Georgia

Child Abuse Prevention & Treatment Act

Citizen Review Panels (CAPTA Panels)

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2019 Annual Report

06/22/2020

Coming together is a beginning.

Keeping together is progress.

Working together is success.

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2019 Annual Report Summary

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, the Justice for Victims of Trafficking Act of 2015 (P.L. 114-22) and was last reauthorized 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]. Most recently, certain provisions of the act were amended on January 7, 2019, by the Victims of Child Abuse Act Reauthorization Act of 2018 (P.L. 115-424). The CAPTA Reauthorization Act of 2019 is currently under review in Senate committee.

CAPTA provides federal funding and guidance to states in support of prevention, assessment, investigation, prosecution, and treatment activities and provides grants to public agencies and nonprofit organizations, including Indian Tribes and Tribal organizations, for demonstration programs and projects. Additionally, CAPTA identifies the federal role in supporting research, evaluation, technical assistance, and data collection activities; establishes the Office on Child Abuse and Neglect; and establishes a national clearinghouse of information relating to child abuse and neglect.

[1] The most recent reauthorization of CAPTA can be found at https://www.acf.hhs.gov/sites/default/files/cb/capta.pdf.

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 also sets forth a federal definition of child abuse and neglect. In 2015, the federal definitions of "child abuse and neglect" and "sexual abuse" were expanded by the Justice for Victims of Trafficking Act to include a child who is identified as a victim of sex trafficking or severe forms of trafficking in persons.

CAPTA 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. CAPTA, Section 106, is the enabling legislation for citizen review panels. Requirements related to CAPTA citizen review panels follows along with a description of Georgia's efforts to satisfy the legislative mandate.

106 c. CITIZEN REVIEW PANELS.—

1. ESTABLISHMENT.—
   - A. IN GENERAL.—Except as provided in subparagraph (B), each State to which a grant is made under this section shall establish not less than 3 citizen review panels.

     EXCEPTIONS.—
     - i. ESTABLISHMENT OF PANELS BY STATES RECEIVING MINIMUM ALLOTMENT.—A State that receives the minimum allotment of $175,000 under section 203(b)(1)(A) [42 U.S.C. 5116(b)(1)(A)] of this title for a fiscal year shall establish not less than 1 citizen review panel.
     - ii. DESIGNATION OF EXISTING ENTITIES.—A State may designate as panels for purposes of this subsection one or more existing entities established under State or Federal law, such as child fatality panels or foster care review panels, if such entities have the capacity to satisfy the requirements of paragraph (4) and the State ensures that such entities will satisfy such requirements.

In 2006, three existing committees were officially designated to serve as Georgia's citizen review panels (CAPTA Panels)[2]: Children's Justice Act Task Force (Task Force), 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[3].
- The CFRP, also has a dual role, serving as both a CAPTA Panel and a state-mandated body charged with reviewing the circumstances in all unexplained, unexpected child deaths and identifying opportunities for prevention. This includes all maltreatment-related deaths. CFRP established the Maltreatment Committee in 2009 to help meet its new obligations as a CAPTA Panel.
- The CPSAC serves solely as a CAPTA Panel.

> 2. MEMBERSHIP.—Each panel established pursuant to paragraph (1) shall be composed of volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse and neglect, and may include adult former victims of child abuse or neglect.

Georgia's CAPTA Panels are representative of the broader child welfare community and include members that represent the full spectrum of stakeholders including families, foster, adoptive and relative caregivers, experts in the prevention and treatment of child abuse and neglect in addition to professional disciplines involved in the investigation, prosecution, and judicial handling of these cases.[4] Due to the complexity of cases involving child maltreatment, special attention is given to ensuring that Panel members are familiar with the complexities of the child protection system, and include a balance among children's attorneys, child advocates, and CASA volunteers.

Ongoing efforts to supplement Panel membership by the Coordinator, individual Panel members, child welfare agency leadership, and a variety of professional and advocacy groups help to identify new candidates, and provide additional expertise relevant to Panel interests and/or its mandate as a CAPTA Panel.

Georgia's CAPTA Panel membership meets the legislative requirement for citizen review panels. A list of members for each Panel is included in the summary of its 2019 activities.

[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 Services.

[3] As a Children's Justice Act state grant recipient, Georgia is also required to maintain a task force on children's justice.

[4] Panels that serve a dual role have additional membership requirements/criteria that are described in their individual reports.

3. MEETINGS. —Each panel established pursuant to paragraph (1) shall meet not less than once every 3 months.

Each of Georgia's CAPTA Panels meet 4-6 times a year satisfying this requirement. Panel committees meet between meetings, as needed.

Annual Retreat

CAPTA Panel members participate in an annual day-long retreat in September. For the past several years, the retreat has been hosted at Cobb County Superior Court. The retreat provides opportunities for networking, inter-panel planning, and information gathering. The retreat also provides a forum for dialogue between Panels and the child welfare agency leadership team on issues of common concern and to identify opportunities for meaningful collaborations with CAPTA Panel members as stakeholders.

Special guests at the 2019 retreat included Tom Rawlings, Director, Georgia Division of Family and Children Services and Donna Dummet, Region IV, Child Welfare Specialist. The agenda for the 2019 retreat included presentations on:

- An overview of CAPTA and CJA legislation
- Priorities and challenges facing the child protection system by Division Director, Tom Rawlings
- A variety of Division statewide and/or local initiatives and pilot programs by members of the Division's leadership team
- A draft of the proposed new state CAPTA plan by the Federal Plans Manager, Shelby Zimmer

4. FUNCTIONS.—
   A. IN GENERAL.—Each panel established pursuant to paragraph (1) shall, by examining the policies, procedures, and practices of State and local agencies and where appropriate, specific cases, evaluate the extent to which State and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with—
      i. the State plan under subsection (b) of this section;
      ii. the child protection standards set forth in subsection (b) of this section; and
      iii. any other criteria that the panel considers important to ensure the protection of children, including—
         I. a review of the extent to which the State and local child protective services system is coordinated with the foster care and adoption programs established under part E of title IV of the Social Security Act (42 U.S.C. 671 et seq.); and
         II. a review of child fatalities and near fatalities (as defined in subsection (b)(4) [of this section]).

B. CONFIDENTIALITY.—
   i. IN GENERAL.—The members and staff of a panel established under paragraph (1)—
      I. shall not disclose to any person or government official any identifying information about any specific child protection case with respect to which the panel is provided information; and
      II. shall not make public other information unless authorized by State statute.

   ii. CIVIL SANCTIONS.—Each State that establishes a panel pursuant to paragraph (1) shall establish civil sanctions for a violation of clause (i).

C. PUBLIC OUTREACH.—Each panel shall provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community and in order to meet its obligations under subparagraph (A).

Georgia's CAPTA Panels function independently of each other, identifying annual priorities and projects or activities. Descriptions of these activities, and resulting recommendations in 2019, are included in the summary of activities for each Panel.

With respect to public outreach, a dedicated website, gacrp.com, is maintained where annual CAPTA Panel reports and state responses are posted, as are descriptions of CAPTA, CAPTA Panels and their objectives, interests and activities, and provides access for direct communication with the CAPTA Panels. In addition, many Panel members are involved as strategic partners on a variety of local, state and/or national boards or organizations that increase not only the collaborative potential of CAPTA Panels but also provide opportunities to a wide variety of stakeholders with comparable child welfare interests that include CAPTA objectives and the CAPTA Panel mandate. This includes groups or organizations, such as:

- 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
- Youth Protection Seminar Steering Committee
- Child Abuse and Neglect Strategic Planning Task Force
- Injury Prevention Plan Work Group

5. STATE ASSISTANCE.—Each State that establishes a panel pursuant to paragraph (1)—
   A. shall provide the panel access to information on cases that the panel desires to review if such information is necessary for the panel to carry out its functions under paragraph (4); and
   B. shall provide the panel, upon its request, staff assistance for the performance of the duties of the panel.

The state child welfare agency is 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 regarding its CAPTA Panels.

To sustain the efforts of the CAPTA Panels and ensure that it continues to meet its CAPTA obligations, the Division provides ongoing administrative support, including:

- Creating a Federal Plans Manager[5] position in 2016 to serve as a liaison with the Panels, and whose responsibilities include facilitating communication between the Division and the Panels, and management of CJA contracts related to Task Force recommendations. The Federal Plans Manager frequently attends meetings to strengthen relationships with Panel members, provide agency updates, and solicit feedback on Division initiatives. This allows for prompt sharing of information between the Panels and the Division to supports its ongoing work.
- Contracting with a firm for the services of an independent coordinator who:
  - Provides day-to-day operational support and technical assistance to the Panels and its committees
  - Facilitates the exchange of information between the Panels and the Division
  - Assists in the identification, recruitment, and retention of Panel members
  - Coordinates intra- and inter-Panel communications
  - Promotes and supports collaboration between the Panels
  - Promotes and supports collaborations between the Panels and the Division

The Division Director and the leadership team meet as needed during the year 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. Division Director, Tom Rawlings, spoke at an all-Panel meeting in February regarding the upcoming legislative session, Division priorities for the coming year, budgetary challenges, workplace culture, and opportunities resulting from FFPSA. Members of his

[5] Shelby Zimmer transitioned from her position as Federal Plans Manager to Families First Program Director in 2019 and Arleymah Gray was appointed as her replacement in April 2020.

leadership team responded to 2018 recommendations and answered questions from Panel members on actions taken on prior year's recommendations. Members of the Division's leadership team are frequently guests at Panel meetings when their area child welfare practice intersects with Panel interests or projects.

6. REPORTS.—Each panel established under paragraph (1) shall prepare and make available to the State and the public, on an annual basis, a report containing a summary of the activities of the panel and recommendations to improve the child protection services system at the State and local levels. Not later than 6 months after the date on which a report is submitted by the panel to the State, the appropriate State agency shall submit a written response to State and local child protection systems and the citizen review panel that describes whether or how the State will incorporate the recommendations of such panel (where appropriate) to make measurable progress in improving the State and local child protection system.

Since 2005, Georgia CAPTA Panels have prepared and submitted annual reports with a description of their activities evaluating state and local child protection system agencies, through the examination of policies, practices, and procedures of state and local agencies, and recommendations for improvement. 2019 CAPTA Panel activities and resulting recommendations are described in the individual summary reports that follow.

The Division has been consistent in providing written responses within the six-month time frame. In addition to describing its actions related to the state CAPTA plan and CAPTA Panel recommendations in the Annual Progress and Services Report, Division leadership also meets periodically with CAPTA Panels to provide updates on progress related to previous recommendations. Annual reports and state responses are posted on the CAPTA Panel website, gacrp.com.

The Panels and the Division have a collaborative and mutually respectful working relationship. The Division consults regularly with members of the Panels, formally and informally. The expertise and opinions of the Panel members are valued and opportunities for stakeholder involvement often happen organically, without the need for the federal mandate. This positive relationship contributes to the stability and effectiveness of Georgia's CAPTA Panels.

For many years, Georgia's Panel members have been involved to varying degrees in strategic planning activities and invited to participate on advisory groups, providing input or feedback, to the state agency on its development, revision, implementation, monitoring and/or evaluation of its plans, practice strategies, models, and programs. In 2019, this included, but was not limited to:

- State's 2020-2024 CFSP
- CFSP Stakeholder Planning Group
- APSR Joint Collaboration Meeting
- Revision of the state's CAPTA Plan

- NCWWI Workforce Excellence Project: Stakeholder Focus Group
- FFPSA Communications Stakeholder Focus Group
- State Child Abuse and Neglect Prevention Plan
- State Child Abuse Protocol
- Mandated Reporting Work Group
- CDNFSI Multidisciplinary Fatality Review
- Child welfare policy review, including:
    - Several policies related to caregiver substance use/abuse including:
        - 3.07 Intakes Involving Substance Use or Abuse, Prenatal Exposure, Prenatal Abuse or FASD
        - 5.12 Investigations: Newborn Exposure to Substances
        - 19.26 and 19.27 Case Management Involving Caregiver Substance Use/Abuse and Plan of Safe Care for Infants Prenatally Exposed or FASD
    - 19.3 Family Team Meetings (Jan 2019)
    - 10.21 Expectant or Parenting Youth in Foster Care (Jan 2019)
    - 19.3 Case Management: Solution Based Casework (Jan 2019)
    - Chapter 6.0-6.9 Special Investigations (Feb 2019)
    - 19.07 Avoiding Conflicts of Interests When Approving Caregivers (Mar 2019)
    - TBD Use of Voluntary Kinship in Child Protective Services (Mar 2019)
    - 19.24 Family Treatment Courts (Apr 2019)
    - 9.5 Reasonable Efforts (JUL 2019)
    - 10.17 Working with Immigrant and Refugee/Families (AUG 2019)

Several CAPTA Panel members were also closely involved in the revision of the state's CAPTA Plan. In May 2019, a work group was convened to solicit input on priority areas for the plan from CAPTA Panel members and other stakeholder groups to ensure coordination and collaboration with other state plans. Members from all three of Georgia's CAPTA Panels, were represented on the work group, in addition to representatives from the Court Improvement Project, Georgia CASA, Office of the Child Advocate, Georgia Departments of Education and Public Health, Prevent Child Abuse Georgia, as were Division subject matter experts.

The goal of the CAPTA plan work group was to identify priority areas for improvement and develop measurable objectives for each of the priority areas. The focus of the new plan addresses a wide spectrum of CAPTA Panel and Division priorities, including:

- Child Fatality Investigations
- Plans of Safe Care
- Work Force Development
- Mandated Reporting
- Child Representation

The Panels recommend that the Division develop and implement a protocol that institutionalizes engagement of its stakeholders, with mutual interests and expertise in these priority areas, to ensure that the use of CAPTA state grant is consistent with the CAPTA mandate and CAPTA plan goals and objectives. This would include developing a process for evaluating the effectiveness of activities as well as for the overall effectiveness of its CAPTA plan to affect system improvement in the priority areas.

National Citizen Review Panel Conference: Albuquerque, NM

Panel members who attended the national conference included, Judge Patterson, Task Force co-chair, Julia Neighbors, Task Force Mandated Reporter Committee chair, and Dr. Angela Boy, Child Protective Services Advisory Committee. CAPTA Panel and CJA Task Force Coordinator, Deb Farrell, also attended the conference. The theme for the annual conference was "Rising to the Challenge: Improving Child Protection Response Systems". Representatives from more than 25 states attended the conference. The agenda included a broad range of topics relevant to the CAPTA mandate of citizen review panels. Sessions were facilitated by a wide array of national, state and local experts, from both the academic and professional fields of child welfare, as well as stakeholder advocacy groups and citizen review panel members. Keynote addresses included presentations on sociology and criminal justice, creating culture for change, and organizational transformation by experts in those fields. Breakout sessions included:

- CRP 101
- Real World Implementation of CRP
- Reviews Get Real Results: Best Practices for CRPs
- Facilitation Tools and Techniques for Collaborative System Change
- Community Engagement Approaches to Evaluation
- Substance Impaired Parents
- How to Quickly Collect Data and How to Use It
- An Overview of QPR Institute Gatekeeper Training for Suicide Prevention plus Counseling on Access to Lethal Means (CALM)
- QSR: A Case-Based Methodology for Collaboration, Partnering and Shared Responsibility
- Interdisciplinary Representation

- Safety Organized Practice
- Childhood Sexual Abuse: What CRP Members Need to Know
- Child Abuse from a Multidisciplinary Lens
- Honoring Tribal Connections by Following the Indian Child Welfare Act
- A Journey Through a Youth's Eyes
- Families First: Responding to the Shifting Landscape of Child Welfare
- The Impact of Changing Immigration Policy on Child Wellbeing and Child Welfare
- Supporting the Emotional Wellness of Child Welfare Staff
- Transgender 101

Georgia's CAPTA Panel and CJA Task Force Coordinator also serves as the chair of the recently reconstituted (May 2017) National Citizen Review Panel Advisory Board. The purpose of the advisory board is to support and advocate for the citizen review panel community and to serve as a resource for community. In addition to facilitating a strategic planning session for the Advisory Board, Ms. Farrell also presented at the conference on the recent activities of the advisory board and its plans for 2020.

Attached are summaries prepared by each of Georgia's CAPTA Panels on their activities in 2019. Panel members look forward to meeting with the Division leadership team to discuss their recommendations and identify opportunities to support the Division's efforts in responding to their recommendations.

Respectfully submitted on behalf of Georgia's CAPTA Panels

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

Children's Justice Act Task Force

Vision

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

Mission

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

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Children's Justice Act, Section 107 of the Child Abuse Prevention and Treatment Act (CAPTA)

The Children's Justice Act (CJA) provides grants to states to improve the investigation, prosecution, and judicial handling of cases of child abuse and neglect, particularly child sexual abuse and exploitation, in a manner that limits additional trauma to the child victim. This also includes the handling of child fatality cases where child abuse or neglect is suspected and cases involving children with disabilities or serious health problems who are the victims of abuse and neglect. The intent of the funding is to create systemic changes that prevent additional trauma to child victims, and to protect their rights more effectively, when child abuse and neglect occur. This includes developing, establishing, and operating programs designed to support front-end efforts or intake and investigation phases of child welfare cases. States receiving CJA grants must implement recommendations in each of the following categories, as required by legislation:

A. Investigative, administrative, and judicial handling of cases of child abuse and neglect.
B. Experimental, model, and demonstration programs for testing innovative approaches.
C. Reform of state laws, ordinances, regulations, protocols, and procedures.

As CJA grants are intended to address issues at the front end of the state's multidisciplinary response and focus on general systemic improvements specifically for children's justice, funding for direct treatment services or prevention programs is not an appropriate use of CJA funding.

Funding for CJA comes from the Crime Victims Fund, which collects fines and fees charged to persons convicted of federal crimes. The fund is administered by the U.S. Department of Justice, Office for Victims of Crime (OVC), and the grants are awarded by the Administration on Children, Youth and Families, U.S. Department of Health and Human Services. State recipients of CJA grants are responsible for implementing the requirements of the CJA grant program to reform state processes for responding to child abuse and neglect. Georgia's CJA grant is administered by Georgia's Department of Human Services, Division of Family and Children Services (Division).

Children's Justice Grant Eligibility and Requirements

Specific eligibility criteria related to CJA state grants follow as well as a description of Georgia's efforts to satisfy these legislative requirements.

1. State must fulfill the eligibility requirements for a CAPTA basic state grant as outlined in Section 106(b) of CAPTA

Georgia currently meets all eligibility requirements as a CAPTA basic state grant recipient.[1]

2. State must establish and maintain a multidisciplinary task force on children justice

The purpose of a CJA task force is to review and evaluate practices and protocols associated with the investigative, administrative, and judicial handling of cases of child abuse and neglect and to make policy and training recommendations that will improve the handling of these cases and result in reduced trauma to the child victim and victim's family while ensuring fairness to the accused. Georgia's Children's Justice Act Task Force (Task Force)[2] was established in 2003 and designated as one of Georgia's three CAPTA Panels[3] in 2005. The Task Force has operated since that time in compliance with both legislated mandates.

[1] CAPTA was amended most recently by P.L. 115-271, the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act or the SUPPORT for Patients and Communities Act. https://www.acf.hhs.gov/sites/default/files/cb/capta.pdf.

[2] A CJA multidisciplinary task force and a CAPTA citizen review panel share complementary purposes and objectives related to system improvement in child welfare and for children's justice. Georgia's CJA Task Force serves a dual role as both a CAPTA citizen review panel and a task force on children's justice.

[3] In Georgia, CAPTA citizen review panels are referred to as "CAPTA Panels."

Section 107 of CAPTA, legislates that a CJA task force must be composed of professionals with knowledge and experience relating to the criminal justice system and issues of child abuse and neglect, child sexual abuse and exploitation, and child maltreatment-related fatalities. In addition, the task force must include representatives of parents' groups, adult former victims of child abuse and neglect, and individuals experienced in working with children with disabilities and homeless children and youth. 2019 Task Force members and their associated representation include:

Sandra Barrett, Volunteer, Carroll County CASA
Court Appointed Special Advocate

Cheryl Benefield, Program Manager, Safe & Drug-Free Schools, GA Department of Education
Education

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

Kyle Browne, Child Advocate Attorney, Dekalb Child Advocacy Center
Child Attorney

Rachelle Carnesale, Superior Court Judge, Fulton County
Disabilities

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

Nancy Chandler, CEO – Retired, Georgia Center for Child Advocacy
Advocate

Dena Crim, Special Assistant Attorney General, Georgia Department of Law, Cobb County
Juvenile Victim

Latera Davis, Director of Victim and Volunteer Services, Department of Juvenile Justice

Nicholas Forge, PhD, MA, LMSW, Georgia State University Clinical Assistant Professor
Homeless Youth Advocate

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

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

C. LaTain (Tain) Kell, Sr ., Cobb County Superior Court
Superior Court Judge

Beoncia Loveless, Consultant/Trainer, Child Death Investigation Specialist
Adoptive Parent (Former Relative Foster Parent)

Stephen Messner, MD, Medical Director, Children's Healthcare of Atlanta, Stephanie Blank Child Protection Center
Health Professional

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

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

Amber Patterson*, Cobb County Juvenile Court
Juvenile Court Judge

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

Mitzie Smith, Unit Director, Georgia Division of Family and Children Services, Knowledge Management Section, Policy and Regulations Unit
Child Protective Services

Angela Tanzella-Tyner, JD, Director of Advocacy & Program Development, Georgia CASA
Court Appointed Special Advocate

Kelly Tonelli, Sergeant, Special Victims Unit, Gwinnett County Police Department
Law Enforcement

Ashley Willcott, Dekalb Juvenile Court
Judge Pro Tem

Deb Farrell, Care Solutions, Inc.
Task Force Coordinator

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 Amber Patterson, Juvenile Court Judge for Cobb County. Ms. Carter has been a member since 2007 and Judge Patterson since 2017. At this time, all mandated positions on the Task Force have been satisfied.

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 to provide additional expertise relevant to Task Force priorities and/or its mandate as a CAPTA Panel.

CJA task forces, like CAPTA citizen review panels, are required to meet at least quarterly. Georgia's Task Force holds five regularly scheduled meetings each year, satisfying the federally mandated minimum requirement. These meetings occurred in November 2018, and January, March, June, and August 2019.

Committee meetings, special meetings, and conference calls were held as needed. Task Force members consulted regularly with each other and the CJA Coordinator for updates on work 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. Members of the Division's leadership team are frequent guests at Task Force meetings to either provide or gather information and to explore opportunities to collaborate when mutual interests or priorities intersect.

In 2019, Criminal Justice Coordinating Council (CJCC) was invited to the November meeting to share information on programs they support in Georgia with Victims of Crime Act (VOCA) grants. CJA and VOCA grants have intersecting interests and often support projects of similar objectives. In June, newly appointed Office of the Child Advocate Director (OCA), Rachel Davidson, was invited to share her vision and priorities for that office under her leadership. CJA funds have supported several OCA projects over the years.

3. State must submit an annual CJA application that includes assurances and information necessary to demonstrates compliance with legislative requirements and to report on how the CJA grant was used, with particular attention to activities that address CJA objectives.

Georgia submits a CJA grant application annually that includes:

- Assurances from the Governor that the state has fulfilled all requirements outlined in Section 106 of CAPTA.
- Documentation that the state has established and maintained a multidisciplinary Task Force on children's justice composed of the required professional disciplines, including membership list and meeting schedule.
- Description of task force activities and recommendations related to the use of the CJA state grant with emphasis on:
    - The assessment and investigation of suspected child abuse and neglect cases, including cases of suspected child sexual abuse and exploitation, in a manner that limits additional trauma to the child and the child's family.
    - The assessment and investigation of cases of suspected child abuse-related fatalities and suspected child neglect-related fatalities.
    - The investigation and prosecution of cases of child abuse and neglect, including child sexual abuse and exploitation.
    - The assessment and investigation of cases involving children with disabilities or serious health-related problems who are suspected victims of child abuse or neglect.

Documentation must identify that all Task Force recommendations adopted and/or comparable alternatives; describe the actions yet to be taken and timetables for implementing each recommendation or comparable alternative; or be sufficient to support a showing that the state is making substantial progress in adopting Task Force recommendations or comparable alternatives. Documentation must also clearly articulate demonstration of the awareness of Child and Family Services Plan (CFSP) and Annual Program and Services Report (APSR) strategies and goals, and the ways in which the CJA program's activities and goals align with those of the CFSP and APSR, as appropriate.

Since 2003, the Task Force has collaborated with Georgia's child welfare agency on the administration of the CJA funds, including the solicitation and review of proposals and funding recommendations. The Task Force Grants Committee reviews all CJA grant proposals and annual performance reports and develops recommendations on CJA grant allocations for those projects that support CJA objectives, and state and Task Force priorities related to the CJA mandate. These recommendations are submitted to the Division for review, approval, and contract management.

4. Every three years, the State Task Force must undertake a comprehensive review and evaluation of the investigative, administrative, and both civil and criminal judicial handling of cases of child abuse and neglect and to make training and policy recommendations in each of the three categories in Section 107(e)(1)(A), (B) and (C).

- The assessment must include a report clearly outlining the review, evaluation, and recommendations in all the areas required in Section 107(e)(1)(A), (B) and (C).
- The report must detail the process used to conduct and complete the three-year assessment. The review and evaluation should build on prior assessments and note system improvements related to prior work. The review must outline proposed policy and training recommendations.

Since 2005, the Task Force has completed four three-year assessments (Assessment). The first, in 2009, focused on child sexual abuse training, mandated reporting, and practice regarding the appointment of representation for children in dependency cases. The second, in 2012, evaluated policy, practice, and training related to the handling of cases involving victims with special needs. The third, in 2015, addressed concerns related to reported inconsistencies in how various agencies respond to allegations of child abuse and neglect.

The most recent Assessment, completed in 2018, examined the training provided to individuals from the multi-disciplines who respond to and investigate all forms of child maltreatment to identify potential training gaps or barriers and opportunities to enhance best practices. Based on the findings, and recommendations resulting

from the evaluation of the findings, Task Force committees identified and incorporated opportunities to support system improvement into their activities and to guide decisions regarding future projects funded with the CJA grant.

The priorities and activities of the Task Force reflect its commitment to continued improvement in the policy and practice areas identified in each of the three-year assessments.

Task Force Special Legislative Interest: Child Abuse and Neglect Terminology[4]

In 2019, the Task Force continued its efforts to address issues identified in the 2015 three-year assessment and alignment of definitions of child abuse and neglect in different sections of Georgia Code for state agencies with child-caring or child protection responsibilities, or oversight of agencies or institutions with child-caring or child protection responsibilities. Inconsistencies identified in terminology give rise to potential inconsistencies in interpretation including the identification, reporting, and response to suspected child abuse and neglect by those agencies. These inconsistencies have also had an impact on the implementation of Georgia's Child Abuse Registry.

In its 2015 system assessment, 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 state's model Child Abuse Protocol.

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's investigations of maltreatment in care reports, and subsequently, in the implementation of the child abuse registry.

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

After the Task Force submitted its recommendations to Division leadership, the Division Director and General Counsel collaborated with the Executive Director of the Barton Center and Task Force Co-chair and others (including the Prosecuting Attorneys Council, Georgia Court Appointed Special Advocates, the Georgia Supreme Court Committee on Justice for Children (the state's Court Improvement Program), the Georgia Association of Criminal Defense Lawyers, and the Office of State Administrative Hearings) to develop a legislative proposal to amend the definition of "child abuse" 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 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 further.

To increase chances of passage in the 2019-2020 legislative session, the Division included the proposed amendment redefining "child abuse" in the mandated reporter statute as an agency priority submitted for consideration by the Governor's office. Once permission was obtained, the proposal was, in fact, included in an omnibus child welfare bill prepared as part of Governor Kemp's legislative package. That omnibus bill was later separated into several individual bills, and the definitions were included in a substitute version of House Bill 971.

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.

Update: Due to a number of extenuating circumstances including a critical health event befalling the committee chair, the bill did not pass out of the House Juvenile Justice Committee. Plans were underway, however, to recover the underlying policy and advance it during the latter part of the session using another bill. The Georgia General Assembly suspended the session on March 13, however, due to COVID-19. The legislature will reconvene, possibly as early as June 11, to complete its work on the state budget. Further deliberation on

substantive policy bills is not expected, however. Thus, the amendments will need to be introduced again next year.

The next three-year assessment is due with Georgia's 2021 CJA grant application.

5. State must participate in at least one Federally initiated CJA meeting each year that the grant is in effect and are authorized to use grant funds to cover travel and per diem expenses for two CJA representatives (CJA Coordinator and Task Force Chairperson) to attend the meeting.

Annual CJA Grantee Meeting: Washington, DC

The Children's Bureau hosts annual grantee meetings for all discretionary and formula grant programs. Representing Georgia at the one-and-a-half-day meeting in 2019 were:

- Laresa Price, Safety Unit Director, SLO
- Shelby Zimmer, Federal Plans Manager (CAPTA Panel Liaison)
- Melissa Carter, Task Force Co-Chair
- Deb Farrell, Task Force Coordinator

In addition to a facilitated discussion with Children's Bureau Associate Commissioner, Jerry Milner, the 2019 annual meeting provided updates from federal partner agencies, an opportunity for CJA grantee states to hear from national experts and network with CJA task force representatives from other states.

Task Force Priorities

Since its establishment in 2003, the Task Force has collaborated with the Division in the administration of the CJA grant by operationalizing CJA grant processes for the solicitation and review of proposals, and identification of projects that support CJA goals that include:

- Improving communication, collaboration, and coordination between agencies and among the professionals involved in cases of child maltreatment, from initial allegation and response to investigation and prosecution
- Improving the collection, analysis, and exchange of data
- Advocating for and supporting the development of child welfare professionals

The Task Force prioritizes 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
- Improve the quality and consistency of the community's collaborative response to reports of abuse
- Ensure the appropriate handling of cases involving child victims with special developmental or medical needs
- Ensure the appropriate handling of cases involving victims of sex trafficking
- Ensure the identification of maltreatment-related fatalities
- Reduce trauma to child victims of abuse
- Ensure that all children have access to and are appointed qualified individuals to represent their interests in judicial proceedings

The Task Force continues to support coordinated, multidisciplinary approaches that improve the investigation, prosecution, and judicial handling of cases of child abuse and neglect and support CJA goals and objectives, as well as state and Task Force interests and priorities, such as:

- Increasing access to multidisciplinary education and training (forensic interview training)
- Improving the identification of child abuse and neglect (mandated reporting)
- Improving the response to allegations of child abuse and neglect (centralized call center)
- Improving the collection, analysis, and exchange of data (analysis of child fatality data)
- Increasing opportunities for professionals interested in the field of child advocacy from both a dependency and criminal justice perspectives

Task Force Activities

Task Force has established several committees to support its ongoing priorities and interests. These include:

- Child Abuse Protocol Committee
- Mandated Reporter Training Committee
- Child Fatality Investigations Committee
- Special Needs Committee
- Sex trafficking Committee
- Child Representation Committee
- CJA Grants Committee

The level of committee activity varies from year-to-year depending on Task Force priorities and collaborative opportunities.

Child Abuse Protocol Committee

The Committee has two primary objectives for its work on the state Child Abuse Protocol (CAP):

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

The state's model CAP) outlines the procedures to be used in the multidisciplinary investigation and prosecution cases of suspected child abuse and neglect, child sexual abuse and child sexual exploitation and to assist local jurisdictions with the development of local protocols which reflect the best practices in the handling of these cases. The purpose of the CAP is to ensure coordination and cooperation between all agencies involved in a child abuse case so as to increase the efficiency of all agencies handling such cases, to minimize the stress created for the allegedly abused child by the legal and investigatory process, and to ensure that more effective treatment is provided including counseling. O.C.G.A.§19-15-2 (f).

In 2019, the Office of the Child Advocate (OCA) engaged a contractor to review and update the state's model CAP. This was completed and distributed for review to a broad multidisciplinary audience including members of the Task Force. Task Force members provided feedback on proposed CAP[5] updates.

The Committee acknowledges that policy and practice related to child abuse and neglect is constantly responding to changes in the child welfare environment to improve the multidisciplinary response. The Task Force recommends that the Division collaborate with OCA and other stakeholders to determine how best to institutionalize a process for the regular review, revision, and dissemination of future updated CAP to improve its efficacy.

To increase the local use of the CAP, and the efficiency of disseminating regular updated policy and practice, the Committee has previously recommended that the development of a mobile friendly version of the CAP be considered and the Task Force further recommends that the Division and OCA investigate the viability of this as a more cost effective, efficient option for the CAP. CJA funds could be used to support this effort.

The Committee continues its efforts to identify opportunities to increase the commitment, at both the state and community levels, to the multidisciplinary response to child maltreatment. Intersecting work with other committees suggests that there are elements of Georgia Code 19-15-2 related to the Child Abuse Protocol that are outdated, and in need of review and update. The Task Force recommends that the Division undertake such a review to

[5] A copy of the most recently updated protocol can be found https://oca.georgia.gov/protocols-resources/statewide-model-child-abuse-protocol.

identify inconsistencies, deficiencies, or dated information that may need to be addressed legislatively to improve the coordinated response to child abuse and neglect by all parties involved.

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 Assessment. 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.

To further these objectives, the Committee identified several opportunities it wanted to investigate further. These included:

1. Identifying and evaluating both mandated reporter training requirements and mandated reporter training for each state agency with child-caring or child protection responsibilities
2. Conducting research on other state training requirements for mandated reporters
3. Developing standards for content and delivery to ensure that mandated reporter training is consistent with child welfare policy and practice
4. Developing a review and approval mechanism for mandated reporter training
5. Evaluating mandated reporter training

The Committee recognized that a Division-led, multi-agency, multidisciplinary committee would be needed to facilitate the development of a state-level agreement/protocol (analogous to state child abuse protocols with specified agencies and agency responsibilities) and coordinate any effort to develop standards for mandated reporters and mandated reporter training for any state agencies with child-caring or child protection responsibilities that are required to report and respond to incidents of child abuse and neglect. In 2019, several members of the Committee were invited to participate in a state-level multi-agency Mandated Reporter Training Standards work group convened by the Division's Prevention and Community Support Section to develop standards for mandated reporter training, as has been previously recommended by the Committee. It is recommended by the Task Force that the Division-led work group include in its scope of work:

1. Developing standards for mandated reporter training for specific agencies/roles.
2. Institutionalizing the Division's role in the approval of mandated reporter training content.

3. Developing appropriate protocols for interviewing child victims to minimize duplication and trauma to the child and to improve communication and information-sharing when suspected child abuse or neglect is reported.

Child Fatality Investigations Committee

The objectives of the Child Fatality Investigations Committee are:

- To promote and support timely, consistent, coordinated, and effective investigations of maltreatment-related deaths
- To improve the identification of maltreatment in any child death, but particularly in medical/natural deaths or cases involving victims with special needs
- To improve the identification and evaluation of cases of prenatally exposed infants in sleep-related deaths

This Committee identified several opportunities in the 2018 Assessment to improve the identification of maltreatment-related fatalities. One was the development of a training on child abuse and neglect for first responders and a previous recommendation. The second was enhancing the CAP with a model protocol for investigating juvenile deaths as this had been identified as an opportunity to improve the state model CAP. In 2019, the efforts of the Committee focused on development of a model protocol.

Report from the Committee on Development of Proposed State Model Protocol for Investigating Child Deaths

The investigation of any juvenile death is complex and multi-faceted. Even in the most innocuous of circumstances, multiple individuals and agencies are involved and must assess the nature of the death. In 2019/2020, the committee focused its efforts on drafting a statewide child fatality investigation protocol, having identified that the state model Child Abuse Protocol provided no substantive guidelines on conducting these most complex of investigations. Initial investigative decisions are often made under duress and based on information derived during stressful interviews with grief-stricken, panicked caregivers. In addition, neglect and maltreatment play a role in many juvenile deaths and more extensive investigative strategies and interviews must be utilized to determine the nature of the death and prepare a strong case for judicial proceedings, if applicable.

In Georgia, there is a fragmented, multi-layered death investigation system involving 159 counties; most counties have elected coroners in office. There is a state Medical Examiner's Office within the Georgia Bureau of Investigation, as well as four independent, county-supported Medical Examiner facilities within the four largest metro-Atlanta counties. All medical examiner's offices in the state employ forensic pathologists, death investigators, and pathology assistants. Various law enforcement agencies at both the local and state level

routinely conduct death investigations. The state's child welfare agency, the Division of Family and Children Services, functions in every county and is frequently involved in death investigations as well.

In recent years, there has been a concerted effort within the medicolegal death investigation and public health communities to increase the efficacy of juvenile death investigations, most notably surrounding sleep-related infant deaths. Because of this national effort, the vast majority (96%+) of sleep-related infant deaths in Georgia from 2012-2018 were subject to a scene investigation, as medical examiner personnel in the state worked in conjunction with coroners and law enforcement to gather as much investigative data as possible prior to assigning cause and manner of death.

However, doll reenactments were not standard procedure for many years despite the consistently high numbers of scene investigations. As training and awareness surrounding the value of doll reenactments improved, investigative entities in the field began to utilize the practice more frequently and there has been a steady increase. In 2018, almost 70% of infant death investigations in Georgia included a doll reenactment, an incredible increase from only 28% in 2014. [6]Although the Committee is gratified to see the increase in doll reenactments, it recommends that doll reenactments be conducted on the scene of all sleep-related deaths. The committee further recommends that CJA funds should be made available to jurisdictions that do not have access to this resource.

The intense scrutiny of sleep-related deaths has not only provided more accurate determinations for cause and manner of death, it has revealed more subtle maltreatment cases and exposed the need for such exhaustive enquiries in all types of juvenile death.

A statewide protocol, outlining "best practices," training guidelines, and available resources, has been drafted by the committee and will provide the foundation on which to build a robust, coordinated response to juvenile deaths, regardless of jurisdiction. A basic protocol for child death investigation ensures a uniform response, a strong investigative foundation, and a thorough review of all the details associated with a death. In addition, consistent and thorough death investigation increases the accuracy of data gathered by various entities responsible for surveillance and prevention efforts in all types of deaths.

[6] Data reported on 2014-2018 Georgia Child Death Reviews.

The Committee has completed its proposed model protocol for the 'Multidisciplinary Investigation of Juvenile Death'. It is attached to this summary report as *Appendix A*. The Task Force recommends that the proposed protocol be incorporated into an update of the state model Child Abuse Protocol.

Furthermore, the Committee is recommending that each professional discipline or agency with a role in the investigation of a juvenile death review the protocol in conjunction with its own policies and procedures and conduct an evaluation and update of policy in light of "Best Practice" guidelines, as may be necessary. This may require legislative action associated with an update of the Georgia Code 19-15-2. The Task Force supports this recommendation.

The Committee has previously recommended that first responders/EMS be incorporated into the state model CAP. Including this professional discipline in the CAP would help to increase the likelihood, that when maltreatment is a possible contributing factor, it will be identified earlier and more consistently at a scene of a child fatality, and help to improve the preservation of evidence should criminal charges be forthcoming. The Task Force recommends that the Division collaborate with OCA to facilitate this enhancement of the state model CAP. It also recommends, if necessary, that the Division support legislative activities related to Georgia Code 19-15-2 that would facilitate this or any other Task Force recommendation that impacts the multidisciplinary response to child abuse and neglect.

Special Needs Committee

The Special Needs Committee continues to play a role on each of the other Task Force committees to ensure that their activities and recommendations align with CJA goals and objectives regarding child victims with special developmental and medical needs.

Sex-Trafficking Committee

In 2019, committee members raised concerns regarding the ongoing challenge in securing appropriate placements for trafficked youth. It was reported that the few placement sites that are available, are underutilized, primarily due to eligibility criteria. The Committee also expressed an interest in examining data on the state's homeless youth population as this is a high-risk group for exploitation. The Committee plans to pursue both opportunities in 2020.

Child Representation Committee

Georgia's CJA Task Force has been involved in previous efforts to ensure that all children in dependency cases have representation. This included a role in the state's Program Improvement Plan (PIP) in 2009 that resulted in updates to policy and the state's SACWIS system to facilitate the collection of information on the appointments of attorneys and/or CASAs. The objective of the committee is:

- To ensure that all children have access to and are appointed qualified individuals to represent their interests in judicial proceedings

The Task Force is also committed to establishing a collaborative working relationship with the Court Improvement Project (CIP) to coordinate work that supports their mutual objectives. The Child Representation committee has identified a potential joint project to evaluate state practice related child representation and related CAPTA assurances. The objective of such a project would be to produce recommendations for system change and to generate qualifications and training standards for professionals who represent children.

In response to recent changes in federal legislation allowing IV-E reimbursement for administrative costs related to legal representation and development of Georgia's new state CAPTA plan that includes a focus on child representation, the committee recommends that the Division convene a work group that includes, in addition to members of the Child Representation Committee, its General Counsel, CIP, OCA, CASA and other relevant stakeholders to assess current practice and coordinate efforts among the various state plans. Current child representation data, CAPTA requirements, and degree of compliance with CAPTA assurances should be evaluated to identify gaps, areas needing improvement, and additional opportunities. Based on the results of the evaluation, a plan should be developed to address any legislative changes needed, documentation and reporting requirements, inter-agency data-sharing expectations, training standards, and targets for improvement.

CIP Director, Jerry Bruce attended several Task Force meetings in 2019 to discuss mutual interests and explore potential collaborative opportunities. As a result, the Task Force has since decided to make 'child representation' the focus of its next three-year assessment, due in 2021. It is expected that the project will be structured as a multi-year effort and include, in addition to the CIP, the General Counsel for the child welfare agency, Office of the Child Advocate, CASA, Office of the Child Attorney and Barton Child Law and Policy Center.

Grants Committee

To further its primary objectives as a task force on children's justice and meet its mandate, the Task Force continues to recommend supporting those activities that improve and strengthen the investigation and prosecution of cases of child abuse and maltreatment-related fatalities, in addition to supporting projects that address the new priorities identified in the three-year assessment. In 2018, the committee updated the proposal solicitation document to support clear alignment of proposed activities with objectives and priorities and to encourage applicants to clearly identify evaluation strategies for projects with the proposal.

Evaluation of activities continues to be a challenge for the Committee and there are plans to revamp the performance report guidelines and develop a standard evaluation tool for training, as many projects funded by the

CJA grant include specialized training. Future proposal solicitation documents will be updated accordingly to reflect changes in performance expectations and reporting. It is also expected that additional changes may be required after the next Three-Year Assessment, in 2021, have been completed.

The Committee also intends to invite current grantees to make presentations to the Task Force on their projects, especially those that receive ongoing support. In 2019, Child Advocacy Centers of Georgia's, "One Team" conference made a presentation on their conference at a Task Force meeting. The presentation highlighted the benefits of sustained support as a CJA grantee as well as the many achievements of the conference over the years. At the encouragement of the Task Force, the conference has expanded the multidisciplinary focus in its participants, presenters, and content. The Committee plans to provide more of these opportunities for grantees in an effort to increase responsiveness and accountability and to help strengthen the quality of proposals and the evaluation of grantee performance.

FFY2019 Projects Funded

The Task Force recommended CJA awards for several projects that were responsive to CJA objectives, Task Force interests and state agency priorities. Each project reflects the CJA emphasis on advocacy, multidisciplinary approaches, collaboration, and Task Force special interests. Additionally, projects that address children with special needs and/or commercial sexual exploitation of children are encouraged, and supported, whenever possible. CJA grantees have been identified below with brief descriptions of activities funded in 2019.

Grantee: Cherokee Child Advocacy Center, Inc., ChildFirst Training

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

The ChildFirst™ Georgia program provided six forensic interview trainings, including:

- Three ChildFirst Basic 40-hour Forensic Interview courses
- One 3-day Advanced ChildFirst course- Your Role in the Judicial Process
- Two 3-day ChildFirst Expanded courses

In FFY 2019, 121 professionals from 47 counties received training. Professionals represented the following disciplines: Law Enforcement (34); Child Advocacy Centers (74); District Attorney's Offices (8); and Department of Family and Children Services (2); Other (3). Priority for participation was given to professionals who:

- Applied as a part of a multi-disciplinary team.
- Work in counties that do not current have ChildFirst™ trained forensic interviewer and/or do not have access to a Child Advocacy Center.
- Are able to conduct forensic interviews in languages other than English.
- Would be providing forensic interviews to children with special needs.
- Would be providing forensic interviews to children who have been commercially sexually exploited.

Grantee: Children's Advocacy Center of Georgia, One Team Conference

On October 15-18, 2018, the Children's Advocacy Center of Georgia held its 12th annual One Team Conference, providing multidisciplinary training on a wide spectrum of topics on child sexual abuse, child commercial sexual exploitation, and children with special needs to more than 250 professionals involved in the investigation and prosecution of child abuse cases.

Task Force members that presented at the conference included:

- Donnie Winokur on sex-trafficked special needs victims, "The Perfect Storm"
- Dr. Stephen Messner on "Medical Evidence Testimony in Child Abuse Hearings" and "Forensic Medical Exams 101"
- Lalaine Briones on "Investigating and Prosecuting Severe Child Abuse and Child Homicide Cases"

Grantee: Emory University – Barton Child Law and Policy Center, Emory Summer Child Advocacy Program

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 2019 ESCAP program included an intensive, 4-day orientation training followed by 10 weeks of a paid internship for 8 graduate students from across the United States. Placements are carefully selected to represent a range of opportunities, from direct practice settings to agency administrative and public policy positions. In 2019, placements included juvenile courts, non-profit policy and advocacy organizations, the Georgia Bureau of Investigation, and the Wilbanks Child Endangerment and Sexual Exploitation (CEASE) Clinic at the University of Georgia School of Law.

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.

Grantee: Georgia CASA, CASA Advocacy Training

The Advocacy Training project was designed to strengthen the advocacy skills of CASA staff and volunteers at 46 affiliated CASA programs across the state. Advanced training was provided by webinar, in-person, and made available on the CASA website. In addition to webinar, Juvenile Court 101, training sessions were provided on the following:

- Courtroom Advocacy: 66 volunteers and staff
- Education Advocacy for Children: 40 staff
- Path to Permanence - Practical Considerations: 33 volunteers and staff
- Supervisory Training: 33 volunteers and staff
- In Pursuit of the Best Interest of the Child: 64 volunteers and staff
- Cultural Humility: 60 volunteers and staff
- Caring and Coaching: 50 staff
- Writing Effective Court Reports: 30 volunteers and staff
- Federal Framework & Best Interest of Children: 30 volunteers and staff
- Trauma-Informed Advocacy: 15 volunteers and staff

Two quick reference guides, Supporting Kin Caregivers and Placement Stability Part 1 were updated due to legislative and policy changes.

Eleven onsite court visits were also conducted to review cases, provide feedback to staff and volunteers and 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 to receive all relevant information needed to make sound decisions.

Children's Healthcare of Atlanta, Medical Provider Network

In partnership with professionals from the Stephanie V. Blank Center for Safe and Healthy Children (CSHC) at Children's Healthcare of Atlanta and staff from the Division of Family and Children's 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. Local access to forensic medical exams decreases missed or erroneous diagnoses, subsequent escalation of abuse, wrongful accusations of caregivers, and further trauma to the child and family. Physicians and staff at the CSHC provide ongoing mentoring, training, and consultation to network providers to improve the assessment and investigation of child abuse and neglect.

In FFY 2019, the Medical Network conducted 59 medical evaluations from 12 underserved and under resourced counties in South Georgia. CSHC consulted with local Division staff, as needed, to provide information on the network and how to access providers and consulted regularly with agency leadership on strategies to increase utilization of the network. A statewide multidisciplinary team composed of CSHC physicians, Special Investigations Unit caseworkers and managers was convened in 2019 to review the most severe cases. The team met monthly and reviewed 21 cases.

A change in organizational structure to dispersing the state's Special Investigations Unit responsibilities has had an impact on utilization of the network and it is hoped that this trend will be reversed in 2020/2021 as new protocols are implemented.

Grantee: Office of the Child Advocate, Child Protection Summit

The Office of the Child Advocate partnered with the Division of Family and Children Services and the Georgia Supreme Court's Committee on Justice for Children to host the inaugural Child Protection Summit December 3-5, 2018. The Summit hosted 514 participants including frontline and state office Division staff, child welfare attorneys, Court Appointed Special Advocates, judges, and law enforcement. In 2018, at the urging of the Task Force, the Summit expanded its multidisciplinary focus to include medical personnel and representatives from the faith-based community.

The Summit provided multidisciplinary education on topics such as:

- Trauma-Informed Systems of Care: Creating a Culture of Well-Being
- Renewing a Multi-Disciplinary Team (MDT) Approach to Non-Accidental Trauma in Serious Injury Cases
- Risk & Remedy: Foster Care's Response to Commercially Sexually Exploited Children
- Representing the Whole Child: Your Role as the Child's Attorney

Grants Committee Recommendations for CJA Funding (Projects proposed in FFY2019 for funding in FFY2020

In consideration of the recommendations made by the Task Force, which are based on CJA and CAPTA objectives, Task Force priorities, results from the three-year assessment, and in consultation with the state's child welfare

agency with considerations of its CFSP goals, Georgia proposes to continue to utilize the Children's Justice Act grant to support programs or activities that encourage collaboration in the investigation, assessment, and prosecution of cases of child abuse. These efforts also include work to expand the use of multi-disciplinary investigation teams and enhance child advocacy in cases of child abuse and neglect, child sexual abuse and exploitation, and maltreatment-related fatalities. The following projects were recommended for funding in FFY2020 (* indicates also a FFY2019 grantee):

Cherokee Child Advocacy Center, Inc.*, ChildFirst Forensic Interview Training
Award: $100,000

Children's Advocacy Center of Georgia*, Project: One Team Conference
Award: $25,000

Emory University – Barton Child Law and Policy Center*, Emory Summer Child Advocacy Program
Award: $100,000

Georgia CASA*, CASA Advocacy Training
Award: $25,688

Children's Healthcare of Atlanta*, Medical Provider Network
Award: $73,000

Georgia Office of the Child Advocate*, Georgia Child Protection Summit
Award: $50,000

Division of Family & Children Services, Annual Special Assistants Attorney General Conference
Award: $40,000

Habersham County Sheriff's Office (new for FFY2020)
Project: Habersham County Special Victims Unit Patrol Task Force
Award: $61,738

As a new CJA grantee, Habersham County Sheriff's Office was invited to make a presentation on their project to the Task Force in 2019. The project proposes to establish a Special Victims Unit Patrol Task Force to implement a coordinated community response to crimes against children to increase victim safety and offender accountability. This will include designing a curriculum and providing school resource officers, patrol officers, and investigators with specialized training on identifying, responding to and investigating suspected child abuse and neglect, in a manner which limits additional trauma to the child victim and the child's family. It is expected that the project will increase the number of professionals with appropriate training on recognizing, investigating, or reviewing cases of suspected child abuse and neglect, including child fatalities, commensurate with their role in the response to and/or assessment of these cases.

In closing…

The Task Force submits its report to Division leadership on its FFY2019 activities, including findings and resulting recommendations. Additionally, priorities and plans for 2019 highlight several collaborative opportunities to better coordinate efforts on shared goals and objectives in 2020.

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. The Task Force looks forward to the Division's continued efforts to identify opportunities to strategically engage with the Task Force as a valued stakeholder in 2020.

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

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

Judge Amber Patterson, (Co-Chair)
Cobb County Juvenile Court

Child Protective Services Advisory Committee

Vision

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

Mission

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

2019 Annual Report

Child Protective Services Advisory Committee (CPSAC) History

A Statewide Child Protective Services Advisory Panel (SCPSAP) was established in July 2000 by the Department of Human Services, Division of Family and Children Services (Division) to increase system transparency by soliciting input from stakeholders on the activities of the Child Protective Services Unit. The purpose of the SCPSAP had been to support the Division's child welfare goals by examining issues, identifying best practices, and making recommendations for improvement. Early priorities included improving the Division's negative public image and addressing workplace culture. In 2005, as the Children's Bureau sought to increase accountability of all CAPTA state grant recipients, the SCPSAP was designated as a CAPTA citizen review panel.

In 2006, the SCPSAP was renamed the Child Protective Services Advisory Committee and has since served as one of Georgia's three Child Abuse Prevention and Treatment Act (CAPTA) Panels.[1] Unlike Georgia's other two CAPTA Panels that each serve a dual role with additional federal or state legislative obligations, the CPSAC serves solely as a CAPTA citizen review panel.

[1] The other two CAPTA Panels are the Children's Justice Act Task Force and the Child Fatality Review Panel.

Membership

CPSAC membership satisfies the CAPTA requirement that it be broadly representative of the community, geographically, professionally, and demographically. 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 its geographic areas, most geographic regions are represented on the CPSAC. The diversity of personal and professional backgrounds and the wide range of experience and expertise of CPSAC members bring many unique perspectives to their common interest - the safety and well-being of Georgia's families, children, and youth.

CPSAC Members

Angie Boy, Program Manager, Children's Healthcare of Atlanta, *Adoptive Parent*

Angela Burda, Program Director, Clayton County Kinship Care Resource Center

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

Yvette Dennis, *Grandparent Caregiver*

Suzanne Dow, Executive Director, Georgia Mountain Women's Center, Inc.

Michelle Girtman, Executive Director, Battered Women's Shelter, Inc., *Foster/Adoptive Parent*

Sarah Jones, *Foster Parent*

Jennifer King, Executive Director, Georgia CASA

Karl Lehman, President & CEO, Childkind, Inc.

Mike Patton, Program Manager, Healthy Grandparents Program, Augusta University

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

Jennifer Stein, Executive Director (Co-Chair), PCA Habersham, Inc.

Sherelle Thomas, Executive Director, Rainbow House, Inc.

Belisa Urbina, CEO, Ser Familia, Inc.

The CPSAC has maintained a stable and committed core membership for many years. It is currently chaired by Amy Rene, Vice President of Clinical Programs, Hillside, Inc. and Jennifer Stein, Executive Director (Co-Chair), PCA Habersham, Inc. Ms. Rene has been a member since 2007 and Ms. Stein since 2017.

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.

Meetings

During FFY2019, the CPSAC met in November 2018, January, March, May, and August of 2019, satisfying the federally mandated minimum requirement for quarterly meetings. Additional committee meetings, special meetings, and conference calls were held as needed. Consultation with child welfare agency representatives were scheduled when requested.

2019 CPSAC Activities

Since its establishment, CPSAC 's interests have spanned the full child welfare continuum from the early intersection of families with the child protection system - the initial report, its screening and disposition - to policy and practice related to treatment and services when children are placed in out-of-home care. These interests have been reflected in their annual reports and have included:

- Worker safety
- Special investigations involving allegations against foster parents
- Relative kinship caregivers
- Foster parent training
- Workforce recruitment and retention
- Safety resource practice
- Public perception of the child welfare system

Georgia's CPSAC focuses its efforts on the prevention, early intervention, and placement stability efforts of the state's child protection system. The committee's current interests and priorities relate the policies and practices that guide the important work of Georgia's Division of Family and Children Services staff, primarily at the county level. Based on their 2019 priorities, the following report represents a summary of their operations, activities, and resulting recommendations.

The CPSAC also has had an ongoing interest in the state's CAPTA plan and was pleased that its interests in the stabilizing and supporting Georgia's child welfare workforce that includes recruitment, retention, and worker safety, and its interest in Plans Of Safe Care were both reflected in the state's new CAPTA plan. The CPSAC was represented at the CAPTA Plan planning meeting in May 2019, participating on the Workforce Development and Plan of Safe Care groups. To further the institutionalization of processes to support the objectives of the state CAPTA plan, the CPSAC recommends developing a standardized decision-making process for determining how the grant is utilized involving internal and external stakeholders, and developing a plan for evaluating supported projects

or activities to insure that they are consistent with CAPTA Plan objectives and support the federal mandate. Several CPSAC members have expressed an interest in participating in such efforts.

Because of the CPSAC's long standing interests in the workforce, its members were also pleased when Georgia was chosen as one of the National Child Welfare Workforce Institute (NCWWI) Workforce Excellence sites. The project will identify workforce needs, select and adopt strategies, plan and operationalize strategies, and evaluate plan effectiveness. CPSAC was represented on Workforce Excellence Stakeholder Focus Group in July 2019.

CPSAC Priorities for 2019

As staff turnover continued to be the number one reason cited that affected practice quality and consistency, the CPSAC had planned to continue its focus on job satisfaction and worker retention in 2019. However, when Georgia was chosen by the NCWWI as one of its five national Work Force Development sites, it was decided to postpone these plans until such time as the Workforce Development project has moved into the implementation phase. CPSAC decided to wait to identify a specific focus for its ongoing interest in recruitment and retention of caseworkers as the Workforce Excellence project unfolds.

Two additional areas of concern that CPSAC had identified as potential focus for 2019 were policy and practice related to Plans of Safe Care, including use of the additional funds added to the state CAPTA grant in 2018 and 2019, and risk assessment, based on the state's performance on CFSR Safety Outcome 2, Item 3: reported in the "Rolling Trend Comparison Report October 2018-March 2019," which indicated a drop from 43% in the 2015 CFSR to 28% for the period of the report and its potential impact on the success of the state's Family First Prevention Services Act (FFPSA).

Plans of Safe Care

The Keeping Children and Families Safe Act of 2003 created new conditions for states receiving CAPTA state grants intended to provide needed services and support for infants, their mothers, and their families, and to ensure a comprehensive response to the effects of prenatal drug exposure. These new conditions included state policies and procedures for:

- Appropriate referral to child protection service systems and for other appropriate services, to address the needs of infants born with and identified as affected by prenatal drug exposure.
- Requiring that health care providers involved in the delivery or care of such infants notify the child protective services system.
- Plans of Safe Care for the infant born with and identified as being affected by prenatal drug exposure.

- Screening, risk and safety assessment, and prompt investigation of such reports.

CAPTA Reauthorization Act of 2010 made further changes related to prenatal exposure and specifically required the identification of infants affected by Fetal Alcohol Spectrum Disorder (FASD) and a requirement for the development of Plans of Safe Care for infants affected by FASD. The Comprehensive Addiction and Recovery Act (CARA) of 2016 went into effect July 22, 2016, including Title V, Section 503 - "Infant Plan of Safe Care." Changes to CAPTA were made in the context of attention generated by the nation's prescription drug and opioid epidemic and included requiring that:

- Plans of Safe Care address the needs of both the infant and the affected family or caregiver.
- States develop and implement monitoring systems for Plans of Safe Care to determine whether and in what manner local entities are providing, in accordance with state requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver.

CAPTA Reauthorization Act of 2010 required that states include in their Annual Progress and Services Report (APSR) data on the number of children:

- Referred to a child protective services system born with and identified as being affected from prenatal drug exposure or FASD.
- Involved in a substantiated case of abuse or neglect determined to be eligible for referral.
- Referred to agencies providing early intervention services under Part C of the Individuals with Disabilities Education Act.

Comprehensive Addiction and Recovery Act (CARA) of 2016 expanded these reporting requirements to include data on the number of infants:

- Identified as being affected by substance abuse, withdrawal symptoms resulting from prenatal drug exposure, or FASD
- With a Plan of Safe Care
- Receiving referrals for appropriate services — including services for the affected family or caregiver.

The Plan of Safe Care for infants requires a state that receives Child Abuse Prevention and Treatment Act (CAPTA) grants to (1) address the health and substance use disorder treatment needs of the affected infant and family or

caregiver, and (2) specify a system for monitoring the local provision services in accordance with these state requirements[2].

The goal of the legislation was that non-punitive, supportive, voluntary plans would be created with the mother's and family's input to ensure that necessary services are in place for the infant, mother, and family. As is reported frequently in other states, coordination of a Plan of Safe Care is challenging partly because not only is it intended as an intervention and treatment strategy when acknowledged caregiver substance use disorders present clear safety risks to the infant at birth, but that it is also intended as a child abuse prevention strategy when the risk for child abuse and neglect is elevated, or may become elevated, as the result of prenatal exposure to specific substances, or when caregiver has an insufficient support system to insure the safety and well-being of a prenatally exposed child.

Georgia has had a Plan of Safe Care (POSC) process in place since 2013 that it updated in 2017 to include the provisions enacted by CARA. The Division has policies and procedures in place to meet the legislative requirements. Georgia's mandated reporter statute (OCGA 19-7-5) was amended to require that healthcare providers (identified specifically as physicians, hospital or medical personnel, and certain specialists) to report "prenatal abuse" as that term is defined in the Juvenile Code (OCGA 15-11-2). "Prenatal abuse" is defined as:

> (56) … exposure to chronic or severe use of alcohol or the unlawful use of any controlled substance, as such term is defined in Code Section 16-13-21, which results in:
>
> (A) Symptoms of withdrawal in a newborn or the presence of a controlled substance or a metabolite thereof in a newborn's body, blood, urine, or meconium that is not the result of medical treatment; or
>
> (B) Medically diagnosed and harmful effects in a newborn's physical appearance or functioning.

CPSAC began exploring POSC January 2019. It reviewed child welfare policies related to cases involving caregiver substance use and prenatal exposure (3.07 Intakes Involving Substance Use or Abuse, Prenatal Exposure, Prenatal Abuse or FASD, 5.12 Investigations: Newborn Exposure to Substances and 19.26 and 19.27 Case Management Involving Caregiver Substance Use/Abuse and Plan of Safe Care for Infants Prenatally Exposed or FASD).

In June, Judge Peggy Walker, Douglas County Juvenile Court, was invited to speak to CPSAC on that county's POSC program[3]. Division Safety Services Director, Laresa Price, was also invited to the June meeting to provide her

[2] Children & Family Futures. (2016). The Role of Plans of Safe Care in Ensuring the Safety and Well-Being of Infants with Prenatal Exposure, Their Mothers and Families: A Discussion Draft in Development of a Technical Assistance White Paper. Retrieved from http://www.cffutures.org/files/Plans%20of%20Safe%20Care%20 Draft_100416.pdf.

[3] In 2018, Douglas County was selected as a National Quality Improvement Center for Collaborative Community Court Teams (QIC-CCCT) demonstration site, to Address the Needs of Infants, Young Children, and Families Affected by Substance Use Disorders. With the assistance of

perspective on the challenges of implementing a consistent and effective POSC practice. With each presentation, review of legislation and policy, or discussion of best practices, the CPSAC endeavored to gain a better understanding of the intent of CAPTA legislation, POSC objectives, and the challenges in implementing a consistent and effective POSC program that would provide a safety net for children and their families that was responsive to their circumstances.

An effective Plan of Safe Care requires a coordinated multi-systemic approach that includes:

- Treatment providers who work with pregnant and parenting mothers in active treatment
- Medical community (obstetricians, midwives, birthing hospitals, pediatricians) when prenatal substance use is suspected or confirmed prior to, at or immediately following the birth
- POSC prepared by child welfare agency when maltreatment has been substantiated or risk of removal is high due to severity of prenatal exposure and reduced capacity of caregiver to protect child
- Community-based providers/family service agencies, including Public Health, when mothers are not engaged in treatment services at birth, and circumstances are assessed as low risk for abuse and neglect, but additional services would be beneficial

Each of these groups share the responsibility for appropriate identification and reporting of these cases, however, the Plan of Safe Care response for each should be specific to their role or involvement with the caregiver, infant and family, the circumstances at birth, needs identified by an assessment, and monitoring of their Plan of Safe Care plans. However, in Georgia, the preponderance of the responsibility for POSC has been assumed by the child welfare agency. Without an effective multi-systemic collaboration and a clear, coordinated model of practice with identified roles and responsibilities, achieving the objectives of Plans of Safe Care will be difficult. Additionally, any practice must include a seamless sharing of data and effective communication protocols as often families will move from system to system.

dedicated Training and Technical Assistance Change Teams, demonstration sites are designing, implementing and testing new and innovative approaches that meet the requirements of the Comprehensive Addiction and Recovery Act (CARA) amendments to the Child Abuse Prevention and Treatment Act (CAPTA) and that better meet the needs of infants and families. Evaluation findings and lessons from demonstration sites will provide the field and local courts across the country with valuable information on the most effective multi-system strategies and approaches to improve the way in which parents and caregivers and their children are served.

Initial observations and/or concerns identified by the CPSAC:

- Primary responsibility for meeting the Plan of Safe Care legislative requirements fell to the child welfare agency. It is unclear how the other critical stakeholders, identified above, were engaged in the development of the state's POSC program. This engagement should have clearly outlined roles and responsibilities, agency specific POSC requirements and standards including assessment, service referrals, monitoring and reporting standards, community supports, and interagency relationships and expectations including policy, communications, data collection and sharing, and program evaluation.
- The definition of prenatal abuse does not sufficiently provide for the impact of prenatal exposure due to alcohol abuse, FASD, which can be profound having long-term effects on child development and increased risk for child abuse and neglect and victimization, but not necessarily be observable at birth. This was a population of infants specified by the CAPTA Reauthorization Act of 2010.
- With respect to identification of affected infants at birth, several inherent issues were identified. Georgia does not have universal testing of mother's or infant's cord blood at birth. It is reported that testing is subjective at birthing centers and often targets minorities and mothers of low economic status - Medicare recipients. It is suspected that prenatal exposure is also under-reported due in part to concerns related to being reported on the Child Abuse Registry and the misunderstanding of the overall intent of POSC (non-punitive, supportive, voluntary plans).

Based on these observations, the CPSAC, recommends that the Division:

1. If it has not already done so, convene a task force of influential representatives from each of the identified a stakeholder groups to clearly outline roles and responsibilities, agency specific POSC requirements and standards including assessment (including identification), service referrals, monitoring and reporting standards, community supports, and interagency relationships and expectations including policy, communications, data collection and sharing, and program evaluation. This should include a timeline and outcome measures.
2. Revisit and clarify criteria for identifying POSC children/infants, including legislative and policy changes if necessary, to improve consistency and inclusivity in the identification of infants by respective stakeholder groups and to ensure that infants/children who meet the criteria receive the supports and services needed to insure the safety of children.

3. Develop a plan for communicating:
    a. The objective and benefits of POSC meant to increase the likelihood that public and private sectors will see the benefits of a POSC program, increase referrals, and reduce the stigma of involvement.
    b. The requirements for reporting suspected prenatal exposure by medical professionals.
    c. The Division should also consider universal reporting of all prenatally exposed infants to a central call line to improve collection of data, identify resource needs, and objectivity of reporting.

The CPSAC plans to continue its work with POSC in 2020 and will:

- Explore the viability of community-based networks to conduct POSC assessments and provide, or make referrals to, supports and services for prenatally exposed infants with no imminent safety threat that are identified as low risk and do not require investigation.
- Consider evaluating the effectiveness of the current POSC program.

Risk Assessment and Safety Management

As the state prepares to implement a Family First Prevention Services Act (FFPSA) plan, appropriate assessment of families at referral, as well as throughout the life of a case, is critical to ensuring the safety of children, preventing additional trauma to the family, and preventing unnecessary removal to foster care. Decisions regarding removal of children from their homes is based on an identified, direct threat to their safety and are designed to protect them from further harm. The CPSAC suggests that prevention of removal is predicated on risk reduction, particularly if there is no imminent safety threat. Assessment of risk will be essential to identifying appropriate and effective risk reduction strategies and to the success of the state's Families First Prevention Services (FFPSA) plan.

The state's performance on CFSR Safety Outcome 2, Item 3: Risk Assessment and Safety Management reported in the "Rolling Trend Comparison Report October 2018-March 2019," which indicated a drop from 43% in the 2015 CFSR to 28% for the six-month period ending March 2019, and its continued poor performance, suggests that a rigorous evaluation is needed to determine the cause for declining performance, and to identify strategies, policies and practice changes that might be needed to achieve and sustain better outcomes. The CPSAC plans to continue to explore this issue in 2020.

In closing…

Effectiveness of any CAPTA Panel is largely dependent on an open and mutually supportive relationship with the state's child welfare agency. The Division and its leadership team are commended for their responsiveness to the committees' many requests and recommendations. The CPSAC would especially like to acknowledge the Division's continued support of its efforts to meet its mandate as a CAPTA Panel. The CPSAC looks forward to 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

Amy Rene	Jennifer Stein (Co-Chair)
Vice President Clinical Programs, Hillside, Inc.	Executive Director, PCA Habersham

Child Fatality Review Panel

Child Fatality Review Maltreatment Committee
2019 Summary 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 July 22, 2016, by the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198). With each reauthorization, including the most recent, 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. Although the primary responsibility for addressing the child welfare needs of children and families lies with state agencies, CAPTA provides federal funding to support child abuse prevention, assessment, investigation, prosecution, and treatment activities[1] for the purpose of improving state child protection systems.

In the 1990's, Child Abuse Prevention and Treatment Act (CAPTA) required states to report on child fatality reviews in their program plans and in 1996, CAPTA required each state, as an eligibility requirement for CAPTA state grants, to establish citizen review panels (CAPTA Panels) and that at least one of them review child maltreatment deaths in order to make improvements to the child welfare system to prevent future fatalities or near-fatalities.

In 2007, the Georgia Child Fatality Review Panel (CFRP) was designated to serve as the third of Georgia's three CAPTA Panels,[2] 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. 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 who review and monitor the work of Georgia's 159 county Local Child Fatality Review (LCFR) committees, analyze results, and develop recommendations based on their findings and issues raised by local committees and CFRP members.

The CFRP, committed to fulfilling its mandate as a CAPTA Panel, established the CAPTA Maltreatment (MalTx) Committee in 2009 to address additional obligations of the CFRP as a CAPTA citizen review panel, including its

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

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

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 family involvement with state agencies that have safety, care, and well-being responsibilities

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 statute, the Governor appoints other members, except for one appointment by the Lt. Governor and one by the Speaker of the House of Representatives. CFRP membership 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 current CFRP membership satisfies the CAPTA membership requirements. The MalTx Committee includes members of the CFRP as well as child welfare experts and advocates who provide additional expertise and experience relevant to MalTx Committee interests, priorities, and its mandate.

Child Fatality Review Panel Members Appointed by the Governor

Judge Superior Court, Vacant

Peggy Walker, Interim Chair, Judge Douglas County Juvenile Court*

Mandi Ballinger, Georgia House of Representatives

Gloria Butler, Georgia State Senate

Kathleen Toomey, Commissioner, Department of Public Health

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

Jay Neal, Chair, Criminal Justice Coordinating Council

Amy Jacobs, Commissioner, Department of Early Care and Learning

Tiffany Sawyer, Prevention Director, Georgia Center for Child Advocacy*

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

Jonathan Eisenstat, Chief Medical Examiner, Georgia Bureau of Investigation

Tom Rawlings, Director, Division of Family and Children Services

Robertiena Fletcher, Board Chair, Department of Human Services

Rachel Davidson, Director, Office of the Child Advocate*

Ashley Wright, District Attorney Augusta Judicial Circuit

Richard Hawk, Coroner, Coweta County

Cheryl Benefield, Department of Education*

Vic Reynolds, Director, Georgia Bureau of Investigation

**Serve on the Maltreatment Committee*

In addition to the CFRP members identified above, the following individuals also serve on the Maltreatment Committee:

Julia Neighbors, Director, Prevent Child Abuse Georgia

Lisa Dawson MPH, Director, Injury Prevention Program, Georgia Department of Public Health

John Carter, Epidemiologist

Martha Dukes, Manager CDNFSI-CHOA Liaisons, Division of Family and Children Services

Angela Boy, Program Manager, Prevention and Training, Stephanie V. Blank Center

Meetings

The CFRP meets quarterly, satisfying the CAPTA requirement. In FFY2019, meetings were held in November 2018, January, April, and July 2019. The MalTx Committee met in November 2018, February, May, July, and August 2019. Additionally, CFRP and MalTx Committee members were invited to participate in the annual retreat for all Georgia CAPTA Panels in September. The day-long retreat was hosted at the Cobb Superior Court by Judge Tain Kell, CFRP Chair.[3]

CFRP meets all statutory membership and meeting requirements for a CAPTA Panel.

Reports

The CFRP submits an annual report on the findings of local child fatality review committees[4] to the Georgia legislature. An annual summary of MalTx Committee activities and recommendations is submitted to the child welfare agency to satisfy the CAPTA requirement for an annual report.

Mechanisms for Reviewing Child Fatalities

In Georgia, there are several mechanisms for investigating and/or reviewing child fatalities, in multiple systems, with varying interests, objectives, roles and responsibilities. It is important to recognize the different child fatality

[3] Judge Kell resigned from the CFRP in January of 2019. Judge Peggy Walker is currently serving as interim chair.

[4] Data on the finding s of Local Child Fatality Review Committees is collected in the National Child Death Reporting System.

review mechanisms, each with unique timing, purpose, objectives, and reporting obligations. These include state CFRP, local child fatality review committees, the Division of Family & Children Services (the Division) and the MalTx Committee. Following are brief descriptions of each.

State Child Fatality Review Panel (CFRP)

The CFRP is a statutory body established in 1990 by the Georgia State Legislature. 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.[5] Its purpose is to identify systemic prevention opportunities and recommend measures to decrease the incidence of child fatality.

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 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 child fatality review committees.

Local Child Fatality Review Committees

Local child fatality review (LCFR) committees have been established in each of Georgia's 159 counties. Mandated by O.C.G.A.§ 19-15-3, LCFR committees conduct multiagency reviews of all reviewable child deaths within 30-45 days. Information gathered during LCFR reviews is documented in the National Child Death Review Case - Reporting System (NCDR-CRS). Individual reports submitted by LCFR committees are monitored and carefully reviewed by Georgia Bureau of Investigations/Office of Child Fatality Review (GBI/OCFR) staff. LCFR committees are also mandated to publish an annual report on local review activity for the preceding year by the first of July.

Annual aggregate data on all reviewed fatalities is then analyzed with the help of state epidemiologists, child fatality experts, and prevention experts who assist in the development and preparation of the annual CFRP report.

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

Child Fatality Review by the Child Welfare Agency

Georgia's child welfare agency (Division) responds to all child fatality reports to determine which cases warrant additional review or staffing. 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[6]
- The circumstances of the death suggest a high probability that maltreatment was a factor
- Immediate safety issues are identified for any surviving siblings

These reviews primarily involve Division management and county DFCS staff but external partners with special expertise may also be involved. The objectives of these reviews are:

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

The MalTx Committee previously recommended and continues to advocate for the reconstitution of a multidisciplinary process that engages a variety of stakeholders and experts in the regular review of maltreatment-related deaths to identify opportunities not only to examine policy, practice, training, and culture, but to identify effective prevention strategies to reduce the incidence of maltreatment-related deaths. In 2019, several members of the CFRP and/or MalTx Committee were invited to participate in an exercise facilitated by a representative from Chapin Hall of a multi-disciplinary child fatality review process the Division was planning to implement. The day-long event included an overview of the process in the morning and review of an actual case in the afternoon. The intent of the review process is to move away from a punitive process resulting in more trauma to more of an analysis of events that would focus on lessons learned and opportunities to improve where system inconsistencies or failures may have contributed to the poor outcome. All participants were excited about this new direction and looked forward to seeing it put into practice.

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

To date, the Division has utilized this new multidisciplinary process as a county level review of child fatalities and has not published any summary findings. The MalTx Committee recommends that in the spirit of transparency and to identify opportunities for system reform, that the Division develop a reporting framework from lessons learned to support, in part, the public disclosure intent of CAPTA.

The MalTx Committee also recommends that the Division consider convening a broader state level multidisciplinary group periodically to review, utilizing the same process, high profile child deaths to identify prevention or intervention opportunities that may have altered outcomes.

Maltreatment Committee Activities and Recommendations

For FFY2018, a national estimate of 1,770 children died from abuse and neglect at a rate of 2.39 per 100,000 children in the population, according to the Child Maltreatment 2018 Report[7], released by the Children's Bureau. Georgia reported 86 maltreatment-related child fatalities[8] in 2018, 3.43 per 100,000 children in the population. While these numbers are staggering, recent federal commission, charged with examining child abuse and neglect deaths, estimates that the actual number could be much higher due to reporting differences across states, as well as varying definitions of child abuse and neglect fatality and differences in the way states collect information.

Although maltreatment-related deaths are a small subset of Georgia's reviewable deaths, the identification and prevention of maltreatment-related deaths is an ongoing CFRP priority. The primary objective of the MalTx Committee is to ensure that no maltreatment-related death is missed, and when child abuse or neglect has been identified as the cause or a contributing factor in a child death, that circumstances are examined thoroughly so as to evaluate effectiveness of any contributory CPS policy and/or practice and identify prevention strategies to reduce the risk of future deaths under similar circumstances. The MalTx Committee efforts in 2019 continued to be focused on the quality and consistency of data reported in the NCDR-CRS. Additional quality assurance concerns included the long delay that often occurs between a death, its review, and the completion of the report (data entered in NCDR-CRS).

In 2019, to further investigate its concerns regarding child fatality review, the MalTx Committee deployed a survey to local jurisdictions to help identify opportunities to improve compliance with reporting requirements and the quality and consistency of data. The survey included questions on the legislative mandate and initial and ongoing

[7] 2018 Child Maltreatment Report , https://www.acf.hhs.gov/sites/default/files/cb/cm2018.pdf

[8] Table 4–1 Child Fatalities by Submission Type, 2018 Child Maltreatment Report

training and technical assistance needs. The survey also included questions on local conditions that had the potential to impact the effectiveness of the review process, such as experience level of committee members, turnover, and resources. A copy of the survey is attached as Appendix B.

The results from the survey were not particularly informative, partly due to a poor response rate and partly due to the roles of the individuals who completed to the survey on behalf of the jurisdiction. The intent was to solicit one response per jurisdiction from an individual with historical knowledge and experience in the child fatality review process in that community. In many cases surveys were completed by multiple individuals from a jurisdiction or by a designee not necessarily a member of the local child fatality review committee. However, frequent responses, although not definitively conclusive, did seem to support some of the MalTx Committee's suppositions.

During the development of the survey in 2018, the MalTx Committee reviewed legislation governing child fatality review and discovered that it had not been substantially updated since enacted in 1990. Several legislative concerns were identified, such as less than realistic timeframes, an outdated reporting protocol, and inconsistent terminology. To address these legislative issues, the MalTx Committee has recommended that the Division partner with the OCA and the GBI to review current legislation, conduct research on legislation and best practices for child fatality review in other states, and develop recommendations to revise Georgia code. Based on the MalTx Committee survey experience, it is evident that child fatality legislation needs updating both with respect to the state panel composition, purpose, operations, and obligations as well as local child fatality review protocols and procedures.

Maltreatment Committee Plans for 2020

Late in 2019, the MalTx Committee turned its attention to suicide deaths. The last four years (2015 – 2018) has seen a jump (from 2014 to 2015) in both homicide and suicide deaths. The Committee is particularly concerned about the increase in early teen suicides and would like to explore any intersection between these deaths, school and social climate, and maltreatment history.

Summary [9] of infant/child deaths in Georgia from 2010 through 2018.

Table B1: Infant and Child Deaths, Age 0 - 17, GA Residents									
	Year of Death								
DC_Cause	2010	2011	2012	2013	2014	2015	2016	2017	2018
Drowning	39	32	27	29	49	34	41	39	30
Fall	3	2	2	3		1		3	3
Fire	9	13	7	24	14	7	14	8	10
Firearm	4	2	5	1	4	6	5	2	5
Homicide	58	59	59	58	47	79	74	72	76
Medical	883	936	942	1,035	1,067	1,093	1,007	935	952
MVC	127	103	78	104	87	109	111	102	88
OthInjury	18	21	13	18	17	20	18	22	16
CauseB,C SIDS	1				1	1		2	3
Poison	9	11	5	5	3	7	6	5	5
SIDS	123	128	102	91	109	105	97	109	104
Suffocation in Bed	22	13	19	16	32	36	30	36	30
Asphyxia	14	17	18	17	17	9	8	17	15
Suicide	30	22	32	39	30	51	57	59	63
Unknown Intent	13	6	4	4	6	6	3	10	9
Unknown	34	31	25	33	32	35	46	30	26
Totals	1,387	1,396	1,338	1,477	1,515	1,599	1,517	1,451	1,435
Non-Medical Totals	504	460	396	442	448	506	510	516	483

Comparing consecutive four-year periods, homicides increased 35% and suicides increased 87%. Sixty-two of the additional 78 homicide deaths (comparing the two four-year periods) were Black males. However, the increase in suicide deaths (107 comparing the four-year periods) was distributed across all four major race/sex categories. The largest percent increase (160%) was among White females, although white males account for 45% of all suicides (age < 18, 2015 – 2018).

In 2020, the intention of the MalTx Committee is to collect and analyze data from several sources including CFRP, Department of Public Health, Department of Education and the Division, to identify factors or trends that may help to explain the rise in youth suicides. The MalTx Committee is hopeful that this effort will also help to institutionalize the process for information gathering/sharing among these entities to improve their collective prevention and early intervention efforts to reduce child fatalities.

An ongoing concern for the MalTx Committee is the reported difference between the number of maltreatment-related deaths reported in OASIS, Georgia's official vital records and what is reported by the Division required by CAPTA. In 2018 OASIS had 178 documented child deaths with some indication that there was history of maltreatment and/or local child death review teams reported that maltreatment was a cause or contributing factor

[9] Source for Table B1 is the 2019 Child Fatality Review Report (review of 2018 deaths) that was prepared using a National Child Death Reporting database download on September 7, 2019. The annual totals have been reconciled with OASIS data, the official Georgia public vital records source.

in the child's death. This represents 31.1% of all reviewable child deaths in 2018. The Division reported 86 maltreatment-related fatalities for 2018.[10] It is acknowledged that there are several explanations for this difference such as calendar versus fiscal year reporting periods, inconsistencies in definitions, etc. The MalTx Committee has recognized that there is a need to address these inconsistencies to ensure that no child death due to maltreatment be missed, one of its primary objectives, and will explore its options to do so in 2020.

Respectfully submitted on behalf of Georgia's Child Fatality Review Panel Maltreatment Committee

[10] 2018 Child Maltreatment Report , https://www.acf.hhs.gov/sites/default/files/cb/cm2018.pdf, Table 4–1 Child Fatalities by Submission Type.

Georgia Model Protocol

Multidisciplinary Juvenile Death Investigation

A special thanks to protocol contributors, including experts from professional disciplines/agencies that included; Emergency Medical Services (EMS); Child Welfare Experts in Special Investigations or Child Death Investigations; State and County Law Enforcement; Medical Examiner; Assistant District Attorney; and Juvenile and Superior Court Judges

Table of Contents

I. Introduction

This model protocol outlines a multi-disciplinary approach to the investigation of child deaths in accordance with OCGA § 45-16-20, with specific emphasis on those deaths related to, or as a result of, maltreatment. For the purposes of this protocol, "child" and "juvenile" refer to any individual under the age of 18. The purpose of this protocol is to 1) ensure all child deaths are thoroughly scrutinized in an effort to identify maltreatment cases, especially those cases potentially caused by neglect or inconspicuous maltreatment 2) ensure the cooperation and coordination of all agencies involved in a child death investigation 3) establish a solid investigative foundation, comprehensive death scene investigation, and timeline of events to aid in the prosecution of child maltreatment deaths and 4) ensure detailed death scene investigation and data collection to enhance the Child Fatality Review (CFR) process and bolster prevention efforts. While best practices, as determined by The National Institute of Justice (NIJ), The Centers for Disease Control and Prevention (CDC), The National Association of Medical Examiners (NAME), and the American Board of Medicolegal Death Investigators (ABMDI), are emphasized, every involved party must follow all applicable laws and agency policies and directives.

II. Personnel

Various agencies are routinely involved in the death investigation process. This protocol details best practices and specifically addresses personnel most involved in a child death investigation. Each county, jurisdiction, or agency should evaluate its resources and incorporate the model protocol and best practices into its framework for death investigation while complying with all laws, individual agency policies, and directives.

a. Emergency Medical Services
b. Emergency Room Staff and Hospital Personnel
c. Law Enforcement
d. Division of Family and Children Services (DFCS) Personnel
e. Coroners/Death Investigators
f. Medical Examiners
g. District Attorneys
h. Other Investigative Agencies (e.g. State Fire Marshal, Department of Natural Resources, Department of Juvenile Justice, Department of Behavioral Health and Development, Child Advocacy Center, etc.)

III. Roles and Responsibilities

The Children's Justice Act Task Force is committed to its mission to identify opportunities to reform state systems and improve processes by which Georgia's child welfare system and its investigative partners responds to cases of child abuse or neglect-related fatalities. The model protocol should be reviewed in conjunction with the Child Abuse Protocol, with legal, data, and/or policy updates, as necessary.

a. Emergency Medical Services

In general, response to an incident involving a severely ill or injured child is stressful. If abuse is suspected, stress is compounded. There is a natural propensity for all involved to have stress reactions once all responders converge on scene. Regardless of the tenor for the activation, it is the responsibility of the EMS Clinician (or Medical First Responder) and the Law Enforcement Officers who respond to the call to evaluate the scene, evaluate the child, and follow established agency protocols.

When considering best practices for EMS response to calls of this type, the potential for a hostile environment begets immediate collaboration with Law Enforcement. Synchronized response with Law Enforcement grants the EMS Clinician some assurance of assistance with scene management so greater attention may be accorded assessment of the child's life status. The EMS Clinician responding to the scene should be a Paramedic as the Paramedic is adept in determining modality of care and if the necessity for transportation to pediatric emergency care destination exists. If assessment findings determine the patient is deceased, it is best practice to abstain from transportation to an emergency facility.

While transportation is not indicated, the onus of documenting assessment findings remains. Assessment findings should be included in the EMS patient care report; immediate assessment of the decedent and scene is critical. Information collected should include a review of the decedent's medical and psychosocial history. Information collection should also include a list of medications and natural remedies if administration is known. Perform a cursory examination of the decedent's body and document findings while considering age, level of development, and level of activity when documenting possible injuries. Be precise when documenting all timeframes as referenced by the parent or guardian. When performing the physical examination, take extra care to preserve evidence and avoid disturbing the integrity of a potential crime scene. Injuries and circumstances meeting the following criteria must be thoroughly documented in the Patient Care Report:

- Injuries on non-mobile children (Injuries on non-mobile children (i.e. infants, children with disabilities which prevent movement compatible with their age range)
- Patterned Trauma
- Injuries on protected surfaces of the body, with specific emphasis on the ears and inside the mouth; check for intraoral trauma prior to intubation
- Multiple injuries and/or injuries which appear to be of varying ages
- Significant injury/ies and the caregiver cannot recall or cannot provide an explanation of the event
- Injuries inconsistent with the provided explanation
- Delay in contacting EMS
- Poor skin turgor, sunken fontanelle, cachexia, other signs of dehydration/malnutrition
- Bed sores/decubitus ulcers/pressure ulcers
- Insect activity, especially on non-mobile children
- Prior child deaths within family unit
- Prior DFCS history with the decedent, family unit/caregiver(s)
- Prior EMS/Law Enforcement calls to residence
- i.e. infants, children with disabilities which prevent movement compatible with their age range)

- Patterned Trauma
- Injuries on protected surfaces of the body, with specific emphasis on the ears and inside the mouth; check for intraoral trauma prior to intubation
- Multiple injuries and/or injuries which appear to be of varying ages
- Significant injury/ies and the caregiver cannot recall or cannot provide an explanation of the event
- Injuries inconsistent with the provided explanation
- Delay in contacting EMS
- Poor skin turgor, sunken fontanelle, cachexia, other signs of dehydration/malnutrition
- Bed sores/decubitus ulcers/pressure ulcers
- Insect activity, especially on non-mobile children
- Prior child deaths within family unit
- Prior DFCS history with the decedent, family unit/caregiver(s)
- Prior EMS/Law Enforcement calls to residence

If any of the above injuries/circumstances are noted and/or anything suspicious is noted during the cursory examination of the decedent and/or the scene, Law Enforcement and DFCS should be notified immediately. Law Enforcement will separate parents and guardians for detailed interviews and the scene will be secured per the responding Law Enforcement agency's policies/protocols, if necessary. When documenting the decedent's surroundings, placement of the decedent's body and historical information provided by the caregivers should be scrutinized, with attention to the immediate sleeping environment in sleep-related infant deaths. In addition, EMS Clinicians should note any stains/signs of emesis on the caregiver's clothing and Law Enforcement, the Coroner/Death Investigator, and DFCS should be notified if such stains are present. Sleep-related deaths of toddler-age children should also be thoroughly scrutinized, with attention to the placement of the decedent's body, the sleeping environment, and the history provided by the caregivers. The overall condition of the scene should be noted, with considerations given to unsafe or hazardous conditions, including the presence of drug paraphernalia. If EMS Clinicians arrive on scene prior to Law Enforcement, suspicious activity observed by EMS Clinicians—particularly if the decedent's parent or guardian exhibits behaviors consistent with intoxication—should be reported to Law Enforcement and/or DFCS immediately upon their arrival to the scene.

If the decedent is <1-year-old, EMS Clinicians should assist the Coroner/Death Investigator with completion of the Sudden Unexpected Infant Death Investigation Form (SUIDI Form). The Sudden Unexpected Child Death Investigation Form (SUDCI Form) is a useful tool for older children, though it is not required.

Complete and thoroughly documented patient care report should be forwarded to the Coroner and/or Medical Examiner's Office; a subpoena can be provided if necessary.

EMS Clinicians should attend the Child Fatality Review meeting regarding the decedent and participate in the CFR process and prevention efforts within the community, as appropriate, in accordance with OCGA§ 19-15-3.

EMS Clinicians should attend basic training for child death investigations, including Sleep-Related Infant Death Investigation. See IV. Training Recommendations.

b. Emergency Room Staff and Hospital Personnel

Following pronouncement, hospital staff should contact the Coroner and/or Death Investigator as soon as possible to report the death. OCGA § 45-16-24 details the criteria for deaths which are legally required to be reported to the Coroner and/or Medical Examiner's Office. If hospital staff is uncertain of the legal criteria or there is any ambiguity regarding the death, the Coroner and/or Death Investigator should be consulted for clarification. In general, deaths should be reported if:

- the cause and/or manner is unknown
- the death was sudden, unexpected, unexplained, and/or suspicious
- the death was a result of trauma
- the death was a result of maltreatment, including neglect
- drugs/alcohol are the cause or a contributing factor

Injuries/Circumstances which meet the following criteria should be thoroughly documented in the medical record, along with the caregiver's explanation for such:

- Injuries on non-mobile children (i.e. infants, children with disabilities which prevent movement compatible with their age range)
- Patterned Trauma
- Injuries on protected surfaces of the body, with specific emphasis on the ears and inside the mouth; check for intraoral trauma prior to intubation
- Multiple injuries and/or injuries which appear to be of differing ages
- Significant injuries and the caregiver cannot recall or cannot provide an explanation of the event
- Injuries inconsistent with the provided explanation
- Delay in contacting EMS
- Poor skin turgor, sunken fontanelle, cachexia, other signs of dehydration/malnutrition
- Bed sores/decubitus ulcers/pressure ulcers
- Insect activity, especially on non-mobile children
- Prior child deaths within family unit
- Prior DFCS history with the decedent, family unit/caregiver(s)
- Prior EMS/Law Enforcement calls to residence

If any of the above criteria are noted, Law Enforcement and DFCS should be notified. Law Enforcement and DFCS should also be notified of any suspicious activity, and staff should inform the authorities if the decedent's caregivers exhibit behaviors consistent with intoxication of any substance.

A detailed account of the incident and and/or injuries/medical conditions causing or contributing to the death should be included in the report to the Coroner/Death Investigator, as well as summaries of all medical procedures and medications administered. The results of any tests or procedures, such as drug screens, should also be reported. Copies of the decedent's medical chart, including all tests results, toxicology screens, progress notes, and scans should be forwarded to the Coroner and/or Medical Examiner's Office; a subpoena can be provided if necessary. If the decedent is <1-year-old, assist Coroner/Death Investigator with completion of the Sudden Unexpected Infant Death Investigation Form (SUIDI Form). The Sudden Unexpected

Child Death Investigation Form (SUDCI Form) is a useful tool for older children, though it is not required.

c. Law Enforcement

Law Enforcement officers are frequently initial responders to emergency calls involving children and are tasked with quickly assessing the incident and determining the nature of the call. Officers should respond to such calls according to their agency's directives and comply with all laws, policies, and procedures for securing and containing the scene and preserving evidence, managing and separating potential witnesses/suspects, and conducting brief initial interviews and a cursory examination of the decedent, whether on scene or if the decedent is transported to a medical facility and pronounced. Initial responders should notify their agency for additional/specialized investigative personnel (Homicide Detectives, Crimes Against Children Investigators, etc.) per agency policy as soon as possible if/when any suspicious circumstances and/or trauma is identified.

Law Enforcement should conduct initial interviews to determine the events preceding the incident/death and perform an examination of the decedent. The initial assessment should include a review of the deceased's social history, medical and mental health history, detailed medication list and natural remedies if administration is known, and an examination of the body. DFCS history with the family unit/caregiver(s) should be obtained/reviewed as soon as possible. Prior EMS and/or Law Enforcement calls to the residence should be obtained/reviewed. Injuries/marks on the body should be documented, with careful consideration of the child's age and level of development. Dates and timeframes provided by caregivers should be precisely documented. Injuries/Circumstances which meet the following criteria should be thoroughly documented, along with the caregiver's explanation for such:

- Injuries on non-mobile children (i.e. infants, children with disabilities which prevent movement compatible with their age range)
- Patterned Trauma
- Injuries on protected surfaces of the body, with specific emphasis on the ears and inside the mouth; check for intraoral trauma prior to intubation
- Multiple injuries and/or injuries which appear to be of varying ages
- Significant injuries and the caregiver cannot recall or cannot provide an explanation of the event
- Injuries inconsistent with the provided explanation
- Delay in contacting EMS
- Poor skin turgor, sunken fontanelle, cachexia, other signs of dehydration/malnutrition
- Bed sores/decubitus ulcers/pressure ulcers
- Insect activity, especially on non-mobile children
- Prior child deaths within family unit
- Prior DFCS history with the decedent, family unit/caregiver(s)
- Prior EMS/Law Enforcement calls to residence

If any of the above criteria are noted, DFCS should be notified. In addition, the District Attorney should be notified if maltreatment is suspected. Detailed interviews, scene investigations, scene reconstructions, and evidence processing should be conducted by thoroughly trained staff.

A joint scene investigation should be conducted with the Coroner/Death Investigator and DFCS, if appropriate. Law Enforcement should obtain consent/search warrant(s) and process the scene and collect evidence per laws and agency policies. The decedent's immediate vicinity should be scrutinized, with attention to the immediate sleeping environment in sleep-related infant deaths. In addition, the caregiver(s)' clothing should be inspected for stains/signs of emesis in sleep-related deaths. The Sudden Unexpected Infant Death Investigation or Sudden Unexpected Child Death guidelines should be followed when investigating the deaths of infants and young children. Aggravating circumstances in sleep-related deaths, such as caregiver intoxication or prior infant deaths in the family, should be meticulously documented. Sleep-related deaths of toddler-age children should also be thoroughly scrutinized, with attention to the placement of the decedent's body, the sleeping environment, and the history provided by the caregivers.

Extensive photographs of the scene, including macro and micro details, should be obtained and forwarded to the Medical Examiner for review. Doll reenactments should be conducted and recorded in all sleep-related infant deaths. In addition, doll reenactments are extremely useful for those investigations involving the death during sleep of developmentally delayed children and children with a seizure history. Doll reenactments and scene reconstructions may be necessary and directed by the Medical Examiner or other investigative entity in a variety of cases.

Law Enforcement should evaluate the need for drug screens of the caregiver(s), other children in the home, or other individuals with access to the decedent, and proceed according to applicable laws and agency policies.

Law enforcement should immediately evaluate other children in the home, if applicable, and coordinate medical examinations, forensic interviews, and/or other services as necessary with DFCS, the Child Advocacy Center, and other investigative/medical entities per agency directives, in accordance with the Child Abuse Protocol. In addition, Law Enforcement and DFCS personnel should clearly communicate the needs of their independent investigations to ensure cohesive, parallel investigations are conducted without compromising the integrity of either agency's investigation and/or judicial proceedings.

Law Enforcement should attend the autopsy as necessary and/or discuss findings with the Medical Examiner; in addition, law enforcement should report additional information to the Medical Examiner as the investigation progresses and review the autopsy report when complete. Numerous discussions with the medical examiner may be necessary as an investigation progresses.

Law Enforcement should attend the Child Fatality Review meeting regarding the decedent and participate in the CFR process and prevention efforts within the community, as appropriate, in accordance with OCGA§ 19-15-3.

Law Enforcement should attend basic training for child death investigations, including Sleep-Related Infant Death Investigation. Specialized investigators, such as Homicide Detectives and Crimes Against Children Investigators, should attend extensive training for the recognition and investigation of child maltreatment in all forms. See IV. Training Recommendations.

d. Division of Family and Children Services (DFCS) Personnel

The Division of Family and Children Services (DFCS) has multi-faceted roles in a child death investigation. In accordance with *DFCS Policy 6.7 Special Investigations: Conducting Special Investigations of Child Death, Near Fatality or Serious Injury* (April 2020), DFCS personnel should request a joint investigation with Law Enforcement for child deaths. DFCS personnel should review these policies and ensure compliance during child death investigations.

DFCS personnel should respond to child death scenes and/or medical facilities to examine the decedent in conjunction with Law Enforcement and the Coroner/Death Investigator or contact such representatives to gather pertinent information RE: the examination. In conjunction with Law Enforcement, DFCS personnel should conduct initial interviews to determine the events preceding the incident/death and examine the decedent. The initial assessment should include a review of the deceased's social history, medical and mental health history, detailed medication list and natural remedies if administration is known, and an examination of the body. Injuries/marks on the body should be documented, with careful consideration of the child's age and level of development. Dates and timeframes provided by caregivers should be precisely documented. Injuries/Circumstances which meet the following criteria should be thoroughly documented, along with the caregiver's explanation for such:

- Injuries on non-mobile children (i.e. infants, children with disabilities which prevent movement compatible with their age range)
- Patterned Trauma
- Injuries on protected surfaces of the body, with specific emphasis on the ears and inside the mouth; check for intraoral trauma prior to intubation
- Multiple injuries and/or injuries which appear to be of varying ages
- Significant injury/ies and the caregiver cannot recall or cannot provide an explanation of the event
- Injuries inconsistent with the provided explanation
- Delay in contacting EMS
- Poor skin turgor, sunken fontanelle, cachexia, other signs of dehydration/malnutrition
- Bed sores/decubitus ulcers/pressure ulcers
- Insect activity, especially on non-mobile children
- Prior child deaths within family unit
- Prior DFCS history with the decedent, family unit/caregiver(s)
- Prior EMS/Law Enforcement calls to residence

In conjunction with Law Enforcement, DFCS personnel should respond to the death scene and conduct an investigation/assessment in accordance with *DFCS Policy 6.7 Special Investigations: Conducting Special Investigations of Child Death, Near Fatality or Serious Injury* (April 2020). Safety hazards or conditions of the home environment related to the death and/or safety and well-being of other children in the home should be addressed according to policy. The decedent's immediate vicinity should be thoroughly evaluated with attention to the immediate sleeping environment in sleep-related infant deaths. In addition, the caregiver(s)' clothing should be inspected for stains/signs of emesis in sleep-related deaths. The SUIDI Form should be utilized and the CDC's guidelines should be followed when investigating the death of a child < 1 year old.

Sleep-related deaths of toddler-age children should also be thoroughly scrutinized, with attention to the placement of the decedent's body, the sleeping environment, and the history provided by the caregivers.

DFCS personnel should review any history the decedent, family unit, and/or caregivers has with the Division, especially related to Safe Sleep Practices and/or prior allegations of maltreatment in the family. Aggravating circumstances in sleep-related deaths, such as caregiver intoxication or prior infant deaths in the family, should be meticulously documented and toxicology screens should be requested according to policy.

Extensive photographs of the scene, including macro and micro details, should be obtained and uploaded to External Documentation. Doll reenactments should be conducted and recorded in all sleep-related infant deaths. Doll reenactments and scene reconstructions may be necessary and directed by the Medical Examiner or other investigative entity in a variety of cases. In most cases, evidentiary and documentary photographs, doll reenactments, and scene reconstructions are conducted by Law Enforcement and/or the Coroner/Death Investigator, therefore DFCS personnel should contact such representatives and gather pertinent information and/or participate in reconstructions when possible.

DFCS should evaluate the need for drug screens of the caregiver(s), other children in the home, or other individuals with access to the decedent, and proceed according to applicable laws and agency policies.

DFCS personnel should evaluate other children in the home and coordinate medical examinations, forensic interviews, and/or other services as necessary with Law Enforcement, the Child Advocacy Center, and other investigative/medical entities per agency policy, in accordance with the Child Abuse Protocol. In addition, DFCS personnel and Law Enforcement should clearly communicate the needs of their independent investigations to ensure cohesive, parallel investigations are conducted without compromising the integrity of either agency's investigation and/or judicial proceedings. Confidentiality laws are applicable, however, information sharing among agencies is allowed and encouraged when investigating the safety of surviving children in the home and/or allegations of child maltreatment.

DFCS personnel should attend the autopsy and/or discuss findings with the Medical Examiner; in addition, DFCS personnel should report additional information to the Medical Examiner as the investigation progresses and obtain and review the autopsy report when complete. Numerous discussions with the medical examiner may be necessary as an investigation progresses.

DFCS personnel should attend the Child Fatality Review meeting regarding the decedent and participate in the CFR process and prevention efforts within the community, in accordance with OCGA§ 19-15-3.

DFCS personnel should attend basic training for child death investigations, including Sleep-Related Infant Death Investigation. Extensive maltreatment investigation training is required for DFCS personnel. See IV. Training Recommendations.

e. Coroners/Death Investigators

It is ultimately the responsibility of the Coroner and/or Death Investigator to ensure a thorough death investigation and coordinate the receipt of all information from the various services and agencies involved in the investigation. Upon receipt of a child death report, Coroners/Death Investigators, in consort with the appropriate Medical Examiner(s), should determine jurisdiction according to OCGA § 45-16-20 and their office's policies, procedures, and directives. If the decedent is <1-year-old, complete the Sudden Unexpected Infant Death Investigation Form (SUIDI Form). The Sudden Unexpected Child Death Investigation Form (SUDCI Form) is a useful tool for older children, though it is not required.

For natural deaths associated with chronic medical conditions, an autopsy may not be performed. In such cases when death is pronounced on scene or in the emergency room, the Coroner or Death Investigator should thoroughly examine the decedent, review the medical, mental health, social, and family histories, and obtain a detailed list of the decedent's medication and natural remedies if administration is known; a toxicology screen should be considered. The Coroner/Death Investigator should obtain the decedent's and caregiver's history, if any, with DFCS, and EMS and Law Enforcement should provide information regarding prior calls/incidences at the residence and/or involving the decedent and/or caregiver(s).

Ideally, the Coroner/Death Investigator should examine the decedent and the appropriate Medical Examiner should review all available information prior to declining jurisdiction of any child death case. Additional scrutiny is necessary for children who die while in the state's custody and/or have history with DFCS.

If the Medical Examiner accepts jurisdiction, the Coroner/Death Investigator's initial assessment should include a review of the deceased's social and family history, medical and mental health history, detailed medication list and natural remedies if administration is known, thorough examination of the body, and exhaustive interview with the decedent's parents and/or immediate caregivers. Rigor, livor, and algor mortis should be assessed and documented. Injuries/marks on the body should be documented, with careful consideration of the child's age and level of development. Dates and timeframes provided by caregivers should be precisely documented. Injuries/Circumstances which meet the following criteria should be thoroughly documented, along with the caregiver's explanation for such:

- Injuries on non-mobile children (i.e. infants, children with disabilities which prevent movement contemporaneous to their age range)
- Patterned Trauma
- Injuries on protected surfaces of the body, with specific emphasis on the ears and inside the mouth; check for intraoral trauma prior to intubation
- Multiple injuries and/or injuries which appear to be of varying ages
- Significant injuries and the caregiver cannot recall or cannot provide an explanation of the event
- Injuries inconsistent with the provided explanation
- Delay in contacting EMS
- Poor skin turgor, sunken fontanelle, cachexia, other signs of dehydration/malnutrition
- Bed sores/decubitus ulcers/pressure ulcers

- Insect activity, especially on non-mobile children

Law Enforcement and DFCS should be notified of any suspicious activity, and the Coroner or Death Investigator should inform Law Enforcement and DFCS if the decedent's caregivers exhibit behaviors consistent with intoxication of any substance.

i. Scene Investigation

A joint scene investigation should be conducted with Law Enforcement and DFCS, if appropriate, as well as any other investigative agencies. The overall condition of the scene should be noted, with attention to unsafe or hazardous conditions and/or drug paraphernalia. The decedent's immediate vicinity should be scrutinized, with attention to the immediate sleeping environment in sleep-related infant deaths. In addition, the caregiver(s)' clothing should be inspected for stains/signs of emesis in sleep-related deaths. The SUIDI Form should be utilized and the CDC's guidelines should be followed when investigating the death of a child < 1 year old. Sleep-related deaths of toddler-age children should also be thoroughly scrutinized, with attention to the placement of the decedent's body, the sleeping environment, and the history provided by the caregivers.

Extensive photographs of the scene, including macro and micro details, should be obtained and forwarded to the Medical Examiner for review. Doll reenactments should be conducted and recorded in all sleep-related infant deaths. In addition, doll reenactments are extremely useful for those investigations involving the death during sleep of developmentally delayed children and children with a seizure history. Doll reenactments and scene reconstructions may be necessary and directed by the Medical Examiner or other investigative entity in a variety of cases.

ii. ER/Hospital Deaths

When notified of a child death at an emergency room or other medical facility, the Coroner and/or Death Investigator should respond to the facility, examine the decedent, and interview the caregivers if possible. As soon as possible, the Coroner/Death Investigator should return to the scene with Law Enforcement and DFCS, as appropriate, to conduct a scene investigation.

Subpoenas, if required, should be forwarded to the appropriate entities to ensure the receipt of EMS Patient Care Report and/or hospital medical record/ER chart. In addition, if maltreatment is suspected, the Coroner/Death Investigator should request the 911 call from the appropriate authorities. The Coroner/Death Investigator should request any other investigating agency's (Child Advocacy Center, State Fire Marshal, Department of Juvenile Justice, Department of Natural Resources, Department of Behavioral Health and Developmental Disabilities, etc.) reports regarding the death.

Autopsy examination should be scheduled with the appropriate Medical Examiner, Law Enforcement, DFCS personnel, and/or other investigative agencies. The Coroner/Death Investigator should discuss the findings of the examination with the Medical Examiner and appropriate investigative agencies to ensure all investigative parties understand the nature of the death. In addition, the Coroner or Death Investigator should provide updated information, as appropriate, to the decedent's caregivers/family members in accordance with agency policy and

directives. The Coroner/Death Investigator should notify DFCS if support services and/or grief resources are needed.

The Coroner/Death Investigator should report the death to the District Attorney's Office as soon as possible for the purposes of Child Fatality Review and participate in the CFR process and prevention efforts within the community, as appropriate, in accordance with OCGA§ 19-15-3.

Coroners and Death Investigators should attend extensive training which thoroughly details all aspects of child death investigations. Routine review of National Association of Medical Examiners and American Board of Medicolegal Death Investigators standards regarding child death investigation is recommended. See IV. Training Recommendations.

f. Medical Examiners

Upon notification of a child death, Medical Examiners should exercise caution and request additional information from investigative or medical sources if necessary, prior to declining jurisdiction of any child death case. In cases of natural death and/or "expected deaths," especially those which occur outside a medical facility, the Medical Examiner should also review the decedent's and caregiver's DFCS history and any potential history with EMS and/or Law Enforcement prior to declining jurisdiction. Toxicology screens should be considered.

Medical Examiners should adhere to the NAME standards for performing forensic autopsies in cases of child death and require comprehensive death scene investigations and witness interviews in adherence to ABMDI standards. Prior to assigning cause and manner of death, the Medical Examiner should review all investigative information from each participating agency, review the death scene investigation, medical/mental health history, and social history, and request additional information if necessary. If the cause of death is pending for an extended period, the Medical Examiner should contact all pertinent investigators to ensure current investigative information is considered when assigning cause and manner of death.

The Medical Examiner should explain the findings of the examination and/or cause and manner of death to the appropriate investigative entities and be available for clarification of medical issues or forensic findings as an investigation progresses. If requested, the Medical Examiner should participate in the Child Fatality Review and prevention efforts within the community, as appropriate, in accordance with OCGA§ 19-15-3.

Medical Examiners should maintain their Continuing Education per licensing requirements and agency policy. Routine review of applicable NAME and ABMDI standards regarding child death investigation is recommended. See IV. Training Recommendations.

g. District Attorneys

District Attorneys have a vested interest in the proper investigation of child deaths, as a thorough investigation is critical to the prosecution of child maltreatment cases. In addition, as the Chair of the Child Fatality Review Committee, the District Attorney is ultimately responsible for the timely review of each child death.

District Attorneys should coordinate with Law Enforcement and local DFCS personnel in cases in which maltreatment is suspected and be available to respond to the scene or medical facility and assist with Search Warrants or other legal issues, as necessary.

District Attorneys should attend the autopsy and/or discuss the findings of the examination with the Medical Examiner. In addition, pre-trial meetings with the Medical Examiner and Coroner/Death Investigator are critical in child maltreatment cases.

District Attorneys should maintain a high standard for participation and level of engagement for the Child Fatality Review Committee Members to ensure a thorough review of each death and complete report submission to the Child Fatality Review Office, Georgia Bureau of Investigation, in accordance with OCGA§ 19-15-3. In addition, District Attorneys should routinely engage in prevention efforts within the community, as appropriate.

District Attorneys should maintain their Continuing Education per licensing requirements and agency policy. Child Death Investigation, Sleep-Related Infant Death Investigation, and extensive Maltreatment training is recommended. See IV. Training Recommendations.

h. Other Investigative Agencies

Numerous agencies/entities may be involved in a child death investigation and should comply with agency directives, policies, and procedures when investigating a child death. A coordinated investigative effort among all agencies is critical in a child death investigation. Any agency involved in an investigation should contact the Coroner/Death Investigator and/or Law Enforcement to report pertinent information. Finalized autopsy reports should be requested and reviewed, as appropriate.

Training regarding basic child death investigation is recommended for anyone who may be involved in such an investigation, and extensive training in the investigation of child maltreatment may be required.

IV. Training Recommendations

Specialized training is advised for any entity who may potentially be involved in a child death investigation. Keen observation, medical and legal knowledge, and significant interviewing skills are necessary for the swift recognition of maltreatment and/or detection of subtle maltreatment. Basic Child Death Investigation training (minimum 4 hours) is recommended for any individual involved in a child death investigation in any capacity. In addition, Sleep-Related Infant Death Investigation and Maltreatment Investigation training is critical for Law Enforcement, DFCS, and Coroner/Death Investigation personnel.

Sample Curriculum

GA Death Investigation Act (45-16-20)

Review of agency's policies/protocols

Death Scene Protocols

- Examination of body
    - Postmortem Changes
        - Livor, Rigor, Algor Mortis
        - Tardieu Spots/Tache Noir
    - Injuries

- Scene Investigation
    - Walk-through of home/scene location
    - Detailed photography
    - Extensive scrutiny of immediate death environment, regardless of transport status
    - Doll reenactment
    - Evidence of maltreatment
        - Drug paraphernalia; tox screens
        - Neglect
- Review of DFCS HX and prior Law Enforcement involvement
- Protocol for children who will not be autopsied; tox samples

Autopsy Protocols

- Scene Investigation is required prior to autopsy; follow-up as needed
- Medical HX and Medical Records
- EMS Patient Care Report; 911 call tape PRN
- Circumstances of Death

Certification of Death

- Cause of Death versus Mechanism of Death
- Medical Opinion, based on scene investigation, interviews, and autopsy results
    - Reporting new/additional information
- Proximate versus Immediate Cause of Death

Manners of Death

- Natural
- Accident
- Suicide
- Homicide
- Undetermined

Child Fatality Data

Sleep-Related Infant Deaths

- Traditional SIDS/SUID/Asphyxia Paradigm
- Examination of body; significant postmortem findings
- Scene Investigation
    - Doll reenactments
- Tox screens
- Aggravating Circumstances
- DFCS HX, substantiating neglect

Child Maltreatment

- Neglect
- Subtle neglect, medical neglect, “expected deaths”
    - Tox samples
- Risk Factors
- Physical Injuries
    - Types of Trauma
    - Inflicted versus accidental trauma
- Conducting the Investigation

- Joint Investigations
- Interviews
- Timeline of events

Trauma-Informed Practice

Secondary Trauma

CFR Process and Prevention Initiatives

Resources (Local, State, Federal)

V. Resources

Numerous resources are available for those agencies and individuals involved in child death investigations. The most comprehensive collection of investigative tools, including body diagrams, scene diagrams, and autopsy specimen guidance, can be found at www.sudpeds.com and are available for download. The CDC, NAME, and ABMDI also provide tools such as investigative guidance and body diagrams. Information for obtaining dolls for reenactments is also available. During implementation of this protocol, local resources should be included. Resources should be updated during the periodic reviews.

a. OCGA § 45-16-20, The Georgia Death Investigation Act
b. National Association of Medical Examiners (NAME)
    i. Centers for Disease Control (CDC)
        1. Sudden Unexpected Infant Death and Sudden Infant Death Syndrome
            a. https://www.cdc.gov/sids/index.htm
        2. American Academy of Pediatrics (AAP), I*dentifying Child Abuse Fatalities in Infancy*
            a. https://www.thename.org/assets/docs/AAP%20Identifying%20child%20abuse%20fatalities%20during%20infancy%202019%20e20192076.full%20%281%29.pdf
        3. Unexpected Pediatric Deaths: Investigation, Certification, and Family Needs
            a. https://sudpeds.com/
                i. Appendix 4: Sudden Unexpected Infant Death Investigation Reporting Form
                ii. Appendix 5: Sudden Unexpected Child Death Investigation Reporting Form
                iii. Appendix 8: AMA Guidelines for Communication between Hospitals, Medical Examiners, and Next of Kin following Unexplained or Unexpected Deaths in the Hospital

c. American Board of Medicolegal Death Investigators (ABMDI)
    ii. National Institute of Justice *Death Investigation: A Guide for the Scene Investigator* https://www.ncjrs.gov/pdffiles1/nij/234457.pdf

d. Scene Reconstruction Dolls

Maltreatment Committee

CFR Local Practices Survey

CFR Local Practices Survey

Local Child Fatality Review (CFR) Committees are charged with reviewing the circumstances of specific child deaths with an intent to identify ways to prevent such deaths in the future. The Official Code of Georgia 19-15-3 identifies the make-up of these committees, the deaths to be reviewed based on cause of death, what information is to be reviewed, and reporting requirements.

The purpose of this survey is to seek information regarding local CFR committee operations, identify any barriers to meeting review and reporting requirements, and request recommendations for improvement.

* 1. What is your role with respect to your local CFR committee?

- ◯ Superior court judge or designee
- ◯ County medical examiner or coroner
- ◯ District attorney or designee
- ◯ DFCS representative
- ◯ Law enforcement representative
- ◯ Other (please specify)
- ◯ Juvenile court representative
- ◯ County board of health representative
- ◯ County mental health representative
- ◯ Prevention advocate

* 2. How long have you served in this role with respect to your local CFR committee?

- ◯ One year or less
- ◯ 2-3 years
- ◯ 4-5 years
- ◯ More than 5 years

* 3. Your county:

4. How often does your local CFR committee meet to review child deaths?

- ◯ Less than once a year
- ◯ 1-4 times a year
- ◯ 5-8 times a year
- ◯ 9-12 times a year
- ◯ More than 12 times a year
- ◯ Don’t know

5. How many child deaths did your local CFR committee review in 2018?*(enter number)*

6. Which of the following members usually attend your local CFR committee meetings to participate in reviews: *(check all that apply)*

- [ ] County medical examiner or coroner
- [ ] District attorney or designee
- [ ] DFCS representative
- [ ] Law enforcement representative
- [ ] County sheriff or police chief or designee
- [ ] Juvenile court representative
- [ ] County board of health representative
- [ ] County mental health representative
- [ ] Prevention advocate

Other (specify)

CFR Local Practices Survey

7. How often does the county coroner or medical examiner notify your local CFR committee chair of a child's death within the required 48 hours?

Always	Usually	Sometimes	Rarely	Never	Don't know
○	○	○	○	○	○

8. How often does the county coroner or medical examiner notify your local CFR committee chair of whether a child's death meets the criteria for review within 7 days of the child's death?

Always	Usually	Sometimes	Rarely	Never	Don't know
○	○	○	○	○	○

9. How often does your local CFR committee:

	Always	Usually	Sometimes	Rarely	Never	Don't know
Meet within 30 days of receiving the child death notification?	○	○	○	○	○	○
Complete its review and prepare a report within 20 business days of its first meeting regarding the case?	○	○	○	○	○	○

CFR Local Practices Survey

10. How often does your local CFR committee experience difficulty in completing its review and/or meeting reporting deadlines due to difficulty or delays in obtaining the following health/medical-related information:

	Always	Usually	Sometimes	Rarely	Never	Don't know
Autopsy reports	○	○	○	○	○	○
Cause of death	○	○	○	○	○	○
Circumstances leading up to death	○	○	○	○	○	○
Child’s health/medical information	○	○	○	○	○	○
Toxicology/lab reports	○	○	○	○	○	○
Whether there was a previous child death in the family	○	○	○	○	○	○

11. How often does your local CFR committee experience difficulty in completing its review and/or meeting reporting deadlines due to difficulty or delays in obtaining the following case-related information:

	Always	Usually	Sometimes	Rarely	Never	Don't know
Birth information	○	○	○	○	○	○
Information from agencies providing social services to the child/family (such as DFCS, DPH, DBHDD, DJJ)	○	○	○	○	○	○
Law enforcement investigative data	○	○	○	○	○	○
Parole and probation information/records	○	○	○	○	○	○
Whether child maltreatment (abuse or neglect) was involved or whether there was a history of such maltreatment	○	○	○	○	○	○

12. How often does your local CFR committee experience difficulty in completing its review and/or meeting reporting deadlines due to difficulty or delays in obtaining the following information on the child's caregiver or supervisor:

	Always	Usually	Sometimes	Rarely	Never	Don't know
Caregiver or supervisor involvement in the circumstances leading up to child’s death	○	○	○	○	○	○
Caregiver or supervisor health/medical information	○	○	○	○	○	○
Whether there were any acts or reports of violence between family members or others living or formerly living in the household	○	○	○	○	○	○
Whether any family member or other person living or formerly living in the household had a substance abuse issue	○	○	○	○	○	○
Whether any family member or other person living or formerly living in the household had a mental health issue	○	○	○	○	○	○

* 13. Who is responsible for entering your local CFR committee's child death case review data into the National Child Death Reporting (NCDR) system?

- ◯ County medical examiner or coroner
- ◯ District attorney or designee
- ◯ DFCS representative
- ◯ Law enforcement representative
- ◯ County sheriff or police chief or designee
- ◯ Other (please specify position or CFR committee role, not name)
- ◯ Juvenile court representative
- ◯ County board of health representative
- ◯ County mental health representative
- ◯ Prevention advocate

14. How often are the information collected during the review and the local CFR committee findings completed and entered into the NCDR system within 72 days of the child's death?

Always	Usually	Sometimes	Rarely	Never	Don't know
◯	◯	◯	◯	◯	◯

15. What challenges does your local CFR committee experience in meeting its legislatively mandated review and reporting deadlines? *(check all that apply)*

- ☐ Availability of CFR committee members to participate in review meeting
- ☐ Availability of other individuals to participate in review meeting
- ☐ Scheduling meeting within required time frame
- ☐ Receiving information needed for review within required time frame
- ☐ Receiving incomplete information
- ☐ Receiving information from another county
- ☐ Interpreting and evaluating the information collected during the review

Please explain WHY the challenges you identified occur:

CFR Local Practices Survey

16. Please rate the sufficiency of the training your local CFR committee members have received in each of the following CFR processes:

	More than sufficient	Sufficient	Less than sufficient	Don't know
Legal requirements for conducting child death reviews (Georgia Code Section 19-15-3)	○	○	○	○
How to conduct a child death review	○	○	○	○
How to document a child death review	○	○	○	○
Understanding the National Child Death Reporting (NCDR) form	○	○	○	○
How to complete the NCDR form	○	○	○	○

17. Please rate the sufficiency of the training your local review committee members have received in each of the following review areas:

	More than sufficient	Sufficient	Less than sufficient	Don't know
a. How to obtain any additional information needed for the review	○	○	○	○
b. How to interpret and evaluate information collected during the review	○	○	○	○
c. How to determine whether a child's death may have been preventable	○	○	○	○
d. How to identify child maltreatment if there was no CPS history	○	○	○	○
e. How to identify child death prevention opportunities/strategies for your community	○	○	○	○

18. What additional training, or other resources or supports, does the committee need to help it conduct reviews and complete reporting within mandated timelines?

The Georgia Code (Section 19-15-3.2.b) provides the option for establishing child death review committees at either the county level or the judicial circuit level.

* 19. Would your local CFR committee have any interest in transitioning from a county-level committee to a judicial circuit-level committee that covers more than one county?

- ◯ Yes
- ◯ No
- ◯ Maybe
- ◯ Not applicable (already jurisdiction level or county and judicial circuit territories are the same)
- ◯ Don't know

Comments:

20. What recommendations would you make to improve the child death review and reporting process in your county, judicial circuit, or the state?

21. Other comments:

Thank you for your input on this survey! Your responses will help us develop recommendations for improvement.

For questions about this survey, please feel free to email us at ChildFatalityReview@gbi.ga.gov.