Learning from the Data: Maltreatment in Care & Child Fatalities

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Vision, Mission and Core Values

Vision

Stronger Families for a Stronger Georgia.

Mission

Strengthen Georgia by providing Individuals and Families access to services that promote self-sufficiency, independence, and protect Georgia's vulnerable children and adults.

Core Values

- Provide access to resources that offer support and empower Georgians and their families.
- Deliver services professionally and treat all clients with dignity and respect. Manage business operations effectively and efficiently by aligning resources across the agency.
- Promote accountability, transparency and quality in all services we deliver and programs we administer.
- Develop our employees at all levels of the agency.

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Focus on Two Negative Outcomes for Children

- Maltreatment in Care
- Child Fatalities

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Root Cause Theory: Method to Learn from the Data

The central aim of root cause analysis is to find points in a system where improvements are feasible that will reduce the likelihood of another similar negative event in the future.

Source: Jens Rasmussen, 1990

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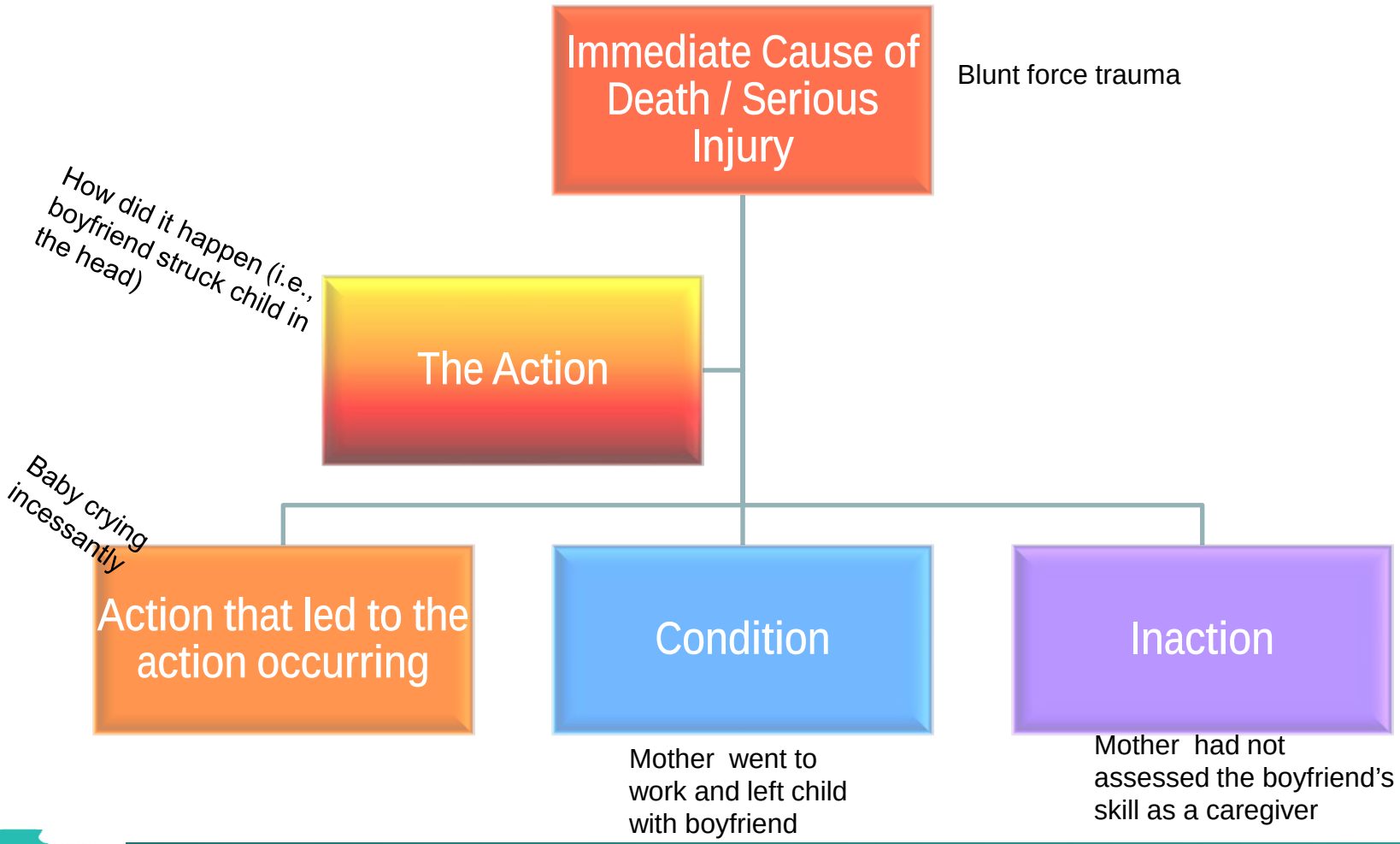
Root Cause Analytic Methods

- Focus on the set of conditions / actions or inactions that made it possible for the negative event to occur (such as child being left with inappropriate caregiver)
- Questions: "what led to this event?," what allowed it to happen?"
- Root cause analysis moves beyond assignment of individual culpability to the identification of organizational or system problems that lead to individual errors.
- Root Cause Analysis prompts examination of larger system failures, some of which may result from organizational culture and seeks solutions that may prevent future incidents.

Visual Diagram of the Root Cause Analysis



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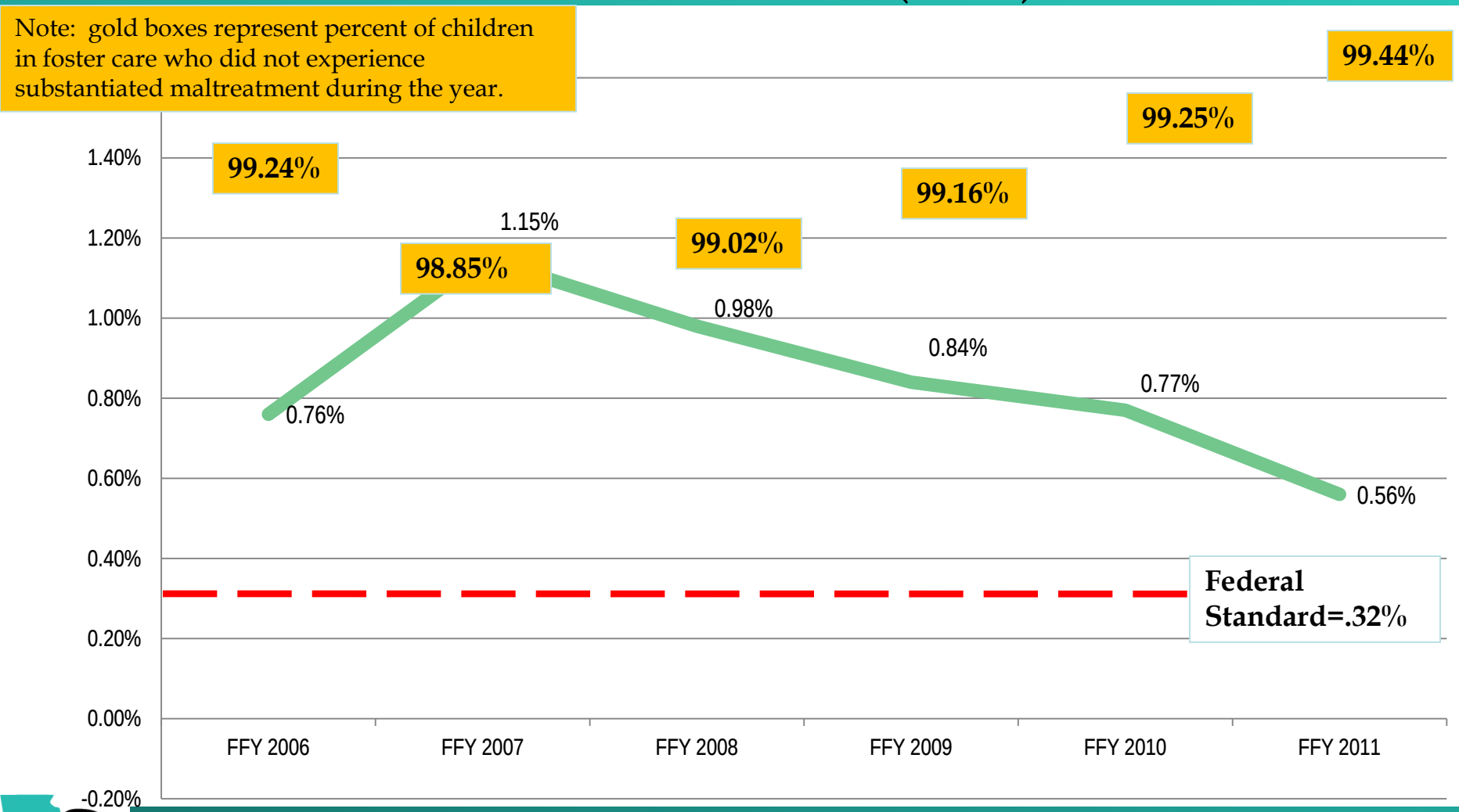
Substantiated Maltreatment in Care in Georgia
FFY 2006 – FFY 2011 (N=90)

Note: gold boxes represent percent of children in foster care who did not experience substantiated maltreatment during the year.



We believe that no child who has ever been maltreated should be maltreated again!

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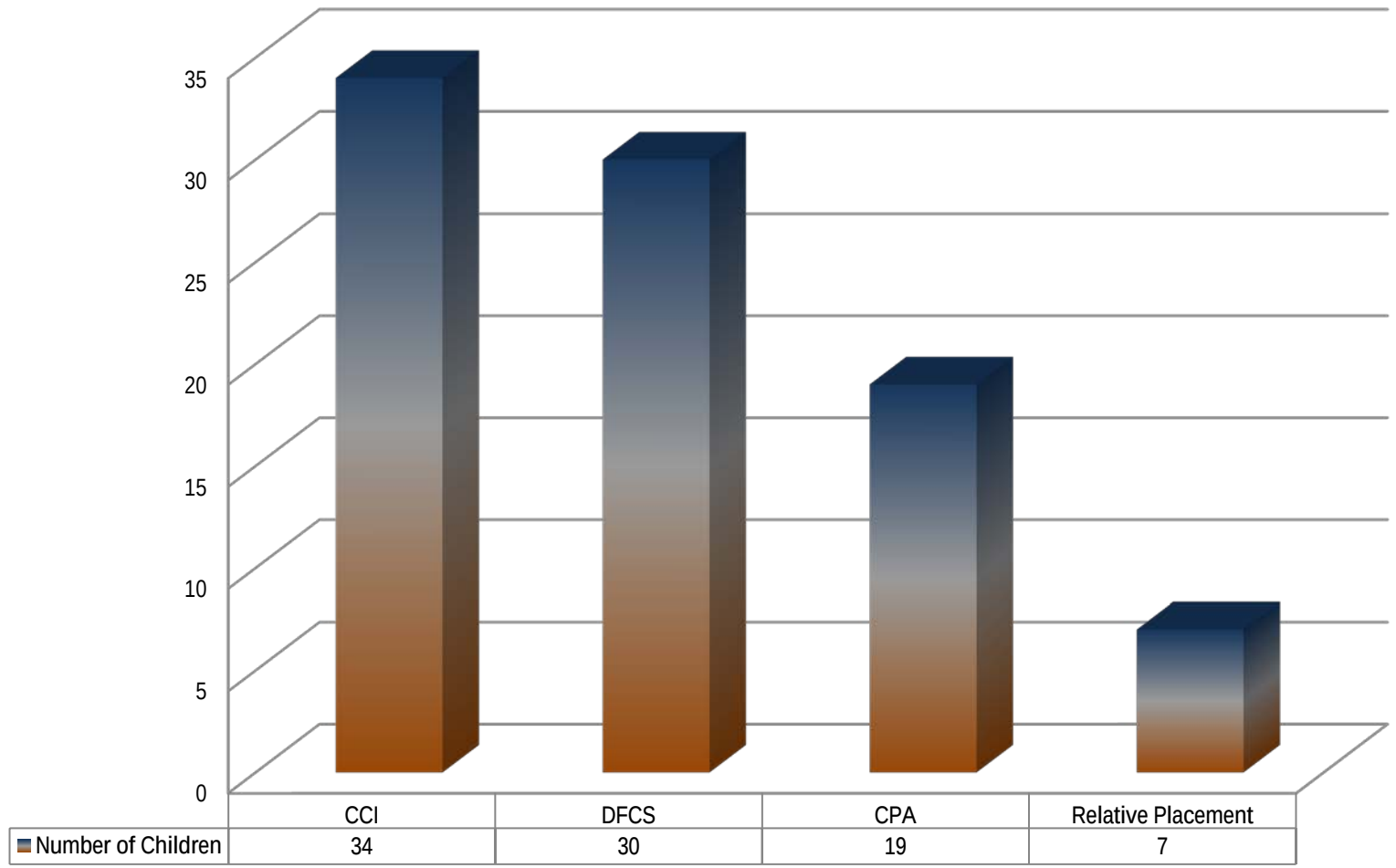
Alleged Maltreator / Location of Substantiated Maltreatment (N=90)



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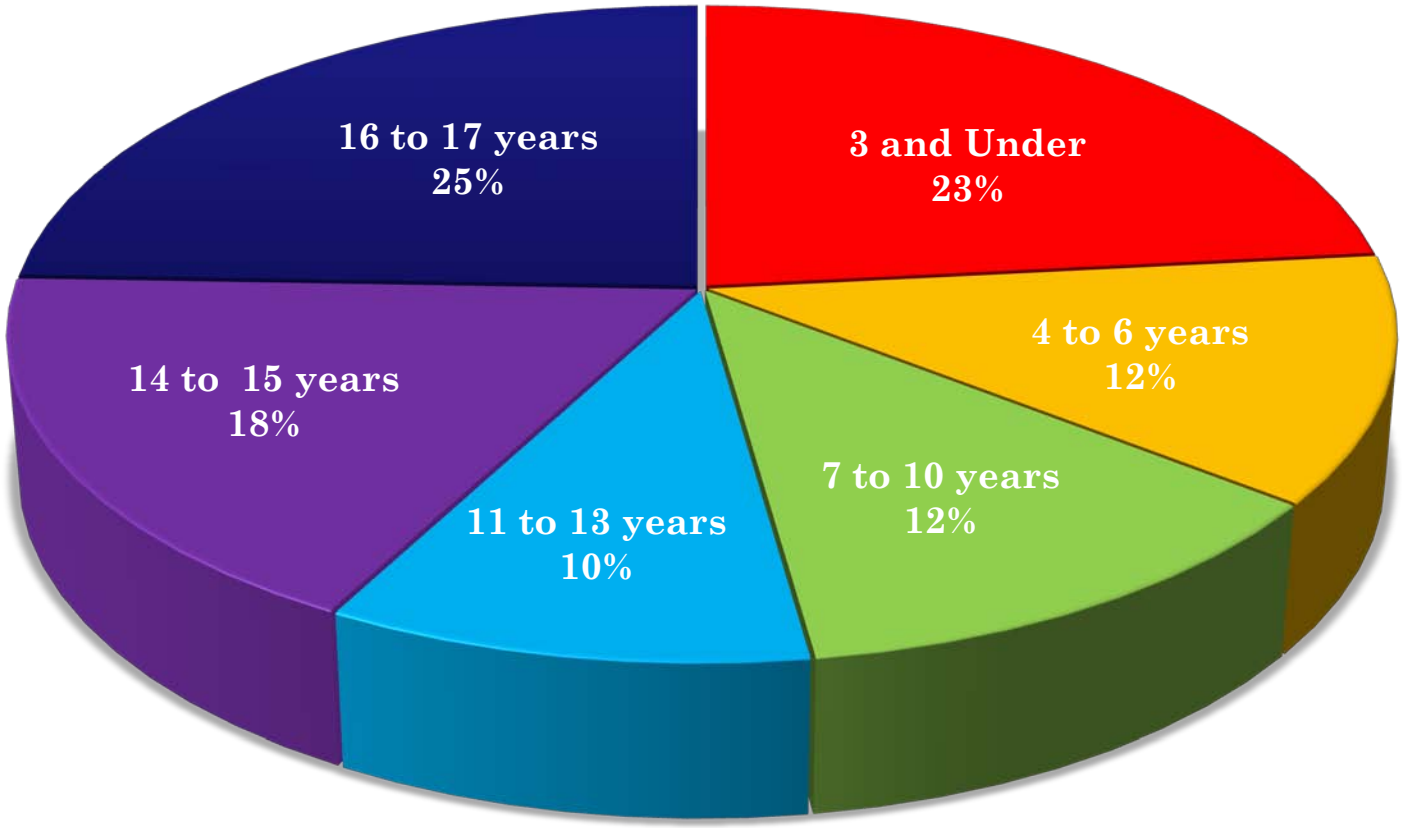
Age of Children with Substantiated Maltreatment in Care (N=90)



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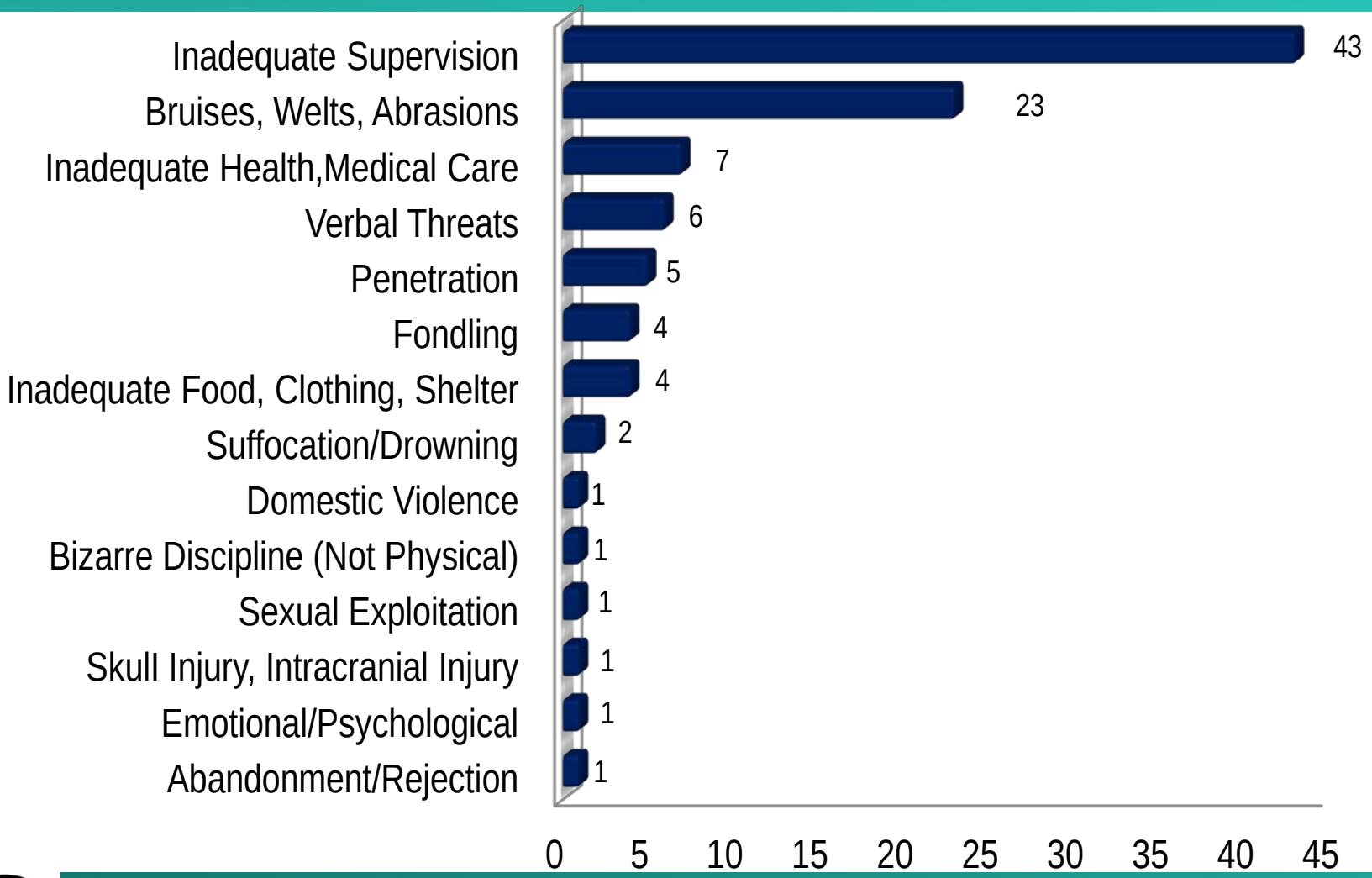
Substantiated Allegations (N=90)



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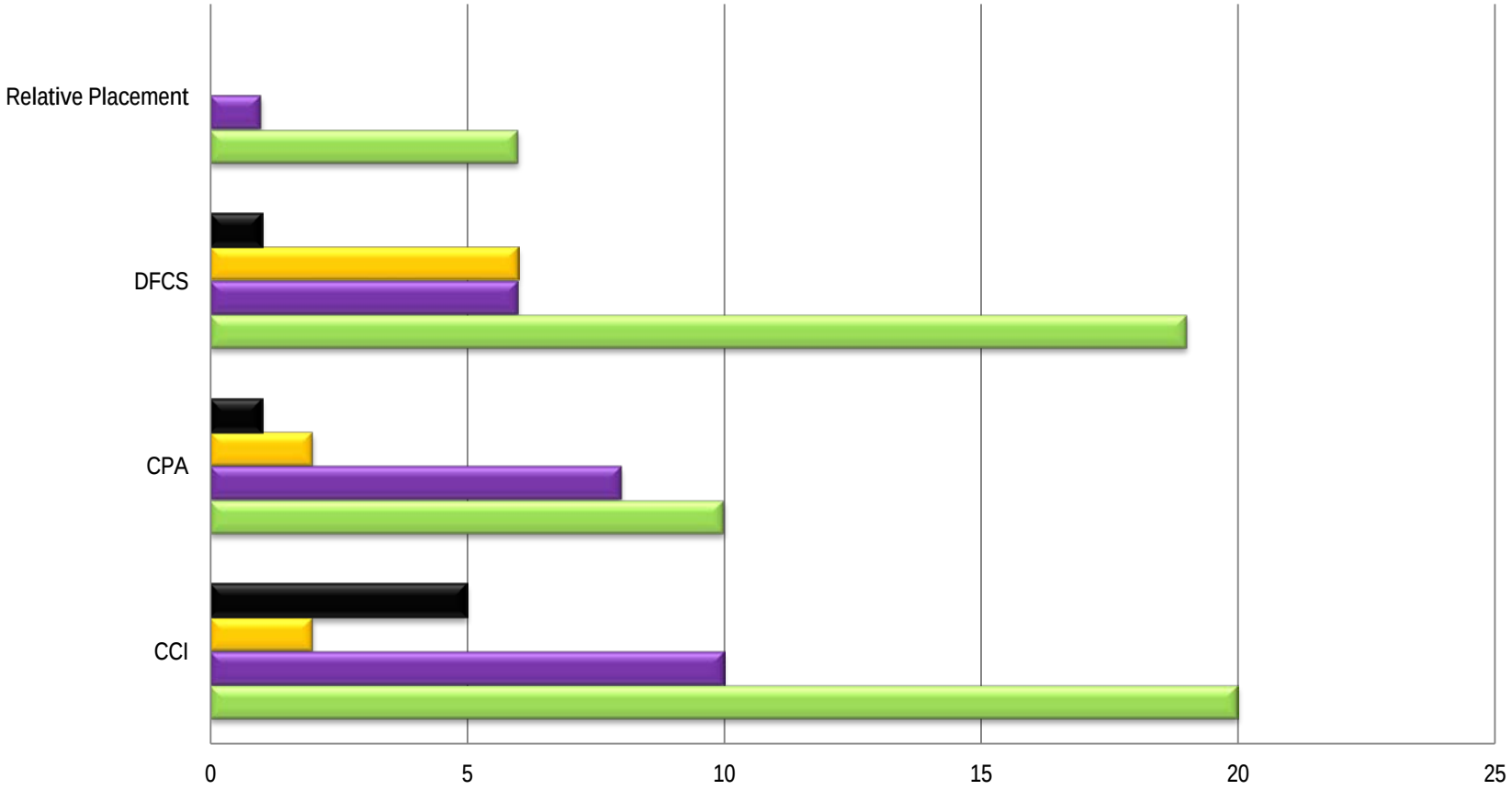
Type of Substantiated Maltreatment Incidents (N=90)

(A child may be a victim of more than one type of maltreatment)



	CCI	CPA	DFCS	Relative Placement
Emotional	5	1	1	0
Sexual	2	2	6	0
Physical	10	8	6	1
Neglect	20	10	19	6

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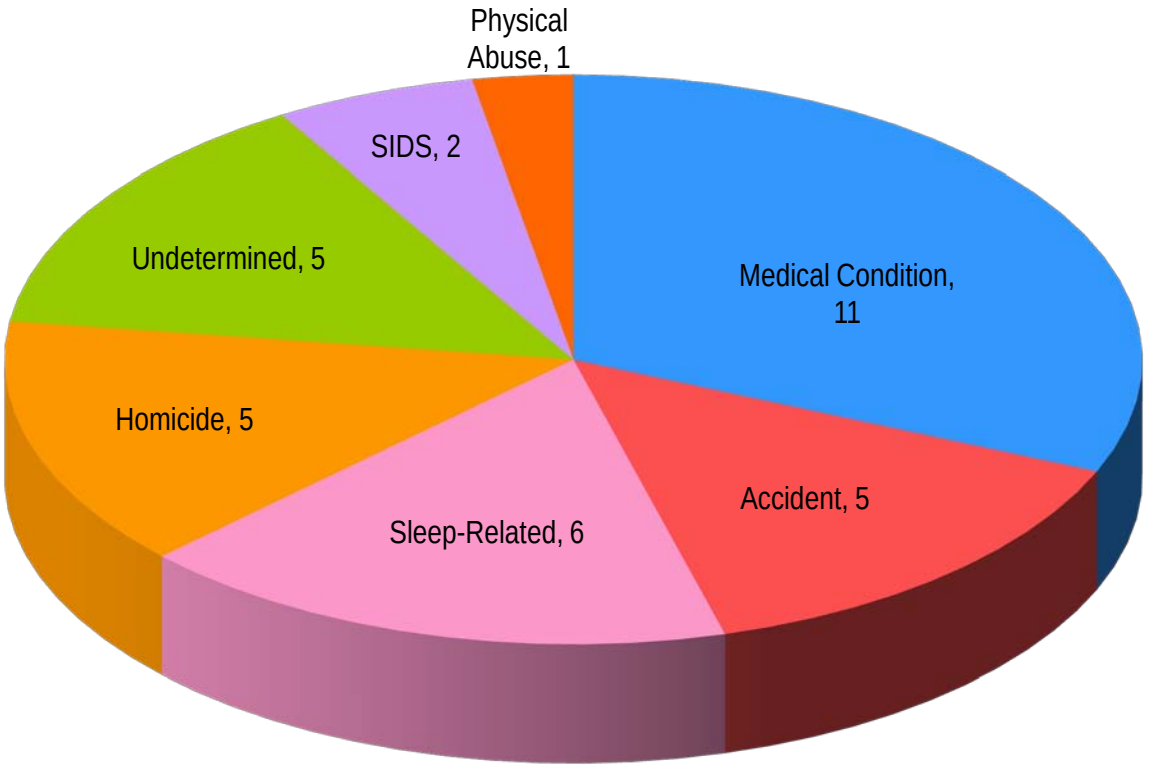
Maltreatment in Care

- What do we know from the data?

- How can we use this data to decrease likelihood of maltreatment of children in foster care?

Child Deaths from December 1, 2011 – February 12, 2012: Cause of Death (n=35)

Of the 35 deaths, 69% were due to medical, sleep-related, SIDS, or accidents (including bathtub drownings and house fire).



Note: "undetermined" is an official finding by the medical examiner.

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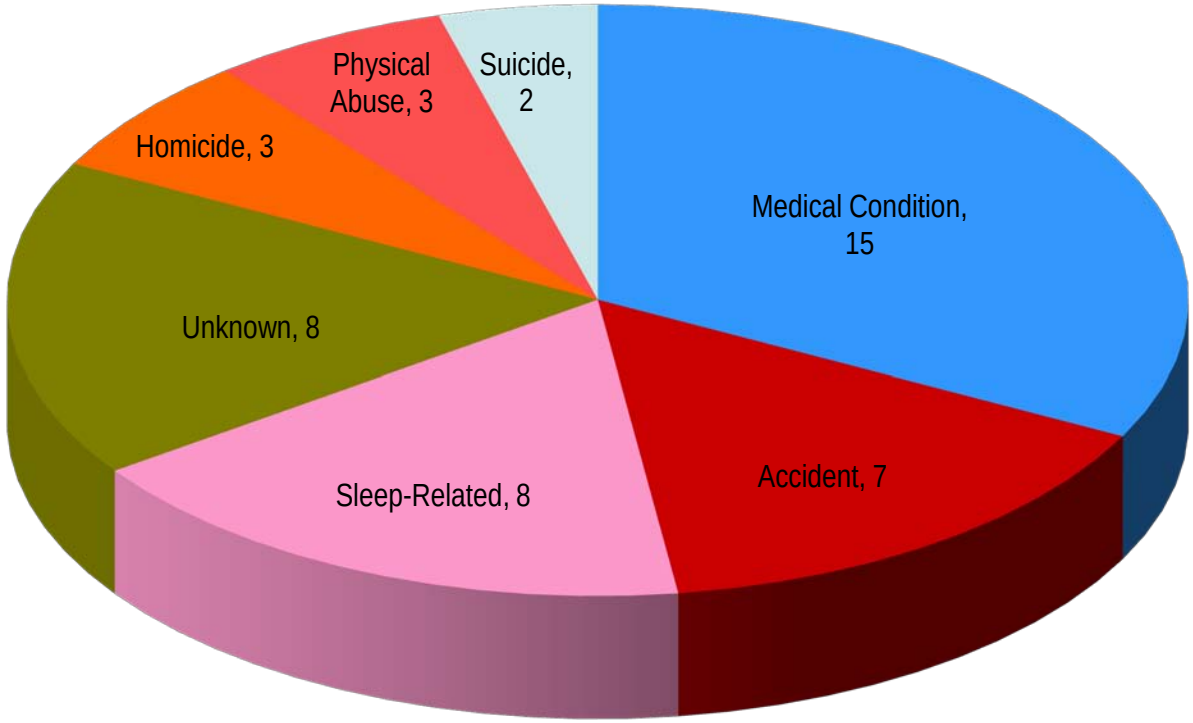
Child Deaths from February 13-May 31, 2012 Cause of Death (n=46)

Of the 46 deaths, 65% were due to medical, sleep-related, or accidents (including bathtub drowning, motor vehicle accident, house fires, and suffocations).



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Notes: The percentage of child deaths related to medical, co-sleeping and accidents are fairly similar during both time periods. In this period, there were three gun-related deaths (2 homicides and a suicide) compared to one in the first period. Many of the "unknown" deaths are because they occurred in April & May 2012 and the official autopsy findings are incomplete.

Description of Medically-Related Deaths (n=15)

There were 15 child deaths related to severe medical conditions at birth or shortly afterwards:

- Enlarged heart, hypothyroidism, hypopitutary hypoadrenalinism, missing 1P36 Chromosome, deaf and developmentally delayed.
- Premature birth / child born at 24 weeks gestation – On a ventilator and could not regulate body temp. Child never left hospital.
- Premature birth / heart murmur and fed through an NG tube. Child died while sleeping in bed with Mother, child's twin seven-year old and a three-year old; mother awoke to find the three -year old laying on top of this twin.
- Child contracted Herpes Encephalitis/Meningitis at birth, suffering brain damage as a result. Child also diagnosed with Dysphasia (difficulty swallowing), seizure disorder and inability to regulate body temperature. Child died from pneumonia. *(child in foster care at time of death).*

Description of Medically-Related Deaths (n=15), cont'd

Medical conditions continued:

- Myasthenia Gravis (muscle condition causes muscles to be weak). Child had 2 strokes as a result of a blood infection.
- Brain cancer and respiratory disease with poor prognosis (open investigation at time of death).
- Premature birth with long hospitalization; VP shunt and G-tube. Child diagnosed with Hydrocephalus, retrolental fibroplasia, Esophageal reflux and inguinal hernia. In and out of hospital for treatment of pneumonia and asthma (open Family Preservation Services at time of death).
- Premature birth (23 week gestation); death related to extreme prematurity.
- Renal condition. After child developed a high fever, mother was to alternate between Motrin and Tylenol; autopsy pending to determine the amount of medication in the child's system.

Description of Medically-Related Deaths (n=15), cont'd

Medical conditions continued:

- Congenital brain tumor resulting in significant hydrocephalus; child never left the hospital.
- Cancerous brain tumor.
- Cerebral Palsy and epilepsy, hospitalized due to dehydration; suffered and died from septic shock while in hospital.
- Missing chromosome / as an infant child placed with an uncle who shook her. Child entered foster care with numerous medical conditions and short life expectancy. No Autopsy completed (child in foster care at time of death).
- Seizure disorder, possibly suffered a "terminal seizure." Autopsy unremarkable but awaiting toxicology and histology.
- Neimann Pick's diagnosis at 9 months of age; child was also co-sleeping with mother and found unresponsive.

DFCS Prior History & Child Death Comparison for Similar Time Periods & February 13 – May 31, 2012

	December 1, 2009-February 22, 2010	December 1, 2010-February 22, 2011	*December 1, 2011-February 12, 2012	February 13, 2012 – May 31, 2012
Previous DFCS involvement	40	29	35	46
Previous Child Protective Services (CPS)	22	20	21	34
Open CPS *(investigation & Family Preservation)* case at the time of the child's death	4	4	6	8*
Previous Diversion case	11	7	14	12
Open Diversion case at the time of the child's death	1	0	1	0
Foster Care history	7	2	4	4
Children in foster care at the time of his/her death	7	1	4	3*

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Note: The next set of slides provides a description of circumstances related to child deaths with current DFCS involvement (open investigation, Family Preservation and foster care at the time of death.

Child Deaths & Current DFCS Involvement (Open Investigation) (February 13 – May 31, 2012)

The four cases that were open as an *Investigation* at the time of the child's death included allegations of:

- emotional abuse with domestic violence (child died of pre-existing brain cancer)
- physical abuse of sibling (child found deceased in bed with father; cause and manner of death still pending)
- medical neglect report received and case opened the day before child's death; child had a blood infection
- Newborn with drug exposure; mother also has another child currently in foster care who also tested positive for drugs at birth

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Child Deaths & Current DFCS Involvement (Open Family Preservation Services (February 13 – May 31, 2012)

The four cases open and family receiving *Family Preservation Services* at the time of the child's death were based on the following allegations:

- lack of supervision and failure to thrive; child died from physical abuse by the father (autopsy pending)
- medical neglect of a medically fragile child; child died from multiple medical issues
- child's mother tested positive for drugs at child's birth; mother has mental health issues. Child found deceased in crib; SIDS suspected
- child born testing positive for drugs; medical neglect substantiated. Child found wedged between the bed and wall

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Child Deaths & Current DFCS Involvement (Children in Foster Care) (February 13 – May 31, 2012)

All three children in *Foster Care* at the time of death had **medical conditions/complications** that led to their deaths including:

- child in care for ten years following abusive head trauma by an uncle that left her with severe medical complications
- premature infant in hospital; child taken into custody due to parents' religious objections to blood transfusion. Child died from medical complications and never left the hospital
- medically fragile child taken into custody at hospital due to mother's unstable living conditions and neglect

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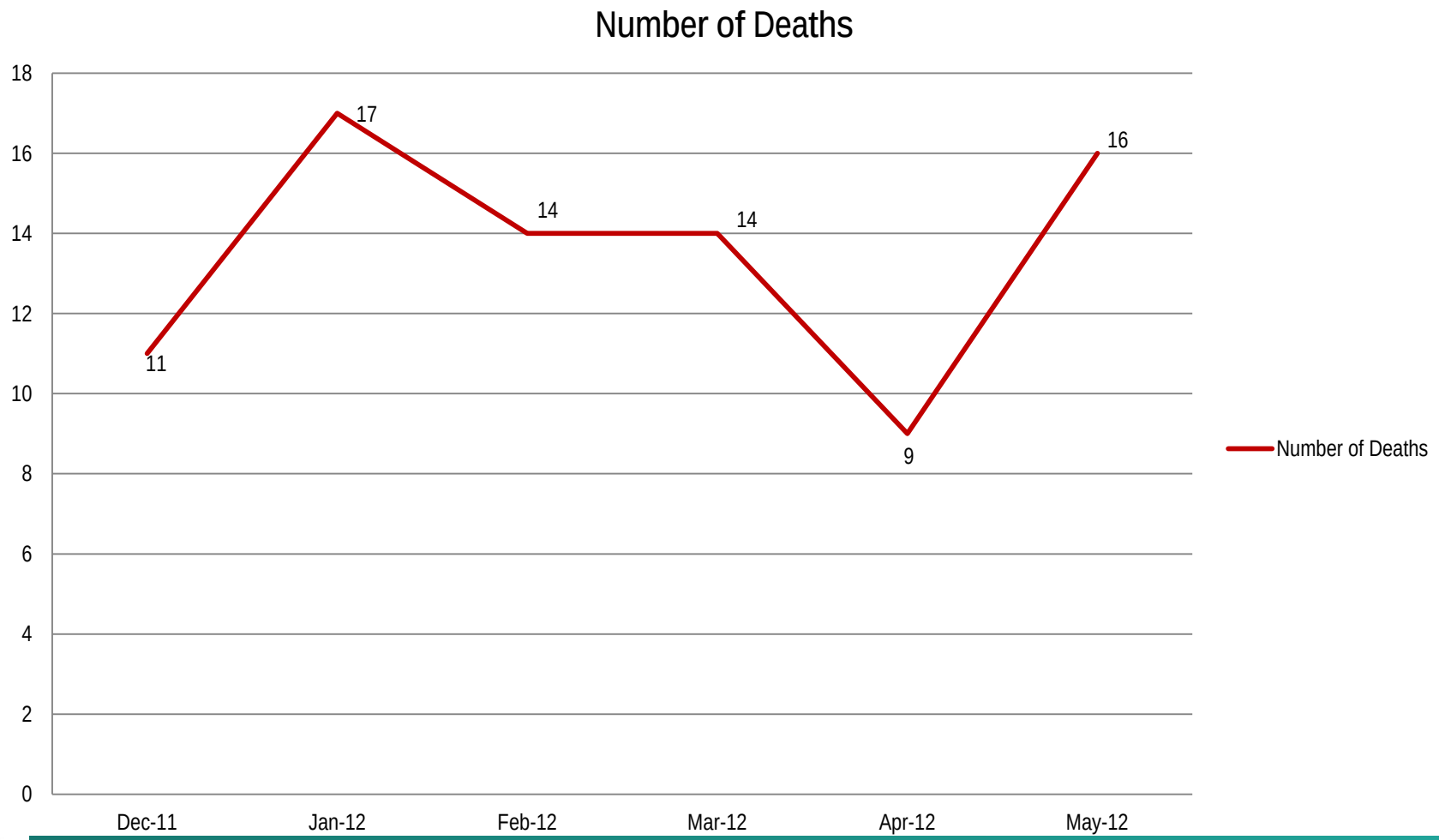
Child Death Trend by Month (December 1, 2011 – May 31, 2012)



Note: There were a total of 81 child deaths whose families had a prior DFCS history from December 1, 2011 through May 31, 2012.

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DFCS CORE BELIEF: NO CHILD SHALL DIE IN VAIN

The Georgia Department of Human Services and Division of Family and Children Services, in collaboration with other agencies, have taken pro-active measures to learn from *every* child death so that no child shall die in vain, as such we have committed to analyzing and evaluating these cases to develop trends, sound practice and policy, increase prevention awareness, and train staff to respond thoroughly & appropriately to all reports of child maltreatment.

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Child Deaths with Prior DFCS History: Pro-Active Measures Implemented

Some of the measures implemented thus far include:

- Quarterly Meetings with Governor's Office COO Staff, Child Advocate, DHS Commissioner, and DFCS Director
- 24-Hour staffing of child death cases with alleged maltreatment and history; staffings include county staff and DFCS Collaborative Partners' Section
- Participation of Office of Child Advocate and DHS OHRMD in the child death staffings
- Child Advocate conducted a training for DFCS Child Welfare staff at a Child Safety Summit
- Public Awareness Campaigns that included:
  - 1st phase: Dangers of Co-Sleeping
  - 2nd phase: Drownings - water safety
  - 3rd phase: Car Seat Safety
- For all three of the above, we presented information to *Good Day Atlanta* on how to prevent those deaths

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Child Deaths with Prior DFCS History: Pro-Active Measures Implemented, cont'd

- A by-line press release done on how to prevent unintentional child deaths
  - creating safe sleep environment
  - water safety
  - fire safety
  - child car seat safety
- Implemented Differential Response Practice Model (effective April 1, 2012)
  - First phase of the Safety Response Framework
- Work with GOCF on Domestic Violence/Children Issue
- Internal DFCS Newsletter for March 2012 focused on Child Death
- Regular communication between Collaborative Partners and GBI Medical Examiner

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Child Deaths with Prior DFCS History: Pro-Active Measures Implemented, cont'd

- Dangers of leaving children in hot cars scheduled for this month (possibly Good Day Atlanta and other morning shows)
- Covered topics related to Preventing Unintentional Child Deaths and Injuries during Child Abuse Prevention month in April (we are continuing this)
- DFCS Liaison staff partnered with medical child protection team at Children's Healthcare of Atlanta for expert and immediate response to critical cases (ongoing)
- Ongoing development of evaluating serious injury cases to apply findings to prevent child death by abuse/neglect.