Office of the Child Advocate For the Protection of Children

Annual Report 2011

Tonya Boga, Child Advocate

Nathan Deal, Governor

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OFFICE OF THE CHILD ADVOCATE

December 2011

The Honorable Nathan Deal, Governor
Honorable Members of the Georgia Legislature

In accordance with my statutory responsibility as the Child Advocate for the State of Georgia, I respectfully submit the 2011 Annual Report.

This report provides an overview of the activities of the Office of the Child Advocate for the Protection of Children from January 2011-December 2011, a summary of the complaints received and investigated, and an overview of Georgia's child fatality review. In addition to the aforestated information, it includes recommendations for positive change within our child welfare system in order to improve the outcomes for our precious children.

The Office of the Child Advocate for the Protection of Children is very pleased and proud of the leadership and support of Governor Deal and the Georgia Legislature.

Thank you for the opportunity to serve the children of our great state.

Very Respectfully,

Tonya Boga
Georgia's Child Advocate

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MISSION

The Office Child Advocate for the Protection of Children ("OCA") retained the mission statement as adopted in 2010. *Our mission is to promote positive change in public policy and improvements in practice to ensure the safety, health, and well-being of Georgia's children.* As advocates for the protection of children, OCA developed and utilized a daily working mission: "Leave it better than you found it" to implement its mission. Our mission is a daily goal for which we all strive to achieve. Sometimes that means we advocate for a policy change within the Division of Family and Children Services; sometimes we advocate for a specific child's placement to change; we advocate for prevention efforts on the primary causes of child deaths to occur as community based initiatives; other times we train groups of coroners, law enforcement officers, nurses, medical unit responders, school personnel, attorneys, social workers, forensic interviewers, counselors, and other professionals who work in the area of child welfare.

HISTORY

In the years leading up to 2000, the Georgia Department of Family and Children Services ("DFCS") as it was then called experienced a period of intense scrutiny for inadequate and untimely responses to cases of abuse and neglect of children in Georgia. A number of these cases resulted in fatalities and eventual prosecution of either foster or natural parents. During the latter part of 1999, Georgia received national exposure in a segment of 60 Minutes that highlighted failures within the protective services system. The focus of the 60 Minutes segment was on the death of Terrell Peterson, a five-year-old boy who died of severe abuse despite repeated warnings to DFCS that he was in extreme danger. During the 2000 session of the Georgia General Assembly, legislation designed to improve the child protective services and to bring a system in which there is more accountability to DFCS was introduced, thus, the creation of the Office of the Child Advocate ("OCA") in 2000. Georgia became the twelfth state to open an independent ombudsman office designed to protect the rights of children in state care and to monitor the agencies charged with protecting those children. OCA has independent oversight of DFCS and others responsible for providing services to or caring for children who are victims of child abuse or neglect, or whose domestic situation requires intervention by the state.[1]
In 2008, initially through Executive Order and later legislation, the Office of the Child Fatality Review was merged into the Office of the Child Advocate. The General Assembly found that the well-intentioned efforts over the years have resulted in the creation of several agencies focused on preventing child abuse and juvenile delinquency, on serving at-risk families and troubled

[1] O.C.G.A. 15-11-170

children, and on promoting the improvement of our state's child welfare system. The General Assembly further found that the work of some of the agencies overlapped and that the at-risk families and troubled children of our state would be more efficiently and effectively served by placing the functions of the Georgia Child Fatality Review Panel under the supervision of the Child Advocate for the Protection of Children and encouraging the consolidated agencies to create a consistent vision for serving the needs of Georgia's families.[2]

Our current vision at OCA is a Georgia in which all children and youth reach their fullest potential in a safe and permanent family environment.

AUTHORITY

The purpose, authority, and duties of the Child Advocate are set forth in O.C.G.A.§ 15-11-170 through §15-11-177. OCA is entrusted with the responsibility to

1) Investigate and seek the resolution of complaints made by persons where it appears that the health, safety, or welfare of a child has been adversely affected;
2) Communicate privately with any child and with the child's parents or guardian;
3) To fulfill these duties and responsibilities it is given the authority to access all records and files of DFCS concerning or relating to a child;
4) Inspect, copy and subpoena records held by clerks of the various courts, law enforcement agencies, service providers, including medical and mental health, and placement providers;
5) Review the facilities and procedures of any institution or residence, public and private, where a child has been placed by DFCS or a court and is currently residing;
6) Engage in programs of public education and legislative advocacy concerning the needs of children requiring the intervention, protection, and supervision of courts and state and county agencies;
7) Coordinate and supervise the work of the Georgia Child Fatality Review Panel created by Code Section 19-5-4 and provide such staffing and administrative support to the panel as may be necessary to enable the panel to carry out its statutory duties.

[2] Ga. L. 2008, p. 568, section 2, not codified by the General Assembly

BUDGET AND OPERATIONAL CHANGES

OCA absorbed an 8% budget reduction during the 2011 legislative session. More recently to comply with instructions for the amended 2012 fiscal year, OCA submitted a reduction plan at the 2% level. The reduction was satisfied through adjustments within the agency's operating budget.

OCA began its move to Capitol Hill in late 2010 and completely settled into its new location in 2011. The Macon and Atlanta office formerly located at Park Place are completely closed. All staff are now in one location on Capitol Hill which results in significant cost savings, and an office that is able to work together more cohesively to better serve the needs of Georgia's children.

AGENCY BOARDS

OCA is associated with two advisory boards; the Child Fatality Review Panel and the Office of the Child Advocate Advisory Committee both dedicated to helping fulfill the mission of protecting our children. The members of the Child Advocate Advisory Committee are: David Crooke, CarePartners of Georgia (For Profit Children Agency); Dr. Allison Doerr, Northstar Educational and Therapeutic Services (Psychologist) ;Laura Eubanks, Gwinnett County Public Schools (Social Worker); Amy Howell, (Attorney);Lisa Coogle Jones, Southwestern Judicial Circuit Judge (Juvenile Court Judge); Jose Rodriquez, WellStar Kennestone Pediatric Associates (Pediatrician) and *Vacant*, (Non-Profit Children Agency).

The members of the Child Fatality Review Panel are Judge Velma Tilley, Bartow County Juvenile Court (service ended in 2011) and Judge Peggy Walker, Douglas County Juvenile Court (service began in 2011); Vanita Hullander, Catoosa County Coroner (service began in 2011); E.K. May, Washington County Coroner (service began in 2011); Barbara Lynn Howell, Criminal Justice Coordinating Council ;Dr. Mary Burns, Georgia Department of Human Resources ;Dr. Nancy Fajman, Emory University School of Medicine; Brett Harrell, GA Representative; Vernon Keenan, Georgia Bureau of Investigations ;Rachelle Carnesale, Division of Family and Children Services (services ended 2011) and Ron Scroggy (services began 2011);Dr. Frank Shelp, Dept of Behavioral Health & Developmental Disabilities ;District Attorney J. David Miller, Southern Judicial Circuit ;Tonya Boga, Office of the Child Advocate ;Dr. Kris Sperry, GBI Medical Examiner ;Gloria Butler, GA Senator ;Brenda Fitzgerald, Division of Public Health Beverly Losman, Safe Kids GA; Children's Healthcare of

Atlanta ;Judge LaTain Kell, Cobb County Superior Court; Major Paula Sparks, Cobb County Police Department; and Kathleen A. Bennett, Richmond County, Disabilities and Mental Health Specialist Central Savannah River Economic Opportunity Authority Head Start Program.

STAFF

The Office of the Child Advocate for the Protection of Children (OCA) marked its second year of housing two units, the Child Welfare unit and the Child Fatality Review (CFR) unit.[3] OCA began the process of cross-training all of its employees and also began a process in which the Child Fatality Review unit and the Child Welfare unit work closely together in a team approach. Recognizing the wisdom of the legislature in combining the two agencies and the need to work together to better serve the needs of Georgia's children and their families in need, OCA began a team approach of reviewing the child death cases in which there was a prior DFCS history or the child was in the custody or control of DFCS at the time of the child's death. Cross-training employees and combining the work of reviewing child deaths promotes efficiency and helps to better serve the children of Georgia. The goal for 2012 is to train the child fatality review program managers in the review of DFCS policies so they can participate in the policy analysis of the issues presented in a child death case. Continuing the cross-training by equipping child fatality review program managers with the skills to review and analyze policy will better serve families proactively.

The child welfare unit is comprised of two child welfare analysts, Charles Pittman and Vickie White; an intake specialist, Sarah Stocker; two assistant child advocates, Cynthia Cartwright and Kenneith Perrin; a data analyst[4], Tomia White; and a child welfare intake coordinator[5], Crystal Dixon. The assistant child advocates are attorneys and share child fatality review responsibilities. The assistant child advocates primarily investigate the complaints received from the governor's office but also investigate child fatality and serious injury cases. The assistant child advocates work with the yearly child fatality review trainings held in various parts of the state teaching the Child Abuse Protocol materials and facilitating the training. The child welfare analysts primarily investigate the reporter contact complaints received via the Office of

[3] As a result of the Children and Family Services Strengthening Act of 2008, the Office of the Child Fatality Review was consolidated into the Office of the Child Advocate for the Protection of Children.
[4] The data analyst is also cross-trained in the child fatality review process as a data analyst.
[5] The Child Welfare Intake Coordinator is cross-trained as a data specialist for the child fatality unit which means that she retrieves the child death reports and enters them into the state's electronic system and names and files all child death cases.

Child Advocate website or intake personnel. The analysts also investigate child fatality and serious injury cases.

The child fatality review unit consists of two program managers, Wende Parker, and Malaika Shakir; a prevention specialist, Arleymah Raheem; a data support analyst[6], Tomia White; a data specialist[7], Crystal Dixon; and two assistant child advocates, Cynthia Cartwright and Kenneith Perrin.[8] OCA divides the state into two regions in order to provide support to the local teams in their review of child fatality cases. The eastern region is serviced through one program manager and the western another program manager. The program managers and the data support analyst provide support to the teams in the collection and review of cases. The data support analyst focuses on infant deaths in the southern part of the state. The assistant child advocates provide child abuse protocol training to the local child fatality review teams and facilitate the trainings.

ADVOCACY, COLLABORATION, OUTREACH AND ACTIVITIES

OCA fulfills its mission and responsibility to children through advocacy on behalf of children. Listed below are the advocacy goals of OCA.

1) To identify and advocate for needed changes in the laws that affect our children.
2) To promote the development of more and better resources for those children that are deemed to be especially high risk involvement for DFCS.
3) To promote a better understanding of the policies and procedures of DFCS by those entities that most directly impact the health and welfare of Georgia's children, including the courts, law enforcement, Special Assistant Attorneys General ("SAAG"), Court Appointed Special Advocates ("CASA") and attorney guardians ad item ("GAL").

In 2011, our advocacy consisted of, but was not limited to, hosting trainings to promote better advocacy for children; attendance and participation in seminars; trainings and meetings focused on child advocacy; visits to juvenile courts to review and evaluate local systems; visits to DFCS offices to review and evaluate local systems; visits to facilities that serve foster children and/or

[6] The data support analyst is cross-trained and is also the data support analyst for the child welfare unit.
[7] The data specialist is cross-trained and also serves as a member of the child welfare intake Unit.
[8] The Assistant Child Advocates also teach Child Abuse Protocol at the annual CFR trainings held around the state and serve as a moderator for the trainings when needed. The Confidential Administrative Assistant to the Director also serves as a moderator and logistics coordinator for the trainings.

children who are wards of the state of Georgia to review and evaluate local systems; and service on various boards that focus on serving and protecting our children. A representative sampling of our advocacy efforts for 2011 are listed below.

State Bar of Georgia Children and the Courts Standing Committee

The Children and the Courts Standing Committee considers the interests of children in the judicial system and proposals for reform of laws governing juveniles. It also provides advice and expertise to the Executive Committee and the Board of Governors.

The First Lady's Children's Cabinet

The First Lady's Children's Cabinet, headed by First Lady, Sandra Deal, assures the safety and protection of Georgia's children. The Cabinet focuses on each child's right to be safe, healthy, and educated.

Stakeholders Committee for The Child Protection and Public Safety Act

The focus of the committee is the Juvenile Code Rewrite. The proposed bill addresses abused and neglected children, children who commit delinquent acts, and children who are deemed unruly. The director of OCA is an active member of the committee.

The Safety Summit

The Safety Summit is comprised of juvenile court judges, DFCS employees, the Office of the Child Advocate, the Barton Child Law and Policy Center, IMPACT Georgia, and other stakeholders in the child welfare system. Some of the topics that have been discussed are DFCS encouragement and facilitation of temporary guardianships to resolve deprivation investigations, diversion program policies, definitions and implementation, consistency with three-year reviews of children in the custody of a relative until age 18, and effective transitional plans and reviews for youth aging out of foster care.

Governor's Office of Children and Families Task Force on the Criminal Sexual Exploitation of Children (CSEC)

In November of 2011, OCA became a member of the Georgia Governor's Office of Children and Families Task Force on the Criminal Sexual Exploitation of Children (CSEC). This task force is charged with the responsibility of developing policies, procedures, and guidelines to direct the treatment of sexually exploited children in Georgia. Currently, Georgia has developed a process,

through a contract with the Georgia Care Connection and Child Advocacy Centers of Georgia, to accept referrals of sexually exploited children from law enforcement, DFCS employees, school employees and others in the community. This process allows these children, in many instances, to be removed from the criminal justice system and provided the necessary care and treatment to address their trauma issues. Future plans are to expand these services statewide and to provide additional training to law enforcement and others to enhance the identification of these issues.

Child Passenger Safety Board of Georgia

OCA staff served as chairperson of the Child Passenger Safety Board of Georgia. This board provides program direction and technical guidance to communities and organizations with a focus of maintaining the quality and integrity of the National Standardized Child Passenger Safety Training Program.

Child Abuse and Prevention Treatment Act Maltreatment Review Committee

OCA served on the Child Abuse Prevention Treatment Act Maltreatment Review Committee. The committee advocates for the utilization of a multi-disciplinary committee to review maltreatment-related child fatalities, near fatalities, and serious injuries.

Northwest Georgia Child Abuse Conference

About 30 presenters and 540 Child Fatality Review Committee Members; Child Advocates; Forensic Interviewers; CASA's; DFCS; Social Workers; Educators; law enforcement officers; Judges; District Attorney's; Emergency Medical Service personnel; and medical technicians attended the Northwest Georgia Child Abuse Conference held October 3-4, 2011 at The Colonnade in Ringgold, Georgia. The conference focused on prevention, recognition, investigation and prosecution of child abuse. The Office of the Child Advocate was the lead sponsoring agency along with Catoosa County Coroner's Office, Lookout Mountain Judicial Circuit District Attorney's Office, Prosecuting Attorney's Council, Lookout Mountain Bar Association, U.S. Attorney's Office, North District of Georgia, and Catoosa County Juvenile Court. OCA provided an educational exhibition and presented the Child Death Review 2009: Trend Analysis for 2004-2008.

Suicide Prevention Conference

As Georgia marked the tenth anniversary of the state suicide prevention plan, OCA provided training at its conference. A focus for OCA during the training was the exploration and identification of the relationship, if any, between suicide and past school troubles, relationship issues, and/or behavioral health conditions. Child Fatality Review data was used to present and discuss trends from 2004-2008, as well as the most current account of cases from 2009-2011.

Georgia Association of Emergency Medical Services Conference

OCA fostered a working relationship with Emergency Medical Services (EMS) professionals, who are often first on the scene when a child is seriously injured or dies. At the conference, OCA focused on child death trends, prevention opportunities, multidisciplinary Unit approach to death scene investigation, scene reconstruction with doll-reenactment, and the Sudden Unexpected Infant Death project (SUID). The Georgia Association of Emergency Medical Services is a nonprofit organization dedicated to helping Emergency Medical Technicians and Paramedics.

Region II Georgia (EMS-C) Emergency Medical Services Conference

OCA staff participated in the Region II Georgia EMS-C Conference by presenting on child death trends, prevention opportunities, a multidisciplinary unit approach to death scene investigation, scene reconstruction with doll-reenactment and the Sudden Unexpected Infant Death project.

Georgia Association for Young Children Conference

In an effort to reach out to those who work with children and/or their families that may be at risk for DFCS and/or state involvement, OCA participated in the Georgia Association for Young Children Conference. OCA's goal in participating in this conference was to offer timely and valuable educational experiences to individuals who work with young children and/or their families. Attendees were provided information on how children die in Georgia by analyzing county-specific data, overall demographics, and the child development risk relationship. They also learned how to identify and predict risk factors for infants, early childhood, middle childhood, early adolescence and older teens. Attendees were given an opportunity to produce preliminary prevention action plans for child death reduction within their respective disciplines and communities. In furtherance of its mission *to ensure the safety, health, and well-being of Georgia's children*, through promoting positive change and improvements in practice, OCA is active in training others and provided the following training in 2011, Child Abuse Protocol, Georgia Coroner Association, Finding Words Georgia and Child Fatality Review Training.

Child Abuse Protocol Review

OCA sent letters to all counties requesting their annual child abuse protocol (CAP) updates and their annual reports as mandated by OCGA 19-15-2. Out of 159 counties, 56 counties have submitted the required materials. The annual training was based on the counties' participation, and the need for understanding and compliance with the Code. Emphasis was placed on reviewing the entire Code section concerning the CAP. Additionally, open meetings and records law about the CAP and CFR committees was reviewed. Training planned for next year will build on this year's training and further enhance attendees' knowledge by including a workshop on writing the CAP based on the county's specialized circumstances.

Georgia Coroner Association

OCA provided an annual training to the coroners. The presentation was specific to CFR data analysis for causes of death and specific case scenarios to improve the death scene investigation process.

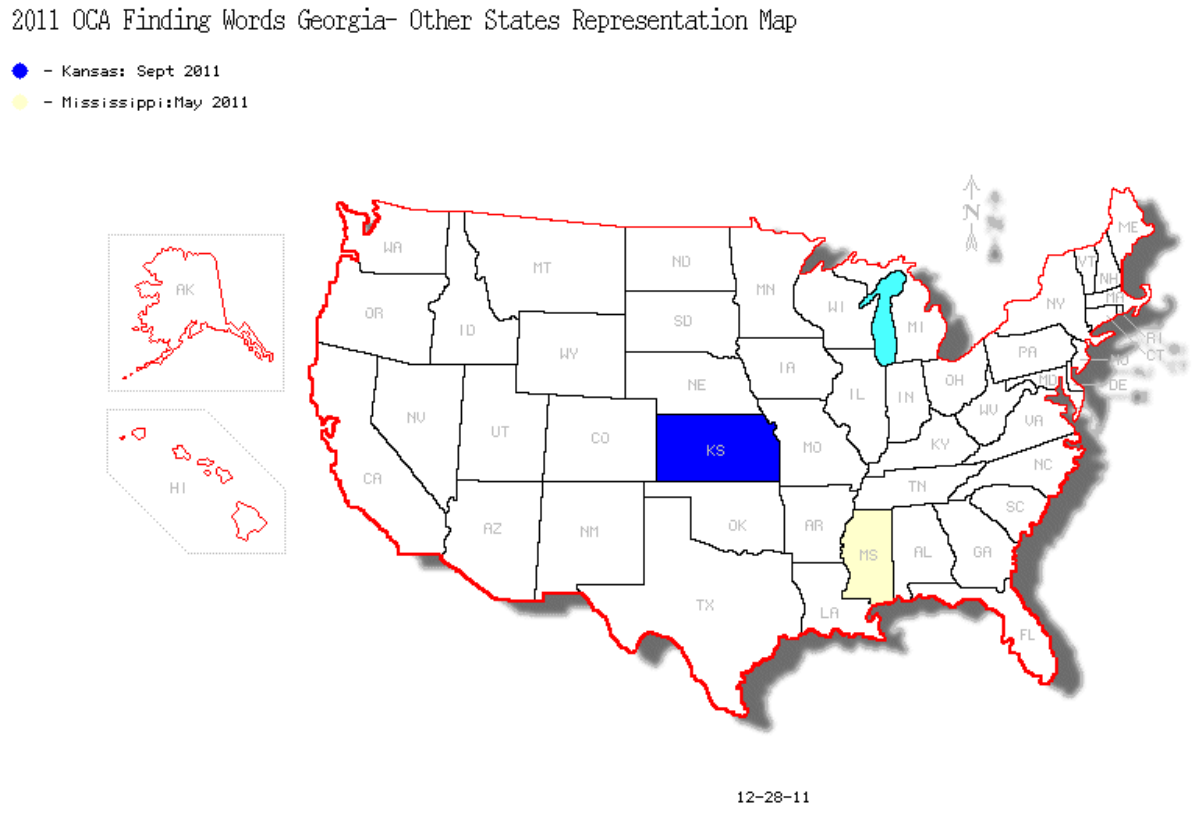
Finding Words Georgia: Child First Training

The Office of the Child Advocate was successful in making Georgia one of the first "Finding Words" training sites in the country in 2003. To date, Finding Words Georgia has trained 1,084 professionals, representing 113 counties in Georgia. Finding Words is sponsored by OCA and supported by DFCS and the Children's Advocacy Centers of Georgia. The National Center for the Prosecution of Child Abuse and Corner House Children's Advocacy Center developed the original multi-disciplinary forensic original interviewing course entitled Finding Words now entitled ChildFirst. The five-day training is designed to instruct multi-disciplinary teams in forensic interviewing of maltreated children. In 2011, trainings were held at Georgia Southern University, Statesboro; Central Georgia Conference Center, Forsyth; and the Georgia Public Safety Training Center, Forsyth. The Advanced Finding Words Georgia course was held at the University of Georgia's Law School in Athens.

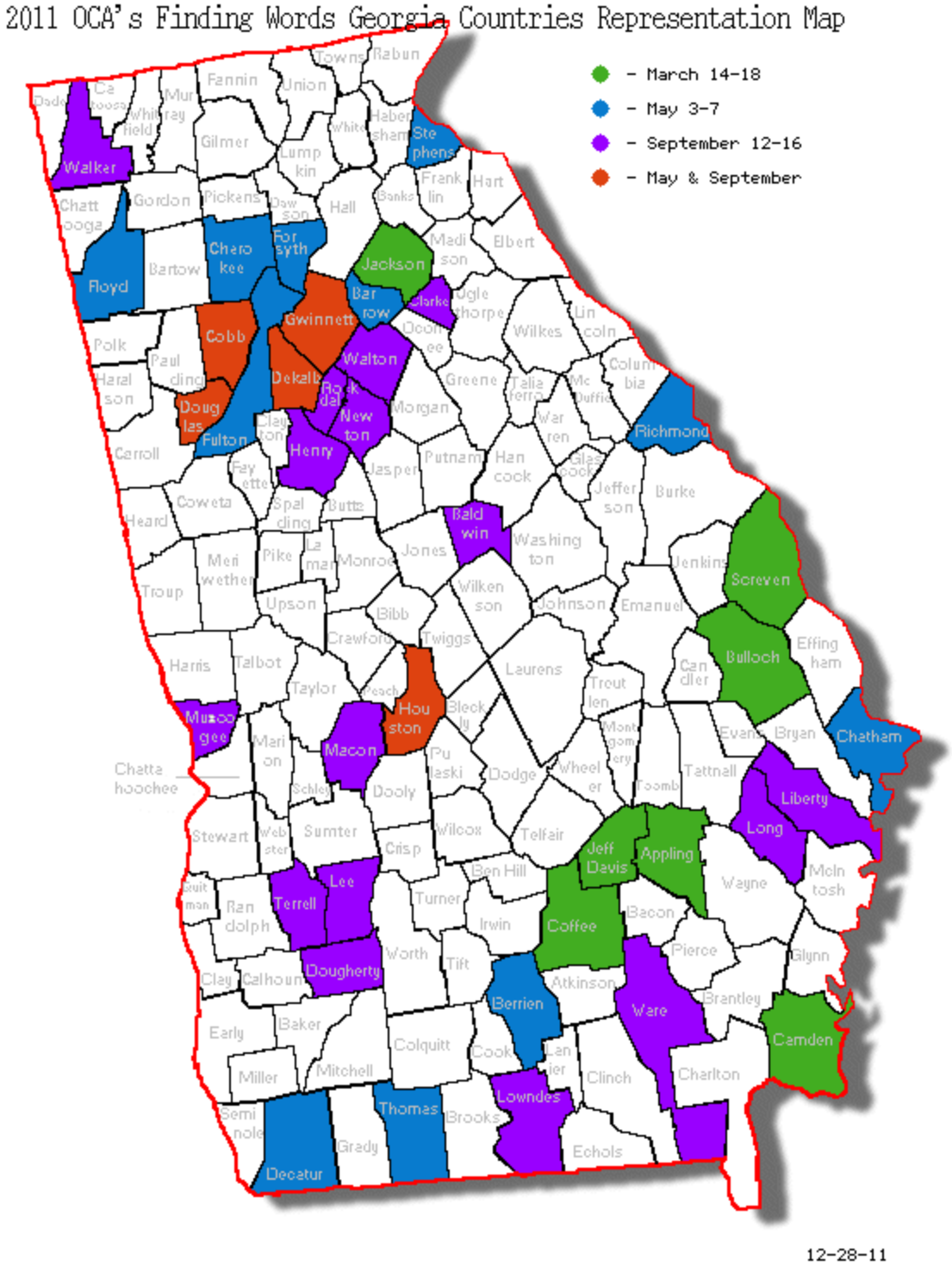
OCA Finding Words Child First Unit includes faculty, training coordinators and actors portraying sexually abused children. OCA state coordinator and four faculty members of the Finding Words Unit were awarded sponsorship to attend the When Words Matter: Emerging Issues in Forensic Interviewing September 19-22, 2011 in Chicago, Illinois, a four-day national conference bringing together nationally recognized experts from the child protection fields. This year, led by OCA's Tammy Mills and Theressa Hamilton and an outstanding team of faculty

from across the state, OCA trained 111 professionals representing 41 counties, three states (Georgia, Mississippi and Kansas) in forensic interview techniques. Child First is Peace Officer Standards Training (POST) certified and trained many members of law enforcement in 2011.

OCA Finding Words Training sessions scheduled for FY 2012 already have waiting lists, demonstrating the continuing need for such a training program in Georgia. OCA received requests to train Faculty and Forensic Interviewers from northwest and southwestern states as well as Native American lands. OCA intends to continue to offer Finding Words Georgia and the ChildFirst Protocol training in order to promote consistency in the investigation and prosecution of child abuse throughout the state.



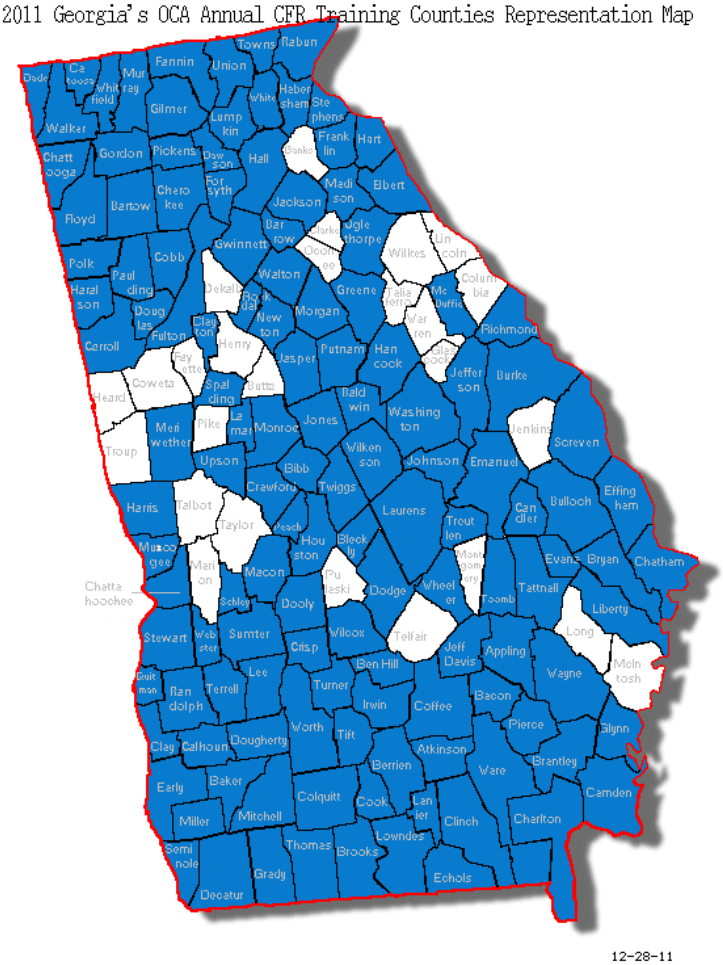
2011 OCA's Finding Words Georgia Countries Representation Map



Child Fatality Review (CFR) Unit Trainings

Recognizing the need to make sure that all professionals who review child death cases with the ultimate goal being prevention of future child deaths are trained and supported by the Office of the Child Advocate for the Protection of Children, the CFR unit provided eight trainings around the state. The trainings provided through OCA covered north, south and middle Georgia as well as the metropolitan Atlanta area. Each training specifically addressed the cause of death analysis with opportunities for improvement in death scene investigations and processes at the local level. In 2011, 480 child welfare professionals were trained through OCA's CFR trainings. The trainings included an overview of the child abuse protocol statute. We partnered with other child focused agencies who served as guest speakers at the trainings. Guest speakers included Department of Behavioral Health Suicide Prevention, medical examiners, and DFCS.

2011 Georgia's OCA Annual CFR Training Counties Representation Map



MONITORING TO BRING POSITIVE CHANGE

Consistent with the actions of OCA since its year of inception, OCA continued to monitor DFCS in 2011 through participation in various initiatives and membership on certain important committees that afford OCA the opportunity to be aware of the changes envisioned by DFCS and to help fashion those changes, where appropriate.

Currently, DFCS is involved in a number of initiatives designed to enhance the practice within the department. OCA has worked with proactively with DFCS to promote the best plans possible for Georgia's children. In addition to inviting DFCS to join in with the CFR training to help teach prevention, some highlights of other collaborative efforts are shown through OCA's participation in a monthly collaborative meeting and the Child Death Serious Injury Near Fatality Review meetings.

Court Improvement Project, Office of Child Advocate and Division of Family and Children Services Collaborative Meeting

OCA meets monthly with the CIP and DFCS representatives about joint efforts to:

- Identify practice needs and issues in child fatality and near fatality cases in Georgia counties.
- DFCS seeks to have more information and practice on prevention.
- To bring awareness of prevention to the community and DFCS staff which may involve a change in policy.

Goals of the Committee:

- To become more specific in identifying missed opportunities to prevent Sudden Infant Death Syndrome and other near child fatalities. DFCS wants to know how to talk to families more about safe sleep issues.
- Their focus is also on maltreatment investigation and prevention.
- The general goal is seeking to improve on how to convey the importance of prevention to families.

Child Death Near Fatality Serious Injury Review Process

Over the past year, OCA joined with representatives of several divisions of DHS including DFCS, to revive the old Child Death Near Fatality Serious Injury (CDNFSI) review process. Originally, this process was designed as a meeting of outside community partners to review selected cases for compliance of policy and procedure. The new committee has decided to amend the purpose of the committee somewhat by bringing awareness to prevention by looking for opportunities to speak with families about potential problems. This new purpose is in addition to a continued general review of selected cases and is intended to ultimately reduce the number of child deaths

related to preventable deaths. The plan of action for this committee is still being developed. The top three leading causes of death of children in Georgia have been identified as the target. A logic model has been prepared and the proposed plan is being fine tuned in preparation of a presentation to the leadership of DFCS in January of 2012. If approved, the committee hopes to be able to revise the current curriculum of the new DFCS case manager training to promote more awareness for the presence of factors that contribute to child deaths in the homes of DFCS clients. The committee hopes this process will provide educational materials that can be presented to new mothers and at risk families in an effort to bring more awareness to child deaths and their prevention.

The State Mediation Committee (SMC)

The Office of the Child Advocate also addresses issues that arise between DFCS and foster parents. It does so by coordinating the activities of the State Mediation Committee (SMC).

The Foster Parent Bill of Rights, signed into law by Governor Sonny Perdue on May 5, 2004, requires a mediation process for foster parents to file grievances if they believe their rights under this state law and policies have been violated by DFCS—both locally and on a state level. This process establishes a way to redress grievances above and beyond local mediation and arbitration. It is meant to complement rather than replace local problem solving processes that are working for a county.[9] The SMC is subject to all applicable federal and state laws regarding confidentiality. A SMC mediation is not a legal proceeding; however, foster parents may have an Adoptive and Foster Parent Association of Georgia (AFPAG) advocate or other personal support person present. However, personal support persons are not provided the same access to confidential information as AFPAG advocates. Therefore, they are limited to participating only in the portions of the staffing which do not violate confidentiality laws.

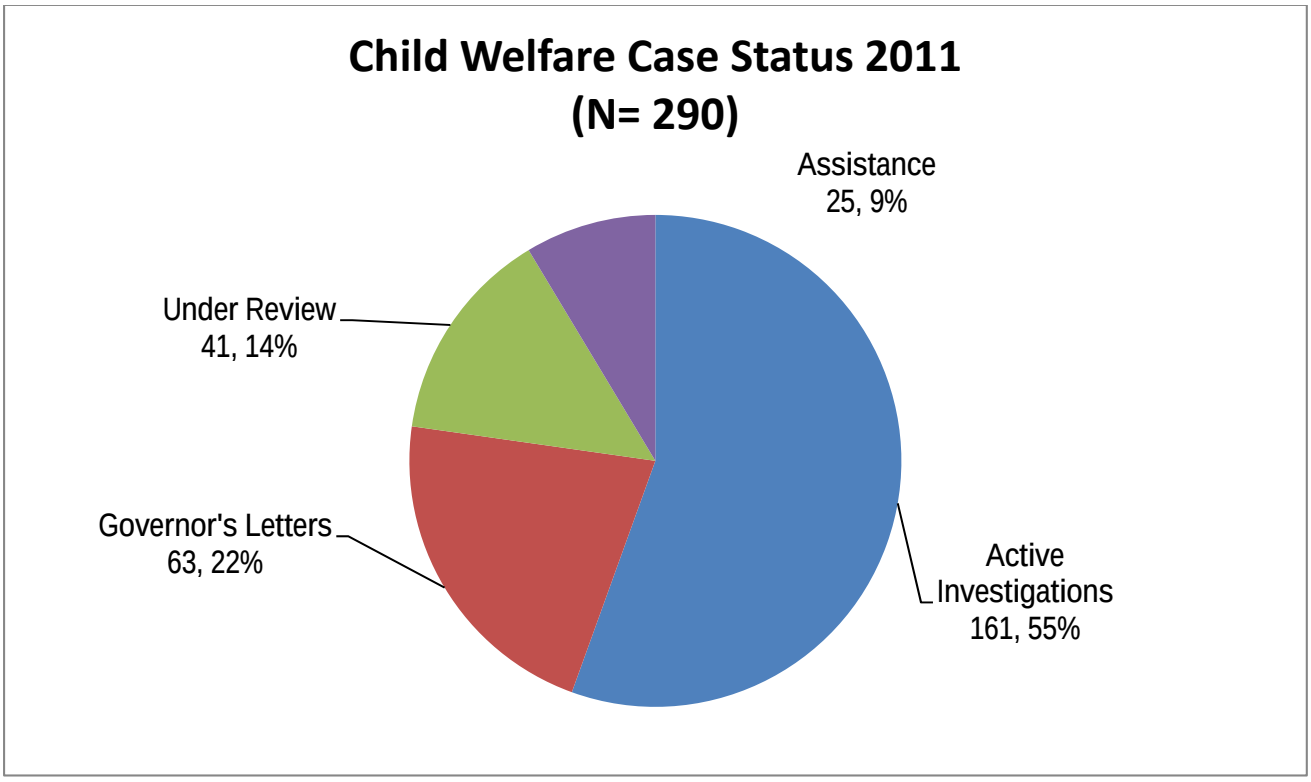
The SMC is a standing committee composed of two representatives from the Georgia Department of Human Resources/Division of Family and Children Services (DFCS), two representatives from the Adoptive and Foster Parent Association of Georgia (AFPAG), and the Director of the Office of the Child Advocate (OCA), totaling five members of the committee. The Director of the Office of the Child Advocate serves as the chairperson of the SMC and coordinates administrative matters through OCA.

[9] The Foster Parent Bill of Rights Act. O.C.G.A. 49-5-280

Some of the issues presented to the SMC include claims of discrimination based on physical disability, failure to provide per diem payments for foster children, issues with completion of Interstate Compact on the Placement of Children to secure placement of children residing outside of Georgia with relatives in Georgia, and allegations of closing of a foster home without sufficient cause.

COMPLAINT INTAKE AND REFERRAL

For the reporting period beginning January 2011 and ending December 21, 2011, the Office of the Child Advocate received a total of 290 referrals.



Within OCA, there are two child welfare analysts and one assistant child advocate who are currently each assigned approximately 35 active cases, with one assistant child advocate managing a case load of approximately 60 active cases. The calculated total of those active investigations serves as 55% (161) of the current child welfare cases. Fourteen percent (41) of total cases are currently under review. The final 9% (25) are cases where assistance was offered.

Assistance Cases

Assistance cases are cases which can be referred to community services, provided information, or similar brief intervention for resolution. In 2011, there were 25 assistance cases opened in the office. Of the 290 referrals made to the Office of the Child Advocate during the current calendar year, 25 of these were handled as assistance cases. The cases are approximately nine percent of the total number of referrals received. This percent is actually less than the percent of cases assigned as assistance cases the previous year but is consistent with the current administration's approach of conducting more intensive reviews of potentially troubling cases.

Under Review

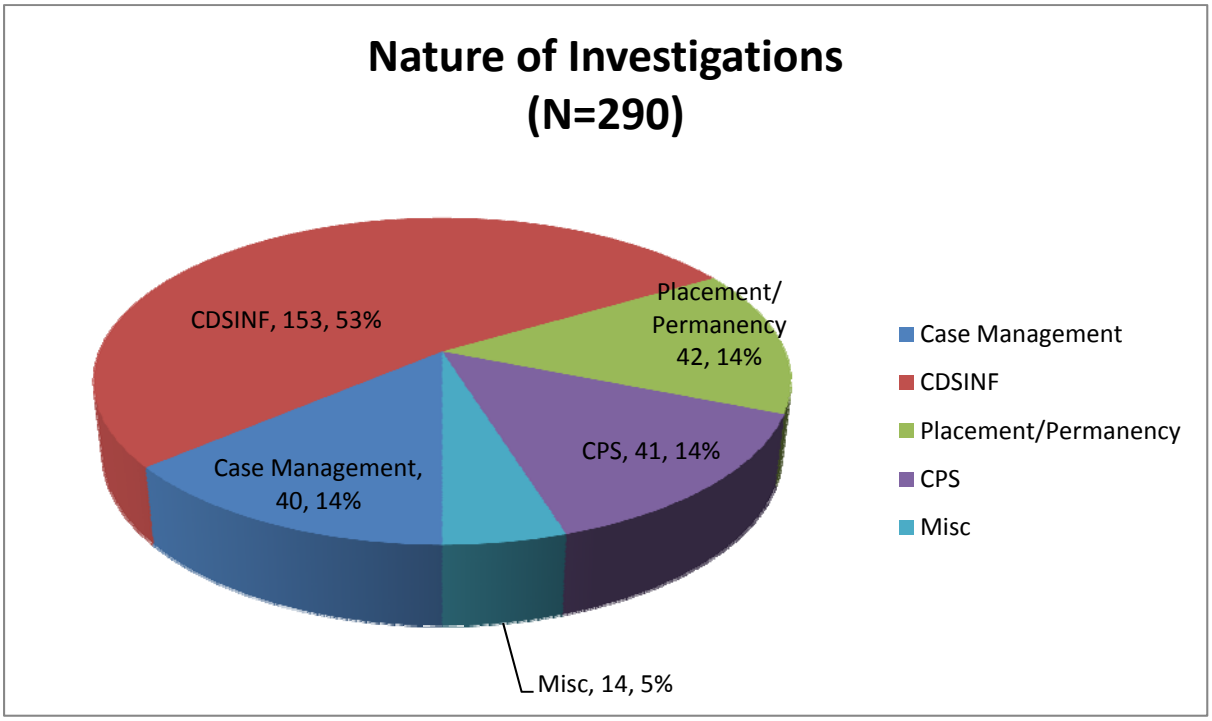
These cases start as investigations and follow the normal investigation process which is outlined below in the Investigations section. After the initial investigation and determination that there are no major violations of policies and procedures by DFCS, the case is moved into "under review" status pending receipt of an autopsy confirming the child did not die from abuse or neglect.

Investigations

Investigations are cases that require intensive examination by the Office of the Child Advocate's child welfare analysts or assistant child advocates. As a routine part of their investigation, staff will contact the reporter, DFCS or private agency case managers and their superiors if necessary, and collateral contacts with knowledge or information about the basis of the complaint. Investigators compile and review all information related to the case including DFCS case record, court documents, school and treatment records and any other relevant information. During this phase of the investigation, investigators may also offer suggestions to DFCS employees concerning the health, safety and wellbeing of children and families. The suggestions emphasize what is in the best interest of the children and families in promoting the best outcome. Upon completion of the investigation, a Concerns Letter may be issued outlining practices, policies and/or procedures that were violated or deficient.

During the current calendar year, investigations have accounted for the bulk of the cases referred to OCA. Of the 315 referrals received, 290 were assigned as an investigation. This accounts for approximately 92% of the total number of referrals made to OCA. Of the 290 cases assigned as investigations, child death near fatality or serious injury reports accounted for 150 or nearly 52%. Concerns reported to the governor's office by constituents were the second most

common source of investigatory concern, comprising 63 or 22% of the total referrals received. Complaints regarding all other matters totaled 49 or 16% of the year's totals.



- The nature of investigations refers to the issues raised in the cases investigated.
- CDSINF are the child death, serious injury or near fatality reports received by OCA.
- Placement and permanency issues include complaints about a foster care home, the length of time spent in foster care, and with whom the child is placed.
- Child Protective Services (CPS) represents complaints regarding initial contact to families made by DFCS. This can be failure to investigate a referral or that response time was not met.
- Case Management issues include complaints on how DFCS case was handled during the 30 day investigation.
- Miscellaneous category comprises other issues investigated, including legal and custody issues.

Governor's Letters Investigations

Historically, the Office of the Child Advocate has monitored cases received by the Georgia Governor's Office of Constituent Services and referred jointly to the Office of the Child Advocate and to the Department of Human Services' Constituent Services Office. Under the current administration, OCA investigates each referral received from the Governor's office to determine if the Department of Families and Children Services properly handled the case. These cases are typically handled by attorneys in OCA. Issues found in letters from the governor's office range from removal of children from families, requirements of case plans, the failure to timely return children to families, failure to protect children, failure to properly investigate allegations, failure to remove children from families, interstate placement of children and other concerns. Currently, 68 cases received as letters to the governor are under active investigation.

Direct Report Investigations

Our investigatory work over the past year has determined that DFCS is continuing to make significant strides to improve the lives of children and families in Georgia. Over the past year, DFCS has begun the process of refining their Diversion/Family Support Practices to include development of those components of a model differential response system. OCA is pleased that this process is continuing and looks forward to the issuance of state wide policy that guides critical practice decisions.

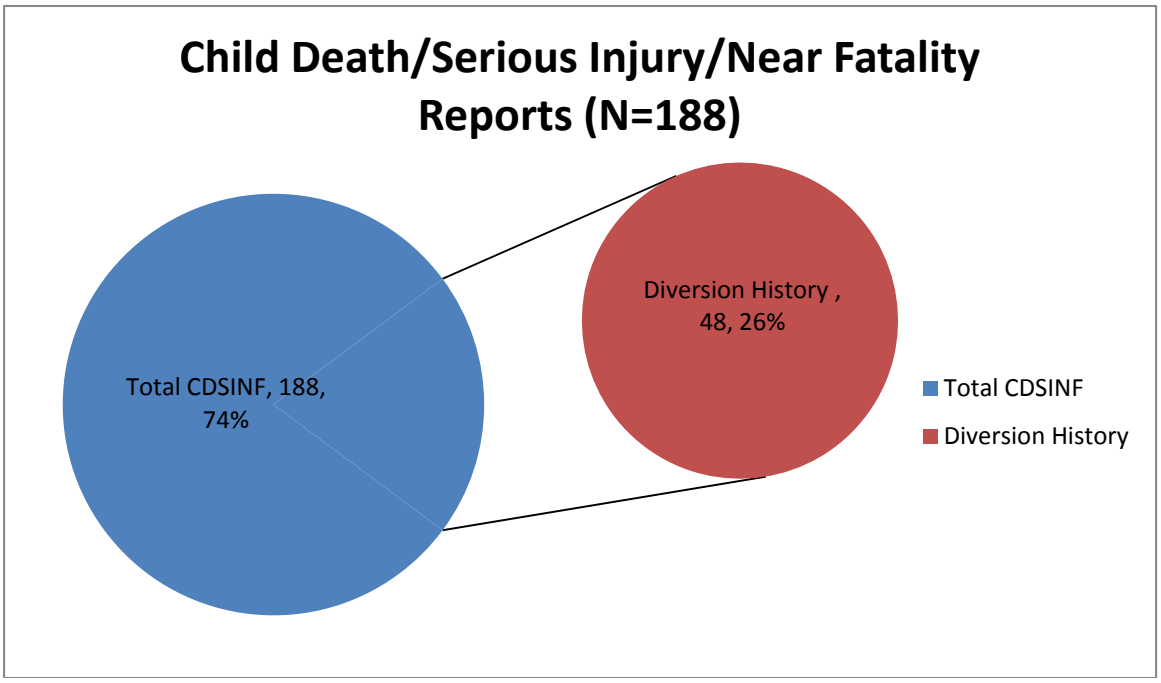
The following charts illustrate the nature of investigations by region. Specifically, the charts show how many child deaths, serious injury or near fatality occurred (CDSINF), issues concerning the placement and permanency, case management, child protection, and miscellaneous complaints. Case management complaints include concerns about the length of time the Department of Families and Children Services took to resolve the case, inappropriate case plans, etc. Examples of placement and permanency concerns include multiple placements of children in foster care, placing children out of the county, leaving children in foster care for extended periods of time, not returning children to their parents within an appropriate time, improper removal of children from their homes. Child protective services complaints include primarily a failure to protect children from harm. The counties in each region are listed below the charts.

Region 16, which consists of DeKalb County, ranked highest in child deaths and serious injury reviewed the child welfare team totaling 16. The highest number of complaints reviewed was in Region 17, including Counties: Cherokee, Cobb and Douglas. Ranking the region with the highest number of child protective services complaints was Regions 5 and 6, with 7 complaints

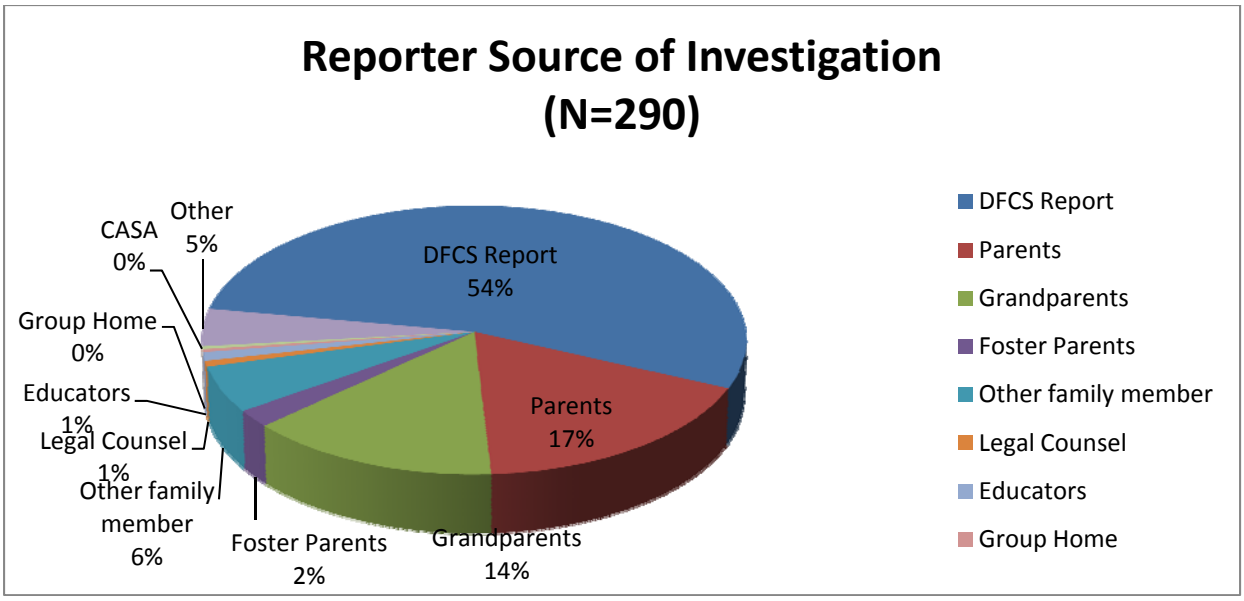
investigated each. The most miscellaneous complaints investigated came from Region 17 with 4 complaints, which include Cherokee, Cobb and Douglas Counties.

Child Death, Serious Injury, or Near Fatality Investigations

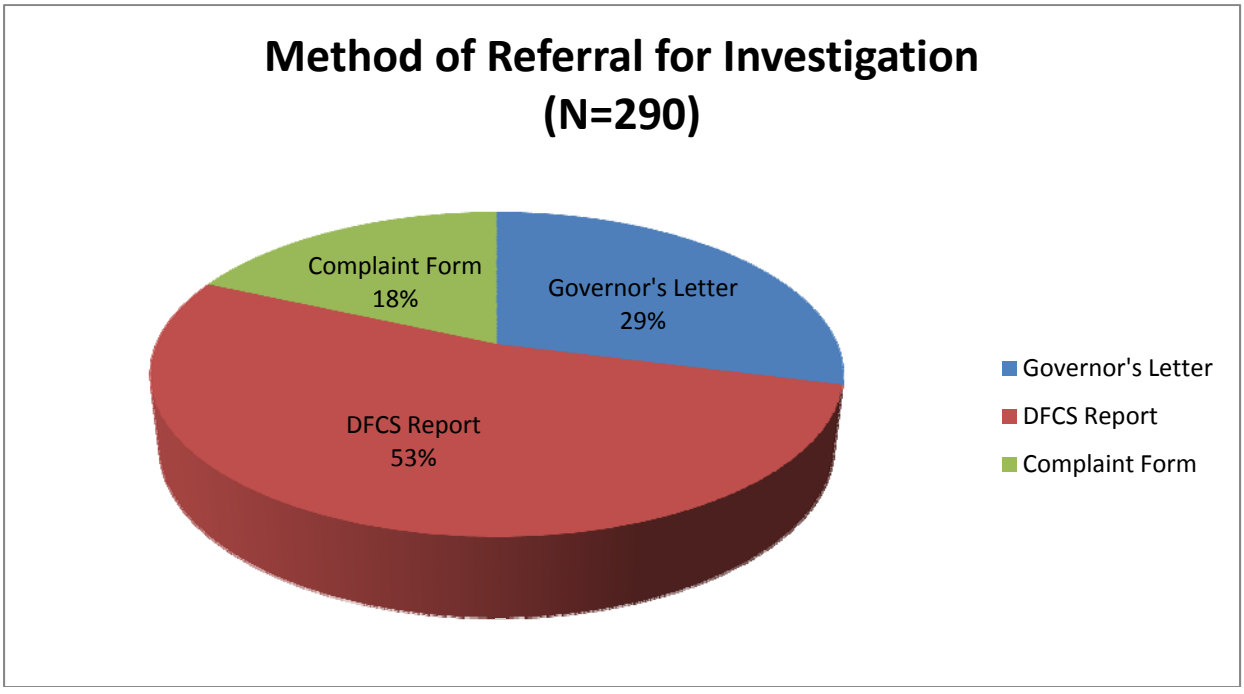
Child death, serious injury, or near fatality cases gave rise to the largest portion of the full investigations undertaken by OCA. The CDSINF reports are a mechanism for required internal reporting of critical incidents involving children who have an active DFCS child protective services case, placement or preventive services case, or whose family had such a case within the past five years. According to DFCS Child Protection Policy 2108.2, the county DFCS director must submit the CDSINF report electronically to the Office of the Child Advocate by the close of business on the day the county is notified of the event. Additional information obtained through DFCS' investigation is also required to be electronically reported as an update to the initial report.



This graph illustrates the total number of CDSINF cases as 188. Of that 188, 48 reports had previous diversion history, as disclosed by DFCS. Those 48 reports comprise 26% of the total number of reports.



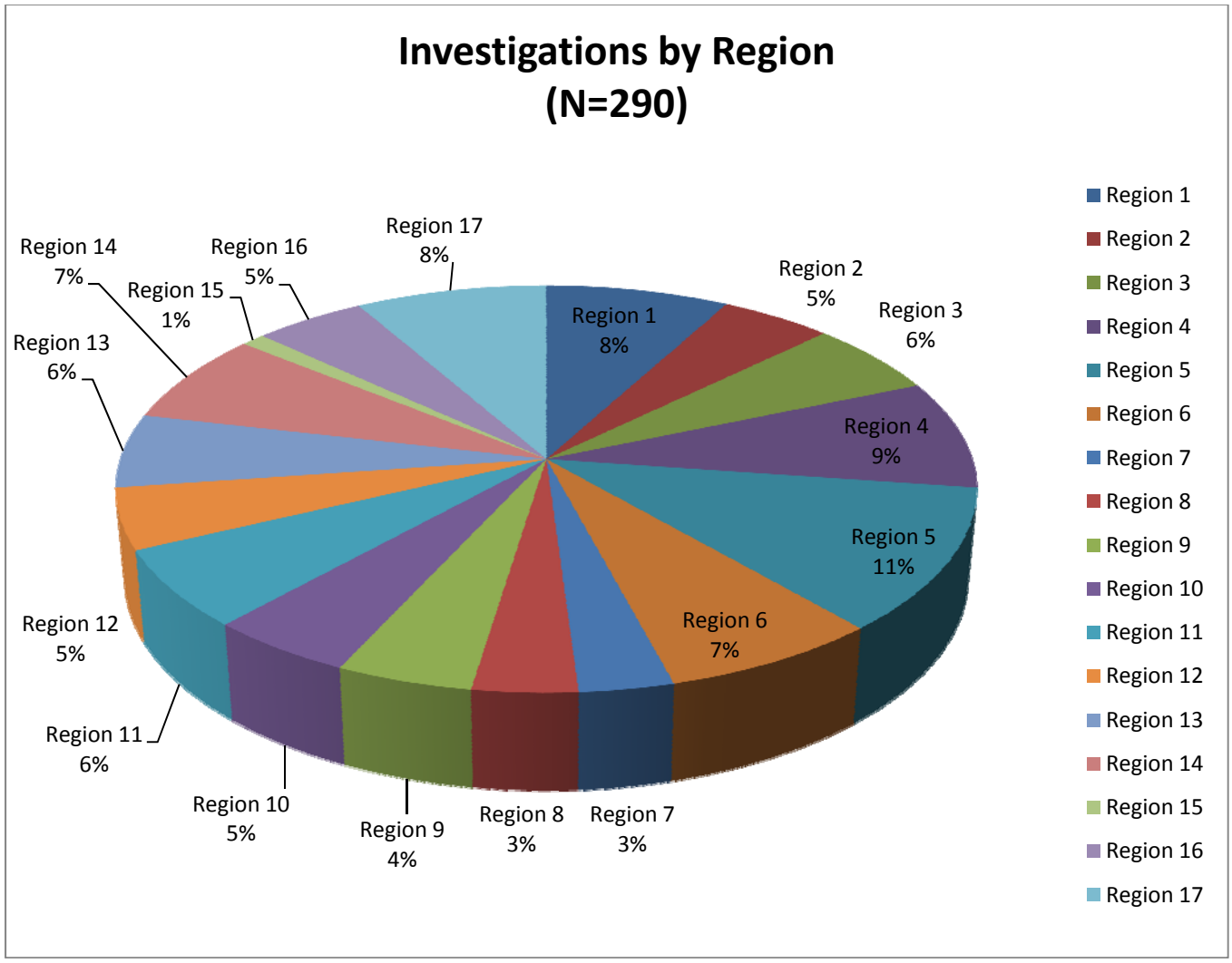
Reporter source refers to who contacted OCA to make a report. The majority of the referrals were opened due to reports of a child death and serious injuries.



Referrals derive from three main sources. The first source of referrals is DFCS reports (representing CDSINF reports). The second source of referrals is a governor's letter initially submitted to the governor's office by constituents and then forwarded to

OCA. The third source of referrals is direct contact from the public with OCA. The direct contact occurs via telephone calls or our web based contact system.

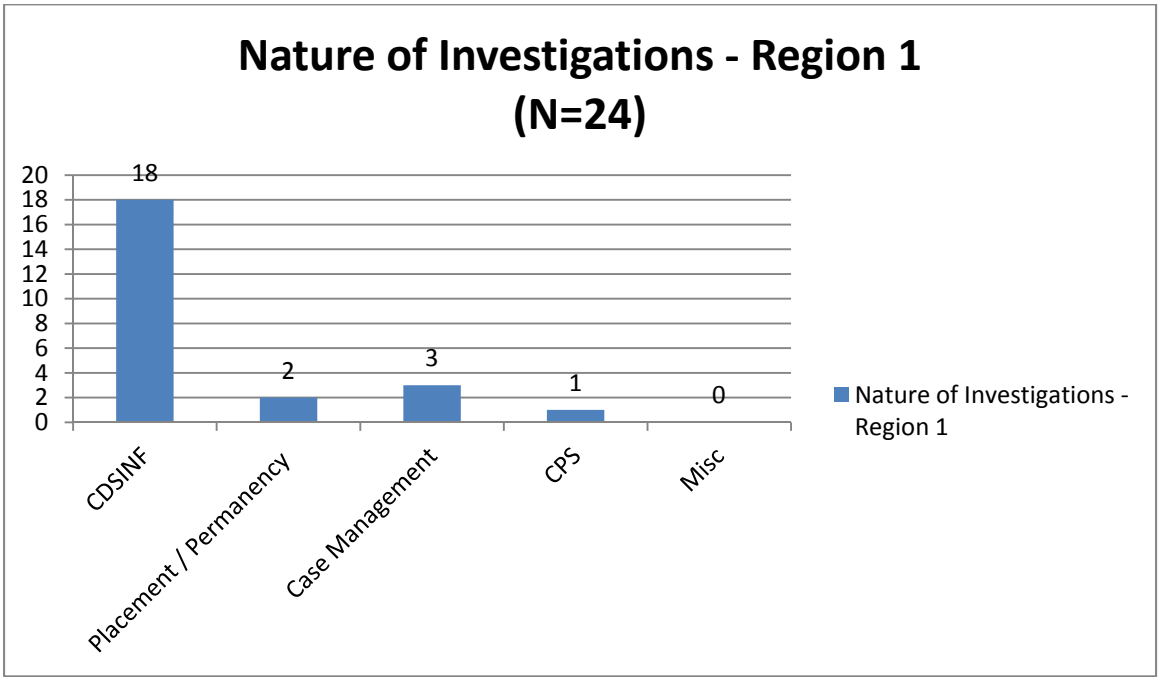
The following charts illustrate the nature of investigations by region. Specifically, the charts show how many child deaths, serious injury or near fatality occurred (CDSINF), issues concerning the placement and permanency, case management, child protection, and miscellaneous complaints.



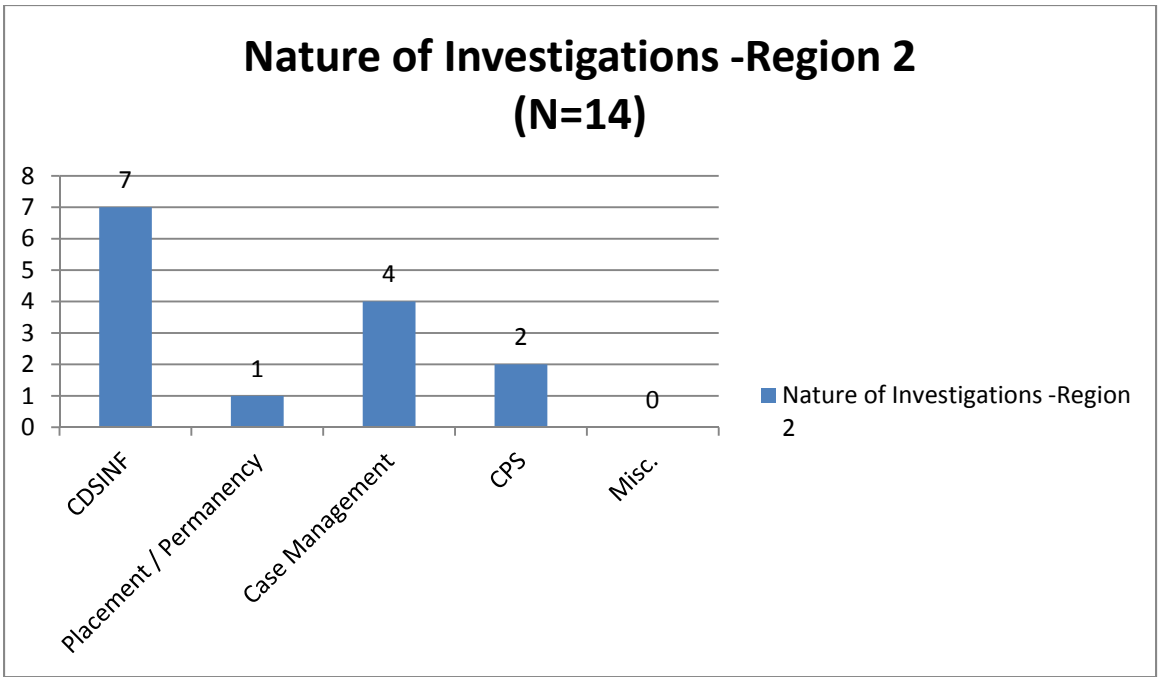
Case management complaints include concerns about the length of time the Division of Family and Children Services took to resolve the case, inappropriate case plans, etc. Examples of placement and permanency concerns include multiple placements of children in foster care, placing children out of the county, leaving children in foster care for extended periods of time,

not returning children to their parents within an appropriate time, improper removal of children from their homes. Child protective services complaints include primarily a failure to protect children from harm. The counties in each region are listed below the charts.

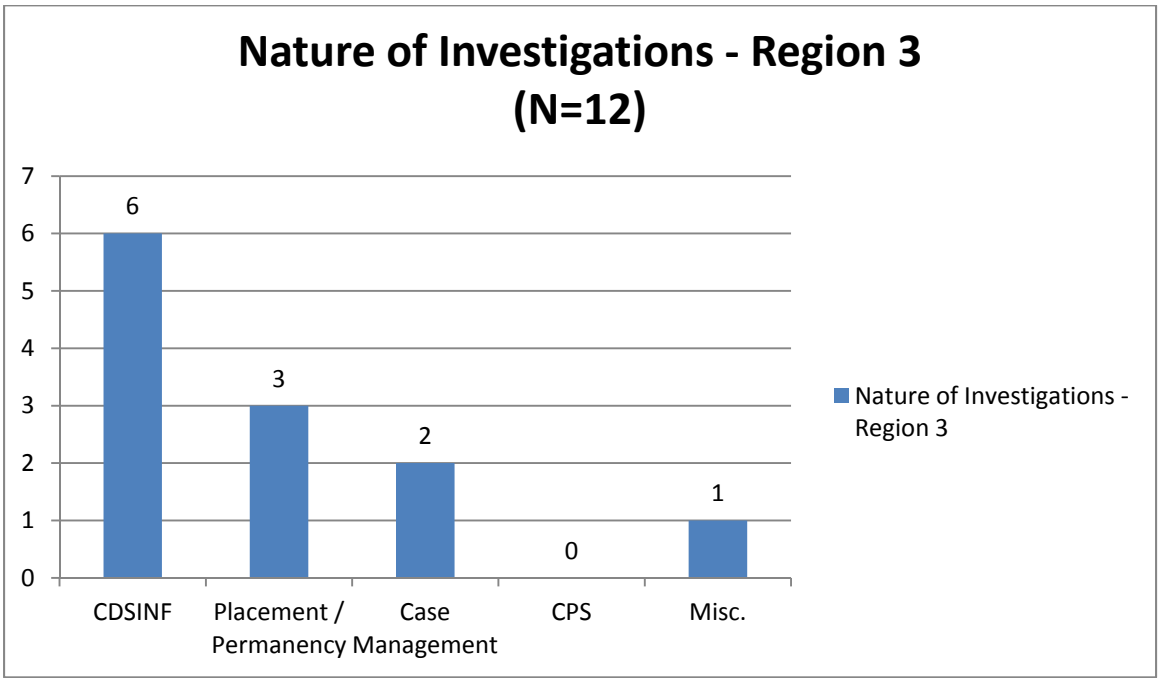
Ranking the region with the highest number of child protective services complaints was Region 5 with seven complaints for Barrow, Clarke, Elbert, Jackson, Jasper, Newton, Morgan and Walton counties. Investigations by region illustrate the percentage of cases received per DFCS region. Region 15 (Gwinnett and Rockdale Counties) had the least amount of complaints (1%). Region 16, which consists of DeKalb County, ranked highest in child deaths and serious injury. Region 5, Barrow, Clarke, Elbert, Jackson, Jasper, Newton, Morgan, Walton Counties, had the highest cases reviewed, with eleven complaints filed. The highest number of complaints reviewed was in Region 17, including Counties: Cherokee, Cobb and Douglas.



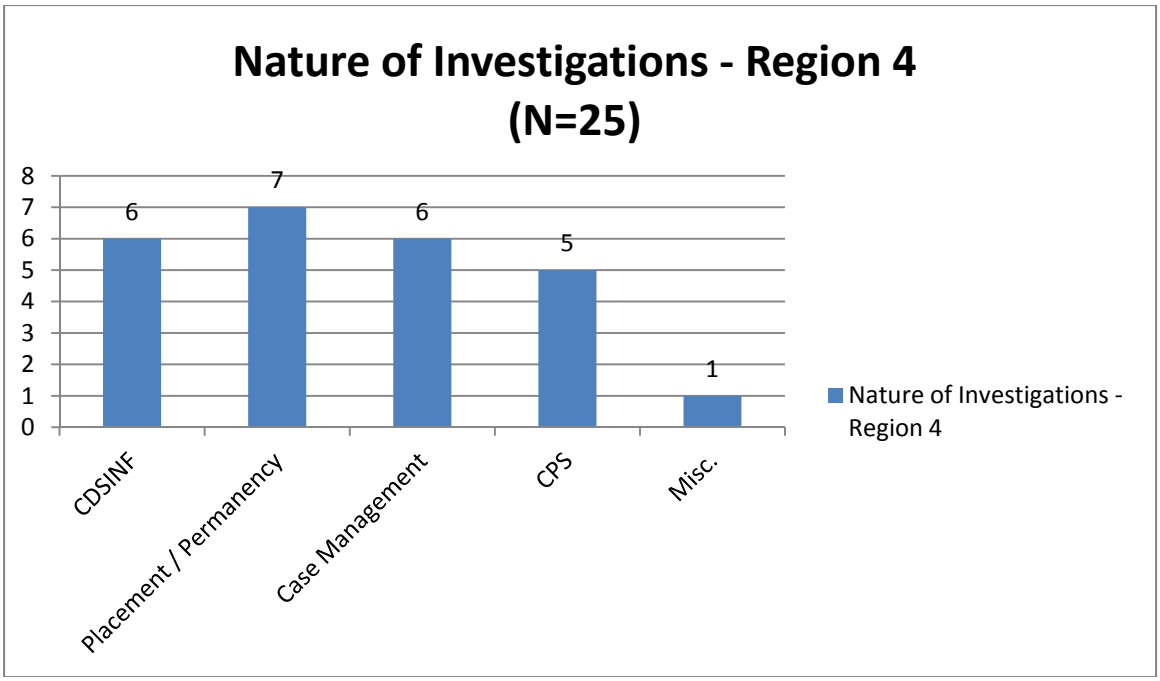
Region 1: Catoosa, Chatooga, Fannin, Murray, Walker, Whitfield



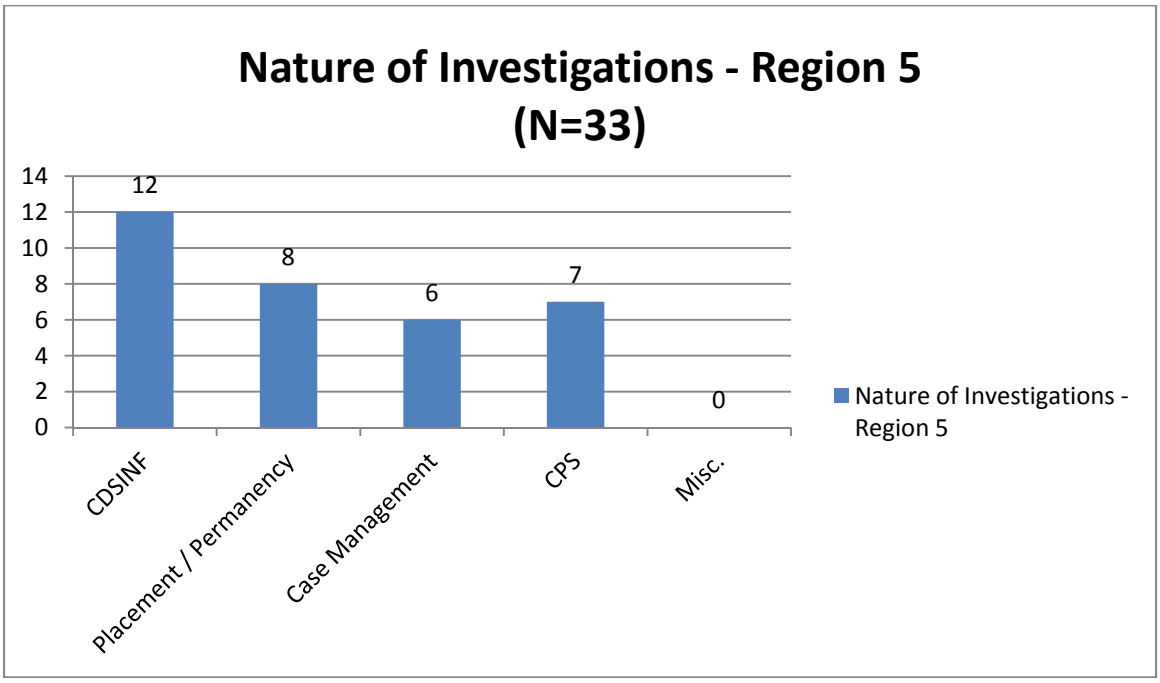
Region 2: Banks, Dawson, Forsyth, Hall, Hart, Lumpkin, Rabun, White



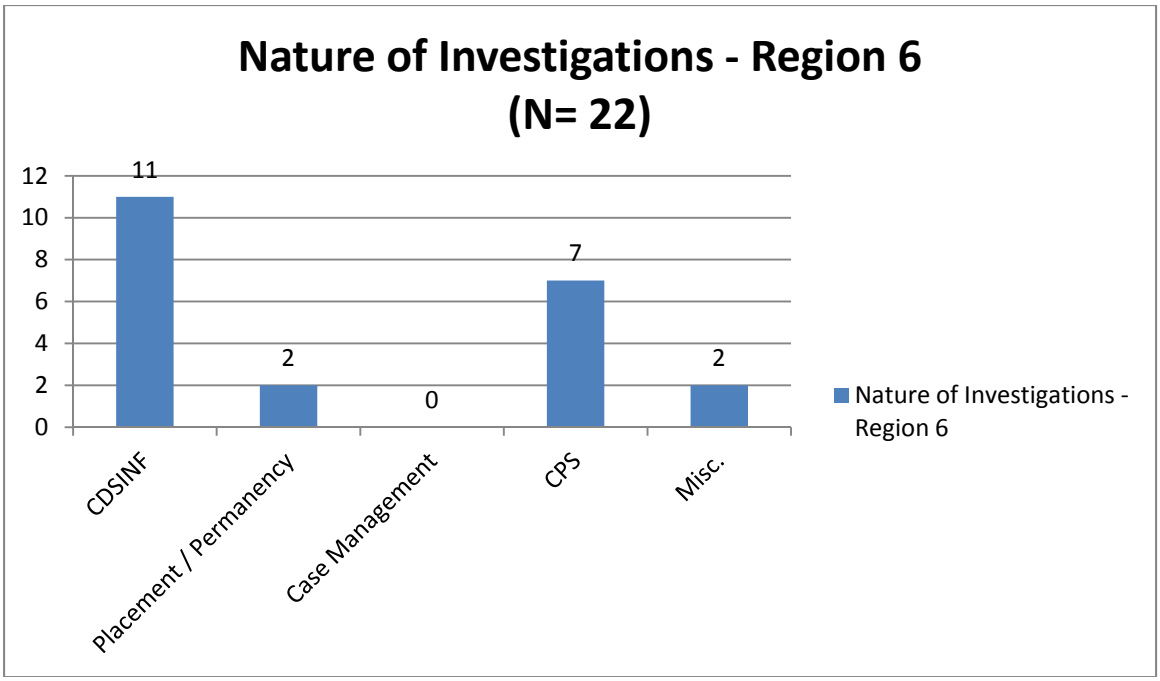
Region 3: Bartow, Floyd, Gordon, Haralson, Paulding, Polk



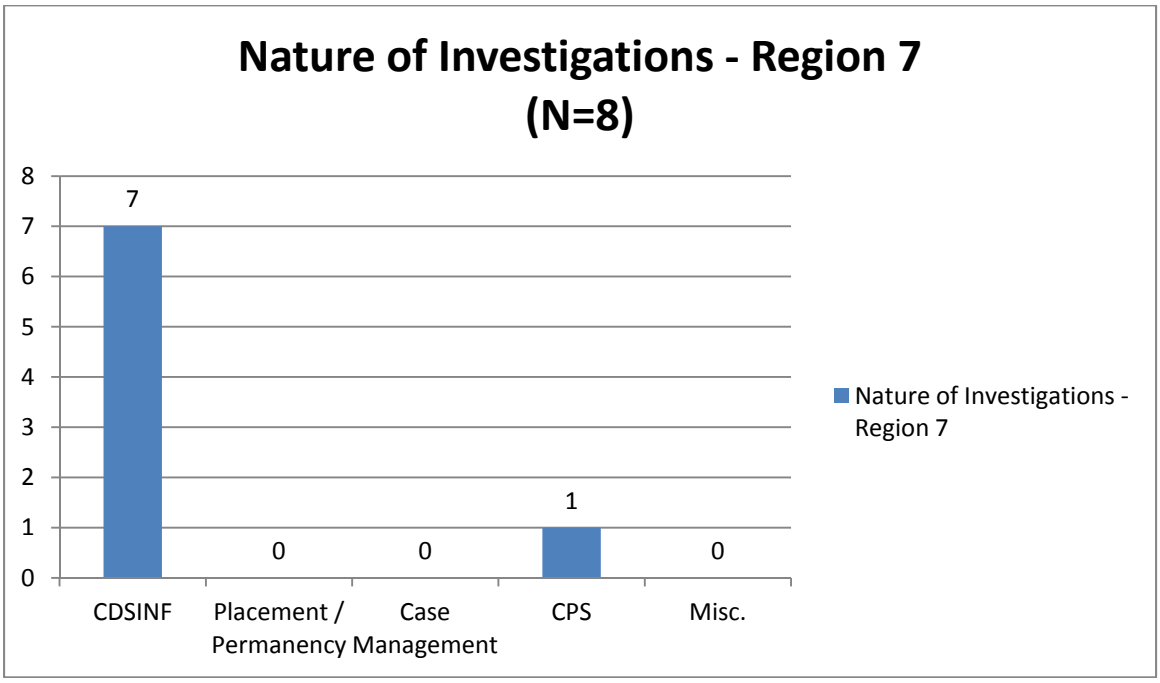
Region 4: Butts, Carroll, Coweta, Heard, Lamar, Spalding, Troup, Upson



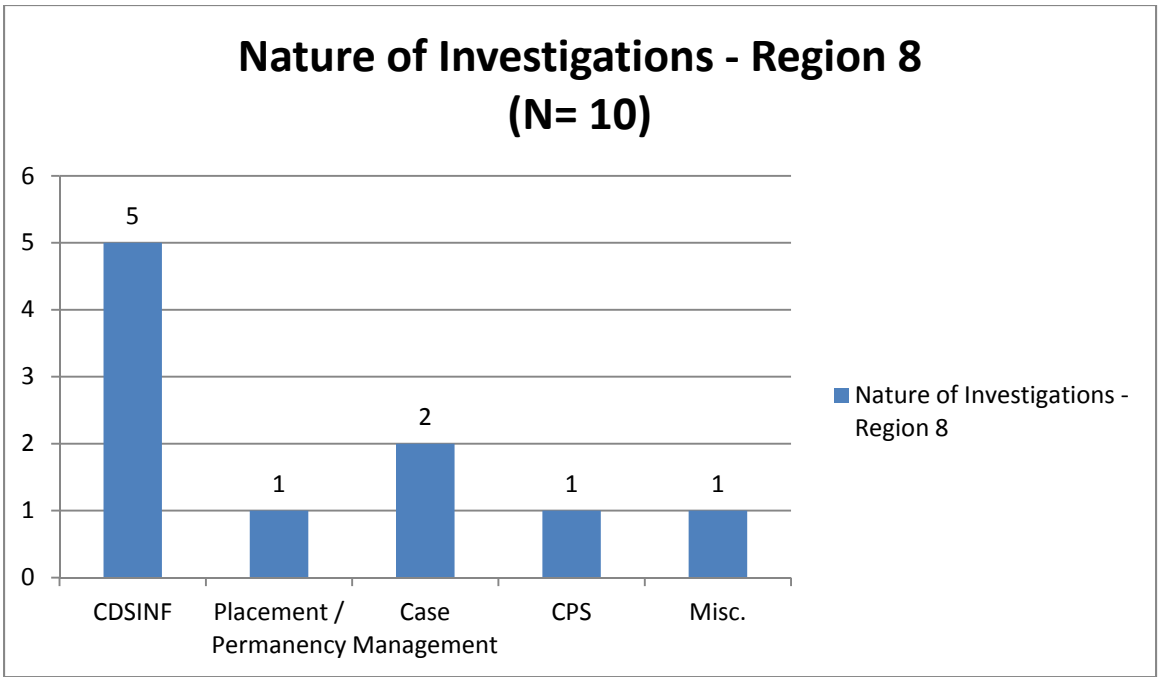
Region 5: Barrow, Clarke, Elbert, Jackson, Jasper, Newton, Morgan, Walton



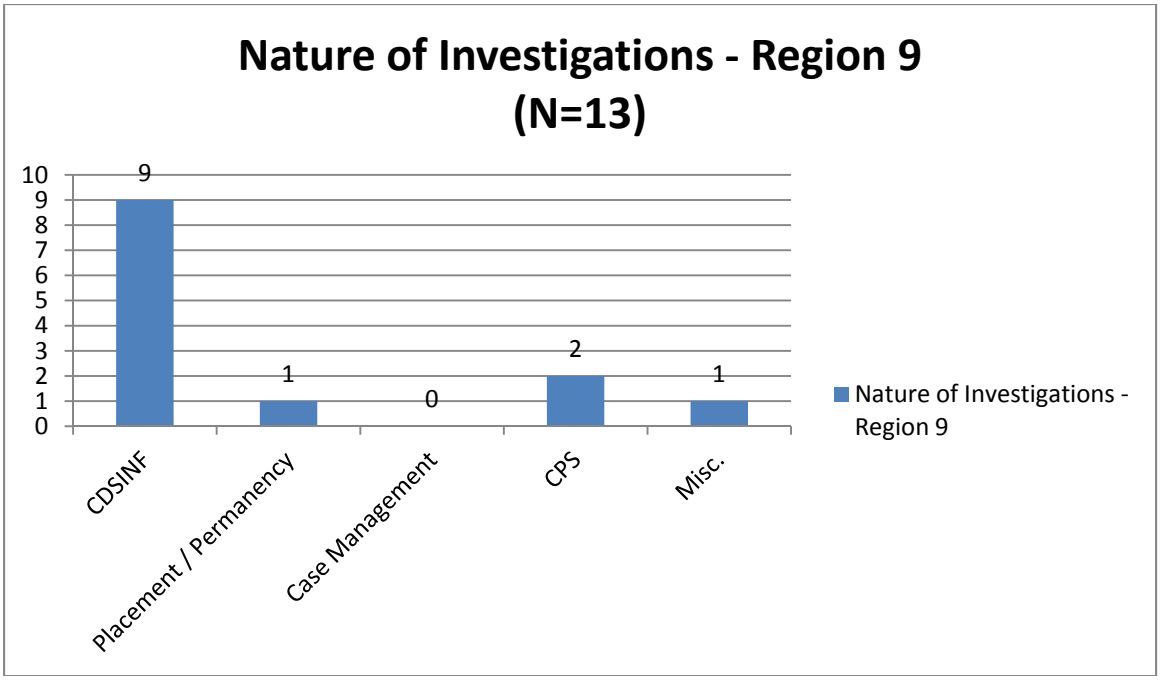
Region 6: Baldwin, Bibb, Houston, Jones, Peach, Putnam



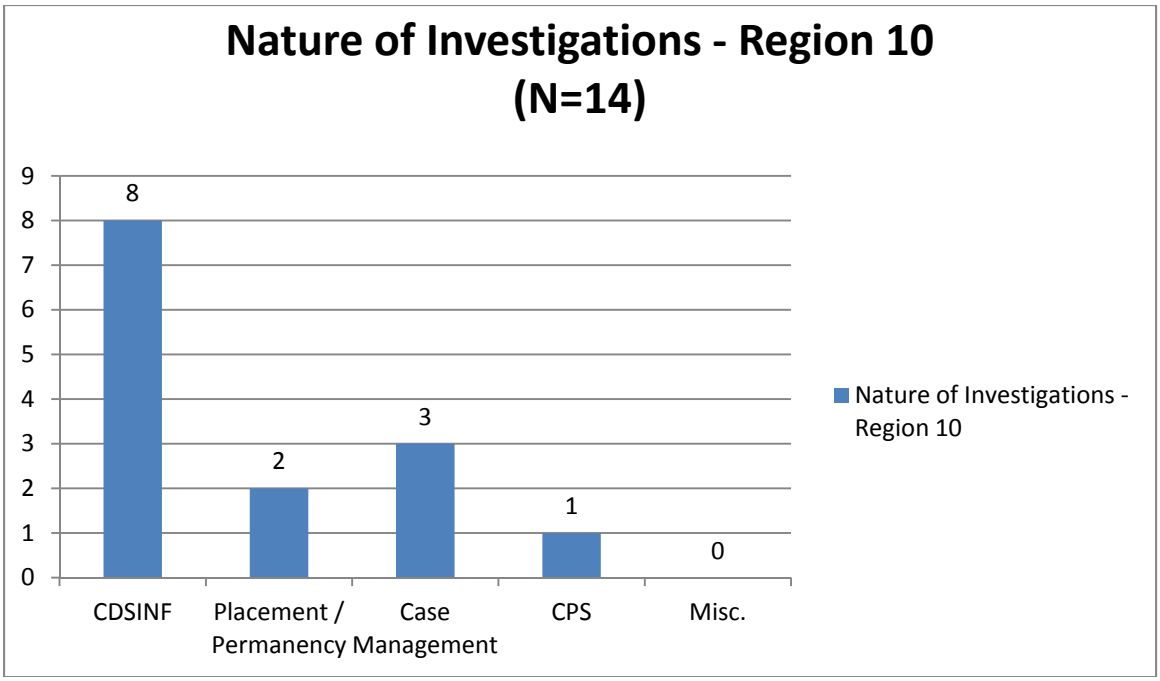
Region 7: Columbia, Richmond, Washington



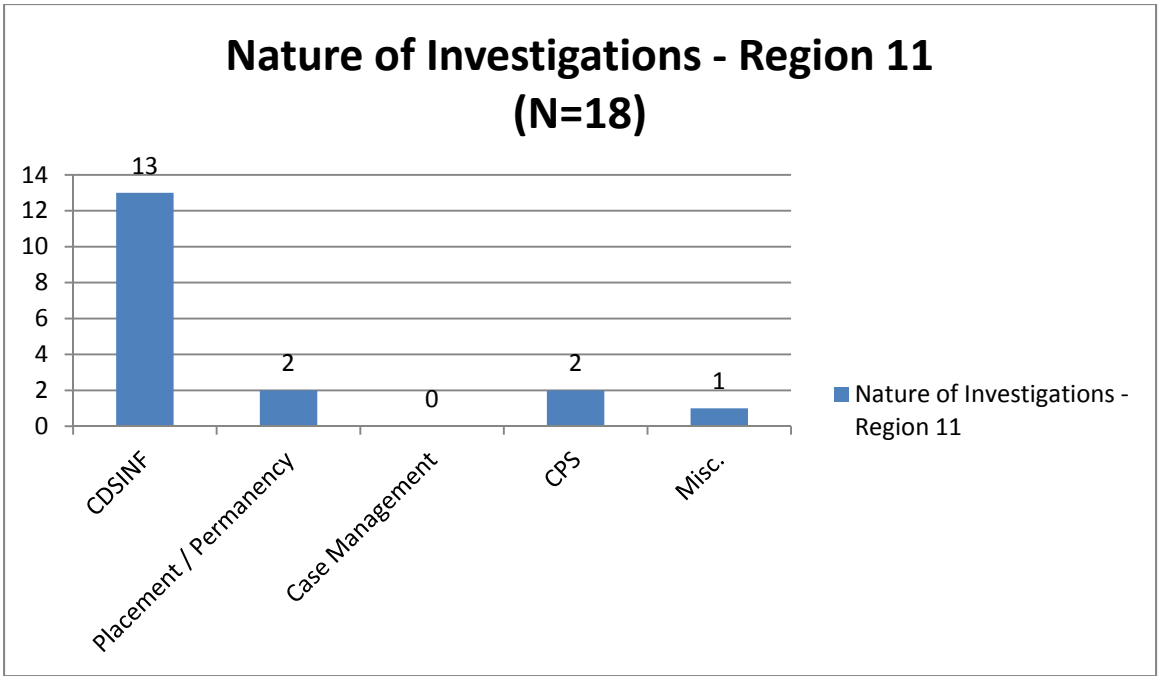
Region 8: Muscogee



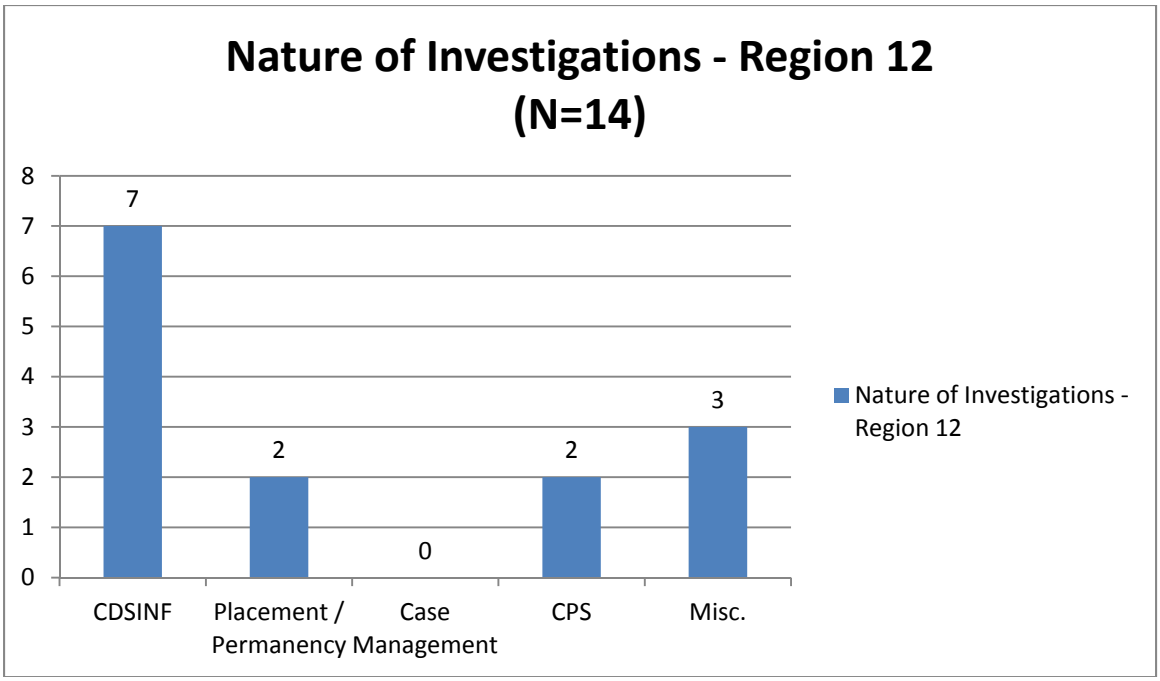
Region 9: Bleckley, Candler, Dodge, Evans, Jeff Davis, Laurens, Telfair, Wilcox



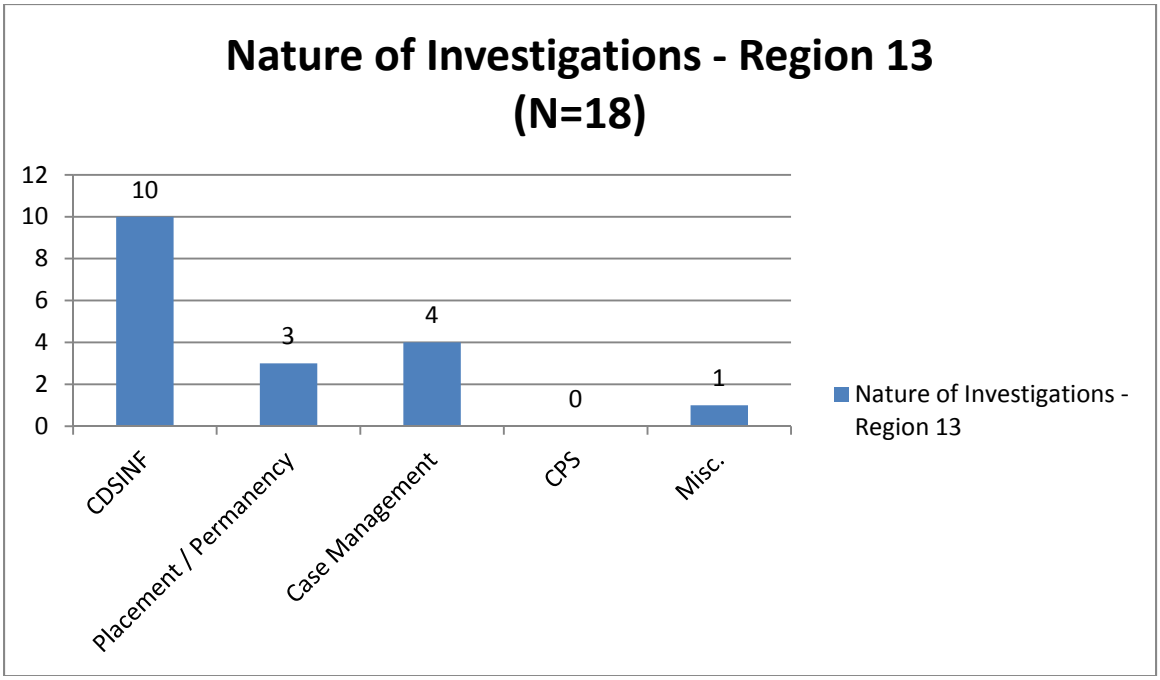
Region 10: Colquitt, Dougherty, Mitchell, Terrell, Thomas



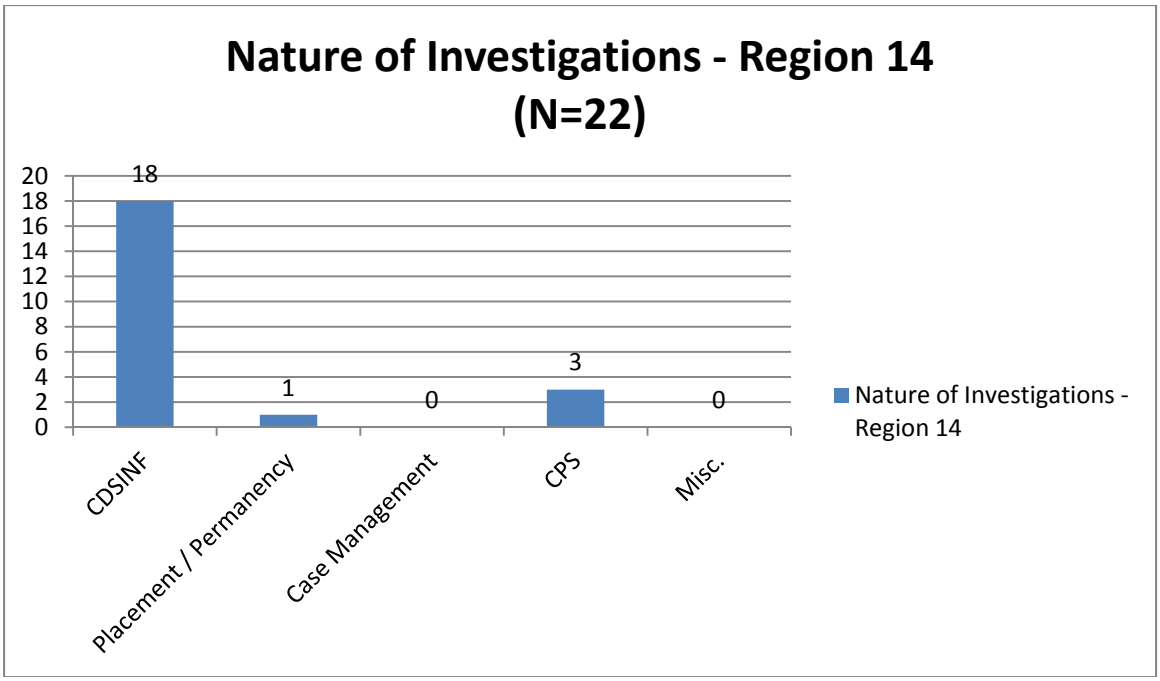
Region 11: Berrien, Coffee, Cook, Irwin, Lowndes, Tift, Turner, Ware



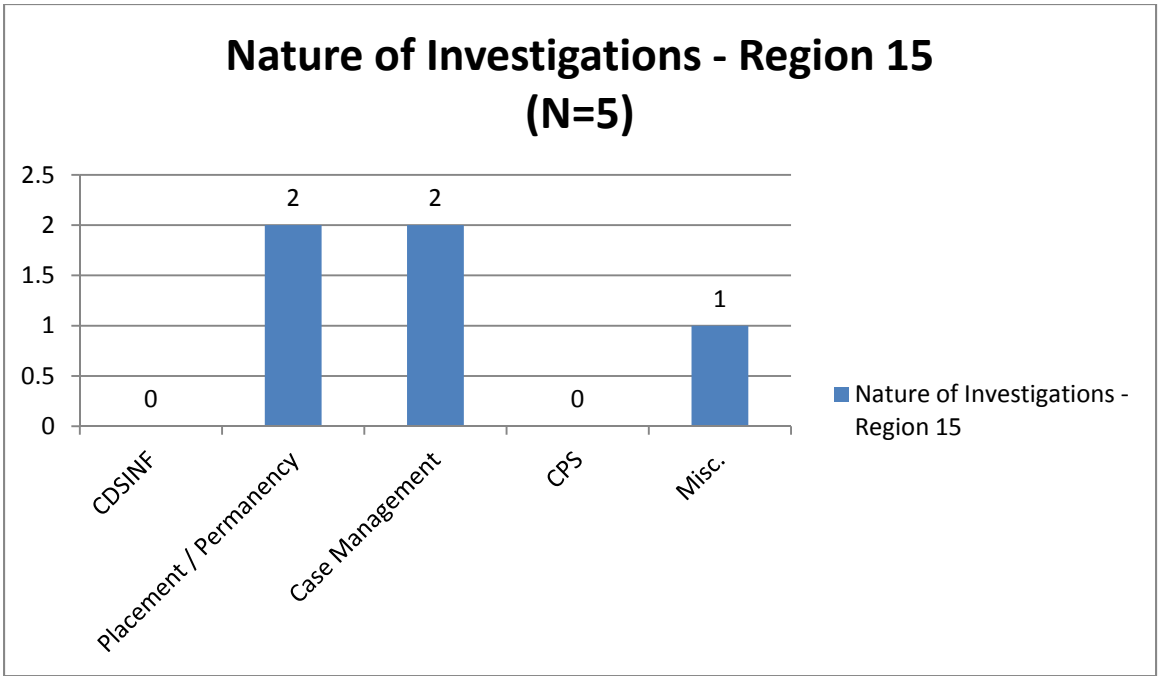
Region 12: Bryan, Bulloch, Chatham, Glynn, Liberty



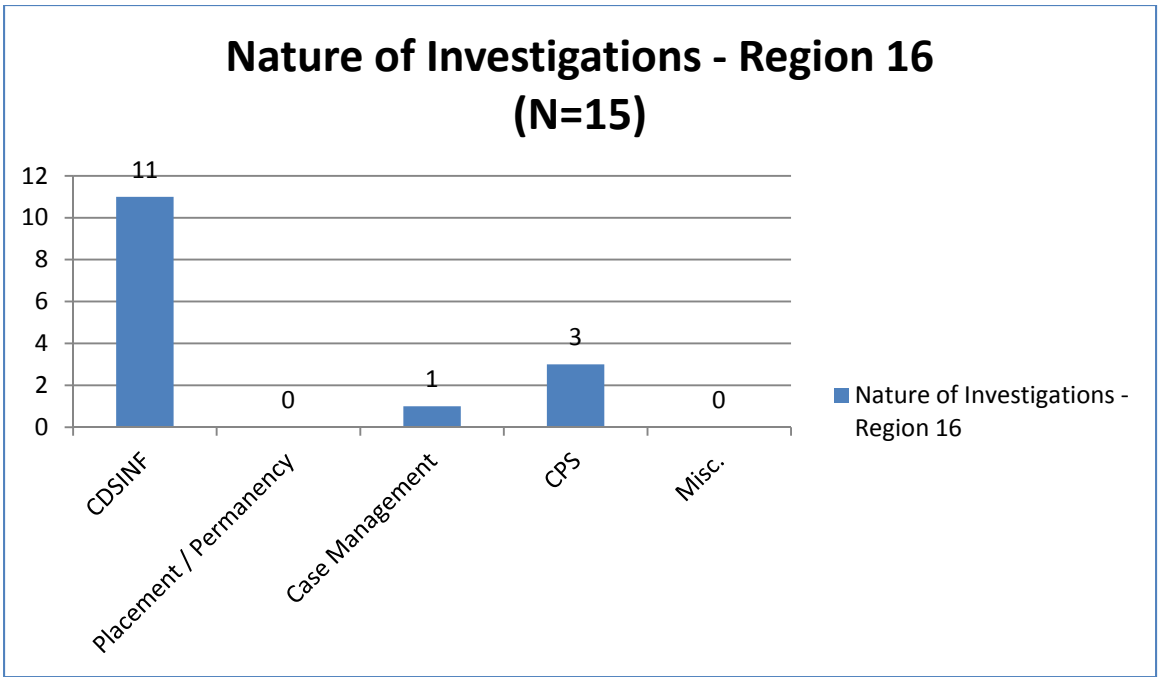
Region 13: Fulton



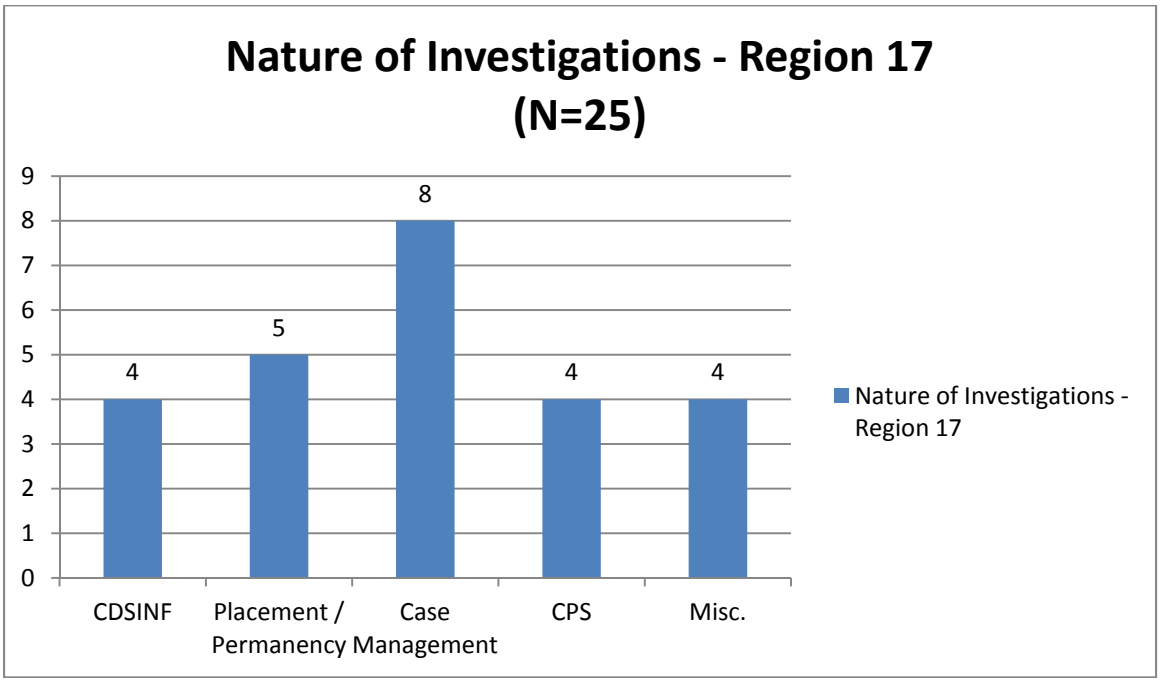
Region 14: DeKalb



Region 15: Gwinnett, Rockdale



Region 16: Clayton, Fayette, Henry



Region 17: Cherokee, Cobb, Douglas

Child Fatality Review (CFR) Child Death Reviews

In Georgia, all 159 counties are legislatively mandated to convene a CFR committee which is comprised of a multi-agency, multi-disciplinary approach to understanding the circumstances surrounding every preventable child death. During this process, CFR committees utilize vital information gleaned from multiple sources e.g., autopsies, coroner and medical examiner investigative reports, and child protective services historical documentation. Most often, the cause and manner of death is clearly identifiable, but occasionally, a constellation of factors make it difficult to definitively assign an accurate cause and manner of death. In such instances, multiple systems (e.g. the medical examiner's office, the coroner's office, and law enforcement entities) render a death undetermined based on inconclusive information, underscoring the importance of continuously enhancing scene investigation and data collection processes.
OCA staff developed and published a report detailing the circumstances of death for children under age 18 in Georgia for the calendar year of 2010 as has been its historical practice. The report is published under the Child Fatality Review Panel.

The local committees reviewed data for 2011 deaths and OCA staff provided support to them in the review process. A report will be issued in 2012 on the deaths that occurred in 2011. A trend report covering child deaths for the years of 2004-2008 was also developed and published in 2011.

In Georgia, local CFR committees convene a review meeting for those deaths that are considered eligible for review by CFR legislation, that is, those deaths that are unexpected, unexplained, or due to suspicious circumstances. The circumstances of each death are recorded on a national standardized surveillance form which is the basis for the data analyses presented in the annual report. The forms are completed at the local county level and submitted to the Office of the Child Advocate for data cleaning and processing.

OCA began discussions to share data with State of Georgia Department of Behavioral Health and Development Disabilities Suicide Prevention Program (DBHDD). State of Georgia Department of Early Childhood Learning (DECAL). The agreement with DECAL should be fully executed by February 2012 and DBHDD before the Spring of 2012.

GRANTS AND NEW INITIATIVES

The Sudden Unexplained Infant Death (SUID) Case Registry Pilot Project is a 3-year initiative (2009-2012) funded by the Centers for Disease Control and Prevention (CDC). Georgia is one of seven pilot states chosen to receive this grant. The focus of this grant is to improve investigation, review, and reporting of unexpected infant deaths. The end goal of this initiative is to enhance state-based SUID information collection systems to eventually form the basis of a national SUID Case Registry. This is a cooperative agreement, so that the CDC program staff are able to provide support and guidance to the pilot states throughout the project period, and the pilot states are able to share descriptive analysis reports and quarterly progress updates to CDC. One of the greatest challenges to successful implementation of the planned activities was the fact that Georgia has 159 counties, and that each county must conduct investigations and report on SUID cases in a consistent and standardized manner, using a mixed-model coroner/medical examiner system. Through this initiative, OCA has been able to provide a variety of tools and trainings to each of the local CFR committees and their death scene investigators to greatly improve the collection of infant death surveillance data in Georgia, as well as the accuracy and completeness of surveillance reports. OCA developed relationships with several state agencies to share information on SUID cases and to support our efforts at reporting within the requested three-month timeframe. The activities and findings of this pilot project thus far have been presented at several state and national conferences highlighting our successes and remaining challenges. "Georgia's Experience with the CDC SUID Case Registry" has been presented to multidisciplinary audiences at the Georgia Association of Young Children (GAYC) Annual Conference in October 2011, the Maternal and Child Health Epidemiology (MCH EPI) Annual Conference in December 2011, and we are invited to present at the Association of Maternal and Child Health Programs (AMCHP) Annual Meeting in January 2012. In addition, we have developed a poster of our activities and findings, which was displayed at the American Public Health Association (APHA) Annual Meeting in November 2011 and the MCH EPI Conference in December 2011. OCA will continue to pursue opportunities to present to state and national audiences and describe our experiences with the Case Registry, and its importance in building a national model for infant death investigation, review, reporting and most importantly, prevention.

ANNUAL REPORT RECOMMENDATIONS

In many cases, diversion and active Child Protective Services cases and DFCS identifies issues need addressing in order to keep children safe and healthy. These services include psychologicals, mental health therapy, alcohol and drug therapy and assessments, domestic violence assessments and many others. For some reason, possibly allocation of funding and selection of providers, these services are usually delayed and sometimes are not even started until the case is set to close. This prevents DFCS from being able to supervise the completion of the services and therefore assurance that the identified issues have been addressed. OCA would recommend that this process be restructured to allow for faster response by providers and improved supervision by DFCS. DFCS should establish written policies regarding Diversion so that a consistent standard is applied. DFCS should establish a mechanism through which DFCS will follow-up with families after initial brief services are offered to ensure that the family received the help that it needed before closing a case as a diversion. If the case is opened and closed without identifying and properly addressing critical issues, we should only expect the problem to get worse.

Due to the large turnover of DFCS case managers, a more comprehensive training curriculum should be implemented for all new staff. This curriculum should be based on standard statewide policies. The training should stress to case managers the importance of educating families of the precautions that may need to be taken when parenting young children.

DFCS should consistently assess the needs of children and families, identifying appropriate services to meet the needs, and ensure services meet the goals for children and families. This should be done on a case by case basis rather than a cookie cutter one size fits all approach.

DFCS should provide training to its case managers on the requirements of the Foster Care Bill of Rights.

DFCS should identify appropriate permanency goals in a timely manner to meet the needs of children.

DFCS should provide on-going training to its employees to include case managers and supervisors on sensitivity issues when dealing with families to include disability, racial, ethnic and religion.