Child Abuse Prevention and Treatment Act (CAPTA) Panels

2017 Annual Report

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

Georgia

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'Be the change you wish to see in the world" …Ghandi

Child Abuse Prevention and Treatment Act (CAPTA) Panels 2017 Annual Report

An Overview

Child Abuse Prevention and Treatment Act

The Child Abuse Prevention and Treatment Act (CAPTA) is the key federal legislation addressing child abuse and neglect. CAPTA was first passed into law in 1974 - Public Law 93-247, and re-authorized in 1978, 1984, 1988, 1992, 1996, in 2003 as Keeping Children and Families Safe Act of 2003, in 2010 by P.L. 111-320, the CAPTA Reauthorization Act of 2010, the Adoption Opportunities program, and the Abandoned Infants Assistance Act, and was last reauthorized on May 29, 2015 by the Justice for Victims of Trafficking Act of 2015 (P.L. 114-22) and on July 22, 2016, by the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198). Amendments have been made to expand and refine the law with each reauthorization[1].

CAPTA allows the federal government to provide leadership and assist states in their child and family protection efforts by:

- promoting coordinated planning among all levels of government
- generating and sharing knowledge relevant to child and family protection
- strengthening the capacity of states to assist communities
- allocating financial resources to assist states in implementing plans
- helping states to carry out their child and family protection plans by promoting the competence of professional, paraprofessional, and volunteer resources

CAPTA provides federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities in addition to grants to public agencies and nonprofit organizations, including Indian Tribes and Tribal organizations, for demonstration programs and projects.

CAPTA Citizen Review Panels

CAPTA, Section 106, is the enabling legislation for citizen review panels. When CAPTA was amended in 1996, each state, to be eligible for a CAPTA state grant, was required to establish at least three citizen review panels to provide opportunities for community members to play an integral role in ensuring that communities and the state are meeting the goal of protecting children from abuse and neglect. Federal law authorized these panels to evaluate the

[1] The most recent reauthorization of CAPTA can be found at https://www.acf.hhs.gov/cb/resource/capta2016.

policies, procedures, and practices of state and local child welfare agencies and the extent to which these agencies are effectively discharging their child protection responsibilities in accordance with the state's child protective services system plan and the specific child protection standards contained in CAPTA. Panels may review any other criteria that they consider important to ensure the protection of children, including the extent to which the state child protective services system coordinates with the title IV-E foster care and adoption assistance programs of the Social Security Act, and child fatalities and near fatalities.

In 2006, three existing committees were officially designated to serve as Georgia's citizen review panels (CAPTA Panels)[2]: the Children's Justice Act Task Force (Task Force), the Georgia Child Fatality Review Panel (CFRP) and the Child Protective Services Advisory Committee (CPSAC). The Task Force serves a dual role as a CAPTA Panel and as a task force on children's justice. The CFRP serves as both a CAPTA Panel and a state-mandated body charged with reviewing the circumstances in all child deaths and identifying opportunities for prevention. CFRP established a Maltreatment Committee in 2009 to help meet its new obligations as a CAPTA Panel. The CPSAC serves solely as a CAPTA Panel.

Georgia's CAPTA Panels are composed of volunteer members who broadly represent the community in which they operate and include individuals with expertise in the prevention and treatment of child abuse and neglect. Panels meet quarterly, provide for public outreach[3], and prepare an annual report on activities that provides feedback on the effectiveness of the state's child abuse prevention and treatment strategies and includes recommendations for improvements. Each of Georgia's CAPTA Panels meets all the statutory requirements for a citizen review panel as demonstrated in each of their individual annual reports.

State child welfare agencies are required to provide access to information that panels desire to review, to provide administrative support so that the panels can fulfill their duties, and to respond to the panel recommendations included in their annual reports. Georgia's Division of Family and Children Services (the Division) meets all its statutory obligations with regard to its CAPTA Panels. Georgia's Division of Family and Children Services (the Division) provides ongoing administrative support through:

- A Federal Plans Manager[4] position created in 2016 to serve as a liaison with the Panels, and whose responsibilities include facilitating communication and the exchange of information between the Division and the Panels

[2] In Georgia, CAPTA citizen review panels are known as 'CAPTA Panels' to distinguish them from the foster care review process known as the Citizen Panel Review Program that utilizes volunteers to conduct legally mandated reviews of the status and welfare of children placed by the Juvenile Court in the legal custody of the Division of Family and Children.

[3] Georgia's CAPTA Panels maintain a website, www.gacrp.com, to allow public access to information on CAPTA citizen review panels. Information and links to state and national child welfare resources are also available on the website.

[4] Shelby Zimmer assumed this position in March 2016.

- A contract with a firm for the services of an independent coordinator who provides day-to-day operational support and technical assistance

The Division Director and the leadership team meet quarterly with CAPTA Panel members to discuss current recommendations, shared and individual concerns, priorities and interests, in addition to providing updates on actions taken by the Division in response to previous recommendations.

CAPTA Panels continue to reinforce the importance of early and meaningful engagement of stakeholders by the Division, including CAPTA Panel members, in any planning or consultative process to ensure increased system transparency and effectual stakeholder contribution. In 2017, CAPTA Panel members were included in several state sponsored activities, such as:

- Joint planning, including participation at meetings hosted by Region IV Child Welfare Specialist
- Contribution to, and review of, the Annual Progress and Services Report
- Contribution to, and review of, the Program Improvement Plan
- Review of State CAPTA Plan
- Continuous Quality Improvement Leadership Committee

The Division frequently acknowledges the contributions of its CAPTA Panel members as valued partners. Their willingness to work in partnership with CAPTA Panels and other external stakeholders is to be commended.

CAPTA Panel Member Receives Special Recognition by the Division

Outstanding Individual Award: CPSAC member Jen King was honored at an Awards Celebration Luncheon at the 2017 Georgia Conference on Children & Families. Nominated by Division leadership, Jen was recognized as an individual who has demonstrated excellence, resilience and achievement in her work in child welfare.

Jen's role as Georgia CASA's Program Operations Director is to build a strong and supportive network of affiliates through statewide training efforts, support, leadership development and relationship building to strengthen collaboration and advocacy needed to improve outcomes for children and families. Jen's strengths make her a valued contributor to many child welfare efforts and was recognized by the Division for her contributions as a respected stakeholder to the State's Continuous Quality Improvement (CQI) team, the CAPTA Panel program, and the GA Youth Opportunities Initiative, to name a few.

2017 Activities and Recommendations

Georgia's CAPTA Panels have a statewide systemic approach to examining issues that impact the effectiveness of the state's child protection system. Although each CAPTA Panel has its own unique vision and mission, the common goal among all three is to improve the child welfare system and community response to protecting victims and supporting families. In 2017, CAPTA Panels interests and activities included:

- Policy and practice related to safety resource and relative caregiver placements
- Basic and specialized foster parent training
- Mandated reporter training guidelines and standards
- Updated model child abuse protocol
- Improving the identification of maltreatment-related fatalities
- Assessment[5] of the investigation of reports of child abuse and neglect including the training of individuals who respond to and are involved in the investigation of reports

Individual reports, detailing the 2017 activities and resulting recommendations, from each of Georgia's CAPTA Panels has been prepared and are attached.

[5] The Task Force undertook the assessment of investigations as the subject of their 2018 three-year CJA assessment.

Child Protective Services Advisory Committee

2017 Annual Report

Vision

Every child will live in a safe and nurturing home, and every family will have
the community-based supports and services they need to provide
safe and nurturing homes for their children

Mission

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

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The Child Protective Services Advisory Committee (CPSAC) serves as one of Georgia's three Child Abuse Prevention and Treatment Act (CAPTA) Panels. All state CAPTA grant recipients are required to establish and maintain CAPTA Panels to increase system transparency and accountability and provide opportunities for community input by:

- Examining the policies, procedures, and practices of state and local agencies, and, where appropriate, specific cases
- Evaluating the extent to which state and local child protection agencies are effectively discharging their child protection responsibilities in accordance with:
    a) The state's CAPTA plan
    b) Child protection standards required by CAPTA
- Any other criteria that the CAPTA Panels consider important to ensure the protection of children, including:
    a) Reviewing the extent to which the state and local child protective services system is coordinated with the foster care and adoption programs established under Title IV Part E of the Social Security Act
    b) Reviewing child fatalities and near fatalities

Georgia's CPSAC interests and priorities are primarily related to policy and practice with respect to the prevention, early intervention and placement stability efforts of Georgia's child protection system. The following report represents a summary of their activities and presents recommendations resulting from their work in 2017.

Membership

The CPSAC includes members from both rural and urban communities, some of whom travel several hours to attend meetings. Although the size of the state presents a challenge when recruiting and engaging members that represent all of its geographic areas, most regions are represented on the CPSAC. The diversity of personal and professional backgrounds, and the wide range of experience and expertise of CPSAC members, brings many unique perspectives to their common interest - the safety and well-being of Georgia's families, children and youth.

CPSAC membership was stable during 2017. Additions to the CPSAC in 2017 included an adoptive parent with prevention and training expertise, and a grandparent caregiver. Ongoing recruitment efforts continue to identify and engage individuals from the community with an interest in improving Georgia's child welfare system or who have expertise in a subject matter of interest to the CPSAC. Identifying and engaging consumers, parents and youth who have been involved in the system is most challenging; however, the CPSAC is committed to providing those opportunities whenever possible. [1]

Meetings

In 2017, the CPSAC satisfied the federally-mandated minimum requirement for quarterly meetings. Dates for these meetings in FFY2017 were:

- November 18, 2016
- January 18, 2017
- March 23, 2017
- May 26, 2017
- August 16, 2017

CPSAC members also participated in an all CAPTA panel annual retreat held in September where each of Georgia's CAPTA Panels facilitated sessions related to their current activities. This year, CPSAC coordinated a panel of grandparent caregivers to speak on their experiences with the child welfare system.

2017 Annual Citizen Review Panel National Conference, May 10-12, 2017, Anchorage, AK

CPSAC Co-Chair, Amy Rene, was invited to present at the national conference on the relative caregiver work undertaken by that committee. Her presentation described the efforts that have taken place in Georgia in recent years towards putting relative/kinship care at the center of placement practices and helping to reduce trauma in care as a result of placing children with kin first. Georgia experienced large increases in the numbers of children

[1] CPSAC has since added new members representing a north Georgia community and an expert on homeless and exploited youth.

entering foster care in recent years that resulted in a shortage of placement resources in the state. In an effort to improve outcomes for these children, the Director of the Division of Family and Children Services (DFCS) issued a directive to have 50% of DFCS children in relative placements. The private provider network and CPSAC worked diligently with DFCS to develop a relative/kinship caregiver continuum of placements and services. Through this work they have examined child protective services and foster care policies. Georgia was also involved in a project with the Family Focused Treatment Association (FFTA) Georgia Chapter supported by the Annie E. Casey Foundation. The project focused on removing barriers and developing opportunities to promote relative/kinship therapeutic foster care in Georgia. These collaborative efforts were highlighted in Amy's presentation.

Feedback on presentation from the conference committee…. "Your proposal is particularly interesting because of the role your CRP may have played in building and sustaining partnerships among various stakeholders and Georgia's DFCS. In addition to all the accomplishments, we hope you can discuss ways that CRP helped build those relationships and promoted accountability."

2017 CPSAC Priorities, Interests, and Activities

In 2015, the CPSAC focused its efforts on issues related to Georgia's child welfare workforce due to concerns regarding high caseloads, high staff turnover rates, below market compensation, and considerable delays in the hiring of qualified individuals. A survey conducted by the panel at the time indicated that these factors had a negative impact on recruitment, retention and overall job satisfaction. Recommendations from the panel in 2015, and reinforced in 2016, were well received, and intervening actions taken by the Division, legislators and child welfare advocates have begun to show promising, positive change. The CPSAC continues to monitor these workforce-related issues and the Division provides regular updates on progress related to prior year's recommendations.

In 2016, CPSAC members were also interested in the implementation of the new solutions-based casework (SBC) practice model as a cornerstone of the Division's "Blueprint for Change" initiative. Although supportive of SBC in principle, panel members had concerns related to a successful statewide implementation. In addition to the huge 're-training' effort of the workforce, SBC requires a significant culture change, by staff and leadership, to sustain and support the practice. The Division has been responsive to these concerns and has been transparent in providing updates on progress, both challenges and successes, in follow up reports to the Panel.

Also in 2016, the CPSAC established two committees to begin reviews of two practice areas: 1) foster parent training, and 2) relative/kinship caregiver supports and services, as it shifted its focus from the workforce back to

the efficacy of the policies and procedures related to these two areas of practice. The 2016 annual report included preliminary observations and findings. The committees concluded their final reviews in 2017.

1. Foster Parent Training

Georgia currently utilizes IMPACT[2] as its foster parent training curriculum. The curriculum replaced the previously utilized MAPP[3] curriculum, which is a universally and nationally used curricula. The CPSAC respects and appreciates the evolution of foster parent training in our state, as well as the Division's investment in, and provider commitment to, the current IMPACT training model. However, members of the committee had some concerns, based on anecdotal reports and their own experiences regarding the efficacy of IMPACT training, both content and delivery, as a model for preparing and retaining foster families. While the panel cannot make a direct correlation between specific training programs and placement success, it is suspected that there is some relationship.

Although the state and many partners have made a significant investment in IMPACT training since 2004, there is no data to support that it has been a more effective model for recruiting, training and retaining foster caregivers. The committee feels that its delivery has been inconsistent; the content is not reflective of the advances in research and best practices; and it is not sufficiently responsive to the needs of the community it serves, nor the current child welfare environment.

The committee was split on whether IMPACT should be revamped or replaced. Several felt very strongly that MAPP training was superior and more responsive to the needs of Georgia's foster care community. Committee members' personal experiences or observations include:

"Based on my experience with IMPACT, it presented an unrealistic picture of foster parenting. It didn't focus enough on the essentials of foster parenting from a trauma-informed perspective; relied too heavily on lectures (needs more small group work); and had some outdated or incorrect information."

"I took MAPP training as a foster parent when it was used in Georgia. It gave us the information we needed to make an informed decision about becoming foster parents. It also gave us information related to DFCS expectations and what we could expect as foster parents. It was a small group setting; we were able to ask questions and; it felt more supportive. However, my daughter and her husband went through IMPACT training last year. They felt it was unorganized and lacked support and essential information on what to expect as foster parents. Training was provided mostly as lectures."

[2] Georgia developed its "Initial Interest Mutual Selection, Pre-Service Training Assessment, Continuing Development and Trauma-Informed Teamwork" (IMPACT) training for foster parents in 2004.

[3] Model Approach to Partnerships in Parenting (MAPP) widely utilized as a foster parent training curriculum.

"MAPP has the benefit of more research, results analysis and delivery across a broader population. IMPACT tends to be more stagnant and lacks engaging activities. Its inconsistent delivery makes it difficult to collect outcomes."

However, committee members were uncertain of the viability of re-establishing MAPP as the foster parent training model in Georgia. At a minimum, the committee recommends that a thorough evaluation be conducted[4] to assess the current training, curriculum and its delivery, prior to any decision to revise or replace the curriculum. The evaluation should include, in addition to the expertise of the Division's Education and Training Unit and its training partners, consultation and collaboration with the broader foster care community in Georgia including current and former foster parents and community partners and national experts to include current trends, promising practices, and lived experiences of all involved in foster care.

The Review

- Reports on two evaluations conducted, one by the Georgia Welfare Reform Council and the second by Clark Atlanta University students, were reviewed.
- A review of the IMPACT curriculum was conducted.
- An expert from the Division's Knowledge Management Unit was invited to meet with the committee to provide some additional history and context on IMPACT in Georgia, respond to their questions or concerns, as well as how IMPACT training was reviewed, evaluated, and updated to meet the current needs of new foster parents.[5]
- Committee solicited feedback from foster parents.
- Finally, the committee met again to summarize findings and discuss recommendations. This report outlines the findings and includes recommendations.

Observations

With respect to both reviewing the IMPACT training and the personal experience of committee members who have taken the training, one major concern is the pace of the presentation. Although the Division recommends several weekend training days, IMPACT training is often rushed and there is not enough time to cover the material presented. For example, a foster parent reported completing IMPACT training in a single weekend.

While each module gives time for activities, there is insufficient time for discussion and reflection, thus losing opportunities for potential foster parents to deeply consider the experiences of children in foster care. In Module 4,

[4] As MAPP is more widely used, there is more potential for comparative evaluation on the effectiveness of our foster parent training.

[5] Carol Moses, Division of Family and Children Services, Knowledge Management Unit, IMPACT Training, provided the committee with an overview on the current foster parent training model.

for example, facilitators have less than two hours to cover nine objectives, this rush to cover material takes away from opportunities for discussion and reflection.

Another concern is that the training, which covers a variety of subject matter, includes only limited opportunities for potential foster parents to learn how to navigate the foster care system. In fact, the training focuses on best practice which is not always possible given the dire need of youth entering care. Furthermore, the training is generic for most placement situations and regions when, given the size and diverse nature of our state, it could be modified to include regionally specific information.

Finally, IMPACT curriculum was created in 2004 and last updated in 2010 and does not include current trends in foster care. For example, lifelong foster care is not mentioned in the training, but is currently being discussed as an option throughout GA, especially for youth who have a bond with their foster parent. Furthermore, the curriculum lacks a component of cultural competency and inclusion and no time is given to discuss implications for raising a child who is culturally or racially different from their foster family.

Based on their review, at a minimum, the committee recommends the following actions related to IMPACT training be considered:

Key Findings	Recommendations
IMPACT training is only used in Georgia. This limits the ability to evaluate its comparative effectiveness.[6]	Assess the comparative effectiveness of training to recruit and retain a population of foster caregivers to provide appropriate and stable placements that meet the needs of children in foster care. If results are better with another training curriculum, it should be considered as a replacement.
Availability of training was identified as an issue. This included frequency (how often) and accessibility (where offered).	To address the ongoing demand for foster care, training needs to be more universally available - more often, more locations. Alternative forms of training may be needed in order to be cost effective.

[6] It should be noted that in ACF Region IV, Georgia and South Carolina, the only two states to have developed their own foster parent training programs, have the lowest rates of placement stability.

Key Findings	Recommendations
Delivery was inconsistent among approved trainers. Some were reported delivering 24 hours of training over a single weekend. Many reported that there just wasn't enough time to digest information and ask questions. The delivery protocol should be consistent among approved trainers to ensure fidelity of the training model.	Conduct periodic site visits to evaluate trainers. Reinforce established delivery standards and provide guidelines on permissible alternatives.
Delivery was not sufficiently adult learning focused and often does not include sufficient time for reflection.	Recent advances in understanding adult learning styles need to be incorporated into the design and delivery of each training module to maximize training efficacy.
There is a lot of content covered in the initial foster parent training, however, foster parents are often not prepared for the unique needs of some of the children placed in their care.	Initial foster parent training should provide a solid foundation and set expectations. Recommend developing supplemental training modules on fostering children that may be challenging, need specialized care or come from unique circumstances, as part of ongoing professional development for foster parents but that can also be used as immediate resources prior to, or at the time, a child needing specialized care is placed in the home.
Content was deficient in several areas including trauma-informed practice, special needs populations, and lacked cultural diversity reflective of potential fosters or the backgrounds of the children in care or the communities from which they came. Specific content of concern to the committee included: • Learning disabilities referred to as mental health issue • Insufficient information on grief experienced by foster children • Unrealistic use of 'best case' scenarios when children in care often come from 'worst case' scenarios • Lack of information on the fostering children of a different, race, religion, or sexual orientation • Not enough on trauma and trauma-informed practice	Review and address current gaps in content such as those identified by the committee. Plan regular review of content to incorporate updates and advances identified in research, literature, and the child welfare community. Update or expand curriculum to address deficiencies identified.

Key Findings	Recommendations
There are limited opportunities during IMPACT training to learn about DFCS, what to expect when a child arrives in their home, how to navigate within the system, and how to access needed resources.	Include sufficient time in foster parent training to ensure that foster parents are aware of the resources available to them – local and regional and state, such as doctors, child care, etc.
Miscellaneous: • Multiple sources of information on a single topic at times somewhat conflicting or inconsistent • Many of the links provided in the training were broken • Language used was not 'common' to the population being trained • Need more comprehensive handouts	Avoid generalization and extremes. Be realistic so that expectations are realistic. Find a balance between too much on minor topics and too little on important ones. Use consistent sources and provide citations for sources of information. Verify and repair all resource links. When revising, use language that is understood by the population being trained. Review, update and expand handouts.

2. Relative/Kinship Caregiver Supports and Services

With the Division's plan to significantly increase the use of relatives as placement resources to help address the lack of foster homes, the committee was established to examine current policy and practice related to temporary, formal and informal, placements with relatives. Relative placements need to be fully evaluated, assessed and long-term family system issues need to be considered when it is determined that a child should be safety planned or placed with a relative caregiver.

The Review

- Review of Policy - Safety Resource Policy 5.6, dated October 2015[7] was reviewed to identify policy relevant to placing children with relative/kinship caregivers.
- A subject matter expert on the Division's Kinship Navigator program, from the Division's Safety Unit, was invited to meet with the committee to provide information on the roles and responsibilities of regional Kinship Navigators.
- A relative caregiver was invited to meet with the committee to discuss her experience[8].
- Several relative caregivers were invited to the annual CAPTA Panel retreat to share their experiences with the child welfare system when they took over the care of their grandchildren.

[7] Safety resource policy was revised again late in 2017.
[8] This caregiver has since joined the CPSAC.

Observations

DFCS Safety Policy is comprehensive but not always followed as children in relative caregiver settings are often there past the 45-day time period allowed by the CPS Policy.

Often relative caregivers are not asked if they want to become foster parents for the children in their care. This leaves the children in vulnerable environments at times without enough resources to ensure the safety and stability of those children.

Discussions with relative caregivers were most illuminating and suggest that there is a need for significant practice change, especially how staff interact with relatives during a crisis and how placement options and consequences are presented to them. They reported feeling judged, pressured and uninformed, particularly about 'the system' and resources to assist them. They may not have parented in years, may still be in the workforce, in poor health, have no idea how to navigate the systems that can provide support and relief or are faced with caring for children with complex physical, emotional and mental health needs.

The committee recommends the following actions related to their review:

Key Findings	Recommendations
Relatives want to be respected, informed on the options and opportunities, and supported so that children are not placed in foster care unnecessarily.	Conduct a review of practice to identify and address the root cause of these inconsistencies. Provide training for staff on working more effectively and responsively with relative caregivers. Develop of a continuum of care that includes and values relative caregivers.
Not all relative caregivers need to become licensed foster parents, however, this should be an option if there are resource, support or other complex issues around caring for these children that cannot be provided otherwise.	Ensure that all potential relative caregivers are informed of and provided the resources, including legal resources, that are available to support their decision to take on the care of these children.
Relative caregivers are not prepared to meet the complex needs of children in their care, many who have suffered significant trauma or have complex medical needs. Often, special needs children are placed with a relative caregiver, but resources are not provided (health connections, support groups, respite care).	Provide training and resources for relative caregivers who will be caring for children with special needs or who are mentally and/or physically disabled. Identify and provide appropriate list of resources and referrals to caregivers to help them meet the challenge of caring for special needs children. Provide trauma informed/responsive training to relative caregivers.

The CPSAC respectfully submits its report and recommendations to the Division on its 2017 activities. Additionally, priorities and plans for 2018 have been identified to highlight opportunities to coordinate efforts on shared goals and objectives in the coming year.

In 2018, the CPSAC has established two new committees, one that will focus on caseworker safety and a second that will focus on the response to child safety investigations involving foster parents. It will continue to monitor progress on workforce recruitment and retention as well as seek to play an active role in any redesign of foster parent training and offer its resources to help ensure that relative caregivers are valued and supported.

Effectiveness of any CAPTA Panel is largely dependent on an open and mutually supportive relationship with the state's child welfare agency. The CPSAC commends former Division Director, Bobby Cagle, for his leadership in this regard, and his replacement, Virginia Pryor, for continuing to value the contribution of CAPTA Panel members and the advocate community. The CPSAC appreciates the efforts of the Division's management team, and that of state and field staff who have presented to the committee, as well as those who have facilitated the exchange of information in response to the many CPSAC requests. We would especially like to acknowledge the Division's continued support of our efforts to meet our mandate as a CAPTA Panel. We look forward to our ongoing dialogue to improve the safety, permanency and well-being of Georgia's children and their families.

Respectfully submitted on behalf of the Child Protective Services Advisory Committee

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

Children's Justice Act Task Force

2017 Annual Report

Vision

All of Georgia's children will receive the best possible protection from all forms of child abuse and neglect from a system of highly trained professionals who thoroughly investigate alleged abuse and adequately prosecute those who abuse children, while protecting children from repeat maltreatment.

Mission

To identify opportunities to reform state systems and improve processes by which Georgia's child welfare system responds to cases of child abuse and neglect, particularly cases of child sexual abuse and sexual exploitation, and child abuse or neglect-related fatalities; and, in collaboration with the state's child protection agency and its external partners, make policy and training recommendations regarding methods to better handle these cases with the expectation that it will result in reduced trauma to the child victim and the victim's family while ensuring fairness to the accused.

The Children's Justice Act

The Children's Justice Act (CJA) provides grants to states to improve the investigation, prosecution and judicial handling of cases of child abuse and neglect, particularly child sexual abuse and exploitation. This also includes the handling of child fatality cases where child abuse or neglect is suspected and cases involving children with disabilities or serious health problems who are the victims of abuse and neglect. The source of CJA funds is the Crime Victims Fund, and grants are awarded by the Administration on Children, Youth and Families, US Department of Health and Human Services, as outlined in Section 107 of the Child Abuse Prevention and Treatment Act (CAPTA) [1], as amended by the Keeping Children and Families Safe Act of 2003. CJA grants are intended to address issues at the front end of the state's multidisciplinary response to protect children when abuse and neglect occurs. Use of CJA funds specifically for prevention activities or treatment services is prohibited.

[1] CAPTA is the primary federal legislation addressing child abuse and neglect and authorizes funding to states to support prevention, identification, assessment, investigation and treatment activities.

CJA Task Force

To be eligible for CJA funds, the state must also be eligible for a CAPTA basic state grant. As a CJA grant recipient, the state is required to establish and maintain a multi-disciplinary task force on children's justice. Georgia's Children's Justice Act Task Force (Task Force) was established to satisfy this requirement and is composed of representatives from selected professional and other stakeholder groups involved in child abuse and neglect cases. The purpose of a CJA task force is to review and evaluate practice and protocols associated with the investigative, administrative, and judicial handling of cases of child abuse and neglect and to make legislative, policy and training recommendations that will improve the handling of these cases and reduce trauma to the child victim and victim's family while ensuring fairness to the accused.

Dual Role as a CAPTA Citizen Review Panel (CAPTA Panel)[2]

Georgia's CJA Task Force also serves as one of Georgia's three CAPTA Panels. The purpose and objectives of a CJA multi-disciplinary task force and a CAPTA citizen review panel[3] are complementary. Although the priorities of the Task Force are rooted in the investigation, prosecution and judicial handling of cases of child abuse and neglect, interests span the full spectrum of family involvement in the child protection system, for all types of families and children of all ages. Serving this dual role provides unique opportunities to examine overlapping mandates. They also share several legislative requirements, such as meeting and reporting requirements, and the goal to improve the state's child protection system.

Georgia's CJA Task Force History

Georgia's CJA Task Force[4] was reestablished in 2005 and has strived to satisfy all CJA obligations since that time. The Task Force's early activities focused on building ongoing, interactive relationships between the child welfare agency, criminal justice system and the child advocacy community. It has played a key role in the child welfare continuum by successfully facilitating, supporting and funding innovations in the assessment, investigation, prosecution and judicial handling of cases of child abuse and neglect.

[2] In Georgia, CAPTA citizen review panels are referred to as "CAPTA Panels" to distinguish this stakeholder group from similarly named "Citizen Panel Review", which are foster care review boards.

[3] CAPTA citizen review panels are charged with the examination of child welfare policy, practice and procedures to determine the extent to which the state is meeting its child protection responsibilities and making recommendations for improvement.

[4] The Task Force was formerly known as the Children's Justice Act Advisory Committee. The name was changed in 2013 to distinguish the group as a task force for children's justice.

Membership

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

- Judges[5] and attorneys, including civil and criminal, prosecution and defense
- Law enforcement
- Child protective services
- Child advocates
- Court-appointed special advocates (CASA)
- Health and mental health professionals
- Parents and parent groups
- Individuals who specialize in working with children with disabilities
- Individuals with experience in working with homeless children and youth
- Adult former victims

Georgia's Task Force has maintained a stable and committed core membership for many years. It is currently chaired by Melissa Carter, Emory University School of Law, and David Miller, Senior Assistant District Attorney for the Southern Judicial Circuit. Ms. Carter has been a member since 2007 and Mr. Miller since 2015. Mr. Miller previously served as Vice-Chair on the state's Child Fatality Review Panel.

New members are recruited not only to satisfy CJA membership requirements but also to provide additional expertise and experience relevant to Task Force interests, priorities and its mandate as a CAPTA Panel. In addition to its mandated members, the Task Force includes representatives from:

- Department of Juvenile Justice (DJJ)
- Department of Education (DOE)
- Criminal Justice Coordinating Council (CJCC)
- Prevent Child Abuse Georgia

In 2017, two new members joined the Task Force, Judge Amber Patterson, Cobb County Juvenile Court and Cheryl Benefield, Department of Education.

Even though the Task Force has an established membership, ongoing recruitment efforts by individual Task Force members, child welfare agency leadership and a variety of professional and advocacy groups help to identify new candidates, when needed. The Task Force will identify a CPS investigator to add insight and expertise to the work it has planned related to its findings in the 2018 three-year assessment.

[5] In Georgia, juvenile court judges may preside over criminal cases as they do civil cases.

At this time, all mandated positions on the Task Force have been satisfied with the exception of that by an adult former victim. Although the Task Force has made several attempts to engage youth, it has been difficult to identify one that is able to commit to another advocacy project or obligation. When input is needed from this stakeholder group, Georgia's active foster youth advocacy community are consulted.

CJA membership requirements also satisfy CAPTA citizen review panel membership requirements including that members be broadly representative of the community with experience and/or expertise in child welfare system. See Attachment A for brief bios of current Task Force members.

Task Force Meetings

In 2017/2018, the Task Force held five regularly-scheduled meetings, satisfying the federally-mandated minimum requirement for quarterly meetings for both a CJA task force and a CAPTA Panel. These meetings occurred in August, November, January, March and May. Meetings and conference calls to support the work of the CJA proposal review committee and the three-year assessment committee also occurred in 2017/2018.

Task Force members consult regularly with each other and the CJA Coordinator for updates on work in progress; projects supported with the CJA grant; recent events related to Task Force goals, objectives and interests, collaboration opportunities, recruitment needs and efforts; and to identify and coordinate additional resources.

Task Force members also participated in an all CAPTA panel annual retreat held in September. This year, several CJA grantees were invited to present on their projects. This included presentations by Georgia CASA on the quick reference guides developed on judicial procedures and protocols for juvenile court proceedings; an intern from Emory University advocacy project on his placement at the Child Endangerment and Sexual Exploitation (CEASE) Clinic[6] at the University of Georgia; and Children's Healthcare of Atlanta on the medical network pilot to provide child abuse assessment resources to communities in Georgia without that expert resource.

The retreat agenda also included presentations on:

- Opioids: The Surge in Drug-Affected Newborns by Dr. Karen Kuehn Howell, Emory University School of Medicine, Center for Maternal Substance Abuse
- Opioids: The Changing Face of Investigations by Nelly Miles, Director, Office of Public Affairs Georgia Bureau of Investigation

[6] Child Endangerment and Sexual Exploitation (CEASE) Clinic at the University of Georgia represents survivors of child sexual abuse in juvenile court dependency matters and civil litigation.

National Meetings and Conferences

Annual CJA Grantee Meeting: Washington, DC

The Children's Bureau hosts annual grantee meetings for all discretionary and formula grant programs. The 2017 CJA grantee meeting was held August 10-11, 2017. Georgia's State Liaison Officer (SLO), Laresa Price, Safety Services Director, Division of Family and Childrens Services, Manager, Task Force Co-chair, David Miller, and the CJA Coordinator attended the meeting[7]. The annual meeting provides an opportunity for CJA grantee states to learn about recent legislative priorities from federal representatives, hear from national experts, and receive technical assistance, as well as network with CJA task force representatives from other states.

Joint sessions with state SLO's on the first day included presentations from federal partners on:

- Findings from round three of CFSRs (Georgia was included in the third round)
- CAPTA reauthorization in 2016[8]

Sessions on day two for CJA task force members were facilitated by representatives from Child Welfare Capacity Building Center for States, and included:

- Developing standards on child representation
- Peer-to-Peer Networking
- CJA Community of Practice by the workgroup formed at the 2016 grantee meeting

The Task Force Co-Chair, David Miller, felt the most valuable component of the grantee meeting was the opportunity for peer networking and to hear from other task forces on their successes and challenges to identify opportunities and lessons learned to share with fellow Task Force members.

National Citizen Review Panel Conference: May 10-15, 2017, Anchorage, AK

Two Task Force members, Melissa Carter, Task Force Co-Chair, Donnie Winokur, and the CJA Coordinator[9] attended the annual conference hosted by Alaska's citizen review panels at the University of Alaska Anchorage. The theme for the conference was "*Citizen Participation in Child Protection: Common Goals, Many Paths*". Representatives from more than 25 states attended the conference. The conference agenda included a broad range of topics relevant to both the CAPTA mandate of citizen review panels and the CJA mandate of the Task Force. Sessions were facilitated by a wide array of national, state and local experts, from both the academic and professional fields of child welfare,

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

[8] CAPTA was most recently reauthorized on May 29, 2015 by the Justice for Victims of Trafficking Act of 2015 (P.L. 114-22) and, on July 22, 2016, by the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198).

[9] The CJA Coordinator co-facilitated a plenary at the conference to explore the need, desire and support for an advisory group for the CRP community.

as well as stakeholder advocacy groups and citizen review panel members. Abstracts from Georgia's Task Force members were accepted and both Melissa and Donnie presented at the conference.

Melissa's presentation addressed the CAPTA Panel and Task Force role as external stakeholders of the child welfare system to assist the child welfare organization to transform itself, acting as catalysts for change. To be effective in this way, external stakeholders must be knowledgeable about the cycle of public policy development and skilled at engaging in the policymaking processes, at the local, state, and federal levels. Such knowledge and skills allow external stakeholders to support a clear vision for improvement, persist in efforts to create meaningful and lasting change, ask tough questions, and lead by example, all through a public participation model.

Donnie's presentation focused on a basic understanding of fetal alcohol spectrum disorders (FASDs) and their pervasive impact on the child welfare system. Children prenatally affected by alcohol may be more vulnerable to victimization than children in the general population, because of histories of child abuse and neglect, separation from biological parents or placement instability. The invisible nature of accompanying cognitive impairment and mental illness may contribute to the impact on families and children who are already in at-risk environments. Building child advocacy and informed collaboration among stakeholders that address the goals of CAPTA Panel and Task Force will help mitigate the urgency of the public health crisis of FASDs.

Georgia was also represented at the national conference by the Co-Chair of the Child Protective Services Advisory Committee, Amy Rene. Presentations by all Georgia CAPTA Panel members were well received.

Collaboration with Georgia's Child Welfare Agency and Community Stakeholders

The relationship between the Task Force and Georgia's Division of Family and Children Services (the Division) can be characterized as a collaborative and mutually respectful working relationship. The Division consults regularly with members of the Task Force, formally and informally, as a resource, as advocates and as representatives of a constituent group. The expertise and opinions of the Task Force are valued and opportunities for stakeholder involvement often happen organically, without the need for a federal mandate. This positive relationship contributes to the stability and effectiveness of Georgia's Task Force.

To sustain the efforts of the Task Force and ensure that it continues to meet its CJA obligations, the Division provides ongoing administrative support[10], including:

- Creating a Federal Plans Manager[11] position in 2016 to serve as a liaison with the Task Force, and whose responsibilities include facilitating communication between the Division and the Task Force, and management of CJA contracts related to Task Force recommendations.
- Contracting with a firm for the services of an independent coordinator who provides:
    - Day-to-day operational support and technical assistance to Task Force members and its committees
    - Facilitates the exchange of information between the Panels and the Division
    - Participates in quarterly CJA grantee conference
    - Attends the annual CJA grantee meeting
    - Coordinates communications with other states' Task Forces, as needed

With the creation of the Federal Plans Manager position, the Division Director[12] committed to meeting up to quarterly with CAPTA Panel and Task Force members. These meetings provide an opportunity for open dialogue between the Task Force and the Division's leadership team on shared and individual concerns, priorities and interests, in addition to updates on actions taken by the child welfare agency in response to previous recommendations. These meetings are informative and productive. In December, the Division Director reiterated his appreciation to the Panels for their support during the previous legislative session related to the agency's budget, and discussed his upcoming legislative priorities that included, inter-agency data sharing and child abuse terminology, both priorities of the Task Force. In April, the Division's leadership team responded to the Panels' previous years recommendations and provided updates on ongoing Panel interests. These meetings are always informative and help to build mutual respect and understanding. Members from the Division's leadership team also participated in the annual CAPTA Panel retreat in September where ideas related specifically to current Panel activities were exchanged.

For many years, Georgia's Task Force members have been involved to varying degrees in several strategic planning activities and invited to participate on various advisory groups, providing input or feedback, to the state agency on its development, revision, implementation, monitoring and/or evaluation and revision of its various plans. In 2017, this included:

- Joint planning, including participation at meetings hosted by Region IV Child Welfare Specialist
- Contributions to and review of the Annual Progress and Services Report

[10] CAPTA requires that states provide operational support to assist the panels in carrying out of their mandated duties.

[11] Beth Locker, Federal Grants Manager, resigned in June 2017. Her replacement, Shelby Zimmer, was hired and assumed the position in February 2018. The title of the position was previously "Federal Grants Manager."

[12] Georgia's Director of Family and Children Services, Bobby Cagle, resigned in December 2017. Virginia Pryor appointed as his successor in January 2018.

- Development, implementation and monitoring of Program Improvement Plans
- Revision of the state's CAPTA Plan
- Child welfare policy development, review and approval process

The Division will occasionally consult with the Task Force to help identify a member or community stakeholder to engage in the discussion, design, implementation or evaluation of practice strategies, models or programs.

In addition to these opportunities to work more closely with Georgia's child welfare agency, Task Force members participate on a variety of local, state and/or national boards or organizations that increase the collaborative potential for furthering the goals and objectives of the Children's Justice Act. This includes groups or organizations, such as:

- Georgia Child Sexual Abuse Prevention Coalition
- Strengthening Families Georgia
- Human Trafficking Task Force
- National Center for Missing and Exploited Children
- National Parent Representation Project
- HEAL (health, education, advocacy and leadership) Trafficking Committee
- Georgia Advisory Council on Special Education
- Georgia Child Welfare Training Collaborative Advisory Committee
- National Citizen Panel Advisory Committee
- Child Welfare Training Collaborative
- Youth Protection Seminar Steering Committee

Several Task Force members are legislatively active and provide updates on progress, or lack of progress, on bills related to the CJA mandate and Task Force priorities. At the close of the recent legislative session, the following bills relevant to CJA objectives had successfully passed both houses and were awaiting signature by the Governor:

- HB 732 amending O.C.G.A. 16-5-46, relating to the offense of labor or sex trafficking, to expand the offense of trafficking of persons for sexual servitude to include patronizing an individual to perform sexually explicit conduct, and changes the punishment for sex trafficking to mandate 5 to 20 years' imprisonment for any person convicted of the felony of sex trafficking against an individual age 16 or older.
- SB 336 amending O.C.G.A. 35-3-4.1 and 35-3-4.3 to prohibit the provider of electronic communication services or remote computing services from notifying the subscriber or customer of the service about a subpoena for the production of records used in furtherance of certain offenses against minors.

2017 Priorities and Activities

Ongoing Task Force Activities Related to the 2015 Assessment Recommendations

The 2015 three-year assessment identified several opportunities for the Task Force and resulted in legislative, policy and practice recommendations related to child abuse definitions and the child abuse protocol. Other findings identified in the 2015 assessment were incorporated into Task Force committee activities. Updates on progress related to the 2015 assessment recommendations and any ongoing work by the Task Force are included in the summary of activities that follow.

Child Abuse and Neglect Terminology

Objective: Address inconsistencies in the definitions of child abuse between sections of the Georgia Code and among state agencies.

2015 Recommendations:

1. The Task Force recommended that Georgia code definitions related to child abuse in Georgia Law O.C.G.A. §19-7-5 (reporting of child abuse), Georgia Law O.C.G.A. §19-15-1 (child abuse definitions), Georgia Law O.C.G.A. §49-5-40 (child abuse definitions) be updated to be consistent with and/or cross-referenced to the definitions in Georgia Law O.C.G.A. §15-11-2 (Juvenile Code child abuse definitions).[13]

2. The Task Force recommended that DHS/DFCS request that DHS/OIG-RCC and other state agencies with any child-caring staff or contractors or oversight of same (DBHDD, DCH, DECAL, DJJ, DOE, DPH) update their policies/regulations to specifically incorporate and/or reference appropriate child abuse definitions in Georgia Law O.C.G.A. §15-11-2.

Update[14]: The Task Force undertook an exhaustive study of the statutory approaches to defining child maltreatment and its various forms throughout the Georgia Code. Specific focus was placed on the definitions codified in the Social Services Act (Title 49), the Juvenile Code (Title 15, Chapter 11) and select provisions contained within Title 19 (Child Custody), particularly those concerning mandated reporting of child abuse. Additionally, the Criminal Code (Title 16) and the Education Code (Title 20) were reviewed. This research was supplemented by a limited number of qualitative interviews with child welfare agency staff, law enforcement personnel, and children's hospital staff, and examination of the model Child Abuse Protocol.

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

[14] Update was prepared by Melissa Carter, Task Force Co-chair and Director of The Barton Child Law and Policy Center.

Task Force members observed that while the definitions were not in conflict, inconsistencies in the way child abuse and neglect are conceptualized in statute produce inconsistent responses in the way various authorities (e.g., education, law enforcement) respond to allegations of child maltreatment. Discrepancies in statutory schemes had developed because of the piecemeal fashion in which legislative amendments occur, and investigatory practices had followed. Challenges were revealed in Division of Family and Children Services investigations of maltreatment in care reports and subsequently, in the implementation of the child abuse registry.

After the Task Force submitted its recommendations to Division leadership, Director and General Counsel initiated follow-up with the Executive Director of the Barton Center and Task Force Co-chair about the potential for collaborating to devise a definition of abuse which could be included in the mandated reporter statute and juvenile code definitions and be widely accepted for purposes of substantiation decisions and court determinations of dependency. Thereafter, the Task Force Co-chair initiated a broad and inclusive stakeholder engagement process through which stakeholders from the child welfare and juvenile court communities were consulted on the development of a research-based and practice-informed proposal to amend the statutory definitions in the mandated reporter statute. A final proposal was agreed to in September 2017 that is designed to align definitions across code sections, and to simplify and clarify the definitions in the mandated reporter statute to facilitate more consistent and better quality reporting and child protective services response.

The Barton Center worked closely in partnership with the governmental affairs and legal staff of the Division of Family and Children Services to move the proposal forward during the 2018 term of the Georgia General Assembly. A legislative sponsor was identified and the proposal was drafted into bill form, but ultimately, the sponsor failed to have the bill formally introduced. Several attempts were made to advance the proposal through other parliamentary procedures available in the legislative process, but due to competing political priorities and a shortage of time, the policy was not considered by the legislature this year (2018 legislative session).

The Task Force remains committed to addressing this policy and practice gap to promote best practice in multidisciplinary investigations of child abuse, consistency in response to allegations, and lessening of trauma to child victims. Division leadership also remains committed to collaborating toward the achievement of these goals. Fortunately, the development work is complete and supported by a consensus position on the underlying values and goals, as well as the technical approach. Task Force leadership will work to ensure this effort remains a priority for the Division and develop a strategy for introduction of the legislative proposal during the 2019 legislative session. To that end, the Task Force will keep this priority on its agenda for ongoing and routine discussions with agency leadership.

Child Abuse Protocol & Child Abuse Protocol Committee

The state model Child Abuse Protocol is the standard for Georgia's multidisciplinary response to a report of child abuse. The Task Force established a Child Abuse Protocol committee with the following objectives:

- To promote and support a collaborative and coordinated multidisciplinary response to child abuse and neglect
- To improve the effectiveness of the state model and local Child Abuse Protocols

2015 Recommendations:

1. The Task Force recommended that the Georgia Law O.C.G.A. §19-15-2 (protocol committee on child abuse) be updated to reference the appropriate definitions in Georgia Law O.C.G.A. §15-11-2, to mandate a multi-disciplinary response to child abuse allegations, to require consistent participation (particularly by DFCS and local prosecutors/district attorneys) on Child Abuse Protocol committees (CAPCs) and related multi-disciplinary teams (MDTs), to require that CAPCs meet monthly, and to mandate adherence to local Child Abuse Protocols.
2. The Task Force recommended that the Division request that the Office of the Child Advocate:
    a. Update child abuse definitions in the state's model protocol to incorporate/reference.
    b. Clarify and communicate its collaborative processes for updating the state model protocol, communicating protocol updates, providing training to local CAPCs, collecting and reviewing local Child Abuse Protocols and annual reports.

Update[15]: Child Abuse Protocol Legislation: Language was added to the authorizing code section of Georgia Law O.C.G.A. § 19-15-2 to include a representative from a local Child Advocacy Center and from a local sexual assault center, if one exists in or is served by the County, to the child abuse protocol team. The designated entities to receive the Child Abuse Protocol each year were also changed to reflect that the written protocol should be filed with the Division of Family and Children Services and the Office of the Child Advocate.

Child Abuse Protocol Document: Over the past three years, significant emphasis was placed on updating the state model Child Abuse Protocol and providing training to multidisciplinary teams across the state so that they in turn could update their local Child Abuse Protocol. The Office of the Child Advocate convened stakeholders in a Child Abuse Protocol Summit to review and recommend updates to the model protocol. Most of the recommendations from the 2017 Summit were incorporated into the state model protocol published and distributed in March 2018. It is expected that this annual process of review will continue with the support of the Task Force.

[15] Update was prepared by Nancy Chandler, former CEO of Child Advocacy Centers of Georgia.

The committee, on behalf of the Task Force continues its efforts to support continuous improvement in the multidisciplinary response to reports of child abuse and neglect, from report to resolution, through effective collaboration, communication, and coordination between state and local agencies and organizations involved. The Task Force advocates for continuous quality improvement of the Child Abuse Protocol by regular review and update of the model protocol by its constituent groups to ensure its effectiveness.[16] During 2017, several Task Force members contributed to a review and update of the state's model child abuse protocol facilitated by the Office of the Child Advocate. The annual review and update of the protocol has been a longstanding recommendation by the Task Force that has been supported with CJA funding. The Office of the Child Advocate has agreed to monitor local Child Abuse Protocols, review them for compliance and consistency, as well as their alignment with current child welfare policy and practice.

Findings from the 2018 three-year assessment that impact the Child Abuse Protocol will also be incorporated into the committee's ongoing activities. This will include identifying, developing and supporting specific training on child abuse recommended for individuals that respond to reports of child abuse or may be directly, or indirectly involved, in a child abuse investigation that have been identified in the 2018 three-year assessment or in any subsequent assessment of this need. The committee has also discussed evaluating the effectiveness of the Child Abuse Protocol and will explore options on how to accomplish this task.

The Task Force continues to monitor legislation, policy, and practice changes and the potential impact on the multidisciplinary response to allegations of child abuse and neglect.

Standing Task Force Committees

In addition to the Child Abuse Protocol committee, the Task Force has two standing committees and two adhoc committees:

- Mandated Reporter Training Committee
- Child Fatality Investigations Committee
- Special Needs Committee
- Sex Trafficking Committee

Mandated Reporter Training Committee

The Task Force established the Mandated Reporter Training Committee partly in response to the dramatic increase in reports following implementation of the state's 24/7 call line for reporting suspected child abuse in 2013 and partly in response to additional findings in the 2015 three-year assessment.

[16] In 2017, the Task Force supported a multidisciplinary summit hosted by the Office of the Child Advocate to review and update the current state model CAP.

The objectives of the committee are:

- To improve the quality and consistency of mandated reports to ensure that when a report is received, the call center has the information to determine the appropriate response assignment by:
    - Promoting and supporting quality training for mandated reporters that is consistent with current child welfare policy and practice
    - Reducing inappropriate reports and improving the quality and consistency of reports so that better assignment decisions can be made when a report is received

The Task Force has hypothesized that the dramatic increase in reports from slightly more than 70,000 reports in 2012[17] to more than 115,000 reports in 2016[18] was in all likelihood due not to a single factor, like an increase in child abuse, but to multiple factors, including increased awareness of child abuse by the public, and increased awareness of and access to the statewide 24/7 call number, 1.855.GACHILD (422.4453) to make a report. However, the high percentage of screen-outs and assignment to information and referral[19] suggested that the call center was fielding many inappropriate calls. As the majority of reports are made by mandated reporters[20], the committee would like to determine if, and to what extent, this could be a mandated reporter training issue. This will be incorporated into their 2018/2019 work plans and is addressed in a recommendation in this report.

It should be noted that callers have several menu options to select from to re-direct their call to the most appropriate resource. Many incoming calls were not necessarily made to report child abuse but to access other Division services, such as TANF, or were individuals seeking information about child abuse and neglect or resources for families. To meet this need, in 2015, the Division added the Prevent Child Abuse (PCA) Warmline as a selection option on the menu. PCA Georgia has reported that these re-directed calls have dropped from more than 2,000 redirected calls per year 2015 and 2016[21] to slightly more than 1,500 in 2017. The committee would like to investigate the cause and impact of this decline.

Recommendation: The Task Force recommends that the Division, in collaboration with the Mandated Reporter Training committee, review data on incoming calls and redirected calls to identify the cause for the decline, the impact it has had on CICC efficacy, and determine what action should be taken.

[17] Source: Child Maltreatment 2012, Table 2-1 Screened-In and Screened Out Referrals

[18] Source: Child Maltreatment 2016, Table 2-1 Screened-In and Screened Out Referrals

[19] Data provided by the Division on CICC for 2016 indicates that screenouts/screenouts & referral, and informational & referral make up 33% of reports received.

[20] The highest number of reports comes from schools and other professionals.

[21] This is information was provided by PCA Georgia.

The 2015 three-year assessment included a review of definitions in various sections in Georgia Law O.C.G.A. relevant to agencies with oversight of care settings for children under age 18 and the related state-level policies of those agencies including Department of Education, Department of Juvenile Justice and Department of Early Care and Learning. This included the section in Georgia Law O.C.G.A. related to mandated reporters[22]. In addition to concerns raised related to inconsistent or ambiguous terminology, although Georgia Law O.C.G.A. is clear on the mandated reporting responsibilities of those agencies, it does not require training for its mandated reporters nor provide any guidance on training of those individuals.

Based on the findings 2015 assessment, the Task Force identified several opportunities to pursue.

1. Identify and evaluate both mandated reporter training requirements and mandated reporter training for each of these state agencies
2. Research other state training requirements for mandated reporters
3. Develop standards for content and delivery to ensure that mandated reporter training is consistent with child welfare policy and practice
4. Develop for review and approval a mechanism for mandated reporter training
5. Evaluate mandated reporter training

In 2017, the committee began to research other states' standards for mandated reporter training. Findings from research conducted on behalf of the Task Force identified that several states, such as California, Pennsylvania and Oregon:

- Require training for specified mandated reporters with child caring responsibilities such as school personnel or child care institutions
- Have specified renewal periods and hours for mandated reporter training
- Maintain state sponsored mandated reporter training (online) or maintain lists of approved providers of training

Based on information collected, the committee will explore the feasibility of establishing a state-level multi-agency committee to develop a state-level multi-agency agreement/protocol (analogous to local child abuse protocols with specified agencies and agency responsibilities) on training requirements and standards for mandated reporters. This would include all state agencies with any child-caring staff or contractors (or oversight of same) and state agencies/organizations with oversight of those involved in the investigation or prosecution of cases (e.g., the Prosecuting Attorneys Council, District Attorneys' Association, Council of Juvenile Court Judges, Children's Advocacy Centers, Georgia Bureau of Investigation (GBI), Georgia Professional Standards Commission, Peace Officer Standards Training Council).

[22] Mandated Reporter Law - O.C.G.A. §19-7-5

The protocol would include mandated reporter requirements and time frames; mandated reporter training requirements, standardized mandated reporter training for specific agencies/roles, and DFCS approval of mandated reporter training content; joint investigations and interviewing of child victims to minimize duplication and trauma to child; and communication and information-sharing.

The committee initiated its evaluation of mandated reporter training requirements by various state agencies in 2017 and plans to conduct interviews to gather information on their mandated reporter training policies and practices in 2018/2019. The Task Force, on behalf of its Mandated Reporter Training committee, asks for the Division's support and advocacy, as it conducts this evaluation, in developing standards for mandated reporter training for specific state agencies/roles, including mandated reporter training requirements, standardized mandated reporter training, and Division approval of mandated reporter training content. Formal recommendations related to this work will develop over the next year.

In Georgia, the Division in partnership with ProSolutions Training (PST), Inc., makes available online mandated reporter training[23] that is regularly updated to reflect changes in child welfare policy, practice and/or legislation and approved by the Division. Specialized mandated reporter trainings are available also through PST for medical professionals[24] and school personnel. The module for school personnel[25] was developed in consultation with the Department of Education. All are available to mandated reporters and the public at no cost. Feedback on the trainings is positive and they are rated highly by individuals who take the training.

Recommendation: The Task Force recommends that the Division continue to make these online trainings available, updating as needed to remain consistent with child welfare policy and practice.

Although the online training is cost effective and is universally accessible, the Task Force has found that an online option does not meet all the needs for mandated reporter training. There is still a demand for in-person training by some agencies and community groups. To address the need, the Task Force supported a PCA Georgia project for the development and implementation of a mandated reporter 'train-the-trainer' training in 2016. The training was developed in consultation with the Division. The results of the project were very successful. The 2016 mandated reporting 'train-the-trainer' project equipped 49 professionals with in-depth knowledge and skills to deliver in-

[23] In 2017, 14,423 individuals completed 'Mandated Reporters: Critical Links in Protecting Children In Georgia' and 15,014 completed Recognizing and Reporting Suspected Child Abuse'. Source: PST, Inc.

[24] In 2017, 2,620 medical professionals completed 'Mandated Reporting Requirements: A Track for Georgia Medical Professionals'. Source: PST, Inc.

[25] In 2017, 19,946 school personnel completed 'Child Abuse and Neglect: Mandated Reporting Requirements for Employees, Volunteers and Contractors of Georgia Public Schools'. Source: PST, Inc.

person, approved mandated reporter training that is consistent with child welfare policy and practice to agencies and community groups throughout the Georgia. Although another proposal for the project was not received, the Task Force would like to see the project replicated.

Recommendation: The Task Force recommends that the Division encourage and support future proposals of this or comparable 'train-the-trainer' trainings to increase the access and availability of quality training for communities on recognizing and reporting child abuse and neglect.

Child Fatality Investigations Committee

Maltreatment cases are not always obvious to EMS personnel, law enforcement, DFCS personnel, and medical examiners, as no single investigative authority has complete knowledge of the individual and family circumstances at the time of the death investigation. The Child Fatality Investigations committee was established in 2016 and seeks to identify those cases through a more collaborative effort and multi-disciplinary approach to investigating all child deaths. The objectives of the committee are:

- Promoting and supporting timely, consistent, coordinated and effective investigations of maltreatment-related deaths
- Improving the identification of maltreatment in medical/natural deaths or cases involving victims with special needs
- Improving the identification of prenatally exposed infants in sleep-related deaths

Examination of the mechanisms used in the review of all child deaths, and preliminary results from the 2018 three-year assessment, suggest that additional training on maltreatment for first responders and investigators would help to improve the likelihood that child fatalities where maltreatment is a contributing factor, would be identified earlier and more consistently. The committee will incorporate the findings from the assessment in their ongoing work plans.

Recommendation: However, because of the special nature of investigating these deaths and the importance of a coordinated effort, the Task Force recommends the development of comprehensive protocol in partnership with the Office of Child Fatality Review, Georgia Bureau of Investigation[26], law enforcement and other stakeholders for identifying and investigating maltreatment-related child fatalities. The Task Force further recommends the protocol be incorporated into the state model child abuse protocol.[27]

[26] In 2015, responsibilities for child fatality review were transferred from OCA to GBI. The GBI is also often involved in investigations of child deaths outside of metro Atlanta.
[27] It should be noted that the revision in 2017 to the state model Child Abuse Protocol did include some initial information on investigating child fatalities.

ADHOC Committees

The Special Needs Committee[28] continues to play a role on each of the other Task Force committees to ensure that the activities and recommendations of those committees align with CJA goals and objectives with respect to child victims with special needs who require special handling. This also includes victims with special medical needs.

The Sex Trafficking Committee has only just recently been established in response to CAPTA amendment on May 29, 2015 by the Justice for Victims of Trafficking Act of 2015 (P.L. 114-22). The committee plans to identify its objectives, priorities and potential activities in 2018.

Task Force Priorities and Activities

The ongoing priorities and activities of the Task Force reflect its desire and commitment to continued improvement in the policy and practice areas identified in each of the three-year assessments. The Task Force has completed four three-year assessments. The first, in 2009, focused on child sexual abuse training, mandated reporting and practice regarding the appointment of representation for children in dependency cases.[29] The 2012 assessment evaluated policy, practice and training related to the handling of cases involving special needs victims. The 2015 assessment addressed inconsistencies reported in the response to allegations of maltreatment among selected agencies and organizations, including both initial reports, and reports of maltreatment of children in out-of-home care. In 2018, the subject of the three-year assessment was training on child abuse required for all disciplines that respond to a report of child abuse who may be directly, or indirectly, involved in a child abuse investigation. The 2018 assessment report and findings is attached.

Members continue to monitor system change, provide additional resources to support ongoing efforts, or strengthen previous recommendations as a result of the 2009, 2012 and 2015 assessments to insure progress continues.

[28] The Special Needs Committee was established during the 2012 three-year assessment and continues to advocate for policy and practice responsive to the unique needs of these child victims.

[29] CAPTA requires that state grant recipients have 'provisions for the appointment of an individual appointed to represent a child in judicial proceedings' and that these individuals have pre-appointment training that includes child development.

Task Force Priorities

Since 2005, the Task Force has collaborated with Georgia's child welfare agency on the administration of its CJA grant. The Task Force is responsible for identifying projects that support CJA objectives, soliciting and reviewing proposals, and recommending projects for funding. The Task Force endeavors to support activities that are responsive to CJA objectives, and Task Force and state agency priorities. This includes the following priorities related to its mandate:

1. Promoting and supporting the quality and consistency of the multidisciplinary response
2. Promoting, supporting and improving multidisciplinary education and training
3. Improving communication, collaboration and coordination between agencies and among the professionals involved in the handling of child abuse cases
4. Improving the collection, analysis and exchange of data
5. Advocating for and supporting the development of child welfare professionals

The Task Force prioritizes projects that emphasize advocacy, multidisciplinary approaches, collaboration and Task Force special interests. These special interests include:

6. Child victims with special needs, sexual exploitation of children and child abuse related fatalities
7. Education and training to improve the identification of child abuse and neglect, child sexual abuse, sexual exploitation, and child abuse related fatalities
8. Education and training to improve the investigation, prosecution and judicial handling of child abuse cases of child abuse, both civil and criminal
9. Ensuring that all children have access to and are appointed qualified individuals to represent their interests in judicial proceedings
10. Ensuring that child abuse terminology and definitions are aligned with federal guidelines, O.C.G.A. and consistent among state agencies with child caring and child protection responsibilities

More specifically, this includes projects that:

- Demonstrate collaboration between Georgia's child welfare agency, its partners and community stakeholders
- Improve the alignment of policy and practice among state agencies with child caring or protection responsibilities with child welfare policy and practice
- Reduce trauma to child victims of abuse
- Ensure that the handling of cases involving child victims with special needs is developmentally and culturally appropriate
- Improve the quality and consistency of state and local child abuse protocols – the community's collaborative response to report of abuse
- Improve the consistency and quality of mandated reporter training

Priority is also given to projects that address need for improvement identified in any of the CJA three-year assessments.

Projects Funded in 2017

2017 CJA grantees and projects follow with brief descriptions of activities[30], the project's 2018 status, and plan, if any, proposed for 2019.

Grantee: Cherokee Child Advocacy Center, Inc.

Project: ChildFirst Training

Task Force Priorities[31]: #1, 2, 3 & 6

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

The ChildFirst™ Georgia program provided five forensic interview trainings including:

- Three ChildFirst 40-Hour Forensic Interview courses
- One 3-day Advanced ChildFirst course – Your Role in the Judicial Process
- One 3-day ChildFirst Expanded course

In 2017, 132 professionals from 50 counties received training. Professionals represented the following disciplines:

Law Enforcement – 56
Child Advocacy Centers – 56
District Attorney's Offices – 10
Department of Family and Children Services – 10

Cherokee Child Advocacy Center applied for and was awarded a CJA grant to provide ChildFirst training in 2018 and has submitted a proposal to continue providing the training in 2019.

[30] Copies of 2017 annual performance reports from each grantee are included as appendices submitted with the state's 2018 CJA application.

[31] Corresponding priorities are identified on page 18.

Grantee: Georgia Office of the Child Advocate (OCA)

Project: State Model and Local Child Abuse Protocols

Task Force Priorities: #1, 2, 3, 6, 7 & 8

Each of Georgia's counties are required by state law to develop, implement and evaluate a multidisciplinary response to allegations of child abuse and neglect as spelled out in their child abuse protocol. The protocol outlines the multidisciplinary approach used to investigate and prosecute alleged cases of child neglect, physical and sexual abuse and sexual exploitation. The purpose of the protocol is to ensure coordination and cooperation between agencies involved in the investigation of child abuse cases to improve efficiency and effectiveness in the handling such cases and to minimize the trauma to child victims.

In 2017, the Office of the Child Advocate (OCA) received a CJA grant to conduct three activities related to the child abuse protocol.

1. Communicate prior update of the state model protocol (completed in 2016) via email to local child abuse protocol committees and state agency leadership. Also distribute model protocol at multidisciplinary trainings delivered at various locations across the state.
2. Consult with stakeholders and multidisciplinary partners, state and local, on subsequent update of the state model protocol to reflect 2017 updates to legislation, DFCS policies, procedures and best practices.
3. Evaluate local child abuse protocol committee compliance with OCGA §19-15-2 (that each county or circuit shall develop a local protocol for the investigation and prosecution of alleged cases of child abuse and said protocol shall be filed with the Office of the Child Advocate) to develop a plan for 2018 technical assistance.

In addition to broad distribution electronically of the state model protocol (2016 update), OCA conducted 10 trainings during 2017 for multiple disciplines including child advocacy centers, DA's, DFCS, law enforcement, DJJ, mental health providers, public health, and schools.

In the fall, OCA convened a multidisciplinary summit to solicit input from stakeholders on sections of the model protocol that needed updating. Opening remarks from representatives for the judiciary, DFCS, Criminal Justice Coordinating Council, Prosecuting Attorneys Council, Child Advocacy Centers of Georgia, and a presentation from GBI on child fatalities, set the stage. Breakouts were organized by topic and included legislation, child welfare, prevention, child advocacy, sexual assault, CSEC, law enforcement and prosecution to review related section of the protocol and identify changes needed[32].

[32] These changes were compiled, vetted and the updated state model child abuse protocol was distributed in March 2018.

OCA collected 108 protocols representing 157 of the 159 counties in Georgia. Compliance with the development and update of local protocols were reviewed for each jurisdiction. Training and technical assistance needs were identified and provided, as needed, to local child abuse protocol committees to ensure consistency and compliance with current law, child welfare policy and practice and to improve the effectiveness of the multidisciplinary response to child abuse reports in their respective communities.

Because the Summit and subsequent revision to the state model protocol happened late in 2017, OCA did not submit a proposal for 2018. However, a proposal has been submitted for a protocol summit in 2019.

Grantee: Children's Advocacy Centers of Georgia

Project: One Team Conference

Task Force Priorities: #1, 2, 7 & 8

On November 3-4, 2016, the Children's Advocacy Centers of Georgia held its 10th Annual Children's Advocacy Centers of Georgia "One Team" Conference: "The MDT Response to Child Abuse and Neglect" at the Georgia Coastal Conference Center in Savannah, Georgia. Multidisciplinary training for more than 265 multidisciplinary team professionals (law enforcement, prosecution, medical providers, mental health providers, child protective services workers and supervisors, school staff and others) on a wide spectrum of topics related to responding to child abuse cases.

In addition to a keynote address from a former sexual abuse victim who works in law enforcement, workshops included such topics as:

- Forensic Interviewing: Multiple Protocols
- Children and Teens Who Act Out Sexually
- Physical Signs of Child Abuse
- Wellness/Survival and the MDT Approach to Child Abuse
- Ethical Challenges Facing Children's Advocacy Centers

Child Advocacy Centers of Georgia received a grant for their 2018 conference, held again in Savannah, and have applied for their 12th annual conference in 2019 in Athens.

Grantee: Emory University – Barton Child Law and Policy Center

Project: Emory Summer Child Advocacy Program

Task Force Priorities: #2, 3, 4, 5, 6 & 8

Emory's Summer Child Advocacy Program (ESCAP) is an established interdisciplinary summer internship program designed to support the dual goals of increasing the service capacity of the Georgia child welfare system and promoting careers in the child advocacy field. The program is intentionally designed to support CJA priority to improve the investigation, prosecution, and judicial handling of child abuse and neglect cases. CJA goals are primarily supported through the strategic selection of internship placements. ESCAP is designed as an interdisciplinary program, both from the perspective of the participating student interns and the placement settings and supervisors.

The 2017 ESCAP program includes an intensive, 4-day orientation training followed by 10 weeks of a paid internship for 11 graduate students from law and social work programs across the United States. Twenty-nine student interns attended the program training and orientation. Law schools represented included Cornell Law School, Emory Law School, John Marshall Law School, University of Florida Levin College of Law, University of Georgia School of Law, and Valparaiso University School of Law. Eleven interns from the Emory Summer Child Advocacy Program (ESCAP) were joined by 15 student interns and two professionals from other local child serving agencies, such as the DeKalb County Child Advocacy Center, Voices for Georgia's Children, and Fulton County Juvenile Court. One visiting Chinese family law professor also participated in the training and has expressed interest in replicating it for her colleagues in China.

Placements are carefully selected to represent a range of opportunities, from direct practice settings to agency administrative and public policy positions. In 2017, placements included juvenile courts, non-profit policy and advocacy organizations, child representation office and with providers of child welfare services.

Type of Placement	Tasks/Projects/Activities
Juvenile Court	Observe court proceedings, legal research, research case law and statutes, draft and file orders, develop protocols for the Juvenile Court Administrative Council, create training materials.
Policy	Legal research and writing, non-legal writing, draft publications, update pamphlets, research available grants, investigating and handling constituent complaints, help with trainings.
Child representation (direct, legal)	Interview children, conduct home visits, legal research and writing, observe in juvenile court, observe in drug court, representing child clients in hearings, client consultation.
Direct Services (social services)	Legal research and writing, social science research, attending DFCS meetings and hearings.

The students contribute their skills, knowledge, and enthusiasm to further the work of their internship placement setting, providing valuable staff support to under-resourced and overburdened juvenile courts, law offices, service providers, and agencies. In exchange, the interns benefit from meaningful engagement in, and exposure to, the work of the people and institutions that serve children and families involved in the child welfare system, and encouragement to pursue a career in the child welfare advocacy field[33].

Emory University applied for and received CJA funding for ESCAP 2018 and has submitted a proposal for 2019. It should be noted that several current and former Task Force members participated as law students in the ESCAP program and are practicing in the child welfare field.

[33] Since its inception more than a decade ago, ESCAP has had an impact on over 200 interns, many of whom have pursued careers in the child welfare field. Results from a voluntary survey conducted by Barton Center in 2013 indicated that 92% of respondents reported that they had used the skills acquired during ESCAP. This same percentage indicated that they are, or have, engaged in a paid position in the field of child advocacy and 60% indicated that they are, or have, engaged in pro bono volunteer work in the field.

Grantee: Georgia CASA

Project: CASA Advocacy Training

Task Force Priorities: #2, 3, 6 & 8

This advocacy training project ultimately resulted in improvements in the assessment and investigation of child abuse and neglect cases by helping to limit additional trauma to child victims, including those with disabilities and serious health-related problems, as well as strengthened the quality of representation and advocacy through well-trained, educated CASA advocates. The project was designed to strengthen the advocacy skills of 170 CASA staff and 2,400 volunteers who represent the best interests of children in dependency hearings at 46 affiliated CASA programs across the state. Training was provided by webinar, in-person and made available on the CASA website.

Topics covered included:

- Juvenile Court 101
- Courtroom Advocacy
- Education Advocacy for Children with Special Needs
- Trauma and Childhood Brain Development
- Medically Fragile Children

A set of quick reference guides[34] was developed to provide tools and resources to support CASA's ongoing advocacy efforts. Ten new guides were developed that included:

- Reinstatement of Parental Rights
- CASA Access to Case Information
- Case Planning (2 reference guides)
- Education Advocacy
- Special Education Advocacy
- Trauma and Well-Being (2 reference guides)
- Permanency Options
- Older Youth

Onsite court visits were also conducted to connect training to practice ultimately improving the handling of child abuse and neglect cases by helping to limit additional trauma to child victims, including those with special needs, as well as strengthening the quality of representation and advocacy through well-trained, educated CASA advocates. Because of the advanced training and access to specialized tools provided to CASA volunteers, judges are more likely

[34] Two of the ten previously created Quick Reference Guides were also updated to include relevant law and policy changes, bringing the total number to twenty.

to receive all relevant information needed to make sound decisions. Information gathered through this process also helps to inform Georgia's court improvement efforts, specifically with Georgia CASA's collaboration and involvement with the Cold Case Project, Attorney-GAL Peer Review Project, Council of Juvenile Court Judges, and the Committee on Justice for Children.

Georgia CASA received CJA funding for a similar project in 2018 and has submitted a proposal for 2019.

Grantee: Division of Family and Children Services

Project: Special Assistant Attorneys General Conference

Task Force Priorities: #3 & 8

Georgia's Division of Family and Children Services, Legal Services Unit, hosted its annual training event in September 2017 for Special Assistant Attorneys General (SAAG), who represent the Division in juvenile court in dependency proceedings. The objectives of the conference were:

- To enhance participants knowledge of juvenile court proceedings
- To improve the handling of dependency cases and Child Abuse Registry cases
- To reduce trauma to children and families during a criminal prosecution and a concurrent civil case in juvenile court

The two-day conference provided training to 147 attorneys, associates and Division staff on such topics as:

- Solution Based Casework, the Division's new practice model
- Georgia's transition to a Kin 1st child welfare system as a method of reducing trauma to children and families
- Federal requirements for services to be provided to drug exposed infants and children
- Information concerning the prosecution of child abuse and neglect cases, including sexual abuse and exploitation cases and cases involving maltreatment child fatalities
- Child Abuse Registry appeals

A proposal was not submitted for a conference in 2018, however, one has been submitted for 2019.

Grantee: Division of Family and Children Services

Project: Juvenile Court Training for Caseworkers

Task Force Priorities: #3 & 8

The Georgia Division of Family and Children Services, Knowledge Management, Education and Training Department and the Georgia State University Professional Excellence Program partnered to provide training to Social Services Supervisors and Case Managers on juvenile court preparation and procedures for advocating for children who had been abused or neglected in Georgia. This included one day of classroom training and a second day of Mock Trial. Twenty classes offered during 2017 provided training to 280 supervisors and caseworkers representing all 14 regions in Georgia. Staff were taught how to write and prepare juvenile court documents, meet and communicate with the SAAG prior to court to prepare for hearings, how to testify in court, advocate for the child in court to prevent further abuse and neglect, terminate parental rights, establish permanency for the child, and improve communication with the family on the juvenile court process. While this preparation primarily involves dealings with the juvenile court, information related to gathering evidence and documentation allows for better collaboration when other legal partners need DFCS related information for prosecution.

Proposals were not submitted for either 2018 or 2019.

Grantee: Children's Healthcare of Atlanta (CHOA)

Project #1: Bumps, Bruises, Burns, Broken Bones and Beyond

Task Force Priorities: #1 & 3

Often, DFCS personnel receive little training on the more subtle signs and symptoms of physical abuse and may miss cases where abuse is not egregious. This can put the child at risk of further harm at the hands of an abusive caregiver. Children's Healthcare of Atlanta partnered with the Division of Family and Children Services to offer 5 day-long training sessions for up to 500 DFCS staff. The day-long sessions provided an opportunity for frontline staff to hear from experts in the field of child abuse pediatrics on the physical signs/symptoms and the importance of thorough history taking.

The training project also included a series of webinars developed for DFCS staff that included such topics as a mental health overview, advocating for children's mental health needs, and recognizing the 'red flags' of child abuse.

Project #2: Medical Network

Task Force Priorities: #7 & 8

In partnership with professionals from the Stephanie V. Blank Center for Safe and Healthy Development and staff from the Division of Family and Children Services, this project was designed to build a medical network of pediatric medical professionals who can provide forensic medical examinations to suspected victims of child abuse and neglect in communities that do not have access to this expertise. The goal of the pilot project was to recruit and train five pediatric healthcare providers on the basics of conducting exams and providing appropriate follow-up to DFCS and the family to begin the process of building a sustainable network of providers statewide. Providers would be matched with mentor physicians and initial training would be supplemented with ongoing peer review sessions and webinars specific to the needs of providers.

Both CHOA projects focused on improving the assessment and investigation of child abuse cases and prosecution of cases of child abuse and neglect, including child sexual abuse and exploitation. Accurate interpretation of early, 'sentinel' injuries may prevent subsequent serious injury or fatal child abuse. In addition to more timely examinations, the medical network project would help to reduce trauma to child victims by having the child examined in their community rather than having to travel to an expert at some distant location. A combined report for 2017 was submitted.

A scaled back proposal, in response to challenges encountered in the first year, was submitted for 2018 and received a CJA grant. A proposal to continue the program was submitted for 2019.

New Projects Recommended for CJA Funding for 2018

In addition to the 2017 projects that were identified previously as having received CJA grants in 2018, the Task Force recommended funding for the following projects in 2018:

- Georgia Office of the Child Advocate: Child Welfare Summit (new project)
- Georgia Division of Family and Children Services: Child Fatality and Serious Injury Analysis (returning project)

In closing…

The Task Force submits its report to Division leadership on its 2017 activities, including findings and resulting recommendations. Additionally, priorities and plans for 2018 have been identified highlighting collaborative opportunities to better coordinate efforts on shared goals and objectives in the coming year.

The Task Force would like to express its appreciation to the Division Director and the leadership team for their responsiveness to, and continued support of, the Task Force, its mandate and recommendations, and looks forward to working together in 2018.

Respectfully submitted on behalf of Children's Justice Act Task Force by

Melissa D. Carter, JD (Co-Chair)
Executive Director
Barton Child Law and Policy Center
Emory University School of Law

J. David Miller, (Co-Chair)
Senior Assistant District Attorney
Southern Judicial Circuit

Prepared by Deb Farrell,
Care Solutions, Inc.
Georgia CAPTA Panel & CJA Task Force Coordinator

Children's Justice Act Task Force
2017/2018 Task Force Members

Sandra Barrett **Court Appointed Special Advocate**	Carroll County CASA
Sandra Barrett is a dedicated volunteer and has worked with several organizations that serve children including a teen parent program that supported teen mothers getting their high school diplomas. She currently works for the Criminal Justice Coordinating Council (a state agency) as a Claims Support Supervisor in the Victims' Compensation division. She works with victims of violent crime across the state of Georgia to apply for the program as well as providing referrals for local resources for other needs. She also works with Child Advocacy Centers to verify forensic interviews across the state. In addition, Ms. Barrett has been a CASA volunteer in Carroll County since 2009 and a member of the CAPTA CJA board since 2011. She assists in coordinating the solicitation and review of CAPTA CJA grants that come through the board every year.	
Jennifer Bartl **Mental Health**	Program Director Wellspring Living
Jennifer Bartl currently serves as the Program Director at Wellspring Living in Atlanta GA; providing holistic care to girls and young women survivors of sex trafficking. Ms. Bartl received her bachelor's degree in Psychology from The University of Wisconsin and her master's degree in Marriage and Family Therapy from Syracuse University. She has worked in the field of Behavioral Health & Addiction for over 20 years in several metropolitan cities throughout the United States. She has been instrumental in securing grant funding to start after-school programming for children, and substance abuse prevention/education programming for at-risk adolescents. She has partnered with over 25 community stakeholders to establish a local collaborative system of care in Atlanta that serves to increase access to health services and community resources, and to decrease healthcare disparities. Ms. Bartl has been recognized for her work in raising awareness of intimate partner/teen dating violence; she is well versed in the areas of trauma, play therapy, marriage and family therapy and addiction. Ms. Bartl is a Licensed Marriage and Family Therapist (LMFT), Certified Addiction Counselor-Level II (CACII), and a Certified Clinical Supervisor (CCS) and enjoys teaching and providing clinical supervision and education to clinicians and graduate level counseling interns. She offers trainings in multiple subjects including: Domestic Minor Sex Trafficking (DMST)-What Behavioral Health Providers Need to Know, Teen Dating Violence Prevention, Substance Abuse Prevention and Education, Behavioral Health 101, The Effects of Trauma on the Developing Child and Adolescent Brain, and Educational/Behavioral Health Advocacy. Ms. Bartl is a champion for children of all ages and a dedicated advocate for vulnerable populations including victims of commercial sexual exploitation and trauma. She has been an active member of the Criminal Justice Coordinating Council's (CJCC) Commercial Sexual Exploitation of Children (CSEC) Taskforce since its inception in 2008 and works with CJCC to offer CSEC/DMST trainings for behavioral health service providers throughout the state of Georgia. She is a statewide trainer for Darkness to Light and presents Stewards of Children trainings around metropolitan Atlanta to raise aware of and teach adults how to recognize and prevent child sexual abuse.	
Cheryl Benfield *(new 2017/2018)* **Education**	Program Manager, Safe & Drug-Free Schools Georgia Department of Education
Cheryl is the Program Manager for Safe and Drug-Free Schools at Georgia Department of Education. After spending more than two decades as a teacher, administrator, and parent mentor, Cheryl knows the importance of early identification and treatment of mental health concerns and understands the impact of school climate on the social-emotional wellbeing of students. In addition to committee appointments including the Department of Juvenile Justice Re-entry Task Force, National School Safety Alliance Collaboration Group, Georgia Child Welfare Training Collaborative Advisory Council, and Georgia Statewide Opioid Task Force, Cheryl serves on the Executive Committee of the Board of Directors for NAMI Georgia and is a standing member of the Mental Health America of Georgia Board of Directors. Cheryl holds a B.A. in Early Childhood Education from Augusta University, an M.Ed. in Educational Administration from University of Scranton, and an Ed.S. in Leadership and Supervision from The	

George Washington University with additional certifications and endorsements in K-12 Special Education, Special Education Transition, Reading, and Teacher Support

Sarah Blake Smith **Homeless Youth**	Homeless and Foster Care Liaison Fulton County Schools

Sara Blake Smith is a Licensed Clinical Social Worker. Ms. Smith's focus has always been on children and youth. She started her career working in long-term residential facilities for children both in St. Louis and the Atlanta area. Ms. Smith is originally from St. Louis, MO where she finished her undergraduate studies at Washington University after attending two years at New York University. She also attended Washington University for her MSW.

In 1998 she joined Fulton County Schools as a social worker for the psycho-educational program serving students with severe emotional and behavioral problems. After five years, she transitioned into a regular school social work position and worked at elementary, middle and high schools on both the north and south end of the county. Most recently, in 2010 she became the school district's Homeless Liaison and the Foster Care Liaison in 2016.

Ms. Smith also worked as an adjunct professor at Georgia State University where she taught bachelor level social work students from 2011-2016.

Ms. Smith and her husband have recently become foster parents and hope to adopt through the foster care system. She has two children and lives in the Grant Park neighborhood.

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

Lalaine Briones is currently employed at the Prosecuting Attorney's Council of Georgia. She serves as Director of the State Prosecution Support Division. Prior to that, Ms. Briones was an Executive Assistant District Attorney with the Clayton Judicial Circuit. Ms. Briones supervised the Crimes Against Women and Children Unit. She exclusively handled cases involving: domestic violence murders; sexual abuse and violence; and physical abuse cases, specifically abusive head trauma in children. Prior to that, she was the Deputy Director of Legal Services at the Prosecuting Attorneys' Council of Georgia. Ms. Briones also served as an Assistant District Attorney in the Crimes Against Children Unit with the DeKalb County District Attorney's Office and handled all aspects of prosecuting felony offenses involving child sexual and physical abuse. As a member of the unit, she handled cases ranging from child cruelty to murder. Ms. Briones was also a member of the Clayton County Child Fatality Review Committee, Clayton County Child Abuse Protocol Committee, and a member of the Clayton County/Rainbow Connection Multi-Disciplinary Team.

Rachelle Carnesale **Disabilities**	Assistant District Attorney Cherokee County

Rachelle Carnesale is currently the Chief Assistant District Attorney in Cherokee County, Georgia, specializing in child homicides and serious abusive injuries in children. A career child abuse specialist, Rachelle has previously served as the State Director of DFCS, the Deputy and Interim Director of the Office of the Child Advocate, the head of the DeKalb County District Attorney Office Crimes Against Children Unit, and an Assistant Attorney General. While on staff with the Office of the Child Advocate, Ms. Carnesale utilized a CJA grant to create a statewide training program centered on utilizing a multi-disciplinary approach in the investigation and prosecution of fatal and near fatal child abuse. Ms. Carnesale is the parent of two boys, one of whom has special needs, and she is active in the autism and disabilities communities.

Melissa D. Carter, JD* **Advocate**	Executive Director, Barton Child Law and Policy Center Emory University School of Law

Melissa Carter is a Clinical Professor of Law at Emory Law School and Executive Director of the Barton Child Law and Policy Center, a multidisciplinary child law program seeking to promote and protect the legal rights and interests of children involved with the juvenile court, child welfare, and juvenile justice systems, and to prepare the next generation of juvenile law attorneys. In that role, she is responsible for the administration of the Center, directing the public policy and legislative advocacy clinics, and teaching a related course in child welfare law and policy. Melissa has contributed to the drafting and passage of dozens of pieces of legislation, including the 2013 Juvenile Justice Reform Act which comprehensively revised and modernized the state's Juvenile Code. She is a frequent presenter and has authored several publications on juvenile law topics. Before accepting her faculty appointment, Melissa served as Georgia's Child Advocate, the state's child welfare ombudsman, and she has held previous positions with Georgia's Court Improvement Project and as a practicing attorney focusing on adoption, juvenile court, and assisted reproductive technology cases. Melissa was appointed by Governor Nathan Deal to serve as a member of the Child Welfare Reform Council, Commission on Family Violence, and State Juvenile Justice Advisory Group. She is the Secretary of the Board of Directors for the Multi-Agency Alliance for Children, a member of the Board of Directors for the nsoro Foundation, an advisor to the Supreme Court of Georgia Committee on Justice for Children and to ChildKind, Inc., and a member of the Policy Committee of Voices for Georgia's Children. Melissa earned her Bachelor of Science and *Juris Doctorate* from the University of Illinois.

Nancy Chandler **Advocate**	CEO - Retired Georgia Center for Child Advocacy

Nancy Chandler began her tenure as Chief Executive Officer of the Georgia Center for Child Advocacy in January, 2008. The vision of the Center is a safe community for all children. Services are specifically directed to children at risk for being victims of severe physical abuse or child sexual abuse. Since the initial founding in 1987, the Center has provided forensic and therapeutic services to more than 13,000 children. Children's Advocacy Centers work within a multidisciplinary framework comprised of law enforcement, child protective services, prosecution, medical and mental health professionals whose goal is to ensure that children are safe and protected from further victimization.

Prior to this appointment, she served for 14 years as the Executive Director of National Children's Alliance (NCA), the accrediting and membership association of the more than 700 Children's Advocacy Centers across the United States. As the Executive Director of NCA, Ms. Chandler presented to more than 400 conferences and workshops across the country.

Before being asked to lead the national organization, Ms. Chandler served as the founding Executive Director of the Memphis Child Advocacy Center. She was a member of Leadership Memphis and was a founding board member of the National Network of Children's Advocacy Centers. She currently serves on the Advisory Board for Prevent Child Abuse Georgia, is a member of the Children's Justice Act Task Force and is a Consultant to Children's Advocacy Centers of Georgia.

Ms. Chandler received her MSW from the University of Georgia, a BA from the University of Tennessee and is a member of the Academy of Certified Social Workers.

Latera Davis **Juvenile Victims**	Director of Victim and Volunteer Services Department of Juvenile Justice

Latera Davis serves as the Director of Victim and Volunteer Services for the Georgia Department of Juvenile Justice. She received a B.S. in Criminal Justice at Georgia State University and holds a master's degree in Social Work and Public Administration. Mrs. Davis is a Licensed Clinical Social Worker holding several other specialties in Child Forensic Interviewing, Victim Advocacy, Victim Offender-Dialogue, Registered Mediator and Grant Writing.

As the Director, she is responsible for statewide leadership and oversight of the Victim and Volunteer Services Unit. Her responsibilities include but are not limited to: direct and supervise a staff of regional and statewide victim

advocates and volunteer coordinators; developing and implementing policy and training, public education and outreach, serving as a statewide leader in Commercial Sexual Exploitation, and developing community resources and networks which support and enhance program objectives.

Ms Davis has an extensive background in juvenile justice, dating back to 1998. She serves as an Adjunct Facilitator for the University of Phoenix and over six years of consultation and clinical experience with youth in the foster care system. Her expertise includes providing subject matter training in juvenile and victim related services for a variety of public and private entities.

Megan Gaither **Child/Youth Attorney**	Staff Attorney Truancy Intervention Project, Georgia

Megan Gaither is the staff attorney for the Truancy Intervention Project, Georgia, a legal nonprofit organization that exists to increase student attendance and opportunities through legal and family advocacy. She represents and counsels youth offenders in truancy hearings throughout Georgia, as well as conducts research and develops new initiatives focused on Children In Need of Services (CHINS) policy and programming. She previously served as law clerk for the Superior Court judges of Whitfield and Murray Counties in north Georgia. She is a 2016 magna cum laude graduate of Georgia State University College of Law, where she focused her legal education on child welfare issues. She is also a recipient of a 2016 Emory Summer Child Advocacy Program (ESCAP) grant, funded by the Children's Justice Act, and served as summer law clerk to the Hon. Peggy Walker of Douglas County Juvenile Court.

Darice Good, JD, CWLS **Parent Attorney**	Attorney Good Legal Firm, LLC

Darice Good is a solo practitioner in Georgia who focuses solely on juvenile cases. From 2010 to 2016, she was a certified National Child Welfare Law Specialist (CWLS) and is in the process of re-certification. She is a member of the Georgia and the National Association of Counsel for Children. Ms. Good serves in the CWLS section of the Georgia Supreme Court Committee on Justice for Children. Ms. Good is a Member of the Steering Committee for the National Parents Representation Project at the Children and Law Center of the American Bar Association. Additionally, she co-authored the adjudication (trial) chapter of the first National Parents Representation book. Ms. Good is also a certified trainer for the National Institute of Trial Attorneys.

Her dedication and joy in the practice of juvenile law is evident when you meet and work with her. Ms. Good was voted the 2015 Georgia Juvenile Attorney of the Year. She was honored as the 2014 Shining Star by the Multi- Agency Alliance for Children. She previously served as a pre-tempore judge for Juvenile Court of Fulton County. Ms. Good perfects her craft by regularly attending juvenile law conferences and teaching to juvenile attorneys across the country.

Ms. Good formerly served as the President of the Georgia Parent Attorney Advocacy Committee, a Fellow for the Georgia Supreme Court Committee on Justice for Children Cold Case Project, and as the co-chair of the Juvenile Law Section of the Young Lawyers Division of the State Bar of Georgia. She obtained her bachelor's degree from the University of Washington and her Juris Doctorate from Mercer University School of Law.

Jordan Greenbaum, MD **Health Professional**	Medical Director, Global Child Health and Well Being Initiative International Centre for Missing and Exploited Children

Dr. Greenbaum is a child abuse physician at the Stephanie V. Blank Center for Safe and Healthy Children at Children's Healthcare of Atlanta. Until recently, she served as the medical director for the Child Protection Center at Children's Healthcare of Atlanta. She is the medical director of the Global Initiative for Child Health and Well Being for the International Centre for Missing and Exploited Children. Dr. Greenbaum has served on the board of the American Professional Society on the Abuse of Children, as secretary and as president. She co-chairs the Human Trafficking committee for the Helfer Society, and the Education/Training committee for HEAL (health, education, advocacy, leadership) Trafficking, an organization of medical professionals working on human trafficking issues.

Beoncia Loveless **Relative Foster Parent**	Consultant/Trainer Child Death Investigation Specialist

Beoncia Loveless was a death investigator for 18 years, spending most of her career with the Georgia Bureau of Investigation, where she coordinated a specialized unit tasked with juvenile death and child maltreatment investigations. She is currently the Coordinator for the Sexual Assault Kit Initiative for the Prosecuting Attorneys' Council and she teaches Forensic Science and Criminal Justice classes for Southern Crescent Technical College. She received her Bachelors' Degree in Criminal Justice from the University of Georgia in 1999 and her Master's Degree in Criminal Justice/Public Safety Leadership from Mercer University in May 2018. She is a Board Certified Medicolegal Death Investigator and a POST Certified Instructor. While with the GBI, Ms. Loveless traveled extensively, training law enforcement officers, child welfare personnel, and daycare employees in recognizing and investigating child maltreatment and investigating juvenile deaths, with a special focus on Sleep-Related Infant Deaths. In addition, she co-authored the latest edition of *Portable Guides for Investigating Child Abuse*, published in May 2014. Ms. Loveless and her husband were awarded permanent relative custody of her niece and nephew in 2011 and plan to finalize their adoption of the children in 2018, and she has extensive knowledge of the child welfare system as both a professional and a client.

Stephen Messner **Health Professional**	Medical Director, Children's Healthcare of Atlanta, Stephanie Blank Child Protection Center for Safe and Healthy Children

Dr. Messner is currently serving as the medical director for the Child Protection Center at Children's Healthcare of Atlanta. He is responsible for medical evaluations on children who have been physically or sexually abused or neglected, testifies as an expert witness and serves on local multidisciplinary teams and committees.

J. David Miller* **Prosecuting Attorney**	Sr. Assistant District Attorney Southern Judicial Circuit

J. David Miller is a Sr. Assistant District Attorney in Georgia's Southern Judicial Circuit, where he has been a prosecutor for over 30 years, including serving as the elected DA from 1997-2016. He carries a full felony caseload in the Colquitt County Office, including all cases involving crimes against children. A former President of the District Attorneys Association of Georgia, and twice Chairman of the Prosecuting Attorneys Council of Georgia, Mr. Miller has been active in State legislative efforts on behalf of victims, has lectured at local, state and national conferences on both victim and child abuse issues, and authored his circuit's first child abuse protocol in 1986, a year before the state legislature mandated such for all 159 of Georgia's counties. He was instrumental in the establishment of his circuit's three Child Advocacy Centers, including Georgia's first nationally accredited center in Valdosta.

Julia Neighbors **Prevention Specialist**	Executive Director Prevent Child Abuse Georgia

Julia Neighbors is the Executive Director of Prevent Child Abuse Georgia, housed in the Center for Healthy Development at Georgia State University's School of Public Health. Prior to her work with PCA Georgia, she advocated for children and families through her work with non-profit, private and public sectors for almost two decades. Her experience includes work with Court Appointed Special Advocates around Georgia, community revitalization efforts and as a senior attorney with the Fulton County Child Attorney Office.

Most recently, Ms. Neighbors served as the project manager for JUSTGeorgia, a statewide coalition of organizations and individuals who successfully advocated for the passage of juvenile justice reform in the Georgia General Assembly. She serves on the leadership team for Strengthening Families Georgia and on the boards of Georgia CASA, Georgia's Department of Juvenile Justice and Neighborhood Nexus. She holds a law degree from Emory University and a bachelor's degree from the University of Michigan. She and her husband Ken, live in Atlanta with their two sons, Kenneth and Kaden.

Amber Patterson *(new 2017/2018)* **Judge**	Cobb County Juvenile Court

Amber N. Patterson joined the Cobb County Juvenile Court Bench with a multitude of experience in Juvenile Law. In 2002, she began her career at the Alachua County Family/Civil Justice Center as a Guardian ad Litem. Patterson became an extern with the CASA Program in 2004, and then moved on to become a staff attorney for the Chief Judge of the Fulton County Juvenile Court in 2005. In 2007, she became a child advocate attorney where she represented and counseled children in deprivation hearings in the Fulton County Juvenile Court.

In 2010, Patterson joined the Fulton County Department of Family and Children Services as a SAAG Associate, where she represented the department in various deprivation hearings and organized cases for trials. In 2011, Patterson began serving as a Guardian ad Litem Attorney in Cobb County where she represented and counseled children in all manners of dependency hearings. She was the designated Guardian ad Litem Attorney for the Cobb County Family Dependency Court. Patterson served as a Guardian Ad Litem for Cobb County Superior Court and Fulton County Superior Court for many years.

Throughout the years, she has received hundreds of hours of training in child advocacy. She is a frequent speaker on juvenile law and child advocacy. Patterson received her undergraduate degree in Education from Valdosta State University. She then attended the University of Florida Levin College of Law, where she graduated with honors, and earned her J.D. Patterson resides in East Cobb with her husband and two children.

Megan Paul **Foster Parent**	Clinical Director AmericanWork, Inc.

Megan Fraijo-Paul is a Licensed Professional Counselor, and currently serves as the statewide Clinical Director for AmericanWork, Inc. This agency was founded on the belief that people living with mental illness can and should obtain gainful employment as part of their recovery. Prior to her role as Clinical Director, she worked for Georgia's Department of Behavioral Health and Developmental Disabilities as a Behavior Specialist on the acute unit of a state psychiatric hospital, a Community Case Expediter in one of the regional field offices, and as an Account Manager at the state office. She has worked in the mental health field for over 8 years and specializes in serving adults with severe and persistent mental illness. Ms. Paul earned her bachelor's degree in Psychology from Campbell University, and a master's degree in Counselor Education from Augusta State University. She has been a foster parent for 15 months and has helped support 5 children from 2 different families in DeKalb and Clayton counties. She strongly believes in the practice of partner parenting to support reunification with the biological family when deemed appropriate.

Stephanie L. Pearson, Ph.D. **Mental Health Professional**	Director, Child and Adolescent Services Programs Department of Behavioral Health & Developmental Disabilities

Dr. Stephanie Pearson is a licensed clinical psychologist working as a Child and Adolescent Services Program Director for Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) since May 2009. In this capacity, Dr. Pearson has responsibility for the Outdoor Therapeutic Program, which serves youth with behavioral health challenges in a wilderness environment. Dr. Pearson also works closely with colleagues in the development and state-wide implementation of care management entities, an innovative system designed to meet the needs of Georgia's high-risk and high-need children and adolescents. Prior to this appointment, Dr. Pearson served in a variety of positions with a large public provider of mental health and substance abuse services, most notably as the Child and Adolescent Services Director, for a total of fourteen years. In this capacity, Dr. Pearson served on a local Child Fatality Review Committee and supervised clinical staff who assessed and treated children and adolescents who experienced physical and sexual abuse. Dr. Pearson's own direct care experience over the past twenty-five years includes an emphasis on this same population, having treated these children both in the public and private sector.

Mitzie Smith **Child Protective Services**	Unit Director, Georgia Division of Family and Children Services, Knowledge Management Section, Policy and Regulations Unit
Mitzie earned her master's degree in Social Work at Hunter College, New York. Her more than 15 years of experience in child welfare began in private child welfare agency providing foster care and adoption, foster care prevention, and as director of quality assurance. With New York City's Administration of Children Services, Mitzie's responsibilities included program planning and development for foster care and foster care prevention. As a coordinator she specialized in developing programs for PINS (persons in need of supervision) and developed prevention programs and intervention services for adolescents. Ms. Smith has been with Georgia's Division of Family and Children Services for six years and is currently Unit Director overseeing the Policy and Regulations Unit.	
Angela Tanzella-Tyner, JD **Court Appointed Special Advocates**	Director of Advocacy & Program Development Georgia CASA
Angela Tyner has served as the Director of Advocacy and Program Development with Georgia CASA since 2004. In her role, she educates CASA staff and volunteers on juvenile court process and procedure, strengthening courtroom advocacy, and other topical trainings. She provides legal guidance and technical assistance to the CASA network and participates in policy and legislative reform efforts. Angela serves on several statewide task forces and committees seeking systemic child welfare improvement. She received her Bachelors' Degree from the University of Georgia and her JD from Mercer Law and is a NACC certified Child Welfare Law Specialist. Ms. Tyner also serves on the National Citizen Review Panels Advisory Committee.	
Kelly Tonelli **Law Enforcement**	Sergeant, Special Victims Unit Gwinnett County Police Department
Kelly Tonelli is currently a Sergeant in the Special Victims Unit with Gwinnett County Police Department. She is a senior instructor with the Gwinnett County Police Training Center and has had specialized training in child abuse investigations and commercial sexual exploitation of children.	
Ashley Willcott **Judge**	Pro Tem Dekalb Juvenile Court
Ashley Willcott is a Legal Analyst and Certified Child Welfare Law Specialist who is a judge and trial attorney with many years of courtroom experience. Ms. Willcott most recently served as Executive Director of the Office of the Child Advocate for the Protection of Children and was hand chosen by the Governor of Georgia, Nathan Deal. She is regularly featured as an expert on top tier national outlets and is a guest lecturer and speaker nationally and locally including the American Bar Association, National Association of Counsel for Children, Georgia Supreme Court Committee on Justice for Children, Emory University School of Law, Barton Child Law and Policy Center, Georgia State University. Ms. Willcott has served as a member of the First Lady's Children Cabinet, the Child Welfare Reform Council, the Child Fatality Review Panel, as well as the Supreme Court Justice for Children Court Improvement Project. She earned a Juris Doctorate from Emory University School of Law and practiced family and juvenile law with a boutique law firm. Ms. Willcott was later appointed first as Fulton County Juvenile Court Judge Pro Tem, and then as DeKalb County Juvenile Court Judge Pro Tem. She started her own private practice to specialize as a trial attorney appointed by the Attorney General of the State of Georgia representing the Department of Human Services, Division of Family and Children Services. Ms. Willcott was later selected by the Georgia Supreme Court as the Committee on Justice for Children Cold Case Project Lead. Ms. Willcott is a native of Houston, Texas now living in Georgia with her husband and three children.	

Donnie Winokur **Special Needs (FASD)**	Author and Parent
Donnie Winokur has both personal experience parenting an adopted son with fetal alcohol spectrum disorder (FASD) and professional expertise on special needs. Her passion to educate others on the emerging connection between invisible disabilities and the judicial system involves writing and speaking internationally. She has spoken on FASD and the justice system with Mitigation Investigators at the *Office of the Georgia Capital Defender* and facilitated training at the Georgia's Youth Law Conference on FASD and other developmental disabilities. Ms. Winokur consults with *Georgia State University's Center for Leadership in Disability* and is serving a second appointed 3-year term with Georgia's *State Advisory Panel on Special Education.*	
Deb Farrell CJA Task Force Coordinator	Care Solutions, Inc.

*Task Force Co-Chairs

Georgia's Children's Justice Act Task Force

2018 Three-Year Assessment

BACKGROUND & PURPOSE

Georgia's Children's Justice Act Task Force began discussing a possible focus for its 2018 three-year assessment in May 2017. Task Force members were interested in making the Child Abuse Registry (CAR) or the Child Abuse Protocol (CAP) the focus of the assessment, however, decided that focusing on child abuse investigations would not only address some of their concerns regarding the effectiveness of child abuse investigations but might also provide additional insights relevant to both the CAR and CAP.

Specifically, the Task Force was interested in the training provided to individuals who respond to and investigate cases of child abuse and neglect, sexual abuse, sex trafficking and child fatalities (all forms of child maltreatment) and identifying potential training gaps or barriers and opportunities to enhance or support best practices.

The goal of the Task Force is to develop recommendations based on CJA objectives to guide Task Force priorities and activities and to guide and support funding decisions during the next three years.

Assessment Objectives:

- To improve the quality and consistency of investigations of child maltreatment and maltreatment-related fatalities
- To compile information on training available, provided to, and/or required, for individuals involved in the investigations of cases of child maltreatment and maltreatment-related fatalities
- To assess information gathered to identify gaps and barriers in training and training opportunities
- To identify opportunities to encourage and support additional training for investigators and those who respond to reports

An Assessment Committee was created to direct the three-year assessment work. Task Force members included:

- Nancy Chandler, Georgia Center for Child Advocacy
- Dr. Jordan Greenbaum, National Center for Missing and Exploited Children
- Beoncia Lovelace, Child Death Investigations Expert
- David Miller, Senior Assistant District Attorney, Southern Judicial District
- Judge Amber Patterson, Cobb County Juvenile Court
- Sergeant Kelly Tonelli, Special Victims Unit, Gwinnett County Police Department
- Ashley Willcott, Judge Pro Tem

This committee was supported by the Task Force Coordinator and a research associate.

The assessment was discussed and planned at the following meetings in 2017/2018:

- Regular Task Force meetings (5/5/17, 8/18/17, 10/18/17, 11/17/17, 1/12/18, 3/9/18)
- Assessment Committee meetings and/or conference calls to review compiled assessment results and discuss recommendations (10/18/17, 2/13/18, 3/26/18)

APPROACH

The committee developed a five-part plan for the assessment.

Phase One: Information Gathering

Phase Two: Key Informant Interviews

Phase Three: Observations and Opportunities

Phase Four: Recommendations

Phase Five: Next Steps, Future Activities

Although the Task Force was interested primarily in the formal investigative process by DFCS in the civil context and by law enforcement on the criminal side, the Task Force recognized that the quality, consistency and outcomes of child maltreatment and maltreatment-related fatality investigations are influenced by the actions of all individuals who may be involved in the response to a report. First the Task Force identified the relevant disciplines, including:

- First responders (police, EMTs, firefighters)
- Investigators – police officers, detectives and special investigators, DFCS[1] case workers and CPS special investigators
- Coroners/medical examiners
- Prosecuting attorneys' investigators

The Task Force then identified individuals who would be able to provide the relevant training information and key professionals (informants) who would be able to offer perspectives on investigations and the outcomes related to these investigations.

In meetings, Task Force members identified the topics to be addressed regarding training and practice, and these were used to develop the forms. An outline of the assessment, and two forms were developed, one for gathering training information and another to serve as a key informant interview guide. See attachments A, B & C. Draft forms were distributed to Task Force members for feedback, and then based on that feedback, were revised and distributed to Task Force members with their assignments.

[1] For the purposes of this assessment, the state child welfare agency is identified as "the Division" and local child welfare offices are identified as "DFCS."

Task Force members collected information on and conducted interviews with representatives of metro, suburban and rural counties/cities in different parts of the state January-March 2018. Although not a statistically representative sample, the Task Force felt that this qualitative research was sufficient to identify concerns and potential areas for improvement in practice and outcomes.

RESULTS

PHASE ONE: INFORMATION GATHERING

Task Force members gathered information on training provided to various disciplines involved in cases when child maltreatment has occurred.

The Task Force collected training information from various state and local organizations:

- Four police departments – three metro area and one mid-sized combined county-city department
- One rural sheriff's department
- One regional technical college
- Five statewide organizations – the Georgia Bureau of Investigation (GBI), the Prosecuting Attorneys' Council (PAC), the Division of Family and Children Services (DFCS), Emergency Medical Services (EMS), and Coroner Training Program

Except for DFCS, which handles primarily civil cases, these agencies are involved in criminal investigations more than 95% of the time.

Minimum Training Requirements

Initial Training

Initial training on child maltreatment requirements varied widely. Not surprisingly, initial (basic) training on child maltreatment for DFCS case managers is 80 hours plus track training related to their specific responsibilities (e.g., foster care, child protective services, adoptions, etc.). Initial child maltreatment training requirements for other entities ranges from none (prosecuting attorneys) to 3-4 hours (EMS) to six hours (peace officers) to three days (special investigators) to eight hours on child deaths but not child maltreatment or maltreatment-related deaths (coroners).

Certification of Peace Officers[2]

All employees of any agency granted the full rights and powers under the definition of a peace officer as defined by the Georgia Peace Officer Standards and Training (POST) Act must be certified by the POST Council. This includes the following disciplines that were the subject of the assessment:

- Law Enforcement
- GBI Special Agents
- Sheriff and Deputies

The required basic law enforcement training program is 11 weeks (408 hours) of POST basic training, of which only six hours is on child abuse. It is offered at POST-certified regional, state and college/university academies around the state.[3]

Annual Training or Professional Development

Twenty hours of annual professional development is required for all DFCS case managers. Annual (POST) training requirement is 20 hours for all law enforcement officers. One hour of the 20 hours must include deadly force training. This is the only annual content requirement. There is no requirement for ongoing training on child maltreatment. Annual training requirements were reported for officers/agents with specialization in child maltreatment/child victims, and some training was in the form of specialty certification, such as for forensic interviewing.

Other than DFCS and special investigators, law enforcement, coroners, EMS, and prosecuting attorneys had no annual child maltreatment-specific training requirements.

Training Delivery: Basic and Specialized on Child Abuse

Basic training may be provided by internal department staff or external organizations. Specialized training may be provided by internal department staff or experts from such organizations as Child First, GBI, the Georgia Network to End Sexual Abuse (GNESA), Internet Crimes Against Children (ICAC), and child advocacy centers (CACs).

Basic training is typically face-to-face classroom-based training. Subsequent and specialized training includes classroom as well as online trainings/webinars – live and recorded – for most disciplines. Training may be provided at in-house and/or off-site training centers within the state. However, some travel out-of-state for specialized training.

[2] https://www.gapost.org/div_cert.html

[3] https://www.gpstc.org/training-divisions/basic-training-division/basic-police-officer-training/ and https://www.gapost.org/academies.html

Training frequency also varied, with some offering the initial training once or twice a year and others providing it on an ongoing basis. Specialized training frequency also varied, as did the training requirements.

Regarding updating curricula, responses ranged from updating in response to changes in the law (PAC), to annual review and update as needed (rural sheriff's department) to updating training when policy changes (DFCS[4]).

Most of the training is not evaluated, and that which is evaluated (POST, DFCS) is only evaluated at Levels 1 and 2 (basically comfort and satisfaction), with little or no measurement of effectiveness or learning.

Identified Concerns Regarding Training

Some of those providing information on child maltreatment training noted that first responders, including all law enforcement officers, need more training on child maltreatment, regardless of the types of cases they work. Those who may arrive prior to investigators specially trained to work child abuse cases need to know what to do or not to do, how to interact with/talk to the child, and how to refer for a forensic interview.

One police department that recently assumed the responsibility for child fatality investigations recognized that their officers need additional specialized training in the investigation of maltreatment-related deaths. This source noted that the training investigators received in Child First training concentrates on interviewing and not investigation. Financial resources to provide this training was also cited as a concern.

Recent laws require that paramedic programs be administered by an accredited program or a program affiliated with an accredited institution. Unfortunately, emergency medical technician (EMT) programs are not held to the same standard, and there is "debate" in the first responder community on how this should be remedied.

PHASE TWO: KEY INFORMANT INTERVIEWS

Task Force members interviewed key professionals involved in both civil and criminal child maltreatment cases regarding investigations that result in a successful disposition/prosecution of a case and those in which gaps or barriers negatively impact investigation results and case outcomes.

[4] It should be noted training for DFCS caseworkers was reviewed prior to the roll out of an updated curriculum 04/01/2018.

Ten key informant interviews were completed by Task Force members:

- Two superior court judges – metro counties[5]
- One parent attorney – metro counties
- Two attorneys and guardians ad litem – one metro and one rural county
- Two CAC directors – One suburban and one rural county
- One PAC investigator – state prosecution support
- One assistant district attorney – suburban
- One DFCS case manager[6] - metro county

These professionals were interviewed about the aspects of child maltreatment investigations that seem to be working well and those that are not; types of cases or victims in cases that may not yield desired results; and, for the various participants in child maltreatment investigations, how well prepared they are, which need additional preparation, and how preparation could be improved. They were also asked about administrative law judges' preparation for the handling of child abuse registry appeals, whether there is a multidisciplinary approach to child maltreatment-related fatality investigations, the role of the child abuse protocol, and how investigations could be improved.

As might be expected given the differing roles and locales of the key informants, perspectives varied on some of these topics. Following is a summary of their feedback most relevant to investigation. The committee identified several recurring themes which are incorporated into plans for future activities and recommendations.

What Is or Is Not Working Well in Child Maltreatment Investigations

What is working well:

- Forensic interviews and psychological evaluations (conducted by professionals)
- Following the multidisciplinary (MDT) protocols and child abuse protocol (CAP)
- Agencies (law enforcement, prosecutors, DFCS, CAC) that work together as a team
- The Child Hearsay Statute (allowing investigator testimony and eliminating the need for the child to take the stand)

What is not working well:

- Too many people talking to the child
- Bad or inconsistent investigations; investigations that are not always thorough
- Improper screening on the front end[7]

[5] "Metro" includes four counties - Cobb, Fulton, Dekalb, Gwinnett

[6] During the Assessment Committee review of the information collected, committee members had an opportunity to speak with a DFCS case manager.

[7] It was assumed this was in reference to screening of reports by CICC.

- Cases that involve only DFCS rather than a team of agencies
- Case managers who do not follow protocol prior to removal leading to case dismissal
- More acceptance of physical violence leading to case closure/un-substantiation
- Cases in which a team member fails to respect the decision of the other team members
- Failure to follow the child abuse protocol (communication or investigation)
- Failure to complete all needed interviews (such as siblings in a physical abuse case)
- Failure to ensure children receive proper and timely medical evaluations
- Failure to collect physical evidence

Challenges Investigators Encounter

Difficult cases:

- Families pressuring victim to recant or not be truthful
- Emotional neglect cases (lack of training of the investigators, inability to see this as a hazard to the child)
- Physical abuse cases not accompanied by criminal charges and an arrest (court is left guessing)
- Jurisdictional issues (residence of perpetrator, residence of child, location where abuse took place may all differ)
- Cases in which one parent alleged abuse against the other parent (judges and courts tend to protect the parent perpetrator's rights more than those of the child; criminal investigation is rarely pursued due to lack of resources and lack of evidence)
- Identification of child sexual exploitation/trafficking may be harder to identify in non-metro areas
- Neglect cases may be overlooked; usually only come to court's attention when it is part of a physical abuse case being heard

Difficult victims:

- Sexually exploited children who do not disclose, who are in placements that are not secure (run back to perpetrator), who become perpetrators themselves; lack of treatment options
- Teens seen as wrong-doers or sharing in responsibility (especially in sexual abuse cases); older youth misunderstood by investigators (charges less likely)
- Child victims who are unable to communicate (due to age, disability/ special need/ developmental delay)

Preparation of Individuals Involved in a Child Maltreatment Investigation

Court Perspective [Judges]	
Well-prepared	*Needs Improvement*
• Experienced DFCS case managers, and law enforcement personnel such as crimes against children investigators • Attorneys, prosecutors	• Inexperienced DFCS case managers who are not sufficiently prepared, have insufficient training on courtroom procedures and testifying in court (citing high turnover and high caseloads) • DFCS supervisors who are not actively engaged in supporting case managers • SAAG preparation of DFCS case managers and supervisors for court; not always on same page as witnesses and case managers
[Parent] Attorneys Perspective	
Well-prepared	*Needs Improvement*
• Experienced individuals from all disciplines that were well trained, knowledgeable, and well-prepared • Law enforcement if DFCS is called at the outset	• Inexperience of first responders, law enforcement; poor communication among all disciplines (including DFCS); inadequate preparation (citing high turnover as the primary reason) • Inexperienced, overwhelmed DFCS staff (due to turnover, high caseloads) • Communication among DFCS case managers participating in different aspects of the case • Law enforcement, when called to testify in civil cases without understanding civil law or what evidence to collect for these cases • Law enforcement officers in smaller communities who may have less exposure (inexperienced) to child maltreatment cases and/or have access to fewer training resources

Other Professional Perspectives (ie. CAC, PAC)	
Well-prepared	*Needs Improvement*
• Participants (law enforcement, first responders, DFCS case managers, attorneys) who follow protocols, procedures and guidelines developed through interagency planning • Multidisciplinary team members	• SAAGs lack sufficient training in overall criminal process, lack of training on child maltreatment, weak case preparation • First responders with little or no training on child abuse (rural areas) • Law enforcement without specialized training (who may fail to get a forensic interview) • Law enforcement insufficiently trained on trauma and handling difficult victims • Inexperienced DFCS case managers who don't have sufficient understanding, training and confidence in their role and authority (who may overlook and not investigate important details)

Suggestions to Improve Investigations

For DFCS	For Law Enforcement
• Smaller caseloads • Less turnover • More training • More supervisory support for caseworkers (as well as mentors) • More court preparation • Improved DFCS policy *(specific policy was not identified)*	• Greater access to case information • A better understanding of how civil courts work • Better understanding of domestic calls for first responders and law enforcement on how to handle victims and families and the preservation and collection of evidence

Improving Child Maltreatment Investigations

Court Perspective [Judges]	• Enforce mandatory reporting statute • Provide training for mandated reporters to recognize and report child abuse • Improve screen-out decision-making for call center training and communication with case managers • Increase training for DFCS case managers (*did not identify type of training, but this might be related to the lack of preparedness and lack of awareness of courtroom procedures reported by these the sources)* • Reduced caseloads

[Parent] Attorney Perspective	• Ensure testimony/case/view of the case is based on facts rather than just allegations • Reduce backlog at GBI crime lab • Increase staff and training at DFCS • Conduct more training for local law enforcement • Promote more consistent relationships among agency partners • Create organization and standards for parent attorneys • Provide reliable funding for independent evaluations and reports • Ensure greater access to Guardians ad Litem • Provide more guidance on what constitutes abuse and neglect; lots of gray areas regarding neglect • Provide more information for investigators on the impact of trauma and drug addiction, better techniques for dealing with victims and witnesses with special needs • Conduct statewide multidisciplinary response training
Other Professional Perspectives (ie. CAC, PAC)	• Train more professionals on child maltreatment • Conduct regular trainings for judges, law enforcement, prosecutors, DFCS (how to prevent trauma in court) • Increase awareness of response and investigation protocols

<u>Multidisciplinary Approach to Investigations and the Child Abuse Protocol</u>

Most key informants indicated that their jurisdictions utilized a multidisciplinary approach to child maltreatment and/or child death investigations and that this was an effective approach that had a positive impact on investigations; however, failure to cooperate or disagreement can damage investigations and outcomes.

Some of the key informants were not aware that there was a child abuse protocol or did know whether the protocol was used in their areas.

<u>Child Abuse Registry Appeals</u>

Most key informants did not have any experience in or knowledge of child abuse registry appeals. The few who did indicated that there were few appeals and/or limited understanding/preparation for these hearings.

Special Note

DFCS case managers and law enforcement officers were not interviewed as key informants because their training was a primary focus of the assessment. However, the committee decided that they needed case managers' perspective on the assessment results.

A DFCS case manager who had received training within this past year (2017) met with the committee and answered questions about her training and experiences in the field. In her perspective:

- The training she received, while excellent, did not sufficiently prepare her for the challenges she would encounter in the field (day-to-day, real life situations) or to implement what she had learned.
- Expectations of a case manager, particularly a new case manager, are unrealistic. There is not enough time in a 40-hour work week to gather information, consult with supervisors, document work, meet timelines and deadlines, prepare for court, and make court appearances. Frequently cases are assigned late in the day, requiring overtime due to response time requirements, which conflicts with administration guidelines that discourages overtime.
- She routinely calls her supervisor from the field for decisions. (Committee members were not certain if this was due to her own lack of confidence, or a requirement of her supervisor or DFCS policy.)
- A case manager with one year of experience is considered a veteran.
- Case managers do not receive training on civil and criminal processes.
- She was not aware of the Child Abuse Protocol but was aware of multidisciplinary team meetings.

Her insights helped to reinforced many of the committee's findings.

PHASE THREE: OBSERVATIONS & OPPORTUNITIES

The Assessment committee met to discuss the results of this qualitative assessment and based on their findings identified opportunities to improve practice related to child maltreatment investigations through training. The themes described below form the basis of the recommendations from the Task Force related to their assessment objectives and will inform and guide their work over the next three years.

In addition to recommendations, committee members wanted to also recognize the positive aspects of investigations that were identified by interviewees. Two frequently recurring themes:

1. Investigations worked well when there was a multidisciplinary approach where all disciplines understood their roles and that of the other members, followed protocol, and communicated and coordinated with one another.
2. Investigations involving more experienced professionals yielded more consistent results.

Based on their review, committee members identified the following recurring themes having a negative impact on preparedness and competency of investigators:

DFCS Case Managers

- Lack of experience: Due to high turnover and high caseloads
- Lack of confidence: Lack of sufficient supportive supervision[8] and mentoring (veteran case managers with new case managers)
- Lack of knowledge: Insufficient training on civil court procedures and criminal prosecutions

Law Enforcement

- Lack of experience: Due to high turnover
- Lack of knowledge: Insufficient training on child maltreatment and civil court proceedings

First Responders

- Lack of experience: Due to high turnover
- Lack of knowledge: Insufficient training on child maltreatment

The following tables outlines the specific training needs identified for each discipline in the assessment.

Table 1

Basic Training Recommendations	First Responders	Law Enforcement	DFCS Caseworkers
Child Abuse & Neglect	✓	✓	
Child Abuse Protocol	✓		✓
Child Fatalities	✓	✓	
Civil Court Processes		✓	✓
Criminal Court Processes/Court Preparation			✓
Criminal Court Evidence Requirements	✓		✓
Joint training on respective roles and responsibilities related to civil and criminal cases		✓	✓

Table 2

Annual Professional Development Needs Identified	First Responders*	Law Enforcement*	DFCS Caseworkers
Child Abuse & Neglect	✓	✓	
Child Abuse Protocol	✓		✓
Child Fatalities	✓	✓	

**Annual training offered should make available a variety of child maltreatment-related topics.*

[8] The Assessment Committee recognizes that supervisory staff may also be carrying a caseload and have competing priorities.

Child maltreatment-related training needs were also identified for other professionals involved in investigation, prosecution and judicial handling of civil and/or criminal cases of child abuse and neglect. This included:

- Parent attorneys
- GALs
- SAAGs (on criminal standards)
- Coroners
- Judges hearing Child Abuse Registry appeals

The Task Force will follow up on other findings that were outside of the scope of the assessment and share those results with the Division, its partners and stakeholders during 2018/2019.

PHASE FOUR: RECOMMENDATIONS

While the assessment raised many issues that the Task Force could tackle over the next several years, the Assessment Committee elected to focus on those that, if addressed, have the potential to improve not only the investigations of cases of child maltreatment and maltreatment-related child fatalities, but also lead to successful civil and criminal case resolution.

Recommendations

1. Overall, any training on child maltreatment should be reviewed and updated regularly. The Division, as the state agency responsible for child protection, must ensure that any time it updates child welfare policy, practice or procedures, it has a protocol for communicating and engaging with its partners to identify what impact proposed changes may have on the policy, practice and procedures of each partner; potential conflicts; and ways to resolve those conflicts.

2. Additionally, at a minimum, all professionals involved in any aspect of a case involving child maltreatment (law enforcement, DFCS, DAs, SAAGs, attorneys, coroners, child death investigators, and other first responders, including EMTs, paramedics and firefighters) should be required to have at least some basic training on child maltreatment. The minimum number of hours would be determined based on the nature and extent of their involvement in the investigation of child abuse cases.

3. It is also recommended that the annual professional development requirements for professionals most involved in these cases include child maltreatment-related training.

   More specifically, for law enforcement officers, it is recommended that the POST training on child maltreatment be increased from six to eight hours. It is also recommended that at least one hour of training on child

maltreatment-related topics be included in their annual professional development requirements, as is required for deadly force training. The committee recognizes that this will require legislative action.

4. As it is legislated that paramedic programs be administered by an accredited program or a program affiliated with an accredited institution, similar standards should be considered for emergency medical technician (EMT) preparation programs.

5. For disciplines with training that has a child maltreatment and/or victim specialization or certification, annual professional development requirements should include an appropriate amount of training on child maltreatment-related topics.

6. The position of coroner is an elected position in Georgia. No medical or educational qualifications, beyond high school, are required to serve. Related specifically to child fatality investigations, it is recommended that basic training for coroners include training on child maltreatment in addition to eight hours on child deaths. It is also recommended that child maltreatment-related content be included in their required annual in-service training.

   Training on child maltreatment for all disciplines should include child development, the effects of trauma, and strategies for handling victims with special needs. The latter is a Task Force priority.

7. For the Division, the Task Force offers several recommendations related to its workforce training.
   - Include training for DFCS case managers on civil and criminal processes and court preparation including information on the Child Abuse Protocol (in new case manager training or require for ongoing training)
   - Conduct cross-discipline trainings on child abuse and child fatality investigations with all disciplines, including medical, but particularly with law enforcement and case managers
     There seemed to be a general lack of awareness, understanding and/or coordination with law enforcement when a dependency case rises to the level of criminal prosecution. The Task Force recommends that this be incorporated into cross training between DFCS and law enforcement.
   - Explore new ways to reinforce and supplement case manager learning through mini-webinars, social media, lunch-and-learns, and/or quick reference guides that take into consideration the limited time a case manager has for professional development

- Explore developing a phone app as a quick reference guide for case managers and others involved in child maltreatment investigations. Some topics that would be helpful to case managers, as well as other disciplines, include:
    - Policies and protocols, including local child abuse protocols
    - Child development milestones
    - Interviewing children of different ages
    - Warning signs of child coaching

The Task Force will discuss the potential implementation of the recommendations with the Division.

8. The Task Force further recommends that the various disciplines that were the subject of this assessment develop and implement appropriate evaluations of the trainings. All trainings should include clearly identified, measurable learning objectives.

PHASE FIVE: NEXT STEPS & FUTURE ACTIVITIES

Related to the subject and findings of the assessment, the Task Force will:

- Conduct focus group(s) with DFCS case managers to assess training and transfer of learning based on their experiences in the field
- Research other states' training requirements and standards
- Review existing training content on maltreatment for law enforcement officers and other first responders to assess gaps
- Review the new caseworker training rolled out 04/01/2018 and solicit feedback from case managers and supervisors via a survey

The Task Force will consider conducting a survey of DFCS case managers and supervisors to solicit additional information on the new training curriculum rolled out 04/01/2018 to help inform the ongoing activities of the Task Force related to the assessment and its priorities. The committee will also recommend that the Task Force consider doing something comparable with first responders as a strategy for soliciting input on training related to the assessment recommendations.

The Task Force will also pursue several findings related to other Task Force priorities and the ongoing activities described in its 2017 annual report.

Child Abuse Protocol

- The Child Abuse Protocol committee will conduct a survey on CAP recognition, use, perception of effectiveness, and improvements needed.

Mandated Reporter Training

- Findings reinforced objectives of the Mandated Reporter Training committee's plans for review of mandated reporter training standards outlined in the 2017 annual report. The Task Force will also follow up on a comment regarding the need to 'enforce the mandated reporting requirement.'
- Two comments related to the screening and assignment of reports by CICC staff will be investigated. The Mandated Reporter Training committee has plans to evaluate call distribution and assignment in the qualitative review of calls to the 24/7 call line.

Child Neglect

- Comment regarding often overlooked or unrecognized neglect until more serious physical abuse occurs is troubling. The Task Force will revisit re-establishing its Neglect committee to look at how this might be addressed.

Child Representation

- Two comments related to Guardian ad Litem access were troubling to the committee as CAPTA requires that all children involved in dependency cases have representation. The Task Force will look into this further.

In closing, the Assessment Committee, and by extension the Task Force, were heartened by the many positive aspects of child abuse investigations that were apparent. Several opportunities were identified to encourage and support best practices and to build on what in Georgia is doing well here and to change what needs to be improved. This will take the commitment and collaborative efforts of all partners who also have a stake in justice for children.

The Task Force looks forward to working with the Division over the next three years and taking positive steps towards realizing our vision that…

> *All of Georgia's children will receive the best possible protection from all forms of child abuse and neglect from a system of highly trained professionals who thoroughly investigate alleged abuse and adequately prosecute those who abuse children, while protecting children from repeat maltreatment.*

Respectfully submitted

Georgia's Children's Justice Act Task Force

05/04/2018

Georgia CJA Task Force 2018 Three-Year Assessment: Outline

Task Force members: Below is information on CJA, the Task Force and the assessment meant to help you explain to the individuals you contact or interview what the assessment is and why it is being conducted.

Each of the forms has its own instructions. Only use the form that corresponds to your task to collect and document responses.

Georgia is the recipient of a state Children's Justice Act grant. The CJA grant is used to support projects or activities that improve the investigation, prosecution and judicial handling of cases of child abuse and neglect, sexual abuse and exploitation, both civil and criminal, while limiting additional trauma to victims and ensuring fairness to the accused. GA DFCS administers this annual grant in collaboration with its Children's Justice Act Task Force. Maintaining a Task Force on children's justice is also a federal grant requirement.

Every three years, the Task Force is required, by federal statute, to conduct an assessment of an element of the state's children's justice system to identify areas of legislation, policy or practice for improvement. Prior Task Force assessments have focused on mandated reporter training, child representation, the child abuse protocol, child abuse definitions in the Georgia Code, and cases involving special needs victims. These assessments have resulted in recommendations that addressed deficiencies or inconsistencies identified in policy or practice and/or supported or encouraged best practices that improved results.

This year, the Task Force is compiling information on training provided to individuals who investigate cases of child abuse and neglect, sexual abuse, sex trafficking and child fatalities (all forms of child maltreatment) to identify potential training gaps or barriers and opportunities to enhance or support best practices. There are two components to the assessment. The first is **gathering information on training provided to various disciplines** involved in cases when child maltreatment has occurred. There is one form for this purpose. The second is the **interviewing of key professionals involved in both civil and criminal child maltreatment cases** on the components of an investigation that result in a successful resolution/prosecution of a case and/or gaps or barriers that negatively impact investigative results and case outcomes.

Our goal is to develop recommendations based on CJA objectives to guide Task Force priorities, activities and support funding decisions during the next three years.

Objectives:

- To improve the quality and consistency of investigations of child abuse and neglect and child deaths
- To compile information on the training available, provided to, and/or required, for individuals involved in the investigations of cases of child abuse and neglect and child death
- To assess information gathered to identify gaps and barriers in training and training opportunities
- To identify opportunities to encourage and support additional training for investigators

The assessment is composed of four components.

PHASE ONE: Information Gathering
PHASE TWO: Key Informant Interviews
PHASE THREE: Observations and Opportunities
PHASE FOUR: Recommendations
PHASE FIVE: Next Steps, Future Activities

Task Force members: Please review 'information gathering' assignment plan or 'key informant' assignment plan. What does this involve? Making contact with individual s identified. Explaining what we are trying to do. Collecting and recording information on the form. Submitting completed forms.

Phase One: Information Gathering

The objective of Phase One is to collect information on training requirements and practices specifically on child abuse from a representative sample of all disciplines that respond to a report of child abuse that may be directly or indirectly involved in a child abuse investigation. This includes:

1. Collecting information on training for individuals who conduct child abuse and neglect, child fatality investigations, including law enforcement and DFCS
    a. LE training information (statewide, regional, local) to include:
        i. POST
        ii. Large urban PD
        iii. Metro county PD
        iv. Non-Metro regional PD
        v. Mid-size city PD (with more resource
        vi. Small rural counties/cities PD
        vii. GBI

    Information will be collected on both basic training, specialized training as well as ongoing professional development expectations.

    b. DFCS training on investigations to include:
        i. Basic caseworker training
        ii. CPS investigators
        iii. Special Investigators

    Training is provided primarily by the Division's Education & Training Unit, however, <u>additional</u> supplemental training on investigations may be provided at the regional or local level.

2. Collect information on training for individuals often on the scene or involved in the response to a report of child abuse or a child death, and contribute to the success of an investigation, including, first responders (EMS, fire fighters) and coroners/medical examiners

3. Collect information on training for other individuals who may conduct supplemental investigations on cases such as investigators in the District Attorney's office

Phase Two: Key Informant Interviews

The objective of Phase Two was to obtain feedback from professionals who rely most heavily on the results of the investigation to ensure a fair and successful outcome in both dependency and criminal cases. This includes Juvenile and Superior Court Judges, Special Assistant Attorneys General (SAAGs), District Attorneys, Guardians ad Litem (GAL) and parent attorneys. The committee also decided to include child advocacy centers as a key informant for an additional perspective. A framework was developed to collect and document information collected from these professionals.

CJA Three-Year Assessment 2018:

Training/Preparation for Civil and Criminal Investigations of Child Maltreatment – What is Available/Required

Phase I: Information-Gathering Form

Task Force Member Name: _____ Date: _____

Instructions: The questions on this form are meant to guide your information-gathering. Feel free to add comments/explanations; boxes will expand as needed. Save each form as "IGF_ your initials_the contacts' initials_ date". Email to cindydavis@caresolutions.com.

Subject Agency/Organization:	Subject Professional Discipline/Role/Position:
Contact Name:	Contact Email:

Introduction:
The CJA Task Force is conducting an assessment regarding the preparation/training of individuals who respond to incidents involving, or investigate reports of, child maltreatment. Although the Task Force interest is primarily on the formal investigative process, the Task Force recognizes that the quality, consistency and outcomes of these investigations are influenced by all disciplines involved, from first responders to prosecuting attorneys. We are researching the training and preparation of individuals with a role in these investigations.

1. What counties does this agency/organization/professional discipline serve? *(list counties or area served)*

2. What types of child maltreatment does this agency/organization/professional discipline typically encounter and/or investigate? *(check all that apply):*

- ☐ Child physical abuse
- ☐ Child neglect
- ☐ Child sexual abuse
- ☐ Child sex trafficking
- ☐ Child fatalities

3. If responsible for investigation, about what percentage of the investigations are criminal vs. civil?

_____% criminal

4. Are all ***individuals who respond to incidents involving, or investigate cases of, child maltreatment*** <u>required</u> to have training on child maltreatment?

- ☐ Yes – how much training is required? _____hours initial training; _____ongoing hours/year
- ☐ No

5. Are there any ***individuals who respond to incidents involving, or investigate cases of, child maltreatment*** who do ***not*** receive any special training on child maltreatment?

   ☐ No

   ☐ Yes – *please explain:*

6. Which of the following types of training is provided or available for these individuals? *(check all that apply and ask hours for each one checked):*

   ☐ Included in basic/initial training that <u>all individuals</u> receive (# hours devoted to child maltreatment: _____)

   ☐ Part of subsequent training for <u>all individuals</u> (# hours devoted to child maltreatment: _____)

   ☐ <u>Required</u> additional specialized training on child maltreatment (# hours _____)

   ☐ <u>Optional</u> additional specialized training on child maltreatment (# hours _____)

   Does any of this training on child maltreatment result in a certification or special designation?

   ☐ Yes *(specify):* _____

   ☐ No

7. Who conducts/provides the training for ***individuals who respond to incidents involving, or investigate cases of, child maltreatment***? *(check all that apply)*

   ☐ Internal agency/organization training department/staff

   ☐ External agency/organization training department/staff (other than licensing agency)

   ☐ Licensing agency

   ☐ External contractor *(specify):* _____

   ☐ Other provider *(specify)*: _____

8. How is the training delivered? *(check all that apply in each column)*

	Basic/initial training	**Subsequent training**	**Required or optional specialized training**
Classroom/face-to-face	☐	☐	☐
Live online trainings/webinars	☐	☐	☐
Recorded online trainings/webinars	☐	☐	☐
Online coursework	☐	☐	☐

9. Where is the face-to-face training provided? *(check all that apply in each column)*	**Basic/initial training**	**Subsequent training**	**Required or optional specialized training**
In-house training center	☐	☐	☐
Off-site training center	☐	☐	☐
Other location	☐	☐	☐

10. For most of those participating in training, how far do they need to travel to the primary training location? *(check one response in each column)*	**Basic/initial training**	**Subsequent training**	**Required or optional specialized training**
No travel involved	☐	☐	☐
Less than 25 miles	☐	☐	☐
25 to 49 miles	☐	☐	☐
50 to 149 miles	☐	☐	☐
150 miles or more	☐	☐	☐

11. How often is the training provided or available?

    a. Basic/initial training: _____

    b. Subsequent training: _____

    c. Required or optional additional specialized training: _____

12. What is the cost per person of the training, if any? If there is a cost, who pays for the training?

	Cost per person	**Payor (***Check)*
Basic/initial training:	$	☐ Employer ☐ Employee ☐ Other _____
Subsequent training:	$	☐ Employer ☐ Employee ☐ Other _____
Required or optional additional specialized training:	$	☐ Employer ☐ Employee ☐ Other _____

13. Is a syllabus, course outline or curriculum available? *(please write in name of curriculum or identify source or author)*

    a. Basic/initial training: _____

    b. Subsequent training: _____

    c. Required or optional additional specialized training: _____

(If yes, request a copy of or provide a link) ☐ Copy requested. URL: _____

14. How often is the training content updated?

    a. Basic/initial training: _____

    b. Subsequent training: _____

    c. Required or optional additional specialized training: _____

15. How is training effectiveness evaluated?
Additional comments:

CJA Three-Year Assessment 2018:

Training/Preparation for Civil and Criminal Investigations of Child Maltreatment – Impact on Investigations

Phase II: Key Informant Interview Guide (Semi-Structured)

Task Force Member Name: _____ Date: _____

Key Informant Agency/Organization:	Key Informant Name:
Key Informant Position:	How long in this role?

Instructions: The questions on this guide are qualitative in nature and meant to generate/guide discussion – feel free to word the question based on the informant's role, ask additional/follow-up questions based on the informant's responses or skip questions that the informant may have answered in response to a previous question. Be sure to probe for the "whys". Save each form as "KIIG_ your initials_the contacts' initials_ date". Email to cindydavis@caresolutions.com.

Introduction

The CJA Task Force is conducting an assessment regarding the preparation/training of individuals who respond to incidents involving, or investigate reports of, child maltreatment, including physical or sexual abuse, neglect, trafficking, or child fatalities. Although we are primarily interested in the formal investigative process, we recognize that these investigations are influenced by or affect all of those involved, including first responders, law enforcement agencies, child welfare agencies, private and public attorneys, and coroners and medical examiners.

We are interviewing several individuals with knowledge of child maltreatment investigations or whose work is affected by these investigations, so I would like to get your thoughts about the investigations with which you have had some involvement.

1. First, are you knowledgeable about and/or involved in civil or criminal child maltreatment cases, or both?
   - ☐ Civil
   - ☐ Criminal
   - ☐ Both

2. what aspects of child maltreatment investigations seem to be working well – leading to positive outcomes for children or having a positive impact on your work? Why?

3. What aspects of these investigations do **not seem to work well** – leading to poor outcomes for children or having a negative impact on your work? Why?

4. Are there **specific types of cases** in which investigations often do not yield desired results – for example, whether the investigation relates to a child fatality, physical or sexual abuse, neglect, or child sexual exploitation/trafficking?

5. **Are there specific types of victims** for whom investigations often do not yield desired results – for example, victims who are very young, are older youth, or have special needs?

6. From your perspective, **how well-prepared** are the various participants – first responders, law enforcement, child welfare case managers, attorneys – in child maltreatment investigations? Why do you say that?

7. Which participants seem to be better prepared? Why?

8. Which participants seem to need additional preparation? Why?

9. How could their preparation be improved?

10. What about administrative law judges' preparation for handling child abuse registry appeals?

11. Is there a multidisciplinary approach to child maltreatment or child fatality investigations? How well do the different participants work together? How does this affect investigations?

12. What role does the child abuse protocol play? Are all local investigative partners following the protocol and participating in multidisciplinary meetings? How does this affect investigations?

13. How could child maltreatment investigations in your area be improved?

14. Do you have any other comments about child maltreatment investigations that you would like to add?

Child Fatality Review Panel Maltreatment Committee

2017 Annual Report

Child Abuse Prevention and Treatment Act

Originally enacted in January 1974, the Child Abuse Prevention and Treatment Act (CAPTA) is a key piece of federal legislation addressing child abuse and neglect. This act has been amended several times and was last reauthorized on May 29, 2015 by the Justice for Victims of Trafficking Act of 2015 (P.L. 114-22) and on July 22, 2016, by the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198). Although the primary responsibility for addressing the child welfare needs of children and families lies with each state agency, CAPTA provides federal funding to support child abuse prevention, assessment, investigation, prosecution, and treatment activities[1] for the purpose of improving the state's child protection systems. With each reauthorization, including the most recent in 2016, CAPTA has evolved in response to the child welfare climate, shifting its focus to safety as well as a desire to increase accountability in the child protective services (CPS) system.

CAPTA Citizen Review Panels

The CAPTA reauthorization of 1996 established citizen review panels (CAPTA Panels)[2] as a requirement for all states receiving a CAPTA state grant. The purpose of CAPTA Panels is to increase system transparency and accountability and provide opportunities for community input by:

- Examining the policies, procedures, and practices of state and local agencies, and, where appropriate, specific cases
- Evaluating the extent to which state and local child protection agencies are effectively discharging their child protection responsibilities in accordance with:
    a) The state's CAPTA plan
    b) Child protection standards required by CAPTA
- Any other criteria that the CAPTA Panels consider important to ensure the protection of children, including:
    a) Reviewing the extent to which the state and local child protective services system is coordinated with the foster care and adoption programs established under Title IV Part E of the Social Security Act
    b) Reviewing child fatalities and near fatalities

States were required to establish and maintain a minimum of three CAPTA Panels to provide opportunities for community members to play an integral role in ensuring that states meet their goals of protecting children from

[1] This includes child fatality, near fatality and serious injury cases.

[2] In Georgia, CAPTA citizen review panels are referred to as "CAPTA Panels" to distinguish this stakeholder group from similarly named "Citizen Panel Review", which are foster care review boards.

child abuse and neglect. In 2007, the Child Fatality Review Panel (CFRP) was designated to serve as the third of Georgia's three CAPTA Panels[3] and in 2011, CFRP bylaws were amended to include its role as a CAPTA citizen review panel in the description of its purpose as a statutory body. CFRP established the CAPTA Maltreatment (MalTx) Committee in 2009 in recognition of its obligations as a CAPTA Panel. In 2014, the administrative responsibility for child fatality review transferred from the Office of the Child Advocate (OCA) to the Georgia Bureau of Investigation (GBI). The CFRP is supported by staff that review and monitor the work of the 159 county Child Fatality Review Committees (CFRC), analyze results and develop recommendations based on their findings and the issues raised by the local committees and CFRP members.

Members

The membership of the CFRP, as set forth in state law O.C.G.A. § 19-15-4, is comprised of the heads of all state agencies that play a significant role in the health and welfare of Georgia's children, as well as representatives of agencies/offices involved in the investigation and prosecution of criminal offenders. In addition to members prescribed by the statute, the Governor appoints other members, with the exception of one appointment by the Lt. Governor and one by the Speaker of the House of Representatives. CFRP membership also includes experts in the fields of child abuse prevention, mental health, family law, death investigation, and injury prevention.

Section 106 of the CAPTA legislation stipulates that CAPTA Panels be composed of volunteer members who broadly represent the communities in which they operate and include individuals with expertise in the prevention and treatment of child abuse and neglect. The CFRP membership satisfies the CAPTA membership requirements. The MalTx Committee includes members of the CFRP as well as child welfare experts and advocates to provide additional expertise and experience relevant to MalTx Committee interests, priorities and its mandate as a CAPTA Panel.

Meetings

The CFRP meets quarterly satisfying the CAPTA requirement. In FFY2017, meeting dates were:

- November 18, 2016
- February 2, 2017
- April 28, 2017
- August 11, 2017

The MalTx Committee met 10/12/2016, 11/18/2016, 12/14/2016, 01/05/2017, 03/03/2017, 03/31/2017, 08/02/2017.

[3] The other two designated CAPTA Panels are the Children's Justice Act Task Force and the Child Protective Services Advisory Committee.

Annual All CAPTA Panel Retreat

In addition to regular meetings, CFRP and MalTx Committee members were invited to participate in the annual retreat for all CAPTA Panels on September 26, 2017. The day-long retreat was hosted at Cobb Superior Court by CFRP Chair, Judge Tain Kell.

In addition to presentations from each of the CAPTA Panels on one of their 2017 projects, the retreat agenda included presentations on:

- Opioids: The Surge in Drug-Affected Newborns by Dr. Karen Kuehn Howell, Emory University School of Medicine, Center for Maternal Substance Abuse
- Opioids: The Changing Face of Investigations by Nelly Miles, Director, Office of Public Affairs Georgia Bureau of Investigation

CFRP as Valued Partner

The relationship between CAPTA Panels, including the CFRP, and Georgia's Division of Family and Children Services (the Division) can be characterized as a collaborative and mutually respectful working relationship. The Division solicits input from CFRP members, as needed, as a resource, as advocates, or as representatives of a constituent group.

Expertise and opinions are valued and opportunities for stakeholder involvement often happen organically, without the need for a federal mandate. This positive relationship contributes to the stability and effectiveness of Georgia's CAPTA Panels. In addition to several opportunities to work, formally and informally, with Georgia's child welfare agency, CFRP members are represented on a variety of local, state and/or national boards or organizations with child protection interests compatible with the CAPTA mandate.

The CFRP has initiated and/or participates in a number of collaborative efforts to address current and ongoing prevention strategies. This includes several partnerships to reduce sleep-related deaths, sudden unexpected deaths in youth, and to address the increasing number of suicide deaths.

In 2016 and 2017, CFRP and the Division, released their respective reports on child fatalities CFRP jointly. CFRP leadership continues to support the development of a consolidated annual report on child fatalities incorporating the richness of the findings and recommendations from all review mechanisms and expert sources. To accomplish this, several challenges will need to be addressed, however, progress towards increasing collaboration, coordination and data sharing efforts move closer to that goal.

Reviewing Child Fatalities

In Georgia, there are several mechanisms, in multiple systems, for investigating and/or reviewing child fatalities with varying interests, objectives, roles and responsibilities. It is important to recognize the different child fatality review mechanisms, each with unique timing, purpose, objectives and reporting obligations. This includes state CFRP, local CFRC, the Division and the MalTx Committee.

1. State Child Fatality Review Panel

The CFRP is a statutory body established in 1990 by the Georgia State Legislature[4]. It was created to establish a multi-agency review protocol to identify patterns and trends in child deaths and to identify strategies for prevention. State CFRP, as mandated by O.C.G.A. 19-15-4, reviews and analyzes annual aggregate data collected on all reviewable deaths. Its purpose is to recommend measures to decrease the incidence of child deaths by:

- Identifying factors which place a child at risk for death
- Identifying trends relevant to unexpected or unexplained child death
- Investigating relationship between child deaths and violence reported
- Developing protocol for child fatality investigations and revise as needed[5]
- Providing training and written materials to local CFRC to assist them in carrying out their duties, including model protocols for review committees
- Reviewing each report from local CFRC
- Monitoring operations of local CFRC to determine training needs and service gaps
- Collecting and sharing information among state agencies which provide services to children and families or investigate child deaths
- Making suggestions and recommendations to appropriate participating agencies regarding improving coordination of services and investigations
- Proposing and recommending changes to any statute, regulation or policy needed to decrease the risk of child death, and include such proposed change in its annual report

The CFRP is required statutorily to prepare and submit an annual report on all reviewable child fatalities, including maltreatment-related fatalities to the Governor and state Legislature on January 1. In addition to

[4] Child fatality review was initially included in the responsibilities of local child abuse protocol (CAP) committees. The importance of the review of all child fatalities led to amendment of O.C.G.A. establishing state CFRP and local CFRC emphasizing the need for this function for all reviewable deaths, not only those that were the subject of the CAP.

[5] The child fatality **review** protocol should not be confused with the model Child Abuse Protocol (O.C.G.A. 19-15-2) that is utilized when investigating cases involving child abuse and neglect. The function and responsibility for the Child Abuse Protocol (CAP) developed as the multidisciplinary process for investigating cases of child abuse and neglect, including child fatalities, remained with OCA when responsibility for CFRP transferred to GBI in 2014. It is assumed that it was intended that the function and responsibility for the child fatality **review** protocol remain with the CFRP. This may be an inconsistency or contradiction that needs to be addressed legislatively.

presenting data on all the cause, manner and circumstances of child fatalities, the report includes recommendations for improvement and identifies strategies for prevention to reduce child fatalities.

In summary, CFRP is charged with providing high-quality data, training, technical assistance, investigative support services, and resources to prevent and reduce child abuse and fatalities and make statute, regulation, or policy recommendations to reduce the risk of child death. This includes providing training, support and oversight to local CFRC.

2. Local Child Fatality Review Committees (CFRC)

Local CFRC[6] have been established in each of Georgia's 159 counties. Mandated by O.C.G.A.§ 19-15-3, CFRC conduct multiagency reviews of all reviewable child deaths[7] within 30-45 days. Reports on individual deaths are required to be completed within 90 days that include:

- Circumstances leading up to the death and cause of death
- Prior agency involvement[8], services delivered, reason for agency involvement and reason services, if any, were terminated
- Any court interventions
- Any reports or acts of violence, past or present
- Whether or not services or agency involvement were appropriate and whether child's death could have been prevented
- Recommendations for possible prevention of future deaths of similar incidents
- Any other findings as requested by CFRP

CFRC are also mandated to publish an annual report locally on review activity the preceding year by the first of July.

Information gathered during the local CFRC review is documented in the National Child Death Review Case Reporting System (NCDR-CRS). Individual reports submitted by local CFRC are monitored and carefully reviewed by GBI/OCFR staff. Annual aggregate data on all reviewed fatalities is then analyzed with the help of state epidemiologists, child fatality and prevention experts who assist in the development and preparation of the annual CFRP report. The 2017 annual CFRP report on child fatalities reviewed by local CFRC during CY2016 is attached as Appendix A.

[6] Local CFRC were originally established as a subcommittee of the local Child Abuse Protocol Committee.

[7] Reviewable deaths are all deaths of children under age 18 that were sudden, unexpected and/or unexplained.

[8] This includes involvement with any state agency with child safety, care and well-being responsibilities at any time in the child's life.

Fatalities Reviewed by Local CFRC

During calendar year 2016, 1,529 death certificates were filed with Georgia Vital Records. According to the death certificates, 522 of the 1,529 deaths met the criteria requiring review. Of these, 438 (84%) were reviewed[9]. An additional 9 with no death certificate were also reviewed bringing the total deaths reviewed to 531.

Table 1. CY2016 Deaths by Cause[10]

	Total Child Deaths	Reviewable Deaths	
		Infants	Children ages 1-17
Medical	**1007**	15	60
Sleep-Related	**165**		
• SUID Undetermined		78	
• SUID Asphyxia		58	
• SUID Medical		12	
• SIDS		4	
Motor Vehicle	**112**	5	87
Homicide	**75**	8	60
Suicide	**57**		51
Drowning	**41**		32
Other Injury	**38**	13	5
• Poison			8
• Asphyxia			6
• Firearm			5
Fire	**16**		13
Unknown/Undetermined	**13**	7	4
Unknown Intent	**5**		
Total	**1,529**	200	331

CY2016 CFRP Key Findings for Reviewed Deaths

- Maltreatment-Related Deaths: Of the 531 reviewed deaths, 144 cases identified a history of maltreatment. Poor or absent caregiver supervision was identified in 49 deaths. Abuse or neglect was a direct cause or contributing factor in 29 deaths. It is these 29 deaths that the MalTx Committee hopes to develop a protocol for closer examination in 2018.

[9] The MalTx Committee has made recommendations that it hopes will also improve reporting compliance.

[10] Source: 2016 Death Certificates Georgia Vital Records

- Sleep-Related Infant Deaths: CFRC reviewed 152 sleep-related deaths. Although the number of sleep-related deaths has not changed significantly 1999-2015, the average over the 17-year period is 158 per year, sleep-related deaths remains the leading cause of preventable post-neonatal deaths.[11]
- Injuries: 293 deaths resulted from injuries either intentional (inflicted) or unintentional (accidental). Intentional injuries (119) include 68 homicides and 51 suicides. Motor vehicle related, drowning and fire are the three leading causes in the 174 unintentional injury deaths.
- Preventability: Local CFRC determined that 79% of the reviewed deaths were definitely or probably preventable.
- Suicides: The rising number of suicide deaths among children is a concern for both the CFRP[12] and MalTx Committee. Data revealed that of the 51 suicide deaths reported, 10 had a history of maltreatment, and one had an open CPS case at the time of death. The MalTx Committee is considering examining suicide deaths more rigorously in 2018 to identify policy and or practice implications.

3. Child Fatality Review by the Division

The Division responds to all reports of child fatalities to determine which cases warrant further additional review or staffing. These reviews primarily involve Division management and county DFCS staff but often external partners with special expertise are also involved. The objectives of these reviews are:

- To identify immediate actions needed such as determining the safety of any other children in the home
- To identify and address any gap in policy, practice or procedures that may have failed to adequately protect the child
- To identify additional intervention or prevention strategies to strengthen the safety response for children at risk
- To identify trends that may suggest the need to change or enhance policy, practice and procedures to prevent child fatalities

Those cases warranting additional review would include child fatalities that meet one or more of the following criteria:

- The family has current Child Protective Services (CPS) or foster care involvement
- The family has had CPS history of involvement with the child welfare agency during last five years[13]
- The circumstances of the death suggest a high probability that maltreatment was a factor
- Immediate safety issues are identified for any surviving siblings

[11] In 2017, the Governor Deal and the First Lady appeared in a PSA to increase awareness of sleep-related deaths: https://www.youtube.com/watch?time_continue=4&v=ks9ew3lYRe4

[12] In 2018, a series of PSAs were developed in response to the increase in youth suicides to increase awareness of this growing trend and serve as a prevention strategy: https://www.youtube.com/watch?time_continue=9&v=uclbuCsw-7k .

[13] The Division's 'history' criteria is based on the family's CPS involvement during the five years preceding the death. Local CFRC criteria includes family's involvement with all state agencies as 'history'.

In CY2016, of 369 deaths[14] reported to the Division, 149 cases met this criteria and were reviewed. The findings from these reviews are shared quarterly with Division leadership.

In 2018, the MalTx Committee will explore how the findings from these reviews might also be utilized by the MalTx Committee to support its efforts to meet its CAPTA mandate in examining the effectiveness of the state's child protection efforts, including policy and practice, in preventing child deaths and make recommendations for improvement.

4. Maltreatment Committee

The CFRP, committed to fulfilling its mandate as a CAPTA Panel established the CAPTA MalTx Committee in 2009 to help address additional obligations of the CFRP as a CAPTA citizen review panel, including its obligations related to the examination of maltreatment-related deaths. MalTx Committee objectives include:

- To improve the identification of maltreatment-related child fatalities
- To improve the collection of data and reporting on maltreatment-related fatalities
- To identify opportunities for prevention through examination of the cause and circumstances of maltreatment-related fatalities, and the history of involvement of families with state agencies that have safety, care and well-being responsibilities

Although maltreatment-related deaths are a small subset of all reviewable deaths, the identification and prevention of maltreatment-related deaths is an ongoing CFRP priority.

The annual CFRP report and a summary of MalTx Committee activities are submitted to the child welfare agency to satisfy the CAPTA requirement for an annual report.

[14] The Division also prepares an annual report of the data collected on all child fatalities whose immediate family had a CPS history within the five years preceding the child's death. Of the 369 child fatalities reported to the Division in 2016, 180 had a CPS history. The Division contracts with Georgia State University to complete this annual report.

2017 Maltreatment Committee Activities and Recommendations

State child protection agencies are required to report their child maltreatment data to the National Child Abuse and Neglect Data System (NCANDS) annually. In 2016, the Division reported 97 child maltreatment-related fatalities. For the same period, the number of fatalities reviewed by local CFRC where child abuse or neglect was identified as the direct cause or contributing factor was only 29. This inconsistency in the numbers of maltreatment-related fatalities reported and/or reviewed is due to a number of variables that include, but is not limited to, different criteria for identifying reviewable deaths, inconsistent terminology and/or definitions, and review periods. These variables need to be acknowledged and considered in any comparative review of data.

Improving the Identification of Maltreatment-Related Fatalities

The concern shared by MalTx Committee members is that not all maltreatment-related deaths are being identified as such during local reviews. This concern arose from the review of data and case specific information captured in the NCDR-CRS, when it was observed that responses to questions that may have indicated maltreatment was a factor in a child's death had no response or an 'unknown' response. This was particularly troubling when responses to other questions on the form suggested an elevated risk for maltreatment. This lack of consistency and completeness of information documented during local reviews did not appear to be limited to maltreatment-related cases and was observed for other case types as well.

To identify potential opportunities to improve identification of these cases, the MalTx Committee looked at the training provided to CFRC members on conducting child fatality reviews. Several MalTx Committee members attended child fatality review trainings and observed that although the training was good for conducting investigations, it did not have sufficient focus on the actual process of conducting a review.

1. The *MalTx Committee recommends* that training for local CFRC be more specific to the purpose and process of conducting a thorough review based on a formal child death review protocol. Training for investigators should be done separately as its purpose and objectives are distinctly different from that of a review.

Additionally, it is critical, with respect to identifying maltreatment-related fatalities, that CFRC members are well schooled in the circumstances of a child death that might suggest that maltreatment was a contributing factor and therefore additional scrutiny warranted.

2. The *MalTx Committee recommends* that information on child abuse in the training should include, at a minimum:
    - Relevant child welfare law, policy and procedures
    - Model Child Abuse Protocol (CAP) standards
    - Red flags, best practices

- Communication protocol, including standards/guidelines for notification and sharing information

3. The *MalTx Committee recommends* that initial training for new CFRC include identification of prevention opportunities, including interventions that may have made a difference, and developing recommendations for effective prevention strategies. Training should include a description of the difference between preventability and culpability in a child's death as a preventable death doesn't necessarily mean that there was criminal intent.

4. The *MalTx Committee recommends* that initial training for all new CFRC members include mandated reporting and CFRC member's role as a mandated reporter.
   It is further recommended that the Division collaborate with GBI/OCFR to develop initial training for new CFRC members that will provide appropriate and sufficient training on child maltreatment, and more specifically, maltreatment-related fatalities.

5. In addition to these initial training recommendations, the *MalTx Committee also recommends* that CFRC members be required to complete some annual training to provide an opportunity to learn about current trends, new laws and policies, to network with their peers and to address any concerns and deficiencies.

Additional Observations

- It is difficult to fully grasp the multidisciplinary process in a single day to be adequately prepared to participate effectively in a child death review. Additional time is needed to process and reinforce training. Time should be included during the training to conduct 'practice reviews' in smaller groups that would mimic an actual review. This may require extending the initial training to a day-and-a-half and/or developing a multi-modal training that includes some component of self-directed learning.

- Case scenarios would be helpful to reinforce training content and help to demonstrate not only how to conduct a review but also how to identify circumstances that require further investigation. This would also provide an opportunity for new CFRC to practice how to conduct a review, go through the form, write a narrative and determine preventability. Case scenarios should include the most common and straight-forward types of cases as well as those that are more challenging and more difficult to review.

GBI's Office of Child Fatality Review (GBI/OFCR) assumed the responsibility for providing training and technical assistance to all CFRC when administrative responsibility for CFRP was transferred from OCA in 2014. Technical assistance and training responsibilities are shared primarily by two GBI/OCFR staff, each covering half of the state and a staff member responsible for prevention activities. Technical assistance is provided to individual CFRC based on identified need. Training is offered 6-8 times a year at various sites around the state. With 159 local CFRC, some

of whom review many deaths each year and others than may not review any, and the frequent turnover of members, the MalTx Committee recognizes that it is a challenge to not only train new committee members in a timely manner on the basics of a child death review but also to provide technical assistance and ongoing training to veteran members while monitoring reviews and reporting compliance.

6. The MalTx Committee recommends that an evaluation be conducted of the current child death review protocol, training for CFRC and the review reporting processes by soliciting feedback from local CFRC to help identify opportunities to improve review and reporting quality and compliance. It is hoped that such an evaluation will provide insights on how to optimize limited resources of both GBI/OFCR and new CFRC members as well as identify additional resource needs.

7. The MalTx Committee also recommends that terminology in National Child Death Review Case Reporting System (NCDR-CRS) relevant to maltreatment be reviewed to identify inconsistencies with Georgia child welfare definitions, policy and standards of practice. Discrepancies should be resolved, as needed, and acceptable variations clarified in CFRC training to improve consistency.

The MalTx Committee feels that this additional investment at the front end of the child death review process would improve not only quality and consistency of the review themselves but also result in increased reporting compliance and increased identification of effective and actionable prevention strategies, as well as decrease the likelihood that maltreatment-related fatalities would be overlooked.

2018 Maltreatment Committee Priorities

Examination of Maltreatment-Related Deaths

These deaths represent for the MalTx Committee an opportunity to examine more closely the effectiveness of Georgia's child protection policies, practice and procedures. It is hoped that in 2018 the MalTx committee will develop a viable protocol for in-depth review including criteria for case selection, specific review objectives, and an efficient and effective methodology.

Examination of Sleep-Related Infant Deaths

The MalTx Committee has an interest in the deaths of our most vulnerable children, specifically, sleep-related deaths in infants under six months and the relationship, if any, to prenatal exposure due to alcohol and/or drugs. CAPTA requires that states' have a Plan of Safe Care for all newborns identified at birth as having been prenatally exposed. The MalTx Committee recognizes that the Division is reviewing and revising its collaborative plan to ensure the safety of these high-risk infants. The MalTx Committee's interest is the intersection between these

sleep-related deaths and maltreatment when safety measures have not been put in place or when policy and procedures for those cases with DFCS involvement have been inconsistent.

Examination of Suicides

The increase in suicide deaths among children has also prompted the MalTx Committee to consider looking at how maltreatment may have contributed to these deaths. In 2018, the committee will explore options for doing so. The MalTx Committee will also explore opportunities to participate in the review of sleep-related deaths when it has been determined that the infant was prenatally exposed. These will take both commitment and transparency from the Division to develop a protocol to support this endeavor.

In closing…

The CFRP, and CAPTA Maltreatment Committee, respectfully submit their report to the Division on its 2017 activities. Additionally, priorities and plans for 2018 have been identified to highlight opportunities to coordinate efforts on shared goals and objectives in the coming year.

The CFRP commends the Division for its efforts to reduce child fatalities. CFRP and the MalTx Committee look forward to coordinating efforts on our shared goals and priorities in 2018.

Respectfully submitted on behalf of

CFR Maltreatment Committee

CAPTA Maltreatment Committee

C. LaTain Kell, Chair*
Judge, Cobb Superior Court

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

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'The purpose of life is to contribute in some way to making things better.' …Robert F. Kennedy

Georgia Child Fatality Review Panel

Annual Report - Calendar Year 2016

C. LaTain Kell
Panel Chairman

Nathan Deal
Governor

The Child Fatality Review Panel Members

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

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

Vernon Keenan – Director, Georgia Bureau of Investigation

Mandi Ballinger – Member, Georgia House of Representatives

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

Judy Fitzgerald – Commissioner, Department of Behavioral Health and Developmental Disabilities

Gloria Butler – Member, Georgia State Senate

Dr. Patrick O'Neal – Interim Commissioner, Department of Public Health

Robertiena Fletcher – Board Chair, Department of Human Services

Jay Neal – Chair, Criminal Justice Coordinating Council

Virginia Pryor – Director, Division of Family and Children Services

Tiffany Sawyer – Prevention Director, Georgia Center for Child Advocacy

Richard Hawk – Coroner, Coweta County

Paula Sparks – Investigator, Georgia Peace Officer Standards and Training Council

Dr. Jonathan Eisenstat – Chief Medical Examiner, Georgia Bureau of Investigation

Tom Rawlings – Director, Office of the Child Advocate

Ashley Wright – District Attorney, Augusta Judicial Circuit

Amy Jacobs – Commissioner, Department of Early Care and Learning

Vacant – Member, State Board of Education

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Mission

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

The Georgia Child Fatality Review Panel, each county-level review committee, their functions and membership requirements, are established in Georgia statute (§19-15-1 through -6).

Acknowledgments

The Georgia Child Fatality Review Panel acknowledges the following people and entities whose enormous commitment, dedication, and unwavering support to child fatality review have made this report possible:

- All the members who serve on each of the county level child fatality review committees;
- John T. Carter, Ph.D., M.P.H., Epidemiology Department, Rollins School of Public Health, Emory University

This report was developed by the staff members of the Child Fatality Review Unit within the Georgia Bureau of Investigation. A special thanks to CFR Panel participants, Angela Boy, Tiffany Sawyer, Terri Miller, Lisa Dawson and Deb Ferrell for their assistance.

Letter from the CFR Panel Chair

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

We are honored to present the Annual Report of the Georgia Child Fatality Review Panel for data collected in calendar year 2016. This data has been reported to the Panel by the 159 county fatality review panels of the state pursuant to statutory requirements. As always, this information is provided to you as part of our mutual ongoing efforts to prevent and decrease child fatalities in Georgia. I thank you for the continuing partnership in this important effort.

The bank of data collected by the Panel during the past six years could have significant impact on predicting patterns for future child fatality prevention. A large-scale analysis of this data, together with data collected by other agencies, is needed. The Panel requests your assistance in securing the necessary resources to perform this analysis as soon as possible.

This year's spike in teenage suicides has caused the panel to focus attention and resources in the final quarter of 2017 and the coming year on significant prevention efforts. Members of the Panel from the Department of Education, the Department of Behavioral Health and Developmental Disabilities and the Department of Public Health along with Children's Healthcare of Atlanta and Voices for Georgia's Children are partnering in this effort.

Sleep-related infant deaths remain the leading cause of post-neonatal deaths in the 2016 data. We hope that increased education and public awareness efforts are beginning to have some effect. Efforts in the state's hospitals and neonatal units have continued to bring this topic to the attention of new mothers and families across the state. The panel will continue to work with both state and private partners to bring attention to this issue.

Maltreatment-related deaths continue to be a priority as well. Again this year, the panel staff has conducted statewide training to assist law enforcement, service providers and first responders in identifying the signs of maltreatment and the proper reporting of such maltreatment. The panel continues to emphasize the importance of maltreatment identification as a vital component of prevention.

The Georgia Bureau of Investigation and Director Keenan and his agents and staff continue to enhance their support of this Panel's mission. Their contributions are exceptional.

I greatly appreciate your attention to this report and its findings. Together, we hope to accomplish our mission to reduce and prevent child deaths in Georgia.

Sincerely,

Judge Tain Kell
Chairman, Child Fatality Review Panel

Background and History

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

The Child Fatality Review committees became a statewide, multidisciplinary, multi-agency effort to prevent child deaths. Official Code of Georgia Annotated 19-15-1 thru -6 has been amended over the years, adding even more structure, definition, and members to the process. Members now form a stand-alone committee instead of a subcommittee, which has added emphasis to the importance of the function. Through the State Panel and the work of the local committees, we have the opportunity to learn from tragedy, prevent deaths, and give a new generation hope.

Agencies and organizations working together at the state and local levels offer the greatest potential for effective prevention and intervention strategies.

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

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

The History of Child Fatality Review in Georgia

1990 - 1993

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

1996 - 1998

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

1999 - 2001

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

2002 – 2005

- The Panel published and distributed a child fatality review protocol manual to all county committee members
- Statutory amendments were adopted which resulted in the following:
  - Appointment of District Attorneys to serve as chairpersons of local committees in their circuits
  - Authority of the Superior Court Judge on the Panel to issue an order requiring the participation of mandated agencies on local child fatality review committees. Failure to comply would be cause for contempt
  - Authority of the Panel to compel the production of documents or the attendance of witnesses pursuant to a subpoena
  - Director of the Department of Behavioral Health and Developmental Disabilities added as a member of the Panel
- Funding was secured and an on-line reporting system was established for both the child fatality review report and the coroner/medical examiner report
- A collaboration was established between the OCFR and the National Center for Child Death Review (NCDR)
- The Georgia Child Fatality Investigation Program was established through a partnership between OCFR, DFCS and the Georgia Bureau of Investigation. A director was hired to advance a multi-disciplinary approach to child death investigation through development and training of local teams
- Conducted the first statewide Prevention Readiness Assessment, to evaluate resources and stakeholders available in counties to implement and sustain prevention efforts
- A Statewide Model Child Abuse Protocol was developed and distributed to all Protocol committee members

- A Prevention Advocate was added, by policy, to all child fatality review committees Statewide training was conducted for all prevention advocate members
- A quarterly newsletter was created and distributed to all child fatality review members
- Annual awards were established for the Child Fatality Review Coroner of the Year and Child Fatality Review County Committee of the Year. Awards were presented at the annual Child Fatality and Serious Injury Conference sponsored by the Panel, DHS, GBI and the Office of the Child Advocate
- A sub-committee of the Panel was formed to begin working on a Statewide Prevention Plan

2006-2008

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

2009-2013

- Adopted National Center for Child Death Review online reporting form for all child deaths, allowing Georgia child death data to be captured on a nationally standardized surveillance tool
- Included as one of five states to participate in three-year CDC pilot project to improve investigation, review and reporting of sudden and unexpected infant deaths
- Expanded CFIT program to include a child abuse investigation training academy
- Continued involvement with the Southeast Coalition on Child Fatalities, providing support to other CFR programs within the southeastern states

- Conducted second Prevention Readiness Assessment of counties, to determine the local resources and stakeholders available to implement and sustain prevention efforts
- Created and maintained a CFR Panel subcommittee to address infant sleep-related deaths; the Georgia Infant Safe Sleep Coalition (GISSC) serves as a strong resource for state and local partners, providing evidence-based best practice for prevention and implementation assistance

2014

- Senate Bill 365 was signed by the Governor, moving oversight of the CFR Panel from the Office of the Child Advocate to the GBI. The bill also added language including "child abuse" as one of the criteria for determining a reviewable death, and placed two additional members on the Panel: a member of the state Board of Education, and the commissioner of the Department of Early Care and Learning

2015

- The Georgia Bureau of Investigation CFR Unit in partnership with the Division of Family and Children Services, and Department of Public Health, embarked on an aggressive campaign to prevent sleep – related deaths of infants in Georgia. This was the first law enforcement driven video designed to educate individuals and raise awareness to these tragic preventable deaths
- GBI CFR was awarded a $200,000 grant from the Centers for Disease Control and Prevention (CDC) to help establish the Sudden Death in the Young (SDY) Registry. Nine other states received funding as well. The goals of the SDY registry are to a) establish the incidence of sudden death in the young in the United States using a population-based approach through state public health offices, and b) investigate the etiologies and risk factors for sudden death in the young, including sudden unexpected infant death (SUID), sudden cardiac death (SCD) and sudden unexpected death in epilepsy (SUDEP).

2016

- CFR began a campaign to prevent firearm-related deaths by participating in community events/forums around the state and distributed free cable locks for gun owners to promote safe storage of firearms.

Important Findings and Recommendations

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

1. Due to the ongoing problem of sleep-related deaths occurring in Georgia, new programs need to be developed to target high risk groups as identified through CFR data. It is highly recommended this be done as a joint effort with the Department of Public Health and Division of Family and Children Services.

2. School based health centers continue to be recommended to target students identified as "high risk" in an effort to reduce suicide related deaths. The partnership with CFRP and the Department of Education to continue awareness and education should be funded state-wide.

3. In partnership with the Governor's Office of Highway Safety, expand motor vehicle safety educational efforts in schools and individual communities with an emphasis on the counties with the highest motor vehicle fatalities among teen drivers.

Executive Summary

Child deaths are often viewed as an indicator of the health of the community in which they occur. While child death data provide an overall picture of child deaths by number and cause, it is the meticulous review of each child's death that we can learn how to best prevent future deaths. Each year the Georgia Child Fatality Review Panel (Panel) publishes an annual report detailing these tragic and often preventable deaths of children in Georgia.

Local child fatality review committees examine child deaths that are sudden, unexpected, or unexplained ("eligible"), and complete a standardized form detailing the circumstances of the deaths. These child death data are useful in revealing patterns, prevention gaps and opportunities. We encourage all who are concerned about the welfare of Georgia's children, to use these data to make life-saving decisions for our children. In 2016, child fatality review committees reviewed 531 total child deaths.

Key Findings

MALTREATMENT

In 2016, child fatality review committees determined that maltreatment was the direct cause or contributing factor in 29 deaths (maltreatment includes abuse and neglect). An additional 142 deaths had a history of maltreatment but maltreatment was not identified as a direct cause or contributing factor.

SLEEP-RELATED INFANT

Child fatality review committees reviewed 152 sleep-related infant deaths in 2016. The number of reported sleep-related deaths (based on Vital Records death certificate data) has not demonstrated a significant change over the last 17 years (1999 – 2015). There was a peak of 196 in 2007, but the average over the 17 years is 158 deaths per year. Sleep-related infant deaths remain the leading cause of preventable post-neonatal deaths.

INJURIES

In 2016, child fatality review committees reviewed 293 deaths that resulted from injuries either intentional (inflicted) and unintentional (accidental). ** Note that sleep-related infant asphyxia deaths have been excluded from the injury category; these deaths are included in the sleep-related infant category.

Unintentional Injuries: Child fatality review committees reviewed 174 deaths attributed to unintentional injuries among children ages 0-17. Child fatality review data indicated the three leading causes of death related to unintentional injury for this age group as: motor vehicle-related, drowning, and fire.

Intentional Injuries: Child fatality review committees reviewed 119 deaths to children ages 0-17 from intentional causes – 68 homicides and 51 suicides.

PREVENTABILITY

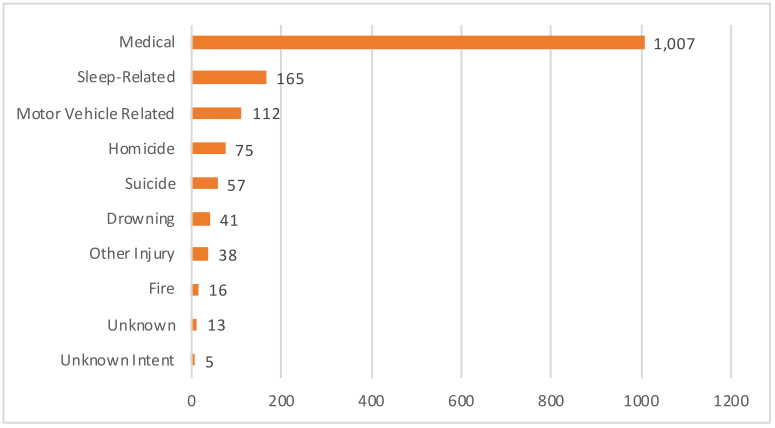
A primary function of the child fatality review process is to identify those deaths deemed to be preventable. Local CFR teams carefully reviewed each death in an effort to determine preventability. Preventability is best determined by evaluating If an individual or the community could reasonably have done something that would have changed the circumstances leading to a child's death. Child fatality review committees determined that 430 (81%) of the 531 reviewed child deaths with preventability data were definitely or possibly preventable (101 of the reviewed deaths did not have a preventability determination).

All Reviewed

In Georgia, every county is legislatively required to convene a Child Fatality Review committee. This committee is comprised of professionals from multiple disciplines that analyze the critical aspects of child deaths to aid in reducing preventable injuries and child deaths in Georgia. Death notifications are obtained from a variety of sources to include the coroner, medical examiner, Vital Records (VR) death certificates, law enforcement, and the Division of Family and Children Services (DFCS). Death data are linked with Vital Records data to ensure a comprehensive and accurate representation of all child deaths in the state of Georgia.

The information used in the preparation of this annual child fatality review report is primarily drawn from two "dynamic" data systems – death certificates submitted to the GA Vital Records Office and fatality reviews submitted to the National Child Death Review database. We have referred to these two systems as "dynamic" because new records are continuously entered into the systems (and previously entered records corrected or completed). Any cut-off or closure date for a given period of time (e.g. CY 2016) is arbitrary. The number of reported deaths (or reviews) on December 1 is likely to be greater than the count was on October 1. The process of comparing death data from the two data sources and adjusting both due to results of the comparison yields death counts slightly different from the GA results on the OASIS database.

Figure 1: Deaths to Children Under Age 18 in Georgia, All Causes based on Death Certificate, 2016 (n=1529)

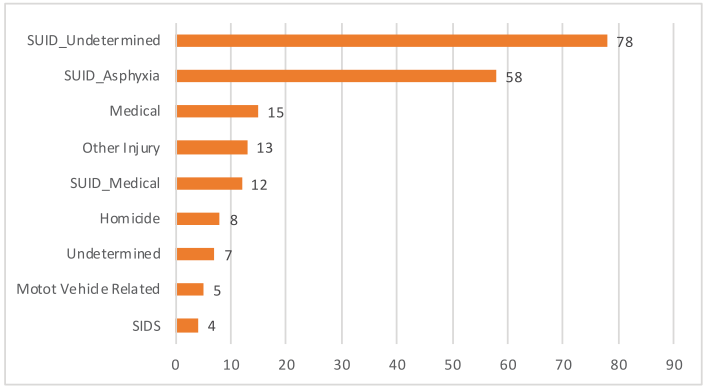


- The "Sleep-Related" category includes Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death (SUID), and asphyxia (see the sleep-related infant section for more detailed information)
- The "unknown Intent" category includes deaths for which a definitive manner could not be determined

A child's death is eligible for review when the death is sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances. The data included in this report are based on information attained from these reviews. The child death review reporting form provides details regarding the decedent's involvement with local agencies, maltreatment, neglect, prior history of medical conditions and a multitude of detailed data collection criteria to help uncover the reason why children die. It is the hope that this report will assist the reader with interpretation of necessary prevention efforts and integration of services in order to solve the manifested problem year after year.

In 2016, 522 of the total 1,529 deaths met the eligibility criteria requiring review according to death certificate data. 438 of those were reviewed (84%). An additional 84 deaths with a medical cause identified on the death certificate were reviewed, and nine deaths were reviewed that did not have a death certificate identified. This report includes information from a total of 531 reviewed deaths.

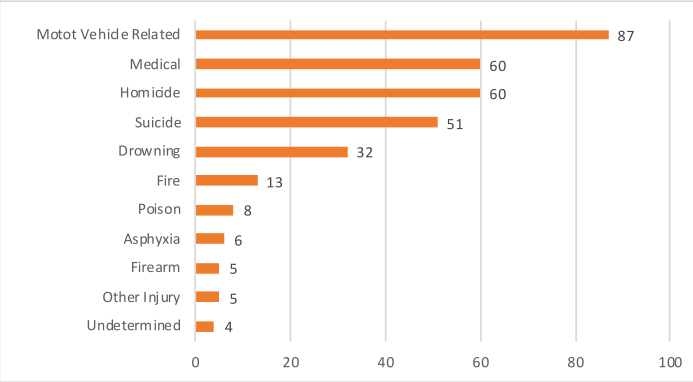
Figure 2: Number of Reviewed Infant Deaths by Cause, GA, 2016 (N=200)



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

- The SUID-Medical category refers to an infant death with a medical cause and manner but the infant was placed in an unsafe sleep environment that likely exacerbated the medical condition(s)

Figure 3: Number of Reviewed Child (ages 1-17) Deaths, By cause, GA, 2016 (N=331)

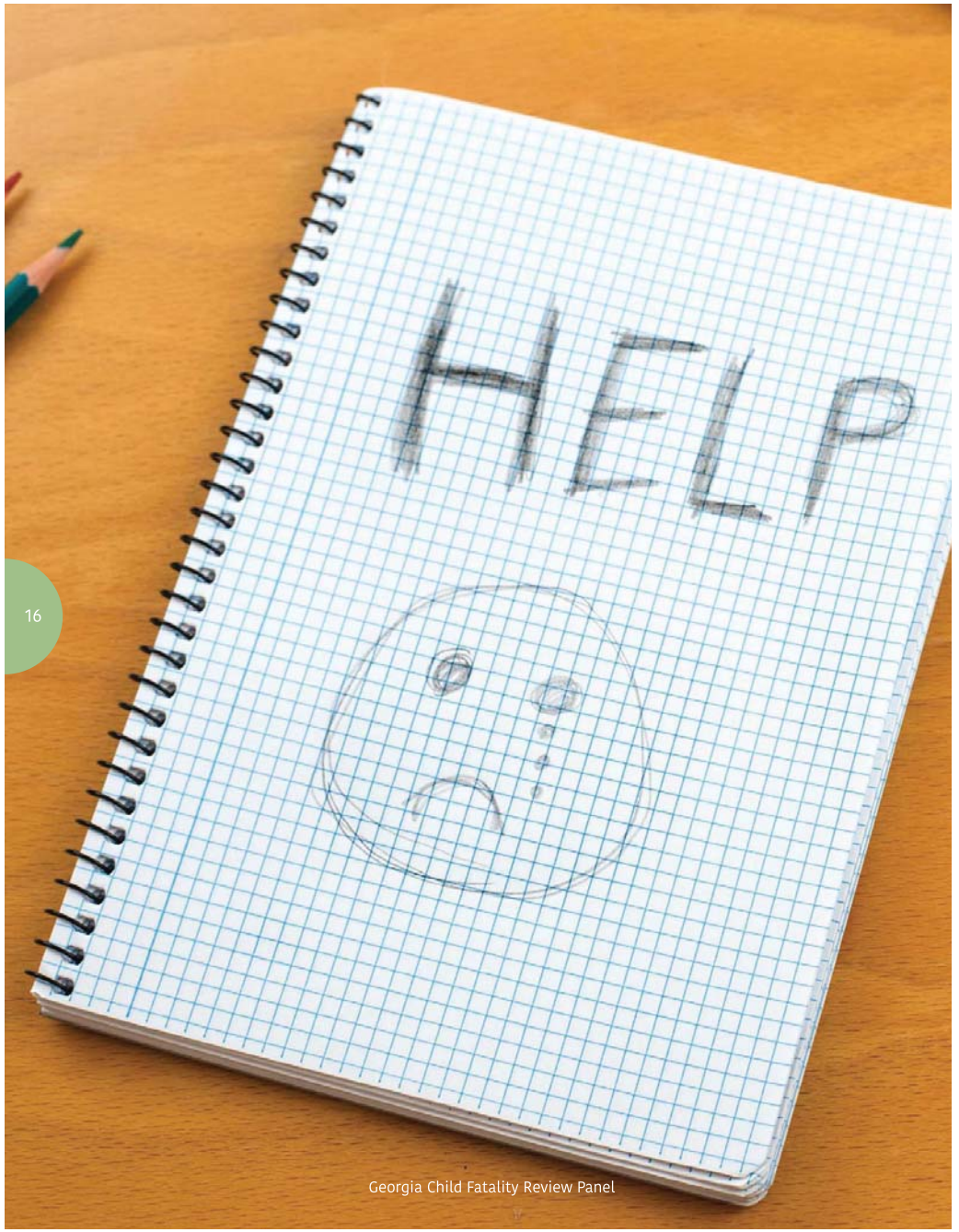


- The "undetermined" category refers to cases for which there is no definitive cause of death.

Figure 4: Demographics of All Reviewed Deaths, GA, 2016 (N=531)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	37	21	8	14	39	119
White Female	32	16	6	12	15	81
African-American Male	59	22	19	11	40	151
African-American Female	51	15	11	7	20	107
Hispanic Male	12	3	3	5	11	33
Hispanic Female	6	7	0	5	4	26
Multi-Race Male	1	2	2	0	1	5
Multi-Race Female	1	0	2	0	1	2
Other Race Male	1	1	0	2	0	4
Other Race Female	0	0	1	0	3	3
Total	**200**	**87**	**54**	**56**	**134**	**531**

- 44% of all reviewed deaths had a caregiver who received social services



Georgia Child Fatality Review Panel

Maltreatment

Child maltreatment fatalities occur in all communities but national trends show risk factors are greater in certain communities (low socioeconomic status in particular) for a variety of reasons. Local child fatality review teams conduct case-specific multi-disciplinary reviews of child fatalities. When they conduct these reviews, they discuss whether acts of omission or commission caused or contributed to the death. This review process allows committees to use a public health approach to assess whether prevention of the death was possible and determine areas of improvement for services and programs available to the family.

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

Figure 5: GA 2016 CDR, Maltreatment Variables

Child had history of child maltreatment? Yes, 144

- The child had a reported history of maltreatment victimization at any point in their life (abuse and/or neglect), but that history was not related to the primary cause of death)

Poor Supervision? Yes, 49

- The committee determined the death to be related to poor supervision

Abuse or Neglect? Yes, 29

- Maltreatment (abuse or neglect) was the direct cause or contributing factor in the death

- Abusive head trauma (previously known as "Shaken Baby Syndrome") comprised 7 of the 29 deaths (5 infants, 2 older children) where maltreatment was the direct cause or contributing factor

In 2016 there were a total of 157 cases with a history of child maltreatment. An identified history of child maltreatment puts a child at higher risk for future maltreatment so these families need additional support and monitoring. It is important to identify how the Division of Family and Children Services works with these families and how support is provided to a family on a continuing basis. Additional areas of focus for prevention efforts should center on educating parents about realistic expectations of children's development (particularly related to child behavior and toilet training). Inappropriate or excessive discipline can lead to injury or death so other prevention messaging should include information on other methods of discipline.

Poor and absent supervision is identified as a factor in 49 child deaths. These deaths are preventable through family support and education. For instance, when families have community supports for childcare, they are less likely to leave a child with an unsafe caregiver. In areas of the state where supports are lacking, efforts should focus on strengthening existing relationships between state agencies such as the Department of Public Health, the Department of Community Health, and the Department of Behavioral Health and Developmental Disabilities to leverage available resources for families to access. Prevention education should focus on child development (knowing what a child is capable of at different ages and stages and knowing when a child can be safely left unsupervised), safe storage of medications, firearms, etc. around the home, and safety around water sources (bathtubs, pools, lakes, etc.). Campaigns like the SPLASH Campaign run by the GA Department of Natural Resources are an example of a community-based program that provides drowning prevention resources.

Adverse childhood experiences (ACES) such as child maltreatment can have a permanent impact on the health and wellbeing of a child well into adulthood. This can pose a greater risk of substance use/abuse as adolescents, risk for bullying or dating violence, and suicidal ideation. Preventing child abuse and neglect can in turn prevent violence and future deaths from suicide and other chronic conditions.

Focus on Prevention: Maltreatment

Potential prevention opportunities include:

- Increasing parental education programs to enhance practices and behaviors, such as age appropriate discipline, promoting positive parent child interactions and accessing community services and support systems.
- Early intervention that involves systems of services that help infants and toddlers with development delays and disabilities.
- Strengthening economic supports to families
- Ensuring that DFCS case managers are well trained to thoroughly assess the safety and well-being of the children on their caseloads
- Advocating a community approach to recognizing abuse and how to intervene appropriately to save a life
- Ensuring access to mental health and substance abuse services for low income families who are not insured and/or not under the supervision of DFCS

Current Prevention Efforts Include:

- DFCS Blue Print for Change is aimed at providing a comprehensive framework to help improve practices and outcomes, reduce maltreatment and recidivism rates and promote productive partnerships with external stakeholders. Since its implementation in 2014 there were 4,000 overdue investigations and there was a significant decrease to 407 in 2016
- DFCS also implemented Solution Based Casework (SBC), an assessment tool that utilizes the family life cycle to frame and locate the "problem" that creates safety threats to the family in their daily functioning.

A 7 week old infant was found unresponsive. During the course of the investigation, she was found to have multiple small hemorrhages over her brain, internal bleeding, and multiple posterior rib fractures in various stages of healing, bilateral clavicle fractures consisting of three separate bones fractured on each shoulder and internal injuries. Both the mother and father were charged with murder; they were both drug impaired.

Disability or Chronic Disease

Developmental disability is a diverse group of chronic conditions that result in mental or physical impairments. These impairments affect language development, mobility, learning and other aspects of functioning. According to the American Academy of Pediatrics, early identification of developmental disorders is critical to the well-being of children and their families and can lead to further evaluation, diagnosis, and treatment.

Children with established developmental disorders often benefit from referrals to community-based family support services such as respite care, parent-to-parent programs, and advocacy organizations. Some children may qualify for additional benefits such as supplemental security income, public insurance, waiver programs, and state programs for children and youth with special health care needs (Title V). Parent organizations, such as Family Voices, and condition-specific associations can provide parents with information and support.

In 2016, there were a total of 531 reviewed deaths. Of these, 132 were identified as having a disability or chronic disease. 35 had no record of prior agency involvement which could be due to cultural, economic or social factors that prevented these children and their families from obtaining adequate resources and assistance. Early intervention programs can be particularly valuable when a child is first identified to be at high risk of delayed development because these programs often provide an array of services that include developmental therapies, service coordination, family training, counseling, and home visits.

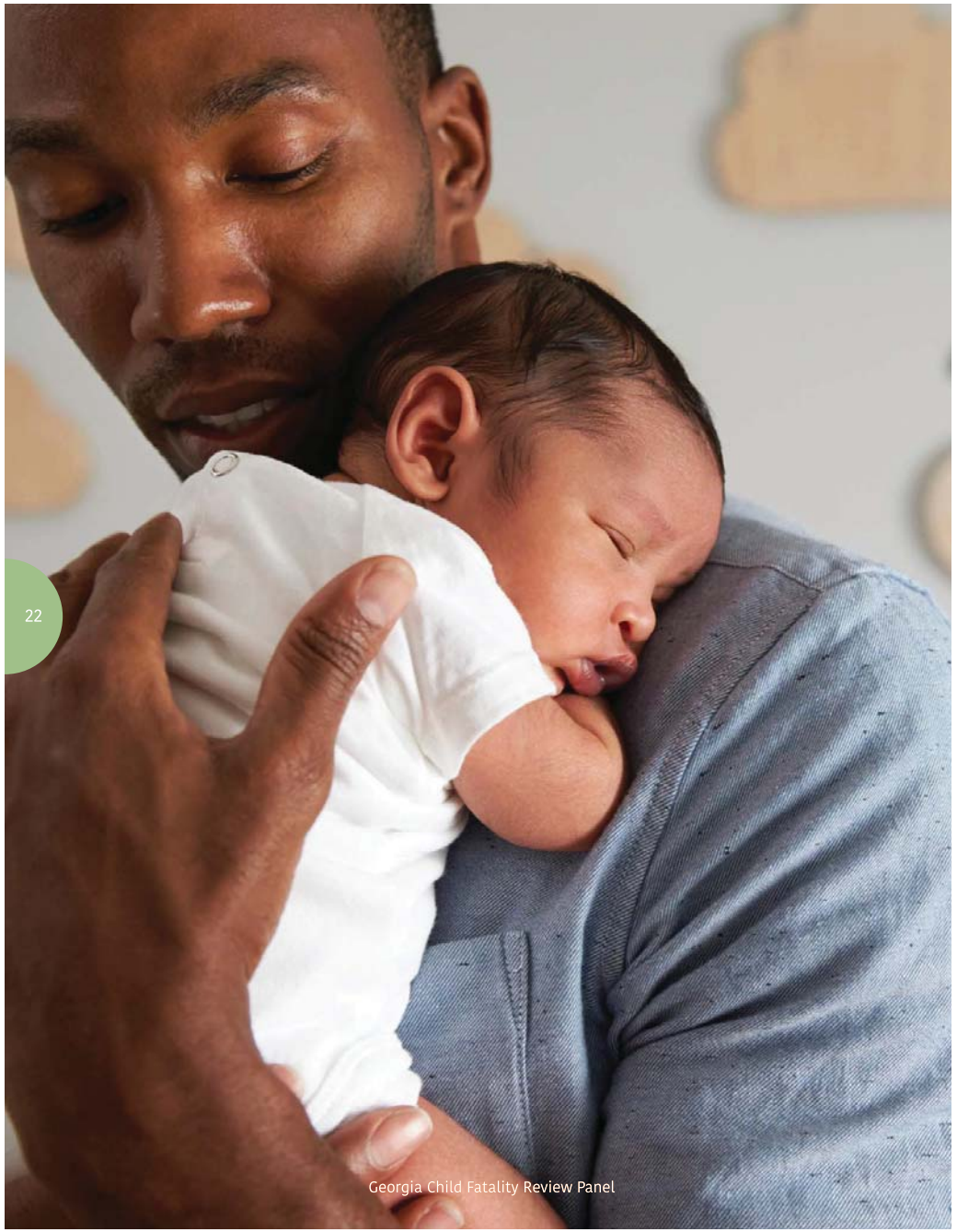
Georgia Child Fatality Review Panel

Figure 6: Demographics of Reviewed Child Deaths with Developmental Disability or Chronic Diseases, GA, 2016 (N=132)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
African-American Male	11	9	8	4	3	35
African-American Female	9	6	6	1	8	30
White Male	8	4	2	6	10	30
White Female	9	3	2	4	3	21
Hispanic Male	1	1			2	4
Hispanic Female	1	2		1	1	5
Multi-Race Male		2				2
Multi-Race Female	1				1	2
Other Male	1			1		2
Other Female					1	1
Total	**41**	**27**	**18**	**17**	**29**	**132**

- Males accounted for slightly over half (55%) of the total reviewed deaths identified with developmental disability and chronic disease
- African-American males ranked the highest with 34 reviewed deaths

16 year old adolescent black female with a history of muscular dystrophy and scoliosis became unresponsive while a passenger on her school bus. She was transported to a local hospital. Resuscitation and therapeutic efforts were unsuccessful.



Sleep-Related Infant Deaths

Sleep-related deaths are the leading cause of post-neonatal (after 27 days of life) infant death. The term "sleep-related" is relatively new and includes – but expands – deaths attributed to SIDS. The sleep related case definition includes infants found unresponsive in a sleep environment and other present risk factors for SIDS in that environment.

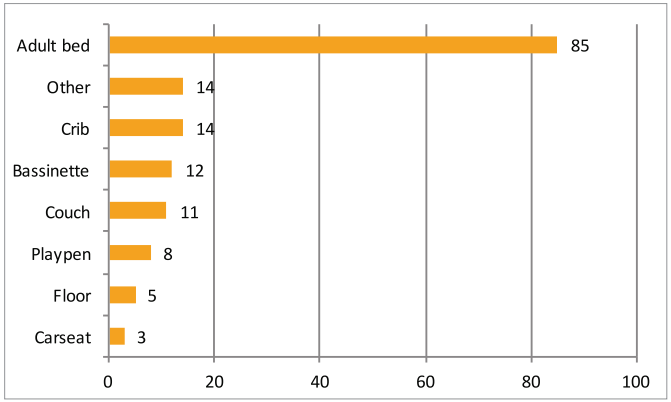
The Child Fatality Review process investigates the unexpected deaths of infants to examine the potential cause through a review of the infant's medical history, a death scene investigation and, autopsy. There is a subjective component to the classification of sleep-related deaths. The CFR typology includes four (rather than the three DC) categories. The additional category for the CFR (SUID, Medical) includes unexpected deaths where there is an underlying medical issue.

There has been an average of 160 sleep-related deaths in GA per year over the last 10 years.

There were a total of 152 sleep-related infant deaths for the year 2016. 58 were SUID related to asphyxia and 78 were SUID undetermined. 12 were SUID with an underlying medical condition and 4 were SIDS. The deaths related to asphyxia are considered preventable and many of the undetermined deaths, also have indicators of possible asphyxiation and prevention efforts may impact these numbers as well.

SIDS can only be selected when, after a full review, there is no apparent explanation for the infant's death. Many deaths are labeled "undetermined" after an investigation, autopsy, and medical review because a definitive cause of infant death can be difficult to conclusively determine due to the events often occurring with no witnesses and incomplete information from the death scene investigation.

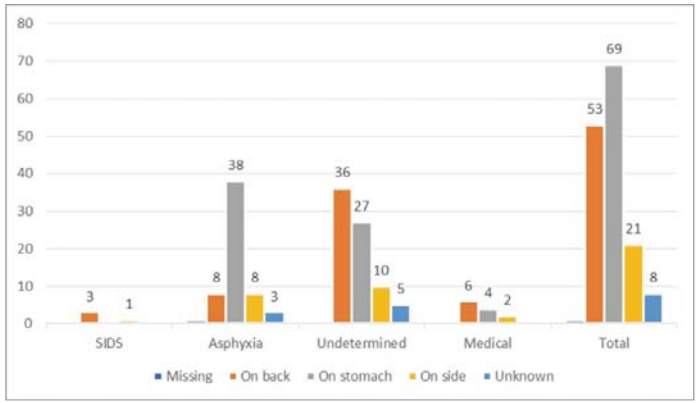
Figure 7: Sleep-Related Infant Deaths by Sleep Location, 2016 (N=152)



- The infant was found in an adult bed for majority (56%) of the sleep related deaths in 2016
- 79 of the infants were sharing the surface with an adult (and an additional 4 were sharing with another child); 20 of the 79 also had another child on the surface
- Within the "other" category, eight of the infants were on a person or in their arms at the time of death
- Cribs and bassinets account for 17% of the locations of infant deaths

The updated 2016 safe infant sleep recommendations from the American Academy of Pediatrics suggest room sharing as opposed to bed sharing and also providing a safe sleep environment that includes a firm, flat surface that is free of soft objects such as crib bumpers, pillows and blankets.

Figure 8: Sleep Position when Found, by Sleep-Related Death Category, 2016 (N=152)



- Stomach and side sleeping is a risk factor for all sleep-related infant deaths. The vulnerability of the developing infant is a major factor for deaths related to SIDS, SUID, and asphyxia due to the lack of muscle strength and coordination to remove themselves from a dangerous situation.

3 month old black female infant was found unresponsive prone on a sofa on which she had been placed to sleep. She was transported to a local children's hospital where she was pronounced dead approximately 45 minutes after arrival. The sofa was the usual sleep location for the infant. The parents only had one crib in the home and it was used for her 15 month old sibling.

Focus on Prevention: Safe Sleep

Potential prevention opportunities include:

- Collaboration with pediatricians to promote safe sleep messaging at well checks
- Targeted messaging geared toward the breast feeding community
- Collaborating with local fire and police departments to incorporate safe sleep messaging into their first responder training to enhance their ability to assess unsafe sleep conditions
- Continue to provide educators, caregivers, and community members with consistent and accurate information on safe infant sleep through as many avenues as possible

Current Prevention Efforts Include:

- Statewide distribution of scene re-enactment dolls and the GBI safe sleep video
- This Side Up campaign is currently implemented in birthing hospitals throughout the state
- Continued partnership with Safe Kids throughout the state

Statewide Partners

The CFRP continues to partner with other agencies to extend the reach of this initiative including:

- Georgia Children's Cabinet under the leadership of First Lady Sandra Deal
- Georgia Department of Public Health
- Georgia Hospital Association
- Georgia Chapter of the American Academy of Pediatrics
- Georgia Division of Family and Children Services
- Georgia Obstetrical and Gynecological Society
- Georgia Connection Partnership
- Voices for Georgia's Children
- Safe Kids Georgia

Motor Vehicle Related Deaths

In the United States, motor vehicle related fatalities are among the top five causes of death in children. In Georgia, specifically in 2012-2016, motor vehicle related injuries were the leading cause of death in children ages 5-19. Among the 1-4 age group, MVC related injuries were the second leading cause of death during the same time frame.

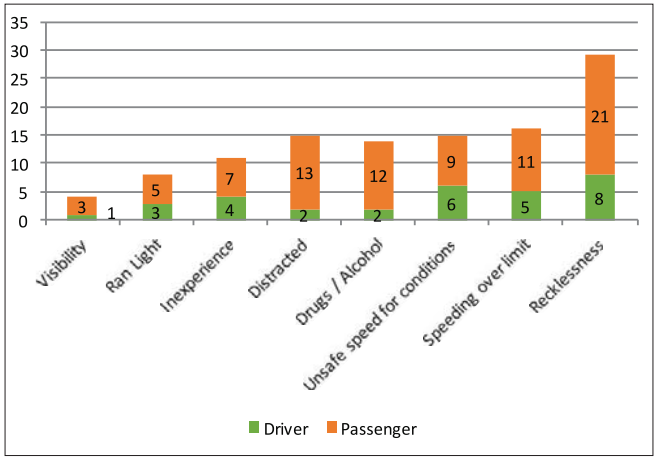
Figure 9: Demographics of Reviewed Motor Vehicle Related Deaths, 2016 (N=92)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male		1	3	6	14	24
White Female	1	6		5	5	17
African-American Male	3	3	7	4	6	23
African-American Female	1	2	3	2	5	13
Hispanic Male		1	2	1	4	8
Hispanic Female		2	2	2	1	7
Total	5	15	17	20	35	92

- Males comprised 60% of all reviewed MVC deaths (n=55)
- Fatalities among the 15 to 17 year old group are significantly higher than any other age group; this age group is more likely to be inexperienced at driving and more likely to engage in risky behaviors

The parents of the 4 year old male decedent were meeting at a bus yard to drop off the children. The children were going from the father's vehicle to the mother's vehicle. The decedent ran after the truck and the father ran over the child. He was dragged approximately 29 feet before the father realized he had run over something. He was on life support for 2 days until his parents decided to withdraw care.

Figure 10: Reviewed Motor Vehicle-Related Death Incident Causes, GA, 2016



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

- The most frequently cited causes for reviewed motor vehicle related deaths were recklessness, speed, and distracted driving. National data shows that any distraction while driving increases the risk of a crash two-fold. Cellphone use leads to a more than three times greater risk of a crash[1].

Georgia law specifies that all children under one year must ride in a rear-facing seat in the back seat of a vehicle. Best practices from advocacy groups like the American Academy of Pediatricians and the Centers for Disease Control and Prevention recommend rear-facing until age 2 or until they reach the maximum height and weight for the seat. In older children, it is recommended that they remain in a five-point harness seat until they reach the maximum height and weight limit of the seat as a forward-facing seat with a harness is safer than a booster. Booster seats should be used by children until they are big enough (weight and height) to fit in a seatbelt properly. Proper use of a lap belt means it lies snugly across the upper thighs not the stomach. Similarly, the shoulder belt must lie across the shoulder and chest, not across the neck or face.

While these safety measures are widely known, they are not routinely practiced by parents and caretakers of all demographics. Schools and other youth-serving organizations are in a great position to impact proper restraint usage by including information, reminders, and random checks in their routine practice. Medical facilities (hospitals and pediatric practices

1 Distracted Driving Presentation to the House Distracted Driving Study Committee by Lisa Dawson from DPH

in particular) should routinely screen parents/caregivers for restraint usage and provide education on proper use and information on community resources where proper car seats and boosters can be obtained and installed or checked.

Distracted driving significantly increases the risk of a motor vehicle crash thereby increasing the risk for fatalities. Research has shown that age-specific cellphone bans are not effective in reducing injuries and fatalities but a total ban (inclusive of all drivers) was effective at reducing fatalities by 8%. This also decreases the risk of pedestrian fatalities. Prevention efforts should focus on increasing awareness of distracted driving via mass media campaigns and school-based instructional programs.

Focus on Prevention: Motor Vehicle

Potential prevention opportunities include:

- To maximize safety, keep your child in a car seat as long as the child fits within the manufacturer's height and weight requirements.
- Keep your child in the back seat at least through age 12.
- Teach children not to play in or around cars.
- Make sure to look behind you while backing up slowly in case a child dashes behind your vehicle unexpectedly.
- Roll down your windows while backing out of your driveway or parking space so that you'll be able to hear what is happening outside of your vehicle.
- Start the Conversation Early: Talk to your teens about safe driving early and often before they reach driving age but don't stop there. Have conversations with the parents of your teen's friends and compare notes.
- Spell out the Rules: No cell phones, no passengers, no speeding, no alcohol, no driving when tired, and always buckle up. These rules could help save your teen's life

Current Prevention Efforts Include:

- The Older Drivers Task Force comprised of multi- disciplinary partners throughout the state developed the Older Driver Safety program serviced by the Georgia Department of Public Health Injury Prevention program. It is designed to maintain the mobility and safety of older drivers while making the roadways safer for all road users.
- The Georgia Youth Adult Program through the Governor's Office of Highway Safety promotes education for young adults about highway safety issues.
- Hands Across the Border is a multi-state enforcement campaign which includes Georgia, Alabama, Florida, North Carolina, South Carolina and Tennessee. This campaign focuses on arresting impaired drivers during the Labor Day holiday.

Georgia Child Fatality Review Panel

Drowning Deaths

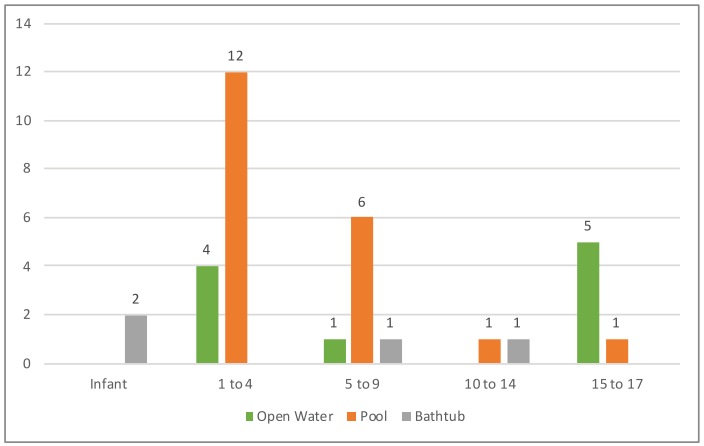
According to Center for Disease Control, from 2005-2014, there were an average of 3,536 fatal unintentional drownings (non-boating related) annually in the United States, about ten deaths per day. Drowning is a leading cause of injury-related death in children and it continues to be a public health problem affecting some of our most vulnerable groups of the population. In Georgia, there were a total of 34 reviewed drowning deaths in 2016.

Figure 11: Demographics of Reviewed Drowning Child Deaths, GA, 2016 (N=34)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
African-American Male	0	4	4	2	4	14
African-American Female	0	1	1	0	0	2
White Male	0	10	2	0	1	13
White Female	1	1	0	0	0	2
Hispanic Male	0	0	0	0	1	1
Hispanic Female	1	0	1	0	0	2
Total	**2**	**16**	**8**	**2**	**6**	**34**

According to Center for Disease Control, from 2005-2014, there were an average of 3,536 fatal unintentional drownings (non-boating related) annually in the United States about ten deaths per day. Drowning is a leading cause of injury-related death in children, and it continues to be a public health problem affecting some of our most vulnerable groups of the population.

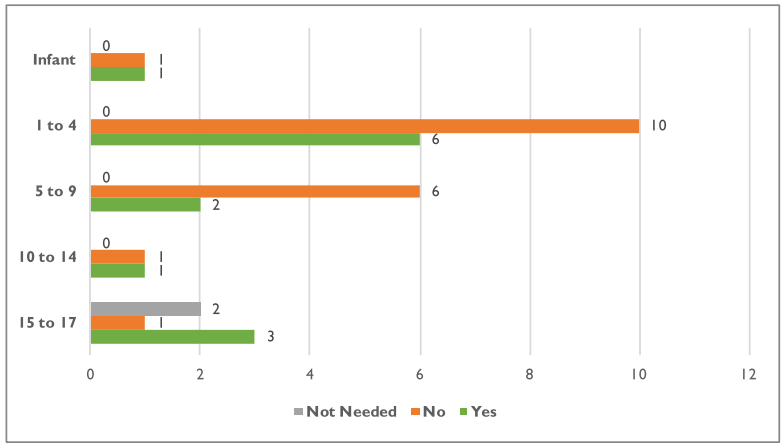
Figure 12: Drowning Fatalities by Age and Location, 2016, GA (N=34)



According to the American Academy of Pediatrics (AAP), most infant drownings occurs in bathtubs and buckets. Toddlers between one and four years most commonly drown in swimming pools. However, many children in this age group drown in ponds, rivers, and lakes. Children older than five years old are most likely to drown in rivers and lakes, but this varies from one area of the country to another.

A 16 year old male was swimming with friends when he became tired and started to panic. He then went under the water; one of his friends tried to help bring him up to the surface but was unsuccessful. The local EMA Dive team responded to the scene and recovered the body of the male approximately three hours after initial incident. His body was recovered 100 feet from shore and approximately 22 feet under the water.

Figure 13: Supervision at Drowning Incident, GA, 2016 (N=34)



The graph above also shows a clear correlation between age and lack of supervision.

Focus on Prevention: Drowning

Potential prevention opportunities include:

- Teaching CPR skills in school as part of health education requirements
- Increasing use of life jacket loaner boards across the state
- Promote swimming lessons in daycare centers for younger children

Current Prevention Efforts Include:

- The Department of Natural Resources developed the SPLASH campaign which is a water safety initiative aimed at reducing drowning deaths through water safety education and community outreach

Homicide

According to 2015 CDC Data, homicide was the third leading cause of death among 1-4 year olds and 4th leading cause of death among 5-9 and 10-14 year olds. It is also the third leading cause of death among adolescents (ages 15-24). Our state level data shows similar trends to the national data.

Figure 14: Demographics of Reviewed Homicide Deaths, GA, 2016 (N=68)

	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Total
White Male	2	1	1	0	3	**7**
White Female	2	1	1	0	3	7
African-American Male	2	5	1	0	19	**27**
African-American Female	1	6	2	2	9	**20**
Hispanic Male	0	1	0	0	0	1
Hispanic Female	1	1	0	1	0	3
Multi-race Male	0	0	1	0	1	2
Other Male	0	1	0	0	0	**1**
Total	8	16	6	3	35	68

- African-American children accounted for 69% of all reviewed homicides (47)
- African-American males were disproportionately more impacted by homicidal violence, representing more than a quarter of the homicides occurring in this population, particularly 15-17 year olds. This highlights the need for work around community violence prevention.

The number and proportion of homicide deaths among teens ages 15 to 17 has increased the past two years. From 2009 through 2014 there was an average of 19 deaths per year (teens, 15 to 17), and that was about 1/3 of the total child homicide deaths. The number in that population doubled for 2015/16 (37 per year), and the proportion increased to 48%. (GA death certificate data)

Focus on Prevention: Homicide

Potential prevention opportunities include:

- Increasing programs that address community deterioration (e.g alcohol abuse, gun safety, nonviolent coping skills) can also help prevent youth violence.
- Continued messaging around the importance of keeping weapons out of the reach of small children and storing in a safe and secure place.
- Ensuring proper supervision of children at all times when outside of the home

Current Prevention Efforts Include:

- Distribution of gun locks within the community
- Continued messaging around gun safety

This 16 year old male and some of his friends were in his living room when one of the friends was playing with a loaded gun. He pointed it at the decedent and shot him. The friend stated that it was an accident and he didn't know that a bullet was in the weapon. The decedent tested positive for marijuana and it was reported that both the decedent and his friend owned a gun.

Suicide

According to the Center for Disease Control (CDC), suicide is the second leading cause of death for youth 15-19 years old and the third leading cause of death for youth ages 10-14 years old. Suicides in Georgia continue to trend upwards with 51 reviewed youth suicides in 2016.

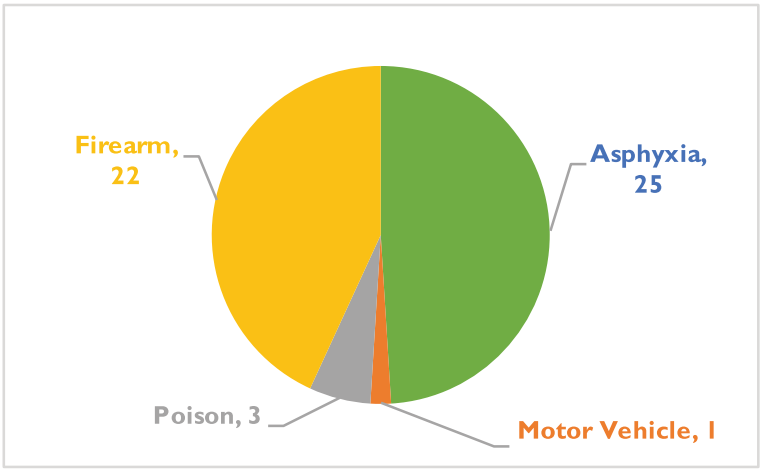
Many youth die by suicide due to depression that is triggered by several negative life experiences such as the death of a loved one, family discord, issues at school and, drug and/or alcohol abuse and bullying (CDC, 2011). Adolescence can be a tumultuous time for many young people and some experiences can be very confusing and difficult to handle. In reviewing the cases, it is clear that many of our youth lack the ability to cope with life stressors.

Figure 15: Demographics of Reviewed Suicide Deaths, GA, 2016 (N= 51)

	5 to 9	10 to 14	15 to 17	Total
White Male	0	2	16	18
White Female	0	4	3	7
African-American Male	1	2	5	8
African-American Female	0	1	0	1
Hispanic Male	0	3	5	8
Hispanic Female	0	2	2	4
Multi-Racial Female				
Other	0	1	3	4
Total	**1**	**15**	**35**	**51**

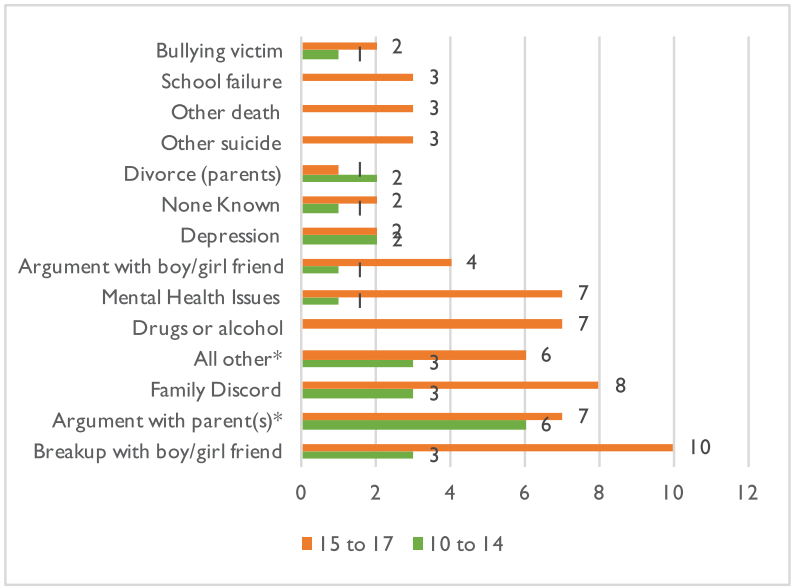
- 69% of reviewed suicide deaths were males
- Youth between the ages of 15 to 17 years old made up two thirds of completed suicides in 2016

Figure 16: Reviewed Suicide Deaths, by Mechanism, GA, 2016 (N= 51)



- 45% of reviewed suicide deaths resulted from the use of a firearm
- Historically, the most frequent mechanisms for youth suicide is asphyxia and firearms (CDC). In Georgia, firearms and asphyxia accounted for 47 reviewed suicide deaths (92%)

Figure 20: Reported Risk Factors for Reviewed Suicide Deaths, GA 2016



- The history reported for a child can include multiple actions for each death; therefore the total is greater than the number of suicide deaths.
- The category “breakup with boy/girlfriend” accounted for the highest numbers among youth ages 15 to 17 years old and argument with parents accounted for the highest numbers among ages 10 to 14 years old.

Potential Prevention Opportunities Include:

- Increase targeted education for youth in elementary, middle, and high school to help them understand the risk factors and warning signs of suicide
- Continue training school staff on identification of at risk students and how to effectively respond to crisis at school
- Restrict access to lethal means of suicide in the household including firearms and lethal medications

Current Prevention Efforts Include:

- As a recommendation of the Jason Flatt Act, the Department of Education and several state agencies have completed a series of suicide prevention summits around the state.
- Georgia Bureau of Investigation and Child Fatality Review Unit along with other stakeholders has formed a suicide prevention task force. The first project completed was a Peer to Peer public service announcement (PSA). This PSA is aimed at youth empowering other youth to get help.
- The suicide prevention task force with the GBI and DOE have distributed resources statewide, provided prevention training, and launched several press releases.

This 14 year old adolescent male was found in his room with a gunshot wound of the head. He was transported to a hospital where he was pronounced dead two days later. The father reported that he had recently given his son a lecture about his grades and chores. He admitted to yelling and treating him more harshly than usual. The father woke up around 9:00 am to the sound of a "pop". He went downstairs and noticed the child's bathroom shower was running. He entered his son's room and noticed he was lying on the bed with his eyes rolled back into his head and his head and face were bloody; he was making breathing noises. There was no suicide note left and this was completely unexpected.

Georgia Child Fatality Review Panel

Resources

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

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

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

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

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

American Red Cross (www.redcross.org)

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

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

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

American Academy of Pediatrics (www.aap.org)

American Association of Suicidology (www.suicidology.org)

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

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

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

The Jason Foundation (www.jasonfoundation.com)

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

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

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

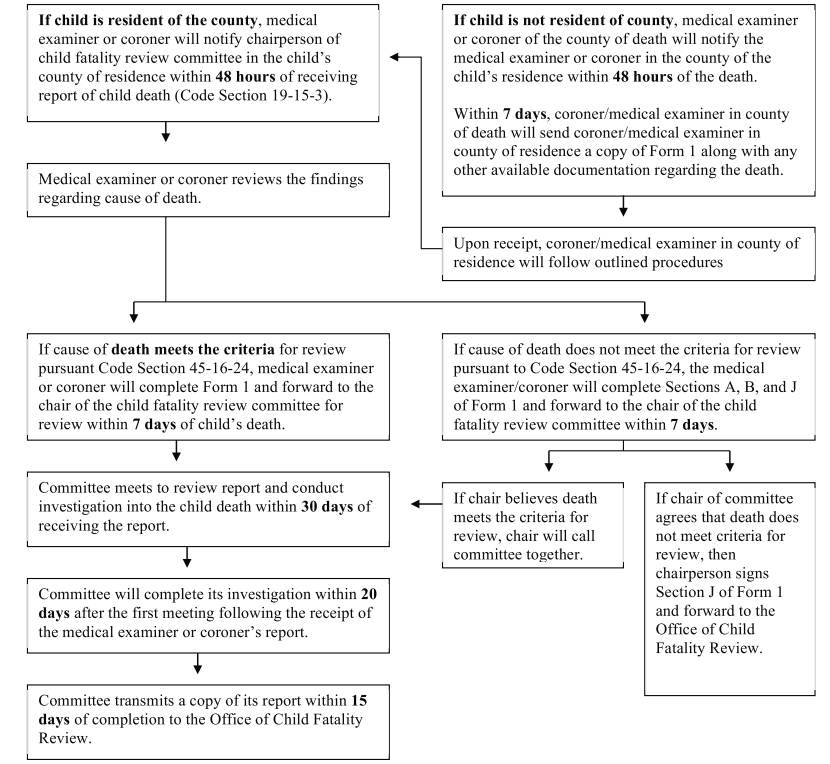
Georgia General Assembly Legislation (www.legis.ga.gov)

Prevent Child Abuse America (www.preventchildabuse.org)

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

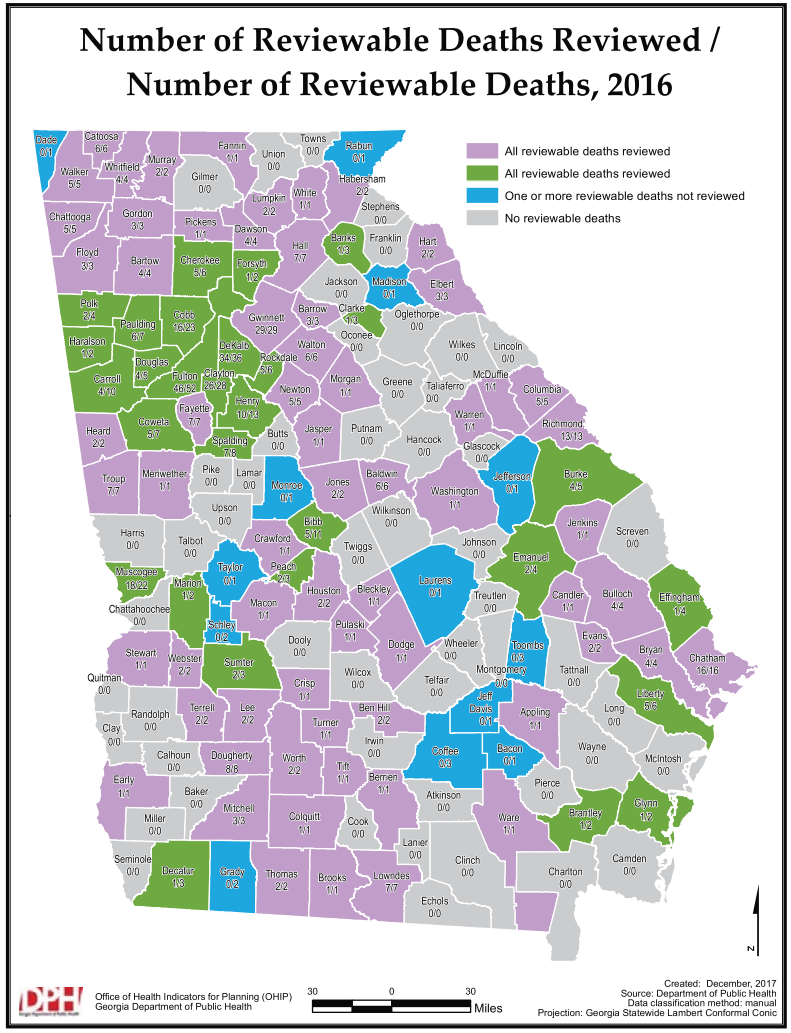
Appendix A

Child Fatality Review Committee Timeframes and Responsibilities



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

Appendix B - Map – Reviewable Deaths Reviewed



Appendix C - Table – Reviewable Deaths Reviewed

** Note that there may be a difference in the numbers of cases deemed reviewable (see "All Reviewed" section of this Report for reviewability criteria) and the number of cases that were reviewed by each county committee

	All 2016 Deaths GA Residents, Age < 18 Years					Reviewable 2016 Deaths					Reviewable 2016 Deaths Reviewed					All 2016 Deaths Reviewed				
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Appling	2					1					1									
Atkinson	1																			
Bacon	2			1					1											
Baker																				
Baldwin	5	1		3	2	3			1	2	3			1	2	3			1	2
Banks	3	2	1	1	1		1		1	1		1					1			
Barrow	1	1		1	1		1		1	1		1		1	1		1		1	1
Bartow	8	2			4		1			3		1			3	1	1			3
Ben Hill	4				1	1				1	1				1	1				1
Berrien	2			1					1					1					1	
Bibb	22	6	1		4	4	3	1		3	3	1			1	1	1			1
Bleckley	1					1					1					2				
Brantley	1				2					2					1					1
Brooks	1		1					1					1					1		
Bryan	4	2	1	1	1	1	1		1	1	1	1		1	1	1	1		1	1
Bulloch	5	1	1	1	1	2		1	1		2		1	1		4		1	1	
Burke	3	1	1		2	2	1			2	2				2	3				2
Butts	1															1				
Calhoun					1															
Camden	6	1																		
Candler		1	1		1					1					1					1
Carroll	7	2	2	2	5	2	2	1	1	4	1		1		2	1		2		2
Catoosa	4	3			4		3			3		3			3		1			3
Charlton																				
Chatham	29	6	5	4	6	6	3	1	1	5	6	3	1	1	5	7	4	2	1	5
Chattahoochee	1																		1	
Chattooga	3	2	3			1	2	2			1	2	2			1	2	2		
Cherokee	16	2	1	3	3	2			2	2	2			1	2	1		1	1	2
Clarke	7	2		2		1			2		1					1				
Clay																				
Clayton	41	3	6	7	9	9	3	4	4	8	9	2	3	4	8	10	2	5	4	11
Clinch																				
Cobb	58	11		7	8	7	6		4	6	4	5		2	5	4	6		2	5
Coffee	6			1	1	2				1										
Colquitt	5	1	1		1					1					1					1
Columbia	21			5	2	1			3	1	1			3	1	1			4	2
Cook																				
Coweta	8			4	2	3			3	1	3			1	1	3	1		2	2
Crawford				1					1					1					1	
Crisp	2			1		1					1					1				

	All 2016 Deaths GA Residents, Age < 18 Years					Reviewable 2016 Deaths					Reviewable 2016 Deaths Reviewed					All 2016 Deaths Reviewed				
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Dade	2					1										1				
Dawson	3			1	2	1			1	2	1			1	2	1			1	2
Decatur	4	1		1	2		1		1	1		1				2	1			1
DeKalb	73	10	8	4	17	14	4	1	1	16	13	4	1	1	15	14	6	2	1	16
Dodge	3				1					1					1	1				1
Dooly	1																			
Dougherty	20	2	3	1	1	3	2	2	1		3	2	2	1		3	2	3	1	
Douglas	12	2	1		3	2	1			2	1	1			2	1	3			2
Early					1					1					1					1
Echols		1																		
Effingham	8	1	2			3		1			1					1	1			
Elbert	1	1			2		1			2		1			2		1			2
Emanuel	2	1	1	2	2	1		1	1	1			1		1			1		1
Evans	1		1		1			1		1			1		1			1		1
Fannin	3			1					1					1					1	
Fayette	5	1	3	1	3	1	1	3	1	1	1	1	3	1	1	2	1	3	1	2
Floyd	10	1			3	1				2	1				2	3	1			2
Forsyth	6		1	2	1				1	1					1			1	1	1
Franklin	1			1	2															
Fulton	81	12	12	6	21	20	6	4	4	18	19	6	3	4	14	29	9	4	5	15
Gilmer	1	2																		
Glascock																				
Glynn	9	1			1	2					1					1				
Gordon	6	2		3	1		1		2			1		2		1	1		2	
Grady	3			1	2	1			1											
Greene		1	1														1	1		
Gwinnett	91	9	8	8	10	11	3	6	6	3	11	3	6	6	3	13	4	7	7	4
Habersham	3	2			1	1				1	1				1	2	2			1
Hall	11	3	2	1	3	2	1	1		3	2	1	1		3	2	2	1		3
Hancock																				
Haralson	4		1			2					1					2				
Harris	2				1															1
Hart	2				1	1				1	1				1	1				1
Heard	3	1				1	1				1	1				1				
Henry	19	5	2	4	4	5	2	1	2	3	3	1	1	2	3	2	1	1	2	1
Houston	13			1	1	1				1	1				1	1				1
Irwin	1	1																		
Jackson	7																			
Jasper	3			1		1					1					2			1	
Jeff Davis	4	1				1														
Jefferson	1	1					1													

	All 2016 Deaths GA Residents, Age < 18 Years					Reviewable 2016 Deaths					Reviewable 2016 Deaths Reviewed					All 2016 Deaths Reviewed				
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Jenkins	1				2					1					1					2
Johnson	1																			
Jones	1	1		1			1		1			1		1		1	1		1	
Lamar																				
Lanier																				
Laurens	5				1	1														
Lee	3		3	1	1			1	1				1	1				1	1	
Liberty	14					6					5					6				
Lincoln	1																			
Long	2				1															
Lowndes	22	1	2	1	1	5		1		1	5		1		1	5		1		1
Lumpkin		2					2					2					2			
Macon	1					1					1					1				
Madison	5					1														
Marion	3					2					1					1				
McDuffie	2		1					1					1					1		
McIntosh	1																			
Meriwether	1	1				1					1					1				
Miller																				
Mitchell	4	1			1	2				1	2				1	2	1			1
Monroe	2	1	1			1														
Montgomery																				
Morgan	1				1					1					1					1
Murray	1	1	2			1	1				1	1				1	1			
Muscogee	31	5	5	2	9	7	4	3	1	7	7	2	3	1	5	7	2	3	1	7
Newton	8	1	3		2	1		3		1	1		3		1	2	1	3		2
Oconee	1																			
Oglethorpe																				
Paulding	14	3	1	3	1	3	2		1	1	3	2		1		3	2	1	2	
Peach	3	1			2		1			2		1			1		1			1
Pickens	2					1					1					1				
Pierce																				
Pike																				
Polk	6	1		1	2	1	1		1	1		1			1		2			1
Pulaski		1			1					1					1		1			1
Putnam																				
Quitman																				
Rabun	1				1	1														
Randolph	1																			
Richmond	33	10	2	4	1	7	5		1		7	5		1		9	5		1	1
Rockdale	10	1		1	2	3			1	2	3				2	3				2

	All 2016 Deaths GA Residents, Age < 18 Years					Reviewable 2016 Deaths					Reviewable 2016 Deaths Reviewed					All 2016 Deaths Reviewed				
County	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17	Infant	1 to 4	5 to 9	10 to 14	15 to 17
Schley	1				2					2										
Screven	4																			
Seminole	1			1																
Spalding	9	1	2		3	4		2		2	4		2		1	3		2		2
Stephens	1															1				
Stewart		1					1					1					1			
Sumter	4	1	2	1			1	1	1			1		1			1		1	
Talbot																				
Taliaferro																				
Tattnall	2			2																
Taylor	1				1					1										
Telfair																				
Terrell			1		1			1		1			1		1			1		1
Thomas	5				1	2					2					2				1
Tift	4	1			1					1					1	1	1			1
Toombs	4	1	2			1	1	1												
Towns	1																			
Treutlen																				
Troup	12	1		2	1	5			1	1	5			1	1	5			1	1
Turner				1					1					1					1	
Twiggs	1																			
Union	2																			
Upson	1																			
Walker	4	2	1			2	2	1			2	2	1			3	3	1		
Walton	9	3	1	1	1	3	1		1	1	3	1		1	1	4	1		1	1
Ware	4	1	2			1					1					1				
Warren					1					1					1					1
Washington	1	1		1					1					1					1	
Wayne	2																			
Webster				1	1				1	1				1	1				1	1
Wheeler	1																			
White		2					1					1					1			
Whitfield	6	2				2	2				2	2				2	3			
Wilcox	4																			
Wilkes																				
Wilkinson																1				
Worth	2		1			1		1			1		1			1		1		

All 2016 Child Deaths (N = 1,599)								
		White		African American		Other Race		Total
AgeCat	Cause	Male	Female	Male	Female	Male	Female	
Infant	Drown				1			966
	Fire		2					
	Homicide	2	3	2	2			
	Medical	160	149	231	206	19	9	
	MVC		2	3	1			
	OthInjury	1	1	1				
	SIDS	20	17	30	29	3		
	Suff_Bed	9	5	11	6		1	
	Suff_Oth	2		2				
	Unk Intent	1		1				
	Unknown	10	8	6	10			
Ages 1 – 4	Drown	10	1	6	2			160
	Fire	1	3		1			
	Firearm	2						
	Homicide	2	1	5	6	1		
	Medical	26	14	20	19	1	2	
	MVC	4	8	5	3			
	OthInjury	2			2			
	Poison			3				
	Suff_Oth		1	1				
	Unk Intent				1			
	Unknown	2	3	1	1			
Ages 5 – 9	Drown	2	1	4	3			103
	Fire	1	2		2			
	Firearm	1						
	Homicide	1		1	2	1		
	Medical	10	16	12	14		3	
	MVC	6	1	6	5			
	OthInjury			2	2			
	Suff_Oth				1			
	Suicide			1				
	Unk Intent	1		1				
	Unknown		1					

All 2016 Child Deaths (N = 1,599) (continued)								
		White		African American		Other Race		Total
AgeCat	Cause	Male	Female	Male	Female	Male	Female	
Ages 10 – 14	Drown	1	1	3				109
	Fire		1					
	Firearm	1						
	Homicide	2	1	1	3			
	Medical	13	7	11	13		1	
	MVC	8	8	5	2			
	OthInjury	1		2	1			
	Poison	1						
	Suff_Oth	1						
	Suicide	8	7	2	2	1		
	Unknown			1				
Ages 15 – 17	Drown	2		4				191
	Fire				3			
	Firearm	1						
	Homicide	4	2	24	9			
	Medical	19	9	8	12		3	
	MVC	20	10	10	4		1	
	OthInjury	3			1			
	Poison	2						
	Suicide	20	6	7			3	
	Unknown	1		3				
Total		384	291	436	369	26	23	

County Totals						
County	All Deaths	Reviewable	Rvbl Rvwd	All Reviewed	Label	Category
Appling	2	1	1	0	1/1	4
Atkinson	1	0	0	0	0/0	1
Bacon	3	1	0	0	0/1	2
Baker	0	0	0	0	0/0	1
Baldwin	11	6	6	6	6/6	4
Banks	8	3	1	1	1/3	3
Barrow	4	3	3	3	3/3	4
Bartow	14	4	4	5	4/4	4
Ben Hill	5	2	2	2	2/2	4
Berrien	3	1	1	1	1/1	4
Bibb	33	11	5	3	5/11	3
Bleckley	1	1	1	2	1/1	4
Brantley	3	2	1	1	1/2	3
Brooks	2	1	1	1	1/1	4
Bryan	9	4	4	4	4/4	4
Bulloch	9	4	4	6	4/4	4
Burke	7	5	4	5	4/5	3
Butts	1	0	0	1	0/0	1
Calhoun	1	0	0	0	0/0	1
Camden	7	0	0	0	0/0	1
Candler	3	1	1	1	1/1	4
Carroll	18	10	4	5	4/10	3
Catoosa	11	6	6	4	6/6	4
Charlton	0	0	0	0	0/0	1
Chatham	50	16	16	19	16/16	4
Chattahoochee	1	0	0	1	0/0	1
Chattooga	8	5	5	5	5/5	4
Cherokee	25	6	5	5	5/6	3
Clarke	11	3	1	1	1/3	3
Clay	0	0	0	0	0/0	1
Clayton	66	28	26	32	26/28	3
Clinch	0	0	0	0	0/0	1
Cobb	84	23	16	17	16/23	3
Coffee	8	3	0	0	0/3	2
Colquitt	8	1	1	1	1/1	4
Columbia	28	5	5	7	5/5	4
Cook	0	0	0	0	0/0	1
Coweta	14	7	5	8	5/7	3
Crawford	1	1	1	1	1/1	4
Crisp	3	1	1	1	1/1	4
Dade	2	1	0	1	0/1	2
Dawson	6	4	4	4	4/4	4
Decatur	8	3	1	4	1/3	3
DeKalb	112	36	34	39	34/36	3

County Totals						
County	All Deaths	Reviewable	Rvbl Rvwd	All Reviewed	Label	Category
Dodge	4	1	1	2	1/1	4
Dooly	1	0	0	0	0/0	1
Dougherty	27	8	8	9	8/8	4
Douglas	18	5	4	6	4/5	3
Early	1	1	1	1	1/1	4
Echols	1	0	0	0	0/0	1
Effingham	11	4	1	2	1/4	3
Elbert	4	3	3	3	3/3	4
Emanuel	8	4	2	2	2/4	3
Evans	3	2	2	2	2/2	4
Fannin	4	1	1	1	1/1	4
Fayette	13	7	7	9	7/7	4
Floyd	14	3	3	6	3/3	4
Forsyth	10	2	1	3	1/2	3
Franklin	4	0	0	0	0/0	1
Fulton	132	52	46	62	46/52	3
Gilmer	3	0	0	0	0/0	1
Glascock	0	0	0	0	0/0	1
Glynn	11	2	1	1	1/2	3
Gordon	12	3	3	4	3/3	4
Grady	6	2	0	0	0/2	2
Greene	2	0	0	2	0/0	1
Gwinnett	126	29	29	35	29/29	4
Habersham	6	2	2	5	2/2	4
Hall	20	7	7	8	7/7	4
Hancock	0	0	0	0	0/0	1
Haralson	5	2	1	2	1/2	3
Harris	3	0	0	1	0/0	1
Hart	3	2	2	2	2/2	4
Heard	4	2	2	1	2/2	4
Henry	34	13	10	7	10/13	3
Houston	15	2	2	2	2/2	4
Irwin	2	0	0	0	0/0	1
Jackson	7	0	0	0	0/0	1
Jasper	4	1	1	3	1/1	4
Jeff Davis	5	1	0	0	0/1	2
Jefferson	2	1	0	0	0/1	2
Jenkins	3	1	1	2	1/1	4
Johnson	1	0	0	0	0/0	1
Jones	3	2	2	3	2/2	4
Lamar	0	0	0	0	0/0	1
Lanier	0	0	0	0	0/0	1
Laurens	6	1	0	0	0/1	2
Lee	8	2	2	2	2/2	4

County Totals						
County	All Deaths	Reviewable	Rvbl Rvwd	All Reviewed	Label	Category
Liberty	14	6	5	6	5/6	3
Lincoln	1	0	0	0	0/0	1
Long	3	0	0	0	0/0	1
Lowndes	27	7	7	7	7/7	4
Lumpkin	2	2	2	2	2/2	4
Macon	1	1	1	1	1/1	4
Madison	5	1	0	0	0/1	2
Marion	3	2	1	1	1/2	3
McDuffie	3	1	1	1	1/1	4
McIntosh	1	0	0	0	0/0	1
Meriwether	2	1	1	1	1/1	4
Miller	0	0	0	0	0/0	1
Mitchell	6	3	3	4	3/3	4
Monroe	4	1	0	0	0/1	2
Montgomery	0	0	0	0	0/0	1
Morgan	2	1	1	1	1/1	4
Murray	4	2	2	2	2/2	4
Muscogee	52	22	18	20	18/22	3
Newton	14	5	5	8	5/5	4
Oconee	1	0	0	0	0/0	1
Oglethorpe	0	0	0	0	0/0	1
Paulding	22	7	6	8	6/7	3
Peach	6	3	2	2	2/3	3
Pickens	2	1	1	1	1/1	4
Pierce	0	0	0	0	0/0	1
Pike	0	0	0	0	0/0	1
Polk	10	4	2	3	2/4	3
Pulaski	2	1	1	2	1/1	4
Putnam	0	0	0	0	0/0	1
Quitman	0	0	0	0	0/0	1
Rabun	2	1	0	0	0/1	2
Randolph	1	0	0	0	0/0	1
Richmond	50	13	13	16	13/13	4
Rockdale	14	6	5	5	5/6	3
Schley	3	2	0	0	0/2	2
Screven	4	0	0	0	0/0	1
Seminole	2	0	0	0	0/0	1
Spalding	15	8	7	7	7/8	3
Stephens	1	0	0	1	0/0	1
Stewart	1	1	1	1	1/1	4
Sumter	8	3	2	2	2/3	3
Talbot	0	0	0	0	0/0	1
Taliaferro	0	0	0	0	0/0	1
Tattnall	4	0	0	0	0/0	1

County Totals						
County	All Deaths	Reviewable	Rvbl Rvwd	All Reviewed	Label	Category
Taylor	2	1	0	0	0/1	2
Telfair	0	0	0	0	0/0	1
Terrell	2	2	2	2	2/2	4
Thomas	6	2	2	3	2/2	4
Tift	6	1	1	3	1/1	4
Toombs	7	3	0	0	0/3	2
Towns	1	0	0	0	0/0	1
Treutlen	0	0	0	0	0/0	1
Troup	16	7	7	7	7/7	4
Turner	1	1	1	1	1/1	4
Twiggs	1	0	0	0	0/0	1
Union	2	0	0	0	0/0	1
Upson	1	0	0	0	0/0	1
Walker	7	5	5	7	5/5	4
Walton	15	6	6	7	6/6	4
Ware	7	1	1	1	1/1	4
Warren	1	1	1	1	1/1	4
Washington	3	1	1	1	1/1	4
Wayne	2	0	0	0	0/0	1
Webster	2	2	2	2	2/2	4
Wheeler	1	0	0	0	0/0	1
White	2	1	1	1	1/1	4
Whitfield	8	4	4	5	4/4	4
Wilcox	4	0	0	0	0/0	1
Wilkes	0	0	0	0	0/0	1
Wilkinson	0	0	0	1	0/0	1
Worth	3	2	2	2	2/2	4
Total	**1529**	**522**	**438**	**531**		

All Reviewed 2016 Infant / Child Deaths (N = 531)								
		White		African American		Other Race		Total
AgeCat	Cause	Male	Female	Male	Female	Male	Female	
Infant	Asphyxia	1		1				200
	Drown		1		1			
	Fall/Crush			1				
	Fire		2					
	Homicide	2	3	2	1			
	Medical	5	1	5	4			
	MVC		1	3	1			
	OtherCause		1	1	1			
	Poison		1	1				
	SIDS	1	1	1	1			
	SUID_Asph	12	11	19	15	1		
	SUID_Med	2	2	3	4		1	
	SUID_Undet	20	11	21	22	3	1	
	Undetermined	1		3	3			
	Weapon					1		
Ages 1 – 4	Asphyxia	1	1	1				87
	Drown	10	1	4	1			
	Exposure	1						
	Fire	1	3		1			
	Homicide	1	1	5	6	2	1	
	Medical	4	5	5	4	2		
	MVC	2	7	2	2	1	1	
	Other Cause		1					
	Poison			3	1		1	
	SUDC	1	1					
	Undetermined			1				
	Weapon	2						
Ages 5 – 9	Asphyxia			1	2			54
	Drown	2	1	4	1			
	Fire	1	2		2			
	Homicide		1	1	2	1		
	Medical	1	4	5	4			
	MVC	5	1	7	3		1	
	Other Cause	1						
	Suicide			1				

All Reviewed 2016 Infant / Child Deaths (N = 531) (continued)								
		White		African American		Other Race		Total
AgeCat	Cause	Male	Female	Male	Female	Male	Female	
Ages 10 – 14	Drown			2				56
	Exposure			1				
	Fire		1					
	Homicide	2			2		1	
	Medical	3	2	1	1	1		
	MVC	6	6	4	2	1	1	
	Poison	1						
	Suicide	4	5	2	1	2	1	
	Undetermined			1				
	Weapon	1			1			
Ages 15 – 17	Bite	1						134
	Drown	1		4		1		
	Fire				2			
	Homicide	2	3	19	9	1		
	Medical	3	3	5	4		1	
	MVC	17	6	6	5	1		
	Poison	2						
	Suicide	19	4	5		2	5	
	Undetermined		1	1				
	Weapon			1				
Total		**139**	**95**	**153**	**109**	**20**	**15**	

Reviewed Deaths with Maltreatment Cause or History (N = 171)								
		White		African American		Other Race		Total
AgeCat	Cause	Male	Female	Male	Female	Male	Female	
Infant	Homicide	1	3	2	1			36
	Medical				1			
	Other Cause				1			
	Poison		1					
	SIDS	1			1			
	SUID_Asph	1		3	3			
	SUID_Med		1					
	SUID_Undet	3	2	3	5	1	1	
	Undet				1			
Ages 1 to 4	Asphyxia			1				39
	Drown	4	1	2	1			
	Fire	1	1					
	Homicide	1	1	5	6	2	1	
	Medical	1	1	3	3	2		
	MVC					1		
	Poison				1			
Ages 5 to 9	Asphyxia				1			24
	Drown	2		1				
	Fire	1	2					
	Homicide		1	1	2	1		
	Medical		2	3				
	MVC	2		3	1			
	Other Cause	1						
Ages 10 to 14	Drown			1				22
	Fire		1					
	Homicide	1					1	
	Medical	1	1	1				
	MVC	4	2	3				
	Suicide	1	3	1				
	Undetermined			1				
Ages 15 to 17	Drown	1		1				50
	Fire				1			
	Homicide	1		7	8	1		
	Medical	2		1	2		1	
	MVC	6	1	1				
	Poison	1						
	Suicide	9	2	1			3	
Total		**46**	**26**	**45**	**39**	**8**	**7**	

Preventability of Reviewed Deaths with No Maltreatment Cause or History (N = 360)			
	Death Preventable?		
Cause	No, probably not	Yes, probably	Could not determine
Asphyxia	1	3	2
Bite		1	
Drown		17	3
Exposure		2	
Fall/Crush			1
Fire		7	1
Homicide	3	16	2
Medical	30	4	14
MVC	2	62	4
Other Cause	1	2	
Poison		6	1
SIDS	1		1
SUDC		1	1
Suicide	8	16	7
SUID_Asph	1	39	11
SUID_Med	4	4	3
SUID_Undet	5	40	18
Undetermined	2	4	3
Weapon		6	

Preventability Determination, All Reviewed 2016 Deaths				
CauSummary	**No**	**Yes**	**?**	**% Preventable***
Asphyxia	1	5	2	
Bite		1		
Drown		30	4	
Exposure		2		
Fall/Crush			1	
Fire		12	3	
MVC	3	84	5	
OtherCause	2	2	1	
Poison		8	2	
Weapon		6		
Unintentional Subtotal	6	150	18	96.2
Homicide	7	56	5	88.9
Suicide	15	25	11	62.5
Sleep-Related Subtotal	15	97	40	86.6
SIDS	3		1	
SUID_Asph	3	43	12	
SUID_Med	4	4	4	
SUID_Undet	5	50	23	
SUDC		1	1	
Undetermined	2	4	5	
All Reviewable Subtotal	45	333	80	88.1
Medical	45	7	21	13.5
All Reviewed	90	340	101	79.1

1 = No, probably not

2 = Yes, probably

3 = Team could not determine

*Calculation of % Preventable excludes deaths for which the team could not determine preventability.

Notes

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Georgia