Georgia's Child Abuse Prevention & Treatment Act

Citizen Review Panels (CAPTA Panels)

2021 Annual Report

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

Georgia

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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). Reauthorization is currently in committee in both the House (H.R. 485 - The Stronger Child Abuse Prevention and Treatment Act) and the Senate (CAPTA Reauthorization Act of 2021).

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.

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

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

- 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.

CAPTA Section 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 citizen review panel.

These three panels continue to constitute the state's CAPTA Panels.

> 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] Georgia's CAPTA Panels have increased efforts to broaden the diversity in its membership - geographically, culturally, and racially. Due to the complexity of cases involving child maltreatment, special attention is given to ensuring that Panel members have some familiarity with the child

[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.

protection system and include a balance of professionals and individuals with life experience that contribute diverse perspectives to the work of the Panels.
The expertise and opinions of the Panel members are valued by the Division 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.

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. New panel members recruited in 2021 have been identified in their individual reports.

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 2021 activities.

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

Each of Georgia's CAPTA Panels meet 4-6 times a year satisfying this requirement. Panel committees meet between meetings, as needed. In response to Covid-19 pandemic restrictions, Georgia's Panels and committees discontinued in-person meeting but continued to meet virtually using the Zoom online platform during 2021.

Annual Retreat

CAPTA Panel members participated in an annual day-long virtual retreat in September 2021. 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.

The agenda for the 2021 retreat included:

- Special Guests who provided federal and state updates:
  - Donna Dummett, Region IV, Child Welfare Specialist
  - Mary Havick, Deputy Division Director of Child Welfare
- Division Leadership Panel Q&A - Deputy Division Director, Mary Havick was joined by:
  - Carmen Calloway, Director, Well-being Section
  - Laresa Price, Director, Safety Section
  - Natalie Towns, Director, Prevention and Community Support Section
  - Arleymah Gray, Director of Federal Plans
  - Shelby Zimmer, Families First Program Director
- Special Presentations:
  - Workforce Resilience & Safety Science in Child Welfare

    Michael Cull, University of Kentucky & National Partnership for Child Safety
  - Safety Science at Work: Georgia's Critical Incident Review

    Martha Dukes, Manager, DFCS CDNFSI Team
- Facilitated Panel Discussion
  - How to Improve Worker Retention

    Title IV-E Caseworker Panel

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).

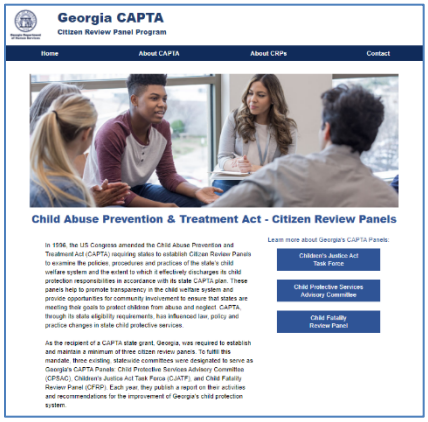
C. PUBLIC OUTREACH.—Each panel shall provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community and in order to meet its obligations under subparagraph (A).

Georgia's CAPTA Panels function independently of each other, identifying annual priorities and projects or activities. During the past 15 years, Georgia's CAPTA Panels have examined and made recommendations for improvement on a wide range of issues, including, but not limited to:

- Workforce recruitment and retention and worker health and safety
- Risk and safety assessment
- Foster parent training
- Relative/kin caregiver supports and services

- A wide range of multidisciplinary training for professionals, including law enforcement, forensic interviewers, advocates, caseworkers, CASAs, individuals who represent children, etc.
- Establishment of a statewide centralized call center
- Web-based mandated reporter training
- Cross agency sharing of data
- Improving the quality of legal representation
- Alignment of maltreatment terminology in Georgia Code and across state agencies
- Enhancement of the state model child abuse protocol to include child fatality investigations

Description of 2021 activities and resulting recommendations are included in the summary reports prepared for each Panel.



With respect to public outreach, a dedicated website, https://www.gacrp.com/, is maintained where annual CAPTA Panel reports and state responses are posted, as are descriptions of CAPTA legislation, CAPTA Panels, 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.

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 to meet its CAPTA obligations, the Division provides ongoing administrative support, including:

- Creating a Director of Federal Plans position in 2016 whose responsibilities include coordination of CAPTA and CJA State grant activities related to the state CAPTA plan and serving as a liaison with the Panels. This allows for timely sharing of information between the Panels, the Division, and other partners to support ongoing activities. The Director of Federal Plans responds to requests from the CAPTA Panels, provides agency updates and ensures engagement of CAPTA Panel members as stakeholders and partners on initiatives, state, and federal plans, reporting and evaluation.
- Contracting with a firm for the services of an independent coordinator who:
    - Assists Panel leadership in the identification, recruitment, and engagement of Panel members
    - Coordinates and facilitates Panel meetings
    - Provides technical assistance and conducts research to support Panel and committee objectives
    - Promotes collaboration and coordination of activities between the Panels
    - Promotes collaboration between the Panels and the Division
    - Represents Panel interests and facilitates the exchange of information between the Panels, the Division and its partners and stakeholders

Members of the Division's leadership team are periodically invited to CAPTA Panels meetings as authorities in their area of responsibility when they intersect with CAPTA Panel priorities, interests,

and concerns. Providing an opportunity for open dialogue, over the years, these meetings have cultivated a transparent and collaborative partnership between the Division and CAPTA Panels based on shared goals and objectives, and mutual respect and understanding.

Members from the Division's leadership team also participate in the annual all Panel retreat in September where information related to current Panel activities are exchanged, and updates provided on actions taken by the Division in response to previous recommendations.

> 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 efforts to evaluate state and local child protection system agencies, through the examination of policies, practices, and procedures of state and local agencies, and recommendations for improvement. 2021 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. Annual reports and state responses are posted on the CAPTA Panel website, https://www.gacrp.com/.

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 2021, this included, but was not limited to:

- APSR Joint Collaboration Meetings
- FFPSA Work Groups

- State Child Abuse and Neglect Prevention Plan
- State Child Abuse Protocol
- Mandated Reporter Training Updates
- Child welfare policy review

Georgia's CAPTA Panel and CJA Task Force Coordinator also serves as the chair of the National Citizen Review Panel Advisory Board. The purpose of the Advisory Board is to advocate for the CAPTA citizen review panel community, to serve as a resource for community, and to promote and support the self-funded, annual national conference for citizen review panels. In 2021, the Advisory Board continued discussions with representatives from the Office of Child Abuse and Neglect, the Capacity Building Center for States, and the national CRP Coordinator, to establish a closer working relationship and to encourage implementation of a Community of Practice as a strategy to provide ongoing support the CRP community.

Attached are summaries prepared by each of Georgia's CAPTA Panels on their activities in 2021. Panel members look forward to receiving feedback from the Division on these recommendations and follow up requests related to its 2020 recommendations.

Respectfully submitted on behalf of Georgia's CAPTA Panels
Prepared by Deb Farrell, CAPTA Panel & CJA Task Force Coordinator, Care Solutions, Inc.

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.

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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 (CPSAC) 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 legislated obligations, the CPSAC serves solely as a CAPTA citizen 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. 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. 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. CPSAC leadership has made a conscious effort to increase the geographic, racial, and cultural diversity in its recruitment of new members.

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

The CPSAC has maintained a stable and committed core membership for many years. It is currently co-chaired by Amy Rene, Vice President of Clinical Programs, Hillside, Inc. and Karl Lehman, President & CEO, Childkind, Inc.

Current CPSAC members also include:

Tanya Anderson, Executive Director, Youth Villages
Angie Boy, Program Manager, Children's Healthcare of Atlanta, *Adoptive Parent*
Suzanne Dow, Executive Director, Georgia Mountain Women's Center, Inc.
Michelle Girtman, Executive Director, Battered Women's Shelter, Inc., *Foster/Adoptive Parent*
Dewanda Jackson. CEO/Clinical Director, Marvelous Light Consultants, LLC Counseling Services
Sarah Jones, *Foster Parent*
Trina Jones, Network Director, Multi-Agency Alliance for Children
Jennifer King, Executive Director, Georgia CASA
Jennifer Stein, Executive Director, PCA Georgia
Belisa Urbina, CEO, Ser Familia, Inc.

The CPSAC is actively recruiting replacements for two members who left the Panel in 2021.

Meetings

During 2021, the CPSAC met in March, May, August, and October satisfying the federally mandated minimum requirement for quarterly meetings. CPSAC members also participated in a day-long, all-panel virtual retreat in September 2021.

Meetings were held virtually through 2021 due to ongoing Covid-19 pandemic restrictions. Although virtual platforms allowed the group to continue to meet regularly, sustaining active engagement of members was challenging. Members are looking forward to a return to in-person meetings in 2022, however, the option to attend via Zoom will continue.

Functions

CAPTA legislation Section 106 c.4. describes the mandate charged to CAPTA citizen review panels. Functions of a panel include:

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 the child protection responsibilities in accordance with –
   i. The State (CAPTA) 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 State and local child protective services system is coordinated with the foster care and adoptions programs established under part E of Title V of the Social Security Act (42 U.S.C. 671 et seq.); and
      II. A review of child fatalities and near fatalities (as defined by subsection (b)(4) [of this section]).

The CPSAC is the one Georgia CAPTA Panel that does not serve a dual role[2] and whose interests focus solely on the child protection standards described in CAPTA legislation, Section 106. 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. Their interests have also extended to include Georgia's child welfare workforce and efforts by the Division to address high staff turnover though its recruitment, training, supervision, health, and safety measures.

[2] The Children's Justice Act Task Force serves as a task force on children's justice as per CAPTA, Section 107. The Child Fatality Review Panel served as a state legislated body charged with the review of sudden, unexpected child fatalities as per OCGA 19-15-1.

CPSAC 2021 Activities & Recommendations

Risk and Safety Assessment

CPSAC's ongoing concern on the lack of significant progress in improving in CFSR Safety Outcome 2, Item 3: Risk and Safety Assessment, continued to dominate discussions during meetings. The state's response to prior recommendations Safety Assessment included identifying several strategies being utilized to address these concerns.

2020 recommendation: The CPSAC recommended that the Division expand its quarterly analysis of the Child Welfare Quality Assurance review process to identify specific causes for deficiencies, implement effective strategies for addressing each causative factor, and monitor and evaluate results.

State Response: The Division's response indicated that it was utilizing a Root Cause Analysis framework to review outcomes, identify the causes, and develop strategic solutions.

Follow Up: The CPSAC requests that the Division provide an update on progress toward improving this CFSR measure describing the implementation of Root Cause Analysis framework including practice deficits identified and where, analysis conducted, actions taken, and results achieved to improve CFSR Risk and Safety Assessment outcomes. A copy of a completed Root Cause Analysis report would be helpful in understanding the process and benefit of utilizing this strategy.

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. 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 (POSC) 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." States that receive a Child Abuse

Prevention and Treatment Act (CAPTA) grant are required to implement POSC 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[3].

POSC, as described in CAPTA sections 106(b)(2)(B)(iii), is a plan developed for infants born and identified as being affected by substance abuse or withdrawal symptoms, or Fetal Alcohol Spectrum Disorder (FASD). The state plan requirement is that the POSC address the health and substance use disorder treatment needs of the infant and affected family member or caregiver.

FFY2020 Maltreatment data show 42,821 infants in 49 states being referred to CPS agencies as infants with prenatal substance exposure. Of those 49 states, 27 reported 21,964 screened-in and have a POSC. Georgia reported 3,769 screened-in, with only 2,656 reported as having a POSC.

Current Division policy[4] dictates that a POSC is required when prenatal abuse has been determined (maltreatment substantiated) and requires intervention and safety plans; or when special circumstances (no maltreatment) criteria is met for prenatally exposed infants, which only applies if the exposure was to prescribed medication. Criteria described in policy 3.18, suggests that identification of prenatal exposure to illegal drugs would always have to meet the criteria for an investigation and substantiated for prenatal abuse in order to receive a POSC. This would suggest that a significant cohort of infants who may have been prenatally exposed and affected may not be identified as eligible and receive a POSC if every report of prenatal exposure to an illegal drug is not investigated. This was not the intent of the CAPTA requirement. This gap should be clarified in policy and allow for a similar special circumstance no maltreatment for both legal and illegal drugs when warranted so that POSC can provide the intended protection to these at-risk infants.

[3] 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.

[4] 3.04, Intakes Involving Substance Use or Abuse, Prenatal Abuse, or Fetal Alcohol Syndrome Disorder (FASD), 3.18 Special Circumstance Intakes Involving Prenatal Exposure (No Maltreatment), and 19.27, Plan of Safe Care for Infants Prenatally Exposed to Substances or a Fetal Alcohol Spectrum Disorder (FASD)

POSC were intended to provide a safety net for children whose prenatal exposure to drugs, legal or illegal, elevated their risk for maltreatment either due to diminished maternal capacity to care for and protect the child or the impact of that exposure on child behaviors and development, both immediate and long-term support treatment and services. It was not intended as a punitive mechanism for responding to maltreatment by the child welfare agency but to provide an alternative response to increased child risk factors due to prenatal exposure. Currently, all Georgia POSC are completed by DFCS personnel. The workforce is already strained so an alternative model for POSC should be explored. An effective POSC system is a coordination of state and local resources in response to assessment of child and caregiver risk and protective factors. Such an alternative response would include local public and mental health, home visiting programs, community-based providers, family resource centers, hospitals, and birthing centers, treatment centers, etc.

Recommendations:

1. Address gap in policy related to identification of children eligible for POSC when prenatal exposure was to an illegal drug, but prenatal abuse is not substantiated.
2. Develop and support the implementation of a collaborative, community based POSC model to respond to 'no maltreatment' cases when infants have been prenatally exposed that satisfies the non-punitive, voluntary, prevention/early intervention intent of CAPTA. Such a community approach model should include specific roles and response expectations of all partners and stakeholders, POSC assessment, monitoring and reporting requirements, timelines, resource needs, clear objectives, and a plan for evaluation, and can be adapted in response to community need and resource availability.
3. State CAPTA grants have been supplemented with additional funds primarily to support the development and implementation of Plan of Safe Care programs. This supplement added more than $1M to Georgia's annual state CAPTA grant for the past three years. As POSC is one of the five priority areas in Georgia's approved state CAPTA Plan, the CPSAC recommends that funds be used to develop such a model and support implementation of a pilot in a community with high rates of caregiver drug abuse associated with maltreatment with a rigorous evaluation of its effectiveness.

State CAPTA Plan and State CAPTA Grant

The CPSAC has an ongoing interest in the state's CAPTA plan and CAPTA grant as the evaluation of the effectiveness of the plan is identified as a function for CAPTA citizen review panels. In 2020, the CPSAC made two recommendations with respect to the state CAPTA Plan and State CAPTA Grant.

- Including Division partners and stakeholders, including CAPTA Panel members, in the decision-making process on the utilization of funds designated for CAPTA in the American Rescue Plan. This recommendation reinforced a similar recommendation regarding the basic state CAPTA Grant.
- Conducting an annual review and evaluation of its state CAPTA plan to ensure its effectiveness

The Division's response to this recommendation was supportive, however, to date, no such collaborative process has been implemented. As a result, the CPSAC further recommends that :

Recommendations:

1. A timeline be developed and implemented to facilitate the engagement of partners and stakeholders, including CAPTA Panel members, to formalize a process for its CAPTA state grant that is similar to that of its CJA grant and includes:
    - Proposal guidelines and performance standards for projects requesting for CAPTA state grant funds, including documentation, reporting and evaluation.
    - Engaging CAPTA Panel members and other partners/stakeholders in review of proposals, the award decision-making process for initial and ongoing requests for continued support, and performance evaluations.
2. A plan be developed for ongoing evaluation of the state CAPTA plan to ensure its meets both state and CAPTA objectives.
3. An annual review be conducted of its state CAPTA Plan in conjunction with key partners and stakeholders to increase awareness of the plan and its objectives and to ensure its effectiveness and responsiveness to community and Division needs, and the CAPTA mandate.

CPSAC Plans for 2022

After two years of meeting virtually and feeling somewhat disconnected from each other, to reenergize and refocus their efforts, the CPSAC decided to implement a new standing committee structure. It is hoped that focusing on ongoing priorities and interests through this committee structure that they could track progress, build on prior year's recommendations, as needed, and monitor long-term impact on the child protection system.

The CPSAC five committees established include:

- Workforce
- State CAPTA Plan/State CAPTA State Grant
- CAPTA Child Protection Standards
- CFSP/CFSR/APRS
- Diversity/Equality/Inclusion

The CPSAC has already begun work developing objectives for each committee and identifying a focus for their 2022 work plans.

In closing…

The CPSAC would like to thank the Commissioner and the Division's leadership team for their continued support of its CAPTA Panel activities. Effectiveness of any CAPTA Panel is largely dependent on an open and mutually supportive and transparent relationship with the state's child welfare agency. Georgia's CAPTA Panels are fortunate to have had a such a relationship and look forward to future collaborative opportunities 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
Vice President Clinical Programs
Hillside, Inc.

Karl Lehman
Executive Director
Childkind, Inc.

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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)

Mandate

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 Act State 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's 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.

   Members

   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 (with life experience), and individuals experienced in working with children with disabilities and homeless children and youth.

[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."

Georgia's Task Force has maintained a stable and committed core membership for many years. It is currently chaired by Melissa Carter, Clinical Professor at 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. In 2021, a new law enforcement representative was successfully recruited. Kim Tesalona, Chief Investigator with the Douglas County District Attorney's office joined the Task Force in November 2021. At this time, all mandated positions on the Task Force have been satisfied.

Current Task Force members and their associated representation[4] include:

Cheryl Benefield, Mental Health & Wellbeing Coordinator
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, Judicial Law Clerk, Dekalb County Juvenile Court
Child Attorney

Rachelle Carnesale, Fulton County Superior Court
Superior Court Judge (criminal)

Jenifer Carreras CWLS, Deputy Director
Office of the Child Advocate
Attorney

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

Nancy Chandler, Retired CEO
Georgia Center for Child Advocacy
Advocate

Dena Crim, Special Assistant Attorney General,
Georgia Department of Law, Cobb County
Lived Experience

[4] Bolded designations indicate required representation on CJA task forces.

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

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

Beoncia Loveless, Child Death & Serious Injury Specialist
GA Division of Family & Children Services
Adoptive Parent (Former Relative Foster Parent)

Stephen Messner, MD, Medical Director
Children's Healthcare of Atlanta Stephanie Blank for Safe & Healthy Children
Health Professional

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

Julia Neighbors, Deputy Chief Administrative Officer
Atlanta Judicial Circuit, Fulton County Juvenile Court
Prevention Specialist

Amber Patterson
Cobb County Juvenile Court
Juvenile Court Judge (civil)

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

Mitzie Smith, Policy & Regulations Director
GA Division of Family & Children Services,
Child Protective Services

Angela Tanzella-Tyner, JD, Advocacy Director
Georgia CASA
Court Appointed Special Advocate

Kim Tesalona, Chief Investigator
Douglas County District Attorney
Law Enforcement

Michele Thomas, Volunteer
Forsyth County CASA
Court Appointed Special Advocate

Donnie Winokur, Author & Adoptive Parent
Special Needs Advocate (FASD Specialist)

Deb Farrell, Care Solutions, Inc.
Task Force Coordinator

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. One such addition was a representative from the Georgia Department of Education several years ago. The contribution of this representative to the Task Force's Mandated Reporting Committee provided an invaluable perspective as the majority of reports of suspected abuse and neglect are made by schools.

Functions

CJA task forces, like CAPTA citizen review panels, are required to meet at least quarterly. Georgia's Task Force holds a minimum of five regularly scheduled meetings each year, satisfying the federally mandated minimum requirement. During 2021/2022, in addition to the annual all-panel retreat in September, the CJA Task Force met in May, August, October, December, February and April. Due to Covid pandemic restrictions, these meetings were held virtually through February 2022. April 13, 2022, marked the return to in-person meetings. Attendance via the Zoom meeting platform will continue to be offered as an option to members who are not able to attend in person for any meeting.

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 on projects whose objectives align with recommendations in the 2021 Three-Year Assessment; 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.

The Task Force has operated since 2005 in compliance with both its CAPTA and CJA legislated mandates.

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. 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.**

   Georgia submits a CJA grant application annually that includes:

   - Assurances from the Governor that the state has fulfilled all requirements outlined in Section 106 & 107 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

   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.

During the year, projects supported by the state's CJA grant included:

- Training for child abuse investigators utilizing the research-based ChildFirst™ forensic interview model.
- One Team Conference & Mini Summits targeting a broad spectrum of multidisciplinary team (MDT) members working in the field of child abuse intervention, prevention, investigation, prosecution, and treatment.
- Georgia Medical Network (telemedicine) to support community medical providers in areas of the state with few expert resources conducting outpatient child abuse medical evaluations to improve the quality of investigations and reduce trauma to the child and family.
- Emory Summer Child Advocacy Program (ESCAP) providing multidisciplinary summer internships for law and other graduate students designed to enhance the capacity and improve the performance of Georgia's child welfare system and to prepare emerging professionals for careers specializing in child advocacy and child welfare.
- Georgia CASA Strengthening Best Interests Advocacy project to provide training, consultation and peer support for CASA staff and volunteers.
- Special Victims Unit Task Force to develop and implement training to patrol and school resource officers on identifying and responding to cases of suspected child abuse and neglect.
- Child Welfare Summit to provide innovative training and education opportunities to child welfare professionals.

The Division's Federal Plans Director works collaboratively with the CJA Task Force Coordinator to support the alignment of Task Force priorities and goals with other federally required plans, including Georgia's state CAPTA plan. Objectives for the five focus areas in the state CAPTA plan are: Workforce, Plans of Safe Care, Child Fatalities, Mandated Reporting, and Quality Legal Representation. The latter three align closely with CJA goals and Task Force committee objectives for improving child fatality investigations, improving the quality and consistency of

mandated reporter training, and improving the quality of legal representation, providing opportunities for robust partner collaboration and coordination of activities.

Recommendation: The Task Force continues to monitor utilization of the state's CAPTA state grant and to improve coordination between CAPTA and CJA state grants, and recommends that the Division adopt a formal process for soliciting, vetting and evaluating projects supported by the CAPTA state grant that supports the objectives of the state's CAPTA plan and is similar to that of its CJA grant, including:

- Development of a proposal framework that includes needs assessment, organizational capacity and qualifications, implementation plan, and outcomes and evaluation for all projects.
- Incorporating a multidisciplinary review and approval of proposed projects that includes both Task Force and CAPTA Panel members in addition to other partners.
- Development of performance expectations, documentation, and periodic and annual reporting requirements.
- Evaluation of projects and activities supported with CAPTA state grant.

Task Force members and members from other CAPTA panels were invited to participate in a series of joint planning Annual Progress and Services Report (APSR) stakeholder engagement meetings. These planning meetings provide a forum for Division leadership and community partners to discuss CFSR data related to child and family outcomes and systemic factors, along with the CFSP goals and objectives, and to identify areas for improvement and strategies to improve outcomes.

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.[5]

Between 2009 - 2018, the Task Force 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. In 2018, the Assessment 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.

In 2020/2021 the Task Force conducted its most recent Assessment on quality legal representation. Child attorneys, parent attorneys, Guardian ad litem (GAL) attorneys, Special Assistants Attorney General (SAAG), and Juvenile Court Judges were surveyed on legal practices in their jurisdictions and several research-based strategies identified as effective in improving the quality of legal representation. Based on the findings, and recommendations resulting from the evaluation of the findings, Task Force committees also identified additional opportunities to support system improvement with respect to their ongoing priorities and interests and to inform decision-making on projects funded with the CJA grant between 2022-2024.

CJA required that recommendations resulting from the 2021 Assessment report include at least one recommendation in each of the three CJA categories. Each subsequent year, in addition to additional recommendations supporting the 2021 Assessment objectives, the Task Force must provide an update in the annual report on progress of each recommendation. It is also expected that each year's Task Force recommendations support and/or further Assessment objectives. Several current funding recommendations by the Grants Committee support

[5] A copy of the 2021 Three-Year Assessment report is available at https://www.gacrp.com/content/cjatf/three_year_assessments.cfm

projects that were responsive to 2021 Assessment recommendations. CJA categories and corresponding 2021 Assessment recommendations with 2021/2022 updates are as follows:

Category A. *Improving investigative, administrative, and judicial handling of cases of child abuse and neglect, including child sexual abuse and exploitation, as well as cases involving suspected child maltreatment related fatalities and cases involving a potential combination of jurisdictions, such as intrastate, interstate, Federal-State, and State-Tribal, in a manner which reduces the additional trauma to the child victim and the victim's family and which also ensures procedural fairness to the accused*.

1. The Task Force recommended that the annual document soliciting proposals for training activities identify and prioritize training for parent, child, and guardian ad litem attorneys that meet these objectives, including providing additional options for delivery (frequency, format) that expand training opportunities and include multidisciplinary options. In the survey results, the Task Force identified several training opportunities it would recommend supporting, such as trial skills, motions practice, and evidence training specific to dependency; role specific pre-appointment training; etc.

   Update

   Projects responsive to this recommendation and recommended for 2023 CJA funding include:

   - Office of the Child Advocate - QLR Project
   - Office of the Child Advocate – GAL/MDCANI Training
   - Georgia Center for Child Advocacy – Training for Attorneys on Forensic Interviews

2. The Task Force recommended that alternative protocols be identified to supplement the annual proposal solicitation process and support a wider variety of more individually targeted training and professional development.

   Update

   The Task Force reiterates this recommendation for 2022 as an alternative for funding projects outside of the Division's Office of Procurement and Contracts annual cycle for federal fiscal year contracts remains a challenge.

Category B. *Experimental, model, and demonstration programs for testing innovative approaches and techniques which may improve the prompt and successful resolution of civil and criminal court proceedings or enhance the effectiveness of judicial and administrative action in child abuse and neglect cases, particularly child sexual abuse and exploitation cases, including the enhancement of performance of court-appointed attorneys and guardians ad litem for children, and which also ensure procedural fairness to the accused.*

1. The Task Force recommended promoting and supporting innovative practices that utilize more collaborative approaches to representation, such as an interdisciplinary model.

   Update

   Projects responsive to this recommendation and recommended for 2023 CJA funding include:

   - Office of the Child Advocate - QLR Project
   - Office of the Child Advocate – GAL/MDCANI Training
   - Georgia Center for Child Advocacy - Training for Attorneys on Forensic Interviews
   - Georgia Center for Child Advocacy - Mentoring Program for Forensic Interviewers

Category C. *Reform of state law, ordinances, regulations, protocols, and procedures to provide comprehensive protection for children, which may include those children involved in reports of child abuse or neglect with a potential combination of jurisdictions, such as intrastate, interstate, Federal-State, and State-Tribal, from child abuse and neglect, including child sexual abuse and exploitation, while ensuring fairness to all affected persons.*

1. The Task Force recommended that a study be commissioned to assess the viability of establishing a formal system of statewide oversight for child, parent, and guardian ad litem attorneys that would develop standards to improve both quality and consistency of practice and provide equitable and on-demand access to resources and training. Such a study, funded by the CJA grant would explore how this might be structured and implemented, recognizing that it would likely require legislative action to establish new agency/organization or add the responsibility for statewide oversight of one or more of these attorney groups to an existing entity.

Update

The Task Force reiterates this recommendation for 2022. Although a commission has not been established, several efforts have been undertaken that support, and may satisfy, this objective. The Office of the Child Advocate put forward legislation to clarify their administrative and oversight role with respect to training for child welfare legal professionals and the Georgia chapter of NACC is in the process of reconstituting a state chapter that would be instrumental in developing, promoting, and monitoring standards of practice for attorneys in the field of child welfare. The Task Force will monitor progress and is prepared to lend its support to both efforts as plans solidify.

5. **States 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: May 4-5, 2022

Although pandemic travel restrictions have loosened, many states are still limiting travel for state employees. As a result, the Children's Bureau opted to hold the annual grantee meetings virtually in 2022. The meeting was convened May 4-5, 2022. representatives from the Task Force at the meeting included the Task Force Coordinator; and two Task Force members, chair of the CJA Grants Committee and chair of the Legal Representation Committee, both serving as proxies for the Co-Chairs who were unable to attend. The Director of Federal Plans and Georgia's SLO also attended the meeting.

The 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.

Additionally, the CJA Task Force is represented at all quarterly calls hosted by the Children's Bureau by the Task Force Coordinator and/or one or more Task Force members.

Task Force Activities & Recommendations

The Task Force continues its support of coordinated, multidisciplinary approaches that improve the investigation, prosecution, and judicial handling of cases of child abuse and neglect, and in particular, projects and activities that improve the handling of cases involving victims with special needs, commercial sexual exploitation of children, and maltreatment-related child fatalities. This includes the following long-standing priorities related to its mandate:

- Advocating for and supporting the development of the full spectrum of professionals involved in cases of child abuse and neglect
- Improving the quality and consistency of the multidisciplinary response in the handling of all suspected cases of child abuse and neglect.
- Improving collaboration between Georgia's child welfare agency, its partners and community stakeholders to improve communication and coordination between agencies and among the professionals involved in the handling of child abuse cases
- Advocating for policies, procedures and practices that are responsive to developmental, mental, and physical health of victims with special needs

The Task Force has several standing committees that promote and support its ongoing priorities and interests. These include:

- Child Abuse Protocol Committee
- Mandated Reporter Training Committee
- Child Fatality Investigations Committee
- Special Needs Committee
- Quality Legal Representation Committee
- CJA Grants Committee

The level of committee activity varies from year-to-year depending on the child welfare climate, Task Force priorities and collaborative opportunities.

Child Abuse Protocol Committee

The state's model child abuse protocol (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 CAP Committee has two primary objectives related to the state Child Abuse Protocol:

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

The Committee continues to monitor updates to local and state child abuse protocols. There were no reported revisions to the state model protocol during the year. The Committee also monitors activities related to the CAP including training for local committees and submission of local protocols to DFCS and the Child Fatality Review Panel as per O.C.G.A. 19-15-2, an effort undertaken by the Office of the Child Advocate Director, Jerry Bruce.

The CAP Committee will continue to identify opportunities to increase the commitment, at both the state and community levels, to improving and supporting the multidisciplinary response to child maltreatment.

Mandated Reporter Training Committee

The Task Force established the Mandated Reporter Training Committee whose objectives are:

- To improve quality of reports of alleged abuse and neglect by mandated reporters to ensure an appropriate and consistent response by the state's child welfare agency.
- To improve the quality training for mandated reporters that is consistent with current child welfare policy and practice.

During the year, the Mandated Reporter Committee met with the Division and its partners to update Georgia's online mandated reporter trainings and explore:

- The development of standards for mandated reporter training to ensure consistency of content with current policy and practice including frequency of 'refresher' training for educators, childcare providers, and other professionals designated as mandated reporters.

- The development of standards for 'training for trainers' of mandated reporters.
- Establishing a clearinghouse for approving mandated reporter training curriculums.

As a result of their activities during the year, the Committee has identified a need for specialized training for individuals at organizations or agencies with child caring responsibilities, such as schools or daycare sites, that have a 'designated reporter'. This specialized training would identify the unique circumstances and reporting requirements to ensure compliance, improve quality and timeliness of reports and include updates on changes to mandated reporting laws and child welfare practice and policy that would also be communicated to the mandated reporters at these organizations or agencies.

Recommendation: The Committee recommends that the Division collaborate with its partners, including organizations/agencies that utilize 'designated reporters' to develop and implement a mandated reporter training module targeting this unique classification of mandated reporters.

Mandated Reporter Training Committee plans for the coming year include:

- Developing survey for designated reporters to determine training needs areas
- Planning focus groups for designated reporters utilizing feedback from surveys
- Reviewing all feedback and making recommendations about training
- Identifying elements needed for designated reporter training

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 deaths due to medical/natural causes or cases involving victims with special needs
- To improve the identification and evaluation of cases of prenatally exposed infants in sleep-related deaths

The Committee continues to be concerned that there are child fatalities due to abuse or neglect which are not identified and investigated because death investigation personnel do not have access to potential prior CPS history at the time of the death which may be relevant to the investigation. It is also a concern that the relevance of prior CPS history may not be evident at the time of the death but may have significant investigative or preventative impact, if made available.

Recommendation: The Committee recommends that the Division address this barrier to obtaining and sharing prior CPS histories with appropriate authorities with policy changes, developing and implementing protocols and/or procedures, as follows:

1. When law enforcement, a coroner, emergency room physician or other authority feels circumstances of a child death suggest that prior CPS history screening is warranted, a protocol should be implemented for obtaining and sharing that history with the authority.
2. Any death being considered as potentially reviewable by the local Child Fatality Review Committee authority should also, at a minimum, be screened for prior CPS history and that information shared with the local authority making that determination.
3. Any child death that rises to the level of a report to CICC by any designated authority, even if the reporter indicates that no foul play or maltreatment is suspected, should at a minimum, be screened for prior CPS history and results shared with that authority to inform their actions.

Remedies to these barriers should also be incorporated into the local child abuse protocol, where appropriate, to avoid triggering an automatic investigation by the Division.

The Committee has also expressed concerns about deaths due to medical or natural causes or deaths of child victims with special needs, all who are at high risk for abuse and neglect, that may not be identified as having been caused by abuse or neglect. The Committee will explore this issue further during the coming year.

Special Needs Committee

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

Quality Legal Representation Committee (QLR)

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 objectives of the Committee are as follows:

- To ensure that all children have access to and are appointed qualified individuals to represent their interests in judicial proceedings.
- To improve the quality of legal representation by child attorneys, parent attorneys, and Guardian ad Litem (GALs), and Special Assistants Attorney General (SAAGs) attorneys involved in civil and criminal cases of child abuse and neglect.

The QLR Committee monitored and provided feedback on CJA funded projects that addressed the objectives of the Committee. This included the implementation of the Title IVE: Quality Legal Representation pilot project in Chatham County; participation by Task Force members on workshop selection committee for the annual Child Welfare Summit in December 2022; and a collaboration between Georgia's Supreme Court Committee on Justice for Children (Georgia's Court Improvement Program), Office of the Child Advocate, Georgia CASA, the Division of Family and Children Services (DFCS) and the Council of Juvenile Court Judges to provide Multi-Disciplinary Child Abuse and Neglect Institutes (MDCANI) training focused on court practice improvement for judges, attorneys, child welfare agency staff, CASAs and other GALs. MDCANI project also involves support from the state's CAPTA grant as this effort was responsive to the quality legal representation focus area included in the state's CAPTA Plan.

The objectives of the QLR Committee were also a priority in its deliberations by the CJA Grants Committee to recommend projects to support with the CJA Grant.

CJA 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.

The CJA Grants Committee's revised its annual performance reporting requirements for grantees as well as the annual proposal solicitation document to emphasize priorities related to the 2021 Assessment recommendations, strengthen evaluation expectations, and streamline proposal submissions. A virtual informational webinar was hosted for potential grantees upon release of the new requirements to clarify expectations, answer questions, and provide technical assistance to potential CJA applicants.

The CJA Grants Committee reviewed and has recommended ten projects for FFY2023 CJA funding. Several projects recommended for ongoing support incorporated elements into their projects that were responsive to the objective of the 2021Three-Year Assessment - improving the quality of legal representation. Additionally, two pilot projects, one in its second year of implementation and one new project in FFY2023, focus on legal representation and attorney training and one new mentoring project have also been recommended for CJA funding.

FFY2023 CJA Funding Recommendations

Grantee: Cherokee Child Advocacy Center, Inc.
Project: ChildFirst™ Training
$100,000
Ongoing Task Force Priority

The overarching goal of the ChildFirst™ training program is to educate multidisciplinary child abuse professionals on a research-based, legally sound, objective, developmentally sensitive approach to forensic interviewing that will elicit reliable information while considering the best interests, cultural background, and any special needs of the child; to effectively inform decision-

making regarding child protection, child abuse investigations and prosecution. The ChildFirst™ training program will provide statewide training on current best practices and recent research in the field of forensic interviewing, including the research based ChildFirst™ forensic interview model. ChildFirst™ Georgia will provide three ChildFirst™ Forensic Interview basic trainings; an Advanced ChildFirst™ - Your Role in the Judicial Process training; and a ChildFirst™ Expanded Forensic Interview training.

Grantee: Children's Advocacy Center of Georgia
Project: 16th Annual Children's Advocacy Centers of Georgia "One Team" Conference: The MDT Response to Child Abuse and Neglect
$40,000
Ongoing Task Force Priority

The One Team conference will offer a one and a half day training to multidisciplinary team (MDT) members from experts and peers on their roles and responsibilities in investigating and prosecuting child abuse cases on a wide spectrum of topics including child sexual abuse, child commercial sexual exploitation, and children with special needs.

Grantee: Emory University – Barton Child Law and Policy Center
Project: Emory Summer Child Advocacy Program
$100,000
Ongoing Task Force Priority

The Emory Summer Child Advocacy Program (ESCAP) is a summer internship program for law and other graduate students interested in gaining experience toward a career specializing in child advocacy. ESCAP has two primary goals. First, ESCAP is committed to inspiring law and graduate interns from relevant disciplines to pursue careers in the child welfare system or child advocacy. Secondly, ESCAP also helps alleviate temporarily the pressures of resource-challenged settings in the state or local child welfare system and increase capacity for research, program innovation, and other means of improving practice by placing highly trained interns with child advocacy organizations; child-service agencies; law offices of children's attorneys, parent attorneys, and Special Assistant Attorneys General (SAAGs); and juvenile court settings across Georgia.

Grantee: Georgia CASA
Project: Strengthening Best Interests Advocacy
$40,000
Ongoing Task Force Priority

The goal of Georgia CASA's Strengthening Best Interests Advocacy program is to strengthen the quality and consistency of CASA's GAL representation and best-interest advocacy for dependent children. Specialized training, tools and resources, and onsite consultation and support are designed and delivered to:

- Improve the administrative and judicial handling of abuse and neglect cases by ensuring that CASA volunteers are well-trained and prepared to prevent further trauma to child victims.
- Increase child welfare system accountability in meeting the needs of children, adhering to time frames, and promoting permanency and well-being.

Additionally, this project has the potential to impact child welfare legislation, policy, and statewide practice through increased understanding and community engagement in the child welfare system.

Grantee: Children's Healthcare of Atlanta
Project: Medical Provider Network
$35,000
Ongoing Task Force Priority

The Medical Provider Network project provides access to expert consultation to medical professionals and child welfare workers in rural/remote communities who are evaluating or investigating suspected cases of child abuse and neglect. Physicians and staff at the Children's Healthcare of Atlanta, Stephanie V. Blank Center for Safe & Healthy Children provide ongoing mentoring, training, and consultation to improve the assessment and investigation of child abuse and neglect.

Grantee: Office of the Child Advocate
Project: The Summit: Georgia's Child Welfare Conference
$99,900.
Ongoing Task Force Priority

The Office of the Child Advocate, in collaboration with the Georgia Division of Family and Children Services (DFCS), and the Committee on Justice for Children (J4C) will host the fifth annual Summit: Georgia's Child Welfare Conference, November 30 - December 2, 2022, in conjunction and collaboration with our partners, the Court Improvement Program (Committee on Justice for Children (J4C)), the Georgia Division of Family and Children Services (DFCS), and Georgia Court Appointed Special Advocates (GA CASA).

Goals for the 2022 Summit include providing an advanced, multidisciplinary training for child welfare professionals across a variety of disciplines to facilitate and improve communication and collaboration between public and private agencies and practitioners, and to refresh the child welfare workforce through comradery, encouragement, and well-being support.

Grantee: Office of the Child Advocate
Project: Chatham County Quality Legal Representation Project
$99,676.
Second Year of Pilot Project Responsive to Three-Year Assessment Objectives

The Office of the Child Advocate (OCA), the Supreme Court Committee on Justice for Children (J4C), the Division of Family and Children Services (DFCS), Chatham County and the Chatham County Juvenile Court have collaborated in the development of a pilot project utilizing an interdisciplinary practice model designed to improve legal representation of children in dependency court.

The goal of the project is to develop and implement an inter-disciplinary practice model to improve the quality of children's legal representation that can be used as a demonstration project that could be replicated in other jurisdictions. The primary shift that will improve representation is changing from a contract attorney model, where mostly part-time attorneys represent children across three different courtrooms, to establishment of a children's law office that will assign one lawyer to each courtroom. This single shift will facilitate improvement in representation by addressing most of the major deficiencies that have been identified in Chatham County.
The model includes:

- Three full-time dedicated attorneys
- Limited caseloads

- Administrative supports
- Dedicated social worker
- Training on legal strategies to expedite permanency
- Ongoing support to ensure implementation of legal strategies
- Case management, tracking and evaluation

Additionally, the project will provide a model for utilization of Title IVE funds.

Grantee: Office of the Child Advocate

Project: Foundational Training Program

$69,000

New Collaborative Project Responsive to Three-Year Assessment Objectives

The Office of the Child Advocate (OCA) is charged statutorily with providing pre-appointment guardian ad litem training for attorneys and lay persons serving as guardians ad litem in dependency cases. In Georgia, the law requires that children be appointed both a guardian ad litem and traditional legal counsel. One representative may serve in both the attorney and guardian ad litem roles so long as no conflict of interest exists between the two roles, and this "dual role" model of representation is by far the most widely used in Georgia. As such, most attorneys serving as guardians ad litem in dependency cases will jointly be serving as legal counsel. OCA's Foundational Training Programming provides a variety of widely accessible, current, and comprehensive training opportunities to professionals working in the dependency and child welfare fields.

OCA will also host three to five Multi-Disciplinary Child Abuse & Neglect Institutes (MDCANI). MDCANI strengthens consistency and the use of best practices in dependency proceedings from removal to permanency, increases collaboration among the court and its stakeholders, and improves outcomes for children and families experiencing the child welfare system.

Additionally, OCA will create and implement an evaluation process that includes the development of an objective and detailed grading tool in collaboration with the Barton Center and the use of the tool, which will include interviews and court observation, to perform pre-assessments and post-assessments of MDCANI recipient jurisdictions. This evaluation process will enable project leaders not only to assist local counties with the implementation of the skills and practices disseminated at

training, but it will provide detailed information as to whether and how those practices actually change as a result of the information learned. This information will not only be crucial to continued advancement of MDCANI, but also to inform child welfare law and policy training needs throughout Georgia on a systemic level.

Grantee: Georgia Center for Child Advocacy
Project: Forensic Interview Legal Training (FILT)
$55,473.
New Pilot Project Responsive to Three-Year Assessment Objectives

From disclosure through prosecution, quality interviews and informed multidisciplinary teams help pursue improved justice for child victims. Currently, one of the few training opportunities for attorneys to be educated about forensic interviewing is ChildFirst™, a weeklong intensive training primarily targeted and structured for forensic interviewers and is not always optimal for lawyers.

Year one of the FILT project will design a customized curriculum and implement a one to two-day pilot training for attorneys involved in cases of child abuse on forensic interviewing practices based on key components of ChildFirst™. Year One of the project will create and pilot FI Legal Training; Years two and three will refine and develop a structure so that the training can be replicated and offered ongoing statewide.

Grantee: Georgia Center for Child Advocacy
Project: Forensic Interviewing: Let's Mentor Statewide (FILMS)
$94,527.
New Pilot Project

FILMS aims to establish a mentoring program for forensic interviewers to provide ongoing supervision, peer support and networking opportunities to increase the quality of forensic interviews and improve functioning of the multidisciplinary team (MDT). Research demonstrates that peer review and ongoing supervision following an initial forensic interview training like ChildFirst™ yields dramatic improvements on the quality of the interview. Furthermore, a higher functioning MDT decreases system trauma to children. From disclosure through prosecution, quality interviews and informed MDTs help pursue improved justice for child victims.

This project is being designed with long-term stability in mind and includes plans for years two and three that each build upon the momentum and structure developed and launched as a pilot during year one.

In closing…

The Task Force would like to express its appreciation to the Commissioner and the Division's leadership team for their continued support of the Task Force, its mandate, and responsiveness to its recommendations. The Task Force looks forward to identifying additional opportunities to engage with the Division and its strategic partners to support and advance Children's Justice Act goals and objectives in the coming year.

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

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

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

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Child Fatality Review Panel

CFR Maltreatment Committee 2021 Summary Report

Child Fatality Review Panel Annual Report CY 2020 Fatalities

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). One of the panels is required to review child maltreatment deaths and make recommendations for improvements to the child welfare system to prevent future fatalities or near-fatalities.

Georgia Child Fatality Review

The Child Fatality Review Panel (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. 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.

In 2007, the 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

[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.

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 provides training and support, monitors, and reviews the work product of Georgia's 159 county Local Child Fatality Review (LCFR) committees, analyzes results, and identifies recommendations based on the findings of local review committees and the priorities of CFRP members.

Members

The membership of the CFRP, as set forth in state law O.C.G.A. § 19-15-4, is comprised of the heads of all state agencies that play a significant role in the health and welfare of Georgia's children, as well as representatives of agencies/offices involved in the investigation and prosecution of criminal offenders. In addition to members prescribed by statute, the Governor appoints other members, except for one appointment made 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. A list of members is included in the annual report attached as Exhibit #1. Several professionals with expertise in child fatality, child safety and wellbeing, and prevention attend meetings regularly as guests.

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. With several new appointments confirmed in 2021, CFRP met the membership requirements for a CAPTA Panel.

Meetings

In 2021, the CFRP met virtually January 8, April 30, July 23, and October 22 (annual retreat, in-person) satisfying the CAPTA quarterly meeting requirement. CFRP members also participated in the annual day-long retreat for all Georgia CAPTA Panels that was held virtually in September 2021. The maltreatment, prevention, legislative and administrative committees continued to meet virtually throughout the year.

Reports

The CFRP submits an annual report on the findings of local child fatality review committees[3] to the Georgia legislature. A copy of the report on Calendar Year 2020 fatalities is attached as Exhibit #1.

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 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.

Child Fatality Review Panel

Georgia's Child Fatality Review Panel (CFRP), mandated by O.C.G.A. 19-15-4, reviews and analyzes annual aggregate data collected on all reviewable deaths.[4] 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.

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.

[3] Data on the finding s of Local Child Fatality Review Committees is collected in the National Child Death Reporting System.
[4] Reviewable deaths are all deaths of children under age 18 that were sudden, unexpected, and/or unexplained.

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.

Review by the Child Welfare Agency

The Division has adopted and implemented a Safety Science approach for all its critical incident reviews, including the child fatalities reported to the Division by the county, or when submitted to the Centralized Intake Call Center (CICC). Critical incident reviews, including child fatalities, are conducted by the Division's experienced Child Death, Near Fatality, Serious Injury (CDNFSI) team.

Selection Criteria for Reviewable Cases

- Victim had CPS history within previous 24 months
- Victim was involved in an open CPS or FC case at time of death
- Leadership or county request
- Unaddressed safety concern was identified

Safety Science seeks to learn from systemic failures and anticipate their recurrence, not place blame. This multi-disciplinary approach looks beyond human error to examine the full range of system forces at work when disasters occur. Inquiries are geared towards learning what systems worked and what systems didn't. System influences are rated based on both their impact & their proximity to the outcome.

The findings and any actions taken as a result of these reviews, and lessons learned, have not made available.

Previous Maltreatment Committee Recommendation

In 2020, the Maltreatment Committee recommended that the Division prepare and make available, a report on the lessons learned during its first year of implementation, a summary of findings, the Division's response to systemic issues identified, and plans for continuing the Safety Science approach. The Division's response to the recommendation indicated that this data was being analyzed and that a report to disseminate findings was in development. To date such a report has

not been made available. The Maltreatment Committee requests an update on expected release of the report.

Recommendation: The Maltreatment Committee would like to further recommend that the Division prepare and make available, an annual report on the critical incident reviews, the lessons learned, a summary of findings, and actions taken by the Division to address the systemic issues identified. Sharing of this information would be beneficial to the CFRP in their review and analysis of child fatality data, and in meeting their mandates as both a state CFRP and a CAPTA Panel to identify prevention opportunities.

Maltreatment Committee

In 2009, when the CFRP was designated as one of Georgia's three citizen review panels (CAPTA Panels), the Maltreatment Committee (MalTx) was established to ensure that the CFRP met its federally mandated role as CAPTA Panel, including its obligations related to the examination of maltreatment-related deaths, in addition to its state-legislated obligations.

The MalTx Committee identified three priority objectives related to its CAPTA mandate:

- 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

The MalTx Committee includes state-legislated 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 the CAPTA Panel mandate.

In addition to GBI/CFR staff and appointed CFRP members, Tiffany Sawyer, Director of Prevention & Education, Georgia Center for Child Advocacy, Judge Carolyn Altman, Paulding Juvenile Court, and Jerry Bruce, Director, Office of the Child Advocate, the MalTx Committee includes the following members:

- Angela Boy, Program Manager, Prevention and Training, Stephanie V. Blank Center
- John Carter, Epidemiologist
- Lisa Dawson MPH, Director, Injury Prevention Program, Georgia Department of Public Health
- Martha Dukes, Manager CDNFSI (Child Death, Near Fatality/Serious Injury) Review Team, Division of Family and Children Services
- Julia Neighbors, Director of Programming & Grants, Fulton County Juvenile Courts
- Peggy Walker, Retired Juvenile Court Judge and former CFRP member

Judge Altman and OCA Director Bruce, both new CFRP appointees, joined the MalTx Committee in 2021.

During 2021, in addition to attending CFRP quarterly meetings, the MalTx Committee met in January June, August, and December.

An annual summary of MalTx Committee activities and recommendations is also prepared and submitted as a supplement to the annual CFRP report.

2021 Priorities, Interests and Activities

Ongoing priorities for the MalTx Committee include:

- Contributing to the update of the CFRP policy and training manual
- Improving training for local child fatality review committee members on the identification and review of maltreatment-related fatalities
- Improving training on identifying prevention opportunities and strategies to prevent maltreatment-related fatalities
- Improving the quality and consistency of data entered into the National Child Death Reporting System
- Improving collaboration and data sharing among agencies with child caring, protection, and prevention responsibilities
- Improving use of data to identify emerging trends, identify prevention opportunities, and develop recommendations for system improvement to prevent maltreatment-related fatalities

In 2021, the MalTx Committee focused primarily on providing feedback on updating the policy and training manual for CFRP. This included supporting selection of a contractor to conduct a needs assessment, interviewing stakeholders, reviewing policies and practices, conducting research on best practices, making recommendations on updates and format for the new manual. The MalTx Committee is confident that such a comprehensive approach will help to address ongoing concerns regarding reporting quality, consistency and compliance and improve the ability of local committees to identify effective prevention strategies and opportunities for system improvement.

The Georgia Child Fatality Review Panel Annual Report: CY2020 has identified that 155 of 537 reviewable deaths (28.8%) identified maltreatment as a cause or contributing factor or had a history of maltreatment. It should be noted that the report also identified that 50.6% of reviewed homicides and 34.0% of suicides had a direct correlation with maltreatment. Identifying options to provide on-demand and up-to-date training on child abuse and neglect related fatalities has been an ongoing priority for the committee.

Recommendation: With respect to training for local committees, the MalTx Committee recommends that the Division, as the expert in child abuse and neglect, develop in conjunction with CFRP representatives, a comprehensive training module on identifying and reviewing child deaths when child abuse or neglect may have been a cause or contributing factor. Such training should be available to both new team members and to local teams as a guide when reviewing a death involving child abuse or neglect.

It is also recommended that the Division review fields in the National Child Death Reporting System that suggest a potential link to maltreatment and provide clear guidance for training local teams to ensure that terminology and data collected and documented is consistent with Georgia policy and practice.

The CFRP report also identified several prevention strategies related to these fatalities included identifying family stressors and focusing on finding appropriate community-support programs. Additionally, the report noted that improving coordination (information sharing) among service providers would help to identify maltreatment risk factors for both perpetrators and child victims.

Local teams, however, did not identify any specific prevention opportunities to implement in their communities. Additional training on identifying, developing, and implementing effective prevention strategies would be beneficial. The CFRP Prevention Committee included this as one of their priorities this year.

It would be also beneficial if local child fatality review teams were represented on their local Child Abuse and Neglect Prevention Plan (CANPP) teams to ensure that communities include child fatality prevention in their strategic plans. It would be appreciated if the Division would encourage and ensure that child fatality prevention plans were incorporated into all CANPP.

The rise in suicide deaths is an ongoing concern for the CFRP and the MalTx Committee. The MalTx Committee has attempted to conduct additional analysis on suicides identified by child fatality review when abuse or neglect was the cause or a contributing factor in a child death, the child had prior maltreatment or CPS history. Unfortunately, aggregate data available to the MalTx Committee on the circumstances of these fatalities is insufficient. Lack of access to case level data is a barrier to adequate evaluation of these cases and to evaluating the extent to which state and local agencies met their child protection responsibilities and identify opportunities for system improvement, in accordance with its CAPTA mandate. Addressing this barrier and improving data sharing has been the object of several previous recommendations. Although CAPTA legislation makes provisions for allowing such case level access for CAPTA Panels, efforts to remove these barriers have not been fruitful.

Recommendation: The MalTx Committee would like to reiterate its previous recommendation and further recommends that the Division facilitate the development of a protocol to provide access to such case level data by CAPTA Panels when deemed necessary by the Panels in the performance of their duties as a CAPTA Panel.

Maltreatment Committee Plans for 2022

The MalTx Committee has determined that it will focus its efforts on sleep-related deaths. The collaborative coordinated approach to educating the public on effective, evidence-based prevention strategies has not resulted in a significant reduction in the number of these preventable deaths.

Their interest is in examining the relationship between these sleep-related deaths, prenatal exposure, maternal drug use, and Plans of Safe Care. This will require collaboration with the Division on access to additional information on cases involving prenatally exposed infants.

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

Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2020

Peggy Walker
Acting Panel Chairman

Brian Kemp
Governor

The Child Fatality Review Panel Members

Peggy Walker – Panel Acting Chair, Judge, Douglas County Juvenile Court

Vacant – Panel Vice-Chair,

Vic Reynolds – Director, Georgia Bureau of Investigation

Mandi Ballinger – Member, Georgia House of Representatives

Kathleen Bennett – Retired Mental Health Specialist

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

Gloria Butler – Member, Georgia State Senate

Kathleen Toomey – Commissioner, Department of Public Health

Robertiena Fletcher – Board Chair, Department of Human Services

Jay Neal – Director, Criminal Justice Coordinating Council

Tom Rawlings – Director, Division of Family and Children Services

Tiffany Sawyer – Prevention Director, Georgia Center for Child Advocacy

Richard Hawk – Coroner, Coweta County

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

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

Rachel Davidson – Director, Office of the Child Advocate

Vacant – Member, District Attorney

Amy Jacobs – Commissioner, Department of Early Care and Learning

Vacant – Member, State Board of Education

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Mission

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

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

Acknowledgments

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

- All the members who serve on each of the County Child Fatality Review Committees
- John T. Carter, PH.D., M.P.H., Emeritus Assistant Professor, Rollins School of Public Health, Emory University

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

Letter from the CFR Panel Vice-Chair

Honorable Governor Brian Kemp and Members of the Georgia General Assembly:

We are honored to present the Annual Report of the Georgia Child Fatality Review Panel for child death data composed in calendar year 2020. This data, representing sudden and unexpected child fatalities of Georgia residents, is compiled by 159 local child fatality review committees pursuant to statutory requirements. The Panel commends local committees for their continued compliance in this work. Thank you for the ongoing partnership and support in the Panel's mission to collect child death data and execute prevention efforts throughout our state.

The 2020 Annual Report uses multi-year data to highlight the leading reviewable causes of death in Georgia's children. There were 537 reviewable deaths for 2020 with 450 eligible reviews completed by local committees. Barriers cited for not completing reviews include turnover with mandated members, lack of knowledge regarding statutory requirements, and COVID-19 restrictions. To enhance compliancy, the Panel will continue to teach, communicate with, and support committee members in the child fatality review process.

Sleep-related infant deaths (SIDS, SUID, and sleep-related asphyxia) remain the leading post-neonatal reviewable cause of death, accounting for nearly one-third of all cases reviewed. We must continue efforts to educate and promote the Georgia Safe to Sleep Campaign and echo the message to the public during their interactions with the medical, public health, public safety, and prevention community. Furthermore, thorough investigation and documentation of these deaths is critical for review, prosecution, and prevention. Law enforcement, coroner, first responder, and other public safety personnel should receive coordinated and consistent instruction for investigating sleep-related infant deaths.

For purposes of this report, deaths not eligible for review are expected natural deaths or deaths due to congenital defects. Those medical deaths eligible for review are cases where children die suddenly and unexpectedly due to natural disease, or the death wasn't expected from the diagnosed medical condition. There were 95 medical deaths reviewed in 2020. Specific concentration should focus on plan and medication compliance as well as access to medical care. The Panel recognizes opportunities for prevention, especially in rural counties with limited medical care.

Child homicides account for the fourth leading reviewable cause of death in 2020, marking a 31% increase from the year prior. There were 89 juvenile homicides in 2020 with teens ages 15-17 comprising 49% of the reported deaths. With the COVID-19 pandemic, most school systems converted from in-person to virtual learning, a new, unexpected, and unchartered territory for families and communities. Coupled with inadequate supervision and unsecured access to firearms, the Panel recognizes the ramifications of the pandemic related to child maltreatment and intentional deaths. We support Georgia's Child Abuse and Neglect Prevention Plan (CANPP), which provides overarching goals for families, society, and systems/governments to ensure all of Georgia's children and families have equitable opportunities to grow and thrive in safe, stable, connected, and nurturing communities where they live, learn, work, and play.

The Panel commends Director Reynolds, the Child Fatality Review staff, Agents, and medical examiner office personnel at the Georgia Bureau of Investigation for their daily work to investigate, review, prosecute, and prevent the deaths of our most vulnerable residents, our children. Thank you for your attention, commitment, and support of the Panel and our Annual Report. Together, we shall continue our mission to reduce and prevent child deaths in Georgia.

Sincerely,
Elizabeth Andrews
Vice-Chair, Child Fatality Review Panel

Background and History

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

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

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

The product of the review process is a description of trends and risk factors for child deaths in Georgia. The CFR local teams and the Georgia CFR Panel use the review information to identify prevention strategies. The Georgia CFR Panel includes experts in the fields of child abuse prevention, mental health, family law, death investigation, and injury prevention. The variety of disciplines involved, and the depth of expertise provided by the Panel allow an in-depth analysis of both contributory and preventative factors for child deaths. This report identifies specific policy recommendations to reduce child deaths in Georgia.

Executive Summary

The Georgia Child Fatality Review Panel publishes an annual report on the deaths of infants and children in Georgia. The Report uses death certificate data provided by the Office of Vital Records within the Division of Public Health to document all deaths to the population under 18 years of age. The CFR process involves a review of a subset of deaths that are unexpected or are due to unintentional or intentional injuries. The review process provides for the systematic collection of "risk factor" data on deaths that are potentially preventable. These child death data are useful in revealing recurring patterns and to indicate prevention gaps and opportunities.

The Georgia trends in infant / child deaths over the last 10 years have been unremarkable. The child death rates tend to vary slightly from year to year, but there has not been any apparent trend. The infant death rate has declined from 7.8 deaths per 1,000 births in 2015 to 7.0 in 2019 and 6.3 in 2020. All the rates remain slightly higher than the National rate.

There were 1,358 reported (Death Certificate) infant and child (< 18 years) deaths in 2020. Five hundred thirty-seven (537) of those deaths were considered as "reviewable", and 450 of the 537 were reviewed (84%) (Table 1). The county review teams also reviewed 95 of the 821 "medical" deaths and 17 deaths that were reported as non-GA residents or were missing a death certificate. This yields a total of 562 reviewed deaths, and the analysis of reviewed deaths includes all 562.

Table 1. Reviewable 2020 Georgia Infant and Child Deaths, Proportion Reviewed

Major Cause of Death Categories	All Deaths	Reviewed	% Reviewed
Unintentional Injuries	211	176	83.4
Intentional Injuries	144	123	85.4
Sleep-Related (Infants)	157	129	82.2
Unknown / Unknown Intent	25	22	88.0
Total	**537**	**450**	**83.8**

The CFR local teams determined that 44 of the 562 reviewed deaths (8%) had maltreatment (abuse or neglect) reported as a cause or contributing factor for the death. An additional 111 deaths (20%) reported a history of maltreatment. Child maltreatment is a valuable factor for identifying populations at risk for child deaths, and agencies serving children need appropriate access to maltreatment information.

The CFR local teams agree that most of these reviewable deaths could have been prevented – 353 of the 400 (88%) of the reviewed deaths (non-medical cause, with a preventability determination) could "Probably" have been prevented. This result highlights the importance of the CFR process for identifying risk factors and contributing to the design of prevention strategies.

Racial disparities in the rates of infant and child deaths have been well documented, and the Georgia data (death certificate and Fatality Review) confirm the disparity. In 2020, 269 White, non-Hispanic infants died (a rate of 5.1 per 1,000 births). The rate was 9.6 (406 deaths) for Black/African American, non-Hispanic infants. The rate was 4.1 for Hispanics (76 deaths) which was down from 5.4 in 2019. Overall Black children were more likely to die a violent death. The disparity varies by cause of death; prevention targets or activities must account for both racial differences as well as differences in cause of deaths.

The National Center for Fatality Review and Prevention (NCFRP) data system is now a source for nine years of GA fatality review data. We are using this multi-year data to conduct analyses on specific topics related to Georgia infant and child deaths. The topics will address demographic characteristics (age, race, and sex), specific causes of death (sleep-related, suicide, homicide, and motor vehicle crashes), and/or cross-cutting subjects (maltreatment, supervision). Completed and documented analyses will be released and posted on the CFR website.

Reported Child Deaths in Georgia

In 2020, the COVID-19 pandemic was a challenge for all the U.S., and the Child Fatality Review process in Georgia was also affected. Due to the many demands on local health departments and other community organizations because of COVID-19, some county CFR local teams were not able to complete all the reviews. The number of reported child deaths decreased while the total number of deaths (all ages) increased by 20 percent. COVID-19 accounts for 9,446 of the 17,473 additional deaths, but that still leaves a 9% increase associated with other causes. The 2020 death certificates only reported six (6) COVID-19 deaths among children less than 18 years of age. However, the number of reviewable deaths increased by almost 15% (from 468 to 537) (Table 2).

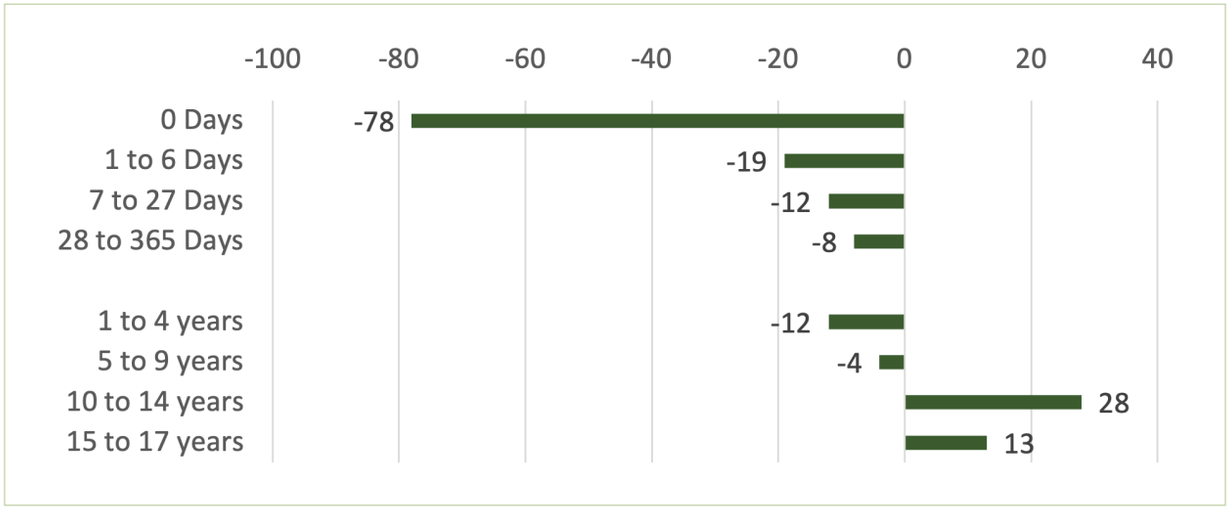
Table 2. 2019-2020 Georgia Infant/Child Deaths

	2019	2020
Total Number of Deaths	1,450	1,358
Reviewable Deaths	468	537
Reviewable Deaths Reviewed	429	450
% Reviewable Deaths Reviewed	91.7	83.8
Total Deaths Reviewed	**557**	**562**

The decrease in number of deaths (2019 to 2020) was not uniform across age categories. The infant mortality rate (deaths per 100,000 births) decreased from 7.0 in 2019 to 6.3 in 2020, corresponding to 117 fewer deaths in 2020. (The 3% drop in births would account for 27 of the 117 fewer infant deaths.) Most of the reduction

in infant deaths was due to the decrease (from 298 to 220) in number of infants dying at birth (within the first day of life). There were small decreases in deaths among children 1 through 9, and the 10 through 17-year-old children experienced an increase in deaths (Figure 1).

Figure 1. Change in Number of Deaths, 2019-2020



In 2020, there were a total of 1,358 infant/child deaths in Georgia. Of those 1,358 deaths, 537 deaths met the eligibility criteria for county level Child Fatality Review. Of the 537 deaths that met the review criteria, 450 were reviewed (83.8%).

Any infant or child death is loss to society and a tragedy for the immediate family. The child fatality review (CFR) process was developed to provide a way to learn from these deaths so that future deaths could be prevented. A "learning process" can take place at three levels:

1

Community (county): A local CFR team reviews the individual deaths, enters data abstracted from the review into a GA (and National) database, and develops recommendations for action at the community level.

2

Georgia: The GA CFR Panel – through work by staff from the GA Child Fatality Review – reviews the analysis of the state-wide CFR data and prepares recommendations (legislation, education, and environmental) designed to reduce childhood injury and associated death.

3

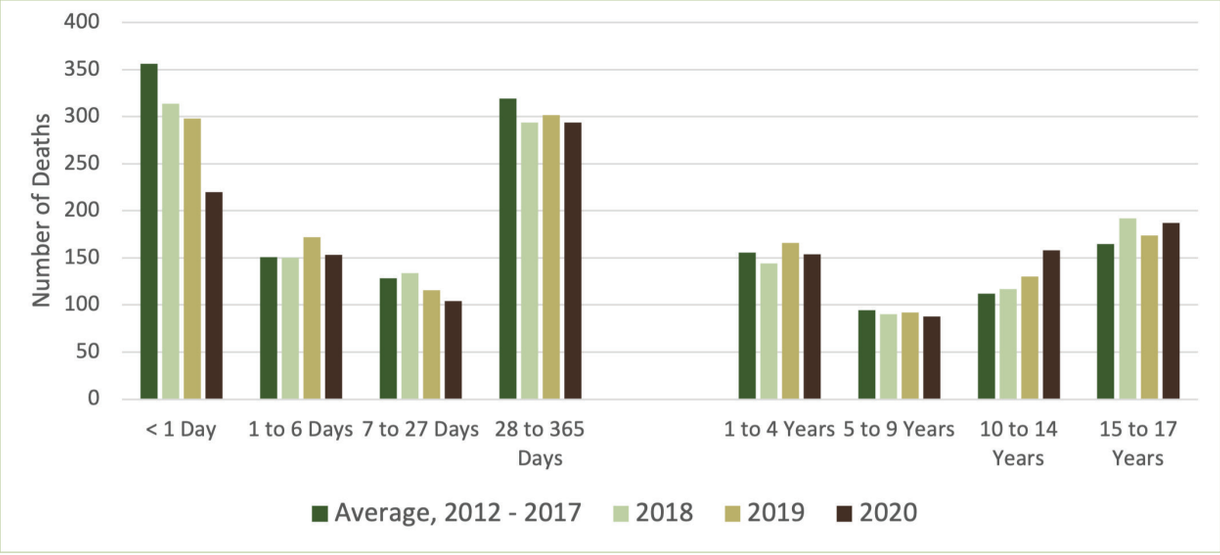
Nation: The National Center for the Review and Prevention of Child Deaths (NCFRP) maintains the national database and provides an opportunity for research on child deaths at the national level.

This annual CFR Report indicates trends in child deaths, summarizes the GA CFR 2020 activities, and provides a synthesis of the CFR local teams' prevention recommendations. The CFR Panel serves as one of the citizen's review panels for the GA Child Abuse Prevention and Treatment Act (CAPTA), so one section explicitly addresses child maltreatment.

2020 Child Deaths:

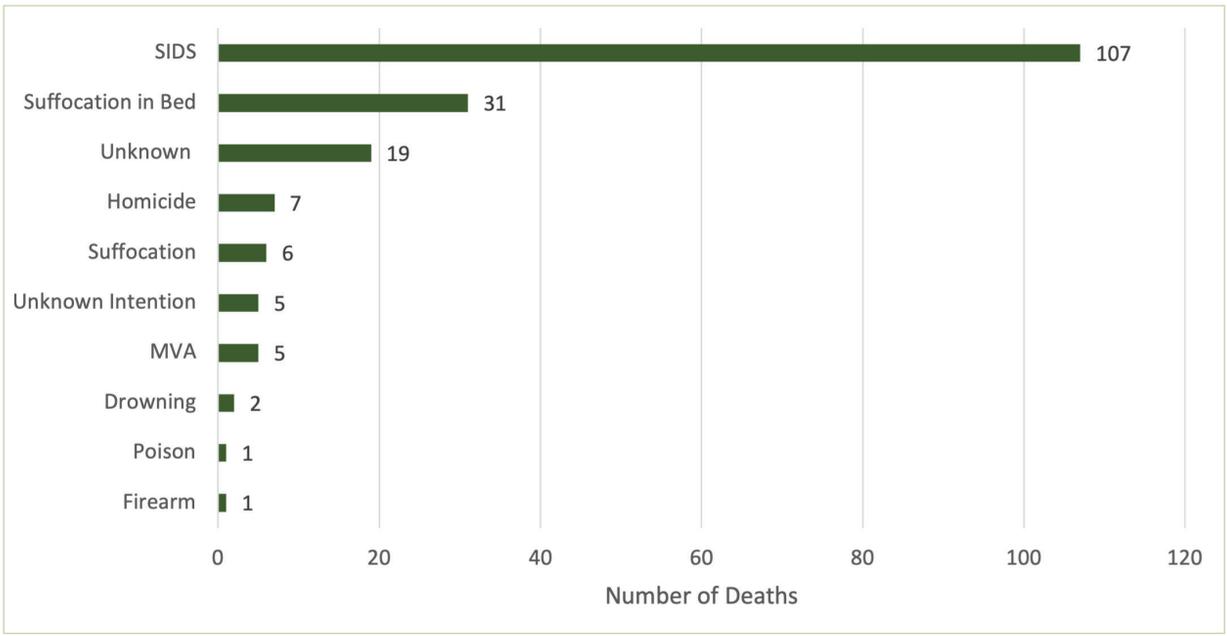
A majority of these 1,358 reported deaths were infant deaths (771, or 57%), and 220 of the infant deaths occurred in the 1st day of life (Figure 2). An additional 257 occur within the 1st month and these three age categories define "neonatal deaths". These neonatal deaths are generally associated with prematurity and congenital defects, and they are not usually a subject for CFR. The sleep-related infant deaths are the largest category of post-neonatal deaths, and they are reviewed.

Figure 2. Age Distribution, Georgia Infant and Child Deaths



The 2020 mortality data (https://www.macrotrends.net/countries/USA/united-states/infant-mortality-rate) showed a U.S. infant mortality rate of 5.68 per 1,000 births. The GA Oasis rate (6.3 per 1,000) is higher than the U.S. rate but represents a "statistically significant" decrease from the 2019 GA rate (7.0 per 1,000). Toddlers (1 to 4) and children (5 to 14) death rates (2019) were 23.3 and 13.4 per 100,000 for the U.S. and the corresponding GA 2020 rates were 29.6 and 17.3. Georgia's rate for all these mortality measures is slightly higher than the National rate.

Figure 3. 2020 Georgia Non-Medical* Infant Deaths, by Cause



*Infant deaths attributed to "Medical" causes=587

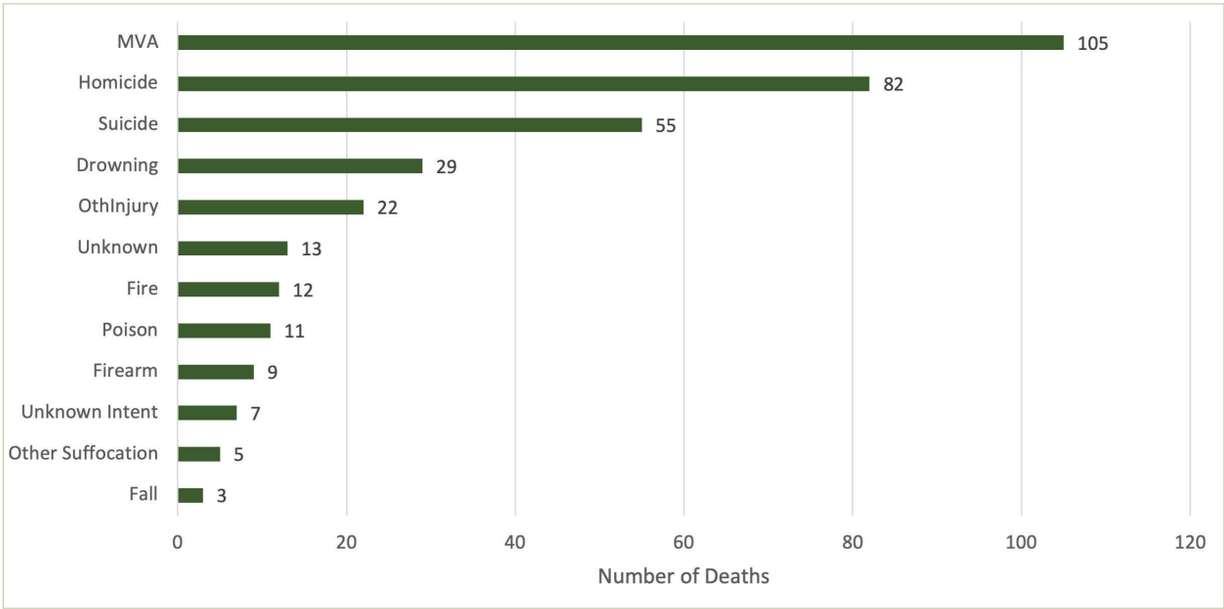
The 2020 infant deaths (Figure 3) are dominated by "medical" causes (76% of all infant deaths). The three next largest causes – SUID, suffocation in bed, and unknown – comprise the combined category of "sleep-related" deaths and account for 20% of all infant deaths. However, these sleep-related deaths made up 49% of all post-neonatal infant deaths (Table 3).

Table 3. Age Distribution for Infant Deaths, Georgia, 2020

	Infant Age Categories (days)				
	< 1 day	**1 to 6**	**7 to 27**	**28 to 365**	**Total < 1 Year**
SUD Categories					
SIDS			7	100	107
Suffocation in Bed		2		29	31
Unknown	1	1	1	16	19
All Other Causes	219	150	96	149	614
			Sleep-related proportion	**49.3**	**20.4**

The estimated population of children ages 1 through 17 in 2020 was 2,372,144, and there were 587 deaths in that population in 2020. Deaths are more common among toddlers and teens, and these age differences are associated with specific causes of death. Deaths attributed to medical causes continue to be the largest category of death for ages 1 through 17 years (42%), but Figure 4 shows the significant number of deaths from unintentional (33%) and intentional (23%) injuries.

Figure 4. 2020 Georgia Non-Medical* Deaths, Ages 1-17, by Cause

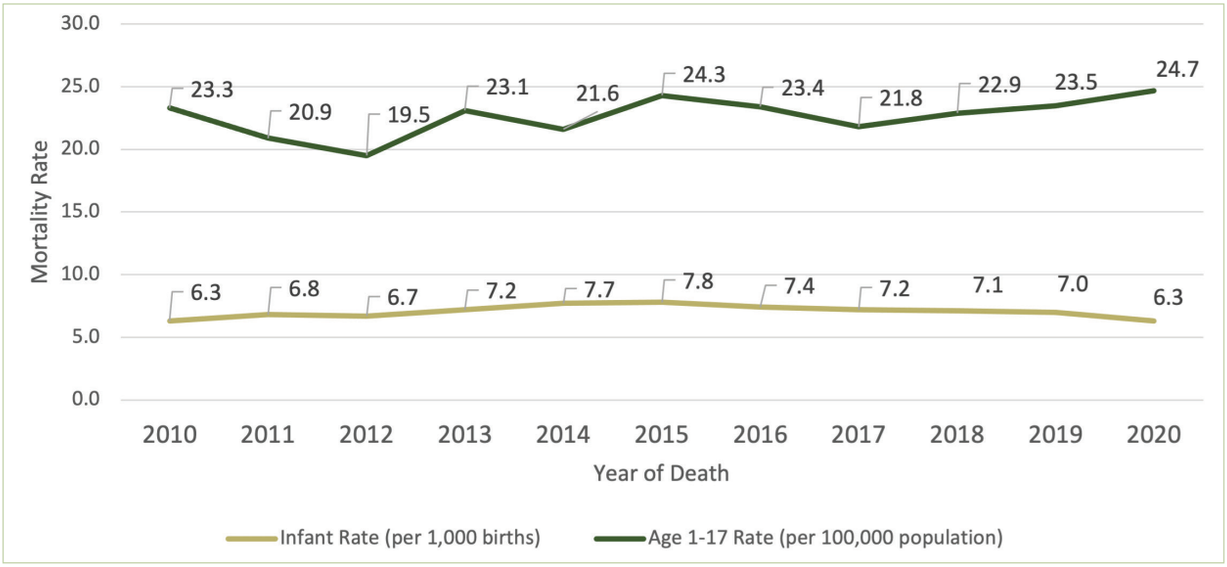


*Child (ages 1 to 17) deaths attributed to "Medical" causes=234

Trends in Georgia Infant and Child Deaths:

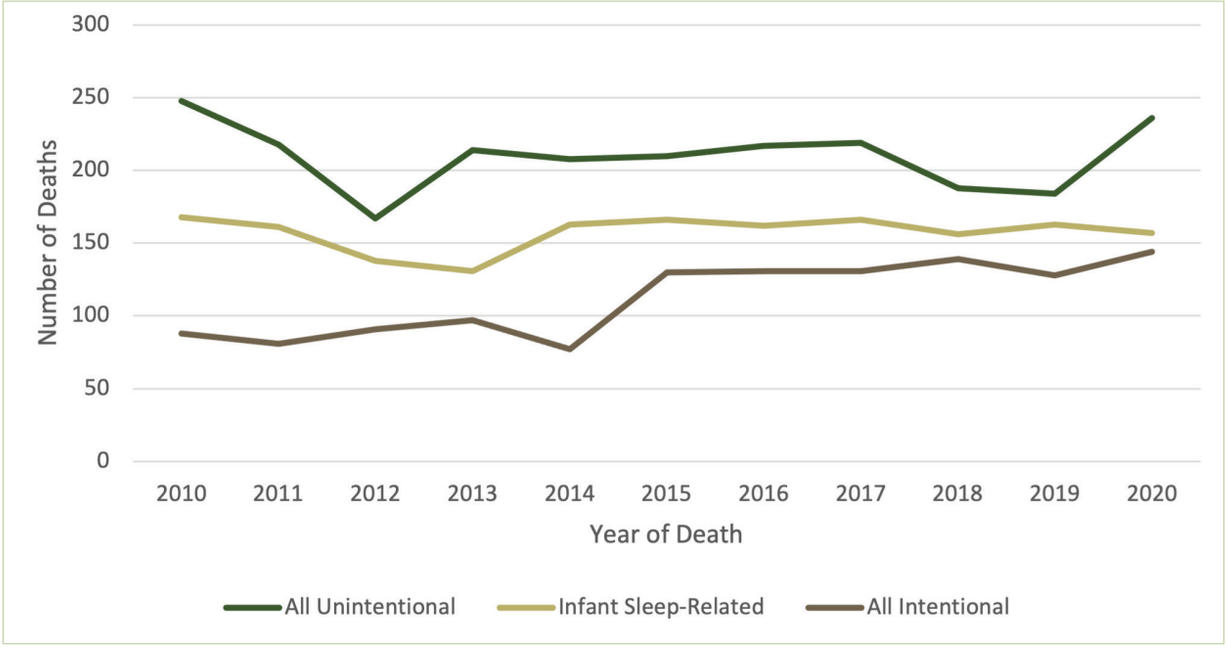
The total (all causes and ages) mortality rates obscure any of the age/cause differences, but they provide an overview of deaths for the past ten years (Figure 5). The infant rate shows an increase between 2010 and 2014/5 and then a decrease the last five years. The 1 – 17 rate appears to fluctuate more from year to year, but there is no obvious trend. The 2020 rate (24.7 per 100,000) is lightly higher than the average rate (22.4) for the preceding ten years.

Figure 5. Georgia Infant and Child Death Rate Trends, 2010-2020



A brief examination of cause of death numbers over time shows a significant increase in the intentional deaths in 2015 (Figure 6), and deaths remained at the higher level for the next five years. These increases in homicides and suicides will be examined in subsequent analysis using the multi-year death certificate and CFR data.

Figure 6. Georgia Deaths, Ages 0-17, Selected Categories, 2010-2020



Child Deaths Reviewed

The Georgia CFR process has been in place and operating since 1991. Over these past 29 years the Georgia CFR and the county teams have worked diligently to complete reviews and enter the reviews into the state (now national) CDR database. The proportion of "reviewable deaths" reviewed has been as high as 95%; however, after decreasing for six years, the teams have reviewed 91% of the reviewable deaths for 2018 & 2019 and 84% in 2020. The extent of county team participation (in an unfunded mandate) after 29 years is very commendable, and it is important to acknowledge and encourage that local effort.

A child fatality review is required for deaths that are sudden, unexpected, unexplained, suspicious, or attributed to unusual circumstances, but the legislation does not provide a specific case definition for reviewable deaths. Historically, any non-medical cause death (defined by the ICD code for the underlying cause of death) has been defined as reviewable. Certain medical deaths (unexpected, decedent not under the care of a physician) are appropriately reviewed and are addressed in the annual report, however they are not included in either denominator or numerator when calculating the proportion of reviewable deaths reviewed. Using the "non-medical cause" criterium for reviewable deaths, there were 537 reviewable 2020 deaths.

The death certificate (DC) and Child Death Review (CDR) databases are linked (using dates of birth and death, decedent and parent names, and street address). The linked files are used to calculate the CDR performance metric – percent of "Reviewable Deaths" reviewed – and to provide data quality review. Seventeen of the 562 reviewed death records did not link with a DC. This list has been provided to Georgia Vital Records for follow-up. Five hundred forty-five (545) of the completed CFR records were linked with a death certificate for a Georgia resident.

The 450 records (reviews of reviewable deaths) are used for the calculation of the proportion of reviewable deaths reviewed (Table 4). However, all 562 completed reviews (which includes the 95 reviews of medical deaths and the 17 with no DC) are included in the analysis of reviewed deaths.

Table 4. Percent of 2020 Georgia Reviewable Deaths Reviewed			
Cause of Death (DC)	**All Deaths**	**Reviewed**	**% Reviewed**
MVC	110	95	86.4
Drowning	31	22	71.0
Other Injury	70	59	84.3
Unintentional Injury Total	**211**	**176**	**83.4**
Homicide	89	74	83.1
Suicide	55	49	89.1
Sleep-Related Total (Infants)	**157**	**129**	**82.2**
Unknown Intent	12	11	91.7
Unknown	13	11	84.6
Reviewable Total	**537**	**450**	**83.8**
Medical	821	95	11.6
All Deaths	**1,358**	**545**	**40.1**

The map in Appendix B displays counts by county for the number of reviewable deaths and the number of reviewable deaths reviewed. Eighty-five of the 159 Georgia counties reviewed all their reviewable deaths (Table 5).

Table 5. Summary of 2020 Review Categories					
Definition	**Category**	**Counties**	**Reviewable Deaths**	**Reviewed**	**No Review**
All reviewable deaths reviewed	4	85	303	303	
One or more reviewable deaths not reviewed	3	17	209	147	62
Reviewable deaths, none reviewed	2	15	25		25
No reviewable deaths	1	42			
Total			**537**	**450**	**87**

Maltreatment

Understanding the Role of Maltreatment in Reviewed Child Deaths

According to the World Health Organization (WHO), child maltreatment is the abuse and neglect that occurs to children under the 18 years old. This includes all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation, which results in actual or potential harm to the child's health, survival, development, or self-identity in terms of a relationship of authority, trust, or power.

The Child Abuse Prevention and Treatment Act (CAPTA) was enacted in federal law January 31, 1974 and has been amended several times. It was established in federal law to address child maltreatment through its prevention, assessment, guidance to states, prosecution, and treatment initiatives. CAPTA also provides grants to public and nonprofit organizations which includes Indian Tribes and Tribal organizations for demonstration programs and plans.

2020 Reviewed Deaths with Maltreatment Reported

The focus of this section is to highlight maltreatment as a reported cause of death and describe deaths with a reported history of maltreatment. The information is captured in the National Child Death Review (NCDR) for maltreatment as it relates to the decedent. Table 6 represents the maltreatment results (2020 reviewed deaths) from a derived summary variable which assigns an order to the maltreatment/ contributing act categories. (The "de-duplication" works from the top down. For example, if "Cause/Contribute" and "History" were both identified, that death is reported under "Cause/Contribute". Fifty-seven deaths had a history of abuse identified, but 13 of those deaths also had "Cause/Contribute" identified. Those 13 deaths are not counted in the "Un-Duplicated" "History, Abuse" xcccccentry.)

Table 6. Maltreatment Reports, Georgia, 2020 Reviewed Deaths

		All Reports	Un-Duplicated
Cause/Contribute	Abuse	22	22
	Neglect	22	22
History	Abuse	57	44
	Neglect	90	67
		Maltreatment Total	**155**
Poor Supervision		82	58
Exposure to Hazard(s)		279	189
No Reported Maltreatment, Poor Supervision, or Hazard Exposure			**160**

The sum of the un-duplicated counts for the four cause / history maltreatment categories (Table 6) is 155 (22+22+44+67). The "descriptive epidemiology" of these maltreatment-related deaths first addresses three basic variables – age, sex, and race-ethnicity. The reason for the analysis is to determine whether the apparent proportion of reviewed deaths with reported maltreatment changes with these three variables. (i.e., Is a male decedent more likely than a female to have experienced maltreatment?)

Of the reviewed death victims, most are male (61.4%), and a disproportionate number are Black/African American (50.9%) (Table 7). The proportions (of deaths with maltreatment) change across the age/race/sex strata over time, but the maltreatment risk is evenly distributed across strata.

Table 7. 2020 Reviewed Deaths with Maltreatment Reported (by Demographic Variables)

	All Reviewed		Reviews with Maltreatment		
	Count	Column Percent	Count	Percent with Maltreatment	Percent 2016-2019
Sex					
Male	345	61.4	84	24.3	30.2
Female	217	38.6	71	32.7	29.7
Total	**562**		**155**	**27.6**	**30.0**
Race/Ethnicity					
Black	286	50.9	87	30.4	30.3
White	194	34.5	50	25.8	31.2
Hispanic	65	11.6	16	24.6	24.0
Multi-race	12	2.1	2	N/A	42.1
Other	5	0.9		N/A	17.5
Age (Years)					
Infants	190	33.8	39	20.5	23.5
1 - 4	87	15.5	26	29.9	39.8
5 - 9	47	8.4	20	42.6	34.3
10 - 14	101	18.0	35	34.7	35.3
15 - 17	137	24.4	35	25.5	29.3

Table 8 shows all reviewed child deaths by cause of death with a cause or history of maltreatment. It exhibits an alarming number (20) of homicides with abuse as the cause. Over 50.6% of homicide related deaths has a history or reported maltreatment cause.

Table 8. Maltreatment Category by Cause of Death: Georgia, 2020 Reviewed Deaths

	Maltreatment Cause		Maltreatment History		% Reviewed w/ Maltreatment
Cause of Death	Abuse	Neglect	Abuse	Neglect	
MVC		1	6	14	20.2
Drowning			1	4	20.8
Other Unintentional	1	2	11	5	31.7
Homicide	20	4	8	8	50.6
Suicide		3	8	6	34.0
Sleep-Related		3	5	17	17.5
Medical		7	5	13	28.7
Undetermined	1	2			
All Reviewed	22	22	44	67	27.6
Duplicated Counts	22	22	57	90	

Summary of Selected Causes

If we exclude infant deaths – which are dominated by medical causes associated with the birth – then the three leading causes of death (over the last five years) for all children ages 1 through 17 are motor vehicle crashes (480), homicide (322), and suicide (294). (Source: OASIS, GA, 2016 – 2020) These three causes accounted for 218 of the 372 (59%) reviewed deaths (ages 1 to 17) in 2020. Sleep-related infant deaths (143) comprised the largest category of reviewed deaths (all ages). This section of the Annual Report provides an overview of the demographics for these four causes, the prevention implications of selected risk factors identified in the review process, and suggestions for data quality improvements.

Motor Vehicle Crash (includes pedestrian and bicycle)

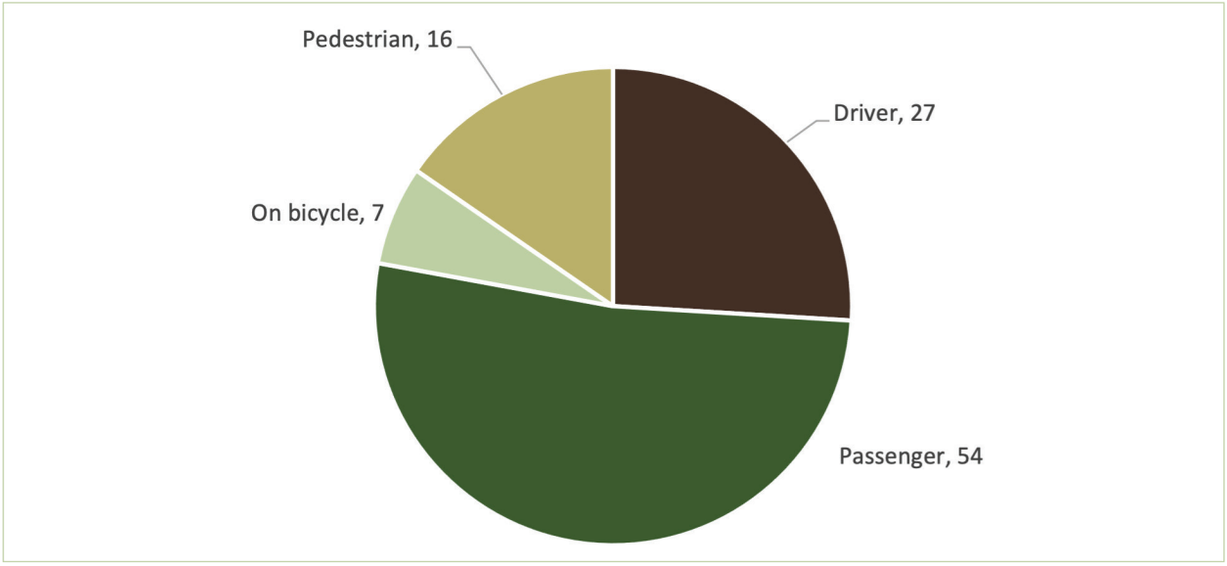
In 2020, there were a total of 104 reviewed motor vehicle deaths in Georgia, an increase from the 84 reviewed motor vehicle-related deaths in 2019 (Table 9).

Table 9. Reviewed Motor Vehicle Crash Deaths, Georgia, 2020

	White, Non-Hispanic		Black, Non-Hispanic		Hispanic & Other Race		
	Male	Female	Male	Female	Male	Female	Total
Infant			1	3			4
1 - 4	5	2	4	5		1	17
5 - 9	4	1	3	2	1	1	12
10 - 14	8	2	6	3	2		21
15 - 17	18	6	7	7	11	1	50
Total	**35**	**11**	**21**	**20**	**14**	**3**	**104**

- 44% (46/104) of the victims were White, non-Hispanic; and 67% were male.
- 48% (50/104) of the victims were between the ages of 15-17.
- 42% (21/50) of the children between the ages 15-17 were the reported drivers.

Figure 7. Reviewed 2020 Motor Vehicle Deaths, by Position



Intentional Injuries

The number of intentional injury (homicide and suicide) deaths in the population ages less than 18 is small – compared to all such deaths – but troubling (Table 10). We need to do a better job of protecting our children from intentional injuries and violent deaths. The following discussion uses death certificate (DC) data to identify trends in homicide and suicide deaths, and multi-year child death review (CDR) data to identify risk factors and target populations for intervention.

Table 10. Georgia 2020 Intentional Injury Deaths

	Number of Deaths		Mortality Rate*	
	All Ages	**< 18**	**15 to 17**	**18 to 24**
Suicide	1,488	55	7.1	19.2
Homicide	1,091	89	10.3	24.5
Cause				
Sum	**2,579**	**144**		

Rate*: Deaths per 100,000 population
Source: OASIS Mortality Query

Suicides and homicides have recognized racial differences in distribution. A White, non-Hispanic teen is about twice as likely to die by suicide as a Black, non-Hispanic teen (Table 11). The racial disparity for teen homicides is much more striking, with an eight-fold increased risk for Black teens compared to White teens.

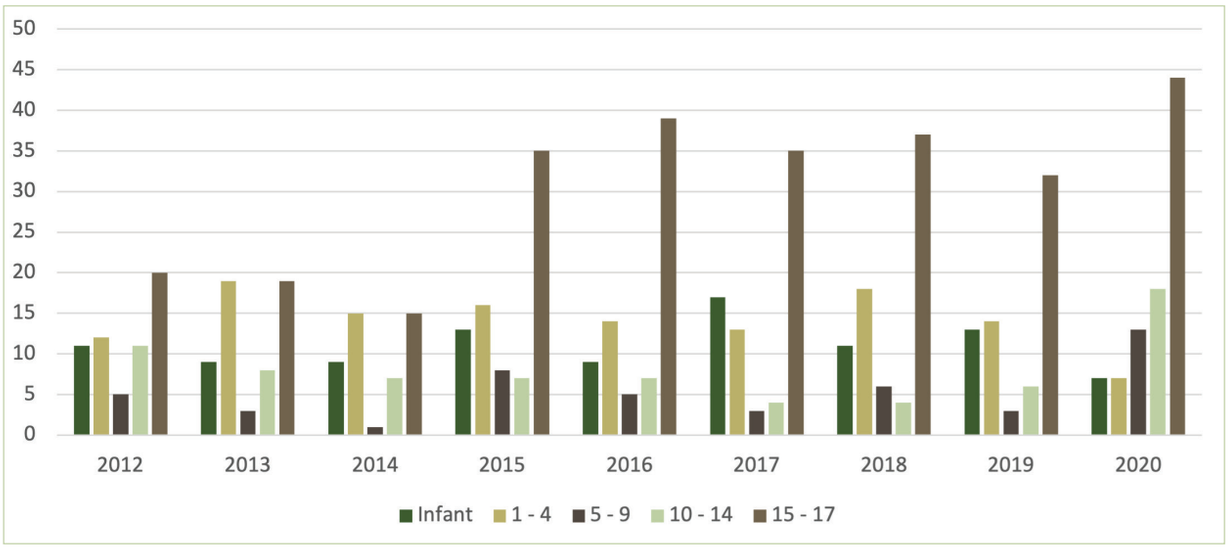
Table 11. Georgia Mortality Rate (per 100,000), Homicide and Suicide: 2016-2020, Ages 15-17

	Non-Hispanic		
	Black	**White**	**Black/White Relative Risk**
Suicide	5.3	11.4	0.5
Homicide	20.7	2.5	8.3

Homicide Deaths

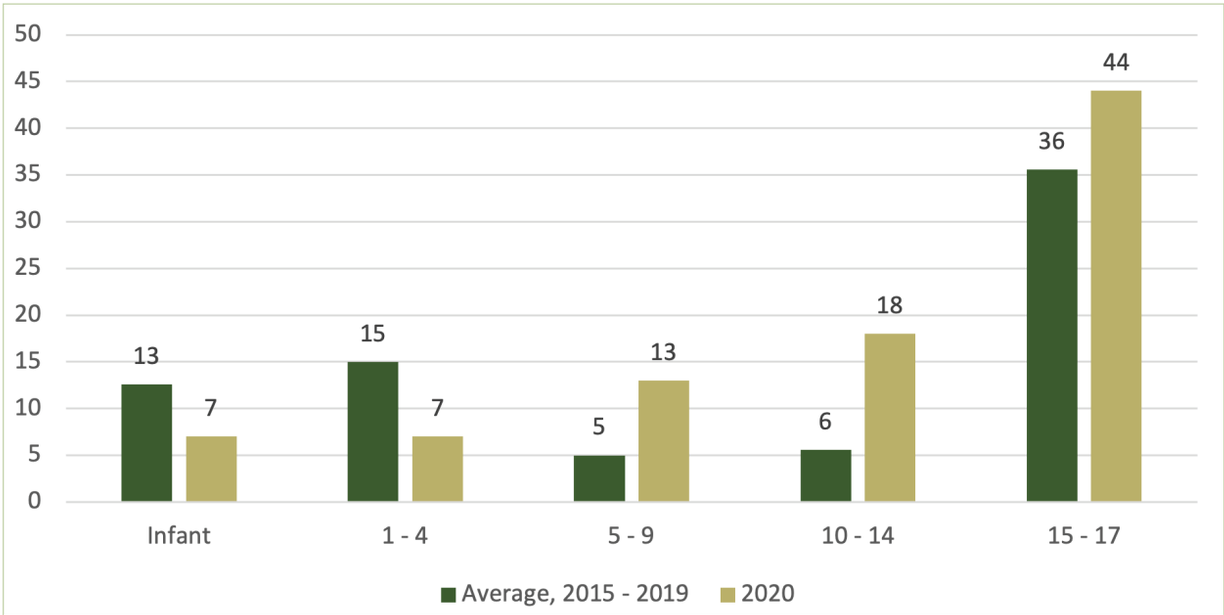
Death Certificate Trends: The homicide trend (based on Death Certificate data) showed an increase in 2015 from an average of 55 per year (2012 – 2014) to 76 (2015 – 2019). The increase was concentrated in the 15- to 17-year-old teens (Figure H1).

Figure H1. Homicide Deaths by Year of Death, by Age: Georgia, 2012-2020



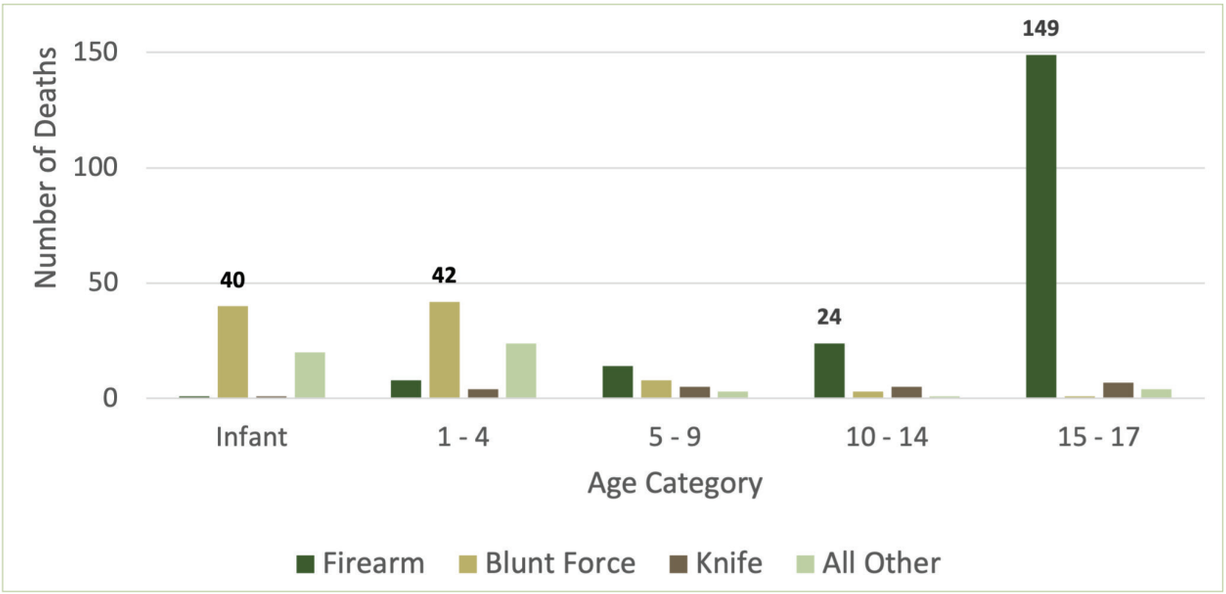
The 2020 homicides (ages < 18) appear to represent another change – perhaps associated with the COVID-19 pandemic. The infant and toddler age categories had fewer homicides than in any of the preceding eight years; and the other three age categories had more homicides. (Figure H2)

Figure H2. 2020 Change in Georgia Homicides, Ages < 18



CDR Results: The most recent five years of CDR data include 364 homicide deaths. The distribution of deaths by age category and mechanism of death (Figure H3) indicates two distinct populations with associated mechanisms: infants and toddlers / blunt force trauma and teens (15 to 17) / firearms.

Figure H3. Reviewed Homicide Deaths by Mechanism and Age, Georgia, 2016-2020



The identified responsible person for a majority of the 140 infant and toddler homicides was the biological mother (53) or father (33), or the mother's partner (21). Eighty-two (82%) percent of the blunt force (BFT) homicides were attributed to one of the three categories, and 76% of all infant/toddler homicides had one of the three. This suggests parents / partners as the intervention target population. A prior history of maltreatment should also serve as a risk factor, and 49% of the BFT victims had prior history reported (Table H1). (Fourteen victims had an open Child Protective Services ({CPS} case.)

Table H1. Blunt Force Trauma Victims with Maltreatment History, 2016-2020

	Ages in Years			
Maltreatment History	**Infant**	**1-4**	**5-9**	**Total < 10 Years**
Yes	16	20	8	44
No	24	**22**		**46**
Total	**40**	**42**	**8**	**90**
% w/ History	40.0	47.6		48.9

The teen firearm homicides present a greater challenge in identifying prevention populations or messages. There were 48 reviewed firearm homicides (all ages) in 2020, but there was no "responsible person type" classification for 28 of the perpetrators. Based on the review narrative, seven of the homicides appear to have been gang-related, six were "drive-by" shootings, and ten involved drug/firearm/ cell phone sales. Four other deaths classified as homicides appear to have been unintentional and caused by mishandling of the weapon.

Looking at 2020 Homicide deaths in children in Georgia alone, 89 homicide deaths were reported, and 83.1% of those were reviewed by the local team. Sixty-one of the reviewed homicide deaths (ages 0 through 17) were non-Hispanic Black (Figure 6). That is a staggering 77% of all homicide deaths in children in Georgia in 2020. In that same category 58% were Black non-Hispanic males, and 19% were Black non-Hispanic females compared to 6% of White, non-Hispanic males, and 6% non-Hispanic females. Homicide deaths in children ages 0-17 is the 3rd leading highest non-medical cause of deaths in children in Georgia. In all age categories, children ages 15 through 17 ranked the highest number of homicide deaths in 2020 (Table H2). According to the local review team 90% of all reviewed homicides deaths in 2020 could have been prevented.

Table H2. Homicides, Ages 0-17, Georgia 2020: Race and Category						
Non-Hispanic	**White**		**Black**		**Other**	
Age Category	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Infants			5	2		
1 to 4		2	1	3		
5 to 9	1	1	1	7		
10 to 14	4	2	9			
15 to 17	3	1	34	5		
Total	**8**	**6**	**50**	**17**		
Hispanic	**White**		**Black**		**Other**	
Infants						
1 to 4	1					
5 to 9	1	1	1			
10 to 14	1		1		1	
15 to 17			1			
Total	**3**	**1**	**3**		**1**	

Prevention strategies for infants and toddlers should focus on two distinct target populations:

1. Prevention strategies targeting parents/caregivers

- Educating parents and caregivers on the gun safety, proper use of firearms. In addition, parents and caregivers should also be educated on the proper storage of firearms in the home, as well as having access to affordable approved gun storage gear in the homes. This will likely decrease the occurrence of firearms related incidents at home by parents/caregivers, hence decrease firearms gun related death of infants and toddlers in Georgia.
- Prevention strategies should also aim at identifying family stressors, especially families with young children. Focusing on finding appropriate support services, with the emphasis on free or low-cost community activities for children and these families. In addition, coordination (sharing information) among different service providers, will help identify maltreatment risks factors for both perpetrators and the victim child early on which will decrease the occurrence of firearms related deaths in infants and toddlers.

2. Prevention strategies targeting teens

- Educating teens on the firearms safety will increase awareness of firearms related injuries in the community. Prevention should also focus on identifying age-appropriate community support programming aim at fostering positive social involvement and deterrence of gang involvement. Activities such as (Boys & Girls Club, YMCA). Hence will decrease gangs' violence amongst teens within the community.

Suicide Deaths

Death Certificate Trends: Georgia teen suicides increased almost 90% from the 2010 – 2014 period (30.6 average per year) to 58.0 for 2015 – 2019. This increase paralleled the observed increase in infant/child homicides. The 2020 suicide count (ages 10 to 17) was down slightly to 55, and the total suicide count (all ages) was also down from 1,582 in 2019 to 1,488 in 2020.

White, non-Hispanic youth account for 56% of all youth (< 18) suicides, and males account for 69% (Table S1). The male proportion is higher for the 15- to 17-year-old teens (74%) than for the 10 to 14 ages (61%).

Table S1. Youth Suicides by Age, Sex, Race, Ethnicity: Georgia, 2016 - 2020

		Non-Hispanic			Hispanic	
Age (yrs)	**Sex**	**White**	**Black**	**Other**		**Total**
5 to 9						
	Male		1		1	**2**
10 to 14	Male	32	20	4	9	**65**
	Female	19	17		6	**42**
15 to 17	Male	87	29	9	12	**137**
	Female	27	11	4	6	**48**
	Total	**165**	**78**	**17**	**34**	**294**

In 2020, local CFR committees reviewed 50 child deaths as the result of suicide. There were 34 males and 16 females. The two most common reviewed mechanisms were firearm (23) and hanging (23) which accounted for 92% of the reviewed suicide child deaths. Mechanisms of suicides due to poison was the least common (4).

Table S2: Reviewed 2020 Georgia Suicide Deaths, Ages 10 - 17					
		Non-Hispanic			
	Mechanism	White	Black	Hispanic	Other
Male					
	Firearm	12	6	2	
	Hanging	10	1		2
	Poison	1			
Female					
	Firearm	2	1		
	Hanging	3	4	3	
	Poison	1	1	1	

CDR Results: The CDR suicide data includes information on risk factors that are potentially useful for planning / developing / implementing prevention activities. There are a series of questions that address possible "early warning" signs:

1. Behavioral history (Question I6a): running away, anxiety, explosive anger, or head injury. Sixty-six of the 271 reviewed deaths had one of these behaviors reported.

2. Diagnosed disorders (I6b): anxiety, depression, bipolar, and others. Twenty-eight decedents had one or more diagnosed disorders.

3. Prior suicidal behavior/attempts (I6c): reported for 18 decedents.

4. Warning signs within 30 days of death (I6h): talking about suicide, expressing hopelessness, and others. 106 of the decedents had displayed at least one of the warning signs.

According to 2020 suicide data, Whites ages 10 through 17 ranked the highest with 29 reviewed suicide deaths in 2020, compared to 13 Blacks, 6 Hispanics, and 2 others. (Table S2). This high number is seen across all age category for whites with 46% males and 12% females. White males maintain the highest number for both mechanisms used combined. Twelve (12) firearms and 10 hangings compared to 7 firearms and 5 hangings amongst Black males and females. However, Black females have a higher rate of suicide by hanging.

86% of 2020 suicide deaths were reviewed by the team in which they found 37 to be "yes, probably" preventable, 7 Undetermined, and 6 "No, probably not".

One hundred ninety-three of the 271 suicide victims (71%) had responses in at least one of the four areas (plus two additional questions on communication of suicidal thoughts {I6d} and self-harm {I6g}).

Firearms were the mechanism for 130 of the 271 reviewed suicide deaths (2016–2020) (Table S3). The storage and safety precautions associated with these weapons provides another area for prevention action. The following section on firearms provides information on storage and safety derived from the CDR firearm data.

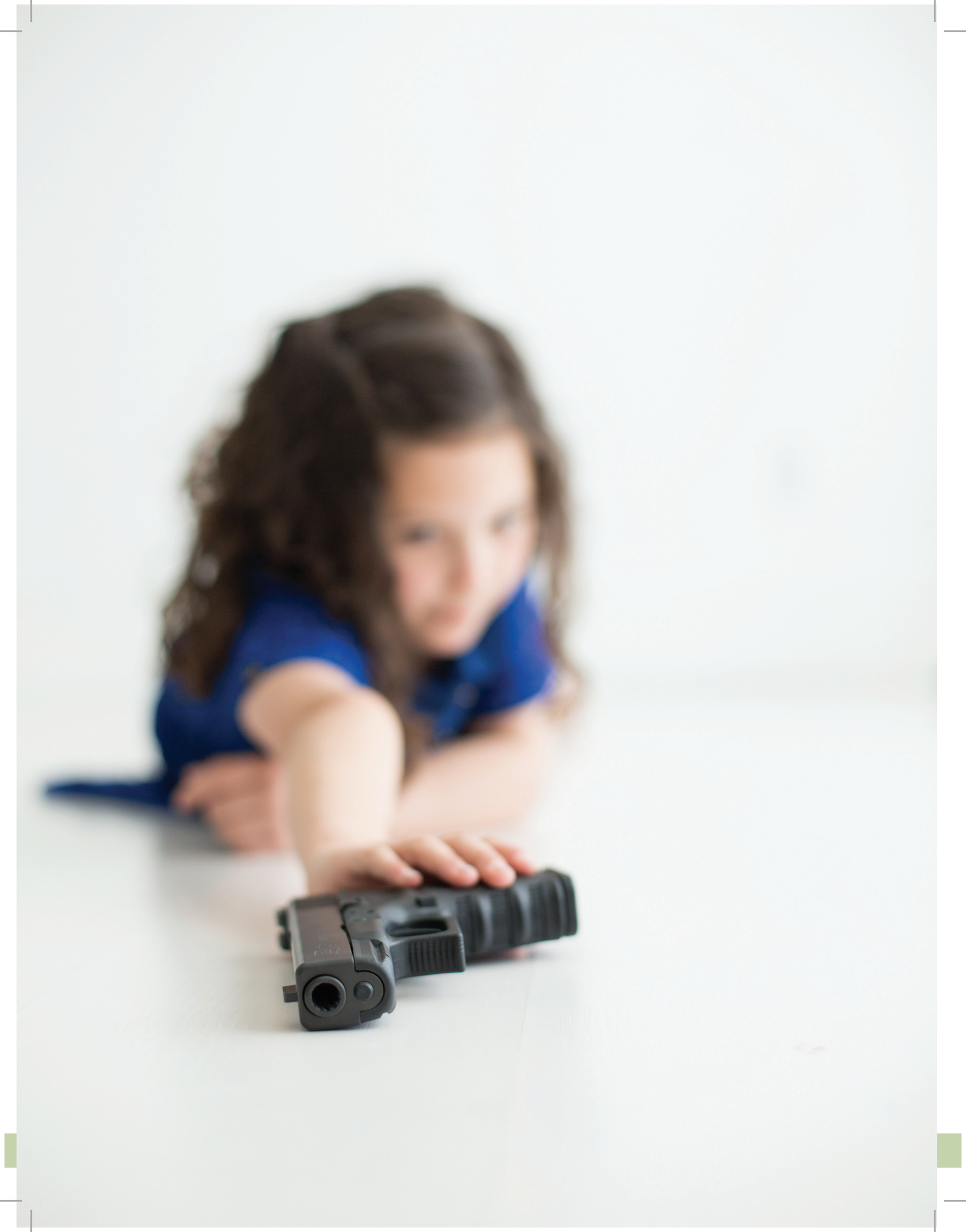
Table S3: Suicide Mechanism by Age: 2016-2020, Age in Years

	5-9	10-14	15-17	Total
Fall		2	6	8
Firearm	1	38	91	130
Hanging	1	52	64	117
Poison		6	10	16
Total	**2**	**98**	**171**	**271**

Suicide prevention strategies targeting teens should be a multi faced collaboration amongst different agencies serving the community. That should involve the school system, mental health services, primary care physicians as well as community support programming, especially those serving teens during after school hours. In addition, education parents and caregivers on intensifying changes in behavior as well as appropriate services within the community. Prevention strategies should also focus on improving community relationship between schools, community services, parents, and caregivers.

As noted above in the CDR results section, many risks factors were identified in most of the 2020 suicide cases, however there seemed to have had no follow ups on those identified risks factors, Evidenced by the number of unknown responses in the CDR reports. Due to the lack of participations from mental health providers within the CFR team. In addition, there needs to be more focus on the county level regarding suicide prevention. This will provide opportunities for intervention and community integration.

CFR team across the state felt higher level of supervision of teenagers and adolescent should be instituted, especially around social media interactions. Immaturity and impulsive adolescent behavior combine with easy access to firearms is a lethal combination for disaster. It was also determined that 50.6% of the reviewed homicides had a direct correlation with maltreatment (maltreatment being the cause or had a history of maltreatment).



Firearm Deaths

Firearms are the major mechanism associated with intentional injury deaths. They are involved in 54% of the homicides and 48% of the suicides (Table F1). An additional seven deaths per year (5-yr average) are attributed to careless handling of firearms.

Table F1. Reviewed Firearm Deaths: Georgia, 2016 - 2020

	Year of Death					
Manner of Death	**2016**	**2017**	**2018**	**2019**	**2020**	**5-Yr Total**
Homicide	40	33	38	37	48	**196**
Suicide	23	26	27	31	23	**130**
Unintentional	5	6	9	4	10	**34**
Total	**68**	**65**	**74**	**72**	**81**	**360**

Most of the CDR data regarding firearm storage and handling is missing for the homicide deaths, and 40% of the Suicide / Unintentional deaths have missing storage information (Table F2).

Table F2. Reported Firearm Storage: 2016-2020 Suicide/Unintentional Deaths

Where Stored	Suicide	Unintentional
Missing	1	
Not stored	12	12
Locked cabinet	5	
Unlocked cabinet	9	1
Glove compartment	5	1
Under mattress/pillow	4	
Other	42	7
Unknown	52	13
% Unknown	40.0	38.2

An inspection of the "Narrative" entry for the reviews with "Other" reported as the storage location revealed that the weapon was generally in an unsecured location in the decedent's home – closet, nightstand, basement. Several of the weapons were in the possession of the decedent. The narratives support the need for gun safety education for any gun owner, and for more attention to warnings of mental/emotional disturbance from teens.

Sleep-Related Infant Deaths

Sleep-Related Infant Deaths: Sleep-related deaths continue to be a disappointing issue. The local CFR committees reviewed 157 sleep-related deaths in 2020 – slightly lower than the average number reviewed over the preceding seven years (Table 12). The distribution of deaths by race/ethnicity and sex is consistent with the distribution over previous the five-year period (2016 – 2020). Black infants are twice as likely to suffer a SIDS death compared to White infants (OASIS: SIDS deaths, 2019- 2020). The SIDS deaths do not include the infant deaths attributed to suffocation in bed or unknown cause.

Table 12. Reviewed Sleep-Related Deaths by SUID Category, Georgia 2020

	Black Non-Hispanic		White Non-Hispanic		Hispanic/Other Race	
SUID Category	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
Asphyxia	13	7	7	9	5	1
Medical	3	3			1	
Undetermined	26	33	17	10	5	3
Total	42	43	24	19	11	4
Column Percent	29.4	30.1	16.8	13.3	7.7	2.8
2015-2020	28.8	26.3	17.0	15.5	6.4	5.9

- Sixty-four percent (92/143) of the deceased infants were reported as sleeping on an adult bed. Nine more were in other locations including an air mattress on the floor, sofa chair, bassinet mattress on an adult bed, twin bunk bed, pack n' play and in mother's arms while being breastfed.
- Seven infant deaths reported supervision was needed at the time of the incident and 103 reported to have had supervision.

The CDR database includes many variables that may be risk factors or indicators for sleep-related deaths. The OCFR continues to support a collaboration between the Safe Infant Sleep program (in the DPH Office of Injury Prevention) and Georgia State University on an analysis of sleep-related death risk factors.

This collaborative effort on sleep-related death provides a good model for additional research on selected causes of child death. The Georgia Bureau of Investigation/ Child Fatality Review State office and the CFR Panel are committed to initiating and supporting data sharing with multi-agencies to identify issues related to the well-being of Georgia's children.

Preventability and Prevention Findings

There is substantial agreement among the review teams that non-medical (violent) deaths can be prevented. Eighty-eight percent of non-medical deaths with a preventability determination ("No, probably not" or "Yes, probably") had "Yes, probably" reported. Ninety percent (90%) of deaths due to unintentional injuries, 85% of sleep-related deaths, 90% of homicide deaths, and 86% of suicide deaths were considered preventable (Table 13).

The CFR local teams are encouraged to discuss possible interventions and to note it in the CDR form of how child death can be prevented (Figure 8). There is also a section in the review form dedicated to prevention (L. Prevention Initiatives Resulting from the Review) designed to capture suggestions or implemented actions in the areas of agency policies, services, education, legal system changes, or environmental factors. Several "open-ended" questions provide opportunities for narrative on recommendations. When these areas are completed, they add significant value to identifying intervention/prevention opportunities. Many of the CDR cases have recommendations regarding prevention measures; however, with Section L near the end of the form, and in-depth comments are not the norm. The prevention review process does not stop with the CFR local team. CFR state office are responsible for summarizing / synthesizing the prevention input from the teams and providing that data and/or draft recommendations to the CFR Panel.

Figure 8. 2020 Reviewed Deaths, % Preventable (Number Preventable)

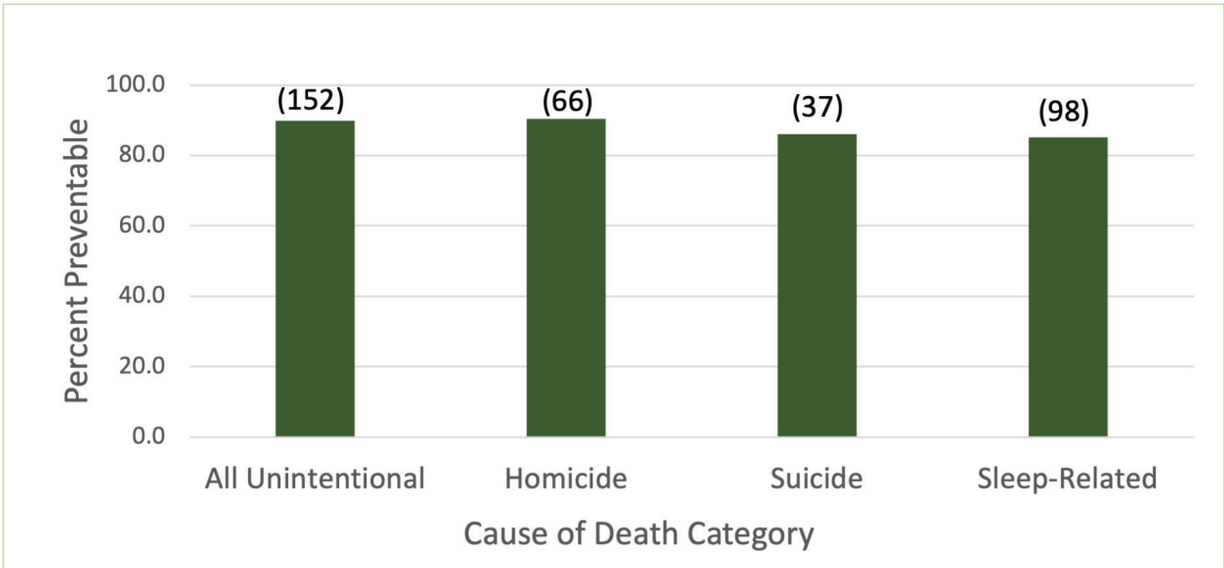


Table 13: CDR Team Determination of Preventability: 2020 Reviewed Deaths
Could the death have been prevented?

Cause of Death	Missing	No, probably not	Yes, Probably	Undetermined	%Prev
Unintentional					
Motor Vehicle Crash	1	9	86	8	90.5
Drowning		1	18	5	94.7
Other Unintentional	1	7	48	4	87.3
Intentional					
Homicide	1	7	66	5	90.4
Suicide		6	37	7	86.0
Sleep-Related	1	17	98	27	85.2
Medical	3	52	13	19	20.0
Undetermined	1	3	3	8	50.0
All Reviewed Deaths	8	102	369	83	78.3
All Non-Medical	5	50	356	64	87.7
		47	353		88.25

Supervision: The CDR form addresses supervision of the decedent in three sections. The "Circumstances" section has a question: "CAN, poor supervision or exposure to hazards cause or contribute to death?" (Table 14). If the answer is "Yes", then "Poor/absent supervision" is one of the possible responses to describe the action. In Section J (Person Responsible), the first question is: "Did person(s) cause/contribute to death?". There are follow-up questions for up to two persons to identify the type of action, and "Poor/absent supervision" is one of the responses. Poor supervision is indicated if it is selected in one or more of these three variables.

In Section D (Supervisor Information), the initial question is: "Did child have supervision at time of the incident leading to death?"; and valid responses are:

1. No, not needed given developmental age or circumstances
2. No, but needed
3. Yes
4. Unable to determine

The sleep-related deaths provide an opportunity to check on the consistency of reporting of these two "supervision" variables. There were 14 deaths that had "Poor/absent supervision" indicated as a contributing factor, but reported the child had supervision (Table 14). This suggests issues with the form design and review team training.

Table 14. Supervision and Sleep-Related Death, 2020

	Poor/absent supervision	
Supervision at Time	**Yes**	**No/Unknown**
No, not needed		1
No, but needed	8	7
Yes	14	103
Unable to determine	3	7

The relationship between supervision and drowning deaths is stronger for accidental deaths (such as drowning), and there is less discordance in the two supervision variables (Table 15). Both variables indicated a supervision issue for 3 of the 24 drowning deaths.

Table 15. Supervision and Drowning Death, 2020

	Poor/absent supervision	
Supervision at Time	**Yes**	**No/Unknown**
No, not needed	2	1
No, but needed	3	1
Yes	3	11
Unable to determine	2	1

Conclusion

This report summarizes the data collected regarding the circumstances related to each child death. It is intended to be a vehicle to share the findings with the community to engage others in concerns about these and other risks.

We are committed to preventing child deaths in Georgia. The preventable death of a child is an unimaginable tragedy for a family. While there is no way to predict most child deaths, we can identify some groups of children who are at greater risk of death. Identifying trends require analysis of the causes of fatalities, which begins with accurate vital statistics/data provided by local CFR teams.

We encourage partners and local resources to assist in developing recommendations and implement policies, programs, and practices that can have a positive impact in reducing the risks and improving the lives of Georgia's children. It is our hope that you will utilize the information in this annual report and share it with others who can influence changes for the betterment of children.

For more information on this report or the Child Fatality Review Unit, please contact:

Georgia Bureau of Investigation

Child Fatality Review Unit

3121 Panthersville Rd
Decatur, GA 30034

Phone: (404) 270-8715 | ChildFatalityReview@gbi.ga.gov

Resources

Prevent Child Abuse America (www.preventchildabuse.org)

Georgia Center for Child Advocacy (georgiacenterforchildadvocacy.org)

Child Abuse and Neglect Prevention Plan (CANPP)
https://abuse.publichealth.gsu.edu/canpp/

Department of Behavioral Health and Developmental Disabilities Suicide Prevention
https://dbhdd.georgia.gov/bh-prevention/suicide-prevention

Georgia Crisis and Access line (GCAL) 1-800-715-4225 available 24/7

The Trevor Project (LGBTQ) Trevor Lifeline 1-866-488-7386, 24/7, 365
or text 678-678-

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

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

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

American Red Cross (www.redcross.org)

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

American Academy of Pediatrics (www.aap.org)

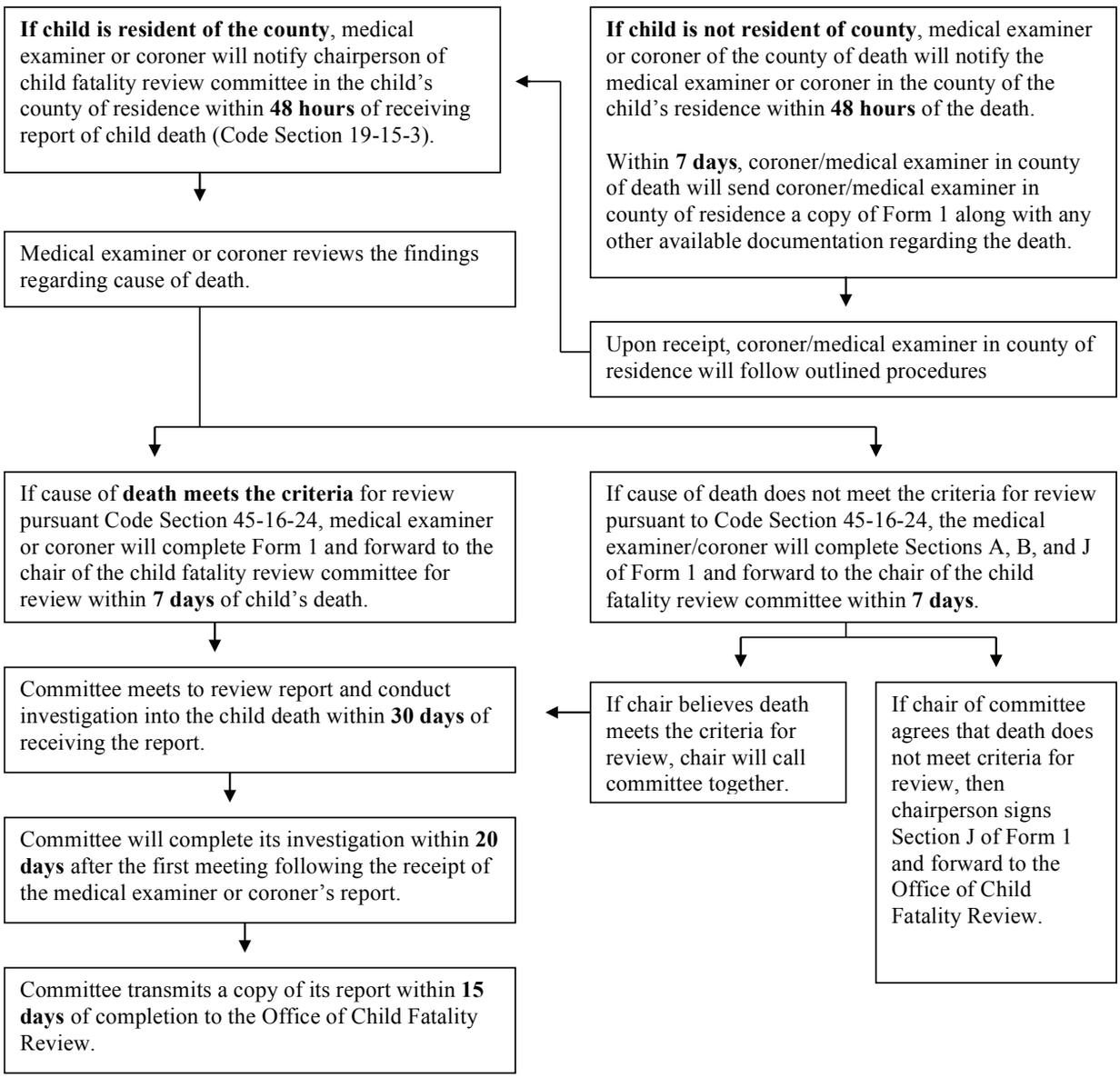
Centers for Disease Control and Prevention, Injury Prevention & Control:
Division of Violence Prevention (www.cdc.gov/violenceprevention)

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

Georgia General Assembly (www.legis.ga.)

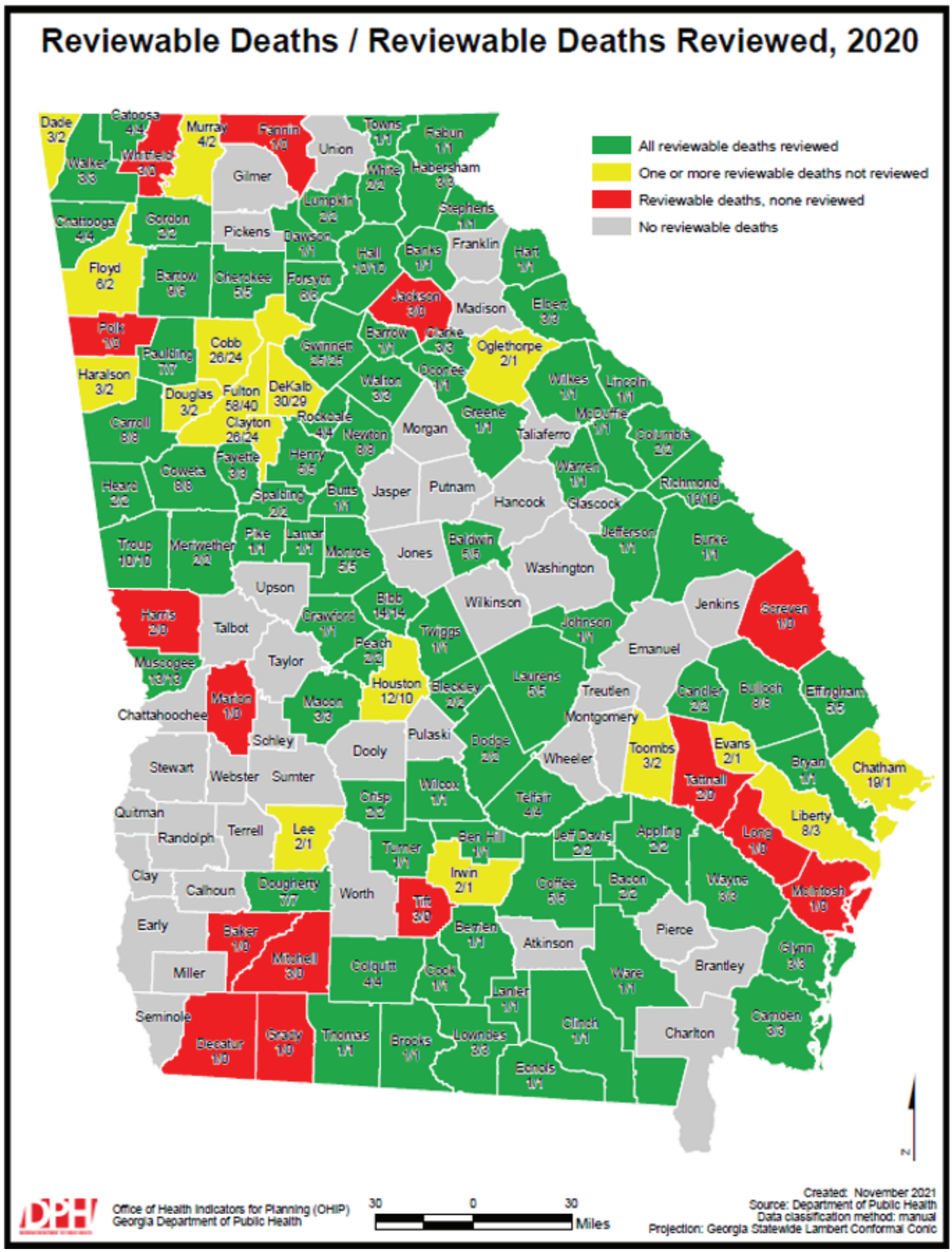
Appendix A

Child Fatality Review Committee Timeframes and Responsibilities



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

Appendix B – 2020 Compliance Map



Notes

Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2020