile Court Judges, Superior Courts and others involved in these cases to address these topics and discuss feedback mechanisms for judges on cases they have handled.
    (*See also recommendation above related to mandated reporter training.)*

5. The task force will use opportunities at national meetings/conferences to:
    a. Address national standards for medical schools on training in the identification and reporting of child abuse and neglect, particularly for pediatricians and general practitioners.
    b. Address interstate reporting, investigation and handling of non-resident maltreatment allegations.

6. The task force will further research issues related to the requiring of national fingerprint background checks for all caregivers and staff with access to children in agency and contractor settings (including foster homes, child caring institutions, hospitals, residential treatment facilities/programs, health and mental health clinics, preschools and schools, child care centers and homes, and detention facilities) that provide care to children and families for any portion of the day. These include issues related to purpose, information provided, cost, and information-sharing.

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Exhibit B

2014 Workforce Survey
Of Georgia Social Service Caseworkers and Supervisors

Conducted by
Child Protective Services Advisory Committee

Summary of Results

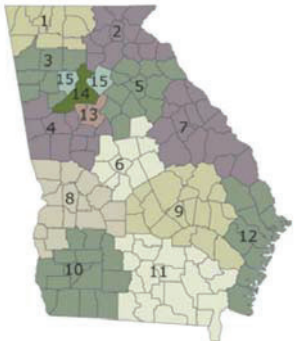
Survey Method and Response

The Georgia Child Protective Services Advisory Committee, a CAPTA Citizens Review Panel, surveyed Division of Family and Children Services (DFCS) staff in March and April 2014 to gain an understanding of the Social Services work environment and workforce concerns. The link to the survey was distributed to all DFCS staff via agency email, and 1,516 staff opted in to take the survey.

Agency data[1] indicated there were 2,039 filled Social Services (SS) positions at the time of the survey, and 703 survey respondents indicated they worked in SS or both SS and the Office of Family Independence (OFI), an approximated response rate of 35% in that section.

Nearly a third (462) of the total 1,516 survey respondents indicated they (a) worked in SS or both SS and OFI and (b) held the position of SS frontline staff (case managers, specialists) or SS supervisor, the group selected for analysis.

While the survey results are not based on a statistically valid sample and results may not be representative of all DFCS staff or of the subset analyzed, results are useful in identifying areas of strength and areas for improvement.



Following is a summary of results for the subset of 462 SS frontline/case management staff and supervisors identifying themselves as working in SS or both SS and OFI.

Respondent Characteristics

All of the regions were represented by these SS frontline staff and supervisors, with the percent for each region ranging from 2% to 10%. Regions 2 and 11 had the highest proportions, with 10% each. Regions 7, 8, 9, 10 and 13 were lowest, with less than 5% of respondents each.

[1] Agency Turnover Report for April 2014.

Most (73%) identified themselves as frontline/case management staff and 28% as supervisors. Nearly all (98%) indicated they worked in SS; 2% indicated they worked in both SS and OFI.

Most of the SS frontline staff and supervisors reported working in Foster Care/Permanency (32%) or Investigation (29%), followed by Family Preservation (13%), Resource Development (10%), and Family Support Services (6%). Others reported working in Intake, Adoption/Adoption Assistance, Independent Living, or did not specify their area (less than 4% each).

More than half (52%) said they had worked for DFCS for six or more years, 28% for one to five years, and 19% for less than a year. More than a third (38%) said they had been in their current position for more than three years. Nearly a third (31%) had held their current position for less than a year, and 31% had been in their current position for one to three years.

Perceptions about Work/Job

The vast majority of these SS frontline staff and supervisors reported their skills are put to use extremely or very effectively (72%). They rated their work as extremely or very meaningful (83%) and challenging (87%). Answers to the open-end question, *"What do you like most about your job?"* suggest these are positive aspects of the job.

The key themes that emerged from SS frontline/case management staff responses to the question about what is liked most about the job are listed below (in no particular order).

Themes related to clients/partners:

- Helping/working with/interacting with families
- Helping/working with/interacting with children/youth
- Making a difference/seeing positive outcomes
- Working/interacting with local community partners

Themes related to nature of work/work environment:

- Challenging work
- Variety in work
- Excitement/staying busy, not boring/dull
- Flexibility in work (hours, office vs. field)
- Independence/responsibility for own work
- Using skills/critical thinking
- Co-workers/supervisor, office camaraderie/support
- Compensatory time, paid holidays

While SS supervisors echoed many of the above themes, including working with/helping families, they also mentioned developing staff/team and mentoring/coaching.

These comments are partially supported by respondent work environment ratings:

- More than half (52%) rated their work environment as very or somewhat exciting, 42% as neither boring nor exciting, and less than 5% as somewhat or very boring.
- Half (50%) rated their work environment as very or somewhat chaotic, 12% as neither chaotic nor organized, and 40% as very or somewhat organized.

Work Quality

Nearly all (92%) of the SS frontline staff and supervisors believed all or most of their co-workers would say that they do a good job, while 78% said that all or most of their co-workers do a good job.

Regions in which at least 20% said none, a few, or only some co-workers do a good job included Regions 2 (20%), 3 (30%), 5 (23%), 8 (35%), 11 (26%), and 12 (31%).

Work Resources

About half of the SS frontline staff and supervisors indicated it was very or somewhat easy to obtain resources needed to do their job well in terms of training and technical assistance (52%), technology (50%), and case practice tools (e.g., assessments) (50%). The percentage indicating difficulty in obtaining training and technical assistance exceeded one-third in Regions 2, 3, 4, and 13.

However, open-end responses to a question about improving work with children and families indicated some training and technology concerns, as described in the following section.

Working with and Getting Resources for Families

One-fifth (20%) of the SS frontline staff and supervisors indicated they always or frequently have sufficient time to work with the children and families on their caseloads; 31% indicated they sometimes have sufficient time, and 39% indicated they seldom or never have sufficient time.

The regions with the most SS frontline staff and supervisors indicating they seldom or never have sufficient time to work with the children and families on their caseloads included Regions 4 (49%), 5 (54%), 13 (58%), and 15 (47%).

Of note is that these findings did not correspond, with the exception of Region 5, to regions with the highest position vacancy rates, according to the agency turnover report cited earlier, in which regions with the highest vacancy rates included Regions 2 (25%), 5 (26%), 7 (27%), and 9 (39%).

Importantly, many SS frontline/case management staff and supervisors indicated that it was very or somewhat difficult to obtain appropriate or sufficient professional/clinical services 45% and community resources (55%) for children and families.

In six of the 15 regions (Regions 2, 3, 4, 8, 9, and 12) half or more (50% to 62%) of the SS frontline staff and supervisors indicated it was very or somewhat difficult to obtain appropriate or sufficient professional/clinical services (percentages ranged from 24% to 62% across the regions). Difficulty in obtaining community resources was even greater, with the percentage indicating it was very or somewhat difficult to obtain appropriate or sufficient community resources was 55%, ranging from 38% to 82% across the regions, with only four regions falling below 50% (1, 6, 7 and 14). Region 9 had the highest percentage indicating difficulty in obtaining community resources, which was not surprising given the mostly rural nature of that region.

Improving Service to Children and Families

The above findings are supported in the open-end responses to the question, *"Other than additional staff or reduced caseloads, what would help you to serve children and families better?"*

Despite the question wording, key themes cited consistently across the regions included both increasing staff and reducing caseloads so that frontline/case management staff have more time to spend on case management, working with families, and documentation – and more time to spend with their own families as well as reduced stress. Several SS frontline staff and supervisors noted the workload/caseload demands creating the need to work evenings and weekends and be on call overnight after working all day.

Other key themes cutting across regions – with related comments – included the following:

- Resources/service providers for families and children
  - More resources, more community resources, more funding for resources, free resources – especially in more rural counties but also in metro counties
  - Better quality, more effective resources
  - Medicaid-accepting providers
  - Services to prevent removal
  - Transportation, counseling, etc.
  - Culturally appropriate, Spanish-speaking
  - Searchable website (with chat for comments on quality, resource solutions); current contact information/directory of resources

> *". . . more community resources, i.e., transitional housing; family shelters; increased PUP funding to assist Family Preservation Cases with: clothing for children; school supplies, pampers, formula, etc. ... State and community partnerships for housing, i.e., partnerships with the local shelters to provide a certain number of slots for families with open DFCS cases . . ."*
> *SS supervisor*

- Supervision
  - Better trained/skilled/qualified/experienced, more professional, better availability, explain reasons for requirements, better communication with staff
- Management (county/region/state)
  - Better support and back-up of staff, more competent, more supportive, team-building, more in touch with field, proactive/planning rather than reactive, better top-down communication
- Technology (access/reliable functioning/training)
  - SHINES data system, Groupwise email, phones/phone reception when office is dependent on cell phones, copiers/scanners, printers, voice recorders, Dragon speech recognition software, Internet cards/hot spots (to support access/documentation from field or court)
- Documentation
  - Less paperwork, clerical support for paperwork/SHINES uploads, easier, more streamlined, reduced duplication (within system and between paper and system)
- Foster and adoptive parent recruitment and support
  - Regionalized, specialized units, more and more appropriate resources, funding for support, training, home studies
- Compensation
  - For long hours, workloads, inflation, merit, increased insurance costs
- Staff appreciation, recognition, respect, encouragement

Other often-cited themes included:

- Training
  - Cross-training across programs (especially in rural areas), more/better initial training, more/better ongoing training (more hands-on, one-on-one mentoring, realistic), more staff trained in safety response system
- Flexibility in schedules and work location
  - Flexibility in hours, teleworking from home or field
- Intake/call center
  - Improved decision-making (contributing to high caseloads with cases that should not be accepted), not getting enough information, have an assessment after intake to determine disposition to Investigation or Family Support Services
- Partner/stakeholder relationships, understanding, support
  - Particularly among judges, courts, SAAGs, law enforcement, DJJ, doctors (mostly more rural regions)
  - Judges/courts to understand implications of case histories, agency constraints (time/budgets)
- Mandated reporter training
  - Information needed, appropriate reports, timely reports – especially for school personnel

- More time for casework
  - To work with families, to check everything prior to case closure, less pressure to close
- Staff travel
  - Access to state vehicles, gas cards for official business; easier process for travel/mileage reimbursement when required to use own vehicle
  - Distances to travel in rural regions, to cover multiple counties, or to visit several siblings in various foster homes for large sibling groups (metro)

The Work Environment

Some of the open-end responses described in the previous section relate to the work environment, such as supervision, management, and staff appreciation.

Most SS frontline staff and supervisors (72%) indicated that, in a typically week, they feel stressed at work frequently or always, not surprising given the staffing and caseload concerns noted in the open-end responses.

About half of the SS frontline staff and supervisors see their work environment as very or somewhat exciting (52%) and chaotic (50%). Many (42%) said their environment was neither boring nor exciting, and only 5% said it was somewhat or very boring. More than a third (38%) said their environment was very or somewhat organized, and 12% said it was neither chaotic nor organized.

More than a fourth (28%) indicated they were concerned for their personal safety at least sometimes when working in the office. This jumped to 68% when working in the field.

The frequency of feeling stressed at work was significantly[2] related to the perception of the work environment as chaotic and the frequency of being concerned about personal safety in the office and in the field. The frequency of concern about personal safety in the office was also significantly related to the frequency of concern about personal safety in the field.

Differences in Staff Perceptions of Work Environment

There were no significant differences in the perceptions of the work environment, feeling stressed, or being concerned about personal safety in the office or in the field between SS frontline staff and supervisors.

Differences based on tenure with DFCS and tenure in the current position were significant[3] for perception of the work environment as exciting and feeling stressed, primarily for workers with less than six months of tenure, who were:

- More likely to see the work environment as exciting (71%), compared to workers with more tenure (51%)

[2] Pearson correlations, $p < .05$
[3] Z tests of differences in proportions, $p < .05$

- More likely to see the work environment as organized (63%) rather than chaotic (31%), while workers with six or more months of tenure tended to see the environment as chaotic (52%) rather than organized (35%)
- Less likely to say they were always or frequently stressed at work in a typical week (40%), compared to workers with more tenure (75%)

Flexibility

As indicated in the open-end responses, flexibility in hours and teleworking were important to SS frontline staff and supervisors:

- 85% indicated being able to adjust their schedules at times was extremely (55%) or very (30%) important.
- 70% said being able to work offsite or from home at times was extremely (46%) or very (25%) important.

Supervision

While open-end responses about improving the ability to help families and children indicated that there were areas in which supervision could be improved, most of the SS frontline staff and supervisors (69%) indicated they were very or somewhat satisfied with the supervision they receive; 14% said they were neither satisfied nor dissatisfied, and 16% said they were very or somewhat dissatisfied.

This general satisfaction with supervision is reflected in responses regarding specific aspects of supervision:

- 76% said they have about the right amount of interaction with their supervisors
- 73% said they have about the right amount of supervision
- 75% indicated their supervisors' expectations were at least moderately realistic (43% said very or extremely realistic)
- 89% indicated there are treated at least moderately fairly by their supervisors (69% said very or extremely fairly)
- 87% said they receive feedback from their supervisors at least sometimes (62% said always or frequently)
- 79% said their supervisors' feedback is at least moderately helpful in improving their performance (54% said extremely or very helpful)
- 84% indicated their supervisors listened to staff opinions when making decisions (61% said always or frequently)

There were no statistically significant differences between the frontline staff and supervisors on most of the above items, with the exceptions that, compared to frontline staff:

- Supervisors tended to rate their supervisors' expectations as less realistic (means of 3.25 and 2.94 on a five-point scale, respectively)

- Supervisors indicated they received feedback from their supervisors less frequently (means of 3.80 and 3.36 on a five-point scale, respectively)
- Supervisors tended to rate their supervisors' feedback as less helpful (means of 3.54 and 3.30 on a five-point scale, respectively)[4]

Onsite Wellness Programs

SS frontline staff and supervisors indicated they would be likely to use several onsite wellness services or programs, if offered.

Fitness/exercise	77%
Weight loss	61%
Health screenings (eg. blood pressure, cholesterol)	58%
Nutrition	50%
Flu shots/immunizations	34%

Seven percent wrote in additional suggestions for onsite wellness programs. Those mentioned most often included onsite stress management and stress relief (e.g., massage), counseling/mental health, support groups, and child care. Other mentions included education advancement and external gym discounts or a gym in the office. One person requested that any such programs not require the employee to use sick leave to take advantage of the programs, indicating this is required for agency-sponsored health screenings.

Job Satisfaction

Half (50%) of the SS frontline and supervisors described their job satisfaction as lower than in the previous year; 23% said their job satisfaction was higher, and 17% said it was the same. (Nine percent were not applicable or did not respond.)

While satisfaction was lower than in the previous year for many, nearly half (48%) indicated they were extremely (10%) or somewhat (38%) satisfied with their job overall. However, 39% said they were somewhat (29%) or extremely (10%) dissatisfied; 11% said they were neither satisfied nor dissatisfied.

Most (89%) indicated they were at least sometimes proud of the work that DFCS does, with 14% saying they are always proud and 38% saying they are frequently proud of the work. Only nine percent said they were seldom or never proud of the work that DFCS does.

Not surprisingly, satisfaction with supervision was significantly positively related to overall job satisfaction.[5]

[4] T-tests of differences between means, $p < .05$
[5] Pearson correlation, $p < .05$

Differences in Job Satisfaction

There was no significant difference in the proportions of supervisors and frontline staff who rated their overall job satisfaction as somewhat or extremely satisfied, although supervisors were significantly more likely to say they were somewhat satisfied and frontline staff significantly more likely to say they were extremely satisfied.[6]

Overall job satisfaction was significantly related to agency tenure. Again, the primary difference was for workers with less than six months of tenure, who were more likely to say they were somewhat or very satisfied (89%) compared to workers with six or more months of tenure (40%).[7]

Increasing Job Satisfaction

SS frontline staff and supervisors were asked, in an open-ended question, what, other than increased pay or lower caseloads, would increase their job satisfaction. Many of the key themes listed under improving service to children and families were repeatedly echoed across the state in their responses regarding job satisfaction, including more staff and lower caseloads; appreciation and respect; flexible time and teleworking; management support (county, region, state); supervision; more time to work with families, children and foster parents; more and better resources for clients; better technology (access, reliability), better intake decision-making; and more/better training.

- In terms of appreciation, respect, an additional dimension was appreciation and respect not only from within DFCS but also from the community, including partner agencies and organizations and the media.
- For management support, staff cited not only knowledge and understanding but also consistency in communications and policy as well as advocacy and better organization.
- Regarding supervision, in addition to the previously noted concerns regarding qualifications and accessibility, staff comments included a desire for more and more positive feedback; less micromanaging; and more consistency.

Despite the question wording, compensation was an overriding theme statewide, with staff noting:

- Lack of raises, even for cost of living, for many years (with more than one commenting they are making less than they did when they started)
- Compensation for overtime worked or being on call after hours
- Hazard pay for Investigation staff
- Performance-based incentives/rewards (e.g., pay, vacation time, gift cards)

Another key theme across the state was time: not only time for working with children and families but also having time for their own children and families, time for themselves, being able to take leave time or compensatory time, having a regular schedule, and not having to work more than 40 hours so frequently.

[6] Z test of differences between proportions, $p < .05$
[7] Z test of difference between proportions, $p < .05$

Other comments related to time included:

- Eliminating or reducing on-call duty
- Fewer meetings/staffings
- Protected time for staffings and paperwork
- Fewer emails
- Less paperwork, fewer reports, fewer tabs in SHINES
- Easing timeframes for casework due to caseloads
- Covering fewer counties/less required travel
- Timely case closure to reduce the need for additional caseworker visits
- More help from foster parents, contracted resources (e.g., with transporting children to court or appointments)

Several additional themes emerged statewide to improve job satisfaction:

- Opportunities for promotion/advancement/growth – available, fair, merit-based (some noted limitation of new requirement for behavioral sciences degree; others commented on office politics/favoritism/preferential treatment and not having an opportunity to apply/interview for an open position filled by appointment)
- Realistic expectations on the part of policy-makers, managers and supervisors regarding workloads, deadlines, and responsibilities
- Cohesion/cooperation/teamwork/interaction within offices and across program areas
- Creating a more positive work environment (less hostile, negative, threatening, yelling, berating, chaotic, stressful, noisy, distracting)
- Morale boosters (e.g., jeans day, motivational speakers, group discounts/free memberships to attractions/events, get-togethers outside of the office)

Other comments on increasing job satisfaction included:

- Fewer changes in policies, communications
- Not assigning new cases while on leave
- Making it easier to get office supplies (and not having to purchase personally)
- Better travel policies/processes to facilitate access to vehicles and mileage reimbursement
- Accountability and changes when work is poor quality/ineffective
- Not being required to take on additional job(s) or work not trained to do
- Office staff trained in SHINES so can support frontline staff in the field in a timely manner
- Better health insurance/benefits
- Onsite access to university classes for MSW or LCSW
- Support groups
- Community understanding of DFCS and its work

Workforce Recruitment/Turnover

Nearly half (48%) of the SS frontline staff and supervisors said they would not be slightly or not at all likely to advise a friend to work in their program area or office if there were an opening; 23% said they would be moderately likely and 26% said they would be extremely or very likely to do so.

These staff were asked how likely it is that they will look for another job outside of DFCS in the coming year, and most (62%) indicated they were at least moderately likely to do so, with 27% extremely likely and 17% very likely to look elsewhere. More than a third (34%) said they were only slightly likely or not at all likely to do so.

Differences in Intention to Leave Agency

On average, frontline staff were significantly more likely than supervisors to indicate they would be looking for another job in the coming year (means of 3.27 and 2.89, respectively).[8] Frontline staff were significantly more likely (32%) to say they were extremely likely to seek another job than were supervisors (16%).[9]

Some differences by tenure were also significant, with those having the least tenure (less than six months) and those having the longest tenure (more than 10 years) being most likely to report they would be only slightly or not at all likely to seek another job (62% and 55%, respectively, vs. 28% for those with six months to 10 years). Those with six months to 10 years of experience were most likely to report they would be extremely or very likely to seek another job (50%, vs. 25% for those with less than six months and 34% for those with more than ten years, although the latter comparison not statistically significant).[10]

Conclusions

It is clear from the SS frontline staff and supervisor responses and comments that there are important strengths as well as opportunities for improving working conditions with the goal of improving staff morale and retention.

Strengths that could be capitalized:

- Frontline and supervisory staff desire to work with families and children, to help others, to see improvement/change in others, to make a difference, to connect families and children with resources that can help them
- Challenging, varied, and non-boring (sometimes exciting) work
- Independence and flexibility in job
- Office camaraderie and support (in some offices)
- Technology, when it is available and reliable

[8] T-test of difference between means, $p < .05$
[9] Z test of difference in proportions, $p < .05$
[10] Z test of differences in proportions, $p < .05$, except for the difference in extremely/very likely between those with less than six months tenure (50%) and those with six months to ten years of tenure (34%)

Areas with opportunities for improvement:

- Supervisory (and management) training – creating a positive work environment, team-building, supporting staff and encouraging staff development, positive/constructive feedback, mentoring/coaching, and staff appreciation/recognition/respect
- Frontline staff training – appreciation/recognition/respect of co-workers, peer support
- Reducing the administrative tasks of frontline staff and supervisors – reducing/streamlining paperwork and SHINES, providing administrative support
- Communication -- improved two-way communication (top-down, bottom-up) – related to policies, realities of fieldwork, expectations, intake decision-making
- Policies related to recruitment, hiring and promotion; creating opportunities for advancement
- Staff incentives/rewards (and action to address poor quality work)
- Low or no-cost morale boosters
- Public awareness (partners, stakeholders, client, community) of DFCS role, limitations, successes; the role that the community plays in preventing and addressing child maltreatment

Areas with opportunities for advocacy to improve morale and facilitate agency work:

- Additional staff/lower caseloads
- Additional and improved/upgraded technology, technology access and reliability, and related training
- Additional, improved and more accessible resources for families and children served by the agency

While staff morale and turnover concerns are not new or unique to Georgia, it is still important to seek ways in which to improve morale and retention for the sake of the staff and for providing continuity of services and support for the families and children they serve.

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Information From
The Georgia Child Protective Services
Advisory Committee
2014 Division of Family and Children Services
Workforce Survey

August 19, 2014

Purpose of the Survey

At it's fall 2012 retreat, the Georgia Child Protective Services Advisory Committee (CPSAC), a CAPTA Citizens Review Panel, decided to get feedback from front line DFCS staff regarding their work environment. Concerned about the affect of low morale on service delivery, CPSAC elected to focus some of its efforts on advising DFCS on ways to improve worker recruiting and retention.

CPSAC's survey was a component of the panel's ongoing efforts to support best practice standards within Georgia's CAPTA funded programs. The survey was not designed or implemented as a means to criticize the management of child protective service activities nor was it designed for use with the advocating of any agenda.

Once evaluation of the survey is complete recommendations will be made regarding workforce recruiting and retention . The panel will complete the survey evaluation at its fall 2014 retreat.

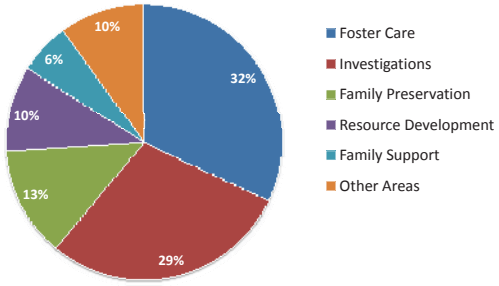
Survey Method and Response

CPSAC surveyed Division of Family and Children Services (DFCS) staff in March and April 2014 to gain an understanding of the Social Services work environment and workforce concerns. The link to the survey was distributed to all DFCS staff and 1,516 staff opted in to take the survey.

The following is a summary of results for the subset of 462 frontline/case management staff and supervisors identifying themselves as working in Social Services . Most (73%) identified themselves as frontline/case management staff and 28% as supervisors.

The survey results are like a photograph at a given moment in time. Through careful analysis and thoughtful recommendations, CPSAC will provide useful tools for DFCS to use to improve worker recruiting and retention.

Work Areas of Frontline Staff and Supervisor Respondents



Tenure at DFCS

6 or more years: 52%

1 to 5 years: 28%

< 1 Year: 20%

Tenure in current position at DFCS

> 3 years: 38%

1 to 3 years: 31%

< 1 Year: 31%

Perceptions about Work/Job

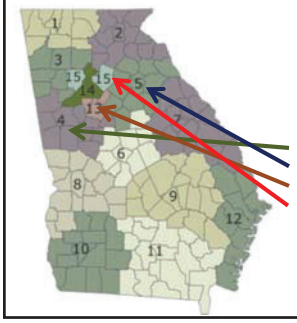
The vast majority of these frontline staff and supervisors reported their skills are put to use extremely or very effectively (94%). They rated their work as extremely or very meaningful (83%) and challenging (87%).

Sample answers to the open-end question:
"What do you like most about your job?"

Related to clients/partners	Related to nature of work
Helping/working with families	Challenging work
Helping/working with children/youth	Excitement/staying busy, not boring
Making a difference/seeing positive outcomes	Office camaraderie and support, Staff and Team Building
Working with local community partners	Coaching/Mentoring (Supervisors)

Working with Families - Time

20% of the frontline staff and supervisors indicated they always or frequently have sufficient time to work with the children and families on their caseloads while 39% indicated they seldom or never have sufficient time.

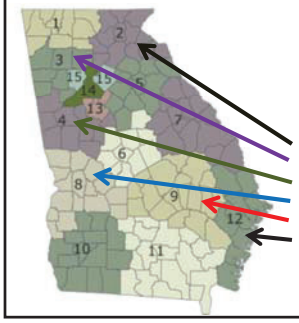


Regions with the most staff indicating they seldom or never have sufficient time to work with the children and families on caseloads:

Region 4 (49%),
Region 5 (54%),
Region 13 (58%), and
Region 15 (47%).

Working with families – Availability of services

Many frontline staff and supervisors indicated that it was very or somewhat difficult to obtain appropriate or sufficient professional/clinical services (44%).

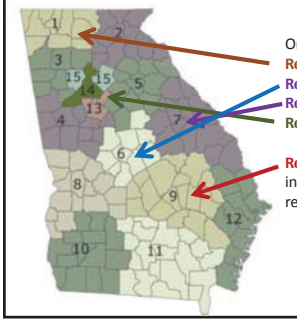


In six of the 15 regions half or more (50% to 62%) of the frontline staff and supervisors indicated it was very or somewhat difficult to obtain appropriate or sufficient professional or clinical services:

Region 2
Region 3
Region 4
Region 8
Region 9, and
Region 12

Working with families – Access to Community Resources

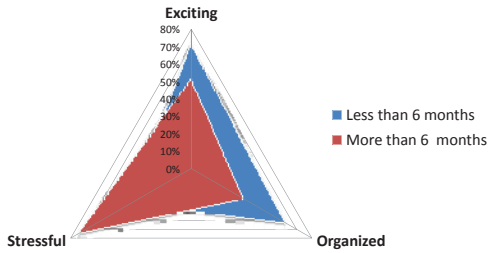
Difficulty in obtaining community resources was even greater. The percentage that indicated it was very or somewhat difficult to obtain sufficient community resources ranged from 38% to 82% across all regions



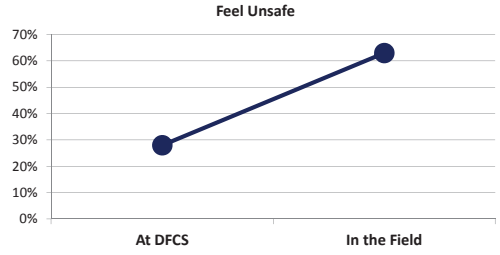
Only four regions fell below 50%:
Region 1,
Region 6,
Region 7 and
Region 14.

Region 9 had the highest percentage indicating difficulty in obtaining community resources (82%).

Working At DFCS
The cumulative effect on work place perceptions

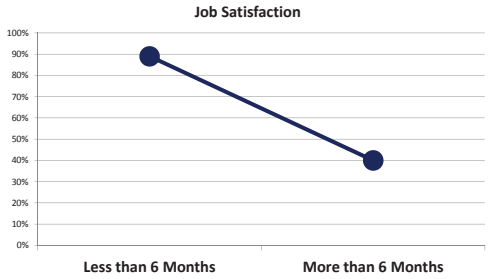


Working At DFCS - Personal Safety



More than a fourth (28%) indicated they were concerned for their personal safety at least sometimes when working in the office. This jumped to 68% when working in the field.

Working At DFCS – Job Satisfaction



Overall job satisfaction was significantly related to agency tenure. The primary difference was for workers with less than six months of tenure, who were more likely to say they were somewhat or very satisfied (89%) compared to workers with six or more months of tenure (40%).

Increasing Job Satisfaction

Frontline staff and supervisors were asked, in an open-ended question, what, other than increased pay or lower caseloads, would increase their job satisfaction. Many of the key themes listed under improving service to children and families were repeatedly echoed across the state in their responses regarding job satisfaction:

More staff and lower caseloads	Better technology (access, reliability)
Appreciation and respect within DFCS and the broader community	More and better resources for clients
Flexible time and teleworking	More/better training
Management support (county, region, state)	More time to work with families, and children

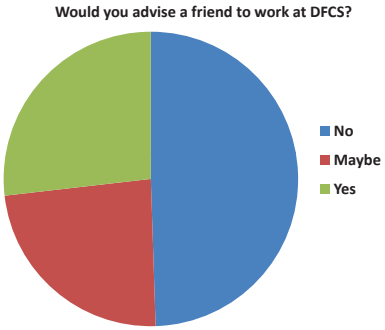
Increasing Job Satisfaction, continued

Despite the question wording, compensation was an overriding theme statewide, with staff noting:

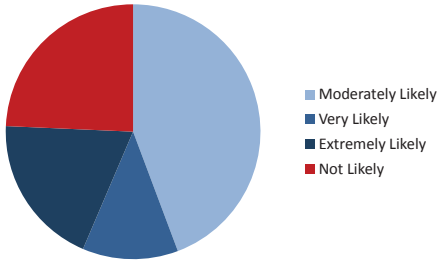
- Lack of raises, even for cost of living, for many years (some commenting they are making less than they did when they started)
- Compensation for overtime worked or being on call after hours
- Hazard pay for Investigation staff
- Performance-based incentives/rewards (e.g., pay, vacation time, gift cards)

Another key theme across the state: time:
Staff wanted not only time for working with children and families but also having time for their own children and families, or time for themselves. They wanted the ability to take leave time or compensatory time, have a regular schedule, and not have to work more than 40 hours so frequently.

Workforce Recruitment and Turnover



Workforce Recruitment and Turnover



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GEORGIA CHILD FATALITY REVIEW PANEL

Annual Report - Calendar Year 2013

LaTain Kell Panel Chairman, **Nathan Deal** Governor

JANUARY 2015

THE CHILD FATALITY REVIEW PANEL MEMBERS

LaTain Kell, Panel Chairman – Judge, Cobb County Superior Court
Peggy Walker, Panel Vice-Chair – Judge, Douglas County Juvenile Court
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
Bobby Cagle – Director, Department of Family and Children Services
Vernon Keenan – Director, Georgia Bureau of Investigation
Tiffany Sawyer – Prevention Director, Georgia Center for Child Advocacy
E.K. May – Coroner, Washington County
Paula Sparks – SafePath Children's Advocacy Center
Dr. Kris Sperry – Chief Medical Examiner, Georgia Bureau of Investigation
Ashley Willcott – Office of the Child Advocate
Ashley Wright – District Attorney, Augusta Judicial Circuit
Amy Jacobs – Commissioner, Department of Early Care and Learning
Vacant – Member, State Board of Education

The Child Fatality Review Panel Members

Mission / Acknowledgements

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

We would also like to thank the 2013 Child Fatality Review Committee of the Year, the 2013 CFR Coroner of the Year, and the 2013 CFR Prevention Committee of the Year for their exceptional support and dedication to the children of Georgia:

- CFR Coroner of the Year: Buddy Bryan, Muscogee County
- CFR Committee of the Year: Cherokee County
- CFR Prevention Committee of the Year: Cherokee County

This report was developed and written by the staff members of the Child Fatality Review Unit within the Georgia Bureau of Investigation: SAC Trebor Randle, Arleymah Gray, Malaika Shakir, and Crystal Dixon.

Mission / Acknowledgements

Georgia Child Fatality Review Panel

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

It is my sincere honor to present to you the Georgia Child Fatality Review Panel's 2013 Annual Report. This report summarizes the analyses of child deaths occurring in Georgia conducted by the Panel during 2013.

In the wake of legislation moving the administrative oversight of the Panel and its staff to the Georgia Bureau of Investigation, the investigative and analytical capabilities of the Panel continue to be enhanced. Cooperation of the various agencies gathering data concerning child deaths and prevention also improved this year, increasing the quality of the information the Panel has reviewed.

The data compiled from each of the 159 local review panels across Georgia continues to be the central tool used by the Panel to focus resources and efforts to prevent child deaths. As you will see from the Annual Report, new and better data regarding child fatalities in Georgia continue to be the emphasis of the Panel in order to carry out its statutory duties.

Significant areas of concern are highlighted in this report, along with specific recommendations for addressing many of these concerns. These issues include the high incidence of sleep-related deaths for infants in Georgia, the disproportionate number of motor vehicle related deaths of children over age nine, the increases in maltreatment, motor vehicle and fire-related deaths and the continuing problem of teen suicides. Special emphasis will be devoted to these areas again in the coming year. We hope that you will consider carefully each of the critical areas outlined in the Panel's recommendations.

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.

I would like to extend my special thanks to Special Agent in Charge Trebor Randle, and staff members Arleymah Gray, Malaika Shakir and Crystal Dixon for their extraordinary efforts in organizing the Child Fatality Review Unit within the Georgia Bureau of Investigation and making this Annual Report possible. I would also like to acknowledge the efforts of Dr. John Carter for his exemplary assistance in this report.
We appreciate your continued assistance in preventing and reducing child fatalities in Georgia. Your support is critical in accomplishing the goals and objectives highlighted in this report. The Panel and I thank you for all that you continue to do for the children of Georgia.

Sincerely,

Judge Tain Kell, Chair

3121 Panthersville Rd. • Decatur, GA 30034
(404) 270-8715 office • (404) 270-8720 fax

Georgia Child Fatality Review Panel

Table of Contents

Background and History

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

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

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

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

The History Of Child Fatality Review In Georgia

1990 - 1993

- Legislation established the Statewide Child Fatality Review Panel with responsibilities for compiling statistics on child fatalities and making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols for the investigation of alleged child abuse and neglect cases. Statutory amendments were adapted to:
  - Establish a separate child fatality review team in each county and determine procedures for conducting reviews and completing reports
  - Require the Panel to:
    - Submit an annual report documenting the prevalence and circumstances of all child fatalities with special emphasis on deaths associated with child abuse
    - Recommend measures to reduce child fatalities to the Governor, the Lieutenant Governor, and the Speaker of the Georgia House of Representatives
    - Establish a protocol for the review of policies, procedures and operations of the Division of Family and Children Services for child abuse cases

1996 - 1998

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

1999 - 2001

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

2002 - 2005

- The Panel published and distributed a child fatality review protocol manual to all county committee members
- Statutory amendments were adopted which resulted in the following:
  - Appointment of District Attorneys to serve as chairpersons of local committees in their circuits
  - Authority of the Superior Court Judge on the Panel to issue an order requiring the participation of mandated agencies on local child fatality review committees. Failure to comply would be cause for contempt
  - Authority of the Panel to compel the production of documents or the attendance of witnesses pursuant to a subpoena
  - Director of the Division of Mental Health added as a member of the Panel
- Funding was secured and an on-line reporting system was established for both the child fatality review report and the coroner/medical examiner report
- A collaboration was established between the Office of Child Fatality Review and the National Center for Child Death Review

- The Georgia Child Fatality Investigation Program was established through a partnership between OCFR, DFCS and the Georgia Bureau of Investigation. A director was hired to advance a multi-disciplinary approach to child death investigation through development and training of local teams.
- Conducted the first statewide Prevention Readiness Assessment, to evaluate resources and stakeholders available in counties to implement and sustain prevention efforts
- A Statewide Model Child Abuse Protocol was developed and distributed to all Protocol committee members
- A Prevention Advocate was added, by policy, to all child fatality review committees Statewide training was conducted for all prevention advocate members
- A quarterly newsletter was created and distributed. The newsletter is sent to all child fatality review members and contains useful information about the process as well as prevention
- Annual awards were established for the Child Fatality Review Coroner of the Year and Child Fatality Review County Committee of the Year. Awards are presented at the annual Child Fatality and Serious Injury Conference sponsored by the Panel, DHR, GBI and the Office of the Child Advocate
- A sub-committee of the Panel was formed to begin working on a Statewide Prevention Plan. The sub-committee also includes outside agencies working in the prevention field

2006 - 2008

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

2009 - 2013

- Adopted National Center for Child Death Review online reporting form for all child deaths, allowing Georgia child death data to be captured on a nationally standardized surveillance tool
- Included as one of five states to participate in three-year CDC pilot project to improve investigation, review and reporting of sudden and unexpected infant deaths
- Expanded CFIT program to include a child abuse investigation training academy
- Continued involvement with the Southeast Coalition on Child Fatalities, providing support to other CFR programs within the southeastern states
- Conducted second Prevention Readiness Assessment of counties, to determine the local resources and stakeholders available to implement and sustain prevention efforts
- Created and maintained a CFR Panel subcommittee to address infant sleep-related deaths; the Georgia Infant Safe Sleep Coalition (GISSC) serves as a strong resource for state and local partners, providing evidence-based best practice for prevention and implementation assistance

How To Read This Report

Throughout this report, you will find INFOGRAPHICS. These images are placed within each topic section to support the data presented, and also to assist the reader in understanding the scope of the issue. Please feel free to print those infographics that are helpful to you and use them in presentations, trainings, or other venues where you can share information on the causes of deaths to children. While these infographics do not represent the specific data from reviewed Georgia child fatalities, Georgia CFR presents these materials as a helpful tool to the reader, and fully endorses the sources where these documents were created.

Important Findings And Recommendations

- The infant mortality rate in Georgia continues to be higher than the national rate, and the rate for African-Americans continues to be higher than the state rate
- Sleep-related deaths continue to be the leading cause of death for infants in Georgia
- Motor vehicle crashes continue to be the leading cause of death for children over age one
- African-Americans continue to have higher incidence of deaths compared to other race/ethnic groups
- The number of deaths due to maltreatment, motor vehicles, and fire/burns has increased
- CFR committees reported that most reviewed deaths were preventable

The Child Fatality Review Panel determined that child fatalities can be reduced in Georgia if the following recommendations to policymakers are adopted and implemented:

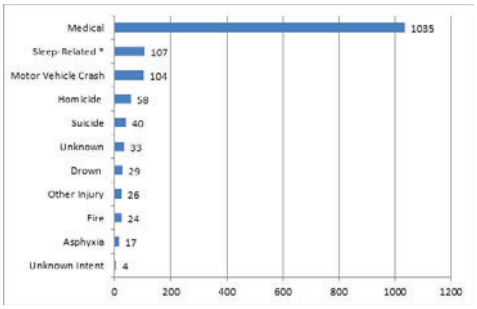
1. Create a consistent and coordinated campaign regarding infant safe sleep to better align with the American Academy of Pediatrics safe sleep recommendations (*published online October 2011*)
2. Continue to enforce the Teenage and Adult Driver Responsibility Act (TADRA) to enhance young driver education and reduce risk associated with newly licensed drivers. Encourage parents and caregivers to model appropriate driving behavior – no texting, eating, applying makeup, or other distractions while operating a motor vehicle (http.gahighwaysafety.org/highway-safety/tadra/)
3. Increase funding for the Suicide Prevention Program to implement the following activities: 1) expand the program's statewide community grant program to more counties and at higher funding levels; 2) expand the implementation and evaluation of means restriction education training at hospitals statewide; and 3) expand implementation and evaluation of school-based suicide prevention programs that promote resilience and positive youth development as protective factors from suicide statewide (http.dbhdd.georgia.gov/suicide-prevention)
4. Require newly licensed K-12 educators and special service providers (nurses, school psychologists, school counselors and social workers) to complete suicide prevention trainings
5. Incorporate infant safe sleep education and how to address safety concerns related to infant safe sleep practices as part of the training and continuing education for child welfare professionals, early childhood education providers, health care providers, and home visitors
6. Support the activities of Safe Kids Georgia, and encourage development of Safe Kids coalitions in every county (http.safekidsgeorgia.org/)
7. Encourage availability of affordable childcare for all families in every community

All Reviewed

In 2013, a total of 540 child deaths were deemed reviewable by death certificate data. A child's death is eligible for review when the death is sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances. Ninety-Three percent of these deaths were reviewed (502) by local CFR committees. These committees are comprised of professionals from multiple disciplines that analyze the critical aspects of child deaths to aid in reducing preventable injuries and child deaths in Georgia. Death notifications are attained from a variety of sources to include coroner/medical examiner reports, Vital Records (VR) death certificates, Georgia Bureau of Investigations (GBI), and Department of Family and Children Services (DFCS). These death data are linked with Vital Records data to ensure a comprehensive and accurate representation of all child deaths in the state of Georgia. The data included in this report are based on information attained from these reviews.

All Child Deaths in Georgia, 2013

Figure 1: Deaths to Children under Age 18 in Georgia, All Causes based on Death Certificate, 2013 (N=1,477)



*Sleep-Related includes SIDS and infant suffocation in bed

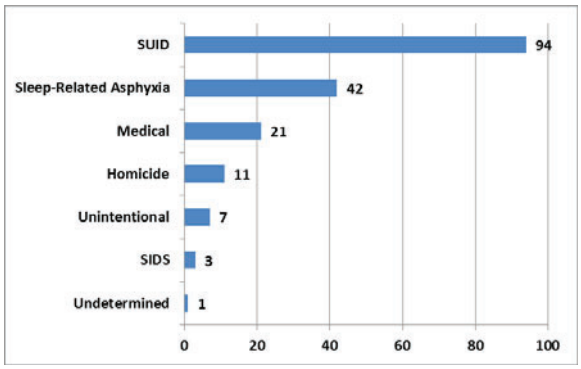
- Infants make-up 26 percent(267) of all medical deaths
- "Unknown" category includes Sudden Unexpected Infant Death (SUID), sleep-related infant deaths with at least one prominent risk factor(see sleep-related infant section for more detailed information)
- "Unknown Intent" includes deaths for which a definitive manner could not be determined

*Note that there is a slight difference in the numbers and types of death reported between death certificate data and "all reviewed" CFR data. This difference is due to the additional information on the circumstances of the death that are obtained and reviewed by local CFR committees. This information sometimes leads to more comprehensive findings and accuracy in determining cause/manner that the death certificate does not report, underscoring the value and importance of CFR data.

Figure 2: Demographics of All Reviewed Deaths, GA, 2013 (N=502)

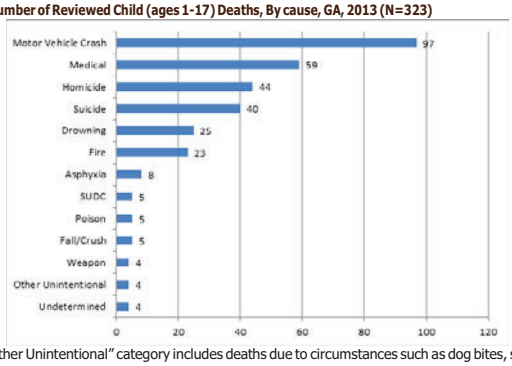
	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	35	26	7	15	48	131
White Female	31	11	5	10	18	75
African-American Male	52	28	14	18	35	147
African-American Female	43	26	8	12	12	101
Hispanic Male	6	2	3	2	7	20
Hispanic Female	7	4	1	1	1	14
Multi-Racial Male	2				1	3
Multi-Racial Female	2	2				4
Other Race Male	1	1	2	1		5
Other Race Female		2				2
Total	179	102	40	59	122	502

Figure 3: Number of Reviewed Infant Deaths by Cause, GA, 2013 (N=179)



- SUID = Sudden Unexplained Infant Death; SIDS = Sudden Infant Death Syndrome (more detail on these types of deaths can be found in the "Sleep Related" section)
- The "Unintentional" category include five motor vehicle deaths, one drowning death, and one fire death
- The "Undetermined" death involves a non-sleep-related sudden infant death

Figure 4: Number of Reviewed Child (ages 1-17) Deaths, By cause, GA, 2013 (N=323)



- The "Other Unintentional" category includes deaths due to circumstances such as dog bites, sports-related head injuries, et cetera
- The "SUDC" category refers to Sudden Unexplained Death in Childhood cases that resemble SIDS or SUID in circumstances (e.g. unexplained cause after full investigation and autopsy), but the child is over the age of one

Disparities in Reviewed Deaths

The 2013 child population up to age 17 in Georgia was 2,492,428 (GA Dept of Public Health, OASIS data). The racial and ethnic makeup of the child population was:

- White, non-Hispanic – 45.8%
- African-American, non-Hispanic – 33.5%
- Multiracial – 3.3%
- All other races (Asian, Pacific Islander, Native American) – 3.7%
- Hispanic, all races – 13.6%

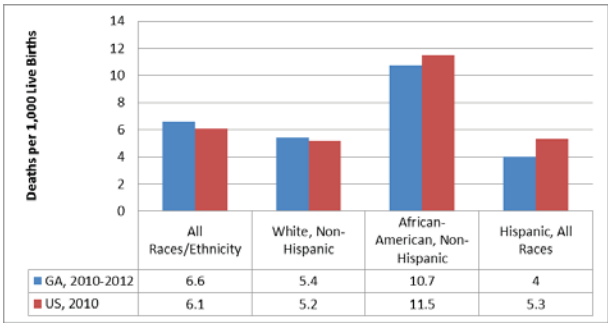
Figure 4: All Infant (<1) and Child (1-17) Deaths, Population, and Mortality Rates, GA death certificate data, 2013

	Deaths		Population		IMR	1 to 17 MR
	<1	1 to 17	<1	1 to 17	(Per 1,000)	(Per 100,000)
White	352	231	72,613	1,347,126	4.8	17.1
African-American	478	232	45,424	823,698	10.5	28.2
Multi-Racial	82	64	7,145	87,495	11.5	73.1
Hispanic	83	41	22,094	317,661	3.8	12.9
Total		546		2,360,962		23.1

The *infant mortality rate* (IMR) is an estimate of the number of infant deaths for every 1,000 live births. This rate is often used as an indicator to measure the health and well-being of a nation, because factors affecting the health of entire populations can also impact the mortality rate of infants. There are obvious differences in infant mortality by age, race, and ethnicity; for instance, the mortality rate for non-Hispanic African-American infants is more than twice that of non-Hispanic white infants.

The child death rate (age 1-17) for Georgia in 2013 was 23.1 per 100,000. Georgia's infant mortality rate for 2013 was 7.1 per 1,000. This is higher than the national average of 6.0 per 1,000. However, the IMR for White, non-Hispanic infants and Hispanic infants was lower than the state and national average (4.8 and 3.8, respectively). The IMR for African-Americans was 10.5 per 1,000. This great disparity in the infant death rate should mobilize agencies and communities to determine what factors are negatively impacting the health of mothers and infants in the African-American community, and take action to reduce the deaths in these communities. As a result, we can also lower the overall Georgia IMR to meet the national standard. According to the CDC, the majority of infant deaths are due to serious birth defects, low birth weight (born too small), prematurity (born too early), sleep-related infant death, or maternal complications of pregnancy.

Figure 5: Infant Mortality, Georgia/US Comparison, by Race/Ethnicity



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.

Prevention and Preventability

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 6: Determination of Preventability, GA, 2013 (N=502)

	Missing/ Blank	No, probably not	Yes, probably	Team could not determine	Percent Preventable *
All Unintentional		8	159	11	95.2
Homicide	1	1	53		98.1
Suicide		5	29	6	85.3
SIDS/SUID		18	86	35	82.7
Medical	2	35	22	20	38.6
Sudden Unexplained Death in Childhood (SUDC)		1	1	3	N/A
Undetermined		3	2	1	N/A
All Reviewed Deaths	3	71	352	76	83.2

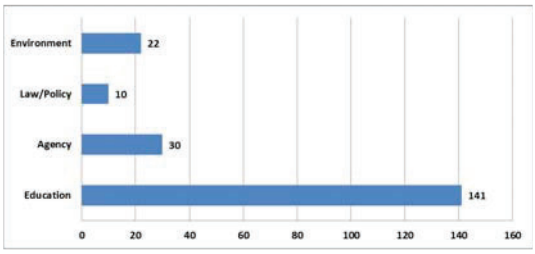
% Preventable calculated excluding "missing/blank" and "team could not determine"

Since 2012, the 'percent preventable' increased for several categories, perhaps due to greater awareness among local review teams on the definition of preventability and/or the availability of resources to address the identified issues.

- "all unintentional" increased slightly from 92.9%
- "homicide" increased slightly from 96.2%
- "suicide" increased 18 percentage points from 66.7%
- "SIDS/SUID" remained constant
- "medical" increased 26 percentage points from 12.1%

Committees determined that 352 of the 502 reviewed deaths could have been prevented. Committees were then tasked with determining which factors could have been modified to prevent the death, and what measures they would recommend to prevent similar deaths in their communities. In 141 cases where the death was preventable, the committees recommended at least one type of prevention strategy – education, law/ordinance, agency policy/ program, or environment/consumer product. A total of 203 prevention recommendations were documented (some case reports had multiple recommendations).

Figure 7: Prevention Recommendations Identified by CFR Committees, 2013



Prevention of child deaths is 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).

Some recommendations made by local CFR committees:

Topic/Cause of Death	Recommendations made by the local CFR committees	Recommendations from the Community Preventive Services Task Force (TheCommunityGuide.org)
Safe Sleep	Safe sleep education for health care providers, parents and caregivers Media campaigns; continue PSA's and education on back to sleep positioning of infants to include a safe sleep environment and the use of a pacifier Education on safe sleep while on vacation or visiting homes where a crib may not be available County Safe Sleep program should initiate contact with all parents through social services including social security and health records department to provide live personnel to provide sleep education to parents	None available
Motor Vehicle	Car seat safety classes for all parents and caregivers; parent education regarding the proper placement and positioning of children in child safety seats School programs for elementary students on seat belt usage and crossing the street Teen driving classes in schools Bus Monitors and Seat Belts on all school buses	Child Safety Seats: Interventions that use distribution and education programs based on strong evidence of their effectiveness in increasing child safety seat use. Seat Belt Use: Enhanced enforcement programs are added to normal enforcement practices and include publicity. They fall into two categories: (1) those that increase citations along with increasing the number of officers on patrol (supplemental), and (2) programs that promote more citations during an officer's normal patrol (targeted).

Fire	Provide smoke alarms for all homes, and enforce code violations for older homes	None available
Drowning	Increase signage at rivers where no lifeguard is present and water conditions may be dangerous Require fencing for private ponds and pools, to restrict access to water Provide pool safety signage in several languages Schools should have swimming pools and lessons for students	None available
Homicide	Education on Russian Roulette Promote gun safety Provide gun locks and safe storage options Provide programs for teens on consequences of poor choices and criminal activity – target delinquent youth and young offenders	Universal, school-based programs on the basis of strong evidence of effectiveness in preventing or reducing violent behavior. Universal school-based programs to reduce violence are designed to teach all students in a given school or grade about the problem of violence and its prevention or about one or more of the following topics or skills intended to reduce aggressive or violent behavior: emotional self-awareness, emotional control, self-esteem, positive social skills, social problem solving, conflict resolution, or team work.
Suicide	Suicide education for parents and schools Improve communication between parents, mental health providers, and schools to monitor at-risk kids Bring mental health providers into schools Incorporate suicide prevention into parent aid classes Educate parents on dangers of having firearms and other weapons in the home with a child who exhibits depression or suicidal behavior	None available

Maltreatment	Increase community education on domestic violence and child abuse	Early childhood home visitation programs based on strong evidence of their effectiveness in reducing child maltreatment among high-risk families.
Medical	Specialized health exams for student-athletes, beyond the traditional sports physicals, which could detect certain heart conditions Educate parents of children with health conditions on proper, safe ways to perform daily activities and compliance with care regimens Provide information to parents on medical tests they can request, even if not suggested by a doctor Schools and recreational leagues should improve the types of physicals required to play sports; there should be a consensus between the Georgia High School Association and local recreational leagues on the requirements for the extent that a physical to play sports should cover	None available
Other	Provide information on contacting emergency services for non-English speakers Mandatory CPR training for all school personnel Media campaigns and awareness programs to secure TVs and other electronics in the home Adult medication should be stored out of reach of children	None available

CFR committees also identified several agencies and organizations which could champion these recommendations, including:

- Department of Juvenile Justice (DJJ)
- county Health Departments
- local school systems
- local law enforcement and School Resource Officers (SROs)
- mental health providers and Community Service Boards (CSBs)
- fire departments
- hospitals
- Safe Kids chapters
- Family Connection Collaboratives

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.**

Resources

State:

Georgia's Framework for Childhood Injury Prevention Planning (www.oca.georgia.gov)
Safe Kids Georgia (www.SafeKidsGeorgia.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 Department of Public Health, Injury Prevention Program (www.health.state.ga.us)
Georgia Governor's Office of Highway Safety (www.gahighwaysafety.org)
Georgia KidsCount Data Center, Family Connection Partnership (www.gafcp.org/count)

National:

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)
The Community Guide (http://www.thecommunityguide.org/index.html)
The Child Welfare Information Gateway (https://www.childwelfare.gov/)

- In 2013, CFR committees reported that 256 of the 502 total deaths reviewed (51%) 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 172 decedents (34%) 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 73 (15%) decedents with a reported disability or chronic illness; of those 73 decedents, 18 were receiving services through Children with Special Health Care Needs (CSHCN) at the time of death (25%)
- There were 25 decedents (5%) who had received mental health services at some point prior to their death; there were 12 decedents who were receiving mental health services at the time of their death
- There were 89 decedents (18%) with a reported history of child maltreatment as a victim, due to either abuse or neglect, at some point during their lifetime; there were 24 decedents (5%) who had an open CPS case at the time of death
- There were 33 decedents (7%) 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 8: Decedents with Prior Agency Involvement, GA, 2013

	Social Services	Disability or Chronic Illness	Children with Special Health Care Needs (CSHCN)	Mental Health (prior or current)	Maltreatment history or open CPS	Delinquent history
Male	104	44	9	22	57	26
Female	68	29	9	4	40	7
Infant	97	27	4		24	
Age 1-4	36	14	7	1	23	
Age 5-9	16	6	2	1	11	
Age 10-14	6	9	3	4	10	2
Age 15-17	17	17	2	20	29	31
Agency Totals	172	73	18	26	97	33

Figure 9: Age of Decedents with Prior Agency Involvement, GA, 2013 (N=256)

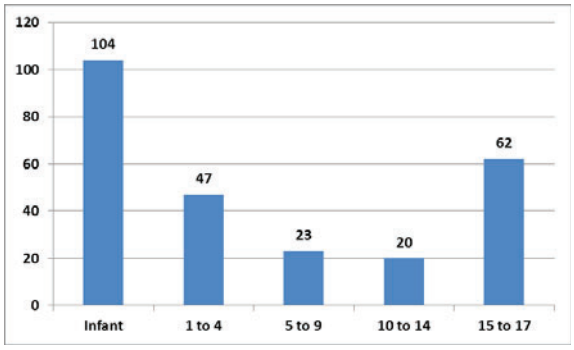


Figure 10: Number of Deaths with Prior Agency Involvement by Cause, GA, 2013 (N=256)

	Prior Agency History	All Reviewed	Percent
Unintentional	72	178	40.4
Sleep-Related	80	139	57.6
Suicide	24	40	60.0
Homicide	38	55	69.1
Medical	37	79	46.8
Undetermined	5	11	45.5
Total	256	502	51.0

Georgia CFR committees are asked to report on the number and types of death related to maltreatment – child abuse and neglect. The committees also report on those deaths related to poor supervision and negligence.

CFR committees identified 123 child deaths with evidence of maltreatment in the child's history or as the direct cause of death (54 were abuse and 46 were neglect). In 23 cases, the committees reported an unknown type of maltreatment (unsure if abuse or neglect was a factor).

- In 103 cases, the decedent had a past history of maltreatment as a victim (compared to 60 cases in 2012, and 47 in 2011), but the maltreatment was not the direct cause of the death
- In 39 cases, the maltreatment was the direct cause or contributing factor in the death (compared to 37 cases in 2012, and 29 in 2011)
- For 19 decedents, both "reported maltreatment history" and "abuse/neglect as cause" were identified (compared to 14 in 2012, and 11 in 2011)
- "Poor/absent supervision" was reported to be a factor in 58 deaths. "Other negligence" was reported to be a factor in 84 deaths

Georgia code section 19-7-5 defines child abuse as "Physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means; provided, however, that physical forms of discipline may be used as long as there is no physical injury to the child".

Child neglect is defined in Georgia Code 49-5-180: "neglect or exploitation of a child by a parent or caretaker thereof if said neglect or exploitation consists of a lack of supervision, abandonment, or intentional or unintentional disregard by a parent or caretaker of a child's basic needs for food, shelter, medical care, or education as evidenced by repeated incidents or a single incident which places the child at substantial risk of harm…".

Figure 11: Decedents with Maltreatment History, GA, 2013 (N=123)

	Infant	Age 1-4	Age 5-9	Age 10-14	Age 15-17	Total
White Male	12	6	2	0	11	31
White Female	5	4	1	4	2	16
African-American Male	9	5	3	5	12	34
African-American Female	7	10	4	4	3	28
Hispanic Male	2	1	2	1	1	7
Hispanic Female	0	1	0	0	1	2
Multi-Racial Male	2	0	0	0	1	3
Multi-Racial Female	0	2	0	0	0	2

National research suggests that the following groups are higher risk populations:

- Infants
- Males
- African-Americans
- Caregivers with alcohol abuse, drug abuse, or intimate partner violence in the home

National statistics provided in the Child Maltreatment 2012 report, developed by the Administration for Children and Families (ACF) Children's Bureau, National Child Abuse and Neglect Data System (NCANDS), states that younger children were the most vulnerable to death as the result of child abuse and neglect. Nearly three-quarters (70.3%) of all child fatalities reported in 2012 were younger than three years and in general, the child fatality rate decreased with age. Children who were younger than one year old died from abuse and neglect at a rate of 18.83 per 100,000 children in the population younger than one year. This is nearly three times the rate of children who were one year old (6.46 per 100,000 children in the population of the same age). Children who were older than five years died at a rate of less than 1.00 per 100,000 in the population. Additionally, males had a higher child fatality rate than females; 2.54 per 100,000 males in the population, compared to 1.94 per 100,000 females in the population.

Figure 12: Causes of death where the maltreatment was the direct cause or contributing factor, GA, 2013 (N=39)

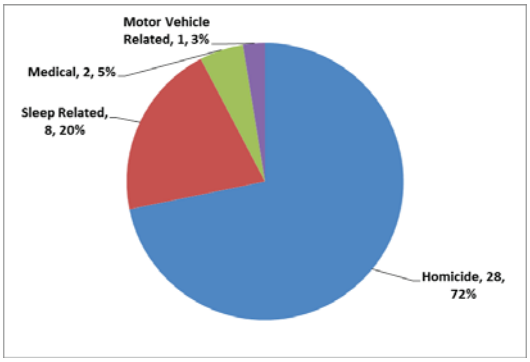
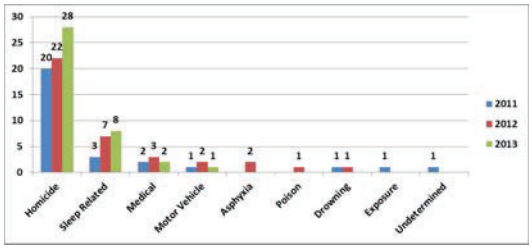
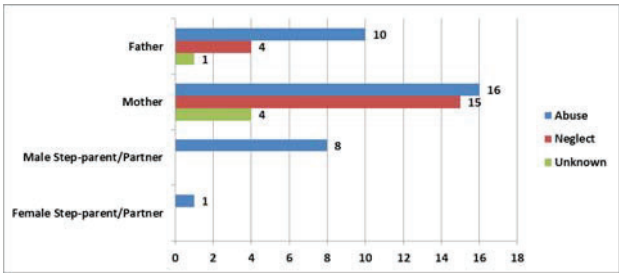


Figure 13: Causes of Death where the maltreatment was the direct cause or contributing factor, three-year trend, GA, 2011-2013



- Homicide was the leading cause of reviewed maltreatment-related death, followed by sleep-related and medical
- The number of maltreatment-related deaths shows an increase from 2011 to 2013

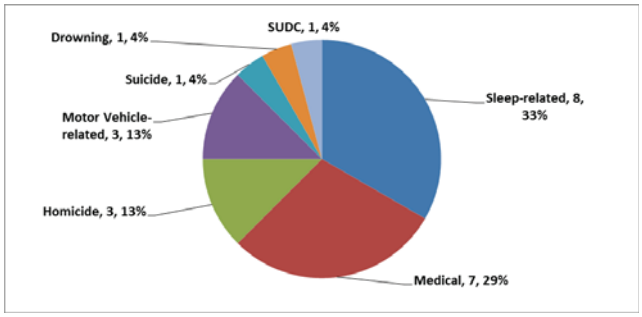
Figure 14: Parental perpetrators of deaths where maltreatment was the direct cause or contributing factor, GA, 2013



** in several cases, both parents, or parent and partner, were identified as perpetrators of the death

CFR committees reported on 24 decedents who had an open CPS case at the time of death. Nearly two-thirds of those deaths were due to medical or sleep-related circumstances

Figure 15: Causes of death for decedents with an open CPS case, GA, 2013 (N=24)



Opportunities for Prevention:

The Child Welfare Information Gateway has published "Child Neglect: A Guide for Prevention, Assessment, and Intervention". According to the Guide, the current theory on maltreatment views neglect from a social-ecological perspective in which multiple factors contribute to child abuse and neglect. From this perspective, it is recommended that we should consider not only the parent's role, but also the societal and environmental variables contributing to the parent's inability to provide for the basic needs of the child. This model is valuable because it recognizes the shared responsibility among individuals, families, communities, and society, thereby enabling a more constructive approach and targeting interventions on multiple levels. www.childwelfare.gov/pubs/usermanuals/neglect/neglect.pdf

PCA Georgia, a state chapter of Prevent Child Abuse America, provides statewide direction to promote healthy children and develop strong families through:

- **Prevention Network** – Building a statewide network of individuals, families, agencies, and communities dedicated to preventing child abuse and neglect in all its forms.
- **Public Awareness** – Increasing public awareness about child abuse and neglect prevention through training and education, information dissemination, and statewide events.
- **Prevention Programs** – Encouraging the development and implementation of innovative prevention programs using research-based models.
- **Research** – Conducting and disseminating academic and community-based research to guide the development of policies, programs and services which will enhance the health and well-being of Georgia's children and their families.
- **Advocacy Activities** – Informing public policy, programs, and practices that strengthen families and protect children by regularly imparting information regarding child abuse prevention research, initiatives, legislation, and campaigns.

PCA Georgia also maintains the 1-800-CHILDREN Helpline - open weekdays from 8 a.m. to 6 p.m. 1-800-CHILDREN is a referral line for Georgians concerned about the healthy development of children and the prevention of child abuse and neglect. Parents, families, professionals, or anyone else who seeks child abuse prevention resources can call the Helpline and speak with a knowledgeable information and referral specialist.

Please join us in our efforts to protect Georgia's children. Anything you do to support kids and parents can help reduce the stress that often leads to abuse and neglect. www.PreventChildAbuseGA.org

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 contributed 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).

Figure 16: Demographics of Reviewed Sleep Related Infant Deaths, GA, 2013 (N=139)

	SIDS		Sleep Related Asphyxia		SUID		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
White Male	1		8	19.0	17	18.1	26	18.7
White Female			5	11.9	21	22.3	26	18.7
African-American Male	2		14	33.3	24	25.5	40	28.8
African-American Female			13	31.0	23	24.5	36	25.9
Hispanic Male			1	2.4	3	3.2	4	2.9
Hispanic Female					4	4.3	4	2.9
Multi-Racial Male					1	1.1	1	0.7
Multi-Racial Female			1	2.4	1	1.1	2	1.4
Total	3		42		94		139	

- Thirty percent of the sleep related deaths were determined to be asphyxia, and 68% were SUID. Only two percent of deaths were determined to be SIDS. Utilization of the appropriate language during prevention and awareness campaigns is crucial in effectively communicating the true nature of sleep related infant deaths. The burden of death to infants in Georgia is not primarily related to SIDS, which many view as unpreventable, but is attributable to SUID and other sleep related deaths which are highly preventable. Parents and caregivers should be empowered with the knowledge and education of simple, yet effective, prevention steps as well as the understanding of the true risk for infant death.

- CFR committees reviewed 139 sleep-related infant deaths in 2013
- Of those, 55% were African-Americans, 37% were non-Hispanic Whites, and six percent were Hispanic
- The majority of sleep-related infant deaths had one or more risk factors present (sleep environment, location, and/or position)

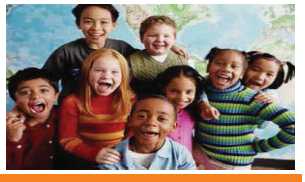
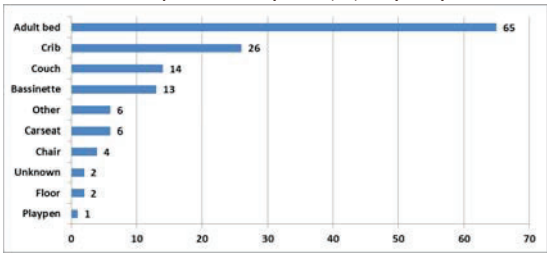


Figure 17: Number of Reviewed Sleep Related Deaths by Location, GA, 2013 (N=139)



- Sleep environment continued to be a critical issue in the reviewed deaths
- Nearly half of the deaths occurred in an adult bed (47%), but this is a slight decrease from 2012, when 58% of sleep related deaths occurred in an adult bed
- Nineteen percent of deaths occurred in a crib, and 10% occurred on a couch/sofa
- Of the 79 deaths that occurred on an adult bed or couch, 57 were sleeping with an adult at the time of death (72%)

- 22% of deaths had a scene re-enactment performed with a doll by a law enforcement officer, coroner, or medical examiner investigator. CFR staff have distributed scene re-enactment dolls since 2009, with CDC grant funding support, as part of an effort to improve death scene investigations and CFR reporting quality

Figure 18: Scene Re-enactment with Doll Performed, GA, 2013 (N=139)

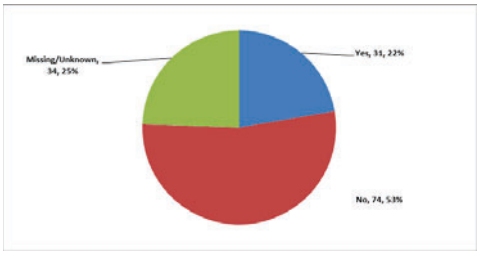
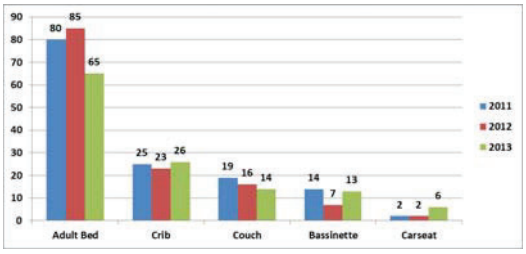
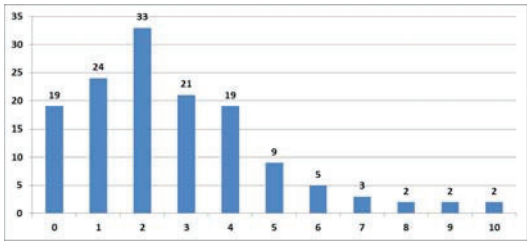


Figure 19: Trend of Top Five Locations for Sleep Related Deaths, GA, 2011-2013



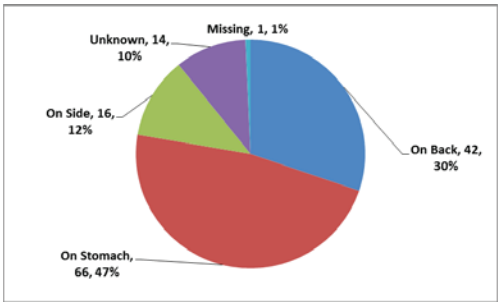
- The number of reviewed sleep related infant deaths has not decreased significantly, from 155 in 2011 to 139 in 2013, despite multiple efforts by state and local agencies to provide prevention education, programs, and services to parents and caregivers. We should continue to work collaboratively and raise awareness of the issue with consistent messaging across the state. Evidence shows that coordinated and sustained efforts at the state level are able to provide necessary information to families and caregivers that enable them to make informed decisions in regards to safe sleep.

Figure 20: Sleep Related Deaths by Age in Months, GA, 2013 (N=139)



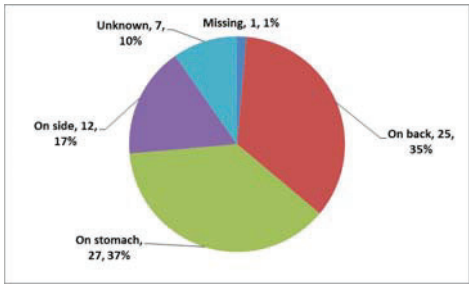
- Eighty-three percent of the deaths occurred among infants younger than five months. This reinforces the need for consistent and continuous education for parents as well as their supportive caregivers, both prior to the birth and in the first few months after the child is born

Figure 21: Sleep Related Deaths by Position when Found, GA, 2013 (N=139)



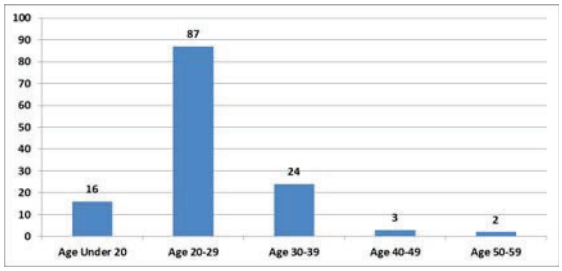
- Of the 139 sleep related infant deaths, 64 were reportedly placed supine – on their back – to sleep (46%), compared to 56 placed prone - on their stomach – or side (40%)
  - However, when the infant was found unresponsive, 42 were on their back (30%) and 82 were found on their stomach or side (59%). The remainder had an "unknown" position

Figure 22: Sleep Related Deaths with Reported Bed Sharing, by Position when Found, GA, 2013 (N=72)



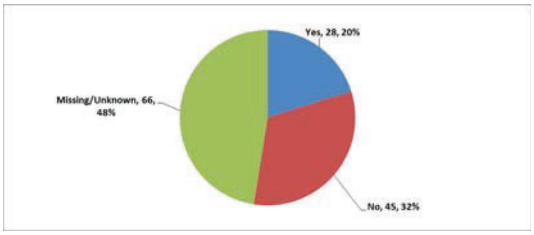
- Infants who were reported as "bed sharing" were sharing a sleep surface, such as a bed, couch, chair, or crib, with at least one other person at the time of death

Figure 23: Age of Caregiver for Sleep Related Infant Deaths, when known, GA, 2013 (N=132)



- In 74% of reviewed sleep related deaths, the caregiver was between the ages of 14 and 29. This reinforces the need for infant safe sleep education for teenagers while still in high school
- In 102 cases, the biological parent was the supervisor at the time of death, but in 17 cases (12%), a grandparent, other relative, or babysitter was caring for the infant

Figure 24: Caregiver Substance Abuse Reported for Sleep Related Infant Deaths, GA, 2013 (N=139)



- In 20% of the reviewed sleep related infant deaths the caregivers were reported to have a history of substance abuse; 32% had no reported history, and 45% were unknown

Successful "Safe Sleep" programs in Georgia should aim to increase the adoption of safe infant sleep behavior among infant caregivers by activating champions of these protective behaviors within systems that intersect with families at risk. An infant caregiver is defined as the individual who puts a baby down for sleep and could be a parent, grandparent, other family members, child care provider or other guardian. Examples of systems that serve infant caregivers include, but are not limited to:

1. Home visiting programs
2. Food and nutrition programs
3. Community-based organizations such as Healthy Start
4. Housing assistance authorities
5. Child care
6. Hospitals and birthing centers
7. Community health clinics
8. Health care provider networks such as pediatricians, family physicians and obstetricians

Providers who serve at-risk families in the delivery of health care, public health and social services have an opportunity to educate and empower infant caregivers to adopt safe infant sleep behavior. However, promoting the latest evidence-based recommendations is more complex than the original "Back to Sleep" campaign message, which focused solely on infant sleep position. To be successful, providers must be supported by organizational policies, practices and resources to enhance their efforts to translate the modern safe infant sleep message to action among infant caregivers. Some resources do exist to support these provider networks. (www.nichd.nih.gov/sts)

While all populations are impacted, African-American and American Indian/Alaskan Native families have a significantly higher risk to suffer the loss of an infant due to sleep-related circumstances. Infant caregivers face barriers to implementing safe infant sleep behavior, which can conflict with cultural and familial norms about sleep habits, or even compete with caregiver needs related to sleep deprivation. The American Academy of Pediatrics (AAP) has summarized the state of scientific evidence surrounding these behaviors and identified the following description of a safe sleep environment: placing the infant to sleep on the back, in the infant's own crib without blankets or soft items or bed-sharing, and breastfeeding. (www.healthychildcare.org/sids.html)

Agency and organizational leadership in Georgia should provide the framework for successful safe sleep programming by establishing, facilitating, and coordinating a safe infant sleep prevention effort with the purpose of integrating safe sleep promotion throughout systems that serve families, with a particular emphasis on reaching communities at higher risk for SUID. Activities should include strategic planning, identifying and convening multi-disciplinary stakeholders, ensuring representation from safe sleep promotion experts, including researchers and public health professionals with experience designing and implementing educational interventions, breastfeeding advocates, and leadership of key systems serving families. Representatives from the communities at increased risk for SUID can heighten the success of the program by providing feedback about the reality of barriers that infant caregivers face when considering safe sleep as a practice. The safe sleep effort should also include coordinating the development of resources such as training modules, model policy templates or health promotion materials, to facilitate the attainment of goals related to safe infant sleep promotion at the national and local levels.

National Resources:

National Action Partnership to Promote Safe Sleep www.nappss.org

National "Safe to Sleep" Public Education Campaign www.nichd.nih.gov/sts

Healthy Child Care America, a program of the American Academy of Pediatrics www.healthychildcare.org/sids.html

Centers for Disease Control and Prevention www.cdc.gov/sids/

National Center for Education in Maternal and Child Health Library www.mchlibrary.info/suid-sids/trainingtoolkit.html

First Candle www.firstcandle.org/new-moms-dads

State Resources:

Georgia Children's Cabinet www.children.georgia.gov

Georgia Infant Safe Sleep Coalition

Reviewed Medical Deaths

All children will likely develop some types of different health issues throughout infancy and childhood, even into their teenage years. For the most part, these health issues vary and usually do not interfere with their everyday life and development. On the other hand, there are a variety of medical conditions that can last for a long time, affect the child's daily activities, require extensive medical care, and in many cases, result in the death of a child. Medical deaths are reviewable by the Child Fatality Review committee if the death occurs unexpectedly, is unexplained, unattended by a physician, or in suspicious or unusual manner.

Many medical deaths may not be reviewed by committees if the death occurred in a hospital, or was not reported to the local coroner/ medical examiner. Deaths that are not reviewed by the Child Fatality Review committee are deaths that occur while in hospice and/or under a physician's care. These are considered "expected" deaths.

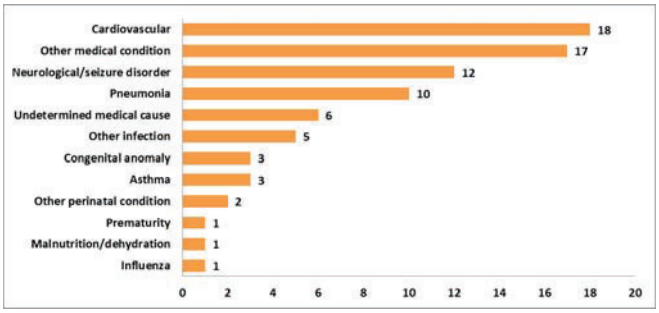
In 2013, there were 79 deaths reviewed due to medical related causes. Medical related deaths were highest among infants and toddlers (age 1-4), followed by older teens, and adolescents.

Reviewed Medical Deaths

Figure 25: Demographics of Reviewed Medical Deaths, GA, 2013 (N=79)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	4	6	2	2	4	18
White Female	4	4		1	2	11
African-American Male	6	5	3	4	5	23
African-American Female	3	6	1	4	5	19
Hispanic Male	1					1
Hispanic Female	2	2		1		5
Multi-racial Female		1				1
Other Male			1			1
	20	24	7	12	16	79

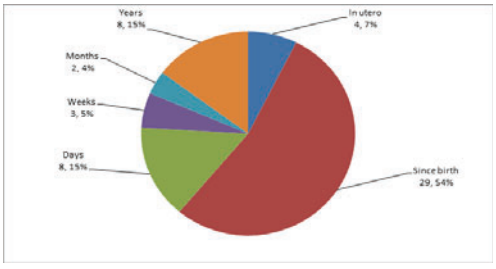
Figure 26: Medical Causes of Reviewed Deaths, GA, 2013 (N=79)



- The leading causes reported by CFR committees were cardiovascular, neurological, and pneumonia
- The category "other infection" includes respiratory infections, appendicitis, peritonitis, necrosis and chorioamnionitis

Reviewed Medical Deaths

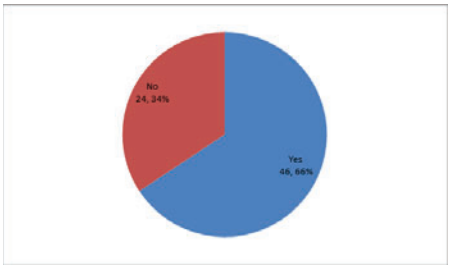
Figure 27: Length of time child had medical condition, when known, GA, 2013 (N=54)



In 54 cases, the committees reported the length of time the child had the medical condition.

- Just over half (54%) of decedents had been living with their medical conditions since birth
- Fifteen percent had received the diagnosis within days of the death

Figure 28: Child receiving health care for medical condition, when known, GA (N=70)



"Receiving health care" includes attending medical appointments, taking medications and following a prescribed plan for the medical condition.

- Forty-six decedents were reported to have been receiving health care for their medical condition (66%)

Reviewed Medical Deaths

Prevention Opportunities

- Make certain to get early and comprehensive prenatal health care and nutrition
- Encourage healthy nutrition at an early age
- Introduce and integrate physical activity when children are young into their daily lives to prevent a sedentary lifestyle
- Be attentive and enable early diagnosis of developmental delays or mental illness to improve access to care designed to help
- Make it a priority to get regular medical care for children to increase the chances of detecting chronic diseases and get them treated early
- School based health centers should be implemented and made available to those who do not have a primary care provider. This could ensure that more children are appropriately screened for potential chronic illnesses including cardiovascular and neurological disorders
- Enhancement should be made to youth school sports physical requirements
- Improve the health care system to make it high quality, comprehensive, affordable, and accessible for everyone

Resources

American Academy of Pediatrics (www.aap.org)
Asthma and Allergy Foundation of America (www.aafa.org)
Centers for Disease Control and Prevention (www.cdc.gov)
Healthy Children (www.healthychildren.org)
Georgia Department of Public Health (http://dph.georgia.gov/)

All Unintentional Reviewed Deaths

In 2013, CFR committees reviewed 179 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. 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. Suffocation rates are on the rise, with a 54 percent increase in reported suffocation among infants less than one year old.

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 (CDC).

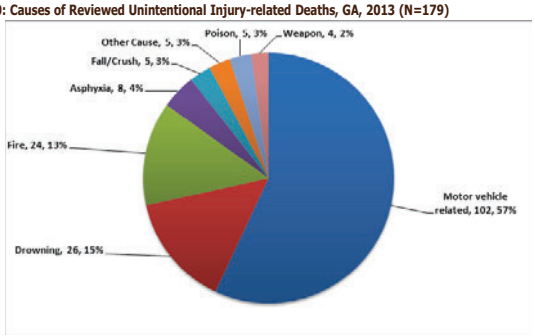
Figure 29: Demographics of Reviewed Unintentional Injury-related Deaths, GA, 2013 (N=179)

Cause	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
Motor vehicle-related	5	19	16	16	46	102
Drowning	1	8	5	4	8	26
Fire	1	11	8	4		24
Asphyxia		6	2			8
Fall/Crush		4			1	5
Other Cause	1	3			1	5
Poison				1	4	5
Weapon		1		1	2	4
Total	8	52	31	26	62	179

- Motor vehicle crashes accounted for more than half of all unintentional injury-related deaths of children (57%). Relevant policies and programs to address injury prevention and fatality should be data-driven, and geared toward the identified risk factors
- Drowning and fire-related deaths together accounted for nearly a third of unintentional injury related deaths (28%). These types of incidents often claim the lives of multiple individuals, often due to the rescue attempts made by caregivers or bystanders, which leads to additional fatalities. Prevention efforts should include safe rescue techniques for the general public
- Other injury deaths that were reviewed include accidental overdoses, television falls, and accidental firearm shootings

All Unintentional Reviewed Deaths

Figure 30: Causes of Reviewed Unintentional Injury-related Deaths, GA, 2013 (N=179)



According to the CDC, unintentional injury is the leading cause of death for Americans age 1-44. For infants younger than 12 months, unintentional injury is the 5th leading cause of death. The following chart breaks down the specific causes of injury in the United States by age group.

All Unintentional Reviewed Deaths

10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2012

Motor Vehicle-Related Deaths

"Motor vehicle-related" include injury related deaths involving motor vehicles and other forms of transportation, including public transport, farm equipment, recreational vehicles, bicycles, scooters, and skateboards.

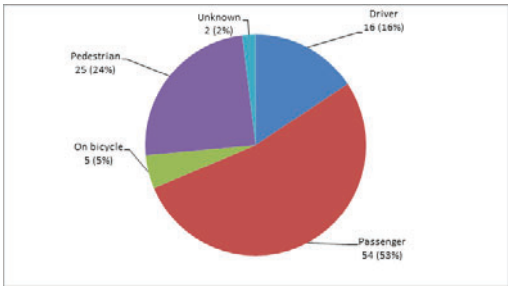
In 2013, motor vehicle-related deaths were the leading cause of unintentional injury-related deaths. Motor vehicle-related deaths accounted for 102 out of 178 reviewed unintentional injury- related deaths (57%) in Georgia. Reviewed motor vehicle-related deaths have increased in the past two years, from 82 motor vehicle related deaths in 2012, and 87 in 2011.

Figure 31: Demographics of Reviewed Motor Vehicle-Related Deaths, GA, 2013 (N=102)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
African-American Male	1	5	6	1	12	25
African-American Female	1	6	3	3	5	18
White Male	2	5	3	6	16	32
White Female			1	6	12	19
Hispanic Male		1	2		1	4
Hispanic Female	1	1	1			3
Other Race Female		1				1
	5	19	16	16	46	102

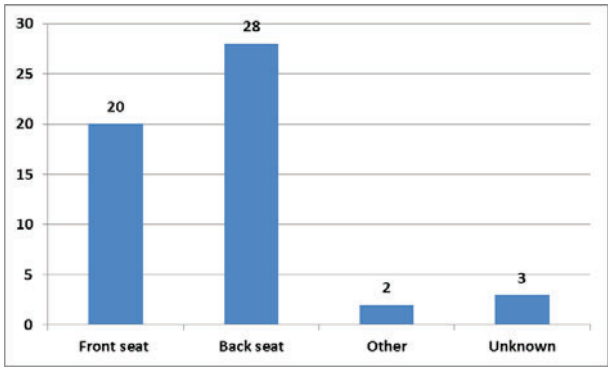
The number of motor vehicle-related deaths has increased for teenagers (ages 15-17) from 31 in 2012 and 34 in 2011. This group had the largest number of reviewed motor vehicle-related fatalities. According to the Centers for Disease Control and Prevention, motor vehicle crashes are the leading cause of death in the United States for teenagers. According to the National Highway Traffic Safety Administration (NHTSA), teenagers are involved in three times as many fatal crashes as all other drivers, on the basis of miles driven. Distracted driving is a concern for this age group, as well as distracted walking, often leading to injury and death.

Figure 32: Reviewed Motor Vehicle-Related Deaths by Position of Decedent, 2013 (N=102)



- The "Driver" category includes 15 teens (age 15-17) and a nine-year-old operating an ATV
- Occupant information was unknown for two (2%) of the motor vehicle-related deaths reviewed by the CFR committees. Unknown occupancy usually occurs when multiple decedents are ejected from the vehicle and there is no indication of the child's position (i.e. driver or passenger) prior to the crash

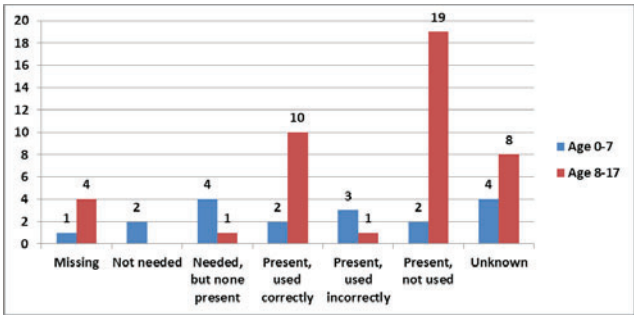
Figure 33: Position of Child as Passenger, when reported, GA, 2013 (N=53)



CFR committees reported 54 motor vehicle passengers who died as a result of a motor vehicle related injury.

- There were 28 children who were located in the back seat of the vehicle (including a school bus)
- Twenty were reported to occupy the front passenger seat
- Two cases reported the child's position as "other". The "Other" category includes circumstances such as horseback rider, and car surfing
- The positions of three of the passengers were unknown

Figure 34: Occupant Restraint Usage (drivers and passengers), 2013 (N=61)



- Of the 61 motor vehicle occupants, 18 were under the age of eight, and 43 were age 8-17
- There were nine infants/young children who were improperly restrained (or completely unrestrained) in a child safety seat
- There were 21 adolescents/teens who were improperly restrained (or completely unrestrained) in a seat belt

Child restraint systems should be used until the child reaches the upper weight or height limit of the seat. A child should remain rear-facing until age two, if possible. Never place rear-facing car seats in the front with an active airbag.

Children age two and older should use a forward- facing car seat with a harness until they reach the upper weight or height limit of the seat. Before transitioning to a seat belt, a child should use a booster seat. Before allowing a child to use a seat belt, make sure it fits properly with the lap belt across the upper thighs and not on the stomach and the shoulder belt across the chest and collar bone and not the neck or face. Georgia law requires that children under age 8 use a child restraint system. Often, children eight and older are not ready for a safety belt. Consider using a booster until the child is at least 57" tall. All children under age 13 should always ride in the back seat.

Figure 35: Pedestrian Deaths by Age and Sex, GA, 2013 (N=25)

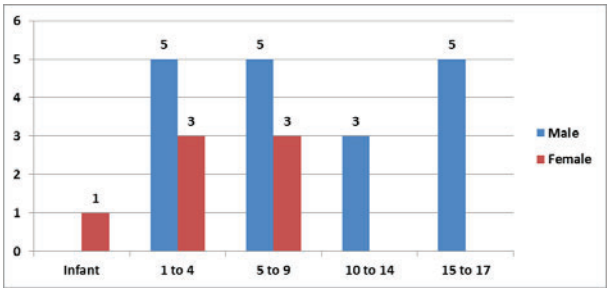
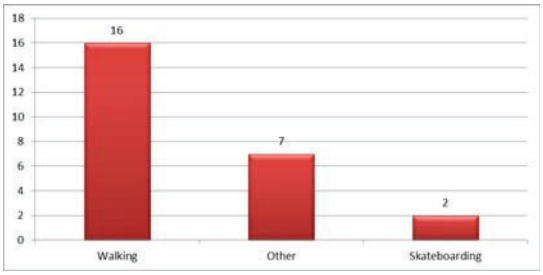


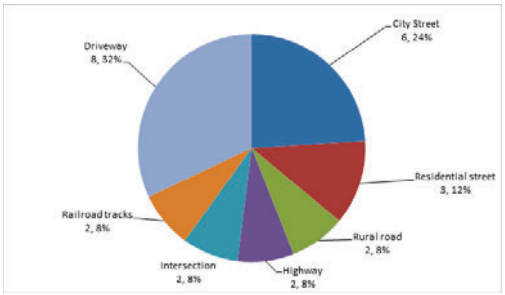
Figure 36: Activity of Child as Pedestrian, GA, 2013 (N=25)



In 2013, there were 25 children who died from a motor vehicle-related injury while pedestrians.

- The "Other" category includes activities such as playing on train tracks and playing/standing in a driveway

Figure 37: Location of Reviewed Motor Vehicle-Related Pedestrian Deaths, GA, 2013 (N=25)



- Six of the eight "driveway" location deaths involved toddlers ages 1-4
- The "city street" was the most common location for children ages 5 to 9
- "The residential street" and "railroad tracks" locations were more common among teens ages 15-17

Passenger Prevention

Always use proper restraints on every trip! Children should be buckled in car seats, booster seats, or seat belts no matter the length of time of the trip. Before transitioning the child from the booster seat to the safety belt alone, make sure that the lap belt fits properly across the upper thighs and not on the stomach and the shoulder belt fits across the chest and not the neck or face. Children often model adult behavior, so parents and caregivers should ride restrained on every trip as well.

Operator Prevention

Driving is a very complex task that requires processing and accurately estimating risk on roadways, cultivating appropriate reactions to minimize risks and gaining experience to predict what actions others may take on the road. Georgia has a Graduated Driver's License law, called TADRA (Teenage and Adult Driver Responsibility Act), which was designed to enhance skill-building for new drivers. TADRA is a graduated driver's license program for young drivers ages 15 to 18. It was established in Georgia by a collaborative effort of highway safety advocates, legislators, law enforcement officials, educators, businesses and media in the wake of a high number of fatal vehicle crashes involving young, inexperienced drivers. TADRA has significantly changed the way young motor vehicle operators earn and maintain driving privileges by developing a controlled means for new drivers to improve driver experience and reducing high risk driving situations. It is additionally important for teen drivers to adhere to the minimum legal drinking age and zero blood-alcohol laws.

Pedestrian Death Prevention

Safer environments separate people from cars, slow traffic in areas most traveled by pedestrians, and improve street crossings. Law enforcement can play an important role to ensure that traffic laws are designed to protect pedestrians. Positioning speed bumps and specialized crosswalks have been shown to reduce the risk of motor vehicle-related deaths.

It is extremely important to always know where children are before moving the vehicle. Make sure that children are moved away from the vehicle, are in full view, and that another adult is properly supervising children before moving the car. Some research suggests using rear-view cameras and sensors to prevent child deaths in driveways and parking areas. There are several vehicle manufacturers that currently provide such devices. Additionally, teach children to not play in, around or behind parked vehicles.

National Resources

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

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

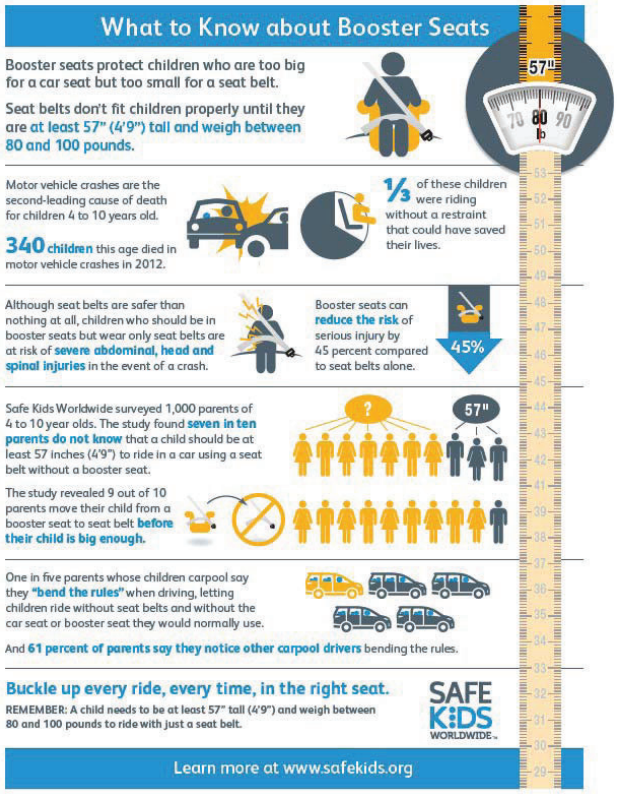
National Highway Traffic Safety Administration (www.nhtsa.gov)

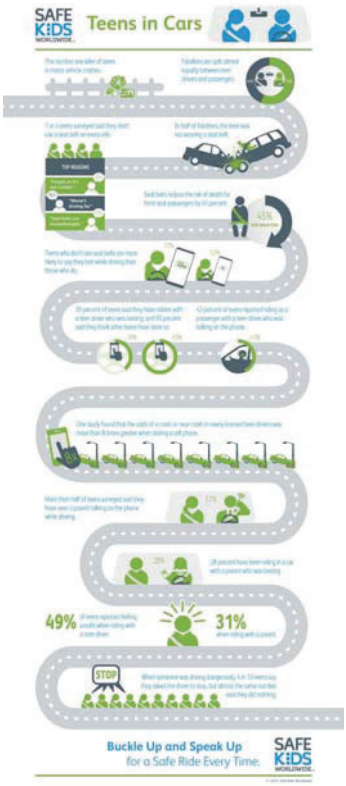
State Resources

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

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

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





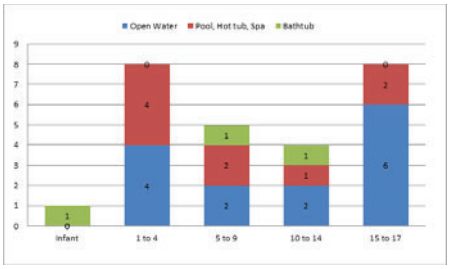
Children of all ages love the water. Drowning can occur quickly and quietly. According to the National Drowning Prevention Alliance, drowning is the leading cause of unintentional injury related deaths for children ages one to four. Additionally, drowning is the second leading cause of unintentional injury deaths for children five to nine years of age.

In 2013, 26 children died from drowning in Georgia. Drowning deaths accounted for 26 of 179 unintentional injury related child deaths (15%). Male children had the largest percentage of drowning deaths (77%). The American Academy of Pediatrics (AAP) 2010 Policy Statement on the Prevention of Drowning states that rates of drowning death vary with age, gender, and race. Age groups at greatest risk are toddlers and male adolescents. After one year of age, male children are at greater risk than are female children. African-American and American Indian/Alaska Native children have higher drowning fatality rates than do White and Asian American children. From 2000 to 2006, the highest death rates were seen in White males less than four years of age and African-American male teens 15 to 19 years of age.

Figure 38: Demographics of Reviewed Drowning Deaths, 2013 (N=26)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male		5			2	7
White Female			2			2
African-American Male		1	3	3	3	10
African-American Female	1	1		1		3
Hispanic Male					3	3
Other Female		1				1
Total	1	8	5	4	8	26

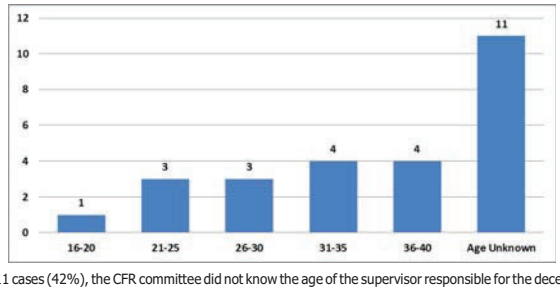
Figure 39: Drowning Fatalities by Age and Location, GA 2013 (N=26)



Location plays a major role in drowning. In 2013, there were 14 decedents who drowned in open water (54%) such as oceans, rivers, lakes and ponds. There were nine decedents who drowned in a pool, hot tub, or spa (35%) and three decedents who drowned in a bathtub.

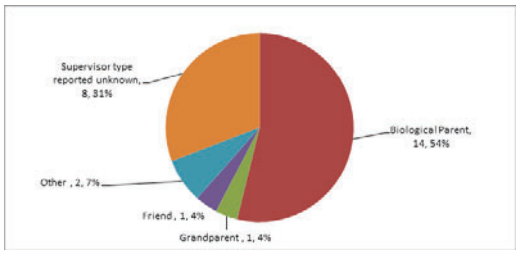
Supervise with your eyes! Children need constant supervision around water whether it's in a bathtub, home pool, pond, beach, or lake. Many drowning deaths occur when a supervisor is distracted for a brief moment or leaves the area for a short period of time.

Figure 40: Supervisor's age for Reviewed Drowning Deaths, GA , 2013 (N=26)



- In 11 cases (42%), the CFR committee did not know the age of the supervisor responsible for the decedent at the time of death

Figure 41: Supervisor's relationship to child for Reviewed Drowning Deaths, GA , 2013 (N=26)



- Biological parents were the reported supervisors for 14 decedents (54%)
- Many times, parents and caregivers were engaged in other distracting activities like caring for multiple children, talking or texting on cell phones, reading, eating, or socializing with others

Drowning Prevention

The level of supervision is essential for prevention of child drowning deaths. It is highly recommended to give children undivided attention and distraction free supervision around any type of water. Supervisors should always be within an arm's reach when watching young children in water. Younger children should be supervised using "touch supervision" while in the bathtub, swimming pool or playing in or around water.

Multilayered protection for young children that include effective pool barriers should be put into place. These include the use of perimeter fencing around pools, self-closing/self-latching gates, and alarms on doors leading directly to pools. Tables, chairs and other items that can be used for climbing to gain access to water should be removed and secured away from the pool area. For hot tubs and spas, specialty covers that support the weight of adults should be used to secure these areas when not in use.

Proper swimming instruction and water survival skills for all children and supervisors are highly recommended. All supervisors of children around water should have CPR training and be first aid certified and have knowledge of proper rescue techniques. Young children and children who don't know how to swim should always wear U.S. Coast Guard approved personal flotation devices or life jackets around any type of open water. Always have rescue equipment and a phone on hand near water.

For children with seizure disorders, the Centers for Disease Control and Prevention suggest the child take showers rather than using the bathtub for bathing. Additionally, one-on-one supervision and the use of flotation devices should be provided for children with medical conditions such as seizure disorders.

National Resources

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

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

National Drowning Prevention Alliance (www.ndpa.org)

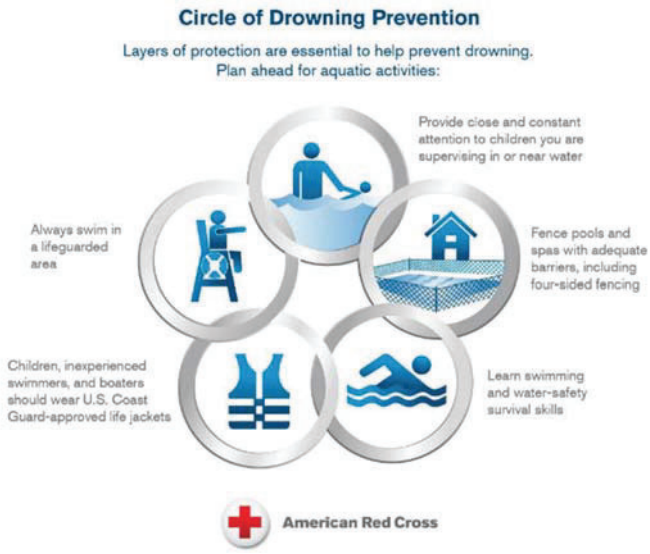
Pool Safely (www.poolsafely.org)

State Resources

Safe Kids of Georgia (www.safekidsgeorgia.org)

Georgia Children's Cabinet (www.children.ga.gov)

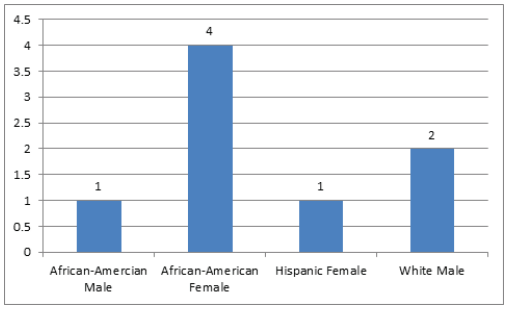
Georgia Department of Natural Resources, Wildlife Division (http://www.georgiawildlife.com)



Suffocation/asphyxia is the fourth leading cause of unintentional child death. Toddlers and preschool aged children are those most at risk for choking and strangulation. Their increased activity puts them at risk of choking on food or small objects. According to a study conducted by the National Center for Child Death Review, most unintentional suffocation occurs due to the following factors:

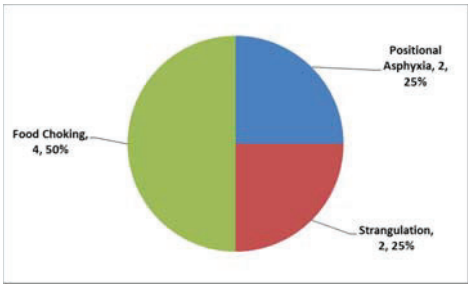
- Overlay: When a person with whom the child is sleeping rolls onto and smothers the child
- Positional asphyxia: A child's face becomes trapped in soft bedding or wedged into a tight place, as between a mattress and wall
- Covering of the face or chest: When an object prevents the child from breathing by covering the mouth or compressing the chest, e.g., plastic bags, heavy bedding or furniture
- Choking: When a child chokes on an object such as food or a small toy
- Confinement: When a child becomes trapped in an airtight place such as a refrigerator or toy chest
- Strangulation: When a rope, cord, hands or other object strangles a child

Figure 42: Reviewed Asphyxia Deaths by Race/Ethnicity, 2013 (N=8)



Asphyxia Deaths

Figure 43: Reviewed Asphyxia Deaths by Mechanism, 2013 (N=8)



- Seventy-Five percent (6) of reviewed asphyxia deaths involved children age one to four; the remaining two deaths involved children age five to nine
- Proper supervision is a prominent factor in preventing non-sleep asphyxia deaths among infants and toddlers

Opportunities for Prevention

- Infants and toddlers should be closely supervised to ensure that they remain safe
- Keep small objects such as deflated balloons, small toy parts, window blind cords, and rope out of the reach of small children
- Small children should be watched closely during mealtime and all food objects should be chopped or ground into small chewable pieces to prevent choking

Safe Kids Georgia

www.safekids.org

The National Center for Child Death Review

www.childdeathreview.org

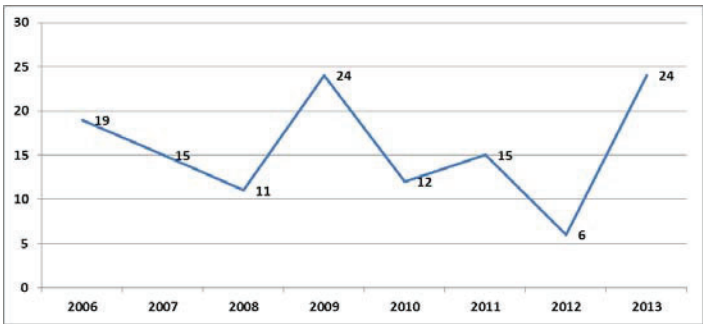
Fire-Related Deaths

According to the National Fire Protection Association (NFPA), fires and burns are the third leading cause of unintentional death among children 14 and under. Forty percent of children ages 14 years and younger who die in home fires in the United States are under the age of five. Most fires occur in the home and cooking equipment is the leading cause of home fires and home fire injuries. More home fires start in the kitchen than in any other place in the house and more than two-thirds of home fire deaths occur in homes without smoke detectors or inoperable smoke detectors (NFPA, 2011).

In Georgia, there were 24 fire-related deaths in 2013. Of these, 13 occurred in single family homes (57%) and seven occurred in duplexes (30%). The fire source breakdown is as follows:

- 7 cigarette lighter/matches
- 3 electrical outlet/wiring
- 2 cooking stove
- 1 space heater
- In 11 cases, the fire source was unknown

Figure 44: Reviewed Fire-Related Deaths, 2006-2013, GA (N=24)



Nationally, the number of fatalities and injuries caused by residential fires has declined gradually over the past several decades (CDC 2012). However, in Georgia, fire-related deaths have fluctuated over the past several years; the current number of fire-related deaths (24) has quadrupled in the last year (6) which underscores the importance of enhancing our efforts toward reducing the incidence of fire-related child deaths in Georgia.

Fire-Related Deaths

Figure 45: Demographics of Reviewed Fire-Related Deaths, 2013 (N=24)

	Infant	1 to 4	5 to 9	10 to 14
White Male		1	1	
White Female		3	2	3
African-American Male	1	3	2	
African-American Female		4	3	1

- Children under the age of five are at increased risk for fire-related deaths and injuries.

General risk factors for fire and burn-related deaths can be attributed to the child and the caregiver. According to research findings (Alnababtah, Khan, & Ashford, 2014), there are several parent/caregiver risk factors which can increase the opportunity for fire/burn injuries:

- Lack of first aid knowledge
- Poor supervision
- Living in rented housing
- Low income family
- Single-parent family
- Smoking in the home/in bed

Risk factors that increase opportunity for fire/burn injuries among children are:

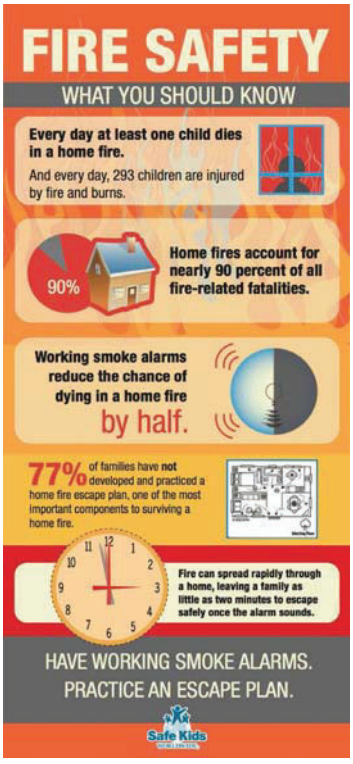
- Children younger than 5
- Males have higher risk of burns than females
- African-American children have higher risk of burns
- Children with disabilities, such as seizure disorders

Opportunities for Prevention:

- Make sure that there are working smoke detectors on every level of your home and test each alarm monthly to ensure that it is working properly
- Fire extinguishers should be kept in high risk areas, such as the kitchen, and all adults in the home should know how to use it correctly
- Create a fire escape plan with every member of your family (to include small children) and practice it regularly (at least four times each year)
- Keep matches, lighters and other fire sources out of the reach of small children
- Adult smokers should do so outside and make sure that smoking materials are properly extinguished

National Fire Protection Association
www.nfpa.org
U.S. Fire Administration
www.usfa.fema.gov
Georgia Office of Insurance and Safety Fire Commissioner/Fire Marshal
www.oci.ga.gov

Fire-Related Deaths



According to the CDC, homicide disproportionately affects persons aged 10–24 years in the United States and consistently ranks in the top three leading causes of death in this age group, resulting in approximately 4,800 deaths and an estimated $9 billion in lost productivity and medical costs in 2010. Nationally, youth homicides represent the greatest proportion of all firearm deaths. Each day in the U.S., there are an average of 10 children and teen firearm-related deaths , even though the number of firearm-related teen deaths has dropped by 35% in the past four years. In 1999, the Youth Risk Behavior Surveillance Survey reported that almost one-fifth of the 10th and 12th graders indicated that they had carried a firearm within the previous 30 days for self-defense or to settle disputes.

Youth homicide is a serious problem in large urban areas, especially among African-American males. Homicides are the number one cause of death for African-American and Hispanic teens. Yet when socio-economic status is held constant, differences in homicide rates by race become insignificant. Major contributing factors in addition to poverty include easy access to handguns, involvement in drug and gang activity, family disruption and school failure. These homicides usually occur in connection with an argument or dispute. They are often committed by casual acquaintances of the same gender, race and age, using inexpensive, easily acquired handguns.

Violence prevention research has demonstrated that strategies are most effective when they identify high-risk children in their earliest years and intervene at multiple levels through collaborative community partnerships.

Major Risk Factors

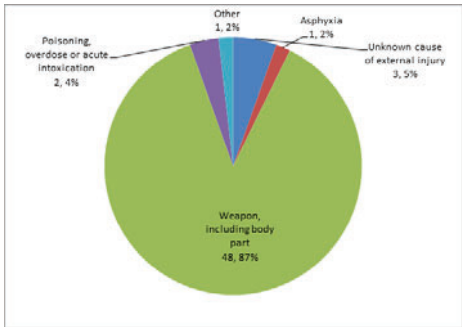
- Youth active in drug and gang activity, with a prior history of early school failure, delinquency and violence
- Easy availability of and access to firearms
- Youth living in neighborhoods with high rates of poverty, social isolation and family violence
- Youth with little or no adult supervision
- Prior witnessing of violence

Figure 46: Demographics of Reviewed Homicide Deaths, GA, 2013 (N=55)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	3	5			5	13
White Female		2				2
African-American Male	3	5		4	8	20
African-American Female	2	5		1	1	9
Hispanic Male	1	1	1	2	1	6
Multi-Racial Male	1					1
Multi-Racial Female		1				1
Other Male	1		1	1		3
TOTAL	11	19	2	8	15	55

- In 2013, 55 children were victims of homicide in Georgia. Homicides were the 4th leading cause of death in children age 14 and under, while it is the 3rd leading cause of death among teens age 15 to 17. A third of all reviewed homicide deaths were among African-American males (36%). Homicides involving males were more than three times the number of females reported.

Figure 47: Homicides among Children by Mechanism, Georgia, 2013 (N=55)



- Weapons, including body parts, were the mechanism in 48 deaths (87%)
- The mechanism for the cause of the external injury was unknown in three homicides (5%)
- Poisoning, overdose or acute intoxication was the mechanism of injury in two homicides (both decedents were under the age of five)

Figure 48: Mechanism of Injury for Reviewed Homicide Deaths by age groups, GA, 2013 (N=55)

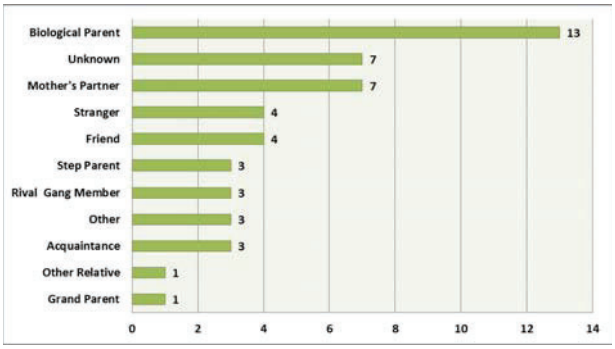
	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Asphyxia		1			
Poisoning, overdose or acute intoxication	1	1			
Missing/Unknown	1	2			
Other				1	
Weapon, including body part	9	15	2	7	15

Figure 49: Type of Weapon for Reviewed Homicide Deaths, GA, 2013 (N=55)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
Blunt Instrument		1				1
Body Part	8	11	1	3		23
Firearm		2		3	14	19
Missing/Unknown	3	4		1		8
Sharp Instrument		1	1	1	1	4
Total	11	19	2	8	15	55

- Deaths caused by body parts were the highest among infants and toddlers (age 1-4). When "body part" is reported, the circumstances generally involve beating, dropping, pushing, biting, shaking, strangling and throwing
- Homicides by firearms were highest among teens (age 15-17). These circumstances were generally due to gang violence and altercations with acquaintances, friends, strangers and family

Figure 50: Homicides among Children by Perpetrator, when reported, GA, 2013 (N=49)



- In 23 cases, the perpetrator was the parent/step-parent/parent's partner (47%)
- In ten cases, the perpetrator was a peer of the decedent (i.e. acquaintances, rival gang member, friend) (20%)

Homicide Prevention

It is important to have patience and take extra care with younger children. Likewise, it is important to recognize and familiarize yourself with child abuse. Many of the victims of homicide are often younger than age five, and fatally injured by a parent or caregiver's direct abuse. In many cases the caregivers are frustrated, have little parental training and/or unrealistic expectations of child behavior and development. Classes are available for parents and caregivers to educate themselves on child behaviors and to enhance their parenting skills.

Teens ages 15 to 17 also had higher numbers of homicide deaths due to firearms. Risk factors include domestic disputes, attempting to commit a crime, and gang related activities. Prevention efforts, starting with parental involvement, are critical in this age group. The most common age for youth to join a gang is between ages 13 to 15.

Community partnerships are available to assist in reinforcing the strengths of families and communities. The reinforcement from communities and families build stronger relationships with parents, teachers and peers and enhance healthier relationships and lifestyle choices. Supportive groups such as teen mentoring and tutoring programs help teens as they go through challenging life transitions. These programs have shown to improve behaviors, interpersonal skills, self-esteem and self-confidence, and encourage higher educational aspirations.

National Resources

National Vital Statistics System (http://www.cdc.gov/nchs/nvss.htm)
National Center for Health Statistics (www.cdc.gov/nchs)

State Resources

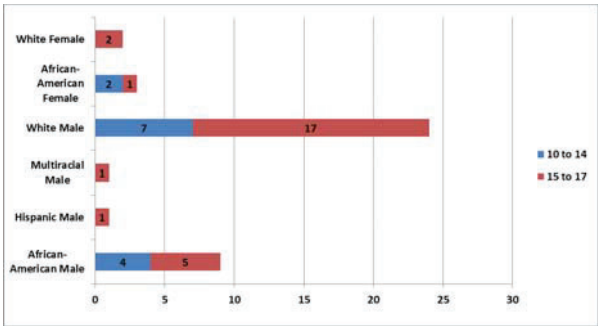
Georgia Criminal Justice Coordinating Council (www.cjcc.georgia.gov)
Georgia Family Connection Partnership (www.gafcp.org)
Prevent Child Abuse Georgia (www.preventchildabusega.org)
Georgia Department of Public Health, Violent Death Reporting System (www.health.state.ga.us)

Suicide is the third leading cause of death among young people in the United States between the ages of 10 and 19. Although the percentage of U.S. high school students who considered suicide fell by nearly half between 1991 to 2009 (from 29 percent to 14 percent), this percentage has increased slightly in recent years. In 2012, roughly one in every six high school students considered suicide.

Research suggests that at least 75 percent of the people who complete suicide are depressed; for this reason, preventing teen suicide means treating teen depression. There is some concern that many young people are not receiving much needed screening and treatment for mental health issues. While youth can face a range of barriers to accessing mental health care, reducing the stigma around mental illness is also key to ensuring more adolescents seek help and that peers, parents, and school personnel are aware of warning signs and effective intervention strategies.

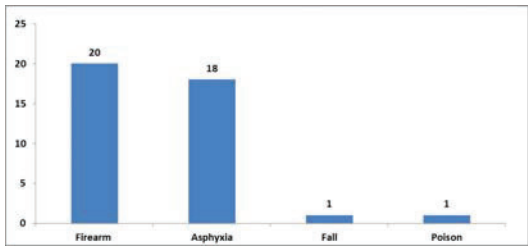
Some public health researchers advocate for paying greater attention to "means reduction" in suicide-prevention efforts—focusing on suicidal youths' access to highly lethal means of completing suicide, such as a parent's gun. Indeed, as we continue to debate the future of gun control laws, it's worth noting that firearms are used in 40 percent of teen suicides (ChildTrends, 2012).

Figure 51: Demographics of Reviewed Suicide Deaths, GA, 2013 (N=40)



- Eighty-Eight percent of reviewed suicide deaths were males
- Nationally, a third of teenage suicide victims have made a suicide attempt. If a male teen has attempted suicide, he is more than 30 times more likely to complete suicide in a subsequent attempt, while a female with a previous attempt has about three times the risk to complete suicide
- Research suggests that positive community support, family and peer connectedness, school connectedness, and positive relationships can help youth build resiliency and reduce the risk that the child will attempt suicide

Figure 52: Mechanism of Injury in Reviewed Suicide Deaths, GA, 2013 (N=40)



- Half of the suicide deaths involved use of a firearm (handgun, hunting rifle, or shotgun)
- The risk of suicide increases dramatically when children and teens have access to firearms at home, and nearly 60% of all suicides in the United States are committed with a gun
- Restricting access to lethal means is one of the most effective strategies to prevent youth suicides. It is critically important that parents who are concerned that their child might be feeling suicidal reduce easy access to lethal means, including firearms, medications, and alcohol

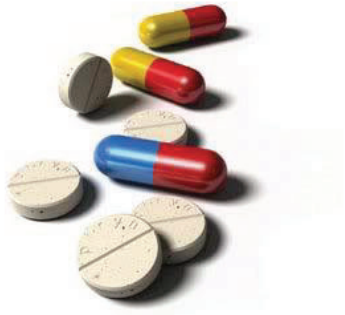
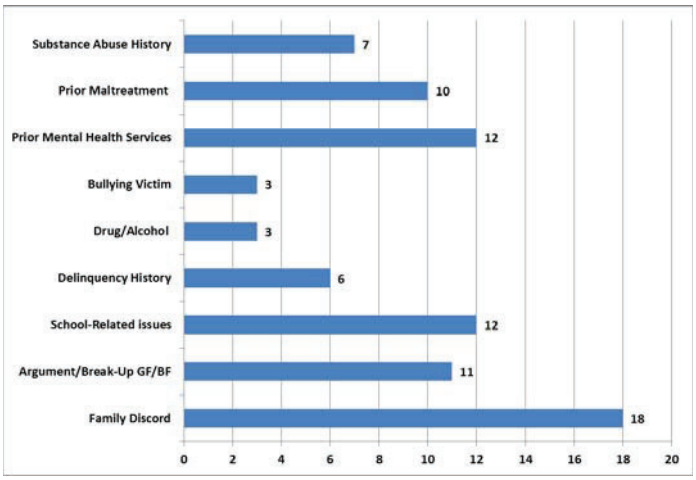


Figure 53: Reported Risk Factors for Reviewed Suicide Deaths, GA, 2013



- The history reported for a child can include multiple actions for each death, therefore the total is greater than the number of suicide deaths
- The "Family Discord" category includes relational issues with parents, recent argument with parent(s) and/or sibling(s)

Opportunities for Prevention:

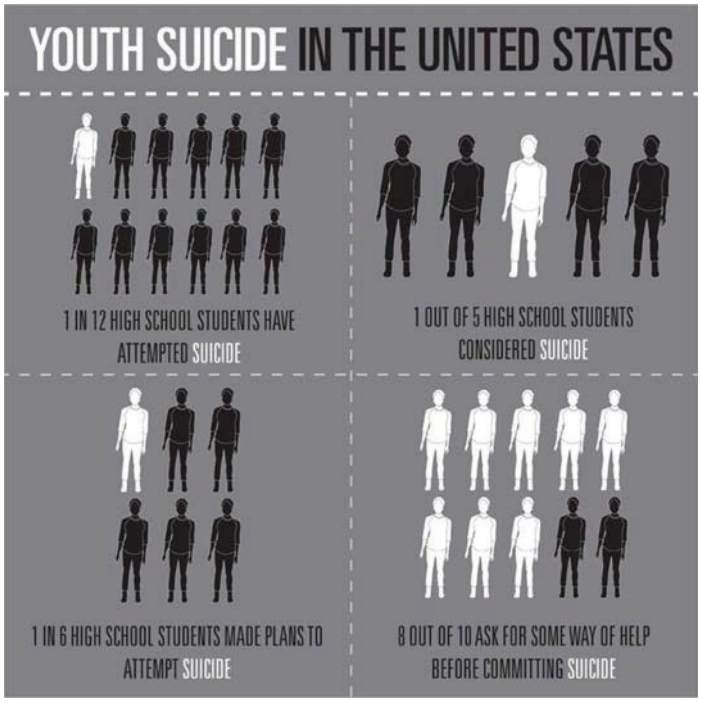
- Address how changing technology and social media landscape affects teens' experience with bullying and mental health issues
- Increase awareness of suicide warning signs and encourage parents, school personnel, counselors, health care providers and other community agents who interact with youth to take prompt action when these signs are recognized
- Increase accessibility and availability of mental health services to children, youth and families
- Advocate for safe and secure storage of firearms

Georgia Suicide Prevention Information Network (www.gspin.org)

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

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

Child Trends (www.childtrends.org)



Appendix A: Child Fatality Review Committee Timeframes andResponsibilities

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

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

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

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

Medical examiner or coroner reviews the findings

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

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

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

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

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

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

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

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

Appendix B – Reviewable Deaths Reviewed

		All Infant/Child Deaths						All Reviewable Deaths						All Reviewable Deaths Reviewed						All Reviewed Deaths					
Reviewed/ Reviewable	County Chattahoochee	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
1/1	Appling	1	1			1	3					1	1					1	1					1	1
2/2	Atkinson					2	2					2	2					2	2					2	2
1/1	Bacon	1					1	1					1	1					1	1					1
0/0	Baker						0						0						0						0
4/4	Baldwin	6	2		1		9	2	1		1		4	2	1		1		4	2	1		1		4
0/0	Banks						0						0						0						0
3/4	Barrow	7	1			2	10	3	1				4	2	1				3	2	1				3
2/2	Bartow	8	1				9	2					2	2					2	2					2
1/1	Ben Hill	2	1				3	1					1	1					1	1					1
2/2	Berrien	2	1			1	4	1	1				2	1	1				2	1	1				2
15/17	Bibb	19	2	5	6	3	35	5	1	4	4	3	17	3	1	4	4	3	15	4	2	4	5	3	18
0/0	Bleckley	1					1						0						0						0
2/2	Brantley				1	1	2				1	1	2				1	1	2				1	1	2
2/2	Brooks	2	3			1	6		2				2		2				2		1				1
0/4	Bryan	5	1	3	1		10		1	2	1		4						0						0
2/2	Bulloch	6	1		1		8	1			1		2	1			1		2	1			1		2
0/0	Burke	3	1				4						0						0						0
0/0	Butts	1	1				2						0						0						0
0/0	Calhoun						0						0						0						0
1/1	Camden	6				1	7					1	1					1	1					1	1
0/0	Candler	1					1						0						0						0
3/3	Carroll	4	1	1	4	2	12	1		1		1	3	1		1		1	3	1	1	1		3	6
2/2	Catoosa	2		1		1	4			1		1	2			1		1	2			1		1	2
0/0	Charlton	1					1						0						0						0
15/15	Chatham	32	8	1	5	4	50	7	2	1	2	3	15	7	2	1	2	3	15	9	3	1	3	3	19
0/0	Chattahoochee	3	1				4						0						0						0
2/2	Chattooga	2	1	1	2		6			1	1		2			1	1		2	1		1	1		3
6/6	Cherokee	15	3			5	23	1				5	6	1				5	6	1	2			5	8
1/1	Clarke	10	1	1	1		13		1				1		1				1		1				1
1/1	Clay				1		1				1		1				1		1				1		1
14/14	Clayton	30	6		3	8	47	3	3		2	6	14	3	3		2	6	14	9	6		4	6	25
0/0	Clinch						0						0						0						0
19/19	Cobb	60	14	7	6	5	92	8	5	1	2	3	19	8	5	1	2	3	19	13	7	2	2	4	28
3/4	Coffee	6	4			1	11	1	2			1	4	1	1			1	3	1	3			1	5
4/4	Colquitt	10	2		1		13	3	1				4	3	1				4	3	2				5
6/6	Columbia	11	2	1	4	2	20	1			3	2	6	1			3	2	6	1	1		4	2	8
1/1	Cook	4	1				5		1				1		1				1	1	1				2
6/6	Coweta	5	5	1		3	14		4	1		1	6		4	1		1	6		5	1		1	7
1/1	Crawford	1					1	1					1	1					1	1					1
3/3	Crisp	4		1			5	2		1			3	2		1			3	3		1			4

Appendix – Reviewable Deaths Reviewed

		All Infant/Child Deaths						All Reviewable Deaths						All Reviewable Deaths Reviewed						All Reviewed Deaths					
Reviewed/ Reviewable	County Chattahoochee	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
1/1	Dade	2		1			3	1					1	1					1	1					1
3/3	Dawson	3			1	1	5	2				1	3	2				1	3	2				1	3
0/0	Decatur	3					3						0						0	1					1
25/26	DeKalb	81	19	3	5	10	118	10	5	2	2	7	26	9	5	2	2	7	25	12	7	3	2	6	30
1/1	Dodge	5					5	1					1	1					1	1					1
1/1	Dooly		1			1	2					1	1					1	1					1	1
5/6	Dougherty	23	4	1		2	30	2	2	1		1	6	2	2	1			5	3	1	1			5
7/7	Douglas	15	2	1		3	21	2	2	1		2	7	2	2	1		2	7	2	2	1		2	7
1/1	Early	2		1	1		4	1					1	1					1	1					1
0/0	Echols	1					1						0						0						0
5/5	Effingham	4	3			2	9	1	2			2	5	1	2			2	5	1	3			2	6
0/0	Elbert	4		1	1		6						0						0			1			1
5/6	Emanuel	7		1		4	12	2		1		3	6	2		1		2	5	2		1		2	5
0/0	Evans	2					2						0						0						0
1/3	Fannin	2			1	1	4	1			1	1	3					1	1	1				1	2
2/2	Fayette	4				2	6					2	2					2	2					2	2
4/4	Floyd	5	2	1	1	3	12	1	1	1		1	4	1	1	1		1	4	1	2	1		2	6
8/8	Forsyth	10	2	1	1	3	17	4	1			3	8	4	1			3	8	5	1		1	3	10
2/3	Franklin	2	1		3	1	7	1			1	1	3	1			1		2	2	1		1		4
41/42	Fulton	86	12	8	8	19	133	14	5	4	6	13	42	14	5	4	5	13	41	20	11	6	5	17	59
1/1	Gilmer		1				1		1				1		1				1		1				1
1/1	Glascock					1	1					1	1					1	1						0
4/4	Glynn	6	1	1	1	1	10	1	1	1		1	4	1	1	1		1	4	2	1	1	1	1	6
4/4	Gordon	3	1	1	1	2	8	1			1	2	4	1			1	2	4	1			1	2	4
0/2	Grady	4	1				5	1	1				2						0						0
0/0	Greene	1			1	1	3						0						0				1		1
20/21	Gwinnett	61	18	4	10	12	105	5	7	1	2	6	21	5	6	1	2	6	20	5	6	1	4	9	25
3/3	Habersham	5		1		1	7	3					3	3					3	3				1	4
6/6	Hall	11	1	2	3	1	18	3		1	1	1	6	3		1	1	1	6	3		1	2	1	7
0/0	Hancock	1					1						0						0						0
0/1	Haralson	5					5	1					1						0						0
0/0	Harris			1			1						0						0						0
2/2	Hart	2	1		1		4		1		1		2		1		1		2				1		1
4/4	Heard	1	1		1	2	5	1			1	2	4	1			1	2	4	1	1		1	1	4
6/6	Henry	9	1	2	3	2	17	1		1	2	2	6	1		1	2	2	6	2		1	2	2	7
6/7	Houston	19	2	1	2	2	26	4	1			2	7	4				2	6	5	1			2	8
0/0	Irwin						0						0						0						0
1/3	Jackson	7	2		2		11	1	1		1		3		1				1		1				1
0/0	Jasper						0						0						0		1				1
2/2	Jeff Davis	3			1		4	2					2	2					2	2					2

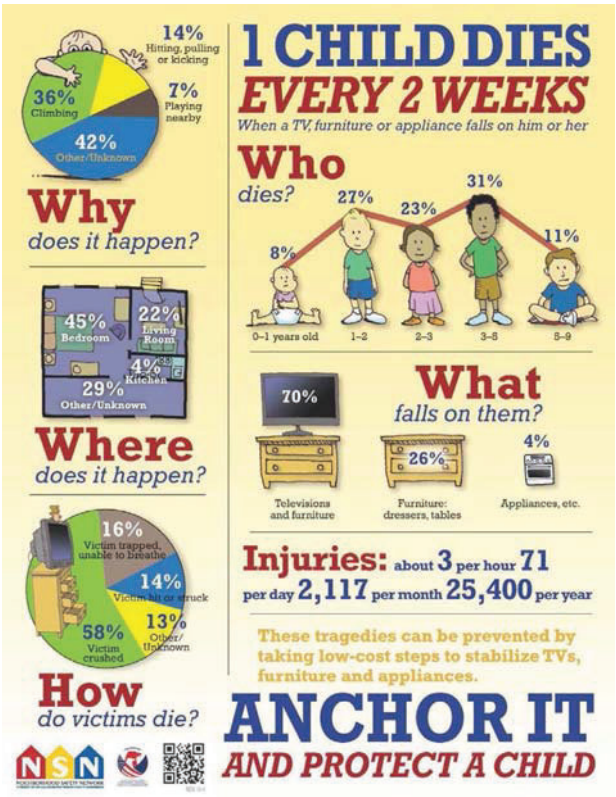
Appendix – Reviewable Deaths Reviewed

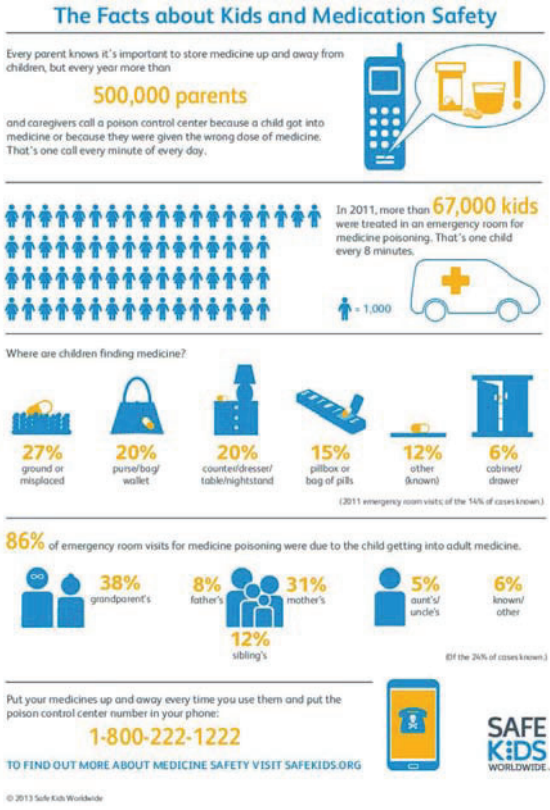
		All Infant/Child Deaths						All Reviewable Deaths						All Reviewable Deaths Reviewed						All Reviewed Deaths					
Reviewed/ Reviewable	County Chattahoochee	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
1/1	Jefferson	2				1	3					1	1					1	1					1	1
0/0	Jenkins						0						0						0						0
0/0	Johnson			1			1						0						0						0
3/3	Jones	4	2	1	1		8		2		1		3		2		1		3		2		1		3
0/1	Lamar					1	1					1	1					1	1						0
0/0	Lanier	1					1						0						0						0
2/3	Laurens	8				1	9	2				1	3	1				1	2	1				1	2
1/2	Lee	4				1	5	2					2	1					1	1					1
3/5	Liberty	8	2	1	2		13	3	2				5	2	1				3	3	1		1		5
0/0	Lincoln	1					1						0						0						0
1/1	Long	2			1		3				1		1				1		1				1	1	2
4/4	Lowndes	12	1	1	3	1	18	1	1		1	1	4	1	1		1	1	4	1	2		1	1	5
0/0	Lumpkin	1					1						0						0						0
0/0	Macon						0						0						0						0
0/0	Madison	2					2						0						0		1				1
0/0	Marion	2					2						0						0						0
0/0	McDuffie	2			1		3						0						0						0
0/0	McIntosh						0						0						0						0
1/1	Meriwether	2			1	1	4					1	1					1	1					1	1
0/0	Miller						0						0						0						0
0/0	Mitchell	2					2						0						0						0
2/2	Monroe			2			2				2		2						2				1		1
0/0	Montgomery	3					3						0						0						0
1/1	Morgan	1					1	1					1	1					1	1					1
4/4	Murray	2	1	1	1	4	9					4	4					4	4					4	4
12/12	Muscogee	39	6	1	2	3	51	7	3		1	1	12	7	3		1	1	12	10	4		1	3	18
4/4	Newton	13	1	2	2		18	2	1		1		4	2	1		1		4	3	1	1	1		6
2/2	Oconee				1	1	2				1	1	2				1	1	2				1	1	2
0/0	Oglethorpe	1					1						0						0						0
2/2	Paulding	4	4	1		1	10		2				2		2				2		1		1	1	3
1/1	Peach	2					2	1					1	1					1	1					1
0/0	Pickens	5		1		1	7						0						0						0
1/1	Pierce		1				1		1				1		1				1		1				1
1/1	Pike					2	2					1	1					1	1					1	1
1/2	Polk	5	1	1			7	1		1			2			1			1			1			1
0/0	Pulaski	1					1						0						0						0
1/1	Putnam	3	1				4	1					1	1					1	1					1
2/2	Quitman		2				2		2				2		2				2		2				2
0/0	Rabun						0						0						0						0
0/0	Randolph		1				1						0						0		1				1

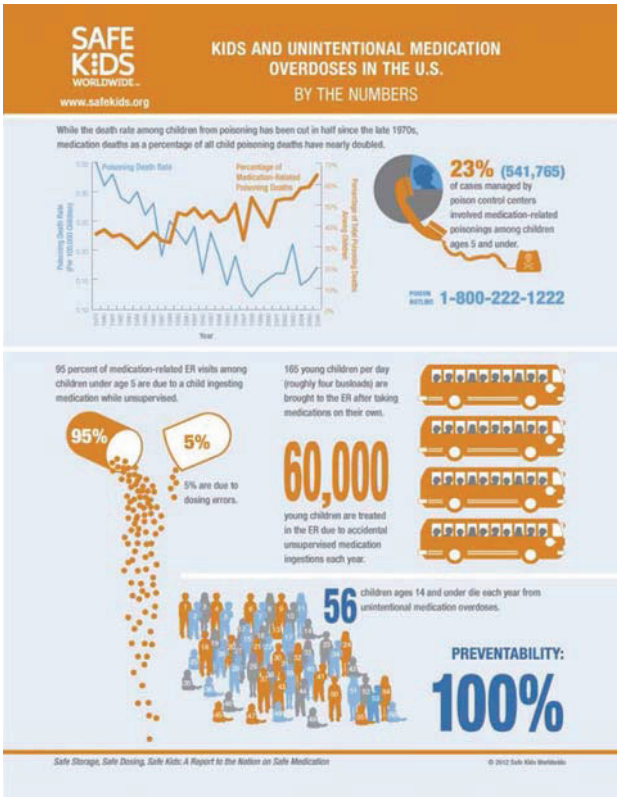
Appendix – Reviewable Deaths Reviewed

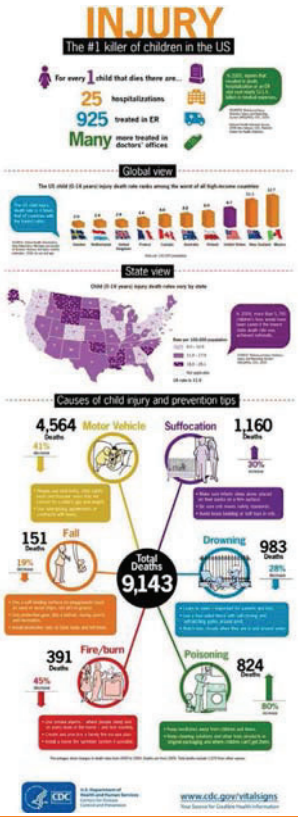
		All Infant/Child Deaths						All Reviewable Deaths						All Reviewable Deaths Reviewed						All Reviewed Deaths					
Reviewed/ Reviewable	County Chattahoochee	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total	Total	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
9/11	Richmond	24	9	3	2	3	41	3	4	2		2	11	2	4	2		1	9	3	4	2	1	2	12
7/8	Rockdale	19	1	4			24	3	1	4			8	3	1	3			7	3	1	3			7
1/2	Schley				2		2				2		2				1		1				1		1
2/2	Screven	2		4			6			2			2			2			2			2			2
0/0	Seminole						0						0						0						0
1/1	Spalding	2	2	2	1		7	1					1	1					1	1					1
1/1	Stephens	5					5	1					1	1					1						0
1/1	Stewart	1					1	1					1	1					1	1					1
1/2	Sumter	2			1	1	4	1				1	2					1	1					1	1
0/0	Talbot						0						0						0						0
0/0	Taliaferro						0						0						0						0
0/1	Tattnall	3	1		1	1	6		1				1						0	1				1	2
0/0	Taylor	2					2						0						0						0
0/1	Telfair	3				1	4	1					1						0						0
0/0	Terrell	2					2						0						0		1				1
0/0	Thomas	5					5						0						0						0
0/1	Tift	5		1		1	7	1					1						0						0
0/0	Toombs	4	1				5						0						0						0
0/0	Towns				1		1						0						0	1					1
2/2	Treutlen	1			1	1	3				1	1	2				1	1	2					1	2
6/6	Troup	12	4	1	1	4	22	2	1			3	6	2	1			3	6	2	1			4	7
0/0	Turner					1	1						0						0						0
0/0	Twiggs		1				1						0						0						0
1/1	Union	1					1	1					1	1					1					1	1
0/0	Upson	1				1	2						0						0						0
2/4	Walker	5		1	2	5	13	1				3	4					2	2					2	2
3/3	Walton	9	1	1		1	12	1	1			1	3	1	1			1	3	1	1	1		1	4
2/2	Ware	5		1		1	7	1				1	2	1				1	2	1				1	2
0/0	Warren						0						0						0					1	1
1/1	Washington	2		1		1	4	1					1	1					1	1				1	2
1/1	Wayne	2		1			3	1					1	1					1						0
0/0	Webster						0						0						0						0
0/0	Wheeler						0						0						0						0
1/1	White	1					1	1					1	1					1	1					1
1/1	Whitfield	6					6	1					1	1					1	2					2
0/0	Wilcox		1				1						0						0						0
1/1	Wilkes	2					2	1					1	1					1	1					1
0/0	Wilkinson	1					1						0						0						0
2/2	Worth	2			1		3	1			1		2	1			1		2	1			1		2

Additional Infographics








INJURY
The #1 killer of children in the US
For every 1 child that dies there are...
25 hospitalizations
925 treated in ER
Many more treated in doctors' offices
Global view
State view
Causes of child injury and prevention tips
4,564 Deaths
Motor Vehicle
41%
Suffocation
1,160 Deaths
30%
151 Deaths
Fall
19%
Total Deaths 9,143
Drowning
983 Deaths
28%
391 Deaths
Fire/burn
45%
Poisoning
824 Deaths
80%
www.cdc.gov/vitalsigns

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed it is the only thing that ever has."

Margaret Mead