



Texas Child Fatality Review Team

Annual Report 2010

TABLE OF CONTENTS

Acknowledgements	1
Letter from the Chair.....	2
Chapter 1 Operations & Activities	4
Operations	5
Local Child Fatality Review Teams	8
Texas Child Fatality Review at the Community Level	10
Colorado/Austin/Waller Counties Child Fatality Review Team	10
Concho Valley Child Fatality Review Team	10
Dallas County Child Death Review Team.....	11
El Paso County Child Fatality Review Team.....	12
Fort Bend County Child Fatality Review Team	13
Heart of Texas Child Fatality Review Team.....	14
Hidalgo/Starr Counties Child Fatality Review Team	14
Houston/Harris County Child Fatality Review Team	15
Johnson County Child Fatality Review Team	15
Nacogdoches County Child Fatality Review Team	16
Special Topic: Protect Children from Hyperthermia	16
Panhandle Child Fatality Review Team	17
South Plains Child Fatality Review Team	17
Victoria County Child Fatality Review Team	18
Williamson County Child Fatality Review Team.....	18
Notable Activities and Collaborations in 2010	19
Chapter 2 Recommendations	25
Background and Introduction.....	26
Recommendations to the Governor and State Legislature.....	27
Recommendations on Child Protective Services Operations	33
Recommendations to the Department of State Health Services	35
Chapter 3 Data & Analysis	36
Data and Limitations.....	37
Generalizability and Completeness of CFRT Data	38
Manner of Death: An Overview.....	40
Manner of Death: Natural	42
Manner of Death: Accident	44
Manner of Death: Homicide	46
Manner of Death: Suicide	48
Sudden Infant Death Syndrome (SIDS).....	50
Unintentional Drowning Deaths	52
Motor Vehicle and Transportation Deaths	54
Special Topic: All Terrain Vehicle (ATV) Deaths.....	56
Firearm Deaths	57
Asphyxia Deaths.....	59
Special Topic: The Choking Game	61
Preventability	62
Appendix A SCFRT Committee Members	64
Appendix B Active Local Child Fatality Review Teams, 2010.....	67
Appendix C: Texas Family Code.....	81
Appendix D How to Start a Child Fatality Review Team In Your Community	91
Appendix E: SCFRT Position Statements on Child Safety	93
Safe Sleep for Infants	94
Motor Vehicle Safety for Infants and Children	96
Water Safety for Children	101
Child Suicide.....	102
Fire and Burn Safety for Children	102



List of Figures, Tables, and Maps

List of Figures

Figure 1. DSHS Support of Child Fatality Review	7
Figure 2. Tools for Safe Pools Campaign	13
Figure 3. Child Suicide Deaths, Ages 10-17	23
Figure 4. Child Suicide Methods, Ages 10-17	23
Figure 5. Frequency of Deaths Reviewed by Child Fatality Review Teams by Manner and Age Group, 2008 ..	40
Figure 6. Frequency of Deaths Reviewed by Child Fatality Review Teams	41
Figure 7. Number of Deaths Reviewed by Child Fatality Review Teams by Manner and Race/Ethnicity, 2008.	41
Figure 8. Natural Manner of Death by Cause of Death, 2008 (N=1,278)	43
Figure 9. Natural Manner of Death for Children Ages 1-17 Years of Age by Cause of Death, 2008 (N=329)	43
Figure 10. Accidental Manner of Death by Cause of Death, 2008 (N=444)	45
Figure 11. Cause of Accidental Child Death by Age Group, 2008 (N=435)	45
Figure 12. Homicide by Perpetrator, 2008 (N=103)	46
Figure 13. Homicide by Place of Occurrence (N=129)	47
Figure 14. Homicide by Mechanism of Death,	47
Figure 15. Suicide by Place, 2008 (N=58)	48
Figure 16. Suicide by Contextual Factors, 2008 (N=58)	49
Figure 17. Suicide by Mechanism and Sex, 2008 (N=58)	49
Figure 18. SIDS by Sleeping Place, 2008 (N=80)	51
Figure 19. SIDS by Sleeping Placement (N=64)	51
Figure 20. Drowning Deaths by Place of Occurrence 2008 (N=74)	52
Figure 21. Drowning Deaths by Water Access Barriers in Place 2008 (N=42)	53
Figure 22. Motor Vehicle Deaths by Child Position 2008 (N=205)	55
Figure 23. Motor Vehicle Deaths by Cause Listed, 2008 (N=164)	55
Figure 24. Motor Vehicle Deaths by Restraint/ Helmet Use among Passengers and Drivers by Age Group, 2008 (N=146)	56
Figure 25. Firearm Deaths by Manner of Death, 2008 (N=81)	57
Figure 26. Firearm Deaths by Type of Firearm, 2008 (N=69)	58
Figure 27. Firearm Deaths by Owner of Firearm, 2008 (N=53)	58
Figure 28. Asphyxia Deaths by Manner and Age Group, 2008 (N=108)	60
Figure 29. Asphyxia Deaths by Type of Event, 2008 (N=117)	60
Figure 30. Asphyxia Deaths by Type of Suffocation, 2008 (N=58)	61
Figure 31. Percent of Preventable Deaths by Manner, 2008 (N=2,106)	62
Figure 32. Percent of Preventable Deaths by Age Group, 2008 (N=2,106)	62
Figure 33. Percent of Preventable Deaths by External Cause of Injury, 2008 (N=820)	63

List of Tables

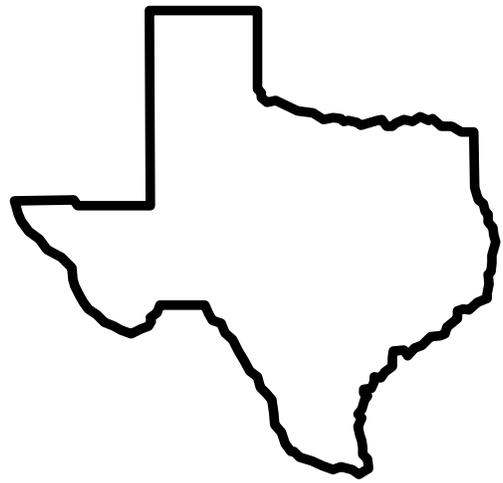
Table 1. Counties Without CFRT to Target in 2011	8
Table 2. Local Child Fatality Review Teams in 2010	9
Table 3. Deaths Reviewed by CFRT, Total Deaths and Population, 2008 (0-17 Years)	38
Table 4. Percent of Deaths Reviewed by Child Fatality Review Teams by Manner, Injury Mechanism, Age Group, Sex, and Race/Ethnicity, 2008	39
Table 5. Natural Deaths by Age Group, Sex, and Race/Ethnicity, 2008	42
Table 6. Accidental Deaths by Age Group, Sex, and Race/Ethnicity, 2008	44
Table 7. Homicide by Age Group, Sex, and Race/Ethnicity, 2008	46
Table 8. Suicide by Age Group, Sex, and Race/Ethnicity, 2008	48
Table 9. SIDS Deaths by Age Group, Sex, and Race/Ethnicity, 2008	50
Table 10. Unintentional Drowning Deaths by Age Group, Sex, and Race/Ethnicity, 2008	52
Table 11. Motor Vehicle and Transportation Deaths by Age Group, Sex, and Race/Ethnicity, 2008	54
Table 12. Firearm Deaths by Age Group, Sex, and Race/Ethnicity, 2008	57
Table 13. Asphyxia Deaths by Age Group, Sex, and Race/Ethnicity, 2008	59

List of Maps

Map 1. Local Child Fatality Review Teams 2010	9
Map 2 . Child Suicide Rates by County, 1999-2006	22



INTRODUCTION



ACKNOWLEDGEMENTS

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

- **Alice Gong**, M.D., neonatologist and professor of Pediatrics at the UT Health Science Center in San Antonio, who served in the Neonatologist role on the SCFRT
- **Elsa Hinojosa**, M.Ed., Hays Consolidated Independent School District, who served in the Educator role on the SCFRT
- **Elizabeth Peacock**, M.D., Bexar County Medical Examiners' Office, who served in the Medical Examiner role on the SCFRT

This report is based on data collected by and recommendations made by local Child Fatality Review Teams (CFRT) and the SCFRT Committee. The report was written and compiled by the Texas Department of State Health Services (DSHS) staff in the Office of Program Decision Support, Division for Family and Community Health Services: Susan Rodriguez, Texas Child Fatality Review Coordinator, Ryan Beal, M.P.H., researcher, and Clint Moehlman, statistician. Paula Kirby of the DSHS Center for Health Statistics also contributed to the preparation of this report. 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 (Appendix B). The wide array of professionals who volunteer as members on their local teams give the child fatality review process its multi-disciplinary perspective and add immeasurably to the goal of understanding child death in Texas and reducing risk to Texas children. Their commitment to understanding and preventing child death is saluted.

A special thank you goes to the Office of Title V & Family Health, DSHS, which provided generous funding for the Protecting Texas Children Conference, April 2010, and travel funds for SCFRT and CFRT members to attend the conference.

Questions about the report should be directed to:

Juan Parra, M.D., M.P.H.
Chair, State Child Fatality Review Team Committee
ATTN: Susan Rodriguez, Texas Child Fatality Review Coordinator
Office of Program Decision Support, MC 1922
Texas Department of State Health Services
P.O. Box 149347
Austin, TX 78714-9317
(512) 458-7111 ext. 2311
susan.rodriguez@dshs.state.tx.us



LETTER FROM THE CHAIR

“Never doubt that a small group of thoughtful committed citizens can change the world: indeed, it’s the only thing that ever has.”

Margaret Mead



Dr. Juan Parra, M.D., M.P.H.

The quote by Margaret Mead exemplifies the commitment and passion of countless volunteers in our communities, state and across the country. I want to personally dedicate this annual report, with a sincere and heartfelt “thank you,” to all the volunteers serving on local CFRT, on the SCFRT Committee and all the volunteers from our community, state and national partners who have made Child Fatality Review in Texas a great success. The members of the SCFRT, after much collegial discussion, collaborative work and consensus, present the 2010 Texas Child Fatality Review Team annual report.

Since our 2009 report, the SCFRT, along with collaborative partners, has accomplished the following:

- Completed new position statements on child suicide and fire and burn safety and one near completion on firearm safety. The position statements are widely shared at the state and national level. As with past position statements, feedback has been positive and they are used to promote injury prevention at the community level.
- Expansion of statewide partnerships in order to promote injury prevention efforts. The SCFRT is currently engaged in discussion and planning of collaborative efforts with the Pediatric Committee of the Governor’s EMS and Trauma Advisory Council (GETAC). The SCFRT chair was invited to participate in a partnership with DSHS and the March of Dimes: the Healthy Texas Babies Initiative. This initiative involved participation in a two-day expert panel with subsequent workgroup collaborations to develop a plan to reduce infant mortality in the state.
- Continued partnership with the Children’s Assessment Center of Houston to plan, conduct and participate in the Protecting Texas Children Conference, April 26-28, 2010. The SCFRT once again hosted a pre-conference session on April 25 with invited speaker Dr. Carolyn Cumpsty Fowler, one of the nation’s experts on childhood injury prevention from Johns Hopkins University, who presented on the topic “Untapped Potential: The Role of Child Fatality Review Teams in Strategic Injury Prevention and Risk Reduction.” The pre-conference session was attended by over 100 local CFRT and SCFRT members as well as community and state agency partners and professionals. The pre-conference session received very positive comments from the attendees. The pre-conference session was followed by the SCFRT quarterly meeting, also attended by many local CFRT members and community partners.
- The SCFRT held its first quarterly meeting outside of Austin and Houston. On August 20, 2010, the SCFRT quarterly meeting was held in San Antonio and was attended by CFRT members and DSHS staff from the region.
- Data from local CFRT reviews were used to write and publish an article “History of Maltreatment among Child Decedents: Analyses of Texas Child Fatality Review Data, 2004-2007” in the journal *Injury Prevention*. The article was co-authored by SCFRT member Dr. John Hellsten, Texas Child Fatality Review (CFR) Coordinator Susan Rodriguez, Centers for Disease Control and Prevention representative Dr. Sharyn E. Parks, and DSHS



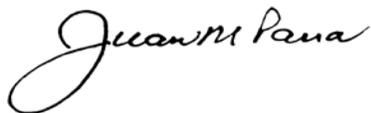
researcher Dr. Gita Mirchandani. The SCFRT Committee congratulates the authors of this landmark journal article as well all local CFRT members who conducted the reviews and collected the data.

- Continual growth and development of active CFRT in the state. At the end of 2009, there were 56 Child Fatality Review Teams which covered 178 counties. At the end of 2010, there were 69 CFRT covering 196 counties operating in the state. Currently, 93 percent of Texas children live in a community where the safety net of a CFRT is located. Great appreciation is given to the CFR coordinator, staff members of the DSHS Office of Program Decision Support and the Office of Title V and Family Health, regional DSHS staff, Center for Health Statistics staff, SCFRT members and all members of local CFRT for their tireless efforts promoting child fatality review in the state.

The SCFRT Committee will continue to seek opportunities and meet our challenges with enthusiasm.

- The SCFRT Committee will begin work on a position statement for Substance Abuse-Related Deaths. Other topics under consideration include driver education and crash-related deaths, child abuse and neglect prevention and infant mortality.
- The SCFRT Committee renews its commitment to work with the CFR Coordinator, DSHS staff and local CFRT members to continuously improve the number and types of fatalities reviewed as well as improving data collection, quality and entry process.
- The SCFRT Committee will continue its commitment to the establishment of new and active CFRT across the state.
- The SCFRT Committee has made a commitment to establish a monitoring process for all recommendations made in annual reports in order to document accomplishments and challenges related to the recommendations.
- The SCFRT Committee reaffirms our commitment to continue to report to the governor, state legislators, local CFRT and partnering agencies all the information learned from the reviews conducted and data collected by the local teams. We will work to incorporate this knowledge in the annual report and in our work with communities to achieve the goal of eliminating preventable deaths in Texas children.

I again applaud the commitment, leadership and accomplishments of all the CFRT members and to all the members of the SCFRT Committee and DSHS for a job well done. The SCFRT Committee welcomes comments on this annual report, and we look forward to another year of hard work, collaborative efforts and making a difference in the lives of children in the State of Texas.

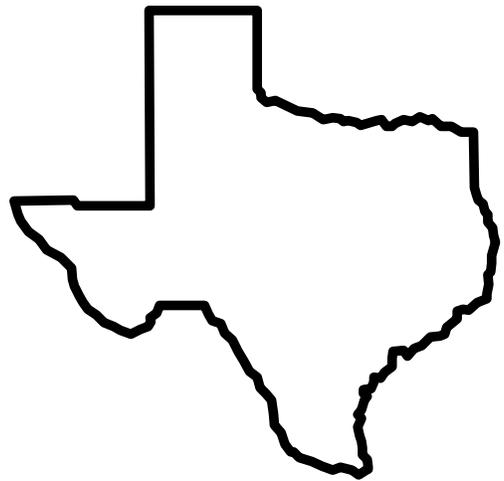


Juan M. Parra, M.D., M.P.H.



CHAPTER 1

OPERATIONS & ACTIVITIES



OPERATIONS

An Overview of Child Fatality Review in Texas

Child Fatality Review (CFR) has been in operation in Texas since 1995 upon the mandated creation of the child fatality review process by the Texas Legislature. CFR consists of two critical components – the SCFRT Committee and CFRT – each with distinct yet complementary roles (Texas Family Code, Title 5, Chapter 264, Subchapter F, §264.501 - §264.515 (Appendix C)).

Role of the State Child Fatality Review Team Committee

The SCFRT Committee is a statutorily-defined multidisciplinary group of professionals who serve to:

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

The SCFRT Committee meets quarterly to discuss issues related to child safety, to suggest strategies to improve child death data collection and analysis, and to determine recommendations that will make Texas safer for children. The SCFRT Committee works closely with local CFRT across the state. These local CFRT conduct and provide data on all reviews and identify local child safety issues.

Role of the Local Child Fatality Review Teams

CFRT are multidisciplinary and multiagency groups of professionals who volunteer to regularly review child (under the age of 18 years) deaths in a specified geographic area. Their task is to understand safety risks for children and reduce the number of preventable child deaths. Typically, teams correspond to a given county, although the statute allows for multi-county teams in areas with a population of less than 50,000.

A local team, in reviewing child deaths, is charged with:

- 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 the county or counties in which the review team is located; and
- advising the SCFRT Committee on changes to law, policy or practice that will assist the team and the agencies represented on local teams in fulfilling their duties.

Ultimately, the mutual role of the local teams and the SCFRT Committee is to prevent future child deaths. Local teams collect data, identify local child safety issues and address them through education and prevention initiatives. In submitting local data, local teams create a detailed picture of child death as a public health issue in Texas. The SCFRT Committee reviews the data collected statewide to develop position statements and make recommendations to the Texas Legislature.



Legislative Authority and State Agency Involvement

Senate Bill 6, passed by the 79th Texas Legislature, amended the Texas Family Code to move the oversight of the child fatality review process from the Department of Family and Protective Services (DFPS) to DSHS.

Multiple components of the agency are involved in providing support and direction to the local CFRT during the 2010 report period (Figure 1). DSHS staff and programs enhance child fatality review in Texas by working together to help teams collect and interpret child death data and turn knowledge into prevention initiatives.

The organizational home of the child fatality review process is within the Division of Family and Community Health Services (FCHS). Within that Division, the Texas CFR coordinator is in the Office of Program Decision Support.

The role of the coordinator is to:

- provide support and training to the local teams;
- develop new teams in areas without coverage;
- support the SCFRT Committee in their quarterly meetings;
- create processes and procedures for effective team meetings and data collection;
- assist the teams in implementing prevention programs on a community level; and
- facilitate communication among the local teams, SCFRT Committee and DSHS staff.

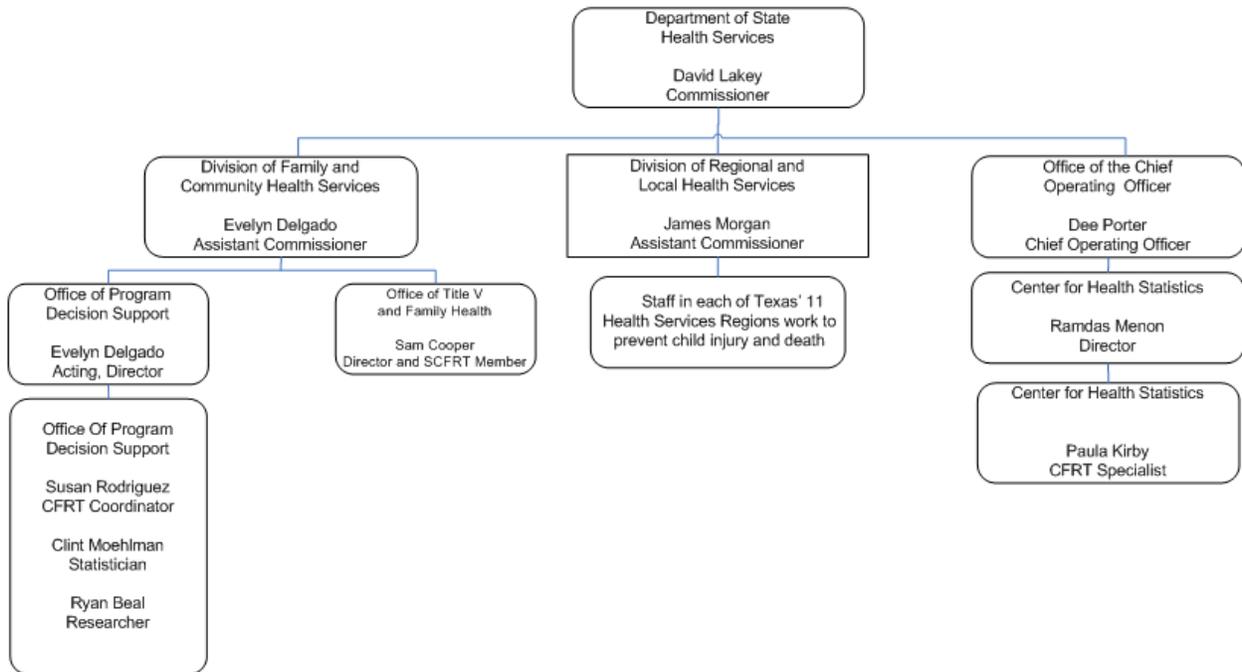
The Center for Health Statistics, housed in the Office of the Chief Operating Officer, has a significant role in CFR process. The Center for Health Statistics is responsible for the annual distribution of over 4,000 death certificates and 1,500 birth transcripts to the local CFRT. The absence of this information would severely limit the ability of local CFRT to function.

In mid-2007, with funding from the Office of Title V and Family Health, staff from each of the eight DSHS Health Service Regions was assigned to focus on understanding the causes of child death and how those deaths could be prevented. In this role, regional staff assists in developing new CFRT and serves as the voice of public health and prevention on existing teams. DSHS regional staff has been trained on the CFR process and are working with the Texas CFR coordinator to identify potential partners, convene community information meetings, organize new teams and work with teams and communities on injury prevention initiatives. The impact of a statewide focus on CFR has been tremendous. In the first year of collaboration, 21 new and returning teams were created through the cooperative efforts of community, region and state partners. In 2009, five new and returning teams were created and many more were in development. In 2010, working together, 13 new CFRT were created.

In addition to the support provided by DSHS staff, the State Registrar, who heads the DSHS Vital Statistics Unit, and the Director of the Office of Title V and Family Health are both permanent members of the SCFRT. The commissioner of the DFPS is the third permanent member of the SCFRT (Title 5, Chapter 264, Subchapter F, Texas Family Code, §264.502).



**Figure 1. DSHS Support of Child Fatality Review
(For 2010 report period)**



LOCAL CHILD FATALITY REVIEW TEAMS

Status of Child Fatality Review Teams in 2010

Tracking the number of active teams and the reviews completed by Texas teams can be a challenge. Teams are voluntarily formed by communities, and members regulate the meeting frequency and review rate. Two CFRT (Dallas and Harris County CFRT) have paid leadership staff while all other teams have leadership from community volunteers. Teams are asked to review deaths from a given year by the end of the calendar year. Further complicating the issue is that in a given year Texas CFRT typically review child deaths that occurred one to two years prior to the time of review. In 2010, teams were to complete all reviews of 2008 child deaths. Another complicating factor is that new teams are in a transitional development phase throughout the year. This leads to irregular review patterns. For example, a team that was formed in October typically begins with child deaths assigned for the next calendar year. Not all teams review all deaths. Urban teams, such as in Bexar and Harris counties, have a high volume that prohibits review of all deaths. Dependent upon community-specific circumstances, some teams do not review any deaths for an indicated year. The consistency of reviewed child deaths fluctuates.

In 2010, Texas CFRT focused on reviewing the deaths of children that occurred in 2008. Forty-six active local teams covering 126 of Texas' 254 counties reviewed 2008 child deaths. Twenty-three local teams (representing 35 Texas counties) did not conduct reviews for a variety of reasons including hurricane recovery, becoming a team too late in the year, and reviewing without inputting the data into the multi-state database. Of the 4,030 child deaths in Texas, 3,664 child deaths corresponded to existing CFRT and 2,106 (57.5 percent of those child deaths) were reviewed.

The stated goal of the SCFRT Committee is to have 100 percent coverage of all Texas children. DSHS staff will work with any community interested in forming a CFRT. Child population is an important factor to consider when prioritizing target counties for CFRT development. At the end of 2010, the following counties are identified as target counties based on child population.

Table 1. Counties Without CFRT to Target in 2011

County Without CFRT	2009 Child Population	County Without CFRT	2009 Child Population
1. Brazoria County	82,017	11. Van Zandt County	12,308
2. Gregg County	30,956	12. Lamar County	12,158
3. Comal County	25,192	13. Medina County	11,475
4. Angelina County	22,150	14. Wilson County	10,330
5. Rockwall County	21,748	15. Caldwell County	9,609
6. Bowie County	21,102	16. Upshur County	9,193
7. Maverick County	17,997	17. Brown County	9,086
8. Hardin County*	13,173	18. Chambers County	8,827
9. Cherokee County	12,771	19. Jasper County	8,486
10. Atascosa County	12,730	20. Uvalde County	7,893

* Hardin County formed a CFRT in 2/2011.

Map 1 and Table 2 identify the 69 local CFRT as of December 2010. The teams cover 196 of the 254 Texas counties (77 percent). At the end of 2010, 93.1 percent of all Texas children lived in a community where there is a CFRT (based on 2009 child population data).



Map 1. Local Child Fatality Review Teams 2010

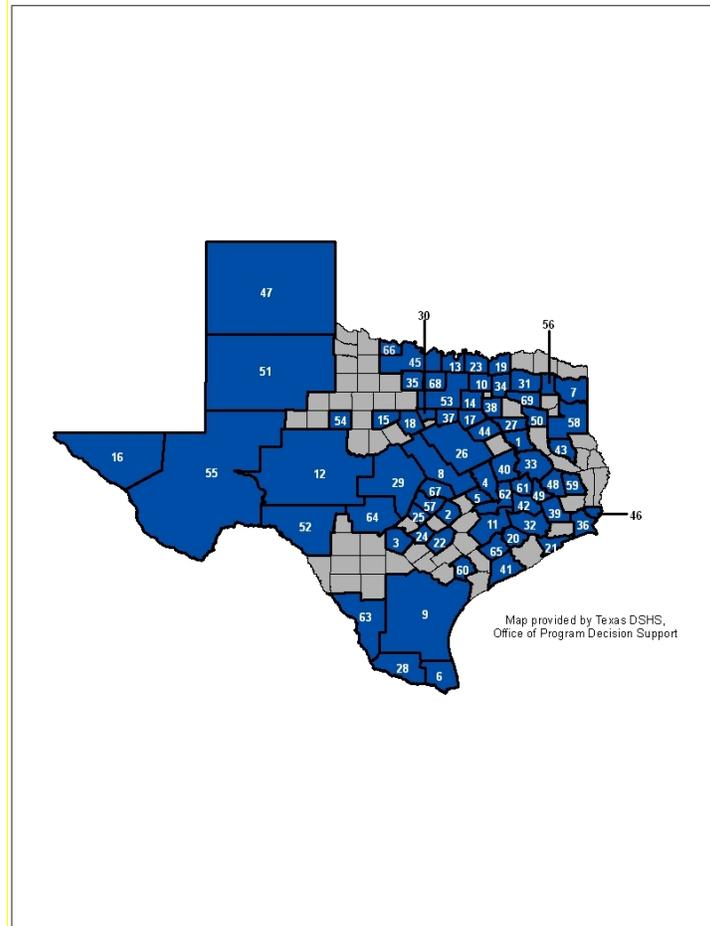


Table 2. Local Child Fatality Review Teams in 2010

1. Anderson County CFRT	24. Guadalupe County CFRT	47. Panhandle CFRT
2. Bastrop County CFRT	25. Hays County CFRT	48. Polk County CFRT
3. Bexar County CFRT	26. Heart of Texas CFRT	49. San Jacinto County CFRT*
4. Brazos County CFRT	27. Henderson County CFRT	50. Smith County CFRT
5. Burleson County CFRT	28. Hidalgo/Starr Counties CFRT	51. South Plains CFRT
6. Cameron/Willacy Counties CFRT	29. Hill Country CFRT	52. South Texas Tri-County CFRT*
7. Cass/Morris/Marion CFRT	30. Hood County CFRT	53. Tarrant County CFRT
8. Central Texas CFRT	31. Hopkins/Franklin/Delta CFRT	54. Taylor County CFRT*
9. Coastal Bend CFRT	32. Houston/Harris County CFRT	55. Texas "J" CFRT
10. Collin County CFRT	33. Houston/Trinity Counties CFRT	56. Titus/Camp Counties CFRT
11. Colorado/Austin/Waller CFRT	34. Hunt County CFRT	57. Travis County CFRT
12. Concho Valley CFRT	35. Jack County CFRT*	58. Tri-County CFRT
13. Cooke County CFRT*	36. Jefferson County CFRT	59. Tyler County CFRT*
14. Dallas County CFRT	37. Johnson County CFRT	60. Victoria County CFRT
15. Eastland County CFRT*	38. Kaufman County CFRT	61. Walker County CFRT
16. El Paso County CFRT	39. Liberty County CFRT*	62. Washington/Grimes CFRT
17. Ellis County CFRT	40. Madison/Leon Counties CFRT	63. Webb County CFRT
18. Erath County CFRT	41. Matagorda County CFRT*	64. Western Hill Country CFRT
19. Fannin County CFRT	42. Montgomery County CFRT*	65. Wharton County CFRT
20. Fort Bend County CFRT	43. Nacogdoches County CFRT	66. Wichita County CFRT
21. Galveston County CFRT	44. Navarro County CFRT*	67. Williamson County CFRT
22. Gonzales County CFRT	45. North Texas Tri-County CFRT*	68. Wise County CFRT
23. Grayson County CFRT	46. Orange County CFRT	69. Wood/Rains Counties CFRT*

* New Teams



TEXAS CHILD FATALITY REVIEW AT THE COMMUNITY LEVEL

The primary purposes of the local multidisciplinary CFRT are: (1) to understand the contributing risk factors that lead to child deaths, and (2) to decrease the incidence of preventable child deaths. To best understand the deaths under review, the teams are comprised of subject matter experts from disciplines that interact with incidents of child fatality. This includes representatives from healthcare (including physicians), Child Protective Services, law enforcement, the court system and child advocacy. By sharing information within the confidential environment of the review team meeting, local team members are best equipped to understand risk factors involved in child deaths and to identify protective factors that could prevent future deaths.

The local CFRT in Texas have embraced the goal of reducing the number of preventable child deaths. They work to identify opportunities to take data to action through implementation of protective policies and interventions that contribute to the reduction of risks for childhood injury and death. The profiles below spotlight the prevention-oriented activities undertaken by Texas teams in 2010.

Colorado/Austin/Waller Counties Child Fatality Review Team

This three-county team has leadership from an area therapist and DSHS staff. Early in 2010, as a result of a child drowning in a pond, the team worked together to create a brochure on pond safety which they distributed in their rural three-county area. Child passenger safety and prevention of motor vehicle crashes are also a high priority for this team. Members conducted two comparative seat belt check-ups at Bellville Primary School and Bellville High School. In checking each departing vehicle at the schools for proper use of restraints, they found that over half of the children leaving the primary school were unrestrained.

Parents were provided written information about booster seat law and seat belt use. At the high school, they checked departing students for seat belt use and provided information on seatbelts, the dangers of texting while driving, and the new laws prohibiting cell phone use in school zones. The team returned six months later for a follow-up check at both schools and found that no improvement was made at the primary school but considerable improvement was made at the high school. An article in the *Bellville Times* reported these findings to the community. They plan to conduct more seat belt surveys at other school districts in their three counties. Team members made a presentation about their activities during the “best practices” session at the Protecting Texas Children Conference in April 2010. The team also hosted free cardiopulmonary resuscitation (CPR) classes for the community.



Concho Valley Child Fatality Review Team

This 13-county team is led by a Tom Green County Justice of the Peace and staff at the Hope House Children's Advocacy Center of Tom Green County. Members of the team delivered injury prevention talks to local civic organizations such as the Lions Club. Education presentations on predators who stalk children on the Internet and how to identify youth who may be contemplating suicide were well-received and reported on by local media.



Dallas County Child Death Review Team

This urban team, under the leadership of the Injury Prevention Center of Greater Dallas, prepared and released an annual report for Dallas County in 2010. This comprehensive report analyzes Dallas County child death data for 2006-2007 and paints a descriptive picture of issues for Dallas County children. Among the findings in the report: unintentional injury was the number one cause of death for children ages 1 – 17; the rate of child maltreatment deaths to children less than one year of age increased 65 percent; African American children comprised 22 percent of the population but accounted for 36 percent of the child deaths; and nearly one in five child deaths in Dallas County was preventable. The Dallas County Child Death Review Team also answered the call for nominations to the SCFRT Committee when they nominated a member to serve. Dr. Reade Quinton was elected and serves in the medical examiner role.



Dallas County Child Death Review Team 2010 Annual Report

[http://www.injurypreventioncenter.org/pdf/2010%20CDRT%20Annual%20Report Final.pdf](http://www.injurypreventioncenter.org/pdf/2010%20CDRT%20Annual%20Report%20Final.pdf)



El Paso County Child Fatality Review Team

This multi-county team covering El Paso, Hudspeth and Culberson counties, led by the El Paso County District Attorney's Office, worked collaboratively with others in the area on two issues: child abuse prevention and drowning prevention. The team was very involved in the activities in April for Child Abuse Prevention Month and worked with other area agencies in the formation of the Drowning Prevention Coalition. The coalition developed and widely distributed a fact sheet in English and Spanish addressing home pool safety, water park safety, the role of parents in water safety and specific El Paso water precautions based on the reviews conducted by the CFRT.



These region-specific precautions included:

- Never play in drainage ditches or arroyos, even when dry.
- Do not allow children to play near or in a river or another body of water, including ponds, channels and drains.
- Do not swim in canals or ponding areas.
- Turn around, don't drown. Do not drive on flooded streets.
- During heavy rains, alleys, backyards, streets and sunken areas can fill with water. Tell children not to play in these areas.
- Pools need to be surrounded with secure fencing with no areas of unlocked entrance.
- Never underestimate the water currents in a river, channel or a drain.
- Backyard ponds are deep enough for a toddler to fall into and drown.
- Small disposable pools should be emptied and turned over when not in use.
- Personal flotation devices should be worn whenever a non-swimmer is in, on, or around water.

Team members made a presentation about their team activities during the "best practices" session at the Protecting Texas Children Conference in April 2010.



Fort Bend County Child Fatality Review Team

This team, led by the Fort Bend County District Attorney's Office, wanted to find a way to reduce the number of child drowning deaths in residential swimming pools. Partnering with local businesses in pool safety, they promoted the Tools for Safe Pools campaign in the summer. Through the partnership, a discount of 30 percent on pool fencing was extended to families with children five years and younger, and pool gates were offered for \$250 (Figure 2). The Tools for Safe Pools campaign ran from June 15, 2010 – July 15, 2010.

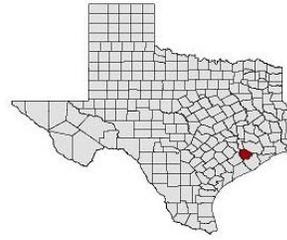


Figure 2. Tools for Safe Pools Campaign

The Fort Bend County Child Fatality Review Team Announces

Tools for Safe Pools

An illustration of three children playing in a pool. One child is in the water with a purple ring, another is on the edge, and a third is standing nearby.

Each year in the United States, nearly 300 children under the age of five drown in residential and public pools and spas. Submersion incidents requiring emergency-room treatment or hospitalization number in the thousands and many victims experience permanent disability, including brain damage.

POOL SAFETY TIPS:

- Never leave a child unattended near a pool. There is no substitute for adult supervision.
- Designate a “water watcher” to maintain constant watch over children in the pool during gatherings.
- Keep a life-saving ring, shepherd’s hook and CPR instructions mounted at poolside.
- Do not use flotation devices as a substitute for supervision.
- Learn CPR and rescue breathing. (Contact www.houstonredcross.org)
- Do not consider children “drownproof” because they have had swimming lessons.
- Remove toys from in and around the pool when not in use.
- Isolate the home from the pool with a fence at least 60” tall, with a self-closing, self-latching gate.

Fort Bend County Child Fatality Review Team members: Fort Bend County District Attorney's Office, Child Advocates of Fort Bend, Rosenberg Police Department, Missouri City Police Department, Katy Police Department, Arcola Police Department, Fort Bend County Attorney's Office, Fort Bend County Sheriff's Office, Fort Bend County Health and Human Services, Fort Bend ISD Police Department, Fulshear Police Department, Katy ISD Police Department, Meadows Place Police Department, Needville Police Department, Richmond Police Department, Stafford Police Department, Sugar Land Police Department, Texas Department of Family and Protective Services, Thompson Police Department, Fort Bend County Juvenile Probation, Fort Bend County Adult Probation, Dr. Stephen Pustilnik (Galveston County Medical Examiner), Dr. Rebecca Girardet (The University of Texas C.A.R.E. Clinic – Houston)

Pool Guard
Making Pools Safe for Kids
Rick Levinton
281-495-8800
www.poolguardtexas.com

KATCHAKID
Georgina Baba
713-483-8305
www.katchakid.com
Code: FTBNDVA250

30% Off Pool Fence

The Fort Bend County Child Fatality Review Team's Corporate Partners in Pool Safety, Pool Guard and Katchakid, are offering 30% off pool fences for families with children 5 years and younger and pool gates for \$250. This discount will begin June 15th and end July 15, 2010. Don't miss this opportunity to make your pool a safer place for children!



Heart of Texas Child Fatality Review Team

This multi-county team is led by the Heart of Texas Regional Advisory Council, the trauma service network for the five-county region covering Bosque, Falls, Hill, Limestone and McLennan counties. In 2010, they pursued multiple activities that corresponded to child deaths reviewed. The team feels education of the community is critical, and members work to develop educational presentations that will increase the safety of Central Texas children. They are working on education and protocols for school nurses to respond to a wide variety of child injuries and illnesses. They are working with the McLennan County Advocacy Center for Crime Victims and Children to develop a curriculum on child maltreatment for medical professionals. Editorials about booster seat laws were printed through the *Waco Herald-Tribune*. Members distributed information about sports concussions at health fair as well as information about safe sleep for infants at the Healthy Women's Health Expo. Focused on education, this CFRT is developing a Speaker's Bureau to address topics from drug awareness in schools to safe home birth practices.



Hidalgo/Starr Counties Child Fatality Review Team

Members of this Rio Grande Valley team are dedicated to making their community a safer place for children. As in the previous year, they participated in a car passenger safety seat clinic at the Edinburg Children's Hospital. Working with certified passenger safety technicians from the Hidalgo County Sheriff's Office, they inspected child passenger safety seats for correct installation and provided car seats to those that needed replacements. Recommendations on child safety in and around vehicles were also provided. A lack of funds prevented this team from conducting many proposed prevention activities. In response to this, they created an injury prevention task force and went through the process of becoming a non-profit organization. The name of the new non-profit entity dedicated to injury prevention is Reaching a Safe Environment (RASE). They conducted two fundraisers in 2010 and are planning more fundraising in 2011. Members of the team made a presentation about their team activities during the "best practices" session at the Protecting Texas Children Conference in April 2010. A team member was nominated to serve on the SCFRT Committee, and now nurse Julie Foster serves in the child abuse prevention specialist role.



Scenes from the car passenger safety seat clinic in Edinburg. Fifty children were seen and 26 unsafe car seats were replaced with new ones that were installed on the scene.



Houston/Harris County Child Fatality Review Team

This team is co-chaired by a pediatrician and an assistant district attorney and is coordinated through the Harris County Public Health and Environmental Services. This urban team marked their fourth year of partnering with the Safe Kids of Greater Houston Water Safety Coalition (Coalition) to host the annual April Pools Day media event.

The Coalition received a proclamation from the City of Houston citing April as April Pools Month. They also received a resolution from Harris County recognizing their drowning prevention efforts. Team members served as part of the steering committee for the annual Protecting Texas Children Conference, and members of the team made a presentation about their team activities during the “best practices” session at the Protecting Texas Children Conference in April 2010. The CFRT chair and a physician presented a paper on child homicide trends in Harris County based on data collected by the team.



Johnson County Child Fatality Review Team

This North Texas team led by the Johnson County Children’s Advocacy Center (CAC) noted that the majority of their child deaths seem to be due to two mechanisms of death: motor vehicle crashes and unsafe infant sleep practices. They have created presentations to address these topics, and members of the team have delivered presentations in a variety of venues. Because of the team’s established relationship with the schools, they have been able to present programs on texting and driving, sexting, bullying and cyber-bullying, and how to recognize and report abuse to schools and school districts. They also have done presentations to high school juniors and seniors just prior to prom to discourage drinking and driving. They have presented parent programs in the evenings in two school districts and have two additional districts that they are working with for presentation of these programs. The team coordinator credits the collaboration between the CFRT and the CAC-based child abuse multi-disciplinary team for a stronger and more united effort to keep Johnson County children safer from unintentional and intentional injury deaths. Members of the team made a presentation about their activities during the “best practices” session at the Protecting Texas Children Conference in April 2010.



Nacogdoches County Child Fatality Review Team

This East Texas team, under the leadership of Lisa King who also serves as Nacogdoches Child Welfare Board President and on the Nacogdoches Memorial Hospital Board, focused on educating the public about the danger of leaving young children unattended in cars. Through a demonstration to local television representatives and the Nacogdoches Daily Sentinel, Ms. King educated a wide audience about how rapidly temperatures rise in a closed car and the risks of hyperthermia deaths in young children. She also provided tips on eliminating these preventable deaths.

PROTECT CHILDREN FROM HYPERTHERMIA Safety Recommendations

- Dial 911 immediately if you see an unattended child in a car. EMS professionals are trained to determine if a child is in trouble.
- Never leave a child unattended in a vehicle, even with the window slightly open.
- Place a cell phone, PDA, purse, briefcase or gym bag on the floor in front of the child in the backseat. This triggers adults to see children when they open the rear door and reach for their belongings.
- Set your cell phone or Blackberry reminder to be sure you dropped your child off at daycare.
- Set your computer calendar program to ask “did you drop off at day care today?”
- Teach children not to play in vehicles.
- Lock all vehicle doors and trunk after everyone has exited the vehicle – especially at home. Keep keys out of children’s reach. Cars are not playgrounds or babysitters.
- Check vehicles and trunks first if a child goes missing.

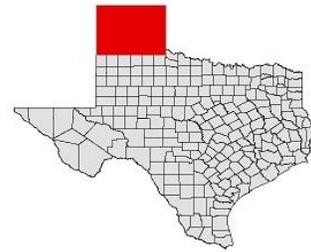


Nacogdoches County CFRT Presiding Officer, Lisa King, demonstrates to the press how rapidly temperatures rise in a closed car and the risks of leaving young children unattended in cars.



Panhandle Child Fatality Review Team

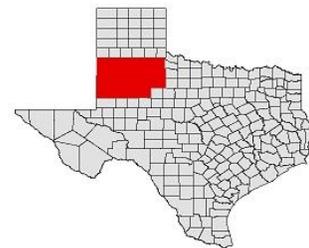
This 26-county team is under the leadership of the Randall County Sheriff's Office and DSHS regional staff. The Panhandle CFRT is closely linked to the Panhandle Safe Kids Coalition due to overlap in the membership. Many of the activities are co-conducted by CFRT and Safe Kids. In 2010, Safety Fairs and progressive Agricultural Farm Safety Days were held throughout the area. Parents and children had opportunity to learn about food safety, chemical and drug awareness, safe operation of all-terrain vehicles (ATV) and more about motor vehicle crashes through the rollover demonstrator. Other joint activities include KIDSFEST, during which the 12,000 children attending received immunizations, school gear distribution and safety information. The Amarillo Fire Department educated children at 60 local schools about fire and burn safety using SMOKE HOUSE, a mobile fire safety display. Kohl's Safety Day included distribution of 500 bike helmets that were fitted and given to children. Justice of the Peace Frank Frausto, a CFRT member, was prompted to establish the non-profit Cribs for Life after reviewing child death information. Cribs for Life publicizes safe sleep recommendations through posters and a website and distributes cribs to families that cannot afford them.



Dr. Eric Levy, member and former chair of the State Child Fatality Review Team Committee and member of the Panhandle CFRT, addresses an audience on the importance of motor vehicle safety for children. At this press event for the Click It or Ticket campaign sponsored by the Texas Department of Transportation, he spoke about his experience as a pediatric intensivist who treats children who have been critically injured in motor vehicle crashes and about the preventability of these injuries and deaths when appropriate safety restraints are installed correctly and used every time.

South Plains Child Fatality Review Team

This 22-county team, under leadership of the Child Advocacy Research Education (C.A.R.E.) Center of the Texas Tech University Health Science Center Department of Pediatrics, hosted the South Plains Child Fatality Review Conference on August 24, 2010, on the Texas Tech University campus. The purpose of the conference was to recruit and involve new members in the outlying counties and to generate more interest and involvement in the prevention aspect of the CFR process. With the support of the City of Lubbock and the First National Bank, which donated \$700 for refreshments and materials, they were able to host 120 participants for a day of information on best practices regarding Child Fatality Review, youth suicide prevention, motor vehicle safety for children, and safe sleep for infants. The medical examiner presented on Sudden Unexpected Infant Death Syndrome (SIDS) from the forensic perspective, and a Child Protective Services supervisor reviewed the statistics on child abuse injuries and deaths in each of the South Plains counties.



Victoria County Child Fatality Review Team

This South Texas team has been working on incorporating more counties. Working with the Texas CFR coordinator and DSHS regional staff, the team is exploring the addition of six surrounding counties that do not have CFRT: Calhoun, DeWitt, Goliad, Karnes, Lavaca and Jackson. With the addition of these counties to the existing Victoria County team, their coverage area would be similar to that of the Golden Crescent Regional Advisory Council, the trauma service network for the six-county area. Karnes County is not included in that trauma service network. The Regional Advisory Council is also very dedicated to injury prevention, so this would be a logical expansion of the team.



Williamson County Child Fatality Review Team

This team co-hosted their 2nd Annual Central Texas April Pools Day in 2010. The county health department, the Central Texas Water Safety Coalition and the Williamson County CFRT presented water safety information to the commissioners court. A proclamation about April Pools Day was signed by the county judge and county commissioners and presented to the group. A presentation on cryptosporidiosis (a waterborne parasitic disease) was made by the county health department, and a display about water safety was exhibited outside the courtroom.



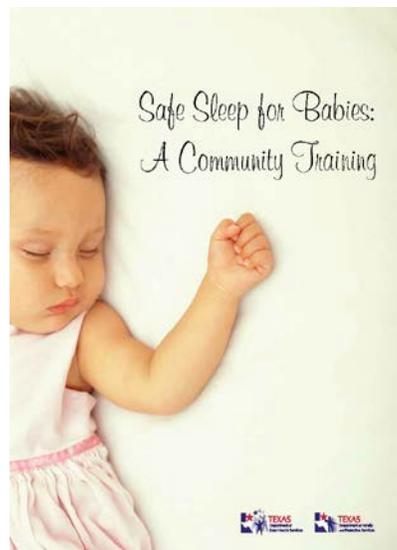
NOTABLE ACTIVITIES AND COLLABORATIONS IN 2010

The nature of the child fatality review process lends itself to collaboration. The model of the multidisciplinary team members sharing information and working together to reinforce the safety net under children was replicated in many partnerships in 2010.

Infant Health Workgroup

This workgroup came out of discussions regarding safe sleep for infants in SCFRT meetings. This workgroup is comprised of Department of Family and Protective Services staff from Child Protective Services (CPS), Child Care Licensing (CCL) and Prevention and Early Intervention (PEI), along with staff from the Office of Program Decision Support including the Women's and Perinatal Health Coordinator, Nurse Consultant and Child Fatality Review Coordinator. These groups have a mutual interest in safe sleep practices due to the significant number of infant deaths reviewed by CFRT and investigated by CPS and the diverse opinions about the most effective strategies for prevention.

The workgroup's two projects came to fruition in 2010: 1) a safe sleep curriculum and 2) safe sleep training designed for CPS caseworkers. The safe sleep curriculum was unveiled at the Protecting Texas Children conference in April 2010. It was developed with funding from PEI. The curriculum can be used in any community. Pilot sites to test the curriculum included the Fort Hood Army Base in Bell County, Jefferson County and Nueces County. Train-the-trainer sessions were held at the pilot sites, generating feedback to help fine-tune the curriculum. It is available online in English and Spanish at <http://www.dshs.state.tx.us/mch/default.shtm>. PEI will provide incentives for attendees upon request. They include a onesie with a sleep placement message, safe sleep magnet, and poster.



The training for CPS caseworkers was developed by a social marketing firm with input from the Infant Health Workgroup. It was funded by the Office of Title V and Family Health. The required online training for CPS caseworkers is called *Safe Sleep 360*. It educates caseworkers on safe sleep practices, how to identify risks during home visits, how to talk to parents about changes necessary to keep their infants safe, and how to empower parents to make sure their behavior changes are honored by other caregivers such as grandparents and babysitters. Below is a sample from the Supervisor Training Guide.

**SAFE SLEEP
360°**

Supervisor Training Guide

As a caseworker supervisor, you have opportunities to check in with caseworkers about how safe sleep assessments are working, where they might need more support, or questions they have about their training, including:

- Unit meetings
- Case transfer staffings
- Conferences with each caseworker
- Reviews of case documentation
- Assessment of caseworker skills in field

B Back A baby should sleep on her back on a firm surface.

A Alone A baby should sleep alone.

B Room to Breathe A baby should sleep with room to breathe.

Y Yes to healthy habits When a baby is awake, say yes to healthy habits like breastfeeding and tummy time.

The images below show some of the hazards that may be encountered in an infant's sleep environment.

BEDROOM



- Baby's sleep area has pillows and comforters.
- The room has evidence of a smoker being present.
- The parent who shares this bed could be under the influence of alcohol or taking medication that causes sleepiness.

LIVING ROOM



- Sleep area is within reach of curtains, venetian blinds, and cords.
- Baby's sleep area has fluffy-blankets, pillows, and stuffed toys.
- Baby sleeps or naps on a sofa.
- The room is cluttered.

NURSERY



- Baby sleeps in heavy sleep clothing.
- Baby's sleep area has fluffy blankets, pillow-like bumpers, stuffed toys, and an infant positioner.
- The room has evidence of a smoker being present.
- The room is cluttered.

The Infant Health Workgroup expanded its membership to include the Office of the Attorney General, the DFPS fatherhood initiative, and the DSHS adolescent health coordinator. The group is developing new projects to address teen pregnancy, particularly among the foster care population.

Protecting Texas Children Conference

Once again, the SCFRT Committee partnered with the Children's Assessment Center of Houston to plan and present the 11th Annual Protecting Texas Children Conference: Innovative Ideas and Progressive Practices, which was held April 25-28, 2010, in Houston. The conference planning committee included the CFR Coordinator, SCFRT Committee members Denise Oncken and Dr. Kim Cheung, and members of the Houston/Harris County CFRT. The DSHS Office of Title V and Family Health provided funds for registration and expenses of SCFRT Committee members and two members of each CFRT. Over 100 CFRT members and regional DSHS staff attended the conference.



As in years past, the SCFRT Committee hosted a pre-conference session specifically for CFRT members. These sessions related to child fatality review/injury prevention throughout the conference. Because CFRT and the MDT found in child protection are comprised of professionals from a diverse group of disciplines, the sessions related to a variety of professions, such as law enforcement, therapy, medical care, child advocacy and justice. Topics presented at the conference specifically designed for the CFRT members interested in injury and violence prevention included:

- *Untapped Potential: The Role of Child Death Review in Strategic Injury Prevention and Risk Reduction* presented by Dr. Carolyn Cumpsty Fowler, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD
- *Unto the Third Generation: A Call to End Child Abuse Within 120 Years* presented by Victor Vieth, National Child Protection Training Center
- *Preventing Premature Births* presented by Dr. Charleta Guillory, Baylor College of Medicine, Neonatal-Perinatal Public Health Program at Texas Children's Hospital
- *Bicycle Safety and Bike Rodeos* presented by June Villarreal, Texas Office for the Prevention of Developmental Disabilities
- *Preventing Children from Becoming Victims of the Choking Game* presented by DSHS nurse Sylvia Millsap
- *Showcase of Child Fatality Review Team Activities to Prevent Injury and Death of Children* a two-part session presented by members of various CFRT
- *Preventing Child Agricultural Injuries and Deaths* presented by DSHS nursing supervisor Marie Reed
- *Keeping Sleeping Infants Safe Train-the-Trainer Curriculum* a two-part session presented by DSHS Women's and Perinatal Health Coordinator, Maria Pena, and DFPS PEI staff, Anjulie Chaubal
- *The Link Between Animal Abuse, Domestic Violence and Child Abuse* presented by Belinda Smith, Chief of the Animal Cruelty Section of the Harris County District Attorney's Office; Trina Burkes-Craddock, Investigator with the Animal Cruelty Section of the Harris County District Attorney's Office; Dr. Jeff Chalkley, Harris County Veterinary Medicine Association
- *Child Homicide: Understanding, Identifying and Preventing* presented by Dr. Rohit Shinoi, Baylor College of Medicine/Texas Children's Hospital, and Stephani Adams, Houston/Harris County CFRT Chair
- *How to Advocate for Children with Legislators* presented by Andrea Sparks, Texas Court Appointed Special Advocates (CASA), and Rosie Valadez McStay, Texas Children's Hospital

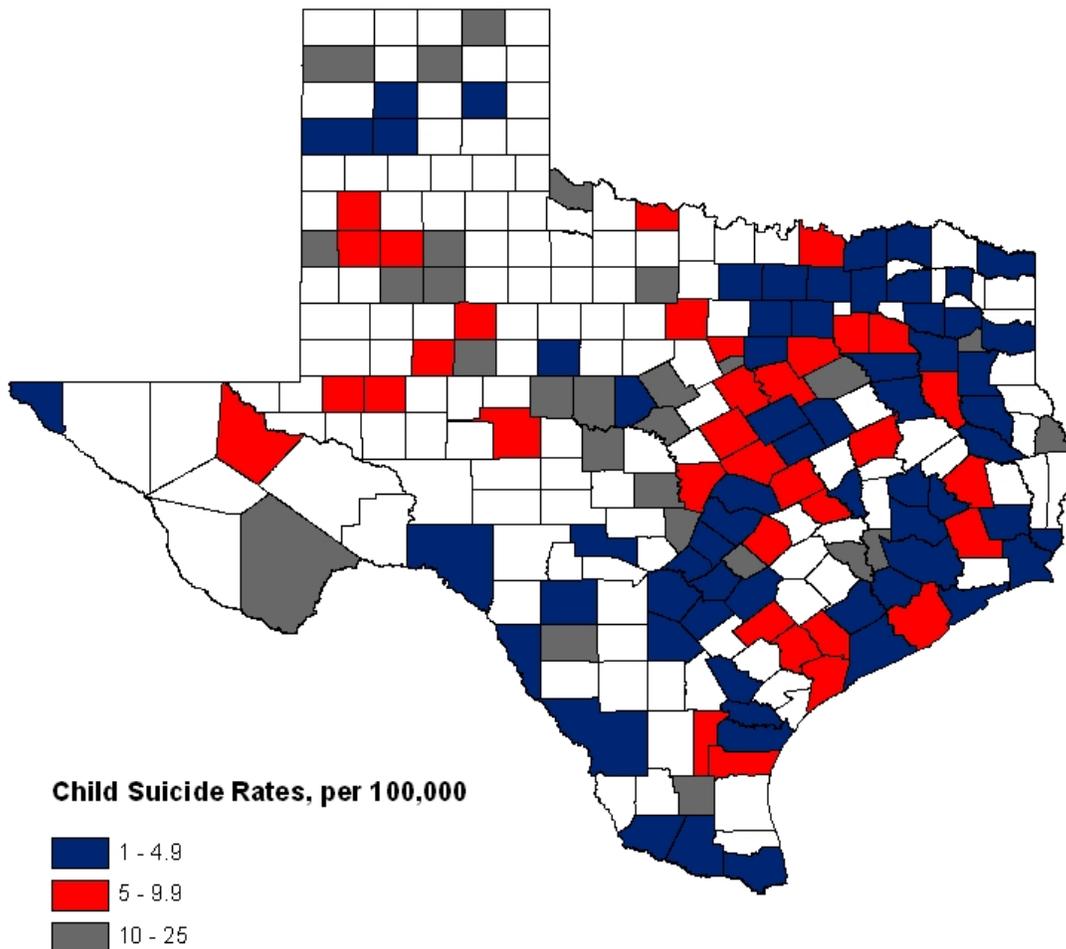


Texas Suicide Symposium

Mental Health America of Texas annually hosts the Texas Suicide Symposium with the support of the Office of Title V and Family Health. At the June 2010 Symposium Texas Child Fatality Review had an exhibit on child suicide in Texas. DSHS epidemiologist and SCFRT Committee member, John Hellsten, Ph.D., and the Texas CFR coordinator, Susan Rodriguez, prepared an exhibit that examined child suicide cases reviewed by CFRT over the years. The SCFRT Committee also took this opportunity to launch the Position Statement on Child Suicide (Appendix E).

Map 2, prepared for the exhibit, shows child suicide rates for the state by county, 1999 – 2006.

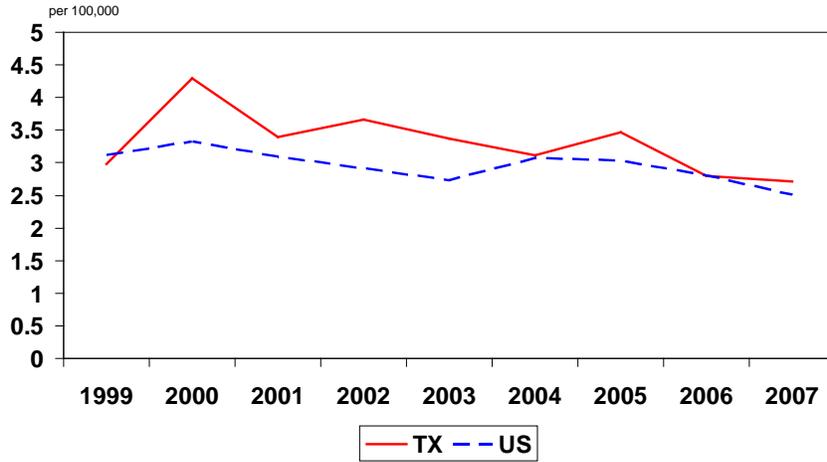
Map 2 . Child Suicide Rates by County, 1999-2006



Map Provided by Texas DSHS,
Office of Program Decision Support

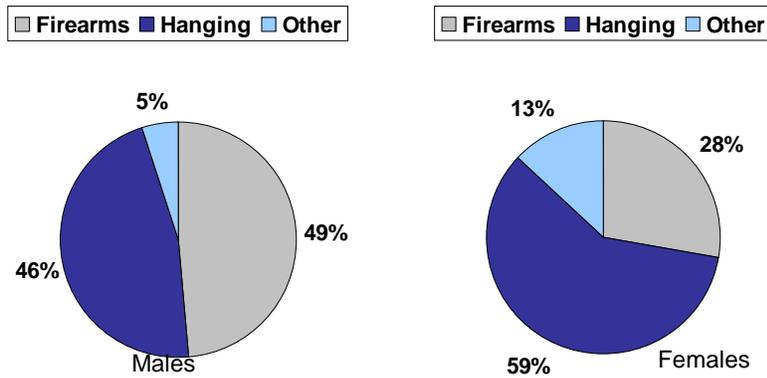


Figure 3. Child Suicide Deaths, Ages 10-17



Source: Centers for Disease Control and Prevention, WISQARS

Figure 4. Child Suicide Methods, Ages 10-17



Source: DSHS, Vital Statistics Mortality, 2005-2007



Texas Injury and Violence Prevention Conference

Dr. Hellsten and Ms. Rodriguez were members of the planning committee for the *Texas Injury and Violence Prevention Conference* that was held at Dell Children's Hospital in August 2010. Organizations planning the conference included Dell Children's Medical Center of Central Texas, the Governor's Emergency Management System & Trauma Advisory Council (GETAC), Mothers Against Drunk Driving, the Injury Prevention Center of Greater Dallas, St. David's Healthcare and DSHS. Members of Texas CFRT and DSHS staff members involved in CFRT and injury prevention attended.

The conference focus was on building core competencies in practitioners in injury and violence prevention. The core competencies¹ are:

- Describe and explain injury and violence as a social and health problem;
- Access, interpret, use, and present injury and violence data;
- Design and implement injury or violence prevention activities;
- Evaluate injury or violence prevention activities;
- Build and manage an injury or violence prevention program;
- Disseminate information through diverse communication networks;
- Stimulate change through policy, enforcement, advocacy, and education;
- Maintain and develop competency as a professional; and
- Demonstrate competency in an injury or violence prevention topic.

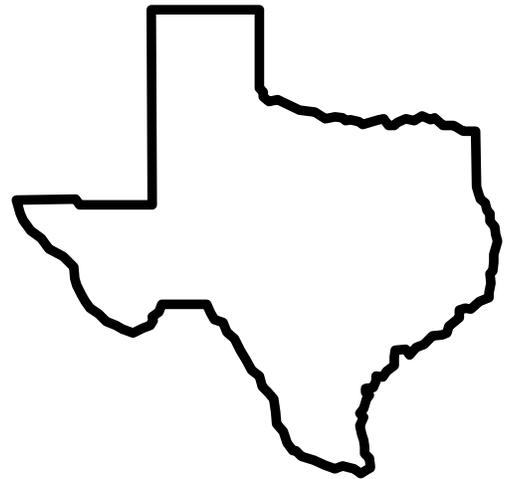
The conference featured nationally known experts, including Larry Cohen of the Prevention Institute; Carolyn Cumpsty Fowler, Ph.D., and Andrea Gielen, Ph.D., Johns Hopkins University Center for Injury Research & Policy; and Lee Annett, Ph.D., and Ruth Shults, Ph.D., from the Centers for Disease Control and Prevention.

The next Texas Injury and Violence Prevention Conference is planned for 2012.

¹ Songer, T, Stephens-Stidham, S, Peek-Asa, C, Bou-Saada, I, Hunter, W, Lindemer, K, Runyan, *Core Competencies for Injury and Violence Prevention*. American Journal of Public Health, 2009; Vol 99, No. 4.



CHAPTER 2 RECOMMENDATIONS



BACKGROUND AND INTRODUCTION

As part of the requirements of Chapter 264, Subchapter F, Section 503 of the Texas Family Code, the SCFRT Committee is tasked to “make recommendations to the governor and the Legislature for changes in law, policy and practice to reduce the number of preventable child deaths.” In this report, recommendations made to the governor and Legislature are organized into two sections: Reducing Preventable Child Death and Improving Child Fatality Review Operations.

As part of the requirements of the Texas Family Code, the SCFRT Committee is tasked to “perform the functions and duties required of a citizen review panel” and provide “recommendations regarding the operation of the child protective services system.” To fulfill this requirement, several SCFRT Committee members serve on the DFPS Child Safety Review Committee. They review CPS child death cases. Based on the input from this group, the SCFRT also provides recommendations to DFPS.

While not specifically requested in the legislation, recommendations are also provided for DSHS’ consideration.

The recommendations offered are based on:

- data presented in this report;
- recommendations made by local teams; and
- expertise and experience of the SCFRT Committee.

It is the belief of the SCFRT Committee that implementation of these recommendations will improve surveillance of child death, the function of the CFR process at the state and local level, and lead to reductions in preventable child death.



Legislative Recommendations to Reduce Preventable Child Death in Texas

- A. Passage of 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. The fence should be at least four feet high and have a self-closing and self-latching gate that opens outward with latches that are out of the reach of children.**

Drowning is the second leading cause of unintentional injury deaths in children and young adolescents. Children ages one to four years old are at high risk for dying as a result of unintentional drowning; 60 percent of the 105 Texas children who drowned in 2008 were in that age group. Data from Texas Child Fatality Review Teams and the Texas Submersion Registry indicate that three out of four of these deaths occurred in residential swimming pools.

The American Academy of Pediatrics (AAP) has published that circumferential isolation fencing could prevent up to 50-90 percent of drowning deaths in young children. However, a national survey indicates that fewer than 30 percent of residential pool owners have a circumferential isolation fence around their pools. Safe Kids Worldwide, an international nonprofit organization dedicated solely to preventing unintentional childhood injury, estimates that medical cost 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 circumferential isolation fencing around new residential swimming pools would prevent unnecessary drowning deaths and reduce the burden of health care costs associated with non-fatal submersions.

- B. Passage of legislation to designate April as Water Safety Awareness Month to bring attention to water related injuries in an effort to reduce the number of drowning and near-drowning incidents suffered by children.**

Each year, up to 100 Texas children die from drowning, making it one of the leading causes of childhood injury deaths. An estimated four times that number receive emergency department care for nonfatal submersion injuries. Children ages 1 to 4 years are at high risk of dying from unintentional drowning. Toddlers and young children are at greatest risk to drown in residential pools, hot tubs, or water storage areas such as wells, cisterns and stock tanks. Young teens most often drown during water recreation activities such as swimming and boating. The number of drowning deaths in Texas has remained relatively unchanged during the past decade with resulting mortality rates consistently higher than the national average. In addition to the pain and hardship inflicted upon families suffering a child drowning death, nonfatal Texas childhood drowning result in medical costs of more than \$2 million annually.²

² Children's Safety Network Economics and Data Analysis Resource Center (CSN EDARC), at Pacific Institute for Research and Evaluation (PIRE), Calverton, MD, in conjunction with the West Virginia University Injury Control Research Center (WVU ICRC), August 2006.



There have been studies documenting seasonal variations for drowning deaths in children. One study showed that two-thirds of drowning deaths in young children and adolescents occurred May through August. April is targeted to bring attention to the prevention of water-related injuries before the peak season of water recreational and sport activities begins. It would provide an official time of the year in which the state can promote the prevention of all types of water-related injuries.

C. Mandate an education campaign for all drivers to ensure the safety of children in and around motor vehicles.

A pedestrian is defined as any person not in or upon a motor vehicle or other vehicle. According to 2008 data from the National Highway Traffic Safety Administration (NHTSA): 1). There were a total of 4,378 pedestrian fatalities of which 316 (7.3 percent) were children 15 years of age and younger, 2). There were an estimated 69,000 pedestrians injured, of which 15,000 (21.8 percent) were children 15 years of age and younger and 3). One in every five children between the ages of 5 and 9 who were killed in traffic crashes was a pedestrian.

Child Fatality Review Teams in Texas have reviewed many tragic deaths in which poor visibility prevented a parent, relative or friend from detecting a young child behind or in front of a motor vehicle. Passage of the Federal Cameron Gulbransen Kids Transportation Safety Act of 2007 requires the U.S. Department of Transportation to issue regulations related to power window safety, rearward visibility and rollaway prevention intended to reduce injuries and death of children occurring inside and near motor vehicles. In conjunction with this U.S. initiative and law, the SCFRT Committee recommends that Texas implement an education program for drivers as to the deadly risks to small children around vehicles. It is also recommended that:

- The Texas Department of Transportation (TxDOT) staff review public education and awareness campaigns, such as Spot the Tot campaign, and put in place a similar campaign for Texas. Spot the Tot is a campaign developed by the Utah Department of Health and Safe Kids Utah and has been expanded to a national campaign through Safe Kids USA.
- TxDOT, Safe Kids coalitions, the Texas Department of Public Safety (DPS) and other prevention organizations work in collaboration to track the effectiveness of the education campaign efforts and driver education programs to identify best practices and model programs.

D. Passage of legislation to amend §545.425 of the Transportation Code 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 2009 Texas crash statistics compiled by the TxDOT, 41 fatalities were attributed to the use of a wireless device while driving, and there were a total of 3,310 motor vehicle crashes with cell or mobile phone use as a contributing factor.

Current Texas law creates a statewide traffic offense for the use of a wireless communication device in a school zone unless the vehicle is stopped or criteria for exemption are met. Current law requires the posting of a sign at the beginning of each



school zone to inform drivers of the law. The SCFRT Committee recommends the statute be amended to prohibit the use of wireless devices in school zones even if there is no signs posted about the law.

The SCFRT Committee also recommends that the statute be expanded to limit the use of wireless communication devices by drivers at all times unless a hands-free device is utilized in the moving vehicle. 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 when drivers are inattentive and distracted while using a wireless communication device with their hands.

E. 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 TxDOT's Crash Records Information System for 2009, 15- to 17-year-old minors were drivers in 123 fatal crashes, 4,368 serious injury crashes and 6,999 crashes with other injuries. In 2009, 46 drivers age 15-17 died in motor vehicle crashes. Additionally drivers age 15-17 in 2009 were in 21,280 non-injury crashes. While a 17-year-old minor is on the cusp of legal adulthood, that 17-year-old minor is a young, less experienced driver who required the permission of his/her parent, guardian or managing conservator to get a driver's license (Transportation Code, Chapter 521, Sec.521.145) and who deserves the protection and involvement of his his/her parent, guardian or managing conservator (Texas Family Code).

Current law requires only defendants younger than 17 years old to appear in court with their parent, guardian or managing conservator on hearings for a moving violation. Minors age 17 years old are excluded from this legal requirement and thereby are missing 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 provided with information on safe driving practices.

Presence of a parent, guardian or managing conservator means an adult responsible for the 17-year-old minor will be advised of the moving violation and any fines; will be reminded of liability for the conduct of the minor; will be able to monitor the safety measures employed by their young driver; and will be able to impose added restrictions on the minor's driving as they see fit for their protection. Presence of parent, guardian or managing conservator also means the adult will be informed and advised that just as the adult granted permission for the minor to have a driver's license, the adult has the option of withdrawing that permission and revoking the minor's driver's license.

F. Repeal Texas statute: 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.

Section 521.205 of the Texas Transportation Code was added in 1995 by Senate Bill 964 during the 74th Texas legislature. The Texas Department of Public Safety (TDPS) 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 U.S. Research studies report that teens 16-19 years of age are at high risk for motor vehicle crashes, especially during the first year of driver eligibility. In 2007, 339 teens in this age group died in motor vehicle-related crashes and accounted for 60 percent of all motor vehicle crash traffic deaths of children and adolescents.

No comparative evaluation of driver education in Texas had been conducted until the National Highway Traffic Safety Administration published a study in April 2007: *Parent-Taught Driver Education in Texas: A Comparative Evaluation*. A review of the study, abstract and executive summary yields the following information:

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, the study does indicate on review of driving records that 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 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.

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

Legislative Recommendations to Improve the Effectiveness of the State Child Fatality Review Team Committee and Child Fatality Review Operations

A. Passage of legislation to provide funding for all Child Fatality Review (CFR) operations inclusive of CFR development, training and childhood injury prevention.

At present the core membership of local CFRT is comprised of volunteers. There is not a consistent funding stream that provides the needed support and assistance for CFRT to conduct timely reviews and develop injury prevention initiatives.

Funding is needed for:

1. Development of new CFRT across the state to achieve 100 percent participation of counties in CFR;
2. Implementation of an efficient method for distribution of death and birth records to the CFRT in a timely manner;
3. Provision of training and support to CFRT membership to improve their skills in fatality review, data entry and in identifying high risk injury and fatality hazards in their communities;
4. Implementation of education campaigns by CFRT on injury prevention in their communities; and



5. Establishment of a competitive grant funding source so that CFRT can develop and implement evidence-based community injury prevention projects.

B. Require all Texas counties to have an independent Child Fatality Review Team or to participate in a multi-county Child Fatality Review Team to review and document all deaths of children less than 18 years of age.

At present, there are 69 active CFRT involving 196 counties. Ninety-three percent of Texas children live in a county where reviews of the deaths of children ages 0-17 are conducted. To fully understand and review the circumstances leading to a child death and to fully address prevention initiatives effectively, the SCFRT Committee recommends that 100 percent of child deaths in Texas be reviewed and documented in a database system. A statutory requirement will reinforce Texas' commitment to CFR and child injury prevention, and will ensure the further development of CFRT in Texas communities.

C. Amend the current Child Fatality Review statute (Texas Family Code 264, Subchapter F, §264.501 – §264.515) to alter the composition of the State Child Fatality Review Team Committee to include representation by an Emergency Medical Services representative, a Family Violence Service provider, and a Texas Department of Transportation (TxDOT) representative.

Child fatality review in Texas is becoming more thorough and sophisticated and the need for additional professional expertise on the SCFRT Committee has been identified. Emergency Medical Services (EMS) personnel are first responders at fatality and injury scenes and have much to contribute in terms of scene information and investigation as well as contributing to injury and fatality prevention efforts in Texas communities. Many county and regional CFRT have EMS represented for their reviews.

Family violence poses a risk of injury to children and is too often a factor in child fatality cases reviewed by local teams. The addition of a Family Violence Service Provider will expand the expertise of the SCFRT Committee, which serves as a multi-disciplinary model to the local teams. Recent legislation added a representative from the newly created Department of Motor Vehicles (DMV). The representative from the DMV replaced the previously designated SCFRT Committee member from TxDOT. Representation from TxDOT on the SCFRT Committee has been an invaluable asset. The experience, insight and innovative ideas of the TxDOT representative have led to successful initiatives for injury prevention as well as being a resource of information for the SCFRT Committee and local CFRT.

D. Revise the current Child Fatality Review statute (Texas Family Code 264, Subchapter F, §264.501 – §264.515) to ensure that it accurately depicts the role of the State Child Fatality Review Team Committee.

The SCFRT Committee does not review child deaths as is currently indicated in the statute. The Texas Family Code §264.503(f) states that “committee shall issue a report for each preventable child death. The report must include findings related to the child’s death, recommendations on how to prevent similar deaths and details surrounding the department’s involvement with the child prior to the child’s death. Not later than April 1 of each year, the committee shall publish a compilation of the reports published under this subsection during the year.”



It is recommended to change the statute to state that the SCFRT Committee will publish an annual report that is submitted no later than April 1 of each year to the Governor, Lieutenant Governor, Speaker of the House of Representatives, DFPS, and DSHS and be made available to the public. The annual report shall contain aggregate child fatality data collected by local CFRT as well as recommendations to the Governor, State legislators, and DSHS to promote the prevention of fatalities and injuries to Texas children. Furthermore, the SCFRT Committee shall make recommendation to DFPS on CPS operations. Recommendations to DFPS made by the SCFRT Committee are based on recommendations of the SCFRT Committee's Child Safety Review workgroup. This workgroup is charged to:

1. Attend quarterly meetings of the DFPS Child Safety Review Committee (CSRC);
2. Use case examples from the CSRC to develop recommendations approved by the SCFRT Committee for inclusion in the annual report; and
3. Report quarterly the activities of the workgroup to the SCFRT Committee.

DFPS will publish a response to the annual recommendations no later than October 1 of the same year as the SCFRT Committee Annual Report.



RECOMMENDATIONS ON CHILD PROTECTIVE SERVICES OPERATIONS

- A. Study and report on the feasibility of developing an automated electronic system that would identify new births to parents whose parental rights have been terminated or who have had a child die of maltreatment. The system would need to automatically trigger a Child Protective Service referral to assess the living situation of the newborn and to provide support services as needed to the newborn in a high-risk environment.**

Review of Child Protective Service (CPS) child death cases reveals that there is repeated involvement with families that have had CPS history resulting in termination of parental rights or with a prior child death due to maltreatment. This CPS intervention too often involves the maltreatment and death of a new infant in the home. It is recommended that CPS:

- Investigate birth-match electronic systems, such as in Michigan, which have successfully implemented this safety net for infants.
- Study and report on the feasibility of working with the DSHS Vital Statistics Unit to develop a birth-match electronic system that will run electronic birth registrations against a list of parents whose rights have been terminated or who have had a child die of maltreatment.
- Study and report on the feasibility of automatically opening a case for investigation and support services for a newborn identified by the birth-match electronic system.

- B. Develop a protocol for assessing and meeting the needs of children with special healthcare needs who are referred for abuse and neglect.**

Review of CPS child death cases reveals that CPS cases involving medically-fragile children with special health care needs are not always given the special attention required to meet the child's needs for protection. These cases require special attention and involvement of medical professionals, home health care providers, schools and childcare, and others involved in meeting the medical needs of the special needs child. Improved investigative skills, medical care and community resources are needed to meet the needs of these children. It is recommended that CPS:

- Train caseworkers and supervisors on the necessity of detailed investigation into the needs of medically fragile children, including consultation with the child's physician(s) and any others in contact with the child, such as home health nurses, Early Child Intervention and childcare providers.
- Train caseworkers and supervisors on the importance of consulting with the regional nurse or the Forensic Assessment Center Network physicians to get a complete assessment of the child's medical needs.
- Train caseworkers and supervisors on commonly seen disabilities and medical conditions and the type of care they require.
- Investigate the feasibility of changing the Information Management Protecting Adults and Children in Texas (IMPACT) case input system to ensure that cases with children with special health care needs cannot be closed without input of specific information that demonstrates that child's medical needs have been investigated and are being met.



C. Facilitate a systematic approach to improving role delineation, needs and communication between caseworkers, law enforcement, justices of the peace and medical examiners in order to improve child death investigations.

Review of CPS child death cases reveals that there is a need for clarity in delineation of roles, mutual understanding of needs and improved communication among the multi-disciplinary systems involved in a child death investigation. It is recommended that CPS work with DSHS and the SCFRT Committee to:

- Engage multi-disciplinary partners in the process of opening dialogue and working together to best serve children.
- Facilitate conversations among the multi-disciplinary partners in each of the regions.
- Engage partners to present their perspective and role at conferences and trainings for other disciplines.
- Use this opportunity to work with multi-disciplinary partners to introduce and promote the Sudden Unexpected Infant Death protocol.



RECOMMENDATIONS TO THE DEPARTMENT OF STATE HEALTH SERVICES

A. It is recommended that DSHS provide ongoing support for an annual training of Texas Child Fatality Review Teams.

CFRT operate in their own jurisdictions with oversight from the CFR Coordinator at the DSHS. In order to promote best practices in child fatality review and prevention, an annual gathering of the teams for training is essential. An annual gathering is an efficient way to deliver consistent messages to all teams, as well as an opportunity for teams to share successes and challenges and be part of a statewide movement to protect Texas children. The SCFRT Committee has partnered successfully with the Children's Assessment Center of Houston to host the annual Protecting Texas Children conference in the past. This training opportunity is now going to be held every other year, with the next conference scheduled in April 2012. It is recommended that DSHS continue to support annual training for CFRT members. DSHS will explore all options that may be available to meet training needs.

B. It is recommended that DSHS explore opportunities for available funding for training and support of new and current community volunteers serving on local CFRT.

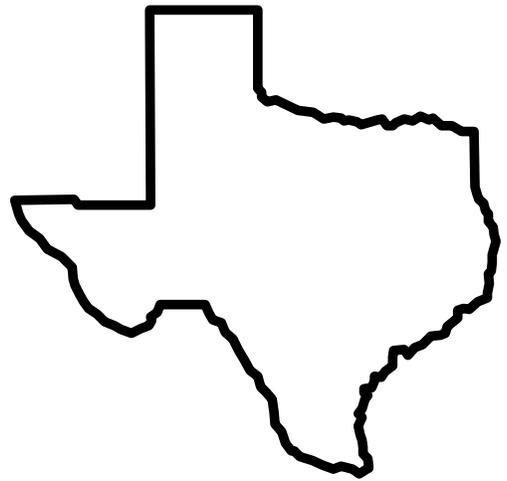
CFRT membership is made up exclusively of volunteers. Physicians, attorneys, law enforcement, social workers, educators and other child advocates donate their time to serve on the local teams. Adequate funding is essential in order to keep CFRT membership current with the latest training, education and implementation of best practices in injury prevention. Of particular need is statewide training in the Sudden Unexpected Infant Death Investigation protocol, as the Centers for Disease Control and Prevention promote this as a nationwide model for infant death scene investigations.

C. It is recommended that DSHS investigate methods for the timely delivery of death certificates and birth abstracts to the local CFRT.

Currently, records necessary for review are received by the local CFRT after substantial time has passed after the child's death. With the current pace of record delivery, the local CFRT have difficulty in obtaining information about the death. Delayed reviews preclude timely prevention efforts about identified risks for further child injury and fatalities in the community. With the growing number of CFRT in the state and the greater number of deaths reviewed, the DSHS staff workload is increasing at a rate that will make it more difficult to distribute hard-copy death certificates and birth abstracts to the local CFRT in a timely manner. It is recommended that DSHS investigate electronic delivery of records. Electronic delivery would eliminate mailing costs and storage space needs.



CHAPTER 3
DATA & ANALYSIS



DATA AND LIMITATIONS

Statistical analyses of data derived from local CFRT reviews are an important facet of the review process. Analyses of these data provide greater insight into the causes and circumstances surrounding child fatalities in Texas. Whereas information from the death certificate provides the demographic characteristics of child fatalities, the more detailed information collected by the local teams in the review process provides better understanding of the scope and nature of child fatalities in Texas that can be used to drive preventive interventions.

Overview of Child Fatality Review Team Data

Data from the reviews conducted by local teams are entered into the National Child Death Review Data Collection System, a multi-state database developed by the National Maternal and Child Health Center for Child Death Review in collaboration with state programs. Inputting data into the multi-state child death review database benefits Texas CFR by implementing a nationally standardized form for data entry and allowing for comparison with CFR data from other states. All local CFRT collect data on each child death reviewed using the national Case Report Form and enter the data using the online web-based system. Thirty-nine states participate in this data collection system.

Given the volume of deaths and the volunteer nature of local CFRT, teams may choose not to review all deaths. Many programs in the United States, including some Texas teams, do not review natural deaths with the exception of SIDS. It is important to consider this information when interpreting child death review data. Case selection depends on factors such as geographic area, number of deaths, access to information and CFRT meeting frequency.

The deaths reviewed by CFRT are a sample of all child deaths that occur in Texas. The data analyzed in this report were collected in reviews conducted by local CFRT. These data include deaths of Texas residents and deaths of non-Texas residents who died in the state. Non-resident deaths are reviewed because local CFRT seek to understand why children die in their designated geographic areas. The efforts of local CFRT to understand and prevent child death ultimately impact local residents and visitors from other counties, states, and countries. This is especially true in cases where local infrastructure can prevent fatalities: fences around pools can prevent drowning and motor vehicle crashes can be prevented by visible signage and a clear line of sight.

Missing and unknown values can limit CFRT data. Specific information about the circumstances of death is not always available for all reviewed deaths. Therefore, the number of cases in which the information was available is noted within each table and chart. These unknown values are difficult to interpret and may indicate the presence of social desirability bias (the inclination to underreport behaviors that are not consistent with current social recommendations). For example, a parent who has an infant die while sleeping may not reveal that the infant was placed in a prone sleep position or that there was smoking in the home, both behaviors counter-indicated with current public health recommendations. Since some reviews involve criminal proceedings, the prevalence of unknown values may indicate a person's desire to conceal aspects of the death that may be incriminating. Some reviews may have unknown values because the information was not collected at the time of the death scene investigation. While it is impossible to know why values may be missing, it is important to consider the prevalence of unknown values when interpreting findings.



GENERALIZABILITY AND COMPLETENESS OF CFRT DATA

How accurately the CFRT data represent all child deaths occurring in Texas describes the generalizability of the data. Similarities between demographic characteristics of CFRT and death certificate data provide evidence that conclusions drawn by examining CFRT data can be generalized to all child fatalities in Texas.

To assess generalizability, CFRT data were compared to death certificate data (Table 3).

Table 3. Deaths Reviewed by CFRT, Total Deaths and Population, 2008 (0-17 Years)

	CFRT		Death Certificates		2008 Population	
	Number	Percent	Number	Percent	Number	Percent
Texas	2,106	100.0%	4,030	100.0%	6,495,224	100.0%
Race/ Ethnicity						
White	801	38.0%	1,490	37.0%	2,429,558	37.4%
Black	326	15.5%	653	16.2%	810,236	12.5%
Hispanic	899	42.7%	1,700	42.2%	3,010,752	46.4%
Other	80	3.8%	187	4.6%	244,678	3.8%
Sex						
Male	1,222	58.0%	2,301	57.1%	3,317,009	51.1%
Female	884	42.0%	1,729	42.9%	3,178,215	48.9%
Age Group						
<1	1,217	57.8%	2,530	62.8%	397,130	6.1%
1-4	317	15.1%	521	12.9%	1,530,851	23.6%
5-9	133	6.3%	237	5.9%	1,746,831	26.9%
10-14	152	7.2%	275	6.8%	1,709,339	26.3%
15-17	287	13.6%	467	11.6%	1,111,073	17.1%

CFRT Source: Texas data from the National Center for Child Death Review, 2008.

Death Certificate Source: Texas Department of State Health Services, Vital Statistics Unit, 2008.

Population Source: Population Estimates and Projections Program, Texas State Data Center, Office of the State Demographer, Institute for Demographic and Socioeconomic Research, The University of Texas at San Antonio.

Demographically, percents vary little between CFRT and death certificate data. The largest differences occur in the age groups, where there's some variation between the two datasets for infants (<one year), ages 1-4 years, and ages 15-17 years in particular. While the proportion of deaths reviewed by CFRT may be relatively low (2,106 of 4,030 deaths were reviewed), the demographic characteristics of reviewed deaths are similar enough to the death certificate data to generalize that the specific circumstances of death derived from the reviews approximate child fatalities in Texas.

The completeness of CFRT data is defined as the proportion of all child fatalities in Texas which are reviewed by CFRT. In order to assess completeness, CFRT records were linked to death certificate data from the Texas Vital Statistics Unit. In addition to state totals, demographic characteristics, manners of death, and injury mechanisms were examined.



Table 4. Percent of Deaths Reviewed by Child Fatality Review Teams by Manner, Injury Mechanism, Age Group, Sex, and Race/Ethnicity, 2008

Of 4,030 deaths occurring among children in 2008, 2,106 (52.3 percent) were reviewed by CFRT (Table 4). Teams were more likely to review injury-related deaths; homicides (81.6 percent), suicides (72.8 percent), and accidents (65.0 percent) than natural deaths (45.7 percent).

	Deaths	Percent of Deaths Reviewed
Texas	4,030	52.3%
Manner		
Natural	2,774	45.7%
Accident	674	65.0%
Suicide	81	72.8%
Homicide	163	81.6%
Pending/ Undetermined	338	61.5%
Injury Mechanism*		
Poisoning	30	80.0%
Firearm	104	79.8%
Suffocation	153	76.5%
Fall	16	75.0%
Drowning	116	67.2%
Fire/Burn	30	60.0%
Transportation	351	59.8%
Other	52	71.2%
Not Specified	66	77.3%
Race/ Ethnicity		
White	1,490	53.8%
Black	653	49.9%
Hispanic	1,700	52.9%
Other	187	42.8%
Sex		
Male	2,301	53.1%
Female	1,729	51.1%
Age Group		
<1	2,530	48.1%
1-4	521	60.8%
5-9	237	56.1%
10-14	275	55.3%
15-17	467	61.5%

CFRT Source: Texas data from the National Center for Child Death Review, 2008.

Death Certificate Source: Texas Department of State Health Services, Vital Statistics Unit, 2008.

* Includes manners accident, suicide, and homicide

Among classifiable injury mechanisms, poisoning (80.0 percent), firearms (79.8 percent), and suffocation (76.5 percent) were most likely to be reviewed. Transportation (59.8 percent) and fire/burn (60.0 percent) were mechanisms less likely to be reviewed.

Variation was low among race and sex with White (53.8 percent), Black (49.9 percent), and Hispanic (52.9 percent) children; and male (53.1 percent) and female (51.1 percent) children reviewed at similar percents.

There was some variation among age groups with deaths among youth 15-17 years of age (61.5 percent) and children 1-4 years of age (60.8 percent) more likely to be reviewed than were deaths among other age groups. In particular, infants less than 1 year of age (48.1 percent) were less likely to be reviewed while representing the vast majority of child deaths.

Because distinct mechanisms of injury are differentially associated with certain age groups or races, many of the differences in demographic groups can be attributed to child fatality review team priorities and available resources. For example, deaths generally considered to be more preventable, such as those related to injury (i.e. accident, homicide, suicide), are more likely to be reviewed. Proportionally fewer infants are likely to die

from injury-related causes, thus fewer infant deaths are reviewed.

Demographic differences may also be attributed to CFRT coverage. Currently teams review cases for 196 of 254 counties (77.2 percent). Deaths occurring among populations residing in regions not yet covered by CFRT are not represented.



MANNER OF DEATH: AN OVERVIEW

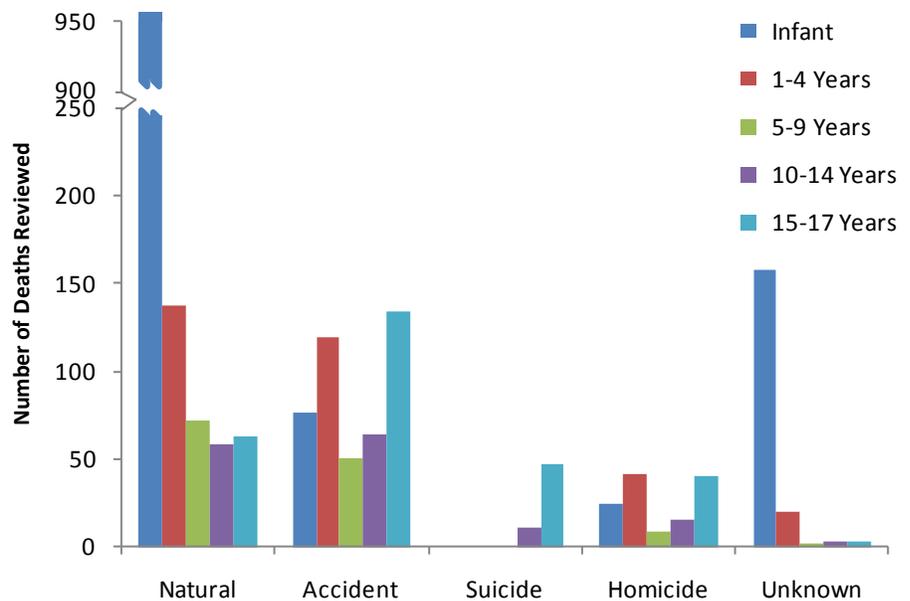
Manner of death helps to define the circumstances under which a death occurs. Every death is assigned to one of four main manner classifications including: natural, accident, suicide and homicide. When a medical certifier (i.e. medical examiner, justice of the peace, or physician) is unable to determine the manner, it is classified as undetermined. A death certificate can initially have a pending manner of death until the medical certifier can determine the specific manner.

For some CFRT, the manner of death determines whether or not the child's death will be reviewed. CFRT that have a high volume of deaths to review may choose to focus their efforts on the more preventable manners of death (accidents, suicides, and homicides), and choose not to review all of the natural deaths. Other Texas CFRT review all deaths, regardless of the manner.

The following figures provide an overview of manner of death by age, sex, and race/ethnicity. More detailed information can be found in the sections that follow.

The proportion of deaths by manner can vary across demographic groups. Despite accounting for 6.1 percent of the child population, 57.8 percent of all deaths reviewed were infants. Figure 5 describes manner of death by age group. The chart shows that infants represent 956 of 1,286 (74.3 percent) natural deaths reviewed. Infants were also at increased risk for accidents and homicides accounting for 17.3 and 18.9 percent in 2008, respectively, despite representing just 6.1 percent of the child population. The number of infants dying from a given manner is likely underestimated in these data due to the large number of infants categorized with an unknown manner of death (Note: Unknown represents undetermined, pending, and otherwise unknown manners of death).

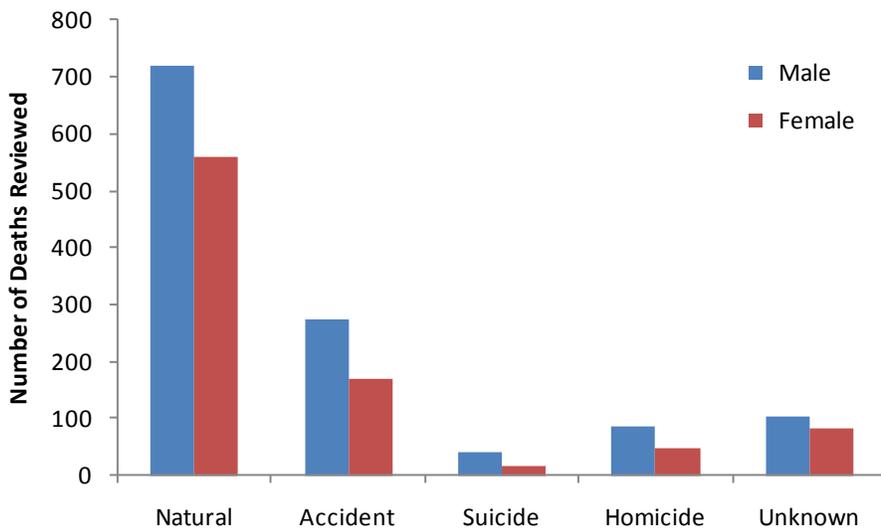
Figure 5. Frequency of Deaths Reviewed by Child Fatality Review Teams by Manner and Age Group, 2008



Source: Texas data from the National Center for Child Death Review, 2008.



Figure 6. Frequency of Deaths Reviewed by Child Fatality Review Teams by Manner and Sex, 2008

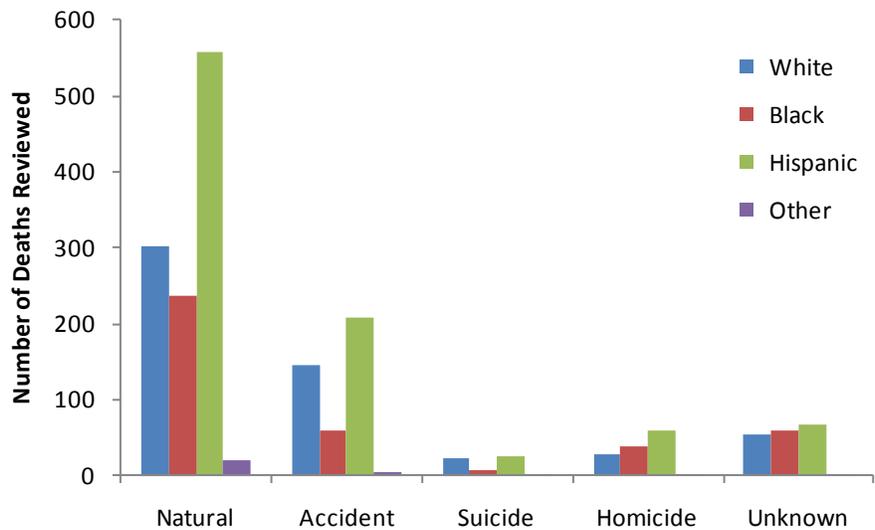


Males accounted for 51.1 percent of children in Texas, but represented 58.1 percent of deaths reviewed in 2008. Figure 6 describes manner of death by sex and shows that male children had a higher proportion of reviewed deaths for each of the manner classifications. Males accounted for 72.4 percent of all the child suicides and 64.4 percent of all child homicides.

Source: Texas data from the National Center for Child Death Review, 2008.

Black children bear a disproportionate burden of death when compared to other races or ethnicities in Texas (Figure 7). Although Black children represented 12.5 percent of children in 2008, they accounted for 21 percent of all child deaths reviewed. The disparity is particularly evident when looking at homicides, where Black children account for 29.7 percent of all homicides reviewed. Overall, Hispanics accounted for 48.4 percent of reviewed deaths while representing 46.4 percent of the child population (NOTE: Percents listed in this section are based on records in which race was known. Ten percent of records did not contain a known race or ethnicity).

Figure 7. Number of Deaths Reviewed by Child Fatality Review Teams by Manner and Race/Ethnicity, 2008



Source: Texas data from the National Center for Child Death Review, 2008.



MANNER OF DEATH: NATURAL

Natural deaths are those due solely or nearly totally to disease and/or the aging process. Some natural causes of death include: prematurity, congenital anomaly, sudden infant death syndrome, cancer, and pneumonia.

In 2008, natural causes accounted for 75.1 percent of all child deaths in Texas and 66.8 percent of all child deaths reviewed by Texas Child Fatality Review Teams.

Table 5. Natural Deaths by Age Group, Sex, and Race/Ethnicity, 2008

	Number	CFRT *Percent	Population **Percent
Total	1,286	100.0%	100.0%
Age Group			
Infant	956	74.3%	6.1%
1-4 Years	137	10.7%	23.6%
5-9 Years	72	5.6%	26.9%
10-14 Years	58	4.5%	26.3%
15-17 Years	63	4.9%	17.1%
Sex			
Male	720	56.3%	51.1%
Female	560	43.8%	48.9%
Not Stated	6	N/A	--
Race/ Ethnicity			
White	302	27.1%	37.4%
Black	236	21.2%	12.5%
Hispanic	557	50.0%	46.4%
Other	19	1.7%	3.8%
Not Stated	172	N/A	--

* Percent of all CFRT records reviewed with natural cause of death

** Percent of applicable population (e.g. Male=all males 0-18 yrs)

Source: Texas data from the National Center for Child Death Review, 2008

Table 5 describes the demographic characteristics of natural child deaths reviewed by Texas CFRT in 2008. Despite representing just 6.1 percent of the total child population, infants accounted for 74.3 percent of natural deaths reviewed with 956 deaths. Males (56.3 percent) were reviewed for natural death at a higher proportion than were females (43.8 percent). Although more Hispanic children were reviewed than any other race/ethnicity, the disparity was more pronounced for Black children accounting for 21.2 percent of natural deaths reviewed despite representing only 12.5 percent of the Texas child population.



Figure 8. Natural Manner of Death for Children 0-17 Years of Age by Cause of Death, 2008 (N=1,278)

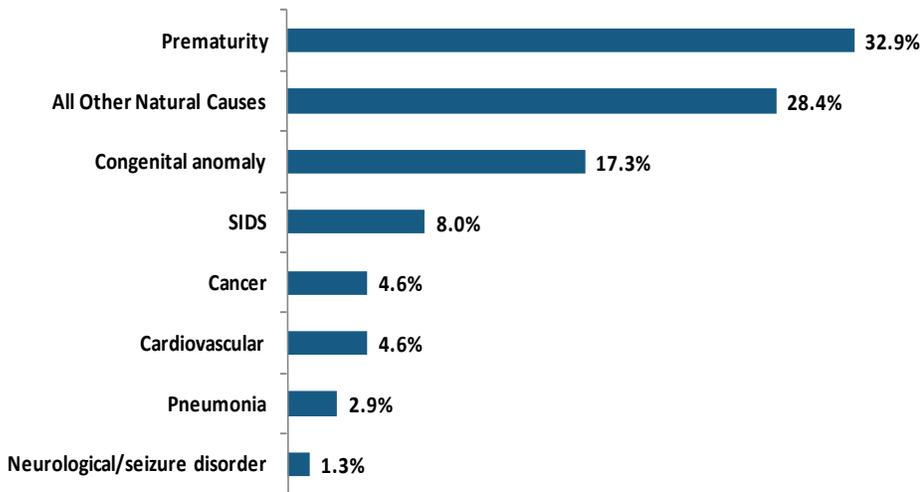


Figure 8 and Figure 9 describe proportions of natural death by cause. Among all children, deaths due to prematurity (32.9 percent) were reviewed most frequently. Congenital anomaly (17.3 percent), SIDS (8.0 percent), cancer (4.6 percent), and cardiovascular (4.6 percent) accounted for the remaining top five causes of natural death reviewed.

Note: Percents are based on the number of records (1,278) in which the cause of death was indicated. Percents may not sum to 100% due to rounding of individual categories. Percents represent natural causes based on natural deaths reviewed. CFRT do not review all natural causes of death.

Source: Texas data from the National Center for Child Death Review, 2008.

Figure 9. Natural Manner of Death for Children 1-17 Years of Age by Cause of Death, 2008 (N=329)

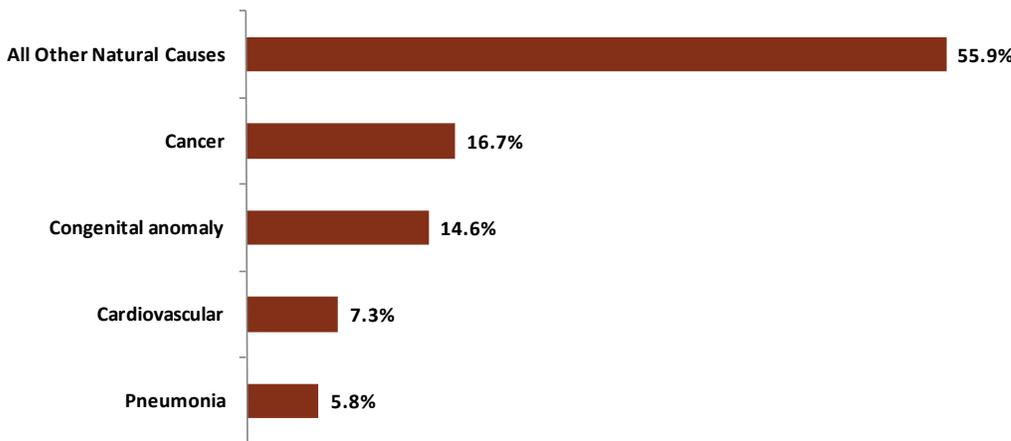


Figure 9 shows natural causes of death when infants were excluded from calculations. Among children older than 1 year of age, reviewed deaths attributed to prematurity and SIDS were nearly non-existent. Cancer (16.7 percent) and congenital anomaly (14.6 percent) were natural causes reviewed most often for children older than 1 year of age.

Note: Percents are based on the number of records (329) in which the cause of death was indicated. Percents may not sum to 100% due to rounding of individual categories. Percents represent natural causes based on natural deaths reviewed. CFRT do not review all natural causes of death.



MANNER OF DEATH: ACCIDENT

Accidental deaths are those that result from injury in which there is little or no evidence that the injury or poisoning occurred with intent to harm or cause death. Some examples of accidental causes of death include motor vehicle collision, asphyxia, drowning, and falling.

In 2008, accidental deaths accounted for 18.3 percent of all child deaths and 23.1 percent of all deaths reviewed.

Although “accident” is used here to describe unintentional injury deaths, “accident” implies the event causing the incident is unavoidable. However, most incidents resulting in injury are preventable (See the Preventability section, later in this report, for more information about cause specific preventability).

Table 6. Accidental Deaths by Age Group, Sex, and Race/Ethnicity, 2008

		CFRT	Population
		Number	*Percent
			**Percent
Total		444	100.0%
Age Group	Infant	77	17.3%
	1-4 Years	119	26.8%
	5-9 Years	50	11.3%
	10-14 Years	64	14.4%
	15-17 Years	134	30.2%
Sex	Male	273	61.5%
	Female	169	38.1%
	Not Stated	2	0.5%
Race/ Ethnicity	White	145	32.7%
	Black	59	13.3%
	Hispanic	209	47.1%
	Other	4	0.9%
	Not Stated	27	6.1%

Table 6 describes the demographic characteristics of accidental child deaths reviewed by Texas Child Fatality Review Teams in 2008. The age group with the greatest number of accidental deaths reviewed was the 15-17 years group accounting for 30.2 percent, while representing only 17.1 percent of the child population. Although males represented 51.1 percent of Texas children in 2008, males were reviewed for accidental death at a much higher percentage (61.5 percent). Hispanics had the greatest number of accidental deaths reviewed (47.1 percent) among races and ethnicities.

* Percent of all CFRT records reviewed with accidental cause of death

** Percent of applicable population (e.g. Male=all males 0-18 yrs)

Source: Texas data from the National Center for Child Death Review, 2008



Figure 10. Accidental Manner of Death by Cause of Death, 2008 (N=444)

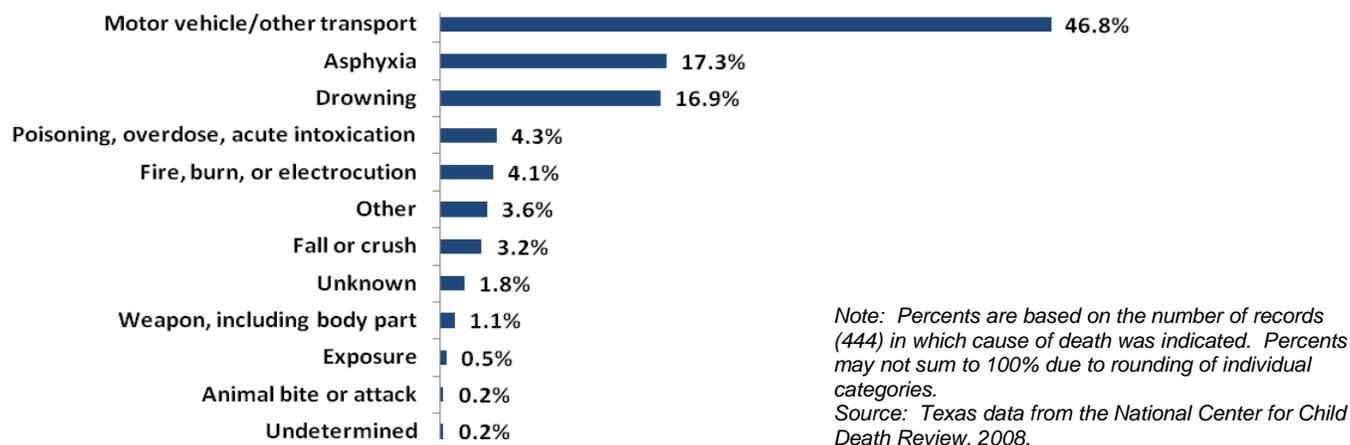


Figure 11. Cause of Accidental Child Death by Age Group, 2008 (N=435)

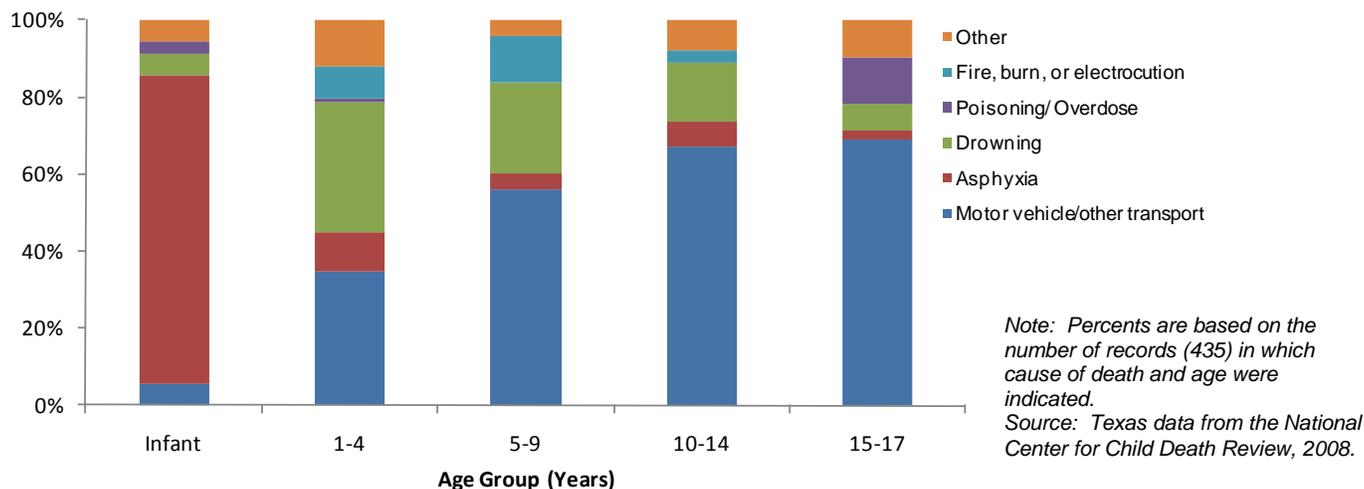


Figure 10 and Figure 11 describe causes of accidental death among children in 2008 (Figure 11 does not include the nine unknown and undetermined causes of death). Motor vehicle collision and transportation-related deaths were reviewed more often (208 deaths) than any other accidental cause, accounting for 46.8 percent of all accidental deaths reviewed. Asphyxia and drowning were also more frequently reviewed with 77 deaths and 75 deaths, respectively.

Some causes of death occurred more frequently for certain age groups. Figure 11 shows proportions of the top five reviewed causes of accidental death by age group. Motor vehicle/transportation was the leading cause for four of the five age groups, with asphyxia as the leading cause for the infant group, representing 80 percent of infant deaths reviewed. Drowning was the second leading cause reviewed for the 1-4, 5-9, and 10-14 years groups. Although there were relatively few reviews for accidental poisoning death among the younger age groups, it was the second most reviewed cause of death among those 15-17 years of age.



MANNER OF DEATH: HOMICIDE

A homicide occurs when death results from an injury or poisoning or from a volitional act committed by another person to cause fear, harm, or death. In 2008, homicides accounted for 4.4 percent of all child deaths and 7.0 percent of all deaths reviewed.

Table 7. Homicide by Age Group, Sex, and Race/Ethnicity, 2008

	Number	CFRT	Population	
		*Percent	**Percent	
Total	132	100.0%	100.0%	
Age Group	Infant	25	18.9%	6.1%
	1-4 Years	42	31.8%	23.6%
	5-9 Years	9	6.8%	26.9%
	10-14 Years	16	12.1%	26.3%
	15-17 Years	40	30.3%	17.1%
Sex	Male	85	64.4%	51.1%
	Female	46	34.8%	48.9%
	Not Stated	1	0.8%	--
Race/ Ethnicity	White	28	21.2%	37.4%
	Black	38	28.8%	12.5%
	Hispanic	60	45.5%	46.4%
	Other	2	1.5%	3.8%
	Not Stated	4	3.0%	--

* Percent of all CFRT records reviewed with homicide cause of death

** Percent of applicable population (e.g. Male=all males 0-18 yrs)

Source: Texas data from the National Center for Child Death Review, 2008

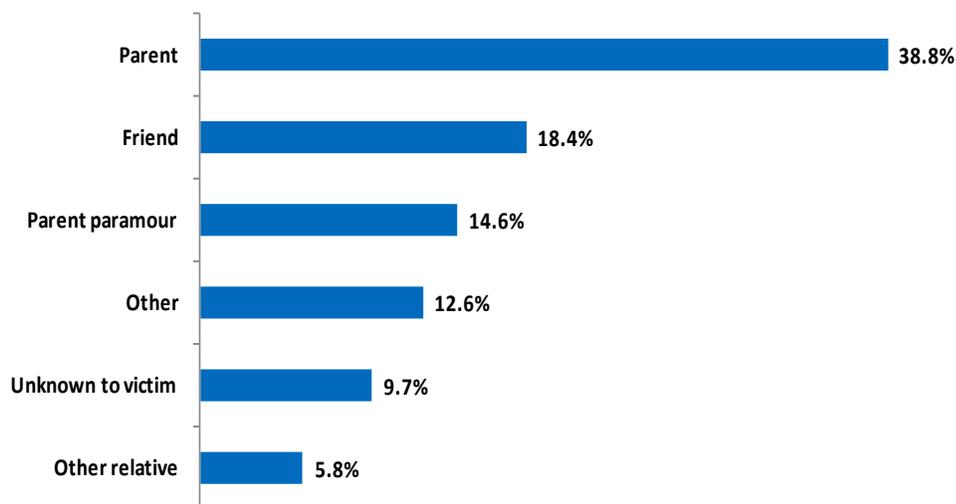
Table 7 describes the demographic characteristics of homicide child deaths reviewed by Texas Child Fatality Review Teams in 2008. Young children, less than 5 years old, represent the majority (50.7 percent) of all child homicides reviewed, with those 1-4 of age accounting for 31.8 percent. Older children, 15-17 years of age, were also reviewed at a disproportionately higher rate (30.3 percent). Although males represented 51.1 percent of Texas children in 2008, they were reviewed for homicide at a much higher percentage (64.4 percent). Although Black children accounted for 12.5 percent of the child population, 28.8 percent of

homicide cases reviewed were Black children. Hispanic children accounted for 45.5 percent of all homicides reviewed.

Figure 12, Figure 13, and Figure 14 describe homicides reviewed among children in 2008 by perpetrator, place, and mechanism.

A parent was the perpetrator for 40 (38.8 percent) of the homicide deaths reviewed (Figure 12). Another 19 were perpetrated by the child's friend, and 15 by a parent paramour (mother's or father's partner). In 10 cases, the child was killed by a stranger.

Figure 12. Homicide by Perpetrator, 2008 (N=103)



Note: Percents are based on the number of records (103) in which the perpetrator was indicated. Percents may not sum to 100% due to rounding of individual categories.

Source: Texas data from the National Center for Child Death Review, 2008.

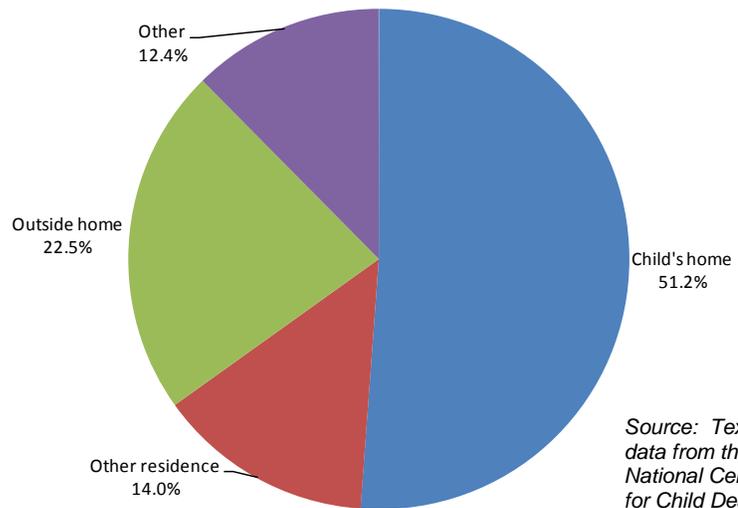


A parent was the leading perpetrator for infants (70.8 percent of infants were killed by a parent), children 1-4 years of age (37.8 percent), and children 5-9 years of age (62.5 percent). A friend was the leading perpetrator for youth ages 10-14 years (36.4 percent) and 15-17 years (37.9 percent). Parent paramour was the second leading perpetrator among children ages 1-4 years (29.7 percent).

More than half (51.2 percent) of the homicides reviewed occurred in the child's home (Figure 13).

The vast majority (74 percent) of reviewed homicides were caused by a weapon (Figure 14). The second leading cause, asphyxia, was substantially lower, accounting for 3 percent of homicides reviewed. Of reviewed homicides caused by weapons, 59.6 percent were firearm-related and 23.4 percent were caused by a person's body part.

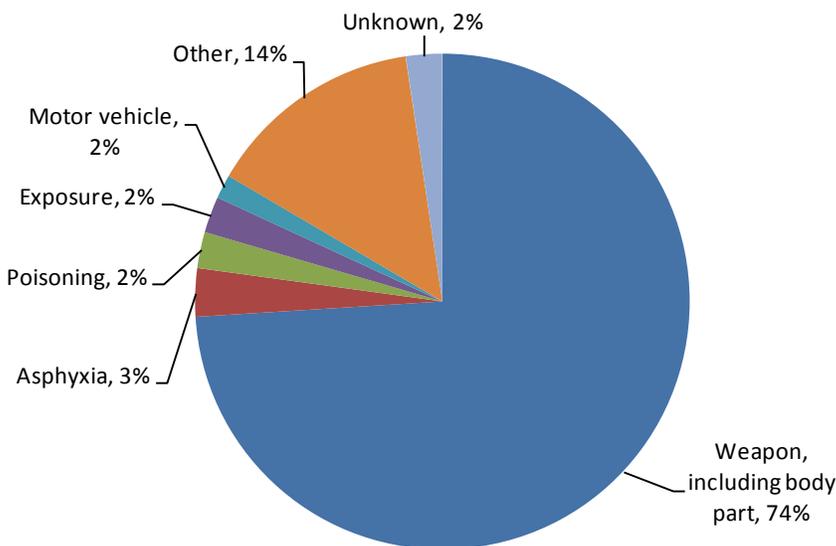
Figure 13. Homicide by Place of Occurrence (N=129)



Source: Texas data from the National Center for Child Death Review, 2008.

Note: Percents are based on the number of records (129) with stated place of death. Three out of the 132 homicides did not have a place of death listed. Percents may not sum to 100% due to rounding of individual categories.

Figure 14. Homicide by Mechanism of Death, 2008 (N=127)



CFRT data show that the younger the child the less likely he/she was to be killed with a weapon. Youth ages 15-17 years were most likely to be killed by a weapon (95.0 percent). In contrast, infants were killed with a weapon in only 36.0 percent of deaths reviewed, although it was still the leading mechanism of death. Among children killed by a weapon, infants (55.6 percent) and children 1-4 years of age (61.5 percent) were most often killed by a person's body part. In contrast, children 5-9 (83.3 percent), 10-14 (80.0 percent) and 15-17 (86.8 percent) years were most frequently killed by a firearm.

Note: Percents are based on the number of records (127) in which the mechanism of death was indicated. Percents may not sum to 100% due to rounding of individual categories. Source: Texas data from the National Center for Child Death Review, 2008.



MANNER OF DEATH: SUICIDE

A suicide occurs from an injury or poisoning as a result of an intentional, self-inflicted act committed to do self-harm or cause the death of one's self. In 2008, suicide accounted for 2.2 percent of child deaths and 3.1 percent of deaths reviewed.

Table 8. Suicide by Age Group, Sex, and Race/Ethnicity, 2008

	Number	CFRT *Percent	Population **Percent
Total	58	100.0%	100.0%
Age Group			
10-14 Years	11	19.0%	26.3%
15-17 Years	47	81.0%	17.1%
Sex			
Male	42	72.4%	51.1%
Female	16	27.6%	48.9%
Race/Ethnicity			
White	22	37.9%	37.4%
Black	8	13.8%	12.5%
Hispanic	26	44.8%	46.4%
Other	1	1.7%	3.8%
Not Stated	1	1.7%	--

* Percent of all CFRT records reviewed with suicide cause of death

** Percent of applicable population (e.g. Male=all males 0-18 yrs)

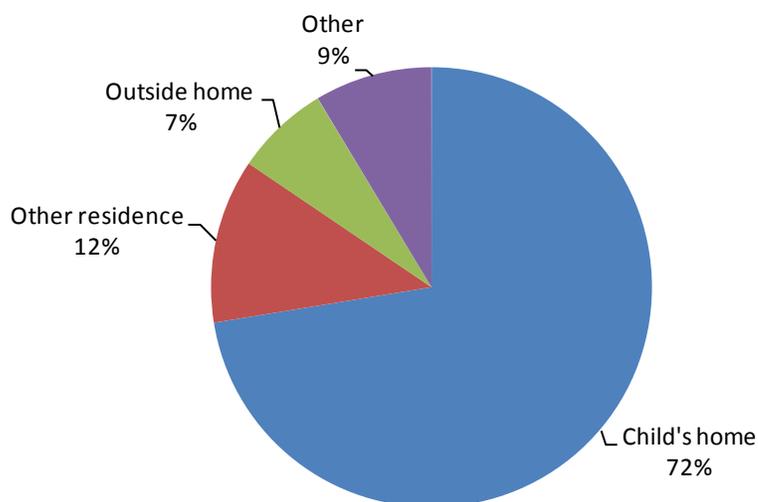
Source: Texas data from the National Center for Child Death Review, 2008

Table 8 describes the demographic characteristics of child suicide deaths reviewed by Texas Child Fatality Review Teams in 2008. Adolescents 15-17 years of age represent the vast majority (81.0 percent) of all child homicides reviewed despite representing just 17.1 percent of the child population. Children in the 10-14 years group were the only other age group with any suicides, representing 19.0 percent of those reviewed. Although males represented 51.1 percent of Texas children in 2008, males were reviewed for suicide at a much higher percentage at 72.4 percent. Forty-five percent

of reviewed suicides occurred among Hispanics.

Figure 15. Suicide by Place, 2008 (N=58)

Figure 15 shows where reviewed suicides occurred and Figure 16 describes the contextual factors associated with reviewed suicides. The vast majority (72 percent) of suicides took place in the child's home with another 12 percent taking place in another residence.



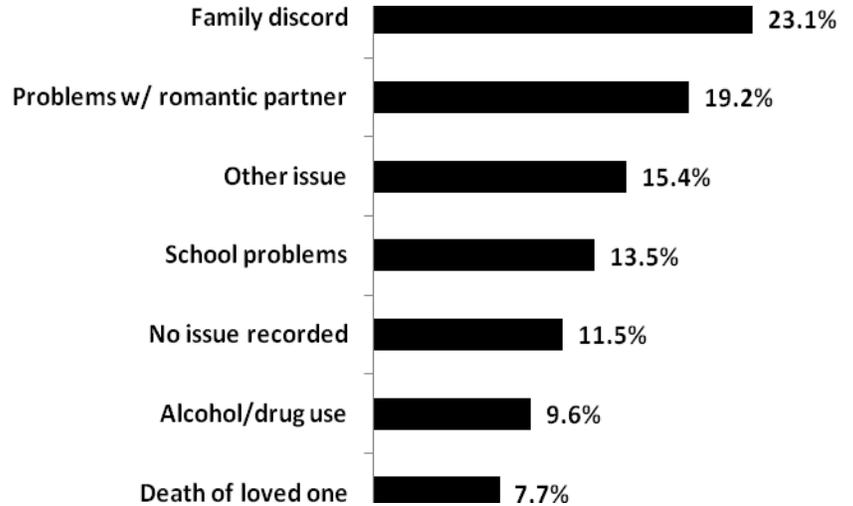
Note: Percents are based on the number of records (58) in which the place of death was indicated. Percents may not sum to 100% due to rounding of individual categories.

Source: Texas data from the National Center for Child Death Review, 2008.



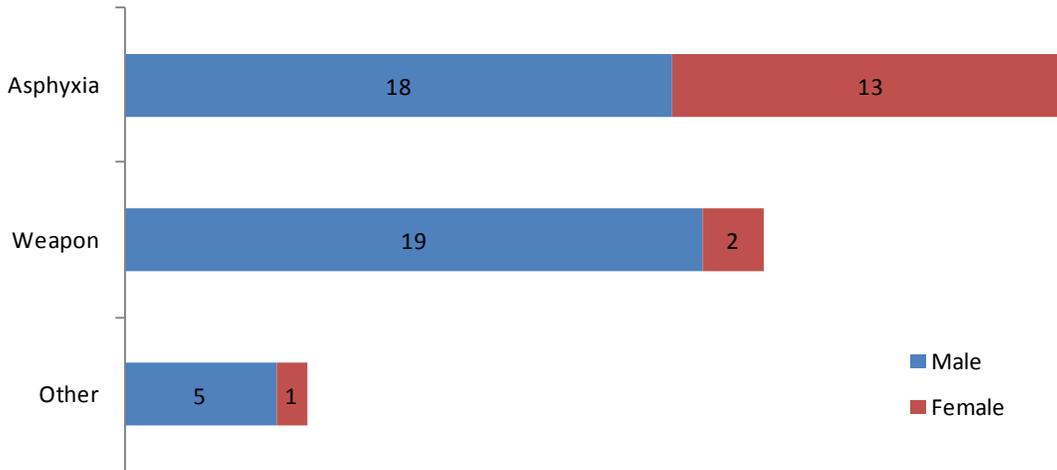
Figure 16. Suicide by Contextual Factors, 2008 (N=58)

Family discord (23.1 percent) and problems with a romantic partner (19.2 percent) were issues reported most frequently among cases reviewed (Figure 16). “Other issues” may include the following examples: argument with friends, rumor mongering, victim of bullying, and pregnancy crisis.



Note: Percents are based on records (58) in which suicide was indicated. Percents may not sum to 100% due to rounding of individual categories. Source: Texas data from the National Center for Child Death Review, 2008.

Figure 17. Suicide by Mechanism and Sex, 2008 (N=58)



Source: Texas data from the National Center for Child Death Review, 2008.

Figure 17 describes suicide by mechanism and sex. Asphyxia (53.4 percent) and weapon (36.2 percent) were the two leading mechanisms. Although males were nearly equally likely to use the mechanisms asphyxia (42.9 percent) or weapon (45.2 percent), females were much more likely to use asphyxia (81.3 percent). Of the 21 suicides reviewed in which a weapon was used, a firearm was used in 19. Examples of the “Other” mechanism include falling and poisoning/acute overdose.



SUDDEN INFANT DEATH SYNDROME (SIDS)

SIDS is a definition of exclusion and can only apply to an infant (1 to 12 months) whose death is sudden and unexpected, and remains unexplained after the performance of an adequate postmortem investigation that includes:

- an autopsy;
- investigation of the scene and circumstances of the death; and
- review of the medical history of the infant and family.

Generally, but not always, the infant is found dead after having been put to sleep and exhibits no signs of having suffered. SIDS is the leading cause of infant death in the postneonatal period (death between 28 and 365 days of life).

Table 9. SIDS Deaths by Age Group, Sex, and Race/Ethnicity, 2008

	Age Group	Number	CFRT *Percent	Population **Percent
	Total	102	100.0%	100.0%
Age Group	< 2 months	26	25.5%	--
	2-4 months	61	59.8%	--
	5-8 months	15	14.7%	--
Sex	Male	52	51.0%	51.0%
	Female	50	49.0%	49.0%
Race/Ethnicity	White	41	40.2%	33.7%
	Black	28	27.5%	11.2%
	Hispanic	32	31.4%	51.1%
	Not stated	1	1.0%	--

* Percent of all CFRT SIDS records reviewed

** Percent of applicable population (e.g. Male=all males <1 yr)

Source: Texas data from the National Center for Child Death Review, 2008

Table 9 describes reviewed SIDS deaths among infants by age, sex, and race/ethnicity. Infants 2 to 4 months of age accounted for the majority of SIDS cases with 59.8 percent of all SIDS cases reviewed. Black children, representing 11.2 percent of all Texas infants, accounted for 27.5 percent of infants reviewed for SIDS, and White infants with a population percent of 33.7 percent accounted for 40.2 percent of SIDS cases reviewed. This contrasts with Hispanic infants with a percent of cases reviewed (31.4 percent) far less than their representative population.



Figure 18. SIDS by Sleeping Place, 2008 (N=80)

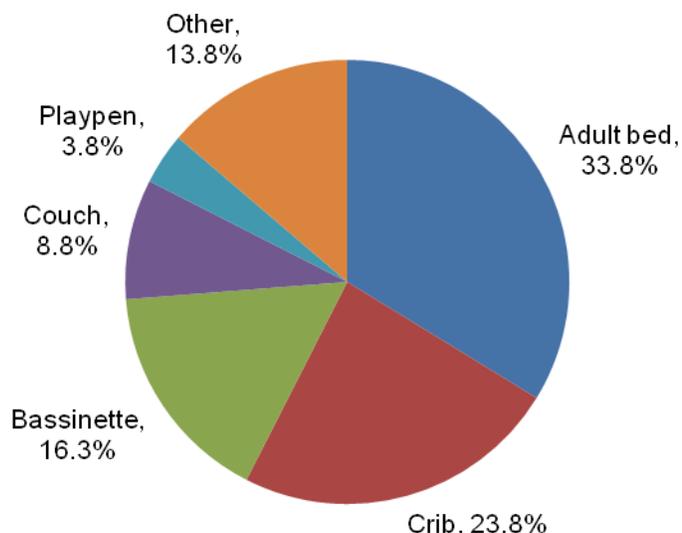


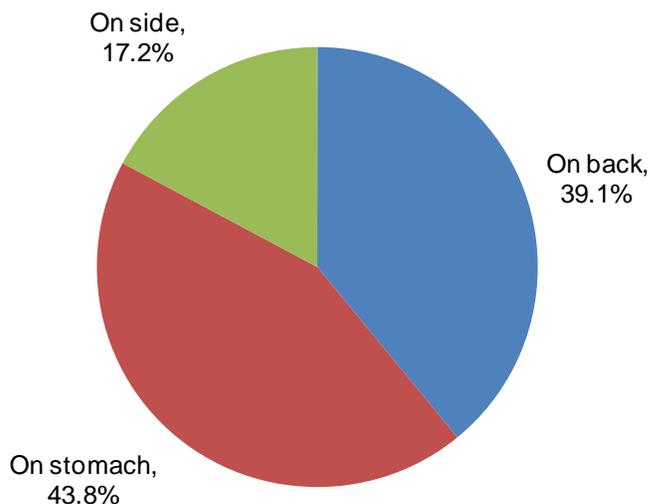
Figure 18 describes SIDS deaths by sleeping place. CFRT data show that infants most often died from SIDS while sleeping in an adult bed (33.8 percent). Infants who died from SIDS were also often set in a crib (23.8 percent) and in a bassinette (16.3 percent).

Figure 19 shows SIDS deaths by sleeping placement. CFRT data show that infants who died from SIDS were most often placed on their stomach (43.8 percent), compared with on the back (39.1 percent) and on the side (17.2 percent).

Note: Sleeping place percents are based on the number of records (80) with stated sleeping place data. Twenty-two of 102 SIDS deaths did not have a sleeping place listed. Percents may not sum to 100% due to rounding of individual categories. Source: Texas data from the National Center for Child Death Review, 2008.

Figure 19. SIDS by Sleeping Placement (N=64)

It is difficult to attribute an infant's death in a sleep environment to any single factor and still call it SIDS. As stated above, SIDS is a diagnosis of exclusion. Understanding infant deaths in sleep environments is very much dependent upon the death scene investigation and what information is collected. Parents may take all the indicated precautions for sleep place and sleep site, yet a baby may still die in the sleep environment from another risk factor, such as secondhand smoking, warmth of the room or change in the surface or placement from that which the infant is accustomed. Erroneously, some death records will state "SIDS with co-sleeping."



Note: Sleeping placement percents are based on the number of records (64) with stated sleeping placement. Thirty-eight of 102 SIDS deaths did not have a sleeping placement listed. Percents may not sum to 100% due to rounding of individual categories. Source: Texas data from the National Center for Child Death Review, 2008.



UNINTENTIONAL DROWNING DEATHS

According to the World Health Organization, "Drowning is the process of experiencing respiratory impairment from submersion/immersion in liquid."

Table 10. Unintentional Drowning Deaths by Age Group, Sex, and Race/Ethnicity, 2008

		CFRT		Population
		Number	*Percent	**Percent
Total		75	100.0%	100.0%
Age Group	Infant	4	5.3%	6.1%
	1-4 Years	40	53.3%	23.6%
	5-9 Years	12	16.0%	26.9%
	10-14 Years	10	13.3%	26.3%
	15-17 Years	9	12.0%	17.1%
Sex	Male	55	73.3%	51.1%
	Female	20	26.7%	48.9%
Race/ Ethnicity	White	26	34.7%	37.4%
	Black	14	18.7%	12.5%
	Hispanic	30	40.0%	46.4%
	Not stated	5	6.7%	--

* Percent of all CFRT records reviewed with natural cause of death

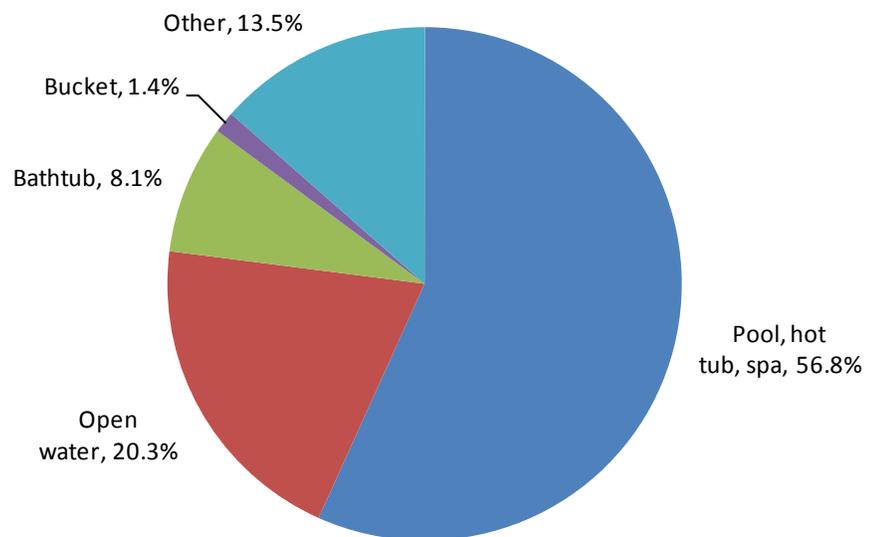
** Percent of applicable population (e.g. Male=all males 0-18 yrs)

Source: Texas data from the National Center for Child Death Review, 2008

Table 10 describes unintentional drowning of Texas children in 2008 by age, sex, and race/ethnicity. Despite representing just 23.6 percent of the child population, children from 1 to 4 years of age accounted for 53.3 percent of drowning deaths reviewed. Males, representing 51.1 percent of children, accounted for 73.3 percent of drowning deaths reviewed. Although Hispanic children had the greatest number of child drowning deaths reviewed, Black children had the greatest disparity, accounting for 18.7 percent of drowning deaths reviewed despite representing just 12.5 percent of the child population.

Figure 20 shows child drowning deaths reviewed by place of occurrence in 2008. The majority of drowning deaths reviewed occurred in pools, hot tubs, and spas (56.8 percent) followed by open bodies of water (20.3 percent). Six children (8.1 percent) drowned in a bathtub. There were 10 instances where "other" location was specified, some of which included: pond, uncovered septic ditch, and drainage ditch.

Figure 20. Drowning Deaths by Place of Occurrence 2008 (N=74)



Note: Percents are based on the number of records (74) with stated place of occurrence. One drowning death did not have the location of drowning listed. Percents may not sum to 100% due to rounding of individual categories.
Source: Texas data from the National Center for Child Death Review, 2008.



**Figure 21. Drowning Deaths by Water Access Barriers in Place
2008 (N=42)**

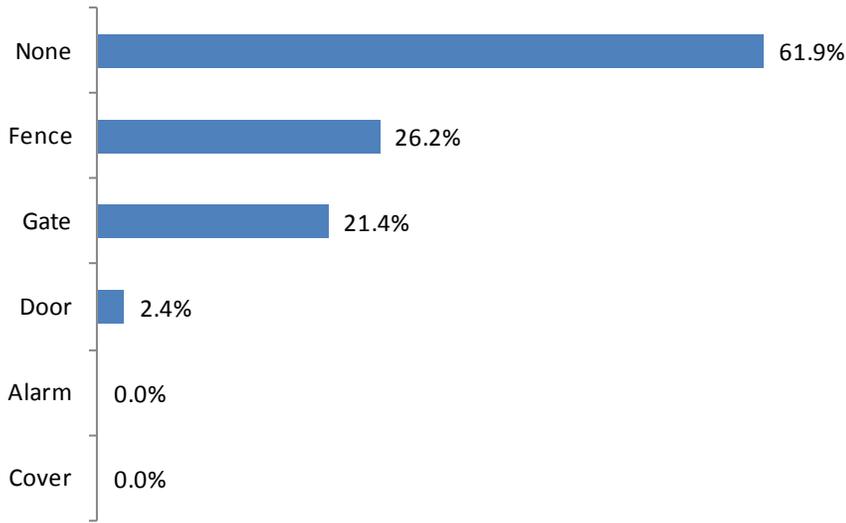


Figure 21 describes child drowning deaths reviewed by the presence of water access barriers. In the majority (61.9 percent) of drowning deaths in 2008, there was no barrier preventing the child access to the water source. A fence was in place for 26.2 and a gate for 21.4 percent of occurrences. When a barrier was in place, the most frequently reported breaches were gate left open, gate was unlocked and gate latch failed.

Note: Percents are based on the number of records (42) in which an access barrier was selected including "none." Water access barriers were unknown for 33 of 75 drowning deaths. Because more than one barrier can be selected, percents sum to more than 100%.

Source: Texas data from the National Center for Child Death Review, 2008.



MOTOR VEHICLE AND TRANSPORTATION DEATHS

Motor vehicle and transportation deaths may include all deaths related to but not limited to the following: cars, trucks, motorcycles, tractors, all terrain vehicles (ATV), bicycles, and trains. Although not all deaths in this category are due to motor vehicles, for brevity, all motor vehicle and transportation deaths will be referred to as motor vehicle deaths.

Although the vast majority (98.6 percent) of motor vehicle deaths are accidental, there were two reported as homicides and one reported as “undetermined”.

Table 11. Motor Vehicle and Transportation Deaths by Age Group, Sex, and Race/Ethnicity, 2008

		Number	CFRT *Percent	Population **Percent
Total		211	100.0%	100.0%
Age Group	Infant	4	1.9%	6.1%
	1-4 Years	44	20.9%	23.6%
	5-9 Years	28	13.3%	26.9%
	10-14 Years	43	20.4%	26.3%
	15-17 Years	92	43.6%	17.1%
Sex	Male	128	60.7%	51.1%
	Female	81	38.4%	48.9%
	Not Stated	2	0.9%	--
Race/ Ethnicity	White	69	32.7%	37.4%
	Black	14	6.6%	12.5%
	Hispanic	113	53.6%	46.4%
	Other	3	1.4%	3.8%
	Not Stated	12	5.7%	--

Table 11 describes reviewed motor vehicle deaths by age, sex, and race/ethnicity. Young drivers, 15-17 years of age, represented just 17.1 percent of the child population in 2008 yet accounted for 43.6 percent of all motor vehicle deaths reviewed. There were only 4 infant deaths reviewed. Males and Hispanic children accounted for a larger percent of reviewed motor vehicle deaths, with percents of 60.7 and 53.6, respectively. In contrast, Black children accounted for only 6.6 percent of reviewed motor vehicle deaths, despite representing 12.5 percent of the child population.

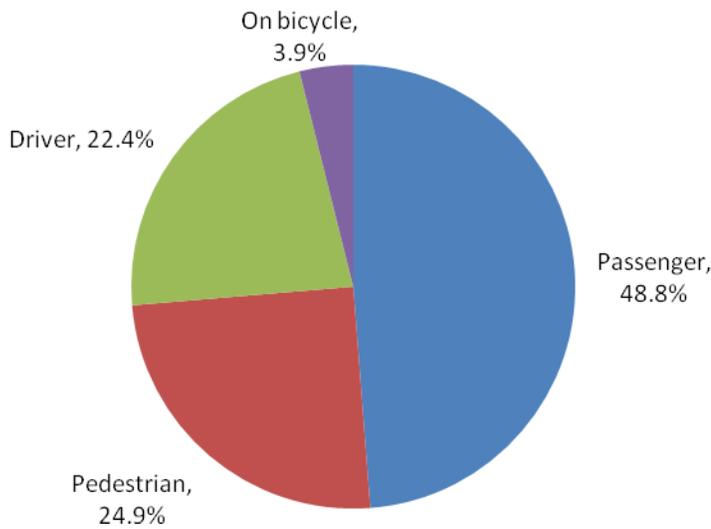
* Percent of all CFRT motor vehicle related records reviewed

** Percent of applicable population (e.g. Male=all males 0-18 yrs)

Source: Texas data from the National Center for Child Death Review, 2008



Figure 22. Motor Vehicle Deaths by Child Position 2008 (N=205)



Note: Percents are based on the number of records (205) in which a child position was indicated. Percents may not sum to 100% due to rounding of individual categories.

Source: Texas data from the National Center for Child Death Review, 2008.

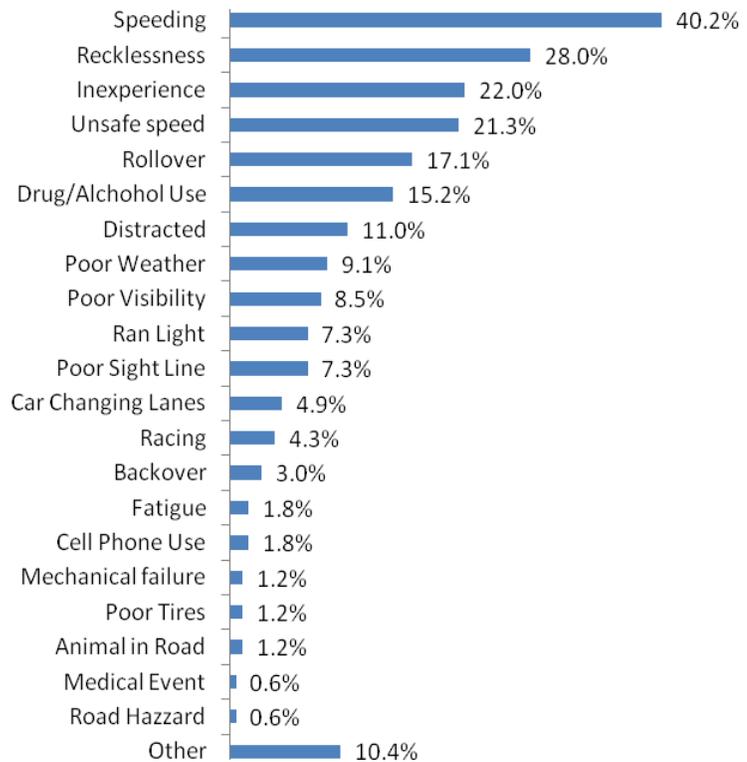
Figure 22 shows motor vehicle deaths reviewed by child position. 71.2 percent of children reviewed for a motor vehicle-related death were passengers or drivers, with 48.8 percent as passengers. Another 24.9 percent were pedestrians and 3.9 percent were on a bicycle.

Driver location varied by age group. Children one to four years of age were more likely (64.3 percent) to be pedestrians, whereas children 5-9 and 10-14 years of age were more likely to be passengers (63.0 and 59.5 percent). Youth 15-17 years of age were equally likely to be a passenger or a driver (43.3 percent).

Figure 23 shows motor vehicle deaths by cause. Speeding, recklessness, inexperience, unsafe speed for road conditions, and rollovers were the leading factors contributing to motor vehicle deaths among those reviewed.

Most of the reviewed motor vehicle deaths (59.8 percent) resulted from multiple causative factors, with five cases having listed as many as six of the causes shown in Figure 23.

Figure 23. Motor Vehicle Deaths by Cause Listed, 2008 (N=164)

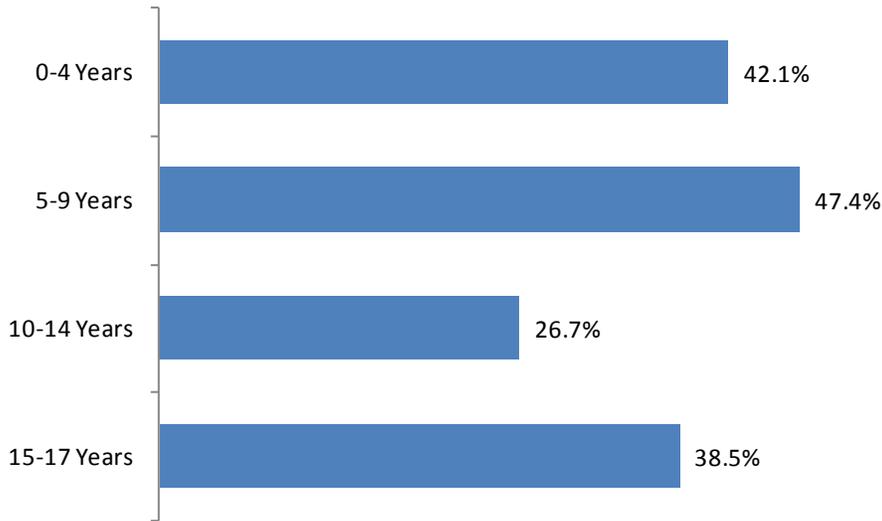


Note: Percents are based on the number of records (164) in which a cause was indicated. More than one cause may be listed for each record. Because more than one cause can be selected, percents sum to more than 100%.

Source: Texas data from the National Center for Child Death Review, 2008.



Figure 24. Motor Vehicle Deaths by Restraint/ Helmet Use among Passengers and Drivers by Age Group, 2008 (N=146)



*Note: Percents are based on the number of records (146) in which restraint or helmet use was indicated.
Source: Texas data from the National Center for Child Death Review, 2008.*

Figure 24 shows the restraint/helmet use by age group. For all child motor vehicle deaths reviewed, 37.7 percent either used a restraint (seat belt, car seat, or booster seat) or a helmet. Children from 10 to 14 years of age were less likely (26.7 percent) to use a restraint or helmet than were the other groups.

Although a restraint may be used, it is sometimes not used correctly. In eight of the 55 (14.5 percent) instances in which a restraint or helmet was used, it was not used correctly.

Among child passengers 0-8 years of age, those years in which a car or booster seat is most needed, a car or booster seat was used correctly in only five of 14 (35.7 percent) cases reviewed in which restraint/helmet use was known. A car or booster seat was used incorrectly in one instance, needed but not present in five instances, and present but not used in three instances. Reviewers determined a car or booster seat was not needed in eight of the passenger deaths. In another 12 deaths reviewed, car and booster seat information was not known.

All-Terrain Vehicle (ATV) Deaths

According to a 2010 Consumer Product Safety Commission report (<http://www.cpsc.gov/library/foia/foia10/os/atv2008.pdf>), Texas ranks third in ATV deaths among all ages. The same report states that since 1990 27 percent of ATV deaths nationwide occurred among kids younger than 16 years of age.

In 2008, there were 16 ATV deaths among Texas children with a median age of 12.5 years ranging 7 to 17 years of age. Seven of those deaths were reviewed by Child Fatality Review Teams. None of the children reviewed were wearing a helmet. The child was the driver for four of the deaths and a passenger for the other three. High speed, recklessness, and inexperience were some of the contributing factors leading to death.



FIREARM DEATHS

A firearm is a weapon consisting of a metal tube that fires a projectile at high velocity using an explosive charge as a propellant. This definition includes handguns, rifles, and shotguns.

Table 12. Firearm Deaths by Age Group, Sex, and Race/Ethnicity, 2008

	Number	CFRT Population	
		*Percent	**Percent
Total	81	100.0%	100.0%
Age Group			
Infant	1	1.2%	6.1%
1-4 Years	6	7.4%	23.6%
5-9 Years	5	6.2%	26.9%
10-14 Years	17	21.0%	26.3%
15-17 Years	52	64.2%	17.1%
Sex			
Male	65	80.2%	51.1%
Female	16	19.8%	48.9%
Race/Ethnicity			
White	19	23.5%	37.4%
Black	21	25.9%	12.5%
Hispanic	39	48.1%	46.4%
Other	1	1.2%	3.8%
Not Stated	1	1.2%	--

* Percent of all CFRT firearm-related records reviewed

** Percent of applicable population (e.g. Male=all males 0-18 yrs)

Source: Texas data from the National Center for Child Death Review, 2008

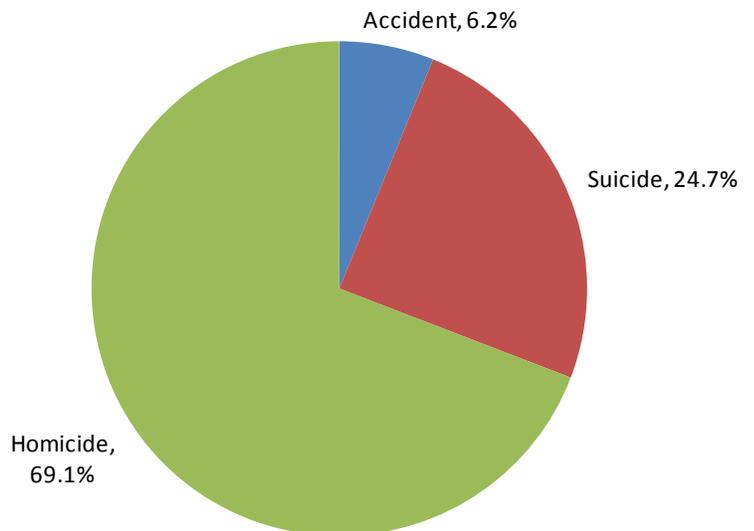
Table 12 describes firearm deaths by age, sex, and race/ethnicity. Youth ages 15-17 accounted for the majority of firearm deaths reviewed (64.2 percent) despite representing just 17.1 percent of the child population. Male children (80.2 percent) were far more likely than female children (19.8 percent) to be reviewed for a firearm death. Black children, representing 12.5 percent of the child population, accounted for 25.9 percent of the child deaths reviewed.

Deaths from firearms can be intentional, such as in cases of homicide and suicide, or unintentional which might occur from a hunting mishap or from an accidental discharge.

The majority of firearm deaths reviewed were homicides (69.1 percent). Suicides accounted for 24.7 percent of firearm deaths reviewed, and accident the remaining 6.2 percent (Figure 25).

CFRT data show that Hispanic (76.2 percent) and Black (79.5) children were more likely to die from a firearm injury resulting from a homicide. White children were more likely to die from a firearm injury resulting from a suicide (57.9 percent).

Figure 25. Firearm Deaths by Manner of Death, 2008 (N=81)



Note: Percents are based on the number of records (81) in which the manner of death was indicated. Percents may not sum to 100% due to rounding of individual categories.

Source: Texas data from the National Center for Child Death Review, 2008.



Figure 26. Firearm Deaths by Type of Firearm, 2008 (N=69)

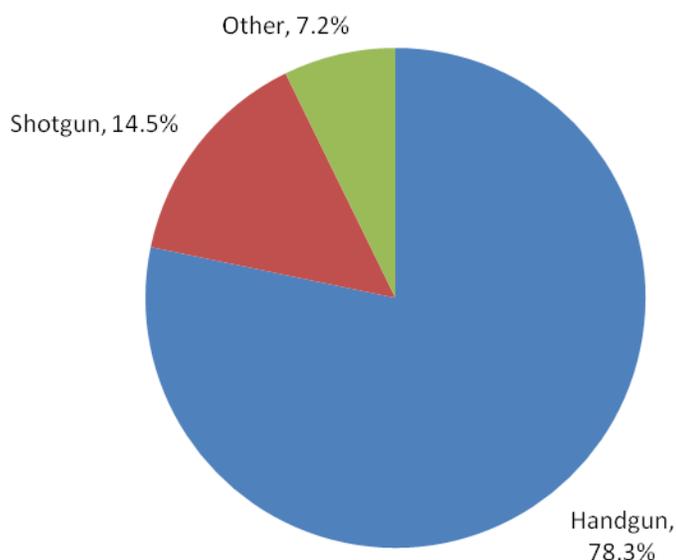


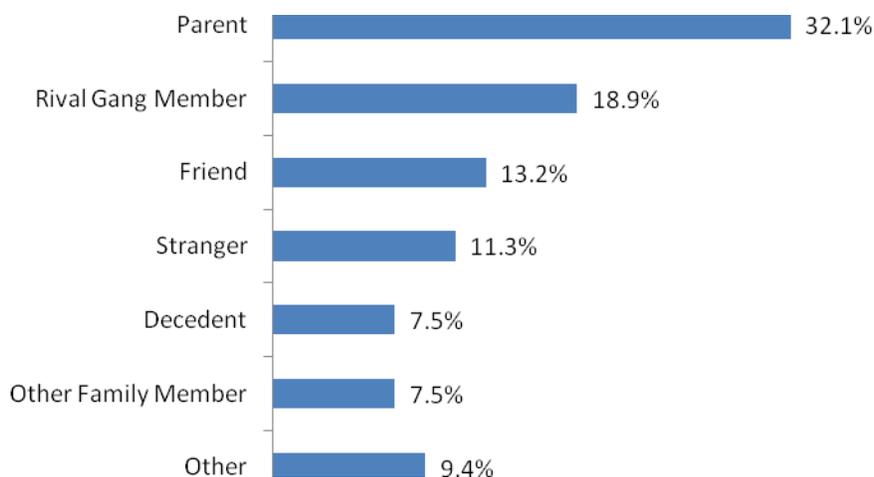
Figure 26 shows firearm death by type of firearm. The vast majority of the reviewed firearm deaths were due to handguns (78.3 percent). Another 14.5 percent were due to shotguns. The type of firearm was unknown for 12 of the firearm deaths reviewed. All but four (86.4 percent) child deaths reviewed for homicide by firearm involved a handgun. Although the majority of reviewed suicides occurred by handgun (70.0 percent), four (20.0 percent) were killed by a shotgun and another by a hunting rifle.

Note: Percents are based on the number of records (69) in which the type of firearm was indicated. Percents may not sum to 100% due to rounding of individual categories.

Source: Texas data from the National Center for Child Death Review, 2008.

Figure 27. Firearm Deaths by Owner of Firearm, 2008 (N=53)

The owner of the firearm resulting in the death of the child is described in Figure 27. The firearm belonged to the parent of the deceased child in 32.1 percent of firearm deaths reviewed. A rival gang member owned the firearm that killed 18.9 percent of children reviewed for firearm death. In 7.5 percent of reviewed cases, the firearm belonged to the deceased child.



Note: Percents are based on the number of records (53) in which the owner of the firearm was indicated. Percents may not sum to 100% due to rounding of individual categories.

Source: Texas data from the National Center for Child Death Review, 2008.



ASPHYXIA DEATHS

Asphyxia deaths are caused by oxygen deprivation. It can be caused by strangulation, suffocation, choking, or smothering.

Table 13. Asphyxia Deaths by Age Group, Sex, and Race/Ethnicity, 2008

		CFRT		Population
		Number	*Percent	**Percent
	Total	117	100.0%	100.0%
Age Group	Infant	61	52.1%	6.1%
	1-4 Years	13	11.1%	23.6%
	5-9 Years	2	1.7%	26.9%
	10-14 Years	11	9.4%	26.3%
	15-17 Years	30	25.6%	17.1%
Sex	Male	65	55.6%	51.1%
	Female	52	44.4%	48.9%
Race/ Ethnicity	White	37	31.6%	37.4%
	Black	21	17.9%	12.5%
	Hispanic	55	47.0%	46.4%
	Not stated	4	3.4%	--

* Percent of all CFRT records reviewed with natural cause of death

** Percent of applicable population (e.g. Male=all males 0-18 yrs)

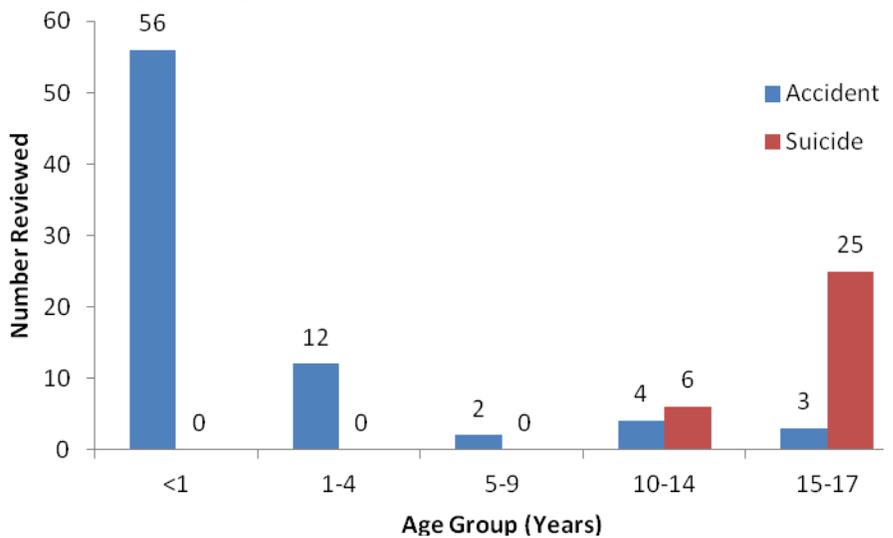
Source: Texas data from the National Center for Child Death Review, 2008

Table 13 describes asphyxia deaths by age, sex, and race/ethnicity among children in 2008. Infants account for the majority (52.1 percent) of asphyxia deaths reviewed, despite representing just 6.1 percent of the child population. Youth 15-17 years of age were also disproportionately represented, accounting for 25.6 percent of asphyxia deaths reviewed and representing 17.1 percent of the population. Males (55.6 percent) were more likely to be reviewed for deaths due to asphyxia than were females (44.4 percent). Black children were disproportionately affected, accounting for 17.9 percent of asphyxia deaths reviewed despite representing 12.5 percent of the population.



Figure 28 shows the frequency of asphyxia deaths by the manners suicide and accident and age group (There were also four asphyxia-related homicides, one natural, and four unknown deaths). The majority (65.8 percent) of asphyxia deaths for all children reviewed were accidents, with infants accounting for 72.7 percent (56 deaths) of accidental asphyxia deaths. Suicide by asphyxia accounted for 26.5 percent of asphyxia deaths reviewed, with youth 15-17 years of age accounting for 80.6 percent (25 deaths). Although accidental asphyxia occurred in every age group in 2008, children 0-4 accounted for 88.3 percent (56 deaths among children less than 1 year of age, and 12 deaths among children ages 1-4 years). All suicides occurred in the older age groups (10-17 years). Although only accidental deaths and suicides are represented in the figure, there were also four homicides, one natural death and four with an unknown nature of death for which asphyxia was the mechanism.

Figure 28. Asphyxia Deaths by Manner and Age Group, 2008 (N=108)



Note: Numbers include reviewed records (108) in which manner of death was accident or suicide and the mechanism was asphyxia.
 Source: Texas data from the National Center for Child Death Review, 2008.

Figure 29. Asphyxia Deaths by Type of Event, 2008 (N=117)

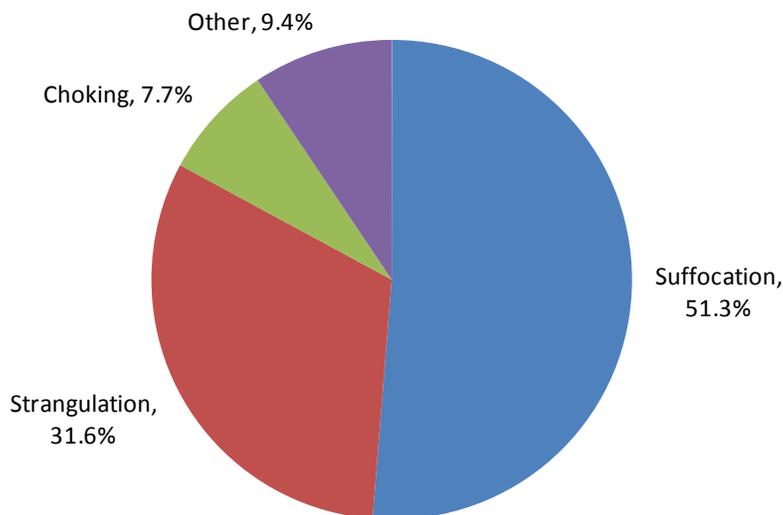


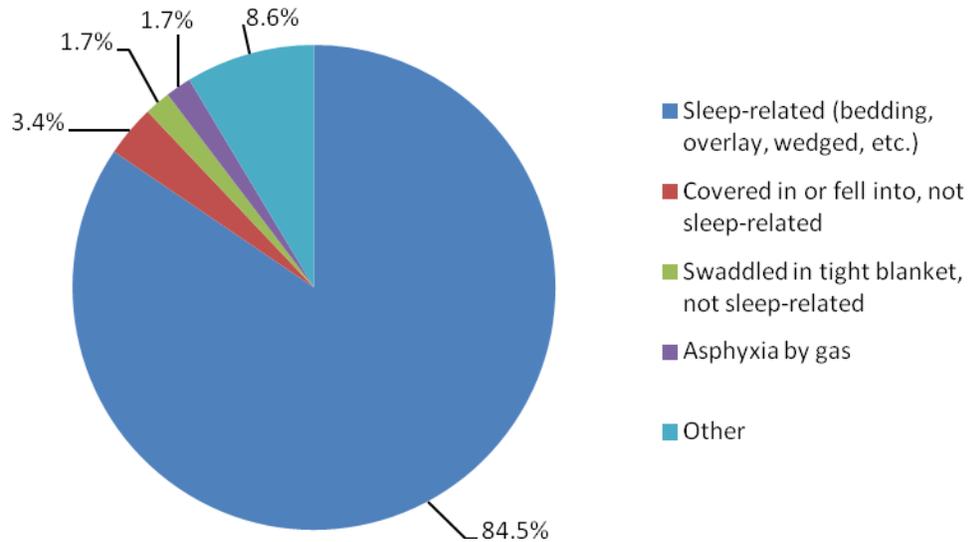
Figure 29 shows asphyxia deaths by the type of event. Most of the asphyxia deaths reviewed occurred via suffocation (51.3 percent), of which infants accounted for 86.7 percent. Another 31.6 percent of asphyxiation deaths occurred from strangulation with youth 15-17 years of age accounting for 70.3 percent. Nine choking cases were reviewed, all of which occurred in the youngest age groups.

Note: Percents are based on the number of records (117) in which the type of asphyxiation was indicated. Percents may not sum to 100% due to rounding of individual categories.
 Source: Texas data from the National Center for Child Death Review, 2008.



Figure 30. Asphyxia Deaths by Type of Suffocation, 2008 (N=58)

As seen in Figure 30, the vast majority of suffocation deaths reviewed (84.5 percent) were sleep-related, of which infants accounted for 93.9 percent. For the sleep-related deaths, 67.3 percent occurred in an adult bed and another 18.4 percent occurred on a couch.



Note: Percents are based on the number of records (58) in which the type of suffocation was indicated. Percents may not sum to 100% due to rounding of individual categories.

Source: Texas data from the National Center for Child Death Review, 2008.

The Choking Game

The choking game, also known by other names such as the “pass out game” and “fainting game”, is an activity in which adolescents and teens sometimes participate to get a brief high. In this game, friends choke each other by hand or use a noose. Although most often played in a group setting, children sometimes play the choking game alone. Although playing this game within a group is dangerous, it is particularly risky when playing alone because the noose (often a belt) can remain tight after the child loses consciousness. The CDC estimates that there have been at least 82 children that have died in the U.S. from the choking game since 1995 (<http://www.cdc.gov/Features/ChokingGame/>).

Of 504 children who died from asphyxia and were reviewed by Texas Child Fatality Review Teams since 2005, 4 were determined to be choking game-related. This is likely an underestimate given that choking game deaths are difficult to verify and that CFRT data are a sample of the all child deaths in Texas.



PREVENTABILITY

According to the National Center for Child Fatality Review, “A child's death is considered to be 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.” Teams may respond “No, probably not,” “Yes, probably,” and “Team could not determine” for each case they review.

Of all deaths reviewed in 2008, 28.9 percent were recorded as “Yes, probably,” 47.0 percent as “No, probably not,” 12.2 percent “Team could not determine,” and 11.9 percent were left blank.

Figure 31. Percent of Preventable Deaths by Manner, 2008 (N=2,106)

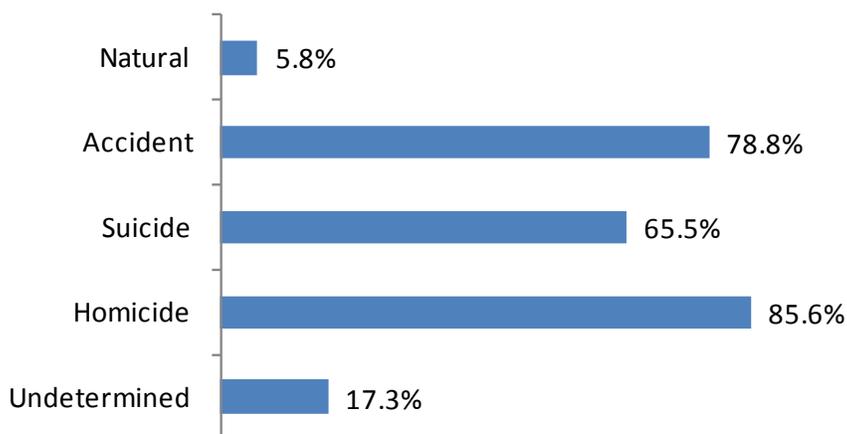


Figure 31 shows the percentage of preventable (“Yes, probably”) deaths by manner of death. Teams determined that homicides were the most preventable (85.6 percent) manner of death, followed by accident (78.8 percent), and suicide (65.5 percent). According to teams, natural deaths were the least likely to be prevented with only 5.8 percent of records recorded as preventable.

*Note: Percents are based on the number of records (2,106) in which manner of death was indicated.
Source: Texas data from the National Center for Child Death Review, 2008.*

Figure 32. Percent of Preventable Deaths by Age Group, 2008 (N=2,106)

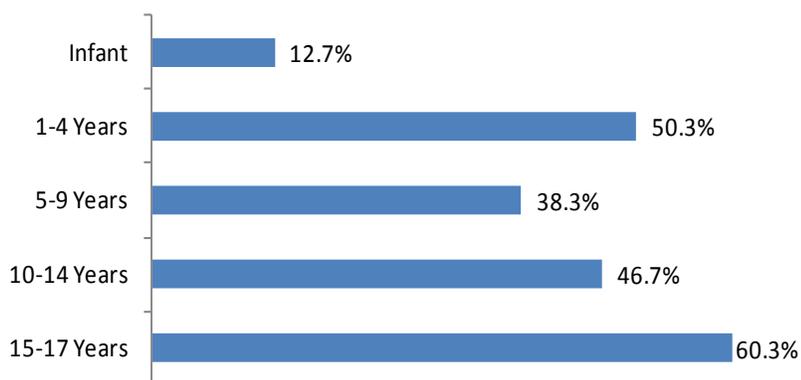
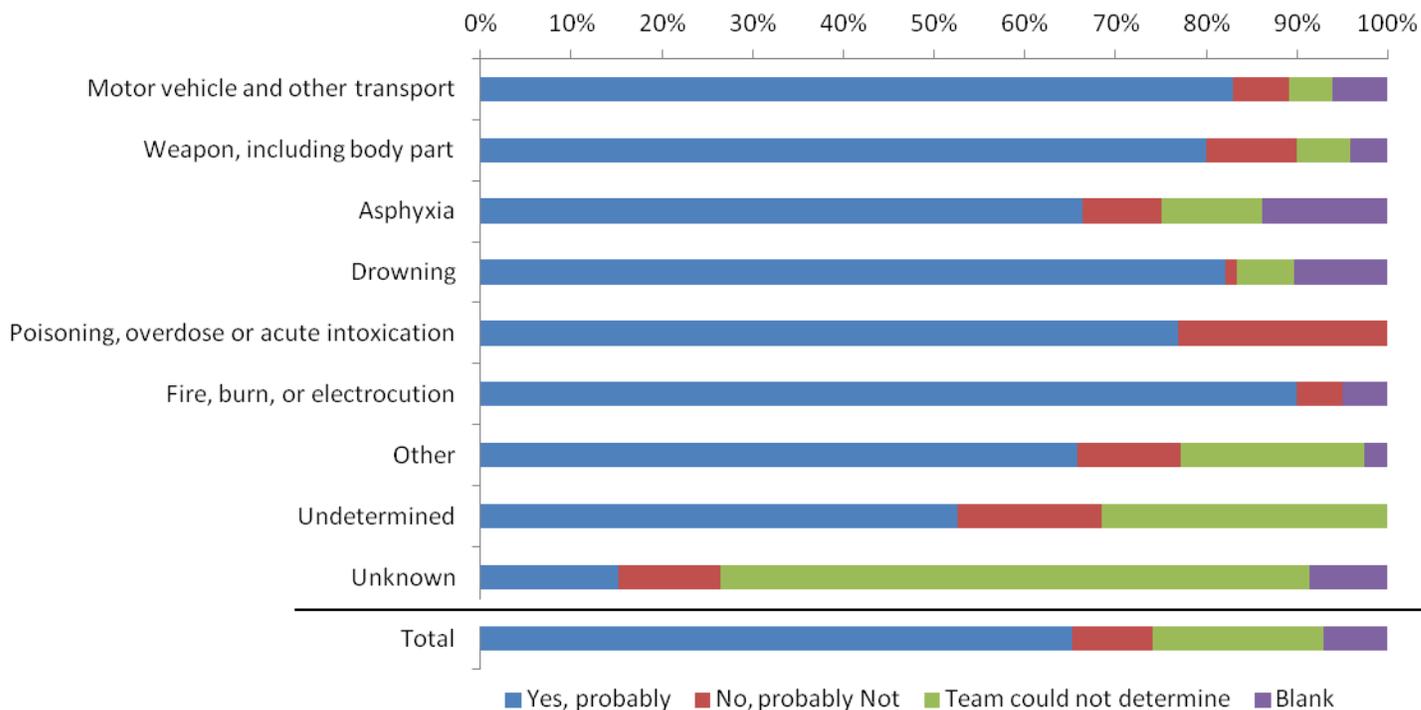


Figure 32 shows the percentage of preventable deaths by age group. Youth deaths (15-17 years) reviewed were the most likely to be prevented, with 60.3 percent of deaths preventable. Children 1-4 years of age were next at 50.3 percent, followed by children 10-14 years of age (46.7 percent). Infant deaths were least likely to be prevented with only 12.7 percent recorded as preventable.

*Note: Percents are based on the number of records (2,106) in which age was indicated.
Source: Texas data from the National Center for Child Death Review, 2008.*



Figure 33. Percent of Preventable Deaths by External Cause of Injury, 2008 (N=820)

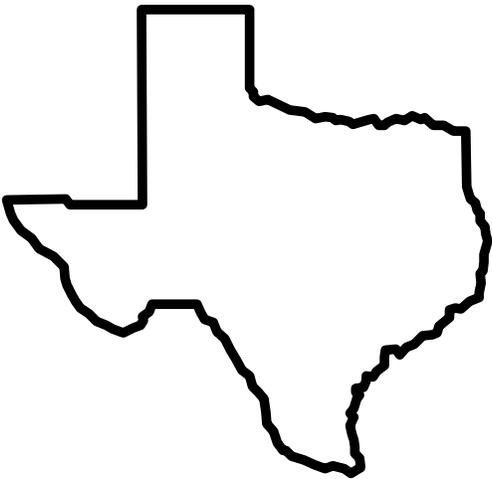


*Note: Percents are based on all manners of death other than natural. Includes only causes where N>=20.
Source: Texas data from the National Center for Child Death Review, 2008.*

Child Fatality Review data show that preventability differs based on the cause of injury death as shown in Figure 33. Teams determined that 65.2 percent of all injury (i.e. accident, suicide, and homicide) deaths reviewed were preventable (i.e. “Yes, probably”), with deaths caused by fire, burn, or electrocution most preventable (90.0 percent). Motor vehicle and other transportation ranked second (82.9 percent), followed by drowning (82.1 percent), and weapon (80.0 percent). The cause teams determined least preventable was asphyxia with just 66.4 percent of reviewed deaths probably able to be prevented. However, for some causes such as asphyxia, teams had more difficulty determining whether or not a death was preventable. For example, in 25.0 percent of asphyxia deaths teams could not determine preventability (i.e. either answered “Could not be determined” or the question was not answered). In contrast, teams could determine preventability for all 20 poisoning deaths reviewed. Although teams answered “Yes, probably” for 76.9 percent of poisoning deaths, they answered “No, probably not” for 23.1 percent; a much higher percentage than for asphyxia (“No, probably not” = 8.6 percent).



APPENDIX A
SCFRT COMMITTEE MEMBERS



STATE CHILD FATALITY REVIEW TEAM COMMITTEE MEMBERS

EMILIE A. BECKER, M.D.

Child Mental Health Provider *Term expires 2/1/13*
Medical Director for Behavioral Health
Department of State Health Services
P.O. Box 149347
Austin, Texas 78714-9347
(512) 206-5936
emilie.becker@dshs.state.tx.us

BRETT BRAY, J.D.

Director, Motor Vehicle Division *Term expires 2/1/14*
Texas Department of Motor Vehicles
P. O. Box 2293
Austin, Texas 78768-2293
(512) 416-4899
BBRAY@dmv.state.tx.us

KIM CHEUNG, M.D., PH.D.

Pediatrician *Term expires 2/1/14*
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

SAM COOPER, M.S.W., LMSW-IPR

Title V and Family Health Director *Permanent member*
Department of State Health Services
P.O. Box 149347
Austin, TX 78714-9317
(512) 458-7111 x2184
sam.cooper@dshs.state.tx.us

AUDREY DECKINGA, LMSW

CPS Assistant Commissioner *Permanent member*
Department of Family and Protective Services
701 W. 51st St.
Austin, TX 78751
(512) 438-3313
audrey.deckinga@dfps.state.tx.us

SHERIFF JACK ELLETT

Sheriff *Term expires 2/1/14*
Panola County Sheriff's Office
314 West Wellington
Carthage, TX
(903) 693-0333
jack.ellett@co.panola.tx.us

SUSAN ETHERIDGE, MSSW, LMSW

Child Advocate *Term Expires 2/1/14*
Executive Director, CASA of Collin County
101 E. Davis
McKinney, TX 75069
(972) 529-2272
setheridge@casaofcollincounty.org

JULIE FOSTER, R.N.

Child Abuse Prevention Specialist *Term expires 2/1/14*
Edinburg Regional Medical Center and Edinburg
Children's Hospital
1400 W. Trenton Rd.
Edinburg, TX 78539
(956) 388-6519
jfosterrn@yahoo.com

CHIEF JOE HAMILTON

Police Chief *Term expires 2/1/12*
Bulverde Police Department
30360 Cougar Bend
Bulverde, TX 78163
(830) 438-3612
hamiltonj@ci.bulverde.tx.us

GERALDINE R. HARRIS, M.L.A.

State Registrar, Vital Statistics *Permanent member*
Department of State Health Services
1100 W. 49th St.
Austin, TX 78756
(512) 458-7366
geraldine.harris@dshs.state.tx.us

JOHN HELLSTEN, PH.D.

Public Health *Term expires 2/1/12*
Epidemiology Studies and Initiatives Branch
Department of State Health Services
P.O. Box 149347
Austin, TX 78714-9317
(512) 458-7111 x2815
john.hellsten@dshs.state.tx.us

JUDGE JUDY SCHIER HOBBS

Justice of the Peace *Term expires 2/1/13*
Pct. 4, Williamson County
P.O. Box 588
Taylor, TX 76574
(512) 365-8922
jhobbs@wilco.org

ERIC LEVY, M.D.

Pediatrician *Term expires 2/1/14*
Director, Pediatric Critical Care Medicine
1600 S. Coulter, F600
Amarillo, TX 79106
(806) 468-4326
elevymd@amaonline.com

DONALD MCCURNIN, M.D.

Neonatologist *Term expires 2/1/12*
UT Health Science Center at San Antonio
San Antonio, TX
(210) 567-5232
mccurnin@uthscsa.edu

STATE CHILD FATALITY REVIEW TEAM COMMITTEE MEMBERS

SUSAN MILLER, J.D.

Child Protective Services Specialist *Term expires 2/1/14*
Director of Investigations
Department of Family and Protective Services
701 W. 51st St.
Austin, TX 78751
(512) 438-4746
susan.miller@dfps.state.tx.us

DENISE ONCKEN, J.D.

Assistant District Attorney *Term expires 2/1/13*
Chief, Crimes Against Children Division
Harris County District Attorney's Office
1201 Franklin, Suite 600
Houston, TX 77002
(713) 755-5546
oncken_denise@dao.hctx.net

JUAN M. PARRA, M.D., M.P.H., CHAIR

Pediatrician *Term expires 2/1/12*
Associate Professor and Interim Division Head of
General Pediatrics, UT Health Science Center at San
Antonio Medical School
7703 Floyd Curl Dr. Mail Code 7808
San Antonio, TX 78229-3900
(210) 562-5344
PARRAJ@uthscsa.edu

TERRY PENCE

Ad Hoc Expert Advisor *Term expires 2/1/13*
Traffic Safety Director
Texas Department of Transportation
125 E. 11th St.
Austin, TX 78701
(512) 416-3167
tpence@dot.state.tx.us

READE QUINTON, M.D.

Medical Examiner *Term expires 2/1/14*
Office of the Dallas County Medical Examiner
5230 Southwestern Medical Ave.
Dallas, TX 75235
(214) 920-5900
rquinton@dallascounty.org

KATHERINE RATCLIFF

SIDS Family Service Provider *Term expires 2/1/13*
Director, 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

CAPTAIN STEVEN A. TELLEZ, CHAIR-ELECT

Texas Department of Public Safety *Term expires 2/1/12*
6502 S. New Braunfels
San Antonio, Texas 78223
(210) 531-2206
Steven.Tellez@txdps.state.tx.us

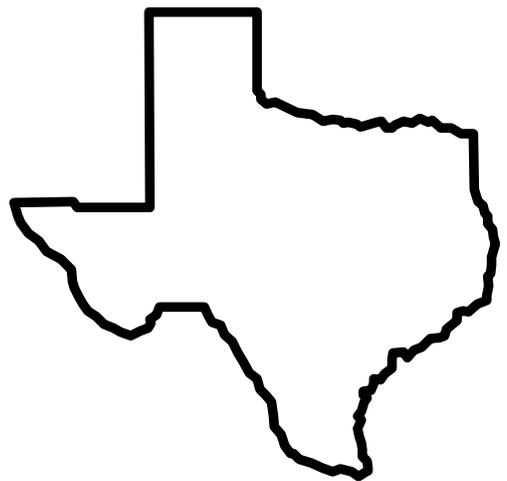
RAYMOND H.C. TESKE, JR., PH.D.

Ad Hoc Expert Advisor *Term expires 2/1/13*
Professor, College of Criminal Justice
Sam Houston State University
304 Elkins Lake
Hunsville, TX 77340
(936) 295-6274
rteske@suddenlink.net

JEANNINE VON STULTZ, PH.D.

Juvenile Probation Officer *Term expires 2/1/12*
Bexar County Juvenile Probation
301 E. Mitchell
San Antonio, TX 78210
(210) 335-7515
jvonstultz@bexar.org

APPENDIX B
ACTIVE LOCAL CHILD FATALITY
REVIEW TEAMS, 2010



TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Anderson County CFRT Serving Anderson County Health Service Region 4/5N	David Giles, EMT-P Asst. Director of EMS Palestine Regional Hospital 2900 South Loop 256 Palestine, TX 75801 (903) 731-5387 david.giles@lpnt.net	Anita Shook Department of State Health Services 100 W. Brazos St. Palestine, TX 75801 (903) 729-1116 anita.shook@dshs.state.tx.us
Bastrop County CFRT Serving Bastrop County Health Service Region 7	Mindy Graber Children's Advocacy Center of Bastrop 1002 Chestnut St. P.O. Box 1098 Bastrop, TX 78602 (512) 321-6161 mindycacbastrop@austin.rr.com	Same as Presiding Officer
Bexar County CFRT Serving Bexar County Health Service Region 8	Laurie Charles, RN, SANE-A, CA/CPSANE SANE Program Coordinator Christus Santa Rosa Children's Hospital 333 N. Santa Rosa San Antonio, TX 78207 (210) 704-3330 laurie.charles@christushealth.org	Cynthia Garcia, RN, SANE Christus Santa Rosa Children's Hospital 333 N. Santa Rosa San Antonio, TX 78207 (210) 704-3330 ca.garcia@christushealth.org
Brazos County CFRT Serving Brazos & Robertson Counties Health Service Region 7	Christopher C. Kirk Brazos County Sheriff 1700 Highway 21 West Bryan, TX 77803-1300 (979) 361-4150 chriskirk@highsheriff.com	Carol McCord St. Joseph Regional Health Center 2715 Osler Blvd. Bryan, TX 77802 CMcCord@st-joseph.org
Burleson County CFRT Serving Burleson County Health Service Region 7	Tiffany Graves Burleson County Sheriff's Dept. Caldwell, TX (979)567-4343 tgraves@burlesoncounty.org	Pam Stetz Burleson St. Joseph Health Center 1101 Woodson Caldwell, TX 77836 (979)567-3245 pstetz@mail.st-joseph.org
Cameron/Willacy Counties CFRT Serving Cameron & Willacy Counties Health Service Region 11	Stanley I. Fisch, MD Harlingen Pediatrics Associates 321 South 21 st Street Harlingen, TX 78550 (956) 425-8761 stan.fisch@gmail.com	Same as Presiding Officer

TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Cass/Morris/Marion Counties CFRT Serving, Cass, Morris & Marion Counties Health Service Region 4/5N	Judge Barbara McMillon Cass Co. Justice of the Peace Pct 1 P.O. Box 341 Linden, Texas 75563 (903)-756-5341 (903)-720-5277 (cell) judgemcmillon@att.net	Dora Whatley Department of State Health Services P.O. Box 300 Linden, Texas 75563 (903)756-7231 dora.whatley@dshs.state.tx.us
Central Texas CFRT Serving Bell, Coryell, Hamilton & Milam Counties Health Service Region 7	David Hardy, MD, FAAP Pediatric Medical Consultant, Scott & White Hospital 2401 South 31 st St. Temple, TX 76508 (254) 724-1199 dhardy@swmail.sw.org	Danielle Lissberger Central Texas Regional Advisory Council Trauma Service Area L 2180 North Main St., Suite H6 Belton, TX 76513 (254) 770-2274 (254) 721-3815 (cell) danielle.schmitz@TSA-L.com
Coastal Bend CFRT Serving Aransas, Bee, Brooks, Duval, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio and San Patricio Counties Health Service Region 11	Sonja Eddleman, RN, CA/CP SANE, SANE-A, DABFN, CMI-III, CFN Driscoll Children's Hospital 3533 S. Alameda Corpus Christi, TX 78411 (361) 694-4240 Sonja.Eddleman@dchstx.org	Same as Presiding Officer
Collin County CFRT Serving Collin County Health Service Region 2/3	Dr. William Rohr, Medical Examiner Collin County Medical Examiner 700 B Wilmeth Road McKinney, TX 75069	Susan Schultz, LPC, LMFT Collin County Medical Examiner 700 B Wilmeth Road McKinney, TX 75069 susanschultz@mac.com
Colorado/Austin/Waller Counties CFRT Serving Colorado, Austin & Waller Counties Health Service Region 6/5S	Rachel Bentke Texana Center 1416 Walnut Columbus, TX 77934 (979) 732-6204 rachel.bentke@texanacenter.com	Lydia Ravenna Department of State Health Services 800 E. Wendt St. Bellville, TX 77418 (979) 865-5211 lydia.ravenna@dshs.state.tx.us
Concho Valley CFRT Serving Coke, Concho, Crockett, Irion, Kimble, Menard, McCulloch, Regan, Runnels, Schleicher, Sterling, Sutton & Tom Green Counties Health Service Regions 9/10 & 2/3	Judge Eddie Howard, JP Tom Green County, Precinct 4 124 W. Beauregard San Angelo, TX 76903 (325) 659-6424 eddie.howard@co.tom-green.tx.us	Melody Jeter Hope House Children's Advocacy Center of Tom Green County P.O. Box 5195 San Angelo, TX 76902 (325) 653-4673 melodyjeter@cactomgreen.org

TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Cooke County CFRT Serving Cooke County Health Service Region 2/3	Judge Dorthy Lewis Justice of the Peace, Pct. 1 320 CR 451 Gainesville, TX 76420 (940) 668-5463 justice@cooke.net	Vicki Robertson CASA 309 S. Commerce St. Gainesville, TX 76420 (940) 665-2244 vrobertson@casant.org
Dallas County CFRT Serving Dallas County Health Service Region 2/3	Carrie Nie Injury Prevention Center of Greater Dallas 6300 Harry Hines, Suite 240 P.O. Box 36067 Dallas, TX 75235 (214) 590-4461 carrie.nie@phhs.org	Amy McSpadden Bailey Injury Prevention Center of Greater Dallas 6300 Harry Hines, Suite 240 P.O. Box 36067 Dallas, TX 75235 (214) 590-4461 amy.bailey@phhs.org
Eastland County CFRT Serving Eastland County Health Service Region 2/3	County Judge Rex Fields 100 W. Main, Suite 203 2 nd Floor, Eastland County Courthouse Eastland, TX 76448 (254) 629-1263 ecjudge@eastlandcountytexas.com	Same as Presiding Officer
El Paso County CFRT Serving Culberson, El Paso & Hudspeth Counties Health Service Region 9/10	Penny Hamilton Chief, Rape and Child Abuse Unit El Paso District Attorney's Office 500 E. San Antonio Ave., Suite 201 El Paso, TX 79901 (915) 546-2059 phamilton@epcounty.com	Donna Welch El Paso District Attorney's Office 500 E. San Antonio Avenue, Suite 201 El Paso, TX 79901 (915) 546-2059 ext 3701 dwelch@epcounty.com
Ellis County CFRT Serving Ellis County Health Service Region 2/3	Marlena Pendley, Investigator Ellis Co. District Attorney's Office 425 E. Ross Waxahachie, TX 75165 (972) 937-1870 Mar9763@aol.com	Same as Presiding Officer
Erath County CFRT Serving Erath County Health Service Region 2/3	TBD	Lucille Coggins Department of State Health Services 214 North Travis Granbury, TX 76048 (817) 573-5603 lucille.coggins@dshs.state.tx.us

TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Fannin County CFRT Serving Fannin County Health Service Region 2/3	Richard Glaser, District Attorney Fannin County Courthouse 101 E. Rayburn Drive, Ste. 301 Bonham, Texas 75418 (903) 583-7448 reglaser@fanninco.net	Britney Martin Fannin County Children's Center 112 W. 5 th St. Bonham, TX 75418 (903) 583-4339 Britney@fanninccc.org
Fort Bend County CFRT Serving Fort Bend County Health Service Region 6/5N	Oshea Spencer Asst. DA, Child Abuse Division Fort Bend County District Attorney 301 Jackson St. Richmond, TX 77469 (281)238-4488 ospencer@co.fort-bend.tx.us	Same as Presiding Officer
Galveston County CFRT Serving Galveston County Health Service Region 6/5S	Louise Pound Advocacy Center for Children of Galveston Co. 5710 Avenue S1/2 Galveston, TX 77551 (409) 741-6000 louise@galvestoncac.com	Same as Presiding Officer
Gonzales County CFRT Serving Gonzales County Health Service Region 8	Humberto Rivas, MD Gonzales Healthcare Systems Sievers Medical Clinic 1110 Sarah Dewitt Dr. Gonzales, TX 78629 (830) 672-8473 hrivas@gonzaleshealthcare.com	Carol Villareal Infection Control Nurse Gonzales Healthcare Systems P.O. Box 587 1110 Sarah Dewitt Dr. Gonzales, TX 78629 (806) 672-7581 ext. 453 bengita51@yahoo.com
Grayson County CFRT Serving Grayson County Health Service Region 2/3	Martha Nuckols, Executive Director Children's Advocacy Center of Grayson County 910 Cottonwood Sherman, TX 75090 (903)957-0440 mnuckols@cacgc.org	Same as Presiding Officer
Guadalupe County CFRT Serving Guadalupe County Health Service Region 8	Paul Marsh Guadalupe County Children's Advocacy Center 424 N. River Seguin, TX 78155 (830) 303-4760 pmarsh@gccac.net	Same as Presiding Officer

TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Hays County CFRT Serving Hays County Health Service Region 7	Melissa Rodriguez Roxanne's House Hays-Caldwell Women's Center P.O. Box 234 San Marcos, TX 78667 (512) 396-7276 mrodriguez@hcwc.org	Same as Presiding Officer
Heart of Texas CFRT Serving Bosque, Falls, Hill, Limestone & McLennan Counties Health Service Region 7	Lori Boyett Hillcrest Hospital 100 Hillcrest Medical Blvd. Waco, TX 76712 (254) 202-5390 lboyett@hillcrest.net	Stephanie Alvey Heart of Texas Regional Advisory Council 405 Londonderry, Suite 201 Waco, TX 76712 (254) 761-7890 salvey@heartoftexasrac.org
Henderson County CFRT Serving Henderson County Health Service Region 4/5N	Sheila Durden The Help Center 309 Royal St. Athens, TX 75751 (903) 675-4357 sdurden@thehelpcenter.org	Angela Menchaca Department of State Health Services 708 E. Corsicana St. Athens, TX 75751 (903) 675-7742 angela.menchaca@dshs.state.tx.us
Hidalgo/Starr Counties CFRT Serving Hidalgo & Starr Counties	Teresa Camacho, MD, FAAP, MCCM, Medical Director of Pediatric ICU Edinburg Regional Medical Center & Children's Hospital 1102 W. Trenton Rd. Edinburg, TX 78539 (956) 421-2414 mateguia@aol.com	Martine Acosta Doctors' Hospital at Renaissance Med Point 1200 Savannah Ave. Suite 21 McAllen, TX 78503 (956) 362-3081 m.acosta@dhr-rgv.com
Hill Country CFRT Serving Blanco, Burnet, Lampasas, Llano, Mason, Mills & San Saba Counties Health Service Regions 7 & 9/10	Deborah Keith Hill Country Children's Advocacy Center P.O. Box 27 Burnet, TX 78611 (512) 756-2607 hccac@tstar.net	Same as Presiding Officer
Hood County CFRT Serving Hood County Health Service Region 2/3	Chief Mitch Galvan Granbury Police Department 116 W. Bridge St. Granbury, TX 76408 (817) 573-2648 galvan@granbury.org	Stephanie Williams Child Protective Services 1430 Southtown Dr Granbury, TX 76048 (817) 573-8612 stephanie.williams@dfps.state.tx.us

TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Hopkins/Franklin/Delta Counties CFRT Serving Hopkins, Franklin & Delta Counties Health Service Region 4/5N	Becke Anderson Sulphur Springs Independent School District, Special Services 219 Ponder Sulphur Springs, TX 75482 (903) 885-6230 banderson@ssisd.net	Same as Presiding Officer
Houston/Harris County CFRT Serving Harris County Health Service Region 6/5S	Co-Presiding Officers: Kim Cheung, MD, PhD UT Health Science Center-Houston Child Protective Services Clinic 6300 Chimney Rock Houston, TX 77081 (713) 295-2579 kim.k.cheung@uth.tmc.edu Tammy Thomas, JD Harris Co. District Attorney's Office 1201 Franklin, Suite 600 Houston, TX 77002 (713) 755-7446 thomas_tammy@dao.hctx.net	Jaennie Yoon Houston/Harris Co. CFRT Coordinator Harris Co. Public Health & Environmental Services 2223 West Loop South Houston, TX 77027 (713) 439-6003 jyoon@hcphe.org
Houston/Trinity Counties CFRT Serving Houston & Trinity Counties Health Service Region 4/5N	Krystal Patterson Department of State Health Services 1034 South 4th Street Crockett, TX 75835 (936) 544-3559 krystal.patterson@dshs.state.tx.us	Linnea Robison 1034 S 4 th St Crockett, TX 75835 (936) 545-0550 linnearobison@wildblue.net
Hunt County CFRT Serving Hunt County Health Service Region 2/3	Bret Freeman, RN, CEN Trauma Coordinator Presbyterian Hospital of Greenville 4215 Joe Ramsey Blvd. Greenville, TX 75401 (903) 408-1412 bfreeman@hmhd.org	Same as Presiding Officer

TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Jack County CFRT Serving Jack County Health Service Region 2/3	Vicky Easter, RN Faith Community Hospital 717 Magnolia St. Jacksboro, TX 76458 (940) 567-6633 ext. 253 veaster@faithcommunityhospital.com	Same as Presiding Officer
Jefferson County CFRT Serving Jefferson County Health Service Region 6/5S	Marion Tanner The Garth House/Mickey Mehaffy Children's Advocacy Program 1895 McFaddin Beaumont, TX 77701 (409) 838-9084 mtanner@garthhouse.org	Janet Cooke Morris The Garth House/Mickey Mehaffy Children's Advocacy Program 1895 McFaddin Beaumont, TX 77701 (409) 838-9084 jmorris@garthhouse.org
Johnson County CFRT Serving Johnson County Health Service Region 2/3	Cathy Marchel Cleburne Chamber of Commerce 1511 W. Henderson P.O. Box 701 Cleburne, TX 76033 (817) 645-2455 cmarchel@cleburnechamber.com	Tammy King Johnson Co. Children's Advocacy Center 910 Granbury St. Cleburne, TX 76033 (817) 558-1599 (office) (817) 517-1689 (cell) cac@hyperusa.com
Kaufman County CFRT Serving Kaufman County Health Service Region 2/3	Laura Peace Kaufman County Juvenile Probation P.O. Box 1137 300 West Mulberry Kaufman, TX 75142 (972) 932-0320 ext. 3111 laurapeace@kaufmancounty.net	Sharna Ellis Kaufman Police Department 105 East Chestnut Kaufman, TX 75142 (972) 932-3094 ext. 109 sellis@kaufmantx.org
Liberty County CFRT Serving Liberty County Health Service Region 6/5S	Dana Janczak 4021 FM 2518 Cleveland, TX 77327 (281) 592-2761 danajanczak@att.net	Hortencia Herrera Department of State Health Services P.O. Box 399 Cleveland, TX 77328 (281) 592-6714 hortencia.herrera@dshs.state.tx.us
Madison/Leon Counties CFRT Serving Madison & Leon Counties Health Service Region 7	Dee Craft Leon County Sheriff's Office P.O. 278 Centerville, TX 75833 (903) 536-2749 dcraftleoncoso@gmail.com	Same as Presiding Officer

TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Matagorda County CFRT Serving Matagorda County Health Service Region 6/5S	Mitchell Irwin Matagorda Sheriff's Office 2323 Avenue E Bay City, TX 77414 (979) 245-5526 mirwin@co.matagorda.tx.us	Julia Gonzales Matagorda County United Way 2417 Avenue G Bay City, TX 77414 (979) 245-5842 mcuw@sbcglobal.net
Montgomery County CFRT Serving Montgomery County Health Service Region 6/5S	JoAnn Linzer Asst. District Atty, Montgomery County D.A.'s office 207 W. Phillips, 2 nd Floor Conroe, TX 77301 (936) 589-7800 joann.linzer@mctx.org	Suzanne Zenga Nurse 5313 Lakeshore Dr. Willis, TX 77318 (936) 890-9826 (936) 525-9159 suzanne.zenga@memorialhermann.org
Nacogdoches County CFRT Serving Nacogdoches County Health Service Region 4/5N	Lisa King, Child Welfare Board 818 Park St. Nacogdoches, TX 75961 (936) 560-2338 lking2338@gmail.com	Same as Presiding Officer
Navarro County CFRT Serving Navarro County Health Service Region 2/3	Amy Cadwell Navarro County District Attorney's Office 300 W. 3 rd St. Corsicana, TX 75110 (903) 654-3045 acadwell@navarrocounty.org	Sherry Dowd County Clerk of Navarro County 300 W. 3 rd St., Suite 101 Corsicana, TX 75110 (903) 654-3035 countyclerk@navarrocounty.org
North Texas Tri-County CFRT Serving Archer, Clay & Montague Counties Health Service Region 2/3	Geneva Schroeder CPS Program Director Department of Family & Protective Services MC-378-2 935 Lamar, Suite 5100 Wichita Falls, TX 76301 (940) 235-1926 geneva.schroeder@dfps.state.tx.us	Co-Coordinator: Blake Davis Patsy's House 1411 Tenth St. Wichita Falls, TX 76301-4402 (940) 322-8890 blake.davis@patsyshouse.org Jennifer Schindler 97 th Judicial District, Juvenile Probation 100 N. Bridge St. Henrietta, TX 76365 (940) 538-5661 97distjuvenileprob@claycountytexas.com

TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Orange County CFRT Serving Orange County Health Service Region 6/5S	Kim Hanks Garth House/Mickey Mehaffy Children's Advocacy Program 1895 McFaddin Beaumont, TX 77701 (409) 838-9084 khanks@garthhouse.org	Same as Presiding Officer
Panhandle CFRT Serving Armstrong, Briscoe, Carson, Castro, Childress, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher & Wheeler Counties Health Service Region 1	Gil Farren Victim/Witness Coordinator Randall County Sheriff's Office 9100 S. Georgia Amarillo, TX 79118 (806) 468-5790 (sheriff's office) (806) 468-5570 (DA's office) gfarren1@randallcounty.org	Don Nicholson Department of State Health Services WTAMU Box 60968 300 Victory Dr. Canyon, TX 79016 (806) 477-1106 (office) (806) 676-1512 don.nicholson@dshs.state.tx.us
Polk County CFRT Serving Polk County Health Service Region 4/5N	Jean LeBlanc Director, 258 th & 411 th Judicial District Polk County Juvenile Probation P.O. Box 1637 Livingston, TX 77351 (936) 327-6850 juvprob@livingston.net	Same as Presiding Officer
San Jacinto County CFRT Serving San Jacinto County Health Service Region 4/5N	Karen Robertson Victims Services San Jacinto Co. District Attorney's Office 1 State Hwy. 150, Room 21 Coldspring, TX 77331 (936) 653-2091 karen.robertson@co.san-jacinto.tx.us	Same as Presiding Officer
Smith County CFRT Serving Smith County Health Service Region 4/5N	Mandy Countryman Children's Advocacy Center of Smith County 2210 Frankston Highway Tyler, TX 75701 (903) 533-1880 mandy@cacsmithcounty.org	Same as Presiding Officer

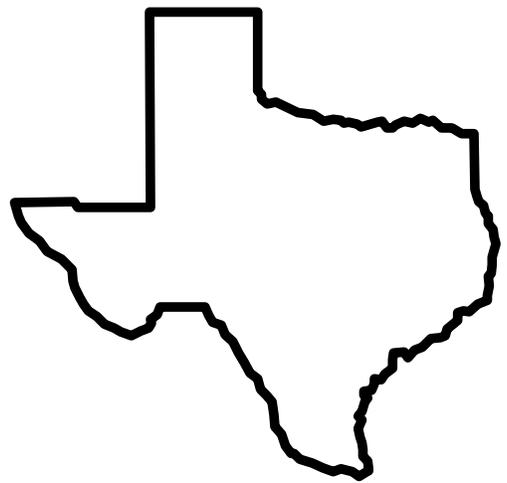
TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
South Plains CFRT Serving Bailey, Borden, Cochran, Cottle, Crosby, Dawson, Dickens, Floyd, Gaines, Garza, Hale, Hockley, Kent, King, Lamb, Lubbock, Lynn, Motley, Scurry, Stonewall, Terry & Yoakum Counties Health Service Regions 1 & 2/3	Patti Salazar, SANE C.A.R.E. Center Texas Tech University MS 7108 4430 S. Loop 289 Lubbock, TX 79414 (806) 743-7770 patricia.salazar@ttuhsc.edu	Same as Presiding Officer
South Texas Tri-County CFRT Serving Edwards, Kinney & Val Verde Counties Health Service Region 8	Susie Jechow EMS Academy Val Verde Regional Medical Center 801 Bedell Ave. Del Rio, TX 78840 (830) 778-3665 susie.jechow@vvrmc.org	Shirley Adriance, MSN, RN, BC Manager of Quality Val Verde Regional Medical Center 801 Bedell Ave. Del Rio, TX 78840 (830) 775-8566 shirley.adriance@vvrmc.org
Tarrant County CFRT Serving Denton, Parker & Tarrant Counties Health Service Region 2/3	Michael V. Floyd Senior Forensic Investigator Tarrant Co. Medical Examiner 200 Feliks Gwozdz Place Fort Worth, TX 76104-4919 (817) 920-5700 ext 120 mfloyd@tarrantcounty.com	Same as Presiding Officer
Taylor County CFRT Serving Taylor County Health Service Region 2/3	Chief Stan Standridge Abilene Police Department P.O. Box 174 450 Pecan St. Abilene, TX 79604-0174 (325) 676-6600 stan.standridge@abilenetx.com	Det. John Graham Taylor County Sheriff's Department 450 Pecan St. Abilene, TX 79604-1692 (325) 674-1334 grahamj@taylorcountytexas.org
Texas "J" CFRT Serving Andrews, Brewster, Crane, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Pecos, Presidio, Reeves, Terrell, Upton, Ward & Winkler Counties Health Service Region 9/10	Scott Layh Ector County DA's Office 300 North Grant, Room 305 Odessa, TX 79761 (432) 498-4230 layhms@co.ector.tx.us	Phyllis Craig-Blanco Trauma Services Medical Center Hospital 500 W. 4 th St. Odessa, TX 79761 (432) 640-1190 pblanco@echd.org

TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Titus/Camp Counties CFRT Serving Titus & Camp Counties Health Service Region 4/5N	Co-Presiding Officers: Peggy Helbert, Co-Presiding Officer Titus Regional Medical Center 2001 N. Jefferson Ave. Mt. Pleasant, TX 75455 (903) 577-6193 peggy.helbert@titusregional.com Dr. Gerald Stagg, Co-Presiding Officer Pediatric Clinic 2001 N. Jefferson Ave., Suite 300 Mt. Pleasant, TX 75455 (903) 572-9823	Linda Thomas Department of State Health Services 1014 N. Jefferson Ave. Mt. Pleasant, TX 75455 (903)572-9877 linda.thomas@dshs.state.tx.us
Travis County CFRT Serving Travis County Health Service Region 7	Dayna Blazey, Asst. District Atty. Office of the District Attorney P.O. Box 1748 Austin, TX 78767 (512) 974-6830 dayna.blazey@ci.austin.tx.us	Sandra Martin Center for Child Protection 8509 FM 969, Bldg 2 Austin, TX 78724 (512) 472-1164 smartin@centerforchildprotection.org
Tri-County CFRT Serving Harrison, Panola & Rusk Counties Health Service Region 4/5N	Sheriff Jack Ellett Panola Co. Sheriff's Department 314 W. Wellington St. Carthage, TX 75633 (903) 693-0333 jack.ellett@co.panola.tx.us	Sgt. Sarah Fields Panola County Sheriff's Department 314 W. Wellington St. Carthage, TX 75633 (903) 693-0333 sgtfields@hotmail.com
Tyler County CFRT Serving Tyler County Health Service Region 4/5N	Terry Allen Tyler Co. Juvenile Probation Chief 100 West Bluff St. Woodville, TX 75979-5245 (409) 283-2503 t_allen45@yahoo.com	Byron Stowe, EMT-P Dogwood EMS P.O. Box 344 Woodville, TX 75979 (409) 283-3908 blstowe@sbcglobal.net
Victoria County CFRT Serving Victoria County Health Service Region 8	Adelaida Resendez, MD Pediatrician 110 Medical Dr. #103 Victoria, TX 77904-3101 (361) 572-0033 adelaidaresendez@gmail.com	Gilda Miller, RNC Citizens medical Center 2701 hospital Dr. Victoria, TX 77901-5749 (361) 574-1777 gmiller@cmcvtx.org

TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Walker County CFRT Serving Walker County Health Service Region 6/5N	Pam Patterson Department of State Health Services 2707 Lake Rd., Suite F Huntsville, TX 77340 (936) 294-2170 pam.patterson@dshs.state.tx.us	Amanda Elkanick Saafe House P.O. Box 1893 Huntsville, TX 77342 (936) 291-3529 aelkanick@saafehouse.org
Washington/Grimes Counties CFRT Serving Washington & Grimes Counties Health Service Region 7	Ann Clodfelter Texas Department of State Health Services 202 S. Judson Navasota, TX 77868 (254) 778-6744 ann.clodfelter@dshs.state.tx.us	Same as Presiding Officer
Webb County CFRT Serving Webb & Zapata Counties Health Service Region 11	Lupita Martinez Children's Advocacy Center of Webb County 111 N. Merida Laredo, TX 78403-4128 (956) 712-1840 fi@caclaredo.org	Same as Presiding Officer
Western Hill Country CFRT Serving Bandera, Gillespie, Kendall & Kerr Counties Health Service Region 8	Judy Sullivan Kids' Advocacy Place P.O. Box 291722 Kerrville, TX 78029 (830) 895-4527 kap@kctc.com	Linda Lively Fredericksburg Police Dept. 1601 E. Main St. Fredericksburg, TX 78624 (830) 990-6264 llively@fbqtx.org
Wharton County CFRT Serving Wharton County Health Service Region 6/5S	Sharon Hill Department of State Health Services 5425 Polk St., Ste J, MC 1906 Houston, TX 77023-1497 (713) 767-3105 sharon.hill@dshs.state.tx.us	Same as Presiding Officer
Wichita County CFRT Serving Wichita County Health Service Region 2/3	Jackie Betts, R.N.-BSN, LP Director, Trauma Hospital Preparedness & Safety United Regional Health Care System 1600 Eleventh St. Wichita Falls, TX 76301 (940) 764-3631 jbetts@urhcs.org	Co-Coordinators: Teresa Stephenson, RN, BSN Wichita Falls-Wichita County Public Health District 1700 Third St. Wichita Falls, TX 76301-2113 teressa.stephenson@wichitafallstx.gov Shannon Fleming shannon.fleming@wichitafallstx.gov

TEXAS CHILD FATALITY REVIEW TEAMS		
CFRT Name & Service Area	Team Presiding Officer	Team Coordinator
Williamson County CFRT Serving Williamson County Health Service Region 7	Kenny Schnell EMS of Williamson County P.O. Box 873 Georgetown, TX 78627 (521) 943-1264 kschnell@wilco.org	Joe Granberry EMS of Williamson County P.O. Box 873 Georgetown, TX 78627 (521) 943-1264 jgranberry@wilco.org
Wise County CFRT Serving Wise County Health Service Region 2/3	Co-Presiding Officers: Amanda Lovette, MD Lovette Pediatrics 2014 Ben Merritt Dr., Suite B Decatur, TX 76234 (940) 627-8044 alovette@childclin.com Rex Hoskins Chief, Decatur Police Department 1601 South State Street Decatur, Texas 76234 (940) 627-1500 rhoskins@decaturpd.net	Co-Coordinators: Paige Dobyns, Alan Wilson & Jerry DeMoss Wise County Sheriff's Office 200 Rook Ramsey Dr. Decatur, TX 76234 (940) 627-5971 dobynsp@sheriff.co.wise.tx.us wilsona@sherrif.co.wise.tx.us demossj@sheriff.co.wise.tx.us
Wood/Rains Counties CFRT	Judge Alice Tomerlin Wood County Pct. 1, Justice of the Peace P.O. Box 172 Quitman, TX 75783-0172 (903) 763-2713 atomerlin@co.wood.tx.us	Jerry Edwards, Executive Director Northeast Texas Child Advocacy Center/Parents Anonymous® of Northeast Texas P.O. Box 484 Winnsboro, Texas 75494 (903) 629-7588 jedwards@netcac.org

**APPENDIX C:
TEXAS FAMILY CODE**



TEXAS FAMILY CODE
CHAPTER 264
SUBCHAPTER F. CHILD FATALITY REVIEW & INVESTIGATION

§ 264.501. DEFINITIONS. In this subchapter:

(1) "Autopsy" and "inquest" have the meanings assigned by Article 49.01, Code of Criminal Procedure.

(2) "Bureau of vital statistics" means the bureau of vital statistics of the Texas Department of Health.

(3) "Child" means a person younger than 18 years of age.

(4) "Committee" means the child fatality review team committee.

(5) "Department" means the Department of Protective and Regulatory Services.

(6) "Health care provider" means any health care practitioner or facility that provides medical evaluation or treatment, including dental and mental health evaluation or treatment.

(7) "Meeting" means an in-person meeting or a meeting held by telephone or other electronic medium.

(8) "Preventable death" means a death that may have been prevented by reasonable medical, social, legal, psychological, or educational intervention. The term includes the death of a child from:

(A) intentional or unintentional injuries;

(B) medical neglect;

(C) lack of access to medical care;

(D) neglect and reckless conduct, including failure to supervise and failure to seek medical care; and

(E) premature birth associated with any factor described by Paragraphs (A) through (D).

(9) "Review" means a reexamination of information regarding a deceased child from relevant agencies, professionals, and health care providers.

(10) "Review team" means a child fatality review team established under this subchapter.

(11) "Unexpected death" includes a death of a child that, before investigation:

(A) appears to have occurred without anticipation or forewarning; and

(B) was caused by trauma, suspicious or obscure circumstances, sudden infant death syndrome, abuse or neglect, or an unknown cause.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995; Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995. Amended by Acts 2001, 77th Leg., ch. 957, § 2, eff. Sept. 1, 2001.

§ 264.502. COMMITTEE. (a) The child fatality review team committee is composed of:

(1) a person appointed by and representing the state registrar of vital statistics;

(2) a person appointed by and representing the commissioner of the department;

(3) a person appointed by and representing the Title V director of the Department of State Health Services; and

(4) individuals selected under Subsection (b).

(b) The members of the committee who serve under Subsections (a)(1) through (3) shall select the following additional committee members:

(1) a criminal prosecutor involved in prosecuting crimes against children;

(2) a sheriff;

(3) a justice of the peace;

(4) a medical examiner;

(5) a police chief;

(6) a pediatrician experienced in diagnosing and treating child abuse and neglect;

(7) a child educator;

(8) a child mental health provider;

(9) a public health professional;

(10) a child protective services specialist;

(11) a sudden infant death syndrome family service provider;

(12) a neonatologist;

(13) a child advocate;

(14) a chief juvenile probation officer;

(15) a child abuse prevention specialist;

(16) a representative of the Department of Public Safety; and

(17) a representative of the Texas Department of Transportation.

(c) Members of the committee selected under Subsection (b) serve three-year terms with the terms of five or six members, as appropriate, expiring February 1 each year.

(d) Members selected under Subsection (b) must reflect the geographical, cultural, racial, and ethnic diversity of the state.

(e) An appointment to a vacancy on the committee shall be made in the same manner as the original appointment. A member is eligible for reappointment.

(f) Members of the committee shall select a presiding officer from the members of the committee.

(g) The presiding officer of the committee shall call the meetings of the committee, which shall be held at least quarterly.

(h) A member of the committee is not entitled to compensation for serving on the committee but is entitled to reimbursement for the member's travel expenses as provided in the General Appropriations Act. Reimbursement under this subsection for a person serving on the committee under Subsection (a)(2) shall be paid from funds appropriated to the department. Reimbursement for other persons serving on the committee shall be paid from funds appropriated to the Department of State Health Services.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995; Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995. Amended by Acts 2001, 77th Leg., ch. 957, § 3, eff. Sept. 1, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 268, § 1.56, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 396, § 1, eff. September 1, 2007.

§ 264.503. PURPOSE AND DUTIES OF COMMITTEE AND SPECIFIED STATE AGENCIES. (a) The purpose of the committee is to:

- (1) develop an understanding of the causes and incidence of child deaths in this state;
- (2) identify procedures within the agencies represented on the committee to reduce the number of preventable child deaths; and
- (3) promote public awareness and make recommendations to the governor and the legislature for changes in law, policy, and practice to reduce the number of preventable child deaths.

(b) To ensure that the committee achieves its purpose, the department and the Department of State Health Services shall perform the duties specified by this section.

(c) The department shall work cooperatively with:

- (1) the Department of State Health Services;
- (2) the committee; and
- (3) individual child fatality review teams.

(d) The Department of State Health Services shall:

- (1) recognize the creation and participation of review teams;
- (2) promote and coordinate training to assist the review teams in carrying out their duties;
- (3) assist the committee in developing model protocols

for:

(A) the reporting and investigating of child fatalities for law enforcement agencies, child protective services, justices of the peace and medical examiners, and other professionals involved in the investigations of child deaths;

(B) the collection of data regarding child deaths; and

(C) the operation of the review teams;

(4) develop and implement procedures necessary for the operation of the committee; and

(5) promote education of the public regarding the incidence and causes of child deaths, the public role in preventing child deaths, and specific steps the public can undertake to prevent child deaths.

(d-1) The committee shall enlist the support and assistance of civic, philanthropic, and public service organizations in the performance of the duties imposed under Subsection (d).

(e) In addition to the duties under Subsection (d), the Department of State Health Services shall:

(1) collect data under this subchapter and coordinate the collection of data under this subchapter with other data collection activities; and

(2) perform annual statistical studies of the incidence and causes of child fatalities using the data collected under this subchapter.

(f) The committee shall issue a report for each preventable child death. The report must include findings related to the child's death, recommendations on how to prevent similar deaths, and details surrounding the department's involvement with the child prior to the child's death. Not later than April 1 of each year, the committee shall publish a compilation of the reports published under this subsection during the year, submit a copy of the compilation to the governor, lieutenant governor, speaker of the house of representatives, and department, and make the compilation available to the public. Not later than October 1 of each year, the

department shall submit a written response on the compilation from the previous year to the committee, governor, lieutenant governor, and speaker of the house of representatives describing which of the committee's recommendations regarding the operation of the child protective services system the department will implement and the methods of implementation.

(g) The committee shall perform the functions and duties required of a citizen review panel under 42 U.S.C. Section 5106a(c)(4)(A).

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995; Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995. Amended by Acts 2001, 77th Leg., ch. 957, § 4, eff. Sept. 1, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 268, § 1.57, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 396, § 2, eff. September 1, 2007.

§ 264.504. MEETINGS OF COMMITTEE. (a) Except as provided by Subsections (b), (c), and (d), meetings of the committee are subject to the open meetings law, Chapter 551, Government Code, as if the committee were a governmental body under that chapter.

(b) Any portion of a meeting of the committee during which the committee discusses an individual child's death is closed to the public and is not subject to the open meetings law, Chapter 551, Government Code.

(c) Information identifying a deceased child, a member of the child's family, a guardian or caretaker of the child, or an alleged or suspected perpetrator of abuse or neglect of the child may not be disclosed during a public meeting. On a majority vote of the committee members, the members shall remove from the committee any member who discloses information described by this subsection in a public meeting.

(d) Information regarding the involvement of a state or local agency with the deceased child or another person described by Subsection (c) may not be disclosed during a public meeting.

(e) The committee may conduct an open or closed meeting by telephone conference call or other electronic medium. A meeting held under this subsection is subject to the notice requirements applicable to other meetings. The notice of the meeting must specify as the location of the meeting the location where meetings of the committee are usually held. Each part of the meeting by telephone conference call that is required to be open to the public shall be audible to the public at the location specified in the notice of the meeting as the location of the meeting and shall be tape-recorded. The tape recording shall be made available to the public.

(f) This section does not prohibit the committee from requesting the attendance at a closed meeting of a person who is not a member of the committee and who has information regarding a deceased child.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995; Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995.

Amended by:

Acts 2005, 79th Leg., Ch. 268, § 1.58, eff. September 1, 2005.

§ 264.505. ESTABLISHMENT OF REVIEW TEAM. (a) A multidisciplinary and multiagency child fatality review team may be established for a county to review child deaths in that county. A review team for a county with a population of less than 50,000 may join with an adjacent county or counties to establish a combined review team.

(b) Any person who may be a member of a review team under Subsection (c) may initiate the establishment of a review team and call the first organizational meeting of the team.

(c) A review team may include:

- (1) a criminal prosecutor involved in prosecuting crimes against children;
- (2) a sheriff;
- (3) a justice of the peace or medical examiner;
- (4) a police chief;
- (5) a pediatrician experienced in diagnosing and treating child abuse and neglect;
- (6) a child educator;
- (7) a child mental health provider;
- (8) a public health professional;
- (9) a child protective services specialist;
- (10) a sudden infant death syndrome family service provider;
- (11) a neonatologist;
- (12) a child advocate;
- (13) a chief juvenile probation officer; and
- (14) a child abuse prevention specialist.

(d) Members of a review team may select additional team members according to community resources and needs.

(e) A review team shall select a presiding officer from its members.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995; Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995.

Amended by:

Acts 2005, 79th Leg., Ch. 268, § 1.59, eff. September 1, 2005.

§ 264.506. PURPOSE AND DUTIES OF REVIEW TEAM. (a) The purpose of a review team is to decrease the incidence of preventable child deaths by:

- (1) providing assistance, direction, and coordination to investigations of child deaths;
- (2) promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities;
- (3) developing an understanding of the causes and incidence of child deaths in the county or counties in which the review team is located;
- (4) recommending changes to agencies, through the agency's representative member, that will reduce the number of preventable child deaths; and

(5) advising the committee on changes to law, policy, or practice that will assist the team and the agencies represented on the team in fulfilling their duties.

(b) To achieve its purpose, a review team shall:

(1) adapt and implement, according to local needs and resources, the model protocols developed by the department and the committee;

(2) meet on a regular basis to review child fatality cases and recommend methods to improve coordination of services and investigations between agencies that are represented on the team;

(3) collect and maintain data as required by the committee; and

(4) submit to the bureau of vital statistics data reports on deaths reviewed as specified by the committee.

(c) A review team shall initiate prevention measures as indicated by the review team's findings.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995;
Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995.

§ 264.507. DUTIES OF PRESIDING OFFICER. The presiding officer of a review team shall:

(1) send notices to the review team members of a meeting to review a child fatality;

(2) provide a list to the review team members of each child fatality to be reviewed at the meeting;

(3) submit data reports to the bureau of vital statistics not later than the 30th day after the date on which the review took place; and

(4) ensure that the review team operates according to the protocols developed by the department and the committee, as adapted by the review team.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995;
Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995.

§ 264.508. REVIEW PROCEDURE. (a) The review team of the county in which the injury, illness, or event that was the cause of the death of the child occurred, as stated on the child's death certificate, shall review the death.

(b) On receipt of the list of child fatalities under Section 264.507, each review team member shall review the member's records and the records of the member's agency for information regarding each listed child.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995;
Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995.

§ 264.509. ACCESS TO INFORMATION. (a) A review team may request information and records regarding a deceased child as necessary to carry out the review team's purpose and duties. Records and information that may be requested under this section include:

(1) medical, dental, and mental health care information; and

(2) information and records maintained by any state or

local government agency, including:

- (A) a birth certificate;
- (B) law enforcement investigative data;
- (C) medical examiner investigative data;
- (D) juvenile court records;
- (E) parole and probation information and

records; and

(F) child protective services information and records.

(b) On request of the presiding officer of a review team, the custodian of the relevant information and records relating to a deceased child shall provide those records to the review team at no cost to the review team.

(c) This subsection does not authorize the release of the original or copies of the mental health or medical records of any member of the child's family or the guardian or caretaker of the child or an alleged or suspected perpetrator of abuse or neglect of the child which are in the possession of any state or local government agency as provided in Subsection (a)(2). Information relating to the mental health or medical condition of a member of of the child's family or the guardian or caretaker of the child or the alleged or suspected perpetrator of abuse or neglect of the child acquired as part of an investigation by a state or local government agency as provided in Subsection (a)(2) may be provided to the review team.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995;
Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995.

Amended by:

Acts 2005, 79th Leg., Ch. 268, § 1.60, eff. September 1, 2005.

§ 264.510. MEETING OF REVIEW TEAM. (a) A meeting of a review team is closed to the public and not subject to the open meetings law, Chapter 551, Government Code.

(b) This section does not prohibit a review team from requesting the attendance at a closed meeting of a person who is not a member of the review team and who has information regarding a deceased child.

(c) Except as necessary to carry out a review team's purpose and duties, members of a review team and persons attending a review team meeting may not disclose what occurred at the meeting.

(d) A member of a review team participating in the review of a child death is immune from civil or criminal liability arising from information presented in or opinions formed as a result of a meeting.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995;
Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995.

§ 264.511. USE OF INFORMATION AND RECORDS;
CONFIDENTIALITY. (a) Information and records acquired by the committee or by a review team in the exercise of its purpose and duties under this subchapter are confidential and exempt from disclosure under the open records law, Chapter 552, Government Code, and may only be disclosed as necessary to carry out the

committee's or review team's purpose and duties.

(b) A report of the committee or of a review team or a statistical compilation of data reports is a public record subject to the open records law, Chapter 552, Government Code, as if the committee or review team were a governmental body under that chapter, if the report or statistical compilation does not contain any information that would permit the identification of an individual.

(c) A member of a review team may not disclose any information that is confidential under this section.

(d) Information, documents, and records of the committee or of a review team that are confidential under this section are not subject to subpoena or discovery and may not be introduced into evidence in any civil or criminal proceeding, except that information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence solely because they were presented during proceedings of the committee or a review team or are maintained by the committee or a review team.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995;
Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995.

§ 264.512. GOVERNMENTAL UNITS. The committee and a review team are governmental units for purposes of Chapter 101, Civil Practice and Remedies Code. A review team is a unit of local government under that chapter.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995;
Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995.

§ 264.513. REPORT OF DEATH OF CHILD. (a) A person who knows of the death of a child younger than six years of age shall immediately report the death to the medical examiner of the county in which the death occurs or, if the death occurs in a county that does not have a medical examiner's office or that is not part of a medical examiner's district, to a justice of the peace in that county.

(b) The requirement of this section is in addition to any other reporting requirement imposed by law, including any requirement that a person report child abuse or neglect under this code.

(c) A person is not required to report a death under this section that is the result of a motor vehicle accident. This subsection does not affect a duty imposed by another law to report a death that is the result of a motor vehicle accident.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995;
Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995.

§ 264.514. PROCEDURE IN THE EVENT OF REPORTABLE DEATH. (a) A medical examiner or justice of the peace notified of a death of a child under Section 264.513 shall hold an inquest under Chapter 49, Code of Criminal Procedure, to determine whether the death is unexpected or the result of abuse or neglect. An inquest is not required under this subchapter if the child's death is expected and

is due to a congenital or neoplastic disease. A death caused by an infectious disease may be considered an expected death if:

(1) the disease was not acquired as a result of trauma or poisoning;

(2) the infectious organism is identified using standard medical procedures; and

(3) the death is not reportable to the Texas Department of Health under Chapter 81, Health and Safety Code.

(b) The medical examiner or justice of the peace shall immediately notify an appropriate local law enforcement agency if the medical examiner or justice of the peace determines that the death is unexpected or the result of abuse or neglect, and that agency shall investigate the child's death.

(c) In this section, the terms "abuse" and "neglect" have the meaning assigned those terms by Section 261.001.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995; Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995. Amended by Acts 1997, 75th Leg., ch. 1022, § 95, eff. Sept. 1, 1997; Acts 1997, 75th Leg., ch. 1301, § 2, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 785, § 3, eff. Sept. 1, 1999.

§ 264.515. INVESTIGATION. (a) The investigation required by Section 264.514 must include:

(1) an autopsy, unless an autopsy was conducted as part of the inquest;

(2) an inquiry into the circumstances of the death, including an investigation of the scene of the death and interviews with the parents of the child, any guardian or caretaker of the child, and the person who reported the child's death; and

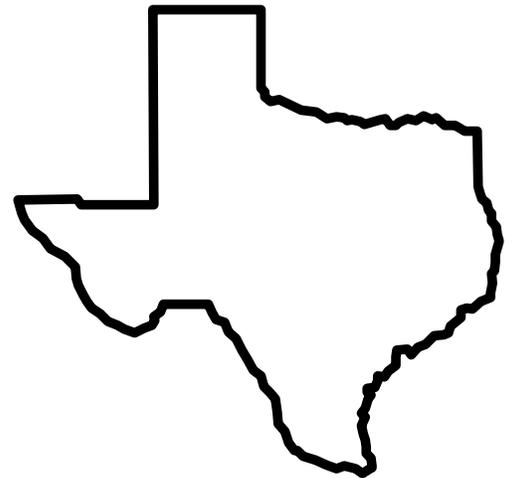
(3) a review of relevant information regarding the child from an agency, professional, or health care provider.

(b) The review required by Subsection (a)(3) must include a review of any applicable medical record, child protective services record, record maintained by an emergency medical services provider, and law enforcement report.

(c) The committee shall develop a protocol relating to investigation of an unexpected death of a child under this section. In developing the protocol, the committee shall consult with individuals and organizations that have knowledge and experience in the issues of child abuse and child deaths.

Added by Acts 1995, 74th Leg., ch. 255, § 2, eff. Sept. 1, 1995; Acts 1995, 74th Leg., ch. 878, § 1, eff. Sept. 1, 1995.

APPENDIX D
HOW TO START A CHILD FATALITY
REVIEW TEAM IN YOUR COMMUNITY



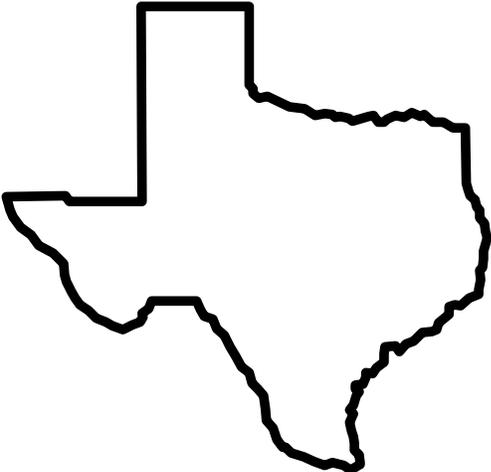
HOW TO START A CFRT IN YOUR COMMUNITY

1. Anyone with a potential role as a member of a Child Fatality Review Team as defined by the legislation may convene a community meeting to discuss the child death review process, CFRT responsibilities and how the community can benefit from reviewing child deaths. The Texas Family Code states that a CFRT may include the following members (or their designees):
 - a. criminal prosecutor involved in the prosecution of crimes against children;
 - b. sheriff;
 - c. justice of the peace or medical examiner;
 - d. police chief;
 - e. pediatrician experienced in diagnosing and treating child abuse and neglect;
 - f. child educator;
 - g. child mental health provider;
 - h. public health professional;
 - i. child protective services specialist;
 - j. Sudden Infant Death Syndrome (SIDS) family services provider;
 - k. neonatologist;
 - l. child advocate;
 - m. chief juvenile probation officer;
 - n. child abuse prevention specialist;
 - o. a representative of the Department of Public Safety; and
 - p. a representative of the Department of Motor Vehicles.

Other important disciplines to include would be EMS, a family violence service provider, and a Traffic Safety Specialist from the Department of Transportation.

2. If you want to convene an information meeting about CFRT in your community, contact the Texas CFR Coordinator to schedule a date to come to your community to make a presentation, answer questions and facilitate discussion about the benefits of child death review and the steps for forming a multidisciplinary team in that community. The Coordinator provides materials to share with participants at the meeting.
3. Invite representatives of all of the CFRT member disciplines to the convened meeting.
4. Host the convened meeting with the Texas CFR Coordinator. After receiving information and discussing how a team would benefit the safety of community children, the attendees and their respective agencies must commit to forming a team. The commitment to formation of a CFRT is formalized by:
 - a. a member agency volunteers to serve as Coordinator (who receives the death records from Texas Vital Statistics, schedules the meetings, informs the team members of which deaths they will be reviewing, and initiates requests for records);
 - b. a member volunteers to collect and submit the data on the online national child death review database (on many teams this is the Coordinator, but it can be another team member);
 - c. election of a Presiding Officer (who facilitates the CFRT meetings and serves as the voice of that team in the community);
 - d. all members and their respective agencies sign an Interagency Agreement to share information about the child death in the team meetings; and
 - e. all members and their agencies agree to honor confidentiality and sign a Confidentiality Statement.
5. Once steps 4a – 4e are completed, the Texas CFR Coordinator is notified and the team is formally recognized by DSHS. DSHS will begin supplying death certificates to the team for review.
6. The new team begins reviewing child deaths using the Case Report Tool. Teams must meet at least once a year. Depending upon the number of child deaths, teams typically meet quarterly, every other month or monthly.
7. The team Coordinator and/or other team member are set up to have access to the National Child Death Review Database so the data collected in the reviews can be entered in the secure online system.

**APPENDIX E:
SCFRT POSITION STATEMENTS ON
CHILD SAFETY**





TEXAS STATE CHILD FATALITY REVIEW TEAM COMMITTEE

POSITION STATEMENT: SAFE SLEEP FOR INFANTS

The State Child Fatality Review Team Committee (SCFRT) works closely with local Child Fatality Review Teams (CFRT) to promote public awareness to reduce the number of preventable child deaths. One of the SCFRT recommendations to Child Protective Services in the 2007 Texas Child Fatality Review Team Annual Report focused on increased understanding of infant deaths in sleep environments. The SCFRT initiated a workgroup of active members to develop a position statement on infant and child safe sleep environments.

The SCFRT, as well as other state and national organizations, supports promoting safe sleep practices and safe sleep environments to reduce the number of preventable infant and child deaths from Sudden Infant Death Syndrome (SIDS) and those deaths classified as Sudden Unexplained Infant Death (SUID).

The SCFRT makes the following recommendations on sleep environments and practices as well as general health practices to help reduce the number of preventable infant and child deaths. These recommendations are made to reinforce researched best practices for safe sleep of infants. This position paper is intended as a support document for those working to reduce infant deaths and not as a general handout.

Recommended Healthy Practices for Parents

It is recommended that:

- Pregnant women take care of themselves during pregnancy and receive early pre-natal care from a licensed doctor.
- Parents quit smoking during pregnancy and remain smoke-free after the birth of the child.
- Children receive regular well-child check-ups by a licensed doctor.
- Parents look for safety information on cribs, bassinets and other related items found in sleep environments, such as toys, bedding and blankets.
- Mothers breastfeed their infants up to one year of age if possible.

Recommended Sleep Position

It is recommended that:

- Babies are placed on their backs to sleep for naps or at night.
- Babies are given time on the tummy while awake and supervised by a responsible older teen or adult.
- Parents tell relatives, friends and babysitters that the baby will be placed on his/her back to sleep.

Recommended Sleep Environment

It is recommended that:

- Babies are placed to sleep in safety-approved crib or bassinet with a firm mattress, using a well-fitting sheet made for the crib or bassinet.
- Parents maintain the home and especially the baby's sleep area free of cigarette smoke.
- Babies are never placed to sleep on soft mattresses or cushions, such as on beds, sofas, chairs or waterbeds.
- Babies' sleep environment is free of toys or other soft bedding items, such as blankets or comforters, stuffed animals and bumper pads.
- Babies' sleep environment is free of unsafe items, such as plastic sheets, plastic bags, strings, cords or ropes.

Along with the above recommendations, parents often ask where in the home their baby should sleep. The SCFRT, as well as other state and national organizations, makes the following recommendation: The safest place for a baby to sleep is in the same room with a parent or caregiver but on a separate sleep surface, such as a safety-approved crib or bassinet. This allows parents to check on and bond with the baby and makes breastfeeding more convenient.

Parents, through their own choice, may decide to bed-share (sleep in the same bed) with their baby. If a parent chooses to bed-share, the SCFRT recommends the following in addition to the above recommendations on health practices, sleep position and sleep environment.

Some situations are never safe for parents to sleep with babies.

It is recommended that an adult never sleep with a baby if the adult is:

- a smoker
- on soft bedding, such as bean bag chairs, sofas, chairs or waterbeds
- under the influence of alcohol
- using drugs or taking medications that cause sleepiness
- sick
- unusually tired
- very upset or angry

If parents choose to sleep with babies in an adult bed, it is recommended that they make sure the mattress is firm and covered with a fitted sheet; that the mattress fits tightly against a headboard and is away from walls where a baby cannot be wedged; and that the baby cannot fall off the bed. If parents do not have a safe, adequate area for a baby to sleep, they should look for resources in their community that can help provide such items.

Sources:

American Academy of Pediatrics:

A Child Care Provider's Guide to Safe Sleep, www.healthychildcare.org/pdf/SIDSchildcaresafesleep.pdf;

A Parent's Guide to Safe Sleep, www.healthychildcare.org/pdf/SIDSparentsafesleep.pdf

Center for Disease Control: Sudden Infant Death Syndrome (SIDS), www.cdc.gov/SIDS/index.htm

First Candle: Important Safe Sleep Tips,

www.firstcandle.org/new_exp_parents/new_exp_safesleeptips.html

Indiana Perinatal Network & Baby First: www.nd.edu/~jmckenna1/lab/pamphlets/safesleepv2.pdf.

National Institute of Child Health and Human Development (NICHD) Pub. No. 06-5759, January 2006.

UNICEF UK's Baby Friendly Initiative, with support of the Foundation for the Study of Infant Deaths (FSIC): www.unicef.org.uk/press/news_detail.asp?news_id=178.

U.S. Consumer Product Safety Commission: Crib Safety Tips (in English and in Spanish) www.cpsc.gov/CPSCPUB/PUBS/5030.pdf, www.cpsc.gov/CPSCPUB/PREREL/prhtml01/01131s.pdf

The SCFRT Position Paper on Safe Sleep is a product of the SCFRT Workgroup on Safe Sleep (Brian Castrucci, Gwen Gray, John Hellsten, Dr. Eric Levy, Laurie Lindsey, Donna Norris, Dr. Juan Parra and Dr. Elizabeth Peacock). The Position Paper on Safe Sleep will be reviewed annually and updated as new validated information indicates.

June 2008, reviewed and renewed August 2009



TEXAS STATE CHILD FATALITY REVIEW TEAM COMMITTEE POSITION STATEMENT: MOTOR VEHICLE SAFETY FOR INFANTS AND CHILDREN

The State Child Fatality Review Team Committee (SCFRT) works closely with local Child Fatality Review Teams (CFRT) to promote public awareness to reduce the number of preventable child deaths. Motor vehicle crashes are the leading cause of death to children ages two to fourteen and the leading cause of injury-related death for children under age two. Seat belts and child safety seats are essential in preventing many deaths and injuries. The statistics are staggering:

- In 2005, more than 1,400 child occupants in the United States (ages birth to 14) died in motor vehicle crashes and nearly half were unrestrained. In the same year, 203,000 child occupants were injured.
- According to the Texas EMS and Trauma Registry, car crashes in Texas during 2003-2004 involving children four to seven years old resulted in 900 hospitalizations, 30 deaths, and left 128 children with chronic disabilities. These crashes resulted in more than \$16.7 million in hospital charges, with 35 percent of the hospitalizations charged to Medicaid and the Children's Health Insurance Program, with an additional 20 percent to uninsured families.
- Observational research in the United States shows that when the driver is properly restrained, the children are buckled up 87 percent of the time. In contrast, when the driver is not restrained, the corresponding restraint use for children drops to 24 percent of the time.
- Research has demonstrated that children between four and eight years of age and 36 to 57 inches tall represent an age group that is at great risk of death or severe injury cause by head, spinal cord and internal organ injuries if they are unrestrained or improperly restrained in motor vehicles.

RECOMMENDATIONS TO THE STATE OF TEXAS, THE TEXAS LEGISLATURE, PARENTS, AND HEALTHCARE PROVIDERS:

STRENGTHEN CHILD PASSENGER SAFETY PROTECTION LAWS TO REQUIRE AGE-APPROPRIATE RESTRAINTS FOR ALL TEXAS CHILDREN

The State Child Fatality Review Team Committee joins other leaders in injury prevention such as the Texas Department of Public Safety (DPS), the National Highway Traffic Safety Administration (NHTSA), the American Academy of Pediatrics (AAP) and Safe Kids Worldwide in recommending that children use booster seats until they can fit safely into an adult lap and shoulder seat belt system. It is recommended for children to use an age-appropriate child passenger safety system until the child reaches a height of four feet and nine inches. In addition to saving young lives, the practice of using booster seats would significantly reduce Texas health care expenditures. Child passenger safety seats reduce fatal injury in passenger cars by 71 percent for infants less than one year of age and by 54 percent for toddlers one to four years of age. Young children restrained in child passenger safety seats have an 80 percent reduced risk of fatal injury than those who are unrestrained. In the United States, it is estimated that a \$46 child passenger safety seat generates on average \$1,900 in benefits to society and a \$31 booster seat generates \$2,200 in benefits to society. Using these estimated figures and population for newborn to eight year old Texas children, the benefits would exceed \$4 billion.

ADOPTION OF AN EDUCATION CAMPAIGN FOR TEXAS DRIVERS TO ENSURE CHILD SAFETY IN AND AROUND VEHICLES

In the United States, from 2001-2003, approximately 2,500 children ages one to fourteen years annually reported to emergency rooms with injuries after being struck by a motor vehicle. Of these children, an average of 229 per year died after being struck by a motor vehicle in a driveway or parking area. Of these children, nearly half were young children one to four years of age. Texas Child Fatality Review

Teams have reviewed many tragic deaths where poor visibility prevented a parent, relative or friend from seeing a young child behind or in front of a vehicle. Recent passage of the federal Cameron Gulbransen Kids Transportation Safety Act of 2007 will require the Department of Transportation to issue regulations related to power window safety, rearward visibility and rollaway prevention intended to reduce the injury and death of children occurring inside and near motor vehicles. Texas should implement an education program to inform drivers about the serious risk to small children behind and in front of motor vehicles. It is recommended that the Texas Department of Transportation (TxDOT) review best practices, public education and awareness campaigns. It is also recommended that TxDOT, DPS, Texas Safe Kids coalitions and other prevention organizations work in collaboration to implement educational campaigns and track the effectiveness of the educational campaigns.

SEAT SELECTION SAFETY BELT USE BASED ON THE NHTSA 4 STEPS FOR KIDS GUIDELINES FOR BEST OPTIMAL CHILD RESTRAINT PRACTICES

1. **Rear-Facing Seats** in the back seat from birth to two years of age as the safety seat allows.
2. **Forward-Facing Toddler Seats** in the back seat from age one to four years of age and from 20 pounds to approximately 40 pounds in weight.
3. **Booster Seats** in the back seat from approximately four to eight years of age or four feet nine inches in height.
4. **Safety Belts** use starting no earlier than eight years of age or when taller than four feet nine inches in height. All children ages under 12 years of age should ride in the back seat.

HEALTHCARE PROVIDERS PLAY A PROMINENT ROLE IN CONVEYING TO PARENTS AND CAREGIVERS THE PRINCIPLES OF CHILD PASSENGER SAFETY

- Air bags can be dangerous to children. Caregivers should read the vehicle owner's manual regarding safety restraints and airbags.
- Premature and small infants should not be placed in car safety seats with shields, abdominal pads, or armrests that could directly impact an infant's face or neck during a motor-vehicle crash.
- Adjustments must be made when convertible seats are changed from rear- to forward-facing. Caregivers should consult the child restraint instructions.
- Safety seats must be secured in the vehicle, and the child must be secured in the seat.
- Children with special health care needs should have access to appropriate restraint systems. Specific information is available in the AAP policy statement "Transporting Children with Special Health Care Needs" and "Safe Transportation of Children with Special Needs: A Guide for Families."
- Motor-vehicle safety belts should not be used until:
 1. The shoulder belt can be positioned across the chest
 2. The lap belt fits low and snug across the thighs
 3. The child fits against the vehicle's seat back with legs hanging down while bent at the knees (This typically occurs at eight of age or when the child reaches four feet and nine inches tall in height).

WIDESPREAD PROMOTION OF CORRECT PLACEMENT AND INSTALLATION OF A CHILD SAFETY SEATS AND CHILDREN IN MOTOR VEHICLES

- To correctly install and use a child restraint system, a caregiver should consult two sources: the child restraint instructions and the vehicle owner's manual.
- A rear-facing car safety seat must not be placed in the front passenger seat of any vehicle equipped with an air bag on the front passenger side. Death or serious injury to an infant can occur from the impact of the air bag against the back of the car safety seat.
- The rear vehicle seat is the safest place for children of any age to ride.
- Any front-seat or front-facing passengers should ride properly restrained and positioned as far back as possible from the front air bag on the passenger side.
- The child restraint system should be installed snugly in the vehicle and the parent or caregiver should test it periodically to ensure it remains snug (except for a booster seat).
- Lower Anchors and Tethers for Children or LATCH is a new standardized car safety seat attachment system that is designed to simplify child restraint installation and thereby enhancing safety. Nearly every child restraint and most vehicles manufactured since September 2002 are required to have the LATCH system.

- A child must never be left unattended in a car safety seat in or out of the car. Ensure that every occupant is properly restrained for every motor vehicle trip.
- Go to the website www.recalls.gov to inquire about recalls or safety notices on child safety seats. Do not purchase safety seats from yard sales, flea markets and second-hand stores or when there is no known history for the seat.
- To be sure the car safety seat is correctly installed; go to a certified inspection station. At inspection stations, certified specialists will work with caregivers to ensure their child restraints are safe and being used correctly. In most cases, the service is provided free-of-charge. To locate certified child seat inspection stations, go to the website www.seatcheck.org or call toll-free 1-866-SEAT-CHECK.

PUBLIC EDUCATION CAMPAIGN ON THE INCREASED RISKS TO CHILDREN RIDING IN THE BED OF PICKUP TRUCKS

- **Children are never to ride in the bed of a pickup truck.** The most effective way to reduce the number of deaths and injuries to children in pickup trucks is to prohibit travel in the cargo area. Compared with restrained occupants in the cab of pickup trucks, the risk of death for those in the cargo area is eight times higher.

PARENTS SHOULD TAKE AN ACTIVE ROLE IN PREPARING AND MONITORING TEEN DRIVERS

- **Do not rely solely on driver education.** Driver education may be the most convenient way to learn driving skills, but it does not produce safer drivers. Poor driving skills are not always to blame: teens' attitudes and decision-making matter more. Teenagers tend not to use safety belts regularly and they deliberately seek thrills like speeding. Training and education do not change these tendencies. Peers are influential, but parents have much more influence on their teenagers.
- **Know the law.** Become familiar with restrictions on young drivers. Enforce the rules. To learn about the law in Texas, go to the website www.txdps.state.tx.us/administration/driver_licensing_control/graduateddriver.htm or www.iihs.org/laws/state_laws/grad_license.html.
- **Restrict night driving.** Most fatal crashes involving young drivers occur from 9:00 p.m. to midnight, so teens should not drive much later than 9:00 p.m. Late outings tend to be recreational, and even teenagers who usually follow the rules can be easily distracted or encouraged to take risks.
- **Restrict passengers.** Teenage passengers in a vehicle can distract a young driver and lead to greater risk-taking behavior. Nearly 60 percent of adolescent passenger deaths occur in crashes where the vehicle was driven by a teenager. While driving at night with passengers poses a risk of injury and death for teenagers, many fatal crashes with teenage passengers occur during the day as well. The best policy is to restrict teenager passengers at all times.
- **Supervised driving.** Take an active role in helping your teenager learn how to drive. Plan a series of practice sessions in a wide variety of situations, including night driving. Give beginners time to work up to challenges like driving in heavy traffic or on the freeway. Supervised driving should be done over a six-month period and continue after a teenager obtains a learner's permit, has a restricted license, and after obtaining a full license.
- **Be a role model.** New drivers learn a lot by example, so practice safe driving. Teenagers who are involved in car crashes and have traffic violations often have parents with poor driving records.
- **Require safety belt use.** Even after proper supervision, do not assume that safety belt use will be practiced when parents are not supervising teenage drivers. Safety belt use is lower among teenagers than older adults. Insist on safety belts being used all of the time.
- **Prohibit driving after drinking alcohol.** Make it clear that it is illegal and highly dangerous to drive after drinking alcohol or using any other drug. While alcohol is not a major factor in most fatal crashes of 16 year old drivers, even small amounts of alcohol can impair teenagers.
- **Choose vehicles for safety, not image.** Teenagers should drive vehicles that reduce the chance of a motor vehicle crash and offer protection in case they are involved in a motor vehicle crash. For example, small cars do not offer the best protection in a motor vehicle crash. Avoid cars with performance images that might encourage speeding. Avoid trucks and sport utility vehicles. Smaller sport utility vehicles are more prone to roll over.

WIDESPREAD PUBLIC EDUCATION CAMPAIGNS ON ALL-TERRAIN VEHICLES (ATV) AND THE RISKS THEY POSE TO CHILDREN

- **An ATV is not a toy.** Children under 16 years of age should not operate an ATV that has an engine size of 90cc or greater. Children under 12 years of age should not operate any ATV. Younger children do not have adequate physical size and strength to control an ATV.
- **Read instruction manuals.** In order to safely operate an ATV, instruction manuals and manufacturers' recommendations for safe use should be strictly followed.
- **Operators need training.** Anyone operating an ATV should attend a hands-on training course before operating the vehicle for maximum safety.
- **Only one rider per ATV.** Only one rider should use an ATV at a time.
- **Limit use to daytime hours.** Riding at night reduces the rider's ability to see potential hazards on the road or trail. It is also much more difficult for other riders to see each other, increasing the chance for collisions.
- **Always wear protective gear.** Helmet use is imperative in reducing the risk of head injuries. Be sure to purchase the right type of helmet that fits properly without interfering with visibility or hearing. Use of protective gloves, goggles and heavy boots can also help reduce the risk for injury.

The SCFRT Position Statement on Motor Vehicle Safety for Infants and Children is a product of the SCFRT Workgroup on Motor Vehicle Safety (Dr. Eric Levy, Dr. Juan Parra, Dr. Kim Cheung, Terry Pence and Capt. Steven Tellez). The Position Paper on Motor Vehicle Safety for Infants and Children will be reviewed annually and updated as new validated information indicates.

November 2008, reviewed and revised October 2009

References:

- Children in Pickup Trucks, American Academy of Pediatrics Committee on Injury and Poison Prevention, *PEDIATRICS* Vol. 106 No. 4, October 2000.
- Cody BE, Mickalide AD, Paul HP, Colella JM. Child passengers at risk in America: A national study of restraint use. Washington (DC): National SAFE KIDS Campaign, 2002 February.
- CPS Issue Report, Partners for Child Passenger Safety, State Farm Insurance Companies, and CHOP in Collaboration with the American Academy of Pediatrics, May 2005.
- The Danger of Premature Graduation to Safety Belts for Young Children, *PEDIATRICS*, June 2000.
- Decina LE and Lococo KH, "Child Restraint System Use and Misuse in Six States," *Accident Analysis and Prevention* 37 (2005): 583 - 590.
- Durbin DR, Elliott MR, Winston FK. Belt-positioning booster seats and reduction in risk of injury among children in vehicle crashes. *JAMA* 2003; 289 (14):2835 - 40.
- Effect of Seating Position and Restraint Use on Injuries to Children in Motor Vehicle Crashes, *PEDIATRICS* Vol. 105 No. 4, April 2000.
- Insurance Institute for Highway Safety - Beginning drivers - www.iihs.org
- Insurance Institute for Highway Safety, *Status Report* 32, no. 9 (Nov. 29, 1997).
- National Center for Health Statistics. Centers for Disease Control and Prevention. National Vital Statistics System. 2000 to 2004 mortality data. Hyattsville (MD): National Center for Health Statistics, 2007.
- National Center for Injury Prevention, WISQARS (2004), <http://www.cdc.gov/ncipc/wisqars>
- National Highway Traffic Safety Administration, *Contrasting Rural and Urban Fatal Crashes 1994 – 2003* (December 2005): 59. <http://www-nrd.nhtsa.dot.gov/pdf/nrd-30/NCSA/Rpts/2005/809896.pdf>
- National Highway Traffic Safety Administration National Center for Statistics & Analysis, Research Note DOT HS 810 742, March 2007.
- National Highway Traffic Safety Administration. National Center for Statistics & Analysis. Traffic safety facts 2004: children. Washington (DC): United States Department of Transportation, 2005.
- National Highway Traffic Safety Administration National Center for Statistics & Analysis, *Traffic Safety Facts 2005: Children* (2005).
- Pacific Institute for Research and Evaluation, *Injury Prevention: What Works? A Summary of Cost-Outcome Analysis for Injury Prevention Programs* (November 28, 2005).
- Partners for Child Passenger Safety Fact and Trend Report* (October 2006).
- Alfredo Quinones-Hinojosa, MD, Peter Jun, MD, Geoffrey T. Manley, MD, PhD, Margaret M. Knudson, MD, and Nalin Gupta, MD, PhD. Airbag Deployment and Improperly Restrained Children: A Lethal Combination. *The Journal of TRAUMA Injury, Infection, and Critical Care*. 2005; 59:729 - 733.
- Safe Kids Worldwide (SKW). Motor Vehicle Fact Sheet. Washington (DC): SKW, 2007.
- Selecting and Using the Most Appropriate Car Safety Seats for Growing Children: Guidelines for Counseling Parents. *PEDIATRICS* Vol. 109 No. 3, March 2002.
- State Farm Insurance Companies, Children's Hospital of Philadelphia, and the American Academy of Pediatrics, *CPS Issue Report: Partners for Child Passenger Safety* (May 2005).
- Strengthening Child Passenger Safety Laws, NHTSA, 2007. <http://www.nhtsa.dot.gov/people/injury/TSFLaws/PDFs/810728W.pdf>
- Texas Child Fatality Review Team Annual Report, 2007. <http://www.dshs.state.tx.us/mch/pdf/Texas%20Child%20Fatality%20Review%20Team%20Annual%20Report%202007.pdf>
- Update for the Pediatrician on Child Passenger Safety: Five Principles for Safer Travel. *PEDIATRICS* Vol. 106 No. 5, November 2000.



TEXAS STATE CHILD FATALITY REVIEW TEAM COMMITTEE POSITION STATEMENT: WATER SAFETY FOR CHILDREN

The State Child Fatality Review Team Committee (SCFRT) works closely with local Child Fatality Review Teams (CFRT) to promote public awareness to reduce the number of preventable child deaths.

Drowning is the second leading cause of unintentional injury-related death among Texas children. Each year, up to 100 children die from drowning in Texas and an estimated four times that number receive emergency department care for nonfatal submersion injuries. Children ages one to four years have the highest drowning mortality rates and account for 45% of all child drowning deaths. While child drowning mortality decreased by almost half during the 1990s, rates for most age groups have remained relatively unchanged since 2000.

The dangers of drowning reflect the culture and setting in which the event occurs. Young children are at high risk for drowning when they live and play around water. Infants are most at risk of drowning when left unsupervised for even seconds in the bathtub. The greatest risk of drowning for toddlers and young children are residential pools, hot tubs, or water storage areas such as wells, cisterns and stock tanks. Young teens most often drown during water recreation such as swimming and boating.

Observational data shows that children can drown in unusual conditions.

- In as little as one inch of water.
- Very quickly and silently.
- Lose consciousness in two minutes after submersion, with irreversible brain damage occurring within four to six minutes.

RECOMMENDATIONS TO THE STATE OF TEXAS, THE TEXAS LEGISLATURE, PARENTS, AND HEALTHCARE PROVIDERS:

The State Child Fatality Review Team Committee joins the National Drowning Prevention Alliance in recognizing that multiple prevention strategies and devices should be used constantly and simultaneously to reduce childhood drowning. Multiple layers of protection need to be used to reduce child drowning deaths. Along with other leaders in injury prevention such as the Texas Parks and Wildlife Department, the U.S. Coast Guard (USCG), the Army Corps of Engineers (USACE), the American Red Cross, the Y.M.C.A., the American Academy of Pediatrics (AAP), the Centers for Disease Control and Prevention, Center for Unintentional Injuries and Safe Kids Worldwide, the State Child Fatality Review Team Committee makes the following recommendations.

ENVIRONMENT

Statement: Drowning occurs in a variety of environments.

- **POOLS, HOT TUBS AND SPAS**

Home swimming pools are the most common site for drowning to occur for a child between ages one to four years. Most of the victims were being supervised by one or both parents when the drowning occurred. Toddlers are inquisitive and are attracted to water. They move quickly and

unpredictably, making swimming pools particularly hazardous for households with young children. Properly installed four-sided isolation fencing that prevents access to pools would reduce 50 to 90 percent of childhood drowning. However, there is no substitute for “eyes and hands-on” supervision.

Recommendations:

Enticements:

- Remove toys from in and around the pool when not in use.

Barriers:

- Properly install and maintain an isolation fence at least four feet high that surrounds all sides of the pool along with a self-closing and self-latching gate.
- Use a gate latch that can be locked with a key and remember to lock the gate when the pool is not in use.
- Place alarms on door and windows with access to pool area.
- Keep a shepherd’s hook, life ring, and telephone by the pool for emergencies.

Entrapment Protection:

- Properly install and maintain anti-entrapment drain covers.
 - Equip pool and spa pumps with safety vacuum release system (SVRS), an emergency sensor that shuts off the switch automatically if the drain is blocked.
 - Replace drain covers immediately if they are broken or damaged.
- **OPEN BODIES OF WATER:** Natural and man-made, which includes lakes, rivers, ponds, and bayous.

There is no substitute for “eyes on” close supervision of children near any open bodies of water. For boating related injuries and deaths, 90 percent of drowning victims were not wearing life jackets. The majority of boating fatalities occurred on boats where the operator had not received safety instructions. In 2006, the U.S. Coast Guard received almost 5000 reports of boating incidents accounting for nearly 3500 people injured and over 700 deaths. Of these incidents 45 percent involved an open motor boat and 24 percent involved a personal watercraft (jet skis, wet bikes, wave runners).

Recommendations:

Boating and Personal Watercrafts (PWC):

- Always have adults and children wear a life jacket (also called personal flotation device or PFD) approved by the U.S. Coast guard while on a boat or PWC. The life jacket should fit snugly and not allow the child’s chin or ears to slip through the neck opening.
- Air-filled swimming aids, such as “water wings” and inner tubes, are NOT safety devices and should never be used as a substitute for a PFD or proper supervision.
- Children younger than 16 years should not operate a boat or PWC.
- Adults and adolescents (16 years and older) should not operate a boat or PWC without taking a boating course and safety training education.
- Never drink alcoholic beverages or use any drug while operating a boat or PWC.
- Do not operate boats or PWC where swimmers are in the water.
- Always have a supervisor face the rear of a boat or PWC when there is a person being towed while skiing, knee boarding or in a tube.
- Participate in a vessel safety check program every year offered free by the U.S. Coast Guard Auxiliary or U.S. Power Squadrons (www.uscgboating.org).

Carbon Monoxide Poisoning:

Each year boaters are injured or killed from carbon monoxide poisoning. Many such incidents occur within the cabin or other enclosed areas without sufficient ventilation. Carbon monoxide-related injuries and/or drowning can also occur near the rear deck and swimming platform. Prolonged exposure to low doses or short exposure to high concentrations of carbon monoxide can lead to death.

Recommendations:

- Install a carbon monoxide detector in the enclosed areas of your motorboat.
- Avoid motor exhaust vent areas.
- Do not swim near or under the back deck or swim platform of a boat or PWC when the motor or generator is operating.
- Do not “break surf” (holding onto the swim platform while towed by a boat).
- Do not confuse carbon monoxide poisoning with sea sickness or intoxication if someone onboard complains of headaches, dizziness, nausea, confusion and fatigue.

- **HOMES:**

Many household areas and items can cause water-related fatalities. Children can drown in only a few inches of water and should be supervised closely in and around areas of the home where water can accumulate. Both the Centers for Disease Control and Prevention and the American Academy of Pediatrics identify the following as potential sites where young children can be injured by accumulated water.

- Bathtubs
- Buckets/Pails
- Ice Chests
- Toilets
- Fountains

Recommendations:

- Never leave a child unattended, alone or cared for by another child in a bathtub.
- Never leave a child in a bathtub to answer the phone or doorbell.
- Empty all buckets/pails, ice chests and bathtubs completely after they are used.
- Keep bathroom and laundry room doors closed. Install door knob covers and/or hook-and-eye latches to keep closed doors secured.
- Keep toilet seats and covers down. Install toilet seat locks.
- Keep your family safe from hot water burns: Set water heater thermostats to 120° F.
- Showers are preferred for bathing when children and adolescents have a seizure disorder.
- Parents and caregivers should learn CPR to provide immediate resuscitation if needed for drowning or other water related injury.

SUPERVISION

Statement: Parents, guardians and caregivers need to understand the dangers of drowning and know the proper steps to take to protect children. Children are especially vulnerable to water hazards. Never leave a young child unsupervised in or around water, even for a moment.

Recommendations:

- Never allow children to swim without adult supervision. An adult should be present in the water with children less than five years of age.
- Always designate a responsible adult to serve as the “water watcher” – a supervisor whose sole responsibility is to constantly observe children in or near the water.
- Supervisors should maintain continuous visual and auditory contact with children in or near the water, and should stay in close proximity (waterside) so that they can effectively intervene if an emergency should arise.
- Supervisors should not engage in distracting behaviors such as talking on the phone, cooking or reading.
- Supervisors should keep children who cannot swim within arm's reach at all times.
- Supervisors should learn infant and child CPR and rescue safety tips.
- Teach children not to dive into unknown water. Check for depth and obstructions before diving and then go in feet first the first time.
- While there is no specific recommended ratio of supervisors to child swimmers, the number of supervisors should increase when many children are swimming, younger or inexperienced swimmers are present, or the swimming area is large.
- Instruct babysitters about potential pool hazards and emphasize the need for constant supervision.

EDUCATION

Statement: Over the years, decreased drowning rates can be attributed to many factors. Injury prevention initiatives raise the awareness of water safety as an important social issue. The delivery of targeted educational and public outreach initiatives has also improved with advances in technology to reach more families and children. Yet, far too many children continue to lose their lives in drowning situations that are frequently preventable circumstances.

Recommendations

- **Swimming Instruction**

Children by age 8 and adolescents should learn how to swim and receive instruction from a certified instructor. However, the SCFRT along with other safety advocates do not recommend swimming and/or other aquatic programs as the only methods to decrease or prevent drowning and other water related injuries. The AAP does not recommend formal swimming lessons until a child reaches their fourth birthday.

The SCFRT recommends the following for swimming instruction, aquatic programs and general safety for children and adolescents in and around water:

- Swimming instruction and aquatic programs should not be considered or promoted as the sole methods to prevent drowning and other water-related injuries.
- Swimming instruction and aquatic programs should provide education on the developmental limitations of young children, strategies for prevention of water related injuries and the importance of proper supervision of children and adolescents in and around water.

Educate children about the rules of water safety such as swimming with a buddy and always have an adult present. Instruct children how to recognize someone is in trouble in the water and to call for help and throw something that floats to the victim. A child should never enter the water to try to save someone.

Along with the above recommendations, parents often ask about water safety for children with disabilities or special needs. Children with disabilities are at increased risk for injuries, including drowning. It is important to know that local communities can provide water skills and safety programs that teach children

with disabilities to be safe and have fun in and around the water. Be sure to connect with qualified aquatic facilities that are appropriately certified to instruct special needs children and their families.

Recommendations:

- Always Swim With a Buddy: It is important to remind children that it is dangerous to swim alone and without adult supervision.
- No Running, No Pushing: Reminds children how to behave in and around water.
- STOP, LOOK, LISTEN: Children must learn to do this when the Lifeguard blows the whistle. This explains the importance of the lifeguard and what they should do.
- Learn to blow bubbles when under the water: Many children are unfamiliar with water and may panic if water is over their heads. This teaches children to stay calm and to blow bubbles out when underwater.
- Put Feet Down/Stand Up When In Trouble: Children may lose their sense of spatial awareness. This teaches children to put their feet down and helps to keep their head above water.

The SCFRT Position Statement on Water Safety for Children is a product of the SCFRT Workgroup on Water Safety (Dr. Kim Cheung, Dr. Juan Parra, John Hellsten, Ph.D., Kristine Brown, M.A., and Dr. Eric Levy). The Position Paper on Water Safety for Children will be reviewed annually and updated as new validated information indicates.
July 2009

References:

- American Academy of Pediatrics, Committee on Injury and Poison Prevention. Personal Watercraft Use by Children and Adolescents. *Pediatrics* 105(2):452-453. February 2000.
- American Academy of Pediatrics, Committee on Injury and Poison Prevention. Prevention of Drowning in Infants and Adolescents. *Pediatrics* 112(2):437-439. August 2003.
- American Academy of Pediatrics, Committee on Sports Medicine and Committee on Injury and Poison Prevention. Swimming Programs for Infants and Toddlers. *Pediatrics* 105(4):868-870. April 2000.
- American Academy of Pediatrics. The Injury Prevention Program: Home Water Hazards for Young Children [online]. <http://www.aap.org/family/homewatr>
- American Academy of Pediatrics. The Injury Prevention Program: Water Safety for your School aged Child [on-line]. <http://aap.org/healthtopics/watersafety>
- Brenner RA. American Academy of Pediatrics, Committee on Injury, Violence and Poison Prevention Technical Report. Prevention of Drowning in Infants and Adolescents. *Pediatrics* 112(2):440-445. August 2003.
- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online] (2009). Available from URL: www.cdc.gov/ncipc/wisqars.
- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. CDC Quick Tips. Strategies for drowning prevention in recreation water settings. Available from URL www.cdc.gov/healthyswimming/pdf/cc_qt_drowning.pdf
- Centers for Disease Control and Prevention, Swimming and Recreational Water Safety In: Health Information for International Travel 2005-2006. Atlanta: US Department of Health and Human Services, Public Health Service, 2005. Date updated: June 22, 2007. Content provided by the Centers for Disease Control. Available from URL: <http://www.revolutionhealth.com/conditions/first-aid-safety/safety-preparedness/beach-pool/water-safety>
- Double Angel Foundation. "Boaters Protect Yourself from this Silent Killer: Carbon Monoxide." Available from URL: www.doubleangel.org/documents/DoubleAngelCObro.pdf
- Gilchrist J, Gotsch K, Ryan GW. Nonfatal and Fatal Drownings in Recreational Water Settings—United States, 2001 and 2002. *MMWR* 2004; 53(21):447–52. Available from URL: <http://jama.ama-assn.org/cgi/content/full/292/2/164>
- Harborview Injury Prevention Center. "Best Practices: Swimming Lessons." Available from URL <http://depts.washington.edu/hiprc/practices/topic/drowning/swimminglessons.html>
- Harborview Injury Prevention Center. "Best Practices: Drowning Interventions. Pool Fencing." Available from URL <http://depts.washington.edu/hiprc/practices/topic/drowning/fencing.html>
- Present P. Child drowning study. A report on the epidemiology of drowning in residential pools to children under age five, Washington (DC): Consumer Product Safety Commission (US); 1987.
- Quan L, Bennett E, Branche C. Interventions to prevent drowning. In Doll L, Bonzo S, Mercy J, Sleet D (Eds). Handbook of injury and violence prevention, New York: Springer, 2007. Literature Update 2005: Preventing Drowning in the United States. Available from URL: <http://www.springerlink.com/content/978-0-387-85769-5>
- Safe Kids USA, Clear Danger: A National Study of Childhood Drowning and Related attitudes and Behavior, 2004. Available from URL: <http://www.usa.safekids.org/NSKW.cfm>
- Texas EMS/Trauma Registry [online]. Available from URL: Available from URL: www.dshs.state.tx.us/injury
- Texas Child Fatality Review 2000-2008 Reports [online]. Available from URL: http://www.dshs.state.tx.us/mch/Child_Fatality_Review.shtm

U. S. Consumer Product Safety Commission. Safety barrier guidelines for home pools [online]. Available from URL: www.cpsc.gov/cpsc/pub/pubs/pool.pdf

U.S. Coast Guard, Department of Homeland Security (US). Boating Statistics – 2006 [online] 2009. Available from URL: www.uscgboating.org/statistics/Boating_Statistics_2006.pdf

U.S. coast Guard. “Carbon Monoxide: THAT Silent Killer”; August 2, 2001. Available from URL: www.uscgboating.org/articles/boatingview.aspx?id=22

DROWNING PREVENTION ONLINE RESOURCES

General Resources

- [National Center for Injury Prevention and Control \(Centers for Disease Control and Prevention\)](#)
- [North American 2004 Boating Campaign Information](#)
- [Harborview Injury Prevention and Research Center](#)
- [SAFE KIDS](#)
- [Clear Danger: A National Study of Childhood Drowning and Related Attitudes and Behaviors](#)
- [Washington State Drowning Prevention Campaign](#)
- [World Congress on Drowning Proceedings](#)
- [American Academy of Pediatrics](#)
- [American Red Cross - King and Kitsap County](#)
- [American Red Cross - Swimming and Lifeguarding](#)
- [Centers for Disease Control National Center for Injury Prevention and Control - Drowning Prevention Fact Sheet](#)
- [Public Health Seattle & King County](#)
- [SAFE KIDS - Water Safety Tips](#)
- [SAFE KIDS - Drowning Injury Facts](#)
- [The Joey Pizzano Memorial Fund Inc](#)
- [Swim Kids](#)

The Home (pools and spas)

- [Above Ground Pools and Spas](#) (PDF)
- [Consumer Product Safety Commission - Pool and Spa Safety](#)
- [Consumer Product Safety Commission - Prevent Child In-Home Drowning Deaths](#)
- [Consumer Product Safety Commission - Preventing Child Drownings](#)
- [Drowning Facts and Prevention Tips for Homeowners](#) (PDF)
- [Private Residential Pools and Spas-Tips for Homeowners](#) (PDF)

Open Water (Playing or Swimming)

- [Rip Currents Awareness](#)
- [Farm Pond Safety](#)
- [National Children's Center - Rural Youth Drowning: Fact Sheet](#)
- [U.S. Army Corps of Engineers - National Water Safety Program](#)
- [Washington State Department of Health - Water Safety Fact Sheet](#)

Boating

- [National Safe Boating Council](#)
- [U.S. Coast Guard - Office of Boating Safety](#)



TEXAS STATE CHILD FATALITY REVIEW TEAM COMMITTEE POSITION STATEMENT: CHILD SUICIDE

The State Child Fatality Review Team Committee (SCFRT) works closely with local Child Fatality Review Teams (CFRT) to promote public awareness and action to reduce the number of preventable child deaths. Each year more than 2,300 Texans die from suicide; about 4% (75-95 deaths annually) of these are children less than 18 years of age, thus making suicide the 3rd leading cause of death for Texas youth. About 75% of all child suicide deaths occur among 15-17 year olds. Perhaps the most important statistic is that **suicide is preventable!**

Suicide is an interplay of individual, interpersonal, social, and environmental factors which must be understood and addressed by a community of caring individuals. A comprehensive and coordinated approach is critical to improving child and adolescent well-being.

RECOMMENDATIONS TO THE STATE OF TEXAS, THE TEXAS LEGISLATURE, PARENTS, AND HEALTHCARE PROVIDERS:

Community Leaders and Organizations: It is essential for the whole community to understand the dangers of suicide and know the proper steps to take to protect children and youth. Linking communities and working together in partnerships (collaboration) facilitates and promotes a more public, broad based involvement to youth suicide prevention and intervention.

Recommendations:

- Develop and expand partnerships that contribute to mental health promotion and prevention efforts. Create a mental health literacy and information plan to ensure that information on mental health and mental disorders is accessible and accurate, and thus improving mental health literacy in the general population and addressing stigma and discrimination.
- Ensure that mental health services are available and accessible to diverse populations within the community. Services should be culturally and linguistically competent with respect for the cultural preferences and traditions of the child and family. These services should be youth and family-driven.
- Take a leadership role in the development of a suicide prevention strategy and activities. Foster support for community-based and school-based prevention strategies. Establish and promote compliance with recommended media guidelines for reporting suicides in an effort to minimize copy-cat suicides.
- Monitor suicide frequencies within the community and establish a protocol for addressing emerging trends. Texas House Bill 1067 (81st Legislative Session) allows for collection and coordination of suicide data on the local level by providing that authorized local government entities specified in the bill may enter into memoranda of understanding to share suicide data that does not name a deceased individual or any other individual.

Educational Institutions and Schools: Educational specialists' have the day-to-day contact with many young individuals who can have problems and issues. Youth in trouble may cause serious injury or even death by their own hand. Educators are in a position to observe students' behavior and to act if they suspect that a student may be at risk of self-harm. There are steps to identify and help young people at risk in order to keep them healthy and safe.

- Ensure parental/teacher coordination. Teachers need to make sure that parents are informed and actively involved in decisions regarding their child's welfare. Connect and communicate with parents and guardians

- Provide training to educators regarding the risk factors associated with youth suicide and mental health literacy.
- Encourage school-based suicide prevention initiatives.
- Develop and ensure that staff are familiar with the school's postvention plan in the event of a local youth suicide.
- Become familiar with community-based resources and advocate for the particular screening and intervention needs of that school population

Medical Institutions and Doctors/Scientists: Community medical and healthcare providers have long been committed to preserving the health, safety, and welfare of children and youth; suicide prevention must be a top priority in this effort. In order to continue making a difference in suicide prevention, professionals believe that an increase of scientific research-based suicide intervention studies, that provide clear standards and replicable results, will help to decrease the loss of young lives to suicide.

Recommendations:

Medical Community

- Provide better training to pediatricians and family practitioners to recognize suicide risks
- Support and encourage the implementation of early identification and screening within primary care settings. Pediatricians should recognize that routine screening of adolescents and children for suicide risk factors and mental health issues is critical. Incorporate suicide screening into routine adolescent health maintenance visits.
- Refer children/adolescents identified as risks to appropriate mental health professionals for treatment. Be familiar with mental health resources available locally and statewide.

Parents

- Seek early treatment for children with emotional problems, possible mental disorders (particularly depression and impulse control disorders) and substance abuse problems.
- Learn how to recognize the signs of suicide and appropriate ways to respond.
- Limit access to lethal means of suicide, particularly firearms.
- Provide supervision, support, and constructive activities for children and adolescents.
- Find professional help if your child appears angry, sad, lonely, is being bullied at school, has other school problems, or is withdrawn.
- Communicate with schools.
- Look, listen, talk, and seek help.

Resources:

Coming Together to Care: A Suicide Prevention Toolkit for Texas Communities. Texas Suicide Prevention Council, www.texassuicideprevention.org.

Suicide Prevention: A Parent & Teen Guide to Recognizing Suicide Warning Signs. Mental Health America of Texas, www.texassuicideprevention.org/pdf/Suicide.pdf

Suicide Prevention Resource Center. www.sprc.org

Teaching Pediatric Residents to Assess Adolescent Suicide Risk With a Standardized Patient Module, Pediatrics Volume 125, Page 953, Number 5, May 2010.

Texas Suicide Prevention Plan.

www.sprc.org/stateinformation/PDF/stateplans/plan_tx.pdf

The SCFRT Position Statement on Child Suicide is a product of the SCFRT workgroup on child suicide (John Hellsten, PhD, Emilie Becker, MD, Kim Cheung, MD, PhD, Jeannine Von Stultz, PhD, and Kristine Brown). The Position Statement on Child Suicide will be reviewed annually and updated as new validated information indicates.

References:

American Academy of Pediatrics. AAP 2007 Policy Statement: B. In: Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition. Elk Grove Village, Ill: American Academy of Pediatrics; 2008. www.medscape.com/viewarticle/711264

CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters. *Morbidity and Mortality Weekly Report* **1998 37(S-6);1-12.**

Committee on Adolescent Health care Services and Models of Care for Treatment, Prevention, and Healthy Development, National Research Council and Institute of Medicine, Board on Children, Youth, and Families. In: Lawrence RS, Appleton Gootman J, Sim LJ, eds. *Adolescent Health Services: Missing Opportunities*. Washington, DC: The National Academies Press; 2009: 293. www.nap.edu/openbook.php?record_id=12063&page=293

Mann JJ et al., *Journal of the American Medical Association*. Suicide Prevention Studies: A Systematic Review. *JAMA*. 2005;294:2064-2074. <http://jama.ama-assn.org/cgi/content/full/294/16/2064>

Miller DN, Eckert TL. Youth Suicidal Behavior: An Introduction and Overview. National Association of School Psychologists, *School Psychology Review*. Volume 38, No. 2, pp. 153-167. www.nasponline.org/publications/spr/pdf/spr382millerintro.pdf

SK Goldsmith, TC Pellmar, AM Kleinman, WE Bunney (eds), *Reducing Suicide: A National Imperative*. Committee on Pathophysiology and Prevention of Adolescent and Adult Suicide, Board on Neuroscience and Behavioral Health. Institute of Medicine of the National Academies, 2002.

US Preventive Services Task Force. Screening and treatment for major depressive disorder in children and adolescents: US Preventive Services Task Force Recommendation Statement. *Pediatrics*. 2009;123:1223-1228 www.pediatrics.org/cgi/content/full/123/4/1223



TEXAS STATE CHILD FATALITY REVIEW TEAM COMMITTEE POSITION STATEMENT: FIRE AND BURN SAFETY FOR CHILDREN

The State Child Fatality Review Team Committee (SCFRT) works closely with local Child Fatality Review Teams (CFRT) to promote public awareness to reduce the number of preventable child deaths. Fire- and burn-related injuries are a cause of much physical suffering and pain as well as a cost of \$7.5 billion each year to care for injured individuals in the U.S. According to the Centers for Disease Control and Prevention (CDC), fire and burn injuries were the third leading cause of unintentional injury death for children one to nine years of age in 2006. In Texas, fire and burn injuries were the third and fourth cause of unintentional injury death respectively for children one to four and five to nine years of age in 2007. Each year in Texas, approximately thirty children and adolescents die due to fire and burn injuries.

Research studies have demonstrated that the groups at most risk for fire related injuries and deaths are children who are:

- Younger than five years of age
- Living in poverty
- Living in substandard housing
- Living in homes without smoke alarms or carbon monoxide detectors
- African American and Native American

The majority of fire and burn injuries occur in homes and most fatalities from house fires are related to inhaling smoke or toxic gases.

Another danger related to home fires, heating of homes and exposure to toxic gases is carbon monoxide poisoning. Carbon monoxide is an odorless, colorless toxic gas that is produced by common household and environmental exposures such as natural gas, propane or other fuel-burning furnaces and heaters, motor vehicle or other gasoline powered engines and generators, fire places and charcoal grills. Breathing in carbon monoxide displaces oxygen carried by hemoglobin, impeding the delivery of oxygen to vital organs and all body tissues. Even small amounts of carbon monoxide can be dangerous because hemoglobin will preferentially bind to carbon monoxide instead of oxygen. This leads to a lack of oxygen or hypoxia that can range from minor and reversible effects to serious brain and heart damage leading to death. Common early signs of carbon monoxide poisoning are headache, nausea, weakness, rapid breathing, and dizziness.

The most common burn-related injury in young children presenting to an emergency room for care is scald burns. One study documented the extent and mechanism of unintentional scald burn injuries of children less than five years old. The majority of the unintentional burns (88 percent) were attributed to non-tap water scald injuries. Unintentional non-tap water scald burns in the study most often occurred in the kitchen or dining area and involved hot liquids during cooking, eating and drinking. An important observation noted for prevention was that young children in the study were burned after they opened the microwave door and removed a container with a hot liquid.

Children are exposed to multiple mechanisms where they can suffer injuries from fire- and burn-related injuries and death such as fire- and smoke-related injuries, scald and appliance burns, electrical burns and injuries related to fireworks.

RECOMMENDATIONS TO THE STATE OF TEXAS, THE TEXAS LEGISLATURE, PARENTS, HEALTHCARE PROVIDERS AND CHILD FATALITY REVIEW TEAMS

The SCFRT, along with other leaders in injury prevention such as the CDC, American Academy of Pediatrics, Safe Kids Worldwide, U.S. Consumer Product Safety Commission, FireSafety.gov, and municipal and volunteer fire departments, makes the following recommendations to prevent fire- and burn-related injuries. Above all else, prevention of burns and all other injuries to children start with age-appropriate supervision of children. Children should not be left unattended or unsupervised in situations where a burn injury can occur.

PREVENTING FIRE AND SMOKE-RELATED INJURIES

- Smoke Alarms:
 - Install smoke alarms on every floor of the house including the basement. Smoke alarms hardwired into the residence power supply are preferred.
 - It is recommended to have smoke alarms outside every bedroom or area where people sleep as well as where a furnace is located.
 - Use smoke alarms with a flashing light and an alarm for children and adults who are deaf.
 - To avoid false alarms, keep smoke alarms away from the kitchen and bathroom areas.
 - Keep smoke alarms in working order.
 - Test and clean smoke alarms once per month.
 - Use long-life batteries, and change batteries at least once per year (coincide with Fall Daylight Savings time change).
 - Replace smoke alarms every 10 years.
 - Never paint a smoke alarm.

- Fire Drills:
 - Develop a fire escape plan for your family.
 - Draw a floor plan of your home.
 - Discuss at least two ways to escape from a room.
 - Insure windows can be opened easily and have room to escape a fire.
 - Children younger than five years old or with special healthcare needs will need to have a plan for adult assistance in the fire escape plan.
 - Discuss and practice the fire escape plan every six months.
 - Have a safe place to meet outside of the home.
 - During a fire always use the stairs, not an elevator.
 - Discuss fire escape plan with all who watch your children: relatives, neighbors, sitters.
 - Do not open any door if you feel heat on the door or see smoke around or under the door.
 - Crawl low to the floor in a smoke-filled room.
 - Do not stop until you have reached safety outside your home.
 - Do not go back into the burning home.

- If Clothes Catch on Fire:
 - **Stop** and do not run.
 - **Drop** to the ground.
 - **Roll** over to put out the fire.
 - **Cool** burned areas with water.
 - **Call** for help.

- House Fires Prevention:
 - Never leave lit cigarettes unattended.
 - Never smoke in bed.
 - Do not place ashes in trash cans.

- Keep ashtrays away from upholstery and curtains.
- Never leave food unattended on the lit stove.
- Keep flammable objects such as towels and potholders away from cooking areas.
- Do not wear clothes with long and loose fitting sleeves while cooking.
- Never place space heaters or candles near upholstery or drapes.
- Store matches and lighters out of reach of children.
- Adults in the home should learn how and when to use fire extinguishers from manufacturers and their local fire department

PREVENTING CARBON MONOXIDE POISONING

The following precautions are advised for preventing carbon monoxide poisoning:

- If you suspect carbon monoxide poisoning, immediately get fresh air, call 911 and seek prompt medical attention.
- Install battery operated carbon monoxide detectors in the home. Replace batteries at Daylight Savings time change each spring and fall.
- Have annual fuel-burning home heating systems checked by qualified service technicians.
- Never use your gas stove or oven to heat your home.
- Never use fuel-burning engines or generators inside your home or near a home window.
- Never use fuel- or charcoal-burning grills or camping stoves inside your home or near a home window.
- Insure your fireplace flue or vent is open and your chimney is clean before lighting a fire.
- Never run your motor vehicle inside your garage.

PREVENTING SCALD BURNS

The following precautions are advised for preventing scald burns:

- Tap water burns:
 - Set hot water heaters to 120° Fahrenheit.
 - Always test the water before young children are allowed in the bathtub or shower.
 - Consider installing anti-scald devices on faucet handles. Anti-scald devices shut off the water if it is too hot.
 - Avoid bathing children in the kitchen sink. Faucet handles on kitchen sinks can be accidentally shifted allowing hot water to flow from the faucet. Sink basins with attached garbage disposal can allow very hot water from a draining dishwasher to flow up into the sink.
- Hot liquid burns:
 - Keep young children out of the kitchen or cooking areas.
 - Use rear burners to cook and turn cookware handles away from the front of the stove.
 - Keep containers with hot liquids or food toward the center or the rear of counter tops and tables.
 - Remove tableclothes from tables that have hot liquids or food on them.
 - Install an anti-tip bracket to stoves.
 - Never carry infants or young children at the same time you are holding containers with hot liquids.
 - Do not allow young children to use a microwave oven.
 - Do not use a microwave oven to heat infant bottles. (Liquids can be hotter than the containers.) Heat infant bottles with warm water.
 - Test cooked food or heated liquids to ensure they are not too hot for infants and children.

PREVENTING APPLIANCE AND ELECTRICAL BURNS

The following precautions are advised for preventing appliance and electrical burns:

- Keep children safe and away from hot appliances and tools. Unplug appliances not in use.
- Heaters and Fireplaces:
 - Keep children away from all space or wall heaters.
 - Use protective coverings for heaters and fireplace.

- Ensure heaters are level, stable and cannot be tripped over easily.
- Turn off space heaters when leaving a room or going to bed.
- Never leave a heater or fireplace on when you sleep or leave the house.
- Never place heaters within three feet of flammable material such as drapes, furniture or paper.
- Electrical Burns:
 - Supervise young children around electrical appliances and outlets in use.
 - Store unused electrical appliances out of reach of young children.
 - Unused electrical outlets should be covered with safety devices that do not pose a choking hazard.
 - Keep electrical cords out of the reach of young children.

PREVENTING FIREWORKS–RELATED INJURIES

Although fireworks-related injuries do not directly account for many deaths in the U.S., they do directly account for significant injuries and can cause fatal residential and motor vehicle fires. A study conducted by the U.S. Consumer Product Safety Commission in 2009 reported two deaths and almost 9,000 emergency room visits due to injuries from fireworks. Most of the injuries occurred to individuals younger than 20 years of age. Other studies also show that young children and adolescents suffer the majority of fireworks-related injuries. Common injuries related to fireworks are burns and lacerations to the hands and fingers, face and head. Most of the injuries are caused by firecrackers, bottle rockets and sparklers. Sparklers are a common type of fireworks that are used by young children and are often felt to be safe. However, sparklers can achieve temperatures of nearly 2000°F and can cause severe injuries directly to body parts or ignite clothing and start residential fires.

State and municipal laws vary and it is recommended that responsible adult caregivers always supervise children and adolescents when using fireworks and that all federal, state and municipal laws be followed.

The Federal Hazardous Substance Act and the U.S. Consumer Product Safety Commission ban the manufacture, sale and acquisition of dangerous fireworks which include:

- M-80's, quarter sticks, half sticks, and other similar large firecrackers.
- All firecrackers with >50 milligrams of explosive powder.
- All aerial fireworks with >130 milligrams of flash powder.
- Mail-order kits and components for fireworks listed above.

In order to prevent most fireworks-related injuries, it is recommended to view fireworks displays performed by trained professionals. If individuals choose to use legal fireworks, these safety precautions are encouraged:

- Always supervise children around fireworks.
- Young children should not ignite, hold or play with fireworks.
- Do not have any part of your body over ignited fireworks; move to a safe distance once fireworks are ignited.
- Do not attempt to re-use or re-ignite fireworks that do not function.
- Do not throw or point fireworks at anyone.
- Do not ignite fireworks in any container.
- Do not carry fireworks in your pockets or anywhere close to you.
- Have a bucket of water or water hose ready to use in case of a fire.
- Wet used fireworks before disposing of them in the trash.
- Do not alter or combine fireworks.
- Do not make your own fireworks or use illegal explosives.

The SCFRT makes the above recommendations to educate the public in our collaborative effort with local CFRT across the state to promote injury prevention and eliminate all preventable deaths to children and adolescents in Texas. The SCFRT Position Statement on Fire and Burn Safety for Children is a product of the research of Dr. Juan Parra, reviewed and approved by the SCFRT membership. This Position Statement will be reviewed annually and updated as new validated information indicates. November 2010

RESOURCES:

- [Centers for Disease Control and Prevention, National Center for Injury Prevention and Control](#)
- [National Maternal Child Health Center for Child Death Review, Child Injury Prevention Tool: Selecting Best Practices](#)
- [National Fire Protection Agency: Safety Information](#)
- [Safe Kids USA, Safety Basics](#)
- [United States Fire Administration](#)
- [US Consumer Product Safety Commission, Safety Tips](#)
- [Home Safety Council: All-ways Fire Safe at Home Toolbox](#)
- [National Council on Fireworks Safety](#)
- [American Academy of Pediatrics: Healthy Children, Safety and Prevention](#)

REFERENCES:

Centers for Disease Control and Prevention (CDC), Fire Deaths and Injuries: Fact Sheet
<http://www.cdc.gov/HomeandRecreationalSafety/Fire-Prevention/fires-factsheet>
<http://www.cdc.gov/homeandrecreationalafety/fire-prevention/fires-factsheet.html>

CDC Fire Deaths and Injuries: Prevention Tips <http://www.cdc.gov/homeandrecreationalafety/fire-prevention/fireprevention.htm>

CDC: Protect the Ones You Love: Burns www.cdc.gov/safekid

CDC: Leading Causes of Injury Death by Age Group: Unintentional Injury Deaths, U.S. 2006. National Center for Health Statistics

CDC: 10 Leading Causes of Unintentional Injury Deaths, Texas 2007. National Center for Health Statistics. CDC: Fireworks-Related Injuries.
<http://www.cdc.gov/homeandrecreationalafety/fireworks/index.html>

CDC: Carbon Monoxide. NIOSH Workplace Safety and Health Topic.
<http://www.cdc.gov/niosh/topics/co-comp/>

CDC: Carbon Monoxide Poisoning, You Can Prevent carbon Monoxide Exposure.
<http://www.cdc.gov/co/guidelines.htm>

CDC: Preventing Carbon Monoxide Poisoning After an Emergency.
<http://www.bt.cdc.gov/disasters/cofacts.asp>

U.S. Consumer Product Safety Commission and U.S. Fire Administration News: Sound Carbon Monoxide Alarm as Temperatures Drop, Potential for Carbon Monoxide Poisonings and Deaths Rise. Release # 07-075 January 5, 2007.
<http://www.cpsc.gov/CPSC/PUB/PREREL/prhtml07/07075.html>

American Academy of Pediatrics (AAP), Committee on Injury and Poison Prevention: Reducing the Number of Deaths and Injuries from Residential Fires. *Pediatrics* 105(6):1355-1357, June 2000.

AAP, Committee on Injury and Poison Prevention: Fireworks-Related Injuries to Children. *Pediatrics* 108(1): 190-191, July 2001.

AAP Clinical Report: Office-Based Counseling for Unintentional Injury Prevention. *Pediatrics* 119(1): 202-206, January 2007.

Souza AL, Nelson NG, McKenzie LB. Pediatric Burn Injuries Treated in US Emergency Departments Between 1990 and 2006. *Pediatrics* 124(5): 1424-1430, November 2009.

Johnston BD, Rivara FP. Injury Control: New Challenges. *Pediatrics in Review* 24(4):111-118, April 2003.

Klein GL, Herndon DN. Burns. *Pediatrics in Review* 25(12): 411-417, December 2004.

Lowell G, Quinlan K, Gottlieb LJ. Preventing Unintentional Scald Burns: Moving Beyond Tap Water. *Pediatrics* 122(4): 799-804, October 2008.

Landen MG, Bauer U, Kohn M. Inadequate Supervision as a Cause of Injury Deaths among Young Children in Alaska and Louisiana. *Pediatrics* 111(2): 328-331, February 2003.

Children and Burns, World Health Organization. World Report on Child Injury Prevention. http://www.who.int/violence_injury_prevention/child/injury/world_report/en/index.html

AAP HealthyChildren.org, Safety and Prevention All Around:

- Fire Safety
- Fire Safety: Planning Saves Lives
- Keeping Safe from Burns

<http://www.healthychildren.org/English/Safety-prevention/all-around/Pages/default.aspx>

Safe Kids USA Position Statement: The Safest Setting for Home Hot Water Heaters

<http://www.safekids.org/safety-professionals/position-statements/home-hot-water-heaters.html>

Safe Kids USA, Safety Basics:

- Burn prevention for little kids at home
- Burn and scald prevention tips

<http://www.safekids.org/safety-basics/>

U.S. Consumer Product Safety Commission: Thousands of Injuries with Sparklers, Firecrackers and Aerials; CPSC Urges Consumers to Put Safety in Play during the Fourth of July. News from CPSC Release #10-282, June 29, 2010

<http://www.cpsc.gov/cpsc/pub/prerel/prhtml10/10282.html>

Kids Health: Fireworks Safety

http://kidshealth.org/parent/firstaid_safe/outdoor/fireworks.html