GACP

Child Lethality
Ad Hoc Committee
White Paper

Louis M. Dekmar
Chief of Police (Retired)
Committee Chair

August 2024

August 13, 2024

President Gray
Georgia Association of Chiefs of Police
3500 Duluth Park Lane
Duluth, Georgia 30096

Dear President Gray,

I am writing to formally submit the enclosed white paper on behalf of the Child Lethality Ad Hoc Committee, appointed by President Scott at the winter conference in Columbus. This document reflects the dedicated efforts of the committee to analyze and address the critical issue of child lethality within our state. Our aim has been to provide a comprehensive review of the current situation, identify key challenges, pilot the child lethality instrument and protocol, and propose actionable recommendations to enhance the safety and well-being of children across Georgia.

The committee has worked diligently to compile data, consult with experts, and engage with various stakeholders to ensure that our findings and recommendations are both thorough and practical. We believe that the insights contained within this white paper will serve as a valuable resource for law enforcement agencies, policymakers, and community organizations committed to safeguarding our youngest and most vulnerable citizens.

We appreciate the opportunity to contribute to this vital discussion and look forward to working with the Georgia Association of Chiefs of Police to implement the recommendations outlined in this report. We are confident that, with your leadership, our collective efforts will lead to significant improvements in protecting children throughout Georgia.

Thank you for your attention to this important matter. Please do not hesitate to contact me should you require further information or wish to discuss the contents of the white paper in greater detail.

Sincerely,

Louis M. Dekmar,
Chief of Police (Retired)
Committee Chair

White Paper On Child Fatality Prevention, Child Risk Assessments, and Implementable Strategies To Reduce Preventable Child Deaths in Georgia.

We would like to thank the generosity of Georgia Power for their kind contribution to this project, their commitment to GACP, and their efforts to protect vulnerable children in the state of Georgia.

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Executive Summary:

The state of Georgia has an abnormally high child maltreatment homicide rate in the context of the United States. In fact, as of 2022, Georgia was the 5th worst performing state in the nation in relation to this.

The majority of the children who die due to maltreatment are very young (4-years-old and younger), and many of them are already known to the Department of Family and Children Services (DFCS) and/or law enforcement.

This Committee has been provided access to unpublished data stored by the Georgia Bureau of Investigation (GBI). This data suggests that over the eleven year period 2012-2022, 858 children were violently killed and 1,800 infants died from sleep-related causes. More than 53% of infants who died, and subsequently had their deaths investigated due to suspected maltreatment, had a DFCS case file at the time of their death.

Annual statewide child fatality reviews (CFR) conducted by GBI indicate that between 90-99% of child deaths are preventable. These preventable deaths lead to billions of dollars ($) of lost productivity. Moreover, there is significant evidence that residents of Georgia would be willing to pay enormous sums to reduce the amount of maltreatment-related child fatalities in the state. In fact, this White Paper estimates that the economic burden incurred by Georgia due child homicides and infant sleep-related deaths was up to $41.2 billion over the period 2012 to 2022.

The loss of productivity due to children being exposed to trauma in Georgia is unknown. This White Paper does not try to quantify this damage, however, the GACP encourages others to investigate this. Nevertheless, many of Georgia's children are exposed to devastating and preventable experiences. Indeed, in 2021, 1 in 29 babies born in Georgia were exposed to substance use before birth; this number may in fact be higher, as some prenatal substance exposure may not have come to the attention of medical personnel.

Currently, there is no coherent or coordinated plan for law enforcement and its partners to tackle this crisis. Officers are not provided with training to examine non-obvious signs of trauma or risk experienced by children. Moreover, there is general confusion amongst law enforcement about how best to make referrals to mandatory reporters such as school personnel and DFCS.

It is the intention of this Committee to improve existing procedures and invent new ones if necessary in order to protect and serve the children of Georgia. Please see 'Recommendations' for more information about how we intend to achieve this.

Facts:

Fatalities:

- Georgia experienced deaths related to child maltreatment at a rate 66.3% higher than the national average in 2022, which at the time of writing this is the year with the most up-to-date national data.
    - Nationally, maltreatment deaths resulting from abuse and neglect occur at a rate of 2.73 per 100,000 children in the population. In Georgia, the rate was 4.54 per 100,000 in 2022.
- According to the Georgia Bureau of Investigation (GBI) in 2019, 98.4% of all child homicides in the state of Georgia were preventable.

Department of Family and Children Services DFCS involved children:

- Between the years 2012-2022, 53.3% of infants (<1 year olds) who died due to maltreatment had an open DFCS case file at the time of their death.
- Between the years 2012-2022, 25% of children (<18 year olds) who died due to maltreatment had an open DFCS case file at the time of their death.
- Between 2015 and 2022, the number of reported and substantiated child victims in Georgia fell by 61%. There is no existing literature explaining the causes for this significant reduction.
- Between 2015 and 2022, investigations and alternative responses provided by DFCS reduced by nearly 36%. There is no existing literature explaining the causes for this significant reduction.

Substance use:

- In 2021, infants in Georgia were 262% more likely to experience prenatal substance exposure (IPSE) than infants in the rest of the United States.
    - Although Georgia had roughly 3% of the US infant population in 2021, Georgia's infant population made up roughly 8% of the United States's infants with prenatal substance exposure
    - At least 1 in every 29 children born in Georgia in 2021 was exposed prenatally to substances. 99% were related to drugs.

Economic loss:

- Between 2012-2022, there were 2,658 child fatalities in Georgia from either sleep-related or homicide-related deaths; 2,482 of these deaths were preventable (extrapolating from GBI analysis). These preventable deaths cost Georgia between $3.2 billion and $41.2 billion.

Recommendations

The pilot phase of this initiative has not formally concluded yet, therefore, recommendations are subject to change. Nevertheless, given the information that has so far been gathered, as well as the preliminary findings from this Committee and the ongoing pilots, this Committee has the following recommendations:

Training for law enforcement:

- Over the 7-month period it took to create this White Paper, members of this Committee designed and created two new educational courses which can be completed by anyone in the United States. The first course is 6-hours long and it is designed for instructors; the second is 3-hours long and it is designed for patrol officers; both courses are POST approved, which means any peace officer in the United States can be trained in them and have the training contribute toward continuous learning requirements. These courses teach peace officers to spot the signs of obvious and non-obvious signs of risk for children. In addition, these courses train the use of a child-focussed risk assessment tool invented by a member of this Committee, Saul Glick, called CARE (child at risk evaluation).
    - The POST approved courses should be made available to all police officers in Georgia. Police executives who want their officers to be trained in these courses should be financially supported in this endeavor.

- Basic training for all law enforcement in Georgia should explain the basics of child development, including the different stages of childhood and the science related to adverse & protective childhood experiences.

- Due to the high volume of SUID and related deaths in Georgia, officers should be trained to discern the risks associated with infant sleep hygiene on scene.

- The CARE risk assessment should become mandatory for officers to use when evaluating the risks experienced by children they come across in a law enforcement scenario.

- Whenever practicable, law enforcement should not arrest parents/guardians in front of their children in order to reduce trauma exposure to children.

Software & Database:

- Referrals made between law enforcement and DFCS are currently of varying style with differing qualities. A shared system which could be used by both law enforcement and DFCS to refer and monitor the risks experienced by children would lead to improved inter-agency cooperation, increased workflow efficiency, and transparency surrounding decision making which will increase accountability.

- Albany PD has been using a software platform called "vimes.io" during the pilot phase.
    - Police executives who want their officers to be able to use this software, or one similar to it, should be financially supported in this endeavor.

Multi Agency Response:

- Whenever practicable and useful to a child's safety, law enforcement and relevant agencies, including DFCS, DPH, and schools, should inform each other of their interaction with a child in order to coordinate a holistic response and reduce information gaps. This should follow on from the success of the Handle With Care program already in use in some of Georgia's counties.

- Specific programs with federal funding should join in the follow up response once the initial law enforcement safety assessment is complete. The DPH initiative WIC is an example of a program that should be deployed once an infant at risk is identified by law enforcement.

I. Introduction, Formation and Purpose of Ad Hoc Committee:

On the 16th January, 2024, Mark Scott, President of the Georgia Association of Chiefs of Police (GACP) Executive Board, appointed an Ad Hoc Committee (Committee) for the purpose of gathering facts and providing recommendations regarding the fatalities, abuse, neglect and maltreatment of at-risk children.

President Scott appointed Louis Dekmar, chief of LaGrange PD [retired] and past president of both GACP and the International Association Of Chiefs Of Police (IACP), to chair the Committee. The Committee has the following goals:

1. Propose ways in which Georgia's law enforcement might be able to reduce child maltreatment and child homicides. Subsequently, produce a white paper outlining the ways in which to implement a plan to achieve this goal as well as justifying the recommendations.

2. Recommend a training curriculum to be completed by law enforcement, which will be available to relevant partner agencies, that will facilitate a greater understanding of child development, child maltreatment, and ways to prevent child homicides.

3. Recommend the use of a risk assessment tool in a trauma-informed response by law enforcement and partner agencies in order to identify and triage risks experienced by children.

4. Pilot the training and risk assessment tool in several of Georgia's police departments; measure the efficacy of this intervention; and propose recommendations regarding best-practice for Georgia's law enforcement to proactively reduce child maltreatment and child homicides in the state.

The following topics will be discussed in relation to what can be done to reduce fatalities for at-risk children:

- Scope of the Challenge;
- Risk Factors for Children;
- Costs of Child Mortality;
- Existing Systems for Reporting Child Maltreatment;
- Risk Assessment Tools;
- Data Sharing and HIPAA;
- Training;

- Best practices;
- Conclusion and Recommendation

II. Overview of the Challenge Nationally:

This subsection will focus on the scale of child maltreatment nationally and will be followed by the subsection 'Scope of the Challenge, Georgia'. The reason for this is to illustrate the abnormal and - in the view of this Committee - suboptimal response to children at-risk in Georgia. The Committee believes this position is made clear upon comparing Georgia to the rest of the United States.

According to the Child Abuse Prevention and Treatment Act (CAPTA), a child is defined as:

> *a person who has not attained the lesser of—*
>
> *A. the age of 18; or*
>
> *B. except in the case of sexual abuse, the age specified by the child protection law of the State in which the child resides;*
>
> (42 U.S.C. §5101, Note)

CAPTA also defines child abuse and neglect as follows in Section 3:

> *At a minimum, any recent act or set of acts or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act, which presents an imminent risk of serious harm.*
>
> (42 U.S.C. §5101, Note)

This federal legislation establishes the basis on which all states, and US Territories, develop and enforce laws requiring certain professionals to report instances of child abuse or neglect to child protective service (CPS) agencies. Professionals required to report child abuse and neglect are known as 'mandatory reporters'.

There are variations across states about what is recognized as child abuse or neglect. Nevertheless, CAPTA provides the guidelines for these definitions while also

necessitating action from mandatory reporters to intervene when a child may be at risk.

Several pillars are laid out by the CAPTA definitions above:

- Children are individuals aged under 18;
- The crime of abuse or neglect occurs if a child is subject to:
    - Acts, or a set of acts leading to -
        - Death;
        - Serious physical harm;
        - Emotional harm;
        - Sexual abuse;
        - Exploitation; or
    - Acts, or failures to act, leading to -
        - Imminent risk of serious harm
    - This is the most minimal definition of abuse or neglect allowed by federal law.

II. A. What is a mandatory reporter, what is their training, etc?

Designated mandatory reporters, as defined by law, vary across states. They typically include but are not limited to: social workers, teachers and other school personnel, physicians, nurses and other health care workers, mental health professionals, child care providers, medical examiners, and law enforcement personnel.[3]

Mandatory reporters who fail to report suspected child abuse or neglect are subject to sanctions and punishments.[4] These range from misdemeanors to felonies. To prevent malicious or intentionally false reporting of cases, many states also impose penalties against any person who files a report known to be false. These range from a misdemeanor or a felony.

II. B. How common is child maltreatment in the United States?

Each year, approximately 1 in every 10 children in the United States are referred to Child Protective Services (CPS).[5] In 2022, nearly 7.5 million children appeared in roughly 4.3 million referrals which were received by CPS.[6] (In years unaffected by

[3] In Georgia, members of the clergy are specified as mandatory reporters, too.

[4] For a full list of mandatory reporters, see Appendix A.

[5] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. *Child Maltreatment Report 2021.* (2023). *Known as CMR from hereon.*

[6] There are approximately 1.8 children's details provided in each referral.

COVID-19, like 2019, the number of children referred to CPS was 7.9 million in 4.4 million referrals.) See *'National estimates for the number of referrals annually made to CPS'* in **Appendix A**.

II. C. Screened-in VS. screened-out:

The lack of tools available for mandatory reporters, especially law enforcement who - as will be seen - uncover the greatest number of child victims, is particularly acute considering CPS attrition rates. Nationally, the median length of time between a caseworker being assigned their first and last case is just 1.8 years; the median turnover rate of caseworkers is between 14 and 22% (some estimate as high as 30%[7], while it is 20% for supervisors[8].[9]

In 2022, 45 states reported a CPS workforce of 30,750; 41 states reported employing 5,036 specialized intake and screening workers. As of 2022, Georgia is one of the states that does not report this data to National Child Abuse and Neglect Data System (NCANDS). This workforce decided whether or not approximately one tenth of the children in the United States were at risk of maltreatment or not. Yet, there are few, if any, standardized tools to assess a child's risk of danger or harm and to help this workforce collaborate across other agencies involved in decision-making about children's environments (e.g. law enforcement, non-profits, schools, family court, criminal courts, etc.). This problem manifests both ways. That is to say, partners of CPS, such as law enforcement and schools, do not have risk assessment tools which can (i) rapidly assess children's risk levels, and then (ii) communicate this risk to CPS. Moreover, there is a lack of consensus amongst law enforcement departments about what constitutes "immediate danger" experienced by a child.

Once a referral is made, CPS workers must make a decision whether to screen-in or screen-out a child(ren). In its simplest terms, 'screen-in' means that a child's welfare will be investigated, and 'screen-out' means that no formal investigation will occur. An investigation will result in a formal decision as to whether or not the child subject to the investigation is a victim of maltreatment. During this process, an assessment as to the needs and services required by the child and their family will be made.

Each year, roughly half of all the children referred to CPS in the United States are screened-in, while the other half are screened-out. In 2022, 49.5% of referrals were screened-in, 50.5% were screened-out. According to CMR, the average response time

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[7] Patel, D., McClure, M., Phillips, S., and Booker, D. 'Child protective services workforce analysis and recommendations.' (*The Texas Association for the Protection of Children*, 2017).

[8] Edwards, F. and Wildeman, C. 'Characteristics of the Front-Line Child Welfare Workforce.' (*Children and Youth Services Review* 89, 2018), 13– 26.

[9] As of 2022, Georgia is one of the states that does not report this data to NCANDS.

for CPS to make contact with an alleged child victim varies across states, but in general it is slow.[10] Based on data from 41 states, the 2022 mean response time of state averages 93 hours or 3.9 days; the median response time of state averages is 56 hours or 2.3 days.[11]

In 2022, approximately 897,486 children received post-response services[12] from a CPS agency in the United States.[13] Based on data from 45 states, the average number of days from receipt of a report to initiation of services in 2022 was 40 days. This was a significant increase from 2021, during which time the average post-response time was 29 days.

II. D. Why law enforcement must act:

In 2021, three sources accounted for more than half of all referrals (53.1%) made to CPS regarding child maltreatment: law enforcement, education personnel, and medical personnel.[14]

- Law enforcement: 21.2%,
- Education personnel: 20.7%
- Medical personnel: 11.2%

70% of all referrals were made by mandatory reporters, 15.2% by non-professionals (parents, friends, etc.), and 14.8% were made by unclassified sources (anonymous, unknown, etc.).[15] See *'National estimates for the referral sources made to CPS and the percentage of victims uncovered'* in **Appendix A**.

Nationally, law enforcement regularly uncovers a disproportionate number of child victims. This is true despite limited availability of law enforcement training regarding child maltreatment and child development more generally.

If a report is substantiated, a child is deemed a victim. The referrals made by law enforcement account for roughly 38% of victims nationally (uncovering more victims than any other referral group).[16] There is no reliable literature to suggest that

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[10] The definition of response time is the time from the CPS agency's receipt of a referral to the initial face-to-face contact with the alleged victim wherever this is appropriate, or with another person who can provide information on the allegation(s). States have either a single response timeframe for all reports or different timeframes for different types of reports. High-priority responses are often stipulated to occur within 24 hours; lower priority responses may occur within several days.

[11] As of 2022, Georgia is one of the states that does not report this data to NCANDS.

[12] Post-response services are defined as, "Activities provided or arranged by the child protective services agency, social services agency, or the child welfare agency for the child or family as a result of needs discovered during an investigation. Includes such services as family preservation, family support, and foster care. Post-response services are delivered within the first 90 days after the disposition of the report."

[13] CMR, 2022

[14] Georgia's referral source figures might not reflect the national average, however, as of 2022, Georgia's CPS does not report this data to NCANDS.

[15] CMR, 2022.

[16] The breakdown of reporting sources for Georgia's DFCS is not publicly available data.

some referrals are taken more seriously or prioritized more highly than others.[17] However, in practice, it seems that some referrals are immediately deemed high-priority, and often this means CPS responses to these cases occur within 24 hours. Considering the nature of scenes attended by law enforcement, including fatalities, assaults, sexual abuse, and domestic violence, it intuitively makes sense why law enforcement uncovers the most victims.

II. E. Who is most likely to be found a victim of child maltreatment?

In 2022, there were roughly 560,000 confirmed victims of maltreatment, 74.3% of whom suffered neglect, 17% were physically abused, 10.6% were sexually abused, and 0.2% were sex trafficked. (Victims include child fatalities.). Reports of psychological maltreatment are substantiated infrequently. For example, in Maryland, only 4 out of 6,303 victims were substantiated for psychological maltreatment in 2021.

Preschool aged children are extremely vulnerable to maltreatment. Those aged 4-years or younger make up a significant portion of children referred for maltreatment. 27.3% of confirmed victims are younger than 2-years old. Infant victims younger than 1-year account for 14.7% of all victims (22.2 of every 1,000 children in the United States younger than 1-years old are substantiated victims of maltreatment.)

66.1% of child fatalities are children aged 2 years or younger. 44.7% of child fatalities are younger than 1-year (fatality rate of 24.37 per 100,000). In 2022, infants (younger than 1 year) were 3.4 times more likely to suffer a maltreatment-related fatality than a 1-year-old child (7.14 per 100,000). The child fatality rate, as it relates to maltreatment, mostly decreases with age.

In 2022, the rate of Black or African American child fatalities (6.37 per 100,000 Black or African American children) was 3.2 times greater than the rate of White child fatalities and 3.8 times greater than the rate of Hispanic child fatalities.

II. F. The long-term view; how the numbers add up:

Identifying children at risk and subsequently responding to their needs in a timely manner is an enormous challenge. As mentioned, 1 in 10 children in the United States are reported to the CPS every year. These referrals are mixed in quality, language (terminology[18]), and delivery method, coming from a number of sources, professional and non-professional, with varying degrees of related training. A small workforce suffering from heavy caseloads and high attrition rates is then tasked with

[17] It is currently unknown why the percentage of referrals made by law enforcement is approximately half the proportion which would be anticipated considering the percentage of victims law enforcement uncovers.

[18] Due to a lack of standardized training across states, jurisdictions, counties, and agencies, different mandatory reporters are trained to use different terminology when referring to child risk

making potentially life or death decisions about children who may or may not have had risk assessed reliably.

Looking at the lifespan of childhood, from birth to age 18, rather than the annual timeframe explored above, the odds of being referred to CPS are shockingly high. Current estimates suggest that 37% of children in the United States are investigated by CPS before their 18th birthday.[19] This increases to 53% for African American children.[20]

Over the next 18 years, it is anticipated that a further 145 million children will be referred to CPS, and more than 33,000 will die from preventable causes (most will be younger than 4-years old).[21]

Quick Facts:

- ***53% of all African American children will be referred for a welfare investigation to the CPS at some point during their childhood.***
- ***In 2022, African American child fatalities were 3.2 times higher than White child fatalities, and 3.8 times higher than Hispanic child fatalities.***
- ***It takes on average 93 hours (roughly 4 days) for CPS to respond to a referral.***
- ***It takes on average 40 days for children to receive post-response services from a CPS agency.***

Recommendations:

- ***Law enforcement should use risk assessment tools to decrease the time it takes for both law enforcement and CPS investigators to decide whether to initiate an investigation.***
- ***The time between law enforcement's initial contact with a child and the decision as to whether an investigation should occur or not should be recorded and tracked.***

[19] Font, S. A. and Maguire-Jack, K. 'It's Not "Just Poverty": Educational, Social, and Economic Functioning Among Young Adults Exposed to Childhood Neglect, Abuse, and Poverty.' (Child Abuse & Neglect 101, 2020).

[20] Kim, H., Wildeman, C., Jonson-Reid, M. et al. . 'Lifetime Prevalence of Investigating Child Maltreatment Among US Children.' (American Journal of Public Health 107(2), 2017).

[21] Glick, S., Spearman, K. J., 'Children betrayed: The unseen victims of domestic violence and how law enforcement can better protect them, Policing.' (A Journal of Policy and Practice: 18, 2024).

III. Overview of the Challenge in Georgia:

According to the 2020 Census, Georgia's population was 10,711,908. In that year, the Department of Human Services reported that 2,515,174 of Georgia's population were children. Every year, approximately 120,000 children are born in the state.

III. A. Child maltreatment fatalities, Georgia:

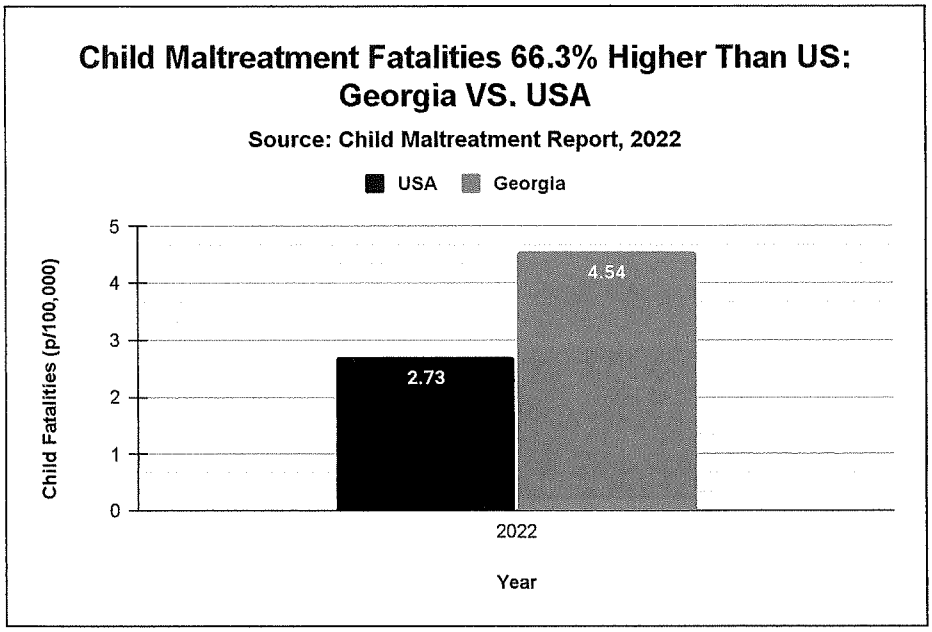
According to the *Child Maltreatment Report* (CMR), an annual report published by the Children's Bureau[22] of the U.S. Department of Health and Human Services, **Georgia experienced deaths related to child maltreatment at a rate 66.3% higher than the national average**. A nationally estimated 1,955 children died from abuse and neglect at a rate of 2.7 per 100,000 children in the population in 2022.[23] The rate per 100,000 child abuse and neglect deaths amongst Georgia's child population was 4.54 in 2022. This is a dramatic rise from 2021, when the rate per 100,000 child abuse and neglect deaths amongst Georgia's child population was 3.64; in 2021, Georgia experienced child maltreatment-related fatalities at a 48% greater rate than the rest of the United States.

As the graphs, *Child Maltreatment Fatalities, 2021; Georgia VS the United States (including Georgia)* and *Child Maltreatment Fatalities, 2022; Georgia VS the United States (including Georgia)* reflect, Georgia consistently experiences a significantly higher number of child maltreatment fatalities than the rest of the states (**see Appendix B**).

Out of 51 jurisdictions (50 states and 1 Territory) **which reported child abuse and neglect fatality figures, Georgia had the 5th highest and 9th highest death rates per 100,000 in 2022 and 2021 respectively**

[22] Also known as Administration on Children, Youth and Families, Administration for Children and Families

[23] The national estimate of child fatalities is calculated by multiplying the national fatality rate by the child population of all 52 states and dividing by 100,000. The estimate is rounded to the nearest 10. For 2021, 50 states reported fatality data.



See *'2021: Table of ten best and worst performing states, according to CMR, related to child maltreatment fatalities'* and *'2022: Table of ten best and worst performing states, according to CMR, related to child maltreatment fatalities'* in Appendix B. These two 1-year studies show that Georgia consistently performs worse than the national average in child maltreatment fatalities.

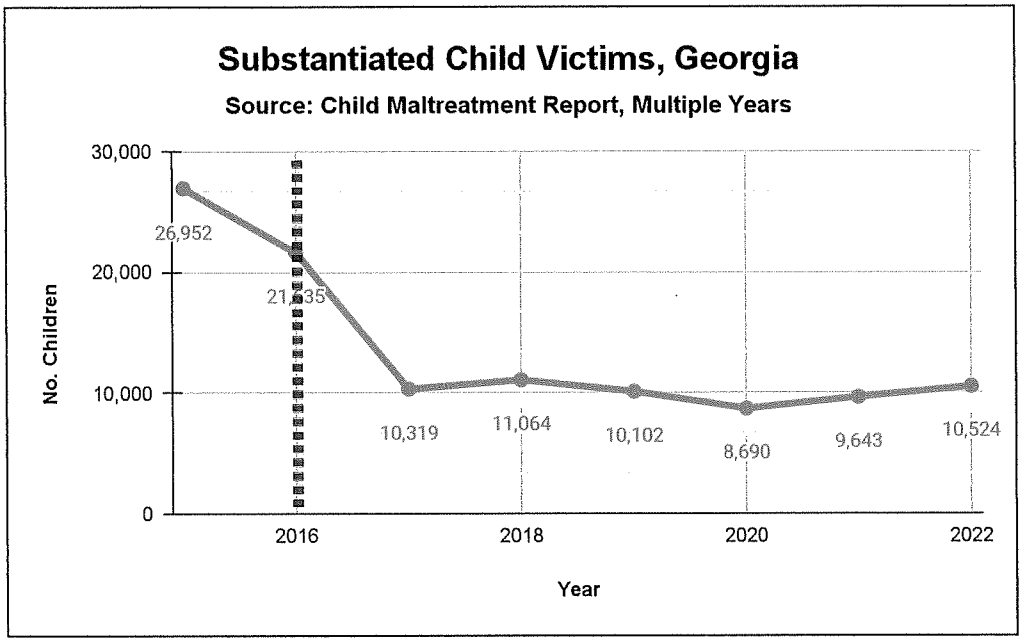
However, this number may well be significantly lower than the true population of children who died due to fatal child abuse or neglect. Indeed, CMR concedes:

> "Some child maltreatment deaths may not come to the attention of child protective services (CPS) agencies. Reasons for this include if there were no surviving siblings in the family, or if the child had not (prior to his or her death) received child welfare services."

In the State of Georgia, there are several agencies which collect data on child fatalities due to maltreatment, and often they come to different conclusions about the number of child fatalities that occur in the state each year. The actual, or 'true', number of child maltreatment fatalities is potentially far greater than the already abnormally high rate the state experiences in comparison to the rest of the United States. This is for a variety of reasons, as will be seen, such as co-sleeping or sudden unexplained infant deaths (SUID), which are often found to be non-criminal accidents.

III. B. Child victim and referral numbers, Georgia:

Although the number of child victims reported in the state has significantly decreased, the number of child fatalities related to maltreatment consistently far exceeds the national average.



(The dotted line indicates when the Initial Safety Assessment Procedure was adopted in Georgia.)

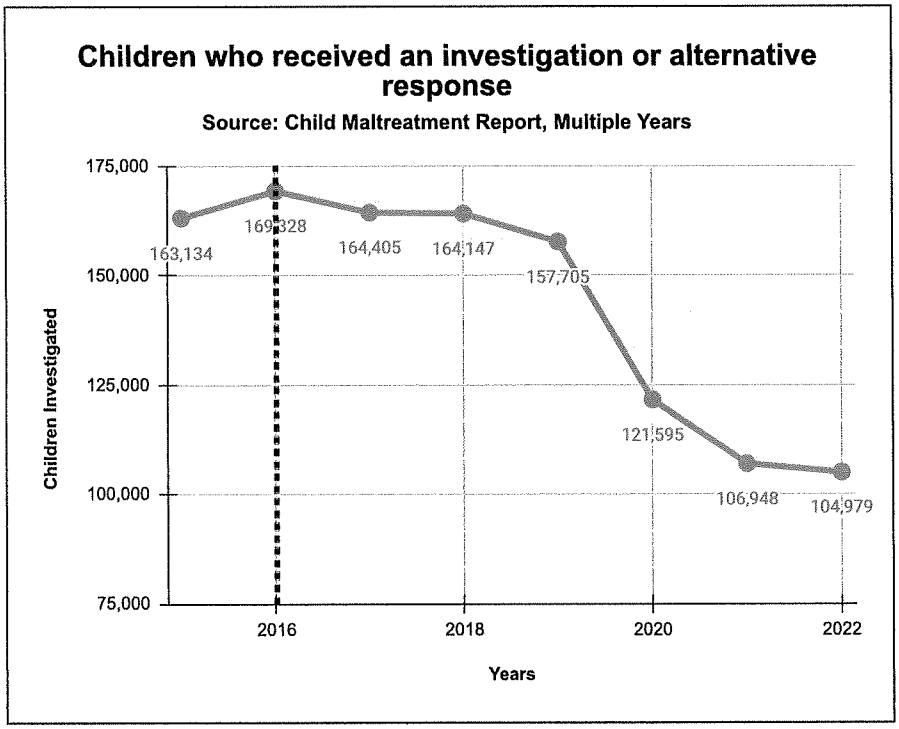
Between 2015 and 2022, the number of reported and substantiated child victims in Georgia fell by 61%. There is no existing literature explaining the causes for this significant reduction, although it appears anecdotally to be related to the introduction of a new procedure: the initial safety assessment, which was adopted by DFCS in 2016.[24] Nevertheless, the data in relation to child maltreatment fatalities over

[24] From CMR (Child Maltreatment Report), 2019: *"The [...] change in Georgia in 2016 was a new practice called the initial Safety Assessment (ISA). Prior to the ISA[sic], intake workers who received a report of child maltreatment made the decision to screen the call out, or assign it to a case worker as an investigation or alternative response (Family Support). The new policy allows the intake worker to screen-out non-qualifying calls (as before), assign a case as an investigation if it meets certain criteria (serious injury, maltreatment in care, etc.), or assign the case as an initial Safety Assessment with a priority of immediate, 24 hour, or 72 hour response times. Initial Safety Assessment workers visit the home and determine whether the investigation track or alternative response is appropriate. This change in policy has been accompanied by a large shift in the number of cases assigned as investigations and alternative response. Previously, about 60 percent of child protective services cases were investigated, and the remaining 40 percent were alternative response[sic]. Since ISA began on August 06, 2016, between 60 percent and 70 percent of cases are alternative response[sic]."*
From CMR, 2021: *"Screened-in referrals in Georgia are directed to either an investigation or alternative response. Alternative response is called Family Support. Cases with allegations that are considered dangerous (sexual abuse, physical abuse, maltreatment in care) are directed immediately to the investigation pathway. Cases with other allegations undergo an initial Safety Assessment (ISA). A case worker interviews in person the alleged*

the same period (as mentioned above) does not reflect this trend. The data for the period suggests child victim numbers are down, while child fatalities related to abuse or neglect are up. See *'Number of substantiated child victims, Georgia, 2015-2022'* in **Appendix B**.

In 2021, Georgia experienced child abuse or neglect related fatalities at a rate roughly 48% higher than the national average. Meanwhile, in the same year Georgia reported just 3.8 child victims per 1,000, which was less than half the national average of 8.2 per 1,000. A similar trend occurred in 2022; in this year Georgia reported 4.2 child victims per 1,000; the national average was 7.7 per 1,000.

Investigations and alternative responses to children who may be at risk of maltreatment have also significantly declined in this period; as *'Children who received an investigation or alternative response, 2015-2022'* (**see** **Appendix B**) shows, between 2015-2022, investigations and alternative responses provided by DFCS reduced by nearly 36%.



(The dotted line indicates when the Initial Safety Assessment Procedure was adopted in Georgia.)

victim(s) and the alleged perpetrator(s) at the home. (Note that in March 2020, the in-person requirement for ISA meetings was relaxed to include virtual/video visits.) Risk is assessed, and the case is then directed either to an investigation or, if risk appears low, to the Family Support pathway. Investigations end with a determination of either substantiated or unsubstantiated, indicating whether a preponderance of evidence supports the allegation(s) or not."

III. C. Recent media scrutiny:

There have been several child deaths in Georgia's recent history which have garnered significant national media attention. These instances have brought to light procedural shortcomings in relation to the way that mandatory reporters engage with and refer children at risk.

In late 2023, United States Senator John Ossof convened a hearing concerning abuse and neglect related child fatalities and heard testimony from Rachel Aldridge, whose 2-year old daughter, Brooklyn, had been killed in 2018 by her father's girlfriend after safety concerns had already been raised.

During the hearing, the Chairman, US Senator Ossoff, reviewed a previously undisclosed DFCS 2023 audit, which found the agency initiated timely investigations in 87% of reviewed cases, but they failed to actually assess and address the risks and safety concerns in the majority of those cases. According to this previously undisclosed 2023 DFCS audit, in 84% of reviewed cases, DFCS failed to "make concerted efforts to assess and address risk and safety concerns to the child(ren) in their own homes or in foster care."[25]

Quick Facts:

- ***In 2022, Georgia had the 5th highest per capita maltreatment homicide rate of the 51 jurisdictions which reported the data.***
- ***In 2022, Child Maltreatment Fatalities in Georgia Were 66.3% Higher than the National Average***

IV. Risk Factors for Children[26]

In Georgia, legally there is a distinction between the term 'Childhood' and 'Child'.[27] The term 'Childhood' means from birth until the age of, but not including, 18.

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[25]Source: https://www.ossoff.senate.gov/press-releases/watch-sen-ossoff-convenes-first-public-hearing-amidst-ongoing-bipartisan-probe-into-safety-of-foster-kids/

[26] This White Paper is not intended to provide a complete and authoritative guide regarding all the risk factors associated with child development. As such, only a brief overview of the issues pertaining to child development will be discussed. The most salient risk factors, relevant to both law enforcement's engagement with children and risk, and how law enforcement might be trained to identify and understand these risks, will be discussed.

[27] O.C.G.A. Section 19-7-1. Statutorily, 17 year olds are charged as adults. For some designated felons, a person aged 14 or older can be charged as adults.

Legally, this is clear. Realistically, childhood is a word which is not so black-and-white. For instance, the experiences of a 1-year old and a 17-year old are quite different; nevertheless, both are technically children. Clearly, the risks facing a 1-year old and a 17-year old are quite different, too. The causes of fatality for different age groups vary greatly. Most obviously, children who have aged out of infancy are far less likely to die from sleep-related causes; meanwhile, adolescents are far more likely to die from firearm and other assault related injuries. Therefore, the realities of these differences must be addressed in policy, training, and the use of a standardized risk assessment.

IV. A. Assessing child risk

It is recommended that any risk assessment used by law enforcement officials must be:

- Simple;
- Clear;
- Legally defensible;
- Scientifically informed; and
- Not overly arduous on either the official completing it, nor the subject who is the focus of the assessment.

Further, it is recommended that requiring officers to complete different risk assessments for different age groups might lead to undue confusion for officers conducting the assessment, and potentially require an untenable level of training. It is therefore a recommendation of this Committee that,

1. A single assessment for all age groups should be used during initial investigations.
2. If concerns are raised by this primary assessment, secondary assessments can be completed by law enforcement and its partners in order to better understand the specific risks the child(ren) are facing.

Furthermore, it is anticipated that risk assessments might be deployed after a traumatic incident, such as domestic violence, substance abuse, sexual abuse, or other incidents defined by agency policy. It is the goal of this Committee to ensure that any risk assessment which is deployed conforms with:

- A trauma-informed approach;
- Minimizing the possibility of re-traumatising victims of crime; while
- Maintaining the need for law enforcement to ask salient questions related to child maltreatment and risk.

IV. B. What is risk?

As explained in Child Abuse Prevention and Treatment Act (CAPTA), the following are certainly risk factors which should be understood and acted upon by all mandatory reporters, including law enforcement:

- Physical harm;
- Emotional harm;
- Sexual abuse;
- Exploitation; or
- Acts, or failures to act, leading to any of the above.

However, there are many more risk factors which children are exposed to, and - as will be seen later in this section - different ages are associated with different risk factors.

There is considerable literature concerning the impacts of Adverse Childhood Experiences (ACE's) on child development and life outcomes.[28] These experiences can fall short of abuse and neglect which meet a criminal threshold, nonetheless, they can be extremely deleterious to children and blight later life outcomes.

According to the Center for Disease Control and Prevention (CDC), ACE's such as violence victimization, substance misuse in the household, or witnessing intimate partner violence, have been linked to leading causes of adult morbidity and mortality.[29] Preventing ACE's and mitigating their effects is therefore crucial for the health of Georgia's citizens and its economy. **The original ACE's questionnaire can be found in Appendix C.**

Exposure to ACE's can lead to a dangerous overstimulation of stress-hormone, which causes a reaction known as toxic stress. This can have immediate and long-term negative physiologic and psychologic impacts. During development, exposure to toxic stress can derail optimal health by altering gene expression, brain connectivity and function, immune system function, and organ function.[30] Indeed, children exposed to multiple ACE's experience higher rates of diabetes, depression,

[28] The term ACE's originated from a CDC and Kaiser Permanente study published in 1998. Since publication, a huge body of literature has manifested in relation to this field. The original ACE study consisted of 10 questions; these questions retrospectively assessed social factors and experiences faced by the participants during their childhood. Findings from the study showed that the higher the ACE score (i.e. more answers out of 10 receiving a "Yes" response), the higher the likelihood of negative life outcomes and events. This is one of the cornerstones of the field the social determinants of health.

[29] Merrick MT, Ford DC, Ports KA, et al. Vital Signs: Estimated Proportion of Adult Health Problems Attributable to Adverse Childhood Experiences and Implications for Prevention — 25 States, 2015–2017. (MMWR Morb Mortal Wkly Rep 2019.) DOI: http://dx.doi.org/10.15585/mmwr.mm6844e1.

[30] Merrick et al. 2019.

obesity, cancer, asthma, kidney disease, substance use, cardiovascular disease, and poor socioeconomic outcomes. (Merrick et al., 2019).

ACE's can compromise development of healthy coping strategies, which can affect health behaviors, physical and mental health, life opportunities, and premature death. ACE's have been linked to increased risk for alcohol and substance use disorders, suicide, mental health conditions, heart disease, other chronic illnesses, and health risk behaviors throughout life. Above average ACE scores are correlated with reduced educational attainment, employment, and income, which directly and indirectly affect health and well-being. At least five of the 10 leading causes of death[31] have been associated with exposure to adverse childhood experiences, including several contributors to declines in life expectancy.[32]

In a large population study done by the CDC in 2019, using results from 25 states (including Georgia), 60% of respondents reported at least one ACE; 15.6% reported four or more ACE's. Respondents with high ACE scores were:

- 5.3 times more likely to suffer from depression;
- 1.8 times more likely to suffer coronary heart disease;
- 1.7 times more likely to be unemployed; and
- 3.1 times more likely to be a current smoker.

The study found that early childhood interventions aimed at preventing ACE's could potentially prevent 1.9 million cases of coronary heart disease, 2.5 million cases of overweight or obesity, 1.5 million incidences of high school noncompletion, and 21 million cases of depression.[33] A more detailed list of child risk factors can be found in Appendix C.

IV. B. i. Domestic violence & intimate partner violence:

In the US, an estimated 10 million adults experience Intimate Partner Violence (IPV) annually.[34] As many as 1 in 4 children experience parental/caregiver IPV before the age of 18.[35] Early childhood experiences of IPV are associated with suffering future child maltreatment.[36]

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[31] Heart disease, chronic lower respiratory diseases, diabetes, kidney disease, and suicide.
[32] Merrick et al. 2019.
[33] Ibid.
[34] Huecker MR, King KC, Jordan GA, et al. *Domestic Violence*. (StatPearls, 2023).
[35] Hamby, S., Finkelhor, D., Turner, H. et al. *Children's Exposure to Intimate Partner Violence and Other Family Violence, Juvenile Justice Bulletin*. (U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 2011).
[36] McGuigan, W. M. and Pratt, C. C. 'The Predictive Impact of Domestic Violence on three Types of Child Maltreatment.' (Child Abuse & Neglect 25(7), 2001).

IPV, child maltreatment, and other adverse childhood experiences (ACE's) frequently co-occur.[37] [38] Of children exposed to domestic violence, 95% have the co-occurrence of another ACE.[39] Additionally, children who experience IPV are more likely to have other family risk factors which trigger law enforcement and child welfare involvement, including parental substance use.[40]

There are numerous adverse health consequences for children who experience IPV and/or maltreatment. Abuse, neglect, and domestic violence are each related to toxic stress levels in children; in turn this can result in stress induced inflammation, immune dysregulation, and disrupted neurodevelopment.[41]

Domestic violence is often the initial reason why law enforcement comes into contact with children. According to Glick & Spearman's recent paper (2024) published by Oxford University Press:

> *Domestic violence-related incidents are believed to be the largest category of service calls received by police, accounting for anywhere between 15 and 50% of all calls and increased during the COVID pandemic in many jurisdictions (Babaloloa et al., 2022).[42] Moreover, domestic violence is also lethal to law enforcement responding: it's the most dangerous call for responding officers. A 5-year study[43] found that nearly one in four officers killed in the line of duty (22%) were killed responding to a domestic dispute (Bruel and Keith, 2016).*[44]

As many of these calls involve the presence of children, it should be a priority for officers to observe the child and their environment to assess their level of risk.

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[37] Renner, L. M. (2021). 'The Co-occurrence of Child Maltreatment and Intimate Partner Violence: A Commentary on the Special Issue.' Child Maltreatment 26(4): 464–469. https://doi. org/10.1177/10775595211034430.

[38] Brown, S. M., Rienks, S., McCrae, J. S. *et al.* 'The Co-occurrence of Adverse Childhood Experiences Among Children Investigated for Child Maltreatment: A Latent Class Analysis.' (Child Abuse & Neglect 87, 2019).

[39] Bethell, C., Davis, M. B., Gombojav, N. et al. 'Issue Brief: A National and Across State Profile on Adverse Childhood Experiences Among Children and Possibilities to Heal and Thrive.' (Johns Hopkins Bloomberg School of Public Health, 2017).

[40] Kohl, P. L., Edleson, J. L., English, D. J. et al. 'Domestic Violence and Pathways Into Child Welfare Services: Findings from the National Survey of Child and Adolescent Well-Being.' (Children and Youth Services Review 27(11), 2005).

[41] Shonkoff, J. P., Boyce, W. T., and McEwen, B. S. 'Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities: Building a New Framework for Health Promotion and Disease Prevention.' (Jama 301(21), 2009).

[42] Babalola, T., Couch, T., Donahoe, M. et al. 'Domestic Violence Calls for Police Service in Five US Cities During the COVID- 19 Pandemic of 2020.' (BMC Public Health (22), 2022).

[43] Bruel, N. and Keith, M. 'Deadly Calls and Fatal Encounters: Analysis of US Law Enforcement Line of Duty Deaths When Officers Responded to Dispatched Calls for Service and Conducted Enforcement (2010–2014).' (Nat'l Law Enforcement Officers Memorial Fund, 2016).

[44] Glick, S., Spearman, K. J., *Children betrayed.*

IV. C. Trauma-informed approach:

It is clear that a deeper understanding of childhood trauma and the warning signs of abuse and neglect will enable law enforcement to make timely interventions. Emphasizing and implementing a trauma-informed approach will save lives and prevent adverse negative life outcomes.

IV. D. Ages and stages of child risk & fatalities:

There are various stages of childhood development typically associated with different ages. These ages and developmental stages are typically associated with certain shared experiences. These experiences are also associated with different genders, i.e. adolescent males and females are likely to display patterns of behavior in response to exposure to certain risk factors associated with their age and gender.

In reality, there is significant variation of both experiences and reactions to experiences amongst age and gender cohorts, as well as variations between and within different racial groups. For example, the risk factors salient to adolescents are different, in at least some notable ways, to the risk factors salient to infants.[45] For example, sleep-related deaths are far more common amongst infants than adolescents, while the reverse is true in relation to firearms related deaths.

There are **four different stages of child development** that will be mentioned. One of these stages is not technically a recognized stage of childhood; this is the period between conception and birth ('pregnancy'). Pregnancy has been included, as experiences during this period are inextricably linked to life outcomes of children, as well as risk factors to the home such as domestic violence.[46] Moreover, prenatal abuse is a crime in Georgia (O.C.G.A. § 19-7-5 subsection (b)14).

The four stages of childhood that will be discussed are as follows:

1. Pregnancy;
2. Infancy and young children (<5 years);
3. Pre-adolescents (<11 years); and
4. Adolescents (<18 years)

In general, younger children - especially infants - are more likely to be found victims of child maltreatment. This is the case in Georgia; **see *'Age of abuse and neglect victimhood in Georgia, 2021 & 2022.'* in** Appendix C**.**

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[45] Steinberg L. A Social Neuroscience Perspective on Adolescent Risk-Taking. (Dev Rev: 28(1), 2008). Steinberg's seminal study examined the ways in which risk-taking increases between childhood and adolescence, but decreases between adolescence and adulthood. The study found that, "mid-adolescence [is] a time of heightened vulnerability to risky and reckless behavior."

[46] Carpenter, G. L., and Stacks, A. M. 'Developmental effects of exposure to Intimate Partner Violence in early childhood: A review of the literature.'(Children and Youth Services Review (31:8), 2009.

IV. D. i. Pregnancy:

Scarce resources, low birthweight, preeclampsia, domestic violence, poor diet and malnutrition, unmanaged levels of toxic stress, insufficient healthcare, maternal depression and other mental disorders, substance use (including tobacco, alcohol, under/overused prescriptions and illicit drugs) are amongst some of the most salient risk factors during pregnancy. Many of these risk factors occur together (comorbidity). Indeed, substance use and low birthweight are commonly associated.[47]

Risk factors during pregnancy are not confined to maternal experiences. Research suggests that paternal, as well as maternal, characteristics appear to impact the pregnancy stage. Indeed, there is significant evidence that paternal illicit drug use preceding conception affects the birthweight of offspring.[48]

Pregnancy and motherhood are also linked to female victimhood of intimate partner violence. Analysis of the Scottish longitudinal survey (2014–15) from 2022 found that "14% of mothers reported experiencing any type of domestic abuse [after] the birth of the study child (age 6)" (i.e. between the time of a child's birth and the time the study was conducted (a period of 6 years), mothers surveyed had a 14% chance of suffering Intimate Partner Violence (IPV)).[49]

IV. D. ii. Infant with prenatal substance exposure (IPSE):

A child is classified as an infant if they are between the age of birth and 12 months-old. For an infant to be reported for prenatal substance abuse (PSA)[50] to the National Child Abuse and Neglect Data System (NCANDS), which the Child Maltreatment Report (CMR) bases a significant amount of its analysis on, either of the following must occur:

- An infant is referred to CPS by a healthcare provider; or
- The infant is born with and identified as being affected by substance abuse or withdrawal symptoms.

The child must have the alcohol abuse, drug abuse, or both alcohol and drug abuse identified.

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[47] Schempf AH, Strobino DM. 'Illicit drug use and adverse birth outcomes: is it drugs or context?' (J Urban Health 85(6), 2008).

[48] Lin C.H., Lin W.S., Wang I.A., Hsu J, Wu S.I., Chen C.Y. 'Adverse effects on birth weight of parental illegal drug use during pregnancy and within two years before pregnancy.' (J Food Drug Anal 29(2), 2001).

[49] Skafida, V., Morrison, F., and Devaney, J. 'Prevalence and Social Inequality in Experiences of Domestic Abuse Among Mothers of Young Children: A Study Using National Survey Data from Scotland.' (Journal of Interpersonal Violence (37:11–12), 2022).

[50] Screened-in means that the child was subject to either an investigation or alternative response from CPS. Screened-out indicates that an investigation or alternative response from CPS did not occur.

Although Georgia had roughly 3% of the US infant population in 2021, **Georgia's infant population made up roughly 8% of the United States' infants with prenatal substance exposure** (IPSE). Indeed, Georgia had 3,942 children screened-in for PSA[51]; **3,899 (99%) of IPSE in Georgia was drug related**. A similar trend occurred in 2022, 3,636 children experienced IPSE, 99% were drug related.[52]

Of the 49 states which reported into NCANDS in 2021, Georgia ranked 9th per infant for IPSE in the country (see '***Table of ten best and worst performing states, according to CMR, related to IPSE***' in Appendix C). Of the 50 states which reported into NCANDS in 2022, Georgia ranked 8th per infant for IPSE in the country.

In Georgia, more than 34 of every 1,000 children born in 2021 experienced IPSE; which means that around **1 in every 29 children born in the state was exposed prenatally to alcohol or drug-related substances**.[53] (In 2022, this fell slightly to 29 of every 1,000 experienced IPSE, or 1 in every 34.5.)

Comparing the number of known IPSE in Georgia with the demographics of the children in the state shows how prevalent this problem is. According to *CMR,* the population of Georgia aged 12 months-old or younger (<1) in 2021 was 120,296.[54] This is how the figure, 1 in every 29 children in Georgia is affected by IPSE, was calculated.

In comparison to the rest of the country in 2021, Georgia fared extremely poorly. During the same period, just over 3.5 million children were born in the United States, and just under 50,000 were affected by IPSE. The per 1,000 rate across the states was 13.7, which means roughly 1 in every 73 children in the United States are affected by IPSE. When Georgia is excluded from the calculations for the US, the severity of the situation in Georgia becomes even more stark: roughly 1 in every 77 children in the United States are affected by IPSE. Therefore, Georgia experiences IPSE at a rate approximately 262% higher than the national average (if Georgia is treated separately from the rest of the other 48 reporting states). See '*Comparison: IPSE in Georgia VS USA, 2021*' in Appendix C.

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[51] The Committee recognizes that the term, 'prenatal substance abuse', or PSA, comes with some controversy. The Committee also recognizes that some experts working in this field would prefer the term prenatal substance use, or misuse, to be used in place of abuse. While understanding the sensitivity of this language, we have decided to use PSA hereon as it is the term used by several influential longitudinal studies which will be cited and referred to in the document. Moreover, Georgia law specifically defines substance exposure as "prenatal abuse."

[52] CMR (Child Maltreatment Report), 2021 and CMR, 2022

[53] This Committee is actively seeking information regarding the areas most badly affected by IPSE in order to tackle this issue with a multi-agency approach.

[54] According to the National Vital Statistics Reports (NVSR), in 2021, 124,073 babies were born in Georgia.

Comparison: IPSE in Georgia VS USA, 2021[55]

Georgia, IPSE exposure for <1's, 2021		USA, IPSE exposure for <1's, 2021		USA without Georgia, IPSE exposure for <1's, 2021	
Georgia:	***Number***	**USA:**	***Number***	**USA w/out GA:**	***Number***
No. Children born	120,296	No. Children born	3,582,882	No. Children born	3,462,586
Total IPSE exposed <1	4,101	Total IPSE exposed <1	49,194	Total IPSE exposed <1	45,093
IPSE related to alcohol	43	IPSE related to alcohol	229	IPSE related to alcohol	186
Screened-in IPSE related to drug abuse in some form[56]	3899	Screened-in IPSE related to drug abuse in some form	40,570	Screened-in IPSE related to drug abuse in some form	36,671
Per 1,000 IPSE <1	34.1	Per 1,000 IPSE <1	13.7	Per 1,000 IPSE <1	13.02
IPSE in Georgia is approximately 248.3% higher than the rest of the United States (if Georgia is included in the calculations for the general US rate).					
***IPSE in Georgia is approximately 261.8% higher than the rest of the United States**, if Georgia is excluded from the other 48 reporting states.*					

[55] Unpublished analysis (of GA Vital Records and CFR data) in support of: Georgia Bureau of Investigation Department of Forensic Science Medical Examiners' Office Child Fatality Review Program. Accessed: 16th July, 2024.

[56] *How was this calculated: See CRM, 2021, p.49; adding the columns 'Screened-in IPSE With Drug Abuse Child Risk Factor' & 'Screened-in IPSE With Alcohol Abuse and Drug Abuse Child Risk Factor', the category above "Screened-in IPSE related to drug abuse in some form" was made.*

IV. D. iii. Infants and young children:

This is both the most sensitive period of child development and the most dangerous period in relation to child fatalities.[57] In Georgia there are on average 175 sudden unexplained infant deaths (SUID) deaths each year, and 27 extremely violent deaths suffered by children 4 years-old or younger per year (years 2018-2022). **Almost every one of these incidents is preventable. According to the Georgia Bureau of Investigation (GBI) in 2019, 98.4% of all child homicides in the state of Georgia were preventable.[58]**

These findings are similar every year and the vast majority of these fatalities are children under the age of 5.[59] Moreover, in the same year, **GBI found that of the 152 sleep-related child deaths (only 109 were reviewed) 91% were preventable**; similarly, **93% of the child 60 suicides were preventable (53 reviewed)** - the majority of these deaths occur amongst the age group 15-17.[60]

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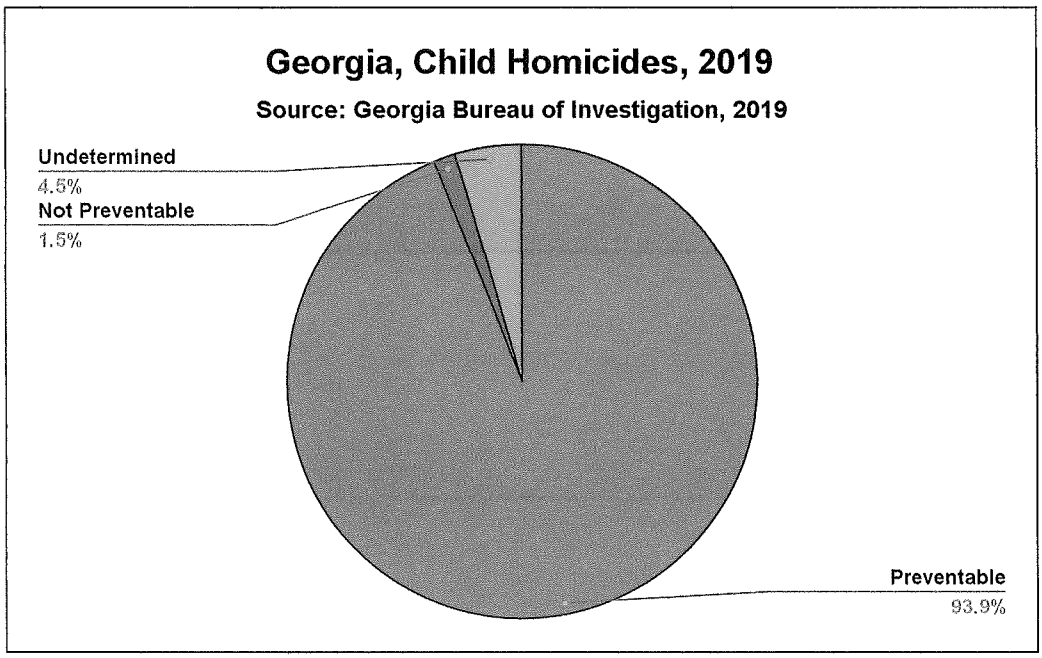
[57] In relation to brain development: *'Early in development, infants are completely reliant on input from their caregivers for help regulating arousal, neuroendocrine functioning, temperature, and other basic functions. With time and with successful experiences in co-regulation, children increasingly take over these functions themselves. Abuse and neglect represent the absence of adequate input (as in the case of neglect) or the presence of threatening input (as in the case of abuse), either of which can compromise development.'* Petersen AC, Joseph J, Feit M, editors. *New Directions in Child Abuse and Neglect Research. Committee on Child Maltreatment Research, Policy, and Practice for the Next Decade: Phase II; Board on Children, Youth, and Families.* (Washington (DC): National Academies Press (US); Committee on Law and Justice; Institute of Medicine; National Research Council; 2014).

[58] In 2019, the Georgia Bureau of Investigation (GBI) reviewed 64 homicide-related child deaths (out of a potential 68 which were deemed reviewable). It was deemed that 91% of the cases investigated were preventable, and only 1.5% were not preventable, meaning 98.4% might have been preventable. Of the 68 homicides, 31 were committed against infants or toddlers; of the remaining 37 homicides, 26 were Black or Hispanic males who died by firearms. Of the child deaths which were reviewed by GBI for the cause of death of homicide due to maltreatment in 2019, over 60% of the children had a history or reported maltreatment before the time of death.

[59] In 2019, the Georgia Bureau of Investigation (GBI) reviewed 152 sleep-related child deaths, ultimately investigating 109 of the cases. It was deemed that 91% of the cases investigated were preventable. In Georgia, Black infants are twice as likely to suffer a sudden infant death syndrome (SIDS) death compared to white infants (OASIS: SIDS deaths, 2015 – 2019). The SIDS deaths do not include the infant deaths attributed to suffocation in bed or unknown cause.

[60] According to GBI's *Child Fatality Review Panel* in 2019, the following was found regarding infant sleep-related deaths: "Sleep-related deaths are a persistent and frustrating problem. The Teams reviewed 152 sleep-related deaths in 2019 – slightly lower than the average number reviewed (156) over the preceding seven years (Table 8). The distribution of deaths by race/ethnicity and sex is consistent with the distribution over the five-year period (2015 – 2019). Black infants are twice as likely to suffer a SIDS death compared to white infants (OASIS: SIDS deaths, 2015 – 2019). The SIDS deaths do not include the infant deaths attributed to suffocation in bed or unknown cause."

In relation to suicides, GBI writes in the same publication: "The increase in teen suicide in 2015 continued in 2019 with 59 deaths – 42 were males and 39 were ages 15 through 17 (Table 7). Suicide is a rare cause of death in which the White rate is higher than the Black/African-American rate, although the risk ratio (White rate / Black rate) is decreasing. In 2019, White teens were 20% more likely to commit suicide than Black teens; prior to 2018 the White teens were almost twice as likely as Black teens to commit suicide."



According to the CDC, the infant mortality rate (IMR) for all races p/100,000 in the United States over the last five years on the basis of available data (5yr 2016-2020) is 91.7. In Georgia, the IMR for the last five years on the basis of available data (5yr 2018-2022) is 139.75. This means Georgia's IMR is 52.3% higher than the national average:

- The IMR for African Americans nationally was 191.4, while in Georgia it was 228.4, or 19% higher.
- Between 2012-2022, there were 1,800 infant sleep-related deaths in Georgia, almost all of which could have been prevented. These disproportionately occur in counties with a high proportion of African Americans.
- In relation to non-sleep-related deaths, there were 292 children 4-years or younger (<5) 2012-2022 who died due to homicides in Georgia. 64% of these children were African American; 25.6% were White; the remainder were Hispanic or 'Other'. Of the 292 homicides for <5-year age group in this period, 55.8% died as a result of blunt force trauma;
- 12.3% died via firearm; 8.2% died via poisoning; 5.8% died as a result of strangulation; the remainder died as a result of maltreatment or 'Other'.[61]

In total, over the period 2012-2022, 482 children 4-years or younger (<5) with a history of child maltreatment died. **261 were infants (<1), and 53.2% of this group had an open CPS case file at the time of their death; 221 were between one and four, 27.1% of whom had an open case file.**[62]

[61] Unpublished: Georgia Bureau of Investigation Department of Forensic Science Medical Examiners' Office Child Fatality Review Program.
[62] Ibid.

It is clear that many of these deaths - especially in relation to infants - could and should have been anticipated and prevented. Law enforcement, with its role in society and powers of intervention, has a heightened opportunity to proactively reduce these fatalities in collaboration with other mandatory reporters.

IV. D. iii. a. Co-sleeping and other factors leading to infant sleep-related deaths:

According to the Department of Public Health (DPH), each year in the United States more than 3,500 infants die suddenly and unexpectedly without a prior known illness or injury. As of 2021, Georgia averaged three infant deaths per week due to sleep-related causes.

Georgia's DPH coordinates the state's Safe Infant Sleep Program, launched in 2016. This is a statewide public health intervention intended to protect infants from Sudden Unexpected Infant Death (SUID) and other sleep-related causes of infant death.

DPH's campaign advises new parents follow the ABC's of good sleep hygiene:

- **A**lone - In their own sleep space, separate but close to you
- **B**ack - On their back, every sleep, every nap, every time
- **C**rib - In a crib or bassinet with a firm, flat surface and no extra items such as pillows, blankets or toys.

Awareness about this issue and useful resources should be incorporated in any training which law enforcement are required to complete.

IV. D. iv. Example: Dougherty County VS. Jackson County:

Between 2018-2022, 5,267 infants were born in Dougherty County; 4,314 were African American, 953 were White. During this period, 21 African American infants and 1 Hispanic infant died. This means that between 2018 and 2022, 487 of every 100,000 African American infants in Dougherty County died during their first year of life. This is nearly 530% higher than the national average for infants in the United States (91.7/100,000) over a similar period (2016-2020). From 2012-2022, 37 infants died: 35 were African American, 1 was Hispanic, and 1 was White.

While the data from Dougherty County DFCS is unavailable, in Georgia, 54% of infants aged 12-months or younger with a history of maltreatment who died had an open DFCS investigation at the time of their death (years 2018-2022).[63] We can extrapolate from existing state data that more than half of the infants who died in Dougherty County during the period were known to be at risk, and their deaths may

[63] Unpublished: Georgia Bureau of Investigation Department of Forensic Science Medical Examiners' Office Child Fatality Review Program.

have been preventable. The opportunity for trained law enforcement, with the aid of a child lethality instrument, to support social services colleagues is essential to reducing fatalities; multi-agency responses and communication must be a priority for any training this Committee recommends.

Comparing Dougherty & Jackson County, GA:[64]

Dougherty County, GA	Jackson County, GA
Population: **82,966** (2022)	Population: **83,936** (2022)
Births 2018-2022: **5,267** - 4,314 African American - 953 White	Births 2018-2022: **3804** - 316 African American - 3,488 White
Infant deaths 2018-2022: **22** - 21 African American - 1 Hispanic	Infant deaths 2018-2022: **5** - 2 African American - 3 White
Children aged between 1-5 deaths, (2012-2022): **5** - 5 African American	Children aged between 1-5 deaths, (2012-2022): **1** - 1 Hispanic
Children aged between 6-17 deaths, (2012-2022): **12** - 12 African American	Children aged between 6-17 deaths, (2012-2022): **1** - 1 White
All Child deaths 2012-2022: **54** - 52 African American - 1 White - 1 Hispanic	All Child deaths 2012-2022: **9** - 2 African American - 1 White - 6 Hispanic
5-year average infant mortality rate p/100,000: **418**	5-year average infant mortality rate p/100,000: **131**
Despite having roughly the same size populations, and being situated in the same state, approximately **6 times as many children die in Dougherty County than did in Jackson County over an 11-year time frame. Moreover, the infant mortality rate is more than 3 times greater in Dougherty than it is in Jackson over a 5-year time frame.**	

It is clear that the odds of experiencing childhood fatality are unevenly distributed in Georgia. Cultural and geographical context must be built into any training that occurs in the state in order to maximize the impact of any child fatality reduction initiative.

A map of the breakdown of sleep-related fatalities in Georgia, 2018-2022 can be seen in map, *'sleep-related child fatalities (all children); by county, GA; 2018-2022,'* **Appendix C.** A map of the breakdown of sleep-related fatalities in Georgia for African

[64] Unpublished: Georgia Bureau of Investigation Department of Forensic Science Medical Examiners' Office Child Fatality Review Program.

American infants, 2018-2022 can be seen in map, *'African American sleep-related child fatalities; by county, GA; 2018-2022,'* Appendix C.

IV. D. v. Pre-adolescence & adolescence:

In Georgia, over the 11-year period 2012-2022, 566 children aged between 5-17 were killed as a result of substantiated homicide. 75.6% (428) of these homicides were African American children, 16.1% were White children, and the remainder were Hispanic (7.4%) and 'Other'.[65] For information on the ten counties with the highest (raw) number of African American pre-adolescent & adolescent homicide numbers, as well as significant risk factors for children, see Appendix C.

Using FBI's supplementary homicide report (SHR), which is a report most law enforcement report their homicide data into annually, it is clear that many law enforcement agencies in Georgia would have a significantly reduced homicide rate if they were able to eradicate homicides of children aged thirteen and younger. Between the years 2016-2020, the following ten law enforcement agencies would experiences the following reductions to their homicide rate:[66]

2016-2020: Ten Law Enforcement Agencies Homicide Rates In GA If Homicides Of Children Aged 13 And Younger Did Not Occur:

Agency name	Number of Homicides: All ages	Number of Homicides: Children 13 and younger	% reduction of homicide rate without children 13 and younger dying
Coweta County Sheriff's Office	16	4	25.0
Hinesville PD	8	2	25.0
Hall County Sheriff's Office	20	3	15.0
Sandy Springs PD	11	1	9.1
East Point PD	46	4	8.7
Athens-Clarke County PD	14	1	7.1
Richmond County Sheriff's Office	79	4	5.1
Clayton County PD	169	7	4.1
Warner Robins Police Dept	26	1	3.8
Gwinnett County PD	94	3	3.2

[65] Unpublished: Georgia Bureau of Investigation Department of Forensic Science Medical Examiners' Office Child Fatality Review Program.

[66] Uniform Crime Reporting (UCR) Program Data: Supplementary Homicide Reports (SHR), 1976-2020. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2021-09-22. https://doi.org/10.3886/E100699V11

IV. D. v.i. Firearms:

Between 2018-2022 there were a significant number of firearms homicides. The majority of these fatal incidents were experienced by adolescents, and African American males were disproportionately represented amongst this group. This was true in Georgia and the United States more generally. This is illustrated by data available from the CDC: in Georgia, during the 5-year period 2018-2022, African American males aged 15-19 were more than 11 times more likely to be killed due to firearm homicides than White males in the same age group.[67]

African American Firearm Homicides, Georgia & USA; Years 2018-2022:[68]

Firearms homicides, Georgia. African American male & females, age group: 15-19; 2018-2022.			
Gender:	African American population:	Number of firearms homicides:	Firearm homicide rate per 100,000
Male	652,164	447	68.5
Female	651,976	52	8.0
Firearms homicides, USA. African American male & females, age group: 15-19; 2018-2022.			
Gender:	African American population:	Number of firearms homicides:	Firearm homicide rate per 100,000
Male	8,035,207	6,501	80.9
Female	7,814,960	761	9.7

[67] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html

[68] Unpublished: Georgia Bureau of Investigation Department of Forensic Science Medical Examiners' Office Child Fatality Review Program.

White Firearm Homicides, Georgia & USA; Years 2018-2022:[69]

Firearms homicides, Georgia. White male & females, age group: 15-19; 2018-2022.			
Gender:	White population:	Number of firearms homicides:	Firearm homicide rate per 100,000
Male	1,070,870	64	6.0
Female	1,010,397	17	1.7
Firearms homicides, USA. White male & females, age group: 15-19; 2018-2022.			
Gender:	White population:	Number of firearms homicides:	Firearm homicide rate per 100,000
Male	39,847,514	2,768	6.9
Female	37,881,017	505	1.3

While these are not all related to maltreatment, and the age groups 18 & 19 are not legally children, it is worth pointing out that certain risk factors are more acutely felt by different groups. Indeed, as children reach the end of the adolescent age range (roughly 14-17), regardless of race and gender, they are at higher risk of homicide due to a firearm. This is true generally amongst African American males, and this is also true in Georgia.

Late Adolescent African American Firearm Homicides, Georgia; Years 2018-2022:[70]

Firearms homicides, Georgia. Late adolescent African American males 2018-2022.			
Age:	African American population:	Number of firearms homicides:	Firearm homicide rate per 100,000
14	133,548	15	11.2
15	131,016	28	21.4
16	128,976	61	47.3
17	129,680	89	68.6

Even though these numbers are a cause for concern, and law enforcement regularly encounters challenges related to firearms, in the context of fatalities in

[69] Unpublished: Georgia Bureau of Investigation Department of Forensic Science Medical Examiners' Office Child Fatality Review Program.

[70] Unpublished: Georgia Bureau of Investigation Department of Forensic Science Medical Examiners' Office Child Fatality Review Program.

Georgia, firearm homicides cause fewer deaths than health complications related to infancy. As pointed out in the table above, African American males in Georgia aged 17 die due to homicide at a rate of 68.6 per 100,000; meanwhile, over 11 years between 2012-2022, African American infants (<1) in Georgia had an sudden unexplained infant death (SUID) rate of 228.4 per 100,000.[71]

IV. E. Low socio-economic status:

Poverty is not a crime, this is the view of this committee and the Supreme Court[72], and parents and guardians should not be penalized for their socio-economic status. Indeed, any training recommendations expressly make clear that poverty is not synonymous with neglect or abuse.[73]

Nevertheless, low income, resources, and social capital are certainly associated with challenges for households and children. The proportion of children living in poverty in Georgia has significantly declined over the past two decades. The federal definition of child poverty is a family which has children under 18 years with income less than 150% of the federal poverty threshold. Between 2009–2013, on average 32.3% (402,082) of Georgia children lived in poverty; whereas in 2018–2022, this fell to 25.5% (322,315).[74]

While this is a positive trend, many counties have not benefited from this increased wealth, and nor have their children. In eleven counties, more than 50% of

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[71] The SUID rate for African American children between 2016-2020 was 191.4. Source: National Vital Statistics System, Mortality Files. Rates calculated via CDC WONDER. Accessible via: https://www.cdc.gov/sids/data.htm

[72] Bearden v. Georgia 461 U.S. 660 (1983).

[73] Poverty is not a crime, however, it has been identified as a risk factor by the Institute of Medicine (IOM) and National Research Council's (NRC) Board on Children, Youth and Families: *Poverty, unemployment, and low socioeconomic status have been reported as risk factors for child abuse and neglect (Berger, 2004; Chaffin et al., 1996; Fryer and Miyoshi, 1996) Kotch et al., 1997; Slack et al., 2003, 2004). Among all types of abuse and neglect, neglect is most strongly associated with poverty and low socioeconomic status (Brown et al., 1998; Chaffin et al., 1996; Drake and Pandey, 1996) Jones and McCurdy, 1992; Korbin et al., 1998), although there is evidence that poverty also is associated with physical abuse (Chaffin et al., 1996) Pears and Capaldi, 2001). Poverty may reduce a parent's capacity to nurture, monitor, and provide consistent parenting by contributing to the number of stressful life events experienced, while also limiting available material and emotional resources. On the other hand, the potential role of poverty as a risk factor for neglect or abuse is complicated by the transmission of poverty, as a household characteristic, from one generation to the next (Behrman et al., 1990; Duncan et al., 1998) Mayer and Lopoo, 2001). [...] The vast majority of the literature examining the associations of neighborhood characteristics with rates and risks of child abuse and neglect has focused on national and urban samples. In contrast, Weissman and colleagues (2003, p. 1145) studied these relationships in one rural area of the United States. They analyzed "county-level data from Iowa between 1984 and 1993 for associations between county characteristics and rates of child abuse. Rates of single-parent families, divorce, and elder abuse were significantly associated with reported and substantiated child abuse,... while economic factors were not." Thus, these authors conclude that family structure is more strongly related to rates of child abuse reports and substantiation than are socioeconomic factors in this rural area.* Petersen AC, Joseph J, Feit M, editors. *New Directions in Child Abuse and Neglect Research.*

[74] This data is gathered by the U.S. Census Bureau, the United States Community Survey, which provides 5-Year estimates.

children live in poverty.[75] For a list of the ten best and worst performing counties in relation to child poverty see, *'Top 10 best and worst performing counties in relation to child poverty, 2018-2022'* in Appendix C.

IV. F. Previous CPS involvement:

In Georgia, children with a history of child protective services (CPS) involvement are at heightened risk of dying. Many of these children, especially young children, have open CPS investigations at the time of their death. This means these children's welfare was being actively investigated by the state during the time they died.

Number Of Children In Georgia Who Died And Had A History Of Maltreatment, Years 2012-2022:[76]

Fatalities of children with a history of child maltreatment, Georgia, 2012-2022						
Year	<1	1-4	5-9	10-14	15-17	Total
2012	15	9	7	10	10	51
2013	20	21	11	10	29	91
2014	23	26	14	21	22	106
2015	28	31	14	18	46	137
2016	28	26	23	22	48	147
2017	25	17	15	18	30	105
2018	32	26	14	24	31	127
2019	25	23	14	14	39	115
2020	23	18	17	31	28	117
2021	30	13	12	31	48	134
2022	12	11	12	15	44	94
Total:	261	221	153	214	375	1224

[75] Most severe first: Randolph, Atkinson, Charlton, Brooks, Quitman, Lanier, Talbot, Macon, Clay, Webster, and Hancock

[76] Unpublished: Georgia Bureau of Investigation Department of Forensic Science Medical Examiners' Office Child Fatality Review Program.

Number Of Children In Georgia Who Died And Had A History Of Maltreatment, Years 2012-2022:[77]

Fatalities of children with an open CPS case file, Georgia, 2012-2022						
Year	<1	1-4	5-9	10-14	15-17	Total
2012	9	3	-	2	2	16
2013	8	3	3	-	3	17
2014	15	7	4	5	6	37
2015	12	6	-	1	6	25
2016	11	10	2	3	7	33
2017	18	3	3	4	3	31
2018	21	9	3	3	1	37
2019	17	9	6	2	3	37
2020	9	5	4	5	1	24
2021	14	2	2	5	7	30
2022	5	3	2	5	4	19
Total	139	60	29	35	43	306
% children who died with an open CPS case file	**53.3**	**27.1**	**19**	**16.4**	**11.5**	**25**

Quick Facts:

- ***In 2021, at least 1 in 29 children born in Georgia were exposed to prenatal substance abuse. 99% were related to drugs.***
- ***In 2021, infants in Georgia were 262% more likely to experience prenatal substance exposure than infants in the rest of the United States.***
- ***95% of children exposed to domestic violence experience some other form of adverse childhood experience.***
- ***In 2021, on average 3 infants per week died due to sleep-related causes each week in Georgia.***

[77] Unpublished: Georgia Bureau of Investigation Department of Forensic Science Medical Examiners' Office Child Fatality Review Program.

- ***Between the ages of 15-19, African American males are more than 11 times more likely to die due to firearms related homicides than White males in Georgia (2018-2022)***
- ***53.3% of dead infants with a history of child maltreatment had an open CPS case file at the time of their death in Georgia (2012-2022).***

Recommendations:

- ***Law enforcement should be trained to identify the signs of Infant Prenatally Substance Exposed (IPSE) and educated on the impact it can have on development.***
- ***The child risk assessment tool should be completed by law enforcement during any domestic violence investigation, especially if physical or sexual violence is involved.***
- ***Law enforcement should join the public health initiative to reduce Sudden Unexplained Infant Death Syndrome (SUID). Brochures should be given to caregivers of children at risk of SUID by officers during interactions.***
- ***If an assessment is completed for a child under 2 years-old, caregivers should be notified by Department of Public Health (DPH) services like Women, Infants, and Children (WIC).***
- ***The likelihood of SUID according to racial group should be taught during any training given.***
- ***The child risk assessment tool used by law enforcement should be trauma-informed so as not to traumatize, or re-traumatize, subjects.***

V. Cost of Child Abuse and Neglect:

There are various methods of calculating the costs associated with social issues such as child abuse and neglect, including, but not limited to:

- Cost of Illness Approach (COI)
- Value of Statistical Life (VSL)
- Social Return on Investment (SROI)
- Quality-adjusted life year (QALY)

V. A. Cost of abuse and neglect:

Between 2012-2022, the upper-bound cost to Georgia's economy as a result of child homicides and infant sleep-related deaths was roughly $41.2 billion.

Total costs of child abuse and neglect are difficult to estimate. Nevertheless, some academics have tried to estimate the costs using various methods. Fang et al. (2012),[78] for instance, estimate that the lifetime cost of new abuse and neglect cases in the United States each year is between $100 billion and $500 billion.

Gelles and Perlman (2012)[79] estimate that cases of abuse or neglect cost society $80.3 billion each year, $33.3 billion in direct costs[80] and $46.9 billion in indirect costs[81]. In 2010, the CDC found that average lifetime cost of a case of nonfatal child abuse and neglect is $210,012 in 2010 dollars; most of this total ($144,360) is due to loss of productivity, but it also encompasses the costs of childhood and adult health care, child welfare, criminal justice, and special education. In 2018, these estimates were revised by Peterson, Florence and Klevens:

> *Updated methods increased the estimated nonfatal child maltreatment per-victim lifetime cost from $210,012 (2010 USD) to $830,928 (2015 USD) and increased the fatal per-victim cost from $1.3 to $16.6 million. The estimated US population economic burden of child maltreatment based on 2015 substantiated incident cases (482,000 nonfatal and 1670 fatal victims) was $428 billion, representing lifetime costs incurred annually.* ***Using estimated incidence of investigated annual incident cases (2,368,000 nonfatal and 1670 fatal victims), the estimated economic burden was $2 trillion.*** *Accounting for victim and community intangible costs increased the estimated cost of child maltreatment considerably compared to previous estimates. The economic burden of child maltreatment is*

[78] Fang, X., D. S. Brown, C. S. Florence, and J. A. Mercya. The economic burden of child maltreatment in the united states and implications for prevention. Child Abuse and Neglect (36), 2012).

[79] Gelles, R., and Perlmen, S. 'Estimated Annual Cost of Child Abuse and Neglect' (Chicago IL: Prevent Child Abuse America, 2012).

[80] Direct medical expenditures include inpatient and outpatient hospital care, mental health care, medical transport required in the event of an emergency, medications and medical devices, and the medical treatment of chronic conditions resulting from the abuse

[81] Indirect costs include loss of productivity, missed school days or suboptimal attainment levels in school because of the abuse, parent / guardian missing work or or suboptimal attainment levels at work because of the abuse situation or having to deal with child welfare and criminal justice services, or permanent losses in lifetime productivity potential because of premature death.

substantial and might off-set the cost of evidence-based interventions that reduce child maltreatment incidence.[82]

Peterson, Florence and Klevens chose to use value of statistical life (VSL) as the method for estimating the cost of child maltreatment-related morbidity in the United States, and so too will this Committee. Essentially, VSL estimates a person's willingness to pay for a defined change in mortality or morbidity risk.

In relation to child maltreatment, there is a specific VSL estimate based on a study originally done in Georgia by academics from the University of Georgia and the CDC.

V. A. i. What is value of statistical life (VSL):

In 2008, a random telephone survey of adult residents in Georgia was conducted. As part of this survey, respondents were asked about their willingness to pay to reduce child maltreatment mortality in their community. In particular, respondents were asked about their willingness to pay for a 50% annual reduction in the risk of a child being killed by a parent or caregiver from 2 per 100,000 to 1 per 100,000.

The study found that respondents in Georgia would be willing to pay $148 (2008 dollars) on average (mean) to reduce child maltreatment-related fatalities. The study concluded that if each person is willing to pay approximately $148 to reduce the number of deaths resulting from child maltreatment by 1 per 100,000 per year, then the value of a life saved from child maltreatment (VSL) is $14.8 million (2008 dollars) for a child in Georgia.[83]

Using this study, as well as Peterson, Florence and Klevens estimates, it is possible to calculate the VSL for children who die in Georgia due to maltreatment-related causes.

At the lower-bound, the VSL[84] for a child abuse or neglect incident is $1.3 million (2010 dollars); this is consistent with previous accepted estimates by Gelles and Perlman of $1.27 million (2012 dollars). At the upper-bound, the VSL[85] for a child abuse or neglect incident is $16.6 million (2015 dollars).

There are obvious issues with VSL estimates, most notably that it is an estimate of how much people would hypothetically pay to prevent death, while not committing

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[82] Peterson C, Florence C, Klevens J. *The economic burden of child maltreatment in the United States, 2015.* (Child Abuse Negl (86). 2018).

[83] Corso, P. S., Fang, X., & Mercy, J. A. "Benefits of preventing a death associated with child maltreatment: evidence from willingness-to-pay survey data." (American journal of public health vol. 101.3, 2011).

[84] Lower-bound VSL will be referred to as *"LBVSL"*.

[85] Upper-bound VSL will be referred to as *"UBVSL"*.

to actually paying the cost. VSL is a measure of preference (i.e. *how much would society be willing to pay to save the life of 'X'*) rather than a measure of productivity.

V. A. ii. Calculating the cost of preventable child deaths in Georgia:

In order to calculate the costs of child maltreatment-related deaths, this Committee has done the following:

1. Used accepted, albeit flawed, methods of calculating the cost of abuse, neglect, and loss of life;
2. Obtained information from the Georgia Bureau of Investigation (GBI) about the actual number of deaths from maltreatment, child homicide, and sleep-related conditions in the state of Georgia 2012-2022; and
3. Used existing Child Fatality Review (CFR)[86] estimates for the number of preventable child deaths by category in Georgia.

V. A. iii. Calculating preventable sleep-related child deaths in Georgia:

Assuming that 91% of the sleep-related infant fatalities (SF) between 2012-2022 could have been prevented (See section, "*IV. D. iii. Infants and young children*"), and the lower-bound value of statistical life (LBVSL) cost remained constant at $1.3 million over the period, Georgia's suffered a more than $2.13 billion dollar loss due to sleep-related infant mortalities over the period at the lower-bound estimate.[87] Calculations below:

- (*SF*) 2012-2022: 1,800 infant sleep-related fatalities;
- (*P*) 2019: GBI finds 91% were potentially preventable; and
- (*LBVSL*) lower-bound estimate for value of statistical life: $1.3 million (2010 dollars).

LBVSL(P x SF) $2,129,400,000[88]

In 2022, when there were 211 infant sleep-related fatalities (SF), the lower-bound cost to Georgia's economy was roughly $249.6 million.[89] The upper-bound cost to Georgia's economy was roughly $3.2 billion.[90]

At the upper-bound, Georgia's suffered more than $27.2 billion loss due to sleep-related infant mortalities over the years 2012-2022.[91] Calculations below:

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[86] This is an annual review conducted by GBI concerning child deaths in Georgia.
[87] Assuming that $1.3 million in 2010 dollars remained constant throughout the period.
[88] *P* = 0.91; *LBVSL* = $1,300,000; and *SF* = 1,800. Year 2012-2022: *LBVSL*(*P x SF*) = $2,129,400,000.
[89] *P* = 0.91; *LBVSL* = $1,300,000; and *SF* = 211. Year 2022: *LBVSL*(*P x SF*) = $249,613,000.
[90] *P* = 0.91; *UBVSL* = $16,000,000; and *SF* = 211. Year 2022: *UBVSL*(*P x SF*) = $3,187,366,000.
[91] Assuming that $16.6 million in 2015 dollars remained constant throughout the period.

- (*SF*) 2012-2022: 1,800 infant sleep-related fatalities;
- (*P*) 2019: GBI finds 91% were potentially preventable; and
- (*UBVSL*) upper-bound estimate for value of statistical life: $16.6 million (2015 dollars).

$$\underline{UBVSL(P \times SF) = \$27{,}190{,}800{,}000}^{92}$$

In 2022, when there were 211 infant sleep-related fatalities (SF), the upper-bound cost to Georgia was roughly $3.2 billion.[93]

These upper-bound calculations for the economic burden experienced by Georgia are similar to projection calculated using the federal government's estimates on the value of statistical life. According to the Department of Human Services (DHS), the current VSL is $11.6 million (2020 dollars).

Using DHS estimates, Georgia's economy lost more than $19 billion due to preventable infant sleep-related fatalities:

- (*SF*) 2012-2022: 1,800 infant sleep-related fatalities;
- (*P*) 2019: GBI finds 91% were potentially preventable; and
- (*DHSVSL*) VSL: $11.6 million (2020 dollars)

$$\underline{DHSVSL(P \times SF) = \$19{,}000{,}800{,}000}^{94}$$

In 2022, when there were 211 infant sleep-related fatalities (SF), the cost to Georgia would be closer to $2.23 billion.[95]

V. A. iv. Calculating preventable homicide-related child deaths in Georgia:

Assuming that 98.4% of the homicide-related child deaths (CH) between 2012-2022 could have been prevented (based on GBI estimates), and the lower-bound value of statistical life (LBVSL) cost remained constant at $1.3 million over the period, Georgia's economy suffered a more than $1.1 billion dollar loss due to child homicides over the years 2012-2022 at the lower-bound estimate.[96] Calculations below:

- (*CH*) 2012-2022: 858 child homicides;
- (*P*) 2019: GBI finds 98.4% were potentially preventable; and

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[92] *P* = 0.91; *UBVSL* = $16,600,000; and *SF* = 1,800. Year 2012-2022: *LBVSL*(*P x SF*) = $27,190,800,000.
[93] *P* = 0.91; *UBVSL* = $16,600,000; and *SF* = 211. Year 2022: *UBVSL*(*P x SF*) = $3,187,366,000.
[94] *P* = 0.91; *DHSVSL* = $11,600,000; and *SF* = 1800. Year 2012-2022: *VSL*(*P x SF*) = $19,000,800,000.
[95] *P* = 0.91; *DHSVSL* = $11,600,000; and *SF* = 211. Year 2022: *VSL*(*P x SF*) = $2,227,316,000.
[96] Assuming that $1.3 million in 2010 dollars remained constant throughout the period.

- (*LBVSL*) lower-bound estimate for value of statistical life: $1.3 million (2010 dollars).

$$\underline{LBVSL(P \times CH) = \$1{,}097{,}553{,}600}^{97}$$

At the upper-bound, Georgia's economy suffered a more than $27.2 billion dollar loss due to homicide-related child deaths (CH) over the years 2012-2022.[98] Calculations below:

- (*SF*) 2012-2022: 858 infant sleep-related fatalities;
- (*P*) 2019: GBI finds 98.4% were potentially preventable; and
- (*UBVSL*) upper-bound estimate for value of statistical life: $16.6 million.

$$\underline{UBVSL(P \times CH) = \$14{,}014{,}915{,}200}^{99}$$

V. A. v. Adding up the cost of these preventable child fatalities:

Over the 11-year period 2012-2022, there were 2,658 child fatalities in Georgia from either sleep-related or homicide-related deaths. Extrapolating preventability estimates from GBI's CFR in 2019 and applying them to the period, 2,482 of these deaths were preventable. At the lower-bound, this cost Georgia $3,226,953,600. At the upper-bound, this cost Georgia $41,205,715,200.

V. B. Costs of adjacent issues: domestic violence and sexual assault:

By way of comparison:

- The UK estimates DV costs £66 billion per year, which equates to 2.95% of GDP.[100]
- Australia estimates violence against women and their children costs $18.2 billion per year.[101]
- The United States estimates IPV against women costs $5.8 billion per year.[102]

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[97] *P* = 0.984; *LBVSL* = $1,300,000; and *CH* = 858. Year 2012-2022: *LBVSL*(*P x CH*) = $1,097,553,600.

[98] Assuming that $16.6 million in 2015 dollars remained constant throughout the period.

[99] *P* = 0.984; *UBVSL* = $16,600,000; and *CH* = 858. Year 2012-2022: *LBVSL*(*P x CH*) = $14,014,915,200.

[100] U.K. Home Office (Oliver, R. Alexander, B. Roe, S. Wlasny, M.). The Economic and Social Costs of Domestic Violence. (U.K. Home Office: Research Report (107), 2019).

[101] KPMG. *The Cost of Violence Against Women and Their Children in Australia—Final Report.* Australia: Department of Social Services: 2016).

[102] National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States.* (Atlanta (GA): Centers for Disease Control and Prevention, 2003).

- Sexual violence in Iowa, 2009, cost $4.7 billion for the State.[103]

Quick Facts:

- ***In 2022, Georgia's economy suffered between roughly $250 million and $3.2 billion loss due to preventable sleep-related infant mortalities.***
- ***Between 2012-2022, Georgia's economy suffered between $2.1 billion and $27.2 billion loss due to preventable sleep-related infant mortalities.***
- ***Between 2012-2022, Georgia's economy suffered between $1.1 billion and $14 billion loss due to preventable child homicides.***
- ***Between 2012-2022, there were 2,658 child fatalities in Georgia from either sleep-related or homicide-related deaths; 2,482 of these deaths were preventable. These preventable deaths cost Georgia between $3.2 billion and $41.2 billion.***

Recommendations:

- ***If 1% ($412 million) of the $41.2 billion cost to Georgia over the period 2012-2022 was invested into maltreatment-related child fatality prevention initiatives, and this investment was able to reduce fatalities by 5%, Georgia would have saved $2.06 billion[104].***

VI. Applicable Laws:

While utilizing Child Abuse Prevention and Treatment Act (CAPTA), Georgia also has specific laws related to child abuse and neglect. There are a multitude of laws contained in the Official Code of Georgia which can be found in O.C.G.A. Title 19 "Domestic Relations", while other acts that are considered crimes are contained in O.C.G.A. Title 16 "Crimes and Offenses". A list of these Code Sections is contained within Appendix E of this report.

Generally, the classification of child abuse falls into one, or more, of four broad categories:

[103] Yang, J., Miller, T. R., Zhang, N. et al. 'Incidence and Cost of Sexual Violence in Iowa.' (American Journal of Preventive Medicine (47:2), 2014).

[104] This saving of $2.06 billion does not include the $412 million investment.

- Child Neglect;
- Physical Abuse;
- Emotional Abuse; and
- Sexual Abuse.

These labels are a common approach used by law enforcement and child protection agencies to define and investigate different forms of maltreatment.

Child Neglect is defined under O.C.G.A. § 19-7-5, Subsection (b)5 ¶ B:

> *"Neglect of a child by a parent, guardian, legal custodian, or other person responsible for the care of such child"*

and is prosecuted under O.C.G.A. § 16-5-70 (a) Cruelty to Children. Cruelty to Children, in the first degree, is defined as willfully

> *"depriving a child, under the age of 18, of necessary sustenance to the extent that the child's health or well-being is jeopardized."*

Additionally, OCGA 16-5-71 Reckless Abandonment of a Child prohibits:

> *"a parent, guardian, or other person supervising the welfare of or having immediate charge or custody of a child under the age of one year commits the offense of reckless abandonment of a child when the person willfully and voluntarily physically abandons such child with the intention of severing all parental or custodial duties and responsibility to such child and leaving such child in a condition which results in the death of said child."*

Similarly, Physical Abuse is defined is defined in O.C.G.A. § 19-7-5, Subsection (b)5 ¶ A and ¶ F:

> *"Physical injury or death inflicted upon a child by a parent, guardian, legal custodian, or other person responsible for the care of such child by other than accidental means; provided, however, that physical forms of discipline may be used as long as there is no physical injury to the child"*

and,

> *"An act or failure to act that presents an immediate risk of serious harm to the child's physical, mental, or emotional health."*

Similar to child neglect, this crime is prosecuted under O.C.G.A. § 16-5-70 (b) and (c) Cruelty to Children which prohibits actions that,

> *"maliciously causes a child under the age of 18 cruel or excessive physical or mental pain",*

or in concert with O.C.G.A. § 16-5-21 Aggravated Assault, O.C.G.A. § 16-5-24 Aggravated Battery, O.C.G.A. § 16-5-20 Simple Assault or O.C.G.A. § 16-5-23 Simple Battery or Murder O.C.G.A. § 16-5-1 or an associative crime as injuries and circumstances dictate.

Emotional Abuse is defined by O.C.G.A. § 19-7-5, Article 1, Subsection (b) ¶ 8 as,

> *"acts or omissions by a parent, guardian, legal custodian, or other person responsible for the care of a child that causes mental injury to such child's intellect or psychological capacity as evidence by an observable and significant impairment in such child's ability to function within a child's normal range of performance and behavior or that creat (sic) a substantial risk of impairment."*

As with the above, Emotional Abuse would be prosecuted under O.C.G.A. § 16-5-20 Cruelty to Children as either a felony or misdemeanor depending on harm created and/or circumstances.

Finally, Sexual Abuse is defined by O.C.G.A. § 19-7-5, Subsection (b)5 ¶D simply as

> *"sexual abuse or exploitation of a child."*

More expansive and definitive explanations of sexual abuse can be found in the myriad of laws contained with the Official Code of Georgia. A few sexual abuse laws that can be applied include:

- Incest O.C.G.A. § 16-6-22;
- Cruelty to Children O.C.G.A. § 16-5-70;
- Sexual Exploitation of Children O.C.G.A. § 16-12-3;
- Sodomy; Aggravated Sodomy O.C.G.A. § 16-6-2;
- Statutory Rape O.C.G.A. § 16-6-3;
- Child Molestation O.C.G.A. § 16-6-4;
- Enticing a Child for Indecent Purposes O.C.G.A. § 16-6-5; and,
- Improper Sexual Contact by Employee, etc. O.C.G.A. § 16-6-5.1.

This list of possible sex related crimes is not complete, but a full listing which officers will be required to understand is contained within the appendix attached (**see** Appendix E).

In cases of child abuse, while law enforcement investigate and report on the elements of the crime, the decision regarding which charges are suitable ultimately lies with the prosecuting attorney. They make this determination based on the facts of the case and evidence available.

In particular, Georgia has a somewhat unusual approach to child cruelty, of which the state recognizes three degrees of severity, according to the O.C.G.A. § 16-5-70. See Appendix D for more details.

VII. Training

Given the information in the previous sections, law enforcement officers should be trained to recognize and identify the apparent signs of trauma and the risk of fatality in children, as well as to quickly and effectively relay information to relevant partner agencies regarding their interactions with the child. It must be emphasized that trauma is experienced by children both "over-the-skin and under-the-skin". Under-the-skin trauma is a notion familiar to law enforcement as awareness around issues such as post traumatic stress disorder (PTSD) has increased in recent years.

The purpose of this training is to give the student a background into the issues of child lethality in Georgia, while ensuring they have an understanding of the risk factors that contribute to lethality. Additionally, participants will be trained in the correct terminology needed to successfully complete the assessment based on Georgia law.

Continuing, the student will be given insight into biases that might impact the lack of or increased reporting of child lethality factors, which could impact the effectiveness of the assessment. Finally, students will be given resources and contact information with both governmental and non-governmental agencies that can help reduce child lethality. The proposed outline is in Appendix E.

VIII. Best Practices:

The causes for Georgia's ranking as "top 5 for child fatalities nationally" are multifaceted with social, cultural, economic, behavioral, and mental health challenges contributing to these deaths. An added, but often overlooked component

of the increase, may be how law enforcement and other agencies collaborate, recognize, interact and investigate child abuse related crimes.

Other states have taken a different path of investigations, which seems to have improved their ability to successfully intervene in child abuse (although not all improvement was for criminal justice related purposes).[105] Herbert's and Broofield's study "Better Together" published in 2017 found that multi-disciplinary teams not only addressed and improved the criminal justice needs of the investigation, and had a positive impact on the delivery of mental health services, improved child protection outcomes, better quality of process, and increased satisfaction with outcomes.[106]

Currently, the most recommended best-practice for the intervention and investigation of child abuse/lethality by the U.S. Department of Justice[107], and others,[108, 109, 110]is the use of multi-disciplinary teams (MDT) to respond to such incidents. Regardless of the naming convention for such teams, 33 states require or support some form of MDT for child abuse investigations[111]; the most developed of the MDT approaches is believed to be in Virginia. Georgia is included in this review as one of the states that has adopted some form of MDT; however, Georgia's approach is limited to developing protocols for the "coordination" of investigations between independent authorities.

The reality in Georgia is that outside the major metropolitan areas the average sized police agency is 24 officers or fewer,[112] therefore, both the police department and the community lack the financial resources, expertise, and personnel resources to adequately staff a multi-disciplinary team. Consequently, smaller law enforcement agencies may have to defer to patrol officers and/or investigators to work collaboratively with local or regional DFCS in child abuse cases, and they may lack essential training that is also regarded as "best practices."

To ensure successful investigations, law enforcement officers and investigators must have the training and skills necessary to recognize, interpret, and document

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[105] Herbert, J. Broofield, L. 'Better Together? A review of evidence for Multi-Disciplinary Teams Responding to physical and sexual child abuse.' (Office of Juvenile Justice and Delinquency Prevention, 2017.)

[106] Herbert, J. Broofield, L. 'Better Together? A review of evidence for Multi-Disciplinary Teams Responding to physical and sexual child abuse.' (Office of Juvenile Justice and Delinquency Prevention, 2017.) .

[107] Elkins, F. 'Multidisciplinary Child Protection Teams: Limiting Victim Trauma and Strengthening Prosecution Cases.' (U.S. Department of Justice (16:5), 2023).

[108] The Kentucky Multidisciplinary Commission on Child Sexual Abuse. *Guide to Kentucky's Multidisciplinary Teams on Child Sexual Abuse and the Kentucky Multidisciplinary Commission on Child Sexual Abuse.* (Kentucky Attorney General's Office, 2002.)

[109] Jones, L., Cross, T., Walsh, W., and Simone, M. 'Criminal Investigation of Child Abuse: The Research Behind "Best Practices".' (Trauma Violence & Abuse (6), 2020).

[110] Herbert., J. Broofield, L. *Better Together* (2017).

[111] Spigel, S. Letter, 'Multidisciplinary Approaches to Child Abuse Investigations.' (Connecticut General Assembly, Office of Legislative Research, 1997).

[112] Gardner, A. and Scott, K. 'Census of State and Local Law Enforcement Agencies, 2018 – Statistical Tables.' Bureau of Justice Statistics, Office of Justice Program, 2022).

incidents and warning signs involving children who experience threats and challenges in their environment. In the absence of MDTs, it is essential that officers responding to and investigating child abuse/lethality cases receive additional training in the following areas:

- Adoption and implementation of a field assessment instrument which provides a data driven result or recommendation to law enforcement and service providers;
- Risk factors affecting child safety;
- Objective documentation;
- Recognition and documentation of injuries, maltreatment, sexual abuse, and/or emotional abuse;
- Mandatory certification for child abuse investigators on interview skills development focused on trauma-informed interview techniques (see Appendix F for a more complete understanding of trauma-informed interviews);
- Policy on use of Child at Risk Evaluation and other recommendations above being included in requirements for State Certification (with adequate time frames for departments to achieve training goals and standards); and,
- Required collaboration between law enforcement and CPS or other child safety programs.

Although not a replacement for a functional multi-disciplinary team, the adoption and institutionalization of these best practices will increase the efficiency and effectiveness of the state's child abuse intervention and investigation efforts.

The facts presented so far, especially in section III, '*Overview of the Challenge, Georgia*', underscore the need for targeted interventions aimed at identifying and then preventing child fatalities, enhancing child protection intervention and improving investigative capability, promoting collaborations, increasing protection measures, and strengthening support systems for vulnerable families. Addressing the crisis of child fatalities requires a multifaceted approach encompassing legislative reforms, investment in social services and healthcare infrastructure, community-based initiatives, and public awareness campaigns.

Policymakers should prioritize funding for early intervention programs, mental health services, and parental support initiatives to mitigate risk factors associated with child maltreatment and neglect. Collaboration between government agencies, healthcare providers, advocacy groups, and community stakeholders is essential to effecting meaningful change and safeguarding the well-being of children.

IX. Risk Assessment Tool

There are currently no known risk assessment tools used by law enforcement in order to assess trauma, maltreatment, or lethality experienced by children which are widely used across large populations.[113] Accordingly, the use of a novel assessment, named CARE, designed by Saul Glick, former London Metropolitan Police Officer and Senior International fellow of Law, Policy and Neuroscience at Harvard Law School's The Petrie Flom Center and program director at Massachusetts General Hospital & Harvard Medical School's Center for Law Brain and Behavior, is recommended. This tool will be piloted by several law enforcement agencies in Georgia and used by law enforcement professionals with the aim of reducing the aforementioned challenges related to child abuse and neglect.

IX. A. Pilot sites:

Law enforcement officers in selected pilot sites will be using an evidence informed risk assessment tool: CARE (child at risk evaluation). There are two (2) different styles of CARE assessment, these are:

1. CARE (also known as CARE1); and
2. CARE2.

The latter assessment should be triggered if the primary assessment indicates perceived heightened or perceived high risk of maltreatment or trauma exposure experienced by a child. For a more detailed breakdown of how these tools work, see **Appendix G**.

IX. B. Training:

Over the 7-month period it took to create this White Paper, members of this Committee designed and created two new educational courses which can be completed by anyone in the United States.

The first course is 6-hours long and it is designed for instructors; the second is 3-hours long and it is designed for patrol officers; both courses are POST approved, which means any peace officer in the United States can be trained in them and have the training contribute toward continuous learning requirements.

Both of these courses teach peace officers to spot the signs of obvious and non-obvious signs of risk for children. In addition, these courses train the use of CARE.

[113] In 2017, the Yale Medicine Child Study Center in partnership with IACP and Office of Juvenile Justice and Delinquency Prevention (OJJDP) published, 'Enhancing Police Responses to Children Exposed to Violence.' This publication provides useful advice to police on how to structure interactions with children exposed to violence, as well as law enforcement executives on how to ensure quality responses from officers. Nevertheless, this publication does not provide any actual assessments that can be used to evaluate a child's risk.

Chief Michael Turner (Committee member) and Saul Glick (Committee member) designed this POST approved course and piloted it on approximately sixty volunteers. Amongst those who took part in the initial training were: law enforcement executives, investigators, patrol officers, local DFCS case managers, teachers and other school personnel, and non-profit employees.

IX. C. Force Policy:

In order to replicate the training and deploy the CARE risk assessment protocol designed by Saul Glick, law enforcement agencies might require a force policy. A model force policy is available in **Appendix H**.

IX. D. Albany, Georgia:

Since June 11th, 2024, Albany, GA, has been trialing the CARE1 assessment. Early results suggest that this pilot has been successful. Anecdotal accounts from local law enforcement, DFCS, non-profits, and school, are overwhelmingly positive. More than thirty children have been risk assessed using this technique and information has - for the first time that this Committee is aware of - flowed seamlessly between these agencies via software in Georgia. The platform Albany has been using during the pilot phase is called "vimes.io".

Fifty-four individuals, representing four agencies, received the POST approved training in Albany between the 11-19th June. By the end of the first day of training, June 11th, the initiative showed signs of efficacy. Moreover, early results show that individuals who were not trained in the POST approved course are also using the CARE risk assessment available on "vimes.io"; interviews with these untrained users indicate that patrol officers that did receive the POST approved training have been teaching patrol officers that did not receive the training on how to utilize the new risk assessment protocol. Untrained users of the tool have cited their experience that the tool is straightforward and self-explanatory during interviews.

Example: "*Kelsey's Case*"

On the evening of June 11th, 2024, Kelsey was found by her mother conscious but unresponsive. Kelsey had turned two earlier that week, and she was behaving in a way that gave her mother reason for concern.

Kelsey's mother took her to the pediatrician who immediately recognized that this was a medical emergency and called an ambulance for her two-year-old.

In the ER, Kelsey received a blood-test and was found to have significant levels of cannabinoids in her blood-stream. The nurse manager followed the hospital and mandatory reporter protocol they had been trained to use: the nurse called the state hotline, 1-855-GA-CHILD, and informed them about Kelsey's situation.

Unfortunately, after completing this process, Kelsey's Information was sent to the wrong county. Kelsey's case was also "screened-out" (see, "*II. C. Screened-in VS. screened-out:*" for more information on what this means). Neither the incorrect location, nor the decision to screen-out Kelsey was relayed to the nurse manager.

Kelsey "fell through the cracks."

Fortunately, the nurse manager also called Albany PD for support. A corporal who had just been trained in the new CARE protocol decided to risk assess Kelsey. Kelsey was deemed RED, or "perceived high-risk", and her information was sent automatically via the "vimes.io" platform to local DFCS, the non-profit Lily Pad, and members of Albany PD's Family Protection Unit.

Within one day, an ad hoc multidisciplinary meeting occurred regarding Kelsey. Albany PD did a deep background check on the household, liaising with the drug enforcement unit and investigators from CID. Local DFCS requested for the case to be transferred to their department; they then reversed the screen-out decision leading to Kelsey's case being screened-in.

It was found that Kelsey's grandmother, who had been looking after Kelsey before she was found unresponsive by her mother, had been investigated for committing child maltreatment on a number of occasions. An investigation into members of Kelsey's adult household members, as well as Kelsey's grandmother, commenced.

Mandatory reporters shared information quickly to put Kelsey at the center of the investigation. Kelsey's family was offered services by local DFCS as well as the non-profit Lily Pad as the case proceeds. A record of this incident now exists which can guide relevant agencies in the future.

Some events and all names were altered in order to protect the identities of individuals in this ongoing case.

For an example of how these CARE cases can be used by law enforcement and other local agencies concerned with child protection, to make data-informed decisions, see the "Albany's CARE Cases" below:

Albany's CARE Cases

Child Name (Changed)	Age in years	Risk Level	Child School	Officer Name	Creation Date	# Police Responses	Child <2 In Household	Child Witnessed DV	Named Suspect	Arrest Made?	Household History Of Violence	Drug/Alcoho l Abuse	Case Number
Kelsey Mason	2	Red	N/A	Cpl. Alex Morgan	Jun 11, 8:09 AM	0	yes	no	no	no	no	yes	24_____
Logan Turner	13	Green	Middle School A	Cpl. Andrew Richards	Jun 19, 7:54 AM	0	yes	no	no	no	no	no	24_____
Brandon Sullivan	8	Red	Elementary A	Cpl. Alex Morgan	Jun 19, 8:00 AM	0	UNKNOWN	yes	no	no	no	no	24_____
Aiden Price	2	Green	N/A	Ptl. Travis Cole	Jun 22, 2:55 AM	1	UNKNOWN	UNKNOWN	no	no	UNKNOWN	UNKNOWN	24_____
Ethan Brooks	<1	Red	N/A	Ptl. Sarah Mitchell	Jun 22, 11:54 AM	0	yes	no	no	no	no	no	24_____
Isaac Murphy	7	Green	Elementary B	Cpl. John Miller	Jun 27, 5:54 PM	1	yes	no	no	no	no	no	24_____
Nathan Collins	6	Yellow	Elementary B	Cpl. Kevin Barnes	Jun 27, 6:01 PM	1	yes	no	no	no	no	no	24_____
Madison White	5	Green	Elementary B	Cpl. Robert Clark	Jun 27, 6:06 PM	1	yes	no	no	no	no	no	24_____
Landon Kelly	<1	Red	N/A	Cpl. James Turner	Jun 29, 2:51 AM	0	yes	yes	yes	yes	no	no	24_____
Gavin Rogers	1	Red	N/A	Ptl. Emily Parker	Jun 30, 5:17 PM	2	yes	yes	yes	yes	no	no	24_____
Brianna Mitchell	9	Green	Elementary C	Cpl. Jordan White	Jul 7, 2:28 AM	0	yes	no	no	no	no	no	24_____
Hunter Thompson	<1	Green	N/A	Ptl. Anthony Walker	Jul 7, 2:40 AM	0	yes	no	no	no	no	no	24_____
Sophia Edwards	2	Green	N/A	Ptl. Matthew Scott	Jul 7, 2:43 AM	0	yes	no	no	no	no	no	24_____
Amelia Martinez	UNKNOWN	Yellow	Elementary D	Ptl. Ryan Taylor	Jul 7, 4:10 AM	2	yes	no	no	no	yes	no	24_____
Lillian Martinez	8	Yellow	Elementary D	Ptl. Ryan Taylor	Jul 7, 4:17 AM	2	yes	no	no	no	yes	no	24_____
Lucas Parker	N/A	Red	N/A	Cpl. Alex Morgan	Jul 10, 9:35 AM	2	yes	yes	yes	yes	no	no	24_____
Liam Anderson	11	Red	Other	Cpl. David Wilson	Jul 14, 11:53 PM	0	no	yes	no	no	no	no	24_____
Noah Stewart	5	Red	UNKNOWN	Ptl. Chris Reed	Jul 14, 11:56 PM	0	no	yes	no	no	no	no	24_____
Elijah Peterson	15	Red	High School A	Ptl. Joshua Hall	Jul 15, 12:04 AM	6	no	yes	yes	no	no	no	24_____
Avery Gray	7	Red	UNKNOWN	Ptl. Mark Davis	Jul 20, 3:49 AM	2	no	yes	yes	no	yes	no	24_____
Benjamin Watson	9	Red	Elementary A	Ptl. Eric Brown	Jul 21, 11:17 AM	3	no	yes	yes	yes	no	no	24_____
Christian Morris	<1	Red	N/A	Cpl. Stephen Lewis	Jul 22, 10:43 PM	2	yes	no	yes	yes	no	yes	24_____
Olivia Carter	<1	Green	N/A	Ptl. Paul Carter	Jul 26, 4:05 AM	0	no	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN	24_____
Amelia Martinez	UNKNOWN	Red	Elementary D	Ptl. Brian Evans	Jul 31, 4:17 AM	6	yes	no	no	no	yes	no	24_____
Lillian Martinez	8	Red	Elementary D	Ptl. Brian Evans	Jul 31, 4:36 AM	6	no	no	no	no	yes	no	24_____

As you can see, Amelia and Lilian Martinez (names changed) were both risk assessed on two separate occasions during the pilot in Albany. The first time they were risk assessed, they were deemed YELLOW, or "perceived heightened risk". The second time they were risk assessed they were deemed RED, or "perceived high risk". This information can be used by local decision makers to spot patterns, such as escalating risk, and take action using objective and unbiased data. In Albany, GA, this information is being shared with other mandatory reporters.

X. HIPAA:

CARE will be treated as a supplemental report to the original child abuse report for the purposes of Georgia's open records act. CARE, completed by the officer, will be considered a supplemental report of an investigation under *Georgia's Open Records Act, O.C.G.A § 50-18-70*. Therefore, this Assessment is not subject to release until the following conditions are met in accordance with Title 50 State Government, Chapter 18 State Printing and Documents, Article 4 Inspection of Public Records, § 50-18-72 When Public Disclosure Not Required, § a Public disclosure shall not be required for records that are:

> *¶ 4: Records of law enforcement, prosecution, or regulatory agencies in any pending investigation or prosecution of criminal or unlawful activity, other than initial police arrest reports and initial incident reports; provided, however, that an investigation or prosecution shall no longer be deemed to be pending when all direct litigation involving such investigation and prosecution has become final or otherwise terminated; and provided, further, that this paragraph shall not apply to records in the possession of an agency that is the subject of the pending investigation or prosecution.*

While HIPAA does authorize the release, without consent, of medical information regarding individuals who are victims of a crime to law enforcement. Specifically, federal law provides:

> 45 C.F.R. § 164.512 (f) HIPAA Exception for Law Enforcement
>
> *(f) Standard: Disclosures for law enforcement purposes.*
>
> *(3) A covered entity may disclose protected health information in response to a law enforcement official's request for such*

information about an individual who is or is suspected to be a victim of a crime.

XI. Existing Methods For Reporting Child Abuse & Neglect:

If a mandated reporter suspects or comes to find that a child is being abused or neglected, they are legally required to make a report to the Division of Family and Children Services (DFCS). In order to make a report to DFCS, mandated reporters can:

- Report by phone: call centralized intake at 1-855-422-4453 (1-855-GA-CHILD). A report can be made 24 hours a day and 7 days a week.
- Report by email: E-mail the completed Mandated Report attached to CPSIntake@DHS.GA.GOV.
- Report by fax: fax the completed Mandated Report to 229-317-9663. Faxed reports convert to a PDF (Adobe) format and are automatically forwarded to the CPSIntake@DHS.GA.GOV e-mail box.
- Report Online: If you are a mandated reporter, you may also submit a child abuse referral online by visiting https://cps.dhs.ga.gov/Main/Default.aspx.

For more information, visit:

- https://oca.georgia.gov/child-abuse-and-neglect-reporting

XII. Conclusions & Recommendations:

Over a 7-month period, members of this Committee and generous volunteers met regularly to create a coherent strategy which could be implemented in order to reduce preventable maltreatment-related child fatalities.

The pilot stage of this initiative has not concluded, and it is expected at the time of completion the data and experiences acquired will lead to specific recommendations being added to this document or one similar to it. Clear legislation and exact recommendations will be attached in an Appendix as time permits.

Nevertheless, it is clear that child fatalities are in a state of crisis in Georgia and action must be taken by law enforcement to reduce the harm currently occurring. The immediate recommendations which the Committee believes should be implemented amongst all law enforcement departments in the state can be found on page 9. In summary, this Committee recommends that:

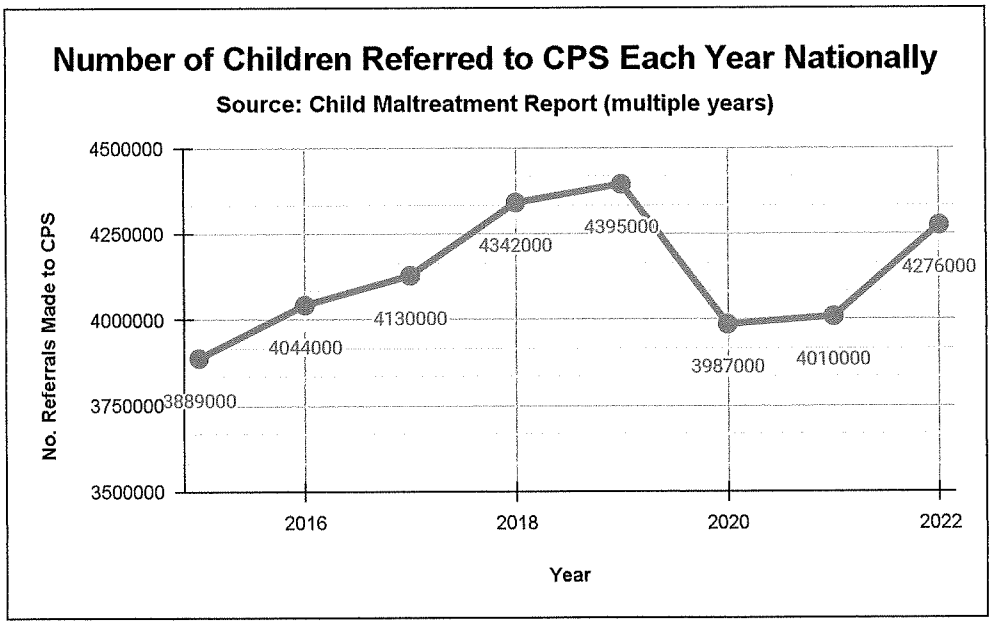
- The POST approved training designed by members of this Committee in relation to child fatality prevention should be made available to all police officers in Georgia. Police executives who want their officers to be trained in these courses should be financially supported in this endeavor.
- The use of the CARE protocol invented by Saul Glick should be used whenever an officer encounters a child who may be at-risk.
- A range of mandatory reporters should adopt these trainings and protocols to encourage multi-agency collaboration
- Software should be made available to all police officers in Georgia to enable the rapid dissemination of information about at-risk children to relevant local stakeholders. Police executives who want their officers to utilize relevant technology should be financially supported in this endeavor.

APPENDIX A: Scope of the Challenge, the United States

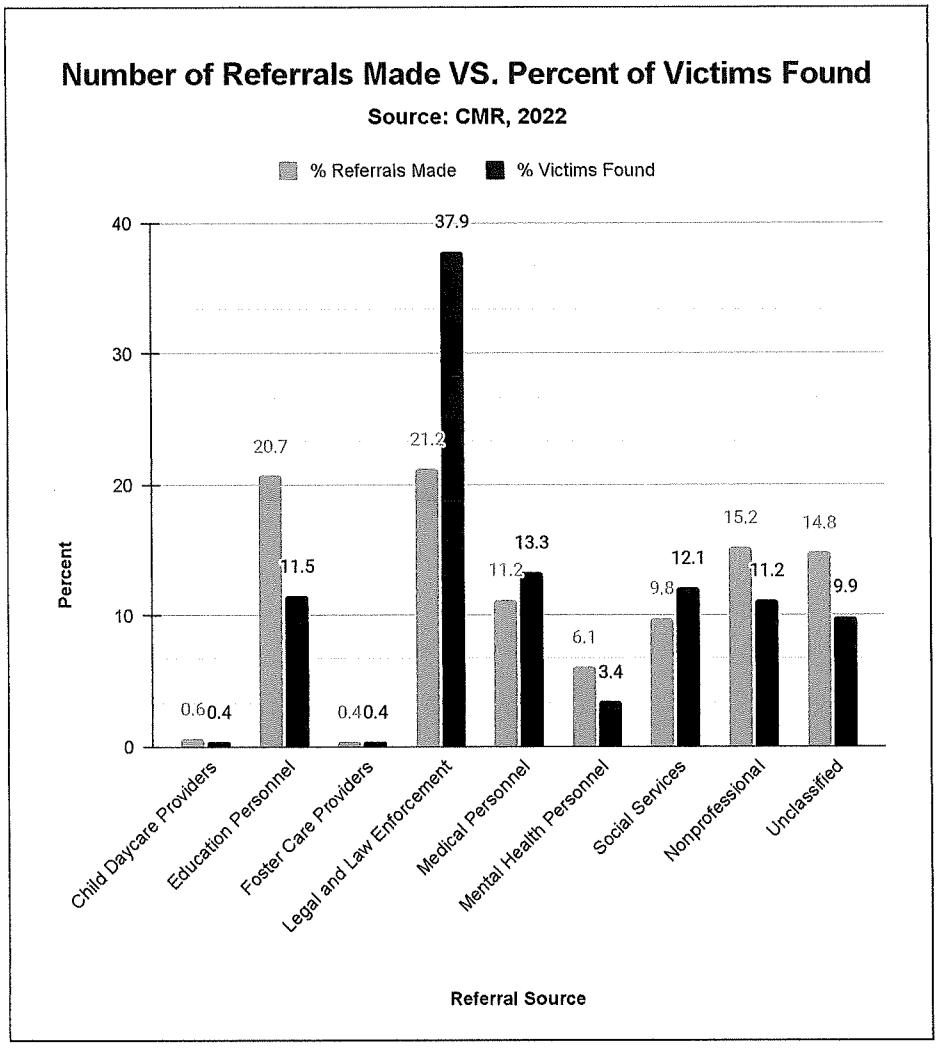
List of mandatory reporters: The following persons are required to report possible child maltreatment:

- Physicians, physician assistants, residents, interns, hospital and medical personnel, podiatrists, dentists, nurses, or nurse's aides.
- Teachers, school administrators, school counselors, visiting teachers, school social workers, or school psychologists.
- Psychologists, counselors, social workers, or marriage and family therapists.
- Child welfare agency personnel (as that agency is defined by § 49-5-12) or child-counseling personnel.
- Child service organization personnel (includes any organization—whether public, private, for-profit, not-for-profit, or voluntary—that provides care, treatment, education, training, supervision, coaching, counseling, recreational programs, or shelter to children).
- Law enforcement personnel.
- Reproductive health-care facility or pregnancy resource center personnel and volunteers.
- Persons who process or produce visual or printed matter.

National estimates for the number of referrals annually made to CPS

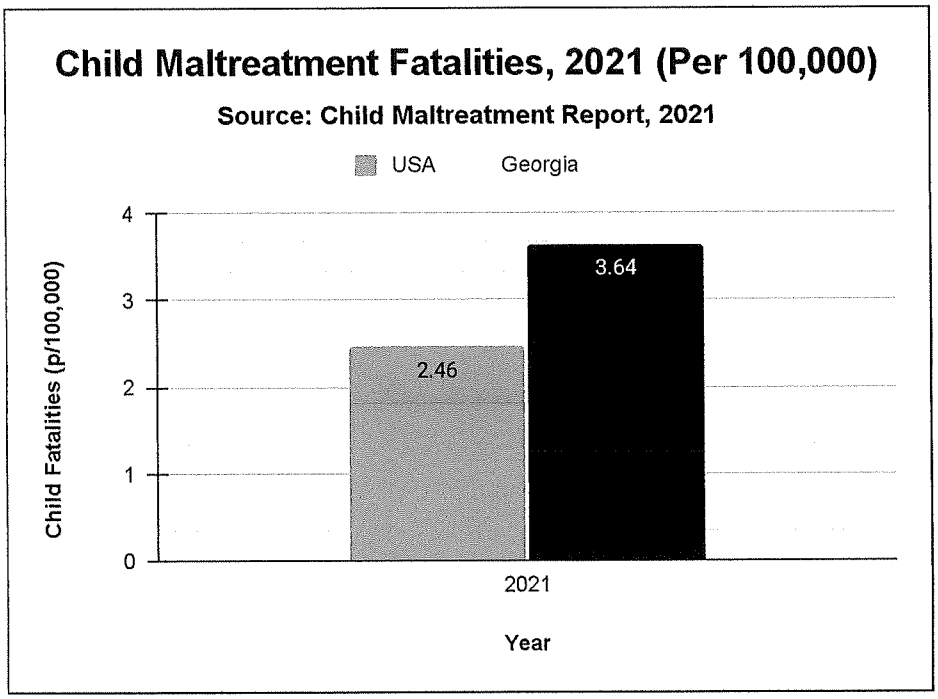


National estimates for the referral sources made to CPS and the percentage of victims uncovered

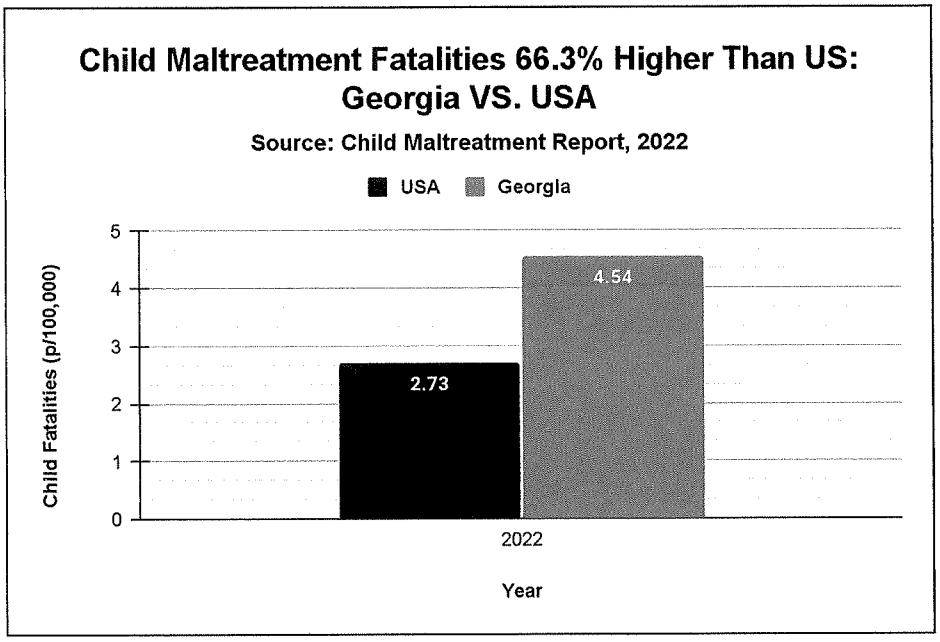


APPENDIX B: Scope of the Challenge, Georgia

Child Maltreatment Fatalities, 2021; Georgia VS the United States (including Georgia)



Child Maltreatment Fatalities, 2022; Georgia VS the United States (including Georgia)



2021: Table of ten best and worst performing states, according to CMR, related to child maltreatment fatalities.

Top 10 states per 100,000 child fatality rates, 2021		Bottom 10 states per 100,000 child fatality rates, 2021	
State:	**Per 100,000 fatalities**	**State:**	**Per 100,000 fatalities**
Mississippi	7.07	Nebraska	0.21
Maryland	6.16	Utah	0.42
Missouri	5.42	New Jersey	0.49
Arkansas	5.12	Idaho	0.64
South Dakota	4.08	Hawaii	0.66
Nevada	4.01	Montana	0.85
Ohio	3.76	Vermont	0.85
South Carolina	3.67	Rhode Island	0.96
Georgia	**3.64**	Kentucky	1.08
Indiana	3.59	Washington	1.13

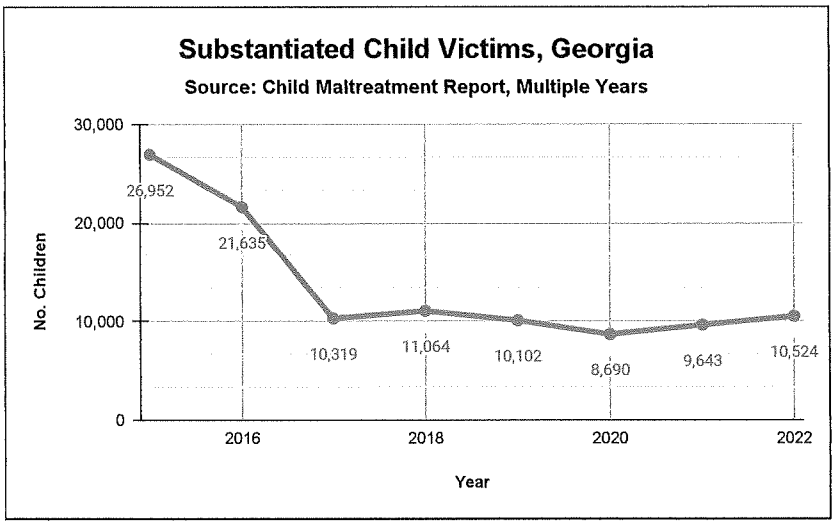
2022: Table of ten best and worst performing states, according to CMR, related to child maltreatment fatalities.

Top 10 states per 100,000 child fatality rates, 2022		Bottom 10 states per 100,000 child fatality rates, 2022[114]	
State:	**Per 100,000 fatalities**	**State:**	**Per 100,000 fatalities**
Mississippi	10.62	Montana	0.43
South Dakota	5.93	Nebraska	0.63
Arkansas	5.59	Puerto Rico	0.77
Maryland	5.05	New Hampshire	0.79
Georgia	**4.54**	Arizona	0.88
Alaska	4.53	New Jersey	0.95
Ohio	4.49	Rhode Island	0.98
Missouri	4.18	Kansas	1.16

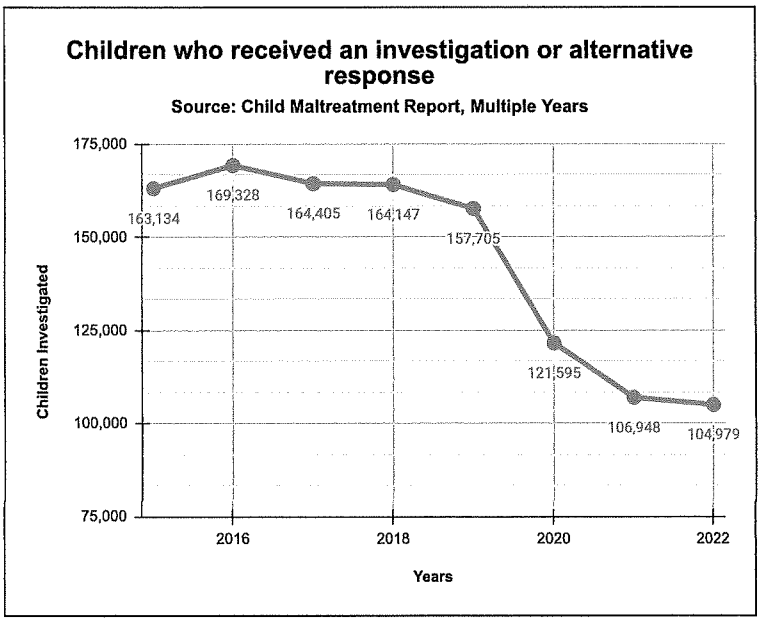
[114] This figure only includes states which reported child fatalities; Vermont, having reported no child maltreatment fatalities, has been excluded.

Top 10 states per 100,000 child fatality rates, 2022		Bottom 10 states per 100,000 child fatality rates, 2022[114]	
State:	**Per 100,000 fatalities**	**State:**	**Per 100,000 fatalities**
Mississippi	10.62	Montana	0.43
New Mexico	4.13	Kentucky	1.19
North Carolina	4.05	Maine	1.21

Number of substantiated child victims, Georgia, 2015-2022.



Children who received an investigation or alternative response, 2015-2022



APPENDIX C: Risk Factors for Children

Original adverse childhood experience questionnaire:[115]

While you were growing up, during your first 18 years of life:
1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? Yes / No If yes enter 1 _____
2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured? Yes / No If yes enter 1 _____
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you? Yes / No If yes enter 1 _____
4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other? Yes / No If yes enter 1 _____
5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Yes / No If yes enter 1 _____
6. Were your parents ever separated or divorced? Yes / No If yes enter 1 _____
7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife? Yes / No If yes enter 1 _____
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? Yes

[115] Source: https://www.ncjfcj.org/wp-content/uploads/2006/10/Finding-Your-Ace-Score.pdf

No If yes enter 1 _____
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? Yes / No If yes enter 1 _____
10. Did a household member go to prison? Yes / No If yes enter 1 _____
Now add up your "Yes" answers: _____ This is your ACE Score.

Risk factors associated with children:

List of risk factors - warning signs for law enforcement.	
Risk Factors	Add description
Parental warning signs	
Parents / guardians were/are in foster care.	
Parents / guardians were/are in prison.	
Parents / guardians have obvious mental disorder(s); this might include: - Antisocial personality disorder - Anxiety - Bipolar - Depression - Psychosis - Schizophrenia	
Parents / guardians are teenagers.	
Parents / guardians were abused and neglected when they were children.	
Parents / guardians are substance abusers.	
Parents / guardians involved in a criminal lifestyle.	
Parents / guardians own firearms. (If this is the case, how are they stored?)	
Non-biological parent in the home.	
Parents / guardians have a history of violence.	

Parents / guardians have a history of sexual crimes / abuse.	
Parents / guardians commit domestic violence / intimate partner violence. Enhanced risk factors might include: - Strangulation - Stalking - Economic control - Coercive behavior - Military history - Police history - Pregnancy - Job loss - Substance abuse - Firearm ownership - Threats to kill	
Parents / guardians do not engage with their young children; this might include: - Not providing stimulation in the form of play or reading - Ignoring their child(ren) - Preventing their child(ren) from doing age appropriate activity - Enabling truancy - Social isolation - General parental deficiencies	
Infant warning signs	
Infant exposed to prenatal substance abuse.	
Low birthweight.	
Inappropriate sleeping conditions.	
Signs of physical abuse.	
Signs of sexual abuse or trafficking.	
Signs of psychological abuse.	
Signs of neglect; this might include: - Unwashed appearance - Malnourished appearance - Unsanitary to the point of dangerous living conditions	
Inappropriate behavior for age group.	
Pre-adolescent warning signs	

Lives/lived in foster care.	
Previously investigated for abuse / neglect	
Child presents with an unmanaged mental disorder.	
Inappropriate living conditions.	
Signs of physical abuse.	
Signs of sexual abuse or trafficking.	
Signs of psychological abuse.	
Signs of neglect; this might include: - Unwashed appearance - Malnourished appearance - Unsanitary to the point of dangerous living conditions - Truancy	
Inappropriate behavior for age group. This might include: - Self-harm - Sexual behavior - Impaired executive function	
Adolescent warning signs	
Lives/lived in foster care.	
Previously investigated for abuse / neglect.	
Child presents with an unmanaged mental disorder.	
Inappropriate sleeping conditions; this might include: - Homelessness	
Signs of physical abuse.	
Signs of sexual abuse or trafficking.	
Signs of psychological abuse.	
Signs of neglect; this might include: - Unwashed appearance - Malnourished appearance - Unsanitary to the point of dangerous living conditions - Truancy	

Inappropriate behavior for age group. This might include: - Self-harm - Sexual behavior - Impaired executive function	

Age of abuse and neglect victimhood in Georgia, 2021 & 2022:

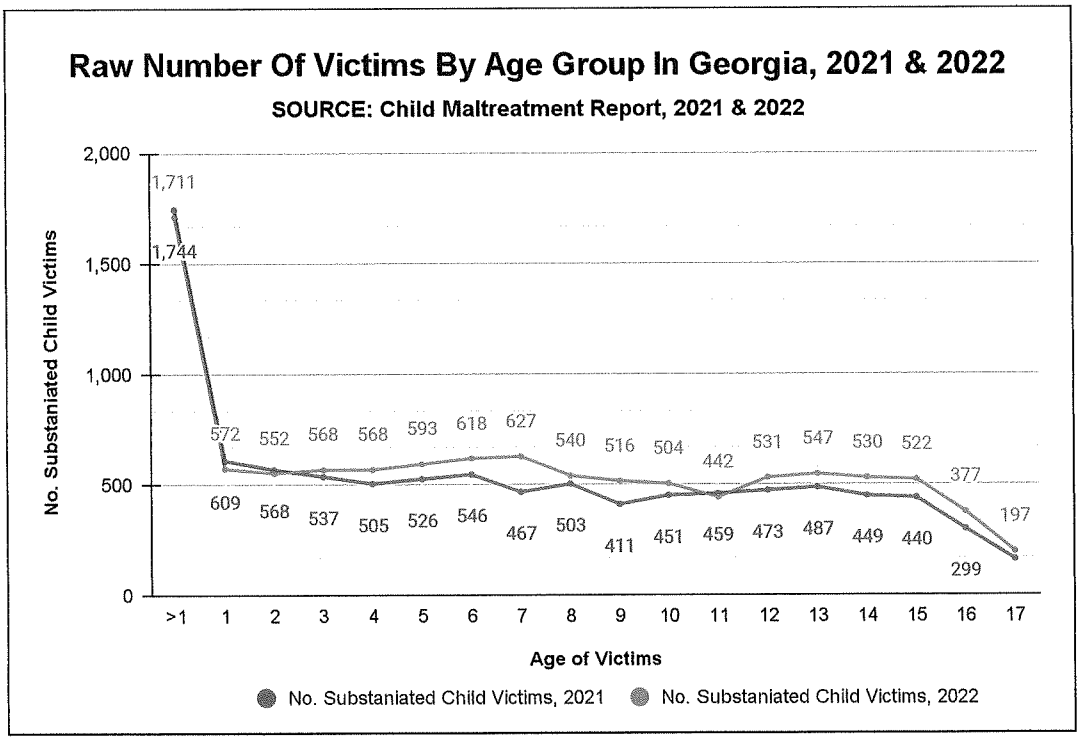


Table of ten best and worst performing states, according to CMR, related to IPSE.

Top 10 states for IPSE, screened-in & screened-out[116], 2021		Bottom 10 states for IPSE, screened-in & screened-out, 2021[117]	
State:	**Per 1,000 Children**	**State:**	**Per 1,000 Children**
Michigan	80.8	Arizona	0.0
Ohio	61.1	North Dakota	0.0
Oklahoma	**54.7**	Pennsylvania	0.0
Arkansas	45.8	Illinois	0.0
Delaware	41.9	Florida	0.1
Louisiana	39.7	Maryland	0.1
Vermont	38.2	Oregon	0.5
West Virginia	37.9	Idaho	0.6
Georgia	**34.1**	Puerto Rico	0.7
Minnesota	31.6	Wisconsin	0.9

[116] 'Screened-in & screened-out' in the table above refers to the CPS investigation decision. Therefore, the 'Per 1,000' represents the total number of IPSE in the state, regardless of CPS investigative decisions.

[117] It seems unlikely that highly populous states such as Florida and Illinois have just one child each who experienced PSA. It might be the case that certain states with unexpectedly low numbers are less diligent at reporting into NCANDS, or rely on a different reporting system, than the majority of states. It should also be noted that Georgia, in spite of its high PSA numbers, might also be underreporting. Nevertheless, this document can only rely on the figures which have been confirmed. Regardless of comparisons against other states, Georgia's infant population has a distressingly high likelihood of being exposed to prenatal substance abuse and it must be a priority of the state to reduce this.

Comparison: IPSE in Georgia VS USA, 2021

Georgia, IPSE exposure for <1's, 2021		USA, IPSE exposure for <1's, 2021		USA without Georgia, IPSE exposure for <1's, 2021	
Georgia:	***Number***	**USA:**	***Number***	**USA w/out GA:**	***Number***
No. Children born	120,296	No. Children born	3,582,882	No. Children born	3,462,586
Total IPSE exposed <1	4,101	Total IPSE exposed <1	49,194	Total IPSE exposed <1	45,093
IPSE related to alcohol	43	IPSE related to alcohol	229	IPSE related to alcohol	186
Screened-in IPSE related to drug abuse in some form[118]	3899	Screened-in IPSE related to drug abuse in some form	40,570	Screened-in IPSE related to drug abuse in some form	36,671
Per 1,000 IPSE <1	34.1	Per 1,000 IPSE <1	13.7	Per 1,000 IPSE <1	13.02

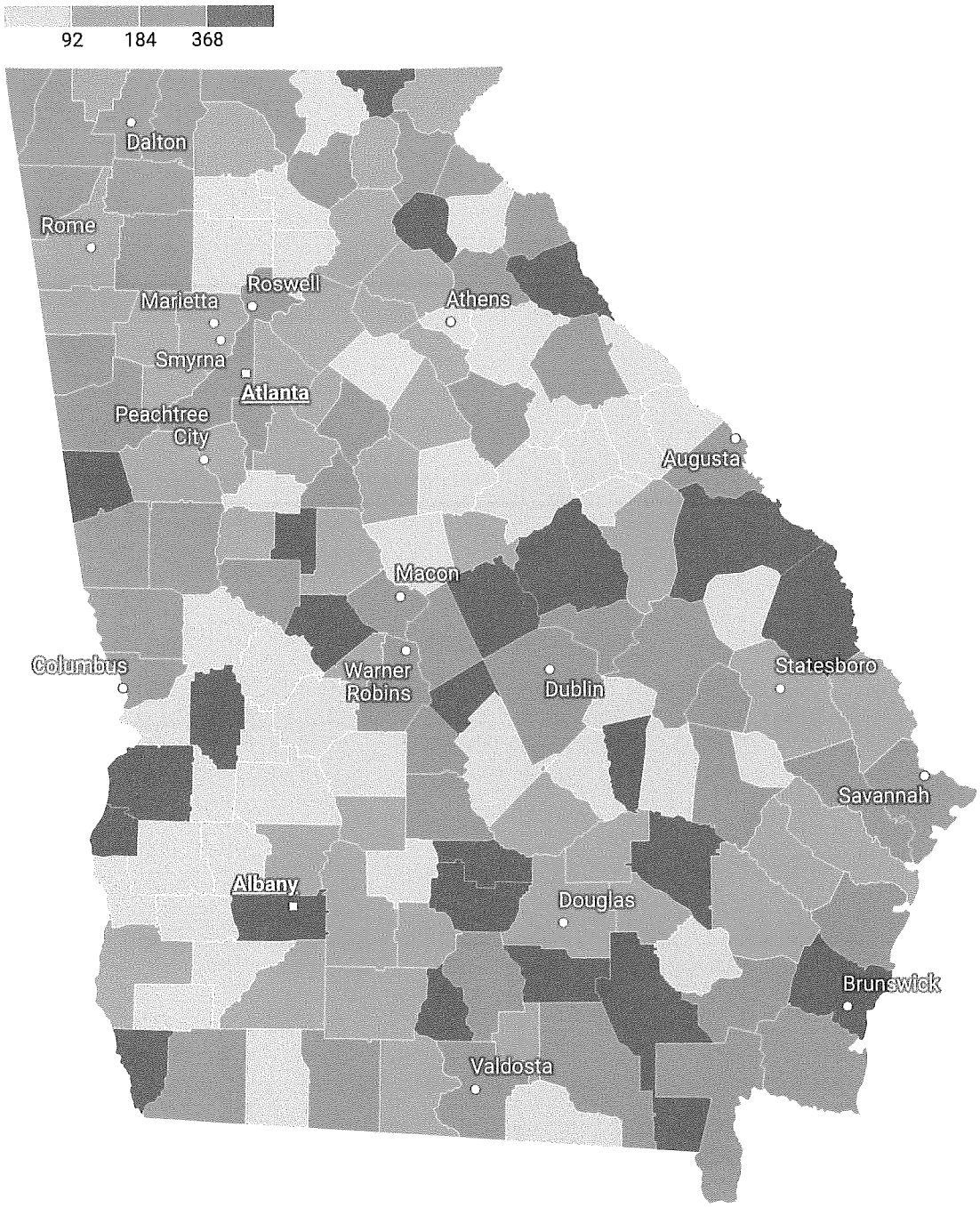
IPSE in Georgia is approximately 248.3% higher than the rest of the United States (if Georgia is included in the calculations for the general US rate).

IPSE in Georgia is approximately 261.8% higher than the rest of the United States, if Georgia is excluded from the other 48 reporting states.

[118] *How was this calculated: See CRM, 2021, p.49; adding the columns 'Screened-in IPSE With Drug Abuse Child Risk Factor' & 'Screened-in IPSE With Alcohol Abuse and Drug Abuse Child Risk Factor', the category above "Screened-in IPSE related to drug abuse in some form" was made.*

Sleep related child fatalities (all children); by county, GA; 2018-2022

How to read this map: Grey = below IMR national average; Blue = IMR 1-to-2 times higher than national average; Orange = 2-to-3 times higher than national average; Red = 3+ times higher than national average.

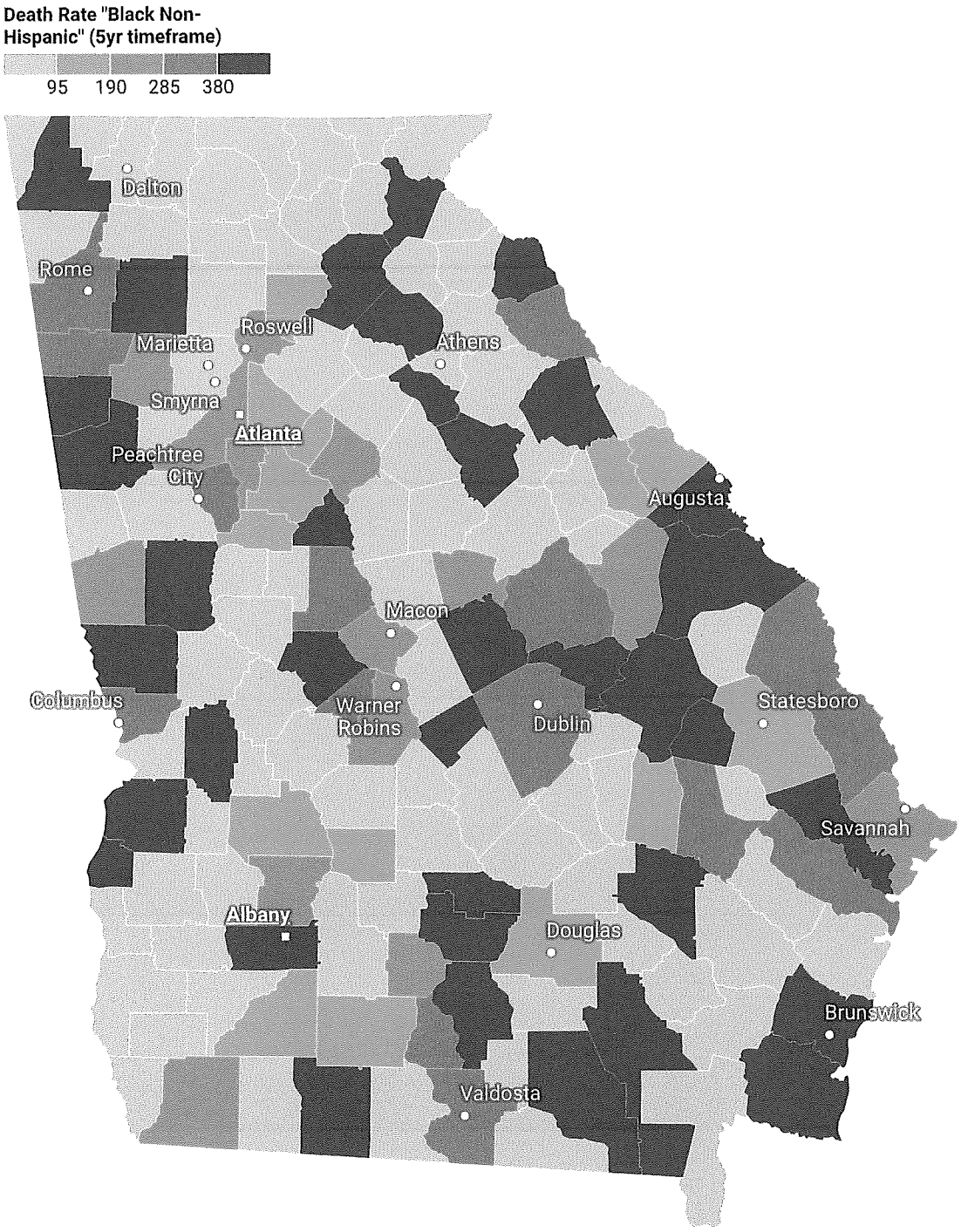


All grey counties there are either no deaths 2018-2022, or inadequate data.

Map: Saul Glick • Created with Datawrapper

African American sleep related child fatalities; by county, GA; 2018-2022

How to read this map. Grey = below IMR national average for all children; Blue = below IMR national average for African American children; Orange = 1-to-1.5 times higher IMR for African American children; Red =2-to-2.5 times higher IMR for African American children; and Dark Red =3+ times higher IMR for African American children.



All grey counties there are either no deaths 2018-2022, or inadequate data.

Map: Saul Glick • Created with Datawrapper

Raw numbers: top 10 counties for African American fatalities, years 2012-2022:

Raw homicide figures for children aged 5-17 by county, filtered by race, Georgia.					
County	African American	White	'Other'	Hispanic	Total
Fulton	80	3	3	2	88
DeKalb	74	4	-	8	86
Chatham	35	5	-	1	41
Clayton	29	1	-	5	35
Bibb	25	2	-	-	27
Muscogee	21	3	-	1	25
Richmond	20	4	-	-	24
Gwinnett	15	4	-	8	27
Cobb	14	2	-	4	20
Henry	13	4	-	-	17

Top 10 best and worst performing counties in relation to child poverty, 2018-2022

Child poverty percentage, 2018-2022, U.S. Census Bureau			
10 Worst Performing Counties		**10 Best Performing Counties**	
County (Worst)	**Child Poverty (%)**	**County (Best)**	**Child Poverty (%)**
Randolph	67.7	Oconee	3.9
Atkinson	66.1	Forsyth	6.2
Charlton	58.5	Fayette	10.7
Brooks	56.4	Bryan	11.3
Quitman	55.8	Harris	11.8
Lanier	54.6	Effingham	12.8
Talbot	54.5	Paulding	14
Macon	54.1	Cherokee	14.4
Clay	52.3	Cobb	14.5
Webster	51.1	Columbia	16

APPENDIX D: Applicable Laws

O.C.G.A. § 16-5-70:

1. *A parent, guardian, or other person supervising the welfare of or having immediate charge or custody of a child under the age of 18 commits the offense of cruelty to children in the first degree when such person willfully deprives the child of necessary sustenance to the extent that the child's health or well-being is jeopardized.*
2. *Any person commits the offense of cruelty to children in the first degree when such person maliciously causes a child under the age of 18 cruel or excessive physical or mental pain.*
3. *Any person commits the offense of cruelty to children in the second degree when such person with criminal negligence causes a child under the age of 18 cruel or excessive physical or mental pain.*
4. *Any person commits the offense of cruelty to children in the third degree when:*
    a. *Such person, who is the primary aggressor, intentionally allows a child under the age of 18 to witness the commission of a forcible felony, battery, or family violence battery; or*
    b. *Such person, who is the primary aggressor, having knowledge that a child under the age of 18 is present and sees or hears the act, commits a forcible felony, battery, or family violence battery.*
    c. *A person convicted of the offense of cruelty to children in the first degree as provided in this Code section shall be punished by imprisonment for not less than five nor more than 20 years.*
    d. *A person convicted of the offense of cruelty to children in the second degree shall be punished by imprisonment for not less than one nor more than ten years.*
    e. *A person convicted of the offense of cruelty to children in the third degree shall be punished as for a misdemeanor upon the first or second conviction. Upon conviction of a third or subsequent offense of cruelty to children in the third degree, the defendant shall be guilty of a felony and shall be sentenced to a fine not less than $1,000.00 nor more*

than $5,000.00 or imprisonment for not less than one year nor more than three years or shall be sentenced to both fine and imprisonment.

APPENDIX E: Training

Proposed 2-hour training:

I. Introduction
- A. Purpose of the Training
- B. Importance of Child Lethality Assessment
- C. Overview of the Assessment Instrument

II. Understanding Child Lethality
- A. Definition and Scope
- B. Risk Factors
- C. Impact on Children, Family, Development, and Society

III. Introduction to the Assessment Instrument
- A. Background and Development of the Instrument
- B. Components of the Instrument
- C. How to Complete the Instrument

IV. Understanding Child Protective Services (CPS) Protocol
- A. Reporting Procedures
- B. Collaboration with DFCS and other partners
- C. Ethical Considerations

V. Cultural Competency and Sensitivity
- A. A. Recognizing Cultural Influences
- B. B. Addressing Bias in Assessment

VI. Case Studies
- A. Real-life Scenarios
- B. Role-Playing Exercises
- C. Debriefing and Feedback

VII. Evaluation and Feedback
- A. Post-Training Assessment
- B. Participant Feedback Forms
- C. Continuous Improvement Strategies

VIII. Conclusion
- A. Summary of Key Points

B. Importance of Ongoing Training
C. Resources for Further Support

IX. Q&A Session
A. Addressing Participants' Questions
B. Providing Additional Clarifications
C. Closing Remarks
D. Presentation of Certificate/Training Materials

Included in this outline are the following:

1. **Background and understanding of the scope of the problem**: The training provides a comprehensive background on child lethality in Georgia, including statistical data, trends, and relevant case studies. Understanding the historical and contextual aspects of child lethality in the region is essential for developing effective interventions and responses.
2. **Factors Contributing to Child Lethality**: The training outlines the various factors that contribute to child lethality. These factors can include domestic violence in the household, substance abuse issues, mental health concerns, access to firearms or other lethal weapons, prior history of abuse or neglect, and dynamics of power and control within the family structure. By understanding these contributing factors, officers can better assess risk and intervene appropriately.
3. **Recognition and Documentation**: One of the primary goals of the training is to teach officers how to recognize potential child lethality factors during their interactions with families. This involves developing skills in assessing risk levels, identifying red flags indicating heightened danger to children, and understanding the interplay between different risk factors. Additionally, officers learn the importance of thorough and accurate documentation of observed or reported risk factors.
4. **Child Lethality Assessment**: The training will include instruction on assessing factors present at the scene and completing the Child Lethality Assessment Instrument (CLA). This assessment tool will help officers, detectives, and child safety advocates systematically evaluate risk factors and make informed decisions about the level of intervention required to ensure child safety. Training participants will learn how to apply these assessment protocols in real-world scenarios and integrate their findings into investigative and case management processes.

5. **Collaborative Response**: Lastly, the training emphasizes the importance of a multidisciplinary and collaborative approach to addressing child lethality. This includes coordination with child protective services, mental health professionals, medical personnel, and other relevant stakeholders. Effective communication and information sharing among these agencies are essential for developing coordinated safety plans and providing comprehensive support to at-risk children and families.

TERMINAL PERFORMANCE OBJECTIVES

Upon completion of this program, the student will be able to help reduce child fatalities in Georgia by accomplishing the following:

1. Successfully identify indicators and evidence contributing to child fatalities;
2. Increase the reliability of information which leads to decision making for law enforcement and child care advocates regarding cases of suspected child abuse;
3. Provide an outline that improves the validity of decision making data based upon both situational and empirical evidence;
4. Provide substantive information to investigators, child welfare, and other advocates to develop an intervention plan or prosecution of behaviors that are contributing to child fatalities;
5. Help to identify resources that are necessary to address behaviors leading to child lethality; and,
6. Provide data that can be used to identify and develop child lethality intervention strategies throughout the State of Georgia.

STUDENT PERFORMANCE OBJECTIVES

1. Provided an overview of current statistics, trends, and case studies students will understand the scope and depth of the problem of child lethality in Georgia.
2. Given the information above, the students will be able to understand and differentiate between the myths and reality of child lethality in Georgia, while developing a systematic, reproducible (ladder of inference) that facilitates the complete identification and documentation of abuse factors, which are documented on the Child Lethality Assessment.

3. Given an overview, students will recognize and be able to overcome issues that interfere with effective reporting and intervention which contributes to continued child lethality. These factors include, but are not limited, to the following: information gaps, bias, culture, and reporting protocols.
4. Provided copies of sections of the Official Code of Georgia Annotated, the student will understand the following:
    a. Abandonment Defined OCGA § 19-7-5(b);
    b. Abortion Defined OCGA § 15-11-681;
    c. Child Defined OCGA § 19-7-5 (b)4;
    d. Child Abuse Define OCGA § 19-7-5 (b)5;
    e. Child Abuse Information Exempt From Public Record OCGA § 19-7-5 (18)l;
    f. Crimes Against Person Referenced In Abuse Definitions OCGA § 16-5-3;
    g. Emotional Abuse Defined OCGA § 19-7-5 (b)8;
    h. Immunity From Civil Liability OCGA § 19-7-5 (18)f,g;
    i. Legal Custodian Defined OCGA § 19-7-5 (b)10;
    j. Mandatory Reporter OCGA § 19-7-5 (18)c,d,g,h;
    k. Person Responsible For Care of Child Defined OCGA § 19-7-5 (b)12;
    l. Parental Abuse Defined OCGA § 19-7-5 (b)14;
    m. Sexual Abuse Defined OCGA § 19-7-5 (b)17;
    n. Sexual Exploitation Defined OCGA § 19-7-5 (b) 18; and,
    o. Sexual Exploitation of Children Defined OCGA § 16-12-3.

5. Given the above, students will be able to identify critical observations and evidence that should be noted in the Child Lethality Assessment; while identifying key shareholders and stakeholders that should be notified and engaged to assist with the continued investigation and necessary intervention.
6. Provide the students with an understanding of the roles of each organization involved in investigating or preventing behaviors that contribute to child lethality.
7. Through case studies, provide examples of behaviors that should be identified and documented in the Child Lethality Assessment.

APPENDIX F: Best Practices:

A trauma-informed interview is an approach to interviewing individuals that acknowledges and addresses the potential impact of trauma on their lives. This method is particularly important when dealing with individuals who may have experienced traumatic events, such as abuse, violence, or natural disasters.

Key principles of a trauma-informed interview include:

1. **Safety**: Ensuring the physical and emotional safety of the interviewee throughout the process.
2. **Trustworthiness and Transparency**: Being transparent about the purpose of the interview and building trust with the interviewee by providing clear information and maintaining confidentiality.
3. **Choice and Control**: Allowing the interviewee to have control over the interview process, including the option to decline answering questions or taking breaks as needed.
4. **Empowerment and Collaboration**: Empowering the interviewee to share their story in their own way and collaborating with them to find solutions or resources that meet their needs.
5. **Cultural, Historical, and Gender Sensitivity**: Recognizing and respecting the cultural, historical, and gender-specific factors that may influence the experience of trauma.
6. **Understanding Trauma's Impact**: Being aware of the potential effects of trauma on cognition, memory, and behavior, and adapting the interview approach accordingly. By adopting a trauma-informed approach, interviewers aim to create a safe and supportive environment that minimizes the risk of re-traumatization and promotes healing and resilience.

APPENDIX G: Risk Assessment Tools:

The risk assessment tools used during these pilots have been invented by Saul Glick, primary author of this White Paper and program director at MGH & HMS (contact details on cover page).

How are the risk assessments used during the pilots designed to work:

1. CARE or CARE1, is a primary assessment which is designed to be used by a frontline responder.
    a. Once CARE is completed, there are three available outcomes: GREEN, YELLOW, and RED.
        i. GREEN indicates *perceived standard risk.*
        ii. YELLOW indicates *perceived heightened risk.*
        iii. RED indicates *perceived high risk.*
    b. If the outcome of CARE is RED or YELLOW, CARE2. Is necessarily triggered.

2. CARE2, is a secondary assessment designed to be used by family protection units, DFCS or other relevant agencies. CARE2 is only to be used if CARE indicates a child is RED or YELLOW.
    a. Once CARE2 is completed, there are three available outcomes: GREEN, YELLOW, and RED.
        i. GREEN indicates *perceived standard risk.*
        ii. YELLOW indicates *perceived heightened risk.*
        iii. RED indicates *perceived high risk.*
    b. If the outcome of CARE2. is RED or YELLOW, local policies related to child protection are triggered.

These assessments can be completed on scene or retroactively. They will also be available on paper, or digitally, depending on force policy.[119]

Overtime, data gathered using CARE forms will enable the analysis of macro trends related to geographic areas, times when maltreatment is likely to occur, school districts, population responses to public policies, etc. as well as micro trends related to neighborhoods, households, parents, and children.

[119] For reasons related to intellectual property, the CARE assessments have not been included in this White Paper, for access to relevant materials contact Saul Glick directly.

APPENDIX H: Policy:

Sample Police Standard Operating Procedure Manual			
Effective Date:	Revision Date:	Chapter (Insert) : Child Risk Assessment	SOP (Insert)
Authority: Chief Executive Officer (Insert name and title)		SOP (Insert): Child Risk Assessment	Page **1** of **5**

I. PURPOSE

The (Insert Agency Name) is committed to reducing child maltreatment, abuse, neglect and death through the thorough investigation of complaints or incidents. This investigation may include the completion of a Child At Risk Evaluation (CARE) intended to identify threats and challenges to the safety of children in a given environment.

The risk assessment provides the department with a method of identifying problems, options and resources. Additionally, the assessment can be used by the responding team to accomplish the following:

- Identify critical decision points in the investigation and/or intervention necessary to protect a child;
- Increase reliability of decisions made by officers and others;
- Increase validity of decisions;
- Facilitate resources to families at the highest risk; and,
- Develop data necessary for informed decisions to facilitate child protection.

II. POLICY

It is the policy of the (Insert Agency Name) for officers to complete a Child At Risk Evaluation (CARE) for evaluating a myriad of possible interventions when any of the following factors is present:

- When a child (4 years of age or younger) is present during a domestic violence incident;
- When the officer reasonably believes that the welfare of the child should be investigated due to issues of child abuse, emotional abuse, neglect, parental abuse, sexual abuse, or sexual exploitation;
- When the guardian is concerned for the safety of the children;
- When there is a pregnant female in the home and there is concern for their safety;
- When there are suspicious injuries on any child in the home;
- When the welfare of the children is currently under investigation by law enforcement or Department of Family and Children Services;
- When there is a history of violence in the home;

- When the current hygiene or conditions of the house raise concerns for the welfare of the child;
- Or any other existing threat or condition within the household that would present a threat to the safety of the child or others.

The Child At Risk Evaluation (CARE) will be completed before the end of shift and submitted to the (Insert responsible unit here) after approval by a supervisor.

III. DEFINITIONS

1. "Child abuse" means:

   A. Physical injury or death inflicted upon a child by a parent, guardian, legal custodian, or other person responsible for the care of such child by other than accidental means; provided, however, that physical forms of discipline may be used as long as there is no physical injury to the child;

   B. Neglect of a child by a parent, guardian, legal custodian, or other person responsible for the care of such child;

   C. Emotional abuse of a child;

   D. Sexual abuse or sexual exploitation of a child;

   E. Prenatal abuse of a child by a parent;

   F. An act or failure to act that presents an imminent risk of serious harm to the child's physical, mental, or emotional health; or

   G. Trafficking a child for labor servitude.

2. "Emotional abuse" means acts or omissions by a parent, guardian, legal custodian, or other person responsible for the care of a child that cause any mental injury to such child's intellectual or psychological capacity as evidenced by an observable and significant impairment in such child's ability to function within a child's normal range of performance and behavior or that create a substantial risk of impairment.

3. "Neglect" means:

   A. The failure to provide proper parental care or control, subsistence, education as required by law, or other care or control necessary for a child's physical, mental, or emotional health or morals;

   B. The failure to provide a child with adequate supervision necessary for such child's well-being; or

   C. The abandonment of a child by his or her parent, guardian, or legal custodian.

4. "Prenatal abuse" means exposure to chronic or severe use of alcohol or the unlawful use of any controlled substance, as such term is defined in Code Section 16-13-21, which results in:

   A. Symptoms of withdrawal in a newborn or the presence of a controlled substance or a metabolite thereof in a newborn's body, blood, urine, or meconium that is not the result of medical treatment; or

   B. Medically diagnosed and harmful effects in a newborn's physical appearance or functioning.

5. "Sexual abuse" means a person's employing, using, persuading, inducing, enticing, or coercing any minor who is not such person's spouse to engage in any act which involves:

   A. Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex; bestiality; masturbation; lewd exhibition of the genitals or pubic area of any person; flagellation or torture by or upon a person who is nude;

   B. Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude;

C. Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts;

D. Defecation or urination for the purpose of sexual stimulation;

E. Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure; or

F. Any act described by subsection (c) of Code Section 16-5-46.

G. Sexual abuse shall include consensual sex acts when the sex acts are between minors if any individual is less than 14 years of age; provided, however, that it shall not include consensual sex acts when the sex acts are between a minor and an adult who is not more than four years older than the minor. This provision shall not be deemed or construed to repeal any law concerning the age or capacity to consent

6. "Sexual exploitation" means conduct by any person who allows, permits, encourages, or requires a child to engage in:

A. Sexual servitude, as defined in Code Section 16-5-46; or

B. Sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct, as defined in Code Section 16-12-100.

IV. COMPLETING THE CHILD AT RISK EVALUATION (CARE) ASSESSMENT

See addendum A and B for instructions on how to successfully complete the Patrol Officer and Investigator's versions of the Child At Risk Evaluation (CARE).

V. THE CHILD AT RISK EVALUATION (CARE) IS A SUPPLEMENTAL REPORT FOR THE PURPOSES OF GEORGIA'S OPEN RECORDS ACT

The Child At Risk Evaluation (CARE), completed by the officer, will be considered a supplemental report of an investigation under *Georgia's Open Records Act, O.C.G.A § 50-18-70.* Therefore, this Assessment is not subject to release until the following conditions are met in accordance with *Title 50 State Government, Chapter 18 State Printing and Documents, Article 4 Inspection of Public Records, § 50-18-72 When Public Disclosure Not Required, § a Public disclosure shall not be required for records that are,*

> *¶ 4: Records of law enforcement, prosecution, or regulatory agencies in any pending investigation or prosecution of criminal or unlawful activity, other than initial police arrest reports and initial incident reports; provided, however, that an investigation or prosecution shall no longer be deemed to be pending when all direct litigation involving such investigation and prosecution has become final or otherwise terminated; and provided, further, that this paragraph shall not apply to records in the possession of an agency that is the subject of the pending investigation or prosecution.*

VI. SUBMITTING THE CHILD AT RISK EVALUATION (CARE)

The assessment can be submitted via fax or email.

Preferably, the assessment would be sent automatically via a shared digital system, for instance "vimes.io" which has been used in Albany, GA.

In Albany, GA, Albany Police Department are using a specially designed software solution ("vimes.io") to automatically transfer information between frontline officers, family protection unit investigators (also in APD), the non-profit Lily Pad, local DFCS representatives, and executives from the Dougherty County School System.

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