State Child Fatality Review Team Committee Biennial Report

As Required by

Texas Family Code

Section 264.503(f)

April 2022

Administrative Support Provided by

Department of State Health Services

Table of Contents

Executive Summary

The State Child Fatality Review Team Committee (committee) biennial report is prepared in compliance with Texas Family Code, Section 264.503(f). The report contains aggregate child fatality data from local child fatality review teams (CFRTs), recommendations to prevent child fatalities and injuries, and recommendations to the Department of Family and Protective Services (DFPS) on child protective services operations based on input from the committee.

The committee works with local CFRTs to establish recommendations for injury prevention activities. Recommendations relate to changing current statute, increasing public education, and how best to strengthen existing systems.

To support the committee in developing this report, the Department of State Health Services (DSHS) calculated child fatality statistics from death data files. These statistics are based on the most currently available data – calendar years 2017 through 2019 finalized death files. Data for more recent years have yet to be finalized.

In 2017-2019, the Texas child death rate remained consistent with previous years. There was a total of 11,195 child deaths in Texas from 2017 through 2019 (an average of 3,731 deaths per year). Active local CFRT volunteer staff reviewed 2,811 (approximately 25 percent) of the total child deaths (an average of 937 cases each year).

Recommendations to the Governor and Legislature

1. Amend Texas Health and Safety Code, Section 161.501, to include in the required resource pamphlet information on appropriate child safety seat (CSS) requirements and recommendations by state agencies. This information should highlight the importance of keeping children in a rear-facing CSS and then in a harnessed CSS for as long as possible to help reduce child injuries and fatalities.
2. Amend 15 Texas Administrative Code, Section 380.501, to require regional-contracted brokers or managed transportation organizations within the Medical Transportation Program to provide the appropriate CSS or booster seat for each child passenger during transport. Also, amend 15 Texas

Administrative Code, Section 380.502, to require a motor vehicle operator seeking to provide transportation services who installs a CSS or booster seat to receive basic child passenger safety education and installation awareness training at least annually.

3. Pass legislation that requires new residential swimming pools to have a circumferential isolation pool fence installed that is at least four feet in height and completely separates the house and play area of the yard from the pool to help prevent child drowning.
4. Fund a public educational campaign on the benefits of means restriction (restricting access to the lethal means individuals use to attempt suicide).
5. Require all 17 and under deaths by suicide be reported to DFPS by the responding law enforcement agency.
6. Fund CFRT coordinators in each DSHS Public Health Region as recommended by the Protect Our Kids Commission.
7. Require state agencies to collaborate and create new parent education with targeted messaging on injury prevention initiatives, including child abuse prevention and cardiopulmonary resuscitation, choking prevention, and first aid methods; and distribute the educational material to new parents in hospitals and birthing centers.

Recommendation to DFPS

1. Provide a collaborative educational campaign on drowning prevention strategies related to touch supervision safety and infant bath supplies.

1. Introduction

Per Texas Family Code, Section 264.503(f), the State Child Fatality Review Team Committee (committee) is required to publish a biennial report containing aggregate child fatality data collected by local child fatality review teams (CFRTs) and include recommendations from the committee and local CFRTs to prevent child fatalities and injuries. The committee is also required to provide recommendations to the Department of Family and Protective Services (DFPS) on child protective services operations based on input from the child safety review subcommittee. The DFPS child safety review subcommittee is an internal committee that meets quarterly to discuss recommendations to improve child protective services practices and prevent child deaths.

The report is submitted to the Governor, Lieutenant Governor, and the Speaker of the House of Representatives no later than April 1 of each even-numbered year.

To satisfy the requirements of statute, this report presents:

- Committee recommendations to the Governor and the Legislature on preventing child fatalities and injuries,
- General child fatality statistics based on calendar years 2017 through 2019 finalized death data files, and
- Aggregate child fatality data collected by local CFRTs.

2. Background

Child fatality review is a public health strategy used to understand child deaths through a multi-disciplinary review at the local level. Deaths are reviewed and data are collected and analyzed to best understand risks to children. Child fatality review is practiced in each state in the U.S. and in many other countries.

In 1995, Texas enacted legislation establishing the State Child Fatality Review Team Committee (committee) and authorized counties to form local and regional child fatality review teams (CFRTs).

The committee consists of six permanent committee members from the Department of State Health Services (DSHS), the Department of Family and Protective Services (DFPS), and representatives from the offices of the Governor, Lieutenant Governor, and Speaker of the House. Additional committee members serve three-year terms and are a multi-disciplinary group of professionals representing law enforcement, the medical community, child advocacy organizations, the court system, the behavioral health community, and state agencies. For a complete list of committee membership, see Appendix A.

The committee meets quarterly to:

- Develop an understanding of the causes and incidences of child death in Texas;
- Identify procedures within agencies represented on the committee to reduce the number of preventable child deaths; and
- Promote public awareness and make recommendations to the Governor and Legislature for changes in law, policy, and practice to reduce the number of preventable child deaths.

Local CFRTs are volunteer-based and organized by county or multi-county geographic areas. Membership mirrors that of the committee. Local CFRTs conduct retrospective reviews of deaths of children ages 17 or younger in their geographic areas.

From 2017-2019, there were 62 active local CFRTs covering 192 of the 254 Texas counties.[1] From 2017-2019, there were 11,195 child deaths in Texas, and active local CFRTs reviewed 2,811 (approximately 25 percent) of these deaths.

- In 2017, there were 3,838 child deaths in Texas and 1,165 of the cases were reviewed (30 percent).
- In 2018, there were 3,640 child deaths in Texas and 940 of the cases were reviewed (26 percent).
- In 2019, there were 3,717 child deaths in Texas and 706 of the cases were reviewed (19 percent).

Of the 11,195 child deaths from 2017-2019, 7,370 child deaths were due to natural causes, a decreasing trend from previous years. There were 2,851 child deaths due to external causes, including accidental deaths, homicides, and suicides. Of the deaths due to external causes, 1,750 were due to accidental injury and 1,101 were due to suicide or homicide. The causes of the remaining 974 child deaths were undetermined, unknown, or pending.

Since the 2020 Legislative Report, the local CFRT death certificate distribution process has improved with the requirement for DSHS to provide local CFRTs with electronic access to preliminary death certificates. Local CFRTs currently receive a secure electronic spreadsheet with death certificate information on a quarterly basis. As of December 2021, local CFRTs received death certificate information through September 2021.

[1] Active CFRTs refers to those teams that entered data on reviewed cases between 2017-2019.

3. State Child Fatality Review Team Committee Recommendations

Local child fatality review teams (CFRTs) receive death certificate information of children ages 17 and younger in their geographic areas from the Department of State Health Services (DSHS) on a quarterly basis. Local CFRTs then conduct a retrospective review of these deaths. Team members collect medical records, incident reports, and other records that correspond to their disciplines. During the review meeting, members share what is known about the cases being reviewed, identify risk factors, and answer specific questions from the National Center for Fatality Review and Prevention (NCFRP) database. A primary purpose of these reviews is to determine if a child's death was preventable.[2]

Local CFRTs enter the data collected during reviews in the NCFRP database. The data collected and lessons learned from local CFRT meetings inform recommendations to the State Child Fatality Review Team Committee (committee), which are submitted to DSHS. The committee reviews, discusses, and votes on each recommendation submitted. Recommendations from the committee and local CFRTs are included in the biennial report and are used to inform local and statewide prevention activities with the aim of reducing preventable child deaths.

As of December 2021, the most recent year for which local CFRTs have completed child fatality case review is 2019. Their 2017-2019 case reviews and recommendations, in addition to other research conducted by the committee, form the basis of the committee's recommendations in this report. A DSHS analysis of 2017 through 2019 death data files is also presented in Appendix B. Aggregate data from local CFRTs are presented in Appendix C.

In 2021, local CFRTs submitted 27 recommendations for the committee to review for this report. Each recommendation was voted on by the committee at the

[2] Per the NCFRP database, a child's death is considered preventable if an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death.

quarterly meeting on November 8, 2021. The following eight recommendations were approved by the committee.

Recommendations to the Governor and Legislature

Recommendation 1: Amend Texas Health and Safety Code, Section 161.501, to include in the required resource pamphlet information on appropriate child safety seat (CSS) requirements and recommendations by state agencies. Information should highlight the importance of keeping children in a rear-facing CSS and then in a harnessed CSS for as long as possible to help reduce child injuries and fatalities.

The American Academy of Pediatrics (AAP), the Centers for Disease Control and Prevention (CDC), and the National Highway Traffic Safety Administration recommend that children should use a rear-facing CSS for as long as possible, but at least until they reach the highest weight or height allowed by their CSS's manufacturer.[3,4,5] Most convertible CSS can be used rear-facing until at least 40 pounds and will cover children from birth to ages 2 to 4.[3,4] In a rear-facing CSS, the harness cradles and moves with a child to reduce the stress to a child's head and neck.[5] After outgrowing rear-facing CSS, children should be buckled in a forward-facing CSS with a harness until they reach the highest weight or height allowed by the CSS's manufacturer and then into a belt-positioning booster seat until at least age 8.[3,4]

In Texas, there were 320 deaths among children ages 8 and younger in motor vehicle crashes from 2017-2019.[6] Local CFRTs reviewed 36 percent of those deaths.

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[3] Durbin DR, Hoffman BD. American Academy of Pediatrics Policy Statement: Child Passenger Safety *Pediatrics.* 2018;142(5). Available at: publications.aap.org/pediatrics/article/142/5/e20182460/38530/Child-Passenger-Safety.

[4] Centers for Disease Control and Prevention. Child Passenger Safety: Get the Facts. Available at: cdc.gov/transportationsafety/child_passenger_safety/cps-factsheet.html. Accessed 17 Nov. 2021.

[5] National Highway Traffic Safety Administration. Car Seats and Booster Seats. Available at: nhtsa.gov/equipment/car-seats-and-booster-seats. Accessed 17 Nov. 2021.

[6] Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2017-2019, Jan. 2022.

Of the cases reviewed, teams indicated that a CSS was used correctly for child passengers only 25 percent of the time.

There has been a substantial increase in scientific evidence to base best-practice recommendations in child passenger safety. Current estimates of child restraint effectiveness indicate that a CSS can reduce the risk of injury by 71-82 percent and reduce the risk of death by 28 percent when compared to children of similar ages using only seat belts.[3]

DSHS produces and regularly updates *Information for Parents of Newborns*, a resource that is available online and for distribution in English and Spanish.[7] The committee recommends an amendment to Texas Health and Safety Code, Section 161.501, to require that CSS requirements and state agency recommendations are included in any resources provided to new parents in hospitals or birthing centers. The committee also recommends including contact information for programs that assist with CSS installation, perform CSS checks, and provide a CSS for families who are unable to afford one.

Recommendation 2: Amend 15 Texas Administrative Code, Section 380.501, to require regionally contracted brokers or managed transportation organizations within the Medical Transportation Program (MTP) to provide the appropriate CSS or booster seat for each child passenger during transport. Amend 15 Texas Administrative Code, Section 380.502, to require a motor vehicle operator seeking to provide transportation services who installs a CSS or booster seat to receive basic child passenger safety education and installation awareness training at least annually.

The MTP provides essential services for children and families who lack transportation to and from non-emergency medical visits. Families that qualify for these services do not have the resources to own a personal vehicle and should not be required to provide a CSS or booster seat to use the program.

Currently, 15 Texas Administrative Code, Section 380.501, specifies all vehicles used to provide transportation services, including MTP vehicles, must be equipped with functioning, clean, and accessible seat belts for each passenger seat position.

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[7] Information for Parents of Newborns is available at dshs.texas.gov/mch/pdf/Info_for_Parents_FINAL_English.pdf

This code does not specify that CSS or booster seats must be provided for child passengers nor does this code state that MTP providers must comply with Transportation Code, Section 545.412. Language requiring all regionally contracted brokers or managed transportation organizations within the MTP to provide a CSS or booster seat for each child passenger should be added to this code.

Currently, 15 Texas Administrative Code, Section 380.502, specifies that motor vehicle operators providing transportation services through the MTP must receive training on passenger safety at least annually. This code does not specify that motor vehicle operators seeking to provide transportation services through the MTP are required to receive child passenger safety education and installation awareness training at least annually. Language requiring training specific to child passenger safety should be added to this code.

Recommendation 3: Pass legislation that requires new residential swimming pools have a circumferential isolation pool fence installed that is at least four feet in height and completely separates the house and play area of the yard from the pool to help prevent child drowning.

Drowning is the leading cause of unintentional injury death in children ages one to four and the second leading cause of unintentional injury death among children ages five to nine in both the U.S. and in Texas.[6,8] In 2019, over 750 children and adolescents, ages 0 to 17, died in the U.S. due to drowning.[9]

From 2017-2019, there were 167 children ages 1 to 4 who died due to drowning in Texas, 95 of these occurred in a swimming pool (56.9 percent).[6] Local CFRTs reviewed 48 percent of these deaths. Local CFRTs recorded that only 22 percent of the reviewed cases indicated that a pool fence was present at the incident scene.

In 2019, the AAP updated drowning prevention recommendations for families, including installation of a four-sided, four-foot-tall fence with self-closing and self-

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[8] Centers for Disease Control and Prevention (CDC). 10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2018. National Center for Health Statistics (NCHS), National Vital Statistics System; cdc.gov/injury/wisqars/pdf/leading_causes_of_injury_deaths_highlighting_unintentional_2018-508.pdf; Accessed 16 Nov. 2021.

[9] Centers for Disease Control and Prevention (CDC). WISQARS (Web-based Injury Statistics Query and Reporting System). National Center for Health Statistics (NCHS), National Vital Statistics System; wisqars.cdc.gov/cgi-bin/broker.exe; Accessed 16 Nov. 2021.

latching gates that completely isolates the pool from the house. The AAP also recommended that policymakers pass state or local legislation or building code(s) that mandates new and existing residential pools have a four-sided isolation fence.[10]

Research has shown that nearly half of swimming pool drownings and near drownings occur in a home or private swimming pool and at least 80 percent of children have access to the pool from the house or yard. Four-sided isolation fencing around the pool itself is part of a multi-layered method to prevent a child's access to the pool.[10]

Currently, 25 states in the U.S. have a law in place regarding pool fences. Since 2007, the committee has made annual recommendations that Texas require new residential swimming pools to have circumferential isolation pool fences.

Recommendation 4: Fund a public educational campaign on the benefits of means restriction (restricting access to the lethal means individuals use to attempt suicide).

Suicide is the second leading external cause of death among children in both the U.S. and Texas.[6,8] From 2017-2019, 5,258 children ages 17 and under died by suicide in the U.S. Of these deaths, 48.9 percent were due to suffocation and 40.1 percent were due to firearms.[8] The remaining 11 percent were due to other causes, including poisoning, falls, and drowning. In Texas, suicide rates among children are increasing. There were 574 suicide deaths among Texas children in 2017-2019, an increase from the 387 suicide deaths that occurred in 2014-2016.[6,11] The two leading causes of child suicide deaths in Texas from 2017-2019 were firearms (45.3 percent) and suffocation (44.1 percent).[6]

Means restriction, restricting access to the lethal means individuals use to attempt suicide, is an important component of a comprehensive approach to suicide prevention. Most suicide attempts are highly impulsive and occur with little

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[10] Denny SA, Quan L, Gilchrist J, et al. The American Academy of Pediatrics Policy Statement: Prevention of Drowning *Pediatrics*. 2019;143(5). Available at pediatrics.aappublications.org/content/143/5/e20190850.

[11] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2019 on CDC WONDER Online Database, released in 2020. wonder.cdc.gov/ucd-icd10.html. Accessed 18 Nov. 2021.

planning.[12] Means restriction attempts to separate the suicidal individual's thoughts from action, thereby reducing the chance of a suicide attempt. Studies indicate it is unlikely that restricting access to a preferred suicide method will lead to the selection of another method, which highlights the need to educate the public about means restriction.[13]

The committee recommends funding for a public educational campaign on means restriction created through collaborative efforts by DSHS, the Texas Department of Family and Protective Services (DFPS), and the Health and Human Services Commission (HHSC). This comprehensive campaign should provide:

- Education for family members and others about ways to limit access to lethal means used to attempt suicide;
- Training for mental health professionals in lethal means counseling; and
- Training for nontraditional providers, such as divorce and defense attorneys, law enforcement, and first responders, in lethal means counseling.

Recommendation 5: Require all 17 and under deaths by suicide be reported to DFPS by the responding law enforcement agency.

Texas Family Code, Section 261.102, states that professionals must report a death to Child Protective Services (CPS) at DFPS if they have a belief that the child had been abused or neglected. The number of suicides among Texas children is increasing, and these deaths are currently not reported uniformly or reviewed by state agencies. Due to the lack of notification and investigation of child suicides by CPS, a true understanding of why child suicides are increasing is not known. Therefore, the committee recommends that all 17 and under deaths by suicide be reported to DFPS by the responding law enforcement agency to improve the reporting of child suicides.

The 2020 *Report on Suicide and Suicide Prevention in Texas*, submitted by the Statewide Behavioral Health Coordinating Council, recommends improving the accuracy in reporting of suicide data for state systems and increasing timeliness of

[12] The Heard Alliance. Means Restriction. Available at: heardalliance.org/wp-content/uploads/MEANS.pdf. Accessed 18 Nov. 2021.

[13] Yip PSF, Yousuf S, Chang SS, et al. Means Restriction and Suicide Prevention *Lancet*. 2012; 379(9834):2393-2399. Available at: ncbi.nlm.nih.gov/pmc/articles/PMC6191653/.

suicide-related data shared between state agencies.[14] Implementation of this recommendation, in consultation with HHSC, will confirm all child suicides are reported to DFPS to improve state agency collaboration in reducing the number of children in Texas who die by suicide.

Recommendation 6: Fund CFRT coordinators in each DSHS Public Health Region (PHR) as recommended by the Protect Our Kids Commission (POK Commission).

The committee has recommended funding for CFRT coordinators in each DSHS PHR since 2016. In 2017, DSHS applied for an Administration for Children and Families Children's Bureau Children's Justice Act grant to fund two CFRT coordinators. The Children's Justice Act pilot project in Bexar County and Burnet County was conducted with the intent to provide support for this recommendation. The pilot, which began in 2017 and ended in August 2019, hired two CFRT coordinators, one in a rural and one in an urban region of Texas, to provide guidance and training to their local CFRT to increase reported data quality and the quantity of the cases reviewed.

Preliminary results showed that Burnet County completed entry for 78 percent of their 2018 cases. Prior to the grant, Burnet County had over 80 cases that were incomplete. Bexar County increased data entry by 92.5 percent from 2015 to 2018. In addition to increasing data entry, the Bexar County Juvenile Justice Department found that having a local CFRT coordinator for their county team also increased stakeholder participation. The Bexar County Juvenile Justice Department then applied for the Children's Justice Act grant in 2019 and, given the success of the DSHS pilot, was awarded the grant to continue housing the Bexar County CFRT coordinator.

The committee supports the POK Commission recommendation to fund a CFRT coordinator in each DSHS PHR. Currently, local CFRT coordinators, presiding officers, and data entry coordinators are volunteer members of the review team. Funding a local CFRT coordinator in each PHR will increase the number of deaths reviewed, improve the consistency of fatality review data entry, and increase the

[14] The 2020 *Report on Suicide and Suicide Prevention in Texas* is available at hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/leg-report-suicide-prevention-tx-nov-2020.pdf

number of injury prevention recommendations provided by local CFRTs throughout the state.

The recommendations contained in the *2015 POK Commission Report* provide a guide for the changes and improvements needed for a safer Texas.[15]

Recommendation 7: Require state agencies to collaborate to create new parent education with targeted messaging on injury prevention initiatives, including child abuse prevention and cardiopulmonary resuscitation (CPR), choking prevention, and first aid methods, and distribute to new parents in hospitals and birthing centers.

The number of fatalities with confirmed abuse or neglect in Texas continues to increase annually. In fiscal year 2019, DFPS reported there were 235 confirmed cases of abuse or neglect in cases of child fatality, an increase from the 172 and 211 cases in fiscal year 2017 and fiscal year 2018, respectively.[16]

Parents play a significant role in injury prevention initiatives for their children. Whether they act in the prevention of abuse or neglect, or provide life-saving efforts when needed, parent education on injury prevention techniques benefits the safety of Texas children. The committee recommends the collaboration of state agencies to create an injury prevention educational resource to be distributed to Texas parents at hospitals or birthing centers.

Currently, there are separate parenting education campaigns supported by DSHS and DFPS. DSHS has two publications, *Information for Parents with Newborns* and *A Parent's Guide to Raising Healthy, Happy Children*.[17] DFPS provides guidance through parenting classes and their Family-Based Safety Services. These campaigns

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[15] The *2015 Protect Our Kids Commission Report* is available at texaschildrenscommission.gov/media/1141/pdf-report-pok-commission-december-2015.pdf

[16] Data from US Census Bureau; Texas State Data Center; DFPS Data Books Fiscal Year 2010-Fiscal Year 2020; DFPS Data Warehouse Report FT_06; U.S. Department of Health and Human Services. Population Data Source: Population Estimates and Projections Program, Texas State Data Center, Office of the State Demographer and the Institute for Demographic and Socioeconomic Research, University of Texas at San Antonio. Current Population Estimates and Projections Data as of December 2020.

[17] *A Parent's Guide to Raising Healthy, Happy Children* is available at dshs.texas.gov/mch/pdf/2019_Parent-Guide_ENG_Final.pdf

lack a unified approach to provide injury prevention education to new parents. The committee recommends the collaboration of these agencies and campaigns to create an educational pamphlet specifically focused on injury prevention initiatives, including child abuse prevention strategies and CPR, choking prevention, and first aid methods.

Recommendation to the Department of Family and Protective Services (DFPS)

Recommendation 1: Provide a collaborative educational campaign on bathtub drowning prevention strategies related to touch supervision safety and infant bath supplies.

Drowning is the leading cause of accidental death for children under the age of five in both the U.S. and in Texas. Toddlers are especially at risk. Most child drownings inside the home occur in the bathtub, usually during a lapse in adult supervision. In Texas from 2017-2019, 22 children under the age of 5 died from drowning in a bathtub.[6] The committee recommends DFPS request funding support for a public education campaign on bathtub safety and drowning prevention.

This campaign should educate the public on the importance of adequate bathtub supervision for infants and children. AAP recommends touch supervision for young children. Touch supervision requires a supervising adult to be within arm's reach of a child, so the adult can pull the child out of the water if the child's head becomes submerged.[10] Parents and caregivers should not leave young children alone or in the care of another child while in or near bathtubs. Designation of a water watcher, or an adult that is responsible for watching children at all times when they are in or around water including bath time, is recommended. This adult should not be engaged in other distracting activities, including using the telephone (talking or texting), socializing, tending to chores, or drinking alcohol. There should be a clear handoff of responsibility from one water watcher to the next. Supervision must be close, constant, and attentive.

This campaign should also include information on bathtub equipment safety. Infant bath seats must be used properly to prevent them from tipping over. If used improperly, children can slip out of bath seats and drown in even a few inches of water in the bathtub. Other important components of bathtub safety may include adding no-slip strips at the bottom of the bathtub and covering the water faucet with a cushioned cover to avoid injuries to a child's head.

The committee supports the allocation of funding to DFPS to initiate a public safety campaign on bathtub safety in collaboration with partner state agencies, including DSHS.

4. Conclusion

Child fatality review is a unique process that brings together multi-disciplinary professionals to discuss how and why Texas children are dying. This report is based on the data collected and recommendations made by local child fatality review teams (CFRTs), as well as the research, recommendations, and advocacy of the State Child Fatality Review Team Committee (committee). Committee members participate in their local CFRT reviews and work to bring the topics discussed in local reviews to the attention of the committee.

For the 2022 report, the committee is making seven recommendations to the Governor and Legislature concerning actions to increase child safety in Texas. Recommendations include legislation around child passenger safety, pool fences, funding CFRT support staff in public health regions, and suicide prevention and reporting. The committee made one recommendation to the Department of Family and Protective Services for the request of funding support for a public education campaign related to bathtub safety.

This report would not be possible without the dedication and input of the members of the committee and the local CFRT coordinators, presiding officers, and respective team members. The diverse range of professionals who volunteer as members of the local CFRTs give the child fatality review process its multi-disciplinary perspective and add immeasurably to the goal of understanding child death and reducing risk to Texas children.

List of Acronyms

Acronym	Full Name
AAP	American Academy of Pediatrics
CDC	Centers for Disease Control and Prevention
CFRT	Child fatality review team
CPR	Cardiopulmonary resuscitation
CPS	Child Protective Services
CSS	Child safety seat
DFPS	Texas Department of Family and Protective Services
DSHS	Texas Department of State Health Services
MTP	Medical Transportation Program
NCFRP	National Center for Fatality Review and Prevention
PHR	Public Health Region
POK	Protect Our Kids

Appendix A. State Child Fatality Review Team Committee Members

The following table lists the members of the State Child Fatality Review Team Committee as of February 2022 who were active during this reporting period.

Name	Committee Position	Professional Affiliation and Location
Michael Baldwin (Chair)	Police Chief	Police Chief, Hudson Oaks Police Department, Hudson Oaks
Dr. Kenton Murthy (Vice Chair)	Public Health Professional	Assistant Medical Director & Deputy Local Health Authority, Tarrant County Public Health, Fort Worth
Dr. Ada Booth	Child Abuse Prevention Specialist	Child Abuse Pediatrician, Driscoll Children's Hospital, Corpus Christi
Shane Brassell	Justice of the Peace	Justice of the Peace, Precinct 2, Hillsboro
Dr. Kim Cheung	Pediatrician	Associate Professor, The University of Texas McGovern Medical School, Houston
Dr. Tara Das	Vital Statistics Representative	State Registrar and Director, Vital Statistics, Texas Department of State Health Services, Austin
Kristi Elliott	Child Educator	Director, Student Support Services, Comal ISD, New Braunfels
Elizabeth Farley	Governor's Office Appointee	Budget & Policy Advisor, Office of Governor Greg Abbott, Austin

Name	Committee Position	Professional Affiliation and Location
Christopher Forbis	Sheriff	Sheriff, Randall County Sheriff's Office, Amarillo
Dr. San Juanita Garza-Cox	Sudden Infant Death Syndrome Family Service Provider	Neonatologist, Pediatrix Medical Group, San Antonio
Michael Hayes	Emergency Medical Services Provider	Captain, City of New Braunfels Fire Department, New Braunfels
Dr. Owais Khan	Neonatologist	Program Development Medical Director, Pediatrix & Obstetrix Specialists, Houston
Diane MacLeod	Child Protective Services Specialist	Investigator, Child Protective Investigations, Austin
Letty Martinez	Lieutenant Governor Appointee	Criminal Law Specialist, Varghese Summersett PLLC, Fort Worth
LaViza Matthews	Texas Department of Transportation Representative	Traffic Safety Specialist, Texas Department of Transportation, Amarillo
Clarissa Mora	Child Advocate	Executive Director, Children's Advocacy Center of the Coastal Bend, Corpus Christi
Anjelica Powers	Criminal Prosecutor	Chief, Family Violence Division, Bexar County Criminal District Attorney's Office, San Antonio
Dr. Jennifer Ross	Medical Examiner	Assistant Medical Examiner, Harris County Institute of Forensic Sciences, Houston
Kathryn Sibley	Department of Family and	Director, Prevention and Early Intervention, Texas Department

Name	Committee Position	Professional Affiliation and Location
	Protective Services Representative	of Family and Protective Services, Austin
Amy Smith	Family Violence Advocate	Deputy Director, Harris County Domestic Violence Coordinating Council, Houston
Steven Tellez	Department of Public Safety Representative	Captain, Texas Highway Patrol, San Antonio
Dr. Lawrence Thompson	Child Mental Health Provider	Director of Integrated Health Services, Harris County Resources for Children and Adults, Houston
Jeremy Triplett	Title V Representative	Deputy Associate Commissioner, Community Health Improvement Division, Texas Department of State Health Services, Austin
Dr. Jeannine Von Stultz	Chief Juvenile Probation Officer	Deputy Chief - Mental Health Services, Bexar County Juvenile Probation, San Antonio
Gene Wu	Speaker of the House of Representatives Appointee	Member, Texas House of Representatives, Austin

Thank you to former members who served on the committee during 2020-2022:

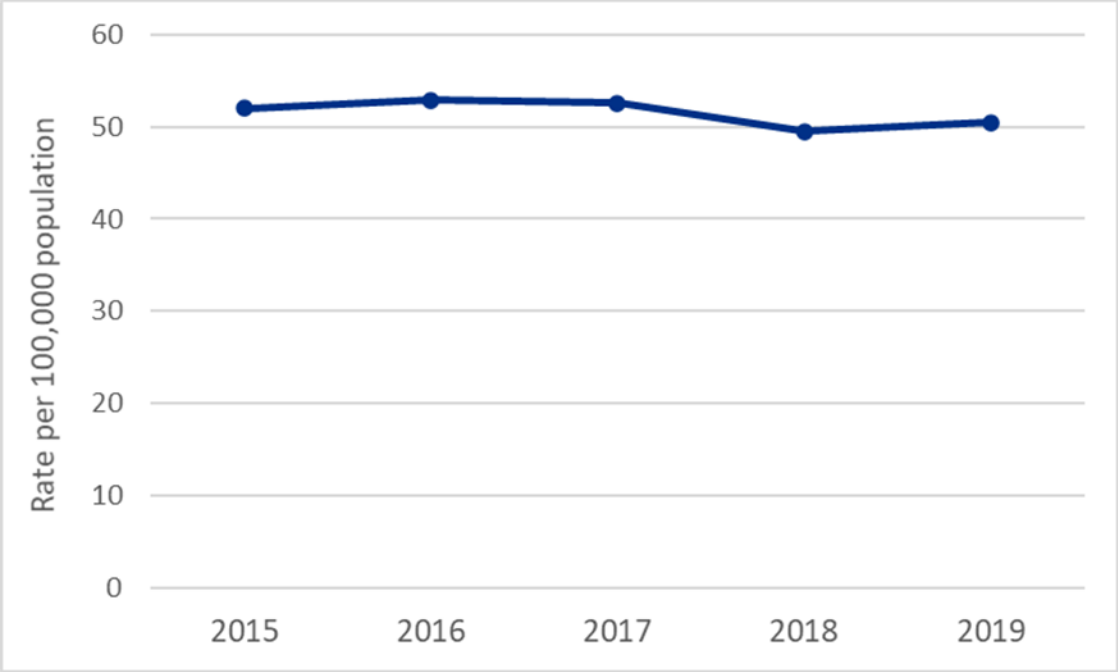
- Steven Clinkscales (Emergency Medical Services Provider)
- Kirk Coker (Sheriff)
- Jackie Lopez (Child Mental Health Provider)
- Dr. Donald McCurnin (Neonatologist)
- Terry Pence (Texas Department of Transportation Representative)
- Marsha Stone (Child Protective Services Specialist)

Appendix B. Death Certificate Analysis

The most recent year for which local child fatality review teams (CFRTs) have completed child fatality case review is 2019. Their 2017-2019 case reviews and recommendations, in addition to other research conducted by the committee, form the basis of this report. To supplement the information provided by local CFRTs, the Department of State Health Services (DSHS) analyzed death certificate data for child deaths that occurred in Texas from 2017-2019 (regardless of the child's residence) to determine state-level trends. Where appropriate, DSHS included in their analysis data for child deaths that occurred in 2015-2016 (available in the 2020 Legislative Report) to provide historical context. Data for 2020 and beyond are not currently finalized and will not be used in the following analysis to ensure consistent and accurate reporting.

Texas death data was extracted from the DSHS mortality file for 2017-2019, ages 0 to 17, on November 23, 2021. All data was previously collected with no additional data added. This dataset was imported into SAS software for analysis.

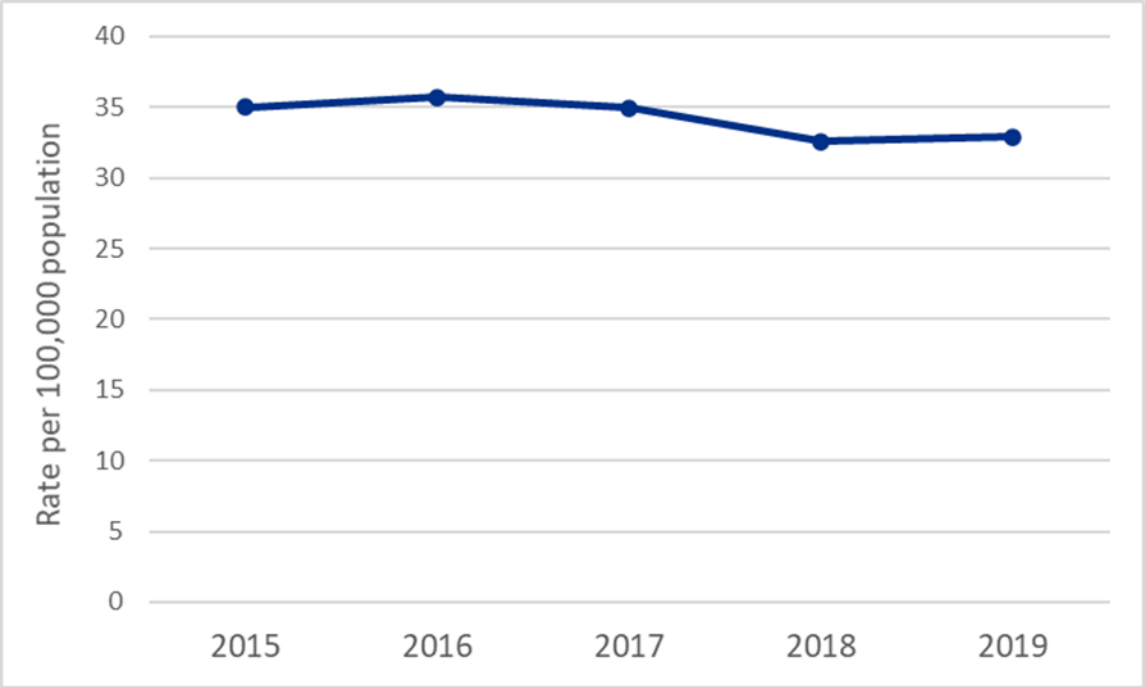
Figure 1. Texas Child Death Rate, All Causes of Death, Ages 0-17, 2015-2019



Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2015-2019 Prepared by: Office of Injury Prevention, Jan. 2022.

The rates for all child deaths for children ages 0-17 in Texas were consistent between 2015 and 2019 (Figure 1).

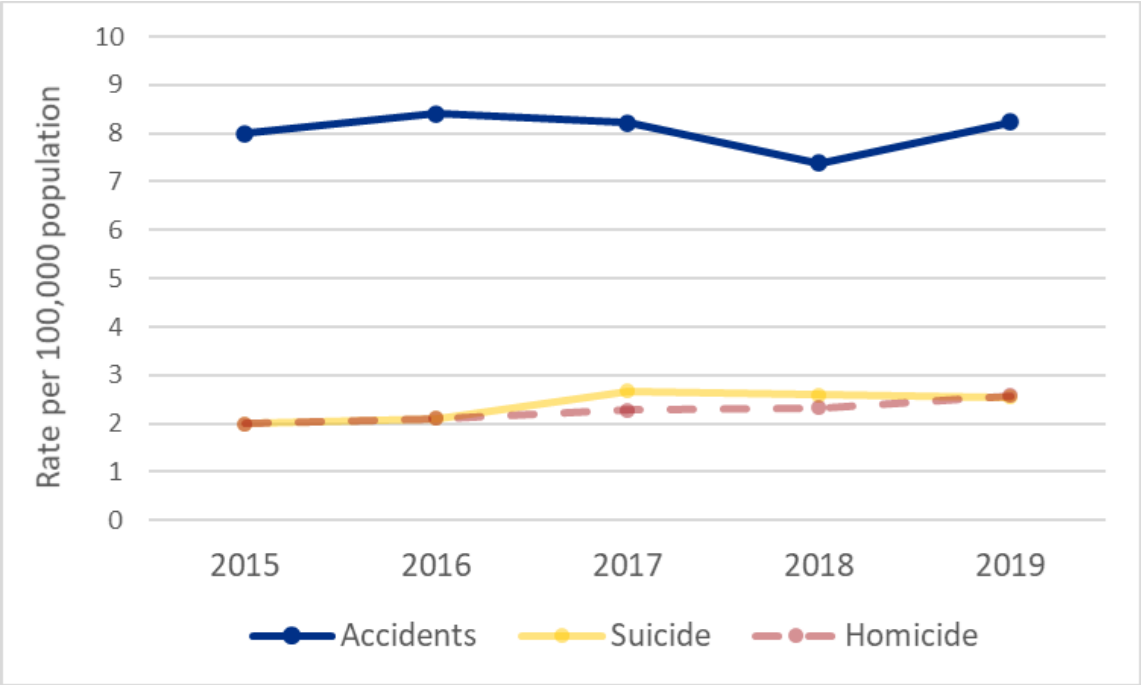
Figure 2. Texas Child Death Rate, Natural Cause of Death, Ages 0-17, 2015-2019



Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2015-2019 Prepared by: Office of Injury Prevention, Jan. 2022.

Natural causes include death due to prematurity, congenital anomalies, cancer, and infectious diseases. Natural child deaths were at the lowest rate in 5 years in 2018 (32.6). The rates of natural child deaths in Texas were consistent between 2015 and 2019 (Figure 2).

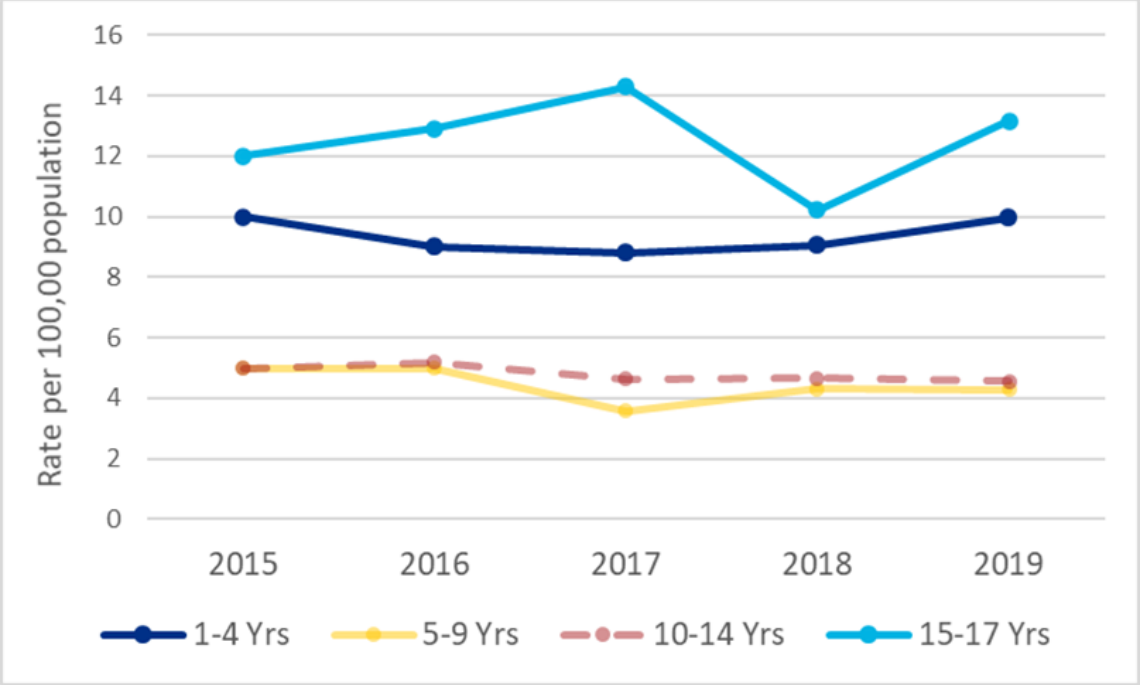
Figure 3. Trends in Injury Child Death Rates by Manner of Death, Texas, Ages 0-17, 2015-2019



Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2015-2019 Prepared by: Office of Injury Prevention, Jan. 2022.

The injury child death rates (Figure 3), which consists of accidents, suicides, and homicides, were considerably lower than the natural child death rates (Figure 2). The rate of accidental death for children ages 0-17 in Texas remained at least three times higher than homicide or suicide deaths between 2015 and 2019 (Figure 3). Accidental deaths included deaths due to motor vehicle injuries, drowning, choking, and other causes of death. Accidental deaths remained constant from 2015 to 2019, while suicides and homicides increased during this time (Figure 3).

Figure 4. Trends in Accidental Child Death Rates by Age Groups, Texas, Ages 1-17, 2015-2019

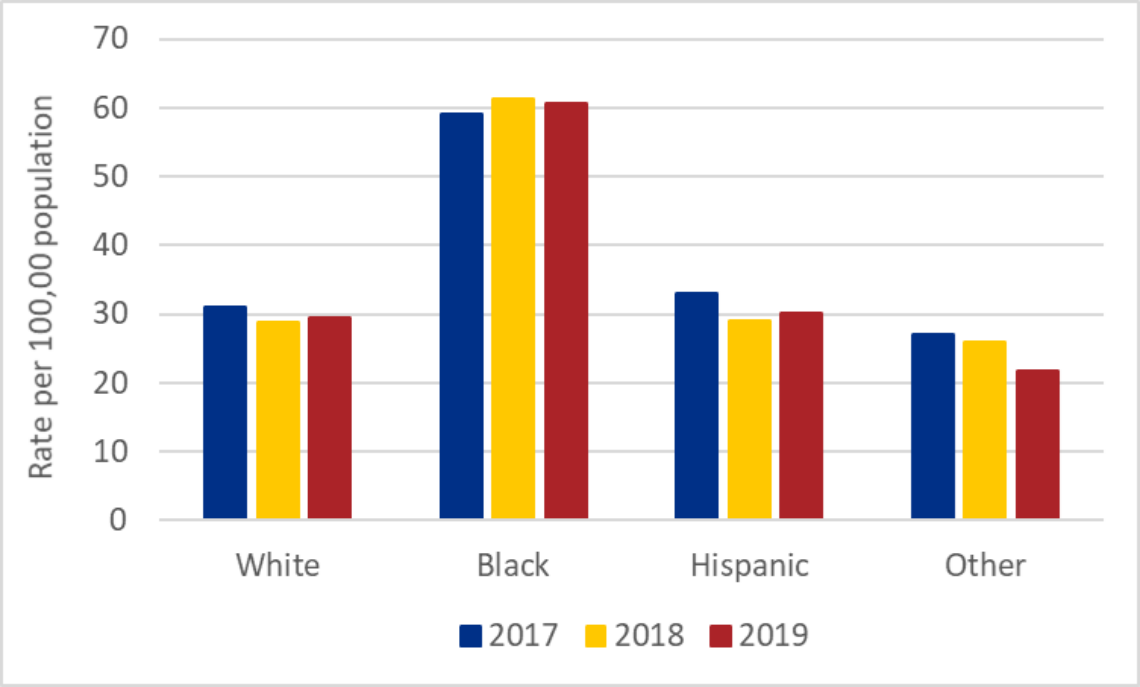


Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2015-2019 Prepared by: Office of Injury Prevention, Jan. 2022.

From 2015 to 2019, the distribution of accidental child death rates stayed generally the same for all age groups, except for children ages 1-4 and 15-17 (Figure 4). There was an increase in accidental death rates between 2017 and 2019 among children ages 1-4. This increase was due to drownings in 2018 and motor vehicle accidents in 2019. There was also a reduction in deaths for youth 15-17 in 2018 because of a decrease in motor vehicle deaths that year, but the rate increased again in 2019.

Demographic data for child deaths occurring in 2017-2019 are highlighted in the figures below. Demographic data for child deaths occurring in 2015-2016 are available in the 2020 Legislative report.

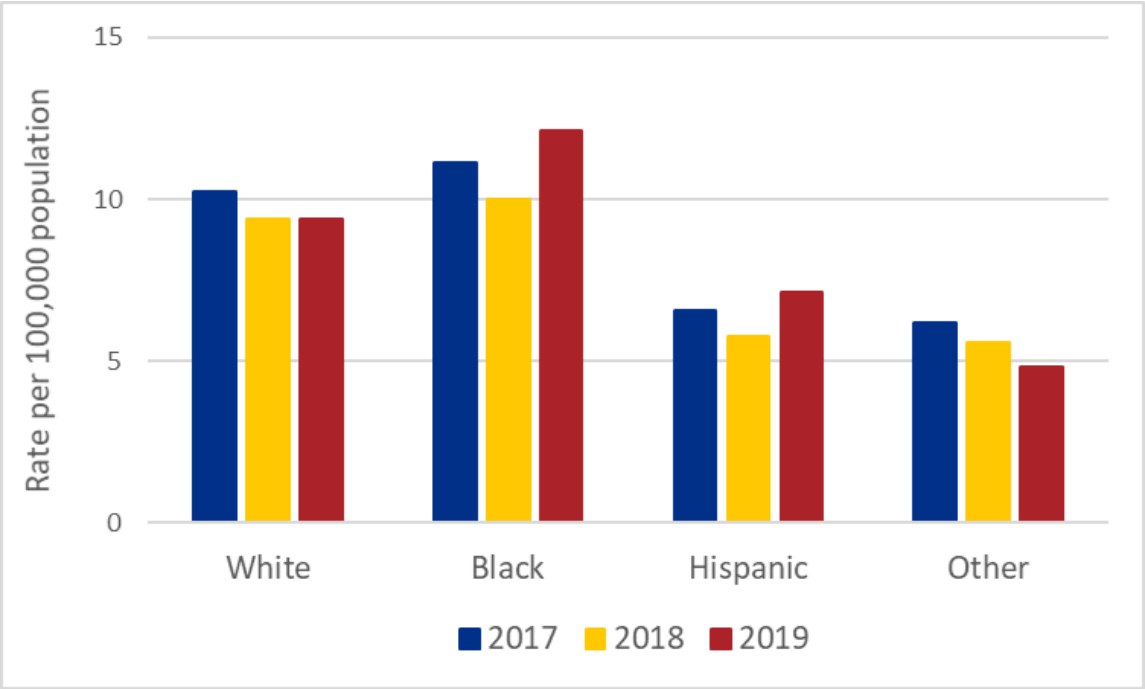
Figure 5. Natural Child Death Rate by Race and Ethnicity, Texas, Ages 0-17, 2017-2019



Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2017-2019 Prepared by: Office of Injury Prevention, Jan. 2022.

Between 2017 and 2019, non-Hispanic Black children were more than twice as likely to die of natural causes than any other race or ethnicity (Figure 5), primarily as a result of prematurity. The natural child death rates by race were consistent from 2017 to 2019 but increased slightly for non-Hispanic Black children and decreased slightly for White, Hispanic, and Other groups.

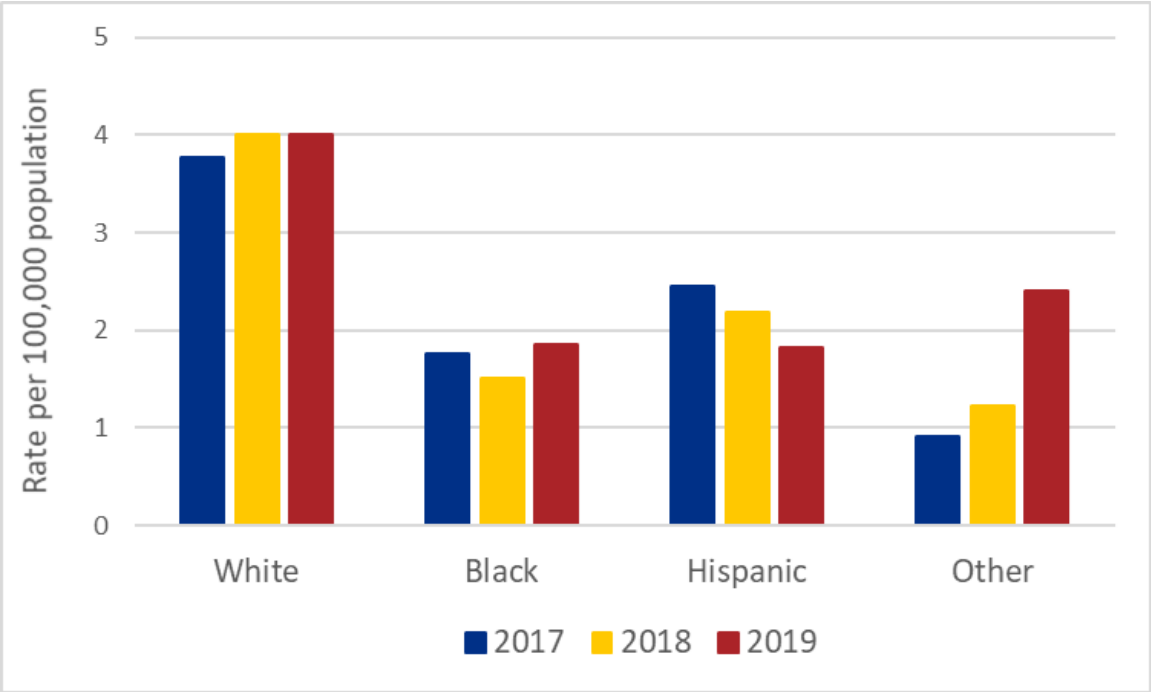
Figure 6. Injury Child Death Rate by Race and Ethnicity (Accidental), Texas, Ages 0-17, 2017-2019



Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2017-2019 Prepared by: Office of Injury Prevention, Jan. 2022.

From 2017-2019, non-Hispanic Black children died of accidents at a higher rate than any other race or ethnicity (Figure 6).

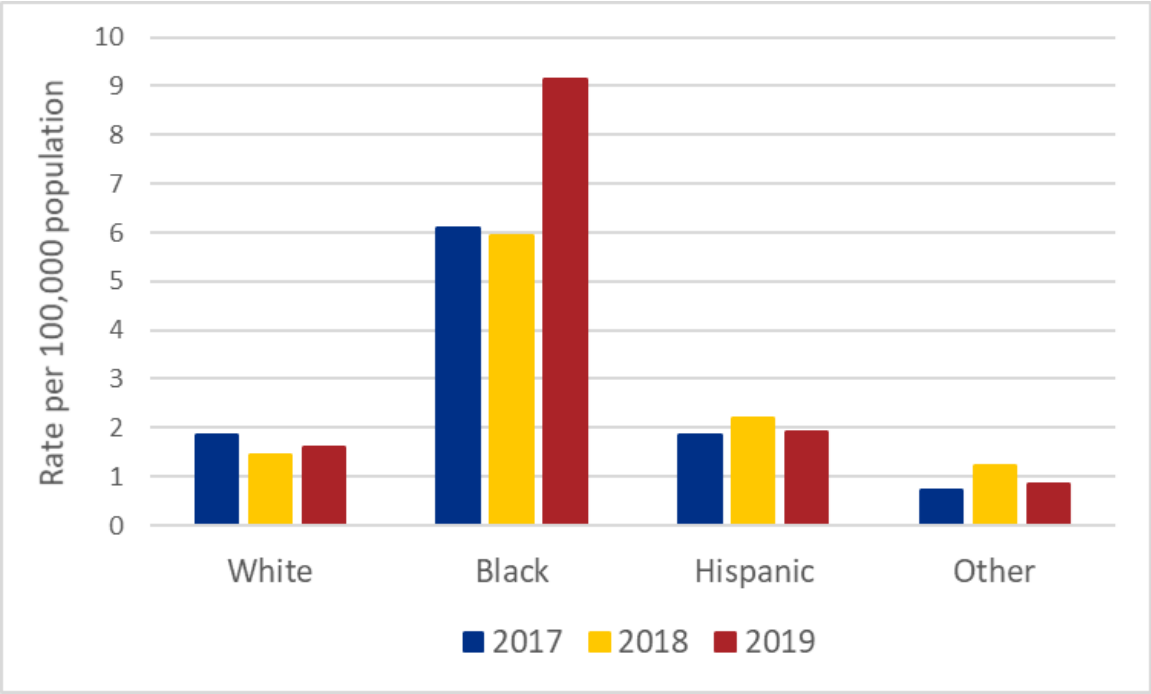
Figure 7. Injury Child Death Rate by Race and Ethnicity (Suicide), Texas, Ages 0-17, 2017-2019



Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2017-2019 Prepared by: Office of Injury Prevention, Jan. 2022.

From 2017-2019, White children died of suicide at a higher rate than any other race or ethnicity (Figure 7).

Figure 8. Injury Child Death Rate by Race and Ethnicity (Homicide), Texas, Ages 0-17, 2017-2019



Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2017-2019 Prepared by: Office of Injury Prevention, Jan. 2022.

From 2017-2019, non-Hispanic Black children died of homicide at a higher rate than any other race or ethnicity (Figure 8).

Appendix C. Data from Child Fatality Review Team

Texas Child Fatality Review Team (CFRT) data was downloaded from the National Center for Fatality Review and Prevention Case Reporting System on November 16, 2021. Deaths occurring from 2017-2019 were abstracted from this dataset, checked for duplicates, and imported into SAS software. All data were previously collected by local CFRTs and no additional data were added. Tables presenting CFRT data by age group only include reviewed deaths where an age of 0 to 17 at the time of death was recorded.

Table 1. Comparison of Child Fatality Cases Reviewed, Death Certificates and CFRT Data by Manner of Death, Texas, Ages 0-17, 2017-2019

Manner of Death	Death Certificate	Reviewed	Percent reviewed
Natural	7,370	1,278	17%
Accident	1,750	658	38%
Suicide	574	259	45%
Homicide	527	194	37%
Other[i]	974	422	43%
Total	**11,195**	**2,811**	**25%**

Source: Child Fatality Review Team Death Data Files 2017-2019 Prepared by: Office of Injury Prevention Epidemiology, Jan. 2022.

[i] Includes records with manner of death coded as undetermined, unknown, or pending.

Table 2. Comparison of Child Fatality Cases Reviewed, Death Certificates, and CFRT Suicide by Age Group, Texas, Ages 10-17, 2017-2019

Age Group	Death Certificate	Reviewed	Percent Reviewed
Ages 10-14	171	86	50%
Ages 15-17	403	169	42%
Total	574	255	44%

Source: Child Fatality Review Team Death Data Files 2017-2019 Prepared by: Office of Injury Prevention Epidemiology, Jan. 2022.

Table 3. Comparison of Child Fatality Cases Reviewed, Death Certificates, and CFRT Homicide by Age Group, Texas, Ages 0-17, 2017-2019

Age Group	Death Certificate	Reviewed	Percent Reviewed
0-4 years	185	59	32%
5-9 years	48	12	25%
10-14 years	67	23	34%
15-17 years	227	100	44%
Total	**527**	**194**	**37%**

Source: Child Fatality Review Team Death Data Files 2017-2019 Prepared by: Office of Injury Prevention Epidemiology, Jan. 2022.

Table 4. Comparison of Child Fatality Cases Reviewed, Death Certificates, and CFRT Accidental Deaths by Age Group, Texas, Ages 0-17, 2017-2019

Age Group	Death Certificate	Reviewed	Percent Reviewed
0-4 years	756	301	40%
5-9 years	249	78	31%
10-14 years	285	108	38%
15-17 years	460	167	36%
Total	**1,750**	**654**	**37%**

Source: Child Fatality Review Team Death Data Files 2017-2019 Prepared by: Office of Injury Prevention Epidemiology, Jan. 2022

Table 5. Comparison of Child Fatality Cases Reviewed, Death Certificates, and CFRT Other Causes by Age Group, Texas, Ages 0-17, 2017-2019

Age Group	Death Certificate	Reviewed	Percent Reviewed
0-9 years[i]	907	385	42%
10-14 years	33	15	45%
15-17 years	34	22	65%
Total	**974**	**422**	**43%**

Source: Child Fatality Review Team Death Data Files 2017-2019 Prepared by: Office of Injury Prevention Epidemiology, Jan. 2022.

[i] Ages 0-9 combined to reduce suppression.

Table 6. Comparison of Child Fatality Cases Reviewed, Death Certificates, and CFRT Natural by Age Group, Texas, Ages 0-17, 2017-2019

Age Group	Death Certificate	Reviewed	Percent Reviewed
0-4 years	6,038	1,056	17%
5-9 years	440	58	13%
10-14 years	481	84	17%
15-17 years	411	75	18%
Total	**7,370**	**1,273**	**17%**

Source: Child Fatality Review Team Death Data Files 2017-2019 Prepared by: Office of Injury Prevention Epidemiology, Jan. 2022.