

Division of Family & Children Services  
Quarterly Child Death Analysis:  
January - September 30, 2012

Date of Presentation: November 2, 2012



Georgia Department of Human Services

# 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*

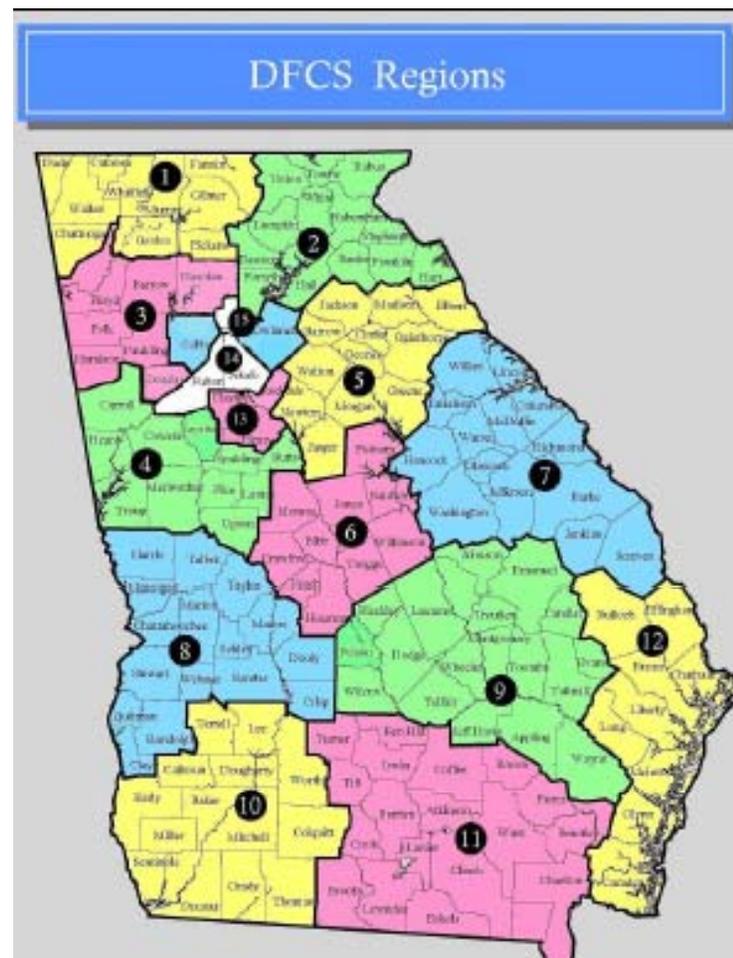
- Provide access to resources that offer support and empower Georgians and their families.
- Deliver services professionally and treat all clients with dignity and respect. Manage business operations effectively and efficiently by aligning resources across the agency.
- Promote accountability, transparency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

## Summary : Child Deaths with DFCS Prior History (N=120)

- Between January 1, 2012 and September 30, 2012 there were 120 child deaths in families with prior DFCS history.
- January had more deaths than any other month, with 17, followed by 16 deaths in February and May.
- The most frequent deaths were natural and accidental; sleep-related deaths were the leading cause of death.
- Boys were more likely to be victims than girls (56% were boys at 44% were girls).
- Prior DFCS Involvement: 54% had a previous investigation; 47% had a previous diversion and 38% of the cases were open at the time of the death of the child.
- There were ten children in DFCS custody at the time of their death; all except one had serious medical conditions that led or contributed to their deaths.

# Summary : Child Deaths with DFCS Prior History (N=120)

- Over half of the deaths occurred in five DFCS regions (4, 10, 11, 13, and 14);
- The counties with the highest number of deaths are Fulton, Clayton and Dougherty counties, with 10, 9 and 6 deaths respectively.



# Child Death Trend by Quarter for Calendar Year 2012

Quarter	Number of Deaths
Quarter 1: Jan - March 2012	46
Quarter 2: April - June 2012	39
Quarter 3: July - Sept 2012	35
<i>Total Deaths with DFCS prior History</i>	<i>120</i>

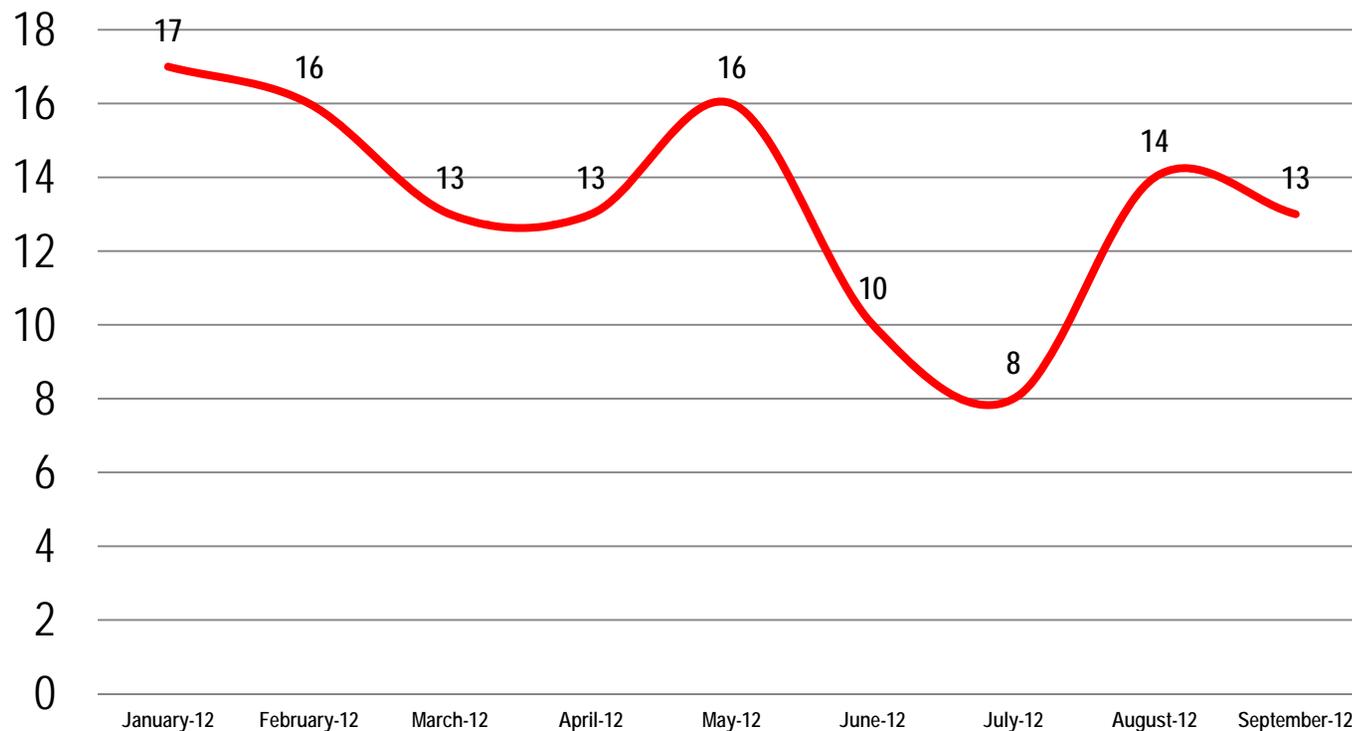
The DFCS Collaborative Partners Section reviewed over 150 child death reports from January 1, 2012 through September 30, 2012. Of those reports, 120 of them had DFCS history prior to child's death.



Note: This information reflects only deaths of children whose families had DFCS involvement prior to the death occurring.

# Child Death Trends by Month (January 1, 2012 – September 30, 2012)

## Fatalities



Overall, there was an average of 13 deaths per month during the first three quarters of calendar year 2012. January had more deaths than any other month.



Note: This information reflects only deaths of children whose families had DFCS involvement prior to the death occurring.

# Classifying Child Deaths by Cause and Manner

- **Cause of Death** refers to a forensic finding of how the death occurred (drowning, gunshot, suffocation, etc.).
- **Manner of Death** is an official finding of how the cause of death arose:
  - Accidental
  - Homicide
  - Natural
  - Suicide
  - Undetermined (when it is medically impossible to establish the circumstances of death)

# Manners of Child Deaths by Quarter

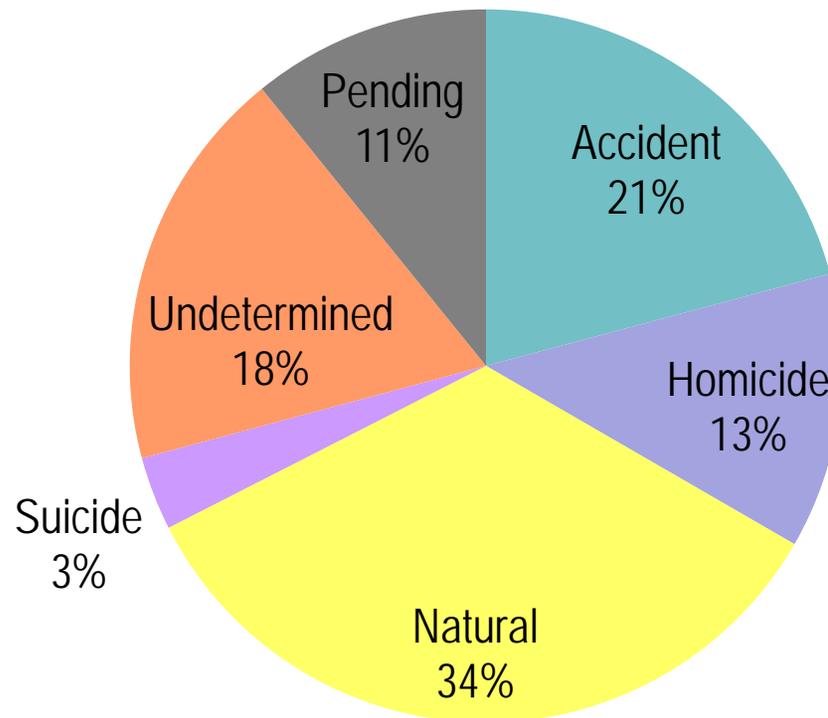
	Jan-March	April-June	July-Sept	Total for Each Manner
Accident	12	5	8	25
Homicide	10	2	3	15
Natural	13	22	6	41
Suicide	1	1	2	4
Undetermined	9	7	6	22
*Pending	1	2	10	13
<b>Total Number</b>	<b>46</b>	<b>39</b>	<b>35</b>	<b>120</b>



\*Pending deaths are those in which information is still being processed in order to make a finding.

# Manners of Child Deaths (Jan-Sept 2012)

## Manners of Death



Note: There were 120 child deaths.

## Causes - Accidental Death (N=25)

	Jan-March 2012	Apr-June 2012	July-Sept 2012	Total for COD
Sleep-related Suffocation	5	3	2	10
Drowning	3	0	2	5
Gunshot	0	2	1	3
House Fire	3	0	0	3
Choking (on object)	0	0	2	2
Canine Mauling	0	0	1	1
Pedestrian hit by Motor Vehicle	1	0	0	1
<b>TOTAL</b>	<b>12</b>	<b>5</b>	<b>8</b>	<b>25</b>

## Causes - Death by Homicide (N=15)

	Jan-March 2012	Apr-June 2012	July-Sept 2012	Total for COD
Blunt Force Head Trauma	5	0	1	6
Gunshot	2	1	1	4
Stabbing	1	0	1	2
Asphyxia	1	0	0	1
Traumatic Brain Injury	1	0	0	1
Motor Vehicle/DUI	1	0	0	1
<b>TOTAL</b>	<b>10</b>	<b>2</b>	<b>3</b>	<b>15</b>

## Causes - Natural Deaths (N=41)

	Jan-March 2012	Apr-June 2012	July-Sept 2012	Total for COD
Congenital or pre-existing medical condition	5	13	3	21
Acute or contracted illness/condition	4	4	2	10
SIDS	1	3	1	5
Birth-related	3	0	0	3
Other	0	2	0	2
<b>TOTAL</b>	<b>13</b>	<b>22</b>	<b>6</b>	<b>41</b>

## Cause - Suicide (N=4)

- In the first three quarters of 2012 there have been 4 reported suicides of children in families with DFCS history.
- Jan-March: (1) Hanging
- Apr-June: (1) Overdose
- July-Sept: (2) Gunshot

## Causes – Undetermined (N=22)

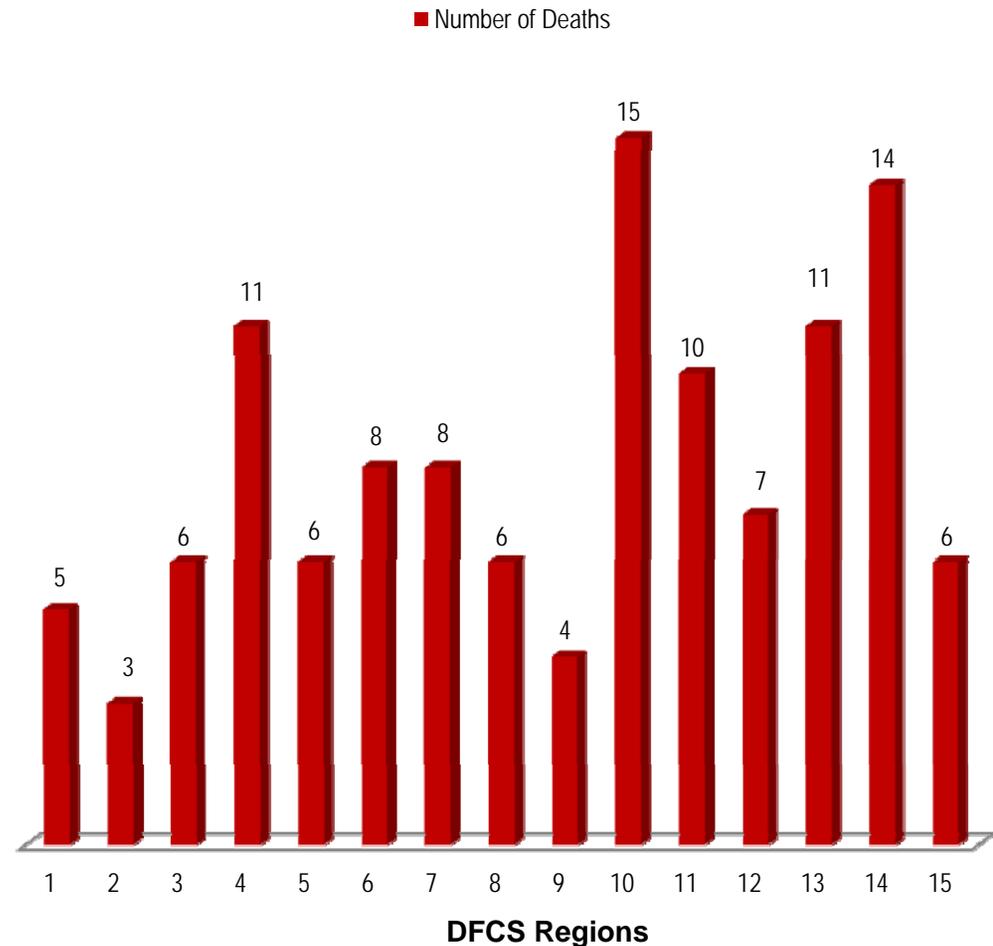
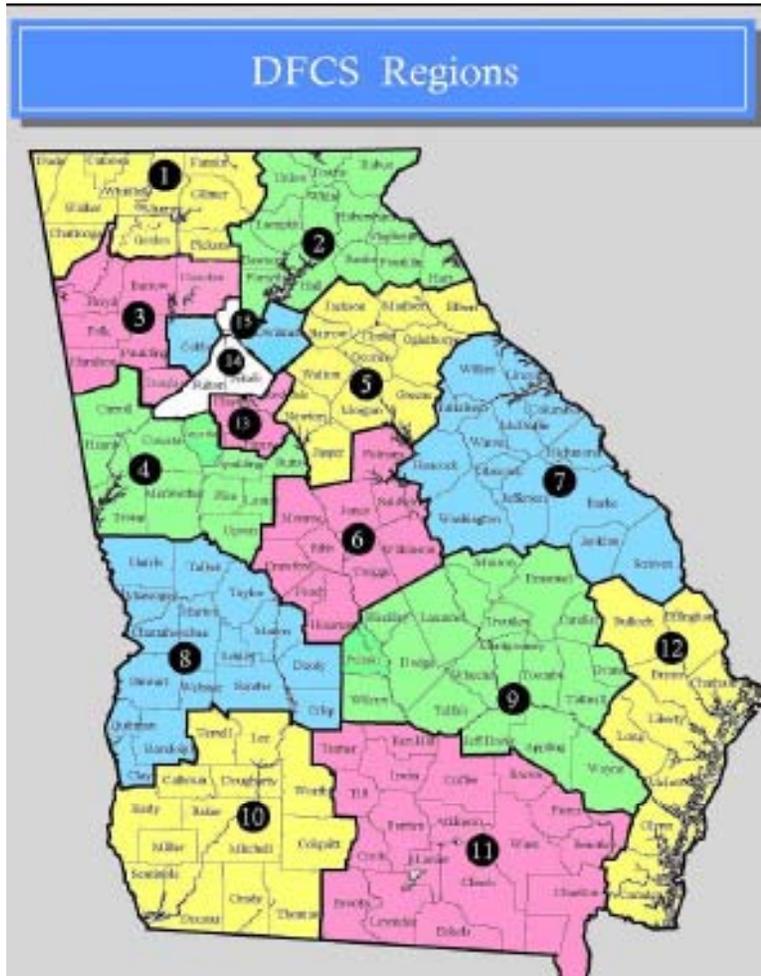
	Jan-March 2012	Apr-June 2012	July-Sept 2012	Total for COD
Undetermined	5	2	1	8
SUIDS	4	5	5	14
<b>Total</b>	<b>9 (6 co-sleeping)</b>	<b>7 (4 co-sleeping)</b>	<b>6 (4 co-sleeping)</b>	<b>22</b>

Uniformity is lacking among medical examiners statewide and nationwide regarding the classification of child deaths related to co-sleeping. The manner of death can be ruled SIDS, SUIDS or undetermined.

## Child Deaths with Pending Outcome (N=13)

- 10 deaths are pending from the third quarter.
- 3 pending from the first two quarters are waiting on lab or toxicology reports.

# Child Deaths in Calendar Year 2012 by DFCS Region



Note: 51% of child deaths during the first three quarters of calendar year 2012 occurred in five DFCS regions (4, 10, 11, 13 and 14).

## Type of DFCS Prior History by Quarter

	January 1, 2012 – March 30, 2012	April 1, 2012 – June 30, 2012	July 1, 2012 – September 30, 2012	Total
Prior Investigation for abuse or neglect	18	25	20	63
Prior Family Preservation Services (in-home support for the family)	6	3	6	15
Previous Diversion case (no maltreatment –short term support services)	26	17	12	55
*Case open at the time of child death	11	14	12	38 (includes the 10 children in foster care below)
Children in foster care at the time of his/her death	4	5	1	10



\*Note: In addition to the above information, four families had only reports that were screened out .One case involved the death of a child who had been adopted but DFCS had a foster child in the home at the time of the death; and one on a child in relative custody.

## Reasons for Deaths of Children in Foster Care at Time of Death (N=10)

- Three died as a result of alleged maltreatment suffered before they were placed into Foster Care. Two died of alleged abuse and one died of alleged neglect
- One child in care for ten years following abusive head trauma by an uncle, leaving her with medical complications that ultimately resulted in her death.
- Two premature infants in hospital taken into custody due to parents' religious objections for blood transfusions (children never left the hospital).
- One child die from an overdose. The child had a serious medical condition that also contributed to the death.
- Medically fragile child taken into custody at hospital due to mother's unstable living conditions and neglect; died from ongoing medical issues.
- Child died of SIDS.
- One medically fragile child died from medical complications

## Child Deaths in Open Investigation Cases at Time of Death (N=10)

### Reason case was open

- Emotional abuse with domestic violence
- Physical abuse of sibling
- Medical neglect of medically fragile child
- Mom of newborn positive for drugs with other kids in foster care
  
- cases open for parental drug abuse
- Drug use by mom
- Open for physical abuse of sibling
- Drugs
- 2 from sleep related incidents.
- Three due to complications from medical issues.

### Reason child died

- child died of pre-existing brain cancer
- victim found unresponsive, in bed with father
- Child died of blood infection
- Child born prematurely with medical complications.
- Child died in an auto accident due to DUI;
- Died of SUIDS
- Died of medical issues at birth
- Bed sharing

## Child Deaths in Open Family Preservation Cases at Time of Death (N=11)

These are cases in which DFCS was currently providing ongoing services to families due to substantiated maltreatment, and a child in the home dies:

- Case was open for lack of supervision and failure to thrive. Another child was born while the case was open and died.
- Child died from physical abuse by the father; autopsy still pending.
- Case had been opened because of medical neglect. Medically fragile child died from multiple medical issues
- Open case because child's mother tested positive for drugs at child's birth; mother also had mental health issues. Child found dead in crib. SIDS is suspected.
- Child born positive for drugs, medical neglect substantiated; child found wedged between the bed and wall during a nap (child was 6 months of age).
- Two cases were opened due to parental drug use and children died during co-sleeping incident.

## Child Deaths in Open Diversion/Family Support Cases (N=7)

These cases were opened subsequent to a DFCS referral in which there was either no allegations of maltreatment (Diversion) or there were no safety threats to the child if maltreatment was alleged (Family Support)

- Homicide of both mother and child by mother's husband
- Homicide by mother's boyfriend
- Accidental death of a child (per family, the three year old sibling dropped the baby)
- Sleep-related death
- Serious medical condition (three children)

## DFCS CORE BELIEF: NO CHILD SHALL DIE IN VAIN

The Georgia Department of Human Services and Division of Family and Children Services, in collaboration with other agencies, has taken pro-active measures to learn from *every* child death so that no child shall die in vain, as such we have committed to analyzing and evaluating these cases to develop trends, sound practice and policy, increase prevention awareness, and train staff to respond thoroughly & appropriately to all reports of child maltreatment.

## 3<sup>rd</sup> Quarter Trends: July 1, 2012 through September 30, 2012

### Sleep-Related Deaths

- 9 children were co-sleeping at the time of their death.
- 8 children were sleeping in a less than optimum sleeping environment, such as: in a crib or bassinet with adult sized blankets/pillows; on a soft sleep surface; on a mattress on the floor and the infant became trapped between the mattress and the wall, or in a swing or on a sofa.

### Medical deaths with previously identified special healthcare needs

- All of the children who died and their death was categorized as “Medical” were special needs children.
- Some of the medical deaths of the special needs children were preventable: children with severe asthma designated as high risk but not getting the proper medication, a child with cerebral palsy who had bed sores that became infected and sepsis set in resulting in a quick demise of overall health; a baby with feeding tube co-sleeping.

## 3<sup>rd</sup> Quarter Trends: July 1, 2012 through September 30, 2012, Cont'd

### Child Abuse Homicides

- Increased number of homicides with prior DFCS history.
- Caretaker Characteristics: Drugs, Domestic Violence and Criminal History
- Increased drug use
- Use of firearms in abusive child deaths; incidents of child-on-child homicides

## Pro-Active Measures Implemented to Date

Some of the measures implemented thus far include:

- Quarterly Meetings with Governor's Office COO Staff, Child Advocate, DHS Commissioner, and DFCS Director.
- 24-Hour staffing of child death cases with alleged maltreatment and history; staffings include county staff, DFCS State Office staff, OCA, DHS OHRMD, law enforcement and other community partners.
- (New) Live training opportunity for new staff when new child death staffing occurs.
- Multi-agency Public Awareness Campaigns :
  - 1<sup>st</sup> phase: Dangers of Co-Sleeping: Develop safe sleep awareness campaign with the GA Infant Safe Sleep Coalition, led by OCA., to create a consistent message across all state agencies.
  - 2<sup>nd</sup> phase: Drownings - water safety: Work with Child Fatality Prevention Committee, led by OCA, to develop strategies on preventing leading causes of death, to include water safety
  - 3<sup>rd</sup> phase: Car Seat Safety: DFC partners with Public Health to obtain literature

## Pro-Active Measures Implemented, cont'd

- Presentation on *Good Day Atlanta* of how to prevent those deaths.
- DFCS Child Safety Symposium topic: Preventing Unintentional Child Death and Serious Injury during Child Abuse Prevention Month in April.
- Press release completed to prevent unintentional child deaths:
  - creating safe sleep environment
  - water safety
  - fire safety
  - child car seat safety
- Participation in Georgia Safe Sleep Campaign with First Lady's Children's Cabinet, Georgia Department of Public Health, Georgia Pediatric Physicians, Governor's Office of Children and Families

## Pro-Active Measures Implemented, cont'd

- DFCS on site presence with medical child protection team at Children's Healthcare of Atlanta for expert and immediate response to critical cases.
- (New) DHS/DFCS purchased 12 setups (camera, microphone and software license) for participation in GA Tele-healthcare Network, to access consultation from the Child Protection Team at Children's Healthcare of Atlanta.
- (New) Working with the Casey Foundation to develop a root cause analysis of child deaths and to strengthen DFCS practice around child death reviews.
- (New) Interviews scheduled in October for the hiring of a Safety Review Specialist whose primary function is to review Serious Injury and Near Fatality cases with the same level of intensity as we review child death cases.
- (New) Partnering with Childkind to create a videotape in November for DFCS case workers on "Making Good Home Assessments for Children with Special Healthcare Needs," to be made available statewide through the Education and Training Department.