Child Fatality Review Process

The new Child Fatality Review Process is focused on reducing and/or eliminating maltreatment-related child fatalities in Georgia. It was developed in partnership with Georgia's Office of the Child Advocate (OCA) and the National Partnership for Child Safety.

STEP 01

Notify all entities

DFCS county staff complete **the Child Fatality Report in SHINES**, the state's automated child welfare information system, within 24 hours of receiving a screened-in report of a child fatality. This report captures information readily available and relevant to the intake and preliminary stages of the investigation.

The report is sent to Senior Leadership, the **Child Death and Serious Injury** (CDSI) Review Team, the **Georgia Bureau of Investigation** and **OCA**.

STEP 02

Ensure well-being

In recognition of the potential trauma front-line staff may experience when involved in a child fatality case, **regional and/or county-level protocols** have been established **to guide the provision of timely supports and services** to impacted individuals.

STEP 03

Provide assistance

The CDSI review team will, upon request, **provide consultation on complex cases** during active investigations.

Additionally, if guidance is needed to provide clarifying information regarding Child Death, Near Fatality, or Serious Injury notification forms, the CDSI review team is available to provide assistance.

STEP 04

Debrief stakeholders

After completing an investigation **involving a case** that was open at the time of the fatality or **when a family had history with DFCS** during the previous two years, a member of the CDSI review team or OCA will conduct one-on-one debriefings with professionals. Debriefs will be guided by the **Safe Systems Improvement Tool** (SSIT). Information shared during debriefs is confidential.

Findings will be aggregated to inform quality improvement efforts.

STEP 05

Facilitate teaming

Division staff and various stakeholders will convene periodically **to conduct multidisciplinary reviews** of select child death cases.

This will **help identify system-level deficits** and, more importantly, highlight opportunities to develop strategies to reduce and ultimately eliminate child maltreatment and maltreatment-related fatalities.