The Best of Intentions:  
An Evaluation of the Child Fatality Review Process in Georgia

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Executive Summary

In 1990, the Georgia General Assembly enacted legislation that required each county in the state to establish a committee to develop local protocols to prevent child abuse. These "Child Abuse Protocol Committees" were also instructed to review unexpected or unexplained deaths of children under the age of 18, determine if any could have been prevented, and to make recommendations to prevent future child deaths.

In 1993, a broad-based package of amendments was enacted to strengthen the process. In the fall of 1996, the Budget Review and Oversight Committee of the Georgia General Assembly asked the Emory Center for Injury Control and the Applied Research Center at Georgia State University to formally evaluate child fatality review process. Key findings include the following:

- The creation of county-level Child Abuse Protocol Committees has enhanced enforcement of laws against child abuse by facilitating interagency communication and cooperation.
- County-level Child Fatality Review Subcommittees have been less successful at preventing child deaths. Despite six years of effort, the pattern and frequency of child deaths in Georgia is essentially unchanged.
- Review of a limited sample of child death investigations revealed a number of deficiencies in the investigative process. Ninety percent of respondents to a statewide survey of Child Fatality Subcommittee chairs reported that their work has been hampered on one or more occasions because of errors or oversights in the original death investigation.
- Participation in the Child Fatality Review process varies widely across the state. Although the child fatality review process is supported by hundreds of dedicated professionals statewide, 57 counties with one or more deaths in 1995 did not forward a single review to the Statewide Child Abuse Prevention Panel. Each year, nearly half of eligible child deaths statewide are not reviewed.
- Subcommittees face enormous obstacles to their work. These include scene investigations of varying quality, lack of cooperation from local officials, erratic participation by key subcommittee members, no staff support, delays in receiving autopsy and toxicological test results, and uncompensated administrative costs.
- No funds are allocated to support the work of county Child Fatality Subcommittees.
- New subcommittee members are supposed to be trained within 12 months of appointment, but this does not always occur. Subcommittees have little or no access to continuing education.
- The Statewide Child Abuse Prevention Panel is responsible for collecting and analyzing county subcommittee reports, but it has no authority to enforce compliance with the process.
- The annual report of the Statewide Child Abuse Prevention Panel is given limited distribution due to cost. As a result, the panel's findings and recommendations have little impact.
- Georgia citizens strongly support the child fatality review process. Although 62% believe that child death investigations are best done at the local level, 89% believe that the Georgia Bureau of Investigation (GBI) should have the authority to intervene if child death investigations are inadequate or incomplete. Ninety-four percent believe that the state should support special training for investigating officials. Eighty-six percent support state funding of this training.

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### Recommendations

**A. Improve Child Death Investigations**

- Detection of deaths due to abuse or neglect is best achieved by insuring that properly trained personnel conduct the initial investigation.
- Law enforcement officers and others who investigate child deaths should receive special training in the subtleties of child death investigation. Local agencies who do not have a trained child death investigator should request the assistance from the GBI.
- Investigators should use a death scene questionnaire or a structured death scene protocol to guide their initial investigation.
- The General Assembly should fund a statewide network of medical examiners.
- The General Assembly should fund enhanced state crime lab resources to meet the rising demand for forensic and toxicological analyses.

**B. Support the Child Fatality Review Process**

- The General Assembly should provide support to enable subcommittees to conduct high-quality child fatality reviews. This support could be allocated through the office of the District Attorney in each Judicial Circuit.
- Counties in rural areas of the state should be permitted to join form multi-county Child Fatality Subcommittees if they choose to do so.
- Child Fatality Review subcommittees should study accidental deaths as carefully as those that are due to abuse or neglect. Many can be prevented by relatively simple measures.
- The General Assembly should fund no less than three (3) subcommittee training sessions per year in different regions of the state.
C. Enhance Oversight and Accountability

- The *General Assembly* should amend legislation to clarify roles, responsibilities, and performance standards of subcommittees.
- The *General Assembly* should assign responsibility for coordination of county subcommittee activity to the District Attorney in each judicial circuit.
- The *General Assembly* should provide the Statewide Child Abuse Prevention Panel with sufficient funding to carry out its mandated responsibilities and provide training and technical assistance to subcommittees. The General Assembly should give the Statewide Child Abuse Prevention Panel the authority to notify the Chief Judge and the District Attorney of a judicial circuit if one or more counties in the circuit is having recurrent problems with inadequate, delayed, or incomplete investigations. If this does not correct the problem, the panel should have the authority to request that the GBI provide assistance by assuming the investigative role.

D. Disseminate Findings and Recommendations Statewide

- The annual report of the Statewide Child Abuse Prevention Panel should identify important causes of child fatality and recommend specific measures to prevent these deaths. The report should also highlight county-level compliance or non-compliance with the child fatality review process.
- The Judiciary Committees of the *General Assembly* should hold an annual hearing to receive the panel’s report. This hearing should take place each autumn before the start of the legislative session, providing legislators sufficient time to prepare legislation if/when they feel it is warranted.
- The *General Assembly* should provide sufficient funding to prepare and disseminate the Statewide Child Abuse Prevention Panel’s annual report. The panel’s report should be widely distributed to state and local officials, interested citizens, and the news media.

I. Introduction

In 1990, the Georgia General Assembly adopted a comprehensive package of legislation to reduce the incidence of child abuse and insure that suspicious child deaths were adequately investigated. The Chief Superior Court Judge in each county in the state was directed to establish a "child abuse protocol committee" comprised of representatives from a number of state and local agencies. These committees were charged with the responsibility of developing local protocols to investigate and prosecute alleged cases of child abuse and to implement treatment programs for the perpetrator, the family, and the child. Committees were also expected to review child deaths in the county to determine if any could have been prevented by appropriate actions.
A Statewide Child Fatality Review Panel was established to compile statistics and make recommendations. No funds were allocated to support this activity.

Although the legislation was intended to create a comprehensive statewide program of children abuse and child fatality prevention, much of the law was unenforced.

In 1993, a package of amendments were adopted to strengthen the investigative process and enhance child fatality reviews. Each child abuse protocol committee was directed to establish a child fatality subcommittee to review death reports and determine if any child deaths could have been prevented. The Statewide Child Fatality Review Panel was renamed the Statewide Child Abuse Prevention Panel, and administrative functions were transferred from the Division of Family and Children Services (DFCS) to the Criminal Justice Coordinating Council (CJCC). On July 1, 1996, the Statewide Panel was moved from the CJCC to the Children’s Trust Fund Commission, and funding was authorized to hire an executive director.

Although the Statewide Child Abuse Prevention panel has issued a series of annual reports, the child fatality review process in Georgia has not been evaluated by an outside group. Last fall, the Budget Review and Oversight Committee (BROC) of the Georgia General Assembly requested that the Emory Center for Injury Control and the Georgia State University Applied Research Center work together to evaluate the child fatality review process in Georgia.

II. Methods and Findings

Progress towards achieving the objectives of this legislation was measured by tracking the process, outcome, and impact of the child fatality review process through its six-year history. Our evaluation focused on five critical issues:

A. Legislative history

B. Child death investigations
   [Graphs: Causes of Death for Ages <1 to 17 Years in Georgia]

C. Child fatality reviews

D. Impact of child fatality reviews

E. Public sentiment about the child fatality review process

A. Legislative History

Objectives:

- Review the legislation that created the child fatality review process
- Identify subsequent amendments
- Determine the intent of the General Assembly in creating the child fatality review process
Methods:

The enabling legislation (OCGA Sec. 19-15-3) was reviewed to clarify the intent of the General Assembly at the time the child fatality review process was created. Amendments to the legislation were examined to understand how it modified the capacity and scope of child fatality reviews.

Results:

In 1989, reporter Jane Hansen published a series of seven articles in the Atlanta Journal and Constitution. The series, entitled "Suffer the Children," detailed 51 deaths among children who were ostensibly under the protection of Georgia’s child welfare system. In addition to exposing shortcomings in the state’s child protective services, Hansen discovered an alarming lack of investigation into the deaths of these children that often led to labeling the causes of death as "accidental" or "natural" after little or no examination.

Hansen found that Georgia was one of only ten states without a record of the number of children killed by parents or relatives. She also determined that inadequate record keeping and lack of access to existing records hindered communication between the caseworkers, police investigators, coroners, medical examiners, prosecutors, judges and other officials who bear responsibility for protecting abused children in Georgia.

Public outcry in response to Hansen’s series led to the formation of a Governor’s task force and legislative committees that examined the child abuse and the child fatality review process in Georgia. The task force concluded that "Georgia must develop a system to provide uniform death investigations by trained forensic pathologists to all areas of Georgia." This led to the development of legislation in 1990 which, along with existing legislation, created a new "Child Abuse" chapter of the Georgia code. Although the legislation was intended to create a comprehensive, statewide program of child abuse and child fatality prevention, much of the law was unenforced. For example, although a Statewide Child Fatality Review Panel was created in 1990 to collect the data and release an annual Child Abuse Report,8 it produced only one report in the first three years of its existence. In a 1993 article, the Atlanta Journal and Constitution described the effort as "flawed and incomplete."

No funds are provided for continuing education, and no state agency is tasked with the responsibility to provide ongoing training to committee members.

The subsequent beating deaths of three two-year-old children brought pressure on the legislature to reform the system. This led to a broad-based package of amendments to child abuse and child fatality legislation in Georgia. Following adoption of these amendments, state law included a comprehensive definition of child abuse and an explicit requirement that each county in Georgia to establish a child abuse protocol committee and a written child abuse protocol. The Chief Superior Court Judge for the circuit in which the county resides is responsible for setting up the protocol committee and designating an interim chair. Representatives from each of the following agencies must serve on the committee: the principle law enforcement agency of the county and
the chief of police from the largest municipality in the county; the county family and children services; the district attorney’s office; the juvenile and the magistrate’s courts; the county board of education; the county mental health organization and a physician from the county board of health; the county coroner’s office or the county medical examiner. Protocol committees are expected to meet at least twice each year and file an annual report evaluating the process for child abuse investigations over the prior 12 months. The legislation also called for the creation of county-level child fatality review subcommittees.

Members of county child abuse protocol committees and child fatality review committees are expected to serve without pay. A 1994 amendment to the law requires the Department of Human Resources to provide appropriate training to each new committee member within 12 months of appointment. No funds are provided for continuing education, and no state agency is tasked with the responsibility to provide ongoing training to committee members.

To enhance the quality of autopsies, the law specifies that medical examiners must be trained in forensic pathology and certified by the American Board of Pathology. An autopsy must be performed whenever the death involves a child under the age of 7. An autopsy is also required whenever a child of any age dies under unusual or suspicious circumstances.

The legislation attempts to balance the need for confidentiality with the need for oversight to ensure the system works.

Under existing state law, child fatality subcommittees are required to initiate an investigation whenever a medical examiner reports a child to the director of forensic sciences of the GBI. The subcommittee is supposed to meet within ten days of receiving a copy of the medical examiner’s report to conduct their own investigation. Subcommittees have the power to legally compel production of needed documents or attendance of witnesses if a superior court judge in the county agrees that this is necessary to complete the investigation.

Subcommittees are expected to complete work within 20 working days of initiating their investigation. Within 15 days of completing their review, the subcommittee is supposed to file a copy of their review and conclusions with the statewide child abuse prevention panel. A copy of the report is also transmitted to the county’s District Attorney if the circumstances of the death are questionable or the subcommittee believes that prosecution is warranted. Finally, subcommittees are expected to issue summary reports of their work to the chairs of the judiciary committees of the House and the Senate no later than July of each year.

In addition to creating county-level child abuse protocol committees and child fatality reviews, the 1990 legislation created a Statewide Child Fatality Review Panel to track the prevalence and circumstances of child fatalities and cases of child abuse statewide. The panel is supposed to analyze all county-level reviews on an annual basis and make recommendations to reduce child fatalities from "other than natural" causes. In 1993, the name of the panel was changed to Statewide Child Abuse Prevention Panel. There is probably no better example of the prevention intent of this legislation than in this name change.
The statewide panel meets quarterly or when called by the Governor. It is expected to prepare a report by December 1 of each calendar year and submit recommendations to the Governor, the Lieutenant Governor, and the Speaker of the House. Unlike members of local child abuse protocol committees, members of the statewide panel receive modest compensation for their time and travel expenses. Responsibility for the panel’s administrative functions has changed hands over time. The panel was initially supported by the DFCS. However, in 1993, it was transferred from DFCS to the CJCC. In 1996, the panel was transferred to the Children’s Trust Fund Commission, and funds were allocated to permit the panel to hire an executive director.

In addition to delineating the process for child fatality review, the 1990 legislation and subsequent 1993 amendments also clarified issues of access to records and confidentiality. Open meetings legislation was limited in its application to the review process. The 1993 amendments expanded the list of individuals with access to the records of the review process, including the Governor, the Lieutenant Governor, the Speaker of the House of Representatives, and the Attorney General. According to the Georgia State University Law Review, this was deemed necessary to permit policy makers to evaluate the process and make changes when necessary. The legislation also includes a strong statement of confidentiality to protect the identity of victims and participants in the process. In this respect, the legislation attempts to balance the need for confidentiality with the need for oversight to ensure that the system works.

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**B. Child death investigations**

**Objectives:**

- Determine if child deaths are being properly investigated
- Determine if appropriate autopsies are being performed
- Identify options to improve the quality of child death investigations

**Methods:**

To generate a "thumb nail sketch" of the quality of investigative information provided to county subcommittees for review, we obtained 21 child fatality review records from the Statewide Child Abuse Prevention Panel. We asked the panel to over-sample cases in which abuse or neglect was suspected, but there was insufficient evidence to warrant further investigation.

These reports were submitted for detailed review by: 1) Two senior investigators at the GBI who have special training in child death investigations, and 2) An out-of-state forensic pathologist who specializes in child death investigations.

**Results:**

The GBI agents noted that a significant number of the reports lacked either one or more of four key documents: 1) Medical Examiner’s report; 2) Report of the death scene investigation; 3) Coroner’s investigative report; 4) Toxicology report. Although it was noted that these documents
may have been provided orally to the subcommittee, this was not documented in the files. Incomplete documentation makes proper review of a case impossible.

The GBI reviewers also noted that several of the files contained information that raised the possibility of neglect. However, most contained little or no evidence that these suspicions were followed up. In the absence of close scrutiny, there is no way to insure that future problems will not occur. This is particularly important if surviving siblings or other children are at potential risk.

**Each county child fatality review subcommittee should contain a sworn law enforcement officer who is trained and experienced in child death investigations.**

The GBI reviewers strongly recommended that each county child fatality review subcommittee should contain a sworn law enforcement officer who is trained and experienced at child death investigations. Current legislation requires law enforcement representation on the committee, but the expertise of the officer is not specified. They also suggested that investigators use an infant death investigation questionnaire. This document prompts investigators to ask the right questions, collect the right information, and conduct more thorough investigations.

The records were also reviewed by Richard Haruff, MD, PhD, a forensic pathologist who works for the King County Medical Examiner’s office in Seattle, Washington. Dr. Haruff specializes in child death investigations and assists the state of Washington with child fatality reviews.

Dr. Haruff identified a number of ways that the death investigations could have been improved. Like the GBI investigators, he acknowledged that the subcommittees who conducted these reviews may have had access to additional information that was not included in their summary report. It is worth repeating, however, that omission of relevant information makes subsequent review of cases uncertain at best.

Dr. Haruff rated 13 of the 21 death investigations "good" or "adequate". One investigation was considered "probably adequate."

Four were rated "marginal," and three were considered inadequate to support the subcommittee’s conclusion.

In Dr. Haruff’s opinion, vehicular deaths were not investigated thoroughly. None of the three files he reviewed included a complete autopsy or scene investigation. Driver behavior (e.g., speeding and/or alcohol) and lack of use of safety belts often play a role in these deaths, but other characteristics of the vehicle, roadway, and surrounding terrain may also be important. Without a careful examination of the vehicle and the crash scene, important clues may be missed.
According to state vital statistics, a total of 1,777 infants and children died in Georgia in 1993.

Sudden Infant Death Syndrome (SIDS) investigations were noted to be of varying quality. One file contained a completed infant death scene questionnaire. Others did not. Dr. Haruff believes that improving investigative techniques will not only contribute to better child fatality reviews, it will also remove the cloud of suspicion that can arise when a death review is conducted with incomplete knowledge of the facts.

There are four potential explanations for the procedural lapses we observed:

1. The quality of child death investigations varies tremendously, depending on the training and experience of the investigator(s). Infant and child death investigations differ in many respects from adult death investigations. Special training is required to pick up clues that suggest neglect or foul play. A visit to the death scene is essential, especially when the child is pronounced dead elsewhere (e.g., a hospital emergency department). To assist local law enforcement, the GBI has placed at least two Special Agents who are child abuse specialists in each of its fifteen regional offices. It is important to note, however, that the GBI cannot participate in an investigation unless it is requested to do so by local law enforcement or the District Attorney. If local officials do not recognize the need for a special child abuse investigator, the GBI cannot get involved.

2. Death questionnaires facilitate investigations, but they are rarely used. Some investigators use a questionnaire to help them investigate unexpected or unexplained deaths of infants. The questionnaire also contains suggestions to assist the medical examiner in his/her examination of the body.

3. Autopsies are not obtained in a consistent manner. In four Georgia counties, all deaths are referred directly to a county medical examiner. In most if the remaining counties, a local coroner participates in the initial investigation and determines if the body will be sent to the state crime lab for autopsy. In a few counties, autopsies are obtained from a local pathologist, who may or may not have special training in forensic pathology.

4. County coroners have a great deal of leeway over whether or not a death will be formally investigated. If the county coroner does not feel that an autopsy is warranted, it will not be performed. Some coroners discharge their responsibilities in a conscientious manner, but others do not. During the course of our evaluation, we encountered a number of complaints about uncooperative coroners.

Lack of training is the most likely explanation for this problem. In contrast to medical examiners, who are licensed physicians with specialized training in forensic pathology, Georgia does not require its county coroners to hold any sort of medical degree. A newly elected coroner must take a short training course in death investigation, but no other credentials are required.
C. Child Fatality Reviews

Three independent measures of Child Fatality Subcommittee activity were obtained: 1) An analysis of rates of review by county, 2) A statewide survey of subcommittee chairs, and 3) Four "case studies" of Child Fatality Subcommittee activity.

1. County-Level Reporting

Objectives:

- Determine how many counties regularly report cases to the Statewide Child Abuse Prevention Panel
- Determine if cases that require review are being reviewed

Methods:

To answer these questions, we obtained a county-by-county analysis of child death reporting from the Statewide Child Abuse Prevention Panel. County vital statistics data (which includes cause of death) were used to identify the total number of child deaths in each county for the years 1993, 1994, and 1995. Deaths from SIDS, violence, or injury were considered "eligible" and appropriate for review since they were identified as priorities in the enabling legislation. Then, the records of the Statewide Child Abuse Prevention Panel were checked to determine how many of the "eligible" deaths in each county were actually reviewed. Since other deaths may have been reviewed for a variety of reasons, the total number of reviews conducted by each subcommittee was documented as well.

Results:

Click here for Georgia Fatality Cases Reviewed by County.

According to state vital statistics, a total of 1,777 infants and children died in Georgia in 1993. The number of documented deaths in 1994 was 1,896. In 1995, 1,812 died.

For purposes of analysis, we considered deaths due to SIDS, accident, or violence "eligible" for review because these conditions are specifically mentioned in the legislation that created the child fatality review process. In any given year, SIDS, accidents, and violence account for one-fourth to one-third of all infant and child deaths in Georgia.

In 1993, 55.2% of these "eligible" cases were reviewed; in 1994, 54.3% were reviewed, and in 1995, 51.9% were reviewed. These differences are not statistically significant.

Rates of reporting varied widely across the state. In 1995, only ten counties with five or more "eligible" deaths reviewed 80 percent or more. Fifty-seven counties with at least one child death did not forward a review to the Statewide Panel that year (see map, following page).
2. Survey of Subcommittee Chairs

Objectives:

- Determine the level of activity of individual child fatality review subcommittees
- Determine if subcommittees have sufficient resources to do their work
- Identify the obstacles that keep county subcommittees from accomplishing their goals

Methods:

To learn more about the activities of local child fatality subcommittees, we attempted to interview the chair of every county Child Abuse Protocol Committee or Child Fatality Review Subcommittee in the state.

Our interview instrument was developed with the assistance of key members of the Statewide Child Abuse Prevention Panel. An early version of the questionnaire was field-tested in face-to-face interviews with county officials. Following feedback, revisions were made.

A list of county Subcommittee chairs was obtained from the Statewide Child Abuse Prevention Panel. Each individual on the list was sent a letter informing them of our evaluation and requesting their cooperation. Confidentiality was assured. These letters were followed up with telephone calls to arrange a convenient time for the interview. When we learned that a chair had changed hands, we contacted the new chair using the same procedure. Non-responding chairs were called more than 30 times before we abandoned efforts to reach them.

Informed consent was obtained prior to initiating each interview. Respondents were told that they did not have to answer any question they did not want to, and that they could terminate the interview at any time. They were also assured that their name and the name of their county would be kept confidential. This procedure was approved by the Institutional Review Board of Emory University.

Questions were asked about the composition of each chair’s subcommittee, the level of participation by key subcommittee members, turnover, training, details of the review process, subcommittee strengths and weaknesses, obstacles to performance, and needs. Each interview took approximately 20-30 minutes to complete.

Results:

Child Fatality Subcommittee chairs in 107 of Georgia’s 159 counties participated in the survey (67% response rate). Fifty-two (33%) could not be contacted or refused to participate. Selected comments from the 197 who participated in the survey follow:
Why was your (child fatality review) subcommittee created? (list all that apply)

- Prevent future fatalities from abuse or neglect: 90%
- Identify any agency that might have intervened to prevent the death: 88%
- Prevent future fatalities from all causes, including accidents and diseases: 79%
- Identify and prosecute perpetrators of abuse and neglect: 71%

Does your subcommittee have a budget?

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<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3%</td>
</tr>
<tr>
<td>No</td>
<td>94%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
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Does your subcommittee have staff resources?

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<table>
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<th>Option</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Yes</td>
<td>38%</td>
</tr>
<tr>
<td>No</td>
<td>57%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>5%</td>
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Have members of your subcommittee been provided with opportunities to obtain special training?

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<tbody>
<tr>
<td>Yes</td>
<td>54%</td>
</tr>
<tr>
<td>No</td>
<td>39%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>7%</td>
</tr>
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(If yes to the previous question) have they (subcommittee members) taken advantage of this opportunity?

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<th>Option</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Yes</td>
<td>46%</td>
</tr>
<tr>
<td>No</td>
<td>8%</td>
</tr>
<tr>
<td>N/A</td>
<td>46%</td>
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Are funds available to support training? (e.g., travel, registration fees)

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<th>Option</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20%</td>
</tr>
<tr>
<td>No</td>
<td>76%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>4%</td>
</tr>
</tbody>
</table>
```
What investigative resources are available (in your county) to help investigate child deaths?

<table>
<thead>
<tr>
<th>Resource</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Specialists in children’s issues</td>
<td>77%</td>
</tr>
<tr>
<td>Special task force for investigating child abuse</td>
<td>79%</td>
</tr>
<tr>
<td>Officers with special training in child death investigation</td>
<td>56%</td>
</tr>
</tbody>
</table>

To your knowledge, has the Georgia Bureau of Investigation been called in to help conduct a child death investigation in your county?

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>53%</td>
</tr>
<tr>
<td>no</td>
<td>33%</td>
</tr>
<tr>
<td>don’t know</td>
<td>14%</td>
</tr>
</tbody>
</table>

Has your committee ever been hampered in its work because of any of the following?

<table>
<thead>
<tr>
<th>Hamper</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>autopsy took too long</td>
<td>51%</td>
</tr>
<tr>
<td>autopsy not done</td>
<td>89%</td>
</tr>
<tr>
<td>inadequate autopsy report</td>
<td>91%</td>
</tr>
<tr>
<td>lack of death scene investigation</td>
<td>89%</td>
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</tbody>
</table>

Using a scale from 1-10, where 1 means not very helpful and 10 means very helpful, rate how helpful the following things would be in assisting child fatality reviews at the local level...

<table>
<thead>
<tr>
<th>Potential Help</th>
<th>Rating</th>
</tr>
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<tbody>
<tr>
<td>State-supported training for local law enforcement officers who conduct child death investigations</td>
<td>8.63</td>
</tr>
<tr>
<td>More state-supported training for medical examiners and coroners in how to conduct investigations</td>
<td>8.22</td>
</tr>
<tr>
<td>&quot;User-friendly&quot; forms</td>
<td>8.17</td>
</tr>
<tr>
<td>Quicker autopsy reports from the state crime lab</td>
<td>7.68</td>
</tr>
<tr>
<td>State funding to support Child Fatality Subcommittees at the local level</td>
<td>7.43</td>
</tr>
<tr>
<td>Education regarding the intent of the legislation</td>
<td>6.91</td>
</tr>
<tr>
<td>Provision of a statewide annual report</td>
<td>6.18</td>
</tr>
</tbody>
</table>

3. County Case Studies

Objective:

- Conduct an in-depth analysis of subcommittee activity in four counties
Methods:

To obtain a more detailed view of the child fatality review process at the local level, we visited two rural and two urban subcommittees and observed them at work. Individual and/or group interviews were conducted with committee members to learn more about the process. To encourage full disclosure, we agreed to keep the identity of respondents and the name of each county confidential.

Results:

Strong leadership by the local District Attorney was identified as a key element of success at two of the four subcommittees we visited. Both of these subcommittees are led by an Assistant District Attorney that specializes in child abuse and child neglect cases. Conversely, lack of involvement by the local DA's office was a major problem at the other two counties we visited. One was inactive because the Assistant DA, who had previously led the effort, had left the community and not been replaced. The fourth committee is quite active, but the county DA was not involved.

Productive committees were characterized by a high degree of organization, motivated members, relatively low turnover, and a good working relationship between subcommittee members.

Lack of funding and lack of staff support were noted to be serious problems. Many subcommittee members complain that they are forced to conduct their business on a "nickel and dimes" basis. The committees we visited attempted to deal with this problem by tapping the resources of local organizations, applying for federal grants, or doing the work themselves. The efficiency of the process was directly related to the amount of staff support available to prepare case files for discussion.

Several of the subcommittee members we interviewed characterized the child fatality review process as an "unfunded mandate" by state government. They recognize the importance of the process, but they resent the fact that funding is not provided to support their efforts.

Many members stressed the need for continuing education. DFCS is supposed to provide training to new committee members within twelve months of appointment, but this does not always occur. No one has responsibility for providing continuing education. To the degree that continuing education occurs, it is generally obtained through local efforts.

In one of the counties we visited, lack of support by the local coroner was identified as a serious problem. In another, active participation by the county medical examiner was a particular strength. Most of the subcommittees we visited complained that turn-around times for toxicological analyses and autopsy results are slow. This is attributed to heavy demands on the state crime lab.

Recently the Statewide Child Abuse Prevention Panel introduced a new review form. Most of the subcommittee members we interviewed feel it is more complete and user-friendly than the old form, which left many terms undefined. The form incorporates specific checklists that help the
committee identify risk and protection factors for various causes of death. This helps subcommittees identify opportunities for prevention. The downside of using the new form is that it is more labor-intensive than the old one. This was of particular concern to one subcommittee because it reviews a large numbers of cases and has no staff support.

One of the most important tasks of subcommittees is to identify preventable causes of child death. However, Child Fatality Review Subcommittees have no authority to mandate changes and no time to follow-up recommendations to see if they are implemented. Most of the subcommittee members we interviewed could not cite examples of specific changes that had been made as a result of their efforts.

Several members requested that a statewide conference on child fatality be held in the near future. They want to share their experiences and learn what others are doing.

D. Impact of fatality reviews

Objective #1:

- Determine if child fatality reviews have led to changes in policy or procedures

Methods:

To assess the potential impact of the child fatality review process, we asked subcommittee chairs who responded to our survey a series of questions about recommendations to prevent future child deaths. Relevant responses follow:

Results:

N = 107 of 159 counties responding (67%)

How many cases did your committee review in calendar year 1996?

<table>
<thead>
<tr>
<th>Cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>none</td>
<td>35%</td>
</tr>
<tr>
<td>1-5</td>
<td>49%</td>
</tr>
<tr>
<td>6-10</td>
<td>8%</td>
</tr>
<tr>
<td>&gt;10</td>
<td>8%</td>
</tr>
</tbody>
</table>
How many (of these) cases did your committee believe were "preventable"?

<table>
<thead>
<tr>
<th>Cases Reviewed</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>no cases reviewed</td>
<td>35%</td>
</tr>
<tr>
<td>none</td>
<td>36%</td>
</tr>
<tr>
<td>1</td>
<td>17%</td>
</tr>
<tr>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>5</td>
<td>2%</td>
</tr>
</tbody>
</table>

Has your committee ever recommended changes to policies, procedures, or personnel to prevent future child deaths? (emphasis added)

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>20%</td>
</tr>
<tr>
<td>no</td>
<td>75%</td>
</tr>
<tr>
<td>don’t know</td>
<td>5%</td>
</tr>
</tbody>
</table>

In 1996, did a child fatality review by your committee prompt criminal investigation that would not otherwise have occurred?

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>12%</td>
</tr>
<tr>
<td>no</td>
<td>77%</td>
</tr>
<tr>
<td>don’t know</td>
<td>11%</td>
</tr>
</tbody>
</table>

Objective #2:

- Determine if child fatality reviews have changed the pattern or frequency of child mortality in Georgia

Methods:

To determine if introduction of the child fatality review process has led to a reduction in child deaths by any cause, we examined trends in child mortality between 1990 and 1995 (the last year for which vital statistics data are currently available). We calculated the proportion of deaths by cause in each of the following age groups: less than 1 year of age, 1-4 years, 5-14 years, and 15-17 years.
Results:

The majority of deaths to children aged 17 and under (59% in 1995) involve infants below one year of age. Most of these are due to congenital and perinatal problems, SIDS, and other medical problems. Few homicides occur in this age group. In the 1-4 year age group, injuries (including homicides) account for slightly less than half of all deaths. In the 5-14 year age group, accidents, homicides, and suicides account for 56% of deaths. Among Georgia youths 15-17 years of age, accidents, homicides and suicides account for more than 80% of deaths (see charts, pages 7-8). There is no evidence that the child fatality review process has altered either the pattern or rate of child deaths in Georgia. With the exception of homicides involving 15-17 year olds (which have increased substantially since 1990), age-specific rates of death from various causes have been stable between 1990 and 1995. Rates of death by various causes fluctuate slightly from year to year, but no significant declines have been observed in any cause of death (see charts, pages 19-20).

Survey responses confirm that Georgians believe that the state has a significant role in ensuring high quality reviews of child fatalities.

E. Public Sentiment About the Child Fatality Review Process

Objective:

- Determine the level of public support for child fatality reviews

Methods:

In a Georgia State University quarterly poll of state citizens, we included a series of questions about the child fatality review process. This enabled us to determine public opinion about the process and ways it might be improved.

Results:

Survey responses confirm that Georgians believe that the state has a significant role in ensuring high-quality review of child fatalities. Although most Georgians agree that the authority to conduct reviews should remain at the local level (62.3%), they also see the need for greater state-level oversight and intervention when local reviews are not of sufficiently high quality.

Georgians strongly believe that the Statewide Child Abuse Prevention Panel should have the authority to call in the GBI to conduct investigations when reviews are not well done (85.0%) and when the reviews are not completed and submitted on a timely basis (91.0%). In addition, Georgians support giving the GBI the authority to audit the child death investigations and reopen an investigation if agents feel this is necessary (89.8%). The need for special training of every official who investigates child deaths is reinforced by public opinion. Ninety-four percent of Georgians agree with the need for specialized training; 55% strongly agree. Public belief that the need for high quality investigations sometimes demands action by state agencies was supported
by the fact that a large majority of respondents favored making the GBI responsible for conducting investigations in jurisdictions where local authorities have not received special training in child death investigations (87.2%). In further support of the issue of state involvement, 85.9% of Georgians support state funding to train local officers to conduct child death investigations.

Graph: Homicides by Age Category in Georgia

III. Discussion

To inform the General Assembly of the impact of OCGA 19-15-3, we conducted a wide-ranging evaluation of the structure, process, and outcome of child fatality reviews in Georgia. Several independent measures of performance were obtained, including a review of the enabling legislation, an analysis of county by county performance, expert analysis of a sample of death investigations, a telephone survey of subcommittee chairs, case studies of county subcommittees, and an epidemiological analysis of child mortality in Georgia. When overlap occurred, findings were consistent. This suggests that we gathered reliable and valid information.

Because cost considerations limited the scope of our work, some of our observations should be interpreted with caution. For example, conclusions based on expert review of 21 child fatality investigations may not be generalizable to all death investigations statewide. Nonetheless, the problems identified in this small series of cases were consistent with the complaints received from county subcommittee chairs.

Despite a great deal of effort, we were unable to contact the subcommittee chair in 52 of Georgia’s 159 counties (33%). The opinions of these nonrespondents may not match those of the 107 chairs who answered our calls. It seems likely, however, that failure to answer 30+ telephone calls reflects either a lack of interest in the child fatality review process or the absence of activity. The fact that 57 subcommittees did not forward a review to the Statewide Panel in 1995 reinforces this view.

In-depth study of Child Fatality Review Subcommittee activity in four counties gave us a clearer perspective of the operational concerns involved in conducting child fatality reviews. Observations based on these visits may not be representative of the situation across the state, but they were generally consistent with the comments we received from our statewide survey of county subcommittee chairs.

Many of the individuals we interviewed spoke strongly of the need for a child advocacy center in each judicial circuit in the state. It is widely believed that these centers are useful for conducting child abuse investigations and providing professional support to victims. An adequate exploration of the merits of child advocacy centers exceeded the scope of our evaluation.

The generally critical tone of our evaluation should not be interpreted as criticism of the concept of child fatality review. In light of the constraints imposed on the process, the current level of activity statewide is remarkable. Child fatality review can be a powerful tool for identifying patterns and trends in child death, modifying contributing factors and mobilizing public opinion.
The primary intent of the legislation was to identify potential cases of abuse and neglect and identify if one or more protective agencies failed to do their job. Although this is a worthy goal, Child Fatality Review Subcommittees can do much more. Systematic examination of child deaths can identify many opportunities for prevention. This is particularly true of deaths due to motor vehicle crashes, drowning, fire, falls, or poisoning. Combining reports from across the state can reveal patterns and trends that are not easily detected at the level of an individual county.

IV. Benchmarks

If any or all of our recommendations are adopted, it will be advisable to monitor the child fatality review process over time to document improvement. We propose several measures of structure (i.e., how the child fatality review process is organized), process (the procedures followed in conducting child fatality investigations and reviews), and outcome (the impact of the child fatality review process) for future evaluations.

A. Structure

- Under the direction of the Chief Superior Court Judge, the District Attorney in every judicial circuit in the state will oversee and/or coordinate child fatality review subcommittee activity in every county in the circuit.
- Every District Attorney in the state will be provided with adequate staff and a budget to support Child Fatality Review Subcommittee activity in his/her circuit.
- Annual continuing education sessions will be provided in at least three (3) locations of the state.
- The Statewide Child Abuse Prevention Panel will have sufficient staff to meet its mandated responsibilities and sufficient funding to print and distribute at least 2,000 copies of its annual report.

B. Process

- At least 80% of infant death investigations will employ an infant death investigation questionnaire.
- Random audits of child death investigations will determine that at least 80% of investigations meet standards for obtaining an autopsy and conducting an adequate investigation.
- Every Child Fatality Subcommittee in a county with one or more eligible deaths will conduct and submit reviews on a timely basis.
- At least 80% of eligible child deaths statewide will be reviewed and reported to the Statewide Child Abuse Prevention Panel.
- Every participating Child Fatality Review Subcommittee will use the panel’s new report form.
- The annual report of the Statewide Child Abuse Prevention Panel will identify factors that contribute to preventable child deaths and make recommendations.
- An annual hearing will be held before the legislative session to hear the statewide panel’s report.
C. Outcome

- Child fatality reviews will prompt changes in local and/or state policies, procedures, or personnel that reduce the risk of future child deaths.
- State mortality statistics will reflect a significant and lasting decline in rates of child death from one or more preventable causes.

For a copy of the appendices that support this report, send $10.00 for postage and handling to: The Center for Injury Control, Rollins School of Public Health, Emory University, Atlanta, GA 30322, or call: (404) 727-9977.

Appendices:

A. GBI analysis of 21 child fatality reviews
B. Infant death investigation questionnaire
C. Forensic pathologist analysis of 21 child fatality reviews
D. Rates of child fatality review by county
E. Interview instruments and methodology
F. Four county case studies

The Center for Injury Control at Emory University’s Rollins School of Public Health is an interdisciplinary center dedicated to the prevention and control of injuries through research, teaching, and service. The Center's staff have internationally recognized expertise in the areas of violence prevention, firearm injuries, motor vehicle injuries, helmet promotion, surveillance, program evaluation, and international health.

The Applied Research Center of Georgia State University conducts research on education, public policy and administration, and other fields. Through research and its dissemination, the center increases the knowledge and understanding of public policy issues by the public, elected and appointed officials, and scholars in the field.