Division of Family & Children Services: Calendar Year 2012 Child Death Report

April 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 Death of Children in Foster Care
- Age of Children at Time of Death
- Findings from Child Death Staffings
- Proactive Measures Taken by DFCS

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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 - September 2012	35
Quarter 4: Oct – December 2012	32
Total Deaths with DFCS prior History	*152*

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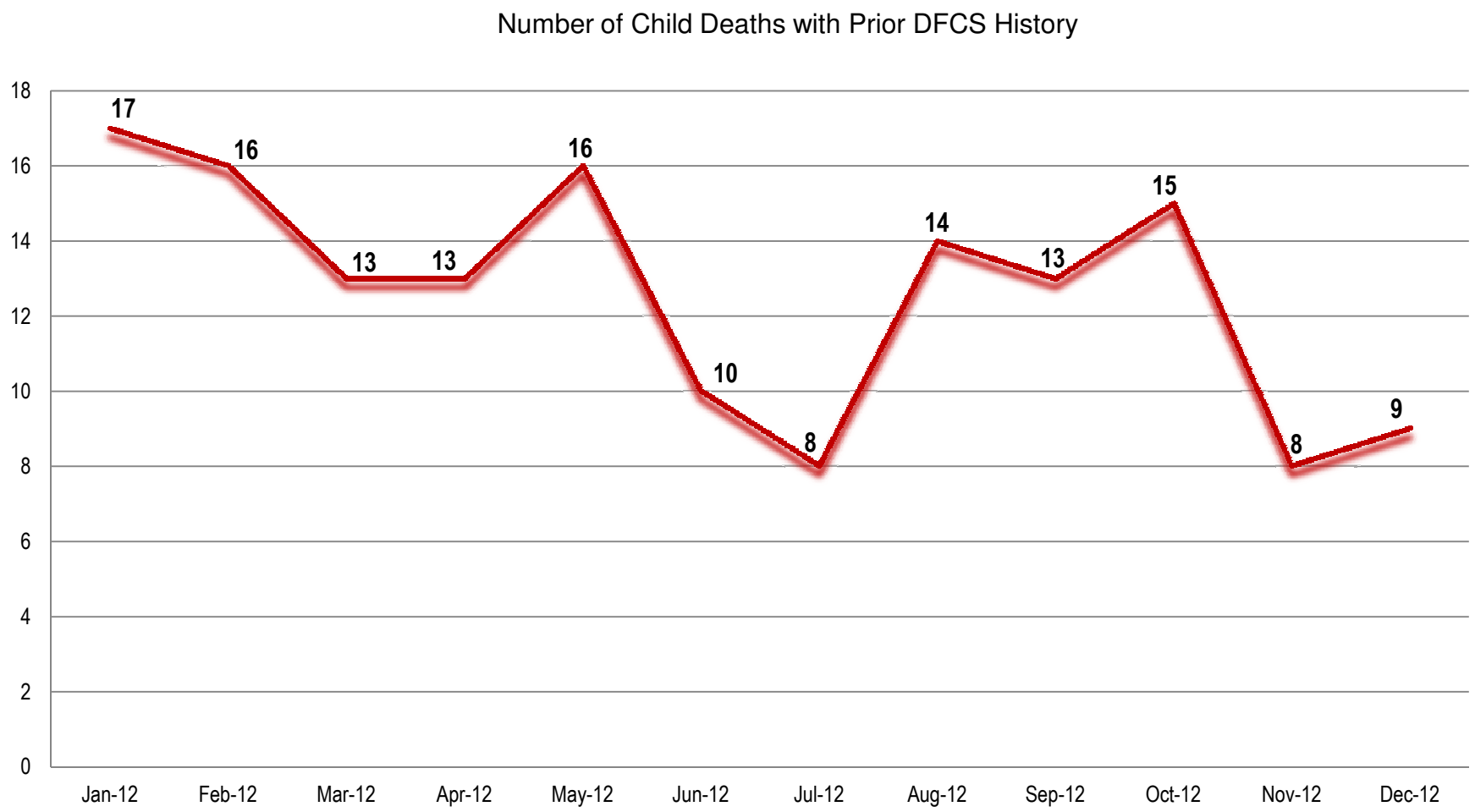
Note: This information reflects only deaths of children whose families had any child protective services DFCS involvement during the five years, prior to the death occurring.

Child Death Trends by Month (January 1, 2012 – December 31, 2012)



Note: There were a total of 152 deaths of children whose family had DFCS involvement prior to the child's death (an average of 13 per month).

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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Manners of Child Deaths by Quarter

	January – March 2012	April – June 2012	July – September 2012	October – December 2012	Total for Each Manner
Accident	12	5	11	7	35
Homicide	10	2	3	3	18
Natural	13	22	8	8	51
Suicide	1	1	2	2	6
Undetermined	9	8	8	2	27
***Pending**	1	1	3	10	15
Total Number	**46**	**39**	**35**	**32**	**152**

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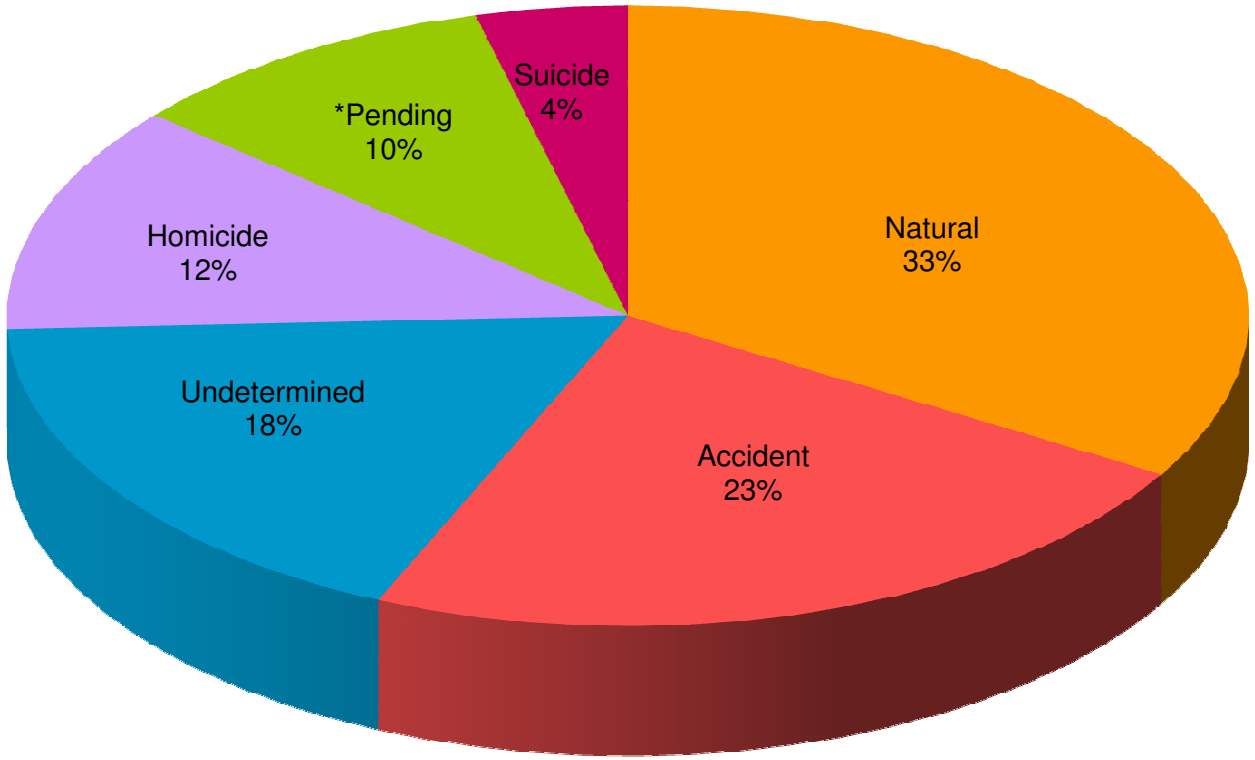
*Pending deaths are those in which information is still being processed in order to make a finding.

Manners of Child Deaths for Calendar Year 2012 (N=152)



Deaths from natural causes and accidents account for 56% of the known manners of death.

Causes - Natural Deaths (N= 51)

	January - March 2012	April - June 2012	July-September 2012	October – December 2012	Total for Each Cause
Congenital or pre-existing medical condition	5	13	4	3	25
Acute or contracted illness/condition	4	5	2	1	12
SIDS	1	3	1	1	6
Birth-related	3	0	0	3	6
Other	0	2	0	0	2
Total Deaths (Natural Causes)	**13**	**23**	**7**	**8**	**51**

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Causes - Accidental Death (N=35)

	January - March 2012	April - June 2012	July -September 2012	October – December 2012	Total for Each Cause
Sleep-related Suffocation	5	3	4	1	13
Drowning	3	0	2	2	7
Gunshot	0	2	1	0	3
House Fire	3	0	1	0	4
Asphyxia due to choking	0	0	2	2	4
Canine Mauling	0	0	1	0	1
Pedestrian hit by Motor Vehicle	1	0	0	2	3
Total (Accidental)	**12**	**5**	**11**	**7**	**35**

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Causes - Death by Homicide (N=18)

	January - March 2012	April - June 2012	July – September 2012	October – December 2012	Total for Each Cause
Blunt Force Head Trauma	5	0	1	0	6
Gunshot	2	1	1	1	5
Stabbing	1	0	1	0	2
Asphyxia	1	0	0	0	1
Traumatic Brain Injury	1	0	0	0	1
Motor Vehicle vs. Pedestrian	1	0	0	0	1
Pending Cause	0	0	0	2	2
Total Deaths (Homicide)	**10**	**2**	**3**	**3**	**18**

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Causes - Death by Suicide (N=6)

	January - March 2012	April - June 2012	July – September 2012	October – December 2012	Total for Each Cause
Gunshot	0	0	2	1	3
Hanging	1	0	0	1	1
Overdose	0	1	0	0	1
Total	**1**	**1**	**2**	**2**	**6**

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Causes – Undetermined (N=27)

	January - March 2012	April - June 2012	July- September 2012	October – December 2012	Total for Each
Undetermined	5	2	2	1	10
SUIDS	4	6	6	1	17
Total	**9** (6 co-sleeping)	**8** (5 co-sleeping)	**8** (5 co-sleeping)	**2** (1 co-sleeping)	**27**

Note: 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.

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Child Deaths with Pending Outcomes (N= 15)

- 10 are pending from the 4th quarter:
  - (4) found unresponsive in crib
  - (4) found unresponsive with co-sleeping
  - (2) found unresponsive on adult bed

- 5 are pending from the first three quarters and are awaiting official findings. Lab reports are complete.

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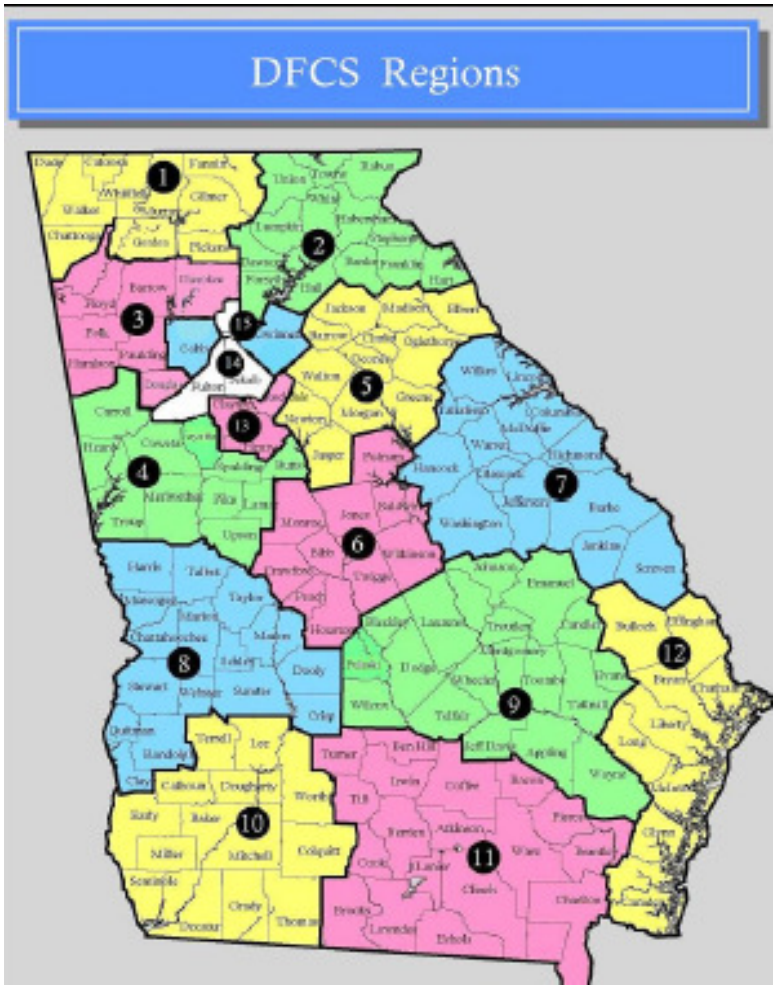
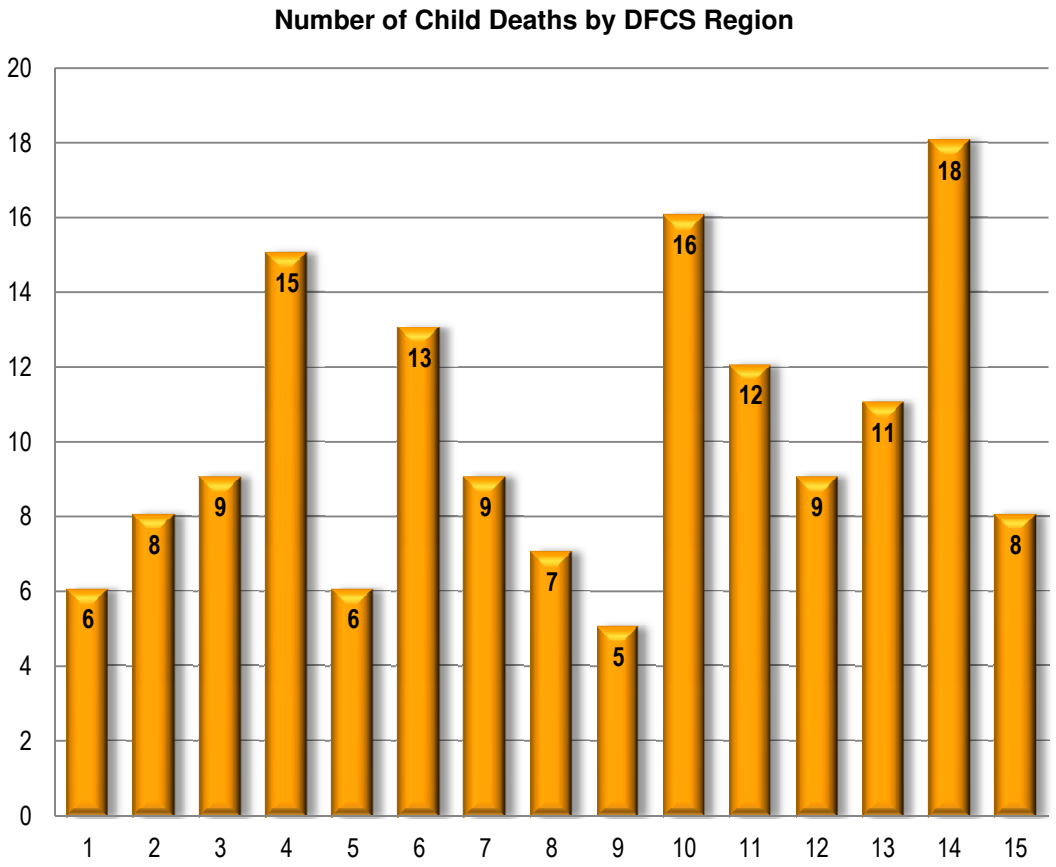
Child Deaths in Calendar Year 2012 by DFCS Region





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Note: Approximately 41% of deaths occurred in four regions (Regions 4, 6, 10, and 14).

Type of DFCS Prior History by Quarter

	January – March 2012	April – June 2012	July – September 2012	October – December 2012	Total
Prior Investigation for abuse or neglect	18	25	20	21	84
Prior Family Preservation Services	6	3	6	8	23
Previous Diversion case (practice ended March 31, 2012)	26	17	12	11	66
Family Support Services (practice began April 1, 2012)	N/A	2	3	4	9
Case open at the time of child death	11	14	12	11	48
Children in foster care at the time of his/her death	4	5	1	*3	13

The types of DFCS prior history is higher than total number of child deaths for the year (152) because some of the children 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 case.

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Note: Although there were three children in foster care at the time of his/her death, only two had prior DFCS history. The other child came into care as a result of a needed blood transfusion. One child was brought into care due to the abusive injuries that led to her death and the other child was a special needs foster child.

Reasons for Deaths of Children in Foster Care at Time of Death (N=13)

- (3) deaths from alleged maltreatment suffered before Foster Care placement. Two died of alleged abuse and one died of alleged neglect
- (1) death of a child in care for ten years following abusive head trauma leaving her with medical complications that ultimately resulted in her death.
- (3) deaths of premature infants in hospital taken into custody due to parents' religious objections for blood transfusions (children never left the hospital).
- (1) death from intentional overdose plus complications of pre-existing medical condition.
- (1) death of medically fragile child from ongoing medical issues; taken into custody at hospital due to mother's unstable living conditions and neglect.
- (1) child died of SIDS.
- (2) medically fragile children died from medical complications
- (1) death with pending cause/manner, taken into custody for suspected maltreatment at time of injury who died in care.

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Age of Children at Time of Death (Families with Prior DFCS History) (N = 152)

Age of Child at Time of Death	Number of Children	Percentage of Total Child Deaths
11 months or less	73	48.0%
1	16	10.5%
2	12	7.9%
3	5	3.3%
4	7	4.6%
5	3	2.0%
7	3	2.0%
9	4	2.6%
10	4	2.6%
12	6	3.9%
13	4	2.6%
14	1	Less than 1%
15	3	2.0%
16	7	4.6%
17	4	2.6%
Total Children	**152**	

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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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Findings from Staffing Child Deaths

Communication, Coordination & Follow-Up

- **Working with others who have knowledge about the family/child, can lead to better outcomes for children.**
  - Improve communication between program areas within DFCS and between supervisors & caseworkers, any time new information is received that may impact a child's safety.
  - Communicate openly (within HIPAA guidelines) with outside providers to ensure everyone has the same information.
  - Ensure documentation accurately reflects the work being done.

Working with Community Partners Strengthens Assessments of Families.

- Collaboration with other professionals yields greater success and better outcomes.
- The ultimate goal is ***child safety*** – but our ways to accomplish this are varied.
- Information from school personnel, juvenile court, doctors, hospital social workers, mental health and private providers, etc. is invaluable to the DFCS assessment and case determination.

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Findings from Staffing Child Deaths, cont'd

Communication, Coordination & Follow-Up, continued

- **Medically-Fragile Children**
  - Are at greater risk of abuse and neglect.
  - Interaction and engagement with the child is critical to making a thorough safety assessment.
  - Verify information with medical professionals and outside agencies to ensure child's special needs are being met and maintained.
- **Multi-disciplinary Staffing Approach.** Provides a greater perspective, more knowledge, and experience to the overall decision making process.
- **Collaboration.** Improving communication with local partners is essential (police, medical, school, DFCS). No-one can do this alone.
- **Personal Safety.** DFCS case managers often walk into potentially volatile situations and must keep open lines of communication with others to ensure their own safety. Take police whenever in doubt.

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Findings from Staffing Child Deaths, cont'd

- **Safety Resources (placing unsafe children with family or friends)**
  - A safety resource provides a temporary, alternate placement for a child – and should not be automatically thought of as a long term placement so a case can be closed. The placement of a child outside their immediate family must be assessed carefully and fully to ensure it is a good fit. Ensure appropriate background checks are completed (criminal and CPS history); fully explain the process to the safety resource and the parent.
  - Judicial oversight can be a valuable resource and provide an additional safety net for the family and child. Children could benefit from the extra support it can offer.
- **Record Keeping**
  - DFCS case files must accurately reflect the work we are doing so when others come behind us, they can tell what services have been provided to a family.

Prior CPS History.

- Should be incorporated into assessments
- It is okay to share pertinent DFCS history with law enforcement when working together to ensure children's safety.

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Pro-Active Measures Implemented to Date

- 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 DFCS history; staffings include county staff, DFCS State Office staff, OCA, DHS OHRMD, law enforcement and other community partners.
- Live training with brand new Social Services employees on Sept. 12th , Nov.16th and Dec. 4th. New case managers observed a child death staffing and the trainers incorporated the staffing into their curriculum.
- Multi-agency Public Awareness Campaigns :

  - 1st 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.
  - 2nd phase: Drowning - water safety: Work with Child Fatality Prevention Committee, led by OCA, to develop strategies on preventing leading causes of death, to include water safety
  - 3rd phase: Car Seat Safety: DFCS partners with Public Health to obtain literature

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Pro-Active Measures Implemented, cont'd

- Presentation on *Good Day Atlanta* on how to prevent those deaths.
- Ongoing presentations and discussions at DFCS Child Safety Summits on preventing unintentional child death and serious injuries
- 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
- Presentation at Georgia Conference on Children and Families on Trends from Child Death Staffings

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