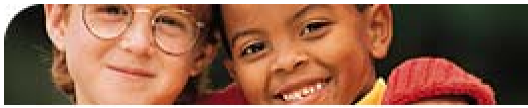

OCA Office of Child Advocate

# OFFICE OF THE CHILD ADVOCATE

***For the Protection of Children***

## ANNUAL REPORT 2003-2004

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## INTRODUCTION

In accordance with my statutory responsibility as the Child Advocate for the Protection of Children, I respectfully submit this annual report reviewing the period from January 1, 2003 to June 30, 2004. Unlike previous reports submitted by the Office of the Child Advocate ("OCA"), this Annual Report covers an eighteen month period. Future reports will cover a twelve month period coinciding with the State's fiscal year.

## HISTORY

During the 1990's the Georgia Department of Human Resources' Division of Family and Children Services ("DFCS") came under intense scrutiny concerning inadequate and untimely responses to cases of abuse and neglect of children in Georgia. Several of these cases resulted in fatalities and eventual prosecution of either foster or natural parents.

During the 2000 session of the Georgia General Assembly, legislation was passed creating the Office of the Child Advocate for the Protection of Children to improve the state's child protective services and to bring more accountability to DFCS. With 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. The OCA is given 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. The specific rights, powers, and duties of the Child Advocate are set forth in O.C.G.A §15-11-170 through §15-11-177 and a complete version has been included in this report as Appendix A. The Child Advocate serves for a term of three years and acts independently of any state official, department, or agency in performing the duties of office.

DeAlvah Hill Simms is the Child Advocate. Ms. Simms is an attorney with over sixteen years of experience. She taught middle and high school prior to attending law school. As an Assistant District Attorney in the Macon Judicial Circuit, she prosecuted crimes against children until 1997 when she left the DA's office to become the Director of Crescent House, a children's advocacy center. In 2000 Ms. Simms returned to

prosecution in the Towaliga Judicial Circuit where she was working when appointed by Governor Roy Barnes as Georgia's first Child Advocate for the Protection of Children. Governor Sonny Perdue appointed Ms. Simms to a second term as Child Advocate in January of 2004. Ms. Simms previously served on the Board of Directors for Children's Advocacy Center's of Georgia ("CACs"), Prevent Child Abuse Heart of Georgia, Macon-Bibb County Family Connection, the Children's Hospital Board for the Medical Center of Central Georgia, the Advisory Committee to Middle Georgia CASA, and the Board of Trustees for the Georgia Children's Museum. Ms. Simms is a member of the American Bar Association, the Georgia Bar Association, the American Professional Society on the Abuse of Children ("APSAC"), the Child Welfare League of America ("CWLA") and the United States Ombudsman Association.

The OCA now has ten state-funded positions: the Child Advocate, the Administrative Assistant to the Child Advocate, the Director of Policy and Evaluation, the Chief Investigator, five Investigators and an Intake Technician. The Victim Advocate Program Manager is funded through the Criminal Justice Coordinating Council's ("CJCC") Victims of Crime Act Grant Program. A detailed list of the OCA staff is contained in Appendix B.

The Child Advocate and her staff meet quarterly with the Child Advocate Advisory Committee to review and assess patterns of treatment and service for children, policy implications, and necessary systemic improvements based on information from the work and findings of the OCA staff. The members of the Child Advocate Advisory Committee are listed in Appendix C.

## MISSION

The mission of the Office of the Child Advocate is to oversee the protection and care of children in Georgia and to advocate for their well-being. In furtherance of this mission, OCA seeks to promote the enhancement of the State's existing protective services system to ensure that our children are secure and free from abuse and neglect. We do so through the operation of three programs:

1. Investigations - OCA staff investigate complaints and referrals from every geographical area of the state. Recommendations for improvement are rendered

based upon OCA's investigative findings. As problem areas are identified in the course of OCA investigations, OCA conducts on-site DFCS audits to provide a more thorough assessment of local county DFCS operations.

2. Advocacy - OCA seeks changes in laws affecting children and promotes positive revisions in the child protection system's policies and procedures. OCA also provides individual advocacy services to child abuse victims and families so that they receive appropriate services to reduce their trauma when prosecution of the offender is warranted.
3. Education - OCA promotes better training of all professionals involved in child deprivation cases and those warranting criminal prosecution through opportunities for professional development as well as facilitation of more public awareness about the issues surrounding the child protective services system.

A detailed discussion of our activities and recommendations within each of these three programs is contained herein.

## INVESTIGATIONS

Since the opening of the office in January of 2001, the OCA investigators have completed 1,810 investigations, finding concerns in approximately 25% - 30% of those cases. We would like to take this opportunity to acknowledge the good work in the many cases we review finding no concerns. The frontline workers have a tremendously difficult job and again this year we have seen caseload sizes that are not compatible with the requirements of that job. We extend our gratitude to those DFCS workers who maintain a good work ethic and continue in their commitment to protect the children of Georgia.

The OCA opened 835 cases for investigation during the report period covering January of 2003 through June of 2004. These 835 cases were from 126 different Georgia counties and the following table shows the number of cases accepted for investigation per county, grouped by DFCS classification code.[1]

[1] Classification codes are based on county population and size

| Class | County | #Cases | Class | County | #Cases | Class | County | #Cases |
|---|---|---|---|---|---|---|---|---|
| 6 | Fulton | 65 | 3 | Emanuel | 1 | 2 | Hancock | 1 |
| 5 | Bibb | 39 | 3 | Fayette | 8 | 2 | Haralson | 3 |
| 5 | Chatham | 12 | 3 | Forsyth | 9 | 2 | Harris | 1 |
| 5 | Clarke | 5 | 3 | Gordon | 6 | 2 | Heard | 1 |
| 5 | Clayton | 15 | 3 | Greene | 4 | 2 | Irwin | 2 |
| 5 | Cobb | 22 | 3 | Habersham | 7 | 2 | Jasper | 1 |
| 5 | DeKalb | 36 | 3 | Hart | 4 | 2 | Jeff Davis | 1 |
| 5 | Dougherty | 3 | 3 | Jackson | 5 | 2 | Jenkins | 3 |
| 5 | Floyd | 8 | 3 | Jefferson | 1 | 2 | Jones | 4 |
| 5 | Gwinnett | 29 | 3 | McDuffie | 2 | 2 | Lamar | 5 |
| 5 | Lowndes | 5 | 3 | Meriwether | 3 | 2 | Long | 1 |
| 5 | Muscogee | 5 | 3 | Mitchell | 4 | 2 | Lumpkin | 6 |
| 5 | Richmond | 23 | 3 | Murray | 3 | 2 | Monroe | 11 |
| 4 | Baldwin | 4 | 3 | Paulding | 13 | 2 | Morgan | 2 |
| 4 | Bartow | 7 | 3 | Peach | 7 | 2 | Oconee | 2 |
| 4 | Carroll | 10 | 3 | Polk | 15 | 2 | Pickens | 7 |
| 4 | Cherokee | 26 | 3 | Stephens | 8 | 2 | Pierce | 4 |
| 4 | Colquitt | 7 | 3 | Tattnall | 1 | 2 | Pike | 11 |
| 4 | Coweta | 15 | 3 | Toombs | 3 | 2 | Pulaski | 1 |
| 4 | Douglas | 17 | 3 | Upson | 8 | 2 | Putnam | 3 |
| 4 | Glynn | 5 | 3 | Walker | 7 | 2 | Rabun | 7 |
| 4 | Hall | 10 | 3 | Walton | 1 | 2 | Randolph | 1 |
| 4 | Henry | 26 | 3 | Washington | 1 | 2 | Screven | 2 |
| 4 | Houston | 18 | 3 | Wayne | 1 | 2 | Taylor | 2 |
| 4 | Laurens | 6 | 3 | Worth | 5 | 2 | Terrell | 1 |
| 4 | Liberty | 8 | 2 | Appling | 2 | 2 | Twiggs | 6 |
| 4 | Newton | 5 | 2 | Bacon | 1 | 2 | Union | 7 |
| 4 | Rockdale | 7 | 2 | Berrien | 2 | 2 | White | 6 |
| 4 | Spalding | 32 | 2 | Brantley | 1 | 2 | Wilkinson | 1 |
| 4 | Sumter | 2 | 2 | Bryan | 2 | 1 | Atkinson | 1 |
| 4 | Thomas | 11 | 2 | Butts | 9 | 1 | Banks | 2 |
| 4 | Tift | 1 | 2 | Candler | 1 | 1 | Bleckley | 2 |
| 4 | Troup | 6 | 2 | Chattooga | 4 | 1 | Chattahoochee | 1 |
| 4 | Ware | 4 | 2 | Cook | 3 | 1 | Echols | 1 |
| 3 | Barrow | 9 | 2 | Crawford | 13 | 1 | Lincoln | 2 |
| 3 | Brooks | 1 | 2 | Dawson | 4 | 1 | Montgomery | 1 |
| 3 | Bulloch | 3 | 2 | Dodge | 5 | 1 | Schley | 1 |
| 3 | Burke | 2 | 2 | Dooly | 1 | 1 | Stewart | 1 |
| 3 | Camden | 5 | 2 | Early | 1 | 1 | Webster | 1 |
| 3 | Catoosa | 6 | 2 | Elbert | 1 | 1 | Towns | 2 |
| 3 | Columbia | 1 | 2 | Fannin | 5 |  | State | 2 |
| 3 | Crisp | 2 | 2 | Franklin | 2 |  |  |  |
| 3 | Effingham | 4 | 2 | Gilmer | 4 |  | **TOTAL** | **835** |

During this reporting period, many common problems were noted by the OCA through the investigations and they are discussed below. The order in which these issues are discussed is in no way indicative of their importance. Each of these problems presents a serious impediment to securing the well-being of Georgia's children and must be addressed before significant positive improvement in the child welfare system will be forthcoming. Appropriate funding to develop the necessary resources for DFCS to be successful is an absolute must.

The OCA closed 667 cases during this reporting period with a concern rate of 31% which marks a slight increase in concerns above that noted in previous reports. The

table found below shows the number of cases closed per county, cases closed with concerns per county and the percentage of cases closed with concerns.

| County | # of Cases Closed | Closed with Concerns | % | County | # of Cases Closed | Closed with Concerns | % | County | # of Cases Closed | Closed with Concerns | % |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Appling | 2 | | | Fannin | 4 | 1 | 25 | Newton | 2 | | |
| Atkinson | 2 | 1 | 50 | Fayette | 7 | 2 | 29 | Oconee | 2 | | |
| Bacon | 1 | | | Floyd | 12 | 3 | 25 | Paulding | 10 | 4 | 40 |
| Baldwin | 6 | 1 | 17 | Forsyth | 8 | 4 | 50 | Peach | 4 | 4 | 100 |
| Barrow | 7 | 3 | 43 | Franklin | 2 | | | Pickens | 6 | 3 | 50 |
| Bartow | 4 | 1 | 25 | Fulton | 44 | 18 | 41 | Pierce | 4 | | |
| Berrien | 2 | | | Gilmer | 4 | 2 | 50 | Pike | 4 | 2 | 50 |
| Bibb | 43 | 11 | 26 | Glynn | 5 | | | Polk | 7 | 2 | 29 |
| Bleckley | 1 | | | Gordon | 4 | 1 | 25 | Pulaski | 1 | | |
| Brooks | 1 | | | Greene | 1 | | | Rabun | 6 | | |
| Bryan | 1 | 1 | 100 | Gwinnett | 25 | 8 | 32 | Randolph | 1 | | |
| Bulloch | 4 | | | Habersham | 4 | 1 | 25 | Richmond | 16 | 8 | 50 |
| Burke | 2 | | | Hall | 15 | 4 | 27 | Rockdale | 7 | 3 | 43 |
| Butts | 6 | 2 | 33 | Hancock | 1 | | | Schley | 1 | | |
| Camden | 3 | 1 | 33 | Haralson | 3 | 1 | 33 | Screven | 1 | | |
| Candler | 1 | | | Hart | 3 | 1 | 33 | Spalding | 23 | 10 | 43 |
| Carroll | 8 | 1 | 13 | Henry | 27 | 7 | 26 | Stephens | 3 | 2 | 67 |
| Catoosa | 3 | 2 | 67 | Houston | 11 | 3 | 27 | Stewart | 1 | | |
| Chatham | 12 | 3 | 25 | Irwin | 1 | | | Sumter | 1 | 1 | 100 |
| Chattooga | 2 | | | Jackson | 7 | 3 | 43 | Tattnall | 1 | | |
| Cherokee | 17 | 4 | 24 | Jeff Davis | 1 | | | Taylor | 1 | | |
| Clarke | 3 | 1 | 33 | Jefferson | 1 | 1 | 100 | Telfair | 1 | | |
| Clayton | 16 | 4 | 25 | Jenkins | 2 | | | Terrell | 1 | | |
| Cobb | 15 | 4 | 27 | Johnson | 2 | | | Thomas | 12 | 3 | 25 |
| Coffee | 1 | | | Jones | 2 | 1 | 50 | Tift | 1 | | |
| Colquitt | 7 | 1 | 14 | Lamar | 3 | | | Toombs | 4 | 1 | 25 |
| Columbia | 1 | | | Lanier | 1 | 1 | | Towns | 2 | | |
| Cook | 2 | | | Laurens | 2 | | | Troup | 7 | 3 | 43 |
| Coweta | 17 | 6 | 35 | Liberty | 6 | 2 | 33 | Twiggs | 6 | | |
| Crawford | 13 | 2 | 15 | Lincoln | 1 | | | Union | 4 | 3 | 75 |
| Crisp | 1 | 1 | 100 | Long | 1 | | | Upson | 6 | 1 | 17 |
| Dawson | 3 | 1 | 33 | Lowndes | 3 | 2 | 67 | Walker | 5 | 3 | 60 |
| Decatur | 1 | | | Lumpkin | 1 | | | Walton | 1 | 1 | 100 |
| DeKalb | 22 | 11 | 50 | Macon | 1 | | | Ware | 3 | | |
| Dodge | 1 | | | Madison | 1 | | | Washington | 2 | | |
| Dooly | 1 | | | McIntosh | 1 | | | Webster | 1 | 1 | 100 |
| Dougherty | 4 | 1 | 25 | Meriwether | 1 | | | White | 8 | 3 | 38 |
| Douglas | 12 | 5 | 42 | Mitchell | 3 | | | Wilkes | 1 | | |
| Early | 1 | 1 | 100 | Monroe | 9 | 4 | 44 | Wilkinson | 1 | | |
| Echols | 2 | 1 | 50 | Morgan | 1 | | | Worth | 4 | 2 | 50 |
| Effingham | 1 | 1 | 100 | Murray | 3 | 1 | 33 | State | 1 | | |
| Emanuel | 1 | | | Muscogee | 7 | 3 | 43 | **Totals** | **667** | **205** | **31** |

The types of concerns noted by OCA investigators are discussed below. Many of the concerns fall within the broad category of Case Management, but in an effort to provide more detail to the reader about the OCA findings, we have divided the discussion into specific practice issues most commonly seen during our investigations.

Case Management:

Georgia DFCS continues to operate in crisis mode, especially in the more populous counties. The county caseworkers that deal directly with children and families still suffer from high caseloads and high staff turnover and the vacancy rate continues to be a challenge. The need to lower caseloads among the caseworkers is paramount. All professionals know that there is a direct link between workloads and the resulting safety of children because of the vital importance of the relationship among the child, the child's family and the caseworker. High caseload size for child welfare workers is a pervasive problem and has led to many policy violations within DFCS and the caseload issue permeates each of the practice issues discussed below.

**Supervision:** Inexperienced frontline workers coupled with inadequate supervision result in bad outcomes for the families and children that are so dependent on an effective protective services system. The lack of true supervision was evidenced in many of our investigations. Far too often we found cases closed without an investigative summary or conclusion and without any indication of a supervisor's review. Very little evidence was found to suggest supervisors were involved in case assessment and determinations through staffing of cases with the frontline workers. The need for direct supervision is great due to the continuing high turnover within the department.

**Response Times:** The OCA investigations revealed a problem in many cases with the assignment of the appropriate response time in which to initiate an investigation and make contact with the children involved in the abuse report. Too many times the wrong response time was assigned to cases involving children age four and under.[2] Correction of this failure to assign the appropriate response time is critical. Children

[2] DFCS policy requires an immediate to 24-hour response to any report of maltreatment to a child age four and under. This age was raised from three to four in December of 2003.

under the age of four are more likely to have far fewer contacts with people outside of the home and thus are at a higher risk for undetected abuse.

In addition to the problem with the assignment of the wrong response time, the OCA investigators found that response times as assigned frequently are not met.[3] This problem clearly had a direct correlation to the number of cases assigned to the workers and is just one of the very many reasons that the caseloads carried by DFCS investigative staff must be decreased. It is completely unjustifiable to fail to make contact and ensure the safety of children who are the subjects of abuse reports. This issue begs for attention and cannot continue to go unaddressed year after year. The State of Georgia must direct the resources necessary to enable the case managers to do the job expected of them.

**Investigative Contacts:** The investigation of child maltreatment of any kind must be thorough and complete and the OCA determined in many cases that the necessary investigative contacts were not made. In others, the documentation in the file to support the case finding was inadequate. Too many times the necessary contacts with children at risk were not made in a manner consistent with ensuring the child's safety. Many times OCA found that DFCS did not notify parents of contacts with children that were made without prior parental consent. This is not only against DFCS policy but it can also lead to difficulty in developing a working relationship with a family in need of help and intervention.

DFCS continues to have problems conducting investigations within the timeframe allowed by state policy. We reviewed numerous cases where the investigation extended beyond the thirty days allowed and no waiver for such was in the file. While there are legitimate reasons for extending the time allowed to complete the investigation, we found very few cases where extension was pursuant to an appropriate waiver. Taking too long to complete an investigation is difficult for everyone involved. The DFCS investigator's caseload continues to increase, making the job more stressful. Stress within the family under investigation also has the potential to increase because of the scrutiny from the agency. Time frames are very important and great effort should be extended to completing an investigation in a timely manner.

[3] OCA investigators did differentiate between cases where multiple attempts were made by caseworkers in meeting the response time assigned and cases where no attempts were made by the DFCS investigators.

**Visits:** We found little information in case files to indicate that mandated visits with parents and children were substantive and related to the issues for which the case had been opened. In many cases, months would be noted with no visits or contacts at all. Contact with the parents and children is the only way to ensure the progress of the family in achieving the goals set forth in the case plan.

OCA also found that DFCS failed to place siblings together in a substantial number of cases and failed to document any concerted efforts to place them together. To make matters worse, the case managers often failed to ensure that sibling visits occurred on a regular basis. This is unacceptable and should be a priority of the case manager when siblings cannot be placed in the same home. Their siblings may very well be the only biological tie some of these children maintain. The State should not countenance a disruption in that relationship simply for lack of effort and lack of adequate placement resources.

**Documentation:** Without proper documentation no one reviewing a case file can understand what has happened. "If it isn't documented it didn't happen." That statement offers so much guidance especially in the context of the ever changing workforce. OCA investigators have found in many cases a lack of clear documentation about contacts and visits – sometimes to the extent of being unclear about the individual to whom the documentation refers. Many counties continue to have difficulty in obtaining timely court orders with language that satisfies all state and federal requirements. A lot of case records have expired court orders or no court orders at all. While it is understandable that there could be some delay in receiving these orders from the court, there should always be detailed documentation in the DFCS file as to what happened at the court hearing. Far too often this is not happening, leaving gaps in the case documentation and history of the case.

**Safety Plans/Assessments:** Upon review of case closures within the review period, we were shocked at the number of cases where we found no attention to assessing safety of a child within the family. We were also concerned with the review findings where we noted the number of serious safety issues that were not noted by the case manager and thus went unaddressed in the development of a safety plan. Many cases simply had <u>no</u> assessment or safety plan in the file. This issue is at the very core of the

responsibilities assigned to case managers. A case manager must be able to ascertain safety issues when conducting an investigation and must be able to develop an appropriate safety plan which will likely result in safety for the child. Much work remains to be done in training the DFCS workforce in this responsibility. Supervisors should always have an active role in the approval of each plan and the state needs to give serious consideration to immediate and intensive training on ensuring and promoting safety within the family.

**Case Plans:** Families, and most especially the children, seldom are truly involved in the development of their own case plans. We saw even more evidence of this problem during this reporting period than in previous years. Upon review of numerous case plans, OCA staff found them to be inconsistent with the findings of the investigation and the issues necessitating removal. Additionally, many case files did not even contain a current authorized case plan. This has to change. The case plan is the guide for the family in achieving success and reunification. Without a case plan many of the parents are left without a true understanding of the expectations they must meet.

We did find cases where assessments were conducted and the information and recommendations in the assessments were used to develop case plans for the children and families. However, far too often the OCA discovered a complete breakdown in the provision of mental health and other services as set forth in the case plan.

**Placements:** The lack of appropriate placement resources remains among the most serious of issues plaguing DFCS. Caseworkers frequently fail to review previous case histories that can often provide very valuable insight into the families and children with whom the worker must interact. Meaningful communication between protective services and placement workers is often lacking. There continues to be a true disconnect between child <u>protective investigative</u> services and child <u>placement</u> services resulting in poor and sometimes dangerous placement decisions. Too often inexperienced caseworkers make critical placement decisions without the benefit of adequate supervisory input.

Georgia is in critical need of more family foster homes. Overcrowding of foster homes has resulted in several serious problems. Relationships between foster parents and DFCS are not maintained at a partnership level. The overcrowding in the homes has

resulted in the placement of children that should not be placed together, often times creating a danger to all persons living in the home. Georgia's foster care system is removing more children and those children are spending more time in out-of-home care. Current staffing levels cannot sustain this pace of growth and the resulting drain on available resources.

Again in this reporting period the OCA noted many cases where children were in basic level foster care when it was obvious from just a file review that a higher level of care was indicated. Indeed, we had to seek and demand an appropriate placement for one child because he had languished in an inappropriate placement for almost twelve months by the time we became involved. The state must implement a system that properly identifies and meets a child's needs on the front end rather than waiting for the foreseeable disruption in placement after placement. Case managers need to thoroughly review the assessments provided and ensure that the case plan addresses the needs identified. We were dismayed at how many times we were told by case managers that they had not had time to review the recommendations in the assessment documentation. Not only did this failure lead to the development of case plans inconsistent with the identified needs of the child but it also led to bad outcomes for families in need of help.

**Permanency:** Children need safe and permanent homes as quickly as possible so that they do not languish in an already overloaded foster care system that does not adequately meet their needs. In the summer of 2003, OCA, in partnership with the Supreme Court of Georgia Child Placement Project, conducted an assessment of six randomly selected DFCS county placement operations. Almost without exception, OCA observed child after child languishing in foster care because they were in otherwise safe environments and were therefore not an emergency commanding a caseworker's immediate attention. The negative consequences to children who spend too much time in foster care are far reaching. Research demonstrates that children who grow up in foster care are less likely to graduate from high school and are at significantly greater risk of juvenile delinquency, adult criminality, homelessness, and public dependency as adults. We owe our children an opportunity for a far brighter future. Priority must be given to ensuring compliance with existing federal and state mandates to achieve more timely permanency for our children.

**Communications:** We continue to see communication problems both within DFCS offices and between county offices. Failure to communicate and work together creates bad outcomes for all involved. As noted above with the placement issues, there exists a true problem with the communication from investigative staff to ongoing and placement staff. It is imperative that this change or the agency will continue to work at a disadvantage with the families and children in need of appropriate intervention.

We have seen far too many cases where the communication and sharing of information from county to county is non-existent. The State has a huge problem with county DFCS offices not cooperating with each other on conducting home evaluations especially in helping to explore possible placement of a child with a relative. DFCS in every county should place this as a priority. It is good for children to be with family! We do applaud the recent efforts of the state office to develop a protocol to address the lack of cooperation between counties and urge the state to adopt a strong policy to ensure the best and most appropriate placements can be achieved for children in a timely manner.

**Community Relations/County Child Abuse Protocols:** The lack of communication between DFCS and outside agencies, including those providing services to the children and families is problematic. DFCS fails to provide information to service and placement providers when such information is absolutely necessary to successful treatment of the child. If the lines of communication are not open and those working with the children are not fully informed, the treatment and proper placement of the children is in jeopardy.

Not only is communication with service providers necessary but communication with other community partners is also vital. DFCS cannot successfully protect children if it is operating in a vacumn. DFCS should be working regularly with law enforcement, the schools and others in the community. In numerous cases reviewed by OCA, we found communication between these agencies to be less than desirable in order to achieve good outcomes for the children. While we do recognize that this is not a problem totally within the control of DFCS, we strongly recommend that each DFCS Director call a meeting of the Child Abuse Protocal Committee in the county. OCGA §19-15-2 (3)(g) requires the child abuse protocol committee to meet at least semiannually for the purpose of evaluating the effectiveness of the protocol and appropriately modifying and updating it. We did not find one county where communication issues were identified that had met

recently or reviewed the protocol. Indeed, in one county no one could even find a copy of the existing protocol. The safety and well being of children does indeed fall on all of us, but DFCS should take the lead and invite the other members back to the table for a review of the protocol and to renew a commitment to work together to protect children in the community. OCA, together with representatives from DFCS and the Child Fatality Review Panel, compiled a model protocol which counties may use as a guide to evaluating and modifying the existing county protocol. The model protocol can be found on the OCA website at www.gachildadvocate.org.

**Mandated Reporting of Child Abuse:** Georgia's Department of Education must commit to a better working relationship with the other agencies and departments that work to protect the children in the state's care. Often Georgia's educational system does not share information and too often introduces problems into the prosecution of child abuse and neglect case by failing to report such situations in a timely manner as mandated by law. Too often DFCS professionals are the last to know of suspected abuse or neglect that was revealed in the school system. DFCS workers have been denied the opportunity to speak with children who have disclosed abuse or neglect while at school. This must change. The very systems that should be working together to enhance the protection of children too often work against each other to the detriment of the children who need their protection. The OCA recommends that the Department of Education and DFCS begin work immediately on a statewide plan of operation for handling such situations. The plan should detail a cooperative relationship designed to enhance the safety and well-being of those children in need of the state's protective services. DFCS should assure those mandated to report abuse of the appropriate initiation of the investigation by sending a letter to them. We found numerous cases where DFCS had not sent a letter to the mandated reporter after receipt of a report of suspected abuse or neglect.

**Lack of services:** Children routinely suffer significant delays between entering state custody and initiation of services appropriate to their needs. Provision of mental health services for this population is fragmented, inconsistent, under-funded and difficult to access. DFCS must place high priority on the physical health of the state’s children and ensure a comprehensive, multi-disciplinary health, mental health and developmental

assessment within one month of a child's placement. Ongoing primary and preventative health care services are absolutely a must and should include reassessments at a minimum of every six months. All records should be maintained in the case file. These children are totally dependent on the state for the provision of health related services and the state should do no less for them than we would do for our own children.

**Transition Periods:** Everyone who works with children should have an understanding of the trauma all children experience when removed from their home. Unfortunately that very decision must be made sometimes to ensure the safety of children. Keeping that in mind, everything should be done to reduce the trauma to children when time allows for a planned transition from one home to another. When removing a child from home due to serious abuse or neglect, the removal must often be done swiftly because of safety concerns. However, when a child who has been in care for an extended period is to be returned home or moved to an adoptive placement, care should be taken to ensure the mental well being of the child and to provide the best possibility of a successful reunification or adoption. Children need time to adjust to changes the same as adults and they should be prepared for all moves when possible. Often, we found that moves were handled in a manner that did not promote the best opportunity for achieving a permanent placement for the child. Too often, OCA saw disruption in the adoption process which resulted primarily from a lack of an appropriate transition period for the child. We encourage DFCS to better train workers and to work to promote a better understanding of these issues within the judiciary.

**Attorney Guardians ad Litem:** GALs are charged with representing our children's best interests and must present adequate information to the court so that sound decisions about our children's safety and futures can be made. Significant deficiencies were identified in the legal representation of our children in abuse and neglect cases. OCA's investigations revealed that attorney GALs are often appointed just prior to court hearings and often do not meet the child or other interested parties before court. Effective advocacy requires knowledge of the juvenile court system and adequate preparation. Our children are depending on GALs to navigate them through the complex juvenile court and foster care systems so that they have safe and permanent homes as quickly as possible and do not languish in state care.

## AUDITS

In 2003, OCA expanded the scope of its investigations to include unannounced on-site audits of DFCS operations in selected counties. These audits were conducted in addition to the investigation of 835 complaints received by OCA during this report period. OCA began conducting these audits in order to more aggressively pursue our mission to enhance the protection of the state's children by taking a closer examination of local DFCS services to children and families.

The following are summaries of eight such audits completed by OCA and the full text of each of the audit reports can be found on our website at www.gachildadvocate.org. The counties selected for these audits were chosen either because OCA received a large volume of complaints in these counties or because the complaints received were of such a nature or severity that they warranted closer inspection by OCA.

The scope of each audit was tailored, where possible, to the nature of the concerns noted by OCA and included a review of randomly selected Child Protective Services (CPS) case files and/or foster care placement case files. In addition to the case file audits, OCA also sought to interview community partners such as juvenile court judges, foster parents, law enforcement, district attorneys, child advocates, and others in order to assess their perceptions of local DFCS responsiveness to the needs of children in families in their communities.

### Richmond County

OCA conducted its first such on-site audit in Richmond County in May 2003. The scope of this audit was limited to foster care placement cases and their corresponding child protective services case files to the extent of the most recent referral that brought the children in question into foster care. OCA also interviewed foster parents in Richmond County in order to ascertain their perspective on the Department's performance in its service to abused and neglected children.

Taken as a whole, our findings revealed mixed results, with some very good casework, some average, and some genuine cause for concern.

Strengths

OCA found the Richmond DFCS management team to be honest and forthcoming about its successes and challenges as well as eager to continue on the path of improving its child welfare system for the children and families of Richmond County. OCA identified valid court orders in eleven of twelve foster care files reviewed, representing solid evidence of the Department's efforts to better document its case files. In addition, the Department is doing an excellent job of preserving family relationships for the children in foster care by providing evidence of visitation and contacts with birth parents and relatives.

Weaknesses

The most common identified concern was that of disorganized case files, particularly among the CPS case files reviewed. OCA often found records in disarray and in no apparent order, some of which jumped from one year to another without any explanation for the gaps in documentation and leaving the reader without the ability to ascertain the history of the case or the Department's response.

Several files in our sample lacked case plans or had unsigned or expired case plans. Where completed and signed case plans were located, several lacked evidence that required services are being provided to the children in question. For example, two case plans in our sample recommended mental health services for children, including counseling and medication, but the file lacked any evidence that these services are being provided, and in particular, for one child with a history of threatened suicide. Several cases also lacked documentation that required contacts were made with children and foster parents, and in some cases, a gap exists of a month or more without any documentation in the case files whatsoever.

Foster Parent Interviews

OCA attempted to interview six randomly selected sets of foster parents in Richmond County in an effort to assess their experiences in fostering and the Department's responsiveness to their needs. We were successful in interviewing only three sets of foster parents and thus our limited findings cannot be taken to represent the experiences of all foster parents.

Overall, the foster parents we interviewed had positive things to say about fostering. They indicated that the caseworkers they dealt with were competent and professional. Two sets of foster parents, however, reported delays in receiving per diem and reimbursement payments from the Department, but that this problem appeared to have been resolved in the most recent two-month period. OCA commends the Department for its efforts to improve in this critical area, but such reform must be uniform and system-wide, as our foster parents should not experience any needless barriers to their ability to care for our children.

Two sets of foster parents also shared acute concern regarding communication. Specifically, they stated that case managers were difficult to reach, did not always return phone calls, and that they sometimes could not even leave messages because voice mailboxes were full. One set of foster parents expressed concern that the Department does not routinely share information that it has concerning children that it seeks to place, particularly where the children have known behavioral problems and/or violent tendencies.

OCA is concerned because such omissions do not create relationships between the Department and foster parents that are characterized by trust and do not permit foster parents to make an informed choice as to whether to accept a child into their home. Such failures can unnecessarily endanger the foster parents, other children residing in the home, and the child exhibiting the dangerous behaviors.

Caseloads

OCA maintains serious concerns about the caseloads under which Richmond DFCS caseworkers must operate. According to the information provided by Richmond

DFCS, the average caseload for these workers is 33.4 – nearly *double* the average of 17 recommended by the Child Welfare League of America. High caseloads such as these cannot help but impact the quality of service delivery to our children and families, as it apparently has in the areas of weakness previously discussed. Given these working conditions, caseworkers seem to be doing the best job they can under the circumstances. On a more positive note, the average number of years experience for these same workers is 3.45, representing a solid foundation upon which the Department can further build.

## Dougherty County

OCA conducted its second on-site audit at Dougherty County DFCS in the summer of 2003. The scope of this audit included a review of child protective services case files as well as ongoing CPS case files. In addition, OCA interviewed several of Dougherty DFCS' community partners in order to gain their assessment of the Department's responsiveness to the needs of children in the community. In this regard, OCA interviewed members of the law enforcement, district attorney, and child advocacy communities.

### Strengths

At all times, we found the Dougherty DFCS staff to be professional and responsive to our requests as well as sincere in their efforts to improve their child welfare system for the children and families of Dougherty County.

In twenty-four of the twenty-five cases reviewed, Dougherty DFCS identified the correct response times for initiating investigations and made face-to-face contacts with child victims of abuse and neglect. These findings represent solid work and effort on the part of the Department. Initiating investigations within correct response times and making direct contacts with child victims are critical to the Department's ability to properly investigate allegations of abuse and neglect and to accurately assessing child safety.

The Department also did an excellent job of making required home visits during the initial assessment phase in all twenty-five cases reviewed. Observing children in the

homes of their caretakers and the conditions in which they live is also critical to the Department's ability to accurately assess child safety and to making sound decisions concerning whether or not these children can safely remain at home or otherwise be placed in foster care.

Weaknesses

The most common identified concern was that of inadequate contacts with children and caretakers, and in particular, with collateral contacts. Of particular concern was that OCA identified three cases in which the families were the subjects of repeated referrals for physical abuse while the children remained in the homes of their caretakers. Repeated referrals for physical abuse suggest red flags in these families that may warrant greater intervention by the Department. OCA strongly recommended that Dougherty DFCS management undertake an immediate review of these cases to ensure child safety and for consideration of possible foster care placement.

Consistent with the finding observed in the three cases noted above is that subsequent reports of alleged abuse or neglect were handled appropriately in only 80% of the cases reviewed. In addition, safety and risk assessments were completed in a timely manner and approved by supervisors in only 80% of the cases reviewed. Supervisory review must occur in all cases if we are to ensure that we have done everything possible to ensure child safety.

Stakeholder Interviews

As noted above, OCA interviewed representatives of law enforcement, the district attorney's office, and the child advocacy communities in order to gain their perspectives on DFCS performance in its service to the children and families of Dougherty County.

Overall, each of these community partners maintains a positive regard for the work of Dougherty DFCS. All partners reported that the local task force/multi-disciplinary team (MDT) now provides them with regular opportunities for open communication and to resolve differences. These same partners praised DFCS and offered appreciation for its more sincere participation in the MDT in recent months.

Members of the district attorney's office reported that requests for DFCS records in the course of a criminal prosecution were always met with swift cooperation. Representatives from the law enforcement community did report concern that DFCS utilized staff from outside the CPS unit to conduct at least a portion of its on-call investigations. OCA strongly encouraged Dougherty DFCS to utilize only experienced and knowledgeable workers to conduct its abuse and neglect investigations in order to ensure the highest quality work and therefore, the safety of children.

Advocates expressed serious concern that, in their perception, the Department does not do an adequate job of assessing risk and is therefore not placing children in foster care that, in their opinions, should be in care. They cited specific instances in which available evidence was not utilized or taken seriously and thus children's best interests went unprotected. Again, advocates emphasized that that these concerns have abated somewhat since the multi-disciplinary team became more active. Nevertheless, Dougherty DFCS must remain vigilant in gathering all available evidence and heeding known risks – and especially in those cases involving repeated referrals for physical abuse.

## Gwinnett County

OCA conducted its third on-site audit at Gwinnett County DFCS in the summer of 2003. The scope of this audit included a review of child protective services case files as well as foster care placement case files. In addition, OCA interviewed Gwinnett DFCS' own case managers as well as several of their community partners in order to gain their assessment of the Department's responsiveness to the needs of children in the community. In this regard, OCA interviewed Gwinnett County juvenile court judges and guardians ad litem.

### Strengths

OCA found front-line DFCS workers to be highly committed to serving the children and families of Gwinnett County and devoted to doing their best on their behalf. OCA also recognizes Gwinnett's significant reduction in past-due investigations over the

last year. These accomplishments are the direct result of sustained efforts to address these critical areas.

CPS fared very well in both documenting correct response times and checking family history in at least eighty percent of cases reviewed. Placement also fared well in maintaining valid court orders as well as documenting efforts to finalize permanency plans within twelve months of removal. These are commendable findings, especially in light of alarmingly high turnover rates and caseloads, discussed below.

Weaknesses

OCA's initial impressions of the Gwinnett County DFCS facility were shocking.[4] OCA found an unsafe and dirty facility in dire need of major repairs, not the least of which was a leaky roof which led to computer equipment damage and loss of data. While OCA acknowledges that these conditions were largely beyond the control of management, management nevertheless maintained responsibility to ensure a clean and professional environment for its employees and the public.[5]

The most common identified case concerns included: failure to make required contacts with children in the course of CPS investigations as well as with children in the Department's care; incomplete or missing records, leading to periods of a month or more without any documentation whatsoever; and disorganized case files. In at least two cases, OCA investigators were told that such history was not merely missing, but simply did not exist. The Department must do a better job of ensuring the safety of children identified at risk of abuse and neglect but who are still in their homes as well as appropriate care for children in its legal custody. There is no other way for the Department to ensure that children are safe than to see these children on a regular basis.

Of greatest concern to OCA is evidence that two children in the Department's custody were sexually assaulted while in care. In one case, there was absolutely no

[4] Gwinnett County DFCS relocated to dramatically improved facilities in December, 2003. Our findings document OCA impressions of the former facility at the time of our review and in which DFCS operated for more than twenty years.
[5] OCA's comments concern the former Gwinnett DFCS management team in place at the time of our review. Since that time, OCA recognizes new leadership at Gwinnett DFCS and expresses confidence in the new team.

documentation that the referral for sexual abuse was even investigated by the Department and in the other, there was no evidence that the child received counseling to address this trauma. OCA is alarmed that children whom the Department is charged with protecting from abuse and neglect are being further victimized by that same system and that these children are not receiving services to address what has happened to them. A shortage of quality foster homes and appropriate placements cannot excuse these failures.

In addition, OCA identified a disturbing lack of supervision, especially in CPS cases. For example, risk assessments were documented with supervisory approval in only thirty-six percent of cases while case dispositions were staffed with a supervisor in only forty-three percent of cases. Supervisory review is the last line of defense for vulnerable children, especially in an office that is experiencing a turnover rate of seventy-nine percent and the average length of experience is eight months.

Stakeholder Interviews

In our interviews with Gwinnett DFCS case managers, several important themes emerged. First, front line case managers do not feel supported by senior management at Gwinnett DFCS.[6] They emphasize that they feel criticized and "attacked if something goes wrong" without being given the opportunity to explain their decision and that they receive no praise or compliments for the good work that they do. This type of environment does not encourage workers to stay with the Department. Given the caseloads under which they labor and the stress of their jobs, it perpetuates the cycle of workers coming and going with alarming speed.

Workers also reported that they begin to drown when they come on board and are assigned caseloads of 40 or more and do not have experienced supervisors to turn to for support. Workers also maintain a sense that, no matter how hard they try, the workload is so great that they will never be able to catch up.

In our interviews with court personnel, several common themes emerged as well. They too commented that the high turnover rates result in a lack of institutional memory

[6] OCA reiterates that its stakeholder interviews, including those with DFCS case managers, were conducted in 2003, before changes occurred in management at Gwinnett DFCS.

within the Department and that case managers often attend court and do not know crucial information about the cases presented.

Overcrowding of foster homes is a serious concern of all parties, including the Department and its staff. Stakeholders reported that known juvenile sex offenders in the Department's custody have been placed in homes where other younger children are also placed, resulting in sexual assaults of the younger children. This cannot stand. While court personnel are sympathetic to the fact that case managers have extremely high caseloads and receive little support, neither they nor OCA can condone poor responses to sexual abuse and serious injury cases, particularly those that occur on the Department's own watch while a child is in foster care.

Children are reported to be languishing in care for extended periods without achieving permanency. While information provided by the Area Field Director states that the average length of time between the time a child becomes free for adoption and the time of actual adoption has dropped dramatically from 22 months in FY 2002 to 4 months in FY 2003, court personnel reported cases in which termination of parental rights occurred eighteen months ago and to date, permanency has not occurred. While this occurrence is not uncommon in cases in which the child is being adopted by his current foster parents, it is no less appalling that we cannot achieve permanency for these children because they are otherwise well cared for and therefore are not an "emergency."

Finally, OCA maintains serious concerns about the caseloads under which Gwinnett DFCS case managers must labor. Based on the information provided by Gwinnett DFCS at the time of our review, the average caseload is 39.65 – nearly *two and one-half times* the average of 17 recommended by the Child Welfare League of America. According to the same data provided by Gwinnett DFCS, one case manager oversees 55 cases that include 124 children while another carries 48 cases that include seventy-five children. OCA cannot overemphasize the need for State Division assistance in securing appropriate staff allocations for Gwinnett DFCS. It is our belief that meaningful and lasting change cannot occur in the absence of dramatically reduced caseloads and efforts to reduce the resulting turnover.

## DeKalb County

OCA conducted its fourth on-site audit of DeKalb County DFCS in the summer of 2003. OCA's audit was, in part, prompted by the death of Kyshawn Punter after being returned home twice to his caretakers despite strong available evidence that Kyshawn was in danger. OCA's investigation into DeKalb DFCS' CPS operations was unprecedented in scale. OCA reviewed five-hundred and eighty CPS cases over more than one month's time.

OCA also conducted numerous stakeholder interviews that included DFCS case managers and supervisors and juvenile court judges. OCA was denied permission by the Attorney General's office to interview the Special Assistant Attorneys General (SAAGs) who represent DFCS in child deprivation cases. Therefore, our comments on SAAG representation reflect firsthand observations of practice in juvenile court as well as the opinions of DFCS workers and judges.

### Overall Observations

OCA maintains concern that DeKalb DFCS was unable to consistently provide the files requested for review despite notice of our requirements and procedures that were developed to ensure a smooth process. On one occasion, OCA investigators were sent back to Macon because no files were available for review and DFCS could not locate nearly 200 files in our sample. At other times, OCA investigators sat idle for shorter periods of time while awaiting the production of records. This is of great concern to OCA because without being able to locate these files, DFCS maintains no written record or documentation as to these families' and children's histories or the Department's response to allegations of abuse and neglect. Proper records management is an essential basic function. The Department must be able to locate its own records for specific children and families at any given time without delay.

Of even greater concern is that once the audit was underway and OCA investigators identified cases that presented safety concerns of such a degree that they were deemed to require an "immediate response" on the part of the Department, it took days and sometimes weeks for DFCS personnel to respond to these cases. To OCA, "immediate response" means just that – *immediate* – and that the Department should take all necessary steps to see these children in order to assess their immediate safety. While OCA sympathizes with DFCS' staffing vacancies, workload, and the additional effort required to respond to the "immediate concern" cases, more can and should be done to ensure an equitable distribution of cases among available workers and completion of necessary documentation to close appropriate cases.

OCA also maintains serious concerns about the culture at DeKalb DFCS. OCA cannot state with any degree of confidence that the majority of management and staff at DeKalb DFCS embraced the safety review as the emergency we believe it was and is.[7] Workers and supervisors appeared to lack appropriate respect for senior management at DeKalb DFCS and for the seriousness of the safety review itself. Such a culture in which the staff ignores the Director's mandates cannot ever result in meaningful across the board improvement if they do not take him seriously.

<u>Strengths</u>

Regrettably, DeKalb DFCS achieved a success rate of eighty percent or higher in only one of the twenty-four specific areas reviewed. CPS correctly identified the appropriate response times to referrals of abuse and neglect in eighty-five percent of the cases reviewed.

<u>Weaknesses</u>

OCA cannot overstate the seriousness of the situation we observed in DeKalb County. In both CPS investigations as well as ongoing services, we observed failures to make face-to-face contact with child victims and outside the presence of the alleged perpetrator in approximately *forty percent* of the cases reviewed. Such consistent

[7] DeKalb County DFCS' senior management team has since been replaced. OCA's comments concerning management reflect those in positions of authority at the time of our review.

breakdowns in our child protection system can and will inevitably have catastrophic consequences.[8]

OCA also observed consistent failures in the supervision and management of DeKalb CPS investigations as well as ongoing services. In both units, risk assessments and case determinations lacked supervisory review in over *fifty percent* of the cases reviewed. DeKalb County's children deserve better odds than these. Their lives are depending on it. This is especially so in a county experiencing alarming turnover in its work force and its workers lack the experience necessary to develop solid judgments about child safety. Case managers should never be placed in the inappropriate position of being the party solely responsible for decision-making in a case.

<u>Stakeholder Interviews</u>

At the time of our review, the Department's relationship with the DeKalb County Juvenile Court had deteriorated to the point that the judges lacked confidence in the agency or that the majority of its workers possessed enough case information to present knowledgeable testimony in court.[9] In addition, the court reported an urgent need for more Special Assistant Attorneys General (SAAGs) to represent DFCS in court. The judges also noted a need for more effective SAAG representation.[10] OCA is especially pleased that DeKalb DFCS now has legal representation at seventy-two hour hearings and that at least some of its cases are being staffed with a SAAG prior to court. Such representation and preparation must continue so case managers never again find themselves in the untenable position of presenting cases in court without legal counsel when children's lives hang in the balance.

OCA interviews with DeKalb DFCS case managers and supervisors brought several important concerns to light. They uniformly lamented what they perceive as a punitive environment at the state office and expressed that they are doing the very best

[8] Not long after OCA's audit, Rita Moody, a four-year-old child, died as a result of horrific abuse after several contacts to the DeKalb DFCS stating that she was in danger and living in a home where she witnessed domestic violence. In Rita's case, the assigned investigator twice attempted to make contact with the family and child, but was unsuccessful.

[9] In the time since OCA's audit, DeKalb DFCS' new management team has made a concerted effort to better prepare its workers for court. The juvenile court reports improving relations with the Department.

[10] Since the time of our audit, a fourth SAAG has been appointed and one SAAG is no longer representing the agency.

they can under very difficult circumstances.[11] They feel the state office too often looks to pinpoint failure rather than guide them to perform better. They expressed acute frustration that discipline begins and ends with the front line workers and supervisors and that upper management and the state office must be more accountable for creating and maintaining a system that is failing the families and children of DeKalb County. They uniformly expressed stress from constant scrutiny and fear that if they are the next person to make a mistake, they will be in the headlines and will be fired. They also added that media scrutiny has resulted in public perception of DFCS as having only bad or incompetent staff and not receiving any respect for the difficult work they do. One case manager stated that she does not tell people she works for DFCS because of the stigma she perceives to be associated with the agency. Clearly, senior management should take a more proactive role in repairing its public image.

## Monroe County

OCA conducted its fifth on-site audit in Monroe County in the fall of 2003. The scope of this audit included child protective services and a small number of foster care placement case files. In addition, OCA interviewed representatives of the district attorney's office, law enforcement, juvenile court, and child advocacy community in order to ascertain their perspectives on the Department's performance in its service to abused and neglected children.

### Strengths

OCA found the Monroe County DFCS management team to be dedicated to their work and to improvement of its child welfare system for the children and families of Monroe County. In CPS, workers are doing a very good job of conducting face-to-face interviews with caretakers and making home visits during the initial assessment phase. CPS ongoing workers are also doing a good job of involving caretakers in the development of case plans and arranging appropriate services for the families they serve. Placement staff are to be congratulated for their efforts to provide quality foster care and reunification services to the children and families of Monroe County.

[11] Since the time of our audit, DHR's Commissioner has been replaced and two State DFCS directors have left the agency.

Weaknesses

The most serious CPS concern identified was inconsistent face-to-face contacts with alleged child victims within the correct response times. While OCA acknowledges the Department's stated challenges with the local school system in receiving timely referrals, we strongly encourage Monroe County DFCS to revisit the local child abuse protocol in order to build the relationships necessary to ensure greater protection of Monroe County's children. OCA also identified significant concerns in the supervision of CPS cases and inconsistent staffing of cases. Management must review every case to ensure that safety has been properly assessed and the appropriate outcome decision has been made.

In CPS ongoing, risk re-assessments are not being completed and/or lack appropriate supervisory signatures prior to case closure. This is an especially crucial indicator because ongoing cases often present the greatest risks to children since they are being maintained in their homes with their alleged maltreaters. Ongoing services were also identified to be lacking in observation of caretakers in these same higher risk environments.

Stakeholder Interviews

Stakeholders praised the full-time placement of a caseworker at the Care Cottage and reported that this practice better equipped them to conduct proper and timely investigation of referrals. OCA hopes that this practice continues and that any concerns regarding productivity can be addressed without disruption.

Stakeholders expressed concern that they often experience great difficulty in contacting a DFCS representative after hours and must often make a series of phone calls in order to identify the appropriate person with whom to speak and to make contact with that person. OCA acknowledges the Department's position that it maintains an established rotation for after-hours referrals, but again encourages re-examination of the local child abuse protocol and discussion with community stakeholders so that all parties understand these procedures.

Stakeholders also maintain a perception that children in the Department's custody are sent home prematurely before their caretakers are able to resolve lengthy histories of substance abuse and mental illness. These same stakeholders reported a perception that the Department does not take children into care who should be in care. DFCS management must address these issues directly with the community and be vigilant in its efforts to protect children while working to resolve any misunderstandings about the Department's position on cases.

## Cherokee County

OCA conducted an audit of Cherokee County DFCS in the winter of 2003. Our review included both CPS and Foster Care Placement operations. This audit was prompted by both the number and severity of referrals that we received in a relatively brief period of time. OCA received fourteen complaints for investigation of Cherokee County DFCS cases in the four month period immediately preceding our review. Such a high number of referrals from a single county in a brief time represents a disproportionate share of OCA investigations and reflects approximately seven and one half (7.5%) percent of all OCA cases received, on average, during any similar four month period.

In addition to case file reviews, OCA also conducted stakeholder interviews that included Cherokee County DFCS staff, juvenile court personnel, guardians ad litem, child advocates, law enforcement, and representatives of the district attorney's office, in order to gain their individual perspectives on DFCS' performance and to seek their suggestions for improvement.

### General Observations

Of immediate and serious concern to OCA is that 50% of case managers had been employed by the Department for one year or less at the time of our review. Stakeholders uniformly expressed concern about the lack of experience of the Cherokee DFCS workforce. Many of these stakeholders believe that that the exodus of workers at Cherokee DFCS is, at least in part, attributable to the case of Rhiannon Gilmore and its aftermath, including the negative media attention that her case received as well as the disciplinary action taken against the staff assigned to her case.

Also of great concern is the apparent dramatic increase in the number of placement cases over the last year from one hundred twenty-five (125) to nearly four hundred (400). Stakeholders expressed that, although their conclusions are unscientific, anecdotal evidence suggests that because of the Rhiannon Gilmore case and a resulting climate of fear, case managers are afraid to make any mistake concerning child safety and are thus taking more children into care that could otherwise be safely maintained in their homes. Consequently, caseloads have increased for those workers and supervisors who remain at DFCS, forcing them to do significantly more work with fewer available resources.[12]

Strengths

CPS and placement are to be commended for the organization of their case files. Proper organization permits the reader to review the record with confidence that it is complete and reflects the Department's history and involvement with a family. Such organization reflects hard work and effort for which Cherokee DFCS should be proud, especially in light of the difficult conditions under which they operate and which are discussed in detail below.

CPS investigations fared very well in identifying correct response times and checking prior family history in over ninety percent of the cases reviewed. CPS also fared well in making appropriate collateral contacts and case determinations in over eighty percent of cases reviewed. In CPS ongoing services, case managers responded appropriately to multiple referrals and made efforts to involve the parent/caretaker in development and implementation of case plan in at least eighty percent of cases reviewed.

Placement findings were very good overall and stood in sharp contrast to the challenges in CPS, most notably in making reasonable efforts to finalize permanency plans, the preparation of case plans and provision of services that address the needs of

[12] Not long after OCA's audit, the state DFCS office sent a "rapid response team" to Cherokee DFCS to help alleviate dangerously high caseloads and backlogs in work. OCA appreciates the responsiveness of the state office in their efforts to address this situation.

children and families, and preserving family relationships through visitation and efforts to place sibling groups together.

Weaknesses

In CPS investigations, workers are not meeting policy requirements calling for face-to-face contacts with child victims within the correct response times nor with parents and caretakers. In addition, child victims of sexual abuse are not being interviewed in settings away from their maltreaters in an unacceptably high percentage of such cases. Moreover, safety assessments and plans exceeded thirty days in more than half of the cases reviewed. While OCA is sympathetic to Cherokee DFCS' staffing shortages and the high caseloads of its case managers, we also maintain grave concern for the safety of children in Cherokee County because these most basic of social work principles are not consistently applied in all cases. Without personally observing the children who are the subject of abuse and neglect referrals in a timely manner, there is no way that the Department can accurately assess their risk of harm and protect them from potentially dangerous circumstances.

In CPS ongoing services, risk re-assessments are not being completed in at least half of the cases reviewed, nor could we identify appropriate supervisory review of those assessments that do exist – even at the time of case closure, which had a success rate of only thirty-three percent.

The most notable challenge in placement is in securing timely permanency for children whose parental rights have been terminated. Practice improvements must include methods of consistent supervisory review of case timelines to ensure that children are not languishing in foster care any longer than is absolutely necessary.

Stakeholder Interviews

Without exception, all stakeholders expressed great respect for the difficult job that DFCS case managers have and for the work that they must do under very trying circumstances. Each, however, also expressed grave concern for what they perceive to be

a workforce crisis at Cherokee DFCS and a belief that further catastrophe would not come as a surprise.

Specifically, stakeholders expressed that the Rhiannon Gilmore case, the media coverage surrounding her case, as well as the perception of a punitive environment at the state office, have all conspired to result in spectacular turnover at the Department and a corresponding spike in caseloads that shows no signs of slowing. Workers confide great stress from constant scrutiny and fear that if they are the next person to make a mistake, they will be fired. Consequently, workers are leaving the Cherokee DFCS in droves and there are simply fewer available workers to do more work. These workers are, at least fifty percent (50%) of the time, inexperienced and/or ill-prepared to present their cases in court because they do not have current information to share in order for the court to make sound decisions concerning children's futures.

Stakeholders reported that growing caseloads are also attributable to more children entering foster care that might otherwise be safely maintained in their homes because of: worker fears of making mistakes concerning children's safety; population increases in Cherokee County as it rapidly develops and grows; and a substantial and growing methamphetamine problem among its citizenry. Nothing short of a major infusion of workforce resources as well as a supportive state office environment will stem this crisis at Cherokee County DFCS.[13]

Several stakeholders expressed serious concern about the shortage of available foster homes in Cherokee County as the number of children entering foster care continues to climb. This shortage of foster homes has resulted in waivers to the prescribed limits on the number of children permitted to be placed in single homes. While the Department states that the number of such waivers is relatively small (7), stakeholders consistently stated that this problem is far more severe and that sibling groups are routinely split up into several different homes because of a lack of available bed space.

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[13] As stated in the preceding footnote, the state office sent a "rapid response team" to Cherokee DFCS to assist in meeting the challenges of this workforce crisis.

Stakeholders expressed great support for the local multi-disciplinary team (MDT) and the promise that it holds toward facilitating better outcomes for children. Stakeholders, however, disagreed in their perceptions of the Department's commitment to this process and the degree of preparedness that workers demonstrate at meetings, with some reporting positive experiences and others reporting less enthusiastic participation by the Department. All stakeholders expressed interest in more frequent communication with the Department, especially in cases having law enforcement and criminal prosecution involvement.

## Henry County

OCA conducted its seventh on-site audit in Henry Count in the spring of 2004 and included both CPS and placement cases. In addition, OCA conducted stakeholder interviews that included Henry County DFCS staff, juvenile court personnel, Special Assistant Attorneys General (SAAGs), foster parents, child advocates, law enforcement, and representatives of the district attorney's office, in order to gain their individual perspectives on DFCS' performance and to seek their suggestions for improvement.

### General Observations

Of immediate and serious concern to OCA is that 88% or thirty-five (35) of forty (40) case managers had been employed by the Department for two years or less at the time of our review, including twenty-seven (27) of the same forty (40) who have been with the Department for one year or less. Stakeholders uniformly expressed concern about the turnover and resulting lack of experience of the Henry DFCS workforce. OCA strongly encourages the Department, with the support of the state office, to intensify its staff retention efforts in order to build a more seasoned and experienced workforce.

### Strengths

CPS investigations performed extremely well in fourteen of fifteen areas reviewed, with success rates of eighty-three percent or higher in each of those fourteen categories. OCA was very pleased to see timely and consistent face-to-face contacts with children and families as well as evidence of strong supervision in nearly all cases reviewed. These findings are noteworthy and commendable, particularly in light of the general inexperience of the Henry County workforce.

CPS ongoing fared well in arranging appropriate services for children and families and also in providing strong supervision throughout families' involvement with the agency. Placement performed well in preserving family relationships, both in exploring relative placements and in their efforts to place sibling groups together. Placement also did an excellent job of providing educational, medical, and mental health services to children in all cases reviewed.

Weaknesses

In CPS, supervisors and management are, in most cases, performing their key oversight function in order to assure quality work by the Department. One area of weakness, however, concerns cases in which the initial assessment exceeds thirty (30) days and no approved waiver could be located in the case record. At the time of our review, 132 investigations, or 19.7% of all active investigations, were past due and did not satisfy the 30-day time limit required by policy.

Management is urged to monitor the status of its investigations for timeliness so that children who are the subject of allegations of abuse or neglect are not left in harm's way pending the completion of these investigations. This is especially true in the case of Henry County DFCS where sixty-eight (68%) of its workforce has one year of DFCS work experience or less and has not yet developed the judgment that can only come with time.

Ongoing CPS performed poorly in a number of areas and warrants prompt attention, particularly in maintaining ongoing contacts with children, parents, and collateral sources and in failing to make these contacts in over sixty percent of cases reviewed. Perhaps no where is it more important to follow required policies than in these cases where children are being maintained in their homes because they are still potentially in harm's way with the caretaker who abused/neglected them. OCA encouraged the Department, in the strongest language possible, to take immediate corrective action to ensure that such contacts are made and continue to occur at regular intervals.

In placement, the Department and its SAAGs are not doing all that they must to ensure timely permanency for the children in care. A compliance rate of 75% with the Adoption and Safe Families Act's requirement to file TPR petitions after 15 months is unacceptable. Moreover, DFCS and their SAAGs must move swiftly to achieve permanency where the court has approved non-reunification and the stated plan is adoption. Practice improvements must include methods of consistent supervisory review of case timelines to ensure that children are not languishing in foster care any longer than is absolutely necessary.

Current and signed case plans were identified in only 24% of the cases reviewed. Priority must be given to ensure improved performance in this area so that all parties, caseworkers and parents alike, have very clear expectations of what is required of them. In addition, case plans can and should be more tailored to meet the particular needs of individual children and families.

Stakeholder Interviews

Most stakeholders expressed great respect for Henry County DFCS and an opinion that they do a good job overall, especially the front line workers and supervisors. Most reported very positive experiences in their communications with and cooperation they receive from the Department. They expressed confidence and trust in the agency and its workforce. In addition, stakeholders expressed that the Department is attentive to the needs of the children in its care and is responsive when concerns are brought to its attention.

One important relationship that requires attention is that with the Henry County Foster and Adoptive Parent Association.[14] While the concerns expressed by the Association do not represent the consensus of all Henry County foster parents, they must nevertheless be addressed in order to reduce genuine fears of the agency and concerns about retribution for speaking out. Most foster parents did express frustration with the Department for the aggressive visitation schedules imposed upon them, often without much advance notice and offering little flexibility in scheduling. Further inquiry in this

[14] Since the time of our audit, a new director has been hired at Henry County DFCS and is working to address the concerns of the Association.

area, however, revealed that the juvenile court had ordered the required visitation and the agency was attempting to comply with these same orders in scheduling visits. Admittedly, the agency should do a much better job in communicating with its foster parents about its challenges and in exercising reasonable flexibility in scheduling.

OCA's own observations of the juvenile court process in Henry County indicate that others share responsibility with the Department for its failure to achieve more timely permanency. OCA observed Henry County Juvenile Court deprivation proceedings on two occasions and in both judges' courtrooms. OCA staff identified several key issues of importance:

Special Assistant Attorneys General (SAAGs)

The attorneys appointed to represent DFCS in court performed inconsistently, particularly in their provision of notice to parties and preparation of court orders. OCA repeatedly observed cases in which parents had not been served with notice despite the known location of the parents (two different parents were in jail and had been for some time) or the known vagrancy of the parents, but the SAAG had nevertheless failed to notify by publication. Each of these cases was needlessly continued because of the failure of the agency's own attorneys to perform this most basic function. On two other occasions, the Court inquired of the SAAG about the status of court orders from a previous hearing and was told that they still were not ready but would be ready "soon" when pressed further by the Court. Two cases were also continued because of an apparent breakdown in arranging transportation of parents from the jail for a hearing.

Several stakeholders reported an urgent need for more Special Assistant Attorneys General (SAAGs) to represent the Department in deprivation hearings. While the population of Henry County continues to soar as one of the fastest growing counties in the nation, the number of SAAGs has not kept pace and remains at two. This shortage was apparent to OCA in its own review of placement case records in which 21% did not maintain appropriate court orders that give the Department legal custody of the children in its care. At a minimum, three (3) SAAGs are needed in order to ensure quality representation of the Department as its caseload continues to climb. DFCS reports that

they are now approved for three SAAG slots, but one remains vacant despite the efforts of the director to recruit local attorneys to this area of practice.

Finally, the Department reports acute frustration with the Attorney General's office in its perceived failure to support the Department in cases they wish to appeal. They report sending cases to Atlanta and nothing happens.

Foster Home Shortages

Stakeholders expressed concern about the shortage of available foster homes in Henry County as its population continues to skyrocket and the number of children entering foster care continues to climb. This has resulted in children being placed out of county, thereby compounding existing difficulties in arranging supervised visits between parents, children, and siblings. According to AFCARS data for April, 2004, Henry County needs an immediate infusion of forty-two (42) new foster homes just to keep pace with current needs and which represents the third greatest need for foster homes in the state.

## Coweta County

OCA conducted its eighth and final audit in the reporting period in Coweta County. Coweta DFCS was selected as an audit site due to the high volume of complaints received relative to the county's size. OCA reviewed both CPS and placement operations and conducted stakeholder interviews that included representatives of the Department, district attorney's office, law enforcement, and juvenile court.

General Observations

Coweta County DFCS has much of which to be proud. OCA identified Coweta County DFCS as its best all-around performer of the eight county DFCS agencies audited during the reporting period. These results are all the more impressive given that fifty-nine percent of its case managers have less than two years experience with the Department. OCA believes these results are largely attributable to the relatively low caseloads observed in Coweta County and having the appropriate number of staff positions allocated to meet the needs of the children and families in the community.

Strengths

At the time of our review, Coweta DFCS had *zero* past due investigations and should be applauded for these outstanding results. Moreover, CPS investigations achieved a success rate of eighty percent or higher in fourteen of the fifteen areas reviewed. In ongoing services, that unit achieved a success rate of eighty percent or higher in all nine areas reviewed. Clearly, CPS is doing an excellent job for which they should be commended.

Placement also fared extremely well in our review. In fact, OCA identified concerns in only twenty-seven percent of the cases reviewed. As was the case with CPS, placement has much of which to be proud. OCA appreciates the effort and commitment of the Coweta DFCS staff that produced such positive results for the children and families of Coweta County.

Weaknesses

CPS investigations experienced some difficulty in meeting response times and completing assessments as well as investigations within thirty days as required by policy. While workers sought waivers in several of these cases, management denied these requests eighty percent of the time. Thus while workers attempted to comply with policy by seeking waivers, supervisors were firm in their expectations of staff, thereby causing a reduced success rate for this indicator. OCA supports Coweta DFCS in maintaining high standards for its workforce.

In placement, OCA identified serious impediments to Coweta DFCS' ability to achieve permanency for its children. OCA identified two cases in which children had been in foster care for *six years and fifteen years*, respectively. However, DFCS alone does not bear sole responsibility for these tragic outcomes. The juvenile court plays a pivotal role as well. In the case of the child in care since 1998, she has been in the same foster home for years with foster parents who wish to adopt her. The child wishes to be adopted by this family and does not want a relationship with her biological mother. The child continues to languish in care to this day while the court has not set the termination of parental rights hearing for trial.

Stakeholder Interviews

Stakeholders reported significantly improved communication across agencies serving children, especially in the last two years and had strong praise for the management team at Coweta DFCS. Case managers are regarded to have greater knowledge of other agencies' procedures, are following established protocols, and are sharing information, where appropriate.

Some stakeholders reported that the Department's relationship with law enforcement could be better and that the two agencies need better coordination in criminal case investigations. As the county continues to grow, they also recommended that both DFCS and law enforcement dedicate specific personnel to respond to crimes scenes involving child victims.

## ADVOCACY

Through our investigations and audits, OCA identifies key areas where we focus our attention on both policy and legislative advocacy. As noted in the Investigations section of this report, necessary improvements rest not only on DFCS but on the entire system established to protect our children from abuse and neglect.

### Victim Advocacy Grant

OCA continues to operate its Victim Advocacy Program with funds from a federal Victims of Crime Act ("VOCA") grant through the CJCC. Through this program, the office is able to represent children in state care in accessing victim compensation funds and appropriate services. We assist children who are involved simultaneously in child welfare, law enforcement and the various court systems to ensure the protection of the child victim's rights. We offer our thanks to the CJCC for such a generous grant award.

The Victim Advocacy Program served 106 victims in this report period. These victims were from 28 counties around the state. Most of these victims received referral information for resources in their community. Sixteen victims were assisted in receiving

Temporary Protective Orders and criminal justice advocacy was provided in other cases. Victim Compensation information was also provided to a number of victims. The victim advocate works closely with Victim Assistance programs around the state in providing victims with information regarding counseling, child advocacy centers, CASA and victim compensation funds and the criminal justice process.

## Accreditation of DFCS

The Office of the Child Advocate again recommends that Georgia DFCS place gaining full accreditation with the Council on Accreditation for Children and Family Services as a top priority of the agency. This will require DFCS to provide services and case management that meet the highest national standards in child welfare. Devotion and a strong financial commitment to this goal from our lawmakers will be necessary, but Georgia can and should do better in meeting the needs of the children and families involved with the state's child welfare system. Georgia cannot continue to rank at the bottom nationally on children's issues.

With the economic downturn that Georgia and the nation have seen in the last few years, the number of children and families needing services is continuing to increase. We will not soon see a decline in the numbers involved with DFCS. Knowing this to be true, Georgia must plan accordingly. Georgia must devote the financial resources necessary to reduce the caseloads of workers to comply with the national standards. DFCS desperately needs better case management and staff retention efforts need to be bolstered. This is the only way caseworkers will ever be able to do the job that is required of them to adequately meet the needs of the families and children that depend on DFCS. Supervisors need specific training in how to manage staff and should be required to have advanced level social work degrees or appropriate experience to offset the lack of formal education.

## Continuum of Care

Georgia must develop an adequately funded continuum of care for the families and children identified as "at risk." Prevention, intervention and treatment are all necessary components of a good child welfare system. To prevent abuse and neglect

before it ever occurs should be a primary focus. Early intervention with families identified as "at risk" is a must. Adequate funding for prevention programs is essential and we will continue to focus attention on this need. DFCS must partner with those in the non-profit community proven successful with prevention programs.

The OCA also recommends that in counties where Court Appointed Special Advocate (CASA) programs are active, CASAs and attorney GALs could make an excellent team to ensure that the best interests of the child are protected. CASA representation for children has proven both effective and cost efficient in the areas where an active CASA program is available. The OCA recommends that each of the judicial circuits explore the opening of a CASA program.

## Senate Bill 236

On May 7, 2003, Governor Perdue signed Senate Bill 236 into law. Senate Bill 236, initiated by Governor Perdue as part of his legislative agenda, accomplishes three primary objectives. First, it requires the Department of Family and Children Services (DFCS) to conduct a diligent search for relatives during the first ninety days that a child enters foster care. This is good social work practice because it will identify relatives earlier in the process to care for their children and prevent them from unnecessarily entering our foster care system in the first place. This provision should also prevent children from developing bonds with their foster parents only to be removed and placed with a relative whom they may not know much later in the process.

Second, S.B. 236 clarifies the rights of foster and pre-adoptive parents to notice and an opportunity to be heard in hearings and reviews concerning children in their care. Since passage of the federal Adoption and Safe Families Act of 1997 and corresponding changes to Georgia law in 1998, foster parents have had these rights but they were not uniformly implemented across the state. For example, some foster parents still were not receiving notice at all while others received less than twenty-four hours oral notice, which did not afford them adequate time to schedule their affairs to attend these hearings. S.B. 236 makes clear that the court or its designee is responsible for providing written notice to caregivers and to provide the same length of notice as parties.

Finally, S.B. 236 also provides that, in certain circumstances, children may be permanently placed with licensed child-caring organizations when compelling reasons exist for doing so. For example, such a placement may be appropriate where a child has been in a family-like setting for a number of years, has bonded with the house parents, and to move the child to another placement could cause irreparable psychological harm to the child.

OCA played a valuable role in the passage of this important legislation by assisting in its drafting and participation in stakeholder meetings to create the best possible bill. OCA also provided extensive advocacy for the bill during Senate and House Committee hearings and in organizing necessary witness testimony by many Georgia foster and pre-adoptive parents.

**Foster Parents' Bill of Rights**

In 2004, the General Assembly passed, and Governor Perdue signed, legislation that enumerates twenty-three specific rights for foster parents. This legislation is significant because it recognizes the value and contribution that foster parents make to our abused and neglected children and recognizes them as critical partners in the child protection process.

The Bill of Rights makes clear that foster parents should have the opportunity to provide input to DFCS and the courts in their decision-making and that foster parents are similarly entitled to receive vital information pertaining to children in their care so that they can provide the best placement environment possible. Most notably, the Bill of Rights unambiguously states that foster parents shall be recognized as a preferential placement for a child who has previously been in their care and also in the case of a child available for adoption if the child has been in their care for a year or more.

OCA supported the creation of the Foster Parents' Bill of Rights during the legislative process and remains integrally involved in the creation of a fair grievance process for alleged violation of these rights.

## Child Endangerment

On July 1, 2004, Georgia became the last state in our country to have a felony child endangerment law on its books. After four long years of sometimes contentious debate and negotiations, legislators passed child endangerment with overwhelming bipartisan support. As passed, child endangerment created the offense of cruelty to children in the second degree. This critical legislation now offers our prosecutors a tool previously missing from their toolbox, making prosecution possible of caregivers who place their children in harm's way with a reckless disregard for their safety.

Legislation was also passed that makes it a crime to possess or manufacture methamphetamine in the presence of a child. Methamphetamine use has reached epidemic proportions in some areas of our state and poses tremendous risks to our children's safety because of its volatile and explosive properties.

OCA applauds the leadership and support of Governor Perdue and Lieutenant Governor Taylor in securing passage of child endangerment, without whom success would not have been possible. OCA also recognizes the tireless and zealous advocacy efforts of Ms. Wendi Clifton who kept child endangerment on the forefront of Georgians' minds.

## Termination of Parental Rights

As observed in the course of OCA case investigations and audits, Georgia's children are waiting unreasonable lengths of time for the child welfare system and courts to determine their fates and sometimes languish for years without achieving permanency. Current Georgia law permits up to one year's time to pass between the filing of a petition to terminate parental rights and a final decision on the issue. OCA believes that this is too long for our children to await a decision concerning their futures and to achieve permanency.

OCA will be pursuing legislation in the 2005 session of the General Assembly that would narrow this timeframe from one year from the date of the filing of the

termination of parental rights petition to a requirement that that the court issue its ruling within thirty days from the conclusion of the hearing. OCA's proposal would also require juvenile courts to set such hearings for trial within ninety days of the filing of the termination of parental rights petition unless compelling reasons exist for additional delay.

## Foster Child Education Grant

In the 2002 legislative session, the General Assembly created the Foster Child Education Grant with a $260,000 appropriation in the Fiscal Year 2003 budget. The Grant provides financial assistance to older foster youth who would otherwise have limited or no access to post-secondary education resources. Young people who have grown up in Georgia's foster care system have often endured multiple residential placements, and in these moves often change schools, sometimes several times in a school year. These same students lose academic credits in this process, thereby delaying their high school graduation and entry into college and technical school.

Prior to the Grant's creation, DFCS provided significant financial assistance with college expenses to our foster youth, but that assistance ended at age twenty-one – the very age that many of our young people are just beginning their post-secondary academic careers, not completing them as many traditional students do. As created, the Grant provides payment for tuition, room and board, books and fees not otherwise covered by the federal Pell Grant or Hope Scholarship. Payment continues as long as the student makes satisfactory progress toward their degree – to age twenty-five.

OCA's legislative proposal would codify the Foster Care Education Grant and thereby re-affirm Georgia's commitment to caring for the children for whom it has served as parent and assure them a greater chance of successfully transitioning into mainstream society without ever being system dependent again.

## Guardian Ad Litem Training

Since its enactment in 1974, the federal Child Abuse and Prevention Treatment Act (CAPTA) has required appointment of a Guardian Ad Litem (GAL) in "every case involving an abused or neglected child which results in a judicial proceeding." The GAL can be "an attorney or a court-appointed special advocate, or both."

CAPTA, as recently amended, now specifies that, in order for states to be eligible for a CAPTA state grant, there must be a certification by the Chief Executive Officer of the State that the State has in effect and is enforcing a state law, or has in effect and is operating a statewide program, that ensures every abused or neglected child is appointed a GAL who has received pre-appointment training appropriate to their role.

Volunteer curricula developed by the National CASA Association provide a model for training of CASA volunteers before they are appointed to represent the best interests of individual children. Georgia CASA has adapted the National CASA new volunteer training curriculum for lay GALs so that it is consistent with both federal and state child deprivation law and practice.

To fulfill CAPTA's new training mandate for attorney GALs, Georgia's Office of the Child Advocate and the Supreme Court of Georgia Child Placement Project propose to combine resources and host, at a minimum, an annual statewide training conference. Two national authorities on the quality of attorney training have approved standards of practice for lawyers representing children in abuse and neglect cases that include a provision specifying the content of "appropriate" training. The proposed legal training for Georgia's attorney GAL is consistent with these standards published by the American Bar Association and the National Association of Counsel for Children.

The Office of the Child Advocate will be supporting legislation in the 2005 session of the General Assembly that codifies CAPTA's requirement of appropriate pre-appointment training for GALs. In order to promote more consistent GAL practice and fulfill CAPTA's mandate for statewide compliance, OCA will also seek legislative authority to approve or administer the required training. Such a provision will enable

OCA to create a training model that can be adapted for statewide usage while also offering local courts the flexibility to create their own training curriculum, so long as it contains the essential elements identified by the American Bar Association and National Association of Counsel for Children as critical subject areas.

### Mandated Reporter Statute

In the nearly four years since OCA's creation, several gaps in our state's mandated reporter statute have emerged and should be addressed to strengthen Georgia's response to children in crisis. OCA is supporting four specific changes to our mandated reporter law as follows. First, OCA supports clarifying Georgia's current requirement of an oral report of suspected abuse from "as soon as possible" to "immediately, but no later than twenty-four hours" from the time the suspicion of abuse arose. This change would provide sorely needed clarity in defining what is required of our mandated reporters. Our second proposal would add the requirement of a written report within seventy-two hours following an oral report. A written report ensures that there is a complete and accurate account of all allegations made involving a child's safety so that the child's case receives a thorough investigation of all issues raised.

Third, OCA proposes adding clergy to the list of mandated reporters, while preserving the privilege of communications made in the course of a confession. An obligation to report would arise if a member of the clergy suspected abuse or neglect based upon information obtained in another manner, such as personal observation. Finally, OCA supports tightening our mandated reporter law so that it unequivocally requires designees within large institutional settings, such as schools and hospitals, to make reports of suspected abuse as conveyed to them by first-hand observers, such as teachers and nurses, without interference or the substituted judgment of the designee.

### Special Assistant Attorneys General (SAAGs)

Earlier this year, OCA and the Supreme Court of Georgia Child Placement Project surveyed county DFCS directors about their satisfaction with their local SAAG representation. Among other items, the survey inquired as to the degrees of accessibility,

preparation, cooperation and level of performance of SAAGs in each county. Because survey participants were anonymous and multiple submissions were received from some counties that have more than one SAAG, the survey results cannot be considered scientific. However, based on all available information, nearly all, if not all, counties were accounted for.

Overall, the news is good. Survey results show that the majority of DFCS county directors and staff are satisfied with their SAAG representation. Approximately 88% of respondents indicated that they felt the SAAG appropriately and adequately considered their input, as the client, in directing the course of the representation. In total, 75% of survey participants rate their SAAG's accessibility and preparation for court as "excellent – always prepared," or "good – usually prepared." Nearly half rated their SAAG's willingness to work with caseworkers as "excellent – always willing," and another third rated it as "good – often/usually willing." Two-thirds rated the SAAG's preparation for meetings with caseworkers as good or excellent. Approximately 14 or 7% of respondents indicated that their SAAG was not performing up to their expectations. OCA is mindful of the fact that we receive few, if any, referrals praising good SAAG work. Rather, it is a relatively small group of SAAGs who appear to present these most serious concerns.

Specifically, fourteen respondents indicated their SAAG was rarely or never accessible or prepared for court. Twelve responded that the SAAG was rarely or never prepared for meetings with caseworkers, most of whom also indicated that the SAAG was rarely or never willing to work with caseworkers. While this number is a small percentage of the total, the concerns associated with these SAAGs are significant. Many survey responses indicated that problematic SAAGs did not file timely orders, needed constant prompting to initiate scheduling of hearings, and failed to provide notice to parties. Generally, county DFCS directors or supervisors initiated formal or informal complaints with the state office concerning these attorneys.

These overall positive findings reflect the hard work and dedication of the SAAG community in their efforts to provide quality legal representation to their DFCS clients. OCA wishes to acknowledge their commitment and service to the state, particularly for providing that representation at rates substantially below prevailing business practice, in both the public and private sectors. The following chart further illustrates the differential

in compensation to SAAGs representing various agencies and departments within state government.

| Type of Case | Hourly Rate |
|---|---|
| DOT/Certain Business Loss Cases | $140.00 |
| DOT/Standard SAAG rate | $125.00 |
| Tort Cases | $125.00 |
| Inmate Litigation - Inmate Represented by Counsel | $125.00 |
| DOAS/DOT Worker's Comp Cases/Standard Rate | $100.00 |
| Inmate Litigation - Pro Se Cases | $ 75.00 |
| Post-Conviction Habeas Corpus Cases | $ 60.00 |
| DFCS - Termination Cases | $ 55.00 |
| DFCS – Deprivation Cases | $ 52.50 |
| Child Support Enforcement | $ 52.50 |

OCA continues to advocate for increased compensation of DFCS SAAGs so that they are paid an hourly rate comparable to that paid to SAAGs serving other state agencies.

**Medicaid**

The federal Foster Care Independence Act of 1999 authorizes, but does not require, states to extend Medicaid benefits to former foster children to age 21. Twenty-six states now have some form of expanded Medicaid eligibility for their foster youth but Georgia is not one of them. While OCA is mindful of the state's continuing struggle to fund Medicaid, at the appropriate time, we strongly recommend consideration of expanding Medicaid eligibility for these youth as they transition from foster care to independence. To do so exhibits a strong commitment to children for whom the state of Georgia has served as the parent.

## EDUCATION

OCA's third program is education. In this area, OCA facilitates and promotes the professional development of all parties involved with our child protection system, including DFCS staff, Guardians Ad Litem, district attorneys, law enforcement, and others. Specialized training and education of all those working in child protection and deprivation are necessary. The OCA participated in numerous training conferences and collaborative efforts throughout the year in order to promote a well-trained workforce across the various disciplines. Further training initiatives are needed to address specific concerns outlined in the investigative findings of this report. Cross-training is a positive and cost effective way of meeting the educational needs of the various disciplines and encouraging communication. A few topics for inclusion in future training are DFCS policies and procedures, child development, medical and psychological aspects of child abuse and neglect, family dynamics and legal issues in deprivation proceedings.

### Celebration of Excellence

The Celebration of Excellence is a statewide annual graduation event and scholarship program designed to recognize the academic achievements of youth in the Georgia foster care system who are graduating from high school, GED programs, vocational school, or college. The event includes a formal awards ceremony much like a commencement exercise and a social gathering with food and entertainment. Graduates receive certificates of recognition for their achievements, graduation gifts, and scholarships.

Many of the youth honored at the Celebration of Excellence have been in foster care for all or most of their lives. The longer a youth is in the state's custody, the more at-risk he/she may become due to a lack of a stable family environment that promotes education, teaches daily living skills, and encourages attendance in school. Some youth have been moved from placement to placement, either from their own families to a foster care home or between foster homes. Often they have had to change schools, sometimes as often as several times a year, thereby missing the opportunity of a normal high school experience or senior year. The youth recognized at the Celebration have met and overcome these challenges. But when it comes time to celebrate these achievements,

they may not have anyone to cheer them on, take them to lunch, give them a present, or assure them of their bright and successful futures.

The Celebration is a program that honors our youth for their academic success in the manner in which they deserve. Recognizing the successes of the "system" and the achievements of these youth is important for our youth, for those who work in the child welfare field, and for the community, who often only hears about the child welfare system when it fails.

The Celebration is organized by community partners in the Georgia child welfare system who include: the Younger Lawyers Division of the State Bar of Georgia; the Department of Family and Children Services; the volunteer and non-profit communities. OCA is proud to serve on the Celebration Volunteer Planning Committee and to have had a staff member serve as its Chairperson for the last five years.

## Building Successful Teams

OCA participated as a partner in sponsoring both the fourth and fifth annual *Building Successful Teams* Multi-Disciplinary Conferences for Investigation and Prosecution of Serious Injury and Fatal Child Abuse during the reporting period. Other sponsoring partners included The Georgia Department of Human Resources Division of Family and Children Services, The Georgia Bureau of Investigation and the Georgia Child Fatality Review Panel. Plans for the sixth annual conference are already underway. Our mission is to foster teamwork at every level through education and training, and by providing accessible expert support services to those working on the front lines of the battle against abuse and neglect.

The groups sponsoring this conference include representatives of every discipline having the legal responsibility of protecting the lives of Georgia children. As outlined in the conference brochure, each sponsoring agency believes strongly that it is only through working together that the enormous task of preventing child death or injury can become a reality. A multi-disciplinary team approach in investigations is critical for accurate identification of child abuse and neglect when it occurs and in successful prosecution of the perpetrator. Each year approximately 700 persons attend the Building Successful Teams conference making it one of the largest conferences in the southeast with the

purpose of collaboratively training those working in the child abuse fields in order to strengthen investigations and prosecutions in child serious injury and child death events. Attendees from various disciplines include the judicial branch, prosecutors, child welfare professionals, medical examiners and coroners, medical professionals, law enforcement and mental health professionals.

### *Finding Words Georgia*

The Office of the Child Advocate was successful in bringing "Finding Words" training to Georgia. *Finding Words GA* is co-sponsored by the Office of the Child Advocate, DFCS, and Children's Advocacy Centers of Georgia. The National Center for the Prosecution of Child Abuse and CornerHouse Children's Advocacy Center developed a model multi-disciplinary forensic interviewing course entitled *Finding Words* and decided to offer the training through approved states in a program called Half a Nation By 2010. We are pleased that Georgia was one of the first six states chosen and the OCA held its first *Finding Words Georgia* in January 2003. The weeklong training presented at the Georgia Public Safety Training Center in Forsyth is designed to instruct multi-disciplinary teams in forensic interviewing of children. *Finding Words GA* received full certification in June of 2003. We have held eight week long trainings to date and *Finding Words Georgia* has trained teams from 48 counties. The training sessions scheduled for 2005 already have waiting lists, demonstrating the continuing need for such a training program in Georgia. The OCA intends to continue to offer *Finding Words Georgia* training opportunities to the teams in Georgia in order to promote consistency in the investigation and prosecution of child abuse throughout the state.

### Child Placement Conference

Since the opening of the OCA, we have been an active participant in the Child Placement Conference, the largest annual cross-training conference offered in Georgia. The hosts of this conference include DFCS, the Georgia Association of Homes and Services for Children ("GAHSC"), the Supreme Court's Child Placement Project, Georgia Court Appointed Special Advocates ("CASA") and the Department of Juvenile Justice ("DJJ"). Over 500 participants attend this conference. They include: new and

experienced DFCS case managers and supervisors, juvenile court judges, attorneys, CASAs, independent living coordinators, DJJ case managers, mental health professionals, group home staff and caseworkers, citizen panel review staff and volunteers and others working in the area of foster care and placement.

Each year, the conference expands its collaborative partnership and the cross-section of topics offering the most current information available on working with children at risk. Unique to this conference is the highlighting of the many services available to children and families in Georgia, how our communities can work together to leverage these resources and how each of us can do our part. The overall evaluations from the Child Placement Conference show consistently high marks and the workshops are well attended. Now in its sixth year, the Child Placement Conference has emerged as the best cross-training opportunity available to child welfare professionals in Georgia. The OCA highly recommends the Child Placement Conference for all people working in or connected to the child welfare system.

## Guardian ad Litem Conference

In previous OCA Annual Reports, we identified significant deficiencies in the legal representation of our children in abuse and neglect cases. OCA's investigations revealed that attorney GALs are often appointed just prior to court hearings and often do not meet the child or other interested parties before court. That practice is unacceptable. Effective advocacy requires knowledge of the child's circumstances, the juvenile court system and adequate preparation. Our children are depending on GALs to navigate them through the complex juvenile court and foster care systems so that they have safe and permanent homes as quickly as possible and do not languish in state care.

OCA again sponsored a training opportunity for GALs in September of 2004. More than one hundred fifty (150) attorney and volunteer GALs from across Georgia attended this conference. Evaluations from this effort overwhelmingly affirmed the need for more training. Training seminars were conducted on such topics as trial skills and preparation, direct and cross-examination, legal principles of juvenile court, methamphetamine, representation of undocumented children, interviewing children, legislative updates, DFCS programs, appropriate usage of medical evaluations, and many others. One hundred percent (100%) of participants rated their overall conference

experience as “Excellent” or “Good” and the majority of written comments stated that the “variety and quality of the workshops and the quality of the information provided by presenters” were the best things about the conference. OCA expresses sincere appreciation to the Department of Human Resources for its award of a Children’s Justice Act grant that made the GAL Conference possible.

## A Final Word

OCA again expresses appreciation for the hard work of so many Georgia child welfare professionals as they continue to strive to improve the lives of our children and families. However, much remains to be done in order to create a child protection system of which Georgia can be proud. OCA will continue to work to ensure more positive outcomes for our at-risk children while advocating for necessary systemic improvements and intensifying our efforts to promote a more professional and well-trained workforce. OCA appreciates Governor Perdue, Lt. Governor Taylor, and all members of the Georgia General Assembly for their sustained support as we continue our efforts to achieve our mission of enhancing the state’s child protection system for our most vulnerable citizens.

# APPENDIX A

## CHILD ADVOCATE FOR THE PROTECTION OF CHILDREN

Effective date. - This article became effective April 6, 2000.

15-11-170

(a) This article shall be known and may be cited as the "Georgia Child Advocate for the Protection of Children Act."
(b) In keeping with this article's purpose of assisting, protecting, and restoring the security of children whose well-being is threatened, it is the intent of the General Assembly that the mission of protection of the children of this state should have the greatest legislative and executive priority. Recognizing that the needs of children must be attended to in a timely manner and that more aggressive action should be taken to protect children from abuse and neglect, the General Assembly creates the Office of the Child Advocate for the Protection of Children to provide independent oversight of persons, organizations, and agencies responsible for providing services to or caring for children who are victims of child abuse and neglect, or whose domestic situation requires intervention by the state. The Office of the Child Advocate for the Protection of Children will provide children with an avenue through which to seek relief when their rights are violated by state officials and agents entrusted with their protection and care.

15-11-171

As used in this article, the term:
(1) "Advocate" or "child advocate" means the Child Advocate for the Protection of Children established under Code Section 15-11-172.
(2) "Agency" shall have the same meaning and application as provided for in paragraph (1) of subsection (a) of Code Section 50-14-1.
(3) "Child" or "children" means an individual receiving protective services from the division, for whom the division has an open case file, or who has been, or whose siblings, parents, or other caretakers have been the subject of a report to the division within the previous five years.
(4) "Department" means the Department of Human Resources.
(5) "Division" means the Division of Family and Children Services of the Department of Human Resources.

15-11-172.

(a) There is created the Office of the Child Advocate for the Protection of Children. The Governor, by executive order, shall create a nominating committee which shall consider nominees for the position of the advocate and shall make a recommendation to the Governor. Such person shall have knowledge of the child welfare system, the juvenile justice system, and the legal system and shall be qualified by training and experience to perform the duties of the office as set forth in this article.

(b) The advocate shall be appointed by the Governor from a list of at least three names submitted by the nominating committee for a term of three years and until his or her successor is appointed and qualified and may be reappointed. The salary of the advocate shall not be less than $60,000.00 per year, shall be fixed by the Governor, and shall come from funds appropriated for the purposes of the advocate.
(c) The Office of the Child Advocate for the Protection of Children shall be assigned to the Office of Planning and Budget for administrative purposes only, as described in Code Section 50-4-3.
(d) The advocate may appoint such staff as may be deemed necessary to effectively fulfill the purposes of this article, within the limitations of the funds available for the purposes of the advocate. The duties of the staff may include the duties and powers of the advocate if performed under the direction of the advocate. The advocate and his or her staff shall receive such reimbursement for travel and other expenses as is normally allowed to state employees, from funds appropriated for the purposes of the advocate.
(e) The advocate shall have the authority to contract with experts in fields including but not limited to medicine, psychology, education, child development, juvenile justice, mental health, and child welfare, as needed to support the work of the advocate, utilizing funds appropriated for the purposes of the advocate.
(f) Notwithstanding any other provision of state law, the advocate shall act independently of any state official, department, or agency in the performance of his or her duties.
(g) The advocate or his or her designee shall be an ex officio member of the State-wide Child Abuse Prevention Panel.

15-11-173

The advocate shall perform the following duties:
(1) Identify, receive, investigate, and seek the resolution or referral of complaints made by or on behalf of children concerning any act, omission to act, practice, policy, or procedure of an agency or any contractor or agent thereof that may adversely affect the health, safety, or welfare of the children;
(2) Refer complaints involving abused children to appropriate regulatory and law enforcement agencies;
(3) Report the death of any child to the chairperson of the child fatality review subcommittee of the county in which such child resided at the time of death, unless the advocate has knowledge that such death has been reported by the county medical examiner or coroner, pursuant to Code Section 19-15-3, and to provide such subcommittee access to any records of the advocate relating to such child;
(4) Provide periodic reports on the work of the Office of the Child Advocate for the Protection of Children, including but not limited to an annual written report for the Governor and the General Assembly and other persons, agencies, and organizations deemed appropriate. Such reports shall include recommendations for changes in policies and procedures to improve the health, safety, and welfare of children and shall be made expeditiously in order to timely influence public policy;
(5) Establish policies and procedures necessary for the Office of the Child Advocate for the Protection of Children to accomplish the purposes of this article including without limitation providing the division with a form of notice of availability of the Office of the Child Advocate for the Protection of Children. Such notice shall be posted prominently, by the division, in division offices and in facilities receiving public moneys for the care and placement of children and shall include information describing the Office of the

Child Advocate for the Protection of Children and procedures for contacting that office; and
(6) Convene quarterly meetings with organizations, agencies, and individuals who work in the area of child protection to seek opportunities to collaborate and improve the status of children in Georgia.

15-11-174

(a) The advocate shall have the following rights and powers:
(1) To communicate privately, by mail or orally, with any child and with each child's parent or guardian;
(2) To have access to all records and files of the division concerning or relating to a child, and to have access, including the right to inspect, copy, and subpoena records held by clerks of the various courts, law enforcement agencies, service providers, including medical and mental health, and institutions, public or private, with whom a particular child has been either voluntarily or otherwise placed for care or from whom the child has received treatment within the state. To the extent any such information provides the names and addresses of individuals who are the subject of any confidential proceeding or statutory confidentiality provisions, such names and addresses or related information which has the effect of identifying such individuals shall not be released to the public without the consent of such individuals;
(3) To enter and inspect any and all institutions, facilities, and residences, public and private, where a child has been placed by a court or the division and is currently residing. Upon entering such a place, the advocate shall notify the administrator or, in the absence of the administrator, the person in charge of the facility, before speaking to any children. After notifying the administrator or the person in charge of the facility, the advocate may communicate privately and confidentially with children in the facility, individually or in groups, or the advocate may inspect the physical plant. To the extent possible, entry and investigation provided by this Code section shall be conducted in a manner which will not significantly disrupt the provision of services to children;
(4) To apply to the Governor to bring legal action in the nature of a writ of mandamus or application for injunction pursuant to Code Section 45-15-18 to require an agency to take or refrain from taking any action required or prohibited by law involving the protection of children;
(5) To apply for and accept grants, gifts, and bequests of funds from other states, federal and interstate agencies, independent authorities, private firms, individuals, and foundations for the purpose of carrying out the lawful responsibilities of the Office of the Child Advocate for the Protection of Children;
(6) When less formal means of resolution do not achieve appropriate results, to pursue remedies provided by this article on behalf of children for the purpose of effectively carrying out the provisions of this article; and
(7) To 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.
(b) (1) Upon issuance by the advocate of a subpoena in accordance with this article for law enforcement investigative records concerning an ongoing investigation, the subpoenaed party may move a court with appropriate jurisdiction to quash said subpoena.
(2) The court shall order a hearing on the motion to quash within 5 days of the filing of the motion to quash, which hearing may be continued for good cause shown by any party or by the court on its own motion. Subject to any right to an open hearing in contempt

proceedings, such hearing shall be closed to the extent necessary to prevent disclosure of the identity of a confidential source; disclosure of confidential investigative or prosecution material which would endanger the life or physical safety or any person or persons; or disclosure of the existence of confidential surveillance, investigation, or grand jury materials or testimony in an ongoing criminal investigation or prosecution. Records, motions and orders relating to a motion to quash shall be kept sealed by the court to the extent and for the time necessary to prevent public disclosure of such matters, materials, evidence or testimony.
(c) The court shall, at or before the time specified in the subpoena for compliance therewith, enter an order:
(1) Enforcing the subpoena as issued;
(2) Quashing or modifying the subpoena if it is unreasonable and oppressive; or
(3) Conditioning enforcement of the subpoena on the advocate maintaining confidential any evidence, testimony, or other information obtained from law enforcement or prosecution sources pursuant to the subpoena until the time the criminal investigation and prosecution are concluded. Unless otherwise ordered by the court, an investigation or prosecution shall be deemed to be concluded when the information becomes subject to public inspection pursuant to Code Section 50-18-72. The court shall include in its order written findings of fact and conclusions of law.

Annotations
The 2001 amendment, effective July 1, 2001, designated the existing provisions of this Code section as subsection (a) and added subsections (b) and (c).

15-11-175. Penalty provision.

(a) No person shall discriminate or retaliate in any manner against any child, parent or guardian of a child, employee of a facility, agency, institution or other type of provider, or any other person because of the making of a complaint or providing of information in good faith to the advocate, or willfully interfere with the advocate in the performance of his or her official duties.
(b) Any person violating subsection (a) of this Code section shall be guilty of a misdemeanor.

15-11-176

The advocate shall be authorized to request an investigation by the Georgia Bureau of Investigation of any complaint of criminal misconduct involving a child.

15-11-177

(a) There is established a Child Advocate Advisory Committee. The advisory committee shall consist of:
(1) One representative of a not for profit children's agency appointed by the Governor;
(2) One representative of a for profit children's agency appointed by the President of the Senate;
(3) One pediatrician appointed by the Speaker of the House of Representatives;
(4) One social worker with experience and knowledge of child protective services who is not employed by the state appointed by the Governor;
(5) One psychologist appointed by the President of the Senate;

(6) One attorney appointed by the Speaker of the House of Representatives from the Children and the Courts Committee of the State Bar of Georgia; and
(7) One juvenile court judge appointed by the Chief Justice of the Supreme Court of Georgia.
Each member of the advisory committee shall serve a two-year term and until the appointment and qualification of such member's successor. Appointments to fill vacancies in such offices shall be filled in the same manner as the original appointment.
(b) The advisory committee shall meet a minimum of three times a year with the advocate and his or her staff to review and assess the following:
(1) Patterns of treatment and service for children;
(2) Policy implications; and
(3) Necessary systemic improvements.

The advisory committee shall also provide for an annual evaluation of the effectiveness of the Office of the Child Advocate for the Protection of Children.

# APPENDIX B

## STAFF

**DeAlvah Hill Simms** - Child Advocate

**Sandra Darby** - Administrative Assistant to the Child Advocate

**Allyson W. Anderson** - Director of Policy and Evaluation

**Russell A. Lewis, Sr.** - Chief Investigator

**Robert Z. Hernandez** - Investigator

**William A. Herndon** - Investigator

**Bobbi Nelson** - Investigator

**Susie Tompkins** - Investigator

**Chris Williams** - Investigator

**Vickie Morgan** - Intake Technician

**Sherry Bryant** - Victim Advocate Program Manager

The Victim Advocate Program Manager is funded through the Criminal Justice Coordinating Council's ("CJCC") Victims of Crime Act Grant Program.

OCA also enjoyed the services of twelve students made possible through the generosity of the Barton Child Law and Policy Clinic at Emory University, Georgia CASA, the Child Advocacy Project of Central Georgia CASA and Mercer University School of Law and a sub grant from the Children and Youth Coordinating Council ("CYCC") of a grant under the Juvenile Justice and Delinquency Prevention Act of 1974. They include: Angela Tanzella, Kelly Hanofee, Jenna Leopold, Kim Yonkers, Margaret

Anne Matthews, Larry Brox, Robyn Mercer, Tori Daniels, Heather Hunt, Kim Saunders, Laura Glass Hess, and Dorothy Harper. We offer our sincere gratitude to each of these students for their hard work on behalf of Georgia's children and each of the named programs and schools for providing these exceptional interns to our office.

# APPENDIX C
# ADVISORY COMMITTEE

OCA is fortunate to have an advisory committee of seven individuals dedicated to helping fulfill our mission of protecting our children. The members include:

- Dr. John Adams is a practicing psychologist in Statesboro and was appointed by Lt. Governor Taylor.

- Ms. Laura Eubanks is a social worker with Children's Healthcare of Atlanta and was appointed by Governor Perdue.

- Judge Tracy Graham is a juvenile court judge in Clayton County and was appointed by Georgia Supreme Court Chief Justice Norman Fletcher.

- Dr. Joy Maxey is a practicing pediatrician in Atlanta and was appointed by Speaker of the House of Representatives, the Honorable Terry Coleman.

- Dr. Alma Noble is the Director of Baby World Daycare Center in Albany and was appointed by Lt. Governor Mark Taylor.

- Mrs. Kathy O'Neal is Region VI Community Facilitator with Family Connection and was appointed by Governor Sonny Perdue.

- Ms. Ellen Williams is an attorney and active lobbyist on children's issues and was appointed by Speaker Coleman. Ms. Williams also serves as Chairperson of the Committee.