**Georgia Child Abuse Prevention & Treatment Act**

# CAPTA Panels' 2015 Annual Report

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

# Georgia's CAPTA Panels

**Child Protective Services Advisory Committee**

**Children's Justice Act Task Force**

**Child Fatality Review Panel**

# 2015 Annual Report: Summary

*Reports from each of the individual Panels are attached as appendices.*

## 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Originally enacted in January 1974, the Child Abuse Prevention and Treatment Act (CAPTA) is a key piece of federal legislation addressing child abuse and neglect.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 the CAPTA Panels is to increase system transparency and accountability and provide opportunities for community input by:

- Examining the policies, procedures, and practices of state and local agencies, and, where appropriate, specific cases
- Evaluating the extent to which state and local child protection agencies are effectively discharging their child protection responsibilities in accordance with:

a) The state's CAPTA plan
b) Child protection standards required by CAPTA

- Any other criteria that the CAPTA Panels consider important to ensure the protection of children, including:
  a) Reviewing the extent to which the state and local child protective services system is coordinated with the foster care and adoption programs established under Title IV Part E of the Social Security Act
  b) Reviewing child fatalities and near fatalities

CAPTA Panels are composed of volunteer members who broadly represent the communities in which they operate and include individuals with expertise in the prevention and treatment of child abuse and neglect. Panels are required to meet quarterly, provide for public outreach, and prepare an annual report on activities that provides feedback on the effectiveness of the state's child abuse prevention and treatment strategies and presents recommendations for improvements. State child welfare agencies are required to provide access to information that CAPTA Panels desire to review, to provide administrative support so that the Panels can fulfill their duties, and to respond to Panel recommendations included in their 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 CAPTA program areas 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. However, changes in leadership priorities, development and implementation of a new practice model, and recent legislative activity, including the establishment of a child abuse registry, suggest that Georgia's CAPTA plan will need to be revised in the coming year as revisions are required any time there is a significant change in priorities and the use of the CAPTA state grant.

## Georgia's Citizen Review Panel (CAPTA Panels)

The mission of Georgia's CAPTA Panels is:

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

In 2006, three committees were officially designated to serve as Georgia's CAPTA Panels: the Children's Justice Act Task Force (Task Force), the Child Protective Services Advisory Committee (CPSAC), and the Georgia Child Fatality Review Panel (CFRP). The Task Force serves a dual role as a CAPTA Panel and as a task force on children's justice. The CFRP serves as both a CAPTA Panel and a state-mandated 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
- Maintaining a membership that is broadly representative of the community and meeting 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 evaluating 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. Concerns identified by individual members are considered for further examination by the Panels based on how closely the problem, or the solution, ties directly to federal or state law, policy or practice, and their mandate as a CAPTA Panel. The Panels' 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.
The co-chairs from each CAPTA Panel serve on a joint steering committee that meets as needed during the year to promote inter-panel collaboration, coordination of Panel activities and joint planning with Georgia's child welfare agency.

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. Additionally, the website is used to post meeting schedules and inter- and intra-panel communications and serves 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. Individuals interested in getting involved with Georgia's CAPTA Panels can download a copy of the application form from the website.

## 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 peer networking opportunities. In 2015, quarterly conference calls, webinars and publications covered such topics as the *New Child Welfare Capacity Building Center for States, Panel Logistics, Recruitment and Retention of Members* and *Developments in Law and Policy Affecting Child Protective Services*. Georgia's CAPTA Panels were also able to take advantage of a wide variety of webinar and training opportunities offered by local and national organizations relevant to their current work and interests, such as:

- Serving Victims of Sexual Exploitation & Sex Trafficking
- The Vulnerability of Homeless Youth
- Sudden and Unexpected Child Deaths
- Effective Strategies for Addressing the Needs of Substance Exposed Newborns and Their Families
- Developing a Coordinated Response to Families Affected by Substance Use Disorders
- Understanding Adverse Childhood Experiences Research
- Working with the Non-Offending Caregiver in Child Abuse Cases
- Mandated Reporting of Child Abuse in Georgia

During 2015, Georgia Panels sought input from panels in other states on CAPTA's public outreach mandate for Panels and on how other states address the poor public image of the child welfare agencies. Conversely, Georgia's Panels had an opportunity to provide feedback on several inquiries from other states, such as how CAPTA Panels have helped to improve permanency

outcomes, how information on CAPTA and CAPTA Panels is shared with transitioning legislators, and how birth parent involvement in the child welfare system has been used as a mechanism for promoting child welfare system reform/improvements. The CJA Task Force also shared surveys it has utilized with states who were considering the same or similar topics for their three-year assessments.

National CAPTA Panel Conference

Representatives from each of Georgia's CAPTA Panels and the Panel coordinator attended the National Citizen Review Panel conference in Portland, OR, May 18-20, 2015. More than 100 participants representing 26 states attended the two-and-a-half day conference. Workshops and plenary sessions included such topics as:

- Reviewing Child Fatalities
- Concept Mapping as an Evaluation Tool for Citizen Review Panels
- CRP's Working Toward More Timely Permanency for Children
- File Review, Surveys and Focus Groups: How to Gather Information to Inform Your CRP's

At the conference, participants also received an update on federal child welfare legislation and related activities from Howard Davidson, Director of the ABA Center for Children and the Law. Tina Naugler, Child Welfare Program Manager Children's Bureau Region 10, provided a presentation on the *CFSR Process and How to Engage CRPs in CFSR Efforts*. Additionally, there were several opportunities available for peer-to-peer networking during the conference.

## Georgia's CAPTA Panels Working Together in 2015

Georgia's CAPTA Panels held their annual retreat on September 17, 2015. Forty panel members attended the retreat, hosted at Cobb Superior Court in Marietta, GA. The morning agenda included a presentation by Tracy Fava, Child Welfare Specialist Children's Bureau Region IV, on joint planning opportunities for CAPTA Panels and an overview of each of the federal funding streams that support state child welfare systems. The morning concluded with a presentation on Georgia's CAPTA Plan and utilization of its CAPTA state grant by Colleen A. Mousinho, Director Practice Guidance Georgia Division of Family and Children Services.

The afternoon sessions were dedicated to discussing and developing individual plans for each of Georgia's Panels for the coming year.

The Children's Justice Act Task Force (the Task Force) has established a subcommittee to advance the work based on their most recent three-year assessment related to the state's child abuse protocol, including:

1. Improving the consistency of maltreatment terminology in the protocol
2. Increasing collaboration opportunities for and communication between stakeholders when changes to child welfare policy or practice necessitate changes in the protocol

A second subcommittee was established and will focus on improving the quality and consistency of mandated reporter training. Also related to the CJA three-year assessment, the Task Force will monitor activities to address inconsistencies in child abuse language and definitions in the Georgia Code and policies for agencies with child caring responsibilities.

The Child Protective Services Advisory Committee's (CPSAC) interests lie in the potential revision of the state's CAPTA plan as the child welfare agency develops an implementation plan for its "Blueprint for Change[1]" that includes solution-based practice, stakeholder engagement and workforce development.

The Child Fatality Review Panel will focus their activities on improving the evaluation of data on maltreatment-related deaths, developing training for first responders on factors (red flags) at the scene of an investigation that might suggest maltreatment as a possible contributing factor in a child death and enhancing local child fatality review committee training on child abuse and neglect. The Child Fatality Review Panel will also identify and address any differences in maltreatment-related terminology between their protocols and Georgia's child welfare system.

## CAPTA Panels Working with Georgia's Child Welfare Agency in 2015

CAPTA Panel members had several opportunities to meet with Bobby Cagle, Division of Family and Children Services Director, and members of the agency's leadership team during the year. These meetings with Division leadership continue to provide CAPTA Panels with invaluable insights 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 influence the interests and advocacy efforts of the Panels. These meetings provided an opportunity to share concerns, exchange ideas, discuss agency actions related to Panel recommendations and identify new opportunities to work together.

[1] Georgia's Division of Family and Children's Services three-pronged child welfare reform plan based upon a new practice model, workforce development and constituent engagement.

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

- Annual Progress and Services Report submitted in 2015
- Child death reviews
- Child and Family Services Review: case planning and case review
- DFCS Training System Self-Assessment
- Joint Planning meeting that included the Division, Children's Bureau, Court Improvement Project and Grantees
- Revised child welfare policy, including:
    - Intake
    - Investigations
    - Family Support
    - Foster Care
    - Resource Development

CAPTA Panel members participate on several state advisory groups or committees such as the Human Trafficking Task Force, Mandated Reporter Steering Committee, Policy Advisory Committee and the state Continuous Quality Improvement team. Several members contributed to reports included in the Annual Progress and Services Report (APSR) or were consulted as expert resources. Several representatives from the CPSAC met with a representative from the Washington Children's Bureau to share insights on community-based service resources in Georgia in conjunction with the 2015 Promoting Safe and Stables Families Symposium.

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 continued to reinforce the importance of early and meaningful engagement of stakeholders, including CAPTA Panel members, in any planning or consultative process to ensure effectual stakeholder contribution.

## Georgia's CAPTA Panels 2015 Recommendations

Reports prepared by each of the CAPTA Panels describe their activities and recommendations. The recommendations in those reports are summarized below.

### Child Protective Services Advisory Committee

See CPSAC report attached as Appendix A.

During 2015, the CPSAC continued its work related to its workforce survey conducted in 2014. Related recommendations address ongoing concerns related to high staff turnover and poor morale at the child welfare agency. These include:

Workforce

- Developing a retention and succession plan, including qualifications, educational background, and selection criteria for County Directors
- Reducing the time it takes the Division to hire new employees from an average of 115 days (or 4 months) to 60 days (or 2 months)
- During the state FY2017, review the physical workplace environment for county staff in the offices where turnover exceeds 30%, paying particular attention to:
    - Lighting levels in all interior and exterior work areas
    - Quality of break rooms
    - Quality of meeting rooms, especially those visited by the public for visitation, adoption, and staffing; and waiting rooms
    - Soliciting suggestions for improvements/changes from the local staff

With CPSAC's longstanding interest in improving the quality and consistency of reports of suspected abuse to the child welfare agency and the response by the agency to those reports, CPSAC presents this follow up to a previous recommendation:

Reports of Suspected Child Abuse

Based on changes in child welfare law, policy and practice and changes or improvements to the central intake system, including electronic reporting options, provide ongoing public education and awareness on:

- Recognizing child abuse and neglect and training availability
- Obligations to report suspected abuse and what to report/not report
- Options for making a report and what to expect

Furthermore, the CPSAC also recommends that the Division solicit feedback regularly from mandated reporters on their experiences in making/filing a report and evaluate the quality and effectiveness of mandated reporter training available.

### Children's Justice Act Task Force

See Task Force report attached as Appendix B.

During 2015, the Task Force focused its efforts on follow-up related to its three-year assessment, establishing two committees to advance those interests. Recommendations from those committees will be included in the 2016 annual report. However, with respect to their ongoing consultation in the administration of the state's Children's Justice Act grant, the Task Force recommends continued support of several projects, including:

- ChildFirst training for investigators
- Summer internships for law students in the field of child advocacy
- Efforts to maintain an effective Child Abuse Protocol that is reflective of federal and state child welfare law, policy and practice
- Training for first responders and local child fatality review committee members on recognizing maltreatment as a factor or cause in child death and/or near-death or serious injury cases

- Improving the consistency of maltreatment terminology among the Georgia Code, state agencies with child caring responsibilities, other stakeholders, and the state's child welfare agency policies
- Training for individuals, Court-Appointed Special Advocates (CASA) and/or guardians ad litem (GAL) who represent children in dependency cases

## Child Fatality Review Panel

See Georgia CFRP report attached as Appendix C.

In 2015, the Child Fatality Review Panel made a considerable effort to enhance their examination of and reporting on maltreatment-related child fatalities. This effort was reflected in their annual report attached. Recommendations included in the report related to the prevention of child abuse and neglect-related fatalities are as follows:

Child fatality review committees determined that maltreatment was the direct cause or contributing factor in 99 deaths (maltreatment includes abuse, neglect, and poor supervision) during 2014. In response to these deaths, the annual report identified several findings and recommendations related to the prevention of child abuse and neglect-related deaths from the Child Fatality Review Panel and/or from local child fatality review committees.

The Child Fatality Review Panel recommended increasing collaboration between the Department of Public Health (DPH) and the Division to assure Part C[2] evaluations are completed, that the recommended services be utilized, and a smooth transition be achieved at age 36 months into Early Head Start or special education. These have tremendous protective potential to reduce child maltreatment in the state's youngest and most vulnerable citizens.

Further recommendations cited in the report from local child fatality review committees include:

- Increasing public education and awareness opportunities on recognizing child abuse
- Increasing opportunities for mandated reporter training in communities
- Screening parents of children ages 0–5 in pediatric primary care settings to identify parental exposure to partner violence, mental illness, or substance abuse and providing appropriate referrals
- Increasing awareness and utilization of support services by at-risk families, including evidence-based home visiting programs and parent education programs
- Increasing awareness of the 1-855-GA CHILD hotline for the CPS Centralized Intake Communication Center

In closing…

On behalf of the members of Georgia's CAPTA Panels, the 2015 annual report and recommendations are respectfully submitted for review and consideration by the Division. CAPTA Panel members look forward to an ongoing dialogue on our shared priorities, the Panels' recommendations included in this report, and the state's response to those recommendations.

We want to express our sincere appreciation to Director Cagle and the leadership team at the Division for their continued support of the Panels and the validation of our contributions. We are especially appreciative of the respect, transparency, and responsiveness of the Division in helping to fulfill our mandate as CAPTA Panels. We look forward to continuing our excellent working relationship.

[2] Part C of IDEA - early intervention services for infants and toddlers with disabilities, ages birth through age 2 years, and their families.

Respectfully

Melissa D. Carter
J. David Miller
**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**

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

Deb Farrell
Georgia CAPTA Panel & CJA Task Force Coordinator

# 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.*

# 2015 Annual Report

The Child Protective Services Advisory Committee (CPSAC) was established to serve as one of Georgia's three required citizen review panels (CAPTA Panel). It is the only Georgia CAPTA Panel that does not serve a dual role. 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.

## 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 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 2015. Additions to the CPSAC in 2015 included individuals who work with relative caregivers and the Latino population. Recruitment efforts are ongoing to identify and engage individuals from the community with an interest in improving Georgia's child welfare system or who have expertise in a subject matter of interest to the CPSAC. Identifying and engaging consumers, parents and youth who have been involved in the system is most

challenging; however, the CPSAC is committed to providing those opportunities whenever possible.

Meetings

In 2015, the CPSAC held five 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 and objectives, recruitment efforts, and to identify and coordinate additional resource needs.

National CAPTA Panel Conference

A representative from the CPSAC and the CAPTA Panel coordinator attended the National Citizen Review Panel conference in Portland, OR, May 18-20, 2015. Participants attending the two-and-a-half day conference included more than 100 CAPTA panel members. In addition to providing an invaluable peer support and networking opportunity, panel members from 26 states participated in a variety of sessions on:

- Increasing Diversity in Public Processes
- Trauma-Informed Child Welfare Practices
- Child Abuse Victims with Special Developmental or Health Needs
- Children/Youth Bill of Rights
- Native American Culture and Trauma
- Parent Mentor Programs
- Concept Mapping as an Evaluation Tool
- Child Fatality Reviews

Participants also received an update on federal child welfare legislation and activities from Howard Davidson, Director of the American Bar Association Center for Children and the Law. Tina Naugler, Child Welfare Program Manager Children's Bureau Region 10 did a presentation on the *CFSR Process and How to Engage CRPs in CFSR Efforts*, reinforcing the importance of engaging of CJA task forces in the states' planning processes. Additionally, several opportunities were available for peer-to-peer networking during the conference.

CPSAC Members Engaged as Valued Stakeholders in 2015

During 2015, CPSAC members had many opportunities to provide input on child welfare policy and/or practice. Several provided feedback on revised child welfare policies. One member serves on the state's Continuous Quality Improvement leadership committee and another serves on the state's Policy Advisory Council[1].

CAPTA Panel member (CPSAC) Jen King was invited to participate in Georgia's state-level child welfare Continuous Quality Improvement (CQI) team. She seized the opportunity to model how stakeholder involvement could support and enhance CQI efforts at all levels and has served as a regular member of the state CQI team for 15 months. In this capacity, she has participated in the creation and adoption of the state's CQI team by-laws, vision, and membership structure; active promotion of the CQI process; support of internal and external communications; provision of regular stakeholder input and feedback; service on the state CQI unit implementation team; contributions to the CQI facilitator guide on stakeholder involvement and engagement; and planning and presenting at the CQI informational meeting.

[1] A description of the planning activities members were engaged in, their comments and contributions are included in the summary report. See CAPTA Panel Members Engaged as Valued Stakeholder in 2015.

Additionally, Jen King serves on the state's Mandated Report and Policy Review advisory committees. This year, she has been involved with the CFSR and APSR meetings, and as a state CQI member, she will have the opportunity to support and provide input on the upcoming CFSR Program Improvement Plan (PIP) creation and implementation. The state CQI team will serve a central function in the implementation and monitoring of this PIP.

> *"Anecdotally, it has been encouraging to hear, from both Division staff and external stakeholders, about increased stakeholder engagement on the local and regional CQI teams, as well as in ongoing regional and statewide efforts."* *Jen King*

Below are some of the observations and recommendations shared with the state's child welfare agency after the CFSR/APSR meetings.

- Use multiple engagement efforts to include key stakeholders in data analysis and practice improvements.
    - Making connections between the data presented and the families served provides context and supports deeper exploration of root causes.
        - Regional CQI specialists can give context to both regional and local efforts aimed at addressing identified areas for improvement. Their knowledge of practice and established relationships with local and regional staff can benefit continued emphasis and focus on practice improvements.
        - Regional Directors use of county comparison data highlights trends and supports the identification of influencing factors. Regional directors hold important information about how county practice, county leadership, and external factors affect outcomes.
    - Unique opportunities exist with stakeholder engagement. Stakeholders are a very large and diverse group and not limited to one specific group (i.e. private providers, contractors, youth, advocates – state and local, courts, community partners, collaborators etc.). Explore the opportunities that exist by being as inclusive as possible with the many different groups. Different stakeholders require different outreach strategies. Particular emphasis on key partners, such as SAAGs, may help to inform and support improved practice.
    - Prepare and support DFCS staff in stakeholder engagement efforts from preparation, clear communication, effective use of time, reciprocal support, etc. Be mindful of stakeholders' interests, strengths, and perspectives. Some may have narrow focus with specific interests, others offer a broader perspective.
    - Partner with other state agencies (i.e. substance abuse and mental health) to create a state plan that articulates and addresses the needs of families and children, gaps, and opportunities for families in Georgia.
- Service array and development
    - Determine if barriers to service delivery are due to the lack or limitations of service

accessibility (resource) or the lack of knowledge (practice issue).

- Clarify responsibility for service development, access, and accountability in rural and remote areas. Some see as a local DFCS responsibility, others see as a state DFCS responsibility. It's likely some of both as well as beyond the scope of the agency. Clear messaging around service gaps & priorities would help to support advocacy at all levels for a more robust service array (see above partner agency bullet).
- Provider quality issues go unaddressed because of the lack of better alternatives and/or perceived authority of local DFCS office to address deficiencies. Similarly, this is one of many issues that local DFCS leadership must troubleshoot and is likely not the most urgent or critical so it can go overlooked for long periods of time.

- Explore supports and service provision for Family Support[2] cases. Consider, too, that some family support cases may not warrant a full array of services. These cases have less outside oversight/accountability than foster care cases.

To address the need for a consistent practice model, the Georgia Division of Family and Children Services (the Division) determined that it would base Georgia's practice model on Dr. Christensen's Solution Based Casework ("SBC"), an evidence-based model of family engagement. In anticipation of model implementation, the Division's Programs and Policy Unit recruited approximately 30 key stakeholders from around the state to work on a comprehensive rewrite of the policies relating to Child Protective Services (CPS) and foster care (Placement) services, as well as topics relating to the recruitment and training of qualified foster parents and kinship care providers. All of these policies are being completely reworked to reflect the new practice model.

CAPTA Panel member (CPSAC) and private provider Scott Rhoden was invited to serve on the Division's Policy and Practice development committee and attended a day-long training with Division leadership on Solution-Based Casework with Dr. Christensen. He also reviewed draft policy, attended related policy meetings, and has volunteered to take a leadership role in presenting the model to university social work programs across the state.

> *"My view is that the new practice model will have a positive impact at every level of practice, including provider collaboration and, most importantly, productive family engagement. I am encouraged by the commitment on the behalf of the Division's leadership to seek this kind of constituent engagement and the open exchange of ideas and resources that have taken place as part of the work of all three CAPTA Citizen Review Panels."*
>
> *Scott Rhoden*

[2]Georgia's Family Support services are an alternative CPS response designed to connect families with informal or formal services needed to strengthen and support their families and to prevent future involvement with the child welfare system.

**2015 CPSAC Activities and Recommendations**

CPSAC members agreed that during 2015 they would continue their focus on the recruitment and retention of child welfare caseworkers. The CPSAC continues to believe an effective workforce is critical if the Division is to be successful in its mission to serve Georgia's children and families. While they continue to have significant concerns over the ability of the Division to retain its employees, they are pleased to see progress towards several of the recommendations made in their 2014 annual report. Those included:

- Funding for new staff positions as well as merit increases included in the 2016 amended budgets and the 2017 budgets is a positive development. While the committee's three-year 11% recommendation was not adopted, it is evident that the Governor and the legislature are supportive of addressing low caseworker salaries.
- The statewide public relations campaign has addressed concerns expressed by the committee over the public perception of the Division and impact of those perceptions on the agency's ability to recruit and retain staff and to engage families and local stakeholders. The Division has found a good balance between transparency and effective media relations management.

Nevertheless, worker turnover remains high and threatens the ability of the Division to improve the efficacy of the services it provides. Contributing factors identified in the CPSAC workforce survey include the quality of supervision and worker support, fear of retribution for mistakes, caseload sizes, leadership turnover, and physical work spaces and caseworker safety. The following recommendations are offered addressing worker turnover concerns.

- Develop a retention and succession plan including qualifications, educational background, and selection criteria for County Directors. A frequent change in county leadership contributes to a sense of instability in the work place felt by all.
- Reduce the time it takes for the Division to hire new employees from an average of 115 days (or 4 months) to 60 days (or 2 months).
- During state FY2017, review the physical work place environment for county staff in the offices where turnover exceeds 30%. Paying particular attention to:
    - Lighting levels in all interior and exterior work areas
    - Quality of break rooms
    - Meeting rooms, especially those visited by the public for visitation, adoption, and staffing; and waiting rooms
    - Solicit suggestions for improvements/changes from the local staff

Jeffrey Brown from the Division's Child Protective Services (CPS) Intake Communications Center was invited to a CPSAC meeting to provide an update on the state's centralized child abuse reporting system. CPSAC members were pleased to hear that the call center has made significant progress and improvements related to ongoing concerns expressed by some members. Of note was the improved consistency in response to child maltreatment reports demonstrated by the low rate that response dispositions are either escalated or de-escalated after review. The CPSAC is cautiously optimistic regarding reported reduced call wait times and dropped calls.

However, with respect to reports, the CPSAC respectfully submits that there is still work to be done to sufficiently

educate the public and mandated reporters on their roles and responsibilities, how and what to report, and what to expect when a report has been made. Information regarding changes in processes or enhancements to the system is slow to reach individuals who will benefit the most from their implementation. Based on this and other feedback from the community, the CPSAC recommends:

Based on changes in child welfare law, policy and practice and changes or improvements to the central intake system, provide ongoing public and stakeholder education and awareness on:

- Recognizing child abuse and neglect and available training
- Obligations to report suspected abuse and what to report/not report
- Options for making a report and what to expect

Furthermore, the CPSAC also recommends that the Division solicit feedback regularly from mandated reporters on their experiences in making/filing maltreatment reports as well as evaluate the quality and effectiveness of mandated reporter training available.

**Looking Ahead to 2016**

At the annual retreat in September 2015, CPSAC members identified several potential opportunities for the coming year in addition to their ongoing interest in workforce issues. It is anticipated that the state's CAPTA plan may need to be revised as the result of the implementation of the new solution-based casework practice and significant child protective services policy revisions and the CPSAC would welcome the opportunity to contribute to that effort. However, with the Division's plan to rely more heavily on relatives as a primary placement resource and the lack of available foster homes, the CPSAC will focus its efforts in 2016 primarily on foster care policy and resource development practice related to the recruitment, training and retention of foster parents.

In closing…

Workforce turnover continues to be of concern to the CPSAC. While increasing compensation, reinstituting Title IV-E tuition reimbursements, reducing caseloads and the other priorities in the Blueprint for Change will have a positive impact on the workforce, Division leadership will continue to face challenges related to historical practices, supervision and other current job-related factors. Improvements to worker morale will take time and will need to be part of the Division's continuous quality improvement efforts in the coming years. While the CPSAC will reduce its focus on worker retention, it will continue to seek updates on the Division's progress. We anticipate positive outcomes in 2016 and beyond.

It goes without saying that the work of the CPSAC depends on a collaborative and open relationship with Division leadership which we have found with the current administration. We appreciate the Division staff who have presented to our committee and those who field and respond to our requests for information during the course of the year. We would especially like to acknowledge the Division's continued support of our efforts to meet our mandate as a CAPTA Panel.

**Child Protective Services Advisory Committee Members**
Karl Lehman (Co-Chair)
CEO Childkind, Inc.

Amy Rene (Co-Chair)
Vice President 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 and former educator

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.

Belisa Urbina, CEO
Ser Familia, Inc.

Deb Farrell
Georgia CAPTA Panel & CJA Task Force Coordinator

# 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.*

# 2015 Annual Report

**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 (Task Force) 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 a CJA 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.

**Dual Role as a CAPTA Citizen Review Panel (CAPTA Panel)**

Georgia's CJA Task Force also serves as one of Georgia's three CAPTA Panels. The purpose and objectives of a CJA multi-disciplinary task force and a CAPTA citizen review panel are complementary. They also share several legislative requirements, such as meeting and reporting requirements and the goal to improve child welfare policy and practice. Serving this dual role provides unique opportunities to examine overlapping mandates.

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

**Task Force at Work 2015**

Membership

A task force on children's justice is required to maintain membership representing the following disciplines:

- Judges[1] and attorneys, including 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
- Individuals with experience in working with homeless children and youth
- Adult former victims

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

Georgia's Task Force has maintained a stable and committed core membership for many years. New members are recruited not only to maintain CJA membership requirements but also to provide additional expertise and experience relevant to Task Force priorities and its mandate as a CAPTA Panel. The Task Force also includes members with experience and expertise in child abuse prevention and education – both in law and social work fields. Based on needs identified in the CJA three-year assessment conducted in 2014, the Task Force supplemented its membership in 2015 with representatives from the Department of Juvenile Justice (DJJ) and the Department of Education (DOE) to support ongoing work related to the interface of those agencies with families with child welfare involvement. During 2015, the Task Force also added an investigator with experience in child fatalities and a juvenile court judge.

At this time, one position for a parent attorney is vacant and recruitment for this position is a priority. In addition to ongoing recruitment efforts by Task Force members, child welfare agency leadership and a variety of professional and advocacy groups will be consulted to assist in identifying and engaging appropriate candidates.

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

Meetings

In 2015, 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 these regular meetings, the Task Force participated in the annual retreat for all CAPTA panels. Subcommittee meetings, special meetings, and conference calls were held as needed. Task Force members consulted regularly with each other

and the contracted coordinator for updates on work in progress; projects supported with the CJA grant; recent events related to Task Force goals, objectives and recruitment efforts; and to identify and coordinate additional resources.

Tracy Fava, Child Welfare Specialist Children's Bureau Region IV, was invited to participate in a task force meeting to discuss the results of the CJA three-year assessment and potential actions by the Task Force. Several CJA grant recipients also met with the Task Force to share their project accomplishments.

Annual CJA Grantee Meeting

June 10-11, 2015, the Task Force co-chair and the CJA coordinator attended the annual CJA grantee meeting[2] held in Washington, DC. Georgia's state liaison officer also attended the grantee meeting. The two-day meeting provided an opportunity for CJA grantee states to hear from federal representatives, national experts and CJA task forces from other states. The first day of the grantee meeting opened with an overview from the Department of Justice, Office for Victims of Crime (VOC) on their work and responsibilities. Information was provided on training and technical assistance available to states, in addition to VOC grants available for individuals and multidisciplinary teams for professional development. Presentations included:

- Exploring the Current State of Maltreatment-Related Child Fatalities, a panel highlighting the progress and initial findings from the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF)[3]
- Child Advocacy Centers and Sex Trafficking of Children, a presentation of results from a survey conducted by the National Child Advocacy Center (NCAC) on cases involving domestic minor sex trafficking (DMST) and/or commercial sexual exploitation of children (CSEC)

The opening plenary on the second day highlighted the call from the Children's Bureau to increase collaborative planning processes among the various grant sources, and more specifically, engagement between the state agency and its CJA task force. This includes meaningful and ongoing engagement of stakeholders in the CFSP, CFSR, APSR and related joint planning activities.

*For many years, Georgia's Task Force members have been involved in these processes and on various advisory groups, providing input or feedback to the state agency on its development, implementation, monitoring and/or evaluation and revision of its various plans. In 2015, this included:*

- *Development and review of the five-year CFSP*
- *Contributions to and review of the APSR*
- *Participation in the CFSR*
- *Development, implementation and monitoring of Program Improvement Plans*

The Children's Bureau also provided updates and/or clarification related to CJA requirements that included structure and management, recruitment of new members, and focusing task force efforts to align with the intent of the CJA legislation.

The 2015 CJA grantee meeting offered several networking opportunities for task force members, including two peer-to-peer sessions. One of these sessions focused on the different approaches taken by states and CJA task forces to meet their mandate, which

[2] Attendance at the annual CJA grantee meeting is a requirement for all state grant recipients.
[3] Commission was established by Congress and the President with the Protect Our Kids Act of 2013.

included a presentation by Georgia's Task Force. A second session focused on collaborative problem-solving.

National CAPTA Panel Conference

Two representatives from the Task Force and the CJA coordinator attended the National Citizen Review Panel conference in Portland, OR, May 18-20, 2015. Participants attending the two-and-a-half day conference included more than 100 CAPTA panel members, many of whom were also CJA task force members. This national conference was hosted by group that serves a dual role as a CAPTA panel, like Georgia's Task Force. As a result, many of the sessions on the agenda were focused on topics relevant to the CJA mandate. Session topics included:

- Increasing Diversity in Public Processes
- Trauma-Informed Child Welfare Practices
- Child Abuse Victims with Special Developmental or Health Needs *(This workshop was presented by a Georgia Task Force member and an advocate for child victims with special needs and a parent of an adopted child with FASD.)*
- Children/Youth Bill of Rights
- Indian Child Welfare Act (ICWA)

Participants also received an update on federal child welfare legislation and activities from Howard Davidson, Director of the American Bar Association Center for Children and the Law. Tina Naugler, Child Welfare Program Manager Children's Bureau Region 10 did a presentation on the *CFSR Process and How to Engage CRPs in CFSR Efforts*, reinforcing the importance of engaging of CJA task forces in the states' planning processes. Additionally, several opportunities were available for peer-to-peer networking during the conference.

**Task Force Priorities**

The Task Force continues its support of coordinated, multidisciplinary approaches that 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. This includes the following long-standing priorities related to its mandate:

- Training and education to improve the quality, consistency and successful identification, investigation, intervention, and prosecution of incidents of child maltreatment
- Reducing trauma to child victims of abuse
- Encouraging and supporting advocacy in the field of child welfare
- Encouraging and supporting collaborative efforts between Georgia's child welfare agency and its external partners
- Ensuring that the handling of cases involving child victims with special needs is developmentally and culturally appropriate

Based on the results of the most recent CJA three-year assessment[4], the Task Force added several new priorities:

1. Improving the consistency of maltreatment terminology and its alignment with child welfare policy and practice among agencies with child caring or protection responsibilities
2. Improving the quality and consistency of state and local child abuse protocols – the community's collaboration response to allegations of child abuse
3. Improving the consistency and quality of mandated reporter training

[4] Conducted in 2014

**Projects Funded in 2015**

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 recommend supporting those activities that improve and strengthen the investigation and prosecution of cases of child abuse and maltreatment-related fatalities, in addition to supporting projects that address the new priorities identified in the three-year assessment.

The Task Force recommended CJA awards for several projects that were responsive to CJA objectives, Task Force interests and state agency priorities. Each project reflects the CJA emphasis on advocacy, multidisciplinary approaches, collaboration and Task Force special interests. Additionally, projects that address children with special needs and/or commercial sexual exploitation of children are encouraged, and supported, whenever possible. Three projects, Multidisciplinary Data System Upgrade, Maltreatment Terminology Research and the Child Abuse Protocol projects received funding in response to specific findings and recommendations in the 2014 three-year assessment. Following are brief descriptions of each funded project.

World Day Conference: On November 19, 2014, the Children's Advocacy Centers of Georgia held its 8th Annual World Day Conference, providing multidisciplinary training on a wide spectrum of topics on child sexual abuse, child commercial sexual exploitation, and children with special needs to more than 330 professionals involved in the investigation and prosecution of child abuse cases.

Multidisciplinary Data System Upgrade: Children's Advocacy Centers of Georgia embarked upon a total upgrade of its case tracking system from a 9-year-old system called MDTIS (Multidisciplinary Team Information System) to a brand new platform called "Collaborate." In addition to new and advanced security features protecting confidentiality, the upgraded data collection system is far more user-friendly, allowing the free exchange of critical information among multidisciplinary team partners – Division, law enforcement, prosecution, medical and mental health – involved in a child abuse investigation, while providing improved reporting and evaluation capabilities.

ChildFirst Training: ChildFirst™ Georgia is a forensic interview training program offered by the Cherokee Child Advocacy Council, Inc. through partnerships with the National Child Protection Training Center (NCPTC) and the Children's Justice Act. The ChildFirst™ model is designed to improve the investigative, administrative and judicial handling of cases of child abuse and neglect, particularly child sexual abuse and exploitation, cases involving children with special needs, and maltreatment-related fatalities, while minimizing additional trauma to the child victim and the victim's family. The purpose of the ChildFirst™ Georgia program is to provide nationally-recognized, comprehensive forensic interview training on a statewide level to teams of frontline child abuse professionals. During 2015, 168 professionals from 41 counties were trained on ChildFirst™ Georgia.

Emory Summer Child Advocacy Program (ESCAP): ESCAP is an established interdisciplinary summer internship program designed to support the dual goals of increasing the service capacity of the Georgia child welfare system and promoting careers in the child advocacy field. The program is intentionally designed to support CJA activities to improve the investigation,

prosecution, and judicial handling of child abuse and neglect cases. The 2015 ESCAP program included an intensive orientation training followed by 10 weeks of a paid internship for eight students from law programs across the United States. The placements are also carefully selected to represent a range of opportunities, from direct practice settings to agency administrative and public policy positions. The students contribute their skills, knowledge, and enthusiasm to further the work of their internship placement setting, providing valuable staff support to under-resourced and overburdened juvenile courts, law offices, service providers, and agencies. In exchange, the interns benefit from meaningful engagement in, and exposure to, the work of the people and institutions that serve children and families involved in the child welfare system, and encouragement to pursue a career in the child welfare advocacy field.

Maltreatment Terminology Research Project: The Barton Child Law & Policy Center, Emory University School of Law Center, undertook a comprehensive research study of the statutory approaches of other states to defining "child abuse" and its subtypes across different areas of law. A comprehensive review of all 50 states and an accompanying analysis of their juvenile court, social services, and related laws was conducted. The goal of this research was to determine the normative approach to defining child abuse from various perspectives under law and to determine whether the various definitions in Georgia law should be reconciled.

Advocacy Training Project: The Georgia CASA Advocacy Training Project was designed to strengthen the advocacy that CASA volunteers provide to children across the state through trainings and information-sharing. Advanced training for staff and CASA volunteers was delivered and onsite court visits were conducted to connect training to practice ultimately improving the handling of child abuse and neglect cases by helping to limit additional trauma to child victims, including those with special needs, as well as strengthening the quality of representation and advocacy through well-trained, educated CASA advocates.

Child Abuse Protocol: Each of Georgia's counties are required by state law to develop, implement and evaluate a multidisciplinary response to allegations of child abuse and neglect as spelled out in their Child Abuse Protocol. In FFY 2015, through their outreach and training efforts, the Georgia Office of the Child Advocate provided education and/or technical assistance to 1,094 participants in 89 counties that included 24 judicial circuits. Training and technical assistance was provided to ensure that state and local Child Abuse Protocols are reflective of, and in compliance with, current law, policy and practice and effective in improving the process and consistency of multidisciplinary collaboration and response to child abuse investigations and prosecutions. In 2015, this included an update to state and local protocols to incorporate sexual exploitation.

Online GAL Training: The Office of the Child Advocate, in response to a long-standing recommendation from the Task Force, and based on Georgia's obligation as a CAPTA state grant recipient "requiring that in every case involving a victim of child abuse or neglect which results in a judicial proceeding, a guardian ad litem (GAL) who has received appropriate training to the role" be appointed to represent the child in such proceedings, undertook to develop an online training to help fulfill this mandate. The training was developed to help the attorney GAL obtain a clear understanding of the circumstances and needs of the child and make recommendations to the court concerning the best interests of the child. Information provided in the training

includes the rights, duties and responsibilities of an attorney GAL under federal and state law; child welfare dependency cases in juvenile court; child development; and child benefits.

Human Trafficking Symposium: The Division of Family and Children Services (the Division), in partnership with the Criminal Justice Coordinating Council (CJCC) and the Office of the Child Advocate (OCA), hosted a one-day symposium for the purpose of:

- Heightening awareness of commercial sexual exploitation of children (CSEC)
- Demonstrating how various public and private child-serving agencies are identifying and responding to the challenge of CSEC and its impact
- Encouraging collaborative efforts to improve the assessment, investigation and prosecution of child abuse and neglect cases that involve sexual abuse and exploitation

The symposium was attended by 171 public and private child welfare professionals that included child welfare staff and other professionals who frequently interact with perpetrators and/or victims of human trafficking. Attendees included medical and mental health treatment providers, community advocates, and representatives from state and federal law enforcement and the adult and juvenile justice systems.

2014 Child Fatality Analysis: The Division engaged the Georgia State University, Mark Chaffin Center for Healthy Development in a review and analysis of its 2014 child fatality data to assist in writing an annual report identifying potential interventions and prevention activities, including media campaigns, for presentation to and consideration by multiple constituencies. The goal of the project was to provide information on the circumstances and environmental factors surrounding 2014 child fatalities to help community members, policy-makers and the media have a better understanding of the data, policy implications, and the efforts DFCS makes and will make to address child fatalities.

The Task Force continues its support of these or comparable activities in 2016.

**Additional Activities in 2015 Related to Findings in the Three-Year Assessment**

The CJA three-year assessment identified many opportunities for the Task Force, many of which were incorporated into 2015 activities. Recommendations resulting from committee work begun in 2015 will be incorporated into the 2016 annual report. These included:

<u>Assessment Recommendation Related to Mandated Reporters</u>

- Establishing an approval mechanism for all mandated reporter training to ensure consistency and compliance with child welfare policy, practice and federal and state law
- Requiring approved mandated reporter training for individuals at state agencies with oversight of child-caring facilities and staff at those facilities, if not already required

In 2015, the Task Force established a "Mandated Reporter" subcommittee. The goal of that committee is to further examine Georgia's mandated reporter training requirements and standards to identify opportunities to improve the quality and consistency with current child welfare law, policy and practice. One of the projects recommended for CJA funding for 2016 includes development of a "train-the-trainer" mandated reporter course in collaboration with the child welfare agency. An element of the project includes research into the

training and approval processes for mandated reporter training in other states.

Assessment Recommendation Related to Quality and Consistency of Investigations

- Improve collaboration and communication among 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 that may impact their respective responsibilities

In 2015, the Task Force also established a "Child Abuse Protocol" subcommittee. The goal of this committee is to support and encourage the continuous improvement of state and local protocols so that they are reflective of current child welfare law, policy and practice. In 2016, in addition to first responder training on the Child Abuse Protocol, the Task Force supported the hosting of a summit for all multidisciplinary stakeholders and partners involved in the investigation and prosecution of child abuse and sexual exploitation cases to facilitate the development of a plan for communication and collaboration on critical child welfare legislative, policy and practice changes that affect the Child Abuse Protocol, and potentially, the practice of various disciplines and other agencies with child-caring responsibilities.

The above findings are the basis for several Task Force recommendations with respect to CJA funding for either new or ongoing activities that support CJA objectives and Task Force priorities.

**Update on Recommendations Included in the 2014 Annual Report Related to CJA Three-Year Assessment**

Legislative recommendations included:

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).

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.

***Update:*** *During the 2016 session of the Georgia General Assembly, O.C.G.A. 19-7-5 was amended by House Bill 905 to add "endangering a child" to the definition of "child abuse" for purposes of mandatory child abuse reporting. HB 905 also amended the definition of "sexual abuse" found in the mandated reporter statute to encompass consensual sex acts between minors if either is under age 14 and to narrow the age differential of the "Romeo and Juliet" clause which exempts from the definition of sexual abuse consensual acts that occur between a minor and an adult who is not more than four years older than the minor. The previous version of the law did not contain the age criterion and tolerated an age differential*

*between an adult and a minor of five years before the sexual acts constituted child sexual abuse. Of note, none of these changes are consistent with the definitions provided in the Juvenile Code at O.C.G.A. 15-11-2, as recommended by the Task Force. By effect of HB 905, O.C.G.A. 19-15-1 and 19-7-5 now share the same definition of sexual abuse, but child endangerment was not added to 19-15-1 when it was added to 19-7-5. Accordingly, the definitions related to child abuse in the statutory provisions focused on by the Task Force are no closer to being reconciled; in fact, changes have been made that create additional inconsistencies. Likewise, the definitions contained in O.C.G.A. 19-15-2, relating to child abuse protocol committees, were not changed. Furthermore, while HB 905 did not explicitly include the changes desired by the Task Force to mandate a multidisciplinary response to child abuse allegations, to require consistent participation on protocol committees and related MDTs, to require that committees meet monthly or to mandate adherence to the protocol, the bill did represent some efforts to improve accountability around protocol committee procedures. The bill permits protocol committees to be established by county or by circuit, which is believed to be a more useful design to accommodate differences statewide. Circuit-wide protocol committees are to be comprised of the same membership as county-wide protocol committees. Sexual assault centers must have been added to the required membership, presumably because the committee must include a written sexual abuse and sexual exploitation section within its protocol. Finally, the written protocol and any updates created by each committee must now be filed with the Office of the Child Advocate*, in addition to DFCS, by September 1 of each year.

Policy recommendations were:

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).

***Update:*** *In its written response to the Georgia CAPTA Panel 2014 recommendations, DHS/DFCS expressed its commitment to exploring further the Task Force recommendations to resolve inconsistencies in child abuse definitions. The agency is making efforts to clarify the meaning of terms in various applications in its new policy and has dedicated staffing resources to assessing gaps that exist in mandated reporter training.*

Child Abuse Protocol recommendations included:

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.

***Update:*** *The state's model child abuse protocol includes the definitions found in the juvenile code within its Juvenile Court Section (Section 6.1A) and within the section addressing the Mandated Reporter Purpose (Section 3.4). This year, the Office of the Child Advocate will coordinate and lead a summit with all stakeholders to update the model protocol. Once the revised protocol is complete, it will be posted to OCA's website for local level use.*

In closing….
While there is still work to be done to address the areas identified in the three-year assessment as needing improvement, the Division and its leadership are to be commended for their validation of Task Force concerns and efforts to engage with Task Force to identify appropriate solutions. The Task Force respectfully submits its annual report on its 2015 activities, findings and any resulting recommendations for consideration by the Division and looks forward to a continued, collaborative relationship in 2016.

**Children's Justice Act Task Force Members**

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Deb Farrell
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# Georgia Child Fatality Review Panel

**Annual Report - Calendar Year 2014**

**C. LaTain Kell**
**Panel Chairman**

**Nathan Deal**
**Governor**

**JANUARY 2016**

## THE CHILD FATALITY REVIEW PANEL MEMBERS

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

**Peggy Walker, Panel Vice-Chair – Judge, Douglas County Juvenile Court**

**Mandi Ballinger – Member, Georgia House of Representatives**

**Kathleen Bennett – Retired Mental Health Specialist, Central Savannah River Area Economic Opportunity Authority Head Start Program**

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

**Gloria Butler – Member, Georgia State Senate**

**Brenda Fitzgerald – Commissioner, Department of Public Health**

**Robertiena Fletcher – Board Chair, Department of Human Services**

**Charles Fuller – Chair, Criminal Justice Coordinating Council**

**Bobby Cagle –Director, Division 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 – Investigator, Georgia Peace Officer Standards and Training Council**

**Jonathan Eisenstat, Chief Medical Examiner, Georgia Bureau of Investigation**

**Ashley Willcott – Director, 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 STAFF

**Trebor Randle – Special Agent in Charge**

**Arleymah Gray – Prevention Specialist**

**Crystal Dixon – Program Manager**

**Malaika Shakir – Program Manager**

**Elizabeth Andrews – SDY Program Manager**

**Chinyere Nwamuo – SDY Specialist**

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## MISSION

The mission of the Georgia Child Fatality Review Panel is to provide the highest quality child fatality data, training, technical assistance, investigative support services, and resources to any entity dedicated to the well-being and safety of children in order to prevent and reduce incidents of child abuse and fatality in the state. This mission is accomplished by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse and child fatalities, and developing and monitoring the statewide child injury prevention plan.

The Georgia Child Fatality Review Panel, each county-level review committee, their functions and membership requirements, are established in the Official Code of Georgia Annotated (OCGA) 19-5-4.

## ACKNOWLEDGMENTS

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
- Georgia Department of Public Health

We would also like to thank the 2014 Child Fatality Review Committee of the Year, the 2014 CFR Coroner of the Year, and the 2014 CFR Prevention Committee of the Year for their exceptional support and dedication to the children of Georgia:

- CFR Coroner/Medical Examiner of the Year: Dr. Lora Darrisaw, Georgia Bureau of Investigation
- CFR Committee of the Year: Chatham County
- CFR Prevention Committee of the Year: Richmond County

This report was developed and written by the staff members of the Child Fatality Review Unit within the Georgia Bureau of Investigation.

# Georgia Child Fatality Review Panel



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

On behalf of the Georgia Child Fatality Review Panel, it is my honor as Chairman to present to you the 2014 Annual Report. This report summarizes the Panel's analysis of child deaths occurring in Georgia during the 2014 calendar year.

On behalf of the Panel, I recognize the special attention and priority that has been extended to the Panel and its work by the Georgia Bureau of Investigation since the administration of the Panel was transferred to that agency in 2014. The contributions of the Bureau and its capable staff have contributed greatly to advances made in the past year.

The Panel notes the continuing high percentage of deaths reviewed by the local panels that are classified by those panels as "preventable". As in past years, potentially preventable child deaths in the areas of 1) unrestrained child automobile passengers, 2) accidental child shootings, 3) child drowning, 4) teen suicide, and 5) co-sleeping infant deaths continue to account for significant percentages of child deaths in Georgia. Future programs will continue to emphasize these areas.

In light of a continuing trend both locally and nationally, the Panel has focused increased efforts preventing infant sleep-related deaths. With the leadership of the Georgia Bureau of Investigation and the assistance of the Governor and First Lady, a public service announcement has been produced to be utilized through the broadcast media and as an educational tool to inform the public of the dangers of co-sleeping and other dangerous sleep practices. A lengthier educational video has also been produced for use by law enforcement, child protective agencies and other partners to alert the public to these causes of preventable infant sleep-related deaths.

The Panel continues to focus on teen driving deaths, exploring efforts to potentially reduce deaths in this area by enhancing the Teen and Adult Driver Responsibility Act (TADRA). That legislation has produced significant results in reducing the number of teen driving deaths in a measurable way since its passage.

As reported last year, child maltreatment-related deaths and accuracy in the reporting of such deaths continue to be a priority with the Panel and with agencies and entities represented by the Panel. Strides have been made in the past year to improve and increase education for law enforcement and child protective agencies to identify and report these cases more accurately with a goal of prevention.

We thank you for continuing to provide the funding that is so essential to the work of this Panel. We request additional resources specifically designated to accurate collection and analysis of the data that are so vital to this Panel's function.

Thank you, as always, for your review of this report and for your ongoing efforts to support the work of this Panel. Working together, we can continue to reduce the number of preventable child deaths in Georgia.

Sincerely,

*Judge Tain Kell*
Chair, Georgia Child Fatality Review Panel

# 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.

The Child Fatality Review committees became a statewide, multidisciplinary, multi-agency effort to prevent child deaths. Georgia Code section 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. Through the State Panel and the work of the local committees, we have the opportunity to learn from tragedy, prevent deaths, and give a new generation 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.

In 2014 Senate Bill 365 was signed by the Governor, moving oversight of the CFR Panel from the Office of the Child Advocate to the GBI. The bill also added language including “child abuse” as one of the criteria for determining a reviewable death, and placed two additional members to the Panel: a member of the state Board of Education, and the commissioner of early care and learning.

# IMPORTANT FINDINGS AND RECOMMENDATIONS

The Georgia Child Fatality Review Panel has determined that injuries and fatalities among children can be reduced if the following recommendations to policymakers are adopted and implemented:

1. Have an annual review of the Youth Risk Behavior Survey (YRBS) to provide targeted suicide prevention services in schools. Develop a protocol for intervention in schools where a youth suicide has occurred; this response is vital to prevention of additional attempts and suicides.
2. Provide Youth Mental Health First Aid Training to communities. Partner with local Family Connections collaboratives to develop a community plan for delivery of these training opportunities, addressing both prevention and intervention.
3. The Program for Infants and Toddlers with Disabilities (Part C of IDEA) is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, ages birth through age two years, and their families. The CFR Panel recommends increasing collaboration between the Department of Public Health (DPH) and the Department of Family and Children Services (DFCS) to assure Part C evaluations be completed, that the recommended services be utilized, and a smooth transition is achieved at age 36 months into Early Head Start or special education. This can have tremendous protective potential to reduce child maltreatment in our youngest and most vulnerable citizens.
4. The CFR Panel recommends that every caregiver/parent be drug screened following a child death. This can be part of an improved investigation protocol to determine sufficient supervision of children and possible negligence in caring for children.
5. Promote School-Based Health Centers to improve both physical and mental/behavioral health short- and long-term outcomes. Also implement Positive Behavior Interventions and Supports (PBIS) in schools, which is a proactive approach to establishing the behavioral supports and social culture and needed for all students in a school to achieve social, emotional and academic success.
6. Systems (public and private) should be synthesized to achieve a continuous positive life trajectory for a child/adolescent. This should include seamless case management, programmatic functionality, data sharing across systems, and evidence-based approaches within health care, education, social services, and juvenile justice.

# EXECUTIVE SUMMARY

Every year the Georgia Child Fatality Review Panel (Panel) publishes an annual report chronicling the tragic, preventable deaths of children in Georgia. These deaths are identified through death certificate data provided by the Office of Vital Records within the Division of Public Health. Local child fatality review committees examine child deaths that are sudden, unexpected, or unexplained ("eligible"), and complete a standardized form detailing the circumstances of the deaths. These child death data are useful in revealing recurring patterns and indicating prevention gaps and opportunities. We encourage parents, communities, organizations, and policymakers to use these data to make life-saving decisions for Georgia's children.

In 2014, child fatality review committees reviewed 503 total child deaths.

## Key Findings

### MALTREATMENT

In 2014, child fatality review committees determined that maltreatment was the direct cause or contributing factor in 99 deaths (maltreatment includes abuse, neglect, and poor supervision). Of those 99, 47 (47%) are ages 1-4 and 30 (30%) are infants less than 12 months of age. An additional 99 decedents had a history of abuse or neglect but maltreatment was not identified as causing or contributing to the death.

### SLEEP-RELATED INFANT

Child fatality review committees reviewed 158 sleep-related infant deaths in 2014. This included:

- 96 sudden unexpected infant deaths (SUID) for which the cause of death is undetermined, however there are prominent factors that could possibly have contributed to the death
- 2 sudden infant death syndrome (SIDS) deaths for which the infant is in the safest sleep environment with no prominent risk factors present
- 8 sleep-related medical deaths for which a medical cause of death has been assigned, however there are also prominent risk factors present that may have contributed to the death
- 52 asphyxia deaths (forensic evidence of suffocation)

### MEDICAL

Child fatality review committees reviewed 90 deaths from medical causes. Committees are required to review all medical deaths that are unexpected or unattended by a physician. Medical deaths reviewed included conditions related to asthma, pneumonia, or heart-related complications.

## UNDETERMINED

Child fatality review committees reported 12 deaths due to undetermined causes. An undetermined cause of death is reported by review committees when the information gathered from the scene investigation, family circumstances, medical history and autopsy cannot conclusively determine what caused the death of the child.

## INJURIES

In 2014, child fatality review committees reviewed 243 deaths that resulted from injuries either intentional (inflicted) and unintentional (accidental).

**Note that sleep-related infant asphyxia deaths have been excluded from the injury category; these deaths are included in the sleep-related infant category**

**Unintentional Injuries**

Child fatality review committees reviewed 168 deaths attributed to unintentional injuries among children ages 0-17. Child fatality review data indicated the three leading causes of death related to unintentional injury for this age group as:

- 79 motor vehicle incidents
- 44 drowning incidents
- 14 asphyxia incidents

**Intentional Injuries**

Child fatality review committees reviewed 75 deaths to children ages 0-17 from intentional causes – 47 homicides and 28 suicides.

# PREVENTABILITY

A primary function of the child fatality review process is to identify those deaths deemed to be preventable. Child fatality review committees determined that 78% (315) of the 402 reviewed child deaths with preventability data were definitely or possibly preventable; the information is missing/blank or the team could not determine preventability for 101 reviewed child deaths.

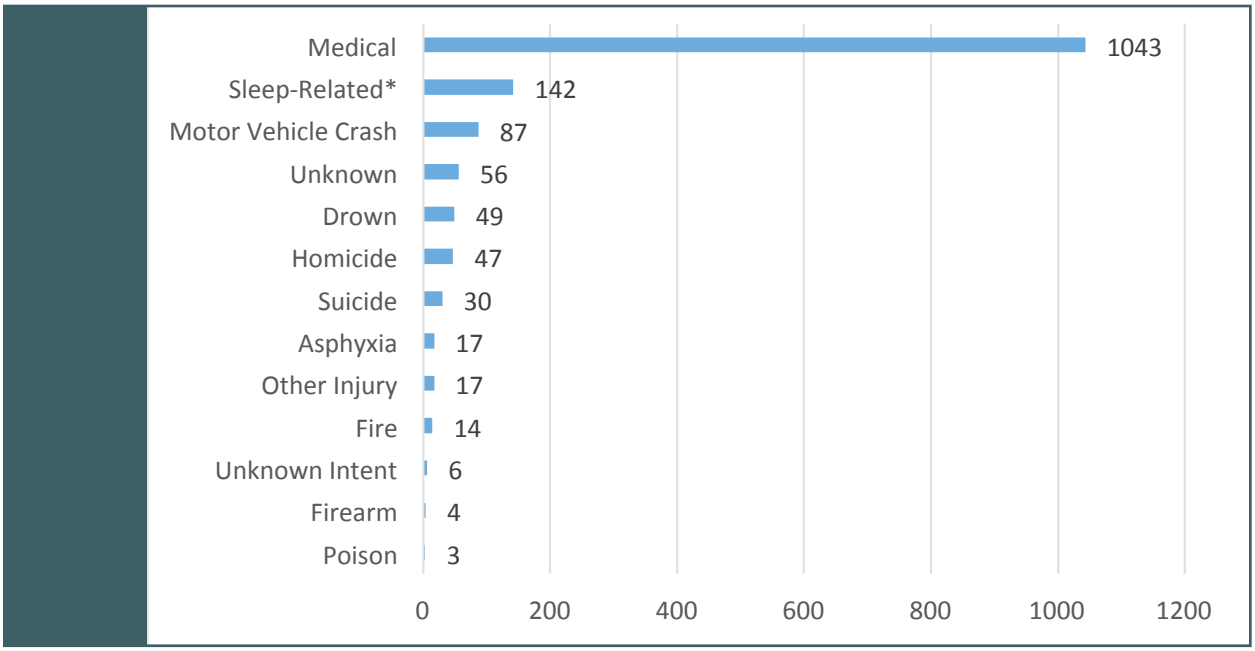
# ALL REVIEWED

In Georgia, every county is legislatively required to convene a Child Fatality Review committee. This committee is 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 obtained from a variety of sources to include coroner/medical examiner reports, Vital Records (VR) death certificates, Georgia Bureau of Investigation (GBI), and Department of Family and Children Services (DFCS). Death data are linked with Vital Records data to ensure a comprehensive and accurate representation of all child deaths in the state of Georgia.

A child's death is eligible for review when the death is sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances. In 2014, a total of 448 child deaths were deemed reviewable by the Department of Public Health's death certificate data. Eighty-six percent (386) of these deaths were reviewed by local CFR committees. Additionally, local CFR committees reviewed 94 medical deaths, eight deaths without a cause of death listed on the death certificate, 12 deaths that could not be linked (the state vital records office has no death certificate on file) and three deaths that were reported as non-GA residents. Local CFR committees reviewed a total of 503 child deaths. The data included in this report are based on information attained from these reviews.

*Note that there is a slight difference in the numbers and types of deaths 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 specify, underscoring the value and importance of CFR data.

**Figure 1: Deaths to Children Under Age 18 in Georgia, All Causes based on Death Certificate, 2014 (n=1515)**



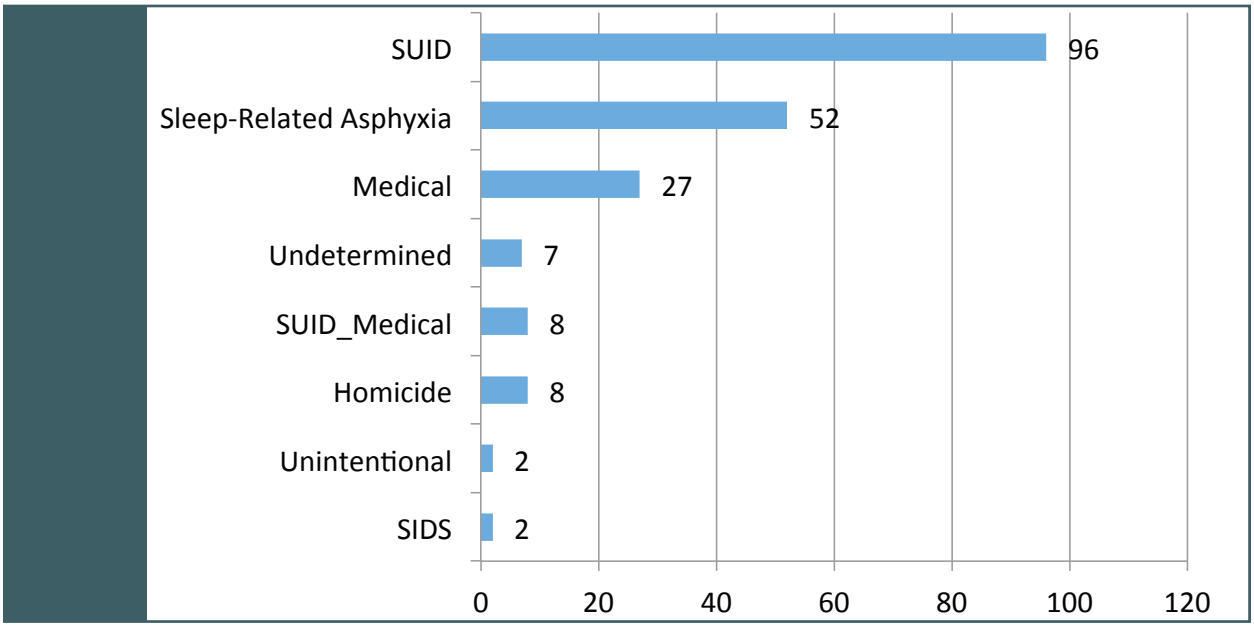

*Sleep-Related includes SIDS and infant asphyxia on a sleep surface

- The "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)
- The "unknown Intent" category includes deaths for which a definitive manner could not be determined

**Figure 2: Demographics of All Reviewed Deaths, GA, 2014 (N=503)**

| | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Total |
|---|---|---|---|---|---|---|
| White Male | 41 | 25 | 9 | 18 | 30 | **123** |
| White Female | 20 | 14 | 5 | 14 | 13 | **66** |
| African-American Male | 69 | 30 | 14 | 24 | 29 | **166** |
| African-American Female | 53 | 19 | 10 | 8 | 9 | **99** |
| Hispanic Male | 7 | 3 | 2 | 3 | 6 | **21** |
| Hispanic Female | 4 | 0 | 0 | 2 | 1 | **7** |
| Multi-Race Male | 5 | 3 | 2 | 0 | 0 | **10** |
| Multi-Race Female | 1 | 1 | 2 | 0 | 1 | **5** |
| Other Race Male | 2 | 0 | 0 | 2 | 0 | **4** |
| Other Race Female | 0 | 1 | 0 | 1 | 0 | **2** |
| **Total** | **202** | **96** | **44** | **72** | **89** | **503** |

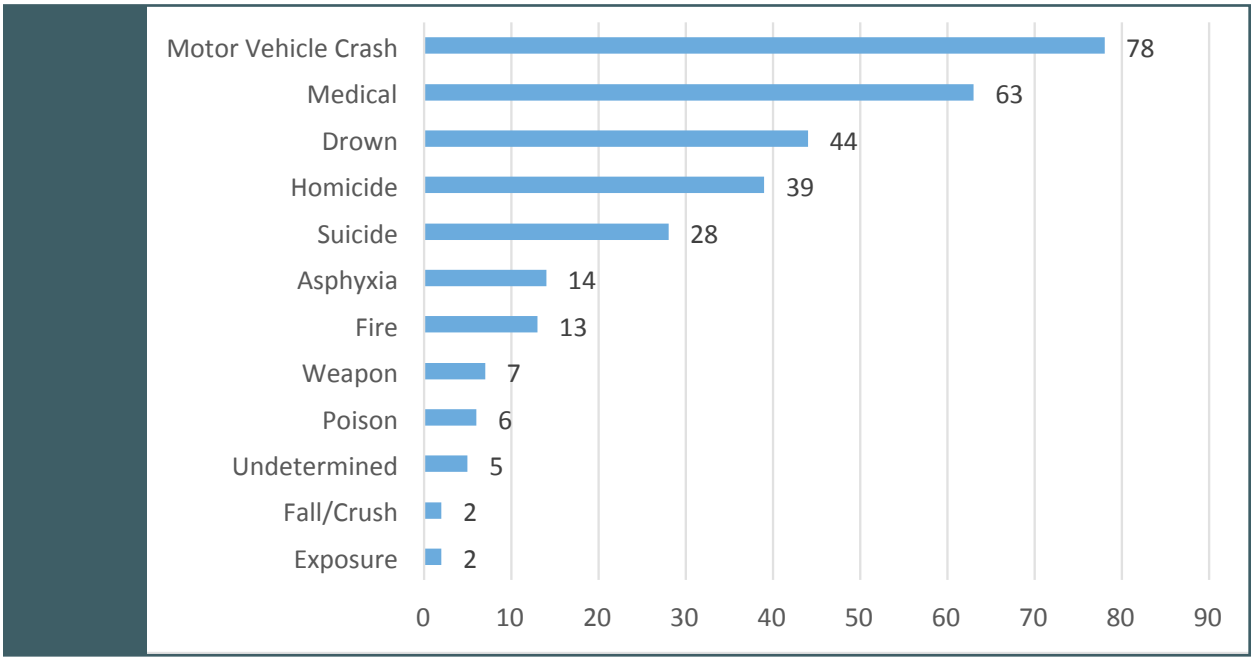
**Figure 3: Number of Reviewed Infant Deaths by Cause, GA, 2014 (N=202)**




*SUID = Sudden Unexplained Infant Death; SIDS = Sudden Infant Death Syndrome
(more information on these types of deaths can be found in the "Sleep Related" section)

- The "SUID medical" category refers to an infant death with a medical cause and manner but the infant was placed in an unsafe sleep environment that likely exacerbated the medical condition(s)
- The "unintentional" category refers to one motor vehicle crash and one non-sleep related asphyxia

**Figure 4: Number of Reviewed Child (ages 1-17) Deaths, By cause, GA, 2014 (N=301)**

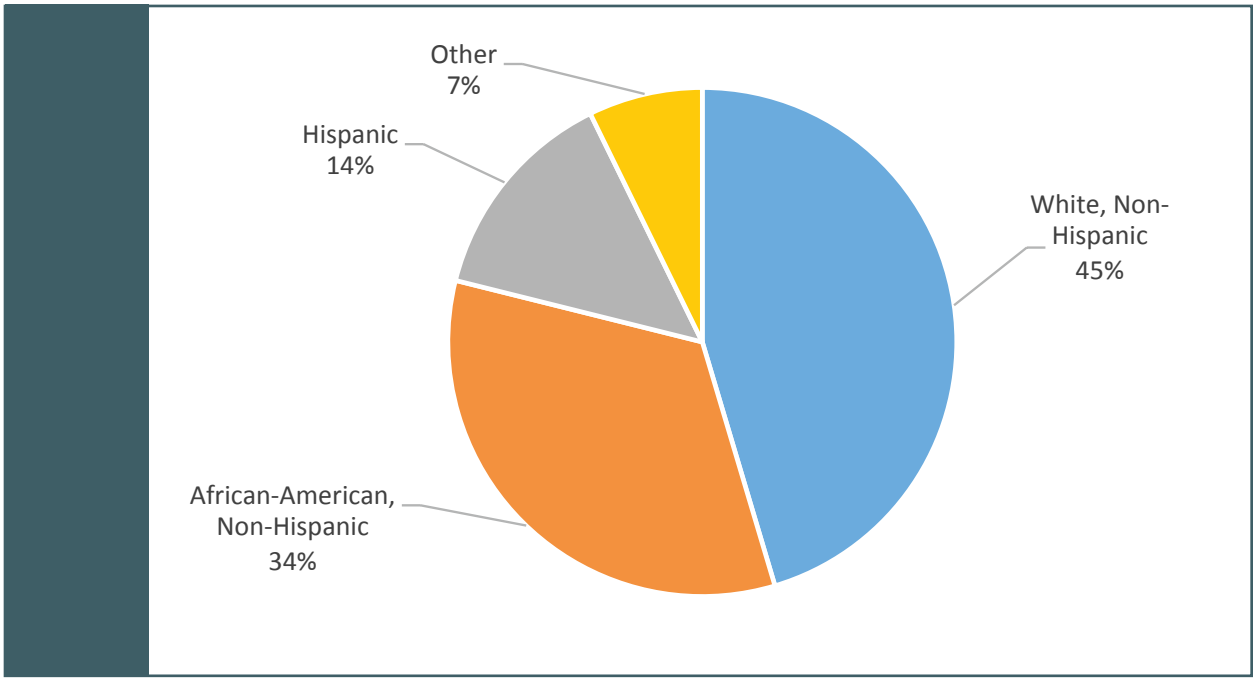



- The "undetermined" category refers to cases for which there is no definitive cause of death

# DISPARITIES IN REVIEWED DEATHS

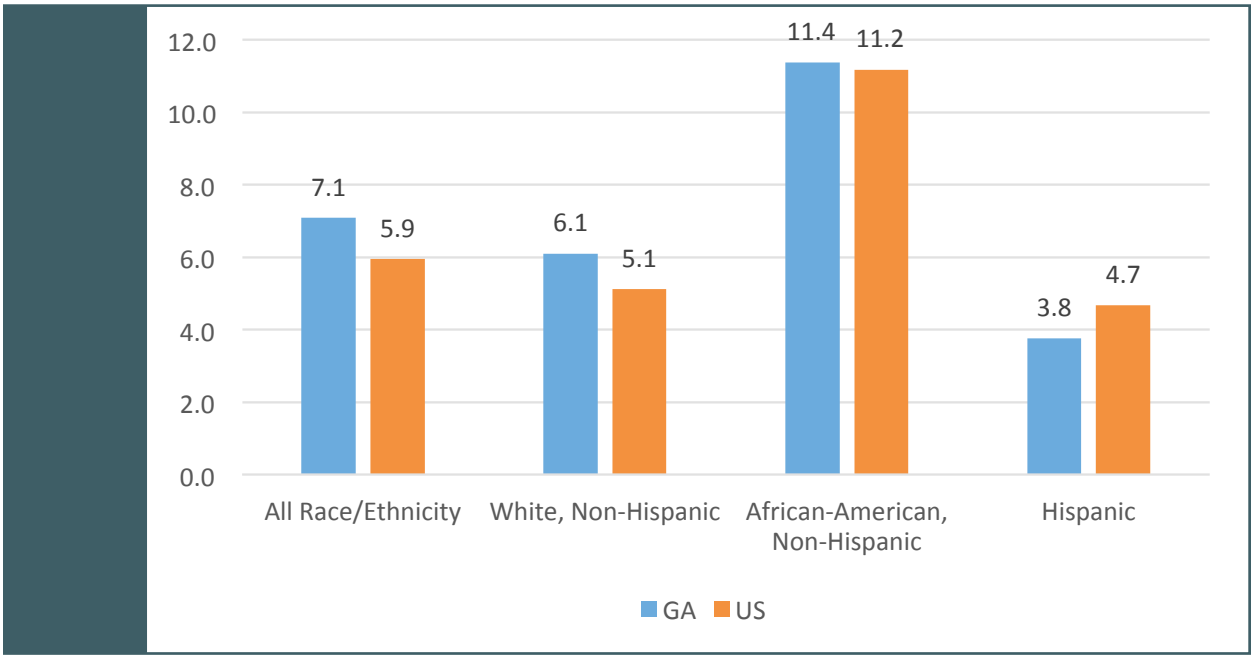
In 2014, there were 73.6 million children under age 18 in the United States (23% of the U.S. population) (ChildStats.gov). The estimated population of children ages 17 and under in Georgia was 2,492,080. (Department of Public Health, Online Analytical Statistical Information System). According to the 2010 Census, approximately 36.3% of the U.S. population currently belongs to a racial or ethnic minority group. Racial and ethnicity minority groups are identified as African-American non-Hispanic, White non-Hispanic, Hispanic, Asian, Pacific Islander, or Native American origin.

**Figure 5: Child Race/ Ethnicity Distribution in Georgia (Age<18), 2014 (source: OASIS)**




- White, non-Hispanic children under the age of 18 were 45% of the total child population of Georgia; racial/ethnic minorities comprised 55% of the child population

**Figure 6: Infant Death Rate (per 1,000 population) for 2013, GA / US Comparison**




- The likelihood of an infant or child death is not the same for all children; In 2013, an African-American, non-Hispanic infant born in the U.S. was over twice as likely to die in their first year of life as a White, non-Hispanic infant
- The infant death rates in Georgia are slightly higher (except for Hispanic) than the U.S. rates
- Georgia's ratio of African-American Non-Hispanic / White Non-Hispanic infant death rates is slightly lower (1.9) than the U.S. ratio (2.2)

**Figure 7: Risk Ratio Comparison of African-American/White, by Cause, GA, 2014**

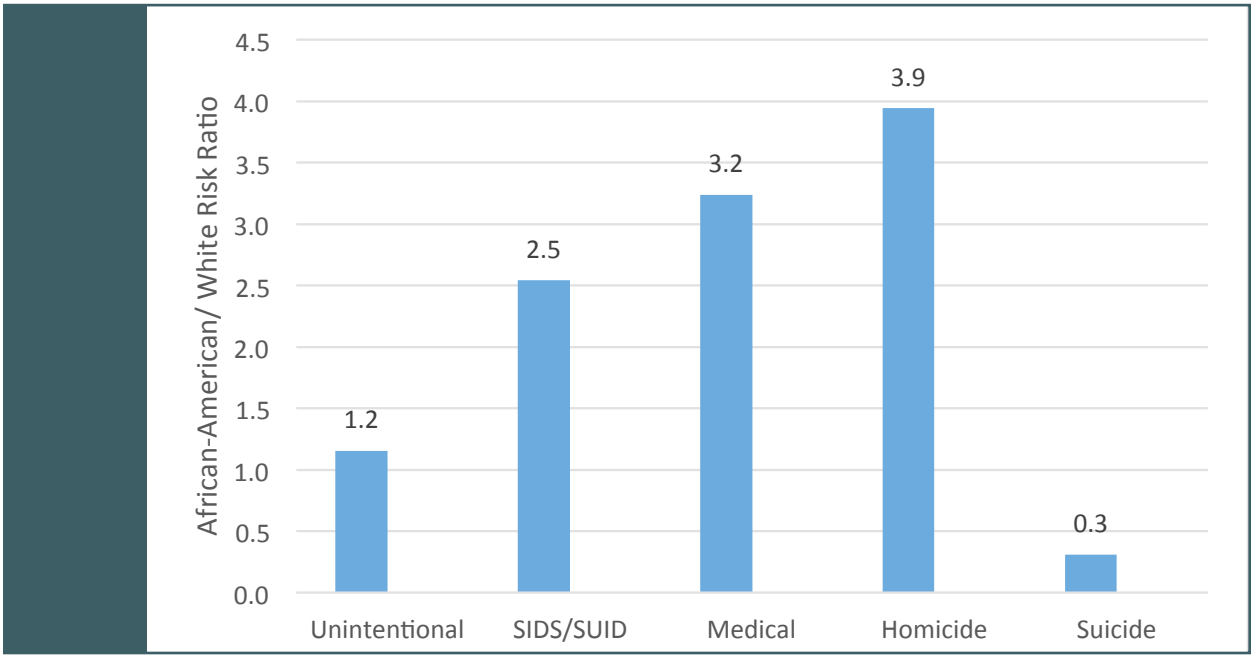


Figure 6 provides the ratios of African-American, non-Hispanic risk to White, non-Hispanic risk for major cause of death categories, as described by the fatality review process. The reviewed death data does not provide information on all deaths in Georgia, but the review process does provide data on risk factors which may contribute to an apparent racial disparity.

- African-American and White children are at a slightly higher risk for death due to unintentional injury (1.2 times)
- African-American infants are 2.5 times more likely to have a sleep-related death
- African-American children are almost four times more likely to be a homicide victim
- White youth are three times more likely to complete suicide than African-American youth

The reasoning for the observed racial differences are much more complicated than genetic differences. Many of the cultural, behavioral, and socio-economic factors that are associated with mortality are also associated with race, but we are struggling to understand how these factors interact.

Disparities in children's health can be tied to individual, social and environmental factors. Low-income children and minority children are disproportionately subject to poor air quality, exposure to pesticides and substandard housing, all of which lead to disparities in childhood asthma. Childhood overweight can similarly be tied to factors affecting poor, racial and ethnic groups, including decreased availability of healthy foods, increased time spent in sedentary activities and limited access to physical activity in schools and neighborhoods (National Institute for Health Care Management, 2007).

Research has shown that residential segregation can create stressful conditions in both the physical and social environments. Neighborhood conditions can encourage violence and create racial differences in homicide. Because of its restriction of educational and employment opportunities, residential segregation creates areas with high rates of concentrated poverty and small pools of stably employed males. In turn, high male unemployment and low wage rates for males are associated with high rates of out-of-wedlock births and female-headed households. Single-parent households are associated with lower levels of social control and supervision of young males, which can potentially lead to elevated rates of violent behavior (Health Affairs, 2005).

# PREVENTION AND PREVENTABILITY

The toll of childhood injuries on society is staggering. Over 8,000 children—more than 20 a day—die annually in the U.S. because of injuries. However, it is estimated that for every child death resulting from injuries, more than 1,000 children receive medical treatment or consultation for non-fatal injuries. Although death rates related to motor vehicles accounted for the leading cause of injury-related deaths among all persons younger than 20, rates of motor-vehicle-related deaths fell 51 percent between 2002 and 2012. Rates associated with most other causes of fatal injuries also declined significantly in the past decade, with the exception of suffocation and poisoning, each of which increased significantly (by 27 and 17 percent, respectively) (Child Trends Data Bank).

The fact that national child death rates have dropped significantly in the past two decades reinforces the need for continued statewide and local prevention efforts. When we implement prevention policies and practices into our communities, we can change behaviors, improve communities, and save lives. Many injury prevention programs for children have been in force in Georgia for more than 20 years; this observed drop in child injuries and injury-related deaths is not entirely coincidental. The federal government, through the *Healthy People 2020* initiative, has set a number of goals to reduce child deaths even further from poor health and medical conditions, homicide, suicide, sleep-related circumstances (SIDS and SUID), and unintentional injuries.

The Child Fatality Review committees are asked to develop actionable prevention recommendations following every reviewed child death. Many of their recommendations have been put forth to agency leadership and legislators, and we are slowly seeing progress. Changes in policy and practice at the state and local level have improved the climate of safety for Georgia's children. However, the CFR Panel continues to reinforce the message with local agencies, leaders, and communities that we must still do more to protect our children.

**Figure 8: Determination of Preventability, GA, 2014 (N=503)**

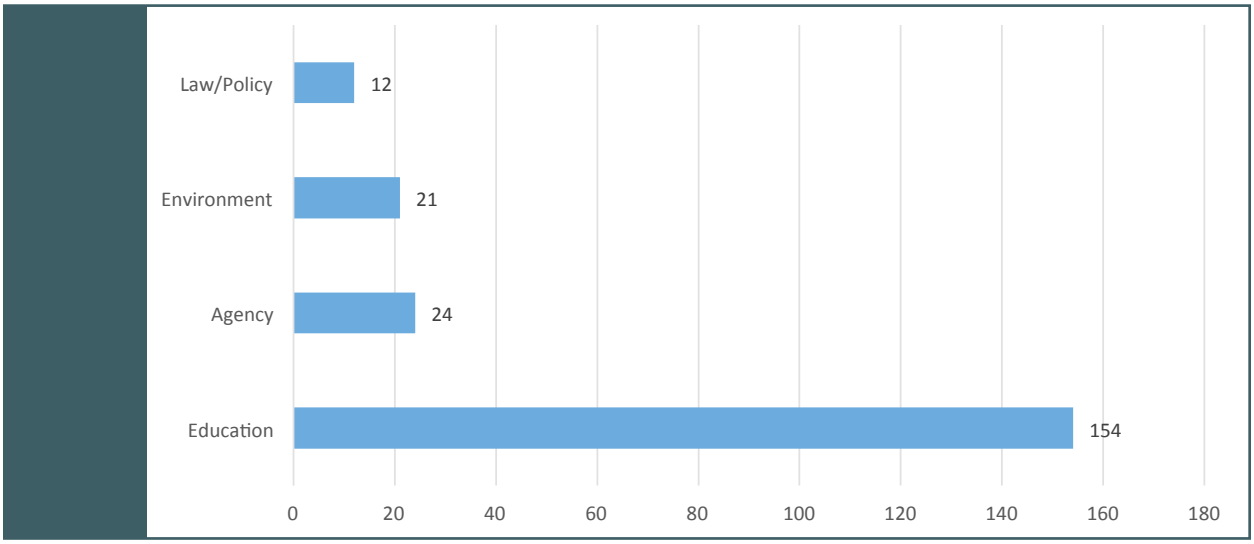
| | Missing | No, probably not | Yes, probably | Team could not determine | Percent Preventable* |
|---|---|---|---|---|---|
| All Unintentional | 1 | 8 | 148 | 13 | 94.9 |
| Homicide | | 3 | 43 | 1 | 93.5 |
| Suicide | | 5 | 16 | 7 | 76.2 |
| SIDS/SUID | 2 | 15 | 94 | 44 | 86.2 |
| Medical | 2 | 53 | 11 | 24 | 17.2 |
| SUDC | | | | 1 | N/A |
| Undetermined | | 3 | 3 | 6 | N/A |
| All Reviewed Deaths | 5 | 87 | 315 | 96 | 78.4 |

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

- CFR committees determined that 78% of all child deaths reviewed were preventable
  - For CFR purposes, **Preventability** is defined 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
- This is a slight decrease from 2013, when committees determined 83% of deaths were preventable
  - "All Unintentional" decreased from 95.2%
  - "Homicide" decreased from 98.1%
  - "Suicide" decreased from 85.3%
  - "SIDS/SUID" increased from 82.7%
  - "Medical" decreased significantly from 38.6%
- The "team could not determine" preventability in 28% of reviewed SIDS/SUID deaths, and 27% of reviewed medical deaths

Committees determined that 315 of the 503 reviewed deaths were 'probably preventable'. Committees were then tasked with determining which factors could have been modified to prevent the death, and what measures they would recommend to prevent future similar deaths in their communities. In 167 cases where the death was preventable, the committees recommended at least one type of prevention strategy – law/policy, environment/consumer product, agency program/service, or education. A total of 211 prevention recommendations were documented (some case reports had multiple recommendations).

**Figure 9: Prevention Recommendations Identified by CFR Committees, GA, 2014 (N=211)**




- Some of the education recommendations also incorporated 'agency' and 'law/policy', as the committees felt that people needed to have ongoing education of the types of agency programs available to them and the policies already in place to protect their children

There are many proven prevention strategies across multiple domains that can be implemented to reduce the risk of death among children. Education on safe behaviors, such as consistent use of protective equipment (e.g., bicycle helmets, seat belts and car seats, stair gates, cabinet locks, and smoke alarms) can reduce the risk of serious injury and/or death. Enforcing or enhancing policies can also be successful in reducing risk. For example, mandatory helmet legislation is strongly associated with reduced bicycle-related head injuries in children.

The following table illustrates the recommendations put forth by the CFR committees. Several CFR committees also recommended engaging social media platforms to connect with parents and caregivers (like FaceTime and Skype) and increasing participation of the business community through online daily deal sites such as Groupon. All community organizations, agency leaders, legislators, and families are encouraged to bring these recommendations into action, to help make each child's world a little safer.

**Table 1: Recommendations for Agencies and Organizations**

| | |
|---|---|
| Division of Family and Children Services | All child deaths should be reported to DFCS |
| Hospitals/Healthcare Providers | Provide information on safe sleep at every visit<br><br>When equipment is prescribed prior to discharge, the hospital should send that equipment home with the child<br><br>Help parents sign up for the free Text4Baby service before hospital discharge<br><br>Screen younger children for depression and suicidal ideation |
| Media | Continue awareness on pool safety<br><br>News articles on boating safety and flotation devices<br><br>Public service announcements on safe sleep |
| Schools | Offer driver safety courses in high schools<br><br>Offer anger management courses<br><br>Mandatory front/rear cameras for every school transport vehicle (including day care vans), and defensive driver courses for school vehicle drivers |
| Military | Family Counseling and Individual Therapy for military personnel upon return to the community to support them in parenting after service |
| Policymakers | Mandatory escape mechanism for homes with burglar bars to allow for exit during a fire<br><br>Provide oversight of rebuilt vehicles following severe damage<br><br>Require helmets for child riders of four wheelers/ATVs |
| Law Enforcement | Increase enforcement for children riding in beds of pickup trucks<br><br>Enforce bicycle helmet laws and support distribution of helmets to children in need of one |

**Table 2: Recommendations to Address Specific Causes of Death**

| Cause | CFR Committee Recommendation | Additional Suggestions for CFR Committees and Communities |
|---|---|---|
| **Safe Sleep** | Provide education at hospitals prior to discharge, and follow up at pediatrician offices<br><br>Media campaigns on safe sleep (social media, PSA, public transportation systems, and retail stores)<br><br>Educate grandparents and other active caregivers on safe sleep | Promote the advantages of safe sleep behaviors, so that caregivers develop positive perceptions of these practices, and adopt them<br><br>Integrate safe sleep messaging with information on soothing a crying infant and breastfeeding<br><br>www.nappss.org |
| **Motor Vehicle** | Provide education for driving on rural roads<br><br>Reinforce education on child safety seats at each stage<br><br>Continue law enforcement patrols on unsafe driving | Continue to support and strengthen Georgia's *Teenage & Adult Driver Responsibility Act (TADRA),* so that young, inexperienced drivers have time to gain skills and confidence on the road<br><br>www.gateendrivereducation.dds.ga.gov/tadra<br><br>Increase awareness campaigns addressing distracted driving |
| **Drowning** | Water safety education at community fairs<br><br>Life preserver stations at outdoor parks and beaches | Encourage communities to provide swim lessons and water safety lessons to children of all ages<br><br>Teach water safety in schools; there are currently several programs with developed curricula that schools can adopt<br><br>www.ndpa.org |
| **Homicide** | Education on consequences of gang affiliation<br><br>Support the Children in Need of Services (CHINS) program to work with children at risk of entering the DJJ system. This program works to decrease violence in homes and communities | Coordinated intervention by the community and law enforcement personnel reduces the likelihood that high-risk youth with become involved in violence and gangs. Involvement of police agencies, prosecutors, probation, educators, job-training resources, parents, and community groups are essential to success<br><br>(National Crime Prevention Council) |

**Table 2: Recommendations to Address Specific Causes of Death (continued)**

| | | |
|---|---|---|
| **Suicide** | A partnership between local law enforcement, mental health, and gun ranges to offer a program where parents can learn about gun safety, keeping guns out of reach of children, and how to keep firearms secured from children at-risk for suicide<br><br>Provide suicide prevention education in schools to educate students, teachers, and parents<br><br>Begin depression screenings by pediatricians and/or school social workers before age 10 | Encourage every individual in the community to learn more about and advocate for health, mental health, and suicide prevention services. Build local support for life skills training, such as coping with stress, conflict resolution, anger management, and communication.<br><br>Reduce inappropriate access to drugs, firearms, and alcohol by youth.<br><br>www.safefirearmsstorage.org<br><br>Implement Positive Behavioral Interventions and Supports (PBIS) in all school settings |
| **Maltreat-ment** | Encourage community to report suspicious bruises or marks on very young children, and continue training on mandated reporter law | Screen parents of children ages 0–5 in pediatric primary care settings to identify parental exposure to partner violence, mental illness, or substance abuse and provide appropriate referrals<br><br>Encourage families to seek subsidized, quality childcare assistance through the Childcare and Parent Services (CAPS)<br><br>Appropriate funds for home and community-based child development education<br><br>Increase awareness of the 1-855-GA CHILD hotline for the CPS Centralized Intake Communication Center |
| **Medical** | Ensure that Medicaid and health insurance companies follow up with parents to monitor compli-ance with medications for chronic conditions (such as asthma)<br><br>Educate parents about safety in athletic events, including recreational sports | Partner with hospitals and health care providers to offer free comprehensive health screenings for youth of all ages who participate in athletic activities, to detect potential cardiac or other health conditions that could be fatal<br><br>Support School-Based Health Centers (with both physical and behavioral health services) |

The Healthy People 2020 strategic plan contains many federal initiatives that have, as part of their programs, information and services to prevent injuries and deaths of children. These initiatives include:

- Safe to Sleep Public Education Campaign
- Healthy Communities
- Head Start
- Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality
- Maternal, Infant and Early Childhood Home Visiting Program (MIECHV)
- National Strategy for Suicide Prevention
- National Initiative to Improve Adolescent Health
- National Stakeholder Strategy for Achieving Health Equity

Georgia is participating in these and other programs designed to reduce child deaths. State and local agencies have dedicated staff and funding sources to provide education and resources to families and caregivers. It is vitally important that Georgia continue to provide these programs and services to children and their families, to expand them wherever possible, and to educate caregivers, health care providers, schools, businesses, and others on their role in prevention.

The Georgia CFR Panel and its partners have developed an Action Plan for Child Injury Prevention. This Plan is based on the public health model – a model that is used for preventing many other diseases. The public health approach includes identifying the magnitude of the problem through surveillance and data collection, identifying risk and protective factors, and, on the basis of this information, developing, implementing, and evaluating interventions, and promoting widespread adoption of evidence-based practices and policies. Interventions can be implemented during various time frames before, during, or after an adverse event. For example, safety latches on medicine cabinets provide protection before an injury event, child safety seats minimize injury during the injury-causing event, and effective emergency response speeds treatment and improves outcomes after an injury event has occurred. Every concerned Georgian is encouraged to review the Action Plan and take steps to coordinate activities in their community to reduce child deaths.

The Georgia Action Plan for Child Injury Prevention can be found online at www.gbi.georgia.gov/CFR.

# AGENCY INVOLVEMENT

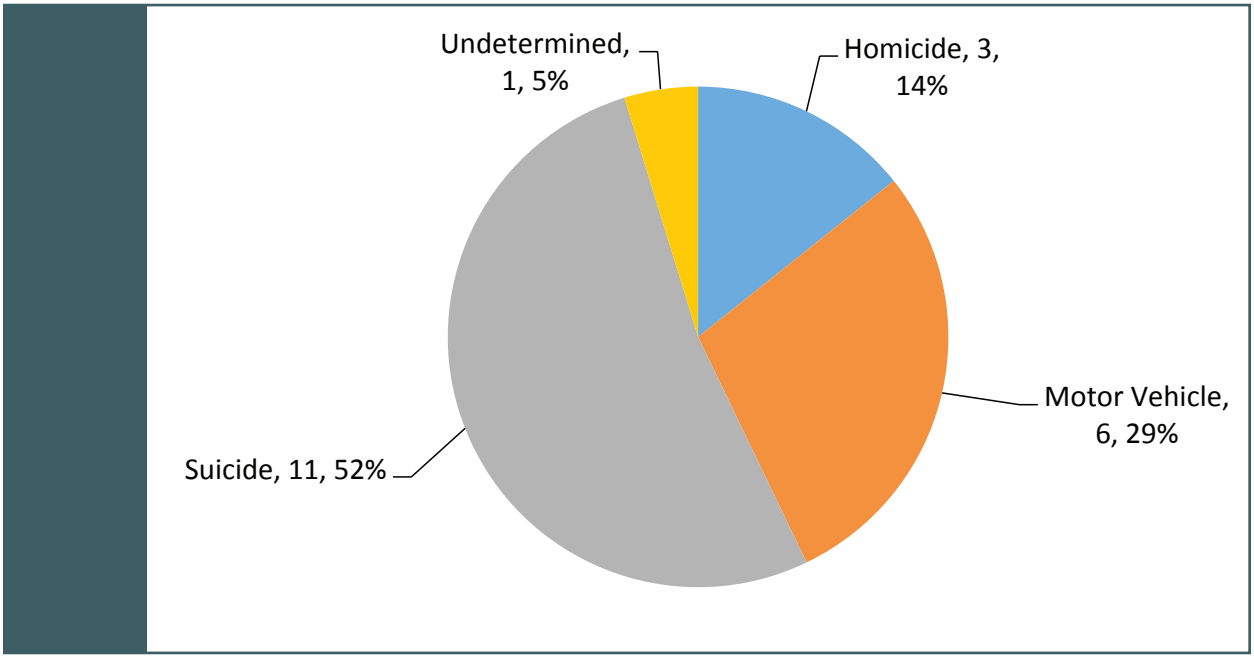
In 2014, the local CFR committees reviewed 503 child deaths. As part of the review process, the committees reported the number and type of agencies that had involvement with the decedent or the decedent's family at any point prior to the death. Of the 503 child deaths reviewed, 267 (53%) had some form of prior agency involvement. "Involvement" as applied by CFR is defined as the provision of some form of service to the decedent or the decedent's family. The agencies involved in these cases include but are not limited to social services, law enforcement (LE), Department of Juvenile Justice (DJJ), and mental health.

**Figure 10: Demographics of Decedents with Prior Agency Involvement, GA, 2014 (N=267)**

| | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Totals |
|---|---|---|---|---|---|---|
| White Male | 18 | 9 | 3 | 9 | 12 | **51** |
| White Female | 13 | 8 | 3 | 7 | 8 | **39** |
| African-American Male | 48 | 19 | 2 | 12 | 18 | **99** |
| African-American Female | 36 | 13 | 5 | 3 | 4 | **61** |
| Hispanic Male | 1 | 1 | | 1 | | **3** |
| Hispanic Female | 2 | | | | | **2** |
| Multi- Race Male | 2 | 2 | 2 | | | **6** |
| Multi- Race Female | 1 | 1 | 2 | | 1 | **5** |
| Other Female | | 1 | | | | **1** |
| **Total** | **121** | **54** | **17** | **32** | **43** | **267** |

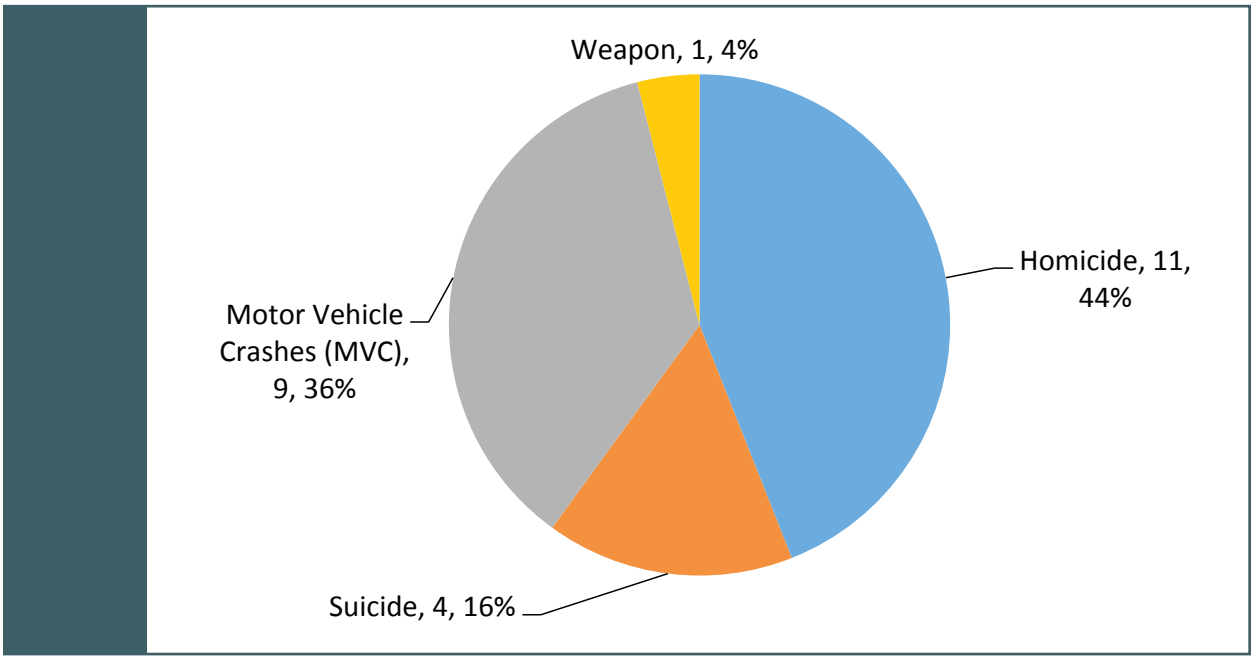
- The demographics of these deaths, where there was agency involvement indicated that 121 (45%), were infants age 12 months and younger
- There were 160 (60%) African-American children reported to have had some type of agency involvement at some point of their life
- Male children accounted for 159 (60%) of child deaths while 108 (40%) were female children

**Figure 11: Cause of Death for Decedents who Received Mental Health Services, GA 2014 (N=21)**




- Out of the 21 decedents who received prior mental health services, 13 were receiving services at the time of their death

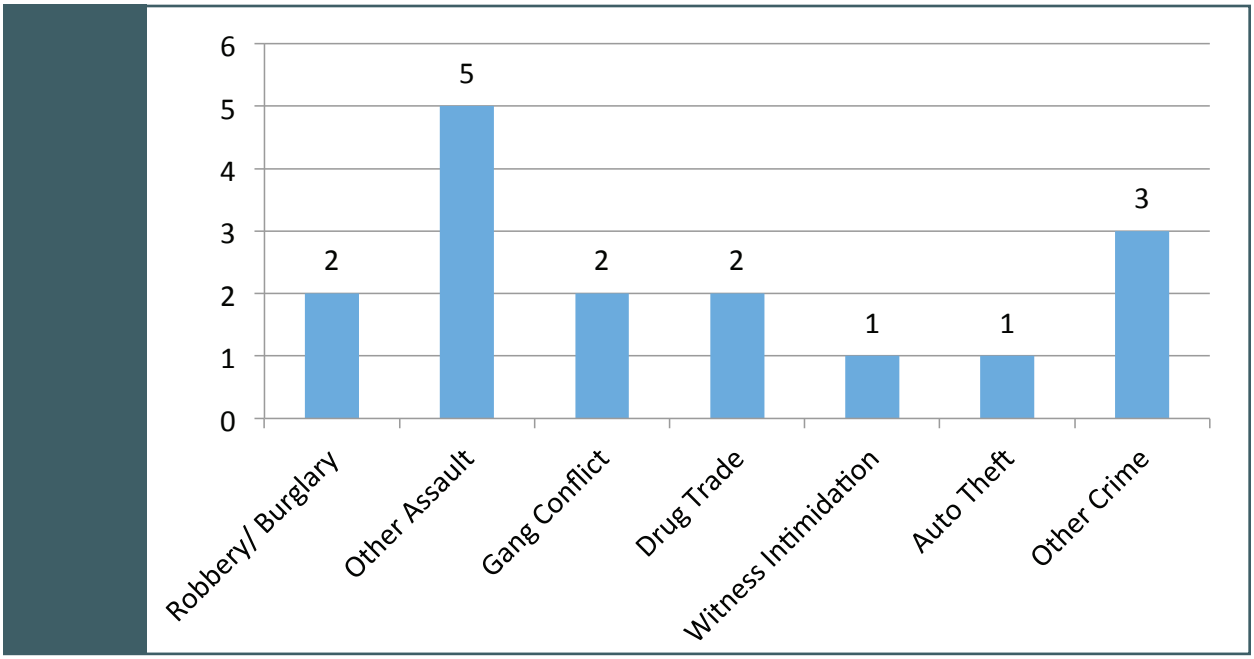
**Figure 12: Cause of Death for Decedents with Delinquent or Criminal History, GA, 2014 (N=25)**




- There were 25 decedents who had delinquent or juvenile history; five were ages 10 to 14 and 20 were ages 15 to 17

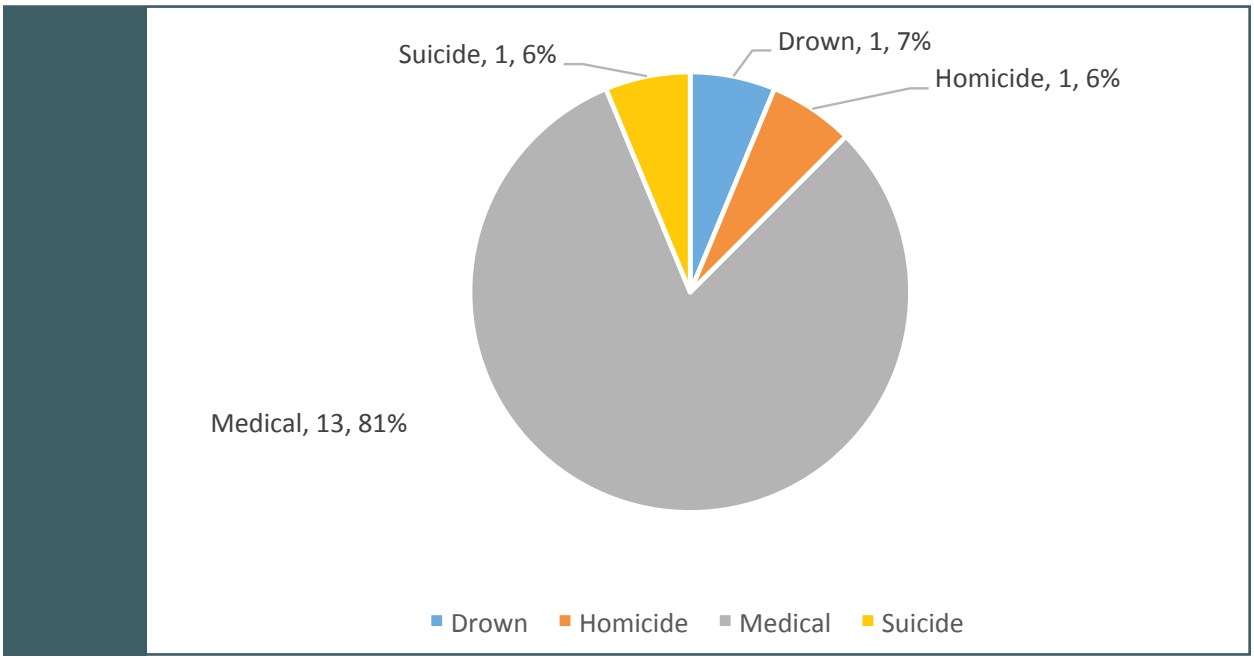
- The 25 decedents that had delinquent or criminal history died as the result of homicides, motor vehicle crashes, suicides and firearms; their history included theft, unruliness, gang activity, probation violation, police obstruction, terroristic threats, simple battery, criminal trespassing, runaway, behavioral problems in school, and fighting
- Out of 25 decedents that had delinquent or criminal history, seven had spent time in juvenile detention

**Figure 13: Decedents with Delinquent History who Died During the Commission of another Crime, GA, 2014 (N=10)**



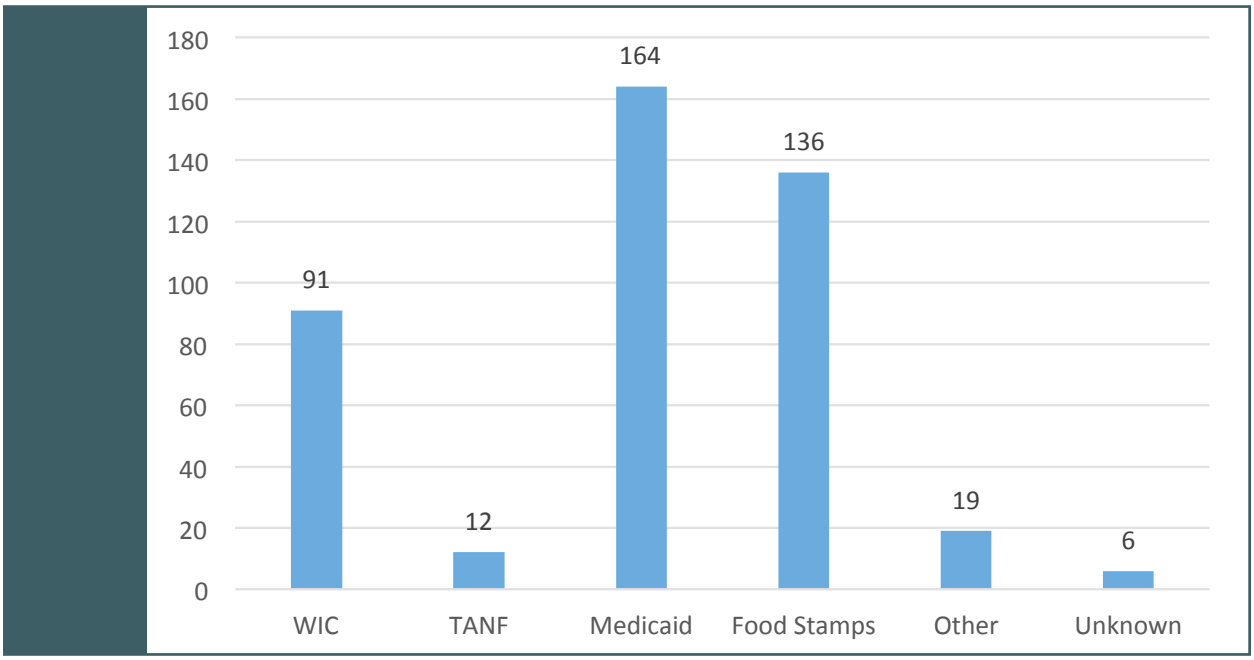

- It was reported that 10 decedents were committing a crime at time of death
- Out of the 10 decedents that died during commission of another crime, four of them were during the commission of multiple crimes
- Other crimes committed include gun trade, drive by shooting, and drug and alcohol impairment

**Figure 14: Cause of Death for Decedents Receiving Children with Special Health Care Needs Services, GA, 2014 (N=16)**




- There were 58 decedents with a reported disability or chronic illness
- Out of those 58, there were 16 who were receiving services through Children with Special Health Care Needs (CSHCN)
    - In Georgia, the CSHCN program is called Children and Youth with Special Healthcare Needs (CYSHN)
    - Those services are provided by Babies Can't Wait (Early Intervention Services) and Children's Medical Services
- Thirteen of these children (81%) who were receiving CSHCN services died from medical-related causes

**Figure 15: Agency Services Received by the Decedent's Caregiver(s) within the 12 Months Prior to Death, GA, 2014 (N=194)**




- There were 194 decedents whose caregiver(s) had received some type of social service assistance within the past 12 months, such as Women, Infants, and Children (WIC), Temporary Assistance for Needy Families (TANF), Medicaid, or Supplemental Nutrition Assistance Program/ food stamps (SNAP)
- Other services reported were Social Security Income (SSI), child support, housing assistance and utility assistance, referrals to private agencies for assistance
- Agency providers and agencies can use this information to develop opportunities to engage caregivers when they visit for services

## Opportunities for Prevention

For those agencies that provide services to youth (including health care services, early intervention, law enforcement, and court systems) this information may be helpful in developing specific prevention programs and services. When agencies are involved with the family, this represents opportunity for prevention, education, and risk reduction counseling with each agency visit or staff intervention.

## Resources

Division of Family and Children Services (www.dfcs.dhs.georgia.gov)

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

Georgia Department of Public Health (www.dph.georgia.gov)

Georgia Juvenile Justice (www.djj.state.ga.us)

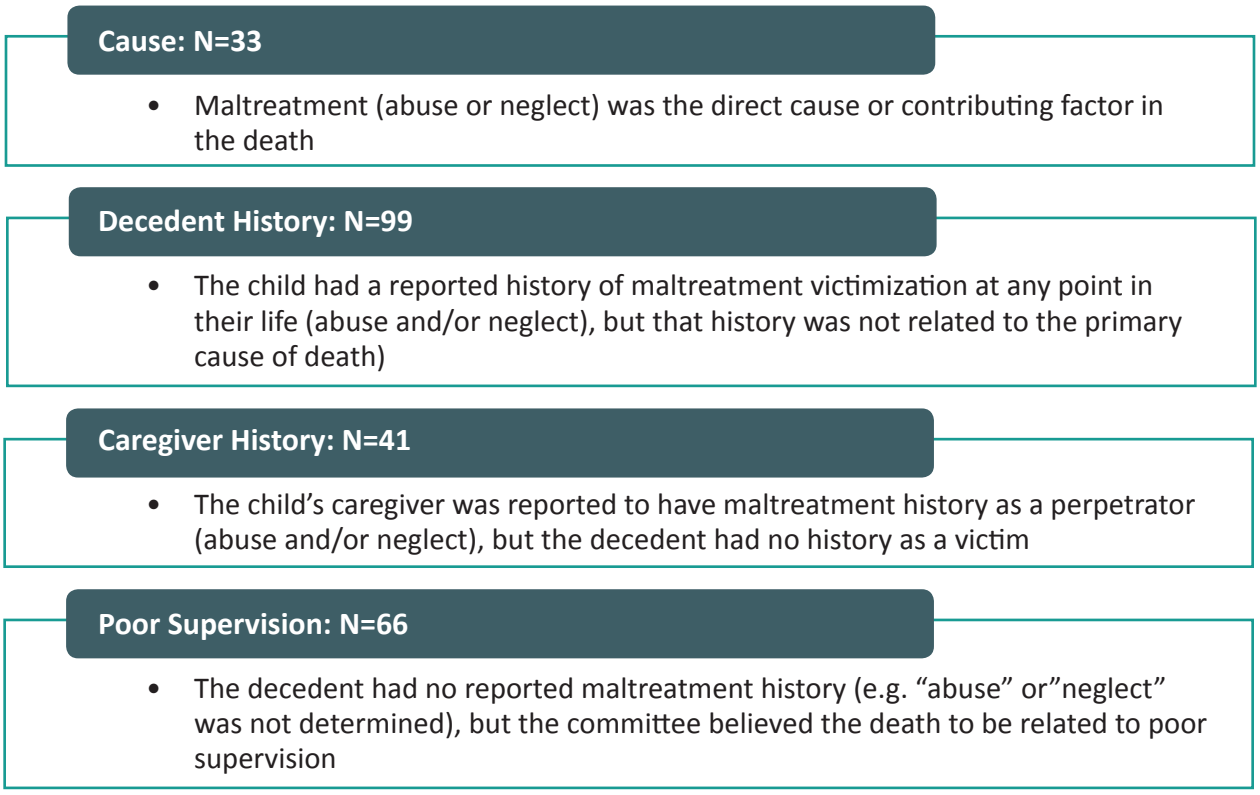
# MALTREATMENT-RELATED DEATHS

Child maltreatment is influenced by a number of factors, including lack of knowledge of child development, substance abuse, forms of domestic or intimate partner violence, and mental illness. Although maltreatment occurs in families at all economic levels, abuse, and especially neglect are more common in poor families than in families with higher incomes (Child Trends Data Bank).

When the local Child Fatality Review (CFR) committees conduct case-specific, multidisciplinary reviews of child fatalities, they must also discuss whether any acts of omission or commission caused or contributed to the death. The committee members are asked to collectively decide, using available information, if they believe that any human action or inaction caused (i.e., directly) and/or substantially contributed (i.e., indirectly) to the death of the child. The direct cause of death refers to an act that was the primary event leading directly to the death. The contributing cause of death refers to an act that played a role, but not the primary role, in the child's death. Fatalities classified as maltreatment by CFR committees are not necessarily reflective of official counts of abuse and neglect as reported by the state Division of Family and Children Services (DFCS). Not all CFR-identified maltreatment deaths had been known or reported to DFCS prior to the fatality occurring, or the maltreatment was not the direct cause of death. The CFR committees are not identifying only the "substantiated" maltreatment, but the deaths where maltreatment was indicated based on a review of the circumstances known to the committee. Committees examine the deaths from a public health approach to determine whether there was opportunity for improvement in services or programs to the family and/or the community.

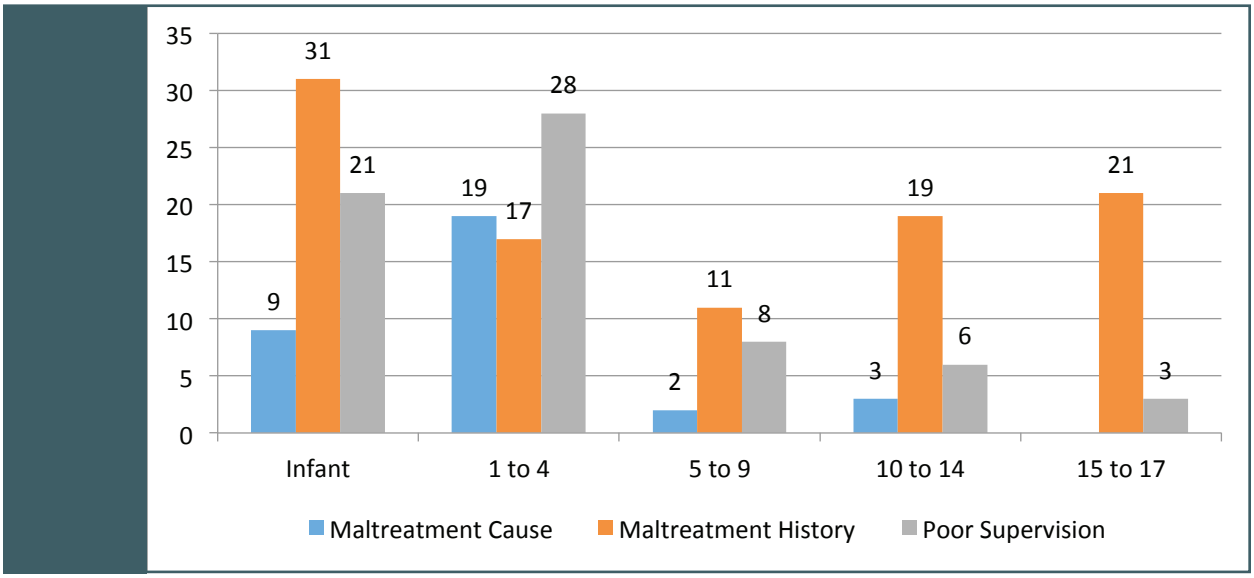
The National Child Abuse and Neglect Data System (NCANDS) collects case-level data on child fatalities that result from maltreatment. In 2013, NCANDS reported 1,484 child fatalities across 50 states. Nearly three-quarters of the child victims (74%) were younger than age three. Males had a higher fatality rate (2.36 per 100,000) compared to females (1.77 per 100,000). There was a higher percentage of deaths among White children (39%) compared to African-American (33%) and Hispanic children (15%). However, the rate of African-American child fatalities (4.52 per 100,000) was three times greater than the rates for White or Hispanic children (1.53 per 100,000 White children, and 1.44 per 100,000 Hispanic children).

**Figure 16: Maltreatment, History, and Other Risk Factors, GA, 2014 (N=239)**




- CFR committees identified 33 child fatalities in 2014 as "maltreatment-related" if the review revealed evidence that an act (abuse), or failure to act (neglect), directly caused or contributed to the death
- In 2013, CFR reported 39 cases that fit those criteria (compared to 37 in 2012, and 29 in 2011)
- Abusive Head Trauma (previously known as "Shaken Baby Syndrome") comprised 15 of the 33 cases

**Figure 17: Deaths Related to Maltreatment or Poor Supervision, by Age, GA, 2014 (N=198)**




- Maltreatment was the direct cause or contributing factor in 33 deaths. Nine deaths occurred among infants less than 12 months of age, and 19 (58%) were among children age 1-4
- Maltreatment history was reported in 99 deaths (although maltreatment was not the direct cause of death), and 31 of those (31%) were among infants
- Poor supervision was reported in 66 deaths (without any other maltreatment identified). Twenty-one occurred among infants less than 12 months of age, and 28 (42%) were among children age 1-4

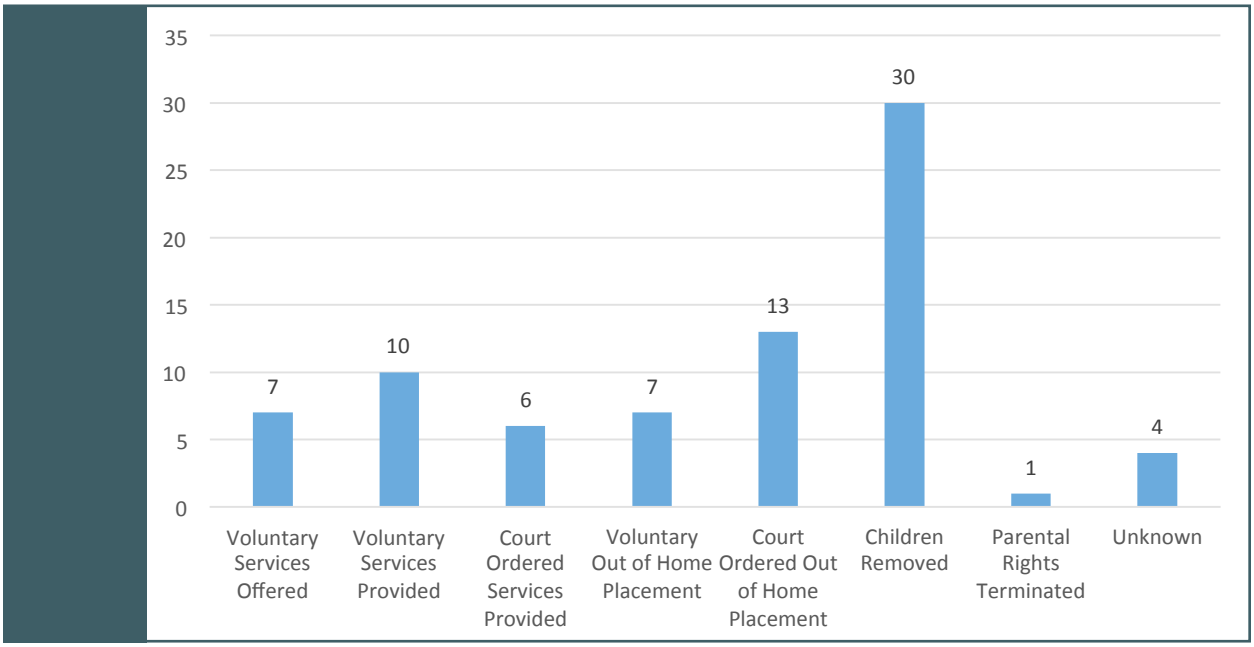
**Figure 18: Cause of Death by Type of Maltreatment for Decedents with Maltreatment History or Cause, GA, 2014 (N=132)**

| | Abuse | Neglect | Unknown |
|---|---|---|---|
| Asphyxia | | 3 | 1 |
| Drown | 2 | 2 | 2 |
| Fire | | 4 | |
| Homicide | 22 | 5 | 4 |
| Medical | 4 | 15 | 4 |
| Motor Vehicle-related | 10 | 7 | 4 |
| Poison | | | 1 |
| Sudden Unexplained Death in Childhood (SUDC) | 1 | | |
| Suicide | 4 | 4 | 2 |
| Sleep-Related | 1 | 11 | 11 |
| Undetermined | 2 | 2 | 2 |
| Weapon | 1 | 1 | |
| **Total** | **47** | **54** | **31** |

- Nearly half of the neglect deaths were due to medical and sleep-related causes (48%)
- Two-thirds of the abuse deaths were due to homicide and motor vehicle-related causes (68%)
- In 31 cases, the CFR committee was unsure whether abuse or neglect was a factor in the death

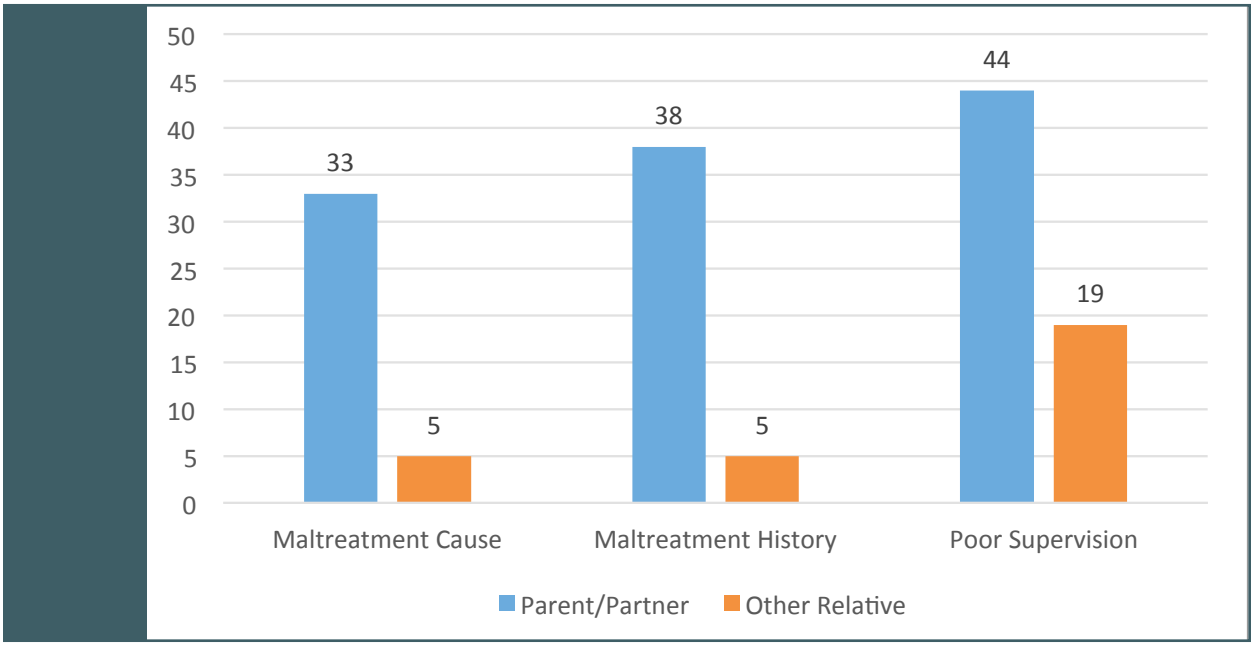
Following the deaths of the 132 decedents with maltreatment history, Child Protective Services (CPS) action was taken in response to 47 of those deaths.

**Figure 19: CPS Action as a Result of the Death, GA, 2014 (N=47)**




- Although 47 deaths prompted CPS action, multiple actions could have been taken on a single case, leading to 78 individual actions reported by CFR committees

**Figure 20: Relationship of Perpetrator/Caregiver among Maltreatment Fatalities, when known, GA 2014 (N=144)**

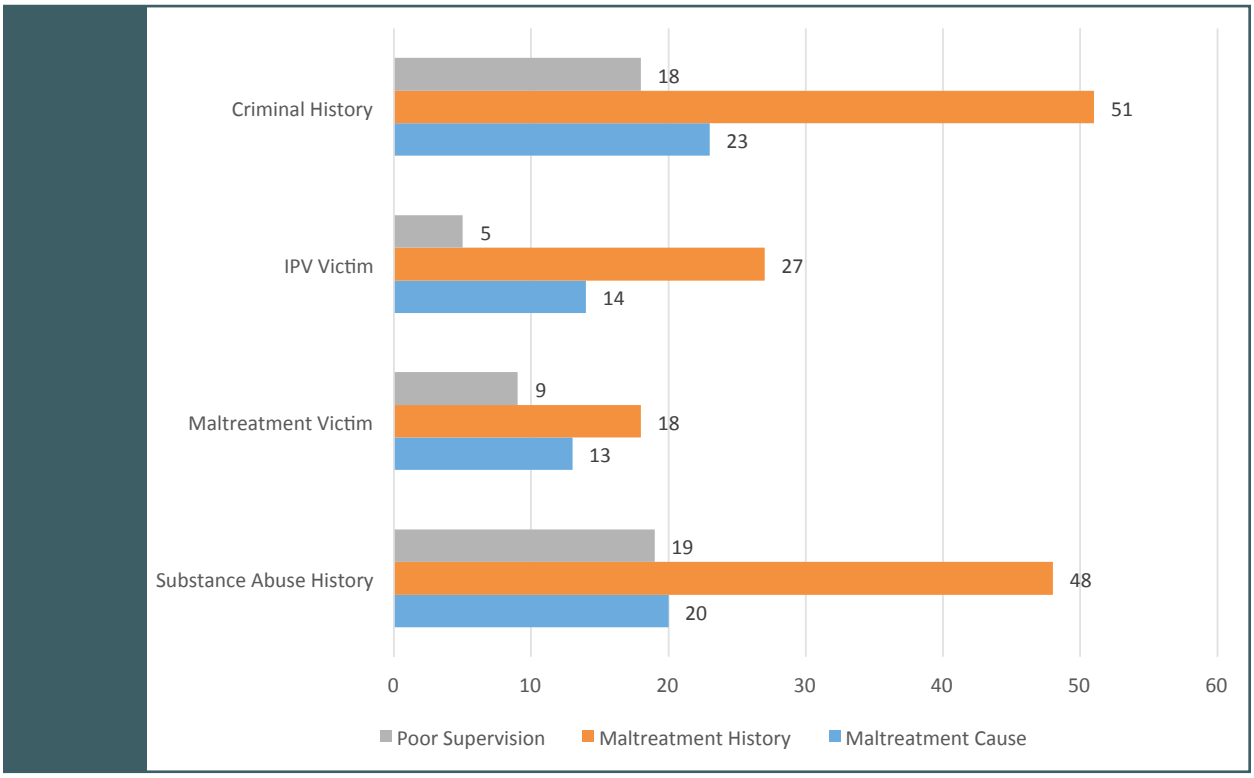



- The "parent/partner" category includes biological parents, adoptive parents, foster parents, step parents, and parent's paramours
- In 80% of reviewed fatalities, the parent or partner was the identified perpetrator

Nationally in 2013, four-fifths (78.9%) of child fatalities involved parents acting alone, together, or with other individuals. Perpetrators without a parental relationship to the child accounted for 17 percent of fatalities (Child Maltreatment 2013). Parents and caregivers who have unrealistic expectations of children, particularly due to lack of knowledge of child development, may also discipline inappropriately or excessively, leading to injury and or death.

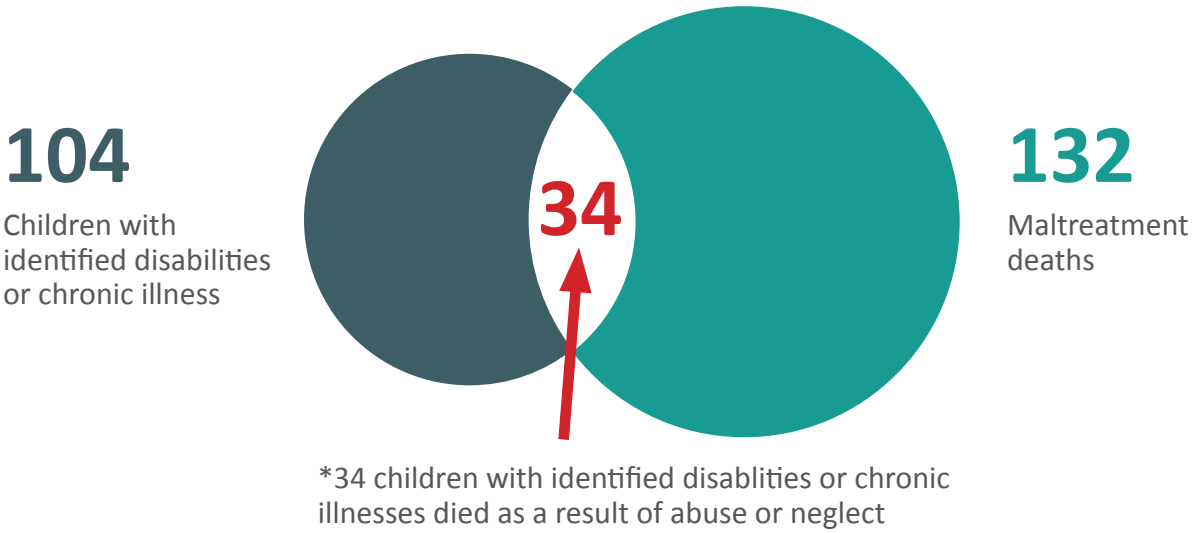
When access to available childcare is an issue, communities should encourage parents to seek assistance through the Childcare and Parent Services (CAPS). Subsidized child care in Georgia is provided through the CAPS program to help low income families afford quality child care. The CAPS program is administered in all 159 Georgia counties through the county Division of Family and Children Services.

**Figure 21: Reported Risk Factor History of Caregivers, GA, 2014**




- Caregivers can have multiple risk factors in their history. Substance abuse and criminal history were highest among caregivers when the decedent had maltreatment history
- There were 46 caregivers that were reported to be victims of intimate partner violence (IPV)
- Although not all states were able to report on certain risk factors, The Children's Bureau report states in 2013 that 32 states reported 15% of child fatalities were exposed to domestic violence in the home

**Figure 22: Child Deaths with Identified Disability/Chronic Illness and Maltreatment, GA, 2014**




There were 104 children with an identified disability or chronic illness; of those, 34 died due to abuse or neglect

- Child abuse and neglect can affect any child, but children with disabilities are at greater risk of maltreatment than children without disabilities
- The Children's Bureau of the Department of Health and Human Services (DHHS) reported in 2013 that children who were reported with any of the following risk factors were considered to have a disability: intellectual disability, emotional disturbance, visual or hearing impairment, learning disability, physical disability, behavioral problems, or other medical problems. Thirteen percent (12.6%) of victims in 43 states were reported as having a disability (Child Maltreatment, 2013)

The CFR Panel is one of three panels designated to serve as Georgia's Citizen Review Panels to fulfill the obligation of the Child Abuse Prevention and Treatment Act (CAPTA). To that end, CFR must report on child fatalities related to abuse or neglect, evaluate the extent to which state and local child protection agencies are effectively discharging their child protection responsibilities, and make recommendations to improve the system.

Under the CAPTA guidelines regarding public disclosure, CFR is reporting on the individual causes and circumstances of the 33 reviewed maltreatment related fatalities. Recent service provider history (within the 12 months immediately preceding the child's death) is also reported.

**Table 3: Child Protective Services History and Recommendations for Identified Maltreatment Cases, GA, 2014 (N=33)**

| Child's Age/Sex | | Cause/ Manner of Death | # CPS referrals / # substantiations | | Services provided? (WIC, food stamps, Medicaid, or TANF) | CFR Committee Prevention recommendations, if any |
|---|---|---|---|---|---|---|
| 3 | Male | Homicide | 1 | 0 | Yes | None |
| 2 | Male | Homicide | 1 | 0 | Unknown | None |
| 1 | Female | Homicide | | | Yes | Yes; provide more mandated reporter training |
| 2 | Female | Homicide | | | Yes | None |
| 4 | Female | Homicide | 1 | | Unknown | None |
| 5 | Female | Homicide | 9 | 1 | Yes | Yes |
| 1 | Male | Homicide | | | Unknown | None |
| Infant | Male | Homicide | 2 | 1 | Yes | Yes; mandate parenting classes for young parents and weekly texts from DFCS |
| 1 | Male | Homicide | | | Yes | None |
| 1 | Female | Homicide | 0 | 0 | Unknown | None |
| 1 | Female | Homicide | | | Yes | Yes; Public Service Announcements and education on identifying trauma to children |
| 1 | Male | Homicide | | | Yes | None |
| Infant | Male | Homicide | | | Unknown | None |
| 3 | Male | Homicide | | | Yes | None |
| 2 | Male | Homicide | 2 | 1 | Unknown | None |
| 9 | Male | Medical | 4 | 3 | Yes | Yes; provide mandated reporter training for community |
| 13 | Male | Medical | | | Unknown | None |
| 1 | Male | Medical | 1 | 0 | Unknown | None |
| 3 | Female | Medical | | | Unknown | None |
| 10 | Male | Undetermined | 1 | 0 | Unknown | None |
| 1 | Female | Asphyxia | | | Yes | Yes; continue education on safe sleep |
| Infant | Female | Homicide | | | Yes | None |
| Infant | Female | Homicide | | | Unknown | None |
| 2 | Male | Homicide | | | No | None |
| Infant | Male | Homicide | | | Yes | None |
| Infant | Male | Homicide | | | Yes | Yes |
| 1 | Female | Homicide | | | Yes | None |
| 1 | Male | Homicide | | | No | None |
| 2 | Male | Homicide | | | No | None |
| Infant | Male | Medical | | | Unknown | None |
| 12 | Female | Medical | | | Unknown | None |
| Infant | Male | SUID | | | Yes | Yes; continue education on safe sleep |
| Infant | Male | Undetermined | | | No | None |

Exposure to maltreatment or violence can disrupt the course of physical, emotional, and intellectual development in children and adolescents. Risks associated with maltreatment include alterations in a child's physical health, impaired psychosocial functioning, mental health conditions, and changes in brain growth and development (such as impairment in cognitive processing and sensory or motor skills). Preventing child abuse and neglect improves the health and quality of life of children and adolescents.

The CFR Panel supports the Blueprint for Change adopted by the Georgia Division of Family and Children Services, as recommended by the Governor's Child Welfare Reform Council in 2014. This plan will develop a robust workforce, reduce caseloads, enhance technology to protect workers and monitor cases, and move toward solution-based casework – a proven practice model that recognizes the connectedness and interdependence of the Division and the families they serve. The CFR Panel also supports the work of the federal Commission to Eliminate Child Abuse and Neglect Fatalities, which was developed following the passage of the Protect Our Kids Act of 2012. The mission of the Commission is to develop a national strategy and recommendations for reducing fatalities across the country resulting from child abuse and neglect. The Commission's report is expected in 2016.

## Strategies for Child Maltreatment Prevention

### Early Intervention (Part C under Individuals with Disabilities Education Act)

System of services that helps infants and toddlers with developmental delays or disabilities. They focus on helping eligible infants and toddlers learn the basic and brand-new skills that typically develop during the first three years life. These services may include medical services, counseling and training for the child and family, psychological services, occupational therapy, speech therapy, and nutrition services (Center for Parent Information and Resources, 2014).

### Evidence-Based Home Visitation Program

Evidence-based program, implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to target the participant outcomes which include improved maternal and child health, prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits. Home visitation services may also target other outcomes such as improvement in school readiness and achievement, reduction in crime or domestic violence, improvements in family economic self-sufficiency, and improvements in the coordination and referrals for other community resources and supports.

### Parent Education Programs

Programs focused on enhancing parenting practices and behaviors, such as developing and practicing positive discipline techniques, learning age-appropriate child development skills and milestones, promoting positive play and interaction between parents and children, and locating and accessing community services and support. The parent education programs are typically delivered in the home by trained progressions coaching parents on meeting the needs of their children through observation, instruction, and demonstration of mastery of skills.

## Family Support Services

Community-based services that promote the well-being of children and families; they often aim to reduce caregiver and family sense of isolation, stress or self-blame, provide education or information, teach skills, and empower and activate them so they can more effectively address the needs of their families.

## Essentials for Childhood Framework

Safe, stable, and nurturing relationships and environments are essential to prevent child maltreatment and to assure children reach their full potential. The Essentials for Childhood Framework proposes evidence-based strategies communities can consider to promote relationships and environments that help children grow up to be healthy and productive citizens so that *they*, in turn, can build stronger and safer families and communities for *their* children.

The *Essentials for Childhood* Framework is intended for communities committed to the positive development of children and families, and specifically to the prevention of child abuse and neglect. While child maltreatment is a significant public health problem, it is also a preventable one. The steps suggested in the *Essentials for Childhood* Framework — along with your commitment to preventing child maltreatment—can help create neighborhoods, communities, and a world in which every child can thrive.
(http://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html)

## Statewide

Expand the state campaign to include a major focus on the safe sleep environment and ways to reduce the risks of all related infant deaths, including sleep-related infant death, suffocation, and other accidental deaths

Continue research and surveillance on the risk factors, causes, and pathophysiological mechanism of sleep-related infant death and other sleep-related infant deaths, with the ultimate goal of eliminating these deaths entirely.

Regulation of the advertisement and sales of sleep devices and bedding for infant cribs to meet safety requirements.

## Childcare Providers and Media


## Resources

Child Welfare Information Gateway (www.childwelfare.gov)

National Child Abuse and Neglect Data System (www.acf.hhs.gov)

National Children's Advocacy Center (www.nationalcac.org)

Georgia Action Plan for Child Injury Prevention (www.gbi.georgia.gov/CFR)

Prevent Child Abuse Georgia (www.preventchildabusega.org)

Centers for Disease Control and Prevention, Essentials for Childhood (http://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html)

# SLEEP-RELATED INFANT DEATHS

Each year in the United States, about 4,000 infants die unexpectedly during sleep time from Sudden Infant Death Syndrome (SIDS), accidental suffocation, or unknown causes. Sleep-related infant deaths are the 3rd leading cause of infant mortality in Georgia, just behind complications related to birth defects and premature birth. Sleep-related infant deaths are considered highly preventable, however, there are several barriers that prevent caregivers from knowing, and accurately following, the safe to sleep recommendations.

**Figure 23: Demographics of Reviewed Sleep-Related Deaths, GA, 2014 (N=158)**

| | SIDS | Sleep-Related Asphyxia | SUID Medical | SUID | Total |
|---|---|---|---|---|---|
| White Male | 1 | 7 | 2 | 22 | **32** |
| White Female | 1 | 5 | | 11 | **17** |
| African-American Male | | 20 | 4 | 28 | **52** |
| African-American Female | | 17 | 2 | 25 | **44** |
| Hispanic Male | | 2 | | 4 | **6** |
| Hispanic Female | | | | 4 | **4** |
| Multiple Race Male | | 1 | | 2 | **3** |
| **Total** | **2** | **52** | **8** | **96** | **158** |

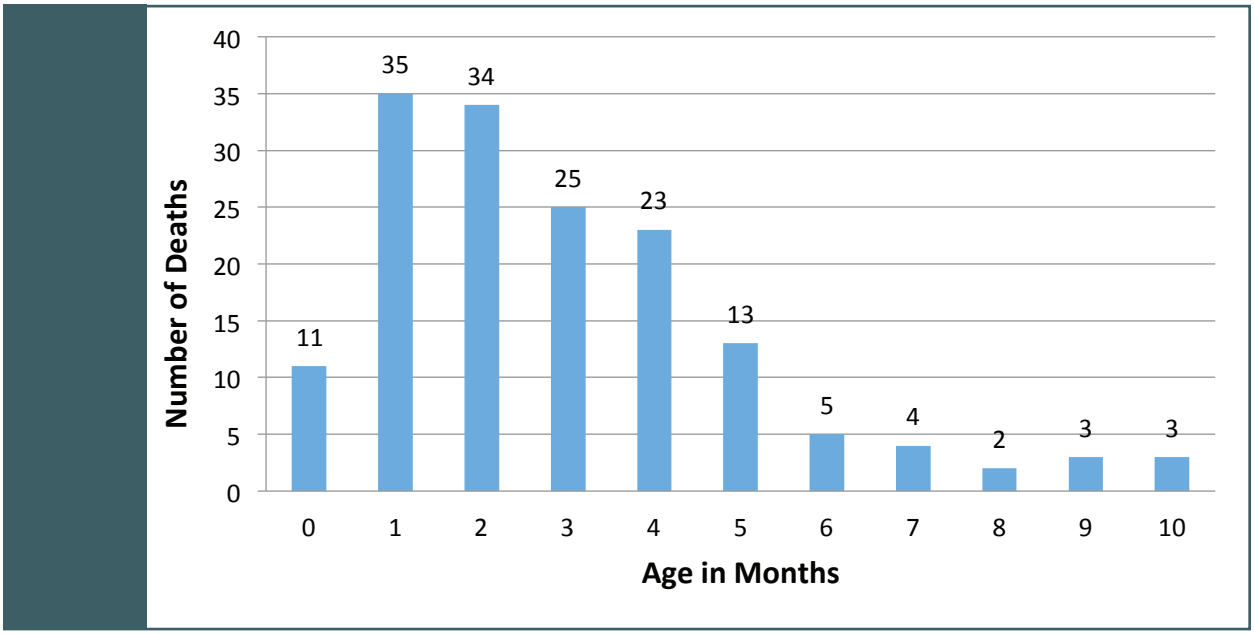
- CFR committees reviewed 158 sleep-related infant deaths in 2014. Of those, 61% were African-American, 31% were non-Hispanic Whites, and six percent were Hispanic
- Thirty-three percent of the sleep-related infant deaths were determined to be due to Asphyxia (e.g. suffocation, overlay, positional asphyxia)
- Sixty-one percent were determined to be Sudden Unexplained Infant Death (SUID) with sleep environment risk factors present
- SUID Medical comprised five percent of the deaths; these were sleep-related infant deaths with medical conditions present that could have contributed to the deaths
- Sudden Infant Death Syndrome (SIDS) is a diagnosis of exclusion when no other risk factors are identified; there were two SIDS deaths reviewed in 2014

A note on SIDS: research has not discovered the specific cause of SIDS but it is important to reduce the identified external infant stressors such as prone (stomach) sleep position, over

bundling/overheating, and airway obstruction. These factors can ultimately result in a combination of progressive asphyxia, low heart rate, hypotension, metabolic acidosis, and ineffectual gasping, leading to death. While there may still be an intrinsic vulnerability for some infants in relation to SIDS, we should take steps to reduce the risks that we can address. These steps are also protective against the more prevalent, sleep-related infant deaths known as SUID (Sudden Unexplained Infant Death).

Risk factors related specifically to the infant involve: low birth weight, infants born preterm (<37 weeks), and any infant younger than 6 months of age. There are additional, modifiable risk factors for sleep-related infant deaths that are external to the infant, which include: bed or other surface sharing, back or side sleeping, infants put on their stomach (5 times greater risk), infants put on their stomach to sleep when they usually sleep on their backs (7-8 times greater risk), over heating/over bundling, soft bedding/soft sleep surface, environmental tobacco smoke (2.5 times greater risk), alcohol or drug use in caregiver, and late or no prenatal care.

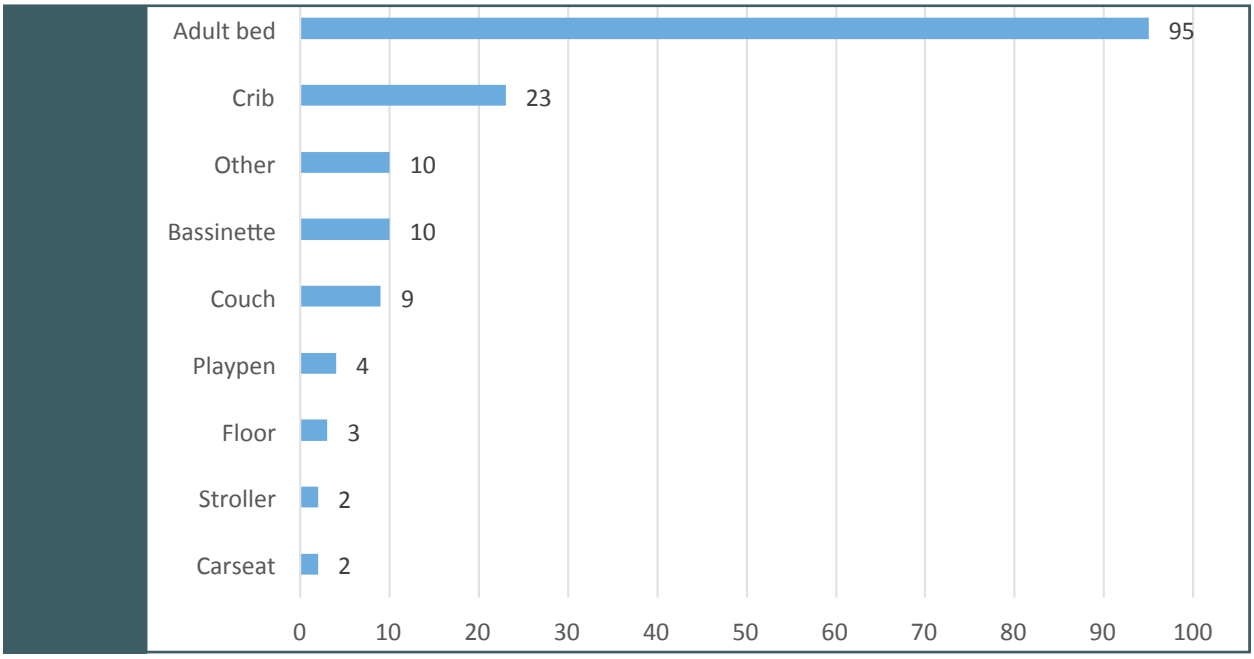
**Figure 24: Reviewed Sleep-Related Deaths by Age (in Months), GA, 2014 (N=158)**




- Younger infants are more vulnerable to sleep-related hazards. Sixty-six percent of the deaths were among infants less than four months old
- Early education is key; pediatricians generally have only three opportunities in this period to discuss safe sleep with parents after the infant is born (the American Academy of Pediatrics schedule recommends a well-check visit at one week, one month, and two months). It is important for caregivers to receive education at prenatal appointments and from hospital staff

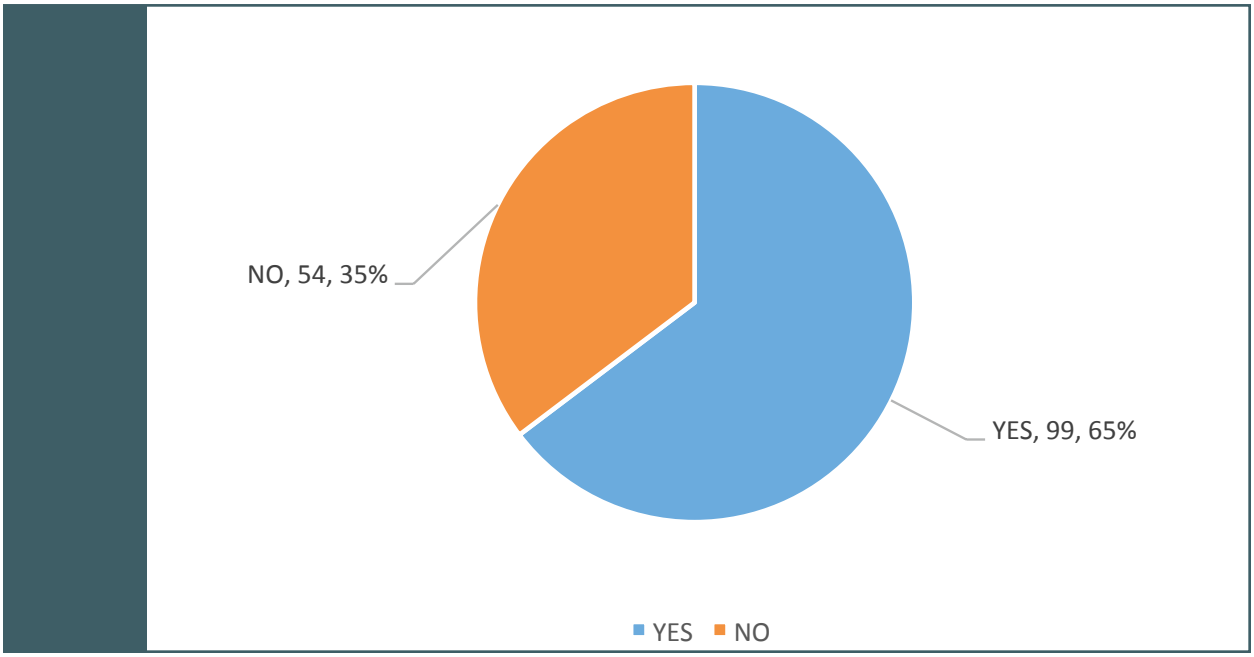
The primary risk factors associated with sleep-related infant deaths in Georgia are location, bedding, bed sharing, position, and tobacco exposure. The following charts illustrate the circumstances reported for the reviewed sleep-related infant deaths in Georgia.

**Figure 25: Sleep Location for Reviewed Sleep-Related Deaths, GA, 2014 (N=158)**



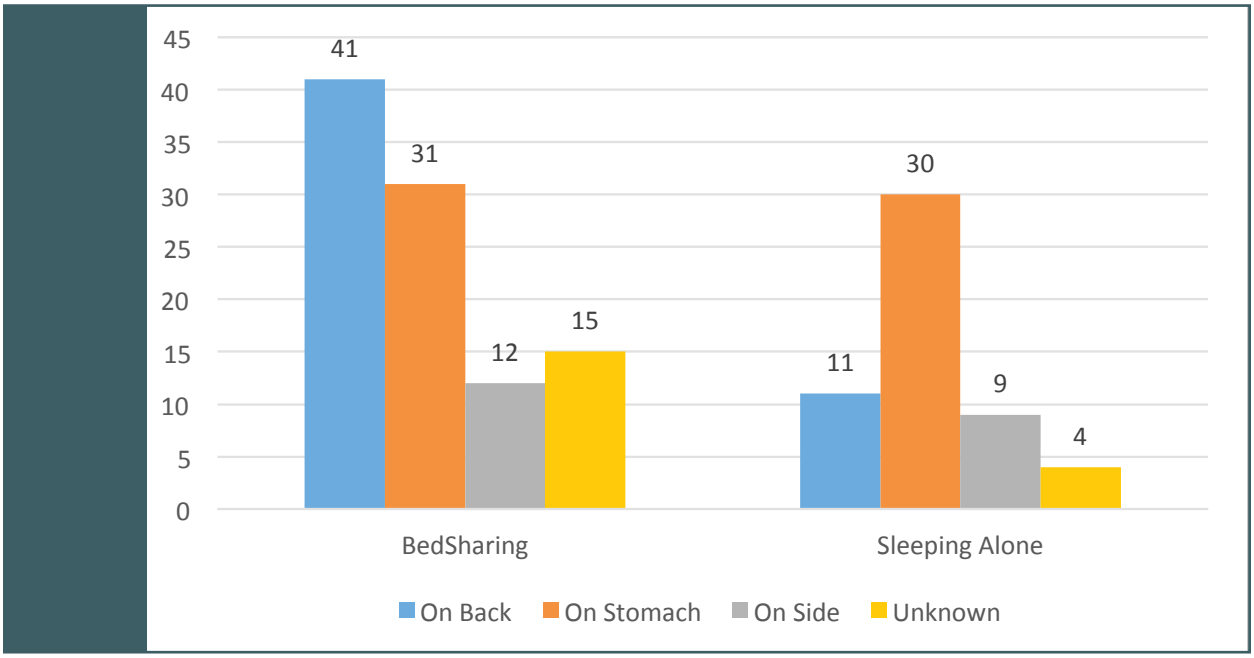

- Sixty percent of reviewed sleep-related infant deaths occurred in an adult bed
- It is recommended that infants room share without bed sharing; that is, the infant and caregiver should sleep close to each other in the same room, but not on the same surface
- "Other" includes places such as bouncers and swings

**Figure 26: Bed sharing Status for Reviewed Sleep-Related Deaths, when known, GA, 2014 (N=153)**



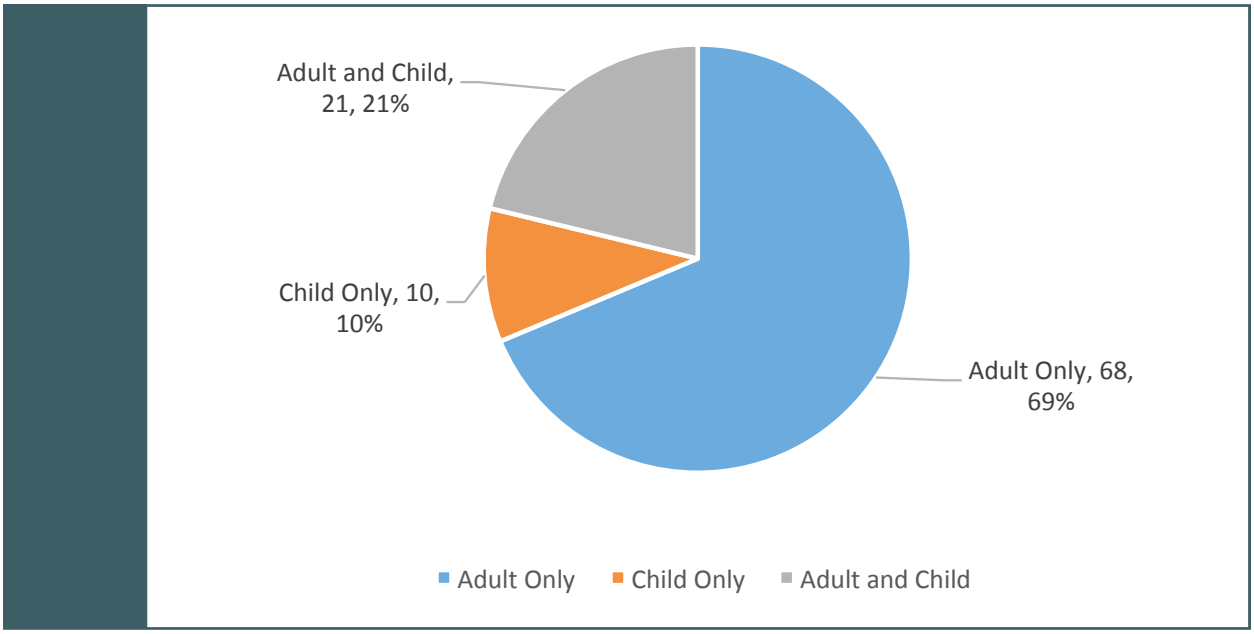
- Seventy percent of the bed sharing infants were younger than four months of age (n=69)
- Bed sharing in an adult bed not designed for an infant exposes the infant to additional risks for unintentional injury and death, such as suffocation, asphyxia, entrapment, falls, and strangulation. Infants younger than four months of age and those born prematurely or with low birth weight are at highest risk. This may be because of their lack of motor skills and muscle strength make it difficult to readjust and avoid potential threats (NICHD, Safe to Sleep Campaign)

**Figure 27: Position when Found and Bed sharing Status, when known, GA, 2014 (N=153)**



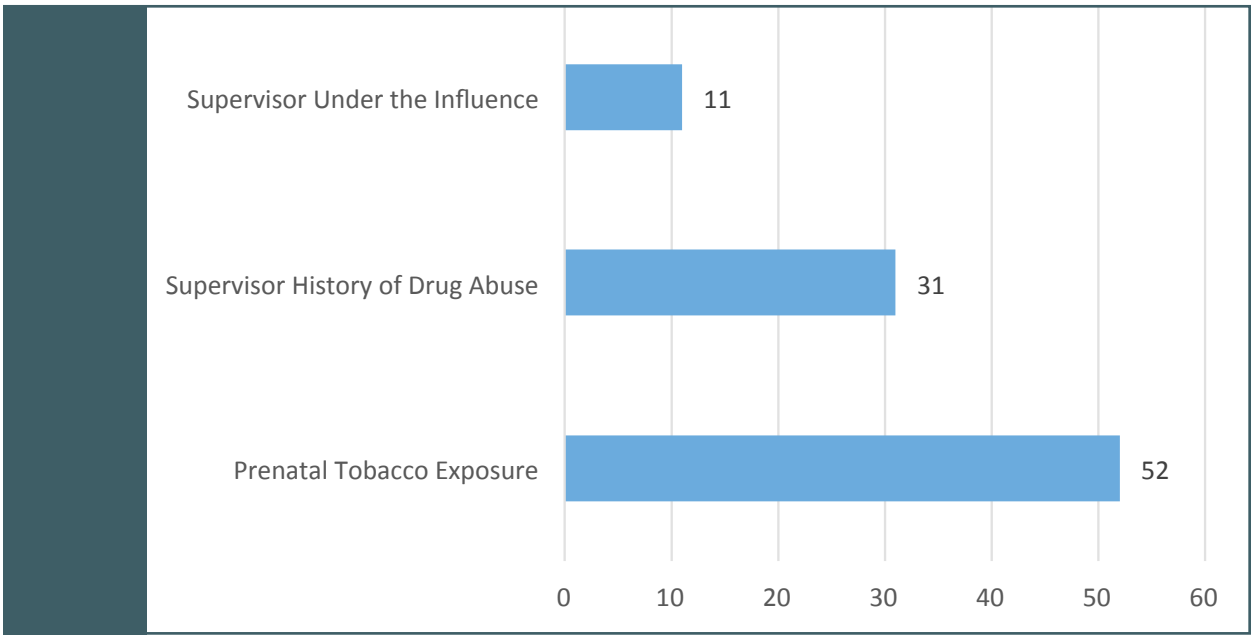

- There were 99 infants who were reportedly bed sharing (sharing a sleep surface) at the time of their death
- Bed sharing decedents were more likely to have been found on their back (supine position) than those who were sleeping alone. The protective factor of infant back sleeping is reduced when other risk factors, such as bed sharing, are introduced. When bed sharing, the risks associated with accidental suffocation (due to overlay and entrapment) and strangulation in bed are still present

**Figure 28: Who Was Sleeping with the Infant at the Time of Death, GA, 2014 (N=99)**



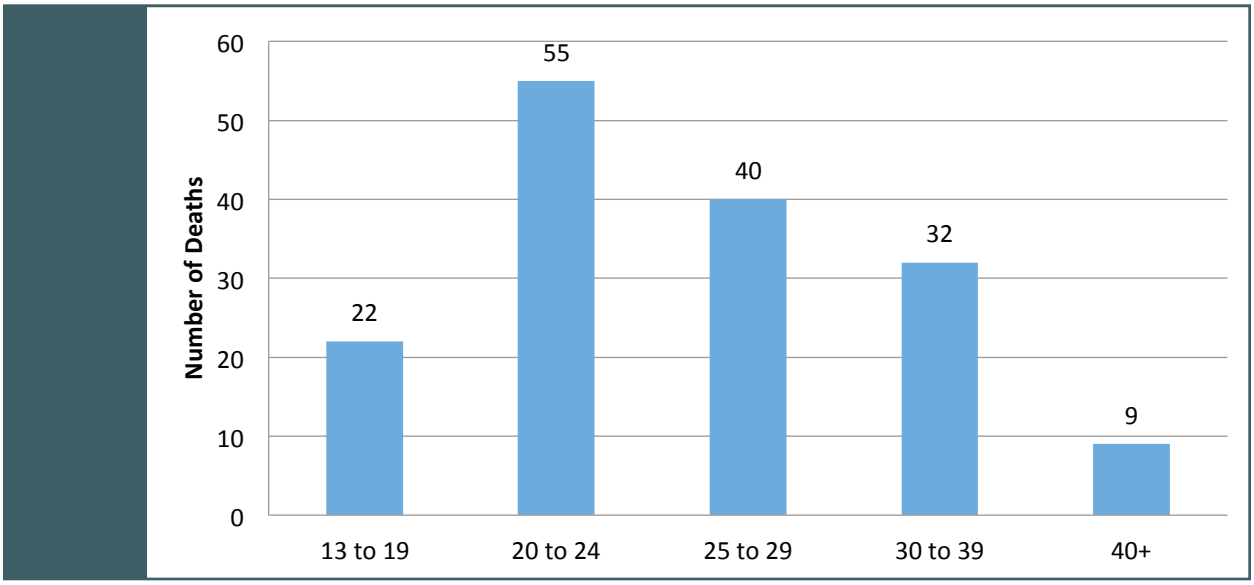

- Sixty-one of the infants bed sharing with an 'adult only' were younger than four months of age
- In 10 cases, another child (most often the sibling) was sleeping with the infant at the time of death; in 21 cases, the infant was sleeping with an adult and at least one other child

**Figure 29: Caregiver Substance Use for Sleep-Related Infant Deaths, GA, 2014**



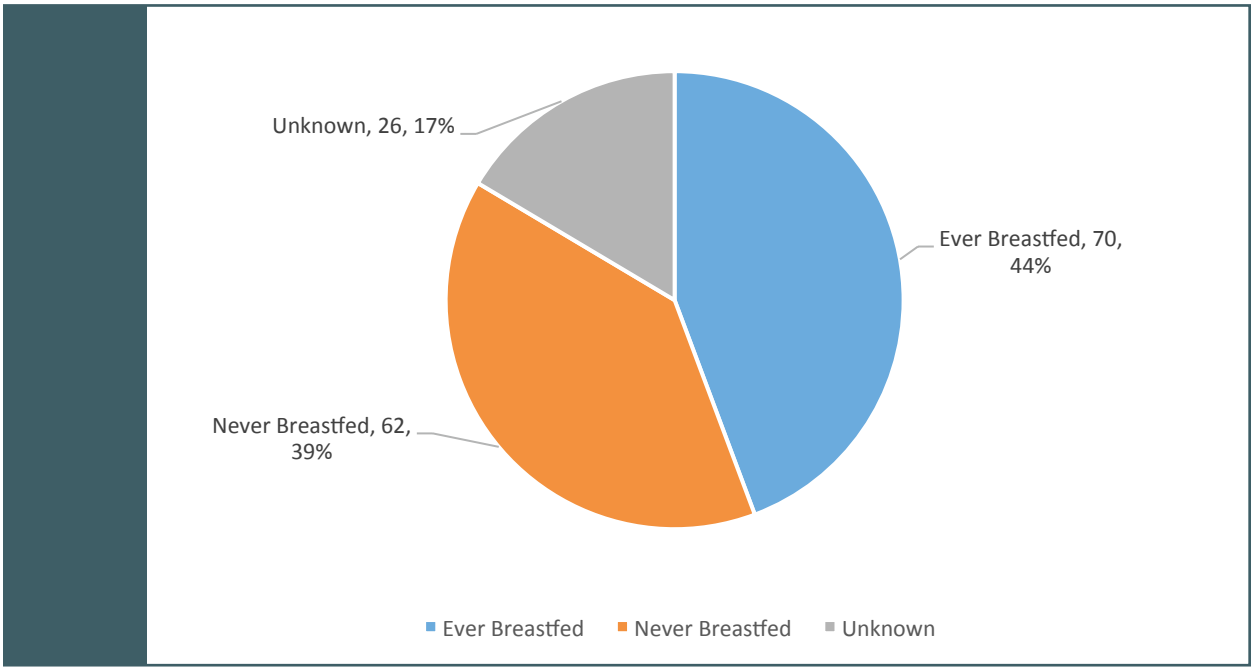
- Other risk factors can include exposure to tobacco smoke and impairment
- Thirty-three percent of mothers of a decedent reported smoking before and/or during the pregnancy (n=52)
- In 31 deaths, the supervisor had a reported history of drug abuse; of those, 22 were bed sharing at the time of death
- There were 11 deaths where the supervisor was reported to be under the influence of drugs and/or alcohol at the time of death
- Thirty-three supervisors were reported to be impaired due to sleeping, but of those 33, eight were also under the influence of drugs and/or alcohol at the time

**Figure 30: Number of Sleep-Related Deaths by Age of Caregiver, GA, 2014 (N=158)**




- Eighty percent of the identified supervisors at the time of death were also the infant's primary caregiver (parent)
- Teens were the identified caregivers in 14% of reviewed deaths, while adults in their 20s comprised 60% of caregivers
- In 2014, the Department of Public Health, Office of Health Indicators for Planning (OHIP) reported that adolescents/teens comprised 7.4% of births in the state, women age 20-29 comprised 53% of births, and women age 30-39 comprised 37% of births

**Figure 31: Reported Breastfeeding Status among Decedents, when known, GA, 2014 (N=158)**




- Nearly half of decedents were reportedly breastfed at some point in their lives (44%)
- Exclusive breastfeeding for at least six months can be a protective measure against SIDS, and provides other health benefits for infants throughout their childhood. Safe sleep messaging at every level should also incorporate information on safe and effective breastfeeding

## Opportunities for Prevention

The Georgia Infant Safe Sleep Coalition (GISSC), together with the National Action Partnership to Promote Safe Sleep (NAPPSS) the national Safe to Sleep Public Education Campaign, and the Georgia Safe to Sleep Campaign are working together to coordinate efforts across the state that will reduce the risk of sleep-related infant death. These efforts are targeted to agencies, communities, businesses, and caregivers, so that all Georgians can be empowered to incorporate safe sleep behaviors into their daily routines.

According to a research report published in the official journal of the American Academy of Pediatrics in 2014, which studied sleep-related infant deaths reported by CFR committees across 24 states, risk factors for sleep-related infant deaths are different for different age groups. The predominant risk factor for younger infants (less than four months) is bed sharing, whereas rolling into objects in the sleep area is the predominant risk factor for older infants (age four months to one year).

This fact highlights the importance of educating everyone on the importance of a safe sleep environment that goes above and beyond just asking parents not to bed share. The recommended safe sleep environment for an infant is:

- **Alone** – Infants need their own sleep space. In other words, room sharing, not bed sharing. Set up the infant's own safe sleeping area in the same room with the caregiver. This is especially important in the early months when the risk of SIDS and SUID are greater
- **Back** – Infants sleep safest on their backs. Every sleep. Every nap. Every time
- **Crib** – Infants need a firm mattress with a tight-fitting bottom sheet, made specifically for the crib or bassinet. No blankets, quilts, crib bumpers or toys, and without exposure to **tobacco smoke**

In 2014, there were only two infant deaths reviewed in Georgia where no environmental risk factors were reported, and the child was sleeping safely.

The CFR Panel also recommends that all sleep-related infant death scene investigations include the use of the Sudden Unexpected Infant Death Investigation (SUIDI) Reporting Form and a doll re-enactment. We must have consistent investigation protocols and reporting across all counties in Georgia to know how and why our infants are dying and take appropriate steps to reduce the risks.

## Resources

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

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

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

Georgia Department of Public Health, Safe to Sleep Campaign (www.dph.ga.gov/safetosleep)

# REVIEWED MEDICAL DEATHS

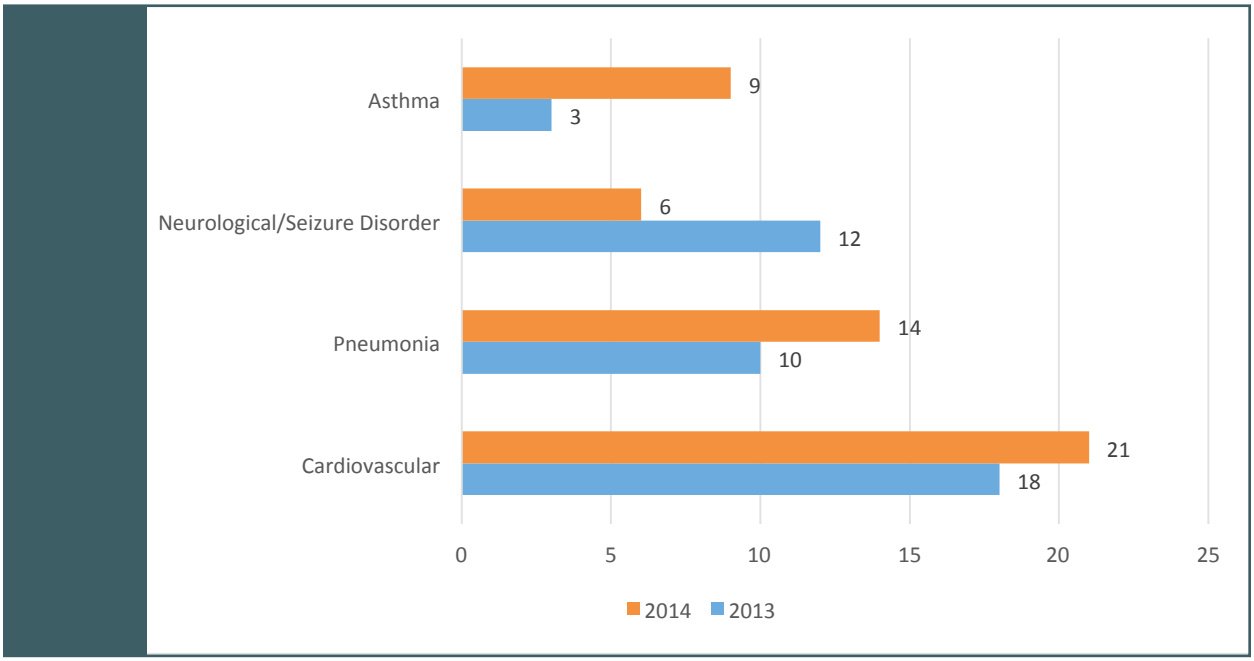
Medical deaths are reviewed by the Child Fatality Review committees if the death was unexpected, suspicious or unusual, unattended by a physician, or unexplained. Deaths that occur while in hospice care are considered to be "expected" and are not reviewable by Child Fatality Review committees. Medical deaths could also be reviewed if the child had a terminal illness but died sooner than expected, or under suspicious circumstances.

**Figure 32: Demographics of Reviewed Medical Deaths, GA, 2014 (N=90)**

| | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Totals |
|---|---|---|---|---|---|---|
| White Male | 6 | | 4 | 4 | 3 | **17** |
| White Female | 2 | 1 | 1 | 2 | | **6** |
| African-American Male | 7 | 7 | 4 | 8 | 6 | **32** |
| African-American Female | 8 | 7 | 4 | 3 | 1 | **23** |
| Hispanic Male | 1 | 1 | | | | **2** |
| Multi-Race Male | | 1 | 1 | | | **2** |
| Multi-Race Female | 1 | 1 | 1 | | 1 | **4** |
| Other Race Male | 2 | | | 1 | | **3** |
| Other Race Female | | | | 1 | | **1** |
| **Totals** | **27** | **18** | **15** | **19** | **11** | **90** |

- In 2014, CFR committees reviewed 90 child deaths that were attributed to medical conditions; of those 90 deaths, 27 were infants (30%)
- Fifty-five African-American children accounted for 61% of all medical deaths compared to the 35 total White, Hispanic, Multi-race and Other Race children (39%)

**Figure 33: Leading Causes of Reviewed Medical Deaths in Georgia, 2013-2014**



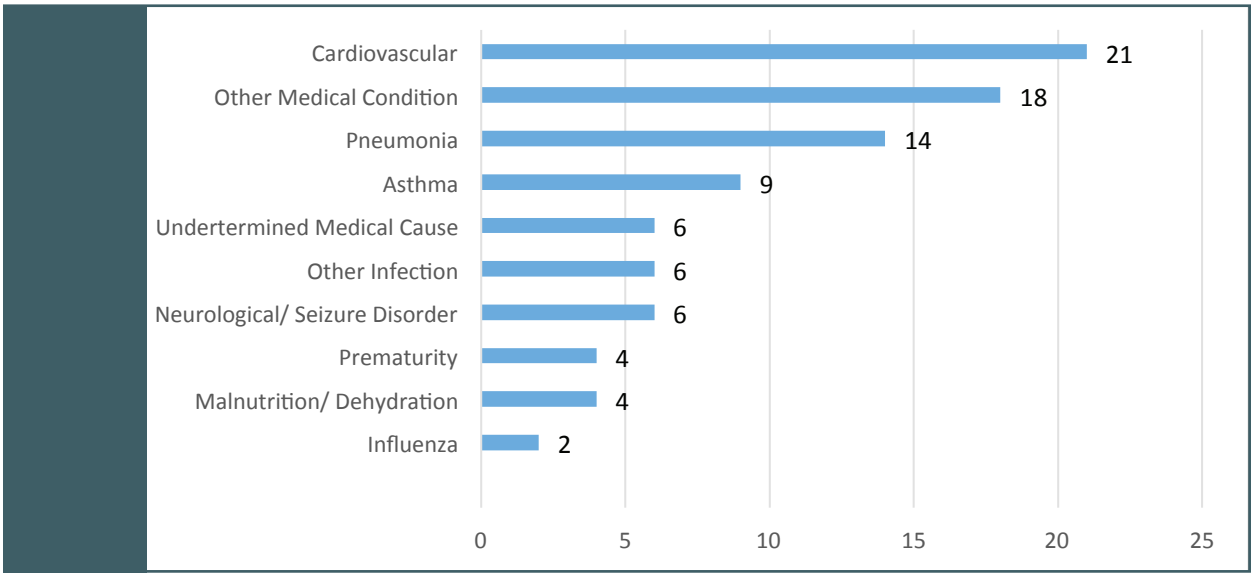

From 2013 to 2014, Georgia has seen an increase in the number of reviewed fatalities due to cardiovascular diseases and pneumonia.

Mortality data from the National Vital Statistics System revealed that cardiovascular disease and pneumonia were also in the top three leading causes of reported medical child deaths in 2013. In Georgia, cardiovascular disease was the number one leading cause of reviewed medical deaths in children under 18.

In 2014, pneumonia was the second leading cause of child death and has remained in the top three single medical causes of deaths in the last five years. According to the CDC, pneumonia is the leading cause of death in children younger than age five worldwide. Risk factors include chronic diseases such as asthma and heart disease (Mayo Clinic). It can cause a range of illnesses from mild to severe. Similarly, in Georgia, 10 of the 14 pneumonia cases reviewed were children under age five.

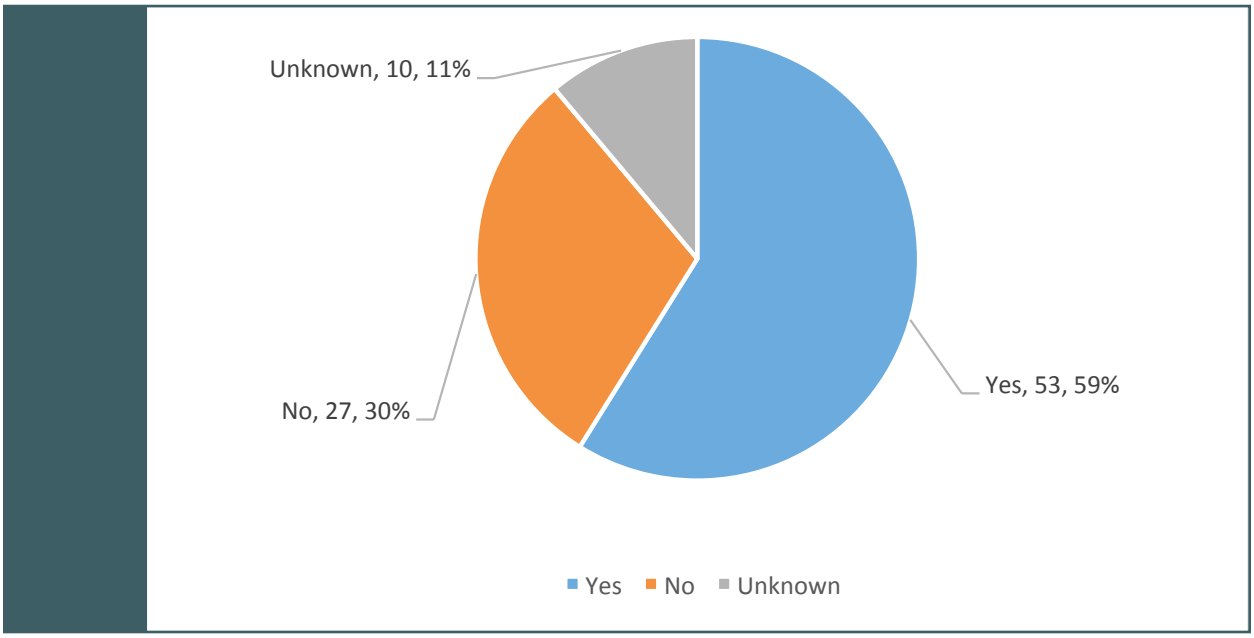
The 3rd leading cause of reviewed medical deaths of children in Georgia was asthma, replacing neurological/seizure disorders in the top three. Out of nine cases reported, seven children were between the ages of five and 14.

**Figure 34: Reviewed Medical Deaths by Cause, GA, 2014 (N=90)**




- In 2014, the three single leading medical causes of reviewed deaths of children in Georgia were cardiovascular, pneumonia and asthma
- Out of 21 cardiovascular causes of death, eight of those were infants (38%), five were between the ages of 10 to 14 (24%), and four were teens (19%)
    - There were 13 reports that the child had a previous diagnosed cardiovascular condition
- The 18 "other medical conditions" reported included conditions such as cerebral palsy, appendicitis, intracranial hemorrhage, hypoxic ischemic encephalopathy, pulmonary thromboembolism, bowel obstruction, and sickle cell disease

**Figure 35: Chronic Illness or Disability known Prior to Death, GA, 2014 (N=90)**

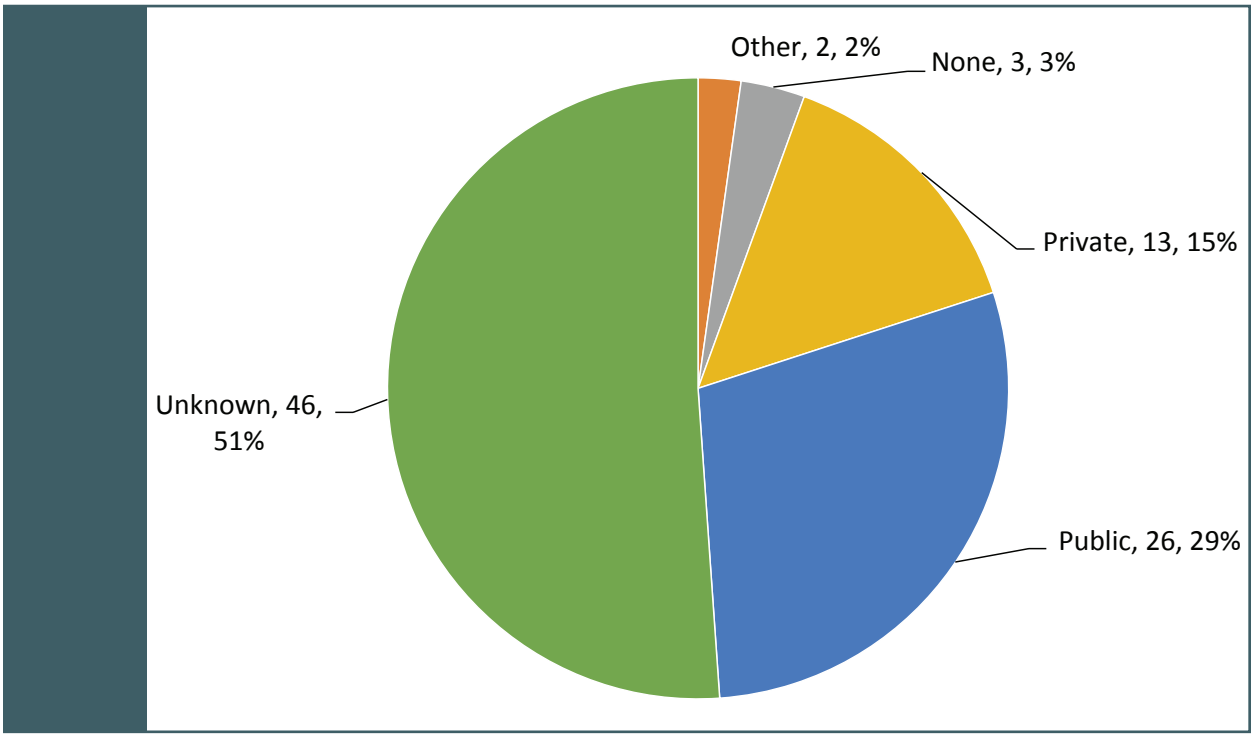



- Out of the 53 children that had previous diagnosed chronic illness or disability, there were six cases where the child/family were not "compliant with the prescribed care plans". Several reasons were cited by the review committees, including not being compliant with appointments, therapy, or medication administration schedules, not having needed medical equipment, and not completing medication

Child Fatality Review's definition of chronic illness or disability incorporates physical, mental and sensory aspects of health. This definition includes: learning disabilities, ADD or ADHD, depression, anxiety problems, autism, developmental delay, speech problems, asthma, diabetes, Tourette syndrome, epilepsy or seizure disorder, hearing problems, vision problems, bone or joint problems and brain injury or concussion (National Survey of Children's Health).

The U.S. Department of Health and Human Services, Office of Adolescent Health conducted a survey about adolescent physical health facts. Parents of children ages 12 to 17 were asked whether they had ever been told by a health care professional if their adolescent had any type of chronic condition and whether the adolescent currently has the chronic condition. The survey results reported nationally by parents of adolescents ages 12 to 17 that 13% had two or more chronic conditions, 18% had at least one chronic condition and 69% reported having no chronic conditions. Similarly, the data from Georgia showed that 13% had two or more chronic conditions, 16% had at least one chronic condition and 71% reported having no chronic conditions (Office of Adolescent Health, Department of Health and Human Services, 2014).

**Figure 36: Child Health Insurance Status, GA, 2014 (N=90)**




Whether it's private or public, health insurance is essential in accessibility to health care (ChildStats.gov). The National Center for Health Statistics, National Health Interview Survey indicated that health insurance allows families to obtain preventive care and health care for those who are ill or injured. Private health insurance is usually purchased directly, obtained through an employer or local and community programs. Private health insurance comprehensive plans that include health maintenance organizations (HMO) and preferred provider organizations (PPO). Public health insurance is Medicaid or any other state sponsored health plans.

According to the 2011-2012 data from the Office of Adolescent Health, Department of Health and Human Services, nationally 94% of adolescents (ages 12 to 17) had health insurance compared to 91% of adolescents in Georgia.

- In 2014, CFR committees reported that 41 out of 90 reviewed medical deaths had health insurance coverage (44%); whereas three were uninsured (3%)
- Out of all insured children, 26 of the 41 were insured through public health insurance such as Medicaid or state sponsored plan (63%)
- Health insurance coverage was unknown at the time of review for 46 cases (51%)

## Opportunities for Prevention

The quality of health care that children receive can affect their health throughout their lifetime. Health care quality is important in ensuring that the level of the health care provided is effective, safe and efficient. According to ChildStats, the Federal Interagency Forum on Child and Family Statistics, the key child health care areas are disease prevention and health promotion which includes well-child visits, access to medical care and prescription drugs, and chronic care management which involves management of any disabilities and chronic illnesses.

- Timely vaccinations
- Frequent hand washing, especially after coughing and sneezing, using the restroom, and preparing foods or eating
- Promote early and comprehensive prenatal healthcare and treatment for optimal fetal and child development
- Maintenance of a healthy and nutritious diet to strengthen immune system and provide the body with needed nutrients for healthy development
- Limited contact with cigarette smoke
- 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
- Increase priority of regular medical care for children to improve chances of detecting chronic disease and providing early preventive care
- Establish early diagnostic tools for the detection of developmental delays or mental illness
- Remove triggers for respiratory and asthma complications such as mold, smoke and insects

In regards to the quality of care for children with asthma, the receipt of an asthma management plan during health care visits is critical. Asthma management plans provide self-management strategies that children and families can use to control asthma at home, school and play. These plans help decrease asthma-related morbidity and mortality and to prevent the exacerbation of this potentially life-threatening condition (National Heart, Lung and Blood Institute).

During the 2015 Georgia General Assembly, Senate Bill 126 was passed and signed by the Governor. Effective July 1, 2015, public and private schools in Georgia are authorized to stock a supply of levalbuterol/albuterol sulfate and school personnel are authorized to administer albuterol sulfate to a student upon the occurrence of perceived respiratory distress by the student, whether or not the student has a prescription for the drug.

## Resources

ChildStats.gov (www.childstats.gov)

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

National Heart Lung and Blood Institute (www.nhlbi.nih.gov)

Unites States Department of Health and Human Services, Office of Adolescent Health (www.hhs.gov)

# ALL UNINTENTIONAL REVIEWED DEATHS

## 10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2013

| | Age Groups | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Rank | <1 | 1-4 | 5-9 | 10-14 | 15-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65+ | Total |
| 1 | Unintentional Suffocation 979 | Unintentional Drowning 393 | Unintentional MV Traffic 342 | Unintentional MV Traffic 414 | Unintentional MV Traffic 6,510 | Unintentional Poisoning 8,251 | Unintentional Poisoning 8,374 | Unintentional Poisoning 10,651 | Unintentional Poisoning 6,388 | Unintentional Fall 25,464 | Unintentional Poisoning 38,851 |
| 2 | Homicide Unspecified 139 | Unintentional MV Traffic 327 | Unintentional Drowning 116 | Suicide Suffocation 231 | Homicide Firearm 3,704 | Unintentional MV Traffic 5,776 | Unintentional MV Traffic 4,448 | Unintentional MV Traffic 5,082 | Unintentional MV Traffic 4,502 | Unintentional MV Traffic 6,333 | Unintentional MV Traffic 33,804 |
| 3 | Homicide Other Spec., classifiable 74 | Unintentional Suffocation 161 | Unintentional Fire/Burn 87 | Suicide Firearm 137 | Unintentional Poisoning 3,293 | Homicide Firearm 3,372 | Suicide Firearm 2,948 | Suicide Firearm 4,057 | Suicide Firearm 3,809 | Suicide Firearm 5,113 | Unintentional Fall 30,208 |
| 4 | Unintentional MV Traffic 66 | Homicide Unspecified 153 | Homicide Firearm 48 | Homicide Firearm 94 | Suicide Firearm 2,210 | Suicide Firearm 2,897 | Suicide Suffocation 1,868 | Suicide Suffocation 2,007 | Unintentional Fall 2,283 | Unintentional Unspecified 4,316 | Suicide Firearm 21,175 |
| 5 | Undetermined Suffocation 43 | Unintentional Fire/Burn 129 | Unintentional Suffocation 44 | Unintentional Drowning 93 | Suicide Suffocation 1,839 | Suicide Suffocation 2,154 | Homicide Firearm 1,843 | Suicide Poisoning 1,867 | Suicide Poisoning 1,528 | Unintentional Suffocation 3,616 | Homicide Firearm 11,208 |
| 6 | Undetermined Unspecified 28 | Unintentional Pedestrian, Other 90 | Unintentional Other Land Transport 29 | Unintentional Other Land Transport 49 | Unintentional Drowning 501 | Suicide Poisoning 716 | Suicide Poisoning 1,193 | Unintentional Fall 1,366 | Suicide Suffocation 1,182 | Unintentional Poisoning 1,824 | Suicide Suffocation 10,062 |
| 7 | Unintentional Drowning 23 | Homicide Other Spec., classifiable 71 | Unintentional Natural/ Environment 22 | Unintentional Fire/Burn 48 | Suicide Poisoning 418 | Undetermined Poisoning 565 | Undetermined Poisoning 633 | Homicide Firearm 1,158 | Unintentional Suffocation 723 | Adverse Effects 1,755 | Suicide Poisoning 6,637 |
| 8 | Homicide Suffocation 22 | Unintentional Natural/ Environment 43 | Unintentional Pedestrian, Other 18 | Unintentional Suffocation 37 | Homicide Cut/Pierce 331 | Unintentional Drowning 424 | Unintentional Fall 522 | Undetermined Poisoning 801 | Homicide Firearm 573 | Unintentional Fire/Burn 1,103 | Unintentional Suffocation 6,601 |
| 9 | Unintentional Natural/ Environment 19 | Homicide Firearm 39 | Homicide, Other Specified., NEC[N] 15 | Unintentional Firearm 24 | Undetermined Poisoning 219 | Homicide Cut/Pierce 409 | Unintentonal Drowning 367 | Unintentional Suffocation 478 | Unintentional Fire/Burn 564 | Suicide Poisoning 905 | Unintentional Unspecified 5,407 |
| 10 | Unintentional Fire/Burn 17 | Unintentional Struck by or Against 33 | Unintentional Firearm 15 | Unintentional Poisoning 21 | Unintentional Fall 205 | Unintentional Fall 305 | Homicide Cut/Pierce 267 | Unintentional Drowning 464 | Undetermined Poisoning 547 | Suicide Suffocation 770 | Unintentional Drowning 3,391 |

[N] Not elsewhere classifiable

**Data Source:** National Center for Health Statistics (NCHS), National Vital Statistics System.
**Produced by:** National Center for Injury Prevention and Control, CDC using WISQARS™.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

# MOTOR VEHICLE-RELATED DEATHS

In the United States, 638 children ages 12 years and younger died as occupants in motor vehicle crashes, and more than 127,250 were injured. Restraint use among young children often depends upon the driver's seat belt use. Almost 40% of children riding with unbelted drivers were themselves unrestrained. One CDC study found that, in one year alone, more than 618,000 children ages 0-12 rode in vehicles without the use of a child safety seat/booster seat or a seat belt at least some of the time (CDC, 2013).

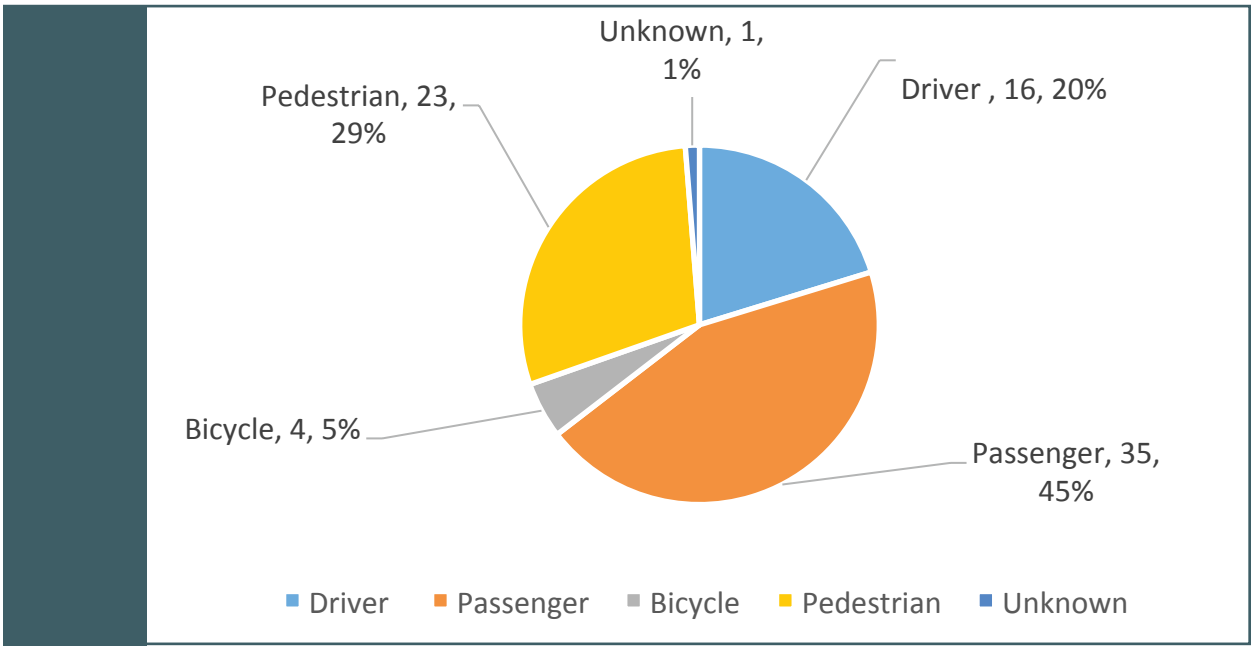
In 2014, motor vehicle-related deaths were the leading cause of unintentional injury-related deaths. Motor vehicle-related deaths accounted for almost half (48%) of 165 reviewed unintentional injury-related deaths (79) in Georgia. Reviewed motor vehicle-related deaths have decreased in 2014 from 102 motor vehicle-related deaths in 2013.

**Figure 37: Demographics of Reviewed Motor Vehicle-Related Deaths, GA, 2014 (N=79)**

| | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Total |
|---|---|---|---|---|---|---|
| African-American Male | 1 | 4 | 3 | 5 | 8 | **21** |
| African-American Female | 0 | 1 | 2 | 2 | 7 | **12** |
| White Male | 0 | 4 | 3 | 5 | 13 | **25** |
| White Female | 0 | 3 | 4 | 4 | 5 | **16** |
| Hispanic Male | 0 | 0 | 2 | 1 | 0 | **3** |
| Hispanic Female | 0 | 0 | 0 | 0 | 1 | **1** |
| Other Race Male | 0 | 0 | 0 | 1 | 0 | **1** |
| **Total** | **1** | **12** | **14** | **18** | **34** | **79** |

- Children ages 15 to 17 accounted for almost half (43%) of all reviewed MVC deaths
- Males comprised 63% of all reviewed MVC deaths (n=50)

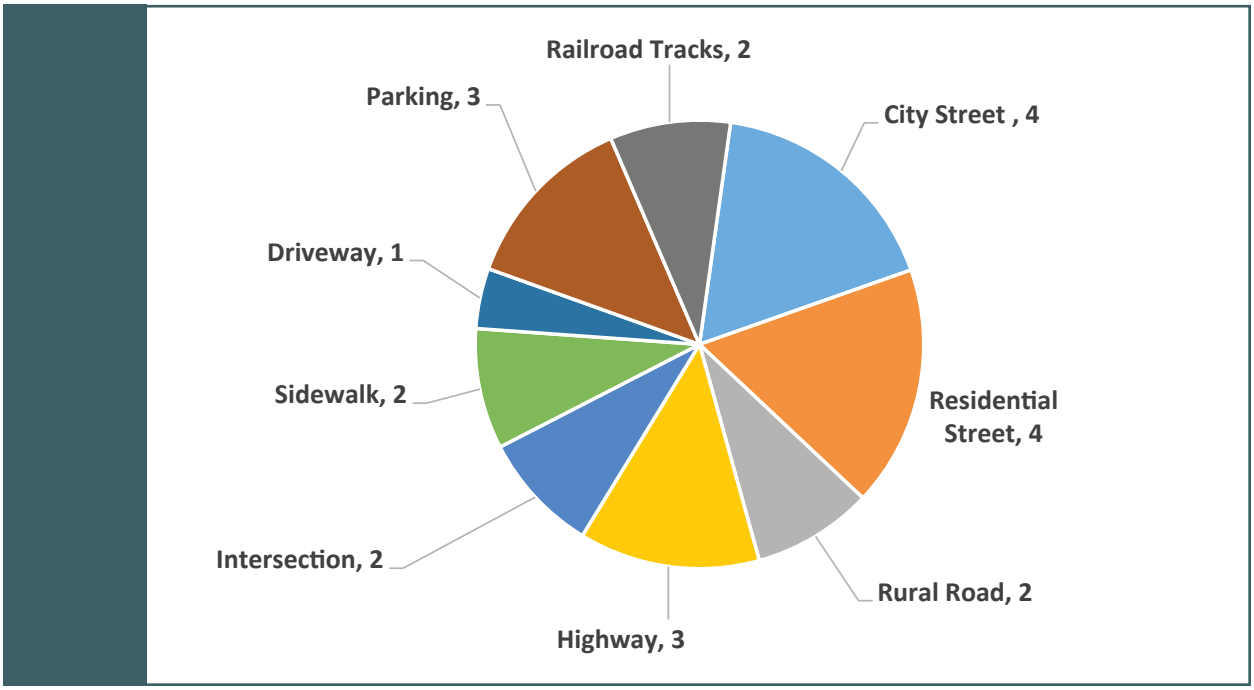
**Figure 38: Reviewed Motor Vehicle-Related Deaths by Position of Decedent, GA, 2014 (N=79)**




- The "driver" category involves 12 standard vehicles (cars, SUVs, trucks), three motorcycles, and one ATV
- A majority (22 out of 35) of MVC victims who were passengers were in cars

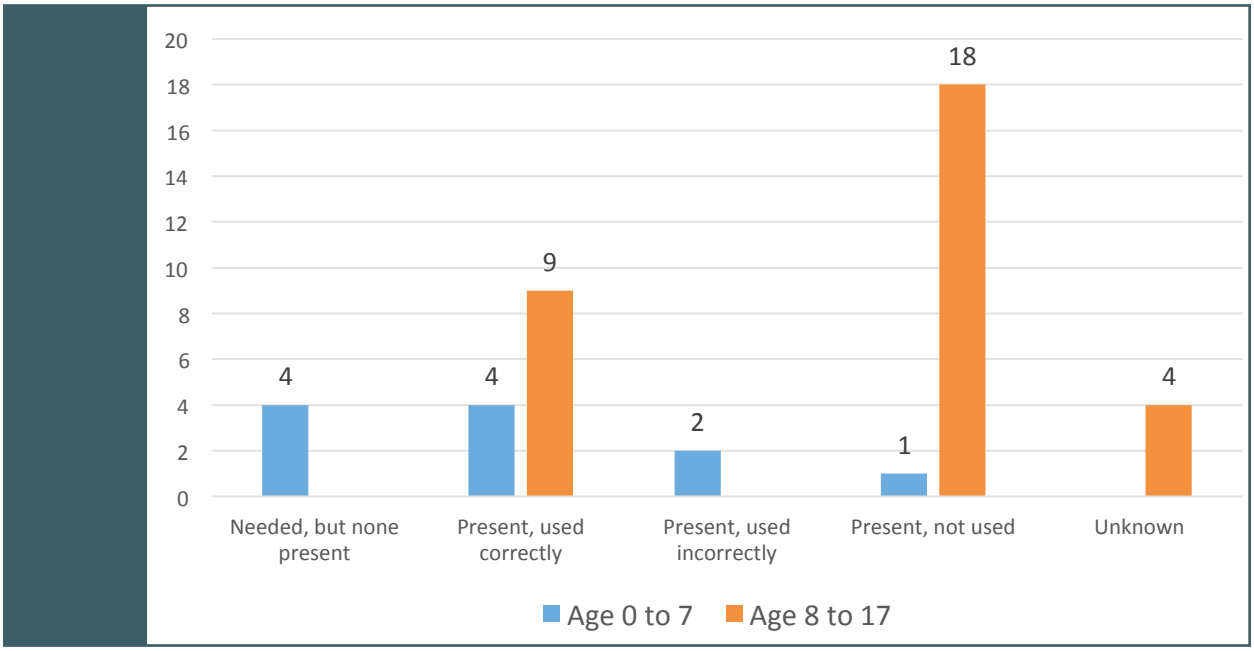
More than one in every five children between the ages of 5 and 15 who were killed in traffic crashes were pedestrians (CDC, 2012). Ten out of 36 (28%) of reviewed MVC deaths (ages 5 through 15) in GA in 2014 were pedestrians.

**Figure 39: Location of Pedestrian Deaths, GA, 2014 (N=23)**



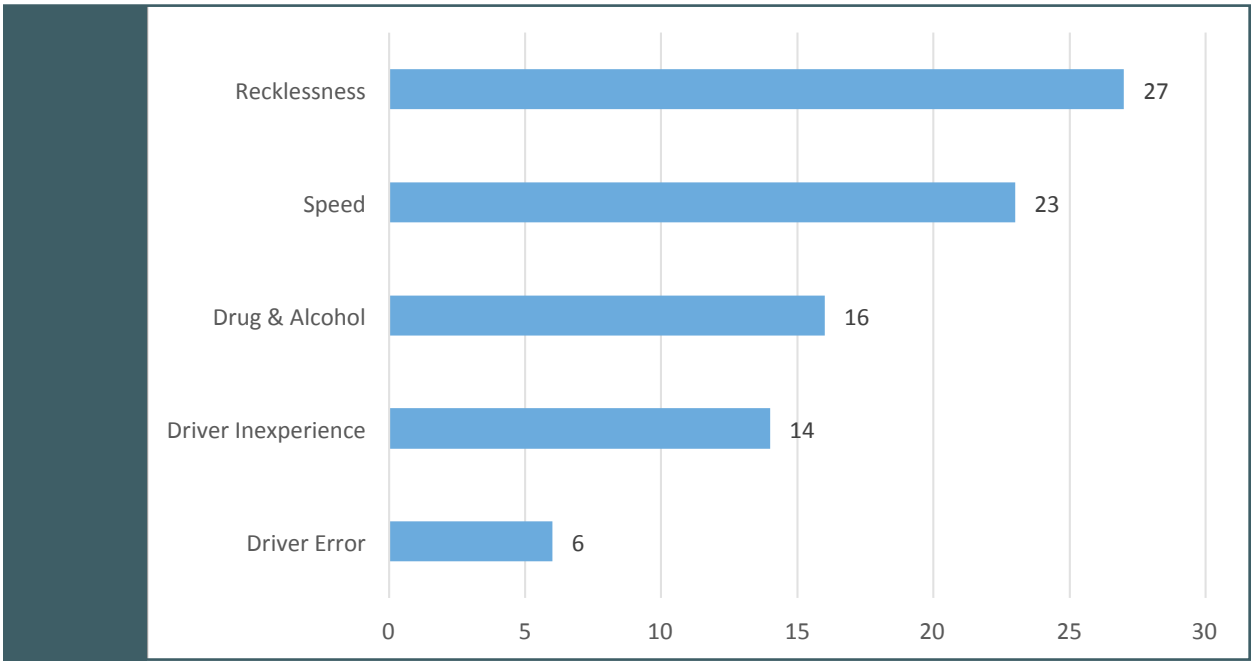
- Males accounted for 78% of all reviewed pedestrian deaths (n=18); African-American children accounted for 74% of reviewed pedestrian deaths (n=17) compared to 26% among White children (n=6)

**Figure 40: Occupant Restraint Usage (Drivers and Passengers), GA, 2014 (N=42)**




- This chart illustrates the presence and correct use of restraints, as determined by review committees
- In four cases, a child under age eight needed an appropriate restraint, but none was present. In three cases, an appropriate seat was present, but used incorrectly (e.g. the seat was not secured to the vehicle, or the child was not secured safely within the seat), or not used at all
    - Effective July 1, 2011, Georgia law requires children under age eight to be in a child safety seat or booster seat appropriate for their height and weight, and used according to the manufacturer's instructions. The law also requires children under eight to ride in the rear seat (www.ridesafegeorgia.org)
- Nationally, child restraint systems are often used incorrectly. One study found that 72% of nearly 3,500 observed car and booster seats were misused in a way that could be expected to increase a child's risk of injury during a crash (CDC, 2013)

**Figure 41: Reviewed Motor Vehicle-Related Death Incident Causes, GA, 2014**




**Note that some deaths have multiple causes identified e.g. one death was attributed to recklessness, driver inexperience and speed

- The most frequently cited causes for reviewed motor-vehicle-related deaths were recklessness, speed, and drugs/alcohol. This chart refers to all vehicle operators, not only those where the decedent was operating the vehicle
- According to the CDC, from 2001 to 2010, approximately one in five child passenger (<15 years old) deaths in the U.S. involved drunk driving; 65% of the time, it was the child's own driver that had been drinking (Blood Alcohol Content ≥ 0.08 g/dl)

## Opportunities for Prevention

- Georgia law specifies that all children under the age of one year must ride in a rear-facing seat in the back seat of the vehicle. Best practice recommendation from the American Academy of Pediatrics states that parents should "…keep their toddlers in rear-facing car seats until age two, or until they reach the maximum height and weight for their seat"(CDC)
- Children who have graduated from a rear-facing seat to a forward-facing seat with a harness should continue to use it until they reach the maximum height or weight limit of the seat, as a forward-facing seat with a harness is safer than a booster. They must remain seated in the back seat of the vehicle
- After outgrowing a forward-facing seat with a harness, a child may utilize a belt positioning booster seat and still must remain in the back seat. A booster seat should be used until a child until a child "is big enough to fit in a seat belt properly." For a seat belt to fit properly the lap belt must lie snugly across the upper thighs, not the stomach. The shoulder belt should lie snug across the shoulder and chest and not cross the neck or face. If you are not sure if your child needs a booster seat, you can take the 5-step test developed by Safety Belt Safe U.S.A. at www.carseat.org
- Once a child transitions to a seat belt, the best practice recommendation from the AAP states that a child should remain in the back seat until at least 13 years of age
- According to the CDC, drunk driving accounted for 3,699 fatalities from 2003 to 2012 in Georgia and nationwide about one in three motor vehicle deaths involves a drunk a driver. Effective strategies used to curtail these activities in adult and young drivers are impaired driving laws, sobriety checkpoints, mass media campaigns, and school-based instructional programs
- Drivers are encouraged to minimize as many distractions as possible when on the road, as distracted driving has also become an issue for occupant safety. According to the CDC, "every day more than nine people are killed and more than 1,153 people are injured in crashes that are reported to involve a distracted driver." Using a cell phone, texting, and eating are all instances of distracted driving. Additional risk factors are driver age (younger, less experienced drivers are more at risk), state of impairment, and the type of distracting activity. Interventions such as media awareness campaigns and laws limiting or prohibiting the use of electronic devices while driving are being utilized to address this issue

## 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)

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

Georgia Governor's Office of Highway Safety (www.gohs.state.ga.us)

# DROWNING DEATHS

According to the Centers for Disease Control and Prevention (CDC), in 2012, an average of 10 people die from unintentional drowning in the United States. Out of those 10 fatalities, two are children aged 14 and younger. The CDC also found that unintentional drowning ranked highest in children ages one to four and was the second leading cause of unintentional injury death in children ages five to nine.

Nationally, 30% of all unintentional injury child deaths were drowning deaths involving children ages one to four (Center for Disease Control and Prevention).

The World Health Organization (WHO) suggests that there are risk factors involved in drownings. These risk factors include:

- Lack of swimming training and skills
- Lack of supervision or distracted supervision
- Substance abuse of the supervisor
- Medical conditions, such as epilepsy

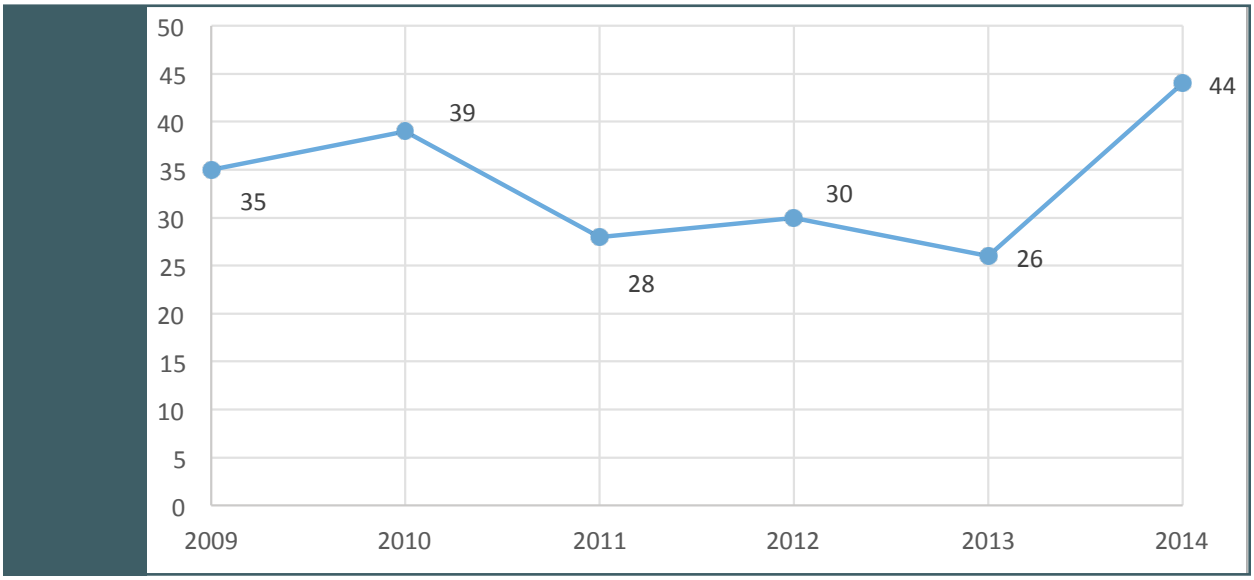
**Figure 42: Demographics of Reviewed Drowning Deaths, GA, 2014 (N=44)**

| | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Total |
|---|---|---|---|---|---|
| White Male | 8 | 1 | 2 | 1 | 12 |
| White Female | 7 | 0 | 2 | 0 | 9 |
| African American Male | 4 | 3 | 3 | 2 | 12 |
| African American Female | 1 | 2 | 2 | 0 | 5 |
| Hispanic Male | 1 | 0 | 0 | 3 | 4 |
| Multi-race Male | 1 | 1 | 0 | 0 | 2 |
| **Total** | **22** | **7** | **9** | **6** | **44** |

In 2014, out of a total of 167 unintentional injury deaths reviewed in Georgia, 44 died as the result of drowning (26%). Unintentional drowning fatalities were the second highest number of unintentional injury related deaths preceded only by 79 reviewed motor vehicle crashes fatalities.

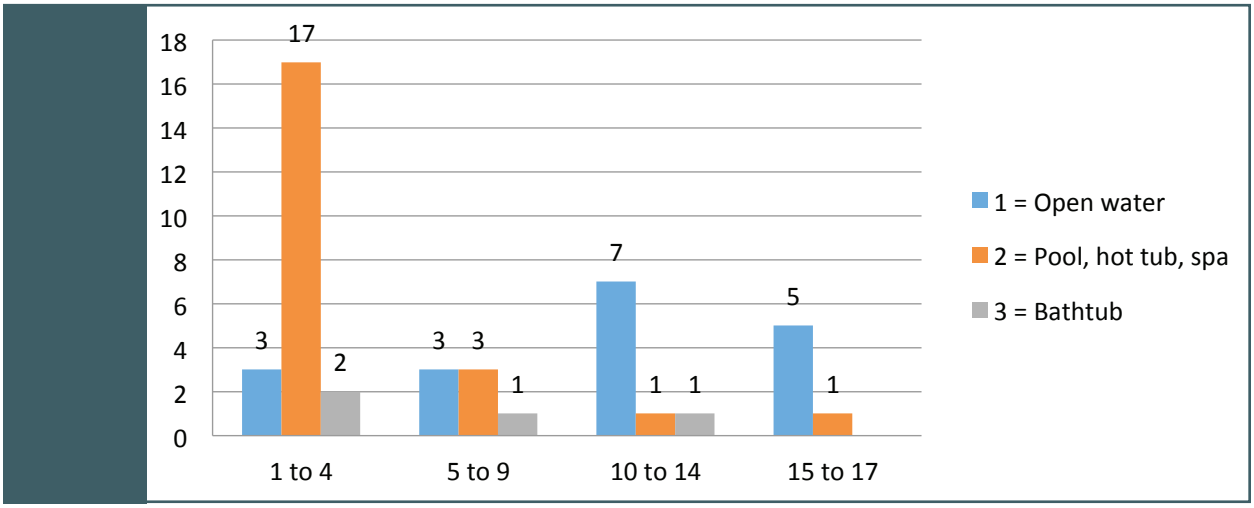
Young children can drown in only a few inches of water. According to the American Academy of Pediatrics, drowning is a leading cause of death among infants and toddlers. Fifty percent of the reviewed drowning deaths were among young children age one to four.

**Figure 43: Trend Chart of Reviewed Drownings in Georgia, 2009-2014**




- 2014 saw the highest number of reviewed drowning deaths during the five-year period 2009-2014

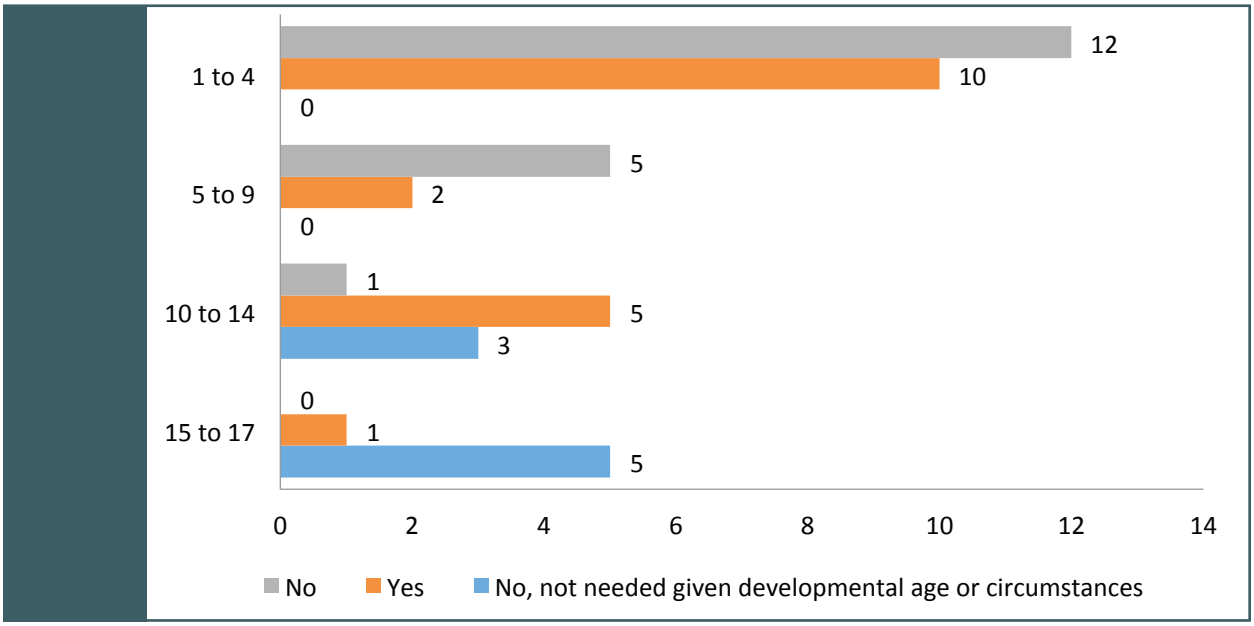
**Figure 44: Drowning Fatalities by Age and Location, GA, 2014 (N=44)**




*Open water includes oceans, rivers, lakes and ponds

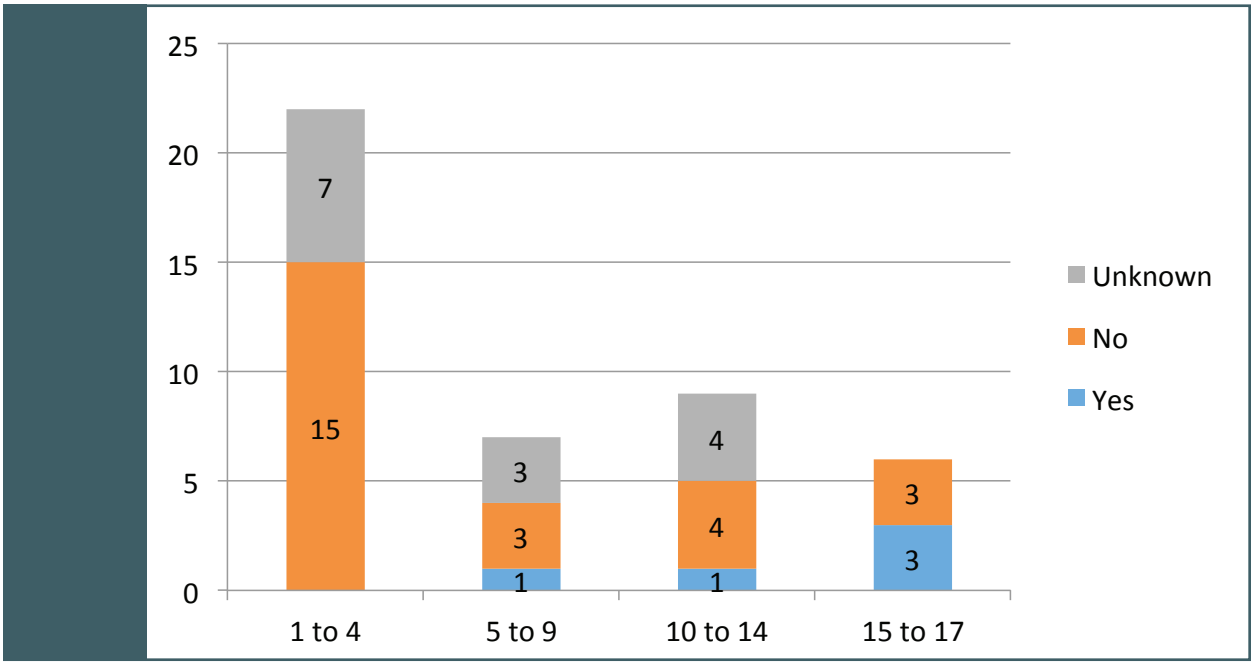
- Toddlers ages one to four most commonly drown in swimming pools
- Open water drownings accounted for 18 of the total child drownings of Georgia children in 2014

**Figure 45: Supervision at Drowning Incident, GA, 2014 (N=44)**




- Fifty percent (n=22) of reviewed drowning deaths were children ages one to four; 12 were found to be unsupervised at the time of death
- Eight children age 10 to 17 were determined to not need supervision at the time of death; however, older children can also be at risk around water and can benefit from having supervision
- According to Seattle Children's Hospital, teens put themselves at risk for drowning due to:
  - Misjudging their swimming ability
  - Diving, swinging or jumping in shallow water
  - Not aware of hazards
  - Delaying getting help
  - Usage of alcohol and drugs around water
  - Boating or swimming in unguarded water without a life jacket

**Figure 46: Reported Swimming Ability of Reviewed Drowning Deaths, GA, 2014 (N=44)**

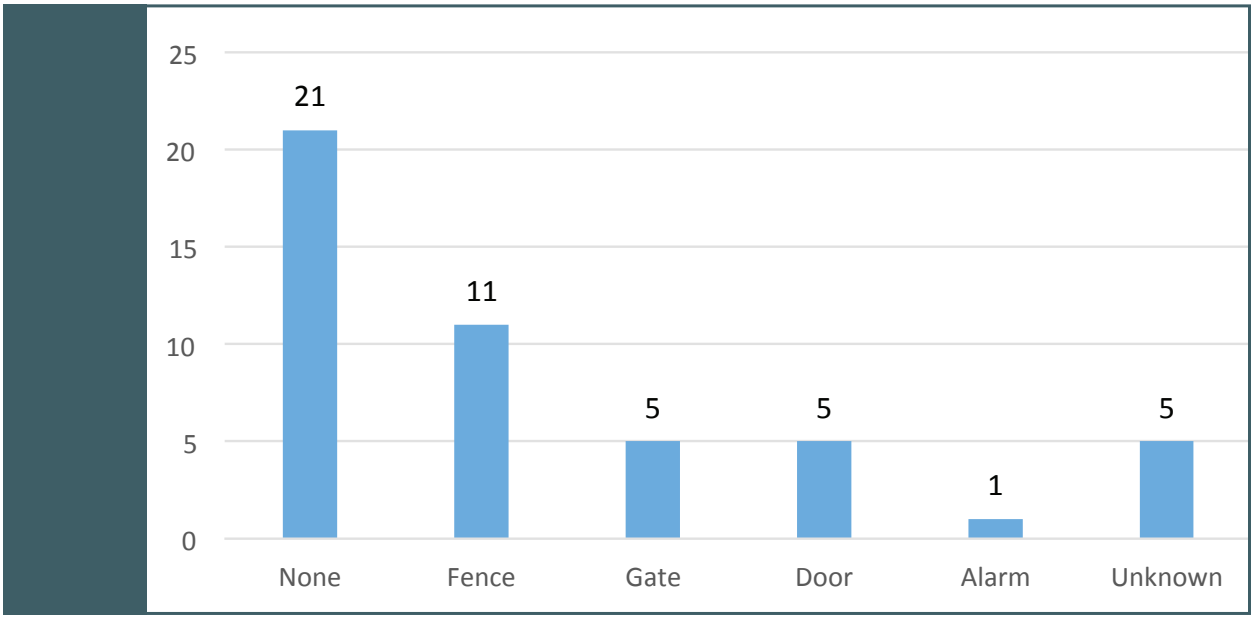



- Of decedents with known swimming ability, only five out of 30 (17%) were reported as knowing how to swim
- Thirty-three percent of children older than age four reported as knowing how to swim

It is imperative that children learn to swim. Research has shown learning how to swim can reduce the risk of drowning among children and adults. In 2014, the American Red Cross released national survey data that found that 61% of children and teens lack basic swim safety skills. Five components of basic swim skills, also known as water competency are:

- Step or jump into the water over your head
- Return to the surface and float or tread water for one minute
- Turn around in a full circle and find an exit from the water
- Swim 25 yards to the exit
- Exit from the water, if in a pool, be able to exit without using the ladder

**Figure 47: Reported Access Barriers/Layers of Protection of Reviewed Drowning Deaths, GA, 2014**




Primarily, when barriers/layers of protection exist, they are used to restrict unauthorized access to water areas. These include physical layers of protection (e.g. fences, gates, safety covers, and alarms) and behavioral protections (e.g. close supervision, education and more).

- In 2014, in 21 cases, no barriers of protection were reported to prevent the child's access to the water
- There were 22 drowning deaths in pools; eight of 22 reported fencing, another eight had no barrier reported
- Fence defects included damages and gaps; there were several instances when the decedent was reported to have climbed the fence
- In six deaths, doors were found to be unlocked or left open
- Gate defects involved were failed latches, left open and unlocked
- In five drowning fatalities, the review committees were unable to determine if any barriers/ layers of protection existed

## Opportunities for Prevention

Drowning can happen quickly and silently. Therefore, active supervision of children in or around open water is critical. Children should never be left alone near open bodies of water such as bathtubs, spas, swimming pools, ponds, lakes, rivers or oceans. Additionally, it is extremely important to know the basics of swimming (floating and moving through the water) and how to perform Cardiopulmonary Resuscitation (CPR) while supervising children in or around open water.

When supervising toddlers, an adult should always be within arm's reach of the child. Active supervision of older children should be free of distractions such as telephone usage, socializing, tending to house chores, consuming alcohol or using drugs and any other activities that may cause distraction or impairment. Close supervision by a responsible adult is the best way to prevent drowning in children.

The U.S. Consumer Product Safety Commission program, Pool Safely, suggests a designated "Water Watcher". Water Watchers are important to have especially in water environments where there are large volumes of people such as parties. Oftentimes, the attendees are swimming, eating and laughing and it is assumed with there being so many adults present, there is someone supervising the children near and in the water. Water Watchers are designated to protect children from drowning and to keep children in sight at all times. Water Watchers should not be distracted and they should never leave a child alone in or near open water, even for a moment. The only time when a Water Watcher will leave the area is when there is another adult is available to replace them.

The National Drowning Prevention Alliance (NDPA) recommends the use of multiple strategies and layers of protection simultaneously to prevent child deaths from drowning. Strategies include learning to swim, learning CPR and rescue techniques and having an emergency action plan. Layers of protection include fencing, gates, safety covers and alarms helps to prevent access to open water areas when caregivers are not aware.

The Pool Safety program provides steps to keep children safe in and around water:

- Fences should be four sided and at least four feet high or taller. It should have no footholds or handholds that could help a young child climb in. Most chain link fencing is not suitable for pool fencing
- Gates should open out from the pool and should be self-closing and self-latching. The latch should be out of a child's reach
- Pools and spas should be kept covered when not in use. Lockable safety covers are a good option
- Safety covers should withstand the weight of two adults and a child to allow a rescue if an individual falls onto the cover. The pool cover should also be able to be easily and swiftly removed from the water to respond to emergencies
- Doors and pool and gate alarms should sound when there is unauthorized access or if something goes wrong around the pool

## Resources

American Red Cross (www.redcross.org)

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

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

United States Consumer Product Safety Commission (www.cpsc.gov)

American Academy of Pediatrics (www.aap.org)

# ASPHYXIA DEATHS

Children ages one to four are most prone to accidental suffocation, especially around the home, where the majority of choking and strangulation accidents occur. Smaller food products such as fruits and vegetables, popcorn, candy, hot dogs, pretzels, etc. are the main cause of suffocation for small children. Other non-perishable items like small toys, pocket change and balloons also play a major role in child suffocation in the home. Additionally, items like window blind strings, appliance cords, shoelaces, ribbons and certain pieces of clothing can lead to strangulation.

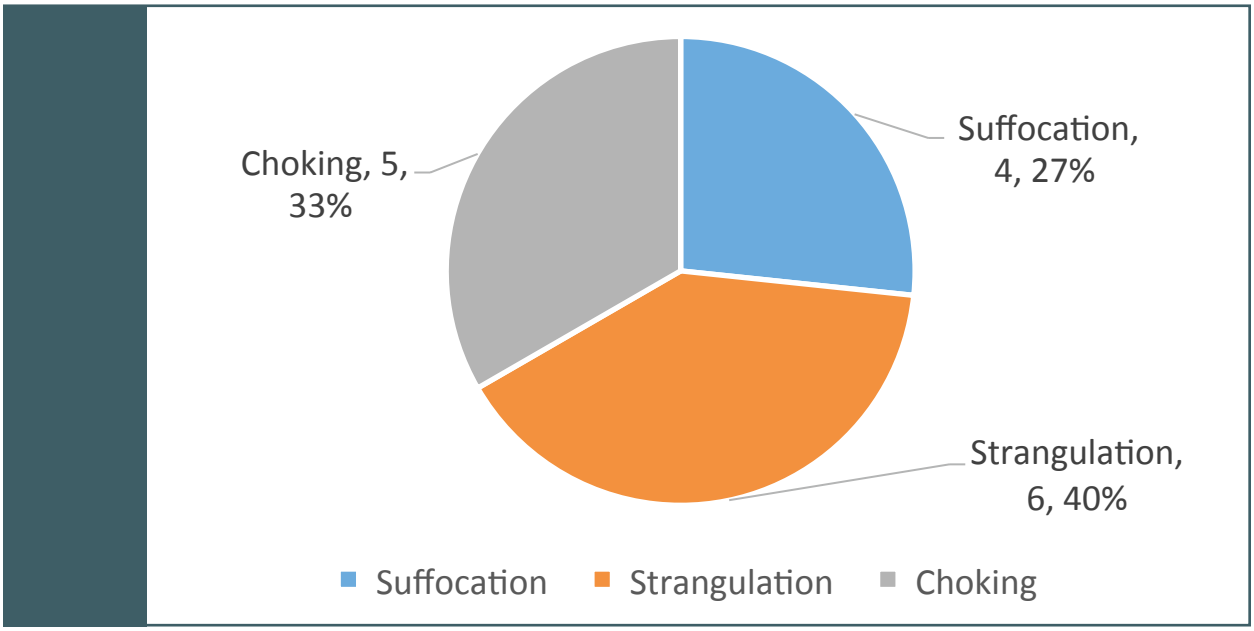
**Figure 48: Demographics of Reviewed Asphyxia Deaths, GA, 2014 (N=15)**

| | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Total |
|---|---|---|---|---|---|---|
| White Male | 0 | 6 | 0 | 0 | 1 | 7 |
| White Female | 0 | 1 | 0 | 1 | 0 | 2 |
| African-American Male | 0 | 2 | 0 | 0 | 0 | 2 |
| African-American Female | 0 | 0 | 1 | 0 | 0 | 1 |
| Multi-Race Male | 1 | 1 | 0 | 0 | 0 | 2 |
| Hispanic Male | 0 | 1 | 0 | 0 | 0 | 1 |
| **Total** | **1** | **11** | **1** | **1** | **1** | **15** |

Children ages 1 to 4 accounted for 73% of all asphyxia deaths (n=11)

- Males accounted for 80% of all asphyxia deaths (n=12)
- Although the majority of reviewed asphyxia deaths were among young children, CFR committees reported that in four events, the child asphyxiated sometime during their normal sleep time (nap or night time). Additionally, in six cases, the child was either in the presence of the caregiver or out of sight for less than ten minutes when the event occurred

**Figure 49: Asphyxia Deaths by Mechanism, GA, 2014 (N=15)**




- Asphyxia events were caused by a multitude of factors, including young children putting small objects in their mouths (n=4), children getting trapped in large objects such as furniture or appliances (n=3), and objects getting wrapped around a child's neck (n=5)
- Reviewed asphyxia deaths have almost doubled in 2014 when compared to the recent years:
  - Eight in 2011
  - Nine in 2012
  - Eight in 2013

## Opportunities for Prevention

According to the American Academy of Pediatrics, nationally, food accounts for over 50% of choking episodes. Caregivers should be alert for small objects that can cause choking, such as coins, buttons, and small toys. Check under furniture and between cushions for small items that children could find and put in their mouths. Toys are designed to be used by children within a certain age range. Age guidelines take into account the safety of a toy based on any possible choking hazard. Caregivers should not let young children play with toys designed for older children. Latex balloons are also a choking hazard. If a child bites a balloon and takes a breath, he/she could suck it into his airway.

- 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
- Infants and toddlers should be closely supervised to ensure that they remain safe

## Resources

Safe Kids Georgia (www.safekids.org)

The National Center for Child Death Review (www.childdeathreview.org)

The American Academy of Pediatrics (www.healthychildren.org)

# FIRE DEATHS

Every day in the U.S., at least one child dies from a house fire and another 293 children are injured due to fires or burns. Ninety percent of all fire deaths are due to house fires. House fires can spread rapidly and leave families as little as two minutes to escape after an alarm sounds.

Nationally, children under five years of age are at the greatest risk from house fire death and injury. Often, young children do not learn proper fire safety behavior such as dropping and rolling on the ground if their clothing catches fire, crawling instead of running out of a house, or covering their mouths if it is smoky. Fire safety education is important and powerful in preparing families and children for a fire emergency (Safe Kids, 2013).

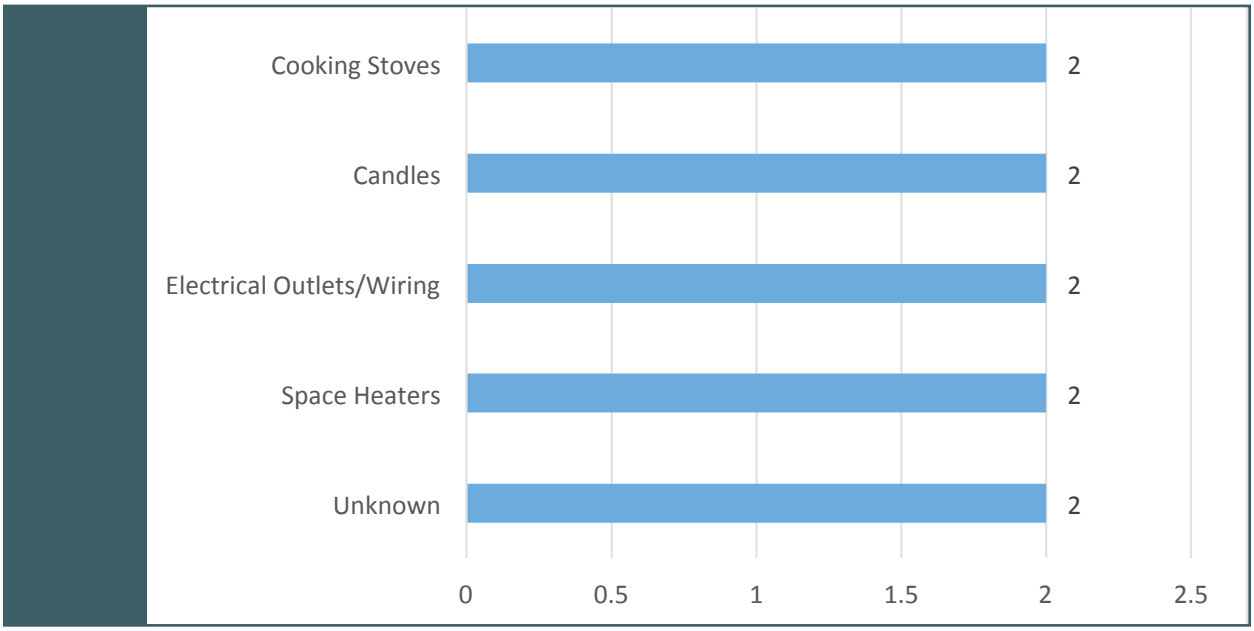
In Georgia, there were 13 reviewed fire deaths in 2014. Of these, there was a total of 10 fire incidents; two incidents involved a sibling pair and a sibling group of three. Eleven deaths occurred in single family homes (92%) and one death occurred in a duplex (8%); the remaining death resulted from accidental electrocution.

**Figure 50: Demographics of Reviewed Fire Deaths, 2014 (N=13)**

| | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 |
|---|---|---|---|---|
| White Male | 2 | 0 | 0 | 1 |
| White Female | 0 | 0 | 1 | 0 |
| African-American Male | 3 | 3 | 1 | 0 |
| African-American Female | 1 | 0 | 0 | 0 |
| Hispanic Male | 0 | 0 | 1 | 0 |
| **Total** | **6** | **3** | **3** | **1** |

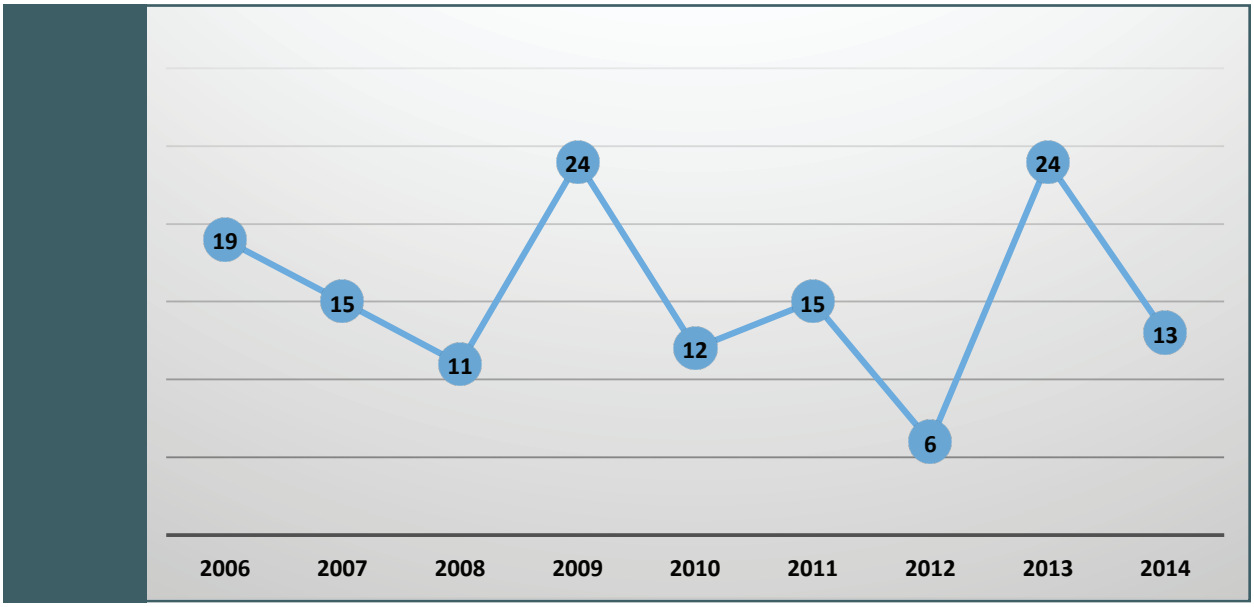
- There were no infant fire-related deaths in 2014
- Children ages one to four accounted for almost half (46%) of all fire deaths

**Figure 51: Fire Incidents by Source, GA, 2014 (N=10)**




- There were 10 reviewed fire incidents, which caused 13 child deaths
- When known, five of the fire incidents were started by a person but there are no suspected arson incidents
- Of the 10 fire incidents, there were no smoke detectors present in three incidents and in seven incidents this information is unknown. This underscores the importance of having fire investigation professionals present during CFR committee reviews that involved fire fatalities

**Figure 52: Reviewed Fire Deaths, 2006-2014, GA**



- 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 with a significant spike in 2013 (24 deaths) followed by a substantial drop in 2014 (13 deaths, almost 50% decrease in the last year)

## Opportunities for Prevention

- Every region should have a mobile demonstration unit to teach fire safety to children at school and at community events
- 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 go outside and make sure that smoking materials are properly extinguished
- 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

## Resources

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)

# POISONING

Georgia reviewed six poisonings in 2014, which comprised four percent of all reviewed unintentional injury fatalities.

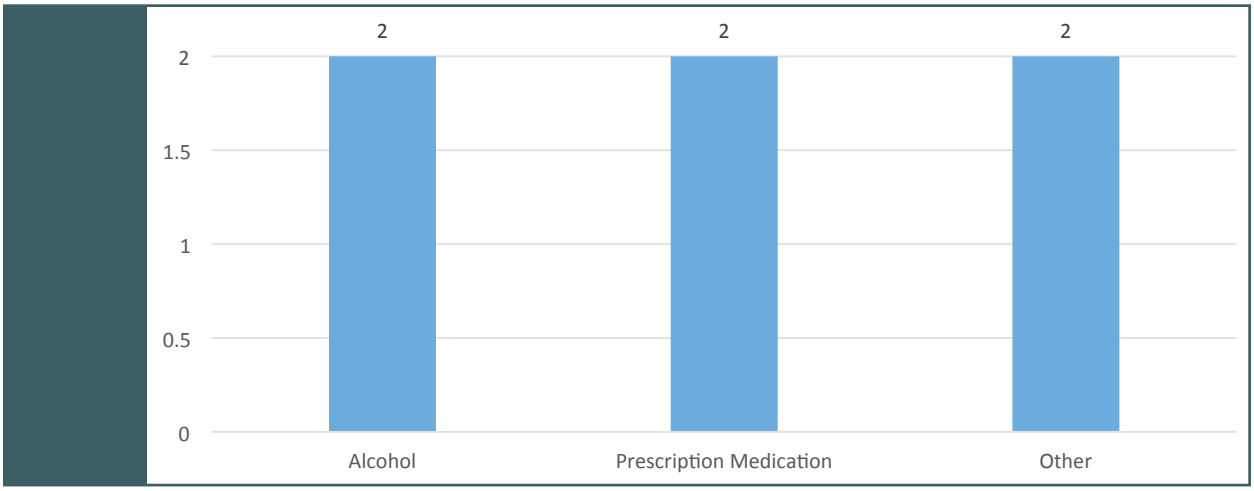
**Figure 53: Demographics of Reviewed Unintentional Poisoning Deaths, GA, 2014 (N=6)**

| | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Total |
|---|---|---|---|---|---|
| African-American Male | 1 | 0 | 0 | 2 | 3 |
| African-American Female | 0 | 0 | 1 | 0 | 1 |
| Hispanic Male | 0 | 0 | 0 | 2 | 2 |
| **Total** | **1** | **0** | **1** | **4** | **6** |

- There were no unintentional poisoning deaths among White children or infants
- Males outnumbered females
- African-American children were most affected by unintentional poisoning

Safe Kids Worldwide reported that 1.34 million calls are answered by poison centers yearly regarding child medication use. A portion of those calls were studied and a startling 81% involved children discovering medicine prescribed to another person.

**Figure 54: Substance of Use in Reviewed Unintentional Poisoning Deaths, GA, 2014 (N=6)**




- Alcohol, prescription medication, or other substances were equally proportionate in Georgia's poisoning fatalities
- In both cases involving prescription medication, the medicine was not prescribed to the child

## Opportunities for Prevention

As over 90% of poisonings occur inside the household, overdose deaths in such parameters are due to a lack of supervision by caregivers (Safe Kids Worldwide). It is suggested that families educate all members about medicines, both over-the-counter (OTC) and prescription. Forming a family medicine action plan may be beneficial, which includes an OTC medicine safety check-list and home inspection suggestions (Scholastic). Additionally, National Poison Prevention Week is held each March and is an opportune time for community awareness and prevention of such lethal occurrences. Communities may air informational videos, provide medicine safety tip sheets, and participate in the National Drug Take Back days for disposal of unused and/or expired medication.

## Resources

Centers for Disease Control and Prevention, Home & Recreational Safety (www.cdc.gov)

Safe Kids Worldwide (www.safekids.org)

Scholastic (www.scholastic.com)

Up and Away and Out of Sight (www.upandaway.org)

# UNINTENTIONAL FIREARMS

The National Center for the Review and Prevention of Child Deaths reported that 78 children died in a firearm accident in 2012. Although these deaths represent a relatively small portion of total firearm deaths in the United States, unintentional firearm fatalities comprise the 10th leading cause of injury for children ages five to nine and the 9th for those 10-14 (CDC).

In 2014, seven unintentional firearm fatalities were reviewed in Georgia. These accidental deaths account for 18% of reviewed child firearm deaths in the state (compared to 32 firearm-related homicides and suicides).

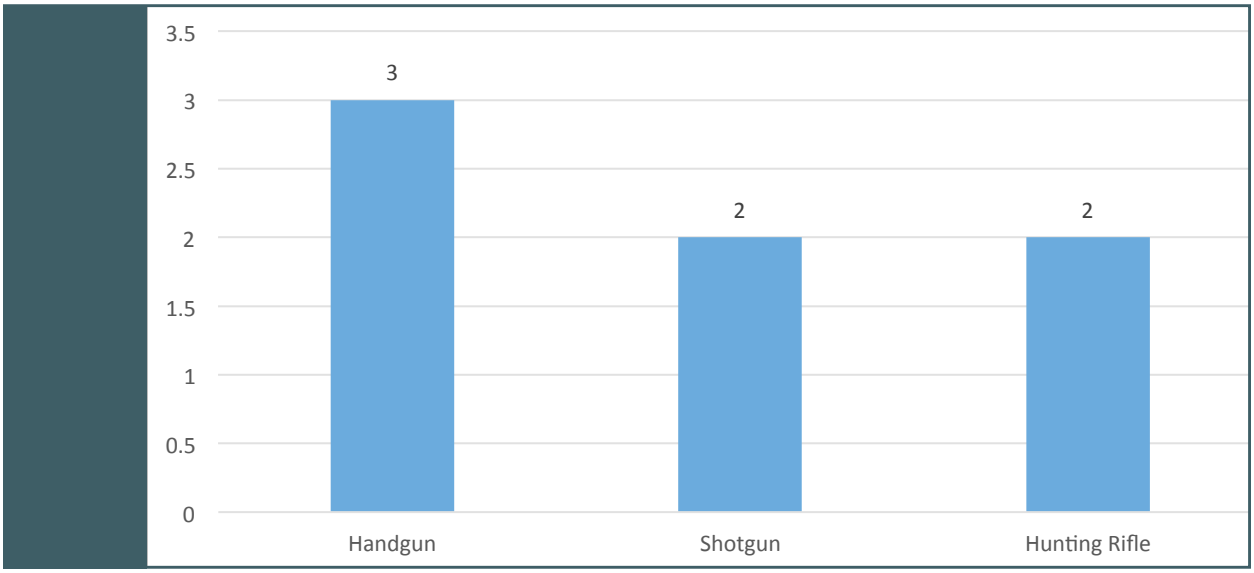
**Figure 55: Demographics of Reviewed Unintentional Firearm Deaths, GA, 2014 (N=7)**

| | 5 to 9 | 10 to 14 | 15 to 17 | Total |
|---|---|---|---|---|
| White Male | 1 | 0 | 2 | **3** |
| White Female | 0 | 1 | 0 | **1** |
| African-American Male | 0 | 0 | 3 | **3** |
| **Total** | **1** | **1** | **5** | **7** |

The majority of these cases involved older teens with handguns

- Males outnumbered females
- In Georgia, there was an increase from four fatalities in 2013 to seven in 2014

**Figure 56: Gun Type in Unintentional Firearm Deaths, GA, 2014 (N=7)**




- Three of the seven unintentional firearm fatalities involved a handgun
- Safe Kids Worldwide reports that an estimated one third of residences housing youth contain a firearm of some sort

## Opportunities for Prevention

- Families should exercise gun safety in the household by ensuring all weapons are secured and stored properly out of the reach of children
- Proper storage practices, safety protocols, and talking guidelines are available at www.safekids.org

## Resources

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

The National Center for the Review and Prevention of Child Deaths (www.childdeathreview.org)

Safe Kids Worldwide (www.safekids.org)

# HOMICIDE

According to the Centers for Disease Control and Prevention, homicide is the third leading cause of death for small children ages one to four as well as youth ages 15 to 24.

The Georgia Youth Risk Behavior Survey (YRBS) reported that in the high school student population, 21% of students were in a physical altercation in the past year compared to the national reported average of 32.8%. While an identified seven percent of Georgia students were threatened or injured with a weapon on school property within the past 12 months, four percent admitted to carrying a weapon to school within the same time period.

A subset included in the homicide category is maltreatment. The CDC defines child maltreatment as all forms of neglect and abuse of an individual under the age of 18 by a caregiver or a custodian. Hindering the youth's physical and mental health and development, neglect is the principal cause of childhood fatalities. Of the child population, children under age 4 are most at risk, accounting for over 81% of maltreatment deaths nationally. Similarly, Georgia's young children ages 1-4 are most susceptible for homicidal violence. For additional information, please refer to the maltreatment section.

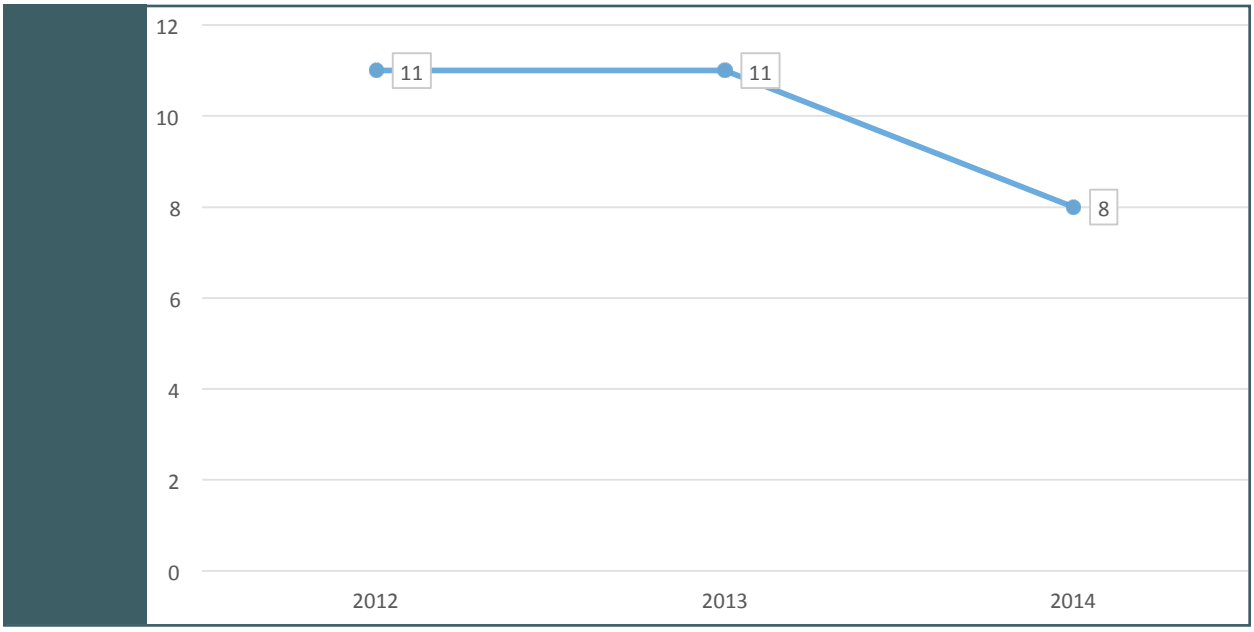
In 2014, CFR committees reviewed 47 child deaths from homicides in Georgia. Similar to 2013, these homicides are the fourth leading cause of death in those 1-17.

**Figure 57: Demographics of Reviewed Homicide Deaths, GA, 2014 (N=47)**

| | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Total |
|---|---|---|---|---|---|---|
| White Male | 1 | 4 | 0 | 1 | 2 | 8 |
| White Female | 1 | 2 | 0 | 0 | 0 | 3 |
| African-American Male | 5 | 8 | 0 | 2 | 8 | 23 |
| African-American Female | 1 | 7 | 0 | 0 | 1 | 9 |
| Hispanic Male | 0 | 0 | 0 | 1 | 0 | 1 |
| Hispanic Female | 0 | 0 | 0 | 2 | 0 | 2 |
| Multi-race Female | 0 | 0 | 1 | 0 | 0 | 1 |
| **Total** | **8** | **21** | **1** | **6** | **11** | **47** |

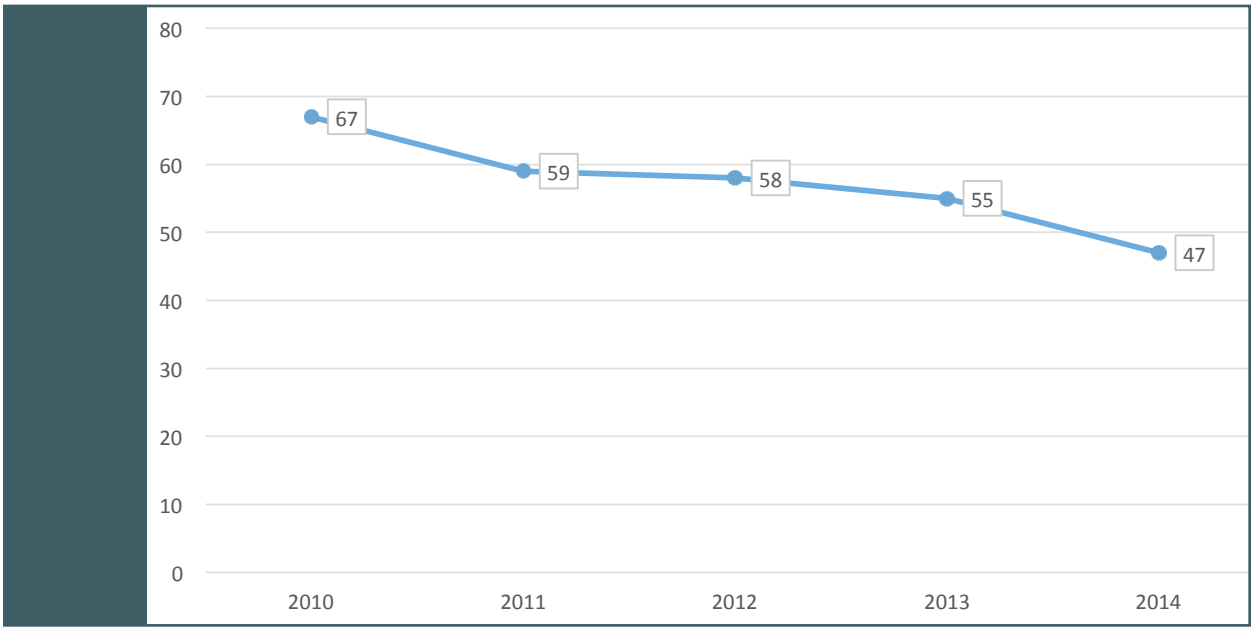
- African-Americans totaled over two-thirds of all homicides
- African-American males were most affected by homicidal violence, accounting for almost half (49%)
- White males were more affected than females of the same race
- Children ages one to four were the most affected age group, accounting for almost half (45%)
- Males were more often victimized than females

**Figure 58: Comparison of Reviewed Infant Homicides by Year, GA, 2012-2014**




- There were 11 reviewed infant homicides in both 2012 and 2013
- Infant homicides have decreased by 27% since 2012

**Figure 59: Comparison of Reviewed Homicides by Year, GA, 2010-2014**



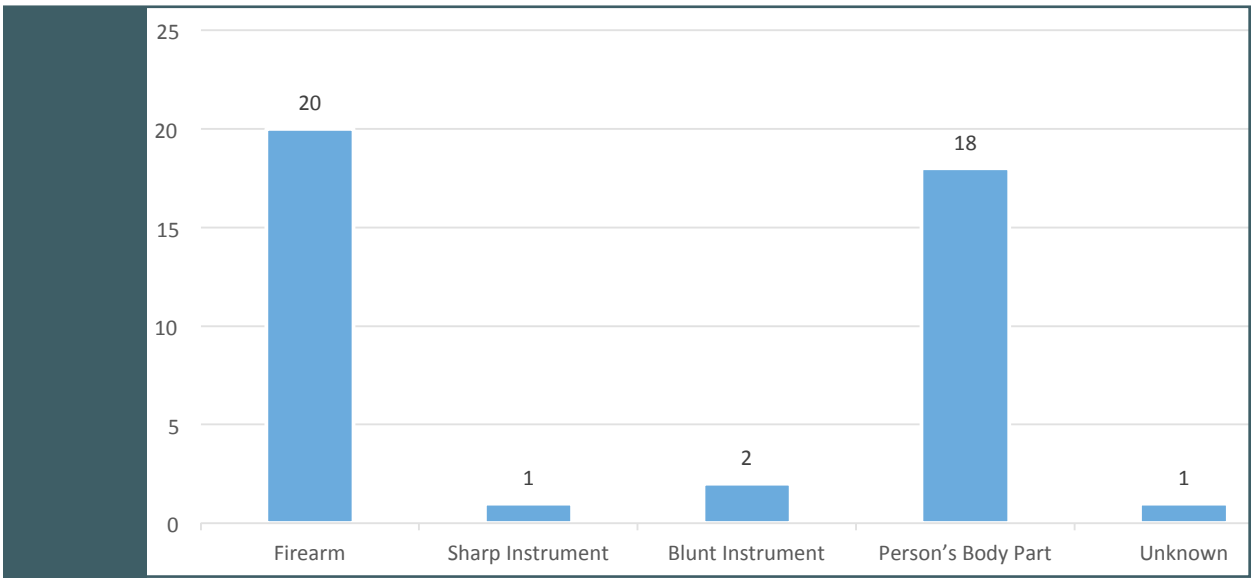

- Reviewed child homicides have decreased since 2010
- 2014 had the fewest reviewed child homicides in the past five years

**Figure 60: Mechanism of Injury for Reviewed Homicide Deaths, GA, 2014 (N=47)**

| | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Total |
|---|---|---|---|---|---|---|
| Asphyxia | 0 | 2 | 0 | 0 | 0 | **2** |
| Poisoning, overdose or acute intoxication | 0 | 2 | 0 | 0 | 0 | **2** |
| Missing/Unknown | 0 | 1 | 0 | 0 | 0 | **1** |
| Weapon, including body part | 8 | 16 | 1 | 6 | 11 | **42** |
| **Total** | **8** | **21** | **1** | **6** | **11** | **47** |

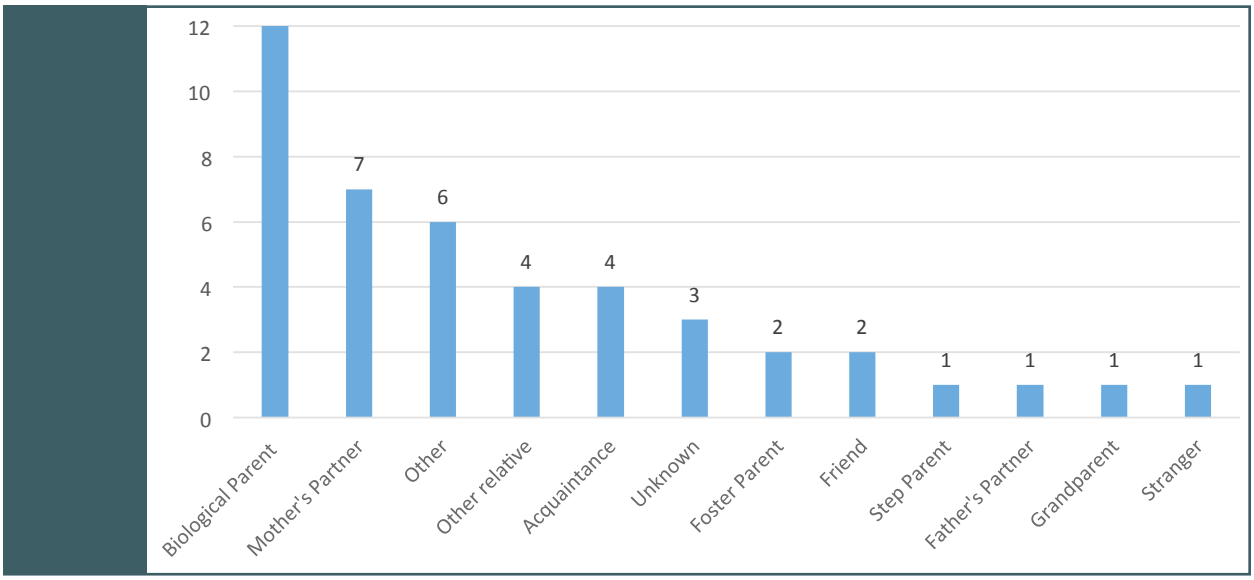
- In over 89% of reviewed cases, the mechanism of injury involved a weapon, including a body part
- Asphyxia and poisoning accounted for under 10% of all child homicides

**Figure 61: Type of Weapon Used for Reviewed Homicide Deaths, GA, 2014 (N=42)**




- Firearms were predominately used in homicidal violence followed closely by a body part
- When a body part was utilized during the injury, beating, kicking, or punching was cited as the primary action in a majority of fatalities

**Figure 62: Homicide Perpetrators, When Reported, GA, 2014 (N=44)**




- A biological parent was identified as the leading perpetrator in 12 of the 44 reviewed homicides (27%)
- Friends or acquaintances were responsible for six of the reviewed homicides (14%)

According to the CDC, bullying is a form of youth violence that encompasses physical, verbal, and virtual means. As a result, victimized students may suffer educational, emotional, and/or physical distress. The Georgia YRBS reported that 41% of middle school students admitted to being bullied at school. While 18% of students disclosed to being victims of cyber-bullying, 73% had also been victimized on school property. Those at risk for bullying include children who hold poor relationships, have depleted self-regard, exhibit disruptive behavior, and are administered severe punitive parenting by caregivers. Youths who act as perpetrators are more susceptible for substance abuse and future violence.

Understanding that bullying has evolved over time to include technological means, lawmakers introduced House Bill 131, also known as The End to Cyberbullying Act. Effective May 6, 2015, House Bill 131 prohibits bullying, including cyber-bullying, in Georgia public schools and other designated areas. Of note, bullying was not identified as a factor in Georgia's 2014 reviewed homicides.

Building and reinforcing affirmative connections both on and off school property will actively engage communities while encouraging open communication. A national initiative for the prevention of youth violence before it starts promotes the formation and sustainability of positive relationships while reducing factors that place youth at risk for violence in the first place. Striving To Reduce Youth Violence Everywhere (STRYVE), spearheaded by the CDC, is a multi-faceted initiative that is also action-oriented (CDC).

Violence prevention will have a positive ripple effect in decreasing the risk for associated familial and communal issues, such as educational and medical problems as well as substance abuse. Such efforts may yield significant financial savings for various entities, including health-care, education, and government while providing a safer community. Likewise, child abuse and neglect prevention focus on implementing policies so that maltreatment never occurs (Prevent Child Abuse America).

The Children's Safety Network provides information and resources to address youth violence and homicide. Factors that may protect some youth from violence include: connectedness to family or other adults; ability to discuss problems with parents; the perception that parental expectations for school performance are high; frequent shared activities with parents; youth involvement in social activities; commitment to school; and the consistent presence of parent during at least one of the following: when awakening, when arriving home from school, during evening mealtimes, and when going to bed. A number of measures may indirectly affect the factors that contribute to youth violence.

Incorporating aspects of national initiatives, the Georgia Child Fatality Review Panel provided the following 2015 recommendations:

- Increase family awareness and access of available community resources
- Strengthen child abuse protocol while developing a certification program to train specialized investigative teams to respond to and investigate maltreatment deaths
- Agency standardization of home visitation programs
- Continued community education on the definition and prevention of child abuse, including mandated reporter trainings

## Opportunities for Prevention

- By increasing support programs, parent education, affordable medical care, and public awareness of maltreatment, the community invests in childrens' successful development
- Improving areas for children to play and providing supervised activities
- Programs that address community deterioration (e.g. alcohol abuse, gun safety, non-violence coping skills, and economic issues) can also help to prevent youth violence.

## Resources

Centers for Disease Control and Prevention, Injury Prevention & Control: Division of Violence Prevention (www.cdc.gov/violenceprevention)

Georgia Department of Public Health, Youth Risk Behavior Surveillance System (www.dph.georgia.gov/YRBS)

Georgia General Assembly Legislation (www.legis.ga.gov)

Prevent Child Abuse America (www.preventchildabuse.org)

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

# SUICIDE

Nationally, suicide is the second leading cause of death for those ages 15-24 and the third leading cause among youth ages 10 to 14 (CDC).

According to Georgia's Youth Risk Behavior Survey (YRBS), 14% of high school students seriously considered a suicide attempt within the past year and 12% admitted to planning their death. This is slightly lower than the national average of 17% who considered suicide with over 13% planning it. The YRBS also reports that nine percent of Georgia high school students confirmed that they attempted suicide at least once within the past year. This is higher than the national average of eight percent.

In almost half of the youth suicides, local CFR committees reported that the child talked about suicide at some point prior to the death. Suicide warning signs include anxiety, withdrawal from friends and family, uncontrolled anger, severe mood changes, substance use, and feeling like there's no sense of purpose. Additionally, risk factors for youth may include feelings of hopelessness and/or sadness for at least two weeks (American Association of Suicidology).

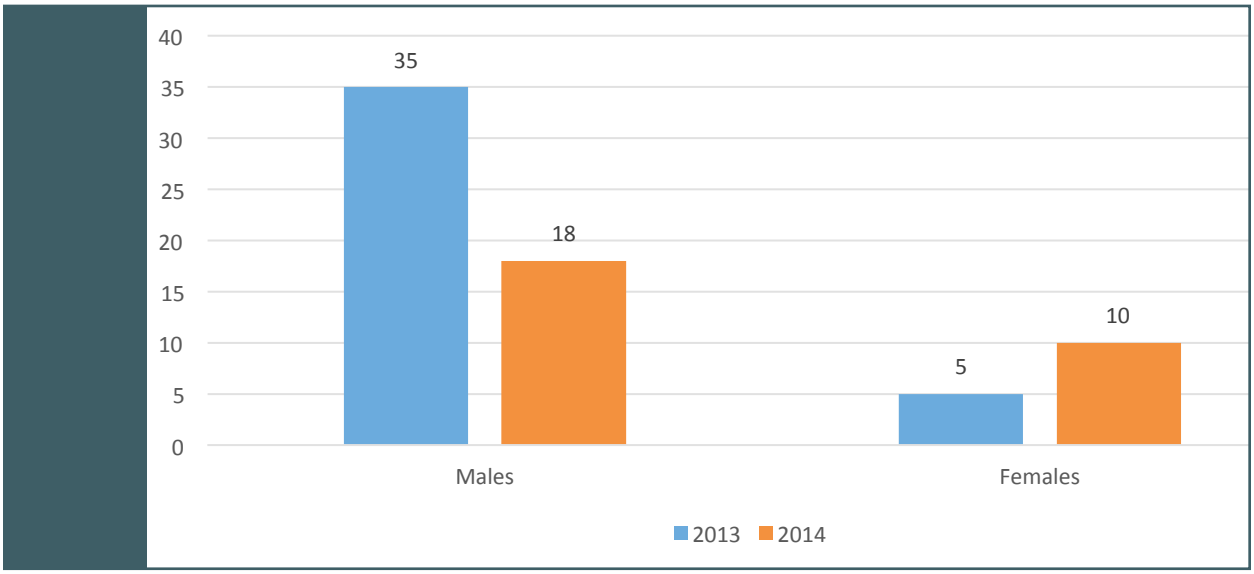
In 2014, 28 suicides were reviewed, marking a decrease from 40 in 2013. This intentional act remains the fifth leading cause of death for Georgia's children.

**Figure 63: Demographics of Reviewed Suicide Deaths, GA, 2014 (N=28)**

| | 5 to 9 | 10 to 14 | 15 to 17 | Total |
|---|---|---|---|---|
| White Male | 0 | 6 | 7 | **13** |
| White Female | 0 | 2 | 7 | **9** |
| African-American Male | 0 | 4 | 0 | **4** |
| African-American Female | 1 | 0 | 0 | **1** |
| Hispanic Male | 0 | 0 | 1 | **1** |
| **Total** | **1** | **12** | **15** | **28** |

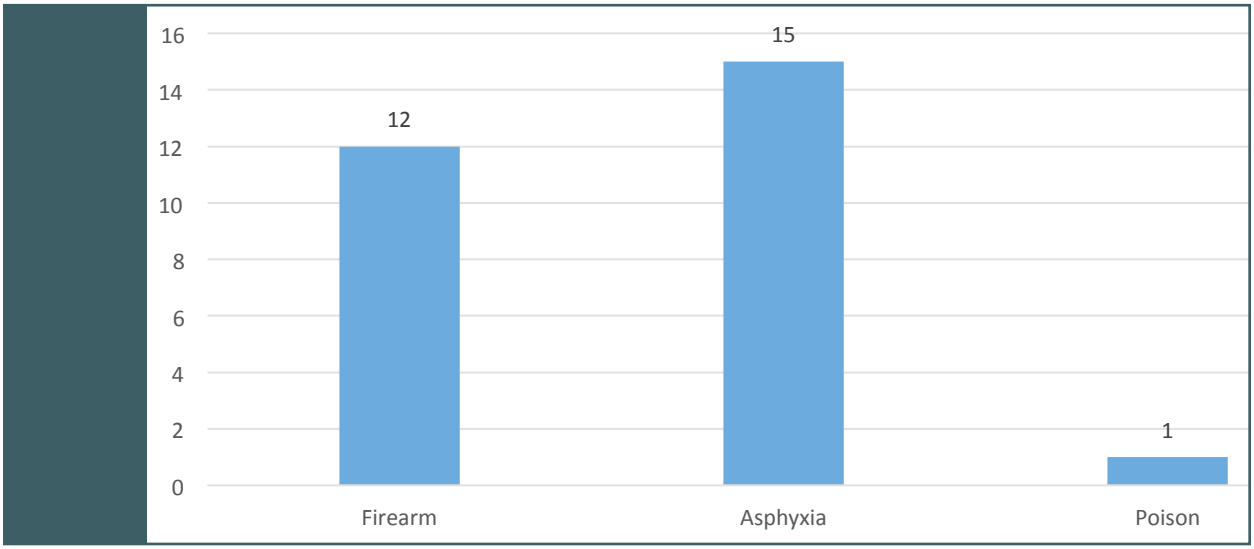
- White males accounted for the highest number of reviewed suicide deaths
- Teens ages 15-17 are most at risk

**Figure 64: Comparison of Suicide Deaths by Sex, GA, 2013-2014**



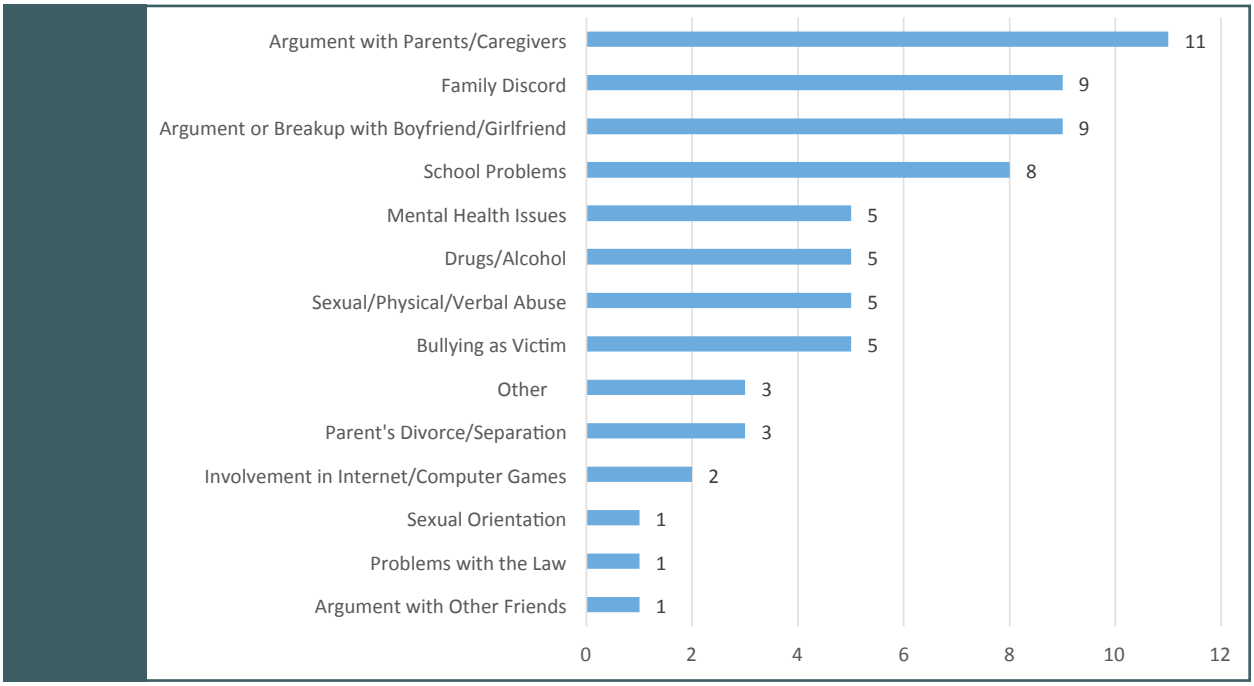

- Research suggests that males are four times more likely to complete suicide and females are more likely to experience suicidal ideations (CDC)
- Suicides among White males decreased from 2013 by 49%, while suicides among females increased by 100%

**Figure 65: Mechanism of Injury in Reviewed Suicide Deaths, GA, 2014 (N=28)**




- Historically, the most frequent mechanisms for suicide in youth are from asphyxia or firearms (CDC). Twenty-seven of the 28 reviewed suicide deaths were due to asphyxia or firearms

**Figure 66: Reported Risk Factors for Reviewed Suicide Deaths, GA, 2014**




*Note that in several cases, CFR committees have identified multiple risk factors for a child

- In 39% of reviewed suicides, a recent argument with a parent or caregiver was indicated
- Family discord was noted in 32% of the reviewed suicides

In over half of the reviewed suicides by the local CFR committees, it was determined that the death was unexpected. Recognizing that there has been an alarming 128% increase in suicide rates since 1980 in the young adolescent population, it is vital that suicide education and prevention be implemented in Georgia's school systems. In 2007, The Jason Flatt Act was passed, which required youth suicide awareness and prevention training to all educators in the state of Tennessee. Many states, including Georgia, followed suit, adopting House Bill 198, also known as the Jason Flatt Act-Georgia. Effective July 1, 2015, HB 198 mandates that Georgia certificated school personnel complete annual suicide prevention education training. Additionally, the Act requires that each school district have a suicide prevention policy, which includes prevention, intervention, and postvention.

## Opportunities for Prevention

- With the implementation of HB 198, the state has demonstrated a strong community commitment to Georgia's children through suicide prevention. Piloting the goal of suicide safe schools, involvement is sought from teachers, administrators, students, support personnel, caregivers, and community volunteers. In conjunction with the Suicide Prevention Coordinator, school systems will develop model protocol and prevention trainings in their administration.
- It is also recommended that CFR committees have an annual review of the YRBS to target suicide prevention services in schools where suicidal ideation and/or attempts are known. CFR committees can also coordinate development of a protocol for intervention in schools where a suicide has occurred; this response protocol can be vital to prevention of additional attempts and suicides. Youth Mental Health First Aid Training is a potential resource raise awareness among agency professionals and families. Local Family Connections collaboratives can be a partner in developing a community plan for both prevention and intervention.
- Linking Education and Awareness of Depression and Suicide (LEADS) is a recognized evidence-based program in which educators implement a provided curriculum to students over three days, both inside and outside the classroom. The program addresses suicide warning signs and symptoms as well as provides prevention resources while promoting assistance-seeking behavior. Increased knowledge is gained and students feel empowered to address suicide issues for themselves and others
- By cultivating and maintaining multiple initiatives, suicide risks will decrease while positive behaviors increase. Furthermore, forming relationships with behavioral health providers as well as community resources will strengthen the collaboration in suicide prevention and awareness both for affected children and their families (CDC)

## Resources

American Association of Suicidology (www.suicidology.org)

Centers for Disease Control and Prevention, Injury Prevention & Control: Division of Violence Prevention (www.cdc.gov/violenceprevention)

Georgia Department of Public Health, Youth Risk Behavior Surveillance System (www.dph.georgia.gov/YRBS)

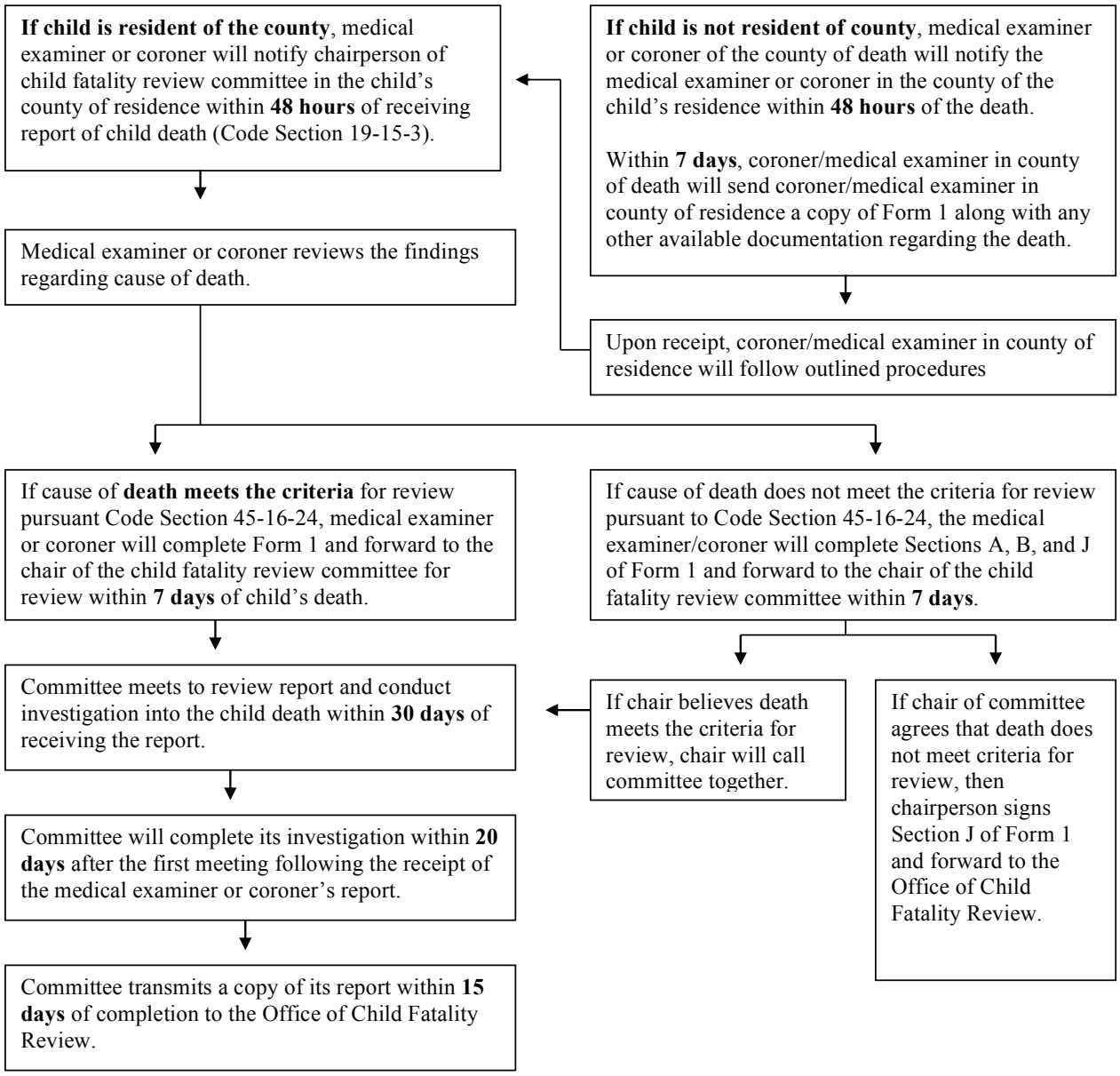
Georgia General Assembly (www.legis.ga.gov)

The Jason Foundation (www.jasonfoundation.com)

Suicide Awareness Voices of Education (www.save.org)

# Appendix A

## Child Fatality Review Committee Timeframes and Responsibilities




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

| | All 2014 Deaths, GA Residents, Age < 18 | | | | | "Reviewable" 2014 Deaths | | | | | Reviewable Deaths Reviewed | | | | | All Reviewed 2014 Deaths | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| County Name | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 |
| Appling | 2 | | | 1 | | | | | 1 | | | | | | | | | | | |
| Atkinson | | | | | | | | | | | | | | | | | | | | |
| Bacon | 1 | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | | |
| Baker | | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | | |
| Baldwin | 3 | 2 | 1 | 1 | | 1 | 1 | | 1 | | 1 | 1 | | 1 | | 1 | 1 | | 1 | |
| Banks | 1 | | | | 1 | | | | | 1 | | | | | | | | | | |
| Barrow | 6 | 1 | 1 | | | 3 | 1 | 1 | | | 3 | 1 | 1 | | | 3 | 1 | 1 | | |
| Bartow | 7 | 2 | 1 | 2 | 2 | 2 | 2 | 1 | | 1 | 2 | 2 | 1 | | 1 | 2 | 2 | 1 | 1 | 1 |
| Ben Hill | 4 | 1 | | | | 1 | 1 | | | | 1 | 1 | | | | 2 | 1 | | | |
| Berrien | 1 | | | | 1 | | | | | 1 | | | | | 1 | | | | | 1 |
| Bibb | 34 | 2 | 3 | 1 | 4 | 6 | 2 | 1 | | 3 | 5 | 2 | 1 | | 3 | 7 | 2 | 2 | 1 | 4 |
| Bleckley | | | | | | | | | | | | | | | | | | | | |
| Brantley | 1 | 1 | | | | 1 | 1 | | | | 1 | | | | | 1 | | | | |
| Brooks | 3 | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | | |
| Bryan | 2 | | | | 1 | 1 | | | | 1 | | | | | | | | | | |
| Bulloch | 8 | | 1 | | | 1 | | | | | 1 | | | | | 1 | | | | |
| Burke | 4 | | | | 1 | | | | | | | | | | | | | | | |
| Butts | 5 | | 1 | | 1 | 1 | | | | 1 | 1 | | | | 1 | | | | | 1 |
| Calhoun | | | | | | | | | | | | | | | | | | | | |
| Camden | 6 | 1 | 1 | | 1 | 3 | 1 | | | 1 | 3 | 1 | | | 1 | 4 | 1 | | | 1 |
| Candler | 1 | 1 | | | | | 1 | | | | | | | | | | | | | |
| Carroll | 13 | 2 | 2 | 6 | 1 | 2 | 2 | 2 | 6 | 1 | 2 | 2 | 2 | 6 | 1 | 2 | 2 | 2 | 6 | 1 |
| Catoosa | 1 | 2 | 1 | 1 | 2 | 1 | 1 | | | 1 | 1 | | | | 1 | 1 | | | 1 | 2 |
| Charlton | | | | | | | | | | | | | | | | | | | | |
| Chatham | 30 | 9 | 3 | 5 | 5 | 6 | 5 | 2 | 4 | 4 | 5 | 4 | 2 | 4 | 4 | 7 | 6 | 2 | 4 | 5 |
| Chattahoochee | 2 | | | 1 | | 1 | | | | | | | | | | | | | | |
| Chattooga | 3 | 1 | | | | 1 | 1 | | | | | 1 | | | | | 1 | | | |
| Cherokee | 12 | | | | 2 | 2 | | | | 2 | 2 | | | | 2 | 3 | | | | 2 |
| Clarke | 13 | | | | 1 | 1 | | | | | | | | | | | | | | |
| Clay | 1 | | | | | | | | | | | | | | | | | | | |
| Clayton | 39 | 6 | 2 | 1 | 5 | 4 | 1 | 2 | | 4 | 3 | 1 | 2 | | 3 | 10 | 5 | 2 | 1 | 3 |
| Clinch | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | | | |
| Cobb | 57 | 8 | 4 | 6 | 7 | 12 | 3 | | 1 | 3 | 10 | 2 | | 1 | 3 | 11 | 3 | | 2 | 3 |
| Coffee | 4 | 2 | | | | 1 | 1 | | | | | | | | | | | | | |
| Colquitt | 5 | 1 | | 4 | 1 | | | | 2 | 1 | | | | 2 | 1 | | | | 3 | 1 |
| Columbia | 15 | | 1 | | 2 | 4 | | | | 1 | 4 | | | | 1 | 6 | | 1 | | 1 |
| Cook | 3 | 1 | | | | 1 | | | | | | | | | | | | | | |
| Coweta | 14 | 1 | 1 | 1 | 6 | 5 | | | | 3 | 5 | | | | 2 | 4 | | | | 1 |
| Crawford | 3 | | | 1 | 1 | | | | | 1 | | | | | 1 | | | | 1 | 1 |
| Crisp | 6 | | | | 2 | | | | | 1 | | | | | 1 | | 1 | | | 1 |
| Dade | 1 | | | | 1 | | | | | 1 | | | | | 1 | | | | | 1 |
| Dawson | 4 | | | | 1 | 1 | | | | 1 | 1 | | | | 1 | 1 | | | | 1 |

| | All 2014 Deaths, GA Residents, Age < 18 | | | | | "Reviewable" 2014 Deaths | | | | | Reviewable Deaths Reviewed | | | | | All Reviewed 2014 Deaths | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| County Name | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 |
| Decatur | 6 | | | 1 | 1 | 1 | | | 1 | | 1 | | | 1 | | 1 | | | 1 | |
| DeKalb | 91 | 16 | 9 | 11 | 5 | 17 | 11 | 3 | 4 | 4 | 16 | 11 | 2 | 4 | 2 | 20 | 12 | 2 | 8 | 2 |
| Dodge | 2 | 3 | | | | | 3 | | | | | 3 | | | | | 3 | | | |
| Dooly | | | | | | | | | | | | | | | | | | | | |
| Dougherty | 18 | 1 | 1 | 3 | 1 | 1 | | | 2 | 1 | 1 | | | 2 | | 1 | 1 | | 2 | |
| Douglas | 5 | 2 | 3 | 1 | 1 | | 1 | 1 | 1 | | | 1 | 1 | 1 | | 1 | 1 | 2 | 1 | 1 |
| Early | 1 | | | | | | | | | | | | | | | | | | | |
| Echols | 2 | | | | | 1 | | | | | 1 | | | | | 1 | | | | |
| Effingham | 8 | 1 | 1 | | 1 | 1 | 1 | 1 | | 1 | 1 | 1 | 1 | | 1 | 1 | 1 | 1 | | 1 |
| Elbert | | | 1 | | 2 | | | | | 2 | | | | | 2 | | | 1 | | 2 |
| Emanuel | 5 | | | 1 | 1 | 1 | | | 1 | 1 | 1 | | | 1 | 1 | 1 | | | 1 | 1 |
| Evans | 2 | | | | 1 | | | | | 1 | | | | | | | | | | |
| Fannin | 3 | 1 | | | 1 | | 1 | | | | | 1 | | | | 1 | 1 | | 1 | 1 |
| Fayette | 4 | | | | | 1 | | | | | 1 | | | | | 1 | | | | |
| Floyd | 9 | | 2 | 1 | 1 | 1 | | 1 | | 1 | 1 | | 1 | | 1 | 1 | | 1 | | 1 |
| Forsyth | 13 | 5 | | 5 | 4 | 3 | 3 | | 1 | 3 | 3 | 3 | | 1 | 3 | 3 | 4 | | 2 | 4 |
| Franklin | 2 | 1 | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | |
| Fulton | 109 | 12 | 9 | 9 | 13 | 21 | 5 | 3 | 5 | 10 | 19 | 5 | 3 | 5 | 9 | 25 | 7 | 4 | 7 | 12 |
| Gilmer | 1 | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | | 1 |
| Glascock | | | | | | | | | | | | | | | | | | | | |
| Glynn | 6 | 1 | | 1 | | 3 | 1 | | | | 3 | 1 | | | | 3 | 1 | | | |
| Gordon | 2 | | | 2 | 1 | 1 | | | 2 | 1 | 1 | | | 2 | 1 | 1 | | 1 | 2 | 1 |
| Grady | 2 | | | 2 | | | | | | | | | | | | | | | | |
| Greene | 2 | | | | | | | | | | | | | | | | | | | |
| Gwinnett | 75 | 8 | 12 | 6 | 6 | 10 | 1 | 2 | 4 | 3 | 10 | 1 | 2 | 3 | 3 | 12 | 4 | 2 | 3 | 3 |
| Habersham | 1 | | | | | | | | | | | | | | | | | | | |
| Hall | 15 | 3 | 2 | 1 | 9 | 1 | 2 | 1 | 1 | 5 | | 2 | 1 | 1 | 3 | | 3 | 1 | 1 | 3 |
| Hancock | | | | | | | | | | | | | | | | | | | | |
| Haralson | | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | | |
| Harris | 3 | | | | | | | | | | | | | | | | | | | |
| Hart | 3 | | | | 1 | | | | | 1 | | | | | | | | | | |
| Heard | | | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | |
| Henry | 19 | | 3 | 1 | 4 | | | | | 2 | | | | | 2 | 3 | | 1 | 1 | 2 |
| Houston | 11 | 1 | | 6 | 1 | 2 | | | 3 | 1 | 2 | | | 3 | 1 | 5 | | | 4 | 2 |
| Irwin | 1 | | | 1 | | | | | | | | | | | | | | | | |
| Jackson | 2 | | 1 | | | | | 1 | | | | | | | | | | | | |
| Jasper | 1 | | | 1 | | 1 | | | 1 | | 1 | | | 1 | | 1 | | | | |
| Jeff Davis | 1 | | | | | | | | | | | | | | | | | | | |
| Jefferson | 6 | | | | | | | | | | | | | | | | | | | |
| Jenkins | 1 | | 1 | | | | | 1 | | | | | | | | | | | | |
| Johnson | | | | | | | | | | | | | | | | | | | | |
| Jones | 4 | | 1 | | 1 | 1 | | | | | 1 | | | | | 1 | | | | |

| | All 2014 Deaths, GA Residents, Age < 18 | | | | | "Reviewable" 2014 Deaths | | | | | Reviewable Deaths Reviewed | | | | | All Reviewed 2014 Deaths | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| County Name | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 |
| Lamar | | | | | | | | | | | | | | | | | | | | |
| Lanier | | | | | | | | | | | | | | | | | | | | |
| Laurens | 9 | 2 | | 1 | | 2 | 2 | | 1 | | | | | | | | | | | |
| Lee | 3 | 1 | 1 | 1 | 1 | 1 | | | 1 | | | | | 1 | | | | | 1 | |
| Liberty | 5 | 1 | 1 | | 2 | 3 | | 1 | | 1 | 1 | | | | | | | | | |
| Lincoln | | | | | 1 | | | | | 1 | | | | | | | | | | |
| Long | 4 | 1 | | | 1 | | 1 | | | 1 | | 1 | | | 1 | 1 | 1 | | | |
| Lowndes | 13 | 4 | | 1 | 2 | 3 | 1 | | 1 | | 3 | 1 | | 1 | | 4 | 4 | | 1 | |
| Lumpkin | 1 | 2 | | 1 | 1 | | 1 | | | 1 | | 1 | | | 1 | 1 | 1 | | | 1 |
| Macon | | | 1 | | | | | | | | | | | | | | | | | |
| Madison | 2 | | | | 1 | | | | | | | | | | | | | | | |
| Marion | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | | | |
| McDuffie | 1 | | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | |
| McIntosh | 2 | | | | | 1 | | | | | | | | | | | | | | |
| Meriwether | 3 | | | | 1 | 1 | | | | | 1 | | | | | 1 | | | | |
| Miller | | | | | | | | | | | | | | | | | | | | |
| Mitchell | 4 | | | 1 | | 1 | | | | | | | | | | | | | | |
| Monroe | 2 | | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | |
| Montgomery | 2 | | | | | | | | | | | | | | | | | | | |
| Morgan | 1 | | 3 | | | 1 | | | | | 1 | | | | | 1 | | 2 | | |
| Murray | | | | | 2 | | | | | 2 | | | | | 2 | | | | | 2 |
| Muscogee | 34 | 5 | 2 | 2 | 4 | 5 | 3 | | 2 | 2 | 4 | 3 | | 2 | 2 | 6 | 4 | 1 | 1 | 2 |
| Newton | 8 | 1 | 3 | 3 | 2 | 3 | | | 2 | 2 | 3 | | | | 1 | 6 | | 2 | 2 | 1 |
| Oconee | 4 | | | | | | | | | | | | | | | | | | 1 | |
| Oglethorpe | | | | | 1 | | | | | 1 | | | | | 1 | | | | | 1 |
| Paulding | 15 | 6 | 2 | | 2 | 3 | 3 | | | | 3 | 3 | | | | 3 | 4 | | | |
| Peach | 2 | | | | 1 | | | | | 1 | | | | | | | | | 1 | |
| Pickens | 2 | | | 1 | 1 | | | | 1 | 1 | | | | 1 | 1 | | | | | 1 |
| Pierce | 2 | | | | | | | | | | | | | | | 1 | | | | |
| Pike | | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | | |
| Polk | 1 | 1 | 1 | 1 | 1 | | 1 | | | 1 | | 1 | | | 1 | | 1 | | | 1 |
| Pulaski | | | | | | | | | | | | | | | | | | | | |
| Putnam | 1 | | | | | | | | | | | | | | | | | | | |
| Quitman | 2 | | | | | | | | | | | | | | | | | | | |
| Rabun | 3 | | | | | | | | | | | | | | | | | | | |
| Randolph | 2 | | | | | | | | | | | | | | | | | | | |
| Richmond | 31 | 5 | 2 | 5 | 4 | 12 | 3 | 1 | 3 | 1 | 12 | 3 | 1 | 3 | 1 | 13 | 3 | 1 | 3 | 4 |
| Rockdale | 17 | | | | | 5 | | | | | 5 | | | | | 3 | | | | |
| Schley | | | | | | | | | | | | | | | | | | | | |
| Screven | 1 | | | 1 | | | | | | | | | | | | | | | | |
| Seminole | 2 | | | | 1 | | | | | 1 | | | | | 1 | | | | | 1 |
| Spalding | 7 | | 1 | 2 | | 1 | | | 1 | | 1 | | | 1 | | 1 | | 1 | 1 | |

| | All 2014 Deaths, GA Residents, Age < 18 | | | | | "Reviewable" 2014 Deaths | | | | | Reviewable Deaths Reviewed | | | | | All Reviewed 2014 Deaths | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| County Name | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 | Infant | 1 to 4 | 5 to 9 | 10 to 14 | 15 to 17 |
| Stephens | | | 1 | | | | | | | | | | | | | | | | | |
| Stewart | 1 | | | | | | | | | | | | | | | | | | | |
| Sumter | 5 | 1 | | 1 | | 1 | 1 | | | | 1 | 1 | | | | 2 | 1 | | | |
| Talbot | | | 1 | | | | | | | | | | | | | | | 1 | | |
| Taliaferro | | | | | | | | | | | | | | | | | | | | |
| Tattnall | 1 | | 3 | | | 1 | | 1 | | | | | | | | | | | | 1 |
| Taylor | 1 | | | | | | | | | | | | | | | | | | | |
| Telfair | 2 | | | | 1 | 1 | | | | 1 | 1 | | | | 1 | 1 | | | | 1 |
| Terrell | | | | | 1 | | | | | 1 | | | | | 1 | | | | | 1 |
| Thomas | 5 | | 1 | 1 | | 1 | | 1 | | | 1 | | 1 | | | 1 | | 1 | 1 | |
| Tift | 5 | 1 | | | 1 | | 1 | | | 1 | | 1 | | | | | 1 | | | |
| Toombs | 5 | 1 | | 1 | 2 | | | | 1 | 1 | | | | | 1 | | | | | 1 |
| Towns | | 1 | | 1 | | | 1 | | | | | 1 | | | | | 1 | | | |
| Treutlen | | | | | 1 | | | | | 1 | | | | | | | | | | |
| Troup | 6 | 2 | | 3 | | | 2 | | 2 | | | 1 | | 2 | | 1 | 1 | | 2 | |
| Turner | | | | | | | | | | | | | | | | | | | | |
| Twiggs | | | | | | | | | | | | | | | | | | | | |
| Union | 1 | | | 1 | | | | | | | | | | | | | | | | |
| Upson | 3 | | 1 | | | | | | | | | | | | | | | | | |
| Walker | 4 | 1 | 1 | | 1 | 1 | | 1 | | 1 | 1 | | 1 | | 1 | 1 | 1 | 1 | | 1 |
| Walton | 8 | 2 | | 1 | 1 | 1 | 1 | | | | 1 | 1 | | | | 1 | 1 | | | |
| Ware | 2 | | 1 | 1 | | 1 | | | 1 | | 1 | | | 1 | | 1 | | 1 | 1 | |
| Warren | 2 | | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | |
| Washington | | | | | 1 | | | | | 1 | | | | | 1 | | | | | 1 |
| Wayne | | | 1 | 1 | | | | | 1 | | | | | 1 | | 1 | | | 1 | |
| Webster | | | | | | | | | | | | | | | | | | | | |
| Wheeler | 1 | | | | | | | | | | | | | | | 1 | | | | |
| White | 1 | | | | | | | | | | | | | | | | | | | |
| Whitfield | 5 | 2 | | 2 | 2 | | 1 | | | | | 1 | | | | | 1 | | | |
| Wilcox | 3 | | 1 | | | | | | | | | | | | | | | 1 | | |
| Wilkes | 1 | | | 1 | | | | | 1 | | | | | 1 | | | | | 1 | |
| Wilkinson | 1 | 1 | | | | | 1 | | | | | 1 | | | | | 1 | | | |
| Worth | 2 | | | | 1 | | | | | 1 | | | | | 1 | | | | | 1 |
| **Total** | **1004** | **146** | **102** | **118** | **145** | **180** | **82** | **33** | **59** | **94** | **156** | **73** | **28** | **53** | **76** | **202** | **96** | **44** | **72** | **89** |

# Appendix C

## Glossary of Terms

**Asphyxia** – Oxygen starvation of tissues. Asphyxia is a broad cause of death that may include more specific causes, such as strangulation, suffocation, or smothering.

**Autopsy** – Medical dissection of a deceased individual for the purpose of determining or confirming an official manner and cause of death.

**Birth Certificate** – Official documentation of human birth.

**Cause of Death** – The effect, illness, or condition leading to an individual's death: Medical Condition or External Cause (Injury). A different classification from Manner of Death.

**Child Maltreatment** – Intentional injury of a child, involving one or more of the following: neglect, physical harm, sexual abuse or exploitation, or emotional abuse.

**Circumstances** – Situational findings.

**Commission (Act of)** – Supervision that willfully endangers a child's health and welfare.

**Congenital anomaly** – A medical or genetic defect present at birth.

**Contributing Factors** – Behavioral actions that may elevate the potential risk of fatality.

**Coroner** – Jurisdictional official charged with determining the manner and cause of death for individuals perishing in sudden, violent, or suspicious circumstances. Performs much the same function as a Medical Examiner, but may or may not be a physician.

**CPS (Child Protective Services)** – Social service system engaged in protecting children from maltreatment.

**Death Certificate** – Official documentation of an individual's death, indicating the manner and cause of death.

**Exposure** – Cause of death directly related to environmental factors; typically death from hyper- or hypothermia.

**External** – Categorization of non-medical manners of death: i.e., accident, homicide, or suicide.

**Full-term** – A gestation of 37 or more weeks.

**Homicide** – Death perpetrated by another with the intent to kill or severely injure.

**Hyperthermia** – High body temperature.

**Hypothermia** – Low body temperature.

**Infant** – Child under one year of age.

**Manner of Death** – The intent of a death, i.e. whether a death was caused by an act carried out on purpose by oneself or another person(s): Natural, Accident, Suicide, Homicide, or Undetermined.

**Medical Examiner** – Physician charged with determining the manner and cause of death for individuals perishing in sudden, violent, or suspicious circumstances.

**Missing** – Case information or data that has not been included.

**Natural** – Categorization of deaths indicating a medical cause, such as congenital conditions, illness, prematurity, or SIDS.

**Neglect** – Failure to provide basic needs, such as food, shelter, and medical care.

**Omission (Act of)** – Supervision entirely absent or inadequate for the age or activity of the child.

**Pending** – Indication that an official manner of death awaits further investigation.

**Preterm** – Birth occurring at a gestation of less than 37 weeks.

**Preventability** – Indicates the likelihood that a death could have been averted with reasonable efforts on the part of an individual or community.

**Sudden Infant Death Syndrome (SIDS)** – An exclusionary manner of death for children less than one year of age, indicating that all evidence (including an autopsy, death scene investigation, and review of the medical record) has failed to yield the specific cause of a natural death.

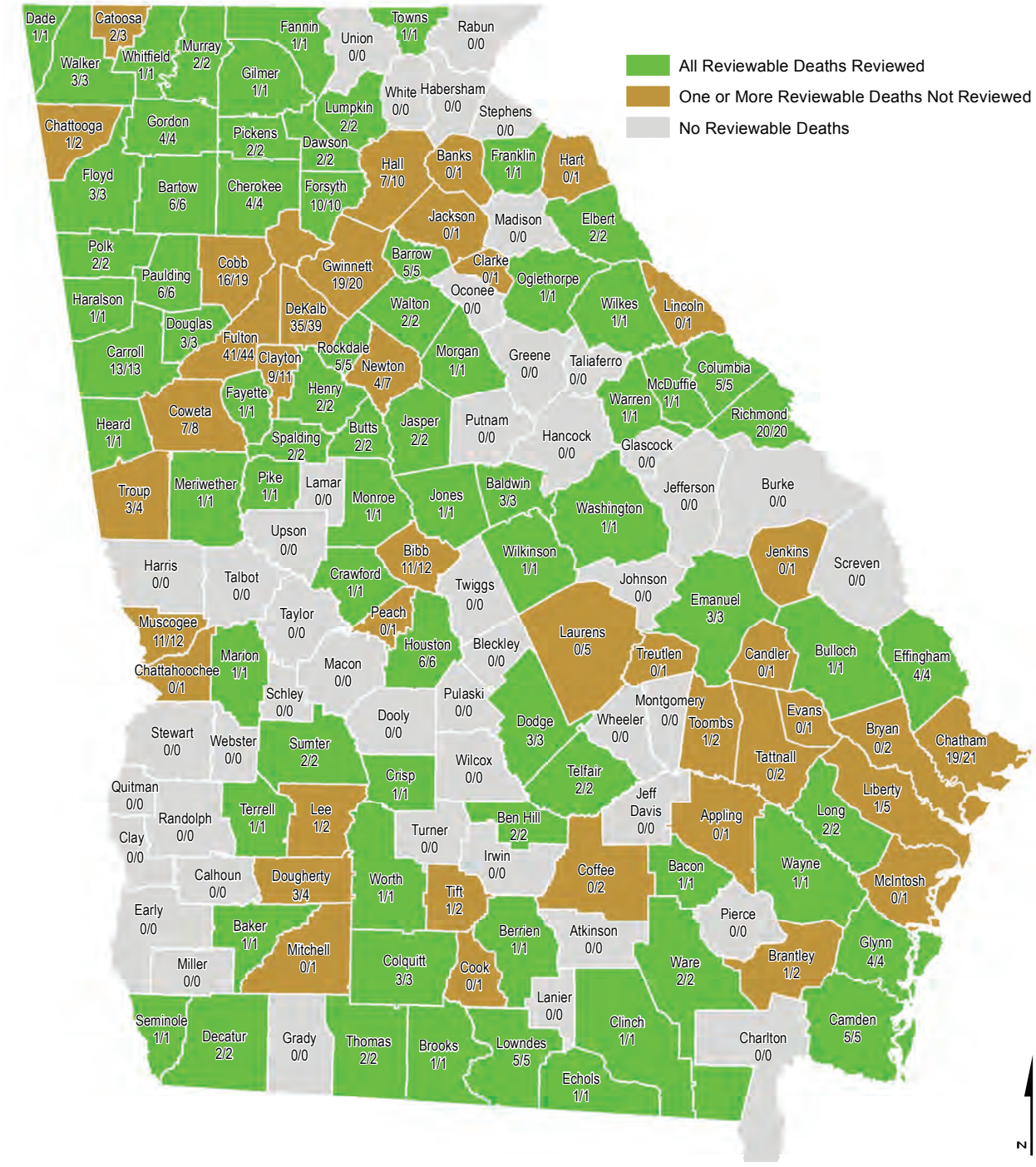
**Supervisor** – Individual charged with the care of a child at the time of his or her death.

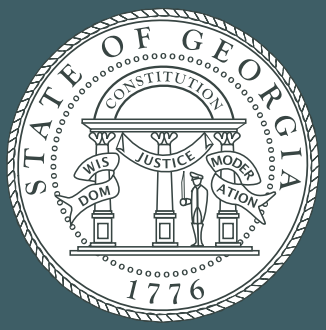
**Undetermined** – Default manner of death when circumstances and/or investigation fail to reveal a clear determination.

**Unknown** – Case information or data that is unattainable or unavailable after review.

# Appendix D

## Number of Reviewable Deaths Reviewed / Number of Reviewable Deaths, 2014



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