Georgia's Child Abuse Prevention and Treatment Act

CAPTA Panel Program Report

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

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"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."

Margaret Mead

Overview

Child Abuse Prevention and Treatment Act

The Child Abuse Prevention and Treatment Act (CAPTA) is the key federal legislation addressing child abuse and neglect. CAPTA was first passed into law in 1974 - Public Law 93-247, and re-authorized in 1978, 1984, 1988, 1992, 1996, in 2003 as Keeping Children and Families Safe Act of 2003, in 2010 by P.L. 111-320, the CAPTA Reauthorization Act of 2010, the Adoption Opportunities program, and the Abandoned Infants Assistance Act, 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.

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 Panels follows along with a description of Georgia's efforts to satisfy the legislative mandate.

As a condition of eligibility for a CAPTA state grant, states must establish and support not less than three CAPTA Panels. States may designate existing entities as CAPTA Panels provided such entities have the capacity to satisfy its CAPTA obligation. In 2006, three existing entities were officially designated to serve as Georgia's CAPTA Panels[2]: Children's Justice Act Task Force (Task Force), Georgia Child Fatality Review Panel (the Panel) and the Child Protective Services Advisory Committee (CPSAC).

The state child welfare agency is also 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. To support and sustain the efforts of Georgia's CAPTA Panels, 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

[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.

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

Georgia CAPTA Panel Program

The Children's Justice Task Force serves a dual role as a CAPTA Panel and as a task force on children's justice. The purpose of a Children's Justice Act 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.

The Child Fatality Review Panel has a dual role and also serves as 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. The maltreatment Committee was established in 2009 to help meet its new obligations as a CAPTA Panel.

The Child Protective Services Advisory Committee (CPSAC) serves solely as a CAPTA citizen review panel.

CAPTA requires that CAPTA Panel membership be broadly representative of the community, include 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. The Children's Justice Act also has specific membership requirements that includes representation by the professional disciplines with expertise in children's justice. Georgia's CAPTA Panels satisfy all CAPTA membership requirements, 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.[3]

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 protection system and include a balance of professionals and individuals with life experience that contribute diverse perspectives to the work of the 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.

Each of Georgia's CAPTA Panels meet 4-6 times a year satisfying the minimum quarterly meeting requirement by CAPTA. Panel committees meet between meetings, as needed. Virtual options for participation are made available for most meetings.

CAPTA Panel members also participate in an annual day-long virtual retreat in September. 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.

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

CAPTA legislation charges CAPTA Panels are to examine the policies, procedures, and practices of State and local agencies and where appropriate, specific cases, to evaluate the extent to which State and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with—

- the state CAPTA plan
- the child protection standards set forth in CAPTA
- any other criteria that the panel considers important to ensure the protection of children, including—
    - Reviewing 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)
      Reviewing child fatalities and near fatalities

Although Georgia's CAPTA Panels function independently of each other identifying annual priorities and activities, their interests often overlap providing an opportunity for inter-panel collaboration and coordination reinforcing objectives and recommendations. Descriptions of their 2022 activities and resulting recommendations are included in the summary.

Georgia's Panel members have also been involved to varying degrees in strategic planning activities and invited to participate on stakeholder advisory groups, providing input or feedback, to the state agency on its development, revision, implementation, monitoring and/or evaluation of its policies, state plans, practice models, and programs. These opportunities include, but are not limited to:

- APSR/CFSR Joint Planning
- FFPSA Work Groups
- State Child Abuse and Neglect Prevention Plan
- State Child Abuse Protocol
- Mandated Reporter Training
- Child welfare policy review

CAPTA Panels are required to 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 state and local levels.

Not later than six months after the date on which a report is submitted by the panel to the state, the state agency shall submit a written response 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. 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. Copies of annual reports and state responses are posted on the CAPTA Panel website, https://www.gacrp.com/content/about/

Georgia's CAPTA Panels continue to maintain all eligibility, compliance, and performance requirements consistent with their CAPTA and CJA mandates.

Attached are summaries prepared by each of Georgia's CAPTA Panels on their 2022/2023 activities.

Panel members appreciate the Division's continued commitment to system improvement and ongoing support of its CAPTA Panel efforts and look forward to receiving feedback from the Division on the recommendations included in their respective reports.

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
2022 Annual Report

Vision

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

Mission

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

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. In 2005, as the Children's Bureau sought to increase accountability of all CAPTA state grant recipients, the SCPSAP was repurposed as one of Georgia's three Child Abuse Prevention and Treatment Act citizen review panels and renamed the Child Protective Services Advisory Committee (CPSAC).

The CPSAC is the one Georgia CAPTA Panel that does not serve a dual role[1] 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 Georgia's child welfare workforce and efforts by the Division to address high staff turnover though its recruitment, training, supervision, health, and safety measures.

CPSAC 2022 Activities & Recommendations

Historically, the CPSAC has identified a specific theme, practice, or policy for its focus each year based on current priorities and interests. During 2022, CPSAC focused on the child welfare workforce crisis and the utilization and performance of the state's CAPTA grant with two related subcommittees.

The Workforce committee, concerned about the ongoing high turnover rate for frontline workers and supervisors, decided it would explore worker retention issues. In response to

[1] 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.

anecdotal reports on open case levels and a recent staffing crisis, information requests were submitted to the Division for a sampling of data from a diverse group of counties on SFY2022 caseloads/open cases by case type and staffing levels.

For comparison purposes, counties selected for review included large urban metropolitan counties, and large and small rural counties, from across the state. Case-level data requested for each county included the number of open Investigations, Family Support, CPS Ongoing (Family Preservation), and Foster care cases. After the initial examination of this data that revealed unexpected case distributions, a subsequent request was submitted for data from the Central Intake Call Center for the same period.

The committee was surprised by anomalies observed in the open case distribution comparison between Georgia's largest urban counties. More specifically, by:

1. The number of open foster care cases in the state's largest county are significantly lower than its two neighboring metro counties.
2. Conversely, open Investigations and cases assigned to Family Support are significantly higher in that county as well.
3. Across all three large counties, the number of Family Preservation cases was much lower than expected.

 # (%) of Open Cases by Type on June 30, 2022

County	**Investigations**	**CPS Ongoing** Family Preservation	**Foster Care**	**Family Support**
Fulton	294 (28.5)	53 (5.1)	355 (34.4)	235 (22.7)
Dekalb	152 (16.6)	56 (6.1)	533 (58.3)	62 (6.8)
Cobb	100 (13.2)	51 (6.7)	408 (54.0)	87 (11.5)

The committee also looked at the same data from a cross section of counties from across the state. In comparing these data to the urban data, the committee observed:

1. The percentage of Foster Care cases was comparable across all five counties and similar to two urban counties.
2. There was significant variation in the percentage of CPS Ongoing/Family Preservation cases between the counties. Percentages, in all but one county, were higher than all of the urban counties. Two counties, Lowndes and Muscogee, had a higher percentage of open Family Preservation cases, by 6-10 points respectively, compared to all three urban counties.
3. The percentage of open Family Support cases was comparable across all five counties. state.

 # (%) of Open Cases by Type on June 30, 2022

County	Investigations	CPS Ongoing Family Preservation	Foster Care	Family Support
Whitfield	32 (13.6)	11 (4.7)	128 (54.2)	12 (5.1)
Lowndes	56 (13.1)	98 (16.3)	221 (51.5)	21 (4.9)
Muscogee	70 (11.2)	71 (11.3)	353 (56.6)	30 (4.8)
Richmond	82 (11.9)	60 (8.7)	381 (55.2)	45 (6.5)
Chatham	101(19.1)	42 (8.0)	284 (53.8)	42 (8.0)

Although the CPSAC also reviewed staffing levels and CICC data, it was difficult to identify any explanation for any of differences identified for open cases. Staffing levels (caseworker and supervisor) did not seem to be related to open caseloads. Further exploration of the above observations will be the focus of a Family Preservation committee in 2023.

Workforce Committee

The Workforce committee has had a longstanding interest in improving caseworker recruitment and retention, reducing turnover, and increasing job satisfaction. With Georgia's annual turnover rate in 2022 for Social Services Specialists[2] (caseworkers) greater than than

[2] Respondents included both former Child Welfare and Office of Financial Independence staff.

55%[3] and exceeding the rate by 17-20 points during the five previous years, the Workforce committee was interested in exploring data gathered in exit surveys collected by the Division from departing staff. The committee reviewed a report[4] prepared by the Division in response to an open records request from a local news outlet. The report included both exit survey feedback and staff turnover rates by position. The committee also obtained a copy of the survey instrument to use in their review.

In addition to demographic and employment history questions, the exit survey included questions on:

- Experience working in the DHS environment/culture
- Relationship with supervisor
- Information on the new job
- The best and worst things about their employment with DHS
- Issues that most influenced their decision to leave

Although the sampling of respondents was small, the data did reveal several areas of concern. Of the Social Services Specialists completing the exit survey, 63% had been on the job for less than one year. In addition to the loss of badly needed front-line staff, the budgetary implications given the large investment in recruiting, onboarding, and training new hires are significant.

'Work conditions' was the most frequently cited reason (37.89%) for leaving; 'personal reasons' and 'career change' (each 18.85%) were second; and 'supervision/management/leadership' was third (11.58%). 'Work conditions' included dissatisfaction with schedule, workload, location, travel, flexibility, etc.

The reported tenure for exiting Social Service Specialist Supervisors was alarming, at 48% for supervisors with five or more years of experience. Data indicated that at any given time,

[3] Annual turnover rate for Social Services Specialists, the preceding five years, 2017 to 2021, were: 29.1%. 27.5%, 34.8%, 29.1% & 30.6%.
[4] Georgia DHS, Office of Human Resources, 10/18/2022

more than 20% of supervisory positions are vacant. The open positions reported for caseworkers was greater than 40%.

The Workforce committee understands that the results from exit surveys are used for internal review by leadership on a monthly basis and feels that the information provided in the results could be better utilized with input from a broader group of stakeholders. As a result, the CPSAC recommends that the Division expand its review and analysis of results to include stakeholders, internal and external, who would participate in the ongoing evaluation of exit survey data. A deeper dive by stakeholders should help to identify root causes, potential solutions, and strategies to address them.

The CPSAC also recommends that the Division consider outsourcing the management of its exit survey to increase response rates and provide a secure, safe, and confidential place for respondents to comment on their employment experience.

At the 2022 annual CAPTA Panel retreat, Child Welfare Deputy Commissioner, Mary Havick, responded to questions submitted by the committee regarding vacancy rates, high turnover, and Division retention efforts. Although several strategies have been implemented, the annual turnover rate remains high. The CPSAC also recommends that this stakeholder group be engaged in evaluating the effectiveness of any strategy implemented to address retention. The CPSAC would like to be part of the evaluation, lending its expertise to the process.

In 2023, the Workforce committee would like to take a deeper dive into exit survey results and conduct exploratory research to identify opportunities pre-resignation to address human resource, professional, environmental, cultural issues that contribute to job dissatisfaction and high vacancy rates.

CAPTA Grant Committee

During 2022, the CPSAC established a CAPTA Grant committee to focus on monitoring state CAPTA grant utilization and alignment with the state's CAPTA plan objectives. Recommendations previously submitted by the CPSAC included institutionalizing the administration and management of the CAPTA state grant to engage external stakeholders in

key decision-making, implementation, and performance evaluation of CAPTA-funded projects to increase transparency and accountability. These included:

1. A timeline be developed and implemented to facilitate the engagement of partners and stakeholders, including CAPTA Panel members, to formalize a process for the CAPTA state grant similar to that of its CJA grant, which includes:
    - Proposal guidelines and performance standards for projects requesting 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 it meets both state and CAPTA objectives.
3. An annual review be conducted of the 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.

Although the Division's response to these recommendations was supportive, no such collaborative process has been initiated to date. The CPSAC reiterates these recommendations and looks forward to an opportunity to participate in improving the effectiveness of the state CAPTA grant in 2023.

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 look forward to identifying future collaborative opportunities around shared interests and priorities.

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.

Current Child Protective Services Advisory Committee Members

Amy Ard, Executive Director, Motherhood Beyond Bars
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
Trina Jones, Network Director, Multi-Agency Alliance for Children
Jennifer King, Executive Director, Georgia CASA
Karl Lehman, CEO, Childkind, Inc. (Co-Chair)
Grace Morrow, DPH, Injury Prevention Program, Program Manager and Principal Investigator
Lindsey Oliver, DOE, Office of Whole Child Supports, School Social Work Specialist
Amy Rene, Vice President Clinical Programs, Hillside, Inc. (Co-Chair)
Jennifer Stein, Executive Director, PCA Georgia
Belisa Urbina, CEO, Ser Familia, Inc.

Children's Justice Act Task Force
2022-2023 Annual Report

Vision

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

Mission

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

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

The Children's Justice Act (CJA) provides grants to states to improve the investigation, prosecution, and judicial handling of cases of child abuse and neglect, particularly child sexual abuse and exploitation, in a manner that limits additional trauma to the child victim. This 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, the intake and investigation phases of child welfare cases.

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). Since 2003, the state's CJA 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 to support and advance recommendations from the CJA-required three-year assessment.

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 grants are awarded by the Administration on Children, Youth and Families, U.S. Department of Health and Human Services.

To be eligible for a CJA grant states must meet all CJA and CAPTA grant eligibility and compliance criteria. States receiving CJA grants must also implement Task Force 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.

CJA requires that at least one recommendation be included every year in each of the three CJA categories that is responsive to the recommendations and objectives identified in the most recent three-year assessment. Each subsequent year, in addition to providing additional recommendations supporting the assessment objectives, the Task Force must provide an update on progress on each recommendation in its annual report. It is also expected that each year's Task Force recommendations support and/or further assessment objectives.

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.

CJA Task Force History

Georgia's CJA Task Force[1] was established in 2003 and was designated as one of Georgia's three CAPTA Panels[2] in 2005 and serves a dual role. The Task Force satisfies all eligibility requirements for both CAPTA and CJA mandates.

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.

Every three years, the Task Force must undertake a comprehensive review and evaluation of the investigative, administrative, and both civil and criminal judicial handling of cases of

[1] 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.

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

child abuse and neglect and make training and policy recommendations in each of the three categories listed above. Between 2009 and 2021, the Task Force completed four three-year assessments.

Georgia's Three-Year Assessment History

Year	Subject
2009	Conducted an assessment of child sexual abuse training, mandated reporting resources, and practice regarding the appointment of representation for children in dependency cases
2012	Conducted an assessment of policy, practice, and training related to the handling of cases involving victims with special needs
2015	Examined Georgia Code and the impact of the Juvenile Code Rewrite on the identification and response to reports of child abuse and neglect by state agencies with child-caring and protection responsibilities
2018	Examined training provided to individuals who respond to and investigate all forms of child maltreatment to identify potential training gaps or barriers and opportunities to enhance best practices.
2021	Conducted an assessment of legal practices, resources, and level of support for research-based strategies identified as effective in improving the quality of legal representation.

Task Force 2022-2023 Activities and 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.

The Task Force has several standing committees that promote and support its ongoing priorities and interests that also inform recommendations regarding system improvement. 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 (CAP) Committee

The CAP Committee has two primary objectives related to the Child Abuse Protocol that 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. These objectives are:

- 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 via the state model and local child abuse protocols

The committee is exploring an opportunity to collaborate with the Office of the Child Advocate in convening a multidisciplinary stakeholder group to evaluate current Georgia Code governing the Child Abuse Protocol and associated state agency responsibilities to identify actions required to address outdated legislation, policy, and practice.

Mandated Reporter Training Committee

The Mandated Reporter Training Committee's 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

The Committee has previously 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. As a result, the Committee recommended 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

particular classification of mandated reporters. The Committee looks forward to an update on its effort to enhance its online mandated reporter training in response to its earlier recommendation.

Committee priorities for the coming year include:

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

During 2022/2023, Committee efforts focused on identifying barriers to gathering medical information or maltreatment history at the time of a child fatality and its impact on the investigative team. This included surveying medical examiners and reviewing DFCS processes and policies. Real-time access to CPS history for law enforcement may influence the direction of the investigation or action by the coroner on scene. Delays in autopsy results (4-6 weeks or more) impact DFCS substantiations, which have a 45-day investigative window and identify risk to other children in the home.

A barrier previously identified is the reported lack of access by local investigators/officials (law enforcement/coroners) to CPS history through either an established local channel or through the statewide Centralized Intake Call Center (CICC). This was the subject of a previous recommendation. DFCS policy has been cited as one of the reasons for this barrier and the Task Force recommends that policy be reviewed and revised to include establishing an appropriate protocol for accessing maltreatment history by authorized individuals on scene

through the statewide system (CICC) to inform their investigative process. Policy triggering an automatic investigation by the Division in response to such an inquiry should also be addressed and the remedy incorporated into the state and/or local Child Abuse Protocol.

Special Needs Committee

The Special Needs Committee continues to contribute their unique perspectives 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)

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 Guardians ad Litem (GALs), and Special Assistant Attorneys General (SAAGs) involved in civil and criminal cases of child abuse and neglect

The QLR Committee continues to provide input and monitor CJA-funded activities that support Task Force priorities, interests, and activities aligned with Three-Year Assessment QLR objectives.

CJA Grants Committee

The CJA Grants Committee reviews all CJA grant proposals and annual performance reports and develops recommendations on CJA grant allocations for projects that support CJA objectives, and state and Task Force priorities related to the CJA mandate. These recommendations are submitted to the Division annually for review, approval, and contract management.

Demand for funding support far exceeded CJA funds available for FFY2024 projects and the Task Force explored several options before making final decisions that would both maximize use of the CJA grant, minimize impact on ongoing priorities and interests, and continue to both support and encourage projects that addressed three-year assessment objectives. This

meant that not all worthy proposals could be supported with the CJA grant in FFY2024. Nine of twelve proposals submitted have been recommended for funding at a reduced amount.

Projects recommended for CJA grant funding include:

Grantee: Cherokee Child Advocacy Center, Inc.
Project: ChildFirst™ Training
Ongoing Task Force Priority Supporting Multidisciplinary Practice Improvement

Grantee: Children's Advocacy Center of Georgia
Project: 17th Annual Children's Advocacy Centers of Georgia "One Team" Conference: The MDT Response to Child Abuse and Neglect
Ongoing Task Force Priority Supporting Multidisciplinary Practice Improvement

Grantee: Emory University – Barton Child Law and Policy Center
Project: Emory Summer Advocacy Program
Ongoing Task Force Priority & Responsive to Three-Year Assessment QLR Objectives

Grantee: Georgia CASA
Project: Strengthening Best Interests Advocacy
Ongoing Task Force Priority & Responsive to Three-Year Assessment QLR Objectives

Grantee: Children's Healthcare of Atlanta
Project: Medical Provider Network
Ongoing Task Force Priority Supporting Multidisciplinary Practice Improvement

Grantee: Georgia Center for Child Advocacy
Project: BRIDGE Trainings: Understanding the Role of the Forensic Interview (for attorneys)
Second Year of Pilot Project Responsive to Three-Year Assessment QLR Objectives

Grantee: Office of the Child Advocate
Project: The Summit: Georgia's Child Welfare Conference
Ongoing Task Force Priority Supporting Multidisciplinary Practice Improvement & Three-Year Assessment QLR Objectives

Grantee: Office of the Child Advocate
Project: Building Capacity for Sustained Improvement
Ongoing Priority Supporting Pilot Project Responsive to Three-Year Assessment QLR Objectives

Grantee: Office of the Child Advocate
Project: Centralization and Resource Coordination
New Project Responsive to Three-Year Assessment QLR Objectives

In addition to recommending the above projects for CJA grant funding, the Task Force recommends that the Division utilize its state CAPTA grant to support the Multi-Disciplinary Child Abuse and Neglect Institute (MDCANI) proposal it was not able to fund. MDCANI provides localized, foundational dependency policy and practice training that supports improved outcomes for children in care through improved legal representation and coordination of child advocacy efforts. The project is responsive to CJA priorities and CJA 2021 three-year assessment recommendations as well the state's CAPTA plan objectives for legal representation and would demonstrate alignment of and collaboration between its federal funding source objectives.

2021 Three-Year Assessment Update

CJA requires that at least one recommendation that is responsive to the recommendations and objectives identified in the most recent three-year assessment be included every year in each of the three CJA categories. These categories, their associated recommendations, and the projects aligned with each recommendation for FY2023 and 2024 follow.

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). Projects funded that aligned with this recommendation include:

- Office of the Child Advocate - QLR Project (FFY2023 & 2024)
- Office of the Child Advocate – GAL/MDCANI Training (FFY2023)
- Office of the Child Advocate – Child Welfare Summit (FFY2023 & 2024)
- Georgia Center for Child Advocacy – Training for Attorneys on Forensic Interviews (FY2023 & 2024)
- Emory University Barton Child Law & Policy Clinic – Summer Internship Program (FFY2023 & 2024)
- Georgia CASA – Strengthening Best Interests Advocacy (FFY2023 & 2024)

Other projects recommended for support that aligned with Task Force ongoing priorities and interests for Category A included:

- Child Advocacy Centers of Georgia - One Team Conference (FFY2023 & 2024)
- Cherokee Child Advocacy Council – ChildFirst Forensic Interview Training (FFY2023 & 2024)
- Georgia Center for Child Advocacy – Forensic Interviewer Mentoring Pilot (FFY2023)
- Children's Healthcare of Atlanta – Medical Network (FFY2023 & 2024)
- Georgia Center for Child Advocacy - Mentoring Program for Forensic Interviewers (FFY2023)

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.

   Although working within the confines of the state's Office of Procurement and Contracts annual cycle for federal fiscal year contracts remains a challenge, especially when the Task Force is interested in responding to immediate or short-term requests

for support, the cost of participation for three Task Force members[3] at a three-day National Association of Counsel for Children (NACC) Inaugural Race Equity Virtual Training Series and two members at the annual multidisciplinary One Team conference was covered. Events supported the Task Force recommendations on improving legal representation and multidisciplinary response, respectively.

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. Projects funded that aligned with this recommendation include:
    - Office of the Child Advocate - QLR Project (FFY2023 & 2024)
    - Office of the Child Advocate – GAL/MDCANI Training (FFY2023)
    - Georgia Center for Child Advocacy - Training for Attorneys on Forensic Interviews (FFY2023 & 2024)
    - Georgia Center for Child Advocacy - Mentoring Program for Forensic Interviewers (FFY2023)

Category C. *Reform of state law, ordinances, regulations, protocols, and procedures to provide comprehensive protection for children, which may include 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, and funded by the CJA grant, to explore the viability of this opportunity to determine how this might be structured and implemented, recognizing that it would likely require legislative action

[3] Three members from other CAPTA Panels also attended the NACC series.

to establish a new agency/organization or add the responsibility for statewide oversight of one or more of these attorney groups to an existing entity.

Although such a commission has not been established, several efforts have been undertaken to 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 reinvigorating its state chapter and may be instrumental in developing, promoting, and monitoring standards of practice for attorneys in the field of child welfare.

Projects recommended in FFY2024 for funding that align with the objectives of this recommendation include:

- Office of the Child Advocate – Building Capacity for Sustained Improvement (FFY2024)
- Office of the Child Advocate – Centralization and Resource Coordination (FFY2024)

For additional information on the CJA Task Force, its three-year assessments and projects supported with the CJA grant, visit: https://www.gacrp.com/content/cjatf/.

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 and responsiveness to the Task Force, its mandate, and 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
Emory University School of Law
Barton Child Law and Policy Center

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

Current CJA Task Force Members

Cheryl Benefield, Education Specialist, T2 Coaching & Consulting

Amy Boney, CEO, Child Advocacy Centers of Georgia

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

Kyle Browne, Staff Attorney, Dekalb County Juvenile Court

Verena Brown, MD, Pediatrician, Children's Healthcare of Atlanta

Rachelle Carnesale, Judge, Fulton County Superior Court

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

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

Nancy Chandler, Retired CEO, Georgia Center for Child Advocacy

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

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

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

Christina Joseph, General Counsel, Coca Cola Bottlers Sales & Services

Beoncia Loveless, Child Death & Serious Injury Specialist, GA Division of Family & Children Services

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

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

Julia Neighbors, Director of Institute of Continuing Legal Education, State Bar of

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

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

Margaret Schweizer, Judicial Staff Attorney, Fulton County Juvenile Court

Mitzie Smith-McCalla, Policy & Regulations Director, GA Division of Family & Children Services

Angela Tanzella-Tyner, JD, Advocacy Director, Georgia CASA

Kim Tesalona, Chief Investigator, Douglas County District Attorney

Donnie Winokur, Author & Adoptive Parent

Deb Farrell, Care Solutions, Inc.
Task Force Coordinator

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Child Fatality Review Panel

CFR Maltreatment Committee 2022 Summary Report

Child Fatality Review Panel Annual Report: CY 2021 Fatalities

Georgia Child Fatality Review History

The Child Fatality Review Panel (the Panel) is a statutory body established in 1990 by the Georgia State Legislature as an amendment to child abuse protocol legislation. It was created initially to improve the investigation of child abuse related fatalities; however, the mandate was expanded to establish a multi-agency review protocol to identify patterns and trends in child deaths and to identify strategies for prevention in all sudden and unexpected child fatalities[1].

In 2007, the Panel was designated to serve as the third of Georgia's three CAPTA Panels,[2] and in 2011, Panel bylaws were amended to include its role as a Child Abuse Prevention and Treatment Act (CAPTA) citizen review panel in the description of its purpose as a statutory body. The Maltreatment (MalTx) Committee was established to ensure that the Panel met its federally mandated role as citizen review panel (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

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 Panel is supported by staff who provide training and support, monitors, and review the work product of Georgia's 159 county Local Child Fatality Review (LCFR) committees, analyze results, and identify recommendations based on the findings of local review committees and the priorities of Panel members and standing committees.

[1] There is an interest by Panel members, the Legislative Committee, and external partners and stakeholders to address outdated CFR legislation.
[2] The other two designated CAPTA Panels are the Children's Justice Act Task Force and the Child Protective Services Advisory Committee.

Mechanisms for Reviewing Child Fatalities

In Georgia, there are several mechanisms for investigating and/or reviewing child fatalities, in multiple systems, with varying interests, mandates, roles and responsibilities. It is important to recognize the different review mechanisms, each with unique timing, purpose, objectives, and reporting obligations. These include the state Panel, local child fatality review committees, and the Division of Family & Children Services (the Division).

Local Child Fatality Review

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 to determine cause and manner of death, determine preventability and make prevention recommendations. Information gathered during LCFR reviews is documented in the National Child Death Review Case Reporting System (NCDR-CRS).

Child Fatality Review Panel

Georgia's Child Fatality Review Panel (the Panel), mandated by O.C.G.A. 19-15-4, reviews, analyzes, and reports annual aggregate data collected on all reviewable deaths with the help of state epidemiologists, child fatality experts, and prevention experts. Its purpose is to identify systemic prevention opportunities and recommend measures to decrease the incidence of child fatality.

The Panel 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. In addition to presenting data on the cause, manner and circumstances of reviewed child fatalities, the report includes recommendations for improvement and identifies prevention strategies to reduce child fatalities.

Review by the Child Welfare Agency

The Division has adopted and implemented a Safety Science[3] approach for all its critical incident reviews, including child fatalities. Critical incident reviews, including child

[3] https://www.casey.org/safety-science-culture/

fatalities, are conducted by the Division's experienced Child Death, Near Fatality, Serious Injury (CDNFSI) team.

Selection criteria for eligible fatalities include:

- 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 to place blame. This multi-disciplinary approach looks beyond human error to examine the full range of system forces at work when disastrous events occur. Inquiries are geared towards learning what systems worked and what systems didn't. System influences are rated based on both their impact and their proximity to the outcome. CAPTA Panels have supported this approach to examining maltreatment-related fatalities as an alternative to the defunct multidisciplinary child death/serious injury/near fatality review approach utilized several years ago.

The findings, actions taken, and lessons learned as a result of these reviews have not been made available. Previously, the Maltreatment Committee has recommended that the Division prepare and make available a report on its critical incident process that includes a summary of findings and actions taken by the Division to address systemic issues identified. Although the Division indicated that reports were in development, to date such reports have not been distributed to any external partners or stakeholders. The Maltreatment Committee, in the interest of transparency and accountability, is reinforcing its previous recommendation that the findings and opportunities identified in the critical incident review process and resulting actions be made available to stakeholders and partners who also have a role in the prevention of child fatalities.

Child Fatality Review Panel 2022 Activities

A copy of the Panel's annual report on Calendar Year 2021 child fatalities is attached as Appendix A.

Maltreatment Committee 2022 Activities

The Georgia Child Fatality Review Panel Annual Report: CY2021 [4]reported that 28% of reviewable deaths identified maltreatment as a cause or contributing factor or had a history of maltreatment. The report also identified that 52% of reviewed homicides and 22% of suicides had a direct correlation with maltreatment. The Committee continues to advocate for the Panel to develop a protocol for analyzing fatalities involving maltreatment, to evaluate the extent that state and local agencies are meeting their child protection responsibilities, to identify opportunities for prevention and system improvement, and to ensure that the Panel has sufficient resources to meet its mandate as a designated CAPTA Panel.

In 2022, the MalTx Committee began exploring potential relationships between sleep-related deaths, maternal substance use/abuse, infants born drug exposed, maltreatment, and the implementation of policy/practice for Plans of Safe Care for prenatally exposed infants related to CAPTA. The MalTx Committee interests also extend to evaluating Georgia's child protection efforts for prenatally exposed infants and the degree to which the state complies with CAPTA legislation.

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. The 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 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 of services in accordance with these state requirements[5]. CARA puts a focus on

[4] Copy attached as Appendix A.
[5] 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.

infants born and identified as affected by substance abuse, having withdrawal symptoms resulting from prenatal drug exposure, or having a Fetal Alcohol Spectrum Disorder.

Federal legislation requires:

- Health care providers involved in the delivery or care of substance-exposed infants to notify CPS.
- States to develop policies and procedures to address the needs of substance-exposed infants, infants with withdrawal symptoms resulting from prenatal drug exposure, or infants affected by Fetal Alcohol Spectrum Disorder.
- Plans of Safe Care be developed to address the health and treatment needs of substance-exposed infants and affected family or caregivers.

CAPTA state grants have been increased since 2018[6] to assist states in developing and implementing a statewide system of POSC to address the health and substance use disorder treatment needs of the infant, among others, and a prevention and treatment strategy to provide a safety net to protect these infants at increased risk from maltreatment (and child fatality).

During the five-year period, 2016-2020, 2514 reviewable deaths (all ages) were reviewed of which 754 were identified as sleep-related. Of the 754 sleep-related deaths, maternal substance use during pregnancy was reported for 159 (21%). Of those 159 sleep-related deaths, 53 infants (33%) were identified as drug-exposed at birth. This cohort of 159 sleep-related deaths will be the focus of the MalTx Committee in 2023. However, of concern to the MalTx Committee were 275 (36%) sleep-related deaths with no response or 'unknown' reported for maternal substance use during pregnancy when information reported on the biological mother indicated a history of drug abuse in 57 of those cases. Thirty of those 275 cases also reported unknown for infants born drug-exposed, suggesting that the number of cases might be higher, if data were complete.

[6] Georgia's CAPTA state grant of $800K has been supplemented with more than $1M annually since 2018 to address Plans of Safe Care and develop a statewide system for protecting this vulnerable population.

The MalTx Committee suggests that incomplete data for sleep-related deaths may result in under-reporting of contributory causes and the identification of effective, and ineffective, prevention/early intervention policy and/or practice. As a result, the MalTx Committee recommends that the Division, in collaboration with the Panel, develop a training for LCFR committees on Plans of Safe Care and their role in the Division's child protection efforts for drug-exposed infants. The training should identify and emphasize critical information collected during a review relevant to POSC and the role of POSC in prevention. This training should be made available on demand so it can be used as a refresher for the LCFR committees when reviewing any infant deaths.

In 2023, the MalTx Committee plans to broaden its review of data to provide additional insight into the circumstances that may have contributed to sleep-related deaths. Initially this will include the following characteristics considered relevant and potentially contributory that were also included in the database for review:

- Maternal characteristics
    - Type of substance use during pregnancy
    - History of substance abuse
    - Disability or chronic illness (includes substance abuse and mental illness)
    - Smoking during pregnancy
    - History of maltreatment as a perpetrator
- Infant characteristics
    - Infant stay in NICU
    - History of maltreatment
    - Maltreatment associated with infant death
- Biological father characteristics
    - History of substance abuse
    - History of maltreatment as a perpetrator
    - Disability or chronic illness
- Primary caregiver at the time of death
    - History of substance abuse
    - History of maltreatment as a perpetrator

- Impairment at the time of the death
  - Drug impaired
  - Alcohol impaired

Maternal health and prenatal care history will also be incorporated into this review.

During 2022, concerns were raised by the MalTx Committee, members of the Panel, and investigative professionals involved in the response to and/or reporting of infant deaths regarding assessment of sleep-related deaths for any potential connection to maltreatment. At the time of the death, although maltreatment may not be evident on the scene, investigators may not be aware of pre-existing conditions, such as maltreatment history, including Plans of Safe Care, that may warrant additional investigation prior to determining the cause and manner of death and appropriate follow up actions required. Both law enforcement and medical examiners/coroners have reported that they were not able to obtain CPS history from Central Intake Call Center (CICC) needed for their investigations at, or near, the time of the sleep-related death. Although it acknowledges the barriers and/or challenges for the Division in meeting this need, there is general consensus that this needs to be addressed. As a result, the MalTx Committee recommends that the Division examine policy and procedures that have been identified as barriers to information-sharing in these circumstances, revise them accordingly, and develop a protocol to ensure that, at a minimum, caregiver or infant maltreatment history is required, and made available to investigative professionals, for all sleep-related deaths, upon request. This will also require an update to the state's child abuse protocol.

Through its efforts, the MlTx Committee looks forward to improving the analysis of maltreatment-related fatalities and identifying opportunities for system improvement that will strengthen the state's child protection efforts and prevent maltreatment-related fatalities.

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

Current Child Fatality Review Panel 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. Several professionals with expertise in child fatality, child safety and wellbeing, and prevention attend meetings regularly as guests.

- Carolyn Altman, Juvenile Court Judge, Paulding County (MalTx)
- Elizabeth Andrews, Director, Child Victims Unit, Georgia Bureau of Investigations
- Mandi Ballinger, Member, Georgia House of Representatives
- Kathleen Bennett, Retired Mental Health Specialist
- Candice Broce, Commissioner, Department of Human Services
- Jerry Bruce, Director, Officer of the Child Advocate (MalTx)
- Robertiena Fletcher, Board Chair, Department of Human Services
- Britt Hammond, Superior Court Judge, Toombs Judicial Circuit (Panel Chair)
- Richard Hawk, Coroner, Coweta County
- Randy McGinley, District Attorney, Alcovy Circuit
- Jay Neal, Director, Criminal Justice Coordinating Council
- Michael Register, Director, Georgia Bureau of Investigations
- Dr. Geoffrey Smith, Chief Medical Examiner, Georgia Bureau of Investigations
- Kevin Tanner, Commissioner, Department of Behavioral Health and Developmental Disabilities
- Kathleen Toomey, Commissioner, Department of Public Health
- Amy Jacobs, Commissioner, Department of Early Care and Learning
- Lisa Kinnemore, Department of Education
- Trina Wilson, Child Abuse Prevention

In addition to appointed CFRP members identified above, the MalTx Committee includes the following members:

- Angela Boy, Program Manager, Prevention and Training, Stephanie V. Blank Center
- Tiffany Sawyer, Director of Prevention & Education, Georgia Center for Child Advocacy
- John Carter, Epidemiologist
- Martha Dukes, Manager CDNFSI (Child Death, Near Fatality/Serious Injury) Review Team, Division of Family and Children Services
- Deb Farrell, CAPTA Panel & CJA Task Force Coordinator

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Appendix A

Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2021

Elizabeth Andrews
Panel Chair

Brian Kemp
Governor

The Child Fatality Review Panel Members

Elizabeth Andrews – Panel Chair, CAISC Coordinator, GBI Medical Examiner's Office

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

Candice Broce – Commissioner, 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

Jerry Bruce – Director, Office of the Child Advocate

Randy McGinley – District Attorney, Alcovy Judicial Circuit

Amy Jacobs – Commissioner, Department of Early Care and Learning

Vacant – Member, State Board of Education

Table of Contents

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 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 CFR Panel 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 2021. This data, representing sudden and unexpected child fatalities of Georgia residents, is compiled by 159 local child fatality review committees pursuant to statutory requirements. This report could not be assembled without the continued diligence and contributions of the local child fatality review committees. On behalf of the Panel, I extend my utmost appreciation for every local committee member's participation in the investigation, prosecution, review, and prevention process. At the Panel's annual retreat, the following local teams/members were recognized for their exceptional service:

CFR Committee of the Year: Clayton County

CFR Community Prevention Efforts of the Year: Macon Judicial Circuit

Coroner of the Year: Leon Jones, Bibb County

Medical Examiner of the Year: Dr. Karen Sullivan, Fulton County

CFR Rookie of the Year: Jeffery Kujawa, Houston County

District Attorney Timothy Vaughn with the Oconee Judicial Circuit was also honored, marking 37 years of faithful service. Congratulations to all the awardees for their excellence, commitment, and compliance in collecting child death data and executing prevention efforts throughout our state.

Within the past year, great strides have been accomplished in partnering with those involved in child death investigation, review, and prevention. Our partnership with The National Center for Fatality Review and Prevention continues with the launch of the Drowning Death Scene Investigation and Child Death Review (CDR) Project. This initiative collects data from pediatric drownings with the intent to create a standardized death scene investigation (DSI) form utilized by first responders in their response to such fatalities. Support and involvement in events surrounding safe sleep and suicide awareness as well as fire, motor vehicle, and gun safety marked a record year for prevention initiatives. The work of the Panel has just begun; we must continue our mission to increase the effectiveness of county-based child death reviews and improve state and community response with increased coordination among agencies. Let us proactively utilize this report to facilitate community education and prevention in efforts to reduce child fatalities.

The Panel commends Director Register, the Child Fatality Review Managers, Agents, and medical examiner office personnel at the Georgia Bureau of Investigation for their commitment to our most vulnerable residents, our children. We thank Governor Kemp and Members of the Georgia General Assembly for their attention to the Panel's Annual Report. Together, we shall continue our mission to reduce and prevent child fatality in Georgia.

Elizabeth Andrews

Sincerely,
Elizabeth Andrews
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 identifies 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.

Introduction

2021 Infant and Child Deaths

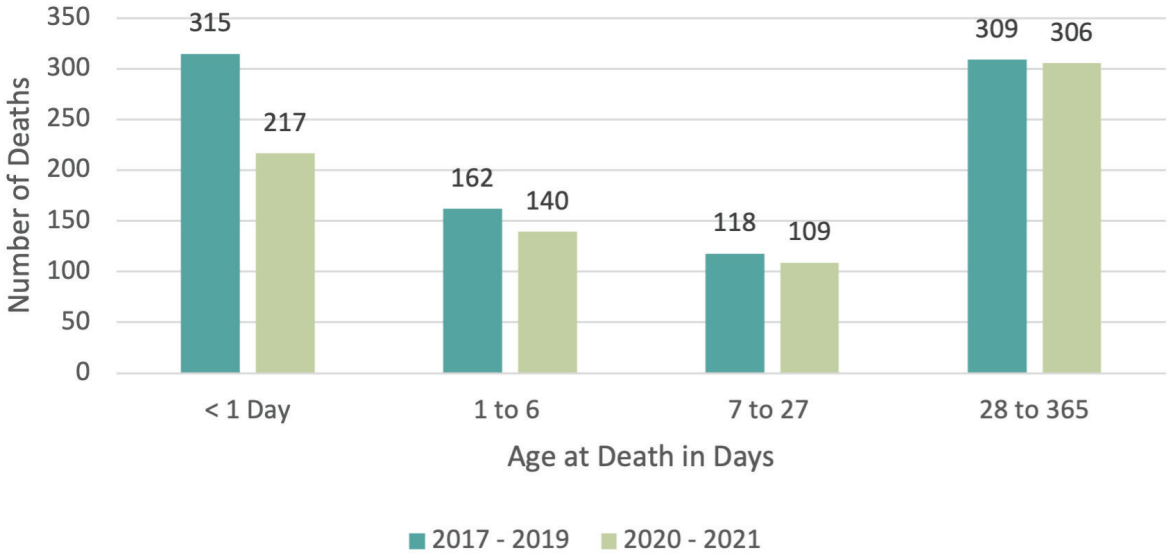
There were 1,440 reported deaths of infants and children in Georgia during calendar year 2021. The count by age group may be an undercount due to an (anecdotally reported) issue with medical examiner staffing and delays in autopsy completion and reporting. There were 48 infant deaths reported as cause of death “unknown” (ICD10 code R99). These deaths are classified as “sleep-related” and are counted as “reviewable” for Child Fatality Review (CFR) purposes.

Table A. 2021 Georgia Infant and Child Deaths

	Age in Years					
DC_Cause	**Infant**	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Totals**
MVA	8	19	17	26	46	116
Other Unintentional	7	30	15	19	32	103
Homicide	11	24	9	13	50	107
Suicide			1	29	56	86
Sleep-Related	182					182
Medical	562	86	47	72	55	822
Unknown Intent	2	1	1	1	1	6
Unknown (>1 Yr)		8	1	5	4	18
Total	**772**	**168**	**91**	**165**	**244**	**1,440**

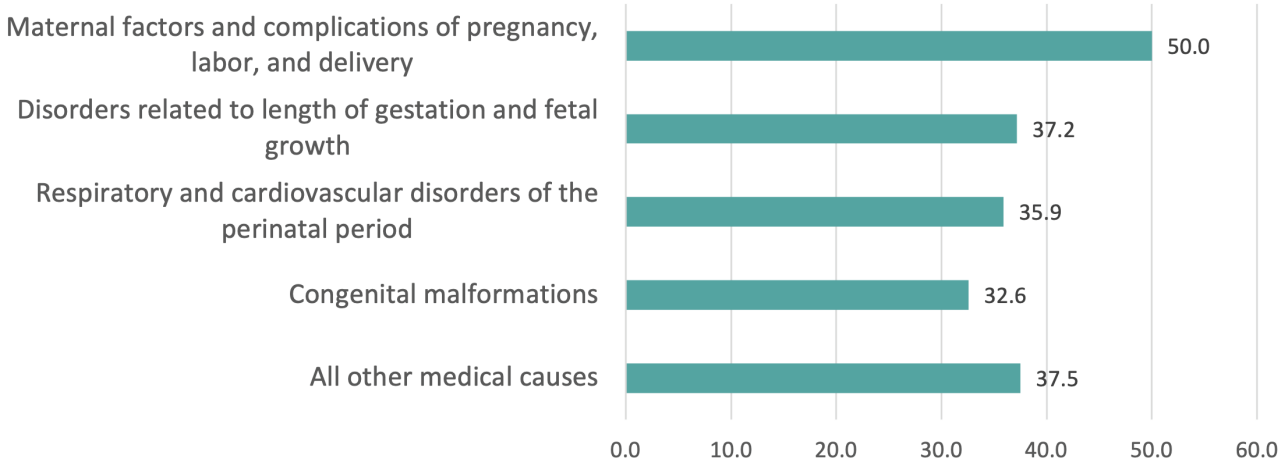
The impact of the COVID-19 pandemic on number of reported child deaths is probably also underestimated. The 2021 death certificates only reported 21 COVID-19 deaths among children less than 18 years of age (an increase from six in 2020). However, there are issues with case definition (COVID-19 not identified as associated with the death) and indirect effects of pandemic-associated stress. The decrease in number of infant deaths (2019 to 2020) reported last year continued into 2021 (772 deaths). The infant mortality rate (deaths per 100,000 births) had decreased to 6.3 in 2020 and continued to decrease slightly to 6.2 in 2021. Most of the reduction in infant deaths was due to the decrease (from 298 to 214) in number of infants dying of medical causes at birth (within the first day of life). (See Attachments, Table A for age and race/ethnicity detail.)

Figure 1. Average Infant Annual Deaths, by Age in Days



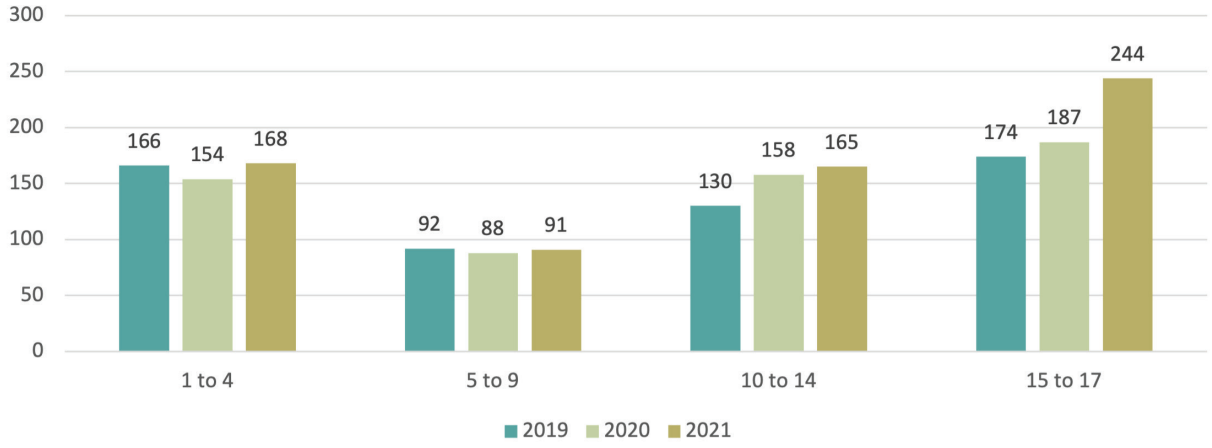
An examination of the race distributions showed that most of the "1 day" decrease was in the Black Non-Hispanic population. (Appendix, Table B.) The total decrease was 39.1% compared to 11.7% for the White Non-Hispanic infants. The decrease was consistent across major categories for cause of death.

Figure 2. % Decrease in Black Non-Hispanic Infant Deaths, Age < 1 Day



The number of deaths of youth ages 10 through 17 increased during the two pandemic years from 304 in 2019 to 409 in 2021. This increase is associated with specific cause of death categories – primarily intentional (homicide and suicide).

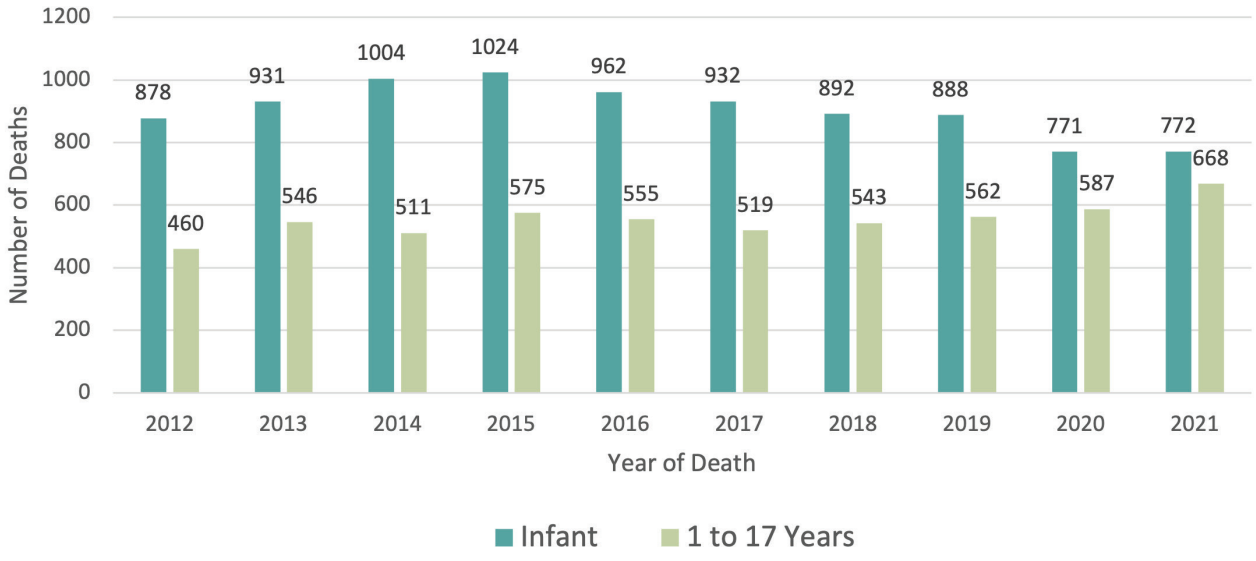
Figure 3. Number of Child Deaths, GA, 2019-2021, by Age Category



Trends in Cause of Death for Georgia Infants and Youth (< 18 years of age)

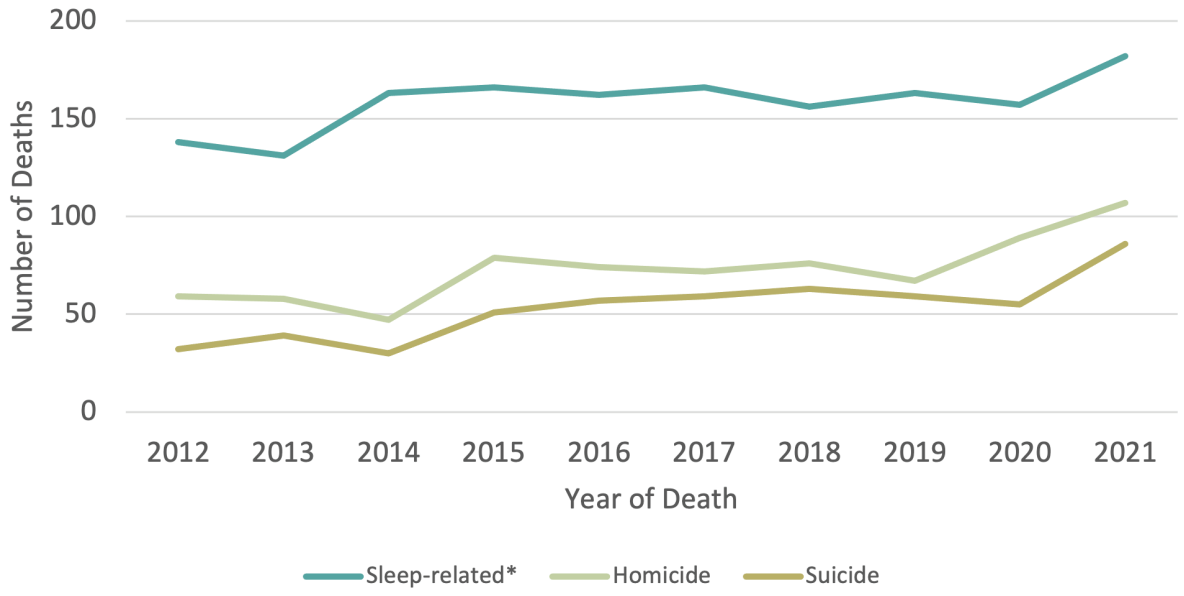
The recent changes in infant and child deaths represent a discontinuity in the longer-term trends (last ten years). The number of infant deaths (and the mortality rate) have been decreasing since 2015, but the rate in 2020 was lowest in 10 years and represented the largest one-year change. A preliminary review of the literature does not reveal an explanation of the decrease in the infant mortality rate. The Georgia low birthweight and premature birth rates have not decreased over the past two years, and they are strong risk factors for infant mortality.

Figure 4. GA Infant and Child Deaths, Ages < 18



The ten-year trend data shows an increase in 2021 in intentional deaths (homicide and suicide) and sleep-related deaths of infants. Forty-four of the “Unknown” cause of death infants were reviewed and 22 were determined to be sleep-related. The 22 non-sleep-related deaths would account for most of the observed increase in the death certificate data. (19 unknown infant deaths in 2020 and 48 in 2021.)

Figure 5. GA Infant and Child Deaths, 2012-2021



2021 Georgia Child Death Review Process

The Child Death Review (CDR) is the multidisciplinary review of individual child deaths to help communities understand why children die and equip them to effectively prevent future fatalities. The COVID-19 pandemic continued to adversely affect the CFR (Child Fatality Review) process in 2021. The proportion of reviewable deaths reviewed dropped an additional 3 percentage points (83.8 to 80.9) after an eight-percentage point decrease between 2019 and 2020. The review rates and changes were consistent across cause categories. (Deaths with a "Medical" cause are not defined as "Reviewable", although a review team may decide that a specific death should be reviewed. In 2021, 100 "medical" deaths were reviewed – perhaps because the death was unexpected or did not occur while the decedent was in the care of a physician.)

Table B. Proportion of Reviewable Deaths Reviewed, 2021

	Reviewed?		
Death Certificate Cause	**No**	**Yes**	**% Reviewed**
Medical (non-reviewable)	722	100	12.2
MVC	19	97	83.6
Other Unintentional	24	79	76.7
Sleep-Related	36	146	80.2
Homicide	22	85	79.4
Suicide	12	74	86.0
Unknown Intent	1	5	83.3
Unknown (Age > 0)	4	14	77.8
Reviewable Total	**118**	**500**	**80.9**

Reviewable deaths (based on death certificate non-medical deaths) in 2021 were distributed across 121 Georgia counties. Thirty-eight counties had no reported reviewable deaths, and 84 counties with a total of 366 reviewable deaths reviewed all deaths. Attachment Table C provides individual county review data.

Table C. Review Summary, 2021 Georgia Child Fatality Review				
Category	**Description**	**#Counties**	**#Deaths**	**Not Reviewed**
1	All Reviewable Deaths Reviewed	84	366	
2	Some Reviewable Deaths Reviewed	20	214	80
3	No Reviewable Deaths Reviewed	17	38	38
4	No Reviewable Deaths	38		

Maltreatment

Action or Failure to Act that Contributes to a Death

Fortunately, an overt act that directly causes a child's death is a rare event. Thirty Infants and toddlers were killed in 2021 by parents and other caregivers; and abuse was identified as the cause for 15 of those 30 deaths. Abuse was reported as the cause for only 22 deaths (all ages under 18) in 2021. The CFR form has questions addressing the role (if any) of maltreatment in causing or contributing to a death. Other questions address any history of maltreatment for the decedent and whether poor supervision or exposure to hazards may have contributed to the death. These various maltreatment questions were used to define a summary maltreatment variable that assigns a single maltreatment-related value to each death. (The "de-duplication" works from the top down. For example, if abuse and neglect were both identified as causing the death, that death is reported as "Cause, Abuse". Twenty deaths had neglect identified as a cause, but one of those deaths also had abuse identified. That single death is not counted in the Total for the "Cause, Neglect" entry.)

Table D. Maltreatment Summary, 2021 Reviewed Deaths

	Cause or Contribute		History					Cause/ History
Cause Category	**Abuse**	**Neglect**	**Abuse**	**Neglect**	**Supervision**	**Exposure to Hazard**	**None**	**Proportion**
Motor Vehicle Crash		5	11	12	17	38	23	26.4
Other Unintentional	0	3	8	9	21	20	19	25.0
Homicide	18	3	11	14	13	14	15	52.3
Suicide			13	4	3	22	34	22.4
Sleep-Related	1	4	13	13	26	82	9	20.9
Medical	1	2	11	16		1	65	31.3
Undetermined	2	2	1		2	4	8	26.3
Total	**22**	**19**	**68**	**68**	**82**	**181**	**173**	**28.9**
Duplicated Totals	**22**	**20**	**85**	**119**	**109**	**280**		

About 29% of all reviewed deaths had maltreatment identified as causing or contributing to the death or had a reported history of maltreatment. That proportion has increased slightly over the last ten years (from 26.6% for 2012-2016 to 28.9, 2017-2021). The five-year comparison shows a doubling in the number of deaths with neglect reported as causing or contributing to the death and 150% increase in deaths with reported exposure to hazard. We do not know how much of these increases is associated with increased sensitivity to these risks by the review teams.

Table E. Reported Maltreatment, Five-Year Comparison

		Average	
		2012-2016	**2017-2021**
Cause or Contribute	Abuse	25	27
	Neglect	11	24
History	Abuse	66	76
	Neglect	37	37
	Poor Supervision	57	73
	Exposure to Hazard	56	146
	None	274	184
Percent	Cause/History	26.6	28.9
	Any	48.1	67.6

Supervision and Exposure to Hazards

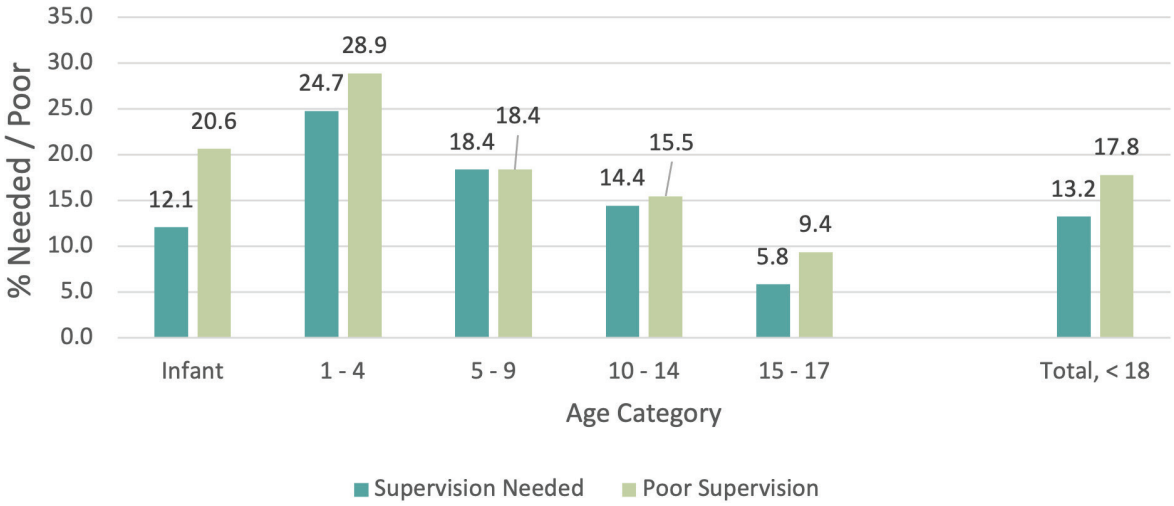
These two topics (supervision and exposure to hazards) were introduced in the preceding section on maltreatment because they indicate possible "lack of action" that may have contributed to a child's death. These three parameters (variables/risk factors) are not independent, but they can be used to examine prevention opportunities for specific cause of death / age populations. A subsequent report section on selected causes of death illustrates this "prevention planning" approach.

Supervision: The CDR form addresses supervision of the decedent in three sections. 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

Eighty-one (81) of the 613 reviewed deaths (13.2%) reported "No but needed". The two supervision measures show similar age distributions, but the second measure addresses deaths where poor supervision is a contributing factor.

Figure 6. Percent Reviewed Deaths with Supervision Issues, GA 2021



The possible contribution of poor supervision to the death is captured by three variables. The "Circumstances" section has a question: "Child abuse or neglect, poor supervision or exposure to hazards cause or contribute to death?". 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. The CFR teams determined that poor supervision was involved in 109 of the 613 reviewed deaths (17.8%).

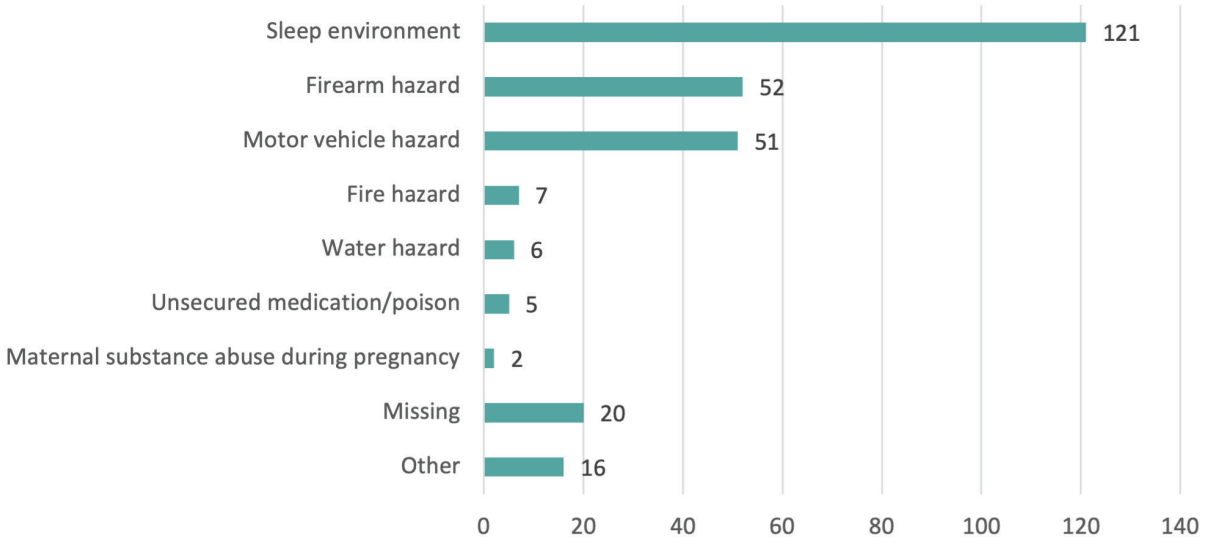
Exposure to Hazards is defined using the same variables as Poor Supervision, with a value for Hazard (4) replacing the Poor Supervision value (3). A total of 280 reviewed deaths had "Hazard" checked for at least one of the three variables. Infants accounted for half of the indicated presence of a hazard. Approximately one-third of the child (ages 1 – 17) deaths had "Hazard" reported.

Table F. Reviewed Deaths with Hazard Indicated

	Hazard Reported		
Age Category	**Yes**	**No**	**Percent**
Infant	141	58	70.9
1 - 4	29	68	29.9
5 - 9	18	31	36.7
10 - 14	32	65	33.0
15 - 17	60	111	35.1
Total, < 18	**280**	**333**	**45.7**

The CDR form has a follow-up question regarding the type of hazard. There was a response for 260 of the 280 deaths that indicated a hazard. The "Sleep environment" response explains the large number of infants exposed to a hazard.

Figure 7. Identified Hazards, GA CDR 2021

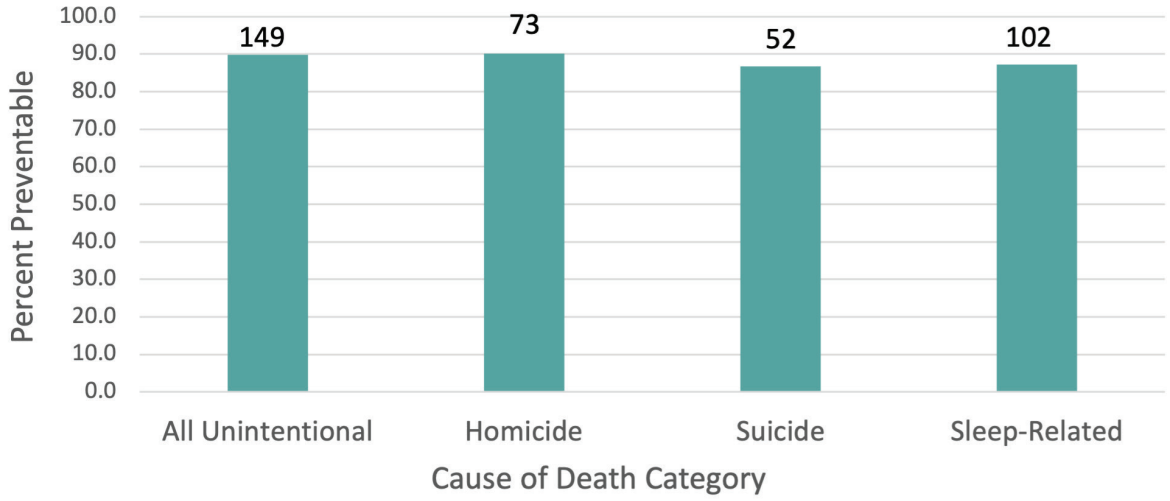


Summary of Selected Causes

Selected Cause of Death Categories: Prevention Target Populations

The county Child Fatality Review (CFR) teams determined that 80% or more of reviewed deaths could probably have been prevented. The central mission of the CFR process is to reduce the number of infant/child deaths; and the intent of the following "cause-specific" discussion is to provide information for use by GA legislators, the CFR Panel, Panel subcommittees, and concerned agencies/organizations.

Figure 8. 2021 Reviewed Deaths, % Preventable (# Preventable)



Unintentional Injuries

There were 186 reviewed unintentional deaths in Georgia in 2021, with motor vehicle-related events (including pedestrians and bicyclists) accounting for 57 percent (106) of the deaths. Drowning – the second-leading cause – accounted for 24 deaths (13%).

Table G. Reviewed 2021 Unintentional Injury Deaths, GA

	Age in Years					
Cause	**Infant**	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Totals**
Asphyxia	2	4		1		7
Drowning	2	11	3	3	5	24
Fall/Crush			1	1		2
Fire		7	5	1	1	14
MVC	8	19	15	24	40	106
Other Cause	4	2			2	8
Poison		1		1	14	16
Weapon		2	1	3	3	9
Totals	**16**	**46**	**25**	**34**	**65**	**186**

The white toddlers are 2.2 times more likely to drown than a black toddler; but the black 5- to 17-year-old is 3.8 times more likely to drown than a white child.

Drowning

An average of 35 GA children die each year due to drowning. There has not been any consistent trend over time in drowning deaths (although the average number of annual deaths has dropped to 31 for the past four years, compared to 37 for the preceding six years), so the following discussion addresses the total deaths over the 10-year period. This aggregation of years provides a sufficient sample to look for age and race differences.

There were 346 reported deaths of youth under the age of 18 in GA between 2012 and 2021. County CFR teams reviewed 285 of those deaths (82.4%). (Appendix Table E) The age and race/ethnicity data indicate two distinct populations – toddlers ages one through four, and children/teens ages five through 17.

Figure 9. GA Drowning Deaths, Ages 1 to 17, 2012-2021

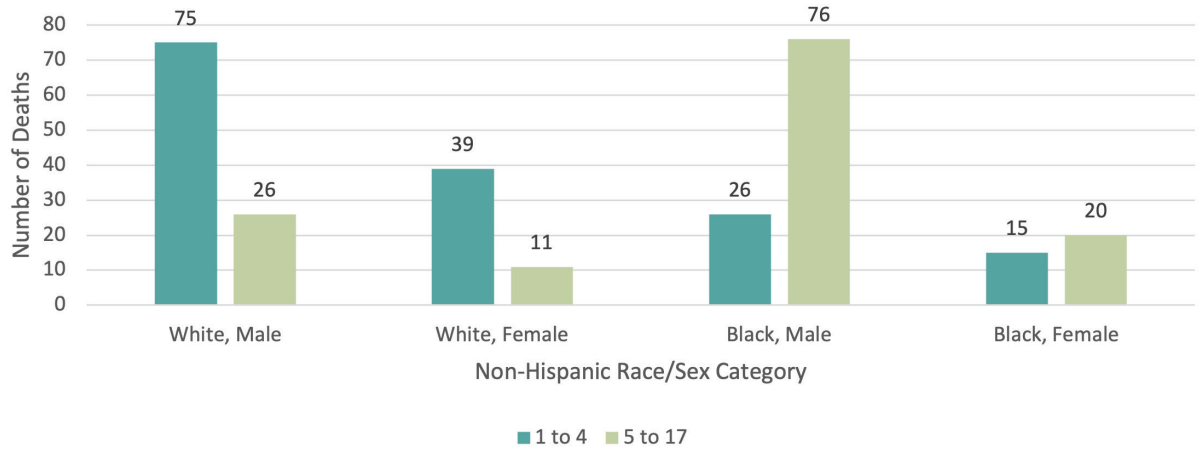
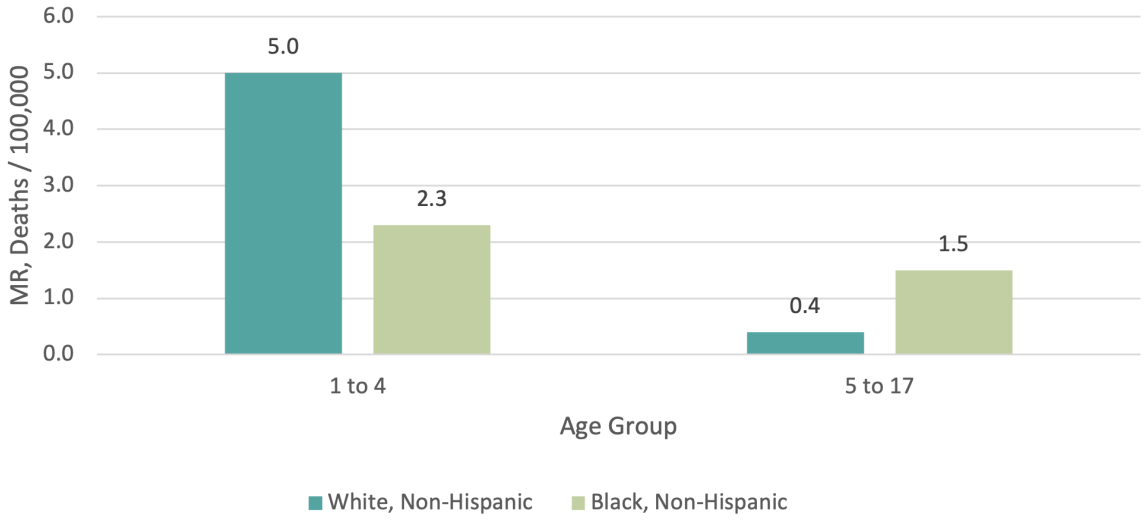


Figure 10. Drowning Mortality Rates by Age Group and Race



The fatality reviews provide information regarding the circumstances of the death and risk factors. Supervision is a factor described under the Responsibility section questions “Did person(s) cause/contribute to death?” and “What act caused/contributed to death?” “Poor supervision” is one of the options for the second question, and it was reported for 84% of the reviewed toddler (ages 1 to 4) deaths and 43% of the youth (ages 5 to 17) deaths.

An ability to swim is important for all children, and a racial disparity was noted in reviewed drowning deaths. The higher drowning risk for Black/African American youth (referenced in the discussion of death certificate data) may be partially explained by a racial disparity in swimming skills. Over 70% of the Black youth drowning victims were reported as unable to swim, compared to less than 40% of the White youth.

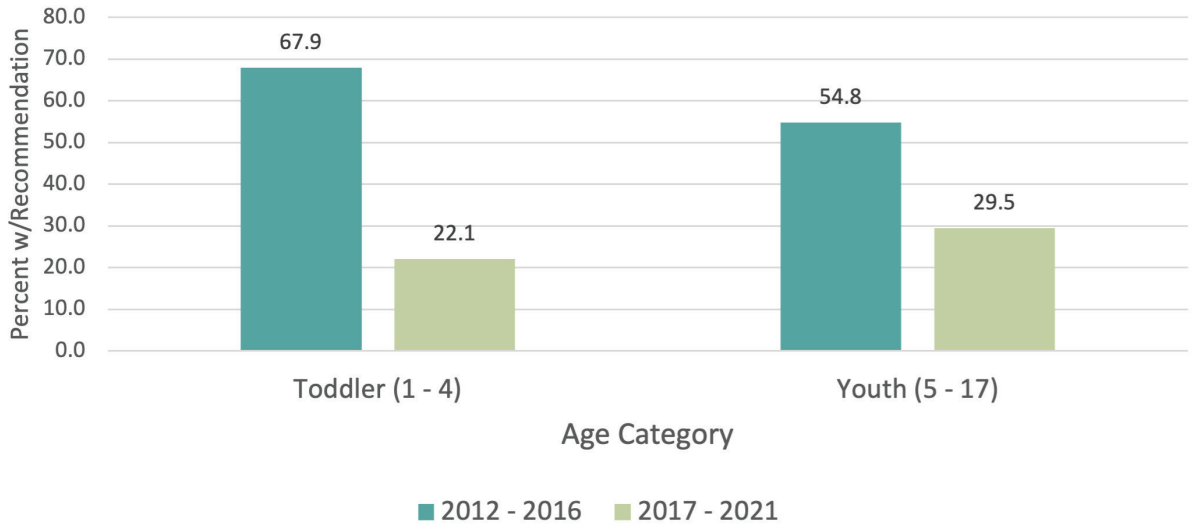
Table H. Racial Disparity in Swimming Skills

	Child able to swim? (DROchswim)			
Race (Non-Hispanic)	**Yes**	**No**	**Unknown**	**% Non-Swimmer***
White	16	10	9	38.5
Black	15	40	28	72.7

* Excludes “Unknown”

The prevention section of the CDR form provides an opportunity for team recommendations. The 10-year data shows a decrease in the responses to the question: “Recommendations and/or initiatives that could be implemented to prevent future deaths”.

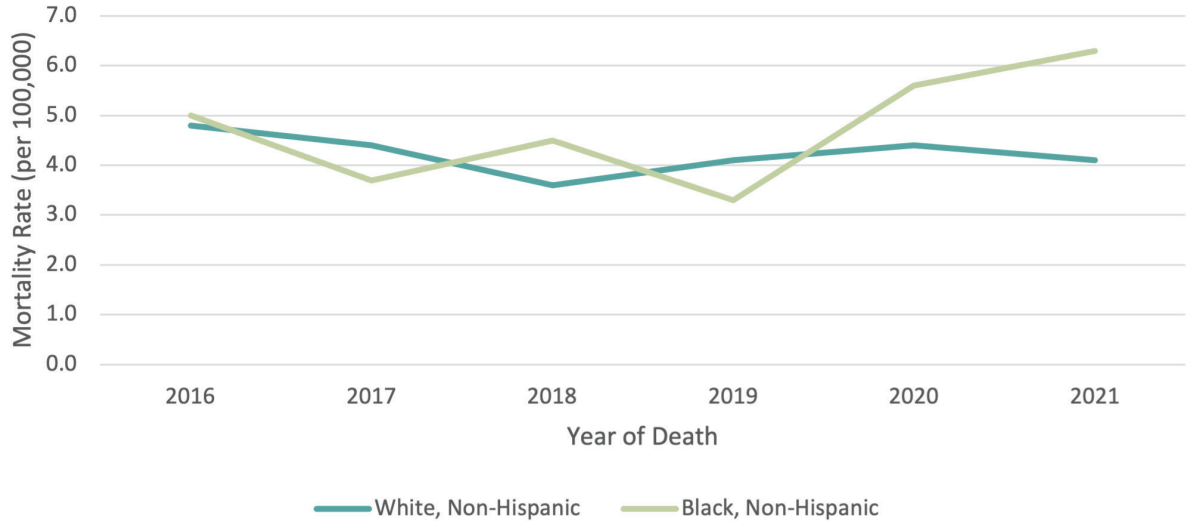
Figure 11. Proportion of Drowning Reviews with Recommendation



Motor Vehicle Incidents

Reported deaths (ages < 18) associated with MV incidents vary from year to year, but the average number is approximately 100 per year. There has been an increase in Black/African American deaths during the first two years of the COVID19 pandemic. The White deaths stayed at about 4 per 100,000, but Black deaths increased to over 6/100,000 in 2021.

Figure 12. Georgia Motor Vehicle Mortality Rate, Ages < 18



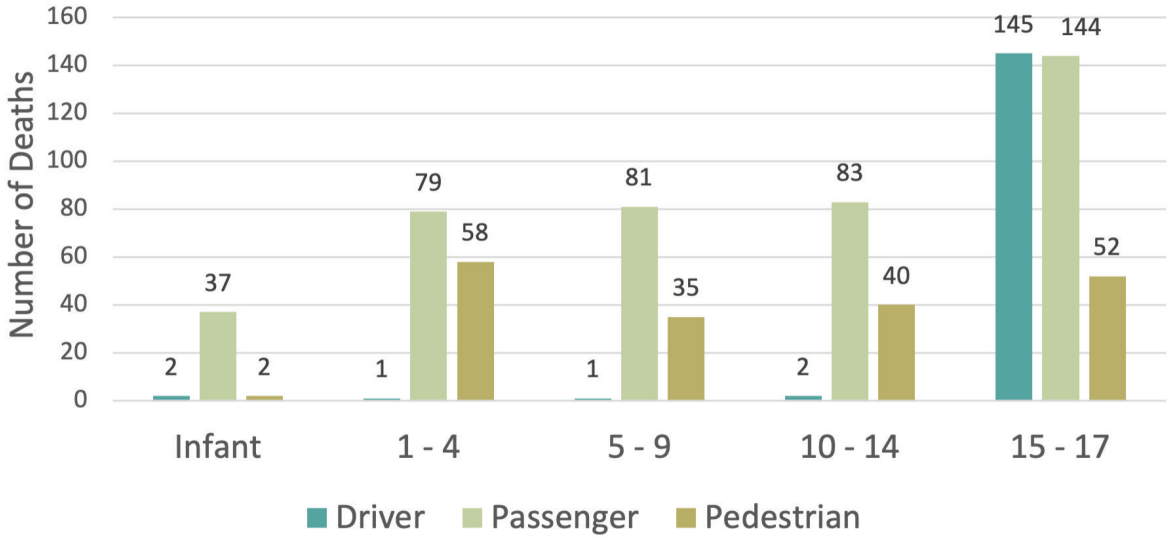
Child Fatality Review (CFR) teams reviewed 106 motor vehicle related deaths in 2021. The majority of the 106 incidents in 2021 were related to cars, vans, SUVs, or trucks, accounting for 58% (61) of these deaths. The 15-17 age group has largest number of deaths in this category with 27, accounting for 44%.

Table I. Reviewed 2021 Motor Vehicle Deaths, by Involved Vehicle

	Age in Years					
Child's Vehicle	**Infant**	**1 to 4**	**5 to 9**	**10 to 14**	**15 to 17**	**Totals**
ATV		1	4	3	4	12
Bicycle				2		2
Car, van, SUV, truck (driver)					17	17
Car, van, SUV, truck (passenger)	7	10	10	7	10	44
Motorcycle					1	1
Pedestrian	1	6	1	6	3	17
Other/Unknown		2		6	5	13
Totals	**8**	**19**	**15**	**24**	**40**	**106**

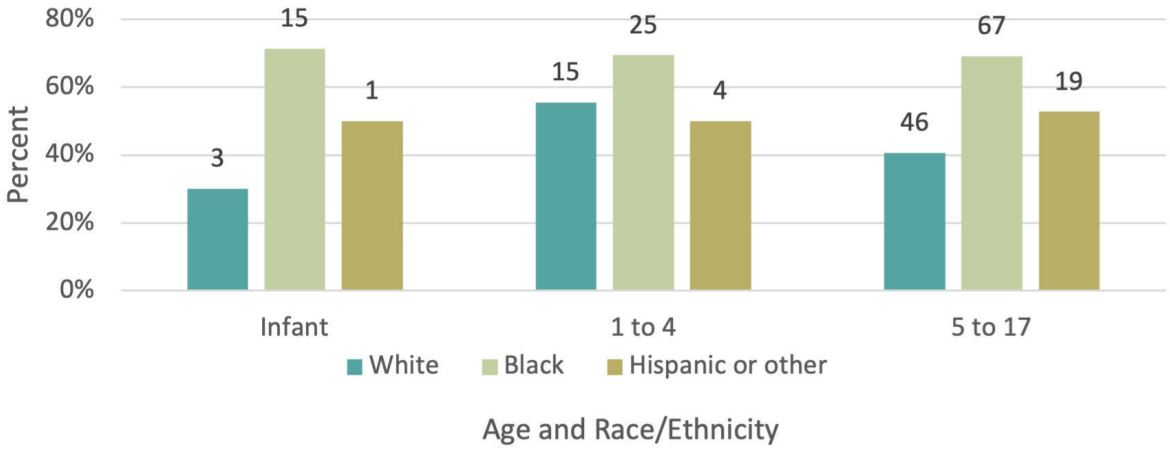
Assuming no significant trends over time, the 10-year set of reviewed data was used to describe the MVC victim population and examine risk factors. Passengers (of car, van, SUV, or truck) comprised the largest population by position (424 out of 938) – 45%.

Figure 13. Position of MVC Decedent by Age, GA 2012-2021



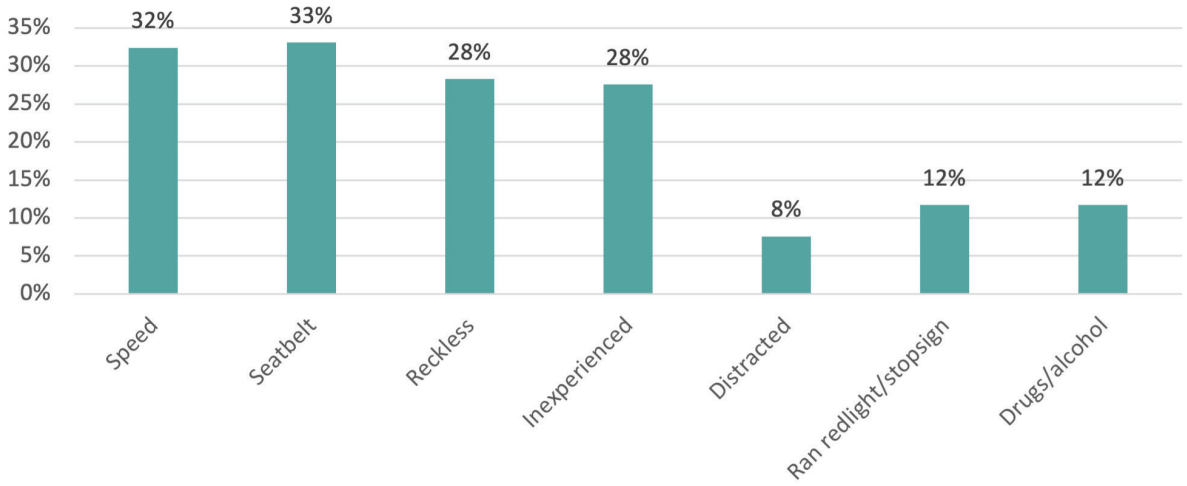
A primary prevention objective for passengers is availability and use of appropriate restraint systems. Over half of reviewed fatalities for children <18 who were passengers in a car, van, SUV, or truck were either not restrained or improperly restrained. Black children accounted for almost 80% of the unrestrained/improperly restrained infants, while they were 57% and 51% of the 1- to 4-year-olds and the 5-to-17-year-olds respectively.

Figure 14. Children who were Passengers in a Car, Van, SUV or Truck and were Unrestrained or Improperly Restrained (Percent and Number)



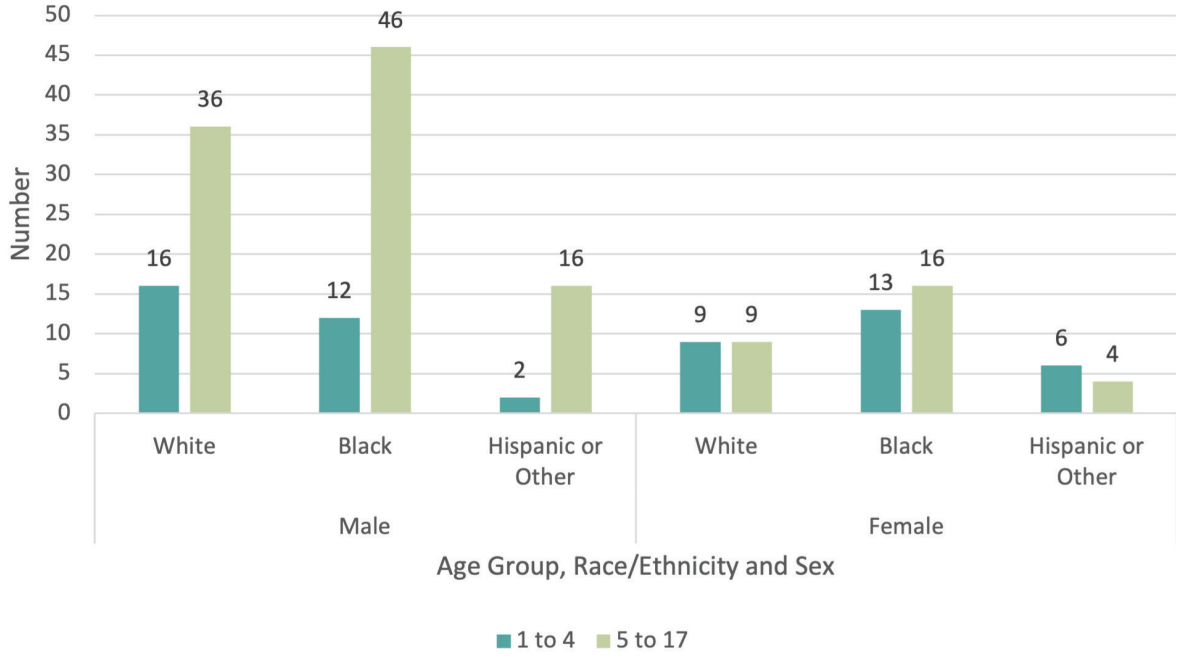
The teenage drivers are a second target population for prevention. There were 145 reviews of deaths of teen drivers from 2012 to 2021. Ninety percent of the time the teen driver was determined to be at fault in the motor vehicle incident. Males were involved in single vehicle accidents twice as often as females (66% of the time versus 32%). Speed, lack of seatbelt use, recklessness and inexperience were top contributing factors to motor vehicle incidents involving teen drivers.

Figure 15. Contributing Factors in Reviewed Fatal Crashes Involving Teen (15 to 17) Drivers, GA, 2012-2021



Pedestrian deaths are distributed across all age groups and represent a prevention challenge. For the 15 to 17 age group, 85% of reviewed pedestrian deaths were male, and 75% of the 10 to 14 age group were male. The toddlers represent a supervision issue, and the older children/youth need education in awareness of their environment.

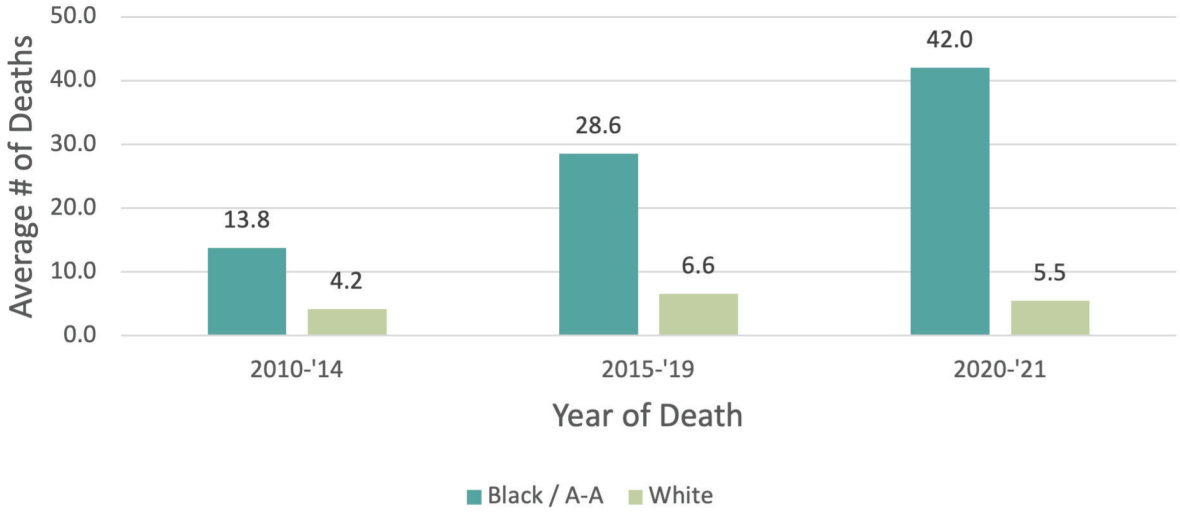
Figure 16. Number of Reviewed Pedestrian Deaths by Race/Ethnicity, Sex and Age Group, 2012-2021

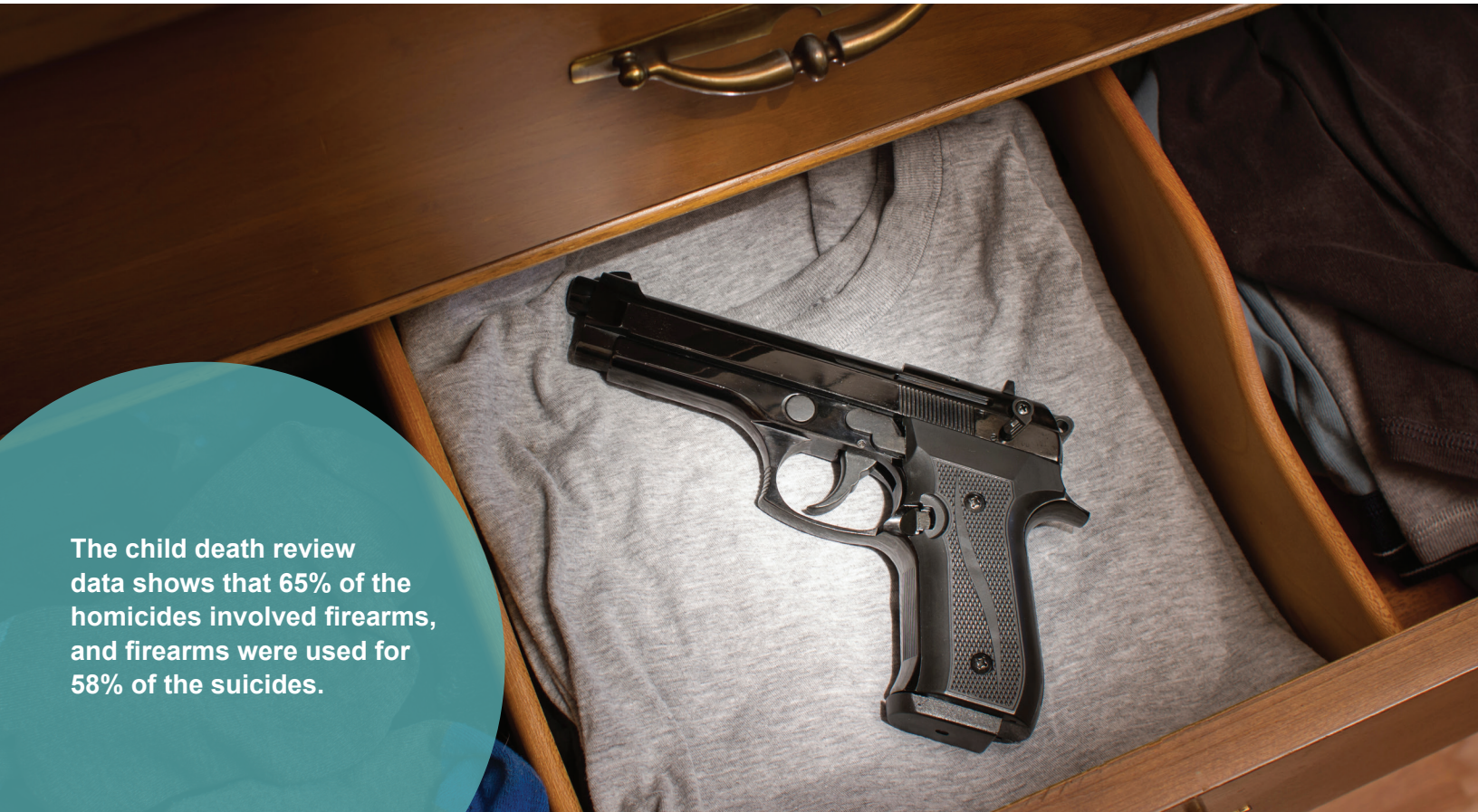


Intentional Injuries

Homicides continued an increase that started in 2020, and suicides (death certificate reports) increased from an average of 59 per year over the previous five years to 86 in 2021. The homicide increase has been associated with an increase within the Black/A-A population ages 15 to 17. The number doubled starting in 2015, and there has been another 50% increase over the past two years.

Figure 17. Average Annual Homicides, GA, Ages 15-17





The child death review data shows that 65% of the homicides involved firearms, and firearms were used for 58% of the suicides.

Table J. Reviewed Intentional Deaths by Mechanism, GA Residents, 2021							
		Age Category (yrs.)					
	Mechanism	Infant	1 - 4	5 - 9	10 - 14	15 - 17	Total
Homicide							
	Blunt Force Trauma	5	9	1			15
	Firearm		3	2	10	42	57
	Hanging		1				1
	Heat	1					1
	Knife		1		1		2
	Maltreatment	1	2	1			4
	Motor Vehicle		1				1
	Poison	1	5				6
	Suffocation					1	1
Total		**8**	**22**	**4**	**11**	**43**	**88**
Suicide							
	Firearm				13	31	44
	Hanging			1	13	14	28
	Poison				2	2	4
Total				**1**	**28**	**47**	**76**

The 10-year review data provides information on risk factors associated with deaths among defined (cause of death, age, race/ethnicity, and mechanism of death) populations. Appendix, Table F has the aggregate homicide and suicide breakout for the period for all four variables. The following table shows some of the disparities in homicide and suicide deaths for ages < 18. Toddlers account for 38% of the Black, non-Hispanic homicides compared to 56% for White, NH. This difference is a result of the large racial disparity in teen homicides. Many of the toddler homicides (approximately 60% for Black and White, NH) are attributed to blunt force trauma. The teen homicides are firearm-related (93% for Black, NH and 76% for White, NH), and over 80% of the firearm homicide victims were male.

Table K. Age and Race/Ethnicity Distributions, GA Intentional Injuries, 2012 - 2021						
Age Distribution (Count)				**Racial Distribution (Percent)**		
		Homicide	Suicide		Homicide	Suicide
Years		**NH Black**		Non-Hispanic		
1 to 4	Toddler	179		Black	68.6	25.8
5 to 14	Child	73	59	White	18.4	57.5
15 to 17	Teen	222	69	Other	4.5	5.8
		NH White		Hispanic		
1 to 4	Toddler	71		All Races	8.5	10.9
5 to 14	Child	22	90			
15 to 17	Teen	34	195			

The described age, race, and mechanism distributions highlight areas for additional risk factor investigation. The toddler homicides raise questions regarding the child's supervision and status of caregivers - responsible person(s). The firearm deaths (including accidental deaths) highlight questions regarding access to firearms.

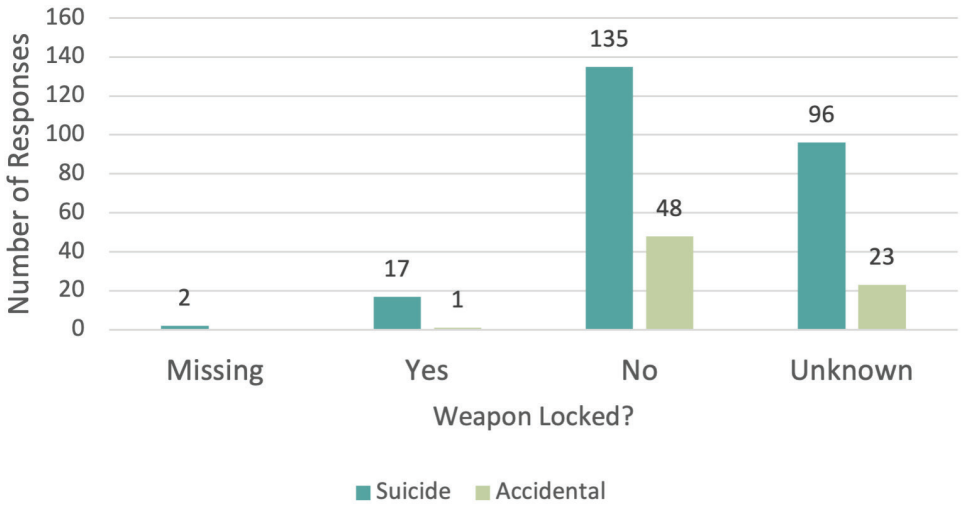
The New York Times reported (12/15/2022) that: "Guns are now the No. 1 cause of deaths among American children and teens, ahead of car crashes, other injuries and congenital disease." Access to firearms and firearm safety are major challenges for public health prevention. Further analysis of CFR firearm-related data will be a priority for future work.

A biological parent or the mother's partner was identified as the person responsible for the death for over 80% of the toddler homicides. The most common mechanism was "blunt force trauma" (59% of the homicides).

Table L. Relationship of Person Responsible for Toddler Homicides		
Description	**Homicide**	**BFT**
Missing	30	10
Biological mother	97	43
Biological father	63	45
Mother's partner	52	49
All Other	50	26
Total	**292**	**173**
% Biological Parent or Partner	80.9	84.0

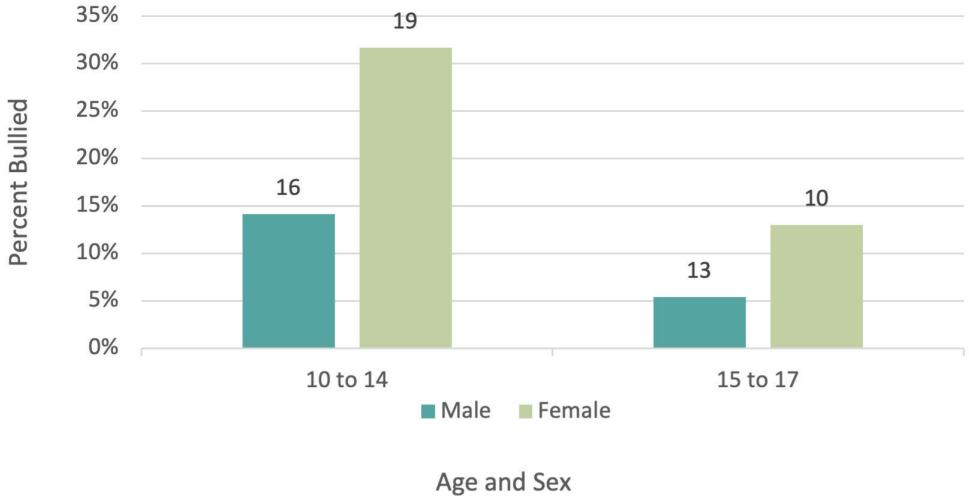
There are a series of questions regarding the firearm used in the deaths, but there are many "Missing" responses. Only 17 out of 152 suicides with a Yes/No response indicated the weapon was locked.

Figure 18. "Was the weapon locked?"



Access to firearms is a serious concern related to suicides, but the mental health of the young person is a major contributing factor. Bullying in school has always been a problem, but the expanded use of social media means that a child is never out of reach of a bully. Younger teen and female suicide victims are more likely to have been bullied (including cyber bullying) than older teens or males. Thirty-two percent of females ages 10 to14 were reported to have been bullied.

Figure 19. Reviewed Suicide Deaths with Reported Bullying, GA, 2012-2021



Of reviewed deaths of children who died by suicide, 29 percent had some form of abuse or neglect at some point in their lives and 56% communicated suicidal thoughts or intentions or talked about suicide.

Sleep-related deaths (Sudden Unexpected Infant Death – SUID):

Sleep-related deaths continue to resist efforts to address recognized risk factors. Safe sleep campaigns have promoted “back-to-sleep” positioning for infants and avoidance of soft bedding and other items in the crib, but the annual number of deaths has remained steady. The GA death certificates reported an average of 162 sleep-related deaths each year from 2014 through 2020. (The increase in 2021 to 182 is suspected to be a reporting anomaly.)

Table M. Reviewed SUID Deaths, GA Residents, 2021

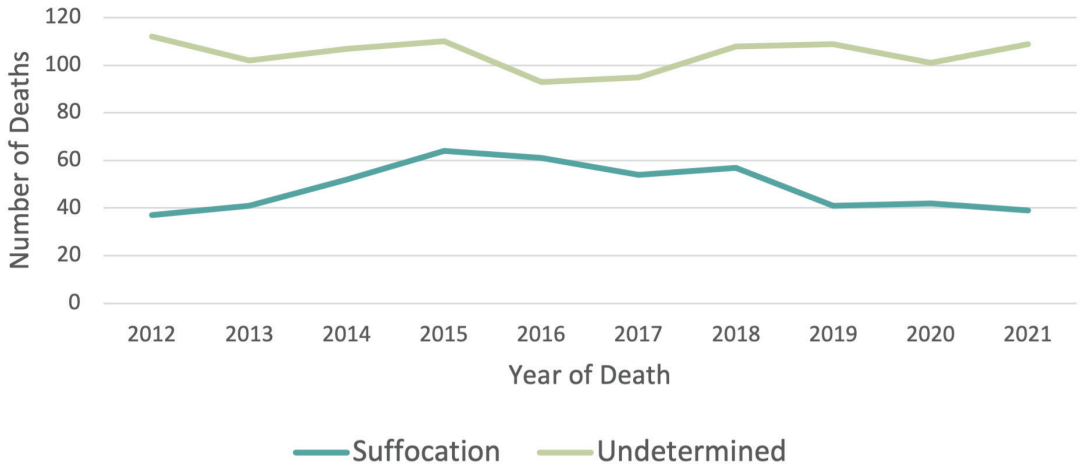
	SUID Category				
	Asphyxia		Undetermined		
Race/Ethnicity	Male	Female	Male	Female	Total
White	7	6	23	10	46
Black	15	6	41	27	89
Hispanic	1	1	1	3	6
Multi-Race	1	2	1	3	7
Total	**24**	**15**	**66**	**43**	**148**

Estimated mortality rates show that Black, non-Hispanic infants were about 2.5 times more likely to die from a sleep-related event than White, NH infants. (“Estimated” rate because not all deaths are reviewed – yielding an underestimate for the mortality rate.) Male infants are also at a slightly higher risk and comprise 61% of SUID deaths.

Fatality review teams determined that 148 reviewed deaths in 2021 were sleep-related.

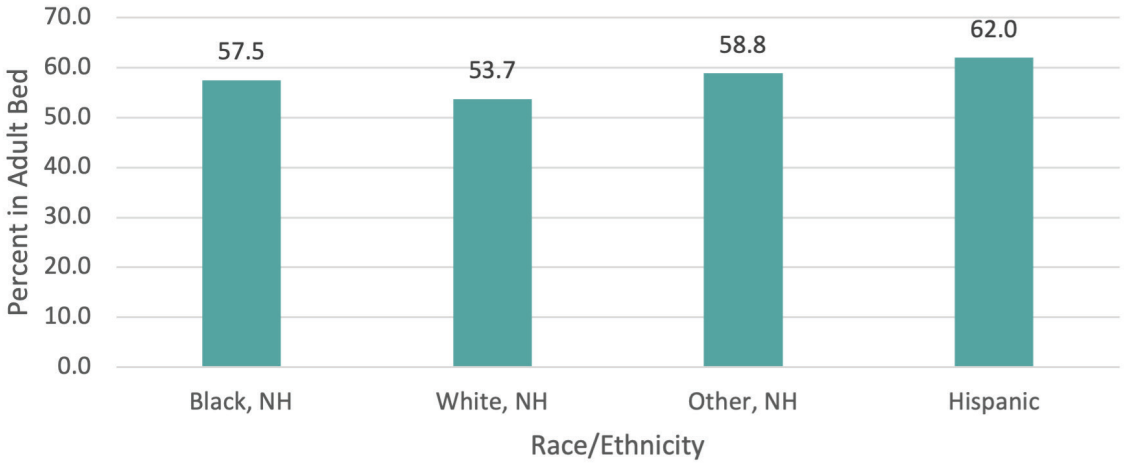
The review process for sleep-related deaths yields four categories for the deaths of infants in a sleep environment. If soft bedding is involved and suffocation is suspected, the cause is considered SUID-Asphyxia (suffocation). The three other SUID categories (SIDS, SUID-Medical, and Undetermined) are combined in "Undetermined" in the following graphic. SUID-Medical indicates that there was some underlying medical condition, but the condition was not determined to be the cause of death. There is some year-to-year fluctuation in SUID, but the count has averaged 153 per year.

Figure 20. Reviewed GA SUID Deaths, by Category, 2012-2021



The risk factors of concern include sleeping position (on back is recommended), sleeping surface (adult bed, crib, other surface), sleeping alone, and soft surfaces/objects on the surface. Over 55% of decedents were reported as sleeping in an adult bed, and the proportion did not vary significantly by race/ethnicity. The presence of a crib in the home (of an infant reported sleeping in an adult bed) was reported for 67% of the Black, NH deaths and 80% of the White, NH deaths.

Figure 21. Proportion of Decedents in Adult Bed, by Race/Ethnicity: Reviewed Deaths



Co-sleeping is a recognized risk factor for sleep-related death – a roll-over, or even a large arm, can block an airway or constrict an infant's chest and compromise breathing. The 10-year review data indicated 74% of the deaths on an adult bed and 57% on other surfaces had a co-sleeping adult. Only 38% of decedents were reported as sleeping alone.

Sleeping on their back has been aggressively promoted for over a generation, but over 60% of decedents were found on their stomach or side. (Fifty-eight percent of decedents were reported as having been put to sleep on their back.) Over 50% of all infants had unsafe sleep surface/bedding reported for each of the three listed variables. Twenty-nine percent were reported with all three of the unsafe conditions.

Summary

There has been a change in the age and cause of death distributions for Georgia infants and youth (<18 years of age) associated with the COVID19 pandemic. The infant mortality rate dropped by 10% from 2019 to 2020, and the rate remained at that low level (6.2 deaths per 1,000 births) in 2021. Most of that decrease was due to a drop in reported deaths in the first day of life for Black / African American newborns. The child (ages 1 through 17) deaths increased during the past two years – from 562 in 2019 to 668 in 2021. The number of deaths defined as "Reviewable" (for Child Fatality Review {CFR}) increased from 480 (2018-2019) to 600 (2020-2021). (All non-medical deaths are considered reviewable.)

Table N. Possible Pandemic-Associated Changes in Number of GA Infant/Child Deaths

		Year of Death			
Cause of Death	**Age Category**	**2018**	**2019**	**2020**	**2021**
Medical	Infant	711	702	587	562
Motor Vehicle	15 to 17	41	33	52	46
Intentional					
Homicide	10 to 14	4	6	18	13
Homicide	15 to 17	37	32	44	50
Suicide	15 to 17	38	41	31	56
Sleep-Related					
SIDS	Infant	104	104	107	101
Suffocation in Bed	Infant	27	33	31	31
Unknown	Infant	22	26	19	48

The medical infant deaths are not generally subject to review, but the CFR teams are charged with the review of all other deaths. Eighty-one percent of reviewable 2021 deaths were reviewed by CFR teams, with 84 teams reviewing all reviewable deaths in their county. The multi-year CFR data base was used to describe the pandemic associated changes noted and to examine risk factors for age, race/ethnicity, and sex for selected cause of death categories. The following provides highlights from those descriptive analyses:

Drowning: The drowning deaths did not show any trends over time, but the multi-year data distinguished two populations with different risk factors and racial distributions. The white toddlers are 2.2 times more likely to drown than black toddlers; but the black 5- to 17-year-old is 3.8 times more likely to drown than a white child. Access to pools and ability to swim may explain some of the observed racial differences.

Motor vehicle incidents: There has been an increase in Black/African American deaths during the first two years of the COVID19 pandemic. The White deaths stayed at about 4 per 100,000, but Black deaths increased to over 6/100,000 in 2021. There are (at least) three distinct prevention target populations:

1. Appropriate restraint use is an issue for passengers of all ages. Over half of passenger decedents in a car, van, SUV, or truck were either not restrained or improperly restrained.

2. Speed, lack of seatbelt use, recklessness and inexperience were top contributing factors to motor vehicle incidents involving teen drivers (about two-thirds male).

3. Pedestrian deaths are distributed across all age groups, with 69% male and 47% Black/African American. Prevention priorities need to be appropriate supervision for the toddlers and awareness of their environment for older youth.

Intentional Injuries: The increase in homicides among Black, 15- to 17-year-old males has been documented. The average number has increased from 14 to 42 per year since 2014. Reduced access to firearms needs to be a prevention priority, but other social/behavioral interventions must be implemented. Infants and toddlers are a different prevention population with biological parents (or caretaker) responsible and blunt force trauma as the mechanism. Prevention approaches include improvement of social support systems, access to parenting training, and more communication among agencies with contact with the infant/toddler.

Black and White youth suicides have displayed similar trends – an increase in 2015, a plateau through 2020, and another increase in 2021. Whites have a higher suicide rate, but the racial difference has narrowed. Prevention needs to address increased sensitivity to warning signs (56% of victims had communicated suicidal thoughts/plans), access to firearms (17 of 152 guns were locked), and use of social media (bullying).

Table O. Average Number of Youth (< 18) Suicides, 2012 - 2021 (GA Death Certificate)			
	2012 - 2014	2015 - 2020	2021
Non-Hispanic			
Black	7.7	15.7	25.0
White	24.0	32.8	48.0
White/Black Ratio	3.1	2.1	1.9

Sleep-Related Deaths: Sudden unexpected infant deaths (SUID) have remained relatively steady over the 10-year period. (The increase in the "Unknown" category in 2021 is suspected to be a reporting anomaly.) Data from the reviewed deaths indicates a high prevalence of recognized risk factors:

Table P. Prevalence of Risk Factors for Sleep-Related Deaths	
	Percent
Stomach or Side Sleep Position	61.1
Sleeping on Adult Bed	56.5
Co-sleeping with Adult	53.1
Soft bedding*	56.0
All 3	29.0

* Pillow and/or Comforter

Maltreatment: Child maltreatment - identified as abuse or neglect causing or contributing to the death, or a reported history of maltreatment – was identified in 29% of the reviewed deaths. The five-year comparison shows a doubling in the number of deaths with neglect reported as causing or contributing to the death and 150% increase in deaths with reported exposure to hazard. We do not know how much of these increases is associated with increased sensitivity to these risks by the review teams. The frequency of a history of maltreatment again highlights the importance of communication among involved agencies. The large increase in reported exposure to hazards (and poor supervision) indicates the need for parent/caregiver education.

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.)

Attachments

Table A. Age and Race/Ethnicity Distribution, GA Deaths Ages < 18, 2019 - 2021						
		Hispanic	Non-Hispanic			
	Age (Yrs)		Black	White	Other	Total
2019	Infant	100	470	286	32	888
	1 to 4	24	76	58	8	166
	5 to 9	8	42	35	7	92
	10 to 14	15	63	50	2	130
	15 to 17	26	68	73	7	174
2020	Infant	76	406	269	20	771
	1 to 4	22	74	54	4	154
	5 to 9	14	47	24	3	88
	10 to 14	23	74	54	7	158
	15 to 17	21	85	78	3	187
2021	Infant	81	400	257	34	772
	1 to 4	20	84	51	13	168
	5 to 9	13	44	33	1	91
	10 to 14	16	81	59	9	165
	15 to 17	34	123	84	3	244
	2021 Totals	164	732	484	60	1,440

	Infant Deaths					
		Hispanic	Non-Hispanic			
	Age (Days)		Black	White	Other	Total
2019	0	40	156	92	10	298
	1 to 6	20	86	60	6	172
	7 to 27	10	60	43	3	116
	28 to 365	30	168	91	13	302
2020	0	23	111	77	9	220
	1 to 6	12	87	49	5	153
	7 to 27	11	51	40	2	104
	28 to 365	30	157	103	4	294
2021	0	30	111	68	5	214
	1 to 6	17	51	51	7	126
	7 to 27	9	58	40	7	114
	28 to 365	25	180	98	15	318

Table B. Infant Mortality Decrease, Age < 1 Day, 2018/'9 to 2020/'1				
	Black Non-Hispanic		**White Non-Hispanic**	
	2018-2019	2020-2021	2018-2019	2020-2021
PregProb	74	37	22	20
IUG	191	120	69	48
Resp	39	25	19	20
Cong	43	29	47	48
Other	16	10	6	8
Totals	363	221	163	144
% Decrease		39.1		11.7
	Other Non-Hispanic		**Hispanic**	
	2018-2019	2020-2021	2018-2019	2020-2021
PregProb	4	1	12	7
IUG	8	7	32	25
Resp	1		5	5
Cong		4	13	10
Other		2	3	6
Totals	13	14	65	53
% Decrease				18.5

Cause Category Definitions		
Label	ICD10 Range	Description
PregProb	P00 - P04	Maternal factors and complications of pregnancy, labor, and delivery
IUG	P05 - P08	Disorders related to length of gestation and fetal growth
Resp	P20 - P29	Respiratory and cardiovascular disorders of the perinatal period
Cong	Q00 - Q99	Congenital malformations
Other		All other medical causes

Table C. Counties with Un-Reviewed Deaths, 2021								
		Reviewable		Not Reviewable				
County	All Reviewable	Reviewed	Not Reviewed	Reviewed	Not Reviewed	CoFIPS	Label*	Category
Fulton	58	28	30	4	72	13121	58/28	2
DeKalb	49	43	6	7	50	13089	49/43	2
Cobb	22	15	7	1	46	13067	22/15	2
Chatham	19	11	8	1	22	13051	19/11	2
Glynn	11	1	10		3	13127	11/1	2
Troup	7	6	1		8	13285	7/6	2
Bulloch	6	5	1		3	13031	6/5	2
Camden	5	3	2		3	13039	5/3	2
Floyd	5	2	3		5	13115	5/2	2
Douglas	4	3	1	2	12	13097	4/3	2
Habersham	4	3	1		2	13137	4/3	2
Pike	4	3	1			13231	4/3	2
Burke	3	2	1	1		13033	3/2	2
Decatur	3	2	1	2	2	13087	3/2	2
Tift	3	1	2	1	5	13277	3/1	2
Walker	3	2	1	1	4	13295	3/2	2
Catoosa	2	1	1	1	6	13047	2/1	2
Chattooga	2	1	1		1	13055	2/1	2
Murray	2	1	1		5	13213	2/1	2
Sumter	2	1	1		1	13261	2/1	2
Liberty	7	0	7		9	13179	7/0	3
Fayette	5	0	5		7	13113	5/0	3
Baldwin	4	0	4	1	2	13009	4/0	3
Greene	4	0	4		1	13133	4/0	3
Bryan	3	0	3			13029	3/0	3
Grady	2	0	2		1	13131	2/0	3
Morgan	2	0	2			13211	2/0	3
Putnam	2	0	2			13237	2/0	3
Baker	1	0	1			13007	1/0	3
Coffee	1	0	1		5	13069	1/0	3
Evans	1	0	1		3	13109	1/0	3
Jasper	1	0	1			13159	1/0	3
Long	1	0	1		2	13183	1/0	3
McIntosh	1	0	1			13191	1/0	3
Mitchell	1	0	1		1	13205	1/0	3
Towns	1	0	1			13281	1/0	3
Wayne	1	0	1		2	13305	1/0	3

Label* = All Reviewable / Reviewable Reviewed

Table D. Child Fatality Review Team Determination of Preventability: 2021 Reviewed Deaths						
		Could the death have been prevented?				
	Cause of Death	Missing	No, probably not	Yes, probably	Undetermined	%Preventable
Unintentional						
	Motor Vehicle Crash		9	87	10	90.6
	Drowning		1	23		95.8
	Other Unintentional		7	39	10	84.8
Intentional						
	Homicide	1	8	73	6	90.1
	Suicide		8	52	16	86.7
	Sleep-Related	1	15	102	30	87.2
	Medical		63	9	24	12.5
	Undetermined		2	10	7	81.8
	Total		**113**	**395**		**77.8**

Table E. GA Resident Drowning Deaths, Ages 0 – 17, 2012 – 2021

		White, Non-Hispanic		Black, Non-Hispanic		Other Non-Hispanic		Hispanic		
Age Group		Male	Female	Male	Female	Male	Female	Male	Female	Totals
No Review										
	Infant		1		1		1			3
	1 - 4	15	4	3	2		1		1	26
	5 - 9	1	1	6	3		1	2		14
	10 - 14		1	4	2			3		10
	15 - 17	1	1	4	1				1	8
	Total	17	8	17	9		3	5	2	61
Reviewed										
	Infant	4	1	2	1				1	9
	1 - 4	60	35	23	13	2		10	3	146
	5 - 9	10	5	23	7	2		1	4	52
	10 - 14	5	3	21	7	1		2		39
	15 - 17	9		18		1		11		39
	Total	**88**	**44**	**87**	**28**	**6**		**24**	**8**	**285**
	% Reviewed	**83.8**	**84.6**	**83.7**	**75.7**			**82.8**		**82.4**

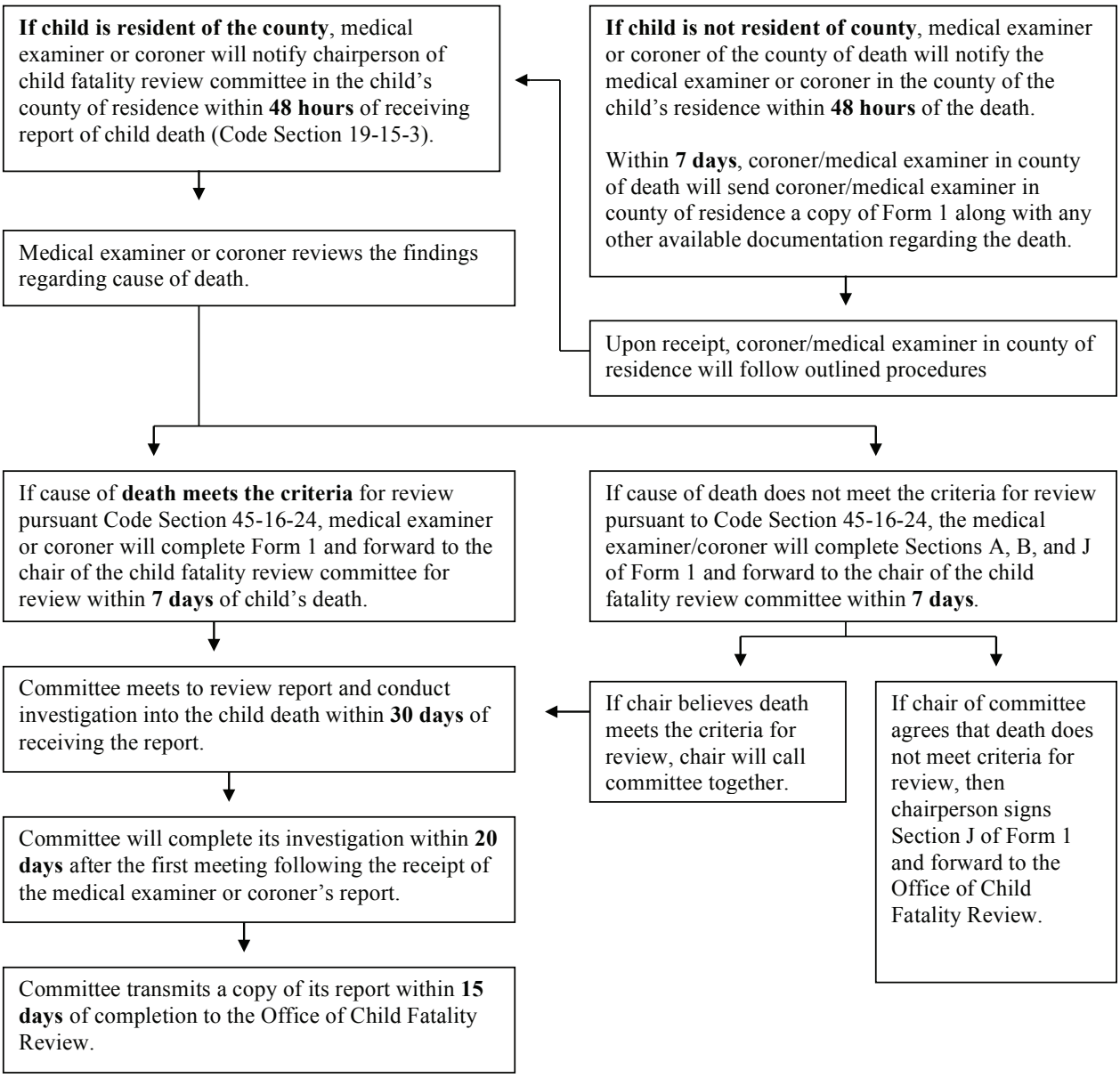
Table F. Reviewed Motor Vehicle Crash Deaths (Ages < 18), GA Residents, 2021

	White, Non-Hispanic		Black, Non-Hispanic		Hispanic & Other Race			
	Male	Female	Male	Female	Male	Female	Total	%Male
Infant	1		2	3	1	1	8	
1 - 4	4	3	5	4	2	1	19	57.9
5 - 9	8		5	1	1		15	93.3
10 - 14	5	6	6	4	2	1	24	54.2
15 - 17	9	6	11	6	6	2	40	65.0
Total	**27**	**15**	**29**	**18**	**12**	**5**	**106**	**64.2**

Table G. Reviewed GA Intentional Injury Deaths, 2012 - 2021: by Race/Ethnicity, Age Category, and Mechanism							
		Black, Non-Hispanic			White, Non-Hispanic		
	Mechanism	Toddler	Child	Teen	Toddler	Child	Teen
Homicide							
	Blunt Force Trauma	107	10	3	44	3	1
	Burns	1			1		
	Drowning	3	2		2		1
	Fire	1					
	Firearm	14	54	206	5	15	26
	Hanging	2			1		
	Heat	1					
	Knife	7	4	8		2	4
	Maltreatment	13	2	1	1		
	Medical Neglect		1		1		
	Motor Vehicle	2					1
	Other				2		
	Poison	10			6		
	Strangulation	10		2	4	1	1
	Suffocation	1		1	2		
	Undetermined	7		1	2	1	
	Total	179	73	222	71	22	34
Suicide							
	Fall		1	1			6
	Fire						1
	Firearm		19	46		47	107
	Hanging		34	19		40	68
	Poison		5	3		3	13
	Total		**59**	**69**		**90**	**195**

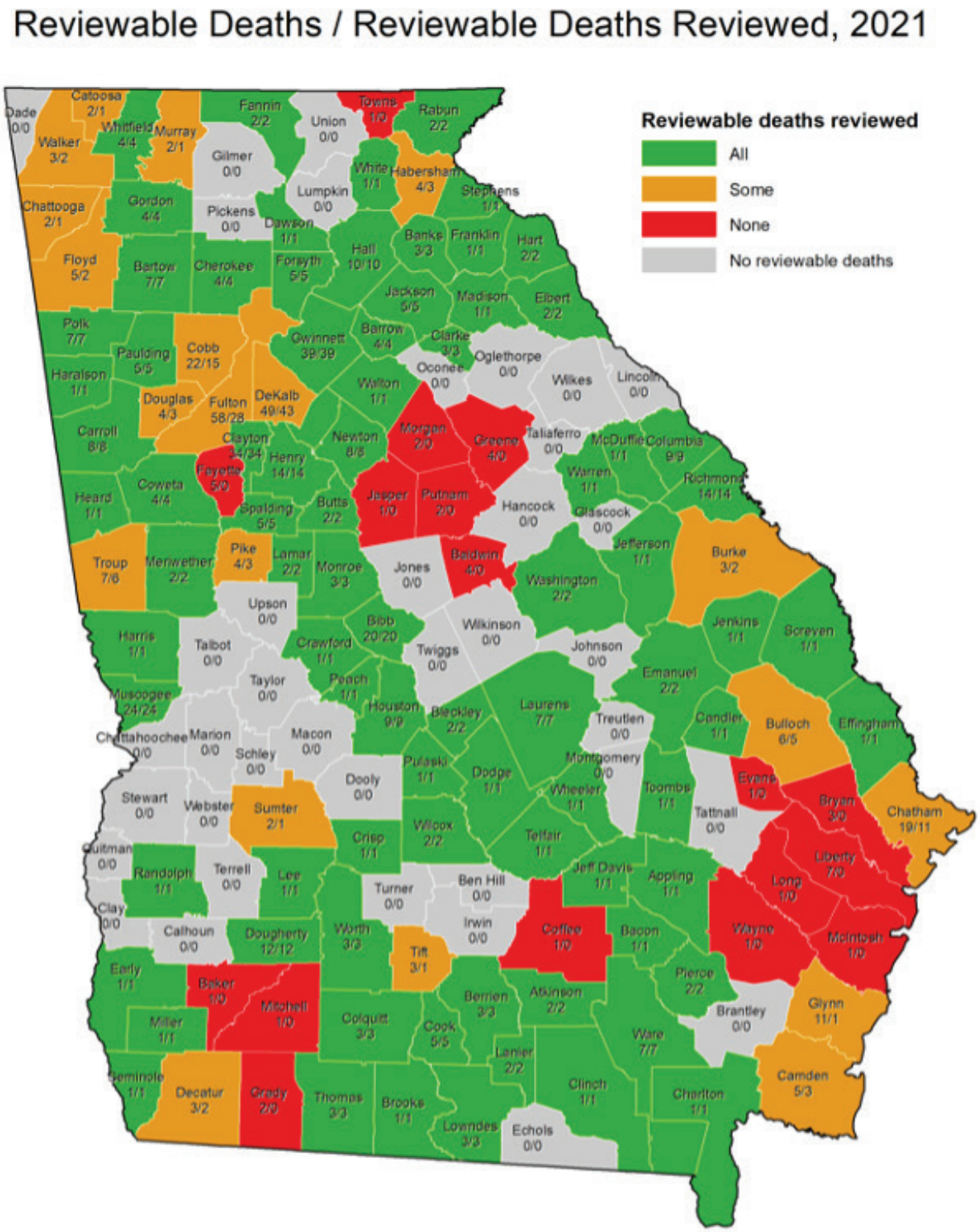
Appendix A

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



Conclusion

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.

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 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

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Decatur, GA 30034

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Georgia Child Fatality Review Panel Annual Report

CALENDAR YEAR 2021