Division of Family & Children Services: First Quarter 2013 Child Death Report

Date of Presentation: May 2013

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.**

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Presentation Outline

- Child Death Trend by Quarter & Month
- Manner & Cause of Child Deaths
- Type of DFCS History by Quarter
- Specific Reasons for Deaths
- Age of Children at Time of Death
- Findings from Child Death Staffings
- Proactive Measures Taken by DFCS

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Executive Summary

- DFCS reviewed 21 child death cases between January and March that were open at the time of the death and had history with the Department.
- There was a total of 55 deaths with DFCS history (within the past five years) reported to the agency.
- Natural causes were the greatest percentage of deaths in open cases. Natural and accidental causes were the greatest percentage of deaths in all cases.

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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)**

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2013 First Quarter Manners of Child Deaths (N=55)

	January	February	March	Total
Accident	5	1	5	11
Natural	5	3	11	19
Homicide	2	2	1	5
Suicide	0	0	0	0
Undetermined	1	0	1	2
Pending	4	9	5	18
Total	**17**	**15**	**23**	**55**

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Pending deaths are those in which information is still being processed by the medical examiner in order to make a finding.

Causes – Accidental Deaths (N= 11)

Hanging	1
Asphyxia/Smoke Inhalation	4
Dog Attack	1
Drowning	1
Motor Vehicle/Pedestrian accident	3
Motor Vehicle/Bicycle accident	1
TOTAL	**11**

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Causes – Natural Deaths (N=19)

Congenital or Pre-existing Medical Condition	13
Acute or Contracted Illness/Condition	4
Birth Related	2
TOTAL	**19**

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Causes – Homicide (N=5)

Abusive Head Trauma by caregiver	1
Blunt Force Trauma by caregiver	1
Gunshot (1 by caregiver, 2 by non-caregivers)	3
TOTAL	**5**

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Causes – Undetermined (N=2)

There were two undetermined causes of death during the first quarter:

*Child found on adult bed alone and not breathing

*Child found unresponsive, death due to anoxic brain injury (no autopsy)

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Causes – Pending (N=18)

Of the 18 pending cases the **official** cause and manner has not been determined:

- (6) sleep related (4 co-sleeping) (2 unsafe sleep environment)
- (2) possible SIDS (found unresponsive in crib)
- (1) asphyxia vs. SUIDS (child being held by intoxicated caretaker)
- (2) unknown (1 special needs child with hemophilia) (1 child found unresponsive on kitchen floor)
- (1) hypoxic anoxia (suspected homicide)
- (3) possibly medical-related (asthma attack, sudden collapse, pre-existing medical condition)
- 3 died in a house fire that is still under investigation.

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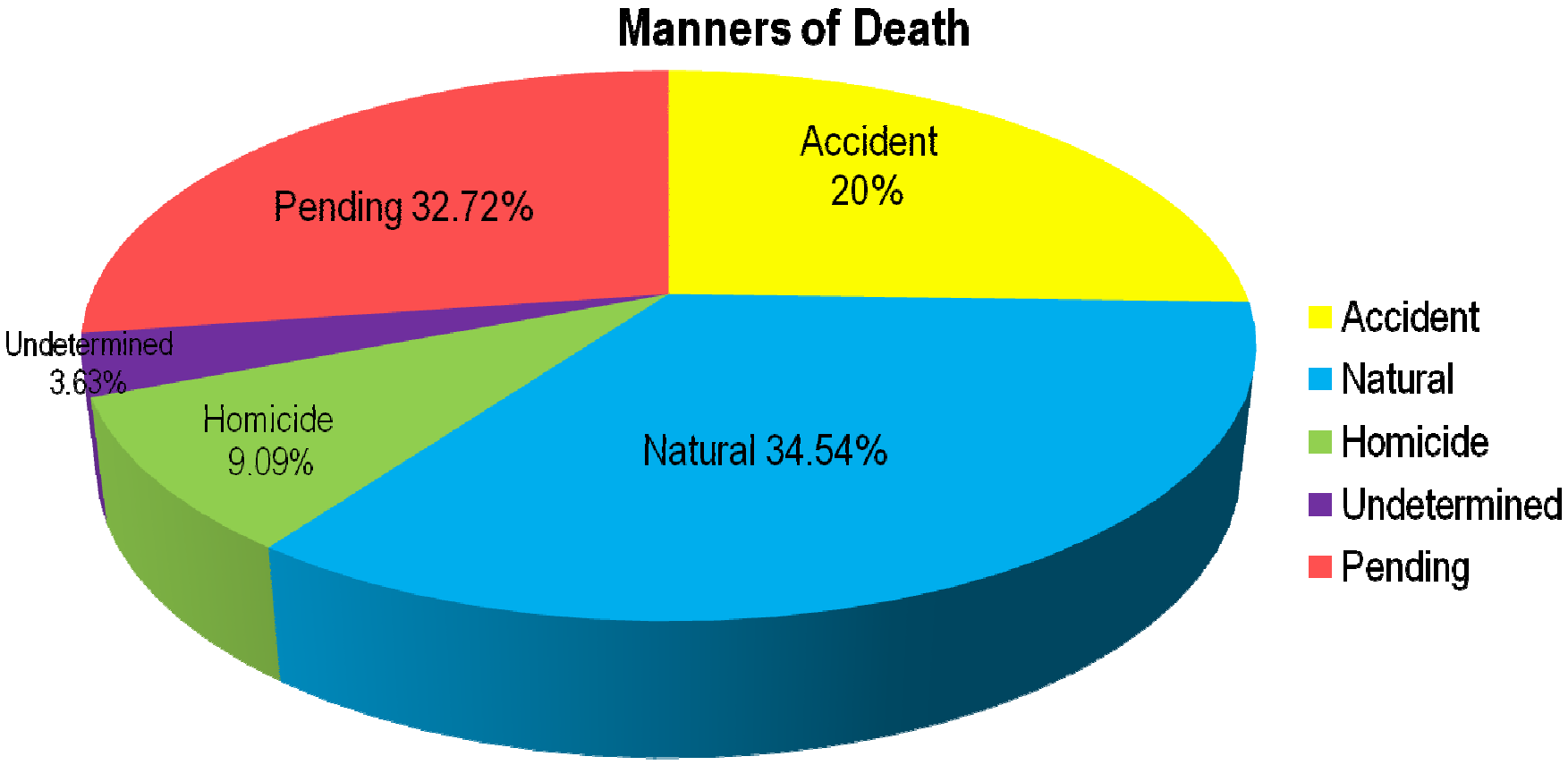
Pending deaths are those in which information is still being processed by The medical examiner in order to make a finding

Manners of Child Deaths for First Quarter 2013 (N=55)



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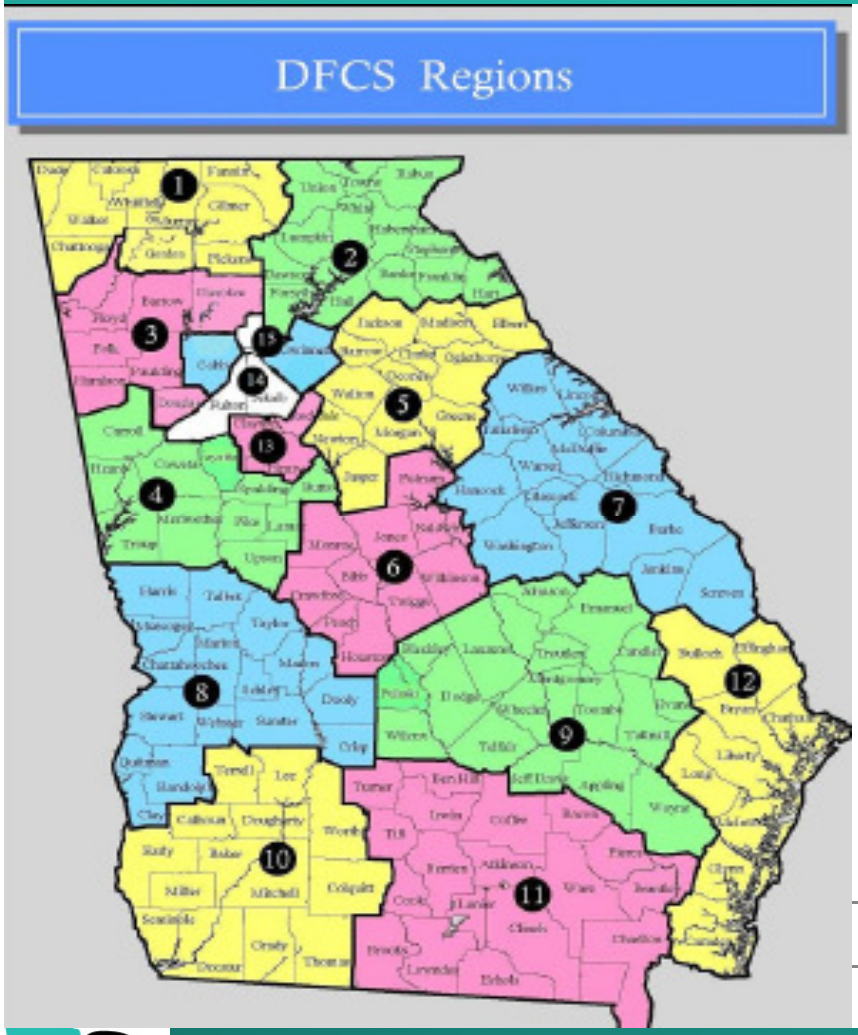
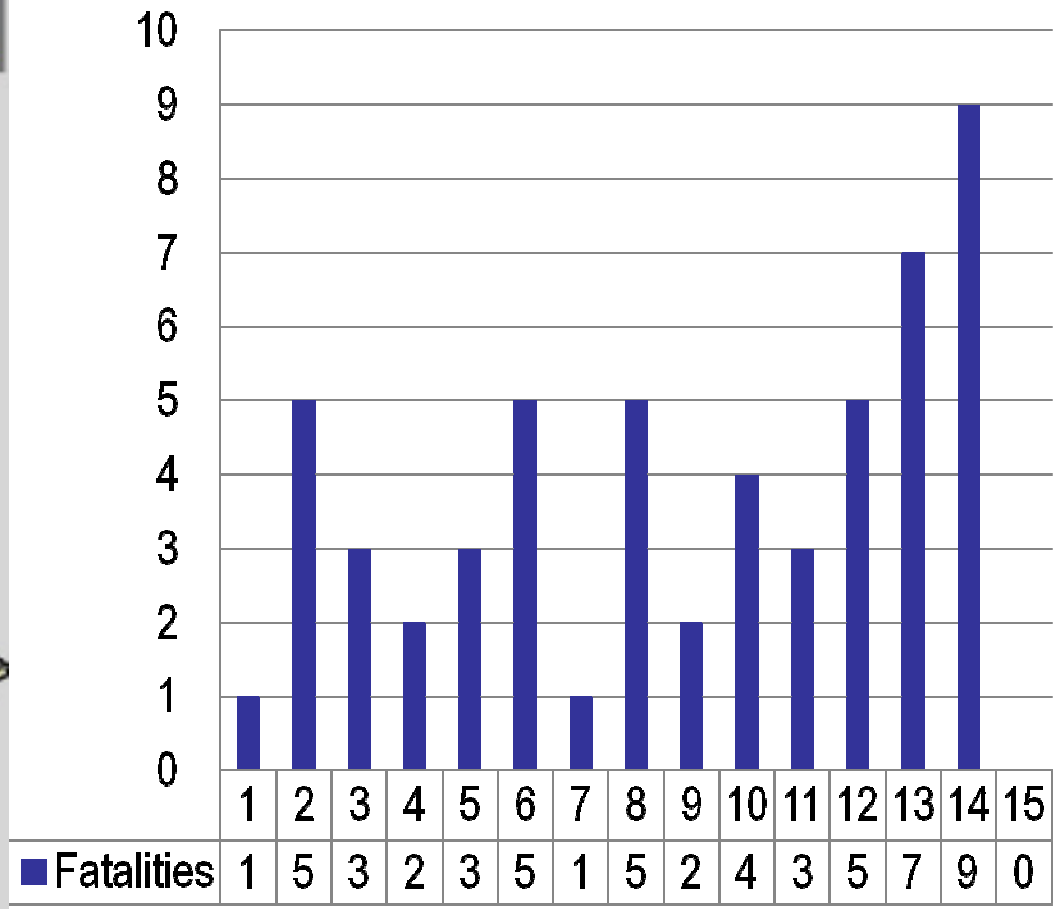
Deaths from accidents and natural causes account for over half of the known manners of death.

Fatalities by Region





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Causes of Fatalities by Region

- **R1** (1) Pending co-sleeping
- **R2** (5) Pending head trauma; medically expected death; natural death of medically fragile child; pending SUIDS; premature birth/drug exposed
- **R3** (3) Accidental hanging; non-accidental blunt force trauma; acute medical death
- **R4** (2) Non-accidental gunshot; anoxic brain injury/no autopsy
- **R5** (3) Medical; medical; pending SUIDS

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Causes of Fatalities by Region

- **R6** (5) Unresponsive in crib; unresponsive on adult bed; house fire/3 siblings
- **R**7 (1) Pending medical/severe asthma attack
- **R8** (5) Natural/sudden cardiac arrest; medical/renal failure; unresponsive in crib; medical/born with bowel deformity; pending/co-sleeping
- **R9** (2) Medical; pending/co-sleeping
- **R10** (4) Medical/prematurity; unknown medical; accidental blunt force head injuries from motor vehicle/pedestrian; accidental motor vehicle/pedestrian

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Causes of Fatalities by Region

- **R11** (3) Undetermined; drowning; motor vehicle/bicycle accident
- **R12** (5) Medical/sudden collapse; medical; medical; gunshot homicide/non-caretaker; dog attack
- **R13** (7) House fire/4 children; pending child abuse; pending SUIDS; medical
- **R14** (9) Medical; motor vehicle/pedestrian accident; medical; pending/found unresponsive on floor; acute medical; homicide by gunshot; medical; pending/stopped breathing; medical/premature
- **R15** (0)

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Type of DFCS History, First Quarter 2013

	January – March 2013
Prior Investigation for abuse or neglect	**43**
Prior Family Preservation Services (in-home support for the family)	**16**
Prior Family Support	**14**
Previous Diversion case (no maltreatment –short term support services)	**20**
Case open at the time of child death	**21**
Children in foster care at the time of his/her death	**8**

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*Note: In addition to the above information, the only CPS history on four families was a screened out report. The totals reflected above are greater than 55 due to some families having involvement in more than one program area.

Reason for Death of Children in Foster Care at Time of Death (N=8)

- **(6)** children classified as **special needs** with medical diagnosis (Leukemia, Downs Syndrome, Trisomy 18 and other Genetic abnormalities). These children were in foster care due to parents' inability to provide for their special needs; and/or neglect/abuse issues related to the parent's overall caretaking abilities. Official Cause and Manner of Death is not confirmed for all six, but deaths are likely to be ruled **Natural deaths** related to complications stemming from their medical issues.

  One of the six children was severely disabled as an infant from abusive head trauma and lived in foster care for another 5 years after his initial injury. His death is related to the abuse he suffered prior to entering care.
- **(1)** child needed a blood transfusion and the parents were unable to accommodate this due to their religious beliefs. The child died in spite of receiving the transfusion.
- **(1)** child came into custody as a result of his injuries (abusive head trauma) and his death will likely be ruled a homicide once all forensics are completed.

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OPEN CASES AT TIME OF DEATH (N=22)

- **8** Placement: 3 were open for placement & investigations simultaneously – (counted as placement.) **[7 medical deaths; 1 abusive trauma, in care because of injury]**
- **6** Investigations **[3 medical deaths; 1 SUIDS; 1 motor vehicle accident]**
- **4** Ongoing Family Preservation **[4 medical deaths;]**
- **2** Family Support **[1 undetermined cause and manner; 1 medical]**
- **1** Aftercare Case **[pending SUIDS]**

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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.

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First Quarter Trends: January 1, 2013 through March 30, 2013

Sleep-Related Deaths (13)

7 children were **co-sleeping** at the time of their death.

5 children were in **unsafe sleep environments.**

- in a crib or bassinet with adult sized blankets/pillows
- on a soft sleep surface (face down on adult bed/comforter)
- on a sofa, cushion etc. (caregiver & child fell asleep on sofa)
- Infant left unattended with a bottle propped in their mouth.

1 child was in a crib alone (likely cause is SIDS)

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First Quarter Trends

Medically Fragile Children – Premature Infants

- **7** Children were born Premature
- **6** mothers of premature infants tested positive for illegal drugs at their birth.
- **2** premature children died while co-sleeping with parents and/or other siblings.

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First Quarter Trends

Domestic Violence

- 17 of our cases had allegations of domestic violence.
- 4 of those also alleged drug use by caretakers.

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Age of Children at Time of Death (N = 55)

Age of Child at Time of Death	Number of Children	Percentage of Child Deaths
11 months or less	26	47.27%
1	8	14.54%
2	1	1.81%
3	2	3.63%
4	1	1.81%
6	1	1.81%
7	2	3.63%
9	4	7.27%
10	2	3.63%
13	1	1.81%
14	1	1.81%
15	1	1.81%
16	2	3.63%
17	3	5.45%

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Formal Staffing of Child Death Cases

Since January 2012 all child deaths with suspected or alleged maltreatment and DFCS history have been staffed between the DFCS State Office Collaborative Partners Section, internal and external partners, and the DFCS county of jurisdiction. A case is staffed as close to 24 hours as possible in order to:

- Obtain current case information, case history and circumstances of the death for immediate feedback to the Division Director and DHS Commissioner.
- Provide consultation and feedback to the County regarding case assessment and best decision-making for the safety and well-being of surviving children; and services for the family.
- Analyze and improve practice in cases as issues are revealed.
- Identify trends in order to implement prevention and practice strategies to reduce child maltreatment.
- Facilitate live learning for case managers in training as they listen to the staffing from the classroom.
- Engage partners to provide a multi-disciplinary approach to child death case assessment and practice.

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Formal Staffing of Child Death Cases

- Formal staffings were held in 30 of the 55 child death cases, involving 37 child fatalities.
- Most staffings are conducted by conference call. 3 cases this quarter were conducted face-to-face with the county.
- All 55 children's cases were reviewed and evaluated for best practice, decision-making and trend development.

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First Quarter Findings

Communication Improvements have been made:

- **In case file documentation**: More detailed information in the record and creation of timelines that clarify inconsistencies in stories. This practice is essential, to ensure clarity of the case circumstances by providing all available information, so that as an Agency we continue to be effective and accountable.
- **In sharing case information between DFCS program areas**.
- **In cases being staffed with supervisors and other case managers working with the child – Communication is flowing**.

Communication Improvement needed:

- **In documenting information that has been gathered from external providers and agencies.** Gathering and recording information from school personnel, juvenile court, doctors, hospital social workers, mental health providers and private agency case managers, Substance abuse assessors etc. is an invaluable part of DFCS assessment and case determination.

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First Quarter Findings

21 of the 55 cases (38%) involved the deaths of children with Special Healthcare Needs

- Assessing children with special needs often mandates thorough communication with many healthcare professionals and other providers involved.
  - All pertinent information involving the child's care must be gathered, documented and understood. Medical discrepancies must be resolved in order to assess the needs of the child.
  - Parents of special needs children *may* need more guidance while learning to adjust to the needs of the child; i.e. what was okay for a healthy child might not be okay for a special needs child.
  - These children continue to come under the DFCS lens. They are at a greater risk for neglect **especially** when their caretakers also have other risk factors

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First Quarter Findings

Children with Special Healthcare Needs, continued:

- Drugs, DV, Instability of care takers (homelessness, lack of employment, unstable relationships, etc.) and inexperienced care givers who lack life skills can impact a caretaker's protective capacity.
- In order to make sound assessments we **MUST** staff these cases with medical professionals who understand the child' s special medical needs and have child specific knowledge.
- Assessing parental capacity should involve both the parent's verbal understanding and demonstration of care of the child. For example, one case manager watched a mother prepare the infant's formula and discovered the mother could not read; and was mixing the child's formula incorrectly, which directly related to the child's overall health.

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First Quarter Findings

31 of the 55 cases (56%) had allegations of caregiver drug use:

- Caregiver drug use has great potential to affect Parental and Protective Capacities, and to increase Child Vulnerability.

  (7 children died in house fires where their caregivers were alleged to be using drugs).
- We must continue to improve our ability to assess substance abuse and its potential impact on the safety and well-being of children and families.
- More education and training about drugs, drug use and addiction; and its impact on caregiver behavior and child safety is needed.

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Pro-Active Measures Implemented in 2013

- 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.
- Hired 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.
- In collaboration with Childkind, created a videotape for DFCS case workers on "Making Good Home Assessments for Children with Special Healthcare Needs," and provided it to Education and Training Department.
- Live learning with the county about a case when practice issues are identified. Meet in person with county staff to go over the agencies actions.

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Pro-Active Measures Implemented in 2013, cont'd

- Meet with outside agencies such as Department of Public Health and Vital Records to enhance tracking and data collection in regards to child death statistics. This collaboration will enhance data collection so that information can be used for prevention.
- Developing an educational curriculum on abusive head trauma for high school youth.

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