

Office of the Child Advocate for the Protection of Children



Annual Report 2012

Tonya Boga, Child Advocate



Nathan Deal, Governor

**Office of the Child Advocate
270 Washington Street, Suite 8101
Atlanta, Georgia 30334
404-656-4200
www.oca.georgia.gov**

Nathan Deal
Governor



Tonya C. Boga
Director

OFFICE OF THE CHILD ADVOCATE

December 2012

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

In accordance with my statutory responsibility as the Child Advocate for the State of Georgia, I respectfully submit the 2012 Annual Report.

This report provides an overview of the activities of the Office of the Child Advocate for the Protection of Children covering the period of January 2012-December 2012, a summary of the complaints received and investigated, and an overview of Georgia's child fatality review.

In addition to the forestated information, it includes recommendations for positive change within our child welfare system in order to improve the outcomes for our precious children.

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

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

Very Respectfully,

Tonya Boga
Georgia's Child Advocate

270 Washington Street SW, Suite 8101, Atlanta, Georgia 30334
404-656-4200/404-656-5200 (fax) www.oca.georgia.gov

Table of Contents

Mission	Page 4
History	Page 4
Authority	Page 6
Budget and Operational Changes	Page 7
Staff	Page 8
Advocacy, Collaboration, Outreach and Activities	Page 10
Monitoring to bring positive change	Page 21
Complaint Intake and Referral	Page 25
Child Fatality Review (CFR) Child Death Reviews	Page 30
Annual Recommendations	Page 32

MISSION

The Office of the Child Advocate for the Protection of Children (“OCA”) retained the mission statement as adopted in 2010. *Our mission is to promote positive change in public policy and improvements in practice to ensure the safety, health, and well-being of Georgia's children.*

As advocates for the protection of children, OCA developed and utilized a daily working mission in 2011 which it also retained in 2012, “Leave it better than you found it.” The daily working mission is used to implement the mission statement. The mission is a daily goal for which we all strive to achieve. Sometimes our work encompasses advocacy for a policy change within the Division of Family and Children Services; other times we advocate for a specific child’s placement to change; we advocate for prevention efforts to address the primary causes of child deaths that occur; and we provide professional training to groups of coroners, law enforcement officers, nurses, medical unit responders, school personnel, attorneys, social workers, forensic interviewers, counselors, and other professionals who work in the area of child welfare.

HISTORY

In the years leading up to 2000, the Georgia Department of Family and Children Services (“DFCS”) as it was then called, experienced a period of intense scrutiny for inadequate and untimely responses to cases of abuse and neglect of children in Georgia. A number of these cases resulted in fatalities and eventual prosecution of either foster or natural parents. During the latter part of 1999, Georgia received national exposure in a segment of 60 Minutes that highlighted failures within the protective services system. The focus of the 60 Minutes segment was on the death of Terrell Peterson, a five-year-

old boy who died of severe abuse despite repeated warnings to DFCS that he was in extreme danger. During the 2000 session of the Georgia General Assembly, legislation designed to improve the child protective services and to bring a system in which there is more accountability from DFCS was introduced, thus, the creation of the Office of the Child Advocate ("OCA") in 2000. Georgia became the twelfth state to open an independent ombudsman office designed to protect the rights of children in state care and to monitor the agencies charged with protecting those children. OCA has independent oversight of DFCS and others responsible for providing services to or caring for children who are victims of child abuse or neglect, or whose domestic situation requires intervention by the state.¹

In 2008, initially through Executive Order and later legislation, the Office of the Child Fatality Review was merged into the Office of the Child Advocate. The General Assembly found that the well-intentioned efforts over the years have resulted in the creation of several agencies focused on preventing child abuse and juvenile delinquency, on serving at-risk families and troubled children, and on promoting the improvement of our state's child welfare system. The General Assembly further found that the work of some of the agencies overlapped and that the at-risk families and troubled children of our state would be more efficiently and effectively served by placing the functions of the Georgia Child Fatality Review Panel under the supervision of the Child Advocate for the Protection of Children and encouraging the consolidated agencies to create a consistent vision for serving the needs of Georgia's families.²

¹ O.C.G.A. 15-11-170

² O.C.G.A. 19-15-4

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

AUTHORITY

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

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

BUDGET AND OPERATIONAL CHANGES

OCA absorbed a 2% budget reduction during the 2012 legislative session. More recently to comply with instructions for the amended 2013 fiscal year, OCA submitted a reduction plan at the 3% level. The reduction was satisfied through adjustments within the agency's operating budget. OCA is pleased to report that it was able to retain the much needed staff that provide the services on behalf of Georgia's children.

AGENCY BOARDS

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

The members of the Child Fatality Review Panel are Judge Peggy Walker, Douglas County Juvenile Court; E.K. May, Washington County Coroner ; Barbara Lynn Howell, Criminal Justice Coordinating Council ; Dr. Mary Burns, Georgia Department of Human Resources ; Dr. Nancy Fajman, Emory University School of Medicine; Brett Harrell, GA Representative; Vernon Keenan, Georgia Bureau of Investigations ;Ron Scroggy ;Frank Berry, Dept of Behavioral Health & Developmental Disabilities; District Attorney J. David Miller, Southern Judicial Circuit ;Tonya Boga, Office of the Child Advocate ;Dr.

Kris Sperry, GBI Medical Examiner ;Gloria Butler, GA Senator ;Brenda Fitzgerald, Division of Public Health Beverly Losman, Safe Kids GA; Children's Healthcare of Atlanta ;Judge C. LaTain Kell, Cobb County Superior Court; Major Paula Sparks, Cobb County Police Department; and Kathleen A. Bennett, Richmond County, Disabilities and Mental Health Specialist Central Savannah River Economic Opportunity Authority Head Start Program.

STAFF

The Office of the Child Advocate for the Protection of Children (OCA) celebrated its third year of housing two units, the Child Welfare unit and the Child Fatality Review (CFR) unit.³ In 2011, OCA began the process of cross-training all of its employees and also began a process in which the Child Fatality Review unit and the Child Welfare unit work closely together in a team approach. Recognizing the wisdom of the legislature in combining the two agencies and the need to work together to better serve the needs of Georgia's children and their families in need, OCA began a team approach of reviewing the child death cases in which there was a prior DFCS history or the child was in the custody or control of DFCS at the time of the child's death. Cross-training employees and combining the work of reviewing child deaths promotes efficiency and helps to better serve the children of Georgia. In 2012, OCA continued cross-training and has successfully completed cross-training of the entire child welfare unit with each member having working knowledge of child fatality review. Each member also is responsible for essential functions in office matters that cover both units.

³ As a result of the Children and Family Services Strengthening Act of 2008, the Office of the Child Fatality Review was consolidated into the Office of the Child Advocate for the Protection of Children.

The child welfare unit is comprised of three child welfare analysts, Brendan Jenkins, Charles Pittman, and Vickie White; three assistant child advocates, Cynthia Cartwright, Kenneth Perrin and Ryan Sanford. Tomia White and Crystal Dixon also serve as staff in the child welfare unit.

All of the assistant child advocates have a legal background⁴ and share child fatality review responsibilities. The assistant child advocates primarily investigate the complaints received from the governor's office but also investigate child fatality and serious injury cases. The assistant child advocates work with the yearly child fatality review trainings held in various parts of the state teaching the Child Abuse Protocol materials, the law governing child fatality review and facilitating the training in addition to providing support to the county child fatality review teams.

The child welfare analysts primarily investigate the reporter contact complaints received via the Office of Child Advocate website or intake personnel. The analysts also investigate child fatality and serious injury cases.

The child fatality review unit provides support to the 159 county review teams through three staff members, Kenneth Perrin⁵, Malaika Shakir, and Tomia White⁶. A prevention specialist, Arleymah Raheem, supports the county teams through prevention plan assistance. Crystal Dixon is the data specialist⁷. The three assistant child advocates, Cynthia Cartwright, Kenneth Perrin, and Ryan Sanford also perform

⁴ All of the Assistant Child Advocates have completed their Doctorate of Jurisprudence degree.

⁵ Assistant Child Advocates also support the child fatality review unit.

⁶ Tomia White also serves as a data analyst and child welfare intake coordinator in the child welfare unit.

⁷ The data specialist is cross-trained and also serves as a member of the child welfare intake unit as an intake coordinator.

child fatality review duties.⁸ OCA divides the state into three regions in order to provide support to the local teams in their review of child fatality cases.

ADVOCACY, COLLABORATION, OUTREACH AND ACTIVITIES

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

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

In 2012, our advocacy consisted of, but was not limited to, hosting trainings to promote better advocacy for children; attendance and participation in seminars; trainings and meetings focused on child advocacy; visits to juvenile courts to review and evaluate local systems; visits to DFCS offices to review and evaluate local systems; visits to facilities that serve foster children and/or children who are wards of the state of Georgia to

⁸ The Assistant Child Advocates also teach Child Abuse Protocol at the annual CFR trainings held around the state and serve as a moderator for the trainings when needed. The Confidential Administrative Assistant to the Director also serves as a moderator and logistics coordinator for the trainings.

review and evaluate local systems; and service on various boards that focus on serving and protecting our children. A representative sampling of our advocacy efforts for 2012 are listed below.

Forensic Interview Training

The Office of the Child Advocate continues to take a cutting edge and innovative approach to addressing the needs of the children in the State of Georgia. In 2012, OCA expanded the Forensic Interview of Children Training (FICT) services provided to professionals to embrace the concept of allowing the participants to practice their interview skills with actual children. In 2012, FICT has trained 77 professionals, representing 27 counties in Georgia. Forensic Interview Training is sponsored by OCA and supported by the Division of Family and Children Services. OCA collaborated with the National Children's Advocacy Center this year to develop the participant-child practicum. The five-day training is designed to instruct multi-disciplinary teams in the forensic interviewing of maltreated children. The trainings were held in Augusta, partnering with Fort-Gordon Army Base; in Carrollton County, partnering with the Carrollton County Police Department; and at the Cobb County main public library. OCA partnered with the Cobb County Police Department for the final 2012 training. The OCA Forensic Interview Training sessions scheduled for FY 2013 already have waiting lists, demonstrating the continued demand and need for such a training program in Georgia. OCA's goal is to ensure there is at least one qualified forensic interviewer in each county so every child will be interviewed within a reasonable time in a maltreatment case. OCA is committed to offering Forensic Interview Trainings and to

continue developing cutting edge protocols and training in order to promote consistency in the investigation and prosecution of child abuse throughout the state.

During the 2012 calendar year, OCA provided forensic interview training to a total of 115 Professionals who represented 51 counties. Listed below are the counties represented in the trainings complete with a map illustration.

Counties that had participants in FICT

Brooks	Carroll	Chatham	Cherokee	Clayton	Cobb	Colquitt	Columbia
Crisp	Decatur	DeKalb	Dooly	Dougherty	Douglas	Elchols	Franklin
Fulton	Glynn	Gwinnett	Hancock	Lowndes	Muscogee	Newton	Richmond
Thomas	Troup	Walton	Wilcox				

Counties that had participants in Finding Words

Camden	Catoosa	Cobb	Colquitt	Crisp	Dooly	Dougherty	Douglas
Early	Fannin	Fulton	Gilmer	Gordon	Gwinnett	Henry	Houston
Jackson	Laurens	Lee	Macon	Muscogee	Rockdale	Shley	Stephens
Stewart	Sumpter	Thomas	Ware	Webster	Wilcox		

Counties that had participants in both FICT and Finding Words

Colquitt	Crisp	Dooly	Dougherty	Douglas	Fulton	Gwinnett	Muscogee	Thomas	Wilcox
----------	-------	-------	-----------	---------	--------	----------	----------	--------	--------

Child Fatality Review (CFR) Unit Trainings

Recognizing the need to make sure that all professionals who review child death cases with the ultimate goal being prevention of future child deaths are trained and supported by the Office of the Child Advocate for the Protection of Children, the CFR unit provided eight trainings around the state. The trainings provided through OCA covered north, south and middle Georgia as well as the metropolitan Atlanta area. Each training specifically addressed the cause of death analysis with opportunities for improvement in death scene investigations and processes at the local level. In 2012, hundreds of child welfare professionals were trained through OCA's CFR trainings. Many received professional development credits for attending the trainings. The trainings included an overview of the child abuse protocol and child fatality review statutes. We partnered with other child focused agencies who served as guest speakers at the trainings. Guest speakers included Department of Behavioral Health Suicide Prevention staff, coroners, medical examiners, and DFCS staff.

DFCS STAFF TRAINING ON COURT PREPARATION

The Director of OCA along with one of the assistant child advocates provided a one-day training to DFCS employees. The training covered preparation for court and in-court testimony. The successful training prepared DFCS caseworkers for effective advocacy on behalf of children. Caseworkers learned to testify with specificity that results in giving the Court the evidence that it needs to make the right decision regarding the child.

Safe-Sleep training

OCA provided training to DFCS employees statewide that covered recognizing safe-sleep practices. The training covered recognizing opportunities to share with families the actual practices and missed opportunities to share.

Educating Youth on Child Abuse and Prevention

OCA provided training to high school students in Georgia. The training helped the students to identify the different forms of child abuse, and prevention and how to report it if they see it.

Mandatory Reporter Training

In addition to the trainings listed above OCA provided training on the topic of Mandated Reporters. OCA received numerous requests to train on the subject matter in the wake of the changes that took place in Georgia's mandated reporter law July 2012. OCA continues to refer citizens to the GOCF online training as well.

Building Successful Teams Conference

OCA was pleased to partner with the Georgia Department of Human Services, Division of Family and Children Services; Georgia Bureau of Investigation; Children's Healthcare of Atlanta Stephanie V. Blank Center for Safe and Healthy Children; and the Prosecuting Attorneys' Council of Georgia to sponsor the Building Successful Teams Conference. During the conference, OCA conducted two training sessions on the child fatality review law, prevention and child fatality review reporting. The conference was designed to facilitate team building amongst child advocates throughout the state.

Georgia Coroner Association

OCA provided two trainings to newly elected coroners at the Georgia Public Safety Training Center. The presentations were specific to child fatality review data analysis for causes of death, prevention, legal aspects of child fatality review and child abuse protocol, as well as an overview of the main functions of OCA. Presenters instructed on case specific scenarios to improve the death scene investigation process and collaboration amongst all agencies involved in child deaths.

Child Crime Analysts Training

OCA provided two trainings to seasoned crimes against children analysts at the Georgia Public Safety Training Center. The presenters explained the role OCA plays in child maltreatment, prevention and child fatality review. The attendees learned about the purpose of the child abuse protocol designed by each county to improve cooperation between agencies at death scenes and during the investigation of maltreatment cases. Prevention of deaths and maltreatment was discussed. There was a child fatality review data analysis and reporting portion of the training as well.

In addition to the random sampling of trainings administered by OCA staff set forth above, OCA also attended trainings to enhance its skills and therefore services provided to children. Some of the trainings attended include:

Psychological Autopsy Training

Two OCA staff members attended the psychological autopsy certification classes sponsored by the Department of Behavioral Health Suicide Prevention. The two day training was held in July and the trainer was Dr. Alan L Berman, Executive Director of the American Association of Suicidology. Within a week of obtaining the knowledge gained at this valuable training, the information assisted in identifying a child in a DFCS case who was in danger of a suicide attempt. Overall it furthered skills needed to serve Georgia's children.

Medicolegal Death Investigation Training

Two staff members attended a medicolegal death investigation training in St Louis Missouri. The Saint Louis University School of Medicine conducted a week long Medicolegal Death Investigator training course. The program teaches individuals how to conduct scientific, systematic and thorough death scene and telephone investigations. This training is equally valuable to police officers, physicians, nurses, emergency medical personnel, attorneys, forensic scientists and others who are involved with the investigation of violent, suspicious or unexpected deaths. Attendees learn to develop the essential facts regarding the death scene, medical history and other information that assists the medical examiner/coroner in the determination of a person's cause and manner of death. The course is designed to teach the 29 national guidelines as set forth

in the National Institutes of Justice 1999 publication, *Death Investigation: A Guide for the Scene Investigator*. The attendee is instructed in the proper way to disseminate the information to forensic scientists and law enforcement personnel so that a coordinated, efficient and complete death investigation can be achieved.

The Director of OCA is a member of a number of committees that address child welfare issues. The Director and/or an appropriate designee participate in the following on a regular basis.

State Bar of Georgia Children and the Courts Standing Committee

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

The First Lady's Children's Cabinet

The First Lady's Children's Cabinet, headed by First Lady Sandra Deal, assures the safety and protection of Georgia's children. The Cabinet focuses on each child's right to be safe, healthy, and educated. One of the initiatives for 2012 was the Safe Sleep campaign. OCA was proud to be a part of the Safe Sleep campaign. See the brochure developed by OCA promoting safe sleep at <http://oca.georgia.gov/documents/safe-sleep-infants>.

State Bar of Georgia Child Advocacy and Protection Section

One of the many accomplishments of the 2012 year of which OCA is extremely proud is its role in the formation of the State Bar of Georgia Child Advocacy and Protection Section. In early 2012, the Child Advocate/Director of OCA and a Marietta Georgia attorney by the name of Diane Woods met to discuss the formation of such a section. Director Boga and Ms. Woods developed a list of people who they thought would be interested in the formation of such a section and began to meet with them. Eventually the section was brought to pass through the State Bar of Georgia Children and the Courts Standing Committee. OCA is extremely pleased to have garnered the support of Georgia's governor in forming this section along with hundreds of lawyers and judges. Today, there are over 230 members of the section and it is continuing to grow. Finally, the children of Georgia have a place where child welfare legal professionals can go to share information and get support as they represent the interests of children.

Criminal Sexual Exploitation of Children – CSEC

In 2012, OCA continued its relationship as a member of the Georgia Governor's Office of Children and Families Task Force on the Criminal Sexual Exploitation of Children (CSEC). This task force is charged with the responsibility of developing policies, procedures, and guidelines to direct the treatment of sexually exploited children in Georgia. Currently, Georgia has developed a process, through a contact with the Georgia Care Connections and Child Advocacy Centers of Georgia to accept referrals of sexually exploited children from law enforcement, DFCS employees, school employees and others in the community. This process allows these children to be removed from the criminal justice system and provided the necessary care and treatment to address their

trauma issues. These services are now in place statewide and additional training is being conducted for law enforcement and others to enhance the identification of these issues.

Georgia Infant Safe Sleep Coalition

The Georgia Infant Safe Sleep Coalition is chaired by OCA staff. It meets to discuss activities and projects dedicated solely to the prevention of unsafe sleeping among Georgia's infants. OCA's prevention specialist and other staff members are regular attendees at the coalition meetings.

SUID Case Registry Program

The Sudden Unexplained Infant Death (SUID) Case Registry Pilot Project is a 3-year initiative (2009-2012) funded by the Centers for Disease Control and Prevention (CDC), and designed to support the seven pilot states' efforts to improve investigation, review, and reporting of unexpected infant deaths. The end goal of this initiative is to enhance state-based SUID information collection systems to eventually form the basis of a national SUID Case Registry. This is a cooperative agreement, so that the CDC Program Staff are able to provide support and guidance to the pilot states throughout the project period, and the pilot states are able to share descriptive analysis reports and quarterly progress updates to CDC. One of the greatest challenges to successful implementation of the planned activities was the fact that Georgia has 159 counties, and that each county must conduct investigations and report on SUID cases in a consistent and standardized manner, using a mixed-model coroner/medical examiner system. Through this initiative, we have been able to provide a variety of tools and trainings to each of the local CFR committees and their death scene investigators to greatly improve the

collection of infant death surveillance data in Georgia, as well as the accuracy and completeness of surveillance reports. We were also able to develop relationships with several state agencies to share information on SUID cases, to support our efforts at reporting within the requested 3-month time frame.

Child Injury Prevention planning workgroup

The mission of this workgroup is to serve as a vehicle for promoting and maintaining comprehensive injury prevention efforts for all of Georgia's children. One of the stated goals of the workgroup during 2012 was to collaborate and align existing prevention plans and policies across the state to create a consistent prevention message promoting safe environments. OCA chaired this workgroup and will continue to work with it in 2013 to accomplish the stated goals.

MONITORING TO BRING POSITIVE CHANGE

Consistent with the actions of OCA since its year of inception, OCA continued to monitor DFCS in 2012 through participation in various initiatives and membership on certain important committees that afford OCA the opportunity to be aware of the changes envisioned by DFCS and to help fashion those changes, where appropriate. Currently, DFCS is involved in a number of initiatives designed to enhance the practice within the department. OCA has worked proactively with DFCS to promote the best plans possible for Georgia's children. In addition to inviting DFCS to join in with the CFR training to help teach prevention, some highlights of other collaborative efforts are shown through OCA's participation in a monthly collaborative meeting and the Child Death Serious Injury Near Fatality Review meetings.

24 hour Child Fatality Staffing

In the January 2012, Commissioner Reese of the Department of Human Services instituted a new policy that requires DFCS to staff a case within 24 hours of a child's death when a child dies who is in the custody and control of DFCS at the time of death or had a DFCS history within 5 years prior to death. The Director of OCA is an official part of the staffing review.

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

OCA meets monthly with the CIP and DFCS representatives about joint efforts to identify practice needs and issues of children in state custody in Georgia. The meeting also serves as a forum to develop strategies to better protect Georgia's children and to discuss other issues such as the state of Georgia's juvenile justice system as well as programs and organizations that affect the welfare of children and Georgia's child welfare system.

Child Death, Near Fatality, and Serious Injury Review Process:

OCA has continued to actively participate in the Child Death, Near Fatality, Serious Injury (CDNFSI) review process with representatives of several divisions of DHS including DFCS. During this meeting, the agencies involved review selected cases to assess the level of compliance with DFCS policy and procedure and to identify opportunities for prevention in order to reduce the number of child deaths that were preventable.

The committee has been active in reviewing recent child death and serious injury cases. At least once per month, the committee convenes to review all of the child death and

serious injury cases from the previous month. Each case is dissected to determine if the level of intervention was appropriate, if the agency complied with policy and procedure and if the best interest of the children was considered. Also, the cases are reviewed to determine if the death or injury could have been prevented and what could or should have been done to prevent the tragedy. Finally, the review is documented and recommendations and/or recognitions are made to the individual county responsible for the case. Note that this is a second opportunity for OCA to review the case in a group setting after the Director's review at the 24 hour staffing.

Differential Response Monitoring

OCA continues to monitor the implementation of Georgia's new Differential Response model. Throughout the calendar year OCA has had several meetings with DFCS state leadership regarding the implement of DR in Georgia. OCA will continue to monitor the implementation indefinitely through regular monthly meeting with DFCS state leadership.

The State Mediation Committee (SMC)

The Office of the Child Advocate also addresses issues that arise between DFCS and foster parents. It does so by coordinating the activities of the State Mediation Committee (SMC). The Foster Parent Bill of Rights, signed into law by Governor Sonny Perdue on May 5, 2004, requires a mediation process for foster parents to file grievances if they believe their rights under this state law and policies have been violated by DFCS—both locally and on a state level.

This process establishes a way to redress grievances above and beyond local mediation and arbitration. It is meant to complement rather than replace local problem solving

processes that are working for a county.⁹ The SMC is subject to all applicable federal and state laws regarding confidentiality. A SMC mediation is not a legal proceeding; however, foster parents may have an Adoptive and Foster Parent Association of Georgia (AFPAG) advocate or other personal support person present. However, personal support persons are not provided the same access to confidential information as AFPAG advocates. Therefore, they are limited to participating only in the portions of the staffing which do not violate confidentiality laws.

The SMC is a standing committee composed of two representatives from the Georgia Department of Human Resources/Division of Family and Children Services (DFCS), two Representatives from the Adoptive and Foster Parent Association of Georgia (AFPAG), and the Director of the Office of the Child Advocate (OCA), totaling five members of the committee. The Director of the Office of the Child Advocate serves as the chairperson of the SMC and coordinates administrative matters through OCA. A new development as of late 2012, the Commissioner of DHS and Director of DFCS will attend and monitor state level mediations. OCA welcomes the presence of the DHS and DFCS leadership and believes that it will make a tremendous difference in the enforcement of agreements reached in mediation.

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

At the heart of the work at OCA is responding to issues raised by concerned citizens, relatives, associates, and friends of Georgia's youngest citizens. Each contact to OCA begins at the complaint intake and referral stage and goes through the investigation to final disposition stage.

COMPLAINT INTAKE AND REFERRAL

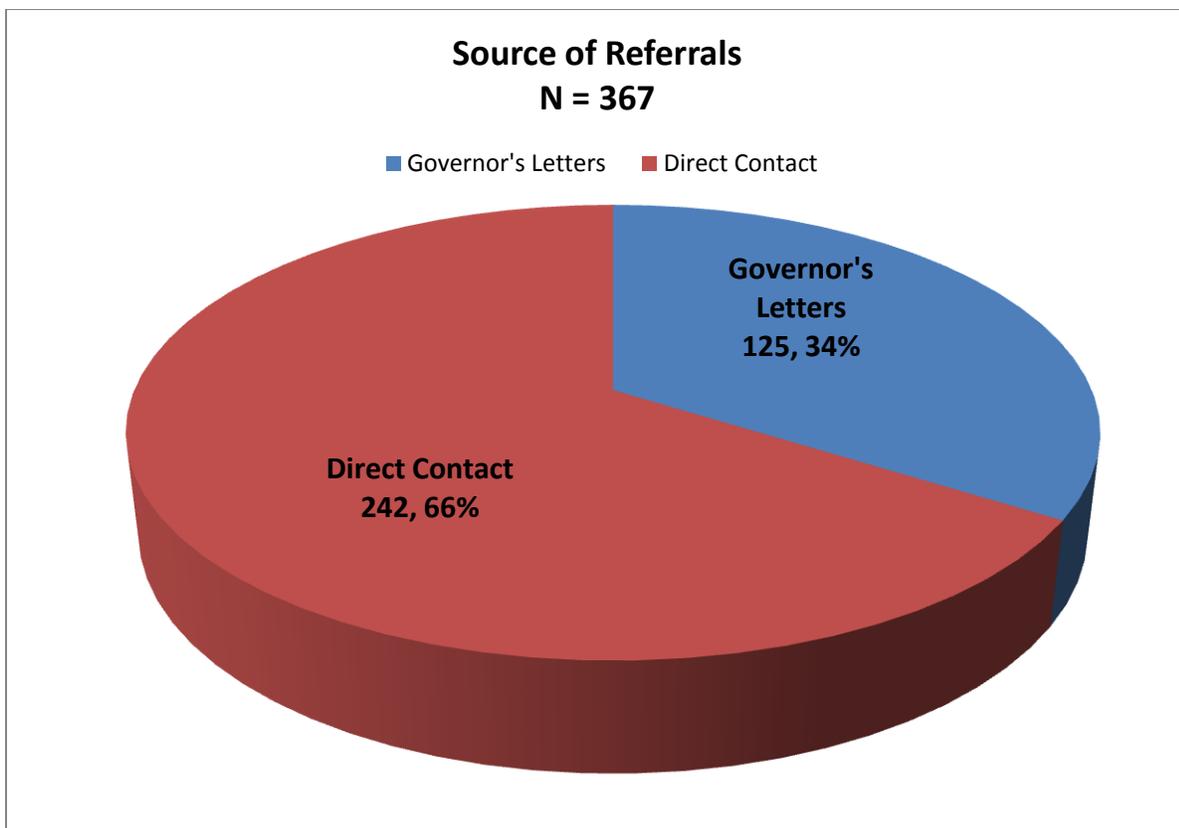
For the reporting period beginning January 2012 and ending November 30, 2012, the Office of the Child Advocate received a total of 360 referrals from its two primary sources of referral, Governor's letters and direct contact.

Governor's Letters Investigations

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

Direct Report Investigations

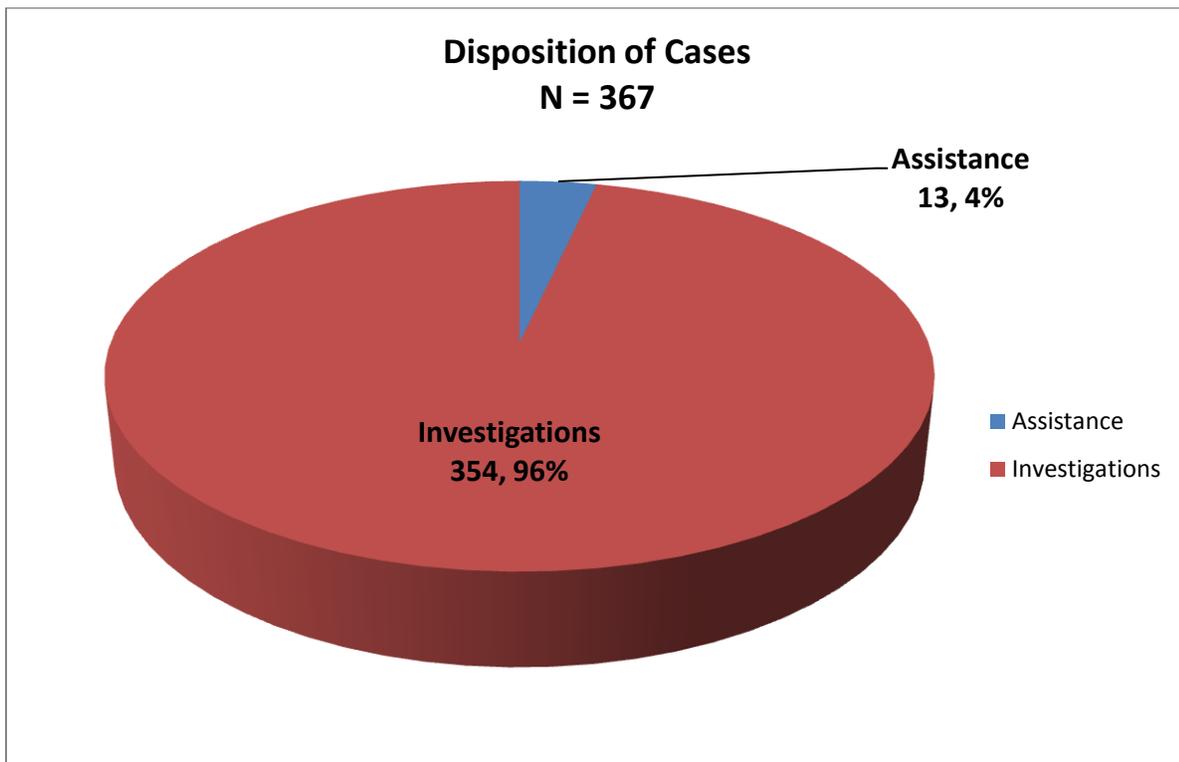
Our investigatory work over the past year has determined that DFCS is continuing to make significant strides to improve the lives of children and families in Georgia. Over the past year, DFCS has begun the process of refining their Diversion/Family Support Practices to include development of those components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



All cases at OCA began in the intake department whether originally received as a Governor's Letter or through Direct Contact with OCA. They move from intake to investigations. OCA does not screen out any cases. After the initial investigation, each case moves into one of three categories (1) Assistance, (2) Investigations, or (3) Under

review.¹⁰ The initial investigation is performed by one of the six staff members that perform investigations. Three of the staff members are child welfare analysts and three are assistant child advocates. All investigations are supervised by the Director/Child Advocate.

Two of the three forms of disposition are discussed herein below. For the purposes of this report, under review is not separated from investigations.



¹⁰ These cases start as investigations and follow the normal investigation process which is outlined below in the Investigations section. After the initial investigation and determination that there are no major violations of policies and procedures by DFCS, the case is moved into “under review” status pending receipt of an autopsy confirming the child did not die from abuse or neglect.

Assistance Cases

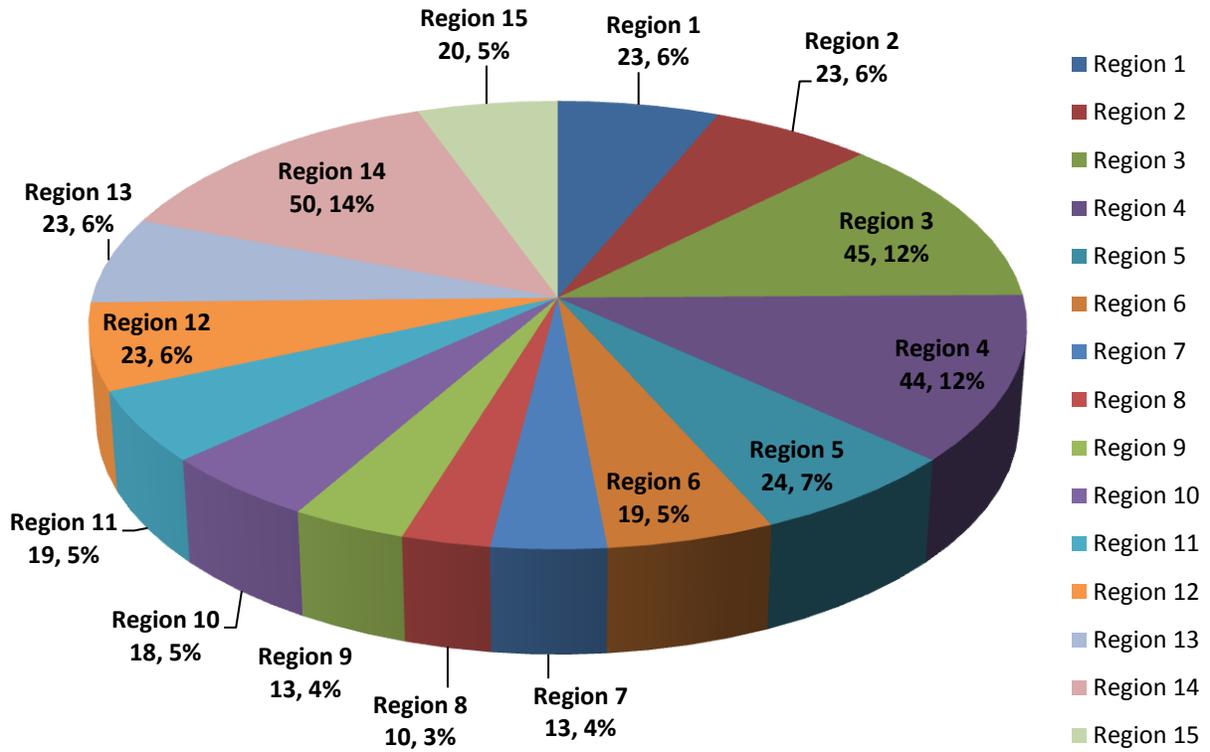
Assistance cases are cases which can be referred to community services, provided information, or similar brief intervention for resolution. In 2012, there were 13 assistance cases opened in the agency.

Investigations

Investigations are cases that require intensive examination by the Office of the Child Advocate's child welfare analysts/investigators or assistant child advocates. As a routine part of their investigation, staff will contact the reporter, DFCS or private agency case managers and their superiors if necessary, and collateral contacts with knowledge or information about the basis of the complaint. Analysts compile and review all information related to the case including DFCS case record, court documents, school and treatment records and any other relevant information. During this phase of the investigation, analysts may also offer suggestions to DFCS employees concerning the health, safety and wellbeing of children and families. The suggestions emphasize what is in the best interest of the children and families in promoting the best outcome. Upon completion of the investigation, a Concerns Letter may be issued outlining practices, policies and/or procedures that were violated or deficient. All cases are staffed with the Director on an ongoing basis as needed. All cases are reviewed by the Director/Child Advocate upon completion. No cases are closed at OCA without the Director/Child Advocate's approval.

All investigations that involve a DFCS matter originate in one of the 15 DFCS regions. The graphs below show the number of investigations by DFCS region.

Investigations By Regions (N = 367)



CHILD FATALITY REVIEW (CFR) CHILD DEATH REVIEWS

In Georgia, all 159 counties are legislatively mandated to convene a CFR committee which is comprised of a multi-agency, multi-disciplinary approach to understanding the circumstances surrounding every preventable child death. During this process, CFR committees utilize vital information gleaned from multiple sources e.g., autopsies, coroner and medical examiner investigative reports, and child protective services historical documentation. Most often, the cause and manner of death is clearly identifiable, but occasionally, a constellation of factors make it difficult to definitively assign an accurate cause and manner of death. In such instances, multiple systems (e.g. the medical examiner's office, the coroner's office, and law enforcement entities) render a death undetermined based on inconclusive information, underscoring the importance of continuously enhancing scene investigation and data collection processes.

OCA staff developed and published a report detailing the circumstances of death for children under age 18 in Georgia for the calendar year of 2011 as has been its historical practice. The report is published under the Child Fatality Review Panel.

The local committees reviewed data for 2012 deaths and OCA staff provided support to them in the review process. A report will be issued in 2013 on the deaths that occurred in 2012.

In Georgia, local CFR committees convene a review meeting for those deaths that are considered eligible for review by CFR legislation, that is, those deaths that are unexpected, unexplained, or due to suspicious circumstances. The circumstances of each death are recorded on a national standardized surveillance form which is the basis for

the data analyses presented in the annual report. The forms are completed at the local county level and submitted to the Office of the Child Advocate for data cleaning and processing.

ANNUAL REPORT RECOMMENDATIONS

DFCS should provide training to all new employees within 30 days of employment in the following areas: recognition of poverty versus neglect; professionalism that covers effective and appropriate communication with clients, reporters, and the general public; community resources available to help families, importance of placement stability for a child, importance of sibling visitation, development of specific and appropriate case plans.

DFCS should provide mandatory training to all employees on an annual basis that addresses the identification of poverty versus willful neglect. DFCS should share information with all employees on the availability of Prevention of Unnecessary Placement funds and other relevant funds that can be used to prevent the removal of a child from a family when the sole issue is poverty.

DFCS should provide annual training to employees on the topic of safe-sleep practices. The training should be similar to the training provided to DFCS employees during the 2012 calendar year by the Office of the Child Advocate and should be mandatory for all employees who provide direct services to the public and employees who supervise those who provide direct services to the public.

DFCS should provide training to all employees on an annual basis that covers testifying in court. The training should specifically address testimony that provides the court with specificity and not generalities. DFCS employees who are called upon to testify in court should be properly prepared to adequately and specifically address their concerns to the court regarding the safety and well-being of a child(ren). They should be fully prepared to testify regarding their observations and opinions with certainty and specificity even if their testimony or opinion differs from other witnesses in the case (i.e. psychologist, GAL, or CASA).

DFCS should provide on-going training as well as initial training to all employees on the importance of professionalism. The training should cover at a minimum appropriate and effective communication to citizens, families, reporters and the general public. The training should also include developing decision making skills under intense pressure and in the face of an uncooperative client that is free from retaliation and biases. The training should be mandatory for all employees.

DFCS should provide ongoing training to all staff on the proper development of case plans. Case plans should be specific to the family that is being worked with and provide a road map to the reunification of the family. DFCS should abandon the practice of using cookie cutter nonspecific boiler plate case plans. All staff should be required to attend training on the development of case plans at least one time per calendar year.

All DFCS employees should attend a mandatory annual training that clearly states to each employee a responsibility for DFCS to make every effort to preserve families when possible. No child should be placed in the care of non-relatives unless absolutely necessary and all reasonable efforts to find a fit and willing relative have been exhausted. DFCS should abandon the practice of placing children with non-relative foster families who seek to adopt when there are fit and willing relatives seeking to adopt the children.

DFCS should engage in an immediate review and revision of its Interstate Compact on the Placement of Children system. The revision should include the assurance of adequate staff and other resources to handle the volume of cases the office receives. The system should be capable of expediting the transition of children into and out of Georgia and capable of providing a timely review of submissions sent into the state office by the county. The initial review should take place within 5 days of submission to the state office. The finalization of the process should conclude in a timely manner based on the facts and circumstances. DFCS should abandon the practice of lengthy delays in responding to requests for home visits as a part of the ICPC process and making a recommendation for the child's transition.

DFCS should provide mandatory training to all employees on an on-going and annual basis that highlights the importance of placement stability for children. The training should include at a minimum the importance of a child remaining at the same school when at all possible, informing potential foster parents of issues that a child may face before placing the child with the foster family, working with a foster family to preserve placement once a child has been placed with them.

DFCS should institute a state-wide policy that makes it mandatory for the regional director of each region to attend a Forensic Interview of Children training course offered by the Office of the Child Advocate within one year of becoming a regional director. The regional director should be required to provide an informational session to all employees within the region within 30 days of completion of the Forensic Interview of Children training that shares the basic fundamentals of forensic interviewing of children. The informational session should be equipped with a working knowledge of the forensic interviewing of children process to include recognizing when an interview should be requested in a case. The policy should further state that once a regional director has been trained at least two county directors per region should be required to attend the annual training so long as it is offered by the Office of the Child Advocate with DFCS as a supporting partner.