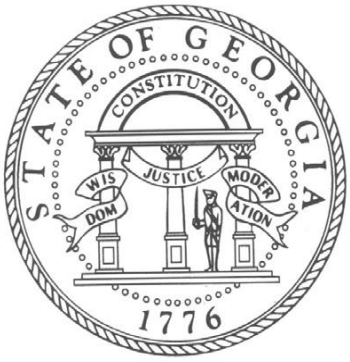

GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES 2014 CHILD FATALITY ANALYSIS

Nathan Deal, Governor

Bobby D. Cagle, Division Director

Note from the Division Director:

The Georgia Division of Family and Children Services is committed to the safety of Georgia's children in decisions made and actions taken. The death of a child is a matter of very serious concern to the Division as well as to the citizens of Georgia and the greater child welfare community. In accordance with the requirements of state law, the *2014 Child Fatality Analysis* focuses on the deaths for children whose families had been the subject of a report or investigation of maltreatment in Georgia within the last five years.

Each child who is a victim of abuse or neglect should be remembered and mourned, and the circumstances of their deaths studied, so that every citizen in Georgia can understand the factors related to their deaths and apply these sobering lessons toward preventing the deaths of other children. Deaths can result from disease, accidents, unintentional injuries, lack of resources and information, poor judgment, or violence. Some deaths may be foreseeable and others unanticipated. It is our belief that many child deaths are preventable and that we can use data to guide us in accomplishing this overarching aim of prevention. The primary purpose of this report is to examine and make Georgia citizens aware of the multidimensional circumstances surrounding unexpected child deaths. Careful analysis of the causes and contributing factors can lead to recommendations for changes in law, policy and practice as well as advance organizational learning. We want to improve outcomes for families while they are in our care, and learn what might be needed after our involvement has ended.

As Director of the Georgia Division of Family and Children Services, my vision is to build a better future for this state by developing the best child welfare agency in the world. My plan to realize this vision is called the *Blueprint for Change*, a three-pillar approach to reforming Georgia's child welfare system. The first pillar includes the establishment and adoption of a practice model that will serve as the foundation to keep children safe and strengthen families. The second pillar focuses on developing a robust workforce for the Division, both in numbers and level of expertise and training. The third pillar is focused on constituent engagement, which is an effort to engage with the public to build consensus and collaboration among partners, staff and stakeholders. The development of this report speaks to and sheds light on the importance of each of these pillars.

The understanding and prevention of child deaths is a shared responsibility among agencies that serve the children and families of Georgia. I am confident that public reporting of child fatalities, coupled with a thoughtful and intentional review, will support the achievement of our common goals to keep children safe, strengthen families and build stronger communities.

Bobby D. Cagle, Director
Georgia Division of Family and Children Services

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PURPOSE OF THE CHILD FATALITY ANALYSIS

As the primary state agency charged with intervening on behalf of vulnerable children in Georgia, the Division of Family and Children Services must continually review its practice and inform the public of efforts to reduce the risk of child abuse and neglect and mitigate its effects. For this reason, since 2012, the Division has generated an annual report on child deaths among children with any prior child welfare history, regardless of the cause of that death. For the purposes of this report, history is defined as any prior child protective services involvement with the agency within the past five years from the date of death. Through this report, the agency endeavors to provide information over and above the federal requirement[1] for states to review and analyze child fatalities.

Multiple, and to some extent, independent, entities collect data on child deaths in Georgia. The *2014 Child Fatality Analysis* complements the work of the Georgia Child Fatality Review Panel because both aid the agency and the public in improving intervention efforts and developing community-based solutions to reduce the risk of harm to Georgia's children. The Division is more closely focused on child deaths where the children and/or their families had child welfare history with the agency. In contrast, the Georgia Child Fatality Review process (led by the Georgia Bureau of Investigation) has a broader focus that reviews all unexplained, suspicious or unexpected deaths of any minor child in the state.

Therefore, the child deaths reported by the Division in this analysis should be understood as a subgroup of the deaths reported by the Georgia Child Fatality Review, as well as a subset of the overall child deaths reported to the Division during calendar year (CY) 2014 (see Figure 1.1 below). Additionally, data reported from the National Child Abuse and Neglect Data System (NCANDS) are yet another subset of Georgia deaths reviewed by the Division and should be separated from the children identified in this analysis. NCANDS does not distinguish whether prior history existed.

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

Figure 1.1. **Illustration of the Subset of Child Fatalities Discussed Within this Report Compared to all Child Fatalities in the General Population.**

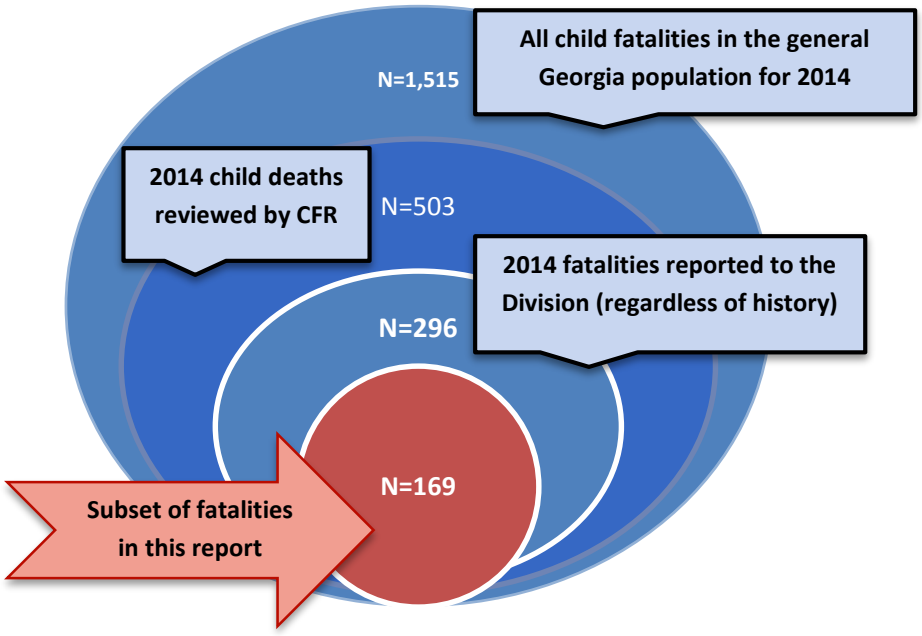


Figure Notes: The most recent data available for all child fatalities in the general Georgia population (1515) are from 2014. In 2014, the Georgia Child Fatality Review Panel reviewed 503 child deaths. For CY2014 a total of 296 child deaths were reported to the Division. Of these, 169 children were identified as members of families who had some form of child welfare involvement with the Division within the previous five years.

Ultimately, our ability to understand and prevent deaths among children with child welfare involvement will hinge on our capacity to contextualize these deaths by contrasting them with all child deaths in Georgia. Such context can provide further insight into case characteristics and circumstances surrounding a child's death. As our access to comparison data grows in the future, we will begin to learn whether these circumstances and characteristics serve to predict risk for child death.

METHODOLOGY OF THE DIVISION'S CHILD FATALITY ANALYSIS

This report reflects data collected only on child deaths that occurred between January 1, 2014 and December 31, 2014. Deaths included are only of children whose families had prior child welfare history with the agency within the previous five years.[2] This report does not include deaths reported to the Division with no prior agency history. Reports of child fatalities in this analysis are classified by cause and manner outlined in the subsequent section.

Since 2011, the Division has sought to improve child death data collection methodologies and strengthen reporting mechanisms. The Division's child death review team has aggressively pursued internal policy requirements regarding the reporting of child deaths. Efforts to engage external stakeholders on the need to provide accurate data have resulted in more consistent reporting of child fatalities. Though this process may reveal an increase in the number of identified child deaths, it has improved the agency's collection of child death data and will result in a more comprehensive analysis of child welfare practice going forward.

Child death data were analyzed by the Division's Data Analysis Unit and by Georgia State University (GSU) School of Public Health researchers. Collaborations with the Office of the Child Advocate and the Child Abuse and Prevention Treatment Act (CAPTA) prevention team also allowed for an additional review of many deaths and offered implications for both prevention and practice enhancements.

[2] *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."

CLASSIFICATION OF CHILD FATALITIES BY CAUSE AND MANNER

Defining the Causes and Manners of Death

The following figure provides a breakdown of the manner of child fatalities for children with prior history for CY2014 by percentage. Note that accidental and natural deaths represent over 50 per cent of the fatalities.

Figure 3.1. **CY2014 Manners of Death by Percentage for Children with Prior History.**

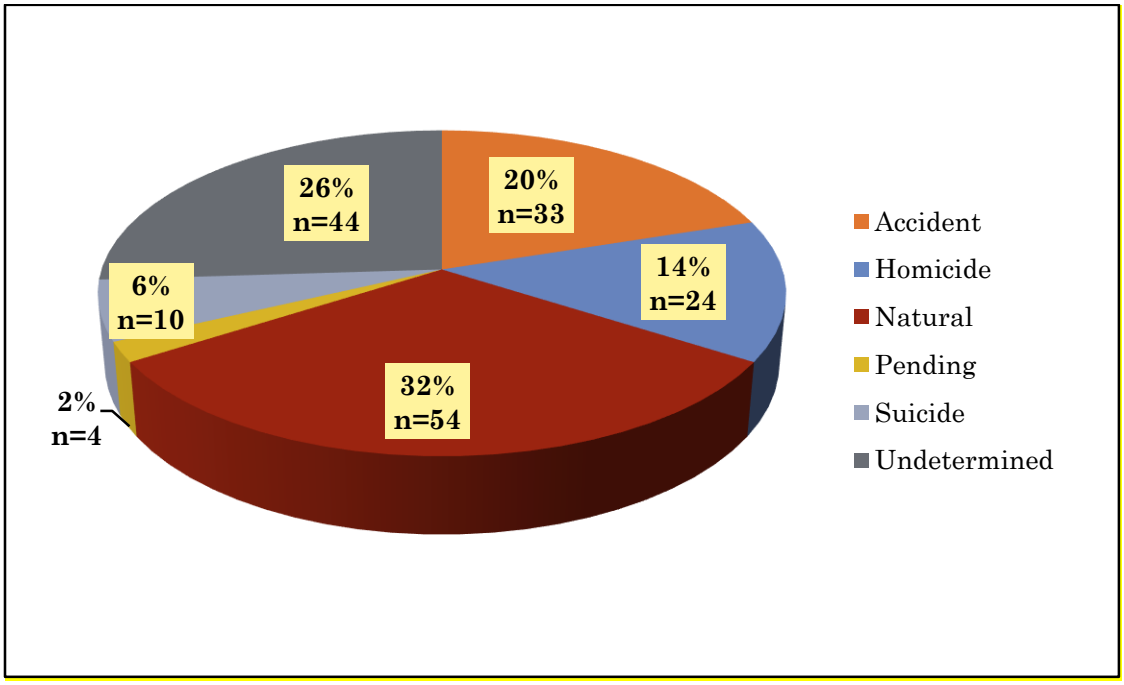
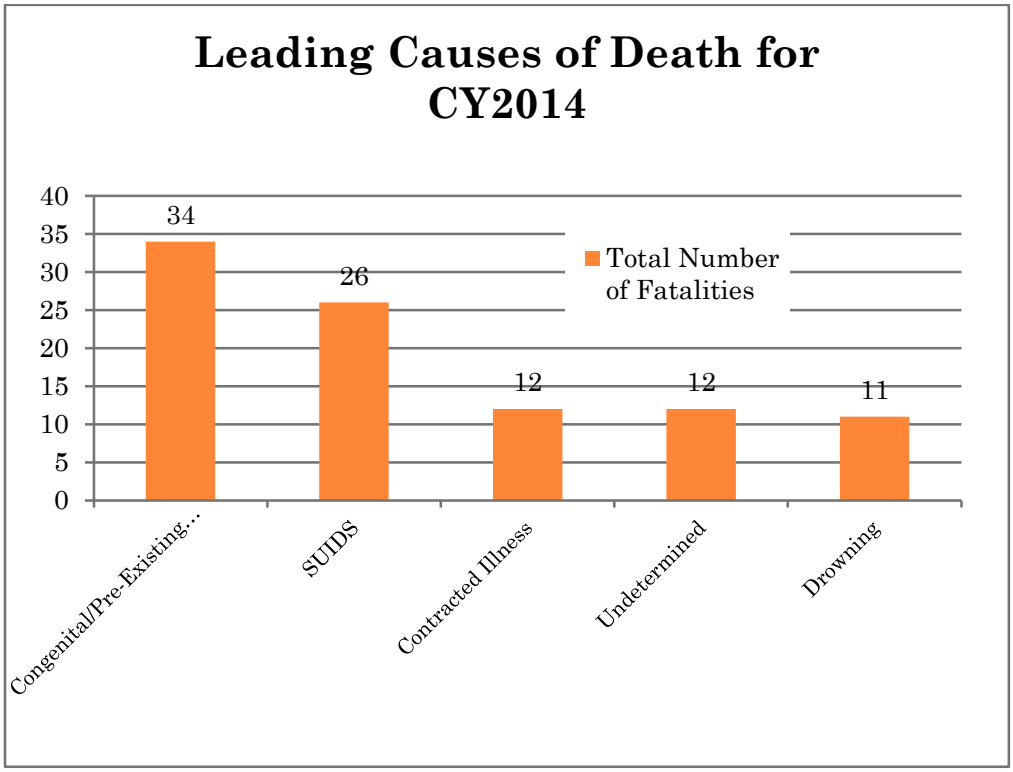


Figure 3.2 below provides information on the five leading causes of death for the CY2014 fatalities for children with prior history. In building on the data included in the previous figure, for those deaths classified as Natural, the leading cause of death was a congenital or pre-existing condition. The next highest cause of death was Sudden Unexplained Infant Death Syndrome (SUIDS) which always corresponds to the death of a child less than two years of age, and which most often occurs during a sleep-related event.

Figure 3.2. **CY2014 Leading Causes of Death for Children with Prior History.**



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. Note that within each manner of death, there could potentially be multiple causes of death. Additionally, it is important to note that an official cause and manner of death does not necessarily always correlate with 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 caregiver's actions (substance use) or inaction (lack of supervision), may have indirectly resulted in the death of the child. In a similar way, deaths attributed to the manner of homicide, may sometimes be at the hands of parents and therefore abuse related, or may be at the hands of a non-caregiver, and while the death may be ruled a homicide, there is no maltreatment by a caregiver.

Five classifications are used to describe the manner of death, including*: accident, homicide, natural, suicide and undetermined*. Each manner of death included in

this report is individually defined below. These are the five manners of death used on death certificates and autopsy reports.

- **Accident**: This classification is due to an unintended death; there is no evidence of intent to harm.
  - Examples of accidental causes of death:
    - Playground accident.
    - Fall from a tree.
    - Vehicular accident.
- **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.*
- **Natural**: This classification is due to diseases or medical conditions.
  - Examples of natural causes of death:
    - Children who were born prematurely or with congenital disorders.
    - Children who were diagnosed with diseases such as Leukemia or Cerebral Palsy, and whose deaths were due to 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.
- **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 of causes of death:
    - Some sleep-related deaths.
    - 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.

CHILD FATALITIES AND PRIOR DIVISION INVOLVEMENT

Description of Data

The data included in the *2014 Child Fatality Analysis* detail the manners and causes of death for children whose families had history with the Division within the previous five years. As noted earlier, the data included in this report do not reflect all child fatalities within the general Georgia child population. (See Figure 1.1 on p. 5). When a death is reported to a local Division office, it is forwarded to an internal review team that examines the circumstances surrounding the death. The Georgia Office of the Child Advocate works in partnership with the Division to further understand the events surrounding the death.

For CY2014 a total of **296** child deaths were reported to the Division. Of these, **169** children were identified as members of families who had some form of child welfare involvement with the Division within the previous five years.[3] During the same time period, the Division had contact with approximately 676,827 children. In CY2014, of the **169** deaths with agency history there were **85** fatalities that occurred after the Division ended involvement. In **84** of the fatalities the Division had an open case with the family at the time of death. This equates to **169** annual deaths per 676,827 children, or a rate of about 25 per 100,000[4]. To place this in context, 1,515 total children died in Georgia in 2014, which corresponds to a rate of about 61 per 100,000.

The following data provide a snapshot of the Division's overall Child Welfare caseloads for CY 2014:

- The total number of reports[5] to the Division: **102,003**
    - Screen Outs[6]: **24,813**
    - The total number of reports assigned to Child Protective Services (CPS) workers: **77,190**
        - **34,464 (45 percent)** were assigned to Family Support [7]
        - **42,726 (55 percent)** were assigned to Investigations[8]

[3] In comparison, for CY2013, the deaths of 180 children whose families had prior child welfare history were reported to the agency.
[4] This estimate is unadjusted for the number of new births in families, number of unreported children in the family, or recurrent reports for the same child during the 5-year period.
[5] A glossary of agency terms is included in Section 9.
[6] A glossary of agency terms is included in Section 9.
[7] A glossary of agency terms is included in Section 9.

- The total number of children in Foster Care[9] at some point in 2014: **15,085**
- The total number of Family Preservation[10] cases: **9499**

Child Fatality Review Process

Once a death has been reported to the agency, a review of circumstances surrounding the death is warranted. Although any preventable death deserves attention, deaths due to maltreatment are of special concern and require additional scrutiny because the Division is charged with investigating child abuse and neglect.

Specific causes and manners are typically determined by a coroner or medical examiner. Findings of maltreatment are not only based on physical indicators; experts often rely on additional information obtained by the Division, first responders and law enforcement. As a result of more in-depth reviews, the Division may identify maltreatment related concerns that were not initially apparent at the time of the death. This additional level of investigation and detection may increase the number of deaths attributed to maltreatment. Because states can differ substantially in their data collection methods and maltreatment definitions, state-to-state comparisons of maltreatment death rates are generally difficult to interpret or potentially misleading. Also, as states increase their scrutiny and improve their data systems, the number of maltreatment-related deaths may appear to rise, even if actual incidences are stable or actually declining.

Agency intervention involves a broad spectrum of potential services, for example:

- Prior or current Foster Care services.
- A report that was screened out because it lacked an allegation of abuse or neglect.
- Family Support cases where the allegation does not necessarily involve immediate child safety.
- Family Preservation cases where allegations of maltreatment or abuse may have been substantiated but the removal of the children was not necessary to ensure safety.
- Investigations where the Division confirmed an allegation of abuse or neglect occurred.

For the purpose of this report, a family includes a caregiver and any children included in the prior report, any newborn child or any child who has moved in since the prior report. Additionally, if the child leaves that home, the prior history follows that child.

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[8] A glossary of agency terms is included in Section 9.
[9] A glossary of agency terms is included in Section 9.
[10] A glossary of agency terms is included in Section 9.

The agency forwards data from both types of reports (with and without prior involvement) to the National Child Abuse and Neglect Data System (NCANDS). In 2014, **127** child death reports without agency history were made to the Division. Those deaths are excluded from this analysis. NCANDS does not distinguish whether the agency had prior history and thus only includes children whose deaths were a) reported to the Division and b) determined to be related to maltreatment.

The following table provides a breakdown of the specific types of history for deaths that occurred in CY2014. The total number of types of prior child welfare history is higher than the total number of child deaths for the year. This is because the Division may have had multiple interventions with a family; for example, the family may have had a prior Investigation as well as a prior Family Support case.

Table 4.1. **Type of History for Deaths that Occurred in CY2014 for Children with Prior History.**

History Type	Total Number
Investigation for abuse or neglect	125
Family Preservation	51
Diversion (practice ended April 1, 2012)	45
Family Support Services (practice began April 1, 2012 and replaced Diversion)	69
Screen Out	49
Foster Care (past and current)	32

Closed Cases

In CY2014 there were **85** fatalities with a closed case at the time of the child's death. In **17 percent** (**29**) of the total deaths for CY2014, the child who died was born after the completion of the Division's most recent involvement with the family.

In looking at child fatalities and prior agency involvement, the length of time between the most recent involvement and the death of the child is noteworthy. It has been shown that evidence-informed programs have a sustained effect at least one year beyond the end of treatment, with no evidence that the effect is lost after

this time.[11] The majority of homicides and suicides occurred more than 12 months after the close of the case. In addition, for suicide, children with history within the last five years committed suicide at a slightly lower rate per 100,000 than the general Georgia population (1.47 with history compared to 1.6 for the general population). For children with history within the last five years the homicide rate is approximately 1.5 times greater (3.39 with history compared to 2.3 for the general Georgia population).[12]

The following table outlines the length of time between prior agency involvement with the family and the child's death (for cases closed at the time of death), delineated by the five official manners of death.

Table 4.2. **Manners of Death and Length of Time Between Prior Division Involvement and CY2014 Child Fatalities for Children with Prior History.**

Length of Time between Prior Involvement with the Family & Child's Death	Homicide	Suicide	Accident	Natural	Un-determined	Pending	Total Number
0-12 months	6	1	8	8	16		39
13-24 months	4	3	5	6	5		23
25-36 months	1	2	4	1	1	2	11
37-48 months	2	1	2	1	2		8
49-60 months	1	0	0	1	2		4

[11] September 2009 FRIENDS National Resource Center for Community-Based Child Abuse Prevention (CBCAP)

[12] Data source: Georgia Department of Public Health, Office of Health Indicators for Planning, Online Analytical Statistical Information System.

Open Cases

An open case indicates active agency involvement with a child or family. In CY2014 there were **84** fatalities with an open case at the time of the child's death.

Of these **84** open cases; **41percent** of them, (**35** cases), had a substantiated finding of maltreatment in the child's death. That is a rate of 5.1 per 100,000 children in the general population. Table 4.3 below breaks down these **35** fatalities by case type and whether the case was open prior to the death or due to the incident that caused the death.

Table 4.3. **Number of CY2014 Substantiated Fatalities with an Open Case at the Time of Death (with case type) for Children with Prior History.**

Substantiated Fatalities with Open Cases at the Time of Death	Investigation for Abuse or Neglect	Family Preservation	Family Support Services	Foster Care
Case open prior to incident that led to the death	15	7	9	3
Case open due to incident that led to the death	0	0	0	1
Total number (and percentage) of open cases at the time of death	15 (18%)	7 (8%)	9 (11%)	4 (5%)

The following table (Table 4.4) provides a similar breakdown to Table 4.3 above for open cases with a substantiated finding of maltreatment in the death, but is broken down by the official manner of death. Again, note that as of September 1, 2015 one death on an open case is still awaiting an official finding from the Medical Examiner and therefore has a manner of death considered "Pending". This death is not included in the table below.

Table 4.4. **Number of CY2014 Substantiated Fatalities with an Open Case at the Time of Death (with manner of death) for Children with Prior History.**

Substantiated Fatalities with Open Cases at the Time of Death	Homicide	Suicide	Accident	Natural	Undetermined
Case open prior to incident that led to the death	7	2	7	4	8
Case open due to incident that led to the death	2	0	2	2	0
Total number (and percentage) of open cases at the time of death	9 (11%)	2 (2%)	9 (11%)	6 (7%)	8 (10%)

Implications for Practice

Deaths of children with agency contact may occur in multiple ways, and therefore have different implications for understanding, learning, and improving practice. One of the most concerning manners of death for the Division is when children suffer a violent death at the hands of a caregiver where the risk was pre-existing and the interventions offered failed to shield the child or to reduce the risk. In these cases, maltreatment is the proximal cause of death. These types of incidents raise service improvement questions about risk assessment (e.g., was the risk detectable?), provision of services (e.g., were the services appropriate?), decision making (e.g., was maintaining the child in the parents' home a reasonable decision?), and management of aftercare needs (e.g., were post-termination services adequate?).

Other manners of death may be caused by complex circumstances in which parental negligence plays a partial but not a proximal or even necessary role. For example a child may die in a vehicular accident in which the child was not properly secured in a car seat, or a child may die from an illness complicated by delayed medical care. These types of cases may alert case managers about possible future maltreatment if other children are present in the home.

However, in some situations the agency may end its involvement with a family after it has ensured the safety of existing children in the home, but the parent(s) may later bear other children who are not known to the Division. For example, a drug addicted mother may have all of her children removed from her care. As a result the

Division would close its case because she has no other children in her home and risk has been reduced. The mother may later have additional children and a report is made because she has given birth to a drug exposed infant; the infant has medical complications and dies due to those complications. The implications for practice under these types of scenarios would focus on strategies involving Georgia's maternal and child health system and community supports.

The Division continuously reviews its practices at many levels. Whenever the agency has had prior involvement with a family, there is an opportunity to review its response and potentially the responses from other agencies that may have been involved in the child's life. Agency intervention in a family's life can be crucial and have lasting effects. Open and effective communication between all parties who have a responsibility to ensure a child's safety is critical to having successful outcomes for children.

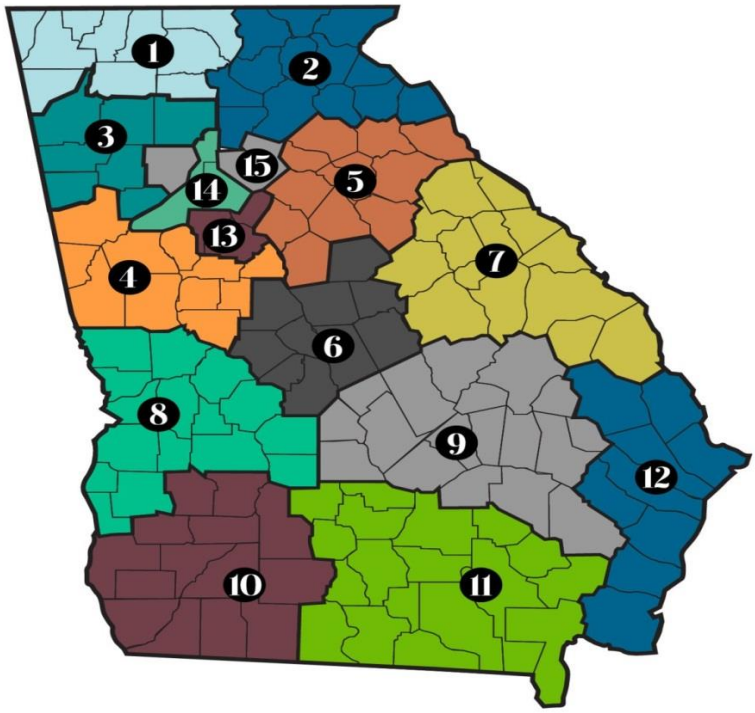
SUMMARY OF DATA FINDINGS

Between January 1 and December 31, 2014, the deaths of **169** children whose families had prior history were reported to the agency. This represents a rate of about 25 deaths per 100,000 children with prior agency involvement. It should be noted that the following statistics are not mutually exclusive; a death may be represented in more than one of the categories below.

- **27** percent (**46**) of children had a substantiated finding of child abuse and/or neglect prior to his/her death.[13]
- **41** percent (**69**) of children had a substantiated finding of maltreatment in relation to their deaths.
- **32** percent (**54**) of the total deaths were determined to be a result of natural causes.
- **46** percent (**77**) of the deaths were of children under the age of one year.
- **50** percent (**84**) of the deaths were of children whose families had an open case at the time of their deaths.
- **32** percent (**54**) of the children who died were classified as having special needs.
- **31** percent (**53**) of deaths were infants who died during a sleep related event.
- **58** percent (**98**) of the deaths were children whose caregivers had an alleged history of substance abuse.
- **27** percent (**45**) of the deaths were children whose caregivers had a history of alleged mental health issues.
- **38** percent (**65**) of the children who died had caregivers who had been convicted of criminal offenses.
- **33** percent (**55**) of the children who died were in families who had caregivers with alleged histories of domestic violence.

[13] 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]

Figure 5.1. **Division of Family and Children Services Regions.**



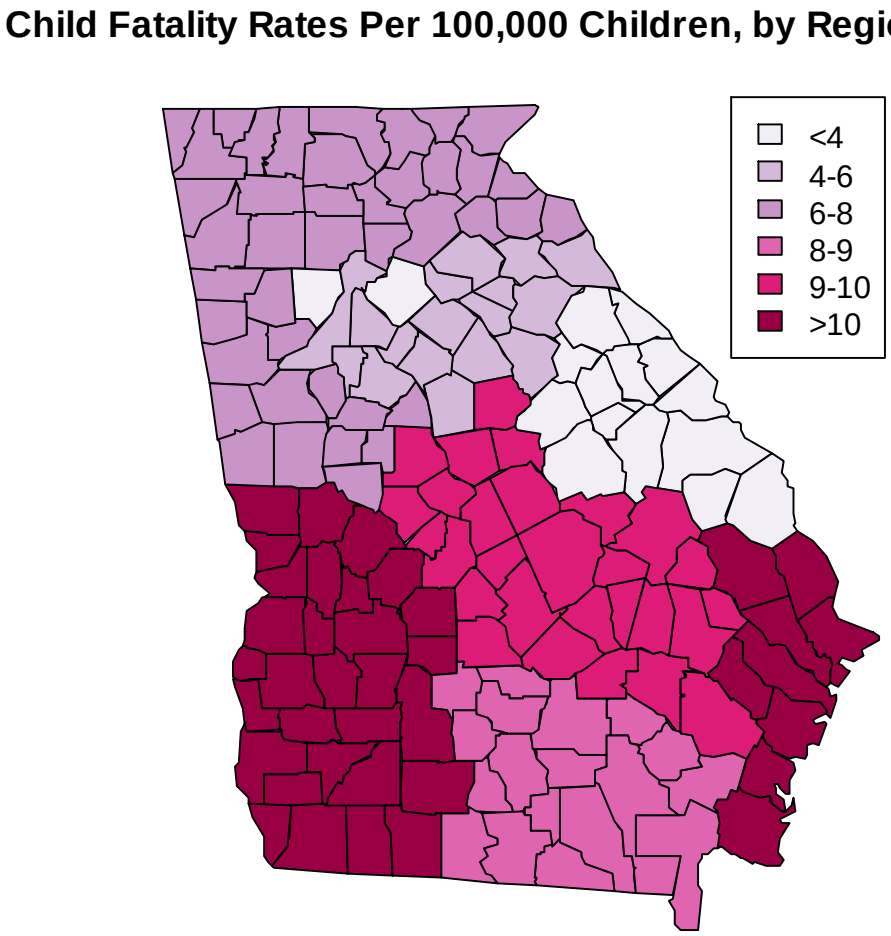
During CY2014 the Division was divided into 15 regions, which cover all 159 counties throughout the state (*see Figure 5.1 at left*). Effective July 2015 a new structure was implemented consisting of three districts that encompass 14 regions and cover all 159 counties throughout the state. Each county office is responsible for providing reports directly to the state office when a child fatality is reported in their county.

Table 5.1. **CY2014 Child Fatality Numbers/Percentages for all Division Regions.**

Region	Counties Within the Region	Total Number	Rate Per 100,000 Children in the Region	Region Percentage of State Total
1	Catoosa, Chattooga, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield	8	6.7	5%
2	Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union, White	12	6.6	7%
3	Bartow, Cherokee, Douglas, Floyd, Haralson, Paulding, Polk	14	6.2	8%
4	Butts, Carroll, Coweta, Fayette, Heard, Lamar, Meriwether, Pike, Spalding, Troup, Upson	12	7.2	7%
5	Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe, Walton	7	4.3	4%
6	Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Putnam, Twiggs, Wilkinson	11	9.2	7%
7	Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes	5	3.9	3%
8	Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor, Webster	10	10.1	6%
9	Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler, Wilcox	8	9.9	5%
10	Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth	11	11.4	6%
11	Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware	8	8.8	5%
12	Bryan, Bulloch, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh	19	10.4	11%
13	Clayton, Henry, Rockdale	7	4.1	4%
14	DeKalb, Fulton	24	5.3	14%
15	Cobb, Gwinnett	13	3.0	8%
Totals	Statewide	169	6.2	100%

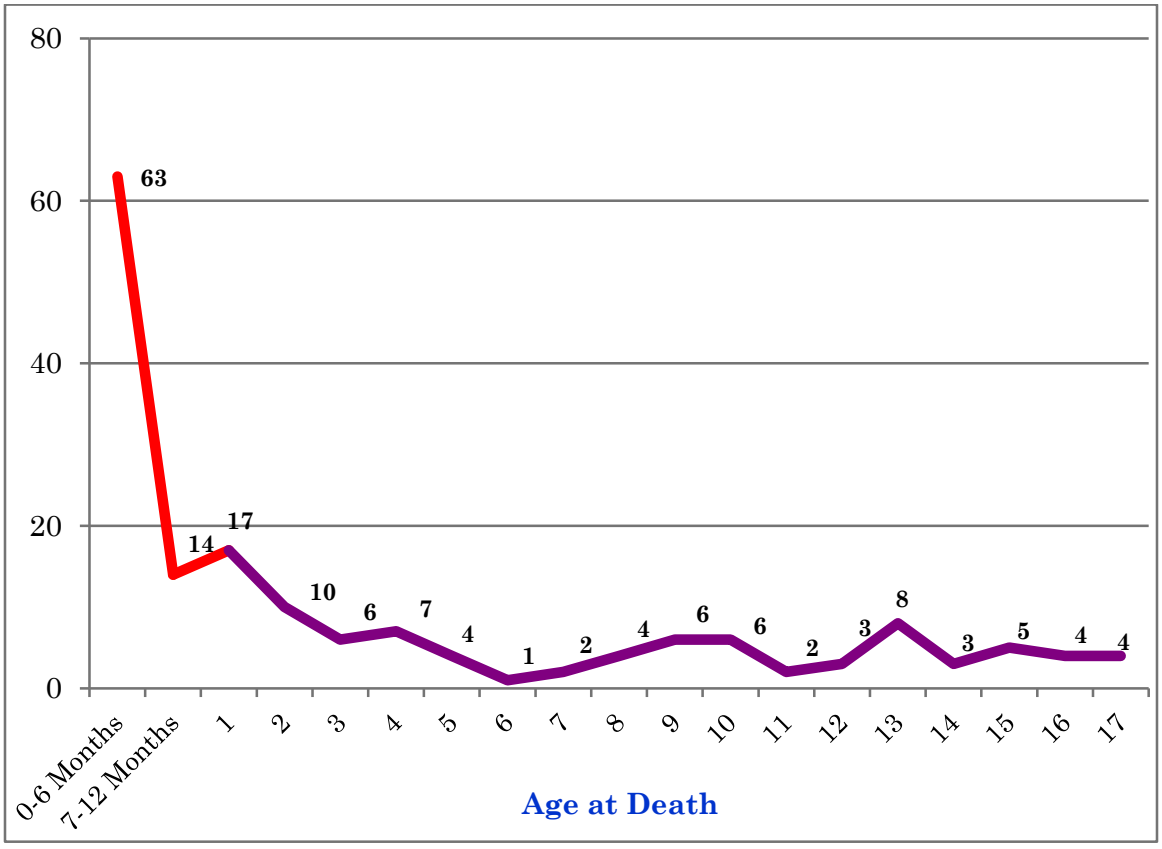
Figure 5.2. **CY2014 Child Fatality Rates per 100,000 Children by Region.**

The following heat map of Georgia shows rates of child fatalities with prior Division history. Rates are calculated per 100,000 children in each region. While there are contextual concerns underlying this representation (e.g. regions with few children that experienced an incident resulting in multiple deaths could see an elevated rate), it does suggest areas worthy of further investigation and increased collaboration with other state agencies.



The following figure displays the ages of children in CY2014 at the time of their deaths. Children under the age of one year account for 77 or 46 per cent of the deaths, and **56 per cent** (**94**) of the deaths were of children under the age of two years. This conforms to national trends that show that children are most at-risk in their first year of life. The remaining **44 per cent,** (75) of the deaths for CY2014 comprise children between two and 17 years of age. This data reinforces the vulnerability of infants and young children, but also draws attention to the need for greater advocacy and for campaigns that inform new parents about risk factors that result in preventable child deaths.

Figure 5.3. **Ages of Children at the Time of Death for Children with Prior History.**



VULNERABLE POPULATIONS

Children Under the Age of One

In CY2014, **77** deaths were children under the age of one year. For these cases, the primary manner of death (see Table 6.1) was Undetermined (**40** total) and the secondary manner was natural causes (**25** total). This corresponds to the leading two causes of death for this age group (see Table 6.2) which were Sudden Unexpected Infant Death Syndrome (**26** total) and congenital or pre-existing conditions (**19** total). Additionally, **50** of the **77** children (**65per cent**) in this age group had caregivers who were alleged to have been engaging in substance use at some time during the Division's involvement with the family. Unsafe sleep practices have also been identified as a major factor in children who died during a sleep-related event. Being placed on a soft surface and/or sharing sleep surfaces with adults or siblings remain factors in sleep-related deaths. This is a recognized public health problem nationwide, and underscores the need for educating parents and caregivers about infant safe-sleep practices not only used during night time sleeping, but also during any sleep related event throughout the day.[14]

Table 6.1. **Manners of Death in CY2014 for Children under the Age of One for Children with Prior History.**

Age	Accident	Homicide	Natural	Undetermined
0-6 months	7	2	22	32
7-12 months	1	2	3	8
Total Number	8	4	25	40
Percentage of Total Deaths	10%	5%	32%	52%

[14] The Centers for Disease Control and Prevention report that in 2013 the leading causes of infant deaths were: birth defects, preterm birth, sudden infant death syndrome (SIDS), maternal complications of pregnancy and injuries (e.g. suffocation).

Table 6.2. **Leading Causes of Death in CY2014 for Children under the Age of One for Children with Prior History.**

Age	Sudden Infant Death Syndrome (SIDS)	Sudden Unexpected Infant Death Syndrome (SUIDS)	Congenital/ Pre-Existing Condition	Undetermined
0-6 months	5	24	15	6
7-12 months	1	2	4	1
Total Number	6	26	19	7
Percentage of Total Deaths	8%	34%	25%	9%

Children in Foster Care

11 foster children died in 2014:

- **6** of those deaths were ruled natural due to complications from medical conditions.
- **4** children died due to homicide:
  - **1** murdered by an unknown person while the child had run away from his placement
  - **2** who allegedly died at the hands of their caregivers (foster parents)
  - **1** child who was allegedly killed by his caregivers (non-foster parents) and brought in to the Division's custody due to that incident
- **1** child was accidentally killed when hit by a car while walking with a friend.

All of the homicides are still under criminal investigation.

Table 6.3. **Manners of Death in CY2014 for Children in Foster Care at the time of Death for Children with Prior History.**

Manner of Death	Accident	Homicide	Natural	Undetermined
Total Number	1	4	6	0
Percentage of Total Deaths	0.6%	2%	3%	0%

Prenatally Substance-Exposed Children

There were **27** (**16per cent**) children of the **169** who had a history of prenatal exposure to drugs. All but four of them were under the age of one at the time of their deaths. While it is difficult to link deaths exclusively to prenatal exposure, both the effects of exposure and the continued impairment of an adult caregiver can put infants at risk. When a child is exposed prenatally, complications can occur, leaving the child more vulnerable due to low birth weight, extreme prematurity, etc. Some women, who abuse or use substances, curtail or stop their use upon pregnancy recognition. Addicted parents can have multiple impairments. A parent or caregiver in an altered state places children at risk, especially when the caregiver is unable to provide and recognize what is a safe environment for the child. In addition, addicted parents may live in households rife with violence and instability. Addiction is treatable, but recovery is neither quick nor easy, and lapses back into substance abuse are not uncommon. Addiction recovery is best viewed as a long-term task, extending well beyond the time frame of involvement of a child welfare agency. Deaths associated with caregivers' abuse of methadone, alcohol, prescription medication, and illegal substances have been reported to the Division and continue to be a challenging feature of the child welfare population. When substance use is coupled with co-sleeping, or a special needs child, the risk is even higher.

There were **11** prenatally-exposed children born prematurely. Of those, many had complex medical issues. Of these children, six died before they left the hospital. The majority of the caregivers for these **11** children had been identified as having mental health needs and/or had domestic violence in their past or present.

Children/Families with Multiple Risk Factors

Often families who have history with the Division and have experienced a child death are affected by multiple risk factors, including, but not limited to, substance abuse, domestic violence, mental health issues, and criminal history and/or having a child with special needs. The greater the complexity of the issues within a family, the more challenging it can be for professionals to assess the ongoing safety of the children. Naturally, families are not always comfortable or willing to expose areas they may find embarrassing or difficult to address, making safety assessments even harder to thoroughly complete. Nevertheless, the Division recognizes the crucial need to consistently assess and address these multiple risk factors for such cases.

The following four tables (Tables 6.4, 6.5, 6.6, and 6.7) provide a breakdown of the CY2014 deaths based on several risk factors: substance abuse, domestic violence and having a child with special needs. Note that **44** (**26 per cent**) of the total deaths for children with history involved the exposure of the child to ***both*** domestic violence and substance abuse.

Table 6.4. **Manners of Death in CY2014 for Children with Prior History and Caregivers Alleged to be Involved in Substance Abuse.**

Exposure History	Accident	Homicide	Natural	Suicide	Undetermined
Children Exposed to Substance Abuse	22	15	30	3	27
Percentage of Total Deaths	13%	9%	18%	2%	16%

Table 6.5. **Manners of Death in CY2014 for Children with Prior History and Caregivers Alleged to be Involved in Domestic Violence.**

Exposure History	Accident	Homicide	Natural	Suicide	Undetermined
Children Exposed to Domestic Violence	13	8	12	2	19
Percentage of Total Deaths	8%	5%	7%	1%	11%

Table Note: The number of fatalities where the child had been exposed to caregivers who had a history of domestic violence may actually be underreported due to a general reluctance of families to disclose its occurrence. Therefore, these numbers may actually be higher than what has been reported in this analysis.

Table 6.6. **Leading Causes of Death in CY2014 for Children with Prior History and Caregivers Alleged to be Involved in Substance Abuse or Domestic Violence. (Note: Some children may be captured in both categories and the total reflects the category of exposure and not the number of children)**

Exposure History	Congenital/ Pre-Existing Condition	SUIDS	Contracted Illness/Disease	Undetermined
Children with Caregivers Alleged to be Exposed to Substance Abuse	18	17	6	6
Children with Caregivers Exposed to Domestic Violence	6	10	2	6
Total Number	24	27	8	12

Table 6.7. **Manners of Death in CY2014 for Special Needs Children with Prior History.**

Manner of Death	Accident	Homicide	Natural	Suicide	Undetermined
Total Number	3	5	40	0	5
Percentage of Total Deaths	2%	3%	23%	0%	3%

Teen Deaths

CY2014 identified **24** teenagers between the ages of 13 and 17 who died and also had prior history with the Division.

- **7** committed **Suicide: 3** by hanging, **3** by self-inflicted gunshot wounds and **1** overdose.
- **6** died due to **Accidental** causes: **4** died in motor vehicle related incidents, **1** drowning and **1** child who was special needs who developed hypothermia and had a seizure disorder.
- **6** died due to **Homicide**: **5** by gunshot wounds and **1** by stabbing. None of the homicides were committed by a direct caregiver; perpetrators were identified as either an unknown person, or a friend of the child. One child was killed by a law enforcement officer.
- **5** died due to **Natural** causes: **4** by a congenital pre-existing condition and **1** due to a bronchial asthma attack.

UNSAFE SLEEP ENVIRONMENT

Many of the sleep-related deaths involved incidents where there was a combination of co-sleeping and an overall unsafe sleep environment. Caretakers falling asleep with infants in chairs, couches, and adult beds was a factor in many cases. It is always recommended that infants sleep alone in their own separate sleep space. For the infants who died in CY2014, many of the causes of death were either ruled as SUIDS or Undetermined. Review of these fatalities has uncovered other mitigating factors not readily observed at the time of death such as substance use, depression of a parent, and/or parents placing children on soft sleep surfaces (blankets, pillows, etc.). Circumstances around sleep related deaths continue to be explored in order to identify underlying contributing factors. All **39** of the deaths for children under the age of one year that were ruled as Undetermined, involved sleep-related factors. Additionally, of the **seven** deaths ruled Accidental for this age group, **five** were sleep-related. In 36 of the **53** sleep-related deaths, caregivers were alleged to be using drugs at some time during the agency's involvement with the family. The Division believes the majority of these deaths were preventable.

CONCLUSIONS AND RECOMMENDATIONS

The following conclusions and recommendations are drawn from the CY2014 child fatality analysis:

Most Vulnerable Children

In CY2014, **94** (**56 per cent**) of the **169** deaths, occurred in children younger than two years of age. For children under the age of two, 37 had a substantiated finding of maltreatment at the time of their death. Further, **77** of this cohort were under age one. This population is at greatest risk of maltreatment. Due to their young age and the likelihood they will spend most of their time out of public view, these children are less visible to the network of mandatory reporters.

Recommendations:

The Division should continue to collaborate with other child serving agencies, such as the Department of Public Health, Department of Early Care and Learning (DECAL), the Office of the Child Advocate and other agencies in continuing to identify educational opportunities that inform parents about the vulnerabilities young children encounter. Additionally, the Division should reach out to all health care providers of this age group and advise them about the criteria for making referrals for this vulnerable population.

Substance Abuse and Prenatal Exposure

Caregiver substance abuse continues to be a contributing factor in child safety. Effectively assessing whether a substance-abusing caregiver is adequately equipped to care for a child is challenging for case managers. Denial of drug use by caregivers 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 as well as gathering pertinent information from collaterals that can either support or negate allegations.

When substance abuse is coupled with caring for a child under the age of two, assessing safety can be even more challenging. Caregivers using substances can be effective at concealing their usage, and often a snapshot of a family does not reveal

the whole picture. Non-verbal children who are at home with substance abusing caregivers are at high risk of maltreatment.

Recommendations:

Staff should receive intensive training annually on how to identify signs of substance abuse by caregivers. This should include developing critical thinking skills leading to more accurate assessments related to substance abuse by caregivers.

Case managers should be trained on how to assess impending danger involving a substance abusing caregiver.

Safe Sleep and Impaired Sleeping

The Division, along with other partner agencies, continues to educate families and the general public about what constitutes a safe sleep environment. Some of the challenges the agency faces are around the perception of a shared sleep surface and bed-sharing. The agency strives to share information with caregivers on the potential dangers of co-sleeping with an infant, but the message behind this is often lost due to preconceived ideas. Some believe co-sleeping with a child increases the bond between a parent and their child and, in this belief, may overlook contributing factors to child safety. For example, caregivers who are impaired by alcohol or drugs (both prescription and non-prescription) continue to increase the risk of death to children under the age of one when coupled with co-sleeping and by placing children on unsafe sleep surfaces.

Additionally, unsafe sleep surfaces can be detrimental to newborns and especially premature infants. Children should sleep on their backs, alone and on a firm surface. Placing blankets, pillows or other soft materials under an infant can lead to an unexpected death.

Recommendations:

The Division should distribute safe sleep information as a part of the administration of food stamps, TANF and Medicaid programs for all families with children younger than two years of age.

The Division should encourage prosecution of impaired adults in egregious circumstances and continue to work collaboratively with law enforcement to ensure all pertinent information is shared between agencies.

The Division should partner with birthing hospitals, pediatricians and public health to distribute safe sleep information.

Teen Deaths

Research indicates teens who have suffered rejection or trauma, like those who have experienced abuse and/or neglect, are at an increased risk for suicidal behavior. Parenting any teen requires continuous monitoring; however, for youth who have experienced rejection and trauma, caregivers need to be even more diligent regardless of whether or not the youth is in state custody.

Recommendations:

The Division should encourage points of contact from other child-serving agencies, including medical professionals and schools, to consider prior Division history as a potential risk factor for the child.

The Division should, at the close of each involvement with youth in this age group, provide information to caregivers at the exit conference about the heightened risk to youth who have experienced trauma due to abuse or neglect.

The Division should encourage youth suicide awareness and prevention training for providers and other community partners.

Systemic Factors

During CY2014 the Division recognized significant gaps in the delivery of services and meeting the expectations of the citizens of Georgia. In response to these challenges, the Blueprint for Change was initiated to strengthen service delivery. A significant portion of the Blueprint for Change relates to the implementation of a practice model. A practice model provides guidance regarding interactions with families. Georgia has chosen Solution Based Case Work (SBC) for the foundation of its comprehensive practice model. At its core SBC addresses the needs of the family, and provides an evidence-informed framework for engagement with the Division.

Recommendation:
The Division should continue with implementation of both the Blueprint for Change and especially the practice model. Special consideration should be given to lessons learned from child deaths as a part of SBC.

GLOSSARY

Abuse - any non-accidental physical injury or physical injury which is inconsistent with the explanation given, suffered by a child as the result of the acts or omissions of a person responsible for care of a child; and includes:

1. Emotional Abuse
2. Sexual Abuse, sexual exploitation or commercial sexual exploitation of children
3. Prenatal abuse
4. The commission of an act of family violence as defined in O.C.G.A. 19-13-1 in the presence of a child. An act includes a single act, multiple acts, or a continuing course of conduct. As used in this subparagraph, the term presence means physically present or able to see or hear.

Closed case - agency involvement with a child or family has been concluded.

Collateral contacts -engage as many persons as necessary as collateral contacts, via face-to-face, telephone or email, in order to provide pertinent and purposeful information for the assessment of allegations of abuse or neglect, child safety and well-being, achievement of permanency, caregiver protective capacity and family conditions during an Investigation, Family Support Services, Family Preservation Services and Permanency intervention. NOTE: Collateral contacts are individuals that can provide reliable information about the family and are not meant to be "character references."

Family Preservation Services (FPS) - is described by the Family Preservation and Support Services Act of 1993 (PL 103-66) as a continuum of family-focused services for at-risk children and families. Services include activities designed to assist families in crisis, often where a child is at risk of being placed in out-of-home care because of abuse and/or neglect. Support services include preventive activities, typically provided by community-based organizations designed to improve the nurturing of children and to strengthen and enhance the stability of families.

Family Support Services - the reported allegations of maltreatment met Georgia statute and DFCS policy requirements; however, no active safety threat or impending danger was identified.

Foster Care - the Foster Care program provides temporary out-of-home care for children who cannot legally remain safely in their home. Foster Care services are also provided for eligible Foster Care youth ages 18-21 through the Extended Youth Support Services program unless they opt out of participation.

History - is often a predictor of future behavior and the information included in DFCS case history concerning a family plays a significant role when making an intake decision. A family's Child Protective Services (CPS) and Permanency (Foster Care) history must be thoroughly analyzed and considered in relation to the new information being communicated by a reporter. This includes but is not limited to all prior involvement with DFCS, whether reports were screened in or screened out. A thorough review of DFCS history includes reviewing any current or prior cases involving Family Support Services, Investigations, Permanency and Resource Development. A thorough review also includes review of pertinent information uploaded in external documents within Georgia SHINES.

Investigation – the stage of the CPS case process during which the CPS caseworker determines the validity of the child maltreatment report, assesses the risk of maltreatment, determines if the child is safe, develops a safety plan if needed to ensure the child's protection, and determines services needed.

Neglect – the failure to provide for the child's basic needs. Neglect can be physical, educational, or emotional. Physical neglect can include not providing adequate food or clothing, appropriate medical care, supervision, or proper weather protection (heat or coats). Educational neglect includes failing to provide appropriate schooling, failing to address special educational needs, or allowing excessive truancies. Psychological neglect includes the lack of any emotional support and love, chronic inattention to the child, exposure to spouse abuse, or exposure to drug and alcohol abuse.

Open case - active CPS agency involvement with a child or family.

Physical abuse – the inflicting of a non-accidental physical injury. This may include burning, hitting, punching, shaking, kicking, beating, or otherwise harming a child. It may, however, have been the result of over-discipline or physical punishment that is inappropriate to the child's age.

Report - any information received by the Division, alleging known or suspected instances of child abuse and/or neglect, including reports of physical or mental injury, sexual abuse or exploitation or negligent treatment or maltreatment of a child under circumstances that indicate the child's health or welfare is threatened.

Screen Out - the reported allegations of maltreatment did not meet Georgia statute and DFCS policy requirements concerning child abuse and neglect.

Substantiated – an investigation disposition concluding that the allegation of maltreatment or risk of maltreatment was supported or founded by State law or State policy. A substantiated finding means credible evidence was found to support that child abuse or neglect has occurred.

Unsubstantiated (not substantiated) – an investigation disposition that determines there is not sufficient evidence under State law or policy to conclude that the child has been maltreated or is at risk of maltreatment. An unsubstantiated finding means that credible evidence was not found to support child abuse or neglect has occurred.