



Texas Child Fatality Review Team

Biennial Report 2014-2015



ACKNOWLEDGEMENTS

The Texas State Child Fatality Review Team (SCFRT) Committee would like to acknowledge the following individuals for their dedicated service to the children of Texas and their contributions to the SCFRT. They are gratefully applauded for their service on the SCFRT and wished the best in future endeavors.

- Juan Parra, M.D., Bexar County pediatrician and founding member of the SCFRT.
- Tammy Sajak, MPH, former Director, Office of Title V and Family Health, Department of State Health Services (DSHS), who served as a permanent member in the role of MCH Director.
- Joe Granbury, Emergency Medical Technician, Williamson County EMS, who served in the role of Emergency Medical Technician.
- Susan Rodriguez, former Child Fatality Review Coordinator, Office of Title V and Family Health, Department of State Health Services (DSHS), who served as the coordinator from 2006 to 2014.

This report is based on the data collected and recommendations made by local Child Fatality Review Teams (local CFRTs), as well as the research, recommendations and advocacy of the SCFRT. This report would not be possible without the dedication and input of the members of the SCFRT (Appendix A) 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.

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LETTER FROM THE CHAIR

During my years as a medical examiner for Dallas County, it has been my pleasure to serve on the local Dallas County Child Death Review Team and subsequently on the State Child Fatality Review Team (SCFRT). It is a distinct honor as the current chair of the SCFRT to present the 2015 Texas Child Fatality Review Team Biennial Report. The report outlines the local child fatality review team data and recommendations developed by the SCFRT aimed at reducing preventable child deaths in the state of Texas. This report would not be possible without the work of health care providers, law enforcement officers, social workers, teachers, lawyers and many others who dedicate their lives to the safety and security of one of our most vulnerable populations – our children.



The following points highlight the activities of the SCFRT over the last two years:

Protect Our Kids Commission: During the 83rd Texas Legislative Session, Senate Bill 66 created the Protect Our Kids Commission to study child abuse and neglect fatalities and make recommendations concerning prevention. This commission began its work in 2015 and several members of DSHS and the SCFRT served as subject matter experts for the commission. Recommendations by the commission recognize the value of the SCFRT and the need for more coordinator support.

Position Statements: Position statements on a variety of child safety topics are one way for the SCFRT to communicate best practices in injury and death prevention to a wide audience. These statements are available on the DSHS Child Fatality Review (CFR) website (www.dshs.state.tx.us/mch/Child_Fatality_Review.shtm) and are distributed widely through local teams and other injury prevention partners. SCFRT workgroups revised and updated position statements on child suicide, child maltreatment, and safe sleep in 2015.

State Team Development: Senate Bill 66 added new disciplines to the SCFRT including an emergency services provider, and a provider of services to, or advocate for, victims of family violence. These new members have been valuable additions to the team. The SCFRT and DSHS also received a grant from the Children's Justice Act to hire two local child fatality review team coordinators in one urban and one rural jurisdiction in Texas. These positions will serve as a pilot project to demonstrate the need for a full time CFRT coordinator in each of the public health service regions. The addition of coordinators throughout Texas will serve to increase effectiveness and consistency by providing coordination, training and data entry assistance to local CFRTs and ultimately lead to a better child fatality review process and prevention efforts.

Local Team Development: The SCFRT has continued to work towards the goal of 100 percent coverage in all Texas counties. As of 2015, there are 74 active local CFRTs covering 194 counties in Texas. Approximately 94% of all Texas children reside in counties covered by a Child Death Review Team. The SCFRT continues to push for 100% coverage while providing support to the existing teams. Local teams have been participating in a wide range of prevention-oriented activities cited in detail in this report. These activities include large-scale media campaigns,

community outreach, and social media campaigns focusing on child suicide, bicycle safety, child passenger safety, infant safe sleep, and child maltreatment.

While we can never prevent everything bad from happening to our children, the SCFRT has focused heavily on certain areas that we have identified as preventable dangers. Unsafe sleep environments, unsafe vehicular practices (including distracted driving, driving under the influence of alcohol or drugs, and even how we administer driver's education), drug overdoses, child suicide, child abuse and neglect, and unsafe firearm storage have been a major focus for the team over the last few years. As advocates for Texas children, the SCFRT will continue dedicating its efforts to reduce the number of preventable child deaths through collaboration, outreach, and action.

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Background

Child Fatality Review (CFR) is a public health strategy to understand child deaths through multidisciplinary review at the local level. Data are collected and analyzed to best understand risks to children. The lessons learned from the reviews inform local and statewide prevention activities and reduce preventable child deaths. CFR is practiced in every U.S state and in other countries.

The Texas CFR process was created in 1995 by the Texas Legislature: Texas Family Code, Title 5, Chapter 264, Subchapter F, §264.501-§264.515. CFR consists of two critical components with distinct yet complementary roles: the State Child Fatality Review Team Committee (SCFRT) which is also known as the Texas Child Fatality Review Team (TCFRT) and local Child Fatality Review Teams (local CFRTs). The Department of State Health Services (DSHS) provides CFR support and oversight.

The 22-member SCFRT is a statutorily-defined multidisciplinary group of professional disciplines with unique perspectives on child safety. SCFRT members serve three-year terms and are subject matter experts who represent fields such as from law enforcement, the medical community, child advocacy organizations, the court system, and the behavioral health community. The Department of Family and Protective Services, Department of State Health Services, Department of Public Safety and Department of Transportation are also members of the Committee. For a complete list of SCFRT membership, see Appendix A.

The SCFRT meets quarterly to discuss issues related to child risks and safety, develop strategies to improve child death data collection and analysis, develop position statements specific to child safety issues, and research and develop recommendations that will make Texas safer for children. The SCFRT statutory charges are to:

- Develop an understanding of the causes and incidences of child death in Texas;
- Identify procedures within agencies represented on the SCFRT 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.

Texas Family Code §264.503(f) requires that not later than April 1 of each even-numbered year, the SCFRT reports to the Governor, Lieutenant Governor, and the Speaker of the House of Representatives the aggregate child fatality data collected by local child fatality review teams and recommendations to prevent child fatalities and injuries. The report is also required to provide recommendations to the Department of Family and Protective Services operations based on input from the child safety review subcommittee.

Local CFRTs are volunteer-based and organized by county or multi-county geographic areas. Local memberships mirror that of the SCFRT. Local CFRTs conduct retrospective reviews of deaths of children 17 years of age or younger in their geographic areas. Team members collect information that corresponds to their disciplines and specific questions in the National Center for Fatality Review and Prevention database. Local CFRTs meet to share what each member knows about the specific child deaths being reviewed and identify risk factors specific to their

communities. All reviews conclude with the question: was this death preventable? Local CFRTs monitor child death trends in the community, share the lessons learned with the SCFRT and stakeholders, and spearhead or participate in local prevention activities. Local CFRTs are responsible for:

- Providing assistance, direction, and coordination in child death investigations;
- Promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities;
- Developing an understanding of the causes and incidence of child death in a designated county or counties where the local CFRT is located; and,
- Advising SCFRT on changes in law, policy, or practice that will assist the local CFRTs and the member agencies represented on the team to best fulfil their duties.

In 2014 and 2015, there were 74 active local CFRTs covering 194 of the 254 counties resulting in 94 percent of Texas children residing in a county where child deaths are reviewed. In 2014 and 2015, local CFRTs reviewed child deaths that occurred in 2012 and 2013. There were 3,741 child deaths in Texas in 2012 and 3,742 child deaths in Texas in 2013. Active local CFRTs reviewed 1503 (40.2 percent deaths) of the total child deaths in 2012 and 1384 (37.0 percent) of the total child deaths in 2013.

Data Trends

The overall child death rate in Texas increased to 54.4 per 100,000 children in 2012 and 54.3 per 100,000 children in 2013 following an all-time low in 2011 (52.7 per 100,000 children). The motor vehicle death rate among children aged 15-17 years increased from 2011 (9.7 per 100,000 children) to 2013 (10.4 per 100,000 children).

The data collected by local CFRTs augment death certificate data and provide rich insight into the causes and circumstances surrounding child fatalities in Texas. The detailed information gathered by local CFRTs provides a better understanding of the scope and nature of child fatalities. This information can then be used to drive the development of quality preventive plans and measures. It is important to understand that local CFRT data are only a sample of all child deaths. Unlike death certificate data that provide exact numbers and rates for fatalities, local CFRT data provide a more general understanding of a smaller number of those deaths.

Analysis of local CFRT data identifies the leading causes of preventable child death. The data illustrate specific conditions and risks that suggest ways to educate the community and to enact statutes that will prevent child deaths.

- **Motor vehicle crash deaths:** Motor vehicle deaths are a leading cause of accidental death for children. Most children were passengers (57.6 percent in 2012 and 54.1 percent in 2013), with the majority sitting in the back seat. Correct seat belt usage among back seat passengers in motor vehicle crash deaths declined from 9.9 percent in 2012 to 4.3 percent in 2013. Contributing factors in all child motor vehicle crash deaths included speed, drugs/alcohol and reckless driving.
- **Drowning deaths:** Pools are the most common site for drowning deaths. Approximately 62 percent of all children who drowned in both years drowned in pools, hot tubs or spas.

Children ages 1-4 years accounted for 68.8 percent of pool, hot tub or spa drowning fatalities. Of those deaths that occurred in a private pool, hot tub or spa, 35 percent of the pools had no barrier to limit access to the pool. Poor or absent supervision was cited as a contributing factor in 44 percent of the deaths of children younger than five years old.

- **Homicides:** Of the child homicides reviewed, local CFRTs determined that 34.9 percent in 2012 and 27.6 percent in 2013 were caused by child abuse or neglect. Child abuse and neglect fatalities primarily involved children under the age of five years. Assault, which does not include child abuse, was the second leading contributing cause to child homicides at 22.9 percent in 2012, and 29.9 percent in 2013. Most homicides involved a weapon (62.7 percent in 2012 and 66.7 percent in 2013).
- **Suicide deaths:** Child suicide rates have remained relatively constant over the past nine years. In 2012, weapon/firearm (45.8 percent) was the most prevalent method by which children less than 18 years old committed suicide, followed by asphyxiation (38.9 percent). In 2013 asphyxiation became the most prevalent method at 43.0 percent followed by weapon/firearms at 36.7 percent.
- **Sleep-related deaths:** Local CFRTs identified 187 sleep-related deaths in 2012 and 153 sleep-related deaths in 2013 to children less than one year of age. Approximately 50 percent of all infant sleep-related deaths occurred while the infant was sleeping on an adult bed. Local CFRTs found that of all infant sleep-related deaths, infants were found primarily on their stomach (41.2 percent in 2012 and 37.3 percent in 2013).

Child Fatality Review Team (CFRT) Data

Data gathered in the Child Fatality Review Team (CFRT) process is an important task of CFRTs. The detailed information gathered by local CFRTs enhances and supports death certificate data, and provides a better understanding of the scope and nature of child fatalities. This information is used to drive the development of quality preventive plans and measures.

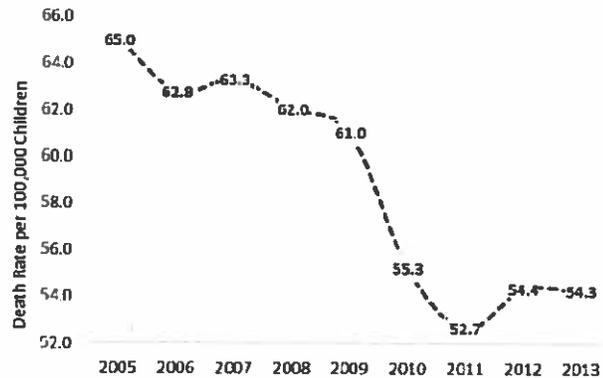
The data presented in this report is a combination of state-level trends from death certificate data, and the more detailed sample data collected by the CFRTs during the review process. The data included in this report are child deaths that occurred in Texas, regardless of the child's residence. Deaths are reviewed based on where they occurred because the prevention efforts developed by the CFRTs are designed to impact a local problem; for example, changing the line of sight at dangerous intersections.

It is important to understand that CFRT data is only a sample of child deaths. Unlike death certificate data that provides exact numbers and rates for fatalities, CFRT data provides a more thorough understanding of a smaller number of those deaths. Therefore, throughout this data section, percentages for CFRT data will be reported instead of exact numbers. The unknown categories throughout this report include missing data, where missing indicates data quality efforts are still needed, a skip due to a lack of information, or an actual unknown.

Overview of Child Deaths in Texas

Overall, there was an increase in the number of child deaths in Texas, from 3,625 in 2011 to 3,741 in 2012 and 3,742 in 2013. The Texas child death rate increased to 54.4 per 100,000 children in 2012 and 54.3 per 100,000 children in 2013. This increase followed an all-time low Texas child death rate of 52.7 per 100,000 children in 2011 (Figure 1). Child deaths include child natural deaths and non-natural deaths.

Figure 1. Texas Child Death Rate – All Deaths

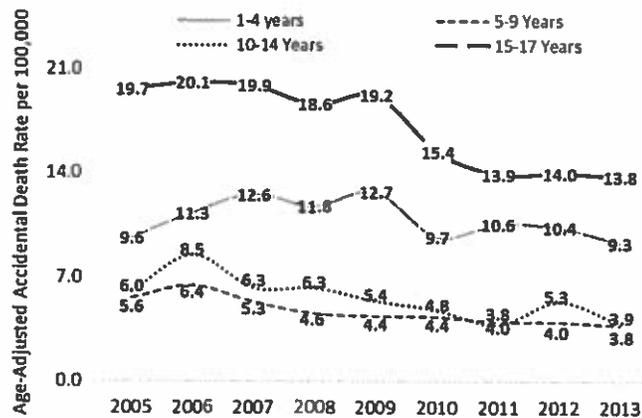


Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections
Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

The child death rate for natural deaths decreased from 2007 to 2011 (Figure 2), but steadily increased from 2011 (36.1 per 100,000 children) to 2013 (38.6 per 100,000 children).

Approximately 75 percent of all natural deaths occur in children younger than one year of age. An increase in natural child deaths can also be explained by the infant mortality rate, which increased from 2011 (5.7 per 1,000 live births) to 2013 (6.0 per 1,000 live births)¹.

Figure 2. Trend in Natural Child Death Rate



Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections
Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

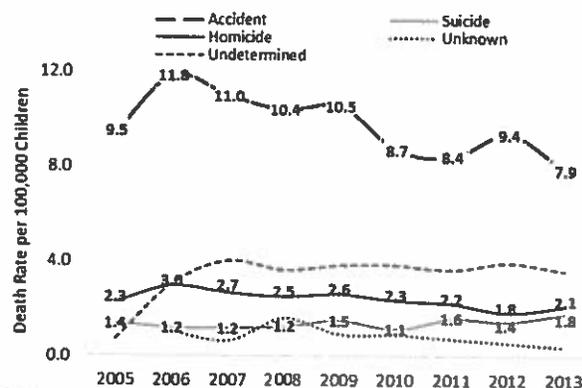
For more information on infant mortality, refer to the latest Healthy Texas Babies Data Book at: <https://www.dshs.state.tx.us/healthytxbabies/data.aspx>

Non-natural deaths primarily consist of accidents, homicides, and suicides. Non-natural deaths also include unknown and undetermined manners of death, but there is too little information available to include details in this report. The non-natural child death rate is considerably lower than the natural child death rate.

¹Mandell, D.J., & Kormondy, M. 2015 Healthy Texas Babies Data Book. Austin, TX: Division for Family and Community Health Services, Texas DSHS, 2015.

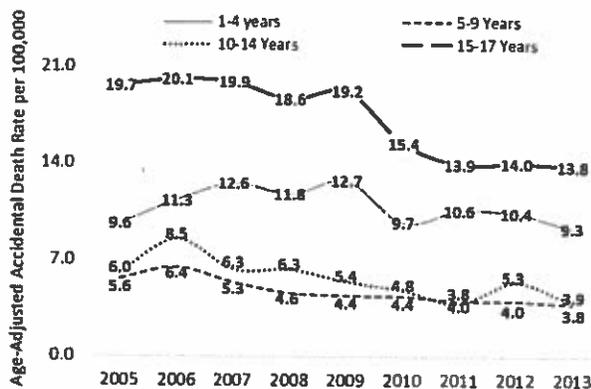
While suicides and homicides may be sensationalized by media, accidents are where preventative efforts can make the greatest impact in decreasing actual deaths and the death rate. The accidental child death rate increased from 2011 (8.4 per 100,000 children) to 2012 (9.4 per 100,000 children), but decreased again in 2013 (7.9 per 100,000 children), the lowest rate in nine years (Figure 3).

Figure 3. Trend in Non-Natural Child Death Rate



Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

Figure 4. Trends in Accidental Child Death Rates



Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

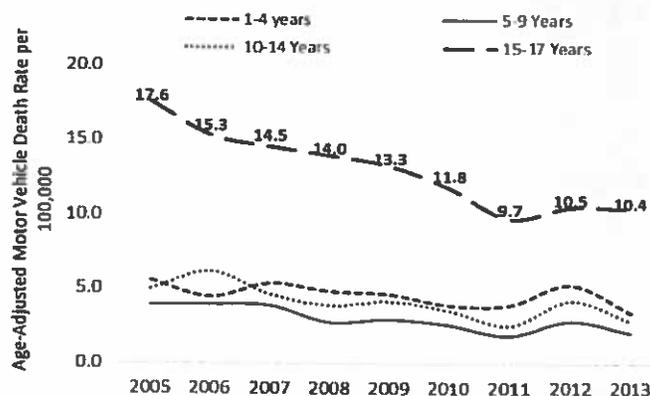
Accidental death rate age-group trends remained consistent among youth aged 15-17 years from 2011 to 2013 (Figure 4). However, there was a spike in the accidental child death rate among children aged 10-14 years from 2011 (3.8 per 100,000 children) to 2012 (5.3 per 100,000 children), which subsided in 2013 (3.9 per 100,000 children). For all age groups, 2013 saw the lowest accidental child death rates in years.

Accidental deaths primarily consist of motor vehicle fatalities followed by drowning deaths.

Motor Vehicle Deaths

Motor vehicle crashes are the leading cause of accidental deaths for children.² Motor vehicle child death rates increased among all age groups from 2011 to 2012, but decreased from 2012 to 2013 (Figure 5). Teens are more likely than all other children to die in motor vehicle accidents. The motor vehicle death rate among children aged 15-17 years increased from 2011 (9.7 per 100,000 children) to 2013 (10.4 per 100,000). This increase followed a seven-year decline from 2005 to 2011, when the age-adjusted motor vehicle death rate for this age group was at its lowest.

Figure 5. Age-Adjusted Motor Vehicle Child Death Rates

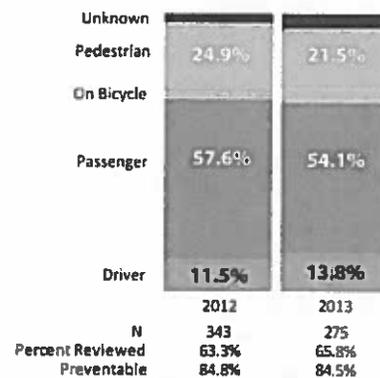


Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

² Motor vehicle deaths are defined by ICD10 codes between V01 through V99.

Figure 6 shows that in 2012 there were 343 child motor vehicle deaths (63.3 percent reviewed by CFRTs) and 275 in 2013 (65.8 percent reviewed by CRFTs). CFRTs estimated that about 85 percent of the motor vehicle child fatalities reviewed for 2012 and 2013 could have been prevented. The CFRTs identified the need for improvement in prevention efforts, and Texas law changed in May 2014, requiring all vehicle occupants to wear a seat belt, regardless of front or back seat — hopefully, reducing future motor vehicle death rates.

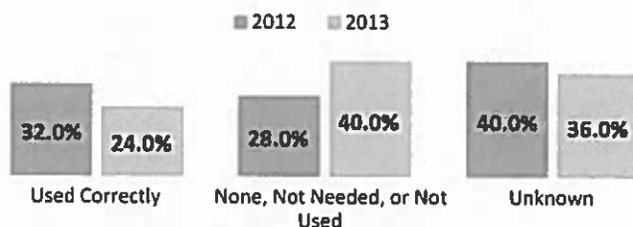
Figure 6. Motor Vehicle Child Deaths by Position



Source: Center for Health Statistics, DSHS, Death Data Files 2012-2013, Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

CFRTs identified that most (57.6 percent in 2012 and 54.1 percent in 2013) children who died from motor vehicle crashes were passengers, while 11.5 percent in 2012 and 13.8 percent in 2013 were drivers. Among drivers, most were between the ages of 15 to 17 years (88 percent in 2012 and 96 percent in 2013). The majority of passengers who died were sitting in the back seat of the vehicle. The seat belt usage and passenger position in the vehicle are determined from the records which are reviewed at CFRT meetings. This information is not available on the death certificate.

Figure 7. Child Driver Motor Vehicle Deaths by Seat Belt Usage

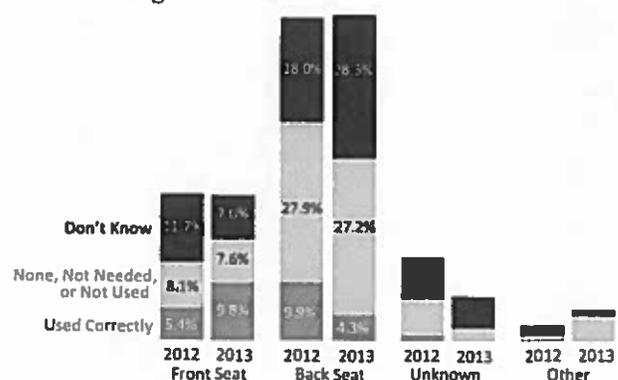


Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

Prevention efforts should primarily focus on correct seat belt usage. CFRTs determined that child drivers who died from motor vehicle crashes used their seat belt correctly 32 percent of the time in 2012, and only 24 percent in 2013 (Figure 7).

Front seat passenger child fatalities were more likely to use their seat belt correctly (5.4 percent in 2012 and 9.8 percent in 2013; Figure 8) compared to back seat passengers. Back seat passengers correct seat belt usage declined from 9.9 percent in 2012 to 4.3 percent in 2013. Many of the CFRTs were not able to determine if a seat belt was used in the majority of motor vehicle child fatalities. The only true unknown is when teams could not determine where the child was in the vehicle at the time of the death. This determination is important to inform the development of targeted prevention and intervention efforts across the state.

Figure 8. Child Passenger Motor Vehicle Deaths by Seat Belt Usage



Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

The top three causes contributing to motor vehicle child deaths were speed, drugs/alcohol, and reckless driving in 2012 and 2013 (Table 1).

In 2012, 18.9 percent of child driver deaths and 13.3 percent in 2013, involved drugs and alcohol. It is important to point out that while these causes contributed to the fatal crash when the child was driving, it does not necessarily mean that the child was taking drugs/alcohol. The local CFRT reviewed data does not indicate the state of the child, only the contributing causes of the fatal crash.

Table 1. Top Causes Contributing to Motor Vehicle Child Deaths

2012		2013	
Speed	22.1%	Speed	26.0%
Drug/Alcohol	17.1%	Reckless Driving	20.4%
Reckless Driving	14.7%	Drug/Alcohol	16.6%
Distracted	10.6%	Unsafe	15.5%

*Multiple causes can be selected per record.

Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

Drowning Deaths

Figure 9. Age-Adjusted Drowning Child Death Rates

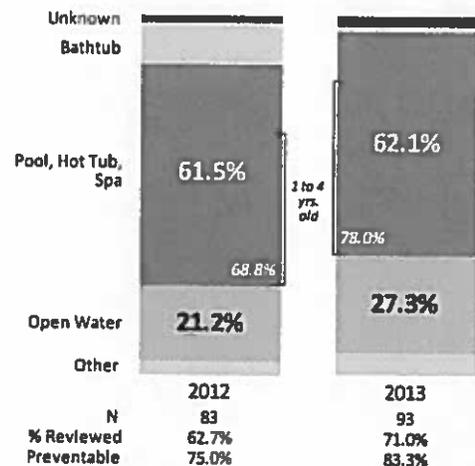


Source: Office of the State Demographer, Texas State Data Center, Texas Population Projections
Center for Health Statistics, DSHS Death Data Files 2005-2013
Prepared by: Office of Program Decision Support 12/14/15

Drowning was the second most prevalent cause of accidental deaths in children. Children ages 1-4 years are the most likely to die in drowning accidents. The age-adjusted drowning child death rate for this age group decreased from 2011 (4.0 per 100,000 children) to 2012 (2.8 per 100,000 children), when it reached the all-time lowest rate (Figure 9) yet this rate increased again in 2013 (3.7 per 100,000 children).

The death certificate identified 83 (62.7 percent reviewed by CFRTs) accidental child drowning deaths in 2012 and 93 (71.0 percent reviewed by CFRTs) in 2013 (Figure 10). Of the child drowning deaths reviewed, CFRTs determined that 75.0 percent in 2012 and 83.3 percent in 2013 could have been prevented. Approximately 62 percent of children in both years drowned in pools, hot tubs or spas. The second most prevalent place of drowning was in open bodies of water, with 21.2 percent in 2012 and 27.3 percent in 2013. Children in the 1-4 year age-group accounted for 68.8 percent (2012) and 78.0 percent (2013) of drowning deaths in pools, hot tubs or spas, while children ages 10-17 years accounted for 55 percent of open water drowning deaths in both years.

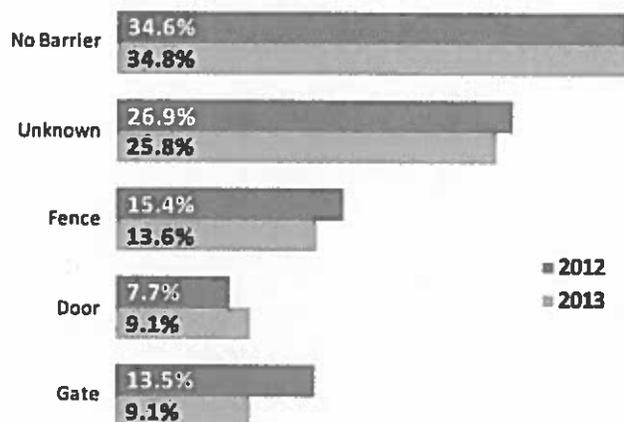
Figure 10. Place of Child Drowning Deaths



Source: Center for Health Statistics, DSHS, Death Data Files 2012-2013
Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

It is clear that improvements in pool safety and continued prevention still need to be made to decrease the child drowning death rate. Of the drowning deaths that occurred in a pool, approximately 35 percent in both 2012 and 2013 had no barrier to limit access to the pool (Figure 11). Local CFRTs found that a fence, door, or gate was used as a barrier in less than 16 percent of pool child deaths; however, it is unclear whether these barriers were being used correctly. Additionally, local CFRTs cited poor or absent supervision as a contributing factor in 44 percent of the child drowning deaths among children younger than 5 years of age.

Figure 11. Pool Child Deaths by Barrier Type

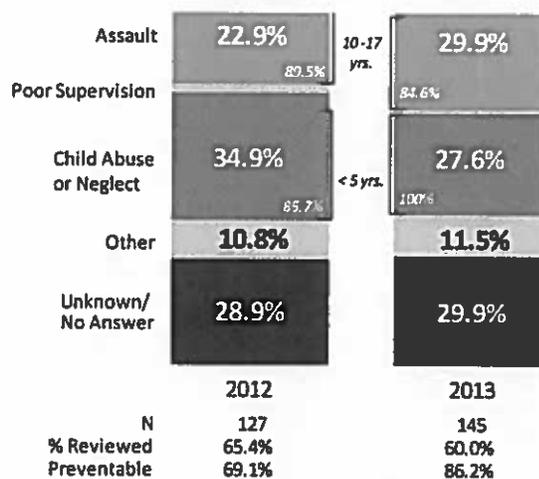


Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

Homicides

There were 127 child homicides in 2012 (65.4 percent reviewed by local CFRTs) and 145 in 2013 (60.0 percent reviewed by local CFRTs; Figure 12). The rate of child homicides reached an all-time low in 2012 at 1.8 per 100,000 children, but returned to rates consistent with the past nine years in 2013 to 2.1 per 100,000 children (see Figure 3). Please note that in previous years, there was some inconsistency between the death certificate and local CFRT in determining the manner of death as homicide, but more recently, the two determinations have been consistent—98 percent in both 2012 and 2013. Local CFRTs determined that 69.1 percent in 2012 and 86.2 percent in 2013 of the reviewed child homicides could have been prevented (Figure 12).

Figure 12. Contributing Causes to Child Homicides



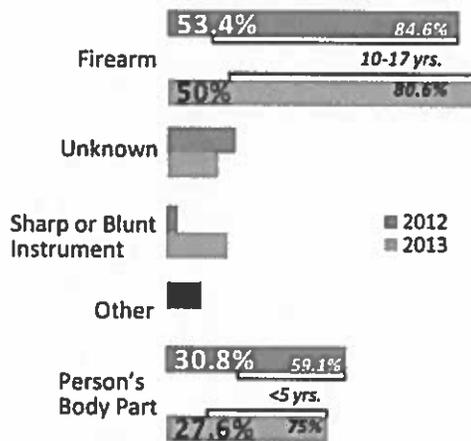
Source: Center for Health Statistics, DSHS Death Data Files 2012-2013
Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

The circumstances and context of the homicides were different based on the age of the child. Of the child homicides reviewed, local CFRTs determined that 34.9 percent in 2012 and 27.6 percent in 2013 were caused by child abuse or neglect (Figure 12). Child abuse or neglect deaths primarily involved children under the age of 5 years (85.7 percent in 2012 and 100.0 percent in 2013). According to the local CFRTs, a small percentage of all homicides, 19.3 percent in 2012 and 18.3 percent in 2013, had a history of maltreatment, but not an open Child Protective Services case at the time of death.

Assault, which does not include child abuse, was the second leading contributing cause to child homicides at 22.9 percent in 2012, and 29.9 percent in 2013. Assault deaths primarily involved children aged 10-17 years (89.5 percent in 2012 and 84.6 percent in 2013).

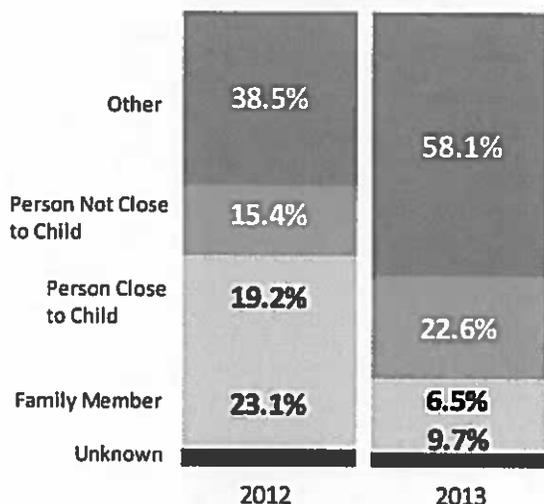
Local CFRTs identified that 62.7 percent of 2012 homicides and 66.7 percent of 2013 homicides involved a weapon. For children younger than 5 years, the weapon most identified in child homicides was a body part (59.1 percent in 2012 and 75.0 percent in 2013; Figure 13). For children aged 10-17 years, most weapon-related homicides involved a firearm (84.6 percent in 2012 and 80.6 percent in 2013).

Figure 13. Child Homicides by Weapon



Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

Figure 14. Firearm Child Homicides by Firearm Owner



Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

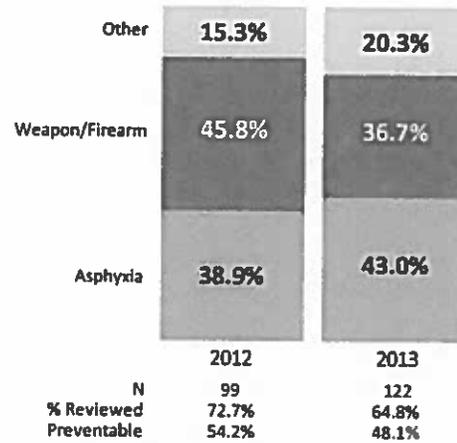
Figure 14 shows the firearm owner among firearm-related child homicides. In many reviewed cases, the owner was listed as “other” by the local CFRT (38.5 percent in 2012 and 58.1 percent in 2013). In cases where the owner was known, the firearm was more likely to belong to a family member in 2012 (23.1 percent), but in 2013, the firearm was more likely to belong to someone not close to the child (22.6 percent).

Suicides

There were 99 child suicides in 2012 and 122 in 2013, of which 72.7 percent and 64.8 percent were reviewed, respectively, by local CFRTs (Figure 15). Of the reviewed cases, local CFRTs determined that 54.2 percent in 2012 and 48.1 percent in 2013 could have been prevented. Please recall that the child suicide rate dropped from 2011 (1.6 per 100,000 children) to 2012 (1.4 per 100,000 children), but then rose again in 2013 (1.8 per 100,000 children; see Figure 3, page 10). Despite the increase in 2013, the nine-year trend in the child suicide rate has remained relatively constant. In 2012, weapon/firearm (45.8 percent) was the most prevalent method by which children younger than 18 years committed suicide, followed by asphyxiation (38.9 percent). In 2013, these methods switched, with asphyxiation at 43.0 percent and weapon/firearm at 36.7 percent.

As with other causes and manners of death, understanding the context that leads to the suicide is important for developing intervention efforts to prevent them in the future. Table 2 outlines some of the top psychosocial factors that local CFRTs identified that contributed to the child suicides. Family and peer relationships were the top two known factors contributing to child suicides in both 2012 (9.7 percent and 9.7 percent, respectively) and 2013 (22.8 percent and 16.5 percent, respectively).

Figure 15. Child Suicides by Method



Source: Center for Health Statistics, DSHS, Death Data Files 2012-2013.
Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

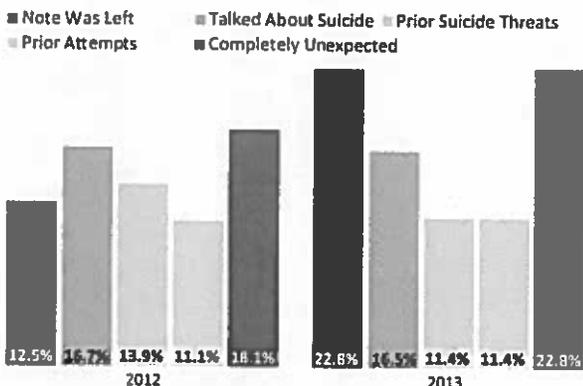
Table 2. Top Factors Contributing to Child Suicide
Top Factors Contributing to Child Suicide*

2012		2013	
Family Relationships	9.7%	Family Relationships	22.8%
Peer Relationships	9.7%	Other Identified Problems	22.8%
Other Identified Problem	5.6%	Peer Relationships	16.5%
No Identified Problem	5.6%	Bullying	8.9%
		Other Unidentified Problem	8.9%

*Multiple factors can be selected per record.

Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/10/15

Figure 16. Indicators of Child Suicide



*Multiple indicators can be selected per record.

Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/10/15

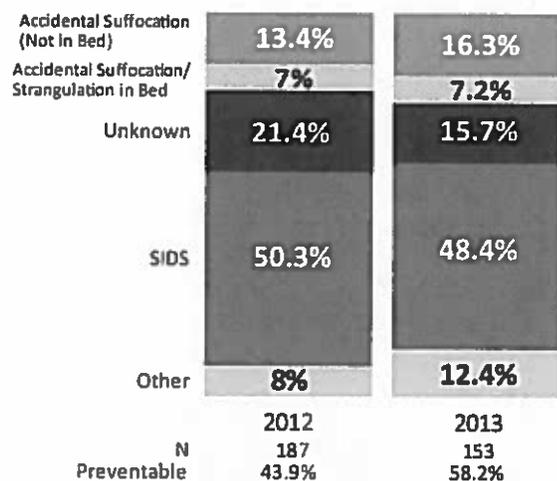
Family relationship factors include arguing with parents, parents getting a divorce, or family discourse. Peer relationship factors include fighting with peers and fighting or breaking up with a boyfriend or girlfriend. It is important to note the low percentages in 2012 because of the lack of information available to the local CFRTs to determine the causes contributing to child suicides.

Approximately one in five child suicides were determined to be completely unexpected—18.1 percent in 2012 and 22.8 percent in 2013 (Figure 16). In 2012, fewer than 17 percent of those who committed suicide showed an indication of

suicide, including talking about suicide (16.7 percent), prior suicide threats (13.9 percent), leaving a note (12.5 percent), or prior attempts (11.1 percent). However, in 2013, 22.8 percent of those who committed suicide left a note, followed by talking about suicide, and prior suicide attempts and threats.

Sleep-Related Deaths

Figure 17. Causes of Infant (<1yr.) Sleep-Related Deaths as Given on Death Certificate



Death certificate data does not provide specific information on sleep-related deaths.

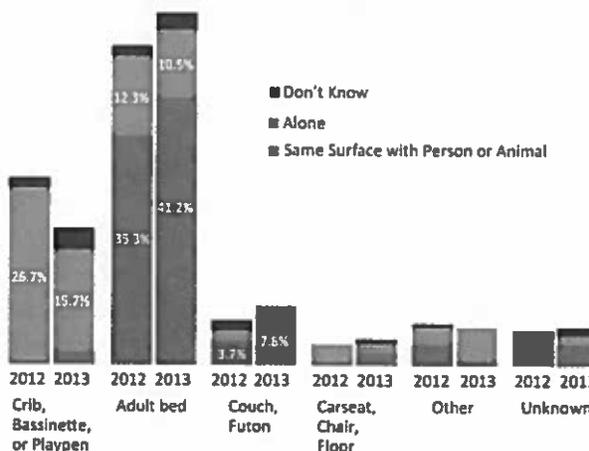
Additionally, because of the ambiguity of the manner and cause of these deaths, it is difficult to identify sleep-related deaths from coded death certificate data. Local CFRTs identified 187 sleep-related deaths in children younger than one year in 2012, and 153 in 2013 (Figure 17). Local CFRTs estimate that close to half (43.9 percent in 2012 and 58.2 percent in 2013) of these deaths could have been prevented. This estimate is based solely on local CFRT samplings as data cannot be identified through the death certificates.

Source: Center for Health Statistics, DSHS, Death Data Files 2012-2013, Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

It is important to note that the local CFRT data does not list a primary cause for most infant sleep-related deaths (49.2 percent in 2012 and 41.8 percent in 2013). In many cases this was left blank because the teams had not ruled out enough possibilities to agree that the death was the same as listed on the death certificate, nor could they determine another clear cause of death.

This is why Figure 17 shows death certificate determinations for sleep-related deaths. Local CFRTs determined approximately 50 percent of all infant sleep-related deaths occurred while the infant was sleeping in an adult bed (Figure 18). Of those sleeping in an adult bed, 35.3 percent in 2012 and 41.2 percent in 2013 were sharing a bed with a person or animal.

Figure 18. Infant (<1yr.) Sleep-Related Deaths by Sleep Surface and Bed Sharing



Source: Texas Child Fatality Review Team Data 2012-2013
Prepared by: Office of Program Decision Support 12/9/15

The leading cause of infant sleep-related deaths identified by the death certificate was Sudden Infant Death Syndrome (SIDS) (50.3 percent in 2012 and 48.4 percent in 2013; Figure 19). SIDS is determined through exclusion; that is, SIDS cannot be determined to be the cause of death until all other possible explanations for the death are ruled out. This exclusion criterion makes determining a SIDS death difficult, and hence, it is often subject to disagreement. Local CFRTs only agreed that the cause of death was SIDS in 39.4 percent of the reviewed cases in 2012 and in 12.2 percent of the reviewed cases in 2013. Asphyxiation, regardless of whether the infant was sleeping in bed, was the second leading cause of infant sleep-related deaths in both years.

Thorough death scene investigations are important for identifying sleep positions, particularly data from local CFRTs, when the team finds a discrepancy between the positions in which the infant was placed to sleep versus the position in which the infant was found (Figure 19). When the position was known, children were reported to most likely have been put to sleep on their back in both years (38.5 percent in 2012 and 27.5 percent in 2013). On the other hand, the local CFRTs have found that among cases of infant sleep-related deaths, infants were found primarily on their stomach (41.2 percent in 2012 and 37.3 percent in 2013). Despite available training, the public service announcement, “Alone on your Back in a Crib (ABC)” has not spread statewide. Cultural and generational beliefs may create barriers for safe sleep. Training to help investigators in these difficult cases can lessen the unknown and also lower discrepancies as to the cause of these infant deaths.

Figure 19. Position Infant (<1yr.) Put to Sleep and Position Found



Source: Texas Child Fatality Review Team Data 2012-2013
 Prepared by: Office of Program Decision Support 12/9/15

SCFRT Committee Recommendations

Recommendations to the Governor and Legislature

1. Pass distracted driver legislation to address the risks of using wireless communication devices while driving.

A study by Virginia Tech Driving Institute revealed that those who resort to texting while driving are 23 times more likely to crash. According to the 2014 Texas crash statistics compiled by TxDOT³, 51 fatalities and 654 serious injuries were attributed to the use of a wireless device while driving. There were a total of 3,423 motor vehicle crashes in which mobile phone use was a contributing factor.

Currently there are 14 states and the District of Columbia with an ordinance to prohibit the use of wireless communication while driving. Thirty-seven states and the District of Columbia ban the use of all cellphones by novice drivers⁴. Many jurisdictions in Texas have a local ordinance prohibiting cell phone use. While this is a step in the right direction, the ordinances are not standardized throughout the state, leading to confusion among drivers.

The SCFRT recommends legislation to limit at all times the use of wireless communication devices by drivers and cyclists, unless a hands-free device is used in the moving vehicle or bicycle. The penalty for violation should be up to the maximum Class C fine. This is necessary due to the increased risk and occurrence of motor vehicle crashes, injuries, and fatalities for motor vehicle operators, passengers, and pedestrians. Drivers of all ages are inattentive and distracted while using a wireless communication device with their hands.

2. Pass legislation that makes it an offense if a person operates a motor vehicle on a public highway while having any detectable amount of alcohol in the person's system while transporting a minor (under the age of 17).

Impaired driving is a national epidemic. Every hour, one person is killed, and 20 people are injured in crashes involving an alcohol-impaired driver. This equates to nearly 10,000 deaths and more than 173,000 injuries each year. In addition, the annual cost of impaired driving is \$129.7 billion⁵.

National Highway Traffic Safety Administration (NHTSA) has demonstrated that virtually every person who has a blood alcohol concentration (BAC) level of at least 0.08 experiences impaired driving. An alcohol-impaired-driving fatality is defined as a fatality in a crash involving a driver or motorcycle rider (operator) with a BAC of 0.08 or greater. According to NHTSA, there were nearly 10,000 alcohol-related motor vehicle traffic fatalities in 2014,

³ Texas Department of Transportation (TxDOT), Texas Motor Vehicle Crash Statistics – 2014, Fatalities by age, person type and gender, <http://ftp.dot.state.tx.us/pub/txdot/trf/crash-statistics/2014/06.pdf>

⁴ Insurance Institute for Highway Safety, Distracted Driving, <http://www.iihs.org/iihs/topics/laws/cellphonelaws/maphandheldcellbans>

⁵ Zaloshnja, Eduard, and Ted R. Miller. 2009. "Cost of Crashes Related to Road Conditions, United States, 2006." *Annals of Advances in Automotive Medicine* 53: 141–53.

accounting for 31 percent of overall traffic fatalities. This translates into one alcohol-impaired driving fatality every 53 minutes in the United States in 2014⁶.

Motor vehicle crashes claim many child victims. According to the Centers for Disease Control and Prevention (CDC), in 2013 a nationwide total of 7,266 children (5 to 24 years of age) died in motor vehicle crashes, making this the leading unintentional injury cause of death among children 5 to 24 years of age⁷. Many child deaths in Texas occur in motor vehicle crashes when the driver was alcohol-impaired. In 2014, there were 1,041 fatalities in Texas due alcohol impaired-driving crashes. These deaths accounted for 32.64 percent of the total number of Texas motor vehicle crash deaths. Of the 1,041 fatalities in alcohol-impaired-driving crashes in 2014, 134 of those deaths were children age 21 or under⁸. NHTSA reports that Texas experienced an increase in motor vehicle crash fatalities from 2010 to 2014, from 3,023 fatalities in 2010 to 3,538 fatalities in 2014, a 17 percent increase⁹. For those over 21 years of age, the legal BAC level for non-commercial drivers is <0.08, and for commercial drivers the legal BAC level is <0.04. For persons younger than 21 years of age, Texas has a zero-tolerance law¹⁰, making driving with any detectable BAC illegal.

Scientific evidence shows that impairment begins with the first drink, and any alcohol consumption associated with driving reduces safety. A review of research findings from laboratory and driving simulator studies concerning the effects of alcohol on driving-related skills, such as divided attention, vigilance, tracking, perception, and reaction time, found that several types of performance are affected by BAC levels as low as 0.01¹¹. Another more recent study found significant cognitive decrements in speed of information processing, reductions in working memory, and increases in errors of commission at 0.04 BAC¹².

The National Transportation Safety Board (NTSB) recommends a set of targeted interventions that will prevent crashes, reduce injuries, and save lives. Specifically, a report adopted by the NTSB in May 2013 recommends reducing the BAC legal limit for all drivers to 0.05 or lower. Three very specific conclusions support the NTSB's decision to recommend lowering the BAC legal limit: (1) alcohol impairs critical driving tasks; (2) crash risk is

⁶ National Highway Traffic Safety Administration, Traffic Safety Facts, 2014, Motor Vehicle Crashes: Overview, December 2015, <http://www-nrd.nhtsa.dot.gov/Pubs/812231.pdf>

⁷ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. 10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2013. http://www.cdc.gov/injury/images/lccharts/leading_causes_of_injury_deaths_highlighting_unintentional_injury_2013-a.gif

⁸ Texas Department of Transportation, Texas Motor Vehicle Crash Statistics – 2012, DUI (Alcohol) Fatalities by Age. http://ftp.dot.state.tx.us/pub/txdot-info/trf/crash_statistics/2012/34_2012.pdf.

⁹ National Highway Traffic Safety Administration, Fatality Rates: Texas, US and Best State. http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/48_TX/2014/48_TX_2014.htm

¹⁰ Tex. Alco. Bev. Code § 106.041. See also https://www.tabc.state.tx.us/laws/underage_drinking_laws.asp

¹¹ Moskowitz, H., and D. Fiorentino. 2000. A Review of the Literature on the Effects of Low Doses of Alcohol on Driving-Related Skills. DOT HS 809 028. Washington, DC: National Highway Traffic Safety Administration.

¹² Dry, Matthew J., Nicholas R. Burns, Ted Nettelbeck, Aaron L. Farquharson, and Jason M. White. 2012. "Dose-Related Effects of Alcohol on Cognitive Functioning." PLoS ONE 7(11): e50977.

consistently and significantly elevated by the time an individual reaches 0.05; and (3) lowering the BAC legal limit has been shown to reduce crashes, injuries, and deaths¹³.

The SCFRT recommends that current statute (Texas Penal Code §49.01) be amended to reduce the legal BAC level in Texas from 0.08 to any detectable level for drivers transporting a passenger who is younger than 15 years of age; and making the offense a Class C fine. Texas Penal Code §49.045 addresses driving while intoxicated with a child passenger. Lowering the BAC legal limit in Texas for drivers transporting a passenger who is younger than 15 years of age would reduce the number of motor vehicle crash deaths on Texas highways and save the lives of many children who are not likely to be able to make the decision to avoid riding with an impaired driver.

3. Repeal Texas Transportation Code, Section 521.205, which allows a parent, step-parent, legal guardian, step-grandparent or grandparent to provide a driver education course to eligible minors 16-18 years of age.

Texas is one of only three states with statutes allowing parent-taught driver education (PTDE). Section 521.205 of the Texas Transportation Code was added in 1995 by Senate Bill 964 during the 74th Texas Legislature. DPS implemented the rules for this legislation in April 1997. An unsuccessful attempt was made to repeal the legislation in 1997.

Motor vehicle crashes are the leading cause of death for all teens in the United States. Research studies report that teens 15-19 years of age are at high risk for motor vehicle crashes, especially during the first year of driver eligibility. The CDC reported that in 2013, about 2,200 teens aged 16-19 in the United States were killed, and almost 243,000 were treated and released from emergency departments for injuries suffered in motor vehicle crashes. This statistic translates into six teens per day dying in motor vehicle crashes¹⁴.

No comparative evaluation of driver education in Texas had been conducted until NHTSA published a study in April 2007: Parent-Taught Driver Education in Texas: A Comparative Evaluation¹⁵. A review of the study, abstract, and executive summary yields that nearly 40 percent of the 218,054 driver education certificates issued in 2004-2005 were from parent-taught driver education (PTDE), and PTDE youth were obtaining driver's permits at a slightly younger age. Although the study cites few self-reported differences in driving knowledge and skills related to the type of driver education, differences are noted when driving records are reviewed.

PTDE drivers demonstrated lower driving knowledge early in their training, poorer driving skills, and a lower rate of passing the state-administered driving test on the first attempt. Furthermore, PTDE novice drivers committed more traffic offenses and were in more

¹³ National Transportation Safety Board, Safety Report. 2013. Reaching Zero: Actions to Eliminate Alcohol Impaired Driving.

¹⁴ National Highway Traffic Safety Administration, Fatality Rates: Texas, US and Best State. http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/STSI/48_TX/2014/48_TX_2014.htm

¹⁵ V,J, Pezoldt, K.N. Womack, and D.E. Morris, Texas Transportation Institute, The Texas A&M University System, College Station, TX. <http://opi.mt.gov/pdf/DriverEd/RR/NHTSA.pdf>

crashes. When most, if not all, supervision is eliminated (full licensure), then PTDE students are involved in more traffic convictions and increasingly serious motor vehicle crashes than their peers trained through other driver education methods.

In Texas, there are approximately 300,000 teens eligible to get a driver license each year. Of those, about one-third of teens wait until they are 18 years old to get their licenses, after which age, driver education is not required. In fiscal year 2013, the number of driver education completion certificates issued to driving schools shows that 13 percent of the driver education students were taught in public schools, 34 percent were parent-taught, and 53 percent received instruction through commercial driving schools.

Given the high risk of serious injury and death experienced by minor drivers and their passengers and the lack of any requirement for parents who teach driver education to demonstrate driving knowledge and skills or undergo DPS monitoring, the SCFRT recommends repeal of legislation allowing for parent- or guardian-taught driver education.

- 4. Pass legislation to amend the Code of Criminal Procedure, Article 45.0215, to include defendants younger than 18 years of age and their parent, guardian or managing conservator to appear in court on hearings of moving violation.**

According to data from the 2014 TxDOT Crash Records Information System, minors 15 to 17 years of age were drivers in 97 fatal crashes, 3,675 serious injury crashes, and 5,131 crashes with other injuries. In 2014, 35 minor drivers 15 to 17 years of age died in motor vehicle crashes¹⁶. Additionally, minor drivers in the same age group were involved in 18,488 non-injury crashes. A 17-year-old minor is a young, less-experienced driver who requires the permission of a parent, guardian, or managing conservator to obtain a driver's license (Transportation Code, Chapter 521, Sec.521.145), and who deserves the protection and involvement of a parent, guardian, or managing conservator (Texas Family Code).

Current law requires only defendants younger than 17 years old to appear in court with their parents, guardians, or managing conservators on hearings for moving violations. The law excludes minors who are 17 years old from this requirement and these minors miss the safety benefits of this statute. Required joint appearance in court means a 17-year-old driver and the accompanying adult will both be aware of the driving behavior that led to the infraction and will both be provided with information on safe driving practices. Amending the law would also enable the parent or guardian to be aware of any fines, liability for the conduct of the minor, and the parent or guardian's options to impose added restrictions, inclusive of withdrawing the permission or revoking the minor's driver's license.

- 5. Pass legislation that requires new residential swimming pools have a circumferential isolation pool fence installed that completely separates the house and play area of the yard from the pool.**

¹⁶ Texas Department of Transportation, Texas Motor Vehicle Crash Statistics – 2014. Ages of Drivers in Crashes. <http://ftp.dot.state.tx.us/pub/txdot/trf/crash-statistics/2014/25.pdf>

Drowning is the leading cause of unintentional injury death for children one to four years of age and the second leading cause of unintentional injury death for children five to nine years of age¹⁷. In 2013, 93 children drowned in Texas¹⁸. Data from reviews conducted by Texas local CFRTs and from the Texas Submersion Registry indicate that the vast majority of these deaths occurred in residential swimming pools (in-ground, above-ground and portable), hot tubs, and spas.

The American Academy of Pediatrics (AAP) Drowning Prevention policy statement asserts that four-sided, or circumferential, isolation fencing controls unsupervised access to residential pools, hot tubs, and spas and could prevent up to 50-90 percent of drowning deaths in young children¹⁹. However, a national survey indicates that fewer than 30 percent of residential pool owners have a circumferential isolation fence around their pools. The Consumer Product Safety Commission (CPSC) stresses the importance of installing an outdoor swimming pool barrier as a physical obstacle that surrounds an outdoor pool or spa so that access to the water is limited to adults. A successful pool barrier prevents a child from getting over, under, or through it to gain access to the pool or spa. The CPSC recognizes this strategy to be an evidence-based strategy to prevent drownings. The CPSC recommends that the fence or other barrier be at least four feet high or taller and have no footholds or handholds that could help a young child to climb it; that vertical fence slats should be less than four inches apart to prevent a child from fitting between; that, if chain link fencing is used, no part of the diamond-shaped opening be larger than 1 ¾ inches; that the gate be self-closing, self-latching, and outside of a child's reach; and that the maximum clearance at the bottom of the barrier should not exceed four inches above ground²⁰.

Safe Kids Worldwide, an international nonprofit organization dedicated to preventing unintentional childhood injury, estimates that medical costs for each near-drowning victim can range from \$8,000 for initial medical care to more than \$250,000 for long-term care. Legislation requiring installation of circumferential isolation fencing around new residential swimming pools, hot tubs, and spas throughout Texas would prevent drowning deaths and reduce the burden of health care costs associated with non-fatal submersions.

The SCFRT has made this recommendation for new residential swimming pools to have circumferential isolation pool fences annually since 2007.

¹⁷ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2010. http://www.cdc.gov/injury/wisqars/pdf/10LCID_Unintentional_Deaths_2010-a.pdf

¹⁸ Texas Department of State Health Services, Texas Vital Statistics, provisional 2011 death data pending review and approval of final data set.

¹⁹ American Academy of Pediatrics Policy Statement—Drowning Prevention. www.pediatrics.org/cgi/doi/10.1542/peds.2010-1264

²⁰ Consumer Product Safety Commission Pool Safety Campaign, Pool and Spa Safety: Barriers. <http://www.poolsafely.gov/pool-spa-safety/safety-system/barriers/>

6. Promote a statewide Safe Storage Campaign for gun safety.

The SCFRT supports the promotion of a statewide Safe Gun Storage Campaign for gun safety. Examples of campaign messages address keeping guns unloaded and locked²¹ and storage of ammunition separately²². Research shows that safe gun storage reduces unintentional injury and suicide risk. A recent systematic review of firearm storage campaigns found that communities which offered free devices had improved safe gun storage practices versus communities which offered economic incentives to obtain safe firearm storage²³.

Parent education is another important aspect of a gun safety campaign. The SCFRT also encourages and supports medical providers' role in gun safety and accident prevention. Medical providers should assess patients' access to firearms and educate on the importance of safe gun storage.

7. Pass legislation to add active shooter training for school personnel to the Center for Safe Schools School Safety Certification Program.

The Texas Education Code, Section 37.1081 mandates that Texas schools have a school safety certification program. The Texas School Safety Center, along with the School Safety Task Force and stakeholders, established a school safety certification program with criteria based on the Texas Unified School Safety and Security Standards. This program assesses school districts on their safety and security practices; and will award school districts with a school safety certificate when they meet all the specified criteria. The SCFRT recommends the addition of active shooter training for school personnel to the criteria specified in the School Safety Certification Program²⁴.

8. Fund Child Fatality Review Team Coordinators in each of the public health service regions as recommended by the Protect Our Children Commission.

The SCFRT supports the Protect Our Kids recommendation²⁵ to fund a Child Fatality Review Team Coordinator in each of the public health service regions. Local CFRT coordinators, presiding officers and data entry coordinators are members who serve as volunteers on their review teams. Funding a local CFRT coordinator in each of the public health service regions will increase consistency in the way local CFRTs function throughout the state. The coordinator will be responsible for assisting with meeting preparation, meeting coordination, data entry and spearheading prevention efforts in the communities in which they serve.

²¹ Ad Council, Safe Firearm Storage, <http://www.adcouncil.org/Our-Campaigns/Safety/Safe-Firearms-Storage>

²² Project Safe Child, Safe Storage, <http://www.projectchildsafe.org/safety/safe-storage>

²³ Ali Rowhani-Rahbar*, Joseph A. Simonetti and Frederick P. Rivara, (2016) Effectiveness of Interventions to Promote Safe Firearm Storage *Epidemiol Rev* (2016) doi: 10.1093/epirev/mxv006 First published online: January 13, 2016

²⁴ Texas State School Safety Certification Program, <https://cert.txssc.txstate.edu/certifications/1>

²⁵ Protect Our Kids Commission, Final Report, [http://texaschildrenscommission.gov/our-work/basic-projects/child-fatalities-protect-our-kids-\(pok\)-commission.aspx](http://texaschildrenscommission.gov/our-work/basic-projects/child-fatalities-protect-our-kids-(pok)-commission.aspx)

Recommendations to the Department of Family and Protective Services

- 1. Amend Texas Family Code. Sec 261.102 [Matters to be reported] to report all children less than six years old that have died due to unexplained or non-natural causes, excluding motor-vehicle occupant deaths unless there is suspicion of alcohol or substance use to DFPS.**

The current law states that professionals must report a death to Child Protective Services if they have a belief that the child has been abused or neglected. Child deaths resulting from possible abuse and/or neglect may be missing due to the lack of notification and investigation by Child Protective Services, as well as potential services to the families of children who have died. Therefore, the SCFRT recommends amending the existing Texas Family Code Chapter 261.102 to include reporting all children less than six years old that have died due to unexplained or non-natural causes, excluding motor-vehicle occupant deaths unless there is suspicion of alcohol or substance use to DFPS in order to better identify possible cases of abuse and/or neglect.

The Department of Family and Protective Services handbook [2311.2 Medical Examiner or Justice of the Peace] states that investigators must report the death of a child younger than six years old to the medical examiner or justice of the peace (JP) in the county in which the death occurred. The death must be reported to the medical examiner or JP regardless of whether the death was alleged to be the result of abuse or neglect. Implementation of this recommendation will help increase the number of timely investigations and services offered to families at the time of a child's death in addition to improving the continuity of reporting among agencies.

Recommendations to the Department of State Health Services

- 1. Amend the current Child Fatality Review statute (Texas Family Code, Chapter 264) to allow adjacent counties of any population size to form joint local CFRTs or join an existing local CFRT and to allow local registrars to notify local CFRTs of child deaths.**

In its December 2015 Report to the Legislature, the Protect Our Kids (POK) Commission recommended these revisions to Chapter 264 of the Texas Family Code. These recommendations are supported by the SCFRT. The POK Commission recommended allowing adjacent counties of any population size to form joint local CFRTs because it would permit counties that do not currently have a local CFRT to create or join with a strong team in an adjacent county, increasing the number of counties covered by local CFRTs. The POK Commission recommended that the Family Code allow local registrars to notify local CFRTs of child deaths. Currently, local CFRTs receive deaths certificates 12-18 months after the death and reviews of child deaths are typically conducted up to two years after the deaths, particularly in urban counties where the volume of child deaths has made it difficult review cases within one year. Allowing local registrars to notify local CFRTs of child deaths will lead to more timely review of child deaths.

- 2. Provide ongoing support for annual training of Texas local CFRT members.**

The SCFRT recommends that DSHS provide funding for annual training for local CFRT members. Local CFRT members come from a wide variety of disciplines and serve as volunteers on their review teams. They are in need of frequent training to keep current with the process, research, and best practices in the prevention of child deaths. More concentrated focus on training specific to child fatality review would go far to improve the Texas process and have greater impact upon the safety of Texas children. The trainings would focus on local CFRT member skill development in collecting data, death scene investigation training, conducting reviews, and implementing effective injury prevention activities at the community level.

- 3. Promote and support work towards the goal that all Texas counties have an independent local CFRT or participate in a multi-county local CFRT to review and document all deaths of children less than 18 years of age.**

In 2015, there were 74 active local CFRTs covering 194 of Texas' 254 counties, and 94 percent of Texas children lived in a county where child deaths are reviewed. A total of 3,742 children died in Texas in 2013. To fully understand the circumstances and risks leading to a child death, identify trends, and implement effective prevention activities, the SCFRT recommends that all Texas counties participate in CFR and that 100 percent of child deaths be reviewed and recorded. It is recommended that DSHS continue to promote and support the development of local CFRTs in counties without teams and to focus on promoting more robust data collection, review, and entry by the existing local CFRTs.

Appendix A. State Child Fatality Review Team Committee Members

<p>EMILIE A. BECKER, MD Child Mental Health Provider Term expires 2/1/16 Medicaid CHIP Mental Health Director Health & Human Services Commission 6330 Hwy. 290 East, Suite 350 Austin, TX 78723 (512) 380-4345 emilie.becker@hhsc.state.tx.us</p>	<p>SUSAN ETHERIDGE, MSSW, LMSW Child Advocate Term Expires 2/1/17 CASA of Collin County Executive Director 101 E. Davis McKinney, TX 75069 (972) 529-2272 setheridge@casaoofcollincounty.org</p>	<p>DONALD MCCURNIN, MD Neonatologist Term expires 2/1/18 UT Health Science Center at San Antonio San Antonio, TX (210) 567-5232 mccurnin@uthscsa.edu</p>
<p>LISA BLACK, MSW CPS Assistant Commissioner Permanent member Department of Family & Protective Services 701 W. 51st St. Austin, TX 78751 (512) 438-3313 lisa.black@dfps.state.tx.us</p>	<p>SGT. SARAH FIELDS Ad Hoc Expert Advisor Term expires 2/1/18 Panola County Sheriff's Office 314 W. Wellington St. Carthage, TX 75633 (903) 693-0333 sgtfields@hotmail.com</p>	<p>DENISE ONCKEN, JD Assistant District Attorney Term expires 2/1/16 Harris County District Attorney's Office 1201 Franklin, Suite 600 Houston, TX 77002 (713) 755-5919 oncken_denise@dao.hctx.net</p>
<p>ADA BOOTH, MD VICE CHAIR Child Abuse Prevention Term expires 2/1/18 Driscoll Children's Hospital 3533 S. Alameda St. Corpus Christi, TX 78411 (361) 694-4345 ada.booth@dchstx.org</p>	<p>ANGELA GOODWIN, JD Child Protective Services Specialist Term expires 2/1/16 Director of Investigations Department of Family & Protective Services 701 W. 51st St. Austin, TX 78751 (512) 438-4746 angela.goodwin@dfps.state.tx.us</p>	<p>TERRY PENCE TxDOT representative Term expires 2/1/16 Traffic Safety Director Dept. of Transportation 125 E. 11th St. Austin, TX 78701 (512) 416-3167 terry.pence@txdot.gov</p>
<p>KIM CHEUNG, MD, PHD Pediatrician Term expires 2/1/17 UT Health Science Center at Houston Department of Pediatrics Child Protective Services Clinic 6300 Chimney Rock Houston, TX 77081 (713) 295-2579 kim.k.cheung@uth.tmc.edu</p>	<p>GERALDINE R. HARRIS, MLA State Registrar, Vital Statistics Permanent member Dept. of State Health Services P.O. Box 149347 Austin, TX 78714-9317 (512) 458-7366 geraldine.harris@dshs.state.tx.us</p>	<p>READE QUINTON, MD CHAIR Medical Examiner Term expires 2/1/17 Office of the Dallas County Medical Examiner 5230 Southwestern Medical Ave. Dallas, TX 75235 (214) 920-5900 reade.quinton@dallascounty.org</p>
<p>STEVEN CLINKSCALES, EMT-P Senior Program Director Term expires 2/1/2018 Air Evac Lifeteam - Central Texas PO Box 713 Rio Vista, TX 76093 (417)-293-2626-Cell (682) 651-0688-Fax Steven.Clinkscases@air- evac.com</p>	<p>JUDGE JUDY SCHIER HOBBS Justice of the Peace Term expires 2/1/16 Pct. 4, Williamson County P.O. Box 588 Taylor, TX 76574 (512) 365-8922 jhobbs@wilco.org</p>	<p>KATHERINE RATCLIFF SIDS Family Service Provider Term expires 2/1/16 Center for Infant & Child Loss Any Baby Can of San Antonio 217 E. Howard St. San Antonio, TX 78212 (210) 547-3026 kratcliff@anybabycansa.org</p>
<p>CHIEF GARY W. COX Chief of Police Term expires 2/1/18 Cibolo Police Department P.O. Box 826 Cibolo, Texas 78108 (210) 659-1999 (210) 659-1080 gcox@cibolotx.gov</p>	<p>SHERIFF CHRISTOPHER KIRK Term expires 2/1/16 Brazos County Sheriff's Office 1700 Highway 21 West Bryan, TX 77803-1300 (979) 361-4150 chriskirk@highsheriff.com</p>	<p>KATHRYN GOERING REID Domestic Violence Victim Advocate Term expires 2/1/16 Family Abuse Center 3407 Chateau Waco, TX 76710 (254) 772-8999 kathy.reid@familyabusecenter.org</p>

<p>ANNA TERAN, RN, BSN, NCSN Educator Term expires 2/1/18 Dallas Independent School District 3700 Ross Ave., Room 206 Dallas, TX 75204 (972) 925-3386 ateran@dallasisd.org</p>	<p>CAPTAIN STEVEN TELLEZ Public Safety representative Term expires 2/1/18 Department of Public Safety 6502 S. New Braunfels San Antonio, Texas 78223 (210) 531-2206 Steven.Tellez@dps.texas.gov</p>	<p>JEANNINE VON STULTZ, PHD Juvenile Probation Officer Term expires 2/1/18 Bexar County Juvenile Probation 301 E. Mitchell San Antonio, TX 78210 (210) 335-7515 jvonstultz@bexar.org</p>
<p>FREDLYN WIDEMAN Public Health Nurse Term expires 2/1/17 Texas Department of State Health Services 112 Joe Carper Drive Uvalde, TX 77801 (830) 591-4387 Fredlyn.wideman@dshs.state.tx.us</p>		



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Texas Child Fatality Review Team