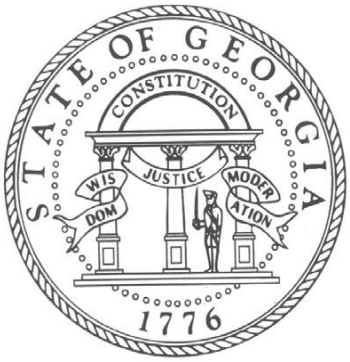


GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES 2013 CHILD FATALITY ANALYSIS

Nathan Deal, Governor

Bobby D. Cagle, Interim Director

DFCS VISION, MISSION AND CORE VALUES

Vision

Stronger Families for a Stronger Georgia

Mission

Strengthen Georgia by providing Individuals and Families access to services that promote self-sufficiency, independence, and protect Georgia's vulnerable children and adults.

Core Values

- **Provide access to resources that offer support and empower Georgians and their families.**
- **Deliver services professionally and treat all clients with dignity and respect.**
- **Manage business operations effectively and efficiently by aligning resources across the agency.**
- **Promote accountability, transparency and quality in all services we deliver and programs we administer.**
- **Develop our employees at all levels of the agency.**

TABLE OF CONTENTS

PURPOSE OF THE CHILD FATALITY ANALYSIS

As the main state agency charged with intervening on behalf of vulnerable children in Georgia, the Division of Family and Children Services (DFCS) must continually review its practice and inform the public of its efforts to mitigate and reduce the risk of child abuse and neglect in Georgia.

The data included in the *2013 Child Fatality Analysis* details the manners and causes of death for children whose families had been the subject of a report or investigation of maltreatment in Georgia in the last five years.[1] Through this report, the agency endeavors to provide information over and above the federal requirements[2] for states to review and analyze child fatalities, and offer additional insight on a specific population with previously reported or identified risks of abuse and/or neglect.

For a child's death to be included in this report, the child must have been in the custody of DFCS or his or her family must have had Child Protective Services history with DFCS within the previous 5 years. Child Protective Services history covers a wide array of potential encounters between DFCS and a family, ranging from a report that did not rise to the level of agency intervention to intensive involvement with the family. Such historical context can provide further insight into risk factors and circumstances surrounding a child's death. These previously identified risk factors – such as allegations of domestic violence and substance abuse – factored in with the details of a child's death, may yield an understanding that improves the agency's intervention efforts and overall child safety in Georgia.

The information that follows is meant to supplement the work of the Georgia Child Fatality Review, aiding the agency and the public in improving intervention efforts and developing community-based solutions to reduce the risk of harm to Georgia's children.

---

[1] *Official Code of Georgia (O.C.G.A.) §15-11-741* defines a child as "an individual receiving protective services from DFCS, for whom DFCS has an open case file, or who has been, or whose siblings, parents, or other caretakers have been, the subject of a report to DFCS within the previous 5 years."[1]

[2] Per 42 U.S. C. Sec. 5106a(b)(2)(B)(x) of the Child Abuse Prevention and Treatment Act.

METHODOLOGY OF THE FATALITY ANALYSIS

Since 2011, the Division has sought to improve data collection methods and strengthen reporting mechanisms for child deaths with DFCS history.

Recent efforts to engage external stakeholders on the need to obtain accurate data on the deaths of children with DFCS history have resulted in more consistent reporting of child deaths that may not have routinely been reported in the past.

This collaboration has improved the agency's collection of child death data in Georgia, and will result in a more comprehensive analysis of agency practice going forward. Additionally, DFCS' child death review team has aggressively pursued policy requirements regarding the reporting of child deaths, thereby improving data collection.

The *2013 Child Fatality Analysis* is the second such report published by the Division. This report reflects data collected on child deaths that occurred between January 1, 2013 and December 31, 2013 and were reported to DFCS by local Child Fatality Review committees, employees of local DFCS offices or other external partners, including law enforcement and medical personnel.

All deaths included in this report were of children whose families had prior contact with the agency within the last five years.

Data for the *2013 Child Fatality Analysis* was compiled and reviewed in June and July of 2014. This is a change from the Division's *2012 Child Death Report*, which was completed during the first three months of 2013 when data elements for some deaths were not available.

In 2014, the Division will continue to enhance data collection methods and improve collaborations with community agencies and law enforcement to develop a more consistent protocol for making DFCS aware of child deaths.

SUMMARY OF STATISTICS

Between January 1 and December 31, 2013, the deaths of **180** children whose families had prior DFCS history were reported to the agency.

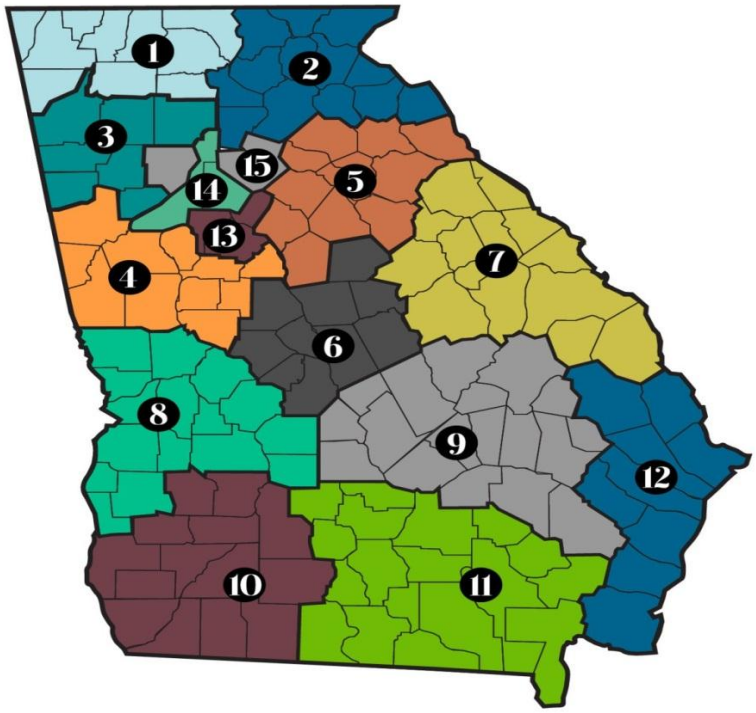
- **63** percent of these deaths were determined to be a result of natural causes and unintentional injuries. For the remaining deaths, manners were either undetermined or ruled as homicides or suicides. *(Figure 3.1)*
- **23** percent of deaths were infants whose cause of death was sleep related. *(Page 12)*
- **48** percent of the deaths were of children under the age of 1. *(Table 3.1)*
- **42** percent of the deaths were of children whose families had an open case at the time of their deaths. Of these, **77** percent of the cases were open as a result of the incident that led to the child's death. *(Tables 4.1 and 4.2)*

The following data provides a snapshot of the Division's overall Child Protective Services response for 2013:

- The total number of reports to DFCS: **76,995**
- The total number of reports assigned to a caseworker: **54,101**
- The total number of children in foster care at some point in 2013: **13,067**
- The total number of Family Preservation[3] cases: **6,057**
- The total number of child deaths in the state of Georgia (per the Georgia Department of Public Health): **1,475**[4]
- The total number of deaths reported to DFCS: **317**[5]

[3] Family Preservation cases are opened following an investigation where maltreatment may have been present but the identified safety threat has been either mitigated or eliminated, meaning the children can safely remain in the home. In these cases, DFCS develops a safety plan to address identified concerns. The goal of the plan is to keep the family together, utilizing a wide array of services, involvement of family members, to find solutions that guarantee the safety of the children.
[4] Public Health data is an estimate based on preliminary data.
[5] 180 of whose families had prior history with the DFCS.

***Figure 2.1* – DFCS Regions:**



DFCS is currently divided into 15 regions, which cover all 159 counties throughout the state (*see Figure 2.1 at left*). Each county office is responsible for providing reports directly to the state office when a child fatality is reported in their county and the child (or family) has had prior DFCS involvement.

***Table 2.1* – Below is a comparison of deaths within each region for CY2012 and CY2013.**

Region	Counties Within the Region	Total Number of Fatalities for CY2013	Total Number of Fatalities for CY2012
1	Catoosa, Chattooga, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield	8	6
2	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	16	8
3	Bartow, Cherokee, Douglas, Floyd, Haralson, Paulding, Polk	11	9
4	Butts, Carroll, Coweta, Fayette, Heard, Lamar, Meriwether, Pike, Spalding, Troup, Upson	13	15
5	Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton	8	6
6	Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson	10	13

Region	Counties Within the Region	Total Number of Fatalities for CY2013	Total Number of Fatalities for CY2012
7	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	8	9
8	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster	11	7
9	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox	10	5
10	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	10	16
11	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware	14	12
12	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh	15	9
13	Clayton, Henry, Rockdale	14	11
14	DeKalb, Fulton	25	18
15	Cobb, Gwinnett	7	8
Totals	Statewide	180	152

Figure 2.2 **-- Child Fatalities by Month:**

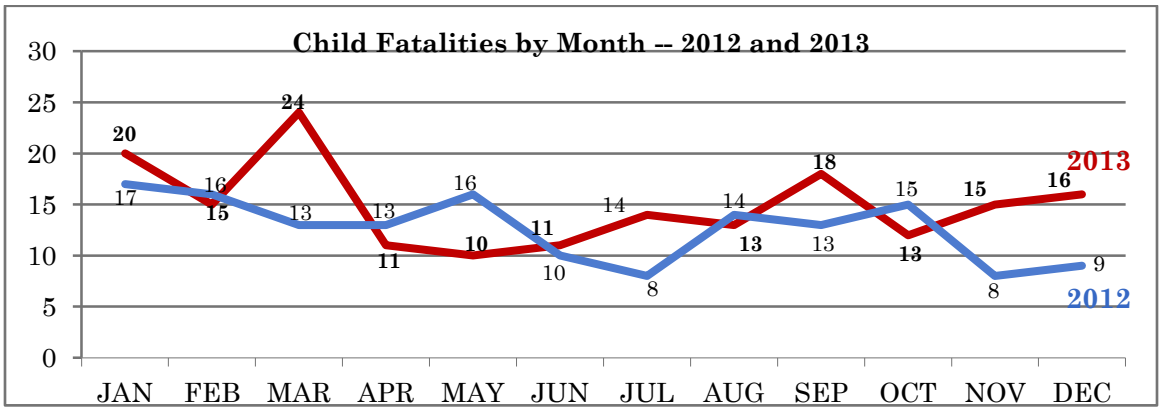


Table 2.2 **– Ages of Children at the Time of Death:**

Age of Child at Time of Death	Number of Children in 2013	Percentage of Child Deaths in 2013	Number of Children in 2012	Percentage of Child Deaths in 2012
0-6 months	64	36%	58	38%
6-12 months	22	12%	20	13%
1	18	10%	12	8%
2	9	5%	12	8%
3	8	4%	5	3%
4	8	4%	7	5%
5	4	2%	3	2%
6	4	2%	0	0%
7	3	2%	3	2%
8	0	0%	0	0%
9	6	3%	2	1%
10	4	2%	4	3%
11	2	1%	0	0%
12	3	2%	6	4%
13	5	3%	4	3%
14	3	2%	2	1%
15	3	2%	3	2%
16	8	4%	7	5%
17	6	3%	4	3%

Note: Further detail regarding the deaths of children under the age of 1 will be provided later in the analysis.

CLASSIFICATION OF CHILD FATALITIES BY CAUSE AND MANNER

Defining the Causes and Manners of Death:

To better understand the appropriate context related to child fatalities, it is important to know how the causes and manners of death are defined.

The **Cause of Death** refers to a specific forensic finding of how the death occurred (e.g. drowning, gunshot, suffocation, Sudden Unexpected Infant Death Syndrome, etc.).

The **Manner of Death** is an official classification by a coroner or Medical Examiner of how the cause of death occurred. Each manner of death included in this report is individually defined below. Definitions were provided by the Georgia Bureau of Investigation. Note that within each manner of death, there are multiple causes of death. Additionally, it is important to note than an official cause and manner of death does not necessarily always correlate with whether there was a finding of abuse or neglect. For example, a child may die as a result of an accident (such as a drowning) but maltreatment may also be found in that a caretaker's actions (substance use) or inaction (lack of supervision) may have indirectly resulted in the death of the child.

- **Accident**: This classification is due to an unintended death -- there is no evidence of intent to harm.
  - Examples:
    - Unintentional hanging while playing on a rope swing.
    - House fires.
    - Asphyxiation of an infant while sleeping in a crib.
- **Homicide**: This classification is due to a volitional act of another person with the intent to cause fear, harm or death. *It is important to note this classification does not always indicate a criminal homicide, which is determined by the legal process and not by the certifier of death. Thus, murders are always homicides but homicides are not always murders.*
  - Example:
    - Children who were placed in foster care after being critically injured by acts committed by their caretakers. These children died as a result of the injuries sustained prior to being placed

in foster care. Some children in this category had no prior DFCS history before the injury that led to their deaths, and some children had a delayed death due to their injuries.

- **Natural**: This classification is due to diseases or medical conditions.
  - Examples:
    - Children who were born prematurely and developed medical conditions due to their lack of development.
    - Children who were diagnosed with diseases such as Leukemia or Cerebral Palsy, and whose deaths were due to complications from these medical conditions.
    - Many SIDS (Sudden Infant Death Syndrome) causes are categorized as natural deaths.
- **Suicide**: This classification is due to an injury that is intentionally self-inflicted.
  - Examples:
    - A child who hangs him or herself;
    - A self-inflicted gunshot wound.
- **Undetermined**: This specific classification is given when there is inadequate information regarding the circumstances of death to determine manner, or there are multiple possibilities and not a preponderance of information or evidence available to definitively choose one.
  - Examples:
    - Several of the undetermined deaths were children less than 1 year of age whose deaths occurred during a sleep-related incident;
    - Children who die as a result of a house fire with an unknown cause may be classified with this manner;
    - Many SUIDS (Sudden Unexpected Infant Death) causes are captured in this manner.

Figures 3.1 and 3.2 **-- Manners of Death by Percentage:**

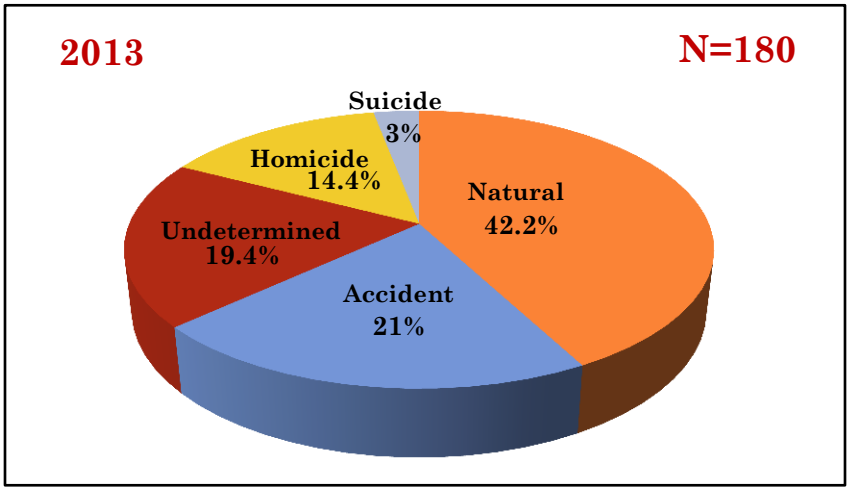


Figure 3.1

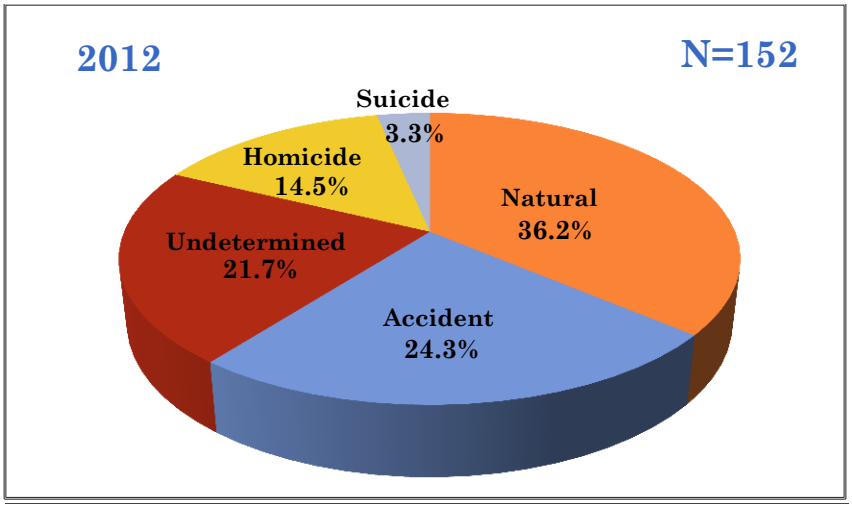


Figure 3.2

***Table 3.1* – Manners of Death in 2013 for Children under the Age of One:**

Age	Accident	Homicide	Natural	Undetermined
0-6 months for 2013	**7**	**4**	**27**	**26**
0-6 months for 2012	**12**	**2**	**20**	**25**
6-12 months for 2013	**3**	**5**	**9**	**5**
6-12 months for 2012	**6**	**0**	**10**	**3**
Total Number for 2013	**10**	**9**	**36**	**31**
Total Number for 2012	**18**	**2**	**30**	**28**

Sleep Related Deaths and Children Under the Age of One:

Twenty-six (26) of the undetermined deaths, nine (9) of the natural deaths, and seven (7) of the accidental deaths occurred while the child was sleeping. This accounts for 23% of all deaths in 2013, and nearly half of deaths for children under the age of one. Co-sleeping with siblings or adults, or unsafe sleeping environments, such as a sofa, car seat or a crib with blankets and pillows, may have been a contributing factor in the deaths.

In 2012, 57 of the 152 deaths were sleep-related. After co-sleeping was identified as a trend in sleep-related deaths, the Division developed a campaign to educate families on the dangers of co-sleeping and the importance of safe sleep habits.

Table 3.3 **– Manners of Death by Region:**

Region	Natural	Accident	Homicide	Suicide	Undetermined
1	4	1	0	0	3
2	5	3	2	2	4
3	3	5	3	0	0
4	4	1	2	1	5
5	3	2	0	0	3
6	3	3	2	0	2
7	5	0	0	1	2
8	6	0	1	0	4
9	5	2	1	0	2
10	5	3	2	0	0
11	5	4	2	1	2
12	6	4	4	0	1
13	3	5	2	1	3
14	16	4	1	0	4
15	3	0	4	0	0
2013 Totals	76	37	26	6	35
2012 Totals	55	37	22	5	33

Causes of Death by Year:

Table 3.4 **Natural – This classification is due to natural disease processes.**

Natural	Total for Each Cause in 2013	Total for Each Cause in 2012
Congenital or pre-existing medical condition and/or contracted illness/condition	68	43
SIDS/SUIDS	6	6
Other	2	6
Total	76	55

Table 3.5 **Suicide -- This classification is due to an injury that occurred with the intent to induce self-harm or cause one's own death.**

Suicide	Total for Each Cause in 2013	Total for Each Cause in 2012
Gunshot	4	2
Hanging	2	2
Overdose	0	1
Total	6	5

Table 3.6 **Accident – This classification is due to an injury when there is no evidence of intent to harm.**

Accident	Total for Each Cause in 2013	Total for Each Cause in 2012
House fire/smoke inhalation	8	4
Asphyxia	8	4
Motor Vehicle Accident	6	0
Drowning	5	7
Run over by Motor Vehicle	5	3
Sleep-related Suffocation	0	13
Other	5	6
Total	37	37

Table 3.7 **Undetermined -- This classification is given when there is inadequate information regarding the circumstances of death to determine manner.**

Undetermined	Total for Each Cause in 2013	Total for Each Cause in 2012
Undetermined	12	10
SUIDS	20	17
Smoke Inhalation	3	0
Other	0	6
Total	35	33

Table 3.8 **Homicide -- This classification is due to a volitional act of another person with the intent to cause fear, harm or death.**

Homicide	Total for Each Cause in 2013	Total for Each Cause in 2012
Blunt Force Head Trauma	13	7
Gunshot	6	6
Multiple Blunt Force Injuries	3	3
Traumatic Brain Injury	2	0
Other	2	6
Total	26	22

CHILD FATALITIES AND PRIOR DFCS INVOLVEMENT

CPS history always originates from the parents or caregivers, and includes anything from a screened-out report to intensive family interventions. Any report that does not meet Georgia statute and DFCS policy requirements for child abuse and/or neglect is screened out and not acted on further by the agency.[6] For the purposes of this report, DFCS history does include families where the only history was a screened-out report. While each child included in this report had parents or caregivers with a history of DFCS involvement, the child who died may or may not have been a part of that history. For 29 of the children listed below, DFCS' prior involvement pre-dated the birth of the child. In other instances, the child may have been placed in foster care due to injuries sustained by the parent or caregiver, but then later died from those injuries. While there may not have been history prior to the foster care placement, the case was open due to the necessity for placement at the time of death. That child would therefore be included in this report.

Table 4.1 **-- Below is a breakdown by manner of death and length of time between prior DFCS involvement and child fatalities for CY2012 and CY2013.**

Length of Time between Prior DFCS Involvement with the Family & Child's Death	Homicide	Suicide	Accident	Natural	Undetermined	Totals for 2013	Totals for 2012
0-12 months*	20	3	24	55	24	126	87
13-24 months	1	2	8	14	5	30	39
25-36 months	3	0	3	2	0	8	15
37-48 months	2	1	2	3	2	10	4
49-60 months	0	0	0	2	4	6	7

[6] If a report does not meet Georgia statute and DFCS policy requirements for child abuse or neglect, but indicates the family has unmet needs that are not related to safety, DFCS will refer the family to community resources that could provide needed support.

Table 4.2 **-- 2013 fatalities when there was an open case at the time of death.[7]**

Length of Time in 2013 between Prior DFCS Involvement with Family & Child's Death	Homicide	Suicide	Accident	Natural	Undetermined
Case open prior to incident that led to the death	4	1	6	34	12
Case open due to incident that led to the death	9	0	3	6	0
Total number of open cases	13	1	9	40	12

Table 4.3 **-- Type of DFCS history for deaths that occurred in 2012 and 2013.[8]**

DFCS History Type	Totals for 2013	Totals for 2012
Investigation for abuse or neglect	132	84
Family Preservation	44	23
Family Support Services (practice began April 1, 2012)	44	9
Previous Diversion case (practice ended March 31, 2012)	55	66
Case open at the time of death	75	48
Children in foster care at death	21	13

[7] It is important to note that in 2013 there were 75 children with open DFCS cases at the time of their death. This includes those children who had been placed in foster care and then died from the injuries related to the abuse that caused them to be placed in care and cases that were opened unrelated to the child's death. Table 4.2 is a subset of the 126 deaths that occurred within 0-12 months of agency contact, as detailed in Table 4.1.

[8] The total number of types of DFCS prior history is higher than the total number of child deaths for the year. This is due to the fact that some of the families had more than one type of prior history with DFCS; for example, the family may have had a prior investigation as well as a prior Diversion or Family Support case.[8]

CONCLUSION

The Georgia Division of Family and Children Services, in collaboration with stakeholders and other partner agencies, has taken and will continue to take proactive measures to learn from *every* child fatality. DFCS has committed to analyzing and evaluating these cases to identify trends, ensure sound practice and policy, increase prevention awareness, and train staff to respond thoroughly and appropriately to all reports of child maltreatment. For the CY2013 report, DFCS and external stakeholders conducted an in-depth staffing on 114 reported child deaths with identified DFCS history and an allegation of maltreatment. The purpose of the case staffing is to enhance policy and practice and improve intervention efforts for families with identified risk factors.

Preliminary Findings and Lessons Learned:

The data show that of the 180[9] children:

- **67** children had been classified as having special medical needs; **12** infants died of natural causes and never left the hospital after birth.
- **42** of the deaths were sleep related;
- **78** children had caretakers who were alleged to be using drugs at some time during the agency's involvement with the family;
- **54** children were in families where domestic violence (DV) had been indicated (due to a reluctance to disclose DV, this number could be underreported and may actually be higher);
- **48** children had a prior substantiated finding of child abuse and neglect[10];
- **56** children had a substantiated finding in relation to their deaths;

[9] The total number for the bullet points above add up to more than 180, as several of the points mentioned applied to many of the fatalities.
[10] According to DFCS policy, a substantiated finding is when "an investigation disposition by an abuse investigator concludes that the allegation of maltreatment, as defined by state law and CPS requirements, is supported by a preponderance of the evidence." [Source: *http://www.odis.dhr.state.ga.us/3000_fam/3030_cps/manuals/chapter4/2104_23.doc*]

Critical Considerations in the Assessment of Child Fatalities:

Children Younger than Two:
Fifty-eight percent (58%) of the deaths in 2013 occurred in children younger than 2 years of age. Investigating case managers must assess nonverbal children carefully utilizing both a visual assessment and pertinent corroborating evidence. The assessment of nonverbal children is an area of emphasis for the Agency. Case managers are receiving specialized training to increase this skill set.

Substance Abuse:
Caretaker substance abuse continues to be a contributing factor in child safety. Effectively assessing whether a substance-abusing caretaker is adequately equipped to care for a child is challenging for case managers. Denial of drug use by caretakers often detracts from the assessment process and can influence a case outcome. Gathering supportive evidence, including drug testing, remains a critical component of ensuring child safety.

Historical Context:
The child protective service (CPS) history must always be reviewed and integrated into the current assessment for child safety. When prior CPS history is not thoroughly reviewed, a meaningful historical context cannot be created and valuable information may be overlooked. Reviewing prior history and incorporating it into the assessment provides a comprehensive evaluation of family functioning.

Verification of Evidence:
Case managers are expected to verify evidence collected during assessments. Validation of information, including contact with collaterals and reporters, assists the agency in being able to make sound overall safety determinations. Before cases are closed, the reviewing entity needs to ensure that all discrepancies found during the assessment have been clarified. Case managers may be too deferential to a parent's account of a situation and will sometimes disregard a child's statement. Children must be taken seriously and the information they provide is critical to assessing their safety.

Recommendations for Future Reports:

Improving Data Reporting Methods:
DFCS is currently enhancing our internal child fatality review team to include experts in data collection and trend analysis.

Action Items:

Developing predictive analytics to guide new child death and serious injury model:
DFCS in partnership with Barton Child Law and Policy Center is exploring a variety of predictive analytics models that will assist the agency with identifying risk factors and improving intervention efforts to ensure the safety of Georgia's children.

Strengthening case managers' interviewing and assessment skills through specialized training:
In partnership with the Children's Advocacy Centers of Georgia, mandatory training has been developed and implemented for frontline staff and supervisors to enhance interviewing techniques. These improved skills will strengthen agency assessments of family functioning.

Collaborating with experts to improve care for medically-fragile children:
DFCS is committed to a continued and enhanced collaboration with Children's Healthcare of Atlanta (CHOA) and entities such as Child Kind to improve its assessments of medically-fragile children, as well as training for frontline workers and foster families caring for these children.

Data Collection and Evaluation:
Georgia DFCS continues to collaborate with other state partners, such as the Office of the Child Advocate, Public Health, Children's Healthcare of Atlanta and the Georgia Bureau of Investigation, in order to gather accurate and complete data on the families and children we encounter. This multi-disciplinary approach is progressive and the shared investment of all of the agencies helps provide a comprehensive analysis of ways to offer assistance to at-risk families.