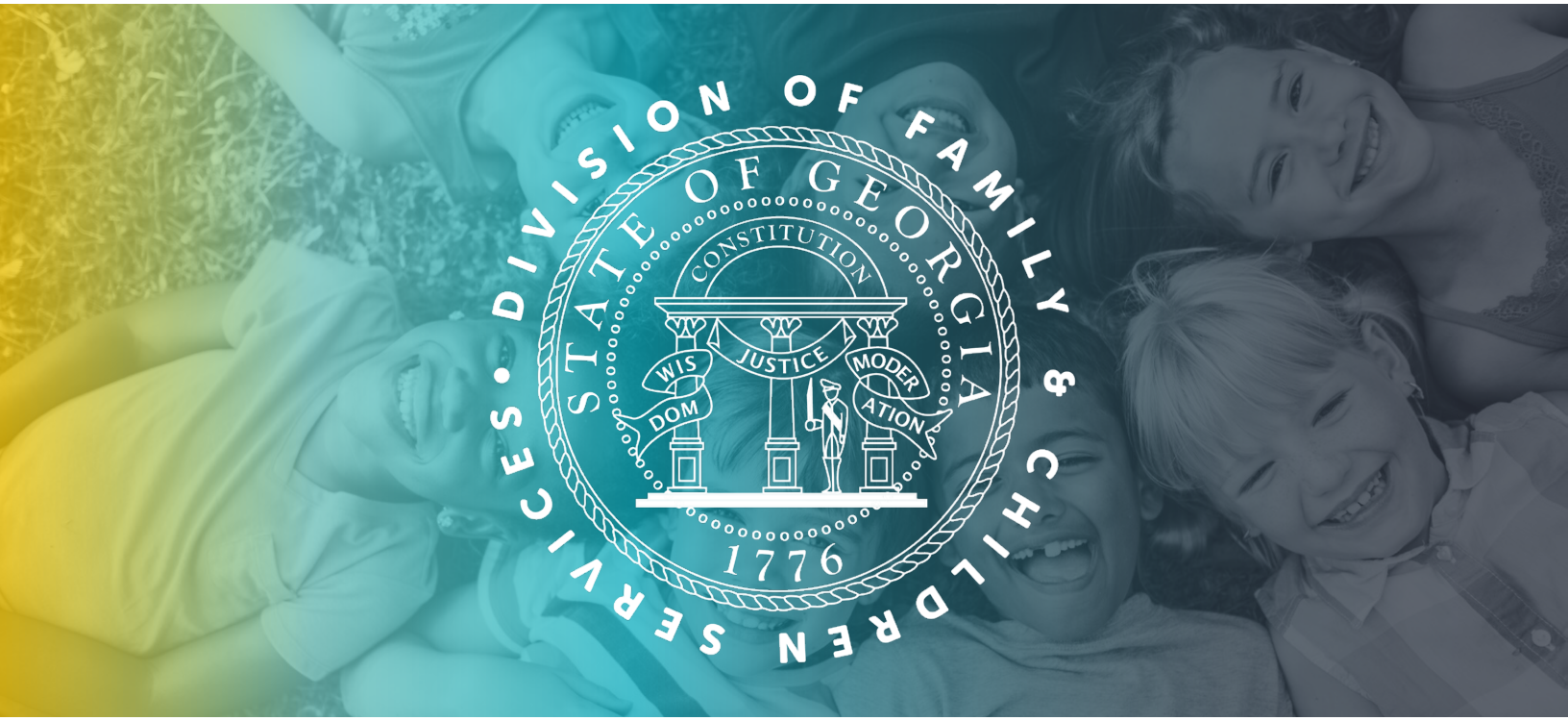

Fiscal Year 2017 Annual Report

Virginia Pryor | Director

There is power in our story!

When I was first asked to come to Georgia almost four years ago the Division was in a precarious state with numerous challenges and barriers at every turn. But with those challenges came opportunities – an opportunity to change the narrative, an opportunity to change the way we served communities, to chart our own story, and an opportunity to do something BIG.

And so we launched our reform effort, the Blueprint for Change, which emerged from the contents of Senate Bill 138. The Blueprint is a three-pronged approach to service improvement through robust workforce development, consistent practice and intentional engagement of constituents. It also included efforts to engage staff across the Division through a branding and marketing campaign which captured the essence of our humanity and why we do this important work. The strategic plan which followed is the tangible demonstration of the Blueprint in action. And so for the past three years we have focused on implementing the strategies and objectives in the plan.

When Governor Deal recently delivered his final State of the State Address he declared that the current state of our state is good and that the future is bright. I also want to echo this sentiment for the Division. We have made remarkable strides in the past three years and those achievements are reflected in this report. And while we still have a long way to go, we are committed to staying the course and continuing to make improvements. The individuals, children and families we serve deserve our best each and every day.

The next evolution of our work is the journey toward a **State of Hope** — an innovative, collaborative approach which seeks to engage a broad base of stakeholders to design communities in which all members, especially those who are most vulnerable, can thrive as a result of strong safety nets and proactive supports. While the Division does not solely "own" the State of Hope and the transformative work that can only happen within individual communities, we have committed to be the convener of this collective impact approach in partnership with several key stakeholders. No single group or organization alone can raise up strong, healthy, thriving communities. The biggest impact will be made through multiple organizations working together across systems in support of the same goal.

I want to thank Governor and First Lady Deal for championing the work of the Division and demonstrating true servant leadership in action. We are also grateful to the Georgia legislature for their consistent support over these past three years. I then want to thank our former Director, Bobby Cagle, for his strategic vision and leadership. But most importantly, I want to thank our staff for their trust, dedication and perseverance. The road has not always been an easy one, but your commitment to service and hope has inspired me as a leader.

I believe that hope is one of the greatest gifts you can give, particularly when it is the hardest to find. Hope is a light, and where there is just a little bit of light there can be no darkness. My brand is hope. Our brand is hope — hope for safe children, strengthened families and a stronger Georgia.

Thank you for the privilege of being able to serve this great state in partnership with each of you. Indeed, there is power in our story!

Forward in Hope,

Virginia S. Pryor, Director, Division of Family & Children Services

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About the Division of Family & Children Services

About the Division of Family & Children Services

The Georgia Division of Family & Children Services (DFCS) investigates reports of child abuse, finds foster and adoptive homes for abused and neglected children and provides several support services to help families in need, including the Supplemental Nutrition Assistance Program (SNAP), Medicaid and Temporary Assistance for Needy Families (TANF).

VISION

Safe Children. Strengthened Families. Stronger Georgia.

MISSION

We prioritize the safety of Georgia's children in the decisions we make and the actions we take. We partner with families on their path to independence and build stronger communities with caring, effective and responsive service.

GUIDING PRINCIPLES

As the Division of Family and Children Services we...

1. Commit to the safety of our children in the decisions we make and the actions we take.
2. Empower, strengthen and support families on their path to independence.
3. Embrace a servant's heart with compassion.
4. Provide caring, responsive and effective service.
5. Listen and respond to our constituents, communities and each other.
6. Collaborate with our communities to create systems of support.
7. Develop a professional and efficient workforce that never stops learning and growing.

Introduction

The Fiscal Year 2017 Annual Report provides the Georgia General Assembly with information about overall operations of the Division and its service to children and families across the state.

The document that follows includes both state-mandated reports to the General Assembly and an update on efforts to meet six Strategic Goals laid out in the Division's Strategic Plan: Safety, Self-Sufficiency, Permanency, Well-Being, Workforce and Stakeholder Engagement.

The DFCS Strategic Plan sets guideposts for long-term progress following the initial success of the Blueprint for Change reform effort and the ongoing journey of the Division toward a State of Hope.

For each goal area in the Strategic Plan, the Fiscal Year 2017 Annual Report includes quantitative data and details of programmatic strategies that support each goal in the plan.

Reports that must be provided by statute, including a statistical analysis of cases referred to the Child Abuse Registry, are included as part of the report's Appendix.

Our Journey Toward a State of Hope

Since 2014, the Division has sought to improve service to children and families through development of a robust workforce, implementation of an evidence-informed practice model and an aggressive effort to engage constituents on all levels. This three-pronged approach to reform, called the Blueprint for Change, has been instrumental in lowering caseloads, reducing staff turnover and improving outcomes for families served by the Division. As the agency moves beyond plans for stabilization into strategic efforts to build communities with safer children and strengthened families, the Blueprint for Change becomes Georgia's journey toward a State of Hope.

A State of Hope is the Division's ultimate vision. It is a place where people share a vision of safety and success for every child. It is a place where public and private organizations collaborate closely to help achieve that vision. And it is a place where, as a result of this shared vision, children are safer, families are stronger and communities are built to thrive.

Georgia's journey toward a State of Hope is fueled by the belief that families and communities – not systems – are best equipped to raise children and that all families need the support of a caring community to thrive.

This journey is just beginning. In partnership with Casey Family Programs, the Division has embarked on a statewide effort to engage a broad base of community stakeholders in a sustained movement to transform the lives of the most vulnerable residents of the state of Georgia.

Executive Summary

Improved caseloads and response times are among the major goals the Division of Family & Children Services reached or exceeded during the fiscal year that wrapped up in 2017. While the Division continues to strive toward goals that produce better results for children and families, the agency made substantial progress in several service areas.

The Division exceeded several goals set out in the Strategic Plan for the fiscal year, including goals to increase the number of children who enter foster care who are placed with a relative and to recruit more foster parents.

Key outcomes found in the report that follows are:

- A reduction in staff turnover from 36 percent to 29 percent for child welfare staff over a two-year period.
- An increase in employee satisfaction from 66 percent to 71 percent over surveys from 2015.
- A reduction in the number of times foster youth were moved from one foster home or placement to another placement.

The Division continues to work toward goals in other areas, including efforts to have 28 percent of foster children achieve adoption prior to their two-year anniversary in foster care.

In addition, the Division continues:

- Increasing the percentage of children in foster care who achieve permanency within the first 12 months of entering care.
- Increasing the percentage of children in foster care who are placed with a relative.
- Increasing family participation in case planning.
- Increasing the number of finalized adoptions for children who are not reunified with their parents within 24 months of foster care entry.

Strategic Goal 1: Safety

Families & individuals are free from abuse and neglect

GOAL OVERVIEW

The safety of Georgia's children is the top priority of the Division and the foundation for every decision.

The Division has established six measurable objectives (these objectives are outlined based on federal standards included in the annual Child and Family Services Review or CFSR) to demonstrate progress in areas of child safety and systemic readiness to respond to concerns of child abuse and neglect.

In all but one area, Division staff met or exceeded annual objectives for safety set out in the two-year Strategic Plan.

An objective to train all Office of Family Independence staff on requirements to report child abuse was affected by the prioritization of the implementation of Georgia Gateway, a new integrated eligibility system for administration and management of economic assistance programs in Georgia.

Objective 1

Reduce recurrence of maltreatment from 8 percent to no more than 5 percent by July 2019.

[Data is a measure of the number of times a child suffers a confirmed case of abuse or neglect within 12 months of a previous incident.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	8%	8%	6.3%
July 2018		6.5%	
July 2019		5%	

Objective 2

Reduce re-entries into foster care from 7.5 percent to 5 percent by July 2019.

[Data is a measure of the percentage of youth in foster care who were in care for a different reason in the 12 months prior.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	7.5%	7.5%	5.59%
July 2018		6.25%	
July 2019		5%	

Objective 3

Reduce maltreatment of children in foster care from 1.084 victimizations per 10,000 days in care to no more than 0.75 by July 2019.

[Data is a measure of the number of substantiated reports of maltreatment received in a 10,000-day period.]

Month / Year	Baseline	Target Measure	Actual Measure Fourth Quarter FY17
July 2017	1.084	1.084	0.28
July 2018		0.92	
July 2019		0.75	

Objective 4

Increase the timely processing of child-care applications resulting from child welfare referrals for eligible foster care children (between the ages of 0-12 years old) by July 2019.

[Data is a measure of the number of child-care applications for children in foster care finalized in a 30-day period.]

Month / Year	Baseline	Target Measure	Actual Measure Fourth Quarter FY17
July 2017	85%	85%	88.22%
July 2018		87%	
July 2019		90%	

Objective 5

Train and educate annually all staff in the Office of Family Independence (OFI) on their requirements to report all signs of child abuse.

[Data is a measure of the number of OFI staff who have completed the mandated-reporter training.]

Month / Year	Baseline	Target Measure	Actual Measure Fourth Quarter FY17
July 2017	0%	100%	82.5%
July 2018		100%	
July 2019		100%	

Objective 6

Reduce the number of sleep-related deaths for children who are currently receiving or previously received services from DFCS.

[There were a total of 44 sleep-related deaths in 2013, 53 deaths in 2014 and 66 deaths in 2015.]

Month / Year	Baseline	Target Measure	Actual Measure Fourth Quarter FY17
July 2017	63	No more than 63 sleep-related deaths (represents a 5% decrease)	49
July 2018		No more than 60 sleep-related deaths (represents a 5% decrease)	
July 2019		No more than 56 sleep-related deaths (represents a 7% decrease)	

Strategic Goal 1: Safety

Families & individuals are free from abuse and neglect

SAFETY STRATEGIES

Through the Blueprint for Change reform effort, the Division has undertaken several initiatives to ensure child safety is at the forefront of each case management decision.

In the last year, child welfare workers adopted a new practice model, called Solution-Based Casework, to guide their approach. The model prioritizes partnerships with families and supports sustainable strategies to create safer, more stable environments for children. All case managers have been trained on the approach and currently are undertaking efforts to achieve certification in the model by the end of Fiscal Year 2018.

The Division has also focused its attention on decision-making related to foster care placements. The initiative, called Safe at Home, seeks to ensure case managers have exhausted all efforts to protect the safety of a child in the home prior to initiating a petition for foster care. The initiative also increases monitoring of foster care cases to ensure no child stays in foster care longer than is necessary for their safety and well-being.

Strategy: Solution-Based Casework

An evidence-informed practice model, Solution-Based Casework (SBC), is the agency's new guide for case managers as they work to address each family's unique situation.

The model supports case managers as they approach their work with families, prioritizing family buy-in for solutions rather than the imposition of a list of requirements based on abstract theory. Using this approach, case managers must be more conscious of speaking in a language the family understands to gain consensus on the problem, tailor solutions to the aspects of everyday family life that threaten child safety, and ensure the proposed solutions support the development of skills that reduce risk and prevent harm.

SBC IN PRACTICE

As of October 2017, 2,900 staff have been trained on the Solution-Based Casework model. Staff are now in the process of becoming certified in SBC, which requires proficiency in the key practices. It is expected that all staff will complete certification by the end of 2018.

Strategic Goal 1: Safety

Families & individuals are free from abuse and neglect

SBC provides a common conceptual map for child welfare professionals and families to work together on agreed outcomes. The program builds on the strengths of the family and focuses on behavioral changes rather than prescribed tasks. The success of SBC depends upon the practice of noticing and celebrating change.

SBC combines accepted knowledge from empirical research on family development, clinical research and knowledge regarding behavioral change, and child welfare outcome studies to help staff stay focused on three key elements or tenets. These foundational tenets are:

- to create a partnership based on problem consensus in language the family understands;
- to focus that partnership on the patterns of everyday family life that directly relate to threats to safety, and;
- to target solutions specific to the prevention skills caretakers need to create safety and reduce risk in those family situations.

SBC is associated in research studies with significantly better performance on all 23 federal outcomes in the Child and Family Services Review (CFSR). This performance improvement is predicated upon a high adherence and fidelity to the SBC model.

Tarrick

Tarrick spent the first 16 months of his life in foster care, due to his parents' substance abuse issues and incarceration. His time in care was longer than is ideal for a young infant. And, at one point, Tarrick's parents said they were at rock bottom, and they felt hopeless that he would ever return to them.

But Kristal, a Barrow County case manager assigned to the family, believed in Tarrick's parents and had hope that they could be together again.

Using the skills she learned from Solution-Based Casework (SBC), Kristal worked with Tarrick's parents to build consensus on how their substance abuse affected his safety and to target solutions specific to the skills that would reduce the risk that Tarrick would be in unsafe situations. Practicing other milestones of SBC, Kristal documented successes and celebrated them with the family, sending encouraging messages each time the parents had negative drug screens, for example.

Thanks to her efforts — and those of Tarrick's foster parents and DFCS partners in the judicial system — Tarrick returned home in September 2017. It was an event that Kristal, Tarrick's parents, foster parents and his Court-Appointed Special Advocate celebrated with a shared breakfast.

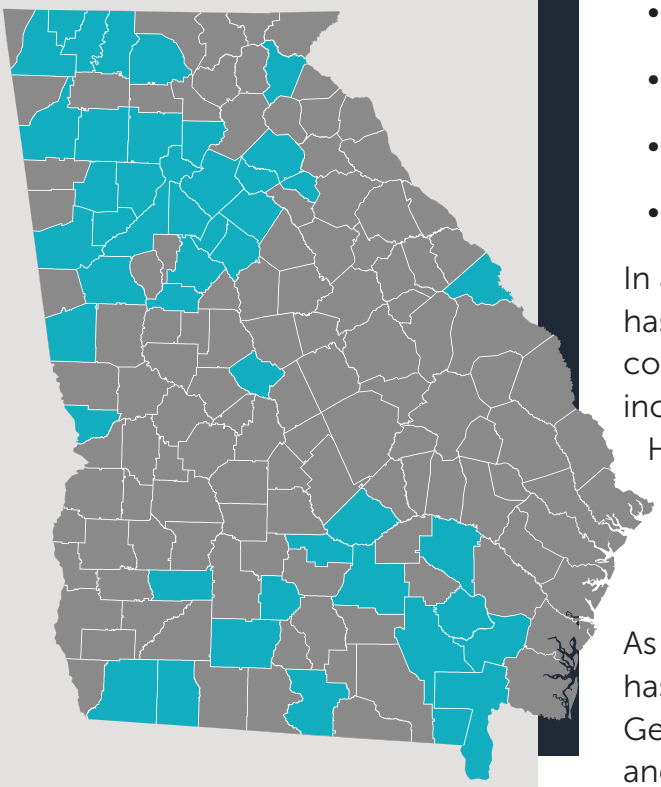
Tarrick's parents, now sober, say they are glad DFCS intervened on Tarrick's behalf. The thought of losing him had been the driving force behind their efforts to get sober.

They also say they are grateful for Tarrick's foster parents, who took care of him when they could not. Tarrick's foster parents supported his return home to his parents and remain involved in his life. Tarrick's parents say they will let him continue to have overnight visits with his foster family and allow his teenage foster sister to babysit him on occasion.

Kristal, Tarrick's case manager, says his successful reunification story is a true example of partnership and the tenets of Solution-Based Casework.

SAFE AT HOME HOPEFULS WORKGROUP

The 44 counties identified in the map below are responsible for the state's 71% increase in Georgia's foster care population from January 2014 to January 2016.



Strategy: Safe at Home

When the population of Georgia's foster care population swelled by 58 percent after January 2014, the Division took action to ensure only children who needed to be removed from their homes were brought into foster care. In an initiative titled Safe at Home, the Division concentrated efforts to provide support and oversight to families in situations where a child could remain safely at home and avoid unnecessary foster care placement and to speed up reunification of families when the circumstances called for children to enter foster care.

The components of the program include:

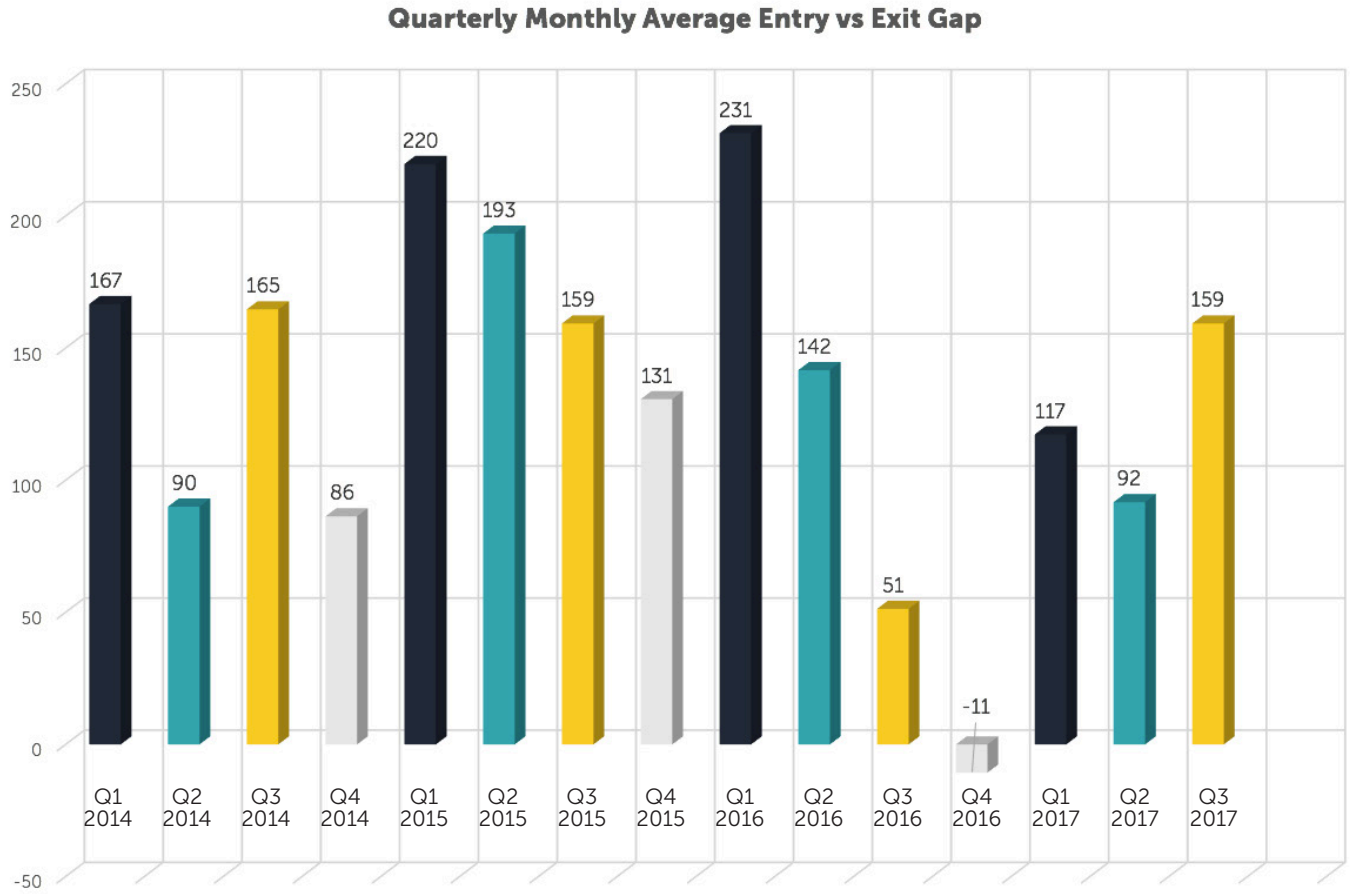
- Strengthening the staffing process for Child Protective Services assessments
- Safely utilizing family preservation services
- Conducting targeted case reviews
- Increasing permanency and adoption efforts
- Increasing the utilization of aftercare services

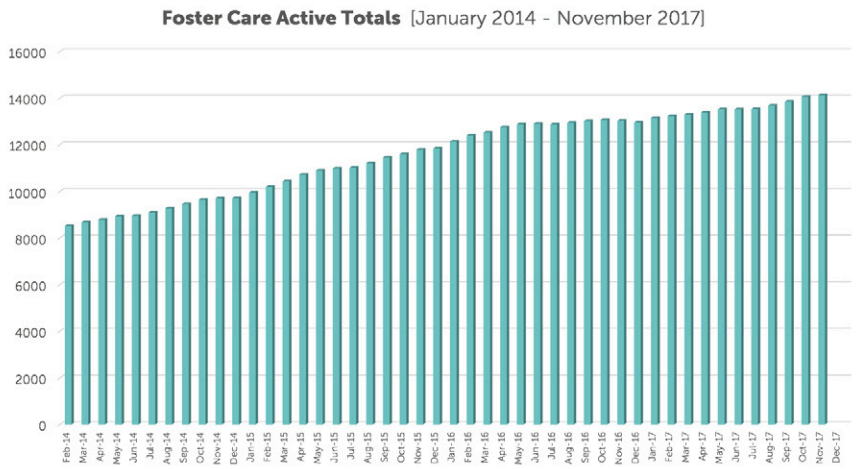
In addition to the Safe at Home initiative, the Division has established a workgroup comprising leaders of 30 county departments where there has been a significant increase in foster care entries. This group, called Safe at Home Hopefuls, serves as a think tank for the Division to create and test hypotheses for reducing foster care entries and speeding the reunification of children in care with their parents.

As a result of the Safe at Home initiative, the Division has begun to slow the growth of foster care entries in Georgia and close the gap between foster care entries and exits, as evidenced in the graphs on Page 12.

Strategic Goal 1: Safety

Families & individuals are free from abuse and neglect





The number of children in foster care increased by 9.6% during the 18-month period between May 2016 (the start of Safe at Home) and November 2017. The previous 18-month period (before Safe at Home) experienced a 32.7% increase.

Strategic Goal 2: Self-sufficiency

Families & individuals have sustainable financial independence, voice and choice in services, and are self-directed.

GOAL OVERVIEW

The Division seeks to help families reach financial and social independence through caring, effective and responsive service. The Division's mission to strengthen families is supported by a guiding principle to empower and support families on their path to success, ensuring each step on that journey is self-directed.

Because strategies to achieve self-sufficiency must reach beyond government to be successful and sustainable, the Division has engaged partner agencies across the state to enhance opportunities for families to build better futures.

The Division has established two measurable objectives based on federal standards included in the annual Child and Family Services Review and set by the Administration of Children and Families to guide the Division's engagement of families in a way that supports their overall and future well-being and self-sufficiency goals.

Tiffney

Tiffney S. found herself jobless and had to turn to the food stamp program for support. Because Tiffney was an "Able-Bodied Adult Without Dependents," she was required to enter job training to maintain her eligibility for the food stamp program. To help get her on her feet, the Cobb County DFCS SNAP Works team referred her to Goodwill of North Georgia for help.

Tiffney was interested in the Highway Construction course and willingly attended the seven weeks of classes offered by Goodwill of North Georgia. There, she learned the basics of highway construction, safety, flagging and operating commercial vehicles. She earned several nationally recognized certifications that would support her in this new career field.

Upon completing the program at Goodwill, Tiffney was thrilled when she was selected for an interview with MARTA. On the day of the interview appointment, however, she received a call that her mother had passed away. Despite her intense grief, Tiffney kept the appointment. Her composure and determination to start a new career so impressed the team at MARTA that they made Tiffney an offer for a job on the spot. But Tiffney faced additional obstacles. Her health had deteriorated and presented specific issues that would have hindered her ability to conduct her job duties for MARTA. Tiffney's determination knew no bounds, however, and despite the additional setback, Tiffney made changes to her diet and lifestyle that allowed her to pass her physical exam and begin her job as a bus operator at MARTA in April 2017.

"Thank you, Goodwill and SNAP for partnering together to create programs to help individuals attain a good job that pays well," she said. "I did exactly what Goodwill asked of me: I was dependable, reliable and motivated to complete the program."

Strategic Goal 2: Self-sufficiency

Families & individuals have sustainable financial independence, voice and choice in services, and are self-directed.

In one of the self-sufficiency objectives, Division staff exceeded standards set out in the two-year Strategic Plan.

An objective to involve families in child welfare case planning should see measurable improvement in Fiscal Year 2018 as staff are more knowledgeable of the tenets of Solution-Based Casework. The Solution-Based Casework practice model holds as a core value engagement of families and prioritizes family involvement in the development of strategies to reduce risk to children and cultivate environments where children are safe.

Objective 1

Increase the portion of Temporary Assistance for Needy Families (TANF) participants engaged in a qualified work activity from 59 percent to 60 percent by July 2019.

[Data is a percentage of eligible adult recipients who participate in work or a work-related activity.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	59%	59%	66.22%
July 2018		60%	
July 2019		60%	

Objective 2

Increase family and individual participation in Child Welfare Case Planning from 42 percent to 95 percent by July 2019. As of the fourth quarter of Fiscal Year 2017, 42 percent of families across the state participated in drafting their plans.

[Data is a percentage of families who actively participate in setting the goals of their case plan, based on Continuous Quality Improvement Reviews or case files.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	42%	59.7%	42%
July 2018		77.3%	
July 2019		95%	

Strategic Goal 2: Self-sufficiency

Families & individuals have sustainable financial independence, voice and choice in services, and are self-directed.

SELF-SUFFICIENCY STRATEGIES

In Fiscal Year 2017, the Division prioritized upgrading its software systems and its support models to ensure families who come to the Division seeking economic or social support are aided on their path to self-sufficiency.

In the last year, Georgia underwent the adoption of a new integrated eligibility system, called Georgia Gateway. The system allows Georgians to manage their accounts for myriad economic assistance programs through a single portal, and improves case workers' ability to verify eligibility for individuals across multiple programs. Georgia piloted the system for most programs in Henry County in February 2017 and gradually implemented it statewide throughout the year.

The implementation of Georgia Gateway has been the most successful integrated eligibility system rollout in the country thus far.

Additionally, the Division expanded efforts to help individuals who come to the Division for support to pursue paths toward sustainable self-sufficiency. The Division's SNAPWorks program supports individuals who receive food stamps in efforts to find a job paying above minimum wage, reducing their reliance on government support. The Division expanded the program to 33 counties in Fiscal Year 2017.

Strategy: Implementation of Georgia Gateway

As the fiscal year concluded June 30, the Division was poised for the September statewide rollout of Georgia's new integrated eligibility system — Georgia Gateway.

Georgia Gateway is a collaborative system between the Division and the departments of Community Health, Human Services, Public Health and Early Care & Learning for determining constituents' eligibility for eligibility-based benefits. Georgia Gateway provides a single point of entry for economic assistance programs that include:

- Medical Assistance through Medicaid, Aged, Blind and Disabled Medicaid, PeachCare for Kids®, Planning for Healthy Babies
- Supplemental Nutrition Assistance Program
- Temporary Assistance for Needy Families
- Special Supplemental Nutrition Program for Women, Infants and Children
- Childcare and Parent Services Program
- Low Income Home Energy Assistance Program to be added in 2019

Strategic Goal 2: Self-sufficiency

Families & individuals have sustainable financial independence, voice and choice in services, and are self-directed.

Georgia Gateway replaced aging computer applications with a modernized, integrated system that enhances fraud-prevention measures, provides real-time eligibility determinations for certain benefit programs, and creates a common portal for customers to apply for and manage their benefits.

Strategy: Expansion of SNAPWorks Program

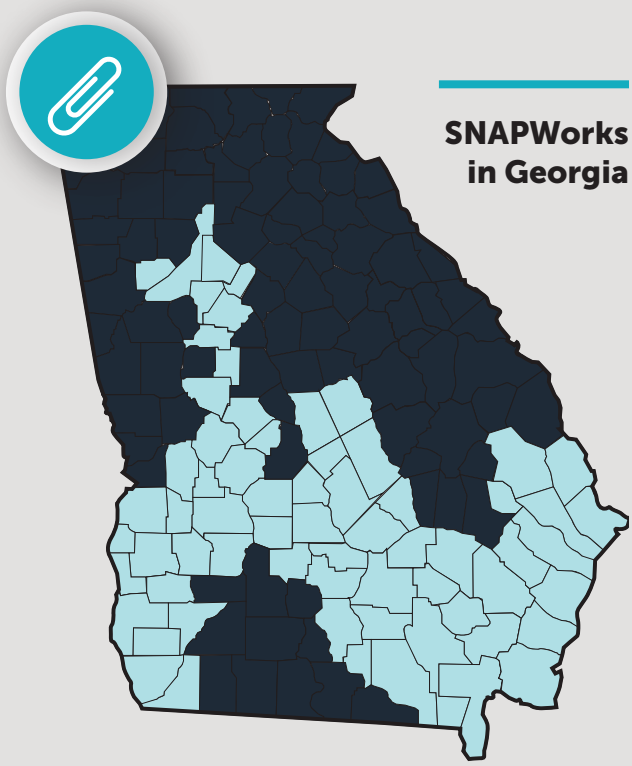
Federal law limits how long able-bodied adults without dependents can receive food stamps, unless they either work or are in a qualified job-training program. However, as Georgia suffered the consequences of reduced private employment following the Great Recession, Georgia, along with most other states, sought and received a waiver from the requirement in counties suffering the highest unemployment rates.

The improving economy of recent years has allowed the Division to reinstate the program and direct recipients to training that helps them access greater employment opportunities.

Beginning with three counties in 2016, the Division reinstated the program and continued with a thoughtful expansion of its efforts to support able-bodied adults without dependents, connecting them with job training programs and partners that help them achieve their goals of self-sufficiency.

During FY17, the Division expanded the program to 24 counties. The program expanded again on Jan. 1, 2018 to a total of 93 counties.

Additionally, in 2018, Georgia will begin a pilot program in Fulton County that allows SNAP recipients who do not fit the definition of able-bodied adults without dependents to receive education and skills training that supports improved employment opportunities.



Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

GOAL OVERVIEW

Children deserve the support and stability that a permanent family offers. It is imperative that the Division focus its efforts toward ensuring children who come to its attention are allowed the opportunity to develop bonds and benefit from relationships that give them their best shot at a successful and fulfilling life.

The Division has established six measurable objectives based on federal standards included in the annual Child and Family Services Review that support the best interest of children who enter foster care. These objectives seek to limit placement moves, maintain children's connection with their families and ensure children do not remain in foster care longer than is necessary for their safety and well-being.

In all but two areas, Division staff met or exceeded annual targets for Permanency set out in the two-year Strategic Plan.

The Division continues to develop and implement strategies that support speedy permanency for children who are eligible for adoption.

The White Family

Lynette White is the paternal grandmother of Chloe, Aleigh, twins Kayden and Jayden, Rico and Bentley, all under age 7.

When the six siblings first came into foster care in 2015, Mrs. White was determined to do anything necessary to ensure her grandchildren remained with family. Initially, she took in three of the children, and another relative stepped up and took in their other three siblings. But Mrs. White, who had previously adopted the siblings' older sister, 9-year-old De'Asia, didn't want the children to live the rest of their lives under separate roofs.

While several family members expressed having the children's best interest at heart in pursuing adoption, none felt they could take all six children.

But Mrs. White, determined to have all of her grandchildren under one roof, moved from a two-bedroom apartment to a three-bedroom home in order to have adequate space for all of the children. She and her partner of 19 years got married in anticipation of the pending adoption. Mrs. White was willing to do whatever it took to have her son's children remain with her.

On April 17, 2017, Mrs. White and her husband made their commitment to the children official, and adopted Chloe, Aleigh, Kayden, Jayden, Rico and Bentley.

Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

Objective 1

Increase the stability of placement for youth in foster care by reducing the rate of placement moves from 5.84 moves per 1,000 days in care to no more than 4.12 moves by July 2019.

[The intent is to reduce the number of times a youth in foster care changes placement.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	5.84	5.84	4.82
July 2018		5.42	
July 2019		4.12	

Data Source: This is a federal data indicator for the Child and Family Services Review pulled from the state's Automated Child Welfare Information System.

Objective 2

Increase the percentage of birth parents who have monthly visits with their children placed in foster care by July 2019. The intent is to maintain family connections and to facilitate reunification if possible.

[Data is the percentage of birth parents who have monthly visits with their children placed in foster care.]

Month / Year	Baseline	Target Measure [Birth mothers]	Actual Measure [Birth mothers]	Baseline	Target Measure [Birth fathers]	Actual Measure [Birth fathers]
July 2017	87%	87%	90.47%	80%	84%	87.02%
July 2018		91%				
July 2019		95%				

Data Source: The Federal Every Parent Every Month data pulled from the state's Automated Child Welfare Information System

Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

Objective 3

Increase the percentage of relative placements for children in foster care from 25.6 percent to 50 percent by July 2019.

[Data is the percentage of children (entering foster care) who are placed with a relative.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	19%	27.4%	29%
July 2018		38.7%	
July 2019		50.0%	

Data Source: The state's Automated Child Welfare Information System

Objective 4

Increase the percentage of children in foster care with adoptions that finalize within 24 months of entering care from 28 percent to 52 percent by July 2019. Children eligible for adoption do not wait longer than 24 months from the day they entered care to be adopted.

[Data is a percentage of children eligible for adoption do not wait longer than 24 months from the day they entered care to be adopted.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	28%	28%	21%
July 2018		40%	
July 2019		52%	

Data Source: The state's Automated Child Welfare Information System

The Zacharewicz Family

Unlike the 1980s sitcom, eight wasn't enough for Jenny and Chris Zacharewicz, and this year they adopted 22-month-old Benjamin to add a ninth child to the family.

The family's eight biological children all live at home on six and a half acres in Dallas, ranging in age from seven to 25. Chris says the household runs smoothly, with each child taking on chores as they become old enough.

So, when he and Jenny decided to grow a little more, they weren't particular about a boy or girl.

"We wanted to add another child," he said. "We love kids, and we thought it would be a blessing to have an adopted child."

They trained to become foster parents with a goal of becoming a forever home for a child whose biological parents would not be able to permanently care for him. Benjamin came into their home shortly after he was born, and Jenny and Chris said they grew so attached to him throughout their period as foster parents that it seemed to take forever for the adoption to be finalized.

At one point, a biological relative of Benjamin's from Massachusetts considered taking him in, but Jenny and Chris were the only ones who followed through for Benjamin, adding him to their family by way of adoption.

Now that Benjamin is a part of the family, Chris and Jenny say the door may be open to another adoption and a tenth Zacharewicz, he said.

"We have seriously talked about one more child," he said, adding that they haven't yet decided.

"We love kids, and we thought it would be a blessing to have an adopted child."

Objective 5

Increase the total number of approved foster caregivers (foster and relative) by 20 percent by July 2019 to increase the overall number of placement options for children in foster care.

[Data is the overall number of placement options for children in foster care.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	4,260	4,544	4,685
July 2018		4,828	
July 2019		5,112	

Data Source: The state's Automated Child Welfare Information System

Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

Objective 6

Increase the percentage of children in foster care who achieve permanency within the first 12 months of entering care from 47 percent to 60 percent by July 2019.

[Data is the percentage of children who are able to safely exit foster care within 12 months of entering care.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	47%	50%	30.84%
July 2018		55%	
July 2019		60%	

Data Source: This is a federal data indicator for the Child and Family Services Review pulled from the state's Automated Child Welfare Information System

PERMANENCY STRATEGIES

Children deserve a permanent place to call home and a family to call their own. With this value in mind, the Division has undertaken several initiatives to ensure that children who must come into foster care are reunified with their families as soon as is safely possible, and that the trauma of entering foster care is limited to the greatest extent possible. For those children who will not return to their parents due to ongoing concerns, the Division works to provide them with an opportunity to receive the love and support of an adoptive family.

To ensure children who come into care are able to maintain connections to their communities, the Division has concentrated efforts to prioritize placement of children who come into care with relatives or close friends of the family. The strategy can support reunification efforts and limit the trauma associated with having to enter foster care.

Additionally, in recognition of the need for children in foster care to be allowed the opportunity for a life with a loving adoptive family, the Division has continued an effort, called There's No Place Like Home, to remove administrative barriers that stand in the way of successful adoption stories. The practice has, for two straight years, increased the number of finalized adoptions of youth in the foster care system.

Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

Strategy: Kin First

When a child who is at risk of coming into foster care is placed with relatives or close family friends, this is known as kinship foster care. Research confirms that children do best in kinship foster care and that placement with relatives limits the trauma and negative impacts of entering care. Family connections are critical to healthy child development and a sense of belonging. Kinship care also helps to preserve children's cultural identity and relationship to their community.

The Division's Kinship Navigator Program serves as a one-stop shop for information and referral services to grandparents, relatives and other caregivers who are currently raising a child. The Division launched the program in 2015 in direct response to the increasing number of grandparents and caregivers who assumed responsibility for raising another relative's child(ren). The Kinship Navigator Program has 15 kinship navigators located statewide that assist kinship families in identifying and locating resources in their local community. The program's overarching goal is to close the gaps and/or delays in service delivery to kinship caregivers by supporting them however possible.

In 2014, 19 percent of children in care were placed with relatives. The goal is to increase that to 50 percent by 2019. Currently, the percentage of children placed with relatives is at 29 percent.

Strategy: There's No Place Like Home

Through the There's No Place Like Home campaign, the Division has worked to identify barriers to adoption and to remove as many as possible in order to increase the number of children who achieve permanency through adoption. The concentrated effort has improved the path to adoption for children who are seeking permanent, loving homes.

Number of Adoptions
[2013-2016]

Strategic Goal 3: Permanency

Families and individuals are healthy and stable.

Since 2015, the Division has seen an increase in the number of finalized adoptions, and in FY17, there were 1,190 children who were adopted by their forever families — a roughly 15 percent increase from 2016. The monthly There's No Place Like Home cadence calls allowed staff the opportunity to troubleshoot issues that stand in the way of adoptions, speaking directly with the Division Director.

The initiative has resulted in policy and practice changes that have improved the statewide system of adoptions in Georgia.

The Allen Family

On September 11, 2014, the Allens in Paulding County received a call asking if they would foster two little boys, ages four and five, who had just entered foster care. The Allens decided they would be open to fostering a sibling group, knowing the need for homes in which siblings like Shiloh and Jasper could remain together even though they have been removed from their biological parents. The Allens only had one biological child, so adding two more didn't seem too difficult, they said.

The day after the Allens received the call, the brothers arrived, and their bond was evident and very strong. Shiloh was accustomed to protecting his little brother. And Jasper often translated for Shiloh, since he had a significant speech delay. They had each other, and the Allens respected those roles, which made the boys' transition to their new home a little bit easier.

Almost immediately after the boys arrived, the Allens noticed Shiloh and Jasper would often reference a baby sister. The Allens inquired with their case worker and learned the boys did have a 21-month-old baby sister named Neriah who had been separated from the boys when they were removed from their biological parents' care. When asked if they wanted their sister to live with them at the Allens' home, Shiloh and Jasper's faces brightened, and they screamed, "yes!" The Allens' biological daughter was also ecstatic to add a little sister to the family.

On October 1, 2014, the three siblings were reunited after one of the most difficult times in their lives. Neriah, after weeks without them, was happy to see her brothers.

For three years, the sibling trio became part of the Allen family, each of them handling their baggage in their own way, yet having peace knowing they were all safe and together. On June 19, 2017, Shiloh, Jasper and Neriah became permanent members of the Allen family. The adoptive mother said the experience with Shiloh, Jasper and Neriah, allowed her to see the importance of the sibling bond in the healing process. Through the diligent efforts of their Adoption Case Manager and Regional Adoption Coordinator and the attention their case received through the There's No Place Like Home Program, permanency for Shiloh, Jasper and Neriah was achieved in record time—only seven months after parental rights were terminated.

Strategic Goal 4: Well-being

Families and individuals have enhanced capacity to meet their physical, cognitive and educational needs.

GOAL OVERVIEW

The Division is committed to empowering, strengthening and supporting families on all levels that impact their well-being by providing resources that benefit physical, mental and social development.

The Division has established seven measurable objectives based on federal standards included in the annual Child and Family Services Review that show results of strategies to improve the well-being of families who come to the Division's attention.

In all but two areas, Division staff met or exceeded annual objectives for well-being set out in the two-year Strategic Plan.

The Division continues to work on strategies that will improve the educational outcomes of youth in foster care and support their long-term success.

Objective 1

Increase the percentage of current and former foster care youth receiving Medicaid or health insurance within six months of their 18th birthday from 45 percent to 85 percent by July 2019.

[Data is the percentage of children who have health insurance coverage within the six months following their 18th birthday.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	45%	45%	94%
July 2018		60%	
July 2019		85%	

Data Source: The state's Automated Child Welfare Information System and the Office of Family Independence

Strategic Goal 4: Well-being

Families & individuals have enhanced capacity to meet their physical, cognitive and educational needs.

Objective 2

Increase the percentage of youth in foster care who successfully graduate from high school from 8 percent to 85 percent by July 2019. [1]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	8%	46%	25%
July 2018		60%	
July 2019		85%	

[1] *Going forward, the Division will rely on the Georgia Department of Education to be the primary source of all education-related data for children and youth in foster care.*

Objective 3

Increase the percentage of Educational Programming and Assessment Consultation referrals for youth in foster care from 46 percent to 90 percent by July 2019.

[Data is the percentage of eligible youth in foster care who have access to the resources and support available from EPAC.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	46%	46%	55%
July 2018		68%	
July 2019		90%	

Data source: The state's Automated Child Welfare Information System

Objective 4

Increase the percentage of initial wellness screenings for youth in foster care from 16.9 percent to 75 percent by July 2019.

[Data is the percentage of youth in care who have a health screening and exam immediately after entering care.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	16.9%	16.9%	20.89%
July 2018		45.95%	
July 2019		75.0%	

Data source: The state's Automated Child Welfare Information System

Strategic Goal 4: Well-being

Families & individuals have enhanced capacity to meet their physical, cognitive and educational needs.

Objective 5

Support the development of executive functioning for children in foster care by increasing the number of these children ages 0–5 who are enrolled in Early Head Start/Head Start, Pre-K, or any other quality-rated child care program by July 2019.

[Data is a percentage of young children in care who participate in Quality Rated Child Care programs.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	32.95%	36.25%	35.12%*
July 2018		60.00%	
July 2019		84.00%	

*Data source: The state's Automated Child Welfare Information System (*Measure as of June 30, 2017.)*

Objective 6

Improve the Family Medicaid Standard of Promptness to 92 percent by July 2019.

[Data is the percentage of families will have their Medicaid application finalized within 45 days.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	85%	85%	87.31%
July 2018		90%	
July 2019		92%	

Data source: The Office of Family Independence Planning, Performance and Reporting Data Management Files

Objective 7

Increase the number of Supplemental Nutrition Assistance Program (SNAP) Nutrition Education participants that receive information regarding healthy and nutritious food choices for low-income families from 49,184 to 81,058 by July 2019.

[Data is the number of SNAP participants who receive educational information regarding the purchase of nutritious foods.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	49,184	53,686	106,614
July 2018		67,504	
July 2019		81,058	

Data source: The Office of Family Independence, Supplemental Nutrition Assistance Program Unit

Strategic Goal 4: Well-being

Families & individuals have enhanced capacity to meet their physical, cognitive and educational needs.

WELL-BEING STRATEGIES

All children deserve their best shot at a good life. The Division must undertake initiatives to ensure that children who enter foster care due to problems resulting in abuse or neglect are afforded the opportunity to thrive, despite their prior circumstances.

In addition, families in economically depressed situations should receive assistance that empowers them to make future decisions that support the health and overall well-being of their families going forward.

With these values in mind, the Division has undertaken several initiatives to bolster families as they seek to improve their social and economic circumstances.

Included is a concentrated effort to improve educational supports and increase the high school graduation rate for children in foster care. This initiative, called Project Graduate, sought to study the effects of placement changes on a young person's educational success and to provide aid and encouragement that would improve a youth's chances of graduating high school. The Division has taken the lessons learned from this year-long initiative and implemented changes in its educational support model for foster youth statewide.

Strategy: Project Graduate

Project Graduate is a collaborative effort between the Georgia Division of Family and Children Services and key stakeholders to improve the graduation rates of Georgia's foster youth by providing coordinated supports while leveraging existing resources available to youth in care. It emerged as a result of then-Division Director Bobby Cagle's participation in the Annie E. Casey Foundation's intensive executive leadership program, and it was developed under the auspices of the Blueprint for Change,

Project Graduate

Jason Livingston and Kenton Pope, both age 19, began the 2016-2017 school year with not enough high school credit hours to be classified as seniors. Each faced challenges with attendance, grades, and repeated moves associated with their stay in foster care. Kenton's long-term foster mom had died earlier in the year, causing him to lose his home and support system. Jason was facing expulsion from school and a threat of being discharged from his foster care placement.

Through much hard work with follow up and a helping hand from the Project Graduate Team, these young men were able to not only become seniors, but both graduated with high school diplomas. Jason is now working with a recruiter to enlist in the U.S. Navy, and Kenton plans to attend a junior college.

Project Graduate is just one example of the Division's efforts to provide caring, responsive and effective service and to champion youth on their path toward independence.

Strategic Goal 4: Well-being

Families & individuals have enhanced capacity to meet their physical, cognitive and educational needs.

Georgia's effort to reform the child welfare system. In its initial phase, Project Graduate served as a demonstration learning project that sought to increase high school graduation rates for a cohort of 41 youth in foster care. Youth from Fulton and DeKalb counties were chosen for the project if they were enrolled in ninth grade in the 2013-2014 school year. The project took place during the 2016-2017 academic year and included youth attending Atlanta Public Schools, Decatur City Schools, and DeKalb and Fulton county schools.

The goal of Project Graduate was for 50 percent of the 41 youth to complete a high school diploma or GED by the end of the 2016-2017 school year. At the conclusion of the project period, the data demonstrated that 41 percent of the cohort successfully completed Project Graduate. If those members of the cohort who ran away, became incarcerated or opted out of foster care during the evaluation period are excluded from the calculation, the completion rate rises to 57 percent.

Project Graduate has allowed Georgia to focus on six strategies that will improve the educational outcomes for all youth in Georgia's foster care system and reconsider the effectiveness of policies and programs aimed at supporting the long-term success of these youth. Statewide implementation will be developed based on the lessons learned in the demonstration project and the successes of each strategy.

Strategic Goal 5: Workforce

The Division's workforce is competent, professional and efficient

GOAL OVERVIEW

To achieve its vision of supporting families and ensuring the safety of children, the Division must develop a competent, professional and efficient workforce that never stops learning and growing.

As part of the Blueprint for Change, the Division's leadership has focused efforts on recruiting quality staff and improving retention rates, which had plummeted in the years leading to 2014. Workforce issues negatively affected the Division's ability to make critical decisions related to child safety and to respond appropriately to the needs of vulnerable Georgians.

The Division has established two measurable objectives to monitor changes in employee retention and satisfaction, which may ultimately impact its ability to serve Georgians. Thanks to efforts to improve retention through market-based salary adjustments and improved supervisory support, the Division exceeded annual objectives for child welfare turnover and employee satisfaction. The Division continues to work to lower turnover rates for Office of Family Independence staff.

Latoya

Latoya came to the Division in 2012 supporting Bulloch County's families in the Temporary Assistance for Needy Families program. While she served some of Bulloch County's neediest families, Latoya was also having a difficult time providing for her own family.

Latoya and her 16-year-old son, Jamari, were living in an area that she said didn't always prove to be the safest or most comfortable place to raise a child. For three years, Latoya said she prayed that she would be able to move somewhere that would be a better fit for her family. But her monthly living expenses and the burden of her medical bills had not yet allowed her to improve her circumstances.

In March, when staff in the Division's Office of Family Independence received a raise to match the market rate, Latoya said she felt like she could finally move her son to a better neighborhood.

"The raise was of great benefit to my family," Latoya said. "The extra income allowed me to purchase a newer vehicle and move to a nicer, safer, more comfortable home. It was a great weight off my shoulders."

Latoya now processes applications for one of the most complex programs the Division administers and says she remains grateful for the raise and the impact it had on her ability to provide for her family.

Strategic Goal 5: Workforce

The Division's workforce is competent, professional and efficient

Objective 1

Decrease the case management staff annualized turnover rates by June 30, 2019. (Baseline OFI – 17 percent, Child Welfare – 36 percent)

[Decrease the turnover rate of staff to: Office of Family Independence – 11 percent; Child Welfare – 18 percent]

Month / Year	Baseline [OFI]	OFI Target Measure	Actual OFI Measure	Baseline [CW]	CW Target Measure	Actual CW Measure
July 2017	17%	15%	19%	36%	30%	29.14%
July 2018		13%			26%	
July 2019		11%			18%	

Data Source: The Office of Human Resources

Objective 2

Increase the percentage of employees highly satisfied with their jobs from 66 percent to 90 percent by July 2019.

[Data is the percentage of staff who participate in an annual survey and indicate they are highly satisfied with their jobs.]

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	66%	80%	71%
July 2018		80%	
July 2019		90%	

Data Source: The Division's Employee Satisfaction Survey compiled by Georgia State University

Strategic Goal 5: Workforce

The Division's workforce is competent, professional and efficient

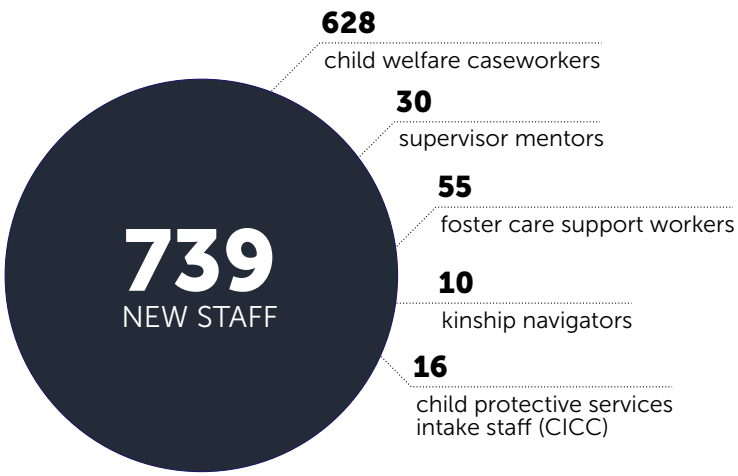
WORKFORCE STRATEGIES

The Division, supported by Gov. Nathan Deal and the General Assembly, has been able to make significant investments in its workforce to improve morale and support safer caseloads for child welfare workers across the state.

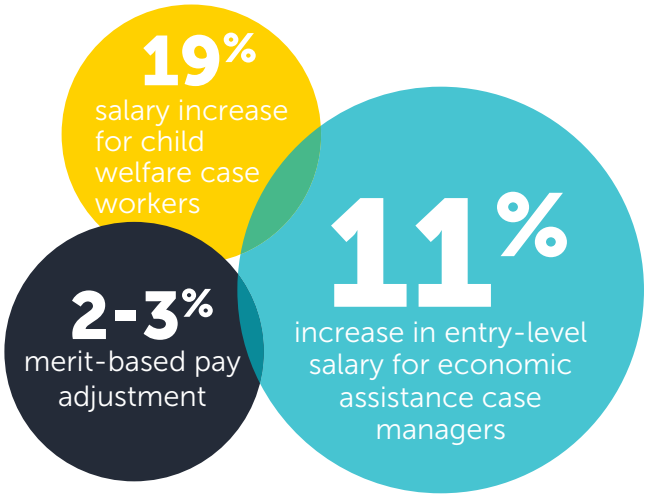
Strategy: Investment in our workforce

SFY 2016 - 2018

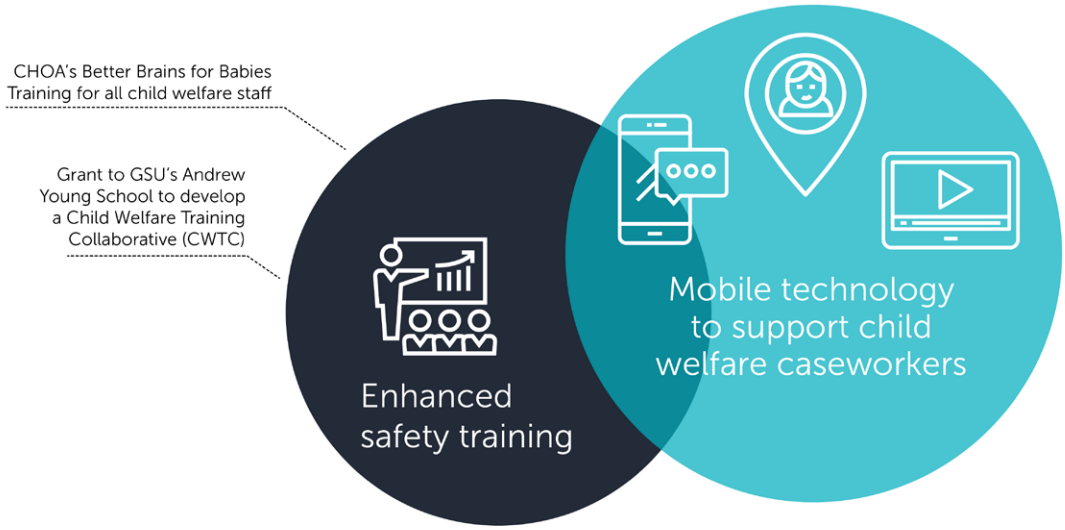
Recruitment



Retention



Training & Technology



Strategic Goal 6: Stakeholder Engagement

The Division and its stakeholders are fully engaged and responsive.

GOAL OVERVIEW

A guiding principle of the Division is to engage, listen and respond to constituents and communities. Another is to collaborate with communities to create systems of support for vulnerable families.

Government can act as a safety net to help families and supplement services available in communities from neighbors, religious and social organizations, and charitable foundations. Where there is a robust network cooperating to support families, there is hope.

In its efforts to support families through community engagement, the Division seeks to foster such communities of hope throughout the state. To do that, it is focusing on developing closer ties to those who have a stake in the success of a State of Hope through better communication and enhanced cooperation.

Launch of Georgia's State of Hope

On May 3, the Division launched its journey to ensure that all of Georgia's children live in communities where they are safe and have the support they and their families need to thrive; this is called a State of Hope.

The event was held at the Georgia Aquarium for the purpose of engaging a broad base of community stakeholders - nonprofits, philanthropies, government agencies, and private businesses – and encourage them to become leaders of this effort. Many signed on as partners and are taking an active role in designing the roll out of the State of Hope for FY18.

DFCS partnered with Casey Family Programs – the nation's largest operating foundation focused on safely reducing the need for foster care and building Communities of Hope across America – for this initiative.

Strategic Goal 6: Stakeholder Engagement

The Division and its stakeholders are fully engaged and responsive.

Objective 1

By July 2019, educate the Division's key stakeholder groups on the Division's revised comprehensive practice model: Solution-Based Casework. Increase the number of stakeholder groups who are knowledgeable about the Division's practice model.

[Data is a measure of the number of stakeholder groups who are knowledgeable about the Division's practice model.]

Month / Year	Baseline	Internal Stakeholder Target Measure	Actual Internal Measure	External Stakeholder Target Measure	Actual External Measure
July 2017	0%	33%	80% staff trained	33%	This will begin November 2017
July 2018		66%		66%	
July 2019		100%		100%	

Objective 2

Reduce the total number of valid complaints received by the Division from 3,687 to 1,796 by July 2019.

Month / Year	Baseline	Target Measure	Actual Measure FY17
July 2017	3,687	2,765	2,284
July 2018		2,212	
July 2019		1,796	

Objective 3

Increase the number of cash match relationships/agreements from 34 to 136 by July 2019.

[Data is the number of positions that are partially funded by local entities.]

Month / Year	Baseline	Target Measure	Actual Measure Fourth Quarter FY17
July 2017	34	34	39
July 2018		68	
July 2019		136	

Strategic Goal 6: Stakeholder Engagement

The Division and its stakeholders are fully engaged and responsive.

STAKEHOLDER ENGAGEMENT STRATEGIES

In order to successfully serve its communities and achieve its goal of strengthening families, the Division must seek out partners in this effort and solicit feedback on how to improve service to its constituents. As part of the Blueprint for Change reform effort, the Division has prioritized the cultivation and engagement of stakeholders throughout the state, including known partners in the judicial and nonprofit communities, as well as unlikely stakeholders in the corporate sector.

With these values in mind, the Division has made a concerted effort to solicit feedback from local communities, through the Blueprint for Change Roadshow, and initiated an effort to engage communities in strategies that make children safer and build stronger families.

Strategy: Regional Roadshows

The Blueprint for Change Roadshow seeks to gather feedback from staff and stakeholders across the state about agency reform efforts and to build consensus on a plan to make Georgia a safer place for children and a state where vulnerable families can access services that put them on a path to self-sufficiency.

During the roadshow visits, the Division engages:

- Community and civic organizations
- Contracted providers
- Faith-based organizations
- Foster parents
- Foster youth
- General public
- Judges
- Law enforcement
- Legislators
- Media
- Staff
- Superintendents and school systems

APPENDICES

Appendix A: Program Year in Reviews

- Field Operations Year in Review
- Knowledge Management Year in Review
- Office of Family Independence Year in Review
- Practice & Program Guidance Year in Review

Appendix B: Funders Briefing

Appendix C: Child Abuse Registry Maltreatment Type Report

Appendix D: Child Fatality Analysis

- CY15 Analysis
- CY16 Analysis

APPENDIX A

Program Year in Reviews

Field Operations Year in Review

Knowledge Management Year in Review

Office of Family Independence Year in Review

Practice & Program Guidance Year in Review

STATE OF GEORGIA

Division of Family and Children Services

Nathan Deal
Governor

Bobby D. Cagle
Director

DFCS Field Operations Section
Year-in-Review
(FY 2017)

This report contains a list of high-level actions taken by DFCS Field Operations in FY 2017 in support of the "Blueprint for Change" and the Division's leadership vision and priorities. These actions provide a foundation of success for Field Operations to build upon in FY 2018 and beyond.

1. **Roll-Out and Implementation of Solution Based Casework and Georgia's Practice Model**
   Statewide 1,600+ staff have been trained – including 400+ supervisors. Training will be concluded early in the next fiscal year.

2. **Completion of Rebuilding & Reorganization of Regional Field Program Specialists (FPS)**
   The following specific FPS roles were created and filled, with one role assigned per team member:

   - CPS Program Specialist
   - Placement Program Specialist
   - Performance Management Specialist
   - Staff Development / Mentoring Specialist
   - Treatment Coordination and Consultation Specialist

   The Placement Program Specialist team met with their counter-parts within State Office Program and Practice guidance to increase communication and to ensure consistency of focus and efforts. The other teams will follow this example during FY2018.

3. **Continuation of "Safe at Home" Foster Care Campaign**
   Field Operations implemented the "Safe at Home" Foster Care campaign plan consisting of the following best practices:

   - Strengthening the Staffing Process for CPS Assessments – Including a Pre-Removal Staffing and a Second Level Approval Above the Case Manager and Supervisor
   - Safely Utilizing Family Preservation Services
   - Conducting Targeted Case Reviews
   - Increasing Permanency and Adoption Efforts
   - Increasing the Utilization of Aftercare Services

The quarterly average monthly "gap" – the difference between Foster Care entries and exits – decreased in July – September, October – December, and January – March compared to the same periods in the prior fiscal year (see Performance Indicator data).

4. Continuation of "Safe at Home 'Hopefuls'" Meetings

As a component of the "Safe at Home" Foster Care Campaign, a monthly meeting was held with counties and regions that experienced the largest percentage of the State's prior Foster Care increase. The meetings included the following topics:

- Role of Leadership
- Mindsets and Bias
- Trauma
- Conditions for Return
- Attachment / Belonging
- Racial Disproportionality
- Poverty – Including a Poverty Simulation Exercise

5. Collaboration with the Department of Community Supervision

DFCS and the Department of Community Supervision (DCS) entered into a Memorandum of Understanding (MOU) in an effort to increase inter-agency cooperation and to reduce any redundancies related to families served by both agencies. A joint "kick-off" meeting was held on 2/14/17. The following key areas are included in the MOU:

- Training Opportunities
- Joint Involvement in Family Team Meetings and Multi-Disciplinary Meetings
- Serving as Collateral Contacts for Each Other
- Exploration of Data Sharing Opportunities (Pending Additional Agreement(s))

6. Emergency Management Activities and Activations

Emergency Management, under the purview of Field Operations, focused on workplace safety and increasing the number of American Red Cross Shelter Trained staff. A core of 15 Field Operations staff were trained as shelter training trainers during the fiscal year to allow training to be conducted internally. Emergency Management also participated in the 11 State activations of the State Emergency Operations Center, including for Hurricane Hermine, Tropical Store Julia, Hurricane Mathew, forest fires, tornados, and various winter weather events.

7. Special Investigations Unit (SIU) Expansion

SIU added several new staff during the fiscal year, including a Quality Assurance team and a Field Program Specialist. SIU also added a team of investigators for Region 12 and Region 5. SIU will continue to expand in the coming fiscal year to provide statewide service provision and targeted, after-hours support.

8. **On-Going Development of Weekly Leadership Development Calls**
   Weekly statewide leadership development calls focused on the fusion of performance, practice, staff retention, and leadership development. The following leadership topics were included, among others, as a part of weekly leadership calls this fiscal year:

   - Leadership Action Series – Think Small to Think Big
   - Leadership Action Series – Lead with Passion
   - Scientific Method
   - Active and Constructive Responding to Good News
   - Partnerships
   - Asking for Help as a Growth Opportunity
   - Mindset Secrets to Achieve Goals Faster
   - Courage Series - Building a Culture of Courage in a Climate of Fear
     - Engage
     - Embolden
     - Inspire
   - The Fearless Leader
   - The Ladder of Inference
   - Interdependence
   - Benevolence
   - Key Leadership Characteristics
   - Year-End Leadership Reflection
   - Affirmations
   - Let Love Inspire your Leadership
   - Self-Compassion
   - Pygmalion Effect
   - Traits of Leaders that do Things Fast and Well
   - Showing Mercy is Your Choice
   - Cultivating Rest and Play
   - Culture of Respect and Civility in the Workplace
   - Problem Solving
   - Critical Incident Stress Debriefing
   - Interactive Series – Conquering the Five Common Fears of Leadership
   - Leadership Series - Introverted Leaders

9. **Statewide CCI Leadership Visits**
   In an effort to increase awareness of the conditions of the CCI facilities and their operations while increasing stakeholder engagement with the CCI directors / managers / owners, Field Operations conducted 135 CCI scheduled visits between September and November 2016. These visits provided an opportunity for a more general assessment of the CCI along with increasing the working relationship between DFCS and the CCI community. These contacts were conducted primarily by Regional, County, and District Directors and other leadership staff.

10. Implementation of a Standard Operations Procedures (SOP) Processes

In an effort to bring consistency to Field Operations, SOP documents were developed for and implemented on the following areas of practice:

- Child Death, Near Fatality, and Serious Injury Cases
- Safety Panel Review Process (updated)
- Monthly "Level Up" CFSR Case Reviews

11. Initial Safety Assessment Review Project

Beginning April 2017, the Field Program Specialists implemented an on-going, statewide review project to assess the quality and fidelity of Initial Safety Assessments.

12. Leadership Succession Planning

Field Operations leadership met with interested County Directors, Field Program Specialists, and State Office staff on 2/14/17 to discuss the Regional Director position and the related duties and responsibilities of the position.

13. Introduction of Harm Statements, Danger Statements, and Consistent Safety Goal Language

Harm statements and danger statements are short, simple, behaviorally based statements about what has happened in the past, why the agency is involved with families, and concerns about may happen in the future. Safety goals are clear statements about what the caregiver will do to ensure the child is safe now and into the future.

14. Expansion of the Vehicle Lease Program

88 leave vehicles were distributed in [pilot] regions 1, 11 and 13.

15. Transition to a Regional Personnel Staffing Allocation and Approval Process

16. Creation of a Case Review Interview Component

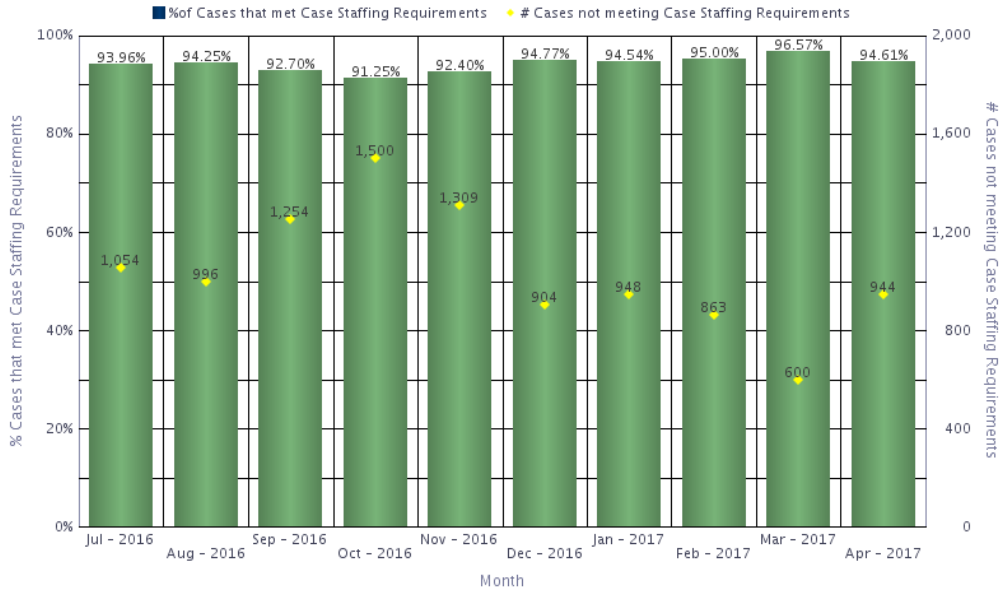
Inclusion of a case review component in the interview process for promotions for Supervisors and above in child welfare to assess the actual quality of a candidate's work.

17. Continued Centralized Intake Call Center (CICC) Efficiency and Service Delivery

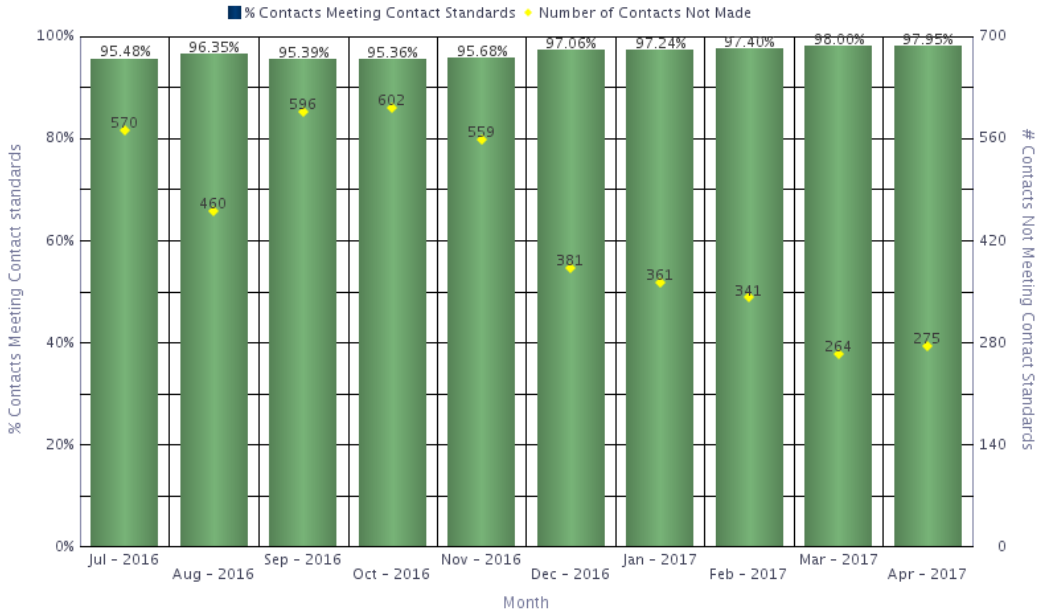
Over the past fiscal year CICC continued to successfully meet the demands of an increasing call volume while implementing a number of strategic changes to benefit both internal staff and front-line field staff as well as produce better quality work to best serve the needs of the children and families served by the Division. This work included, among other efforts, making changes to the Intake Decision Guide to standardize justification statements and to ensure the most appropriate maltreatment codes are utilized based on reported allegations. CICC also implemented a Transitional Unit to work in tandem with the Training Unit to help improve newly trained Intake worker's skills and ease the burden of the fast-paced world of CICC.

Performance Indicators (July 2016 – April 2017)

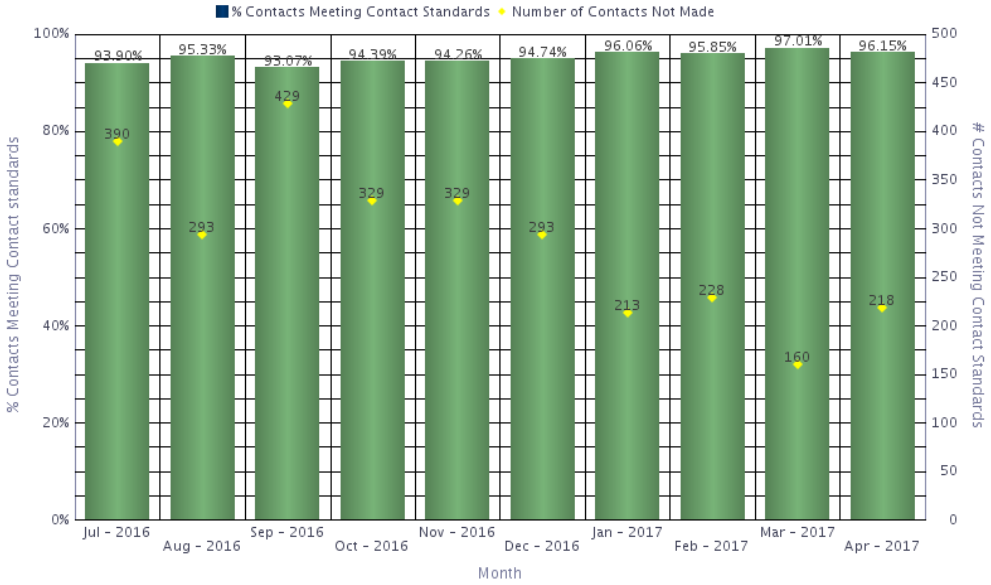
1. Case Staffings



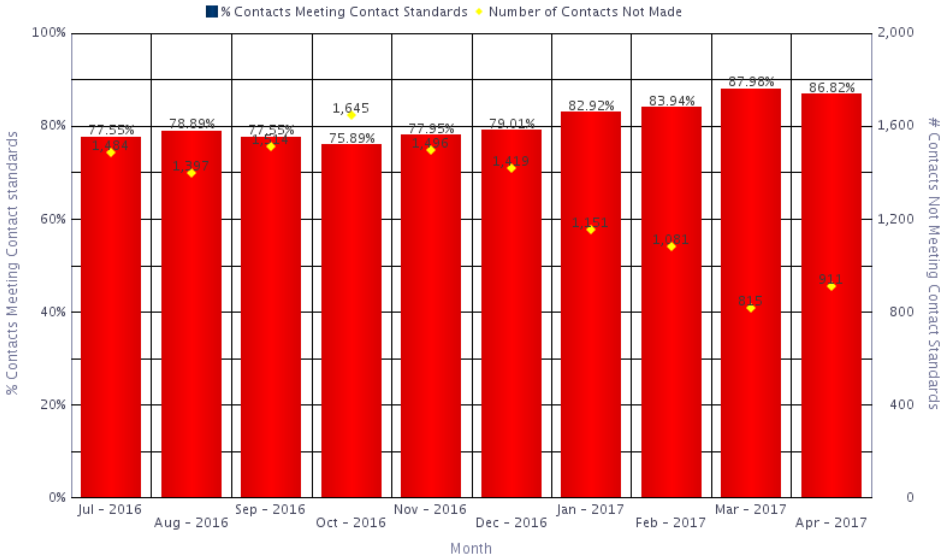
2. Child Visits (Foster Care)



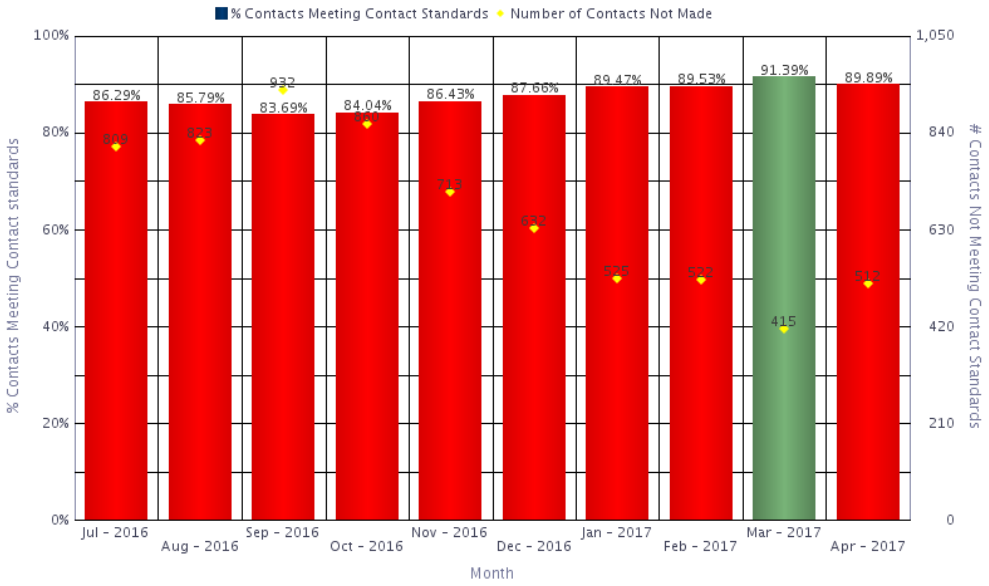
3. Child Visits (CPS)



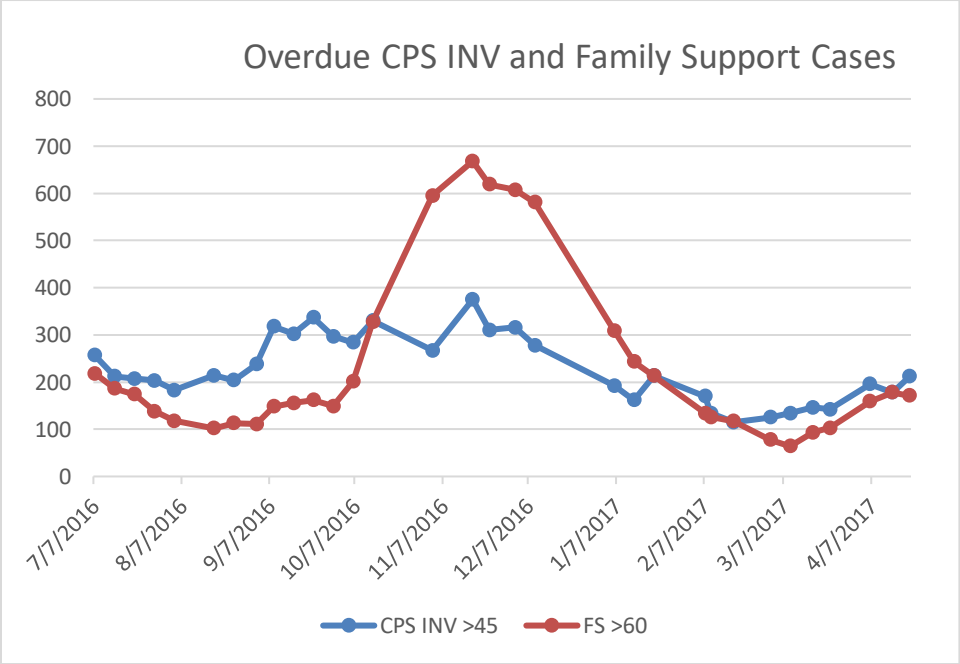
4. Parent Visits (Foster Care)



5. Parent Contacts (CPS)



6. Case Timeliness



Knowledge Management Section

FY-2017 High Level Accomplishments

The following is listing of high-level accomplishments made by the Division's Knowledge Management Section during FY17 and associated with the Division's strategic priorities.

- Administration for Children and Families approved our Program Improvement Plan (PIP) which, when fully executed, will serve to strengthen our practice and service to families. Four of ten quality PIP items were successfully achieve.

- Developed and began piloting our "New Worker Training Academy" which integrates competency-based coursework as well as experiential learning, inclusive of the use of simulation.

- Initiated a year-long project designed to enhance the functioning and impact of our Data Unit. Focused on three main areas; building a data-driven culture across the agency, infrastructure and business need.

- Continued statewide in-class training on Solution Based Casework (SBC) and, for regions that completed training, began facilitation of the certification phase (an on-average six month process during which time trained staff apply learning and develop proficiency in key SBC practice areas).

- Created a fidelity review team dedicated to reviewing the quality of our state-wide implementation of the various structural elements of Georgia's Practice Model.

- Completed development and dissemination of Georgia Practice Model policy.

- Designed and deployed foster care plan in SHINES to support implementation of SBC.

- Presented a workshop on Georgia's Practice Model at Child Welfare League of America's Annual National Conference in Washington D.C.

- Established SHINES interface with Georgia Gateway which allows staff to readily determine if a family is receiving eligible services (i.e. TANF, Food Stamps,Medicaid).

- Enhancements made to SHINES to align with Resource Development policy, thus strengthening safety and permanency-related practice.

- Instrumental in establishing methodology for data collection and review process related to the revised Kenny A. Consent Decree.

- Implemented Performance Improvement Collaborations (PIC) which served to strengthen the process by which results of our internal child and family service reviews are shared, analyzed and, most importantly, put to meaningful use.
.
- Completed evaluation of the agency's Employee Selection Protocol in order to identify frequency and fidelity of use and opportunity to strengthen its effectiveness in identifying viable candidates for front-line positions.

- Planned and held the Section's first annual Knowledge Management Summit, a two-day event that provided opportunity for learning, relationship building and strategic planning.

- Planned and held annual Supervisor Summit.

- Lead planning and facilitation of the Divisions monthly Leadership Development Meetings (joint Social Services and Office of Family Independence).

- Implemented a Policy Advisory Committee to strengthen development, review and dissemination of new child welfare policy.

- Established two SharePoint sites; one to house Federal Regulations and one to house Child Abuse Protocol for easy access.

- Increased Title IV-E Education Program participation from five to seven universities and began placing graduates into full-time agency positions.

- Rolled out Secondary Trauma Training for supervisors and front-line staff in order to educate them on the impact of trauma as well as means to mitigate impact.

- Through persistent and thoughtful advocacy, helped secure $2.5M in funding to develop a Supervisor Mentor Program which will serve to strengthen the agency's workforce.

- Co-founded Georgia PROUD, a multi-agency partnership to identify best practices for interventions with families of infants suffering from Neonatal Abstinence Syndrome.

STATE OF GEORGIA

Division of Family and Children Services

Nathan Deal
Governor

Bobby D. Cagle
Director

DFCS Office of Family Independence Year-in-Review (FY 2017)

This report contains a brief description of high-level accomplishments of the Division's Office of Family Independence (OFI) in FY 2017 in support of the "Blueprint for Change" and the Division's leadership vision and priorities.

1. New Integrated Eligibility System – Georgia Gateway

Together, four Georgia State agencies – Department of Human Services (DHS), Department of Public Health (DPH), Department of Early Care and Learning (DECAL) and Department of Community Health (DCH) – collaborated to design and implement a computer-based integrated eligibility system and business processes across seven State benefit programs. The seven programs include: Medicaid and PeachCare for Kids, Supplemental Nutrition Assistance Program (SNAP, also known as Food Stamps), Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC), Child Care, and coming in the fall of 2018, the Low Income Home Energy Assistance Program (LIHEAP). The new system is called Georgia Gateway, and will be fully implemented in FY18.

2. Continued implementation of the One Caseworker, One Family practice model

OFI continues to operate under the more locally-driven One Caseworker, One Family model. This model is designed to ensure that customers are served in their local counties whenever possible. This practice model, implemented in FY16, has served as the catalyst for many additional improvements in our overall service to the citizens of Georgia.

3. Market Based Pay increases for OFI Staff

To address staff turnover in the OFI section, leadership reviewed the equivalent Job Market Survey from the Southeast region provided by the Georgia Human Resources Association (HRA), which provided data to support an increase in our entry level salaries for all core staff – front-line staff, supervisors and administrators. These increases were effective March 1, 2017.

4. **Progress made in closing findings on the Food and Nutrition Services (FNS) Management Evaluation.**

   During this fiscal year, OFI was successful in closing 8 of 19 findings. It is anticipated that the eleven additional findings (5 issues) will be closed within the next four months.

5. **SNAP QC Accuracy**

   OFI successfully lowered the SNAP error rate from 4.70% in FFY2015 to 4.04% in FFY2016.

6. **SNAP Time-Limit Able Bodied Adult without Dependents (ABAWD) program operational in 24 counties**

   The ABAWD Time-Limit Program was reinstated in January 2016 in three counties – Cobb, Gwinnett and Hall. The ABAWDs in time-limit counties are required to be in a work or skill-building activity to receive SNAP benefits beyond their initial 3 months of eligibility. This program was successfully expanded to an additional 21 counties in FY17. Staffs are planning to add an additional 69 counties to be added in FY18.

7. **Implemented the SNAP Works 2.0 Grant in ten counties**

   Georgia received a $15 million dollar grant from the USDA Food and Nutrition Services (FNS) to provide a pilot SNAP E&T program for 10 counties. This grant is funded for three years from October 2015 through October 2018. The 10 counties included in the pilot are: Bulloch, Chatham, Cherokee, Clayton, DeKalb, Douglas, Glynn, Gwinnett, Henry and Rockdale. The money was fully approved in January 2016, and the services began being rolled out in late January. The program was implemented in waves, with all counties operational as of the end of June 2016 and continued throughout FY17.

8. **Peach Stars, Quality Stars and Quality Leaders Awards**

   A robust recognition program continued to thrive in OFI, with over 1450 Peach Stars awarded since January 2016. Peach Stars are awarded for demonstrations of superior internal and/or external customer service. Staff are nominated for Peach Stars by peers and management. Quality Stars (Front-line Staff) and Quality Leaders (Supervisors) are awards given for accuracy on Quality Control case reviews. Over 175 Quality Stars and Quality Leader Awards are presented each month.

9. Gateway Training

All OFI staff trained on Georgia Gateway. Child Welfare and other staffs that need inquiry access to Gateway were trained as required.

Additionally, Chief Deputy Division Director, Jon Anderson, held 15 Gateway Overview sessions with a total of 2,331 staff. These user-focused workshops were held from January 10, 2017 through August 16, 2017 in Macon, GA in preparation for statewide implementation of the new system.

10. Performance, Feedback and Enhancement Committee

The Performance, Feedback and Enhancement Committee (PFE) continues to be a source of support to the field across all program areas. During the past year, PFE has implemented the following projects to enhance the performance of OFI staff:

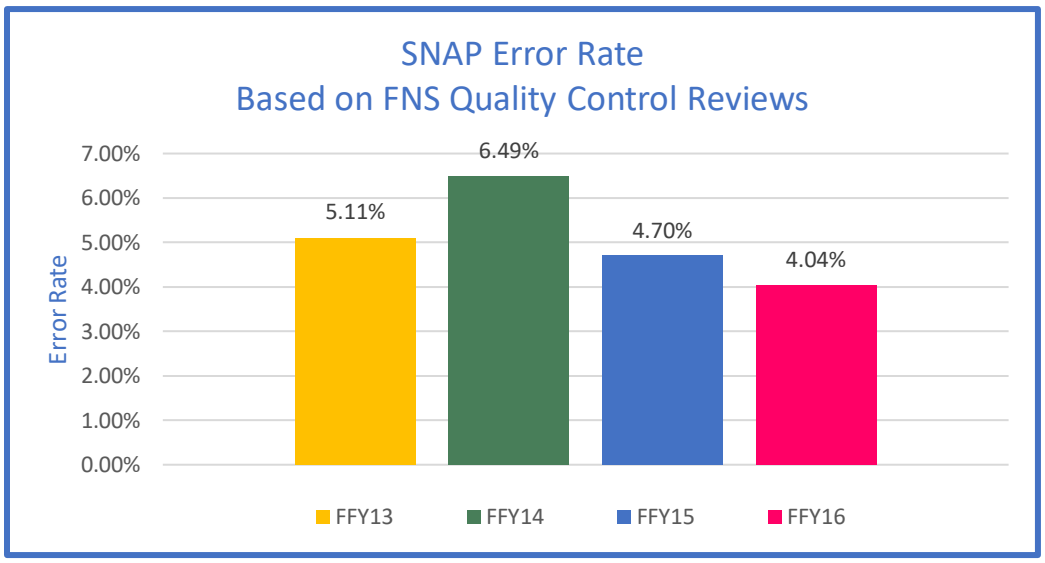
- Quality Checks/Sweet 16 Case Reading Process
- Quality Summit
- Gateway: Crossing the Bridge to Accuracy Training
- Gateway Documentation Requirements Training
- OFI Day 1 Training
- Standardized Unit Meeting Agenda and Supervisor Notes
- Quality Control Corner

11. Community Services Block Grant (CSBG) increases Customer Satisfaction

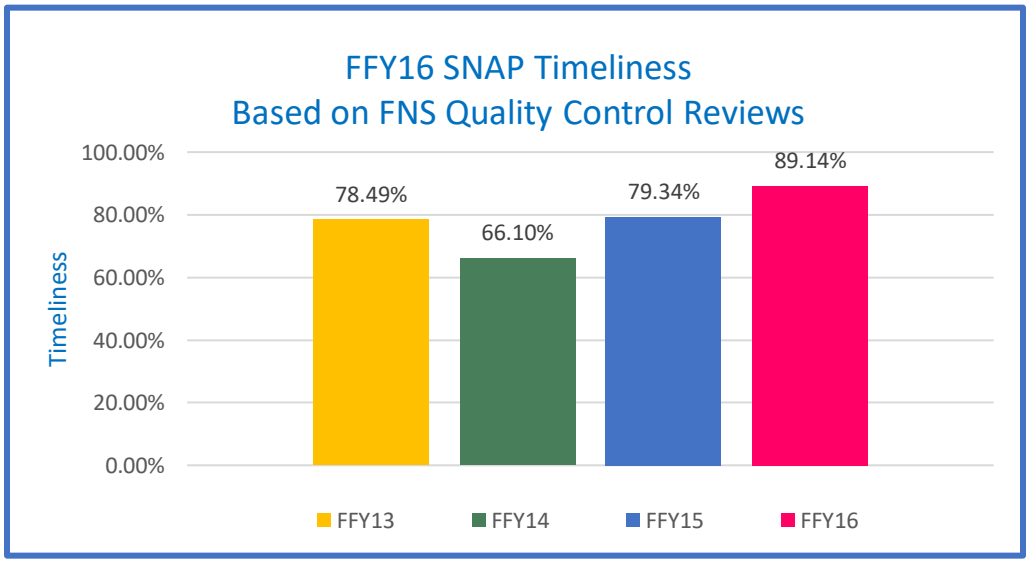
The American Customer Satisfaction Index (ACSI) is the national indicator of customer evaluations of the quality of goods and services available to US residents. The program's objective for CSBG was to measure satisfaction of Community Services Block Grant eligible entities to better understand how well the States are delivering services to the local eligible entities, in which we have 24 in Georgia. During the last year the CSBG program has been working to improve the initial results of a 42% out of 100%. We just received the new results for Georgia and it is now a 66% out of 100%. Increasing our score 24 points is outstanding. The national increase was 5 points and they felt that was a tremendous increase.

OFI Performance Indicators

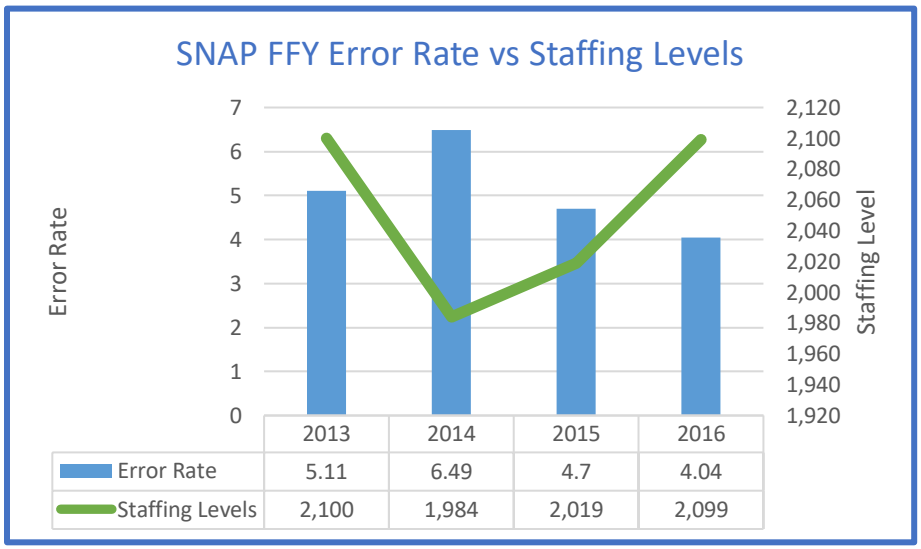
1. SNAP Accuracy



2. SNAP Timeliness



3. Staffing vs Error Rate



Georgia Division of Family and Children Services
Practice and Program Guidance SFY 2017 Accomplishments

Well-Being Services Section

Georgia R.Y.S.E. / ILP Accomplishments	
Completed the plan for CB 21 (extended foster care plan)	Plan will be used to present for legislative consideration
Completed 1.5 years of ETV partnership with UGA/Fanning Institute	• Improved financial distribution to college students. • Improved engagement with colleges/universities • Development of electronic database to track and monitor ETV paperwork • Development of website to
Pilot Project with Georgia's Drivers Education Commission (GDEC)	• Provide additional support for youth to complete the driver's education process from beginning to end. • Increased the number of youth able to access resource by 50 youth.
Partnership with Columbus Housing Authority and local case management provider.	Provide housing opportunities for youth in Columbus with intensive support
Orange Duffel Bag educational partnership	Provide educational support and workshops to at least 50 youth to improve academic outcomes for high school students.
MAAC Partnership for ILP Workshops	Per Chafee purposes resources through workshops for youth are provided monthly covering multiple topics (i.e., finances, education, self-esteem etc.)
Early Childhood Collaboration	
Streamline referral process for children in foster care under the age of five to quality early childhood education programming.	• Increased early childhood education program enrollment from 32.95% to 38%. This is a strategy in the Strategic Plan. • Child and Family Service Review – Well-Being Outcome 2 (Meet the Educational Needs of Foster Youth)
Strengthen relationship between child welfare and Head Start/Early Head Start Association	• Facilitated meetings, trainings, and workshops along with Head Start leadership at the federal, state, and local levels targeted at: Foster Parents, DFCS Staff, Head Start Staff, Community Partners • Total-23

	• Child and Family Service Review – Well-Being Outcome 2 (Meet the Educational Needs of Foster Youth)
Strength relationship between child welfare and DECAL.	• Partnered with the DECAL to ensure priority and facilitate enrollment in the following programs: o Georgia Pre-K- o Quality Rated Child Care Programs o CAPS • Child and Family Service Review – Well-Being Outcome 2 (Meet the Educational Needs of Foster Youth)
Support and In-Home Services	
Paternity Testing Request for Proposal (RFP)	RFP was administered successfully and a new vendor was selected to begin services October 1, 2017.
Interagency Collaboration: DHS Coordinated Transportation	Relationships were developed with DHS Coordinated Transportation to begin discussions surrounding transportation issues in rural areas and provide additional resources to children and families in foster care to meet the needs of visitation requirements and reaching educational goals.
Support Services Programs RFPs revised and posted to meet the demands of the families served in Georgia to ensure quality providers are selected.	Homestead, Early Intervention, Comprehensive Child and Family Assessment (CCFA), WRAP Around Services have posted and are currently under evaluation to increase the pool of qualitative vendors to assist in meeting the mental health needs of families.
Alcohol and Drug Screening Services	• A RFP has been posted for this service and is under negotiation with a final vendor with agreements to train DFCS staff to conduct screenings. • Because of this initiative, the Department should begin seeing a reduction in time for reporting results to court to make decisions on families' futures
Partnership: Timeliness of Payments	Support Services worked collaboratively with the field leadership and the fiscal department to begin developing a plan to better ensure our external partners are paid in a timely manner.
Community Programs	
Afterschool Care Program	Forty (40) community-based organizations and public agencies instituted the *Power up for 30* GA Shape program during their afterschool program. Approximately 56,000 youth participate in GA SHAPE activities during the out-of-school time through this partnership. • Initiated through the Governor's Office.

Afterschool Care Program	Number of youth served: approximately 56,000 youth were supported through DFCS Afterschool Care Program Funding.
Educational Programming, Assessment and Consultation (EPAC)	Increased EPAC referral rate from 48% to 65%
Educational Programming, Assessment and Consultation (EPAC)	Conducted Statewide Education Academies to ensure Case Managers are knowledgeable of the tools, and resources to ensure educational stability for youth on their caseload. • Every Student Succeeds Act • Child and Family Service Review – Well-Being Outcome 2 (Meet the Educational Needs of Foster Youth)
Georgia TeenWork Internship Program	Provide quality job readiness training to youth. Increase the number and breath of job readiness trainings: • Number of job readiness trainings: 15 • Number of Youth Participants: 797 *US Chamber of Commerce: Making Youth Employment Work
Georgia TeenWork Internship Program	Job Readiness Training curriculum was created and provided to 797 foster youth *US Chamber of Commerce: Making Youth Employment Work
Wellness Programming Assessment and Consultation (WPAC)	
Interagency Partnerships	In partnership with PRO Team, created a Hospital Escalation Protocol to improve Agency responsiveness for HealthCare providers
Healthcare Innovations	In partnership with Amerigroup, ensured appropriate counties had Mobile Response Unit, School Clinics, and Court Clinics
Well-Being Services	
25th Celebration of Excellence: ILP and Community Programs	Organized and convened the 25th Annual Celebration of Excellence (COE). This event celebrates high school and post-secondary academic attainment for young people in foster Care. More than 200 young people were recognized
4th Annual Teens R 4 Me Conference: ILP, Community Program, WPAC	Organized and convened the 4th Annual Teens R 4 Me Conference. This event supports positive well-being outcomes for youth in faster care (14-17) and the practitioners that support their trek to adulthood. More than 150 children and 100 adults attend.
Project Graduate	• Project Graduate is a collaborative effort between the Division and key stakeholders to improve the graduation rates of Georgia's foster youth by

	providing coordinated supports while leveraging existing resources. • This initiative spanned the 2016-2017 academic year in DeKalb and Fulton counties. Primarily engaging the four school districts within those counties: Atlanta Public Schools, Decatur City Schools, DeKalb County Schools and Fulton County Schools.
Implementation of new education service delivery model	In partnership with a Lead Education Partner Agency - the Multi-Agency Alliance Children (MAAC) – the Division will ensure the educational needs for children in foster care are met so they can achieve academic success, including improved high school graduation rates and a decrease in negative indicators such as over representation in disciplinary interventions and grade retention. • Beginning August 1, 2017 • Fulton and DeKalb Counties Children/Youth enrolled in the 7th – 12th Grades or pursuing a GED (As of July 15, 2017

Safety Services Section

Safety Accomplishments	
Developed the agency's Comprehensive Addition and Recovery Act implementation plan	Plan will be used to ensure federal compliance by implementing a DFCS Response for infants affected by prenatal exposure or Fetal Alcohol Syndrome AND due to prenatal exposure but the mother's substance use is supervised by a medical professional.
Partnership with Georgia PROUD (Partnership for Recovery Over Using Drugs) Team. Georgia PROUD grew out of the Safety Sections Advisory Committee	• The goal of Georgia PROUD is to identify best practices when developing Plans of Safe Care for infants and their families affected by prenatal substance exposure and to fully comply with all requirements of CAPTA and CARA. • The team is receiving In-Depth Technical Assistance (IDTA) from the National Academy on Substance Abuse and Child Welfare and is ensuring Georgia takes all steps necessary to serve these children and their families and caregivers. • Georgia PROUD was selected to attend the SAMHSA 2017 Policy Academy: Improving

	Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders, and their Infants and Families on February 7-8, 2017
Safe Sleep Initiative	• Decrease sleep related deaths of children known to the department by 5% annually to include the following: • Provided technical assistance and materials to Savannahs Perinatal Initiative Program providers. • Resources provided flip charts and family guides for Latino families to county offices.
Enhanced case review practice of High Risk Cases	In partnership the Safety FPS two additional review levels were included in the Safety Panel Review Process of High Risk Cases.
Georgia's Child Abuse Registry	Maintains a listing of all substantiated cases of child abuse and expanded screening access to the entities, listed below, to prevent maltreators from supervising or caring for children. • Contracted agencies of governmental entities • Any entity licensed by any other state to place children for adoption • A Child-Placing Agency licensed in Georgia to place children in foster homes or for adoption
Completion of Georgia's First Quarter Safety Program Improvement Plans (PIP)	• Developed a substance abuse protocol in partnership with the Courts and Substance Abuse Providers to increase parental capacity and improve safety outcomes. • The Safety Resource Approval Checklist was developed to ensure appropriate practice and compliance with time frames.

Prevention & Family Support Services Section

Prevention Accomplishments	
Safe Sleep Community Educator Training - develop a community educator training program with Clayton and Richmond Counties (two highest risk counties). Partner with DPH to provide the training. The Community Educators will be identified by the county DFCS program managers to be community members such as faith-based organizations, in-home childcare providers, community volunteers, etc. They will then be responsible for providing safe sleep classes to parents of newborns in their	Safe Sleep in strategic plan - safety outcome: reduction in the incidence of babies being killed or injured due to unsafe sleep environments

communities. We will use pack-n-play cribs as incentives for attending the classes.	
Purchase of pack and plays for safe sleep - determine process for purchase of cribs and distribution to DFCS counties/regions.	Safe Sleep in strategic plan
Addition of DFCS C3 Community Resource Guides to Prevent Child Abuse Georgia online resource guide. OPFS provides funding to PCA GA to man a 1-800-CHILDREN Helpline with an online resource directory. We have offered to fund having the DFCS resources from the C3 Coordinators added to the online resource directory. This will also be added into SHINES for a quick link to the map.	Strategic Plan - provide additional resources to families and DFCS staff by providing ready access to local resources to be utilized by staff and/or families and caregivers.
Training of Kinship Navigators in Parent Cafes - we are working with Strengthening Families GA and Tacia Estem to coordinate Parent Café training for the kinship navigators. Trainings will be held in Spring 2018. Planning meetings held in 2017. Parent Cafes are a Strengthening Families initiative based on the World Cafe model where kinship caregivers will be invited to attend, build social connections with other parents or caregivers, and discuss items of relevance to raising their kin.	Strategic Plan - to provide kin placements with more resources
Providing Parentivity as a resource to Kinship Navigators - Parentivity is a web-based application for families of young children. It includes resources about child health and development, child safety, safe sleep, and resources for families. We will be coordinating the use of Parentivity with the Kinship Navigators. Eventually, we intend to expand to all of DFCS.	Strategic Plan - to provide kin placements with additional resources by providing them a web-based application to learn more about child development, parenting skills, safe sleep, and other topics relevant to raising kin.
Strengthening Families - OPFS is the primary funded for the Strengthening Families GA initiative. Works to embed the Protective Factors into work of all family/child-serving agencies, including DFCS.	Agency outcome - SBC and practice model supported by incorporation of SF PFs to help strengthen families.
Essentials for Childhood - a CDC initiative to promote safe, stable, nurturing relationships and environments through a collective impact approach. OPFS provides the funding for the	Agency outcome - CDC's Essentials for Childhood aligns with the State of Hope initiative

initiative and represents DFCS on the steering committee.	
Georgia Family Connection Child Abuse Prevention Cohort - developed a new contract with GA Family Connection Collaborative to develop a cohort of counties to address the prevention of child maltreatment as their primary strategy.	Agency outcome - constituent engagement and aligns with State of Hope
Better Brains for Babies - OPFS is the primary funder for the BBB initiative which provides trainings and expertise on early brain development and the impact of trauma. OPFS sits on the Advisory Board. BBB worked on the Talk With Me Baby brain modules through contract funding from OPFS.	Strategic Plan - offering training to DFCS staff about early brain development.
Child Abuse Prevention Month Activities - coordinated events and activities for the national Child Abuse Prevention month (April). Hosted a CAP Day at 2 Peachtree, coordinated a showing of the Resilience documentary coordinated a Governor's proclamation signing, coordinated resources provided to DFCS Board and DFCS staff throughout counties/regions/districts. Produced a calendar for families and distributed calendars, magnets, pinwheels, and lapel pins to 159 counties/all DFCS staff and providers.	Agency outcome - constituent engagement, prevention
Transition of MIECHV to DPH - the federal Maternal, Infant, Early Childhood Home Visiting grant was officially transferred to DPH. OPFS continues to fund some home visiting sites and First Steps, the screening component of home visiting.	N/A
PREP Adolescent Pregnancy Prevention Program moved under OPFS in April 2017. PREP provided: • 34 New Facilitators Trained in Making a Difference and Making Proud Choices • 1 New Facilitators Trained in Be Proud! Be Responsible! Be Protective! • 6 Professional Development Trainings (3 In-person and 3 Webinars) • 3 Connected Caregiver Trainings for Foster Parents and other Caregivers • Served and graduated 810 youth as of 8/15/2017	Federal grant requirements for PREP grant. PREP grant provides comprehensive sex education to youth throughout the state, both those in and out of care.

Placement and Permanency Services Section

Placement & Permanency Accomplishments	
Formed partnership with private placement providers to further align public and private foster home requirements, develop Flexible Capacity Agreement pilot & further systemic innovations.	The partnership has resulted in the following outcomes thus far: • Modification of program standards for Independent Living Programs (ILPs) and Transitional Living Programs (TLPs), and development of new standards for Personal Care Homes (PCHs). • Flexible Capacity for SMFWO agencies • Assessment of DBHDD Tiered model
Completed SHINES Enhancement/Foster Care Management- Child Placement Referral Form- Universal Application. This allows for one tool to be used by county DFCS offices, all private agencies and the state PRO Team.	• Modifications to existing pages • Three new pages • New system validation/automation • New notice/letter
Completed GA+SCORE Enhancements.	The enhancements resulted in the follow efficiencies: • Modification to existing Referral process for PRO • Allows automated responses and notifications sent between PRO and Field • Allows Providers and Field to know "where they are" in the process by providing system updates • Tracks and keeps record of all correspondence with Field and saves copy of waiver • Decreases timeframe on request
Partnered in the development phase of the Youth Villages Intercept Model pending contract.	The partnership sought to improve outcomes in the following areas: • Crisis Stabilization • Addressing systemic needs of families to move children from state custody to biological family custody
State PRO Team was active in the Children's Freedom Initiative, a collaborative effort to ensure that children who live in facilities are given the chance to live with permanent, loving families.	• The CFI is supported by the Georgia Developmental Disabilities Network, which receives funding from the Administration on Developmental Disabilities, and includes The Georgia Council on Developmental Disabilities (GCDD), the Institute on Human Development and Disability at the University of Georgia (IHDD), The Georgia Advocacy Office (GAO), and the Center for Leadership in Disability at Georgia State University (CLD).

Completed major project to address Non-Contracted Provider Standards and Guidelines and reduce by 85% children who were placed in non-contracted providers.	Accomplishments include: • Cease usage of Non Contracted Providers in 85% of child cases. • Development of Non Contracted Governance Document • Implementation of Non Contracted Monitoring • Onboarding of Non Contracted Agencies • Eliminated Non Contracted providers who do not require licensing
Partnered with MAAC to execute the Crisis Continuum.	• Crisis Stabilization • MAAC has developed a crisis response continuum with partner agencies to decrease the need for hotel "placements". • MAAC will add additional supports for youth referred to this program in order to stabilize the youth and plan for the most appropriate placement DFCS will have 25 "slots" available at any given time to utilize fo1· these youth. MAAC will serve approximately 200 youth over the 12 month period of time. Youth will be place under MAAC's current RBWO contract and receive crisis response services for 30 days
Developed and implemented PRO/OPM Regional Roadshows.	• Engagement with the Field regarding PRO and OPM Units, processes and protocols
Developed FPS/PRO Collaboration, implementation pending.	• Collaborative effort between FPS and PRO to establish a strong partnership. It is further recommended that the scope and authority of the state level PRO Team be refined. Specifically: • Treatment FPS will provide primary education and guidance to field staff regarding the general placement locating process. • Treatment FPS will assist the field in locating base to moderate level placements and serve as a gatekeeper for appropriate high end need referrals to the state level PRO Team. • State level PRO Team Specialists will be assigned to specific Field Operations Districts to better collaboration with specific Treatment FPS and follow District high end children to ensure quality services and placements. • The state level PRO Team will provide direct intervention with high end providers to efficiently secure placements. • State level PRO Team will become more actively engaged in the assessment of available high end placement openings, an understanding of the acuity mix of the placement providers and the negotiation of

	what is needed to secure expedient high end placements. State level PRO Team and Treatment FPS will re-institute "utilization reviews," regularly scheduled meetings with high end placement providers to assess each child's treatment, progress, ability to move to a less restrictive setting and progress towards a permanency plan.
Execution of the National Electronic Interstate Compact Exchange (NEICE) system in Georgia.	• GA ICPC went Live March 03, 2017/ Participating in this cloud-based electronic system that allows the exchange of data and documents necessary to place children across state lines shortens the time it takes to place children across state lines, reduce costs associated with mailing and copying documents, and provide an improved method of tracking ICPC requests.
Developed regional sit visits and training for permanency field staff.	Provided onsite training to all ICPC Liaisons, Region 8, 6, 13, and 3/Increase knowledge and expectation of the ICPC process to the agency as a whole. All regions will receive training and ongoing yearly.
Updated ICPC Policy	• Went over final revisions and waiting on policy unit to provide to all Regions / Reduction of system barriers from the State and Local level
Reduction of and continued focus on overdue cases in the ICPC database.	Accomplishments include: Decreased monthly and currently at 63/Fewer constituent complaints in regards to timeliness of home study request.
Successfully transitioned SSAU to Placement & Permanency Services.	Resulting in the reduction of barriers for families and staff that will improve timely permanency for children.
Completed adoption Re-alignment with specific focus on Adoption Assistance.	Outcome: • Consistency in practice and provision of a continuum of services to adoptive families
Initiated the development of Contracts specific focus and staffing.	• Improved timeliness for contract execution and managing of sections fiscal duties • Improved the quality of contract scope and deliverables.
Completed Gateway transition for Adoption Medicaid.	• Supportive services to adoptive families to ensure finalized adoptions remain stable
PIP Items Finalized for Q1 – Q3	• Improved CSFR outcomes for state and families
State Strategic Plan: Kinship Navigator program provided services and supports to 2700 kinship families. Increased	**State Strategic Plan:** Increasing the stability, identification, and tracking of informal and formal relative placements

engagement of kin caretakers during investigations and family preservation cases.	
The Risk Management section hosts a monthly meeting with various stakeholders and sister agencies to discuss any patterns and trends as it pertains to the providers we contract with.	• During the 2017 fiscal year, representatives from the Fiscal Department, Revenue Maximization Unit and the Dept. of Juvenile Justice Revenue Maximization Unit were included and have initiated participation in the monthly Risk Management roundtable meetings so that all relevant parties are aware of any concerns or identified problematic issues with any of our providers.
The Office of Provider Management have also developed and incorporated various methods in which corrective measures will be implemented with regards to providers that violate any of our policies or procedures.	• Some of these corrective measures include increasing the penalties on provider's PBP scores associated with concerns that were identified to be an ongoing pattern for providers during the year which includes the untimely submission of Policy Violation Assessments, Corrective Action Plans, Significant Events and Performance Improvement Plans. These were concerns that were identified throughout the fiscal year that required immediate resolution.
The Office of Provider Management also initiated meeting with the Policy Unit to provide additional assistance in the development of the RBWO Minimum Standards for the upcoming 2018 fiscal year to ensure that our standards matched and parallel any new or existing changes to DFCS child welfare policy.	Various new policies were also developed and implemented into our existing RBWO Minimum Standards which would address some of the patterns and concerns identified throughout the year.
The Office of Provider Management also provided various trainings to our providers to address the surrounding deficiencies outlined in the PIP which resulted from a recent Title IV-E audit initiated by the federal government.	• 100% Audit was completed on all RBWO providers and this allows course corrections in order for the Division to perform well on our next federal audit.
The Office of Provider Management revised and expanded our New Provider Orientation this year. The Orientation was designed for all newly approved CCI's, CPA's and ILP's and lasted for two days. OPM offered two different Orientation sessions so that all newly approved providers had the opportunity to participate as this has aided the division with moving away from utilizing non-contracted providers.	• The New Provider Orientation is designed to give new providers a full overview of everything that will be expected as a contracted provider. The agenda included a full monitoring overview, a look at contractual obligations, RBWO Minimum Standards and DFCS policy requirements, OPM Training, Fiscal Services overview, accounting and billing process, provider dispute resolutions, waivers and the universal application, risk management, and Caregiver Recruitment and Retention.
The Office of Provider Managements has taken a more active role in monitoring provider Performance Based Placement (PBP) scores. For starters, we began by taking a look at providers	• Providers that fell into this category participated in an Office Conference to discuss their PBP performance, to identify any barriers that may be hindering their performance and for us to provide technical assistance

who had failing PBP scores for two or more consecutive quarters.	in any areas they needed assistance in. OPM met with a total of twenty-one providers between June and July to discuss their PBP performance.
The OPM Leadership Team began conducting technical assistance meetings for contracted providers in October 2016. Different topics were developed into modules for a full day of training. The intent was for providers to be able to participate in an interactive way, with a goal of improving performance. Topics of discussion included DFCS/RBWO Partnership, OPM Structure, Monitoring Reviews, Purposeful Documentation, Individualized Skills Plans, Maintaining GA+SCORE, SHINES Overview, Common Deficiencies, ILPs vs. TLPs, Normalcy for Children, Policy Violation Assessments, and Foster Home Approvals. We conducted successful trainings in Savannah, Macon, Columbus, Thomasville, and several in the Metro Atlanta area. The goal is to continue this project on an on-going basis, however we will update the topics/modules based on the informational needs of each fiscal year.	• OPM received overwhelming positive feedback while travelling the state. However, the one critic that always came up was that DFCS case managers do not seem to be on the same page with what we hold the providers to. As a result, the decision was made to travel once again, but to conduct trainings for a DFCS audience. We sent out an invitation to each of the regions with plans to visit local offices. We received a response from Regions 4, 5, 6, and 11. The response from DFCS employees was also extremely favorable.
With all of the new vacancies that OPM must fill, OPM recognized the need to develop a uniform Unit on-boarding process. All new hires going forward will have to successfully complete the same carefully structured three week orientation, before receiving focused job training in their new OPM role. The OPM New Hire Unit Orientation includes orientation with OHRMD, OPM Structure and Responsibilities, Permanency Section Overview, Unit Overviews, Introductions to GA+SCORE and SHINES, Provider Documentation, Significant Events, Minimum Standards, Risk Management Overview, Provider Relations Overview, Monitoring Tools, Professionalism/Customer Service/Ethics, Monitoring Reviews, RBWO Foundations, and Team Shadowing in Risk Management, Provider Relations, and Monitoring.	• The benefit is that if all new hires understand all aspects of OPM as a whole, it will produce excellence in each specific area of concentration.
Gained SHINES access for Bethany Christian Services for Child Life History completion.	• Reduced work for the field/better quality CLH. • 1,389 CLH completed
Implemented District Adoption Cadence Calls.	• More leadership participation and increase focus and adoptions

Implemented No Place Like Home monthly calls with Director Cagle.	• Leadership participation and drilling down of barriers to improve outcomes. To date 50% of the children in the cohort have been finalized.
Guardianship Waiver Training for waivers to be processed in the Regions.	• Developed and trained FPS on a guardianship decision guide. • Waivers are being processed consistent with State Office meaning better permanency outcomes for children.
Executed the Statewide Adoption Match Meeting.	• 282 Staff attend and received training 227 adoptable children presented, 171 (75%) had at least one potential match.
Executed Adoption Parties throughout the state.	• 195 Children attended Adoption Parties 196 Families 63% Potential Matches made
Contracted CPA (4)	• 150 Adoption placements 130 Finalization
Executed contract for ADOPTS adoption specific counseling & intervention services.	Outcomes: • 741 Family Counseling Sessions 275 Crisis Intervention Hours 530 Parent Coaching Sessions
Initiated the practice of Placement Resource Engagement Meetings between Regional Caregiver Recruitment and Retention (CRR) Teams and Private Agency Providers in their respective Areas.	• ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement*** – improves the local partnership of Field staff and private agency partners by increasing support from the point of inquiry of prospective caregivers, improve the efficiency of prospective caregiver onboarding buy using all available resources; increases availability of local placements to improve placement proximity.
Hosting Monthly Cadence Calls with Regional CRR Teams – *Began February 2016*	• ***2015-2019 CRR Plan Goal #2 – Improve organizational effectiveness regarding placement resource development, retention, and placement matching -*** Continuous accountability and engagement with field staff to assess adherence to practice and identify performance impediments
Hosting Quarterly Statewide Caregiver Recruitment and Retention Meetings with all CRR staff	• *Same as Item 2*
Weekly Webinar Information Sessions for Prospective Caregivers hosted by state-level team *— average 84% participation rate in webinar sessions.*	• ***2015-2019 CRR Plan Goal #3 – Increase the retention of prospective caregivers during the approval process and once approved, retain caregivers for at least five (5) years*** – Enhance the Foster Georgia Inquiry Line for prospective and fully approved caregivers by creating email materials, improving the website interface, and creating more

	effective communication linkages between the call center and county/regional resource development staff by September 2018
Utilization of caregiver navigators (5 part-time paid foster parents) to support prospective caregivers through the onboarding process Launched and Initiated public awareness of new website www.fostergeorgia.com September 2016 –- included web-based inquiry form for prospective caregivers, as well as a chat feature for engagement with site visitors.	• *Same as Item 4* • ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement -*** Enhance the Foster Georgia Inquiry Line for prospective and fully approved caregivers by creating email materials, improving the website interface, and creating more effective communication linkages between the call center and county/regional resource development staff by September 2018
Statewide Recruitment Campaign through contract with vendor that led to the increase of traffic to the inquiry line and new website – September 2016 – February 2017.	• *Same as Item 6*
Launching of the Foster Georgia Inquiry Line manned by a state level team – *formerly outsourced to a vendor.*	• *Same as Item 6*
Resource Development SHINES Enhancements – May 2017	• ***2015-2019 CRR Plan Goal #3 – Increase the retention of prospective caregivers during the approval process and once approved, retain caregivers for at least five (5) years -*** Develop method of tracking prospective caregivers through the approval process by September 2018
Development of LENSE reports and Executive Dashboard for Resource Development	• ***Same as above***
Initiating the training of implementation of the SAFE Home Study	• ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement*** – establish uniformity in the assessment of caregivers using an evidence-based based assessment of both prospective and approved caregivers.
Launching of Statewide Targeted Recruitment Initiatives – February 2017	• ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement -*** Develop enhanced recruitment communication methods/distribution and materials to reach prospective caregivers from all communities.
Train-the-Trainer opportunities for RD and CPA staff December 2016 – March 2017 –	• ***2015-2019 CRR Plan Goal #3: Increase the retention of prospective caregivers during the approval process and once approved, retain caregivers for at least five***

Recognizing Developmental Delays in Children Ages 0-5	***years.*** – 2(a) Use information from the caregiver exit surveys to inform pre-service and ongoing training changes and improvements.
Implemented ongoing communication with caregivers via the *Foster Georgia Newsletter*	• ***2015-2019 CRR Plan Goal #3: Increase the retention of prospective caregivers during the approval process and once approved, retain caregivers for at least five years. -*** Increase support by establishing a regular and ongoing communication channel with foster, adoptive and relative caregivers by December 2016.
Implemented Quality Initial Family Assessment training with Foster Home Development Contractors, and established direct communication with vendors via the *Foster Home Development Contractor Newsletter*	• ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement***
Launching of RD Case Manager Track Training – first course offered September 2017.	• ***2015-2019 CRR Plan Goal #2 – Improve organizational effectiveness regarding placement resource development, retention, and placement matching -*** Implement the Recruit, Prepare and Retain Curriculum for resource development staff by September 2018.
Provided 5 Innovative Recruitment and Retention grants to private Agency Partners	• ***2015-2019 CRR Plan Goal #1 Ensure that children and youth are placed in the least restrictive and most appropriate placement***
Held "Think Tank" sessions with Regional RD Teams throughout the state to assess local practice and performance issues impeding work progress, and conducting solution-focused resolutions	• ***2015-2019 CRR Plan Goal #2 – Improve organizational effectiveness regarding placement resource development, retention, and placement matching -*** Utilize data more effectively in developing recruitment plans and training and providing technical assistance to county/regional resource development staff by September 2019

APPENDIX B

Funders Briefing


INVESTING IN HOPE
Philanthropy and Georgia's Children

INVESTING IN HOPE

Philanthropy and Georgia's Children

According to the latest Annie E. Casey Foundation KIDS COUNT assessment, Georgia ranked 42nd among all states in child well-being[1], pointing to a need for greater investment in child welfare. To help address this crisis, Georgia's child welfare system is teaming up with nonprofits, philanthropy, businesses and communities to create a place where people share a vision of safety and success for every child – **a State of Hope.**

Each year, **more than 163,000 children** come to the attention of child welfare officials in Georgia.[2]
Of that number:

105,900

children receiving services as a result of an investigation.

13,200

children entering the foster care system as of 2017.

Youth in foster care are more likely to **fall behind in school** due to frequent school changes and lack of stability in their home environment. **As a result:**

- **In Georgia, only 11% of foster youth graduate from high school each year.**[3]
- **Nationally, only half of foster youth graduate with a high school diploma.**[4]
- **On average, 17–18 year-olds in foster care can only read at a 7th grade level.**[4]

Foster youth without a diploma are ill-equipped for the job market when they leave the system, hurting not only them but also our state's economy. **Young people who exit out of foster care without a high school diploma typically earn $8,500 less per year in wages.** If foster youth graduated at the same rate as others, they would collectively earn $59,500,000 more per year, require less governmental support and contribute more in income taxes.[5]

Foster care is a direct response to abuse and neglect – **not a solution.**
Yet the number of children in Georgia entering the foster care system is **steadily increasing.**[3]

2013	2014	2015	2016	2017[6]
7,600	9,000	10,000	12,000	13,200

While the number of children entering foster care is growing, this remains a small share of all children in need of support services. Despite the need for increased programming focused on family preservation, the bulk of federal child welfare funds coming into the state can only be directed toward services related to foster care.[2]

$83.7 million of federal dollars spent on foster care services for **3,500 children.**

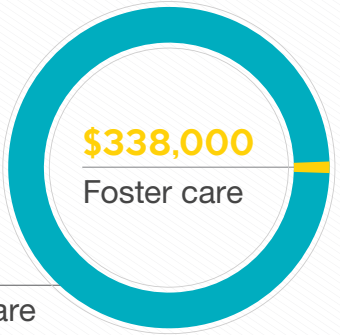
$22.7 million of federal dollars spent on prevention services for **163,000 children.**

*IN*VESTING *IN* HOPE

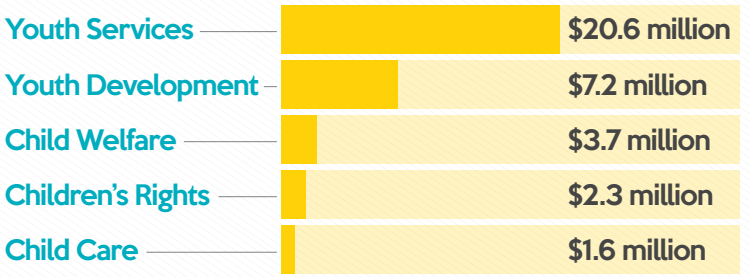
Philanthropy and Child Welfare in Georgia

Over five years ending in 2014, U.S. foundations awarded nearly $185 million to Georgia-based recipients in grants targeted toward children and youth services. Of that amount, **$40.8 million came in 2014** – the most recent year with available data. Here's a closer look at the funding from that year – where it came from, where it went and how it was targeted toward helping Georgia's children.[7]

In 2014, grants to preventative care services outweighed those going directly toward foster care:



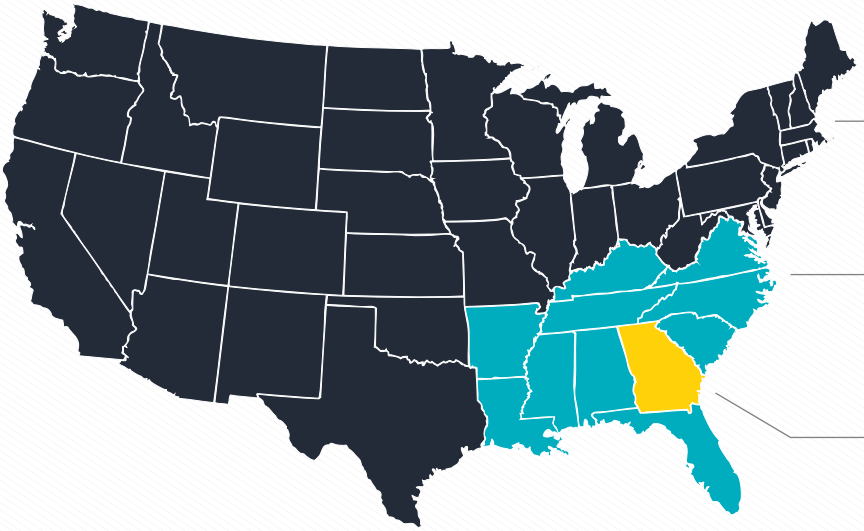
Top funding categories included:



Particularly in **Georgia**, but also throughout the **Southeast** region, independent foundations led the way for funding in 2014. However, family, community and corporate funders have also invested millions in child welfare.[8]

	Independent	Corporate	Family	Community
Georgia	67.4% $27.5 million	11.5% $4.7 million	10.8% $4.4 million	10.4% $4.2 million
Southeast	$60.3 million 44.4%	$26.6 million 19.6%	$21.8 million 16%	$23.2 million 17%

For every $10 in child welfare grant dollars[6] awarded by foundations to recipients in Georgia in 2014, **$5.70 came from in-state funders**. Most of the remaining funding came from foundations located outside the Southeast.



Non-Southeast U.S.
$16.1 million

Non-Georgia Southeast
$1.6 million

State of Georgia
$23.1 million

*IN*VESTING *IN* HOPE

Moving Together Toward a State of Hope

The power of partnership:

Public-private partnerships are essential, especially at the local level, and benefit greatly from the expertise of place-based funders like community and family foundations.

Fueling innovation:

Philanthropic investments are more flexible than public funds – this can be leveraged to support creative work in areas like research, training and leadership development.

Helping those in greatest need:

The creativity and flexibility of philanthropic investments would greatly benefit children already in foster care, who are often poorly positioned for success in school, work and life.

Broad impact:

Supporting those in foster care by developing a strategic focus on improving the quality of care-giving and developing a trauma-informed approach to working with families in crisis, the restoration of families can become a reality. This support has the potential to ensure that more children in care graduate from high school, setting them up for greater financial success and allowing them to contribute to our state's economic engine.

Sources & Footnotes:

1) Source: *Annie E. Casey Foundation. (2017). KIDS COUNT data book 2017. Retrieved from http://www.aecf.org/m/resourcedoc/aecf-2017kidscountdatabook.pdf*

2) Source: *Casey Family Programs. (2017). State fact sheet: Georgia. Retrieved from https://www.casey.org/media/state-data-sheet-GA.pdf*

3) Source: *Georgia Division of Family and Children Services.*

4) Source: *National Working Group on Foster Care and Education. (2014). Fostering success in education: National factsheet on the educational outcomes of children in foster care. Research highlights on education and foster care. Retrieved from: http://www.fostercareandeducation.org/DesktopModules/Bring2mind/DMX/Download.aspx?portalid=0&EntryId=1279&Command=Core_Download*

5) Source: *Jim Casey Youth Opportunities Initiative. (2013). Issue brief: Cost avoidance. The business case for investing in youth aging out of foster care. Retrieved from: http://www.aecf.org/m/resourcedoc/JCYOI-CostAvoidance-2013.pdf*

6) Note: *Data reflected as of August 2017.*

7) Source: *Foundation Center, 2017. Based on all grants of $10,000 or more awarded by a sample of 1,000 of the largest U.S. private and community foundations. For community foundations, only discretionary grants are included. Grants to individuals are not included. Grants may benefit multiple subjects, and may therefore may be counted under more than one category.*

8) Note: *Other types of foundations accounted for approximately 3 percent of giving to the Southeast. Due to rounding, percentages may not total 100.*

casey family programs

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APPENDIX C

Child Abuse Registry Maltreatment Type Report

Nathan Deal
Governor

Bobby D. Cagle
Director

Georgia Department of Human Services

Division of Family and Children Services

Maltreatment Type Report

Report Parameters

Start Date: 07/01/2016
End Date: 12/31/2016
County: All

Maltreatment Type: All
Relationship: All
Maltreator: Adult

Maltreatment Type	Count
Physical Abuse	401
Sexual Abuse	252
Neglect	4519
Emotional Abuse	933

This section provides the total number of Maltreatment Types received by CPSIS based on the Date, Maltreator and Relationship parameters selected.

APPENDIX D

Child Fatality Analysis

CY15 Analysis

CY16 Analysis

GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES 2015 CHILD FATALITY ANALYSIS

Nathan Deal, Governor

Bobby D. Cagle, Division Director

NOTE FROM THE DIVISION DIRECTOR:

The Georgia Division of Family and Children Services is committed to the safety of Georgia's children in decisions made and actions taken. The death of a child is a matter of very serious concern to the Division as well as to the citizens of Georgia and the greater child welfare community. In accordance with the requirements of state law, the *2015 Child Fatality Analysis* focuses on the deaths for children whose families had been the subject of a report or investigation of maltreatment in Georgia within the last five years.

Each child victim of abuse or neglect should be remembered and mourned, and the circumstances of their deaths studied, so that any citizen in Georgia can understand the factors related to their deaths and apply these sobering lessons toward preventing the deaths of other children. Deaths can result from disease, accidents, unintentional injuries, lack of resources and information, poor judgment, or violence. Some deaths may be foreseeable and others unanticipated. It is our belief that many child deaths are preventable and that we can use data to guide us in accomplishing this overarching aim of prevention. The primary purpose of this report is to examine and make Georgia citizens aware of the multidimensional circumstances surrounding unexpected child deaths. Careful analysis of the causes and contributing factors can lead to recommendations for changes in law, policy, and practice as well as advance organizational learning. We want to improve outcomes for families while they are in our care and learn what might be needed after our involvement has ended.

As Director of the Georgia Division of Family and Children Services, my vision is to build a better future for this state by developing the best child welfare agency in the world. My plan to realize this vision is called the *Blueprint for Change*, a three-pillar approach to reforming Georgia's child welfare system. One pillar includes the establishment and adoption of a practice model that will serve as the foundation to keep children safe and strengthen families. A second pillar focuses on developing a robust workforce for the Division, both in numbers and level of expertise and training. The third pillar is focused on constituent engagement, which is an effort to engage with the public to build consensus and collaboration among partners, staff, and stakeholders. The development of this report speaks to and sheds light on the importance of each of these pillars.

The understanding and prevention of child deaths is a shared responsibility among agencies that serve the children and families of Georgia. I am confident that public reporting of child fatalities, coupled with a thoughtful and intentional review, will support the achievement of our common goals to keep children safe, strengthen families, and build stronger communities.

Bobby D. Cagle, Director
Georgia Division of Family and Children Services

ACKNOWLEDGEMENTS

The Georgia Division of Family and Children Services is extremely grateful to Dr. John R. Lutzker, Distinguished University Professor, and his team of experts from Georgia State University, for their knowledge and extraordinary efforts in assisting in the development and writing of this report.

John R. Lutzker, Ph.D.
Distinguished University Professor
Georgia State University
Director, Mark Chaffin Center for Healthy Development

Betty S. Lai, Ph.D.
Assistant Professor
Georgia State University
School of Public Health

Maithili Bhat
Graduate Student
Georgia State University
School of Public Health

We would also like to thank Michelle Livings and Rayleen Lewis, graduate students at Georgia State University, for their editorial assistance with this report.

TABLE OF CONTENTS

SECTION 1: PURPOSE OF THE CHILD FATALITY ANALYSIS

As the primary state agency charged with intervening on behalf of vulnerable children in Georgia, the Division of Family and Children Services (henceforth referred to as the Division) must continually review its practice and inform the public of efforts to reduce the risk of child abuse and neglect and mitigate its effects. For this reason, since 2012, the Division has generated an annual report on child deaths among children with any prior child welfare involvement, regardless of the cause of that death. For the purposes of this report, **involvement** is defined as any prior child protective services involvement with the Division within the five years prior to the date of death. Through this report, the Division endeavors to provide information over and above the federal requirement[1] for states to review and analyze child fatalities.

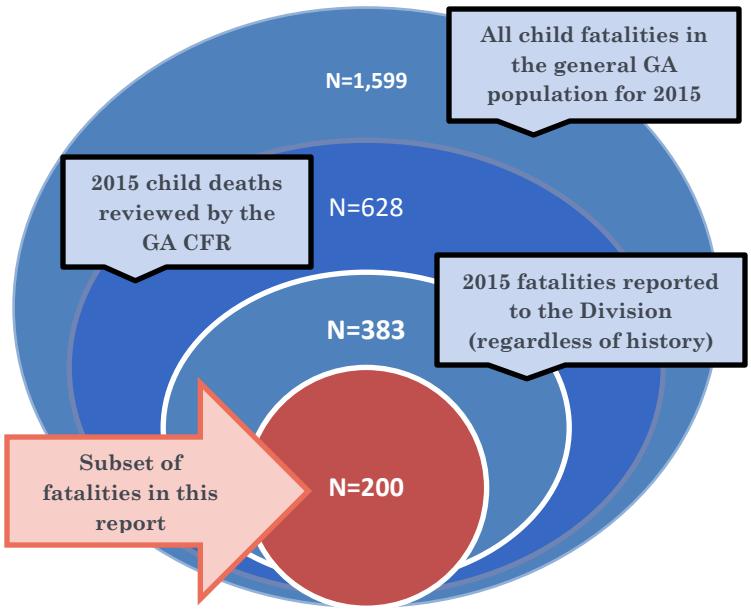
Multiple (and to some extent independent) entities collect data on child deaths in Georgia. The *2015 Child Fatality Analysis* complements the work of the Georgia Child Fatality Review Panel, because it assists the Division and the public in improving intervention efforts and in developing community-based solutions to reduce the risk of harm to Georgia's children. The Division is more closely focused on child deaths in instances where the children and/or their families had prior Division involvement. In contrast, the Georgia Child Fatality Review process (led by the Georgia Bureau of Investigation) has a broader focus that reviews all unexplained, suspicious or unexpected deaths of any minor child in the state.

Therefore, the child deaths reported by the Division in this analysis should be understood as a subgroup of the deaths reported by the Georgia Child Fatality Review, as well as a subset of the overall child deaths reported to the Division during calendar year 2015 (see Figure 1.1). Additionally, data reported from the National Child Abuse and Neglect Data System (NCANDS) are yet another subset of Georgia deaths reviewed by the Division and should be separated from the children identified in this analysis. NCANDS does not distinguish whether prior Division involvement existed.

Ultimately, our ability to understand and prevent deaths among children with child welfare involvement will hinge on our capacity to contextualize these deaths by contrasting them with all child deaths in Georgia. Such context can provide further insight into case characteristics and circumstances surrounding a child's death. As our access to comparison data grows, in the future we will begin to learn whether these circumstances and characteristics serve to predict risk for child deaths.

[1] Per 42 U.S. C. Sec. 5106a (b) (2) (B) (x) of the Child Abuse Prevention and Treatment Act. See: https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap67.htm

Figure 1.1. Child Fatalities Discussed in this Report in the Context of All 2015 Child Fatalities in the General Georgia Population.



Note. The most recent data available for all child fatalities in the general Georgia population are from 2015.[2] In 2015, 1,599 children under the age of 18 years died. In 2015, the Georgia Child Fatality Review Panel reviewed 628 child deaths. For 2015, a total of 383 child deaths were reported to the Division. Of these, 200 children were identified as members of families who had some form of child welfare involvement with the Division within the previous five years.

[2] Georgia Department of Public Health. Online Analytical Statistical Information System (OASIS). Obtained on October 15, 2016 from URL: oasis.state.ga.us.

SECTION 2: METHODOLOGY OF THE DIVISION'S CHILD FATALITY ANALYSIS

This report reflects data collected on child deaths that occurred in Georgia between January 1, 2015 and December 31, 2015 for children whose families had Division involvement within the five years preceding the child's death.[3] For the purpose of this report, a family includes a caregiver and any children included in prior reports, as well as any newborn child or other children who moved into the home after the prior report. This report does not include deaths reported to the Division for children whose families had no prior Division involvement.

Reports of child fatalities in this analysis are classified by cause and manner of death as outlined in Section 3. ***All information presented here is based on data available as of July 22, 2016.***

Since 2011, the Division has sought to improve child death data collection methodologies and strengthen reporting mechanisms. The Division's child death review team has aggressively pursued internal policy requirements regarding the reporting of child deaths. Efforts to engage external stakeholders on the need to provide accurate data have resulted in more consistent reporting of child fatalities. This rigorous process may result in an increase in the number of identified deaths. However, this process has improved the Division's collection of child death data and will result in a more comprehensive analysis of child welfare practice going forward.

Child death data were analyzed by the Division's Data Analysis Unit and by researchers at Georgia State University's School of Public Health. Enhanced collaborations with the Office of the Child Advocate, Child Fatality Review and the Child Abuse and Prevention Treatment Act prevention team also allowed for an additional review of many deaths and offered implications for both prevention and practice enhancements.

[3] As relates to this sample, *Official Code of Georgia (O.C.G.A.) §15-11-741* defines a child as "an individual receiving protective services from DFCS, for whom DFCS has an open case file, or who has been, or whose siblings, parents, or other caretakers have been, the subject of a report to DFCS within the previous 5 years."

SECTION 3: CLASSIFICATION OF CHILD FATALITIES BY CAUSE AND MANNER

Defining Causes and Manners of Death

Cause of Death refers to a specific forensic finding of how a death occurred (e.g., drowning, gunshot, suffocation, Sudden Unexpected Infant Death, etc.).

Manner of Death is an official classification by a coroner or Medical Examiner of how the cause of death occurred. Five classifications are used to describe the manner of death: *accident, homicide, natural, suicide, and undetermined*. These manners of death are used on death certificates and autopsy reports. Note that for each manner of death, there could potentially be multiple causes of death. Each manner of death included in this report is individually defined below.

Table 3.1. Definitions[4] for Manners of Death.

Manner of Death	Definition	Examples
Accident	An unintended death.	• Drowning • Motor vehicle accident • Accidental asphyxiation while sleeping with an infant
Homicide	The death was caused by the actions of another person.	• Malnutrition and/or dehydration due to neglect • Shooting by stranger or caregiver
Natural	The death was from disease or medical conditions.	• Death due to a medical condition such as Sickle Cell Anemia, Cerebral Palsy, or Cancer • Sudden Infant Death Syndrome (SIDS) is often categorized as natural.
Suicide	A death that is intentionally self-inflicted.	• Hanging • Self-inflicted gunshot • Overdose
Undetermined	There is little or no evidence to establish, with medical certainty, the cause of death.	• When specific details surrounding the death are unclear, it is often categorized as undetermined. • Sudden Unexpected Infant Death (SUID) and sleep-related deaths are often categorized as undetermined.

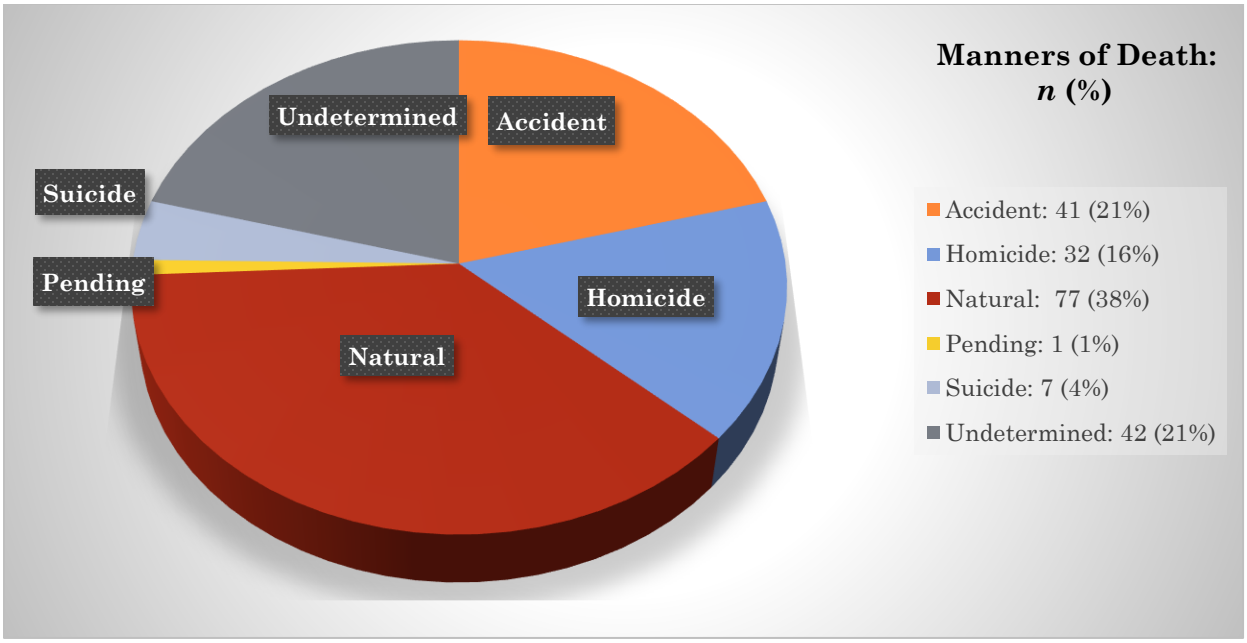
[4] Definitions obtained on September 3, 2016 from https://gbi.georgia.gov/medical-examiners-office.

Of note, many people, confuse the terms homicide and murder. Murder is a criminal charge or the unlawful taking of a human life by another. After the medical examiner determines the manner of death to be a homicide, then law enforcement investigates that death to determine if there is probable cause to bring the criminal charge of murder against the person who caused the death. While all murders are homicides, not all homicides are murders.

An official cause and manner of death is not always associated with a finding of abuse or neglect. For example, a child may die because of an accident (such as a drowning), but maltreatment may also be found in a caregiver's actions (e.g., substance use) or inaction (e.g., lack of supervision), and this may indirectly result in the death of the child. As another example, a death attributed to homicide (i.e., a manner of death) might be at the hands of parents and be abuse-related. Alternatively, the homicide might be at the hands of a non-caregiver, and in that case, there might not be maltreatment by a caregiver.

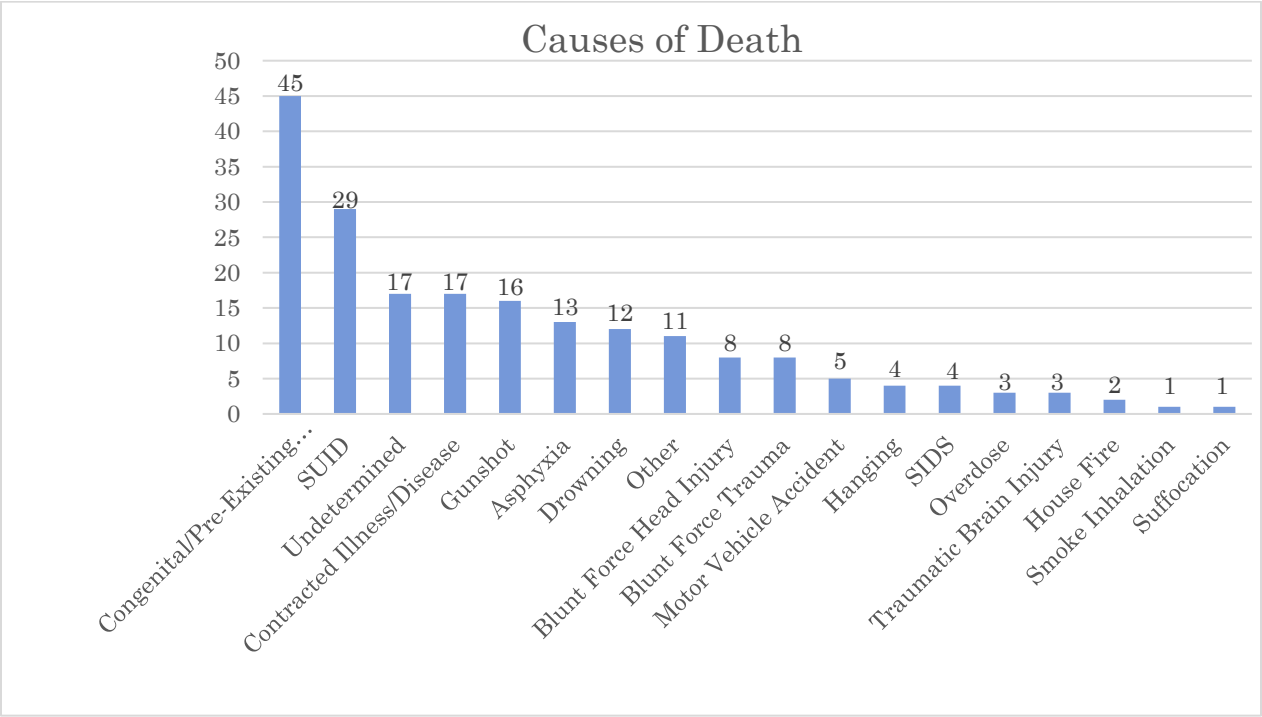
The following figure provides a breakdown of the manner of child fatalities for children with prior involvement for 2015 by percentage. Note that accidental and natural deaths represent 58% (118 children) of the 200 fatalities reviewed in this report. It is noteworthy that 26 of the 118 deaths were substantiated for abuse and/or neglect due to contributing factors that had an impact on the death itself. For example, the drowning death of a child is almost always accidental, but the assessment into the circumstances surrounding the death may reveal inadequate supervision of the child as a contributing factor.

Figure 3.1. 2015 Manners of Death by Percentage for Children with Prior Involvement, $N = 200$.



Next, Figure 3.2 provides information on the causes of death for 2015 fatalities for children with prior child protective services involvement. In building on the data included in the previous figure, for those deaths classified as natural, the leading cause of death was a congenital or pre-existing condition (45 children). The next highest cause of death was Sudden Unexpected Infant Death (SUID; 29 children) which always corresponds to the death of a child less than two years of age, and which most often occurs during a sleep-related event.

Figure 3.2. 2015 Causes of Death for Children with Prior Involvement, *N* = 199**.**



Note. At the time of analysis, cause of death was not known for one child. SUID = Sudden Unexpected Infant Death. SIDS = Sudden Infant Death Syndrome.

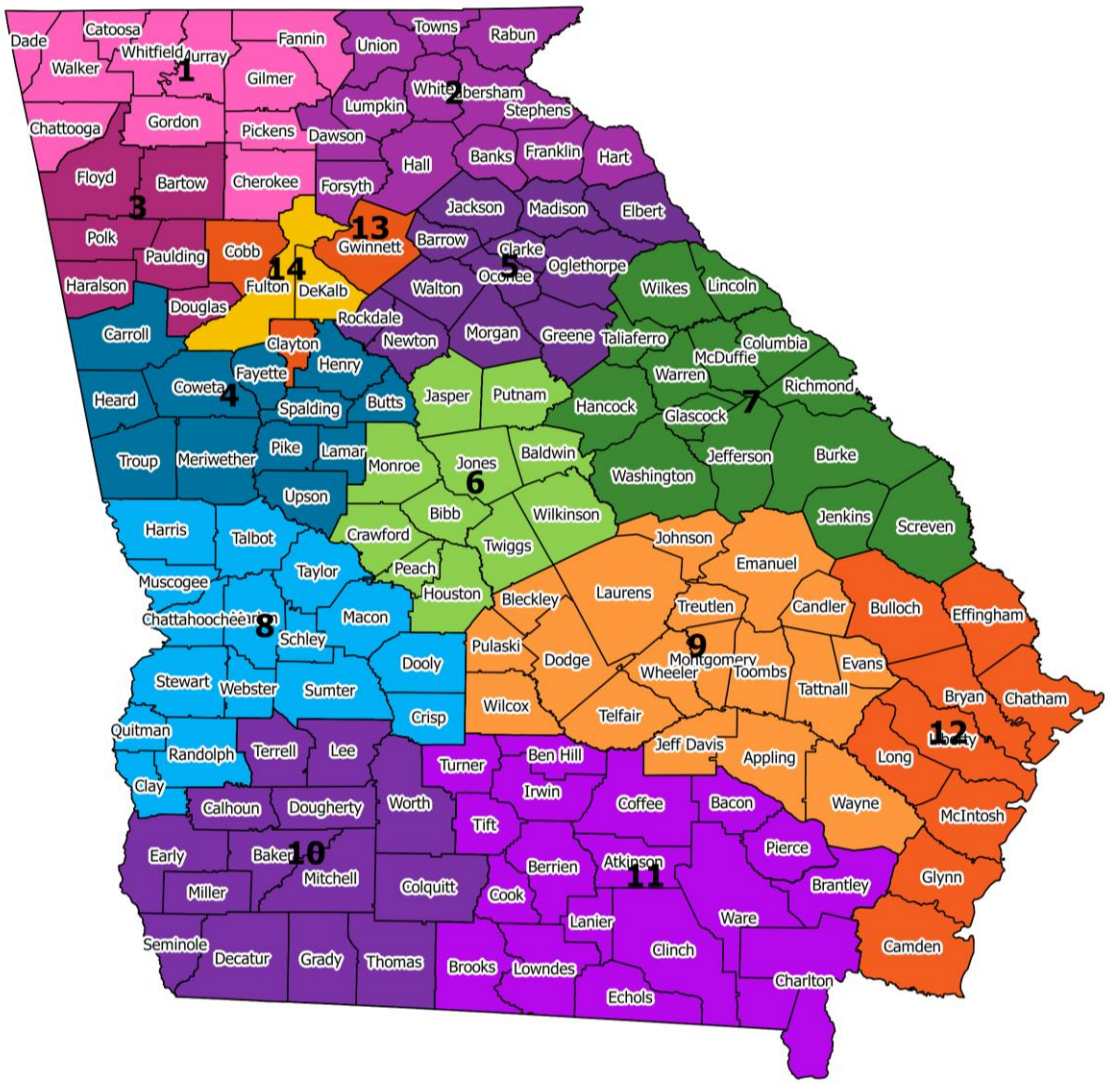
SECTION 4: EXECUTIVE SUMMARY OF DATA FINDINGS

This report reviews the deaths of 200 children who died between January 1 and December 31, 2015, and whose families had prior involvement with the Division. In the past five years, 658,962 children had Division involvement.[5] Below, we provide an executive summary of findings. It should be noted that the following statistics are not mutually exclusive; a death may be represented in more than one of the categories below.

- **47** children (**24%** of the 200 deaths reviewed by the Division) had substantiated findings of child abuse and/or neglect prior to those children's deaths.[6]
- **75** children (**38%**) had substantiated findings of maltreatment in relation to their deaths.
- **77** children (**39%**) were determined to have died because of natural causes.
- **109** children (**55%**) were under the age of one year.
- **74** children (**37%**) had families with open Division cases at the time of their deaths.
- **58** children (**29%**) who died were classified as having special needs.
- **68** children (**34%**) died during a sleep-related event. **61 (31%)** of these children were infants under the age of 12 months.
- **114** children (**57%**) had caregiver(s) who had a history of alleged substance abuse.
- **71** children (**36%**) had caregiver(s) who had a history of alleged mental health issues.
- **76** children (**38%**) had caregiver(s) who had a history of alleged criminal offenses.
- **78** children (**39%**) had caregiver(s) with a history of alleged domestic violence.

[5] There were 236,251 children involved with the Division in 2015.
[6] According to DFCS policy, a substantiated finding is when "an investigation disposition by an abuse investigator concludes that the allegation of maltreatment, as defined by state law and CPS requirements, is supported by a preponderance of the evidence." [Source: *http://www.odis.dhr.state.ga.us/3000_fam/3030_cps/manuals/chapter4/2104_23.doc*]

Figure 4.1. 2015 Map of Division Regions.



Note. Map source: http://dfcs.dhs.georgia.gov/county-offices. The state is divided into 14 regions encompassing all 159 counties throughout the state. Each county office is responsible for providing reports directly to the state office when a child fatality is reported in their county.

Table 4.1. 2015 Child Fatality Numbers/Percentages for all Division Regions.

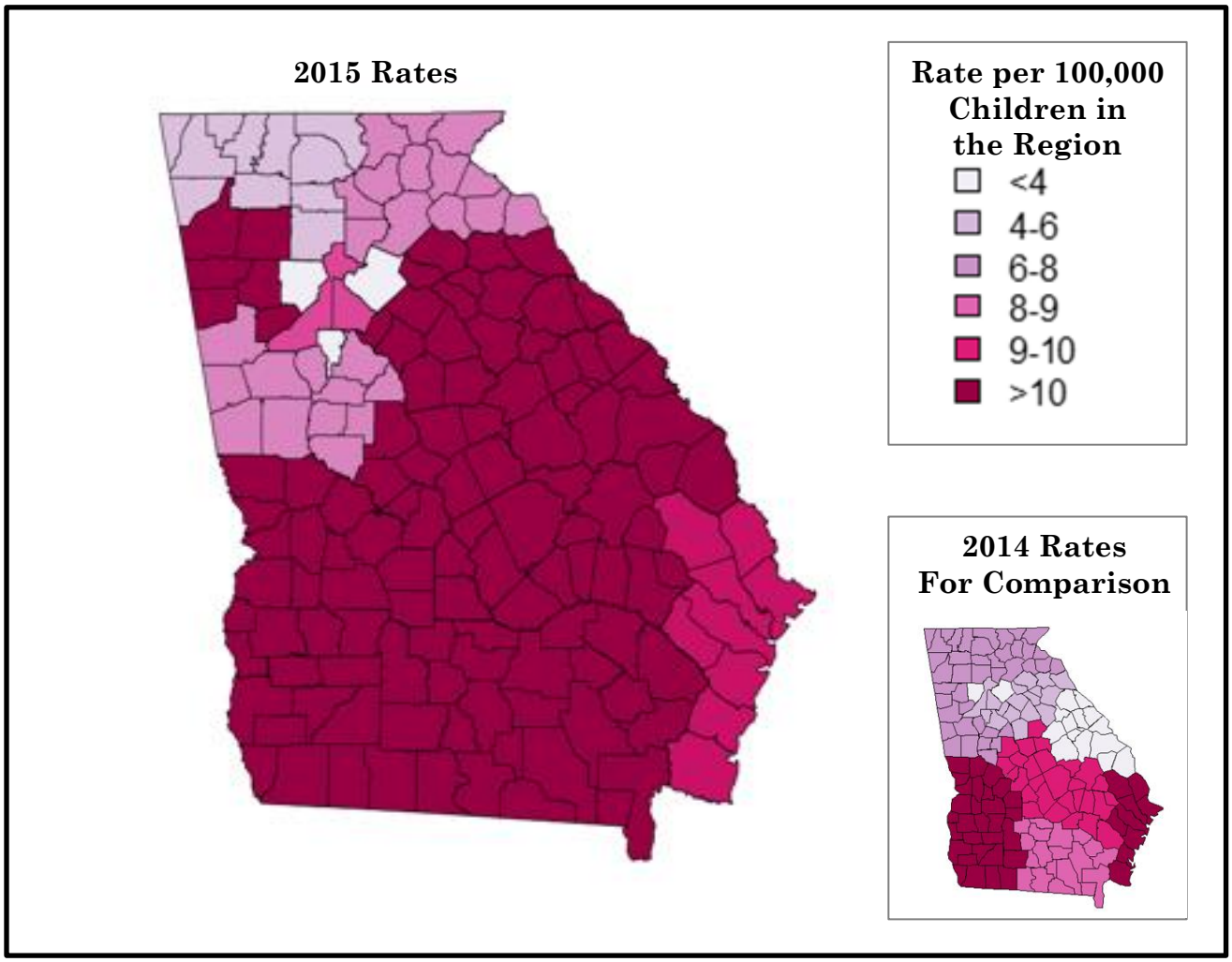
Region	Counties Within the Region	Total Number of Child Fatalities in the Region	Total Number of Children in the Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 200)
1	Catoosa, Chattooga, Cherokee, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield	9	168,818	5.33	4.5%
2	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	12	166,265	7.21	6%
3	Bartow, Douglas, Floyd, Haralson, Paulding, Polk	15	145,240	10.32	7.5%
4	Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, Upson	16	206,434	7.75	8%
5	Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Newton, Oconee, Oglethorpe, Rockdale, Walton	17	162,709	10.45	8.5%
6	Baldwin, Bibb, Crawford, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson	12	117,932	10.18	6%
7	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	12	116,774	10.28	6%
8	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster	10	86,822	11.52	5%
9	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox	9	72,421	12.43	4.5%

Region	Counties Within the Region	Total Number of Child Fatalities in the Region	Total Number of Children in the Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 200)
10	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	11	86,559	12.71	5.5%
11	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware	17	101,418	16.76	8.5%
12	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh	15	160,624	9.34	7.5%
13	Clayton, Cobb, Gwinnett	12	506,718	2.37	6%
14	DeKalb, Fulton	33	405,438	8.14	16.5%
Total	Statewide	200	2,504,172	8.0	100%

Note. As noted earlier, as of 2015, there are 14 regions in Georgia (http://dfcs.dhs.georgia.gov/county-offices). There were 15 regions in Georgia in 2014. Population data for regions were obtained from http://wonder.cdc.gov/bridged-race-population.html, on July 25, 2016.

The following heat map of Georgia shows rates of child fatalities with prior Division involvement. Rates are calculated per 100,000 children in each region. While there are contextual concerns underlying this representation (e.g., regions with few children that experienced an incident resulting in multiple deaths could see an elevated rate), it does suggest areas worthy of further investigation and increased collaboration with other state agencies.

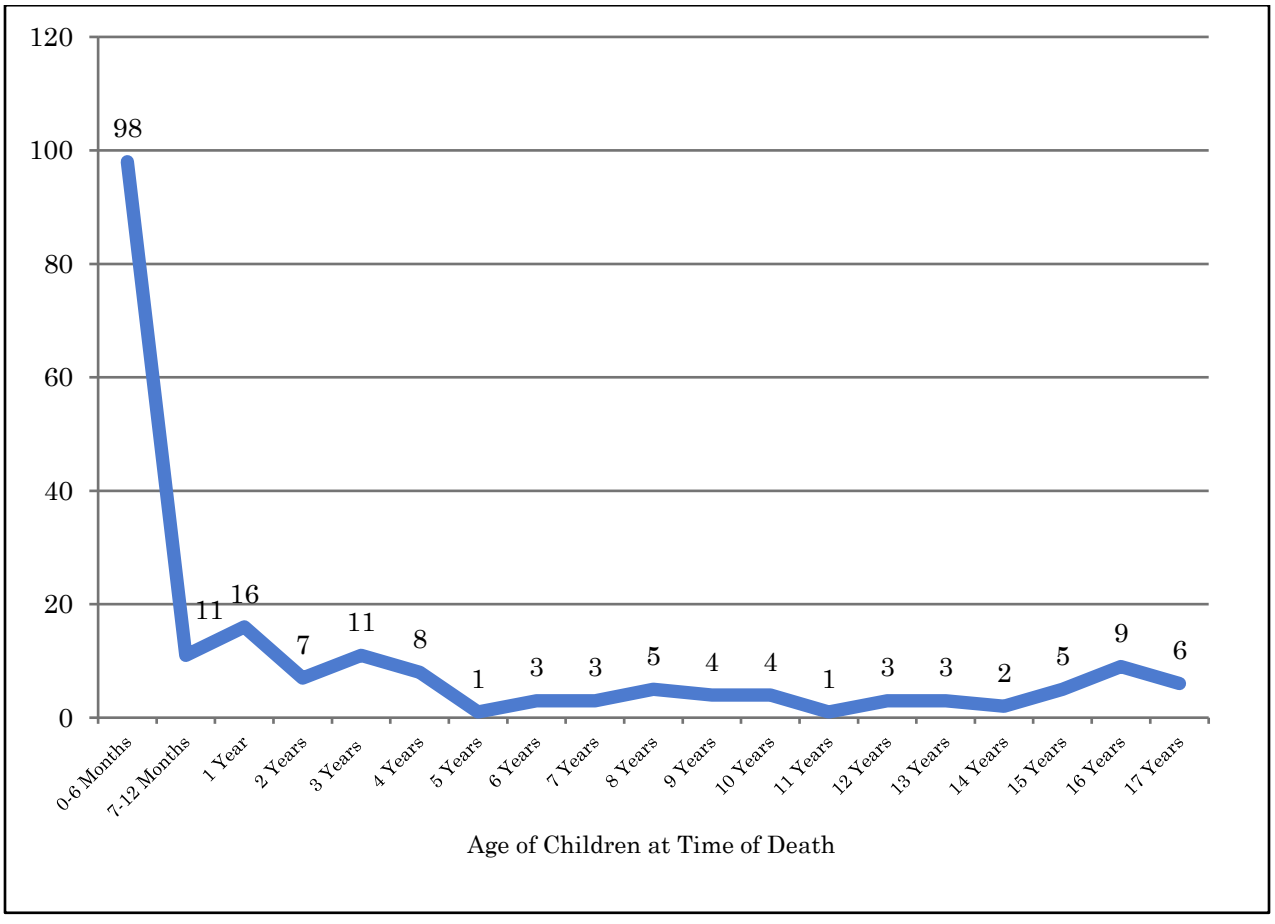
Figure 4.2. 2015 Child Fatality Rates per 100,000 Children by Region.



Note. As a comparison, this map also shows the 2014 heat map for child fatality rates per 100,000 children by region.

The following figure displays the ages of children in this report at the time of their deaths. Children under the age of one-year account for 109 or 55% of the deaths, and 63% (125) of the deaths were children under the age of two years. This conforms to national trends from the Child Trends Databank that show that children are most at-risk in their first year of life.[7] The remaining 37% (75) of the deaths for 2015 comprise children between two and 17 years of age. This data reinforces the vulnerability of infants and young children. Additionally, these outcomes draw attention to the need for greater advocacy and for campaigns that inform new parents and caretakers about risk factors that result in preventable child deaths.

Figure 4.3. Ages of Children at Time of Death for Children with Prior Involvement, *N* = 200.



[7] Child Trends Databank. (2015). *Infant, child, and teen mortality*. Obtained on September 28, 2016 at: http://www.childtrends.org/?indicators=infant-child-and-teen-mortality.

SECTION 5: CHILD FATALITIES AND PRIOR DIVISION INVOLVEMENT

Description of Data

The data included in the *2015 Child Fatality Analysis* detail the manners and causes of death for children whose families had child protective services involvement with the Division within five years from the date of death. As noted earlier, the data included in this report *do not* reflect all child fatalities within the general Georgia child population (see Figure 1.1). When a child's death is reported to a local Division office, it is forwarded to an internal review team that examines the circumstances surrounding the death. The Georgia Office of the Child Advocate and Georgia Child Fatality Review Panel work in partnership with the Division to further understand the events surrounding the deaths of children who have prior involvement and whose death may be maltreatment-related.

In 2015, a total of **383** child deaths were reported to the Division. Of these, **200** children were identified as members of families who had some form of child protective services involvement with the Division within the previous five years.[8] During the same time period, the Division had contact with approximately 658,962 children. This represents a rate of about 30.35 per 100,000[9] children. To place this in context, of the 2,504,172 children living in Georgia, in 2015,[10] 1,599 died from all causes. Thus, the rate of death for children in the general population for 2015 was 63.85 per 100,000, double the rate for children with prior Division history.

In 2015, of the **200** deaths with Division involvement, there were **126** fatalities that occurred after the Division had ended its involvement with the family. In **74** of the fatalities, the Division had an open case with the family at the time of death.

[8] In comparison, for 2014, the deaths of 169 children whose families had prior Division history were reported to the agency.
[9] This estimate is unadjusted for the number of new births in families, number of unreported children in the family, or recurrent reports for the same child during the 5-year period.
[10] Population data for total number of children was obtained on September 15, 2016 from http://wonder.cdc.gov/bridged-race-population.html, on July 25, 2016.

The following data provide a snapshot of the Division's overall Child Welfare caseloads for 2015:

- The total number of reports to the Division: **109,794**
  - Screen-Outs: **27,368**
  - The total number of reports assigned to Child Protective Services (CPS): **82,426.** Of the 82,426:
    - **36,083 (44%)** were assigned to Family Support Services
    - **46,343 (56%)** were assigned to Investigations
- The total number of children in Foster Care at some point in 2015: **18,251**
- The total number of Family Preservation Services cases: **11,546**

Child Fatality Review Process

Once a death has been reported to the agency, a review of circumstances surrounding the death is warranted. Although any preventable death deserves attention, deaths due to maltreatment are of special concern and require additional scrutiny because the Division is charged with investigating child abuse and neglect.

Specific causes and manners are typically determined by a coroner or Medical Examiner. Findings of maltreatment are not only based on physical indicators; experts often rely on additional information obtained by the Division, first responders, and law enforcement. As a result of more in-depth reviews, the Division may identify maltreatment-related concerns that were not initially apparent at the time of the death. This additional level of investigation and detection may increase the number of deaths attributed to maltreatment. Because states can differ substantially in their data collection methods and maltreatment definitions, state-to-state comparisons of maltreatment death rates are generally difficult to interpret or potentially misleading. Also, as states increase their scrutiny and improve their data systems, the number of maltreatment-related deaths may appear to rise, even if actual incidences are stable or declining.

Intervention by the Division involves a broad spectrum of potential services. For example:

- A report that was screened-out because it lacked an allegation of abuse or neglect.
- Family Support cases where the allegation does not necessarily involve immediate child safety.
- Investigations where the Division confirmed an allegation of abuse or neglect.
- Family Preservation cases where allegations of maltreatment or abuse may have been substantiated, but the removal of the children was not necessary to ensure safety.
- Prior or current Foster Care services.

Closed Cases

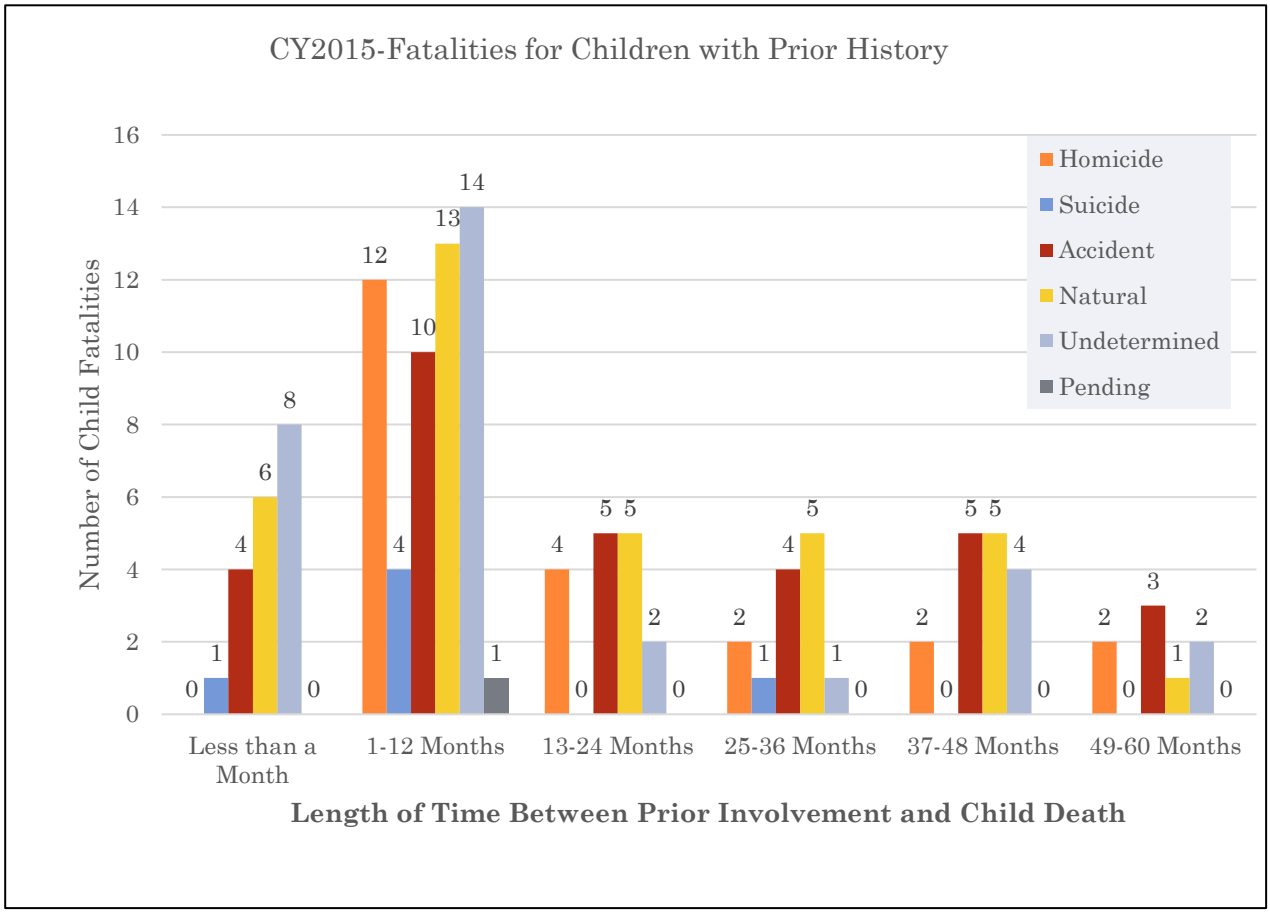
In 2015, 126 of the fatalities reviewed in this report (i.e., 63% of 200 deaths reviewed) were for children from families with closed cases at the time of the child's death. This includes 52 children (26% of 200 deaths in 2015) who were born after the last case closure. In other words, the child who died was born after the completion of the Division's most recent involvement with the family. In looking at child fatalities and prior Division involvement, the length of time between the most recent involvement and the death of the child is noteworthy. It has been shown that evidence-informed programs have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after this time.[11]

For homicides, 12 homicides occurred less than 12 months after case closure, and 10 homicides occurred more than 12 months after case closure. The homicide rate in the general Georgia population for 2015 was 3.54 per 100,000.[12] The children examined in this report include the 658,962 children with Division involvement in the last five years. This constitutes a rate of 3.34 per 100,000 children (i.e., 22 homicides among 658,962 children with Division involvement in the last five years).

The following figure displays the length of time between prior Division involvement with the family and the child's death (for cases closed at the time of death), delineated by the five official manners of death.

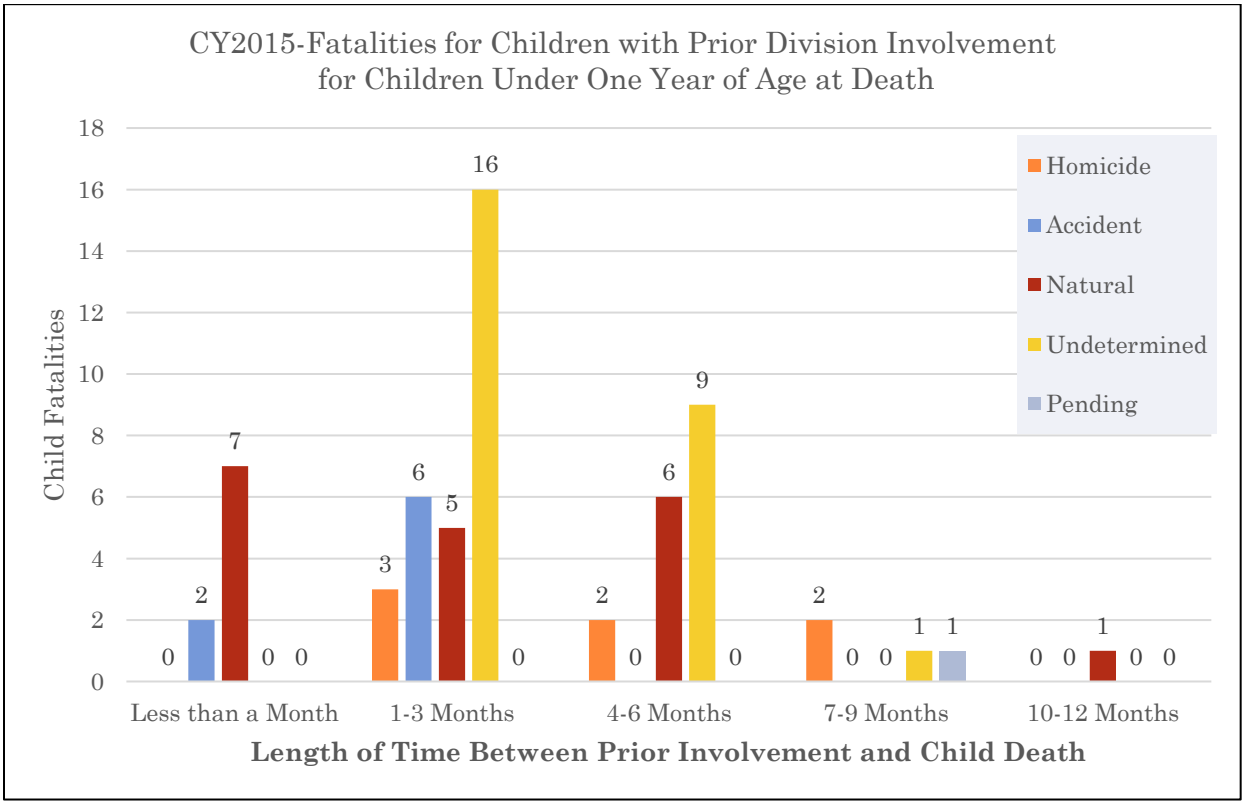
[11] Reynolds, A. J., & Robertson, D. L. (2003). School–based early intervention and later child maltreatment in the Chicago longitudinal study. *Child development*, *74*(1), 3-26.
[12] Data source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (September 2016). Accessed on September 20, 2016 from URL: www.cdc.gov/injury/wisqars

Figure 5.1. Length of Time Between Prior Involvement and Child Death for Those with Closed Cases at Time of Death, Delineated by Manner of Death, $N = 126$.



The next figure provides more detailed information about the subset of children with closed cases who were under one year of age at the time of their death.

Figure 5.2. Length of Time Between Prior Division Involvement and Child Death for Those with Closed Cases Who Were Under One Year of Age at the Time of Death, Delineated by Manner of Death, $N = 61$.



Note. There were 61 children aged 0-12 months in 2015 who had closed cases at the time of death.

Open Cases

An open case indicates active Division involvement with a child or family. In 2015, there were 74 fatalities with an open case at the time of the child's death.

Of these 74 open cases; 32% of them (24 children) had substantiated findings of maltreatment in the children's deaths. Of those 24 children, 6 also had substantiations prior to their deaths. Of the 24 child death substantiations, 6 of those were open due to the incident that resulted in the death. Fifteen (20%) of the 74 open cases were opened due to the incident that resulted in the death.

The next table breaks down these 24 fatalities by case type and whether the case was open prior to the death or due to the incident that caused the death.

Table 5.1. Number of 2015 Substantiated Fatalities with Open Cases at the Time of Death (with Case Type) for Children with Prior Involvement, $N = 24$.

Substantiated Fatalities with Open Cases at the Time of Death	Investigation for Abuse or Neglect	Family Preservation	Family Support Services	Foster Care/ Placement	Total Number (%)
Case Open Prior to Incident that Led to the Death	7 (29%)	4 (17%)	3 (12%)	4 (17%)	18 (75%)
Case Open Due to Incident that Led to the Death	4 (17%)	0	0	2 (8%)	6 (25%)
Total Number and Percentage of Open Cases at the Time of Death	11 (46%)	4 (17%)	3 (12%)	6 (28%)	24 (100%)

The following table (Table 5.2) provides a breakdown for open cases with a substantiated finding of maltreatment in the death and is broken down by the official manner of death. *Again, note that as of July 22, 2016, one case is still awaiting an official finding from the Medical Examiner and therefore had a manner of death considered "Pending." This death is not included in the table below.*

Table 5.2. Number of 2015 Substantiated Fatalities with Open Cases at the Time of Death (with Manner of Death) for Children with Prior Involvement, *N* = 24.

Substantiate Fatalities with Open Cases at the Time of Death	Homicide	Accident	Natural	Undetermined	Total *N* (%)
Case Open Prior to Incident that Lead to Death	6 (25%)	1 (4%)	5 (21%)	6 (25%)	18 (75%)
Case Open Due to Incident that Led to the Death	4 (17%)	1 (4%)	1 (4%)	0	6 (25%)
Total (%)	10 (42%)	2 (8%)	6 (25%)	6 (25%)	24 (100%)

Note. All children with cases open due to the incident that led to the death also had cases open prior to the incident that led to the death.

13 foster children died in 2015:

- **8** of those deaths were ruled natural due to complications from medical conditions or due to congenital or pre-existing conditions.
- **4** children died due to homicide: 3 children died due to blunt force head injury and 1 child due to blunt force trauma.
- **1** child died due to an undetermined cause.

Two of the four homicides were the result of the child being fatally injured while under the care of a relative caregiver or Fictive Kin. The other two homicides involved children that were placed in foster care because of the injury that then led to their death. The undetermined cause of death had to do with an infant who was swaddled and sleeping on an adult bed. The coroner was unable to determine the exact circumstances that led to the death.

Implications for Practice

Deaths of children with Division contact may occur in multiple ways and, therefore, have different implications for understanding, learning, and improving practice. One of the most disconcerting manners of death for the Division is when a child suffers a violent death at the hands of a caregiver where the risk was pre-existing, and the interventions offered failed to shield the child or to reduce the risk. In these cases, maltreatment is the proximal cause of death. These types of incidents raise service improvement questions about risk assessment (e.g., was the risk detectable?), provision of services (e.g., were the services appropriate?), decision-making (e.g., was maintaining the child in their existing home a reasonable decision?), and management of aftercare needs (e.g., were post-termination services adequate?).

Other manners of death may be caused by complex circumstances in which parental negligence plays a partial, but not a proximal, or even necessary role. For example, a child may die in a vehicular accident in which the child was not properly secured in a car seat, or a child may die from an illness complicated by delayed medical care. These types of cases may alert case managers about possible future maltreatment if other children are present in the home.

However, in some situations the Division may end its involvement with a family after it has ensured the safety of existing children in the home, but the parent(s) may later bear other children who are not known to the Division. For example, a drug addicted mother may have all her children removed from her care and her parental rights later terminated. As a result, the Division would close its case because she has no other children under her direct care. The mother may later have additional children and a report is made because she has given birth to a drug exposed infant; the infant has medical complications and dies due to those complications. The implications for practice under these types of scenarios would focus on strategies involving Georgia's maternal and child health system and community supports. For 2015, there were 52 children born after the Division's last involvement with the family, and, therefore intervention efforts for these children were improbable.

The Division continuously reviews its practices at many levels. Whenever there has been prior involvement with a family, there is an opportunity to review its response and potentially the responses from other agencies that may have been involved in the family's life. Division intervention in a family's life can be crucial and have lasting effects. Open and effective communication between all parties who have a responsibility to ensure a child's safety is critical to having successful outcomes for children.

SECTION 6: VULNERABLE POPULATIONS

Children under the Age of One

In 2015, 109 deaths of the 200 deaths reviewed in this report were children under the age of one year. The primary manner of death (see Table 6.1) was natural causes (50 children), and the secondary manner was Undetermined (35 children). This corresponds to the leading two causes of death for this age group (see Table 6.2) which were congenital or pre-existing conditions (31 children) and Sudden Unexpected Infant Death (29 children). Additionally, 72 of the 109 children (66%) in this age group had caregivers who were alleged to have been engaging in substance use at some time during the Division's involvement with the family.

Unsafe sleep practices have also been identified as a major factor contributing to death among children who died during a sleep-related event. Being placed on a soft surface and/or sharing sleep surfaces with adults or siblings remain factors in sleep-related deaths. This is a recognized public health problem nationwide and underscores the need for educating parents and caregivers about infant safe-sleep practices not only used during night time sleeping, but also during any sleep-related event throughout the day.[13]

Table 6.1. Manners of Death in 2015 for Children Under the Age of One for Children with Prior Involvement, *N* = 109.

Age	Accident	Homicide	Natural	Un-determined	Pending	Total *N* (%)
0-6 Months	11	8	45	34	0	98 (90%)
7-12 Months	1	3	5	1	1	11 (10%)
Total	12 (11%)	11 (10%)	50 (46%)	35 (32%)	1 (1%)	109 (100%)

[13] The Centers for Disease Control and Prevention report that in 2014, the leading causes of infant deaths were: birth defects, preterm birth (birth before 37 weeks gestation) and low birth weight, maternal complications of pregnancy, sudden infant death syndrome (SIDS), and injuries (e.g. suffocation).

Table 6.2. Leading Causes of Death in 2015 for Children Under the Age of One for Children with Prior Involvement, *N* = 109.

Causation	Age 0-6 Months	Age 7-12 Months	Total *N* (%)
Asphyxia	10	0	10 (9%)
Blunt Force Head Injury	2	0	2 (2%)
Blunt Force Trauma	1	1	2 (2%)
Congenital/Pre-Existing Condition	28	3	31 (28%)
Contracted Illness/Disease	6	1	7 (6%)
Drowning	0	2	2 (2%)
Other	5	2	7 (6%)
Overdose	1	0	1(1%)
SIDS	4	0	4 (4%)
SUID	28	1	29 (27%)
Suffocation	1	0	1 (1%)
Traumatic Brain Injury	1	0	1(1%)
Undetermined	11	0	11 (10%)
Pending	0	1	1 (1%)
Total	98 (90%)	11 (10%)	109 (100%)

Prenatally Substance-Exposed Children

There were 36 children (18% of 200 children) who had a history of prenatal exposure to drugs. Of these children, 33 were under the age of 7 months at the time of their deaths. While it is difficult to link deaths exclusively to prenatal exposure, the effects of prenatal exposure to substances may put infants at risk. Prenatal exposure to substances is associated with low birth weight, extreme prematurity, and other factors that may create complications for children.[14]

Even after an infant is born, substance use by an adult caregiver may place infants at risk. A parent or caregiver in a compromised state, places children at risk, especially when the caregiver is unable to provide and recognize what is a safe environment for the child. In addition, addicted parents may live in households rife with violence and instability. Addiction is treatable, but recovery is neither quick nor easy, and lapses back into substance abuse are not uncommon. Addiction recovery is best viewed as a long-term task, extending well beyond the time frame of involvement of a child welfare agency. Deaths associated with caregivers' abuse of methadone, alcohol, prescription medication, and illegal substances have been reported to the Division and continue to be a challenging characteristic of the child welfare population. When substance use is coupled with bed-sharing or a special needs child, the risk of harm or death is even higher.

Of the **36** prenatally-exposed children there were **21** born prematurely. Of those, many had complex medical issues. Fourteen died before they left the hospital.

Table 6.3. Prenatal Drug Exposure and Manner of Death, *N* = 36.

Exposure History	Accident	Homicide	Natural	Undetermined	Total *N* (%)
Prenatal Drug Exposure	6 (17%)	2 (6%)	18 (50%)	10 (27%)	36 (100%)

[14] Brady, J.P., Posner, M., Lang, C., Rosati, M.J. (1994). Risk and Reality: Implications of Prenatal Exposure to Alcohol and Other Drugs. Washington, D.C.: U.S. Department of Health and Human Services & U.S. Department of Education. Accessed at http://eric.ed.gov/?id=ED397986

Children/Families with Multiple Risk Factors

Often families who have prior involvement with the Division and have experienced a child death are affected by multiple risk factors, including, but not limited to, substance use, domestic violence, mental health issues, and/or criminal history. The greater the complexity of the issues within a family, the more challenging it can be for professionals to assess the ongoing safety of the children. Naturally, families are not always comfortable or willing to expose areas they may find embarrassing or difficult to address, making safety assessments even harder to thoroughly complete. Nevertheless, the Division recognizes the crucial need to consistently assess and address these multiple risk factors for such cases. The following table describes caregiver risk factors by manner of death.

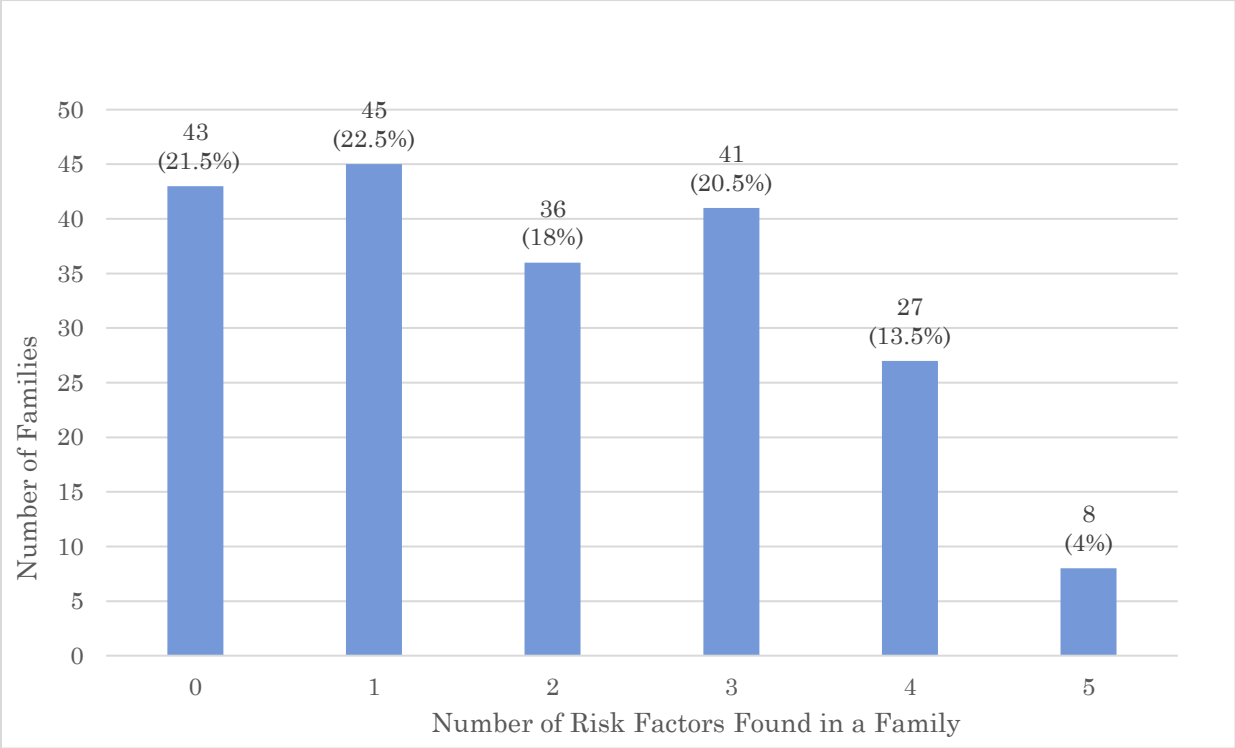
Table 6.4. Risk Factors of Caregivers and Manner of Death.

Caregiver Risk Factors	Accident	Homicide	Natural	Suicide	Undetermined	Total
DFCS History as a Child: Yes (*N* = 48)	7 (14%)	5 (10%)	20 (41%)	1 (2%)	15 (31%)	48
Alleged Substance Use History: Yes (*N* = 114)	23 (20%)	14 (12%)	43 (38%)	3 (3%)	31 (27%)	114
Alleged Criminal History: Yes (*N* = 76)	16 (21%)	11 (14%)	32 (42%)	2 (3%)	15 (20%)	76
Alleged Mental Health History: Yes (*N* = 70)	14 (20%)	14 (20%)	21 (30%)	3 (4%)	18 (25%)	70
Alleged Domestic Violence History: Yes (*N* = 78)	14 (18%)	17 (22%)	30 (38%)	2 (3%)	15 (19%)	78

Note. Caregivers may have met criteria for more than one risk factor.

The next figure highlights the number of risk factors (i.e., Caregiver had DFCS History as a child, Caregiver Substance Use History, Domestic Violence History, Criminal History, and Mental Health History) that were found in each child's family.

Figure 6.1. Number of Identified Risk Factors Found in a Child's Family, $N = 200$.



Note. Caregivers may have met criteria for more than one risk factors.

Table 6.5 provides a breakdown of 2015 deaths based for children with prior involvement and caregivers with alleged substance use and/or domestic violence. Note that **56** (**28%**) of the total deaths for children with prior Division involvement involved the exposure of the child to ***both*** domestic violence and substance use.

Table 6.5. Causes of Death in 2015 for Children with Prior Involvement and Caregivers with Alleged History of Substance Use and/or Domestic Violence, *N=114 and N=78*

Causes of Death	Caregivers with Alleged Substance Use History	Caregivers with Alleged Domestic Violence History
Asphyxia	9	3
Blunt Force Head Injury	1	1
Blunt Force Trauma	3	4
Congenital/Pre-Existing Condition	24	18
Contracted Illness/Disease	9	7
Drowning	6	5
Gunshot	8	9
Hanging	3	2
House Fire	2	2
Motor Vehicle Accident	2	1
Other	9	5
Overdose	1	1
SIDS	2	1
SUID	22	10
Smoke Inhalation	1	1
Suffocation	1	1
Traumatic Brain Injury	0	1
Undetermined	11	6
Total *N*	114	78

Note. At the time of analysis, cause of death was not known for one child. Some children may be captured in both categories. Thus, the total reflects the category of exposure and not the number of children. SIDS = Sudden Infant Death Syndrome. SUID = Sudden Unexpected Infant Death.

Special Needs Children

Table 6.6. Manners of Death in 2015 for Special Needs Children with Prior Division Involvement, *N* = 58.

Manner of Death	Accident	Homicide	Natural	Suicide	Undetermined	Total *N* (%)
Total Number	4 (2%)	7 (3%)	45 (23%)	1 (1%)	1 (1%)	58 (29%)

Teen Deaths

2015 identified **25** teenagers between the ages of 13 and 17 who died and had prior involvement with the Division.

- **6** committed Suicide**: 2** by Hanging, **3** by self-inflicted Gunshot wounds, and **1** by Overdose.
- **7** died due to Accidental causes: **2** died in Motor Vehicle-related incidents, **1** by Blunt Force Head Injury, **1** by Blunt Force Trauma, **1** by Gunshot wound, and **2** by other causes.
- **5** died due to Homicide: All **5** deaths were due to Gunshot wounds; **2** of the Homicides were committed by a direct caregiver.
- **6** died due to Natural causes: **4** by a Congenital Pre-Existing Condition, **1** by Contracting Illness/Disease, and **1** due to Other cause.
- **1** died in an Undetermined Manner due to Blunt Force Trauma.

For suicide, 5 suicides occurred less than 12 months after case closure, and 1 suicide occurred more than 12 months after case closure. In Georgia, the suicide rate for the general Georgia population was 2.0 per 100,000 for children aged 0-17 years.[15] It is difficult to identify a comparison rate. If we consider the 236,251 children that had Division involvement in 2015, the rate would be 2.54 per 100,000 (i.e., 6 suicide deaths among 236,251 children). However, the children examined in this report include the 658,962 children with Division involvement in the last five years, which constitutes a rate of .91 per 100,000 children (i.e., 6 suicide deaths among 658,962 children with Division involvement in the last five years).

[15] Data source: Georgia Department of Public Health. Online Analytical Statistical Information System (OASIS). Obtained on October 15, 2016 from URL: oasis.state.ga.us.

SECTION 7: UNSAFE SLEEP ENVIRONMENT

Many of the sleep-related deaths involved incidents where there was a combination of bed-sharing and an overall unsafe sleep environment. To illustrate, in the case of bed-sharing, caretakers falling asleep with infants in chairs, couches, and adult beds was a factor in 32 of the 68 sleep-related deaths. It is always recommended that infants sleep alone, on their backs, and in a safe sleep setting such as a crib. For the infants who died in 2015, many of the causes of death were either ruled as SUID (Sudden Unexpected Infant Death) or Undetermined. Review of these fatalities has uncovered other mitigating factors not readily observed at the time of death, such as substance use, mental health needs of a caregiver, and/or caregivers placing children on soft sleep surfaces (e.g., blankets, pillows, etc.). Circumstances surrounding sleep-related deaths continue to be explored to identify underlying contributing factors. In this report, 61 of the 68 children with sleep-related deaths were under one year of age at the time of their death. In 48 of the 68 sleep-related deaths, caregivers had a history of alleged substance use. The Division believes the majority of these deaths were preventable.

Figure 7.1. 2015 Sleep-Related Death Rates per 100,000 Children by Region.

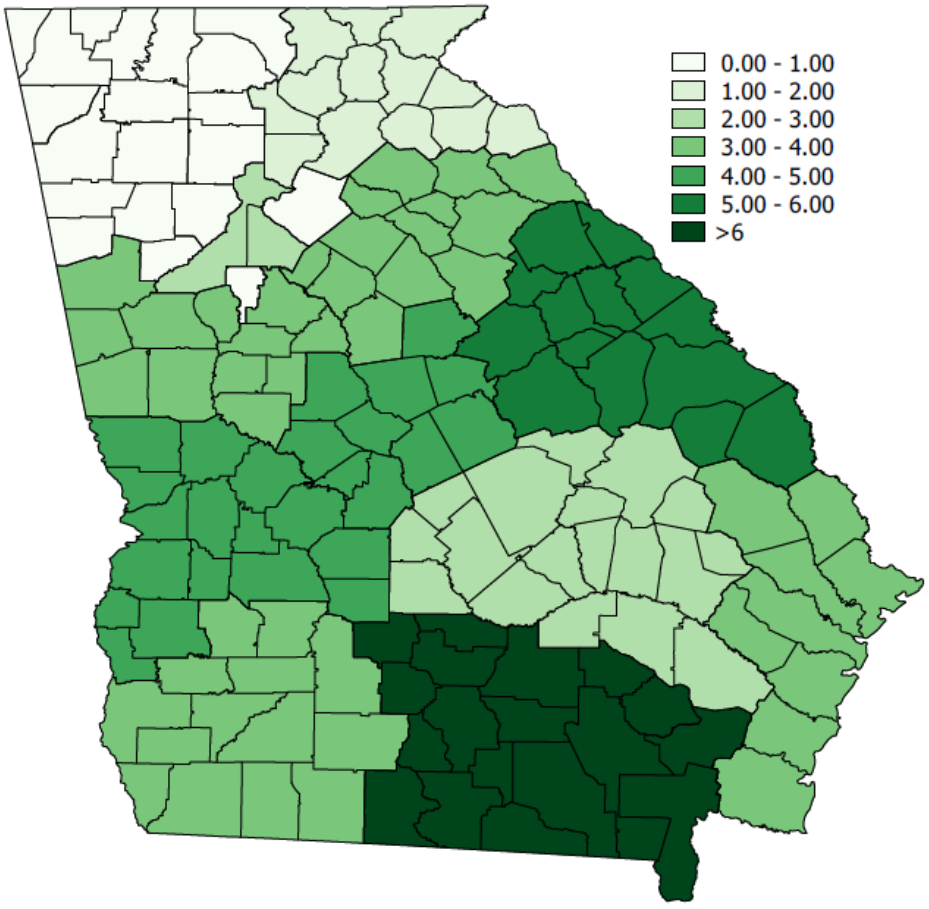


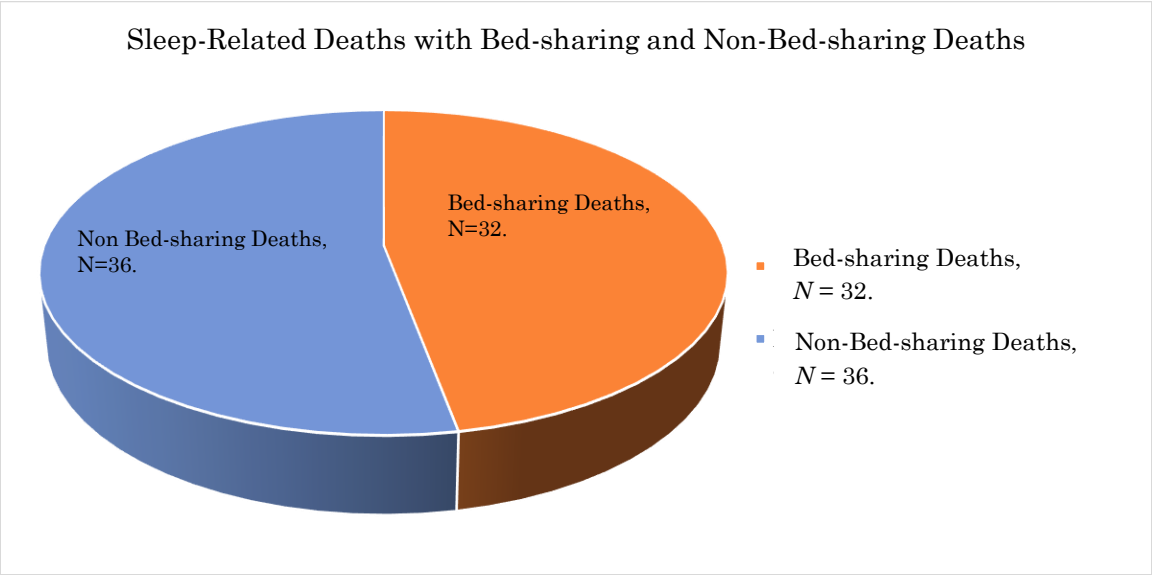
Table 7.1. Fatality Numbers/Percentages for Sleep-Related Deaths for All Division Regions, $N = 68$.

Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in the Region	Rate per 100,000 Children in the Region	Region Percentage of State Total ($N = 68$)
1	Catoosa, Chattooga, Cherokee, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield	2	168,818	1.18	3%
2	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	4	166,265	2.41	6%
3	Bartow, Douglas, Floyd, Haralson, Paulding, Polk	1	145,240	0.69	1%
4	Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, Upson	8	206,434	3.88	12%
5	Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Newton, Oconee, Oglethorpe, Rockdale, Walton	6	162,709	3.69	9%
6	Baldwin, Bibb, Crawford, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson	5	117,932	4.24	8%
7	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	6	116,774	5.14	9%
8	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster	4	86,822	4.61	6%

Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in the Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 68)
9	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox	3	72,421	4.14	4%
10	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	3	86,559	3.46	4%
11	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware	7	101,418	6.90	10%
12	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh	5	160,624	3.11	8%
13	Clayton, Cobb, Gwinnett	3	506,718	0.59	4%
14	DeKalb, Fulton	11	405,438	2.71	16%
Total	Statewide	68	2,504,172	2.72	100%

At the time of analysis, 68 deaths were found to be sleep-related. Of these 68 deaths, 32 involved bed-sharing. *Bed-sharing is a preventable risk factor.*

Figure 7.2. Breakdown of Sleep-Related Deaths by Bed-sharing or Non-Bed-sharing Arrangements, *N* = 68.



Note. Most literature uses bed-sharing for describing infants sleeping on the same space.

SECTION 8: CONCLUSIONS

The following conclusions are drawn from the 2015 child fatality analysis:

Very Young Children

In 2015, 125 (63%) of the 200 children who died were two years old or younger. Additionally, 49 (39%) of the 125 children had a substantiated finding of maltreatment in relation to their death. Further, 45 (36%) of the 125 children in this cohort were under twelve months old. These statistics demonstrate that very young children are at greatest risk of maltreatment. They are more likely to spend their time out of public view and are less likely to encounter mandatory reporters (in contrast to school-aged children who interact daily with teachers, who are mandatory reporters).

Substance Use

Caregiver substance use continues to be a contributing factor in child safety. Effectively assessing whether a substance-using caregiver is adequately equipped to care for a child is challenging for case managers. Denial of drug use by caregivers may affect the assessment process and influence case outcomes. Gathering supportive evidence, including drug testing, and collecting collateral information from family and friends that may either support or negate allegations remains a critical component of ensuring child safety.

When substance use is coupled with caring for a child under the age of two or a child with complex needs, assessing the safety of the child may be even more challenging. Nonverbal children are not able to communicate effectively about their safety. Caregivers using substances can be effective at concealing their usage, and brief encounters with a family may not reveal significant information about substance use and its potential impact on the safety of children. Very young children who live with substance using caregivers are at high risk of maltreatment.

Teen Deaths

Research indicates teens who have suffered rejection or trauma, such as those who have experienced abuse and/or neglect, are at an increased risk for suicidal behavior.[16] Parenting any teen requires continuous monitoring; however, for youth who have experienced rejection and trauma, caregivers need to be even more diligent regardless of whether the youth is in state custody or living with family or friends.
The effects of social influence on teens is great and additional oversight for children who have experienced social isolation and/or rejection or bullying should be taken into consideration when assessing children in this age group.

Safe Sleep and Impaired Sleeping

While the Division and partner agencies continue to educate families and the public about what constitutes a safe sleep environment, challenges remain around the perception of a shared sleep surface and bed-sharing. Often these challenges involve intergenerational family beliefs and/or cultural practices[17]. For example, some caretakers believe bed-sharing with a child increases the bond between a parent and their child. Thus, they may overlook contributing factors to child safety. Additionally, substance use may play a contributing role. Caregivers who are impaired by alcohol or drugs (both prescription and non-prescription) continue to increase the risk of death to children under the age of one when coupled with bed-sharing and by placing children on unsafe sleep surfaces.

Unsafe sleep surfaces can be detrimental to newborns and especially premature infants. Children should sleep on their backs, alone and on a firm surface. Placing blankets, pillows or other soft materials under an infant can lead to an unexpected death.

[16] Miller, A. B., Esposito-Smythers, C., Weismoore, J. T., & Renshaw, K. D. (2013). The Relation Between Child Maltreatment and Adolescent Suicidal Behavior: A Systematic Review and Critical Examination of the Literature.*Clinical Child and Family Psychology Review*, *16*(2), 146–172. http://doi.org/10.1007/s10567-013-0131-5
[17] Moon, R. Y., Hauck, F. R., & Colson, E. R. (2016). Safe Infant Sleep Interventions: What is the Evidence for Successful Behavior Change? *Current Pediatric Reviews*, *12*(1), 67–75. http://doi.org/10.2174/1573396311666151026110148.

Domestic Violence

Domestic violence impacts child safety through its effect on both the adult victim and the perpetrator of the abuse. Adult victims in abusive relationships must be ever vigilant for their own safety and therefore, may not be as well equipped to ensure the safety of minors in their care. Many adult victims and perpetrators use substances to help address underlying emotional issues. When coupled with the frustrations, fear and impaired thinking a domestic event can trigger, adults may make poor decisions that negatively impact a child.

Blueprint for Change

The Division must have a strong community approach. The work of child welfare, and the Division's charge, involves the heavy responsibility of ensuring safety from abuse and neglect, which cannot be done in silos. Working collaboratively is good for children, child welfare staff, external partners, and the community in general. There must be a unified approach and open communication in working to protect and ensure children's safety.

To that end, the Division's Blueprint for Change encourages constituent engagement that strives for each community partner to understand the factors negatively affecting their most vulnerable citizens; and to share in knowledge, service delivery needs, and support and prevention efforts.

The Blueprint for Change also mandates a robust workforce, which plays a critical role in terms of retaining quality staff who can make informed decisions for children. This necessitates enhanced systemic respect for those on the front-lines, evidenced by an investment in competitive salaries, and ongoing support to strengthen our workforce. It includes a work environment where career opportunities are available and where informed, quality supervisory support is delivered. Community and legislative advocacy at all levels is needed to secure the funding required to continue improving Georgia's child welfare system.

The Blueprint for Change utilizes Solution Based Case Work (SBC), a component of Georgia's Comprehensive Practice Model, to strengthen service delivery. A practice model provides guidance regarding interaction with families. At its core, SBC addresses the needs of the family, and provides an evidence-informed framework to address the needs of families.

SECTION 9: GLOSSARY

Child Abuse. (A) Any non-accidental physical injury or physical injury which is inconsistent with the explanation given for it suffered by a child as the result of the acts or omissions of a person responsible for the care of a child; (B) Emotional abuse; (C) Sexual abuse or sexual exploitation; (D) Prenatal abuse; or (E) The commission of an act of family violence as defined in Code Section 19-13-1 in the presence of a child. An act includes a single act, multiple acts, or a continuing course of conduct. As used in this subparagraph, the term "presence" means physically present or able to see or hear. (OCGA § 15-11-2).

Closed Case. Division involvement with a child or family has concluded.

Collateral Contacts. Individuals who can provide reliable information about the family and are not meant to be "character references."

Family Preservation Services (FPS). This term is described by the Family Preservation and Support Services Act of 1993 (PL 103-66) as a continuum of family-focused services for at-risk children and families. Services include activities designed to assist families in crisis, often where a child is at risk of being placed in out-of-home care because of abuse and/or neglect. Support services include preventive activities, typically provided by community-based organizations designed to improve the nurturing of children and to strengthen and enhance the stability of families.

Family Support Services (FSS). Intake reports that are assigned to Family Support Services contain an allegation of child abuse or neglect and there is no preliminary indication of a present danger situation or an impending danger safety threat. Family Support Services are designed to ensure child safety and prevent future involvement in the child welfare system through the use of formal and informal services to strengthen and support families and enhance caregiver protective capacity to ensure the protection and care of children. (Georgia Child Welfare Policy Manual, 7.0).

Foster Care. The Foster Care program provides temporary out-of-home care for children who cannot legally remain safely in their home. Foster Care services are also provided for eligible Foster Care youth ages 18-21 through the Extended Youth Support Services program unless they opt out of participation.

Intake (Report). Any information received by the Division, alleging known or suspected instances of child abuse and/or neglect. The intake assessment begins the process of comprehensively assessing child safety by gathering information to assist in locating the problems and behaviors in the everyday life of the family that led to the maltreatment concerns; as well as information that will help to build partnerships with families in identifying solutions to address child safety.

Investigation (INV). Assigned when a report indicates a present danger situation, an impending danger safety threat, or the reported maltreatment allegations fall into specific

categories requiring the assignment to investigation. An investigation is a non-voluntary intervention with families during which DFCS determines the validity of the child maltreatment report, assesses the risk of maltreatment, determines if the child is safe, develops a safety plan, if needed, to ensure the child's protection and determines services needed.

Involvement. All current and prior involvement with DFCS. This includes, but is not limited to, Intakes that were screened out, Family Support Services, Investigations and Foster Care.

Neglect. (A) The failure to provide proper parental care or control, subsistence, education as required by law, or other care or control necessary for a child's physical, mental, or emotional health or morals; (B) The failure to provide a child with adequate supervision necessary for such child's well-being; or (C) The abandonment of a child by his or her parent, guardian, or legal custodian. (OCGA § 15-11-2).

Screen Out. A report is screened out when there are no allegations of maltreatment based on an analysis of the information gathered. (Georgia Child Welfare Policy Manual, 3.0).

Substantiated. The allegations of maltreatment, as defined by Georgia statute and DFCS policy, are supported by a preponderance of the evidence. A preponderance of evidence means the evidence gathered, makes it more probable than not that the abuse and/or neglect occurred. (Georgia Child Welfare Policy Manual, 5.3).

Unsubstantiated (not substantiated). The allegations of maltreatment, as defined by Georgia statute and DFCS policy, are not supported by a preponderance of the evidence. A preponderance of evidence means the evidence gathered, makes it more probable than not that the abuse and/or neglect occurred. (Georgia Child Welfare Policy Manual, 5.30).

GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES 2016 CHILD FATALITY ANALYSIS

Nathan Deal, Governor

Bobby D. Cagle, Division Director

NOTE FROM THE DIVISION DIRECTOR:

The Georgia Division of Family and Children Services is committed to the safety of Georgia's children in all aspects of its operation. The death of any child is a matter of serious concern to the Division, the citizens of Georgia, and the greater child welfare community. As required by state law, the *2016 Child Fatality Analysis* includes the deaths of children whose families had been the subject of a report or investigation of maltreatment in Georgia within five years prior to their death.

The primary purpose of this report is to examine the complex circumstances surrounding the deaths of children with prior Division involvement and to make these findings available to the general public. Careful analysis of the causes and contributing factors in these deaths can lead to recommendations for changes in law, policy, and practice. We want to improve the long-term outcomes for families both during their involvement with the Division and afterwards.

Any death of a child is a tragedy and circumstances of any child's death should be reviewed, so that lessons can be learned and applied towards protecting other children from similar fates. Children's deaths can result from disease, violence, neglect, unintentional injuries, or even lack of sufficient parental training. Some deaths may be foreseeable and others unanticipated. It is our belief that many child deaths are preventable and we can use our analysis to improve efforts to protect the children of Georgia.

As Director of the Georgia Division of Family and Children Services, my vision is to build a better future for this state by developing the best child welfare agency in the world. My plan to realize this vision is called the *Blueprint for Change*, a three-pillar approach to reforming Georgia's child welfare system. One pillar includes the establishment and adoption of a practice model that will serve as the foundation to keep children safe and strengthen families. A second pillar focuses on developing a robust workforce for the Division, both in numbers and level of expertise and skill. The third pillar is focused on constituent engagement, which is an effort to engage with the public to build consensus and collaboration among partners, staff, and stakeholders. The development of this report speaks to and sheds light on the importance of each of these pillars.

The understanding and prevention of child deaths is a shared responsibility among agencies that serve the children and families of Georgia. I am confident that public, meaningful review of child deaths will support our common missions of keeping children safe, strengthening families, and building stronger communities.

Bobby D. Cagle, Director
Georgia Division of Family and Children Services

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John R. Lutzker, Ph.D.
Distinguished University Professor
Director, Mark Chaffin Center for Healthy Development
School of Public Health
Georgia State University

Betty S. Lai, Ph.D.
Assistant Professor
School of Public Health
Georgia State University

Maithili Bhat, M.P.H.
Data Analyst
School of Public Health
Georgia State University

Philip Hudson
Data Analyst
School of Public Health
Georgia State University

We would also like to thank **Michelle Livings**, a graduate student at Georgia State University, and **Ryan Savage** and **Richard Ortiz**, undergraduate Honors College students at Georgia State University, for their feedback on this report.

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SECTION 1: PURPOSE OF THE CHILD FATALITY ANALYSIS

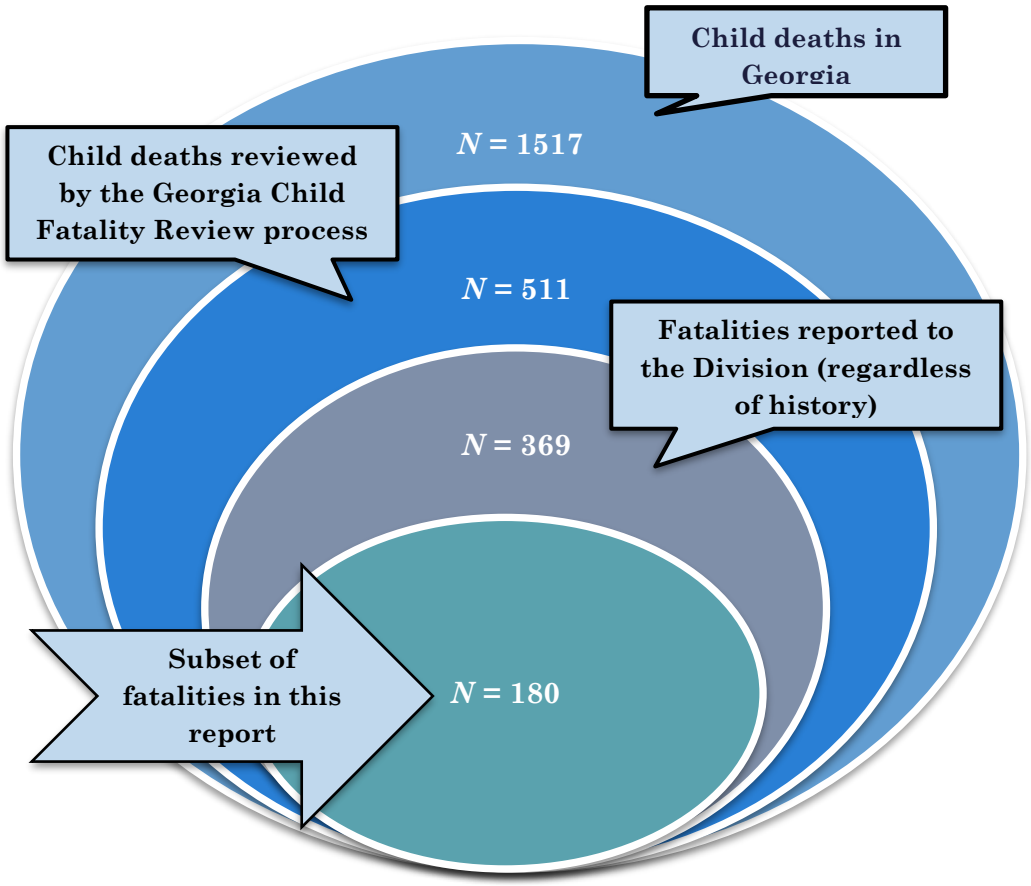
In Georgia, the Division of Family and Children Services (henceforth referred to as the Division) is the primary state agency charged with intervening on behalf of vulnerable children and investigating allegations of abuse or neglect. The Division must continually review its practices and inform the public of efforts to reduce the occurrence and harm of child abuse and neglect. Since 2012, the Division has generated an annual report on child deaths among children with prior child welfare involvement, regardless of the cause of death. For the purposes of this report, **involvement** is defined as any prior child protective services report made to the Division within five years preceding the date of death for either the child or a member of their immediate family. The Division endeavors to provide information above and beyond the state's requirement to report and analyze child fatalities under federal law.[1]

Multiple independent entities collect data on child deaths in Georgia. Complementing the work of the Georgia Child Fatality Review Panel, the *2016 Child Fatality Analysis* assists the Division in improving intervention efforts and in developing community-based solutions to reduce the risk of harm to Georgia's children. The Division closely focuses on child deaths in instances where the children and/or their families had prior Division involvement. In contrast, the Georgia Child Fatality Review process (led by the Georgia Bureau of Investigation) has a broader focus that reviews all unexplained, suspicious, or unexpected deaths of any minor child in the state.

As shown in figure 1.1, the cases in this study are a subset of the cases reported to the Division, which are in turn, a subgroup of all cases reviewed by the Child Fatality Review Panel. Additionally, data reported from the National Child Abuse and Neglect Data System (NCANDS) are yet another subset of Georgia deaths reviewed by the Division and should be separated from the children identified in this analysis. NCANDS does not distinguish between children based on prior Division involvement and highlights the deaths of children with a substantiated finding in relation to their death. Our ability to prevent deaths among children with prior child protective services involvement may be dependent on our capacity to identify common factors in the circumstances of these deaths. Such analysis will allow for the development and implementation of targeted interventions. By endeavoring to deepen our understanding of actions taken and decisions made in these cases, and to apply that knowledge to practice in the field, we anticipate improving the outcomes of Georgia's most vulnerable children.

[1] Per 42 U.S. C. Sec. 5106a (b) (2) (B) (x) of the Child Abuse Prevention and Treatment Act. See: https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/html/USCODE-2010-title42-chap67.htm

Figure 1.1. Child Fatalities Discussed in this Report in the Context of All 2016 Child Fatalities in the General Georgia Population.



Note. In 2016, 1,517 children under 18 years of age died in Georgia (Georgia Department of Public Health, 2017). In 2016, the Georgia Child Fatality Review Panel reviewed 511 child deaths. For 2016, a total of 369 child deaths were reported to the Division. Of these, 180 children were identified as members of families who had some form of child protective services involvement with the Division within the previous five years. In 2015, 200 children met the same criteria.

SECTION 2: METHODOLOGY OF THE DIVISION'S CHILD FATALITY ANALYSIS

This report covers child deaths that occurred in Georgia between January 1, 2016 and December 31, 2016 for children whose families had some form of Division involvement within the *five years* preceding the child's death.[2] For these purposes, a family includes any caregivers, any children included in prior reports, and any newborn children or other children who moved into the home after the prior report. Deaths of children whose families had no prior Division involvement within the five years prior to their death were not included in this report.

Fatalities in this analysis are classified by cause and manner of death as outlined in Section 3. ***All information presented here is based on data available as of June 12, 2017.***

The Division has sought to improve child death data collection methodologies and strengthen reporting mechanisms since 2011. The Division's child death review team has aggressively pursued internal policy requirements regarding the reporting of child deaths. The accuracy of reported data has improved following concerted efforts to engage with stakeholders on the need for more consistent reporting of child fatalities. This process has improved the Division's collection of child death data and will result in a more comprehensive analysis of child protective services going forward. It is worthwhile to note this improved reporting process may result in an increased number of relevant child deaths being identified by the Division, as a function of improved data collection procedures.

Researchers at Georgia State University's School of Public Health analyzed the child death data. Effective collaboration with the Office of the Child Advocate, Child Fatality Review Panel, and CAPTA allowed for an additional review of many deaths and offered implications for both prevention and practice enhancements.

DFCS/GSU Protocol

The Child Fatality Analysis created by the Division includes a subset of children who had a history with the Division in the past five years. This report excludes children who did not have a history with the Division in the past five years.

Child death data were collected and provided by the Division's Data Analysis Unit and the Child Death, Near Fatality, and Serious Injury Review Team. Based on the data obtained, researchers at Georgia State University's School of Public Health analyzed the data to create data elements such as tables and figures; the Georgia State University team also edited this report. A glossary of terms is available in Section 9.

[2] As relates to this sample, *Official Code of Georgia (O.C.G.A.) §15-11-741* defines a child as "an individual receiving protective services from DFCS, for whom DFCS has an open case file, or who has been, or whose siblings, parents, or other caretakers have been, the subject of a report to DFCS within the previous 5 years."

SECTION 3: CLASSIFICATION OF CHILD FATALITIES BY CAUSE AND MANNER

Defining Causes and Manners of Death

Cause of Death refers to a specific forensic finding of how a death occurred (e.g., drowning, gunshot, suffocation, Sudden Unexpected Infant Death, etc.).

Manner of Death is an official classification by a coroner or medical examiner of how the cause of death occurred. Five determinations are used for manner of death: *accident, homicide, natural, suicide,* and *undetermined*. These manners of death are used on death certificates and autopsy reports. Note that for each manner of death, there could potentially be multiple causes of death. Each manner of death included in this report is individually defined below.

Table 3.1. Definitions[3] for Manners of Death.

Manner of Death	Definition	Examples
Accident	An unintended death.	• Drowning • Motor vehicle accident • Accidental asphyxiation due to an unsafe sleep environment
Homicide	The death was caused by the actions of another person.	• Malnutrition and/or dehydration due to neglect • Shooting by stranger or caregiver
Natural	The death was from disease or medical conditions.	• Complications stemming from Sickle Cell Anemia, Cerebral Palsy, or Cancer • Sudden Infant Death Syndrome (SIDS) is often categorized as natural
Suicide	A death that is intentionally self-inflicted.	• Hanging • Self-inflicted gunshot • Overdose
Undetermined	There is little or no evidence to establish with medical certainty, the cause of death	• When specific details surrounding the death are unclear, it is often categorized as undetermined • Sudden Unexpected Infant Death (SUID) and sleep-related deaths are often categorized as undetermined

[3] Definitions accessed on September 9 2017 from https://gbi.georgia.gov/medical-examiners-office.

Of note, many people, as well as the media, confuse the terms homicide and murder. Murder is the unlawful taking of a human life by another. After the medical examiner determines the manner of death to be a homicide, law enforcement investigates the death to determine if there is probable cause to bring the criminal charge of murder against the person who caused the death. While all murders are homicides, not all homicides are murders.

An official cause and manner of death is not always associated with the Department's finding of abuse or neglect. For example, a child may die because of an accident (such as a drowning), but maltreatment may be found in the caregiver's actions (e.g., substance use) or by their inaction (e.g., lack of supervision), and this may indirectly result in the death of the child. As another example, a death attributed to homicide (i.e., a manner of death) may occur at the hands of a caregiver and be abuse-related. Alternatively, the homicide may occur at the hands of a non-caregiver, and in that case, there may not be maltreatment by a caregiver (e.g., a teenager shot by a stranger).

The following figure provides a breakdown of the manner of child fatalities in 2016 for children with prior involvement by percentage. Note that accidental and natural deaths represent 57% (102 children) of the 180 fatalities reviewed in this report. It is noteworthy that 52 of the 102 deaths were substantiated due to contributing factors that had an impact on the death itself. For example, the drowning death of a child is almost always accidental, but the assessment of the circumstances surrounding the death may reveal inadequate supervision of the child as a contributing factor. In 80 of the deaths classified as accidental or natural, maltreatment was not substantiated.

Figure 3.2. Manners of Death by Percentage

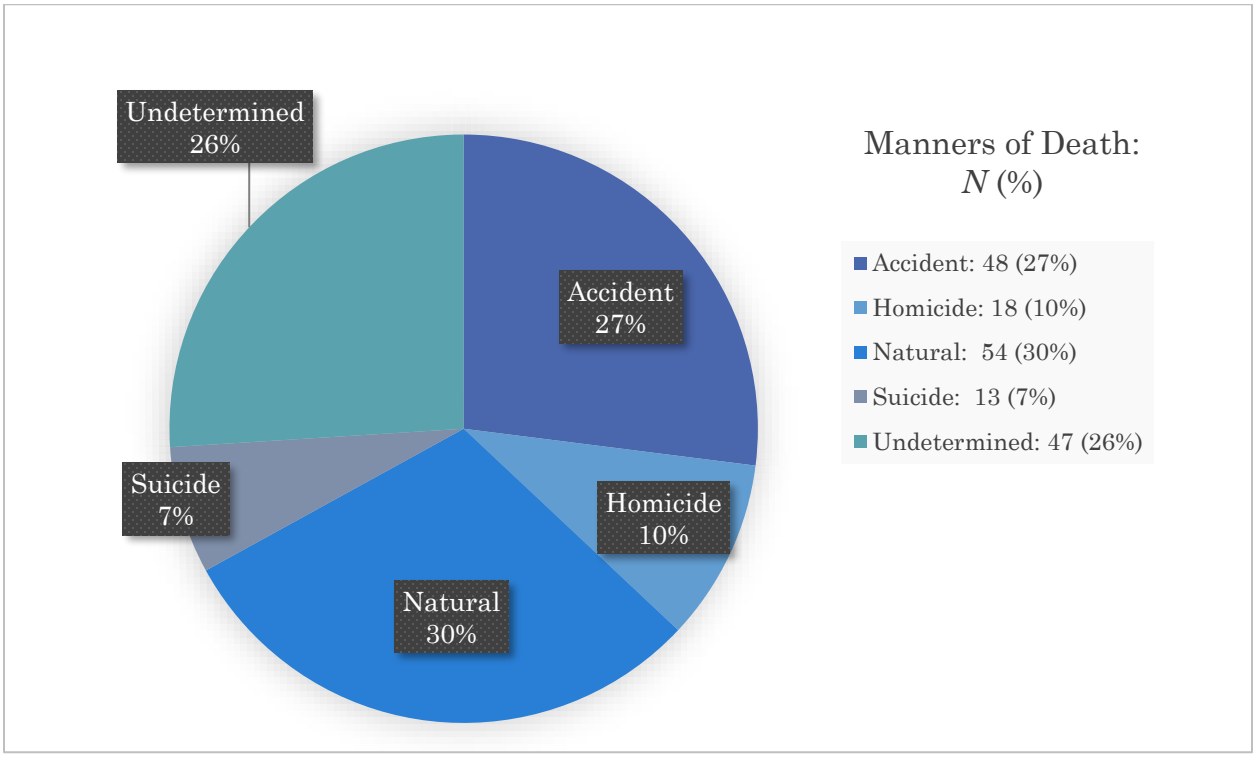
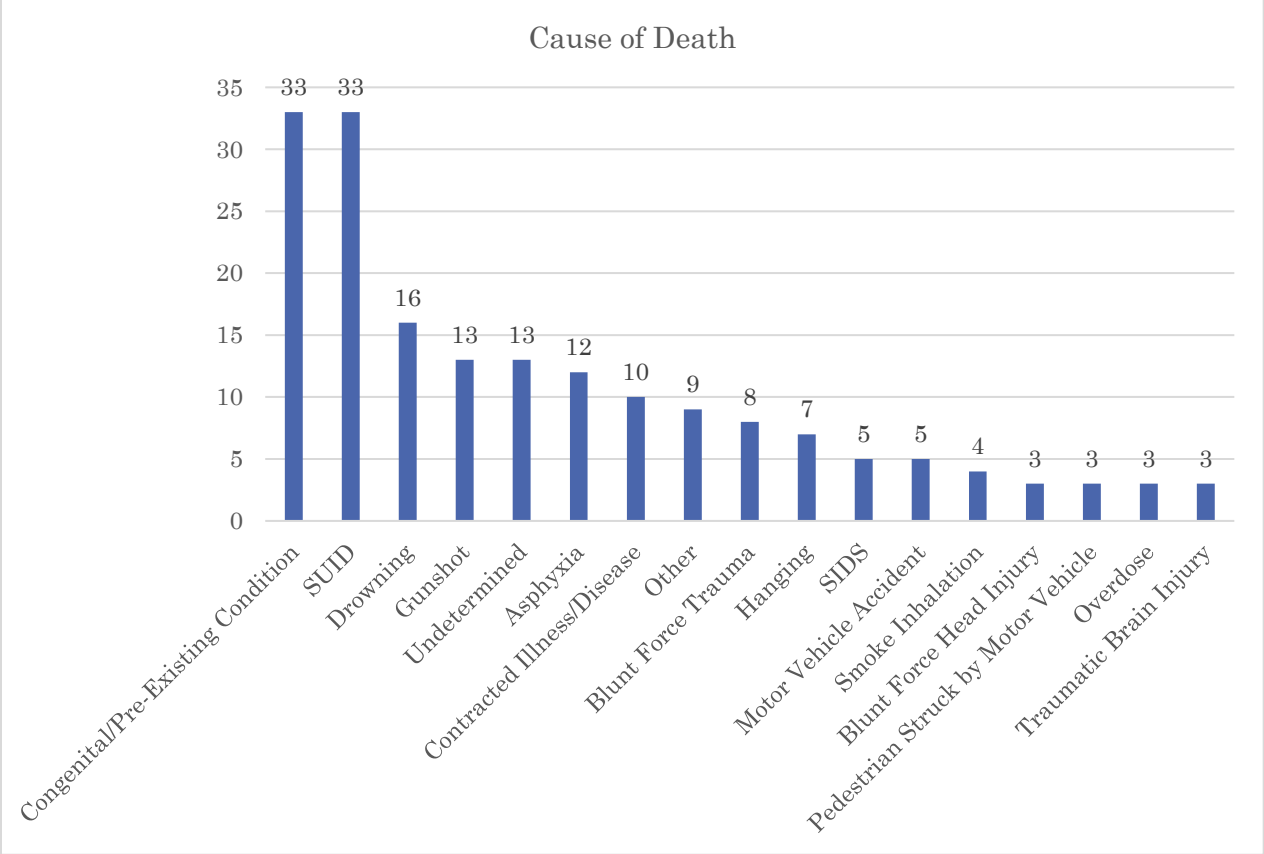


Figure 3.3 provides information on the causes of death in 2016 for children with prior child protective services involvement. In building on the data included in the previous figure, for those deaths classified as natural, the leading cause of death was a congenital or pre-existing condition (33 children) and Sudden Unexpected Infant Death (SUID; 33 children) which always corresponds to the death of a child fewer than two years of age, and which most often occurs during a sleep-related event. The second leading cause of death was drowning (16 children).

The analysis of cause of death is based on causes as they were officially recorded and reported to the Division. Because of differing approaches to investigation and classification in sleep-related deaths of very young children, there is often ambiguity regarding Sudden Unexpected Infant Death (SUID), which is a broad category including SIDS, accidental suffocation and strangulation in bed, and death by unknown causes. While there have been efforts to standardize the reporting of these cases, the cause may be officially reported differently depending on the investigation and examiner (CDC, 2017a).

Figure 3.3. Causes of Death for Children with Prior Involvement

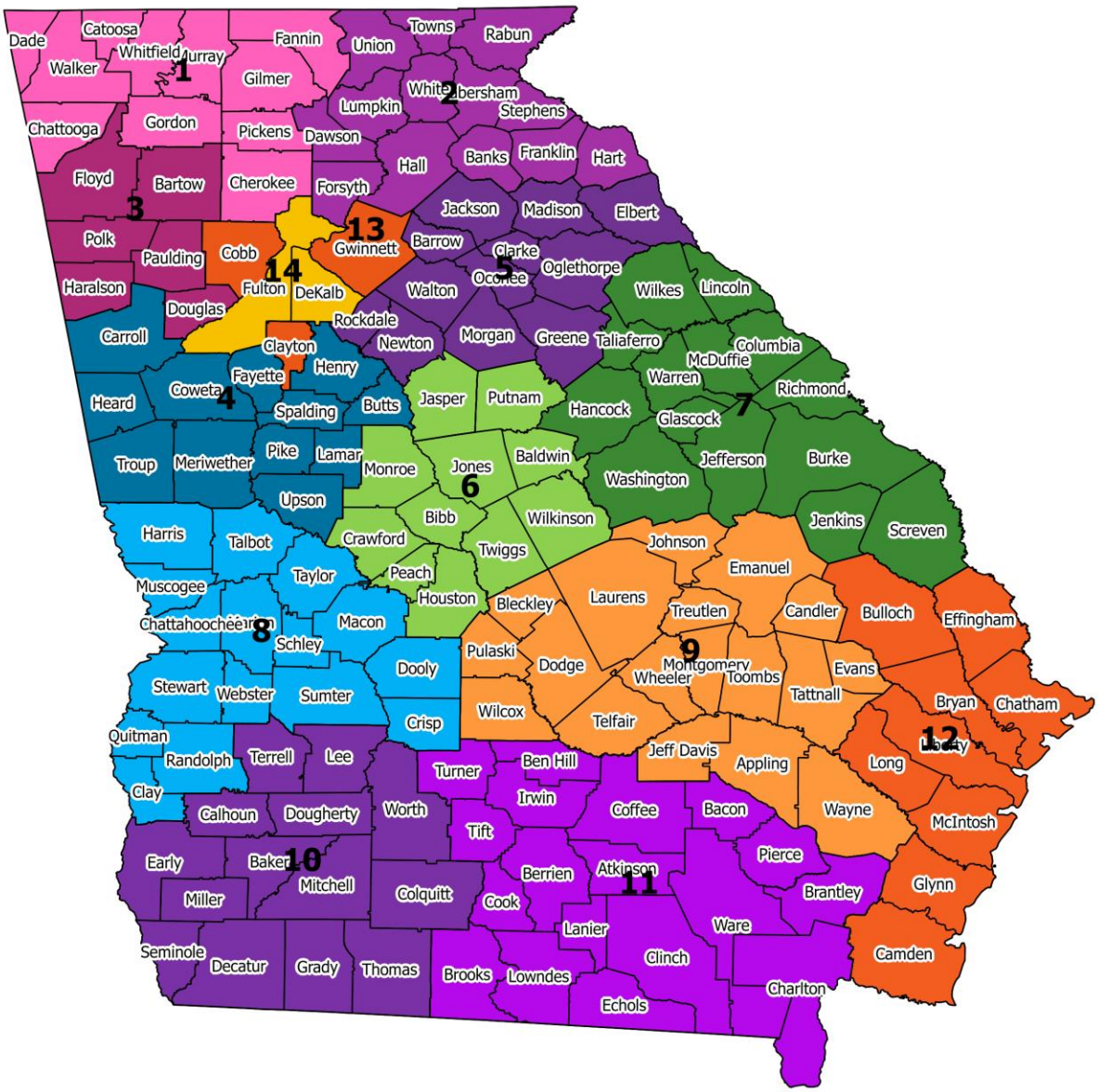


SECTION 4: EXECUTIVE SUMMARY OF DATA FINDINGS

This report reviews the deaths of 180 children who died between January 1 and December 31, 2016, and whose families had prior involvement with the Division. In the past five years, 684,664 children had Division involvement. Below, we provide an executive summary of findings. It should be noted that the following statistics are not mutually exclusive; a death may be represented in more than one of the categories below.

- **40** children **(22% of the 180 deaths reviewed by the Division)** had substantiated findings of child abuse and/or neglect prior to those children's deaths.
- **52** children **(29%)** had substantiated findings of maltreatment in the circumstances resulting in their deaths.
- **8** children **(4%)** had both substantiated findings of maltreatment prior to their deaths and substantiated findings in relation to their deaths.
- **54** children (**30%**) were determined to have died as a result of natural causes.
- **84** children (**47%**) were under the age of one year.
- **71** children (**39%**) had families with open Division cases at the time of their deaths. 9 of the 71 were open due to the incident that led to the death.
- **41** children (**23%**) were classified as having special needs.
- **56** children (**31%**) died during a sleep-related event, **40** of which involved co-sleeping.
- **84** children (**47%**) had caregiver(s) who had a history of alleged substance abuse.
- **57** children (**32%**) had caregiver(s) who had an alleged history of mental health issues.
- **76** children (**42%**) had caregiver(s) who had a history of alleged criminal offenses.
- **69** children (**38%**) had caregiver(s) who had a history of alleged domestic violence.

Figure 4.1. Map of Division Regions.



Note. Map source: http://dfcs.dhs.georgia.gov/county-offices. Each county office is responsible for providing reports directly to the state office when a child fatality is reported in their county.

Table 4.2. DFCS-involved Child Fatality Numbers/Percentages for all Division Regions.

Region	Counties Within the Region	Total Child Fatalities in Each Region	Total Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 180)
1	Catoosa, Chattooga, Cherokee, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield	14	169,036	8.28	8%
2	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	6	168,188	3.57	3%
3	Bartow, Douglas, Floyd, Haralson, Paulding, Polk	13	145,481	8.94	7%
4	Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, Upson	16	207,261	7.72	10%

Region	Counties Within the Region	Total Child Fatalities in Each Region	Total Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 180)
5	Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Newton, Oconee, Oglethorpe, Rockdale, Walton	11	164,024	6.71	6%
6	Baldwin, Bibb, Crawford, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson	8	118,218	6.77	4%
7	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	13	116,928	11.12	7%

Region	Counties Within the Region	Total Child Fatalities in Each Region	Total Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 180)
8	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster	17	85,654	19.85	9%
9	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox	3	71,741	4.18	2%
10	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	8	85,676	9.34	4%

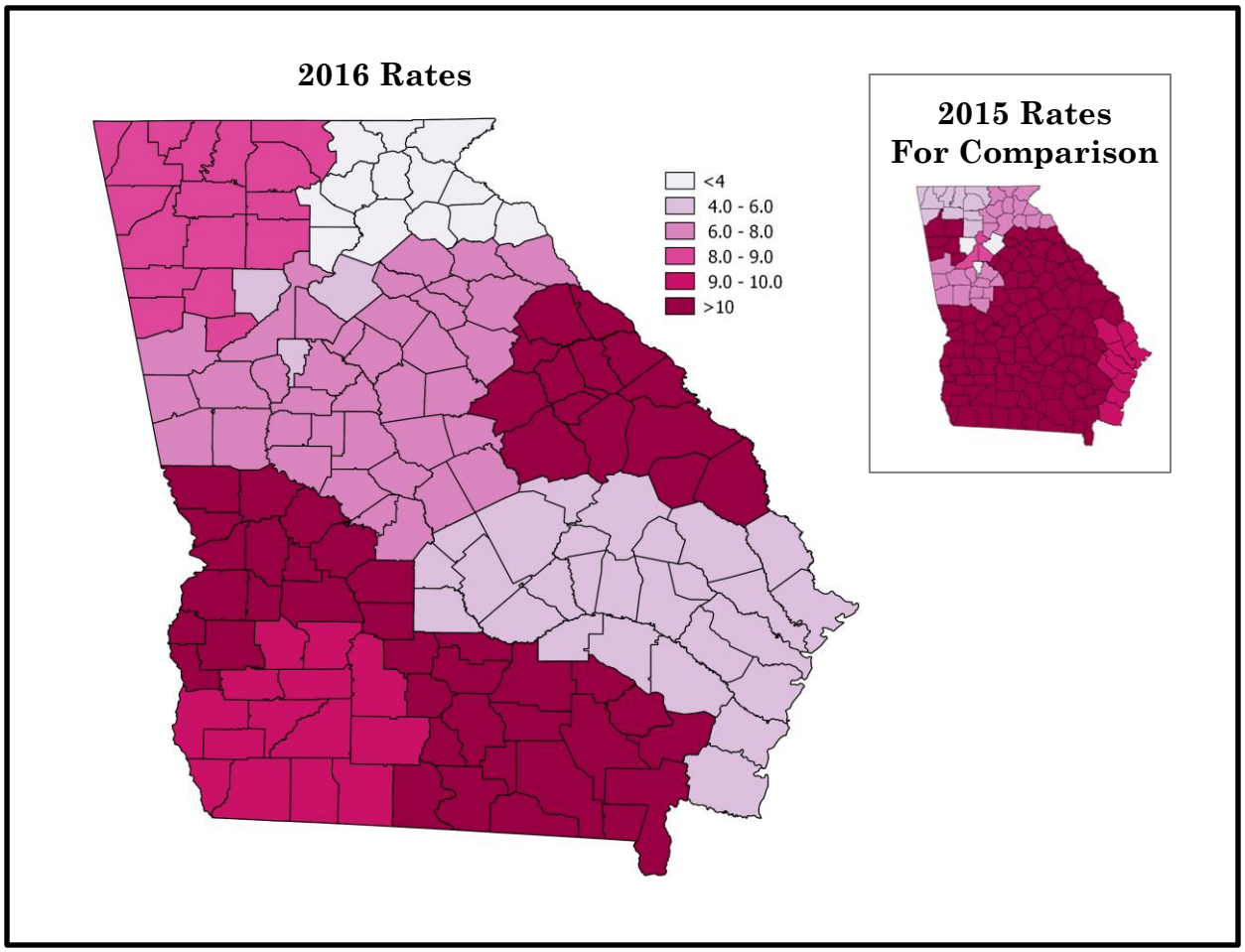
Region	Counties Within the Region	Total Child Fatalities in Each Region	Total Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 180)
11	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware	12	100,152	11.98	7%
12	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh	7	161,854	4.32	4%
13	Clayton, Cobb, Gwinnett	21	510,236	4.12	12%
14	DeKalb, Fulton	31	407,095	7.61	17%
Total	**Statewide**	**180**	**2,511,544**	**7.17**	**100%**

Note. Population data for regions were obtained from http://wonder.cdc.gov/bridged-race-population.html, on June 30, 2017 (CDC, 2017b).

The following heat map of Georgia shows rates of child fatalities with prior Division involvement. Rates are calculated per 100,000 children in each region. While there are contextual concerns underlying this representation (e.g., regions with few children that experienced an incident resulting in multiple deaths could see an elevated rate), it does suggest areas worthy of further investigation and increased collaboration with other state agencies.

Regions 7, 8, and 11 each have rates higher than 10 per 100,000 and may benefit from targeted intervention strategies and efforts to ensure access to quality healthcare. Combined, these three regions contain 12% of the population of children in Georgia (302,734 out of 2,511,544), but account for 23% (42 out of 180) of deaths in this report. It should be noted that the manners and causes of death in these regions follow similar patterns to the entire state and only 26% of the deaths have substantiated findings of maltreatment, compared to 29% statewide.

Figure 4.3. Child Fatality Rates per 100,000 Children by Region.

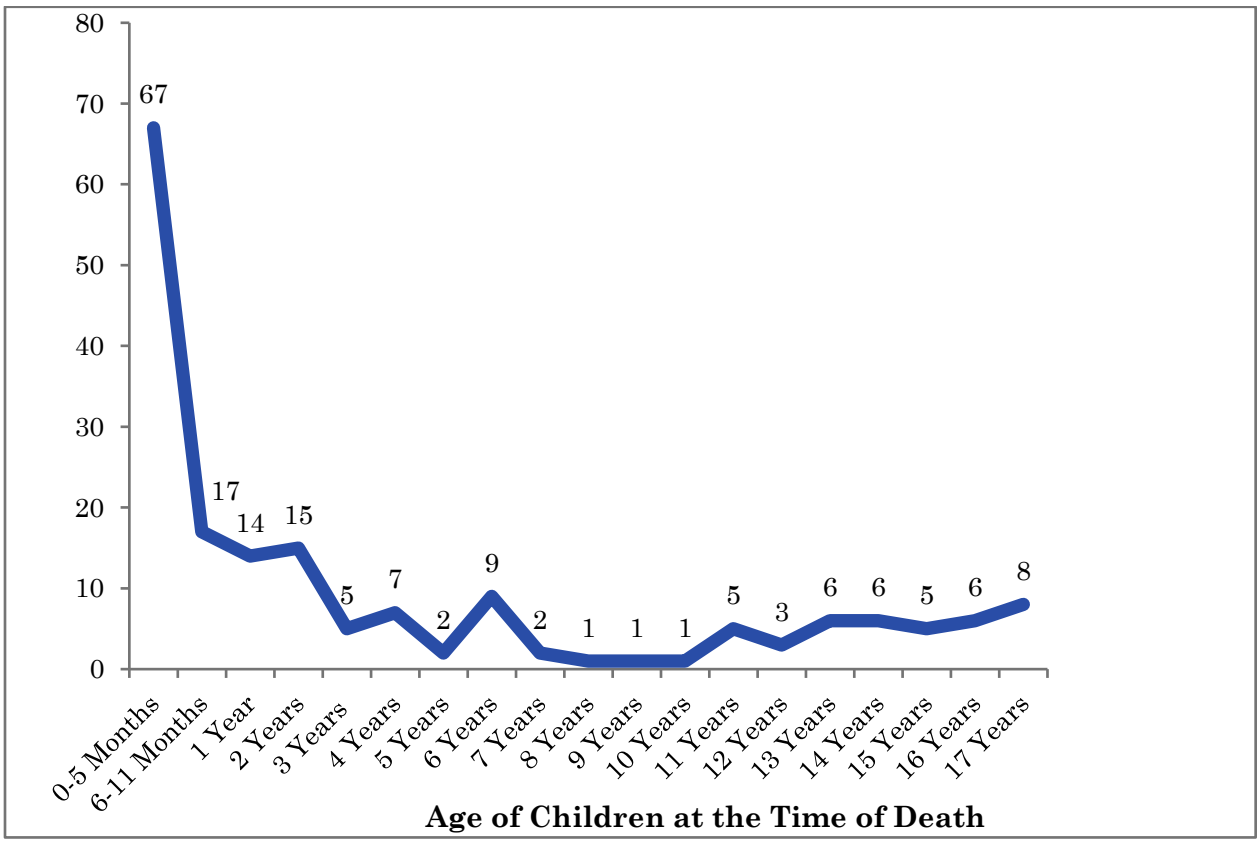


Note. As a comparison, this map also shows the 2015 heat map for child fatality rates per 100,000 children by region.

Figure 4.4 displays the ages of children in this report at the time of their deaths. Children under the age of one year account for 47% (87) of the deaths, and 54% (98) of the deaths were children under the age of two years. This conforms to national trends from the Child Trends Databank showing that children are most at-risk in their first year of life (Child Trends Databank, 2016). These data reinforce the vulnerability of infants and young children, but also draw attention to the need for greater advocacy and for campaigns that inform new parents about risk factors that may result in preventable child deaths.

The remaining 46% (82) of the deaths for 2016 comprise children between 2 and 17 years of age. Of those 82, 27 (32%) children had special needs. Thirteen (16%) of the 82 deaths between 2 and 17 years old were ruled suicides.

Figure 4.4. Ages of Children at Time of Death for Children with Prior Involvement.



SECTION 5: CHILD FATALITIES AND PRIOR DIVISION INVOLVEMENT

Description of Data

The data included in the *2016 Child Fatality Analysis* detail the manners and causes of death for children whose families had child protective services involvement with the Division within five years prior to the date of death. As noted earlier, the data included in this report *do not* reflect all child fatalities within the general Georgia child population (see Figure 1.1). When a child's death is reported to a local Division office, it is forwarded to an internal review team that examines the circumstances surrounding the death. The Georgia Office of the Child Advocate works in partnership with the Division to further understand the events surrounding the deaths of children who have prior involvement and whose deaths may be maltreatment-related.

In 2016, a total of **369** child deaths were reported to the Division. Of these, **180** children were identified as members of families who had some form of child welfare involvement with the Division within the previous five years.[4] During the same time period, the Division had contact with approximately 684,664 children. This equates to **180** deaths in 2016 among 684,664 children with any family involvement with DFCS in the past five years, a rate of about 26.29 deaths per 100,000[5] applicable children. To place this in context, 1,517 children died from all causes in Georgia in 2016. In 2016, there were **2,511,544** children living in Georgia (CDC, 2017b). Thus, the mortality rate for Georgia children for 2016 was 60.40 per 100,000.

In 2016, of the **180** deaths with Division involvement, **109** occurred after the Division had ended its involvement with the family. In **71** of the fatalities, the Division had an open case with the family at the time of death, **9** of which were opened due to the circumstances that led to the death.

The following data provide a snapshot of the Division's overall Child Protective Services caseloads for 2016:

- The total number of reports to the Division: **118,730**
    - Screen-Outs: **27,622**
    - The total number of reports assigned to Child Protective Services (CPS) workers: **91,048**
        - **46,168 (51%)** were assigned to Family Support Services
        - **44,880 (49%)** were assigned to Investigations
- The total number of children in DFCS custody at some point in 2016: **19,080**

[4] In comparison, for 2015, the deaths of 200 children whose families had prior Division history were reported to the agency.

[5] This estimate is unadjusted for the number of new births in families, number of unreported children in the family, or recurrent reports for the same child during the 5-year period.

- The total number of Family Preservation Services cases: **9,989**

Child Fatality Review Process

Once a death has been reported to the Division, a review of circumstances surrounding the death is warranted. Deaths due to maltreatment are of special concern and require additional scrutiny because the Division is charged with investigating child abuse and neglect. It should be noted that not all deaths in this report are due to abuse or neglect; in fact, most were due to circumstances beyond any responsibility of the Division. The Division reviews the deaths of children with prior DFCS history due to the desire to improve practice whenever possible.

Specific causes and manners are typically determined by a coroner or Medical Examiner. Findings of maltreatment are based on physical indicators, as well as additional information obtained from the Division, first responders, and law enforcement. This additional level of investigation and detection may increase the number of deaths attributed to maltreatment, and the number of maltreatment-related deaths may appear to rise, even if actual incidences are stable or declining.

Intervention by the Division involves a broad spectrum of potential services. For example:

- Prior or current Foster Care services.
- A report that was screened-out because it lacked an allegation of abuse or neglect.
- Family Support Services cases in which the allegation does not necessarily involve immediate child safety.
- Family Preservation Services cases in which allegations of maltreatment or abuse may have been substantiated, but the removal of the children was not necessary to ensure safety.
- Investigations in which the Division may have confirmed an allegation of abuse or neglect.

The Division forwards data from both types of reports (with and without prior Division involvement) to the National Child Abuse and Neglect Data System (NCANDS). In 2016, **189** child deaths without prior child protective services involvement, were made to the Division. Those deaths are excluded from this analysis. NCANDS does not distinguish whether or not the Division had prior involvement and thus only includes children whose deaths were a) reported to the Division and b) determined to be related to maltreatment.

Closed Cases

Of the 180 fatalities reviewed in this report, 109 (61%) were for children from families with closed cases at the time of the child's death. This includes 52 children (29% of 180 deaths in 2016) who were born after their family's last case closure. In other words, the child who died was born after the completion of the Division's most recent involvement with the family. In looking at child fatalities and prior Division involvement, the length of time between the most recent involvement and the death of the child is noteworthy.

The 109 deaths occurring after case closure include 8 suicides and 8 homicides. Three suicides occurred fewer than 12 months after case closure, and 5 suicides occurred more than 12 months after case closure. For homicides, 4 homicides occurred less than 12 months after case closure, and 4 homicides occurred more than 12 months after case closure.

Figure 5.1 displays the length of time between prior Division involvement with the family and the child's death (for cases closed at the time of death), delineated by the five official manners of death.

Figure 5.1. Length of Time between Prior Involvement and Child Death for Those with Closed Cases at Time of Death, Delineated by Manner of Death, $N = 109$.

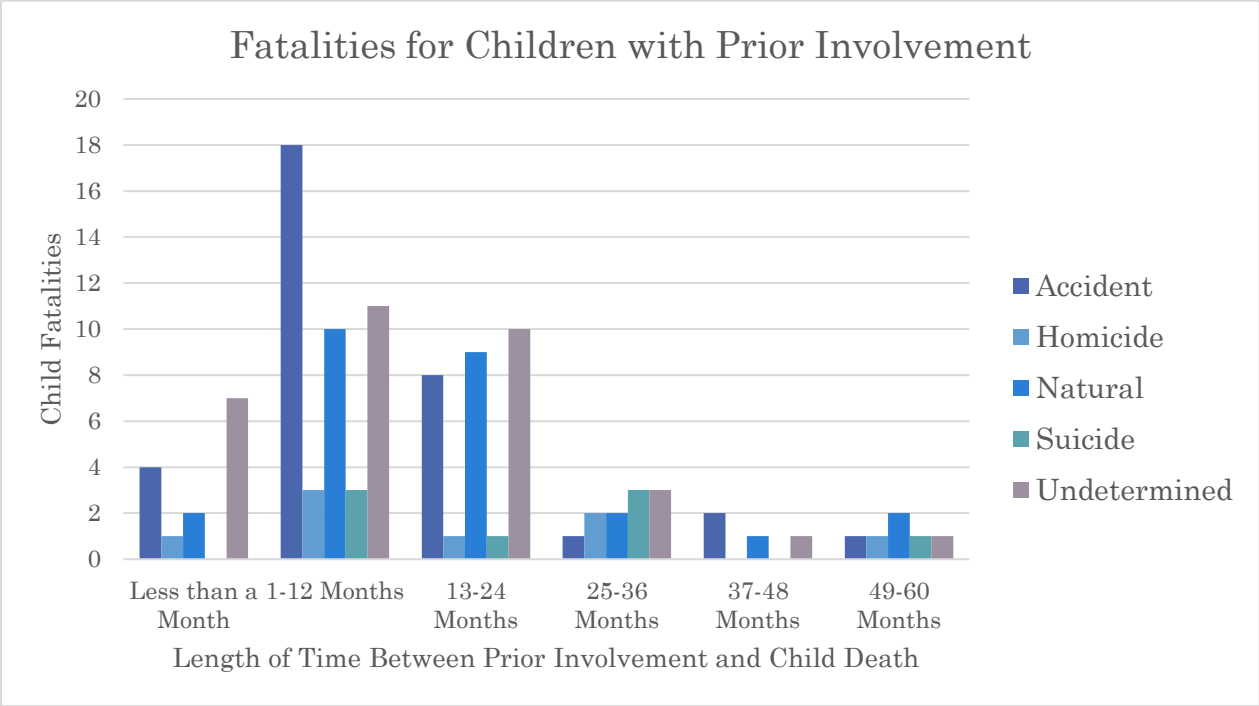


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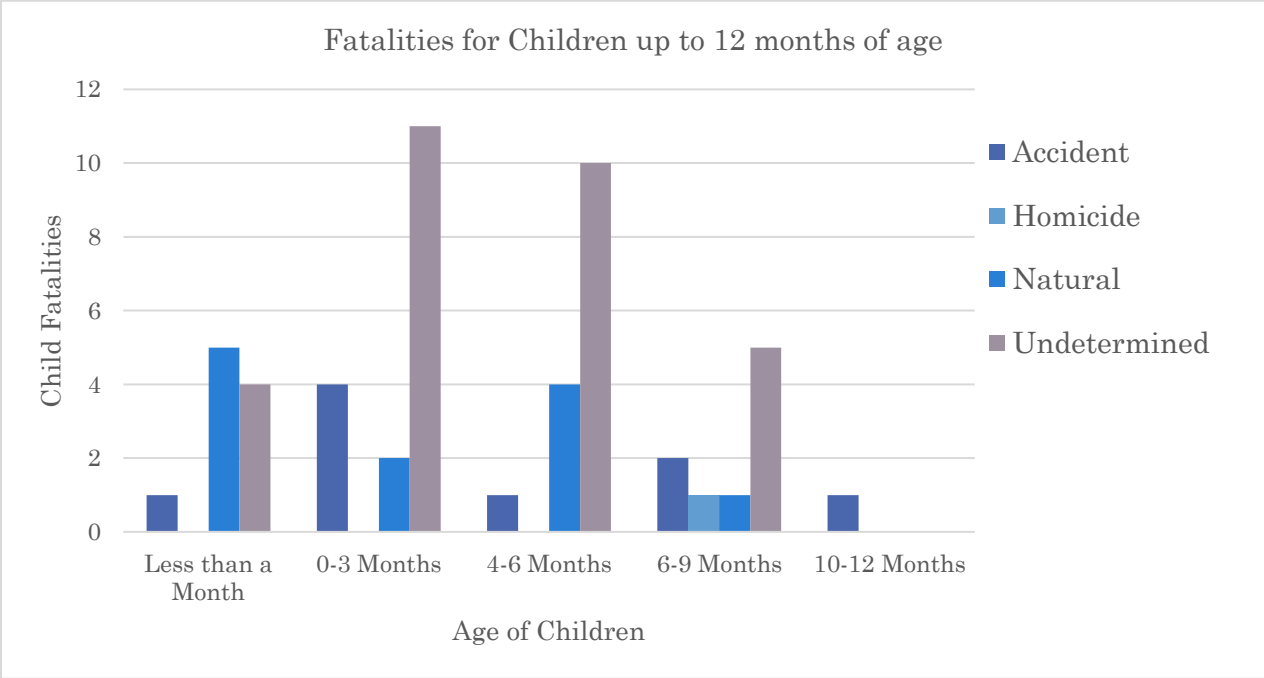
Figure 5.2 examines the age and manner of death for the 52 children who were between 0 and 12 months of age with prior involvement and closed cases at the time of death. This includes 32 cases where the child was born after the case was closed.

Figure 5.2. Fatalities by Age Group for Children Up to 12 Months of Age, Delineated by Manner of Death, $N = 52$.



Note. There were 52 children aged 0-12 months in 2016 who had closed cases at the time of death.

Open Cases

An open case indicates active Division involvement with a child or family. In 2016, there were 71 fatalities with open cases at the time of the child's death.

Of those 71 fatalities with open cases, 17 (24%) had substantiated findings of maltreatment in relation to their deaths. Three of the 17 cases (18%) were open due to the incident which resulted in the child's death. The other 14 (82%) cases had substantiated findings in their death, but had open cases with the Division for various unrelated reasons.

Table 5.3 breaks down these 17 fatalities by case type and whether the case was open due to the incident that caused the death or for other reasons.

Table 5.3. Number of Substantiated Fatalities with Open Cases at the Time of Death (with Case Type) for Children with Prior Involvement, $N = 17$.

Substantiated Fatalities with Open Cases at the Time of Death	Case Open Due to Incident that Led to the Death	Case Open for Other Reasons	Total Number (and Percentage) of Open Cases at the Time of Death
Investigation for Abuse or Neglect	2 (12%)	4 (23%)	6 (35%)
Family Preservation Services	0 (0%)	5 (29%)	5 (29%)
Family Support Services	0 (0%)	3 (18%)	3 (18%)
Foster Care	1 (6%)	1 (6%)	2 (12%)
Post Foster Care	0 (0%)	1 (6%)	1 (6%)
Total *N* (%)	**3 (18%)**	**14 (82%)**	**17 (100%)**

Table 5.4 provides a breakdown for *open cases with a substantiated finding* of maltreatment in the death and is broken down by the official manner of death.

Table 5.4. Number of Substantiated Fatalities with Open Cases at the Time of Death (with Manner of Death) for Children with Prior Involvement, *N* = 17.

Substantiated Fatalities with Open Cases at the Time of Death	Case Open Due to Incident that Led to the Death	Case Open for Other Reasons	Total *N* (%)
Accident	1 (33%)	4 (29%)	**5 (29%)**
Homicide	2 (67%)	2 (14%)	**4 (24%)**
Natural	0 (0%)	1 (7%)	**1 (6%)**
Suicide	0 (0%)	2 (14%)	**2 (12%)**
Undetermined	0 (0%)	5 (36%)	**5 (29%)**
Total *N* (%)	**3 (18%)**	**14 (82%)**	**17 (100%)**

Note. All children with cases open due to the incident that led to the death also had cases open prior to the incident that led to the death. The percentages in individual cells are calculated from the column totals while total percentages represent the percentage from the total N=17.

Implications for Practice

Deaths of children with Division contact may occur in multiple ways and, therefore, have different implications for understanding, learning, and improving practice. One of the most disconcerting manners of death for the Division is when a child suffers an abusive death at the hands of a caregiver in which the risk was pre-existing and interventions offered did not prevent harm from happening to the child. In these cases, maltreatment is the proximal cause of death. These types of incidents raise service improvement questions about risk assessment (e.g., was the risk detectable?), provision of services (e.g., were the services appropriate?), decision-making (e.g., was maintaining the child in their present situation a reasonable decision?), and management of aftercare needs (e.g., were services after reunification or post termination adequate?).

Other manners of death may be caused by complex circumstances in which parental negligence plays a partial, but not a proximal or even necessary role. For example, a child may die in a vehicular accident in which the child was not properly secured in a car seat, or a child may die from an illness complicated by delayed medical care. These types of cases

may alert case managers about possible future maltreatment if other children are present in the home.

In some situations, the Division may end its involvement with a family after it has ensured the safety of existing children in the home, but the parent(s) may later bear other children who are not known to the Division. For example, a drug addicted mother may have all of her children placed in DFCS custody and after reunification efforts have failed, her parental rights are terminated. As a result, the Division would close its case because she has no other children in her home and risk has been eliminated. The mother may later have additional children whom the Division is unaware of, and a report is made because she has given birth to a drug exposed infant; the infant has medical complications and dies due to those complications. The implications for practice under these types of scenarios would focus on strategies involving Georgia's maternal and child health system and community supports. For 2016, there were 52 children born after the Division's last involvement with the family; therefore, intervention efforts were improbable.

The Division continuously reviews its practices at many levels. Whenever there has been prior involvement with a family, there is an opportunity to review its response and potentially the responses from other agencies that may have been involved in the family's life. Division intervention in a family's life can be crucial and have lasting effects. Open and effective communication between all parties who have a responsibility to ensure a child's safety is critical to having successful outcomes for children.

SECTION 6: VULNERABLE POPULATIONS

Children under the Age of One

Of the 180 deaths reviewed in this report, 84 (47%) were children under one-year-old. Of those 84 children, 43 (51%) were born after the Division's last involvement with the family. The primary manner of death of the 84 children under age one (see Table 6.1) was Undetermined (42 children), and the second most common manner was Natural (29 children). Additionally, 51 (61%) of the 84 children in this age group had caregivers who were alleged to have been engaging in substance use at some time.

Unsafe sleep practices have been identified as a major factor contributing to death among children under age one. Being placed on a soft surface and/or sharing sleep surfaces with adults or siblings remain factors in sleep-related deaths. This is a recognized public health matter nationwide and underscores the need to educate parents and caregivers about infant safe-sleep practices used not only during night time sleeping, but also during any sleep-related event throughout the day.[6]

Table 6.1. Manners of Death for Children under the Age of One with Prior Involvement, *N* = 84.

Age	Accident	Homicide	Natural	Undetermined	Total *N* (%)
0-5 Months	7 (70%)	1 (33%)	26 (90%)	33 (86%)	**67 (80%)**
6-11 Months	3 (30%)	2 (67%)	3 (10%)	9 (14%)	**17 (20%)**
Total *N* (%)	**10 (12%)**	**3 (4%)**	**29 (34%)**	**42 (50%)**	**84 (100%)**

Note. Percentages in individual cells represent the percentage the age range constitutes of that manner of death. Total percentages represent the percent of the total *N*=84.

[6] The Centers for Disease Control and Prevention reported that the leading causes of infant deaths in 2014 were: birth defects, preterm birth (birth before 37 weeks gestation) and low birth weight (under 2500 grams), maternal complications of pregnancy, sudden infant death syndrome (SIDS), and injuries (e.g. suffocation).

Table 6.2 examines the causes of death in children under age one, divided into the first and second 6 months of life. The leading two causes of death for this age group were Sudden Unexpected Infant Death (SUID) (33 children) and congenital or pre-existing conditions (19 children).

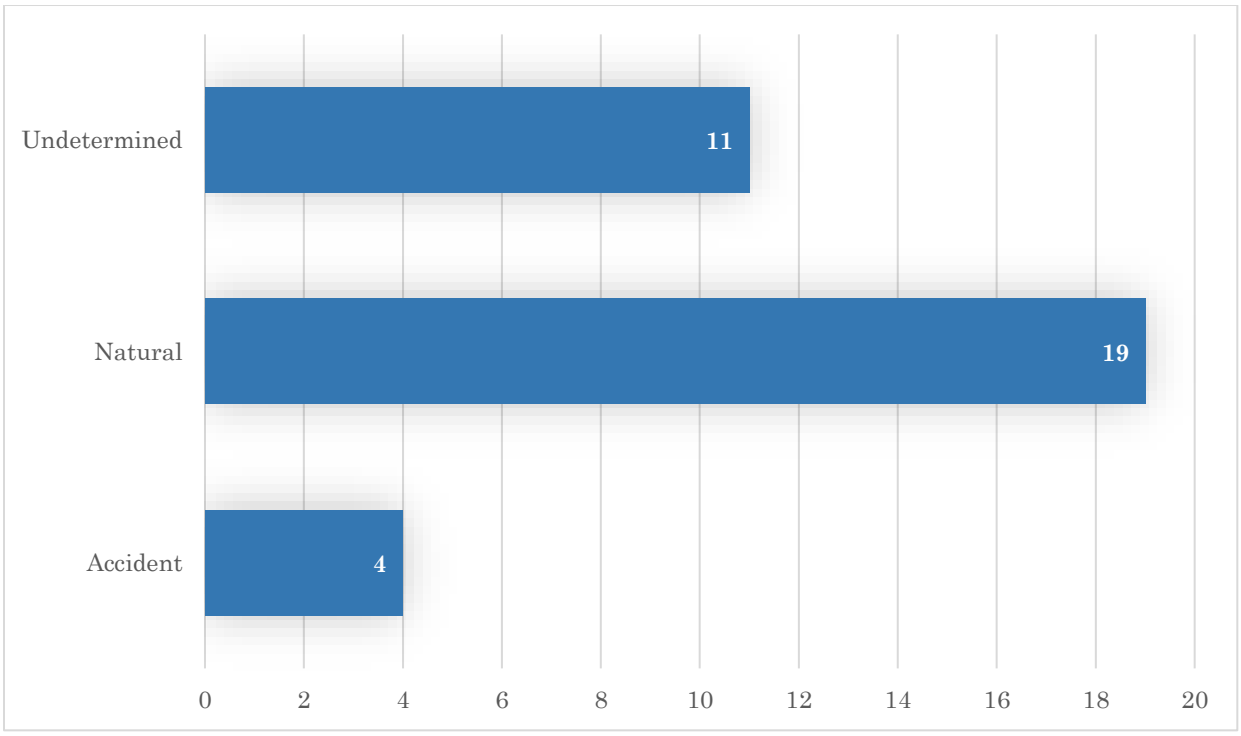
Table 6.2. Causes of Death for Children under the Age of One with Prior Involvement, *N* = 84.

Causation	Age 0-5 Months	Age 6-11 Months	Total *N* (%)
Asphyxia	6 (9%)	2 (12%)	**8 (10%)**
Blunt Force Head Injury	0 (0%)	1 (6%)	**1 (1%)**
Blunt Force Trauma	0 (0%)	1 (6%)	**1 (1%)**
Congenital/Pre-Existing Condition	16 (24%)	2 (12%)	**19 (23%)**
Contracted Illness/Disease	2 (3%)	0 (0%)	**2 (2%)**
Drowning	0 (0%)	1 (6%)	**1 (1%)**
Other	3 (4%)	0 (0%)	**2 (2%)**
SIDS	4 (6%)	1 (6%)	**5 (6%)**
SUID	27 (40%)	6 (34%)	**33 (40%)**
Traumatic Brain Injury	1 (2%)	1 (6%)	**2 (2%)**
Undetermined	8 (12%)	2 (12%)	**10 (12%)**
Total *N* (%)	**67 (80%)**	**17 (20%)**	**84 (100%)**

Premature Children

Premature (or preterm) birth occurs when a child is born before a full 37 weeks of pregnancy. Premature birth increases the risk of developmental delays and congenital defects. **Thirty-four (40%)** of the children in this report younger than 12 months old were also born prematurely. Of those 34 children, **19 (56%)** died of natural causes.

Figure 6.3. Manner of Death in Premature Children under 12 Months of Age, *N* = 34.



In this data set, premature children under 12-months-old appear particularly vulnerable to death from sleep-related causes. Their delayed development may put them at special risk from hazards related to unsafe sleep practices.

- **34** premature children in this report were fewer than 12 months old.
- **12** of the 34 premature children under 12 months died due to congenital/pre-existing conditions, the most frequent cause of death.
- **17** of the 34 premature children under 12 months died from sleep-related causes including asphyxia, SIDS, SUID, and undetermined causes.
- All **4** asphyxia deaths were ruled as accidental and were sleep-related.

Table 6.4. Causes of Death in Premature Children under 12 Months of Age, *N* = 34.

Causation	Non-Sleep-Related	Sleep-Related	Total *N* (%)
Asphyxia	0 (0%)	4 (24%)	**4 (12%)**
Blunt Force Head Injury	1 (6%)	0 (0%)	**1 (3%)**
Congenital/Pre-Existing Condition	12 (70%)	0 (0%)	**12 (35%)**
Other	2 (12%)	0 (0%)	**2 (6%)**
SIDS	0 (0%)	2 (12%)	**2 (6%)**
SUIDs	1 (6%)	8 (46%)	**9 (26%)**
Undetermined	1 (6%)	3 (18%)	**4 (12%)**
Total *N* (%)	**17 (50%)**	**17 (50%)**	**34 (100%)**

Note. Individual percentages represent the proportion of a given sleep-related status attributable to a cause of death. Total percentages represent the percentage of the 34 premature children under 12-months-old.

Prenatally Substance-Exposed Children

There were 28 children (16% of 180 children) who had a history of prenatal exposure to drugs. Of these children, 22 were under the 6 months old at the time of their deaths. While it is difficult to link deaths exclusively to prenatal exposure, the effects of prenatal exposure to substances may put infants at risk. Prenatal exposure to substances is associated with adverse health outcomes including low birth weight, extreme prematurity, congenital anomalies, and neurobehavioral issues (Behnke & Smith, 2013).

Even after an infant is born, substance use by an adult caregiver may place infants at risk. A parent or caregiver in an altered state places the child at risk, especially when the caregiver is unable to provide and recognize what is a safe environment for the child. Addiction recovery is best viewed as a long-term task, extending well beyond the time frame of involvement of a child welfare agency. Deaths associated with caregivers' abuse of methadone, alcohol, prescription medication, and illegal substances have been reported to the Division and continue to be a challenging characteristic of the child welfare population. When substance use is coupled with co-sleeping or a special needs child, the risk of harm or death is even higher.

There were **17** prenatally exposed children also born prematurely. Of those, many had complex medical issues; **9** died before they left the hospital.

Table 6.5. Prenatal Drug Exposure and Manner of Death, *N* = 28.

Exposure History	Accident	Natural	Undetermined	Total *N* (%)
Prenatal Drug Exposure	3 (2%)	17 (9%)	8 (5%)	28 (16%)

Children in DFCS Custody

10 foster children died in 2016:

- **8** deaths were determined to be from natural causes**, 5** were due to congenital or pre-existing conditions, **1** was due to contracting illness/disease, **1** was due to Sudden Infant Death Syndrome (SIDS) and **1** was undetermined.
- **1** child died due to a gunshot and the death was ruled a homicide (unidentified assailant).
- **1** child died due to drowning and the death was ruled an accident.

Table 6.6. Manners of Death for Children in DFCS custody at the Time of Death, *N* = 10.

Manner of Death	Accident	Homicide	Natural	Total *N* (%)
Total *N* (%)	1 (10%)	1 (10%)	8 (80%)	10 (100%)

Children/Families with Multiple Risk Factors

Often families who have prior involvement with the Division and have experienced a child death are affected by multiple risk factors, including, but not limited to, substance abuse, domestic violence, mental health issues, criminal history, and/or having a child with special needs. The greater the complexity of the issues within a family, the more challenging it can be for professionals to assess the ongoing safety of the children. Naturally, families are not always comfortable or willing to expose areas they may find embarrassing or difficult to address, making safety assessments even harder to thoroughly complete. Nevertheless, the Division recognizes the crucial need to consistently assess and address these multiple risk factors for such cases. The following table describes caregiver risk factors by manner of death.

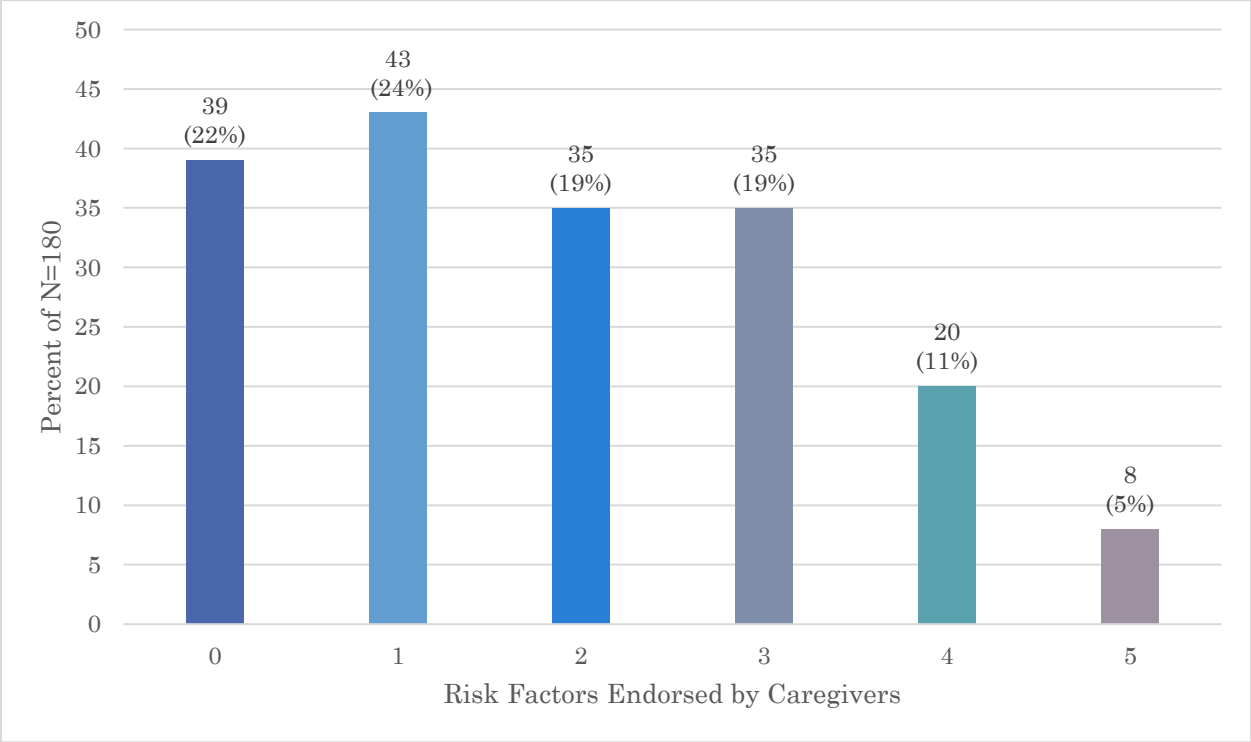
Table 6.7. Risk Factors of Caregivers and Manner of Death.

Caregiver Risk Factors	DFCS History as a Child *N* = 52	Alleged History of Substance Abuse *N* = 84	Alleged Criminal History *N* = 76	Alleged Mental Health History *N* = 57	Alleged History of Domestic Violence *N* = 69
Accident	16 (31%)	18 (21%)	21 (28%)	17 (30%)	17 (25%)
Homicide	3 (5%)	8 (10%)	10 (13%)	3 (5%)	11 (16%)
Natural	17 (33%)	26 (31%)	16 (21%)	19 (33%)	18 (26%)
Suicide	0 (0%)	4 (5%)	4 (5%)	4 (7%)	4 (6%)
Un-determined	16 (31%)	28 (33%)	25 (33%)	14 (25%)	19 (27%)
Total *N* (% of all cases)	**52 (29%)**	**84 (47%)**	**76 (42%)**	**57 (32%)**	**69 (38%)**

Note. Individual percentages represent manner of death in cases with a given risk factor. Caregivers may have met criteria for several risk factors. The total % for each risk factor represents the percentage out of all 180 cases in this report.

Figure 6.8 highlights the number of risk factors for child death endorsed by caregivers. These caregiver risk factors were DFCS history as a child, history of substance abuse, history of domestic violence, criminal history, and history of mental health issues.

Figure 6.8. Number of Risk Factors for Which Caregivers Met Criteria.



Tables 6.9 and 6.10 provide a breakdown of the 2016 deaths based on caregivers with histories substance abuse and/or domestic violence, and having a child with special needs, respectively. Note that **43 (24%)** of the total deaths for children with prior Division involvement involved caregivers with a history of *both* substance abuse and domestic violence.

Table 6.9. Causes of Death in 2016 for Children with Prior Involvement and Caregivers with Alleged History of Substance Abuse and/or Domestic Violence, N = 110, which includes 43 caregivers who had both a history of substance abuse and domestic violence.

Causes of Death	Caregivers with History of Alleged Substance Abuse	Caregivers with History of Alleged Domestic Violence
Asphyxia	8 (10%)	6 (9%)
Blunt Force Head Injury	0 (0%)	0 (0%)
Blunt Force Trauma	2 (2%)	3 (4%)
Congenital/Pre-Existing Condition	17 (21%)	11 (16%)
Contracted Illness/Disease	3 (4%)	4 (6%)
Drowning	7 (8%)	6 (9%)
Gunshot	4 (5%)	7 (10%)
Hanging	1 (1%)	1 (1%)
Pedestrian Hit by Car	1 (1%)	2 (3%)
Motor Vehicle Accident	1 (1%)	2 (3%)
Other	5 (6%)	3 (4%)
Overdose	2 (2%)	0 (0%)
Probable Overlying	1 (1%)	0 (0%)
SIDS	4 (5%)	2 (3%)
SUIDs	15 (18%)	12 (18%)
Smoke Inhalation or House Fire	3 (3%)	1 (1%)
Traumatic Brain Injury	1 (1%)	3 (4%)
Undetermined	9 (11%)	6 (9%)
Total *N* (%)	**84 (76%)**	**69 (63%)**

Note. Some children are captured in both categories; 43 caregivers had both a history of substance abuse and domestic violence. Thus, the total reflects the category of exposure, not number of children.

Special Needs

Table 6.10. Manners of Death for Special Needs Children with Prior Division Involvement, *N* = 41.

Manner of Death	Accident	Homicide	Natural	Suicide	Un-determined	Total *N* (%)
Total Number	5 (3%)	4 (2%)	27 (15%)	3 (2%)	2 (1%)	41 (23%)

Teen Deaths

2016 identified **31** teenagers between the ages of 13 and 17 who died and also had prior involvement with the Division.

- **9** committed suicide**: 4** by hanging, **4** by self-inflicted gunshot wounds, and **1** by overdose.
- **9** died due to accidental causes: **3** died in motor vehicle-related incidents, **3** by blunt force trauma, **2** pedestrians struck by motor vehicle, and **1** by drowning.
- **7** died due to homicide: **5** deaths were due to gunshot wounds; **2** deaths were due to stabbing (Caregiver committed **1** homicide, others were committed by youths or unknown assailants).
- **6** died due to natural causes: **3** by contracting illness/disease, **2** by a congenital pre-existing condition, and **1** due to other cause.

SECTION 7: UNSAFE SLEEP ENVIRONMENT

Many of the sleep-related deaths involved incidents where there was a combination of co-sleeping and an overall unsafe sleep environment. Caregivers or others falling asleep with infants in chairs, couches, or adult beds were a factor in 40 of the 56 sleep-related deaths. It is recommended that infants always sleep alone, on their backs, and in a sleep setting such as a crib (Moon, 2016). 33 infant deaths were ruled as SUIDs (Sudden Unexpected Infant Deaths) and 10 were ruled undetermined. Review of these fatalities has uncovered other contributing factors not readily observed at the time of death, such as substance use and/or untreated mental health needs of caregivers, and the presence of soft bedding material being used in a crib or bassinet. Circumstances surrounding sleep-related deaths continue to be explored to identify underlying contributing factors. In this report, 55 of the 56 children with sleep-related deaths were under one-year-old at the time of their death. In 32 of the 56 sleep-related deaths, caregivers had a history of alleged substance abuse. The Division believes that most of these deaths, though unintentional, were preventable.

Figure 7.1. 2016 Sleep-Related Death Rates per 100,000 Children by Region.

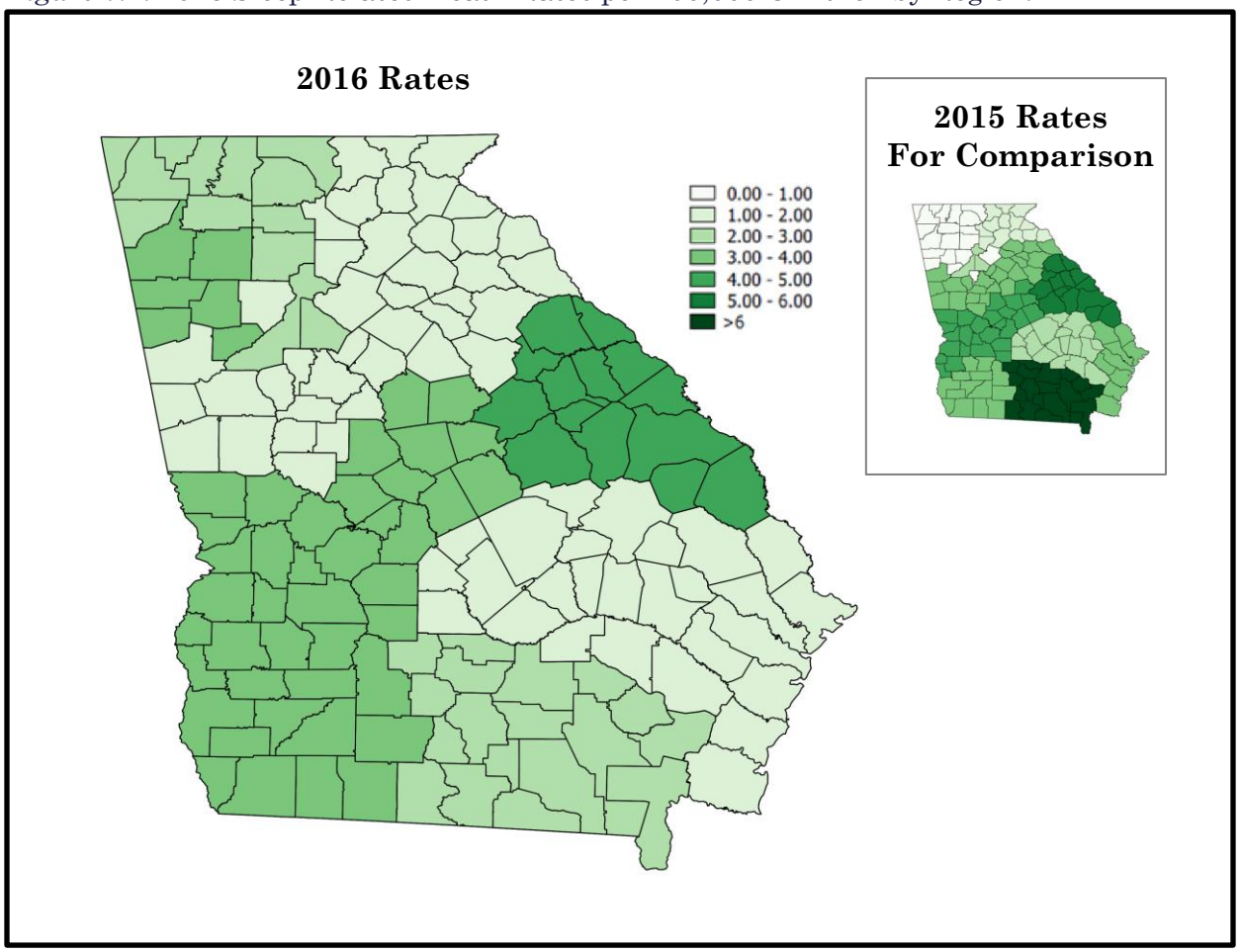


Table 7.2. Fatality Numbers/Percentages for Sleep-Related Deaths for All Division Regions, *N* = 56

Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 56)
1	Catoosa, Chattooga, Cherokee, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield	4	169,036	2.37	7%
2	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	3	168,188	1.78	5%
3	Bartow, Douglas, Floyd, Haralson, Paulding, Polk	5	145,481	3.44	9%
4	Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, Upson	4	207,261	1.93	7%
5	Barrow, Clarke, Elbert, Greene, Jackson, Madison, Morgan, Newton, Oconee, Oglethorpe, Rockdale, Walton	2	164,024	1.22	4%

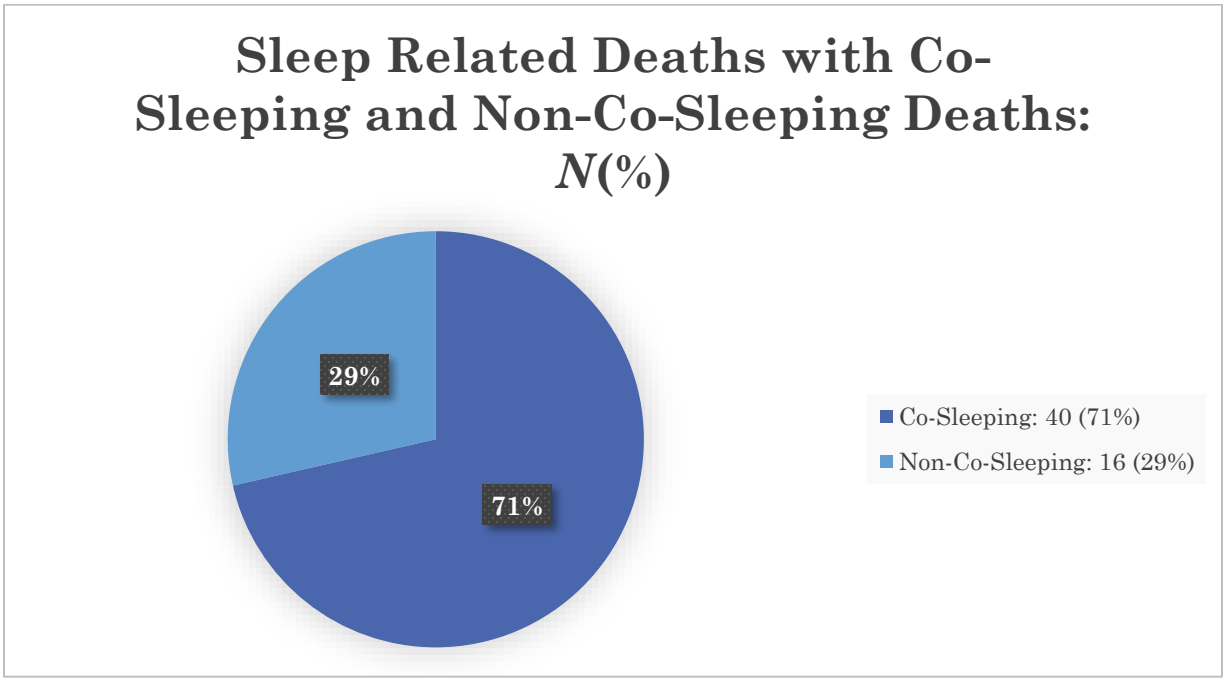
Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 56)
6	Baldwin, Bibb, Crawford, Houston, Jasper, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson	4	118,218	3.38	7%
7	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	5	116,928	4.28	9%
8	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster	3	85,654	3.50	5%

Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 56)
9	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox	1	71,741	1.39	2%
10	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	3	85,676	3.50	5%
11	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware	2	100,152	2.00	4%
12	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh	2	161,854	1.24	4%

Region	Counties Within the Region	Total Number of Sleep-Related Deaths	Total Number of Children in Each Region	Rate per 100,000 Children in the Region	Region Percentage of State Total (*N* = 56)
13	Clayton, Cobb, Gwinnett	6	510,236	1.18	11%
14	DeKalb, Fulton	12	407,095	2.95	21%
Total	**Statewide**	**56**	**2,511,544**	**2.23**	**100%**

At the time of analysis, 56 deaths were sleep-related of which 40 involved co-sleeping. *Co-sleeping is a preventable risk factor.*

Figure 7.3. Breakdown of Sleep-Related Deaths by Co-Sleeping or Non-Co-Sleeping Arrangements, *N* = 56.



SECTION 9: GLOSSARY

Child Abuse: (A) Any non-accidental physical injury or physical injury which is inconsistent with the explanation given for it suffered by a child as the result of the acts or omissions of a person responsible for the care of a child; (B) Emotional abuse; (C) Sexual abuse or sexual exploitation; (D) Prenatal abuse; or (E) The commission of an act of family violence as defined in Code Section 19-13-1 in the presence of a child. An act includes a single act, multiple acts, or a continuing course of conduct. As used in this subparagraph, the term "presence" means physically present or able to see or hear. (OCGA § 15-11-2).

Closed case: Division involvement with a child or family has been concluded.

Collateral contacts: Individuals that can provide reliable information about the family and are not meant to be "character references."

Family Preservation Services: This term is described by the Family Preservation and Support Services Act of 1993 (PL 103-66) as a continuum of family-focused services for at-risk children and families. Services include activities designed to assist families in crisis, often where a child is at risk of being placed in out-of-home care because of abuse and/or neglect. Support services include preventive activities, typically provided by community-based organizations designed to improve the nurturing of children and to strengthen and enhance the stability of families.

Family Support Services: Intake reports that are assigned to Family Support Services contain an allegation of child abuse or neglect and there is no preliminary indication of a present danger situation or an impending danger safety threat. Family Support Services are designed to ensure child safety and prevent future involvement in the child welfare system through the use of formal and informal services to strengthen and support families and enhance caregiver protective capacity to ensure the protection and care of children. (Georgia Child Welfare Policy Manual, 7.0).

Fictive Kin: A person who is known to a child as a relative, but is not, in fact, related by blood or marriage to such child and with whom such child has resided or had significant contact. (Georgia Child Welfare Policy Manual, 19.20).

Foster Care: The Foster Care program provides temporary out-of-home care for children who cannot legally remain safely in their home. Foster Care services are also provided for eligible Foster Care youth ages 18-21 through the Extended Youth Support Services program unless they opt out of participation.

Investigation: The investigative track is utilized when an intake report is received and safety threats are identified during the intake process. An investigation is a non-voluntary intervention with families. During an investigation, the Division assesses and determines child safety, maltreatment and caregiver protective capacities. (Georgia Child Welfare Policy Manual, 5.0).

Involvement: This includes, but is not limited to, all prior Child Protective Services involvement with the Division, whether reports were screened in or screened out. A thorough

review of DFCS history includes reviewing any current or prior cases involving Family Support Services, Investigations, Foster Care (Permanency) and Resource Development. A thorough review also includes review of information uploaded in external documents within Georgia SHINES, a web-based statewide automated child welfare information system. History is often a predictor of future behavior and the information in DFCS case history plays a significant role when making decisions regarding child welfare.

Maltreatment: A term including abuse and/or neglect.

Neglect: (A) The failure to provide proper parental care or control, subsistence, education as required by law, or other care or control necessary for a child's physical, mental, or emotional health or morals; (B) The failure to provide a child with adequate supervision necessary for such child's well-being; or (C) The abandonment of a child by his or her parent, guardian, or legal custodian. (OCGA § 15-11-2).

Open case: Active Child Protective Services involvement with a child or family.

Post Foster Care: When a child transitions from foster care (DFCS custody) to the custody of their parent(s) or another caregiver, and a case remains open in Georgia SHINES.

Report: Any information regarding identified or suspected maltreatment of a child, received by the Division, via the Child Protective Services, Centralized Intake Communication Center (CICC).

Screen Out: There are no allegations of maltreatment based on an analysis of the information gathered. (Georgia Child Welfare Policy Manual, 3.0).

Substantiated: The allegations of child abuse, as defined by Georgia statute, are supported by a preponderance of the evidence. A preponderance of evidence means that the greater the weight of the evidence makes it more probable than not that child abuse/neglect occurred. (Georgia Child Welfare Policy Manual, 5.3).

Unsubstantiated: There is no evidence of maltreatment or the evidence of maltreatment was not supported by a preponderance of the evidence as defined by Georgia statute and DFCS policy. (Georgia Child Welfare Policy Manual, 5.3).

SECTION 10: REFERENCES

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