



Protect Our Kids Commission Meeting

**Friday, March 27, 2015
10:00 am - 2:00 pm**

**Texas Hospital Association
1108 Lavaca Street
Austin, TX 78701**

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Child Abuse Fatalities in Texas: Prevention Solutions

Protect Our Kids Commission

**March 27, 2015
10:00 am – 2:00 pm**

**Texas Hospital Association
1108 Lavaca Street
Austin, Texas 78701**

MEETING AGENDA

- 10:00a.m. Opening Remarks
Judge Robin Sage, Chair
- Public Comment
- 10:15a.m. Sasha Rosco, Director of Prevention and Early Intervention,
DFPS
- 10:30a.m. Committee Reports and Discussion
Carmen Dusek, J.D., Chair of the CFRT Workgroup
- 11:10 a.m. Nancy Kellogg, M.D., Chair of the Data Workgroup
- 11:50 a.m. Madeline McClure, J.D., Chair of the Prevention Workgroup.
- 12:30p.m. Lunch
- 12:40 p.m. Judge Robin Sage, Chair of Sustainability Workgroup
Continuation of Commission Discussion
- 1:30 p.m. Next Steps
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Insert Tab 1

STATE OF TEXAS
Protect Our Kids Commission

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Insert Tab 2

By: Schwertner

S.B. No. 1407

A BILL TO BE ENTITLED

AN ACT

relating to encouraging age-appropriate normalcy activities for children in the managing conservatorship of the state.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 263.001(a), Family Code, is amended by amending Subdivision (1-a) and adding Subdivision (1-b) to read as follows:

(1-a) "Age-appropriate normalcy activity" has the meaning assigned by Section 264.001.

(1-b) "Department" means the Department of Family and Protective Services.

SECTION 2. Section 263.306, Family Code, is amended by adding Subsection (c) to read as follows:

(c) In addition to the requirements of Subsection (a), at each permanency hearing the court shall review the department's efforts to ensure that the child has regular, ongoing opportunities to engage in age-appropriate normalcy activities, including activities not listed in the child's service plan.

SECTION 3. Section 263.503, Family Code, is amended by adding Subsection (c) to read as follows:

(c) In addition to the requirements of Subsection (a), at each placement review hearing the court shall review the department's efforts to ensure that the child has regular, ongoing opportunities to engage in age-appropriate normalcy activities,

1 including activities not listed in the child's service plan.

2 SECTION 4. Section 264.001, Family Code, is amended by
3 amending Subdivision (1) and adding Subdivisions (1-a) and (5) to
4 read as follows:

5 (1) "Age-appropriate normalcy activity" means an
6 activity or experience:

7 (A) that is generally accepted as suitable for a
8 child's age or level of maturity or that is determined to be
9 developmentally appropriate for a child based on the development of
10 cognitive, emotional, physical, and behavioral capacities that are
11 typical for the age or age group; and

12 (B) in which a child who is not in the
13 conservatorship of the state is generally allowed to participate,
14 including extracurricular activities, in-school and out-of-school
15 social activities, cultural and enrichment activities, and
16 employment opportunities.

17 (1-a) "Department" means the Department of Family and
18 Protective Services.

19 (5) "Standard of care of a reasonable and prudent
20 parent" means the standard of care that a parent of reasonable
21 judgment, skill, and caution would exercise in addressing the
22 health, safety, and welfare of a child while encouraging the
23 emotional and developmental growth of the child, taking into
24 consideration:

25 (A) the overall health and safety of the child;

26 (B) the child's age, maturity, and development
27 level;

1 (C) the best interest of the child based on the
2 caregiver's knowledge of the child;

3 (D) the appropriateness of a proposed activity
4 and any potential risk factors;

5 (E) the behavioral history of the child and the
6 child's ability to safely participate in a proposed activity;

7 (F) the importance of encouraging the child's
8 social, emotional, and developmental growth; and

9 (G) the importance of providing the child with
10 the most family-like living experience possible.

11 SECTION 5. The heading to Section 264.114, Family Code, is
12 amended to read as follows:

13 Sec. 264.114. IMMUNITY FROM LIABILITY; ADVERSE
14 DEPARTMENTAL ACTION PROHIBITED.

15 SECTION 6. Section 264.114, Family Code, is amended by
16 adding Subsections (c) and (d) to read as follows:

17 (c) A foster parent, other substitute caregiver, family
18 relative or other designated caregiver, or licensed child placing
19 agency caring for a child in the managing conservatorship of the
20 department is not liable for harm caused to the child resulting from
21 the child's participation in an age-appropriate normalcy activity
22 approved by the caregiver if, in approving the child's
23 participation in the activity, the caregiver exercised the standard
24 of care of a reasonable and prudent parent.

25 (d) A licensed child placing agency is not subject to
26 adverse action by the department, including contractual action or
27 licensing or other regulatory action, arising out of the conduct of

1 a foster parent who has exercised the standard of care of a
2 reasonable and prudent parent.

3 SECTION 7. Subchapter B, Chapter 264, Family Code, is
4 amended by adding Section 264.125 to read as follows:

5 Sec. 264.125. AGE-APPROPRIATE NORMALCY ACTIVITIES;
6 STANDARD OF CARE. (a) The department shall use its best efforts to
7 normalize the lives of children in the managing conservatorship of
8 the department by allowing substitute caregivers, without the
9 department's prior approval, to make decisions similar to those a
10 parent would be entitled to make regarding a child's participation
11 in age-appropriate normalcy activities.

12 (b) In determining whether to allow a child in the managing
13 conservatorship of the department to participate in an activity, a
14 substitute caregiver must exercise the standard of care of a
15 reasonable and prudent parent.

16 (c) The department shall adopt and implement policies
17 consistent with this section promoting a substitute caregiver's
18 ability to make decisions described by Subsection (a). The
19 department shall identify and review any departmental policy or
20 procedure that may impede a substitute caregiver's ability to make
21 such decisions.

22 (d) The department shall require licensed child placing
23 agency personnel, residential child care licensing staff,
24 conservatorship caseworkers, and other persons as may be determined
25 by the department to complete a course of training regarding:

26 (1) the importance of a child's participation in
27 age-appropriate normalcy activities and the benefits of such

1 activities to a child's well-being, mental health, and social,
2 emotional, and developmental growth; and
3 (2) substitute caregiver decision-making under the
4 standard of care of a reasonable and prudent parent.

5 SECTION 8. The changes in law made by this Act to Sections
6 263.306 and 263.503, Family Code, apply only to a permanency
7 hearing or a placement review hearing conducted under Chapter 263,
8 Family Code, on or after the effective date of this Act. A
9 permanency hearing or a placement review hearing conducted before
10 the effective date of this Act is governed by the law in effect on
11 the date the hearing was conducted, and the former law is continued
12 in effect for that purpose.

13 SECTION 9. This Act takes effect September 1, 2015.

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**The Protect Our Kids Commission
Charge from the 83rd Legislature, SB66**

The commission shall:

(1) identify promising practices and evidence-based strategies to address and reduce fatalities from child abuse and neglect;

(2) develop recommendations and identify resources necessary to reduce fatalities from child abuse and neglect for implementation by state and local agencies and private sector and nonprofit organizations, including recommendations to implement a comprehensive statewide strategy for reducing those fatalities; and

(3) develop guidelines for the types of information that should be tracked to improve interventions to prevent fatalities from child abuse and neglect.

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The (Federal) Commission to Eliminate Child Abuse and Neglect Fatalities

The CECANF was charged with:

- Raising visibility and building awareness about the problem
- Reviewing data and best practices to determine what is and is not working
- Helping to identify solutions
- Reporting on findings and making recommendations to drive future policy

The CECANF is composed of 12 members, six appointed by the president and six appointed by Democratic and Republican leaders of the House and Senate. Members will take a broad, multidisciplinary approach to studying and making recommendations about the following key issues:

- The use and effectiveness of federally funded child protective and child welfare services
- Best practices for and barriers to preventing child abuse and neglect fatalities
- The effectiveness of federal, state, and local data collection systems, and how to improve them
- Risk factors for child maltreatment
- How to prioritize prevention services for families with the greatest needs

Insert Tab 3

PROTECT OUR KIDS COMMISSION

MEETING SUMMARY

**January 16, 2015
10:00 am – 2:00 pm**

**Legislative Conference Center
Texas Capitol Extension, E2.002**

The Protect Our Kids Commission held its second meeting on January 16, 2015 with further presentations from the Department of Family and Protective Services (DFPS), and the Department of State Health Services (DSHS). Commissioners and stakeholders asked detailed questions as they began to divide their work into areas for workgroups to research further.

Background

The 83rd Legislature created the Protect Our Kids Commission, followed by the Commissioner appointments from the Governor, Lieutenant Governor, and Speaker of the House. The Legislature directed the POK Commission to:

- (1) identify promising practices and evidence-based strategies to address and reduce fatalities from child abuse and neglect;
- (2) develop recommendations and identify resources necessary to reduce fatalities from child abuse and neglect for implementation by state and local agencies and private sector and nonprofit organizations, including recommendations to implement a comprehensive statewide strategy for reducing those fatalities; and
- (3) develop guidelines for the types of information that should be tracked to improve interventions to prevent fatalities from child abuse and neglect.

Welcome from the POK Chairperson, Judge Robin Sage

Speaker Presentations

Lisa Black, Assistant Commissioner of Child Protective Services, DFPS

Jane Burstain, Ph.D., Director of Systems Improvement, DFPS

Sasha Rasco, Director of Prevention and Early Intervention, DFPS

Kathryn Sibley, Legislative & Policy Analyst, DFPS

Law enforcement, courts, CASA and many other partners work with DFPS to create a community-wide child protection system. Dr. David Sanders, the Chairman of the Federal Commission on the Elimination of Child Abuse and Neglect put it well when he said “Effectively preventing fatalities will require a broader, more coordinated response throughout the system. . .”

The Federal Commission on the Elimination of Child Abuse and Neglect will be issuing recommendations soon that will guide the work of DFPS.

Within DFPS, divisions partner to investigate, review, analyze and prevent child fatalities

- CPS – fatalities with alleged involvement of parents
- CCL and APS – fatalities in licensed facilities
- PEI – prevention resources to high-risk families and high-risk communities
- Office of Child Safety – links CCL, APS, CPS and PEI work and informs with national data and practice

What do we mean when we say “data”?

1. Administrative data – collected from IMPACT; usually consists of data such as race, ethnicity, case action and disposition, region and county
2. Case read data – collected through reading individual cases. It is an important supplement to administrative data but is time-intensive to gather

*Starting in FY 15, DFPS will be tracking the manner (homicide, suicide, etc) and cause (drowning, electrocution, etc.) of death through administrative data

There are two determinations in any fatality investigation:

1. Did abuse or neglect occur?
2. If so, did the abuse or neglect cause the fatality?
 - Under federal and state law, a fatality must meet both criteria to count as an abuse or neglect fatality
 - In all other cases, DFPS required to keep individual case information and records confidential
 - DFPS will expand its external aggregate data reporting on fatalities

Q: What is an example of a case where there was neglect or abuse, but it was NOT the cause of death?

A: DFPS receives a wide range of reports, for example there may be a death by co-sleeping case where neglect may have been found, but not to be determined to have caused the death. In that example, there would be a RTB of abuse and neglect, but the behavior did not cause the death.

Dispositions:

RTB = preponderance of evidence that abuse and neglect occurred

Ruled out = reasonable evidence that abuse and neglect did not occur

Unable to Complete = DFPS was unable to locate a principal

Unable to Determine = based on the information, DFPS was unable to determine whether it was RTB or Ruled Out

Those dispositions are made for every investigation.

In fatalities where abuse and neglect did occur, a second determination must be made with medical evidence as to whether the abuse and neglect caused the death.

Q: Is every child death supposed to be reported to CPS?

A: Yes, but this does not always happen. It is typical for CPS to learn of at least one case for the first time at local CFRT meetings.

Some counties are using the Child Advocacy Centers to bridge the gap between the many disciplines involved.

Q: Are there penalties if a child death is not reported?

A: There are penalties for not reporting abuse and neglect. Recommendations have been made for new legislation for penalties if someone *knowingly* fails to report a child death.

Perhaps there is a training opportunity for first responders and police to ALWAYS report child deaths to CPS.

Or maybe can we solve the problem with death certificates. How can we design a system where the flow of information does not rely on someone's judgment or understanding of their obligations? What if death certificates of all people under 18 went straight from DSHS to DFPS?

How long do death certificates take? Sometimes it takes months for Bureau of Vital Statistics to release the final death certificate. There are a few counties who have created a local workaround. For example, Williamson County has the temporary certificate go to the CFRT.

Trends in the Number of Child Fatalities due to Abuse and Neglect

Increases/Decreases

2009 deaths were higher

2013 deaths were lower

Q: Are these flukes? Are there explanations for the trends?

A: Nationally there has also been a drop in deaths and in the number of reports made since 2013.

DFPS did not find any systemic causes for the drop. DFPS will be looking deeper into the causes with the Office of Child Safety. An Annual Child Fatality Report will be produced.

Q: Are there comparisons between CFRT deaths and the DFPS disposition?

A: CFRT teams are often two years behind, so DFPS are often already dispositioned.

Currently underway is a DSHS/DFPS project to link data and look at cases real time.

Cases are re-disposed if for example, a near fatal child dies, then the disposition is adjusted.

Q: Where are those adjustments visible?

A: Data book is a frozen data set, but DFPS could share those updated numbers in another format.

Q: Was there a policy change or change in definitions in 2013 to explain the decrease in deaths?

A: No policy change or change in definition in 2013 to explain the change. No regional explanation either.

Q: Are these changes statistically significant? For example, if there are 7 million children in Texas, would an increase from 213 to 280 be considered random by a statistician?

A: There are tools such as the Standardized Mortality Ratio to see if differences matter statistically.

Q: Is it possible that statewide numbers are not very helpful because of the great diversity among Texas counties? Should we be looking at regional data? Are there hotspots?

A: DFPS intends to look at the data at a regional basis.

When looking at the data, DFPS is looking for trends, but it is difficult to see trends when looking at such small numbers, especially when they have to be parsed out into even smaller categories because for example, deaths between teenagers and infants are so different.

DFPS is also comparing four years of records of child deaths and births from a public health approach to see what can be learned about all child deaths, rather than just the deaths that were classified as abused and neglect.

Q: Wouldn't it be more meaningful to compare the number of abuse and neglect fatalities to the number of reports filed?

A: Yes, and DFPS is doing that.

Q: Has DFPS seen changes within the categories of dispositions? For example, the category of Reason to Believe seems like it would be more consistent than Unable to Determine. UTD might or might not be abuse, but it seems the RTB numbers would be more consistent.

A: No, DFPS has not seen a huge change within the categories.

A theme to studying data is that it leads to everyone wanting more data.

Starting Sept 1, 2015 DFPS will be tracking near fatalities in the administrative data.

Q: What about serious injuries?

A: No, not at this time because medical expertise is not necessarily included in those cases, so it is more ambiguous and more difficult to track.

Other Trends:

Infants

- Infants Have Highest Rate of Child Abuse and Neglect Deaths
- Infants Represent 41% Of All Abuse and Neglect Fatalities

Intentional Abuse

- Slightly more likely to involve infant females (57%) vs infant males (43%)
- 75% of victims were 6 months or younger
- Almost all involved CPS investigations with physical abuse perpetrated by males, primarily blunt force trauma
- 82% father (14) or boyfriend/other caregiver (8)
- 7% (3) mother and father/boyfriend
- 11% (3) mother

Co-sleeping and Unsafe Sleep

- More likely involve male infants (67%) vs female infants (33%)
- 86% of victims were 4 months or younger
- Involved a myriad of circumstances and perpetrators
- 2 RCL – unsafe sleep
- 6 CCL – unsafe sleep
- 13 CPS – 7 co-sleeping and 6 unsafe sleep

Prior CPS History

- Defined broadly – any CPS history (even if not confirmed) on deceased child or fatality perpetrators
- Of 28 physical abuse fatalities, 10 had some type of prior CPS history
- Of 13 co-sleeping/ unsafe sleep deaths involving parents, 7 had some type of prior CPS history
- Details of prior history are varied with no noticeable trend or pattern

Descriptive Analytics v. Predictive Analytics

Descriptive analytics describe a population after the fact, like the factors we just discussed.

Predictive analytics attempt to identify an outcome. For example, we look at those who experienced an outcome and those who didn't and take statistical tests to predict who are most likely to experience a particular outcome. However, we cannot ever substitute critical thinking and evaluation of a family's particular circumstances. Predictive analytics is useful for identifying cases for real time case reads.

DFPS Is Using Predictive Analytics to Improve Child Safety

- Identifying high risk cases in each stage of service and implementing real time case reads and follow up to improve child safety
 - Piloted in FBSS – moving to statewide implementation
 - Completing identification of high risk cases in investigations along with implementation plan

Tammy Sajak, MPH, Director of the Title V and Family Health Divisions at DSHS

DSHS is the state agency responsible for administration of Title V and is one of four state health and human service agencies under the Health and Human Services Commission. Within DSHS, the Division for Family and Community Health Services is responsible for most women's and children's programs.

DSHS has more activities/programs to add to the Survey of Current Work

DSHS records reflect about 3,000 child deaths/year.

Amy Bailey, State Child Fatality Review Team Coordinator, DSHS

Child Fatality Review is a multi-disciplinary, multi-agency group that meets under Chapter 264 of the Texas Family Code

Child Fatality Review consists of two critical components with distinct yet complementary roles:

- State Child Fatality Review Team Committee (SCFRT)
- Local Child Fatality Review Teams (CFRTs).

The SCFRT meets quarterly:

- to discuss issues related to child risks and safety,
- to develop strategies to improve child death data collection and analysis,
- to develop position statements on specific child safety issues, and
- to research and develop recommendations that will make Texas safer for children.

Local CFRTs: Currently, there are 79 CFRTs covering 208 of the 254 counties.

- volunteer-based
- organized by county or multi-county geographic areas
- based in various offices: hospitals, health departments, advocacy center, medical examiner’s offices, etc.
- membership composition mirrors that of the SCFRT.
- conduct retrospective reviews of deaths of children 17 years of age or younger in their geographic areas.
- The goal of child fatality review is to monitor child death trends in the community, share the lessons learned in the community, and spearhead or participate in local prevention activities
- CFRT data is a snapshot of the deaths in Texas. In 2011, 3625 children 0-17 years of age died in Texas.
- 91% (3296) occurred in counties with an existing CFRT. 54% (1787) were reviewed by CFRTs.

Local Child Fatality Review Team Process and Data Collection

- Notification of death
 - Teams are notified of deaths in their area by receiving death certificates from vital statistics.
 - This usually takes up to a year or longer for teams to be notified of the death.
 - Some team use other sources to be notified of the deaths in a more timely manner
 - Williamson County uses the county registrar
 - Dallas County uses the Medical Examiner’s office, to review deaths
- Review of the child death
 - Team members bring their agency information to the meeting,
 - Share pertinent information from their reports with the team and take their agency reports back to their office.
 - No agency reports should be kept by the CFRT.
- Completion of Data Collection Form
 - Local CFRTs fill out a 20 page form for each child death that they review.
 - This is a form that is used nationally in all 50 states. It is sponsored by the National Center for the Review & Prevention of Child Death (NCRPCD).
 - This form not only asks questions about abuse and neglect deaths but about all manners and causes of child death.
 - The team enters this data into The National Center for the Review & Prevention of Child Death data clearinghouse.

Data Collection Improvement Actions

Assessment of Local Team Capacity

- Types of child deaths being reviewed
 - Are you reviewing all child deaths in your county or multi-county area?
 - If not, what type of deaths are you reviewing?
 - How did you decide what type of deaths to review?
- Data entry capacity
 - How much data entry back log do you currently have?

DSHS Considerations for Increased Support of Local Teams

DSHS contract for:

- Data entry - local teams could enter information onto form and then send form to state and will not be required to enter into the national database, will help quality and timeliness
- Technical Assistance – answer calls from local teams

- CFRT Statewide Conference – it is a goal to do a 2016 conference, first of its kind
 - Data collection training
 - Injury prevention
- Funding for expanded data collection to teams
 - Sleep related deaths
 - Sudden unexplained death in the youth
- Explore possibility of local teams obtaining the preliminary death certificate from their County Registrar
 - Costs associated with providing the data
 - Barriers to the ability of the data to be shared

National Center for the Review and Prevention of Child Deaths

Data collection challenges:

- Caseload
 - Volume of data per case
- 20 page CDR reporting form
- Variable participation among CFRTs
 - Variable terminology (death certificates)

Changeover in staff at DSHS has led to a need to reconnect with the 79 teams.

Q: Data form is huge, up to 300 questions per case. Is some of the data incomplete?

A: Yes. Perhaps we could develop a statewide protocol for a screening process.

Q: Is a preliminary death cert is required by law in certain amount of time?

A: Yes.

Some of this commission's recommendations could include protocols about how to obtain the preliminary death certificates, other protocols about how to screen which cases to study, and then later when the final death certificate comes out, how to compare the information from the death certificate to what was already entered into the database.

Prevention Plans also from the DSHS/DFPS Collaboration:

- Motor vehicle
- Hypothermia (children left in cars)
- Drowning –workgroup has met three times, funding from Title V

Q: The 1995 Report from the U.S. Advisory Board on Child Abuse and Neglect included a recommendation that Medicaid fund autopsies of all child deaths. This recommendation did not happen in Texas. Perhaps one of our recommendations should be that autopsies are funded when the state or local CFRTs requests an autopsy? Could there be some discretionary funding for these autopsies?

A: There is currently some money set aside for autopsies for SIDS deaths, but not for others.

Q: What about hiring a full time employee (FTE) for each region?

A: In the higher populated areas there is enough work for an FTE. In less populated areas, an FTE might need to cover multiple counties or teams.

The CFRTs need standardization and infrastructure to allow something to be prepared when the professionals get there to volunteer their time. The unmandated, unfunded CFRT procedure makes it difficult to gather good data. Even some of the larger counties are meeting and discussing the cases, but not filling out the form.

Madeline McClure, Executive Director of TexProtects

Current Count: DFPS reports child abuse neglect fatalities on cases with the disposition ruling “Reason To Believe (RTB) Fatal” only.

For predictive analytics, prevention focus and caseworker staffing models, further data reporting and/or collection needed:

Recommendations:

- Report CPS cases in which abuse was substantiated (“RTB-Abuse”) and a fatality occurred, regardless of fatality disposition.
- Re-dispose “RTB/Near Fatal” cases to “RTB-Fatal” when the child subsequently dies after case closed (DSHS records).
- Fatality Trends by: Zip code, Age, Disposition and Prior reports.

Track Fatalities with prior reports of abuse by:

- Referrals-including those closed at intake, administratively or merged into existing investigations
- Assigned to investigations and actual investigations
- Subsequent Family Preservation (FBSS) referral
- Removals and return to caregivers prior to child death
- If FBSS or Removal occurred, specify which/ if services were offered (specific), length of service, and compliance/completion.

Evidence-Based Home Visitation and Universal Prevention

Population-Level Examples:

- Period of Purple Crying – Hospital-based parent education program to reduce AHT and SBS
- Triple P (Level 1)- Universal messaging on child abuse prevention

Targeted Evidence-Based Home Visitation Examples:

Nurse-Family Partnership (NFP)

- SafeCare
- Healthy Families
- Parents as Teachers
- Nurturing Parenting Program
- Triple P (Levels 4-5)

Q: Is Fetal Alcohol System addressed in home visiting programs?

A: Yes, home visiting programs often include education regarding FASD and the dangers of drinking while pregnant.

Dr. Nancy Kellogg

1. In regards to the first charge of this Commission, it is important to note that “the practices and evidence-based strategies to address and reduce fatalities” from abuse will likely differ significantly from “the practices and evidence-based strategies to address and reduce fatalities from neglect. Deaths due to neglect are more common than those due to abuse. The strategies to prevent a 7 month old from drowning in a bathtub because they are left unattended is likely different than the strategies involved in preventing a 7 month old from being deliberately drowned because they were crying too much.
2. Several comments in regards to the data that we have and the data that we need, which is the third charge of this Commission (“develop guidelines for the types of information that should be tracked to improve interventions to prevent fatalities”).
 - a. Wide variability in data collection in terms of consistency, completeness, and validity.
 - i. We have child fatality review teams for most of the counties in Texas. There is a very comprehensive 15 page data form to fill out for the child death cases that are reviewed, so about 300 items for each death. We don’t know if the data is consistent, complete or valid. The most recent state-wide fatality review report was in 2011 for data collected in 2008-9. The data in this report is primarily the manner and cause of death for children and infants. I was surprised to find that among infant victims of homicide the most common cause was drowning. In many places, including Bexar a drowning death would be considered accidental or undetermined, with neglect indicated as a contributing factor. Most of the data on the child fatality reporting form is not in the 2011 report.
 - b. We do have some data that appears to be consistent.
 - i. Child maltreatment deaths have decreased significantly, from 2009-2013. This was not a national trend, so it would be interesting to know why this happened in Texas. Currently the child maltreatment death rate in Texas is slightly above the national average (2.13 per 100,000 children v 2.04).
 - ii. Child maltreatment deaths occur predominantly in children and infants younger than 3 years.
 - iii. About ½ of the CM deaths occur in families with prior CPS history.
 - c. What data do we need? (to improve earlier detection of abuse/neglect or associated risk factors, optimize interventions provided when abuse/neglect is detected and to prevent abuse/neglect before it occurs)
 - i. Data to better understand the characteristics of the child maltreatment deaths
 1. Deaths with CPS history: were previous referrals adequately investigated/staffed? Was there a multidisciplinary staffing prior to death? (for example, Serious Abuse/Neglect staffings in Bexar County) What services were provided? Did abuse and/or neglect contribute to the death?

Kathryn Sibley commented that DFPS is currently looking at FY 2013 and in process of getting the 2014 data, using same questions as CFRTs, prior history, prior review (CPS,

CAC, multidisciplinary) DFPS is looking at things like whether interventions did not have an impact or if there wasn't any follow up, etc.) How do we engage other professionals and are there accountability measures in place? CPS interviews a lot of people which is rich information that needs to be linked to CFRT reviews. We should also consider reallocation of resources, to spend more up front for example drug testing rather than after a child has died.

MEDCARES might be a good partner for earlier interventions. Six years ago, the Legislature set aside 2.5 million/year to 8 sites that were designated Pediatric Centers of Excellence with subspecialties of child abuse to house medical expertise, research and prevention, training med professionals. MEDCARES would eventually like to reach out to areas without children's hospitals. The program encourages better evidence gathering and reading and could be expanded with satellite sites or telemedicine for areas without children's hospitals. MEDCARES is also funded in part by Title V funds.

2. Deaths without CPS history: was the child in daycare or did they seek medical care? Were injuries or indicators of abuse/neglect noted in these settings? Are there opportunities to improve recognition in medical and daycare settings which are the predominant domains outside the home for children under 4 years of age. Emergency rooms, in particular, should be targeted as many families do not present for routine medical care in a PCPs office.
3. Are there risk factors/predictors of child maltreatment deaths that could be identified and treated to prevent deaths?
4. Would including data on serious injuries and/or near fatalities provide additional data and information regarding risk factors? (Would have to clearly define "serious" and "near fatality" first) Preliminary studies from Pennsylvania indicate that serious abuse and near fatality cases share a lot of similarities with child maltreatment deaths.

ii. Data to better understand the efficacy of intervention/prevention programs

1. Referrals to CPS and/or law enforcement and any child deaths following interventions
2. Project HOPES(Healthy Outcomes through Prevention and Early Support) and Project HIP(Help through Intervention and Prevention), but there are other programs throughout the state that work outside the CPS system that are based on a similar model of home-visiting and provision of parent education, mentoring, and support. Outcomes should also be tracked in these other programs since many are for at-risk families who are not yet referred to CPS. Nurse-Family Partnership and home-based school-readiness educations for parents is another.

3. In regards to charge 2 for the Commission, recommendations to reduce child maltreatment deaths depend in part on what the data tells us:
 - a. Efficacy of in-home parent support and education programs such as Project HOPES and others (not currently funded or monitored by CPS). If these interventions reduce the child maltreatment deaths in the 5 years following intervention, then prevention programs targeting at-risk parents should be implemented as part of a comprehensive statewide strategy. Most successful, evidence-based child abuse prevention programs involve in-home family mentoring and monitoring; it seems likely this approach would reduce child maltreatment deaths as well.

Jane Burstain commented that to improve efficacy, alternative responses are being utilized for lower risk cases, older children, and priority II cases. For example, DFPS would call the family to make an appointment and make the involvement more collaborative. The results of these alternative response cases will be tracked. DFPS is also working on safety networks to engage extended community for when CPS leaves the family.

- b. Earlier recognition of abuse or neglect by health care professionals or daycare providers. If the data indicates that children dying of child maltreatment were seen in medical or daycare settings prior to death, then statewide strategies should support on-going education in the recognition and management of suspected abuse and neglect.
- c. Impact of multidisciplinary case staffings/review on child maltreatment rates. There are numerous models statewide of how cases are selected, staffed and managed. There are CPS case managers in each region who may be resources for gathering data on how such case reviews impact child maltreatment fatalities

Dr. Giardino recommended the POK take a Public Health approach such as preventable deaths are not acceptable, then we would be able to engage more of the community.

Judge McCown agreed and suggested pushing back against our charge and looking beyond deaths caused by abuse and neglect because those classifications involve moral judgments involved with caretaker culpability. The classifications related to abuse and neglect could lead us astray instead of casting a wider net with a public health approach which would improve all preventable deaths and would capture many deaths that were related to abuse and neglect.

Future Meetings will be:

March 27, 2015

May 11, 2015

Meeting adjourned.

Insert Tab 4

**Department of Family and Protective Services
and Department of State Health Services
Strategic Plan to Reduce Child Abuse and Neglect Fatalities**

A report from the Department of Family and Protective Services
and Department of State Health Services

March 2015

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Executive Summary

A child fatality is the most tragic consequence of abuse and neglect. It is a loss not only to the family but to the child's community and Texans overall. Texas is striving to build a more robust safety net to protect the most vulnerable in society by coordinating initiatives through prevention and early intervention services that reach the entire population. The Texas Department of Family and Protective Services (DFPS) and the Texas Department of State Health Services (DSHS) are charged with addressing the health and safety needs of all Texans, be it through improving health overall or addressing safety, and wellbeing for children, youth, families, and adults across the state. Given that 53% of all abuse and neglect fatalities from calendar year 2010 to 2012 had no prior involvement with Child Protective Services (CPS), it is clear that preventing abuse and neglect fatalities is not a charge that DFPS should be facing alone. Rather, efforts to address and reduce these deaths must be strategically focused on the entire population to reach vulnerable children outside of the CPS system and involve coordinated effort between agencies.

Directed and thorough analysis of abuse and neglect fatalities can lead to understanding the types of abuse and neglect cases that are occurring and where they are occurring. Also, these analyses can help explain the underlying risks that exist in families and communities. Understanding these risks can help guide and direct intervention programs and identify unmet needs so that programs can be developed and coordinated between agencies to better protect vulnerable children. The collaboration between DFPS and DSHS aims to use these results to guide a strategic plan to coordinate support services between DSHS and DFPS. The ultimate goal of this plan is to reduce abuse and neglect fatalities by providing timely, coordinated, and evidence-based services to families and communities in need.

Major Findings

DSHS and DFPS have partnered to analyze and link DFPS-Child Fatality Review Data (DFPS-CFR) with other data sources including birth records, death records, and community-level risk indicators (for example, concentration of poverty, education levels, or mobility). The focus of these analyses is three-fold:

- (1) to understand the prevalence of abuse and neglect fatalities within the population;
- (2) to identify communities that are high risk for specific types of abuse and neglect fatalities;
- and
- (3) to explore which risk factors in the family are associated with abuse and neglect.

Comparing confirmed child abuse and neglect fatalities to all non-natural child fatalities

- 14.5% of all child fatalities without an underlying medical cause were confirmed child abuse and neglect.
- 7.7% of all sleep-related deaths were confirmed child abuse and neglect deaths.
- 6.1% of all motor vehicle deaths were confirmed child abuse and neglect deaths, with 64% of the abuse neglect motor vehicle fatalities being either pedestrian deaths (an unsupervised child being hit by a vehicle) or children left in hot cars.

Community Disparities

- The San Antonio/New Braunfels, Midland/Odessa, and Beaumont/Port Arthur areas had higher-than-expected number of abuse and neglect sleep-related deaths.
- The Dallas/Fort Worth area had a higher-than-expected number of children dying in hot cars.

Point of Contact Identified for Referral

- According to birth certificate information, 65% of the mothers involved in a confirmed child abuse or neglect fatality were enrolled in the Nutrition Program for Women, Infants, and Children (WIC) during their pregnancies.

Risks at Birth

- Many of the risk factors identified for abuse and neglect fatalities are also known risks for domestic violence.
- Infants who died from sleep-related abuse and neglect were likely to have a mother who smoked during pregnancy.

Strategic Plan

Activities related to four major areas identified by the data analysis are currently under way to address child fatalities, including child abuse and neglect, from a public health perspective.

- Motor vehicle-related fatalities, focusing on hyperthermia or "hot car death" prevention efforts in the Dallas/Fort Worth area
- Motor vehicle-related fatalities, focusing on pedestrian fatalities statewide
- Sleep-related fatalities, statewide and focusing on the San Antonio/New Braunfels, Beaumont/Port Arthur, and Midland/Odessa areas
- Physical abuse-related fatalities statewide

Each of the four major areas are part of the strategic plan to deliver a consistent, comprehensive, and evidence-based action plan to address child fatalities, including those that are caused by abuse or neglect. Additionally, two areas have been identified to strengthen ongoing analysis and project coordination between DFPS and DSHS.

Focus Area	Action Plan	Inter-Agency Coordination
<p>Motor Vehicles: Hyperthermia</p> <p>Focus Area: Dallas/Fort Worth</p>	<ul style="list-style-type: none"> • Develop hyperthermia educational materials (DSHS). • Identify and develop partnerships to distribute and promote prevention messages. • Increase temperature gauge demonstrations. • Use billboards in targeted markets. 	<p>DSHS Safe Rider Program and DFPS Prevention and Early Intervention Division</p>
<p>Motor Vehicles: Pedestrian</p> <p>Focus Area: Statewide</p>	<ul style="list-style-type: none"> • Assist local Child Fatality Review Team (CFRT) efforts to address motor vehicle/pedestrian safety. • Use Safe Rider Program (child safety seat program) to promote motor vehicle/pedestrian safety. • Develop a child motor vehicle workgroup to plan and assess child motor vehicle death prevention activities in Texas. <ul style="list-style-type: none"> ○ Review DSHS/DFPS findings as well as 	<p>DSHS Office of Title V and Family Health, DFPS Prevention and Early Intervention Division, and DSHS Safe Rider Program</p>

	<p>data that may be available through local review processes.</p> <ul style="list-style-type: none"> ○ Assess current child pedestrian safety programs being conducted and/or educational materials being distributed in Texas. ○ Develop evidence-based recommendations for child pedestrian death prevention strategies to implement throughout Texas. 	
<p>Sleep-Related</p> <p>Focus Area: San Antonio/New Braunfels, Beaumont/Port Arthur, and Midland/Odessa areas, and statewide</p>	<ul style="list-style-type: none"> • Conduct Education and Referral Pilot in WIC Clinics. • Conduct community assessment and planning. • Create Safe Sleep Workgroup (statewide). • DSHS will work with the State Child Fatality Review Team Committee (SCFRT) and local CFRTs to enhance death scene data collection to increase identification and improve classification of sleep-related deaths (statewide). 	DSHS/DFPS Interagency
<p>Physical Abuse</p> <p>Focus Area: Statewide</p>	<ul style="list-style-type: none"> • Create an Intimate Partner Violence Workgroup to review screening and referral process for community providers. • Coordinate this initiative with the Task Force on Domestic Violence created pursuant to HB 2620 of the 83rd Legislature, Regular Session. • Identify, review, and catalog national intimate partner violence materials, health and human services, enterprise resources, and service providers • Coordinate with local partners to develop targeted strategies to address screening during prenatal/postnatal care for intimate partner violence. 	DSHS/DFPS Interagency
<p>Enhanced Data Analysis and Collaboration</p> <p>Focus Area: Statewide</p>	<ul style="list-style-type: none"> • Improve identification, classification and data collection. • Conduct evaluation of impact of strategic initiatives. • Expand data collaboration to include child abuse and neglect cases not resulting in a fatality. 	DSHS/DFPS Interagency
<p>Ongoing Collaboration</p> <p>Focus Area: Statewide</p>	<p>Continue the joint DSHS-DFPS commitment to promote healthy mothers and healthy babies including examining:</p> <ul style="list-style-type: none"> • The impact of the state's investment in home-visitation programs; • The promising practices of Centering Prenatal Care and mother-child attachment models 	DSHS/DFPS Interagency

	<p>such as Circles of Security; and</p> <ul style="list-style-type: none"> • Innovative local initiatives such as Cook Children's Hospital's newly formed Center for the Prevention of Child Maltreatment and the use of the Period of Purple Crying shaken-baby prevention program by Dell Children's Hospital and Texas Children's Hospital. 	
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Overview

In April 2014, DFPS Commissioner Judge John Specia and DSHS Commissioner Dr. David Lakey brought together their respective agencies to proactively address child fatalities. Almost half of all confirmed child abuse and neglect fatalities are in families that had no previous involvement with DFPS, highlighting the importance of population-based strategies to reduce these deaths. By taking into consideration the entire population to understand, analyze, and build comprehensive strategies to target child abuse and neglect fatalities, DFPS and DSHS can leverage resources, programs, and community collaborations to target specific issues and geographical areas based on their individual needs. By combining data from DFPS with the population-based data systems available to DSHS, a broader picture of influencing factors and possible intervention points can be determined for all child fatalities, including those caused by abuse and neglect.

The goal of this collaboration is not to predict which children in the care of DFPS are at risk of suffering from an abuse and neglect-related fatality. Rather, the goal is to identify risk factors that are associated with child abuse and neglect fatalities as a means to identify warning signs so that services can be provided to the family before a crisis occurs. By using rich data to drive the coordination of prevention efforts and resources, the joint project is designed to reduce preventable child deaths and ensure a clear, consistent response to child fatalities by strategically providing timely, coordinated, and evidence-based services to families and communities in need.

The analyses presented in the report follow an approach that is informed by the public health literature in the United States and other countries. This approach is built on the recognition that risk factors for abuse and neglect are multi-faceted and can be measured across multiple levels of influence: the individual within a family can carry risk, the family can carry risk, and the community can have risk. It is important to understand each level to develop a plan to address these fatalities. The analyses within this report have three main objectives: (1) to understand the prevalence of child abuse and neglect fatalities within the population; (2) to identify communities that are high-risk for specific types of child abuse and neglect fatalities; and (3) to explore family-level risk factors that are associated with child abuse and neglect.

Current System

Texas provides specific health and human services through five agencies, including DSHS and DFPS. These agencies are responsible for meeting the health and safety needs of children, youth, families, and adults across the entire state.

DSHS oversees programs such as disease prevention, family and community health services, environmental and consumer safety, regulatory programs, and mental health and substance abuse prevention and treatment programs. In regard to child fatalities, DSHS has traditionally addressed child fatalities from a public health approach of disseminating prevention activities through maternal and child health programs and safety campaigns. These prevention efforts are developed from and informed by surveillance and research efforts in the agency, as well as through data gathered on birth and death records. Additionally, DSHS provides support to the State Child Fatality Review Team (SCFRT) and local Child Fatality Review Teams (CFRTs), which are multidisciplinary groups comprised of members throughout Texas. SCFRT's mission is to reduce the number of preventable child deaths, regardless of cause, and its purpose is threefold:

- To develop an understanding of the causes and incidence of child deaths in Texas;
- To identify procedures within the agencies represented on the SCFRT to reduce the number of preventable child deaths; and
- To 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.

DFPS works with communities to protect children, the elderly, and people with disabilities from abuse, neglect, and exploitation. It also works to protect the health and safety of children in daycare, as well as foster care and other types of 24-hour care. This work is achieved through prevention and early intervention services, investigations, services and referrals, and regulation of specific types of care providers. Through the Texas Family Code, DFPS is the investigator of child fatalities that are suspected to be from abuse and neglect. In September 2014, DFPS established the Office of Child Safety to address child fatalities and serious injuries through thorough case review, data analysis, practice recommendations and collaboration with local agencies, private sector, non-profits, and government programs to reduce child abuse and neglect fatalities. Additionally, DFPS works in partnership and serves as a member of the SCFRT, as well as with local CFRTs. DFPS also leads the Child Safety Review Committee, which provides recommendations for action to DFPS based on review of confirmed child abuse and neglect related fatalities. This group comprises internal and external stakeholders including law enforcement, medical professionals, early childhood education, and Court Appointed Special Advocates (CASA).

Data and resources from both agencies have helped each agency address child fatalities. However, it is through this project that both DFPS and DSHS have collaborated to focus on reducing child abuse and neglect fatalities. Utilizing a public health approach to prevent all child fatalities allows both agencies to:

- understand child deaths at the local level;
- collect and analyze data to better understand risks to children; and
- inform local and statewide activities to reduce preventable child deaths.

Analysis of Child Abuse and Neglect Fatalities

A major component of the collaboration between DFPS and DSHS centers on data sharing. The literature on the epidemiology of child abuse and neglect is clear that multiple data sources must be linked in order to understand both individual and social risk. This literature has shown that there are strong ties between several risks that public health tries to mitigate and child abuse and neglect. For example,

poverty is a strong predictor of child abuse and neglect. It has been shown that children in families with an annual income of less than \$15,000 are 14 times more likely to be abused and 44 times more likely to be neglected as compared to children in families with an annual income of \$30,000 or more¹. Children with young mothers are more likely to suffer fatal child maltreatment². Also, evidence-based prenatal and infancy support programs, such as home visits by nurses, have been shown to have to fewer verified cases of child abuse and neglect among participating families³.

DFPS provided case-specific data of confirmed child abuse and neglect fatalities from Fiscal Year (FY) 2010 through (FY) 2013. The Office of Program Decision Support within the DSHS Division for Family and Community Health Services then matched this data set to information in its system, based on calendar year. This level of data linking helped identify the official cause and manner of death on the death certificate and provided information to complete geo-coding to allow community-based analysis of where the child lived, such as concentration of poverty, level of education, crime levels, and access to nutritious food, among other information. Additionally, a sub-set of cases of children younger than 3-years old were linked with the child's birth certificate. The birth certificate contains several important pieces of information that enhance analyses of these fatalities, such as presence or absence of paternity, adequate prenatal care, tobacco use during pregnancy, mother's and father's educational level, and a host of other maternal and infant characteristics. This linking also facilitated geo-coding cases based on the mother's residence at the time of birth, which was used to link to a variety of sources about poverty, community risks and other factors.

Major Findings and Action Plans

Summary of Major Findings

The analyses presented in this report follow an approach that is informed by the public health literature in the United States and other countries. The analysis includes 4,723 child fatalities between 2010 and 2013, of which 14.5% (686) were confirmed abuse and neglect related deaths. For this report, child fatalities include all non-natural deaths to a child younger than 18 years old. These child fatalities include accidents, homicides, suicides and all unknown or undetermined causes of death.

Through the rest of the report, all numbers presented in parentheses are the actual number of children who died between calendar year 2010 and the end of 2012. This report presents specific analyses that are the basis for the recommendations that will strengthen the coordination between DFPS and DSHS.

¹ Sedlack, A.J., & Broadhurst, D.D. *Executive summary of third national incidence study of child abuse and neglect*. Administration of Children and Families. Available at: <https://www.childwelfare.gov/pubs/statsinfo/nis3.cfm> (Accessed on March 5, 2014.)

² Stiffman, N.M., et al. Household composition and risk of fatal child maltreatment. *Pediatrics*, 109(4): 615-621. April 2002.

³ Olds, D.L. Preventing child maltreatment and crime with prenatal and infancy support of parents: The nurse-family partnership. *Journal of Scandinavian Studies in Criminology and Crime Prevention*, 9(S1): 2-24. December 2008. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2946620/>. (Accessed on March 5, 2014.)

Major Finding: Motor Vehicle Related Fatalities - Hyperthermia

Findings and Conclusions

In Texas, child fatalities from hyperthermia are an unfortunate seasonal reality and are completely preventable. Hyperthermia (24) due to the child being left in a hot car accounts for 32% of motor vehicle-related child abuse and neglect fatalities (75). Additionally, 75% of all child deaths due to hyperthermia (32) were attributed to child abuse or neglect. A significantly greater than expected number of the child abuse and neglect fatalities related to hyperthermia occurred in the Dallas/Fort Worth area. While DFPS has had a major campaign to address hyperthermia deaths, it has often been targeted to childcare providers rather than caregivers.

Action Plan and Service Coordination

Proposed Hyperthermia Prevention activities will be targeted to Dallas, Fort Worth and other cities/media markets where fatalities due to heat exposure have occurred.

Action Plan	Inter-Agency Coordination
<ul style="list-style-type: none"> • Develop hyperthermia prevention educational materials and distribute through the Safe Riders information and referral request line. • Develop a partnership with the statewide Hyperthermia Task Force and seek other public/private partnerships to promote messages for hyperthermia prevention. • Purchase vehicle temperature gauge displays for distribution to DSHS regional offices, Texas Department of Transportation (TxDOT) traffic safety specialists, and other events • Purchase billboard space in cities/markets where recent hyperthermia deaths have occurred. • DSHS-DFPS Collaboration to: <ul style="list-style-type: none"> ○ Identify community organizations and distribute educational material statewide; and ○ Receive and use temperature gauge displays in hyperthermia demonstrations. 	<p>DSHS Safe Rider Program and DFPS Prevention and Early Intervention Division</p>

Major Finding: Motor Vehicle Related Fatalities - Pedestrian

Findings and Conclusions

Data analysis found that 64% of confirmed child abuse and neglect fatalities related to motor vehicles were hyperthermia (24) or pedestrian deaths (24). The pedestrian fatalities often involved a child who was unsupervised and entered the roadway or who was playing in a driveway where someone backed

out. At times, these events occurred while the caregiver was under the influence of alcohol or drugs, or unable to supervise the child.

Action Plan and Service Coordination

While hyperthermia fatalities were disproportionally found in the Dallas/Fort Worth areas, pedestrian fatalities occur statewide. Because of this trend, the CFRTs located throughout the state have been identified as a possible resource for addressing this specific finding.

Action Plan	Inter-Agency Coordination
<ul style="list-style-type: none"> • DSHS Office of Title V and Family Health will develop a cross-program child motor vehicle workgroup in coordination with the State Child Fatality Review Team Committee to plan and assess child motor vehicle death prevention activities in Texas. An initial project of the workgroup will be to examine child pedestrian deaths. The workgroup will: <ul style="list-style-type: none"> ○ Review state and local data and current child pedestrian safety programs being conducted statewide/in targeted areas. ○ Develop evidence-based recommendations for child pedestrian death prevention strategies to implement in targeted areas and statewide. ○ Partner with Safe Riders distribution and education sites statewide/in targeted areas to promote MV/Pedestrian Safety. 	DSHS Office of Title V and Family Health, DFPS Prevention and Early Intervention Division, and DSHS Safe Riders Program

Major Finding: Sleep-Related Fatalities

Findings and Conclusions

Sudden unexplained infant-death that occurs during sleep (SIDS/SUID) is the second-leading category of death in cases where child abuse and neglect has been substantiated. It is also one of the leading causes of death among all infants in Texas. Between 2010 and 2012, 7.7% of all sleep related deaths (1,449) were found to be child abuse and neglect-related fatalities (112). The greatest number of child abuse and neglect sleep-related infant fatalities occurred in the San Antonio/New Braunfels area. There were also a greater than expected number of cases in both Beaumont/Port Arthur and in Midland/Odessa.

The cases that were matched to birth data also showed that smoking during pregnancy was a risk factor for sleep-related child abuse and neglect-related fatalities. Smoking during pregnancy is also a leading modifiable risk factor for *all* sleep-related infant deaths. The prevalence of tobacco use among pregnant women is significantly higher than the state average (4.7%) in Beaumont/Port Arthur (12.8%) and in Midland/Odessa (8.0%).

One of the major questions leading into these analyses was whether or not these high-risk families could be reached and targeted for intervention before they became involved with CPS. Of the child abuse and neglect cases linked to the birth file (329), 65% of mothers were receiving WIC services during pregnancy (214). Additionally, 72% of these mothers had their deliveries paid for by Medicaid. However, the rate of utilization of prenatal services was lower than the general public, with only 49% of women attending an adequate number of prenatal care visits. These results suggest that WIC may be a valuable component in the safety net services able to reach these families.

Child fatalities that are alleged to be from abuse or neglect must be reported to DFPS for investigation. Additionally, the local CFRTs review the majority of child fatalities in Texas, regardless of abuse or neglect allegations. One group of child fatalities that can be caused by abuse or neglect, but are often not reported, are those where co-sleeping (shared sleep surface/bed) is involved and other factors such as substance abuse may be present. The reason data is not reported is often due to a lack of information being gathered at the death scene.

Action Plan and Service Coordination

Action Plan	Inter-Agency Coordination
<ul style="list-style-type: none"> • WIC staff in Local Agencies serving Greater San Antonio, Beaumont/Port Arthur, and Midland/Odessa will participate in a pilot project to assess feasibility and efficacy of implementing safe sleep activities in the WIC setting. Activities will include: <ul style="list-style-type: none"> ○ WIC clinic staff will be trained on evidence-based information about safe sleep environments and recommended strategies for risk reduction of sleep-related deaths. ○ To address the specific risk factor of prenatal smoking and to reduce child health risks associated exposure to environmental tobacco smoke, WIC clinic staff will be trained to implement an Ask/Advise/Refer brief tobacco-cessation intervention with participants, and Quitline posters will be displayed in local WIC clinics. • Coordinate with key public health and prevention partners in each of the three targeted communities to identify local stakeholders in child abuse and neglect and in risk reduction for sleep-related deaths. • Convene partners and stakeholders for “listening session” meetings in each of the three targeted communities. • Plan, implement and evaluate community-specific strategic actions in each of the three targeted communities for prevention and risk reduction of sleep-related deaths 	<p>DSHS Nutrition Services Section (Texas WIC), DSHS Office of Title V and Family Health and DFPS Prevention and Early Intervention Division</p>

<ul style="list-style-type: none"> • Coordinate across agencies to align messaging and strategies related to safe sleep environments and risk reduction for sleep-related infant deaths. • Develop activities to increase statewide access to consistent, comprehensive, and evidence-based information. • Work with the SCFRT Committee and local CFRTs to enhance death scene data collection to increase identification and improve classification of sleep-related deaths. 	
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Major Finding: Physical Abuse

Findings and Conclusions

Among child fatalities without a clear medical cause from 2010 to 2012, 6.4% were ruled as child abuse or neglect homicides (304); and over half of all child homicides (575) were determined to be abuse- or neglect-related. Many of these homicide cases (129) were linked to the child’s birth record. In-depth analyses of the birth data showed that many of the factors in the Texas data that put the infant at risk for a child abuse and neglect fatality are also risks identified in the research literature for domestic violence. Domestic violence prior to and during pregnancy is a strong predictor of violence in the home once the child is born. It is critical to address violence in home both prior to conception and once the mother is pregnant.

Surveillance data gathered through the *Pregnancy Risk Assessment Monitoring Survey* at DSHS has shown that women receiving Medicaid during pregnancy (58.4%) were significantly more likely to report being screened for domestic violence than non-Medicaid clients (46.3%). While these screening results are encouraging, these data also show that only half of the women who reported incidences of abuse during pregnancy also reported being screened for domestic violence. Given the apparent shared risks, one way to address physical abuse among infants is to strengthen support and screening for domestic violence during pregnancy.

Action Plan and Service Coordination

Action Plan	Inter-Agency Coordination
<ul style="list-style-type: none"> • Form a DSHS-DFPS Interagency Workgroup to focus on the Intimate Partner Violence screening and referral process across community providers and develop a consistent, comprehensive and evidence-based strategic plan. • Coordinate initiative with the <u>Task Force on Domestic Violence created pursuant to HB 2620 of the 83rd Legislature, Regular Session</u>, which is working with a broader group of partners to address these same issues. • Identify, review and catalog existing national materials, relevant health and human services enterprise programmatic resources, and service providers. • Coordinate local partners to develop targeted strategies to address screening for intimate partner violence during prenatal/postnatal care. 	<p>DSHS Office of Title V and Family Health and DFPS Prevention and Early Intervention Division</p>

Major Finding: Data Analysis and Ongoing Collaboration

Findings and Conclusions

During this initial phase of data sharing, resource mapping, and collaboration of intervention efforts to address child abuse and neglect fatalities, specific issues were noted that would strengthen ongoing action items. One of these issues was to strengthen data sharing between DFPS and DSHS. The analyses in this initial phase were based on data from confirmed child abuse and neglect fatalities. While focusing on fatalities helps target a specifically tragic outcome, there remains a gap in knowledge about preventing abuse and neglect generally.

Future data sharing must still include all fatalities resulting from abuse or neglect, but should be expanded to include all cases where abuse or neglect occurred and identify cases where the child suffered a near fatal injury or where a serious injury did not occur.

These data will be utilized to examine local level risk factors in greater depth to help in identifying specific areas of need.

While the four major areas for current intervention have been identified and action plans for each are under way, it is also essential to conduct ongoing evaluations to determine the impact of these strategic initiatives.

Additionally, DFPS and DSHS are committed to providing support and partnering with other agencies and stakeholders who also want to reduce child fatalities through prevention and intervention

strategies. By promoting research and initiatives in Texas communities to support healthy mothers and healthy babies, DFPS and DSHS can reach exponentially more families. This work includes examining and working in partnership with:

- in-home visitation programs, and
- the promising practices of Centering Prenatal Care and mother-child attachment models such as Circles of Security; and innovative local initiatives such as Cook Children's Hospital's newly-formed Center for the Prevention of Child Maltreatment and the use of the Period of Purple Crying (shaken-baby prevention program) by Dell Children's Hospital and Texas Children's Hospital.

Conclusion

The first wave of data analysis has provided several beneficial touchstones for work between the agencies to address child fatalities. While this analysis was based on confirmed child abuse and neglect fatalities, future collaboration will look at near fatalities, serious injuries and general child abuse and neglect. This ongoing work will allow both agencies to further pinpoint particular geographic areas and specific risk factors that need targeted services and outreach. With these data, DFPS and DSHS can continue to collaborate with families, stakeholders, law enforcement, the medical community, service providers, community agencies, and other governmental agencies to address the specific issues identified in their area and reduce the unnecessary deaths of our children, our future.

Insert Tab 5

**Texas Department of Family and Protective Services
A Better Understanding of Child Abuse and Neglect Fatalities**

FY2010 through FY2013 Analysis

A report from the Department of Family and Protective Services

March 2015

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Executive Summary

Nearly one in 10 children in the United States lives in Texas. Of those children, about one third are under the age of six, which according to state and national data is the most vulnerable population for abuse and neglect. DFPS, in partnership with law enforcement, the medical community, service providers and the community, is committed to the continuing decline of child abuse and neglect fatalities.

To dedicate thoughtful and innovative analysis to these tragedies, Commissioner John Specia formed the Office of Child Safety in September of 2014. The Office of Child Safety will independently analyze both individual child abuse and neglect fatalities, near fatalities and serious injuries as well as patterns and the systemic issues involved. This very important work will involve reviewing state and national trends regarding child fatalities, near fatalities, and serious injuries in DFPS cases and in the general population as well as strategies that can be deployed by DFPS programs and by other state agencies and local communities. With this overarching goal of supporting implementation of prevention and intervention strategies to address and reduce fatal and serious child maltreatment, the Office of Child Safety is specifically tasked with:

- Producing consistent, transparent, and timely review of child fatalities and serious injuries by independent experts outside any specific program.
- Assessing root causes of child fatalities to provide guidance on the most effective prevention changes as well as improvements in child welfare practices;
- Operating with the understanding that many systems impact outcomes for children and that prevention and intervention efforts will involve many sectors and non-traditional partners;
- Working closely with the Department of State Health Services (DSHS) and others to share data and information; and
- Developing strategic recommendations to bring together local agencies, private sector, non-profits, and government programs to reduce child abuse and neglect fatalities.

As part of this effort, in March 2015 the Department of Family and Protective Services (DFPS) and the Department of State Health Services (DSHS) released the joint report "Strategic Plan to Reduce Child Abuse and Neglect Fatalities." This report identified certain risk factors and commonalities between confirmed child abuse and neglect fatalities including individual and community risk factors for child abuse and neglect. The "Strategic Plan" provides recommendations to address child fatalities from a public health prospective in four broad areas such as fatalities surrounding vehicle safety (hyperthermia and pedestrian fatalities), safe sleep practices, and intimate partner violence.

As its first major publication and demonstration of the transparency and trend analysis to come, the DFPS Office of Child Safety is releasing this companion report, "A Better Understanding of Child Abuse and Neglect Fatalities," to explore how Texas reports fatalities and to offer context and show trend analysis for the information reported. DFPS, through the Office of Child Safety, is using this data to evaluate, review, and strengthen policy and practices across the agency. Together with the "Strategic Plan," the information from these reports can be utilized in the development of prevention and early intervention programs, intervention strategies where abuse and neglect is suspected, and community initiatives to support child safety and healthy families.

This report is divided into four major sections:

- Definitions: Child Abuse and Neglect Fatalities Investigation Dispositions
- Findings: Data Analysis for FY2010 through FY2013

- Child Fatalities in Texas within the National Context
- Initiatives & Program Improvement

Based on administrative data and individual case reviews for confirmed child abuse and neglect related fatalities from FY2010 through FY2013, the following trends and areas for review have been identified:

General Findings

- There were 156 confirmed child abuse and neglect fatalities in FY 2013 – a 26 percent decrease from the 212 confirmed fatalities in FY 2012. (Table 2)
- Confirmed physical abuse/intentional trauma fatalities have decreased by 35 percent since FY2010. (Figure 3)
- Confirmed neglect related fatalities have decreased by 31 percent since FY2010. (Table 2)
 - In fatalities involving neglect, the most common causes of death were drowning, unsafe sleep, and car and firearm accidents. (Figure 7, 8)
- Children who die due to abuse and neglect are more likely to have suffered from physical abuse compared to all investigations where abuse or neglect has been confirmed.
- Child abuse and neglect-related fatalities in foster care (those where the caregiver is implicated in the death) are less likely to involve physical abuse and more likely to involve some form of neglectful supervision. (Figure 13, 16)

Victims

- In FY2013, 81 percent of children in abuse and neglect fatalities were 3 years old or younger and 58 percent were male. (Figure 9, 10)
- The largest percentage of children who die from abuse or neglect are Hispanic, who also represent the greatest percentage of overall child abuse and neglect victims. (Table 3)

Perpetrators

- Physical abuse in fatalities most commonly involved blunt force trauma inflicted by a father or boyfriend. (Figure 12)
- Parents are the most common perpetrators in fatal child abuse and neglect investigations. (Figure 11)
- In the majority of child abuse and neglect-related fatalities, the child or the perpetrator had no prior history with CPS. (Figure 18)
 - In cases where CPS was involved with the family at the time of the death, most fatalities were caused by unintentional acts involving inadequate supervision.
 - In the remaining cases where CPS was involved with the child or perpetrator in the past, most fatalities were the result of intentional acts such as physical abuse.

Definitions: Child Abuse and Neglect Fatalities Investigation Dispositions

The Department of Family and Protective Services is required under the Texas Family Code to investigate child fatalities where there are allegations of abuse or neglect in order to determine if abuse and/or neglect occurred and, if applicable, whether the fatality was caused by abuse or neglect.¹

DFPS investigates child abuse or neglect fatalities based on where the child was living at the time of death. Adult Protective Services investigates deaths of children placed in Adult Protective Services regulated placements. Child Care Licensing (CCL) and Residential Child Care Licensing (RCCL) investigate deaths of children in daycare settings and regulated care placement, including children in DFPS conservatorship in foster care placements. Child Protective Services (CPS) investigates deaths of children living with their families or who are in DFPS conservatorship and in non-foster care kinship placements. Both CPS and RCCL may investigate cases jointly, such as when a child dies in foster care from injuries sustained before coming into foster care or when a potentially abusive foster parent has his or her own biological children. If either division determines that the death is related to abuse or neglect, it is counted as a confirmed child abuse or neglect related fatality.

In abuse and neglect investigations, investigators by law are required to establish a preponderance of evidence in order to confirm an allegation of abuse and neglect. "Preponderance of evidence" is a standard of proof in which the facts sought to be proved are more likely than not. Sometimes this is referred to as the "51 percent" standard, a more stringent standard than "reasonable doubt" but less stringent of a standard as clear and convincing evidence. For CPS investigations, child abuse and neglect is defined in Texas Family Code §261.101. For CCL and RCCL investigations, abuse and neglect is defined in Texas Family Code §261.401, and additional guidance is available in Texas Administrative Code 40 TAC §§745.8551 – 745.8559.

The data used in this report were compiled from the IMPACT case reporting system as well as from individual case reviews completed on confirmed child abuse and neglect related fatalities.

Investigation Dispositions

Texas Family Code Section 261.203 states that "if, after a child abuse or neglect investigation is completed, the department determines a child's death was caused by abuse or neglect, the department shall promptly release" specific information. In order to track and report on these fatalities, DFPS utilizes case dispositions that exist on every investigation.

Reason to Believe (RTB) - Based on a preponderance of evidence, staff concludes that abuse or neglect has occurred. For fatalities that have a disposition of Reason to Believe, a severity code as outlined below must be determined.

- **RTB-Fatal** - Staff determine that there is enough evidence to support a finding that abuse or neglect caused or contributed to the death (e.g., when a parent physically assaults a child and the child dies from the injuries).
- **RTB - without the severity code of fatal** - Staff determine there is sufficient evidence to support a finding of abuse or neglect, but not enough evidence that it caused or contributed to the death (e.g., child was malnourished but died in a car accident).

Ruled Out (RO) - Staff determine, based on available information, that it is reasonable to conclude that the abuse or neglect has not occurred. "Available information," in the context of the "ruled out"

disposition, is the evidence that the worker gathered through the required and supplemental actions he or she took to conduct a thorough or an abbreviated investigation.

Unable to Complete (UTC) - Before staff could draw a conclusion, the persons involved in the allegation moved and could not be located, or the family refused to cooperate with the investigation. (CPS Investigations only)

Unable to Determine (UTD) - Staff conclude that:

- there is not a preponderance of the evidence that abuse or neglect occurred; but
- it is not reasonable to conclude that abuse or neglect has not occurred.
- the family did not move and become unable to locate before the worker could draw a conclusion about the allegation. (CPS Investigations only)

Preliminary Investigations/Administrative Closure (ADMIN) - Information received after a case was assigned for investigation reveals that continued intervention is unwarranted such as when there is no allegation of abuse or neglect or the fatality is not in DFPS' jurisdiction to investigate.

Findings: Investigating Child Abuse and Neglect (CAN) Related Fatalities

Table 1 provides data regarding overall trends in child abuse and neglect in Texas. While reports in general have decreased, confirmed investigations have increased. In terms of child fatalities, the number of reports involving a child fatality also has declined. The percent of confirmed child abuse and neglect related fatalities have varied between 19 percent and 24 percent in the past four years.

Table 1. Child Population and Reports of Child Abuse and Neglect

	FY2010	FY2011	FY2012	FY2013
Child Population of Texas	6,865,824 ⁱⁱ	6,952,177 ⁱⁱⁱ	6,996,352	7,121,499
Number of child abuse/neglect reports that were reported to DFPS	231,532	222,541	206,200	194,801
Number of Investigated Child Fatalities	1024	973	882	804
Number of fatalities where abuse/neglect was confirmed	227	231	212	156
Child Fatality Rate per 100,000 Children	3.31	3.32	3.03	2.19
National Rate for Equivalent Federal Fiscal Year^{iv}	2.10	2.10	2.20	2.04

Source: Data from US Census Bureau; Texas State Data Center; DFPS Data Books FY2010-FY 2013; DFPS Data Warehouse Report FT_06; U.S. Department of Health and Human Services.

The distribution of case disposition codes for investigations conducted in FY2010 through FY2013 are presented in Table 2 - Percentage of Child Fatality Investigations by Disposition. The total number of child fatalities investigated between FY2010 and FY2013 has decreased by more than 20 percent. The decrease in the number of confirmed child abuse and neglect fatalities in Texas is mirrored in the national data with a national decline of 12.7 percent in confirmed child abuse and neglect fatalities between FFY2009 and FFY2013.^v

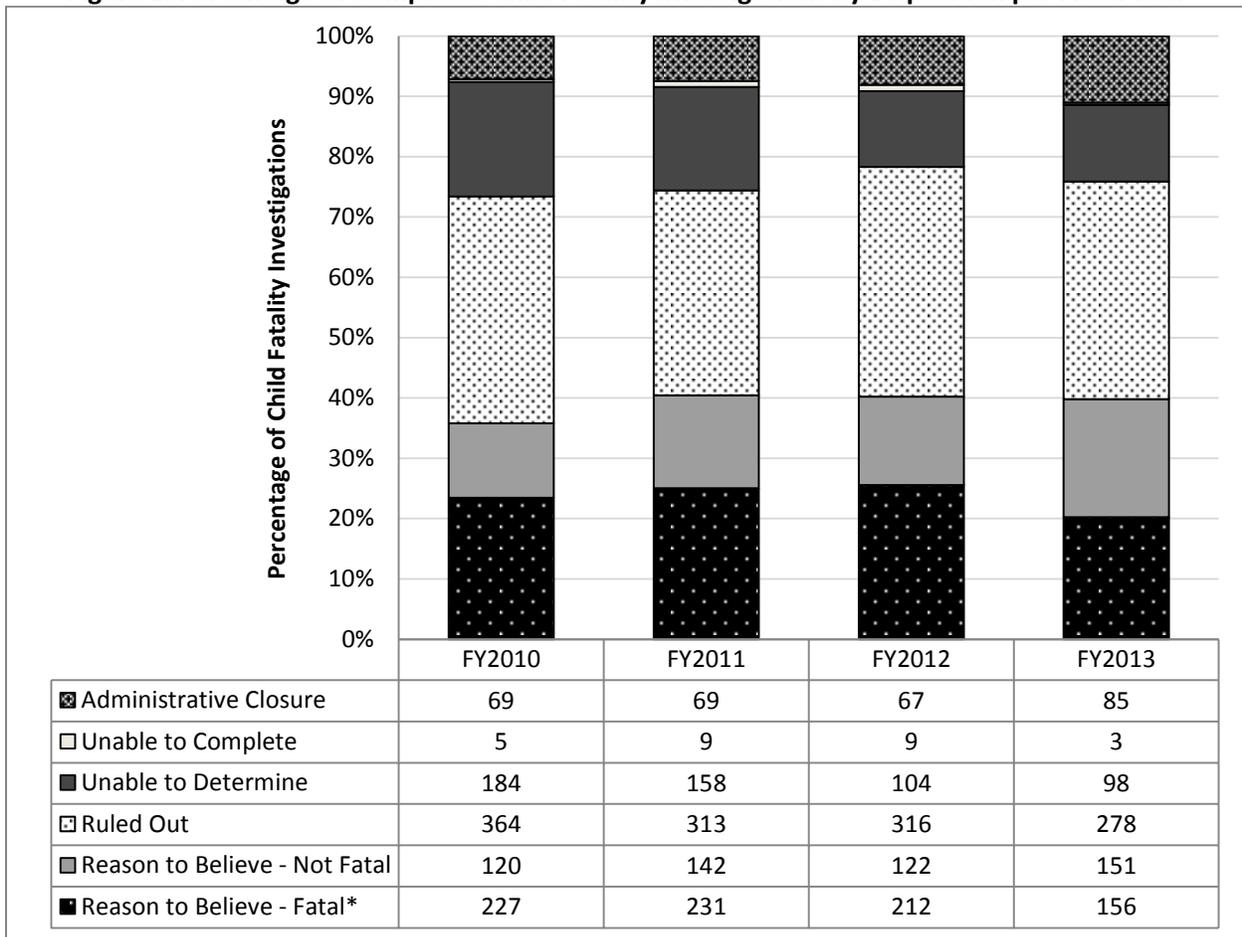
Table 2. Percentage of Child Fatality Investigations by Disposition

State Fiscal Year	Number of Investigated Child Fatalities	Reason to Believe and Fatality Confirmed for Abuse or Neglect* (RTB-Fatal)	Reason to Believe but Fatality not from Abuse or Neglect (RTB but not Fatal)	Ruled Out (RO)	Unable to Determine (UTD)	Unable to Complete (UTC)	Administrative Closure (Admin)
FY2010	1024	22.17%	11.72%	35.55%	17.97%	0.49%	6.74%
FY2011	973	23.74%	14.59%	32.17%	16.24%	0.92%	7.09%
FY2012	882	24.04%	13.83%	35.83%	11.79%	1.02%	7.60%
FY2013	804	19.40%	18.78%	34.58%	12.19%	0.37%	10.57%

*Count by child. All other dispositions are count by investigation. Count by investigation includes duplicated children and may include confirmation of abuse and neglect of a child that is not the deceased child. Multiple DFPS divisions such as Child Protective Services (CPS) or Residential Child Care Licensing (RCCL) may investigate a child fatality. Additionally, a child may die in a home where there are multiple families being investigated due to the child fatality.

Source: DFPS Data Request Intake and Tracking (DRIT) Request

Figure 1. Percentage of Completed Child Fatality Investigations by Disposition per Fiscal Year



* Count by Child
 Source: DFPS DRIT Request

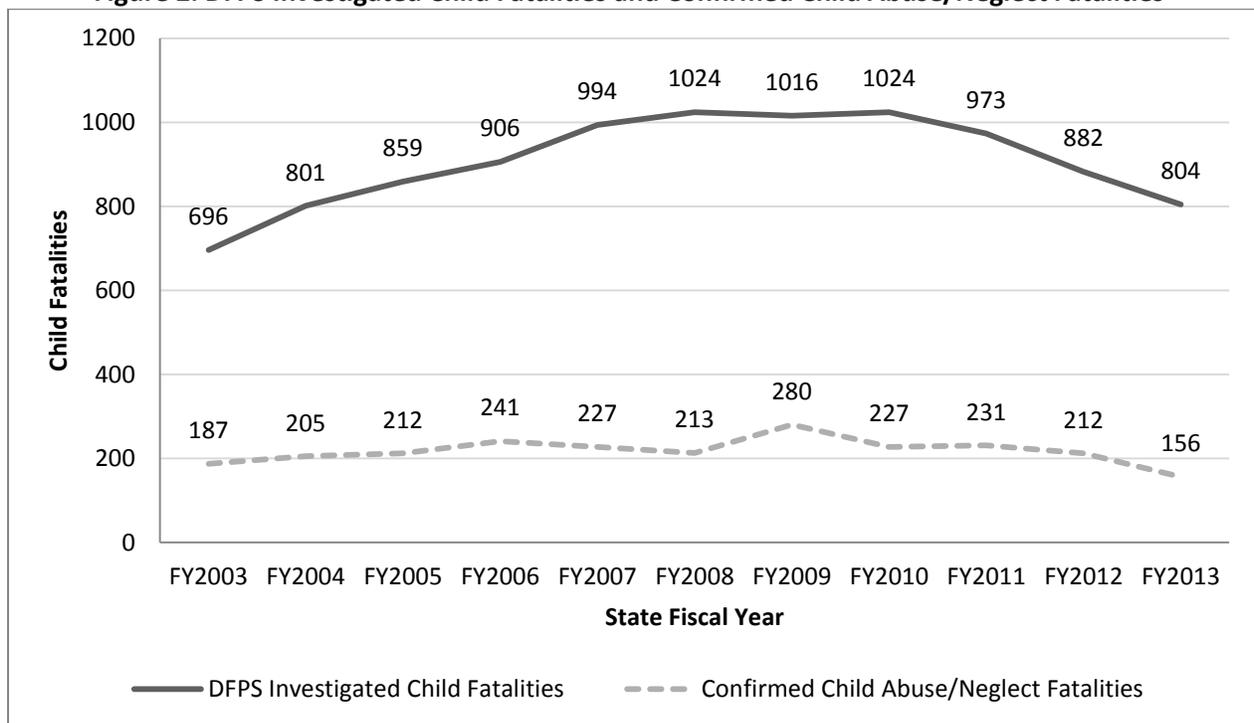
In the past four fiscal years, there has been an increase in the percent of administrative closures which coincides with strengthening the review process at intake and utilizing screeners to review all child fatality intakes so that investigations are only initiated when allegations clearly meet statutory authority for DFPS to investigate (Figure 1). Additionally, there has been a 26 percent increase in the number of investigations where there is a reason to believe finding for abuse or neglect to a child in the investigation but that the child fatality was not caused by abuse or neglect. This increase corresponds with providing enhanced disposition guidelines to field staff investigating child fatalities where the role of abuse or neglect causing the fatality may be medically undetermined or the level of abuse or neglect rising to fatal may be subjective such as cosleeping, drowning, suicide, or firearm-related fatalities.

Despite a growing child population in Texas, the number of confirmed child abuse and neglect related fatalities has dropped by more than 30 percent in the last four years. There are a number of reasons that have likely contributed to the decline, including:

- Reduction in number of reports overall about alleged child abuse and neglect fatalities
- Communities have increased prevention and early intervention efforts, including campaigns by the Blue Ribbon Task Force^{vi} and the State Child Fatality Review Team^{vii}

- As the economy stabilizes in communities, there may be less financial stress on families^{viii}
- Access to community services
- Increased medical community knowledge about child abuse and neglect as well as specialized treatment centers including Medical Child Abuse Resources and Education System (MEDCARES)^{ix} and the Forensic Assessment Center Network (FACN)^x
- Access to community health care, mental health services, substance abuse services
- Community programs and media campaigns such as Water Safety Month and child safety programs (like car seat use, safety around water, safe sleep)^{xi}
- DFPS' focus on enhanced child safety practices

Figure 2. DFPS Investigated Child Fatalities and Confirmed Child Abuse/Neglect Fatalities



Source: DFPS Data Warehouse Report FT_06

In the last decade, DFPS averaged approximately 907 investigated child fatalities per fiscal year. In FY2013, DFPS investigated 804 reports regarding possible child abuse and neglect related fatalities. Compared to FY2008 and FY2010 when DFPS had record highs of 1024 investigations, this is a decrease of over 20 percent of alleged child abuse and neglect fatalities reported and investigated. (Figure 2)

Part of the decline in child abuse and neglect fatalities in FY2013 is also related to more consistent disposition of fatalities. In FY2012, guidelines were provided to staff to help ensure consistent dispositions on child fatalities that involved cosleeping, drownings, firearm accidents, suicides and children left in cars. CPS in FY2013 created the Statewide Child Fatality Disposition Review Team, comprised of regional and state office staff, to ensure consistency in child fatality investigations with a disposition of Reason to Believe-fatal for abuse or neglect. CPS also trained staff and management in all stages of service to strengthen information gathering, engaging the family and their support systems, as well as utilizing information from professionals who have contact with the family to complete thorough

investigations and service delivery practices. This has helped in determining and supporting consistent dispositions in child fatality investigations.

Additionally, CPS has worked to ensure that the intakes sent on to field staff for full investigation meet DFPS jurisdiction to investigate. Before FY2013, an intake that involved a child fatality but did not have clear abuse or neglect allegations would be sent to the field as a Priority 1 investigation. This likely increased the number of child fatalities that would be administratively closed or ruled out. In FY2013, CPS and DFPS Statewide Intake (SWI) worked to clarify what intakes regarding a child fatality should be sent to field staff for investigations directly. When SWI receives an intake regarding a child fatality but there is no clear allegation of abuse or neglect, the intake is now reviewed by a CPS screener for follow-up before progressing to a full investigation.

The decline in FY2013 may also reflect some random fluctuation. The number of child abuse and neglect fatalities spiked in FY2009 despite a slight decline in the number of reported deaths. After an exhaustive review of the fatalities through an independent analysis conducted by the Texas Health and Human Services Commission, the spike was attributed to a random increase in Harris County. No single factor was responsible for this increase. The following year, child abuse and neglect fatalities returned to previous lower levels, including Harris County. (Figure 2) This same trend is true at the national reporting level with a spike in confirmed child abuse and neglect fatalities in FFY2009 and a return to lower levels in the following year.^{xii}

FY2010 - FY2013 Confirmed Child Abuse and Neglect Related Fatalities

During the 81st Texas Legislature, passed legislation (SB1050) codifying Child Abuse Prevention and Treatment Act (CAPTA) reporting requirements and directing DFPS to provide specific information regarding all child fatalities alleged to be from abuse or neglect as well as detailed information if the DFPS "determines a child's death was caused by abuse or neglect."^{xiii} The following data are collected from IMPACT data and individual case reads where the child's death was caused by abuse or neglect which is distinguished with the disposition of reason to believe - fatal.

General Findings

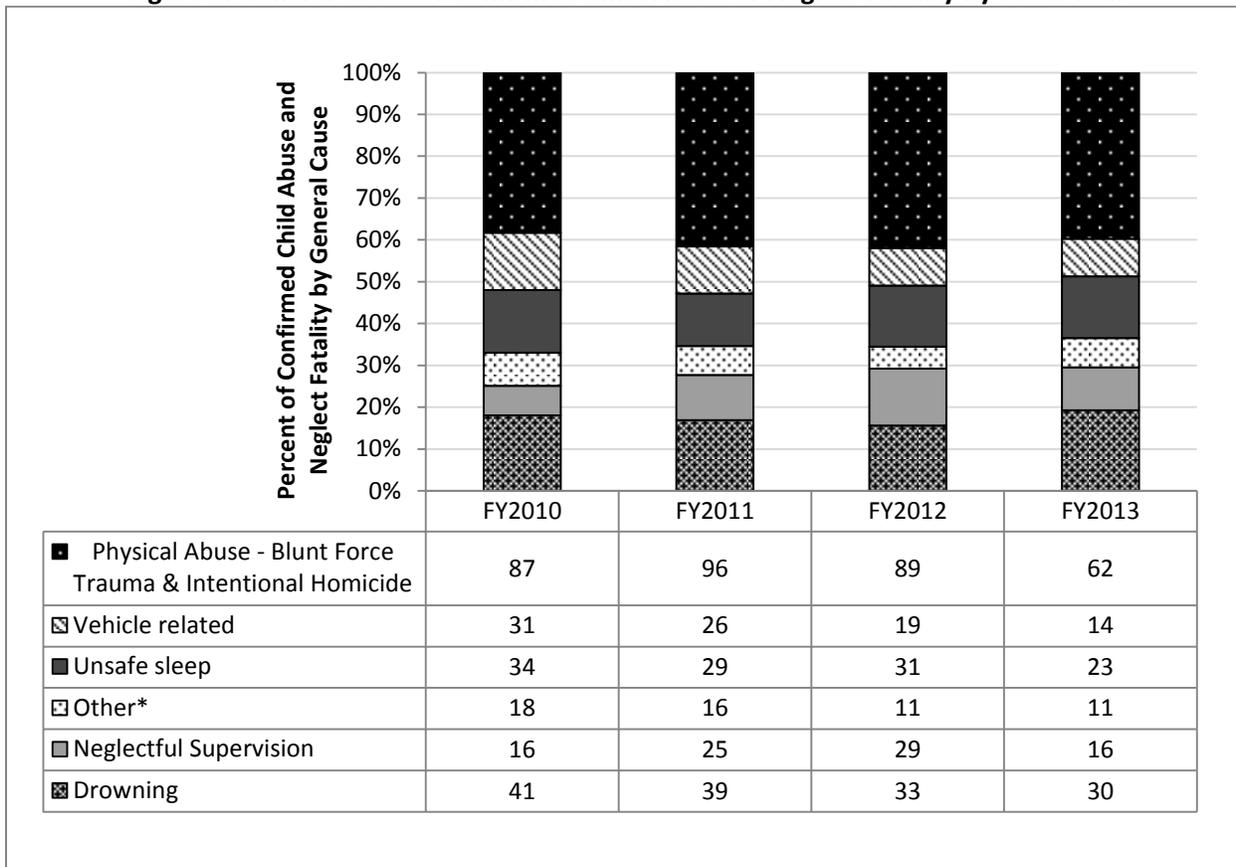
- There were 156 confirmed child abuse and neglect fatalities in FY 2013 – a 31 percent decrease from the 227 confirmed fatalities in FY2010. (Table 2)
- Confirmed physical abuse/intentional trauma fatalities have decreased by 35 percent since FY2010. (Figure 3)
- Confirmed neglect related fatalities have decreased by 31 percent since FY2010. (Table 2)
 - In fatalities involving neglect, the most common causes of death were drowning, unsafe sleep, and car and firearm accidents. (Figure 7, 8)
- Children who die from abuse and neglect are more likely to have suffered from physical abuse compared to all investigations where abuse or neglect has been confirmed.
- Child abuse and neglect-related fatalities in foster care (those where the caregiver is implicated in the death) are less likely to involve physical abuse and more likely to involve some form of neglectful supervision. (Figure 13, 16)

General Cause/Manner of Child Abuse or Neglect Fatality

Medical examiners and community-based fatality review teams differentiate intentional/homicides and unintentional/accidental fatalities. In the data discussed below, child fatalities are divided into these categories to allow for common understanding and provide more information to target child abuse and neglect prevention efforts.

In this section, intentional deaths are defined as those where the perpetrator intended to cause harm or death to the child and are most often to be a confirmed allegation of child abuse. Unintentional deaths are those where the level of inattention and or impairment by the child's caregiver was so high that it was considered neglect.

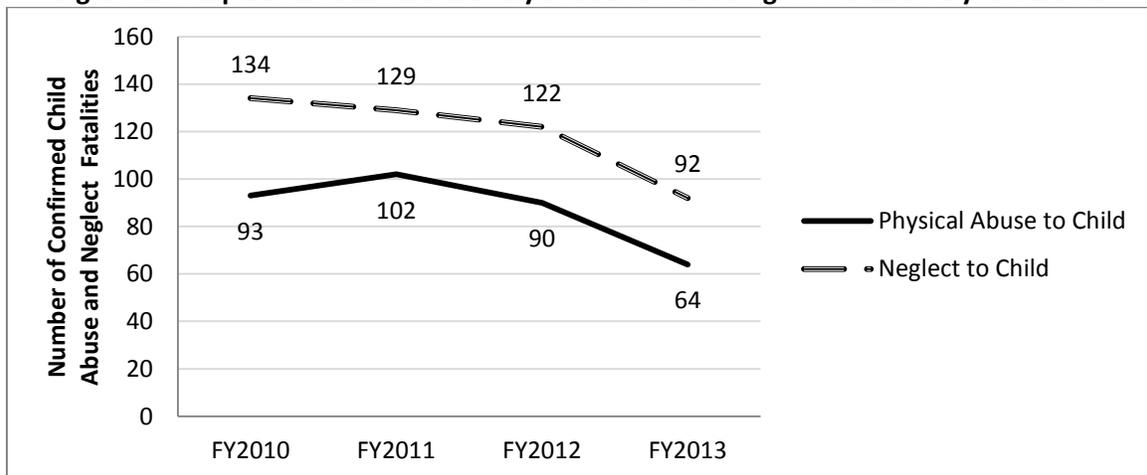
Figure 3. General Cause of Confirmed Child Abuse or Neglect Fatality by Fiscal Year



*Other category includes medical neglect, physical neglect, suicide, premature birth due to drug use, abandonment at birth.

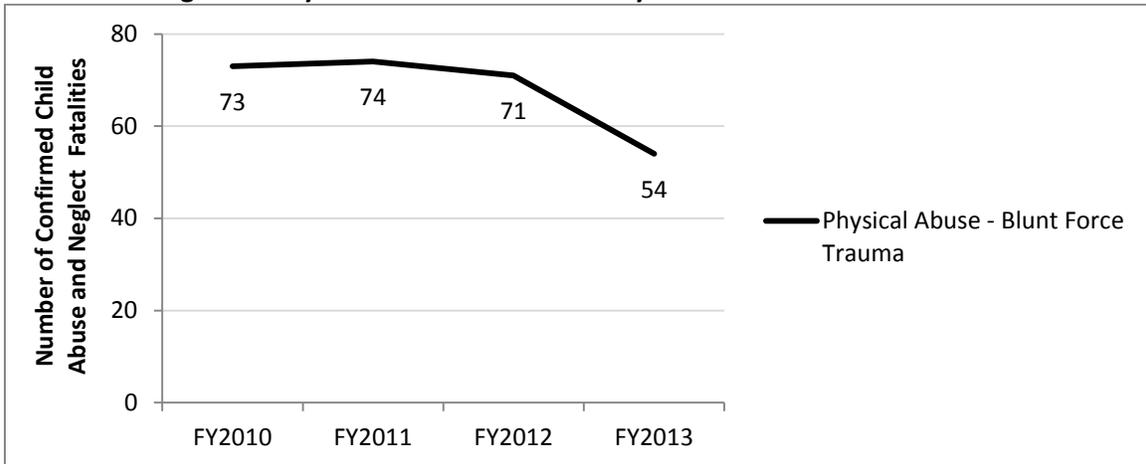
Source: DFPS individual case reviews

Figure 4. Comparison of Intentional Physical Abuse and Neglect Fatalities by Fiscal Year



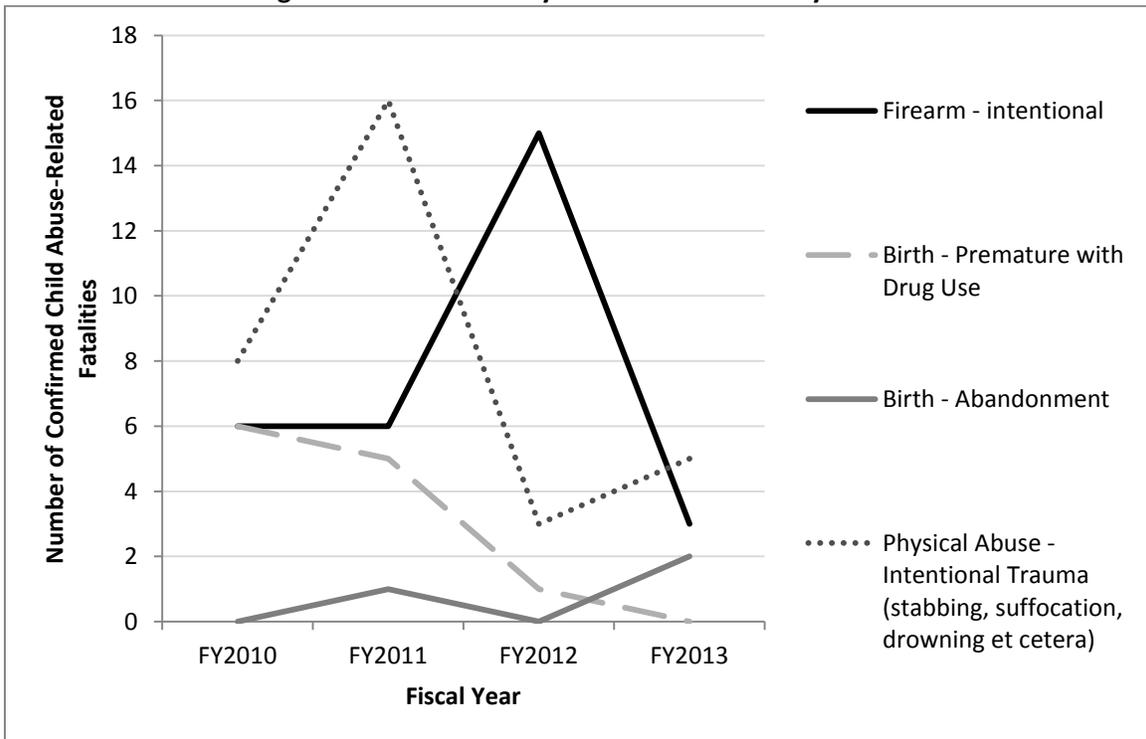
Source: DFPS individual case reviews

Figure 5. Physical Abuse Related Fatality: Blunt Force Trauma to Child



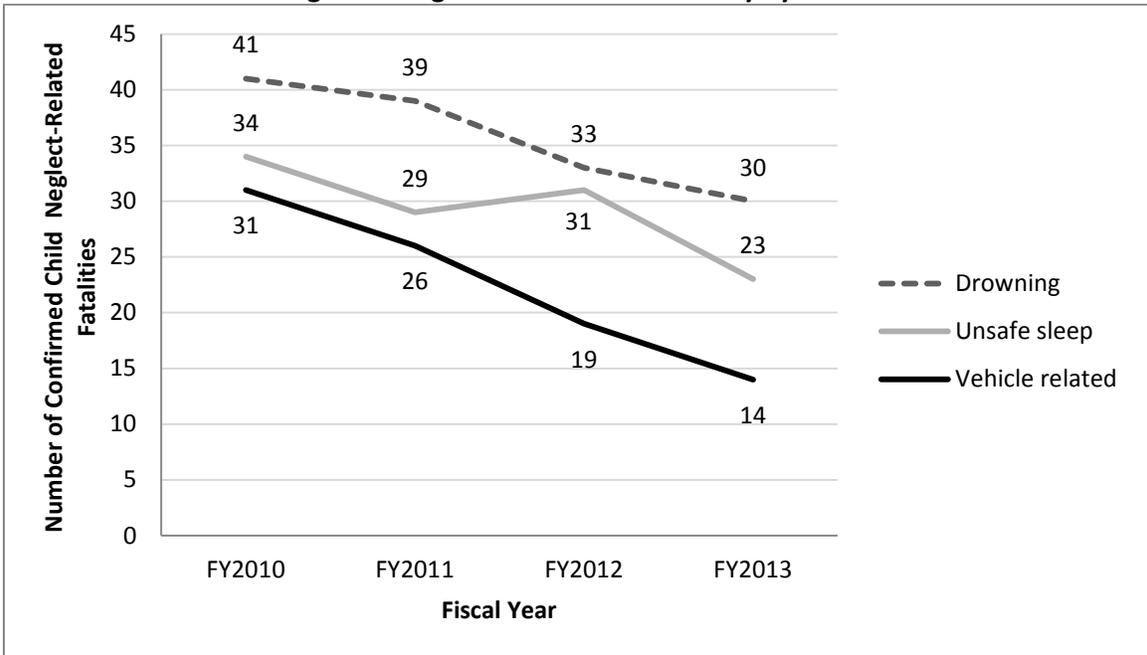
Source: DFPS individual case reviews

Figure 6. Intentional Physical Abuse to Child by Cause



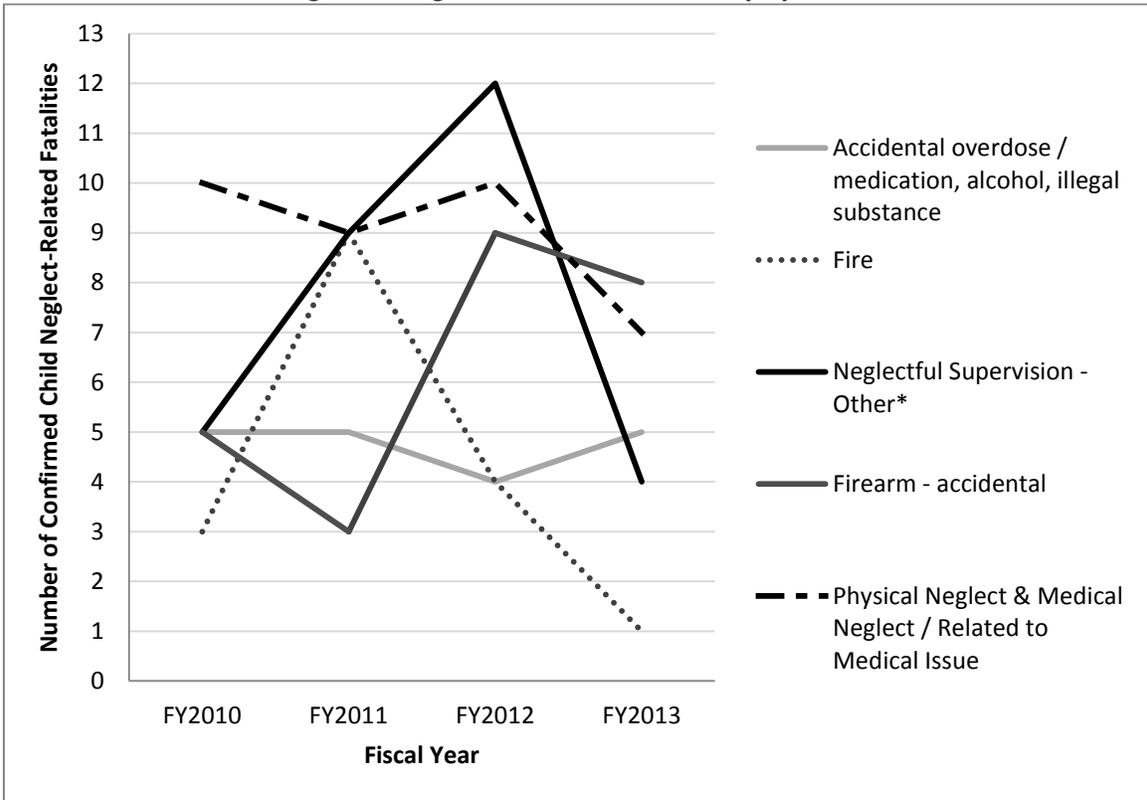
Source: DFPS individual case reviews

Figure 7. Neglect-Related Child Fatality by Cause



Source: DFPS individual case reviews

Figure 8. Neglect-Related Child Fatality by Cause



* Neglectful Supervision - Other includes dog attack, object falling on child, suicide

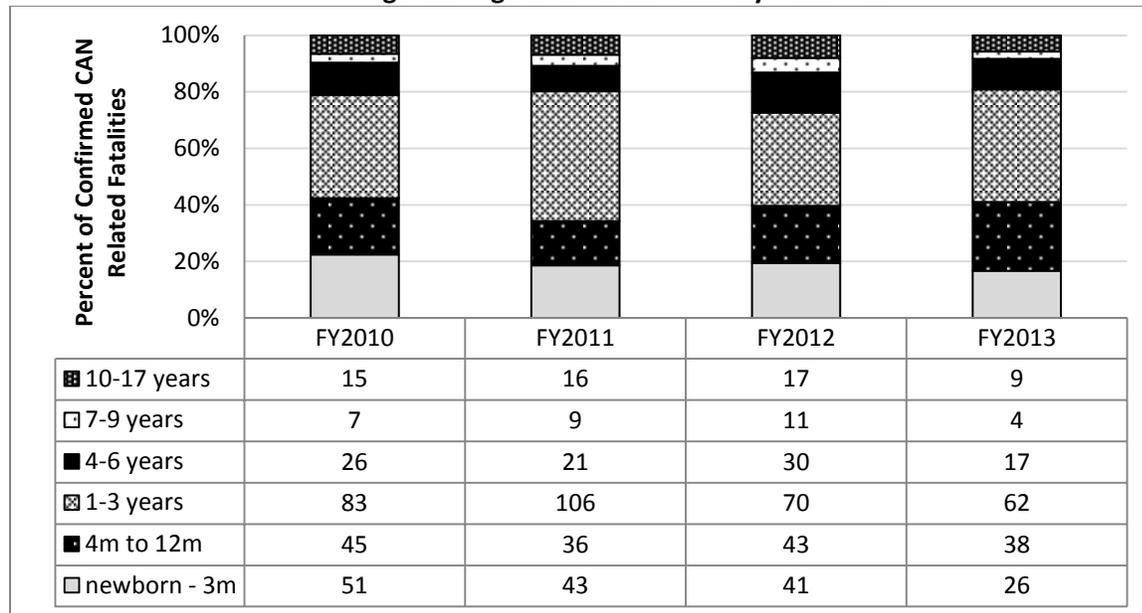
Source: DFPS individual case reviews

Victim Demographic Characteristics - Age, Gender, Ethnicity

Victims of Confirmed Child Abuse and Neglect (CAN) Related Fatalities

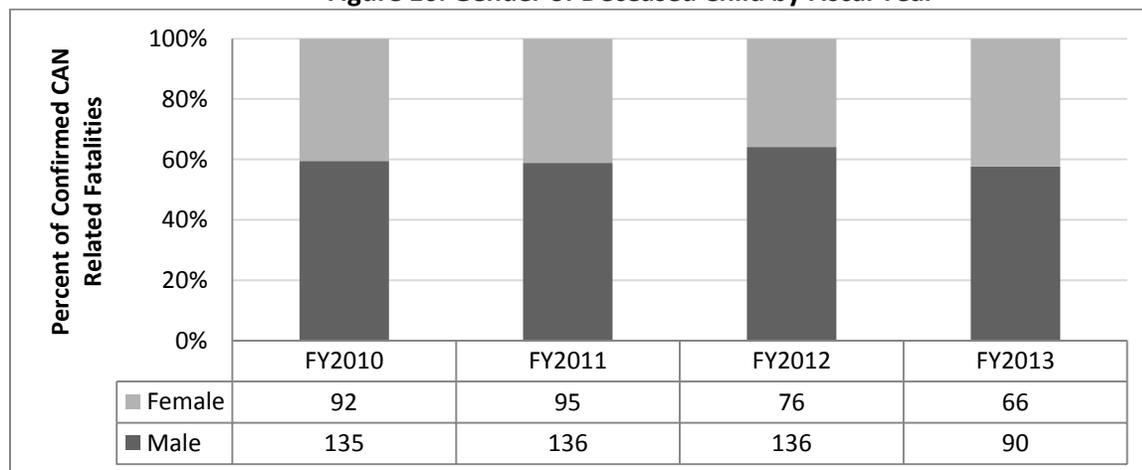
- Based on the confirmed child abuse and neglect related fatalities, children 3 years of age and younger made up 80 percent of all confirmed child abuse and neglect fatalities. Male children made up more than half of all confirmed child abuse and neglect related fatalities.
- In FY2013, 81 percent of children in abuse and neglect fatalities were 3 years old or younger and 58 percent were male.
- The largest percentage of children who die from abuse or neglect are Hispanic, who also represent the greatest percentage of overall child abuse and neglect victims.

Figure 9. Age of Child at Death by Fiscal Year



Source: DFPS Data Warehouse Report FT_06

Figure 10. Gender of Deceased Child by Fiscal Year



Source: DFPS Data Warehouse Report FT_06

When reviewing the ethnicity of the victim, it is important to view these fatalities in context of the child per capita rate for Texas. While children of Hispanic heritage represent the largest percentage of child abuse and neglect fatalities, the child per capita rate of fatal abuse/neglect for African American children is disproportionately higher compared to their overall representation in the Texas child population (Table 3). Texas Health and Human Services is actively working with state and federal agencies, universities, private groups, communities, foundations, and offices of minority health to decrease or eliminate health and health access disparities among racial, multicultural, disadvantaged, ethnic, and regional populations.^{xiv}

**Table 3. Per Capita Rate (per 100,000 Children) by Ethnicity
for Confirmed Child Abuse or Neglect Fatalities
FY2010**

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Total Child Population	810,543	2,322,661	3,317,777	414,843	6,865,824
Number of Fatalities	46	78	85	18	227
Per Capita Rate of Fatality	5.68	3.36	2.56	4.34	3.31

FY2011

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	811,081	2,317,712	3,389,573	433,811	6,952,177
Number of Fatalities	51	59	104	17	231
Per Capita Rate of Fatality	6.29	2.55	3.07	3.92	3.32

FY2012

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	809,036	2,332,640	3,415,186	439,490	6,996,352
Number of Fatalities	56	70	73	13	212
Per Capita Rate of Fatality	6.92	3.00	2.14	2.96	3.03

FY2013

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	819,438	2,327,549	3,509,752	464,760	7,121,499
Number of Fatalities	40	48	60	8	156
Per Capita Rate of Fatality	4.88	2.06	1.71	1.72	2.19

Sources: Texas State Data Center; DFPS Data Warehouse Report FT_06

Perpetrator Demographic and Characteristics - Relationship and History

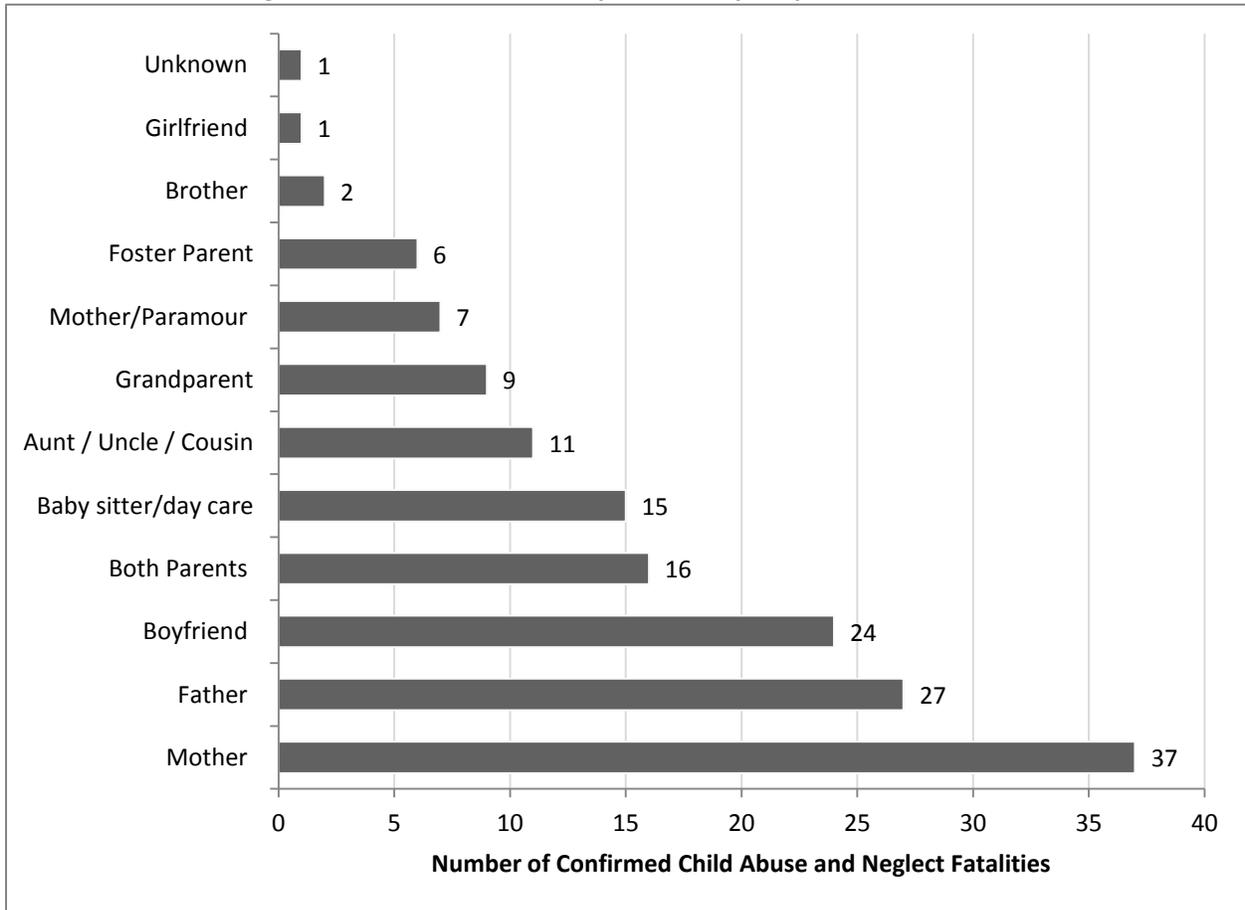
To analyze the perpetrator demographics, FY2013 cases were utilized for an in-depth review. Based on the confirmed child abuse and neglect fatalities that occurred during FY2013, several key demographic areas allow for specialized targeting of prevention and intervention in child abuse and neglect cases. Data from these fatalities infer that these parents would benefit from support, education and other targeted campaigns. Communities could use this data to target their messaging and provision of available resources to families and caregivers.

For purposes of this analysis, DFPS identified the individual who harmed or was responsible for the child at the time of the fatality based on a review of the individual cases. In the actual investigation, others in the home at the time of the injury or those who knowingly allowed the primary perpetrator to harm the child may have also been designated as perpetrators. For example, in a case where a paramour beat the child and the mother was neglectful in allowing the paramour access, the paramour would be identified as the primary perpetrator. As with the majority of all child abuse and neglect, cases with a fatality most commonly had a parent as the primary perpetrator. A paramour, however, was the primary perpetrator in 20 percent of the fatalities.

Perpetrators

- Physical abuse in fatalities most commonly involved blunt force trauma inflicted by a father or boyfriend.
- In all confirmed cases of abuse and neglect, parents are the most common perpetrators.
- In the majority of child abuse and neglect-related fatalities, the child or the perpetrator had no prior history with CPS.
 - In cases where CPS was involved with the family at the time of the death, most fatalities were caused by unintentional acts involving inadequate supervision.
 - In the remaining cases where CPS was involved with the child or perpetrator in the past, most fatalities were the result of intentional acts such as physical abuse.

Figure 11. FY2013 Relationship of Primary Perpetrator to Victim

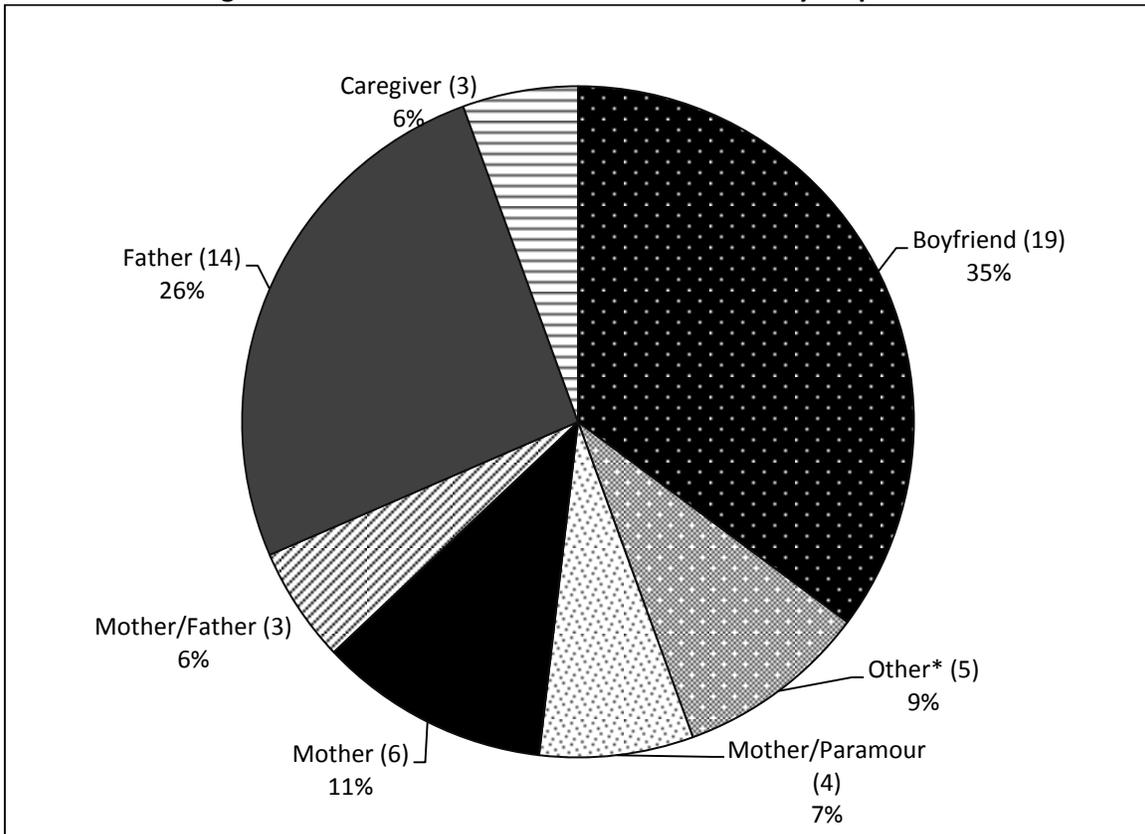


Source: DFPS individual case reviews

FY2013 Primary Perpetrator, Child Age and Cause of Death Together

This analysis looks for patterns in the child's age and the type of primary perpetrator for causes of death involving six children or more. Other categories (such as accidental overdose, dog related, fire, intentional fatality at birth, suicide and intentional acts such as suffocation, shooting, drowning, strangulation and stabbing), each involved less than six children. All data in this section is based on the DFPS individual case reviews completed for FY2013 confirmed child abuse and neglect related child fatalities.

Figure 12. FY2013 Blunt Force Trauma Fatalities by Perpetrator



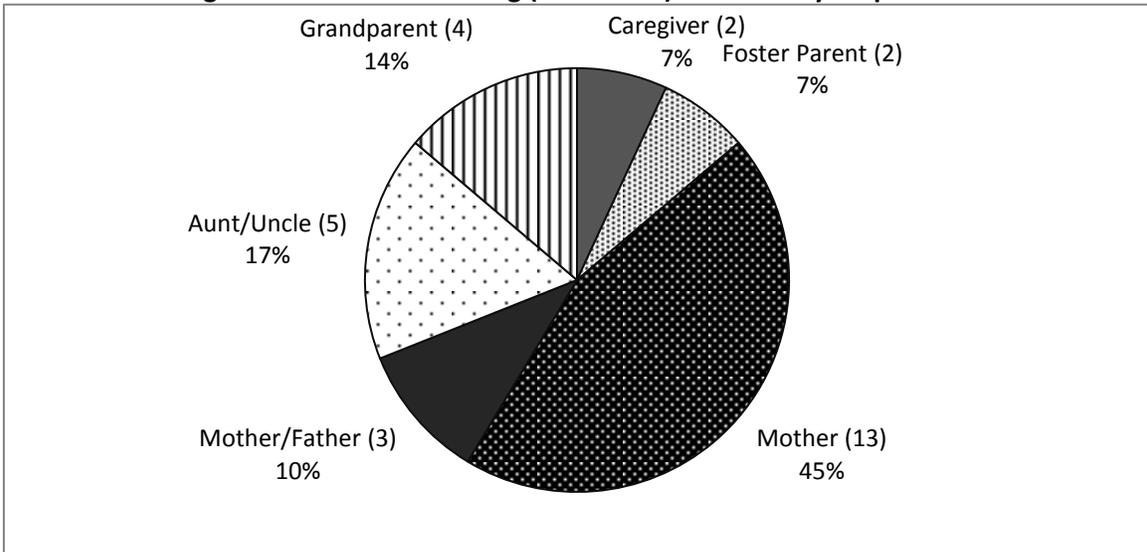
*Other includes: Girlfriend (1), Uncle, (1), Babysitter (1), Foster Parent (1), Unknown (1)

Number of victims: 54 children

Age range of victims: Newborn to 6-year-old child. 25 children were younger than one year old.

Finding: Usually involve young children being physical abused by father (30 percent) or a boyfriend (42 percent)

Figure 13. FY2013 Drowning (Accidental) Fatalities by Perpetrator

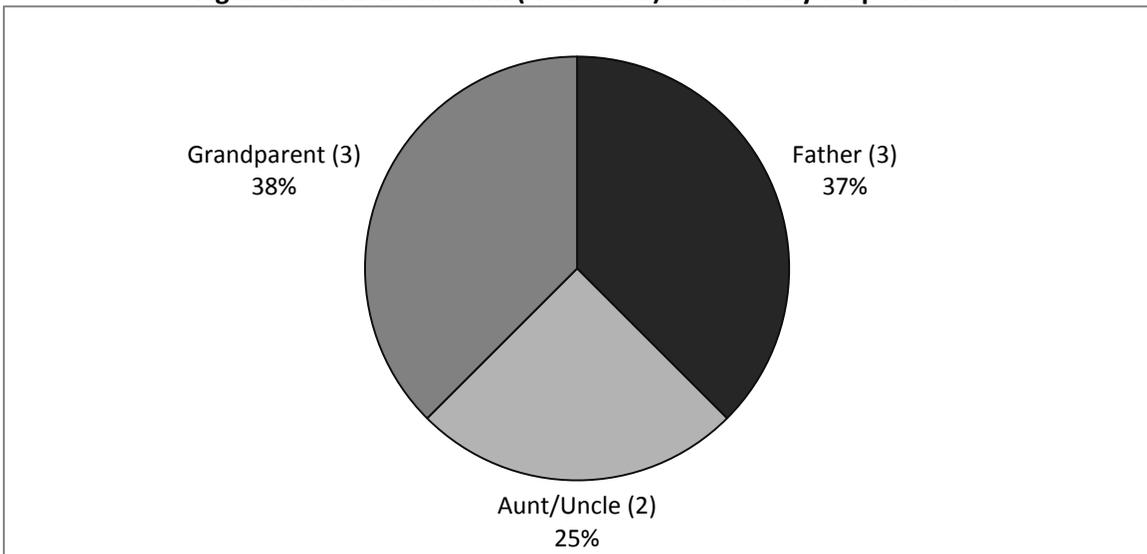


Number of victims: 29 children

Age range of victims: 9 months to 6 years old

Finding: Usually involve young children with mother as primary perpetrator (55 percent)

Figure 14. FY2013 Firearm (Accidental) Fatalities by Perpetrator

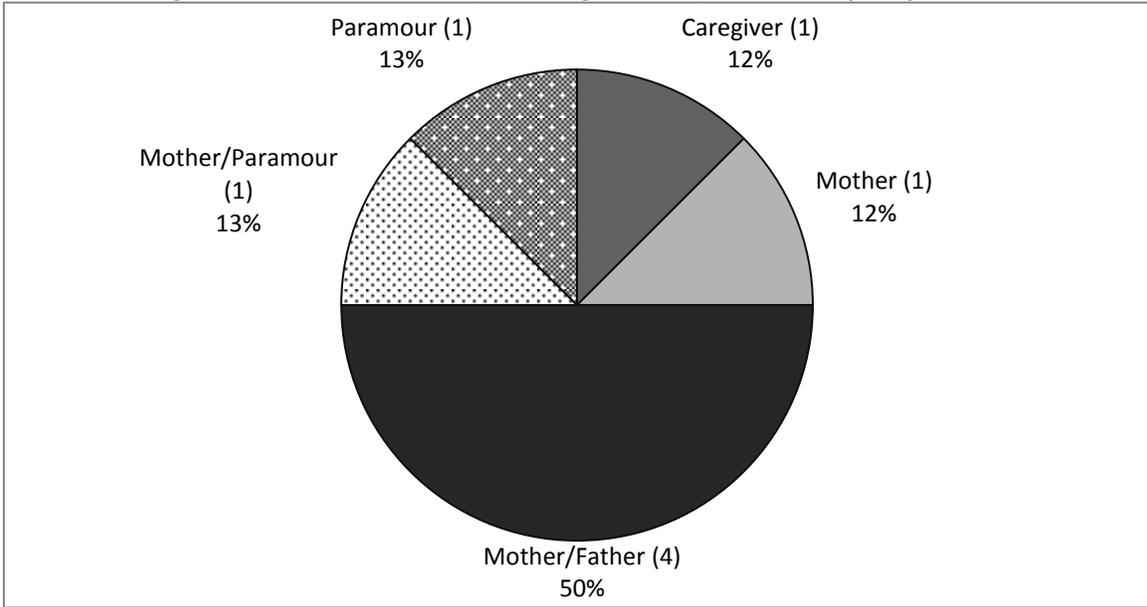


Number of victims: 8 children

Age range of victims: 2 years old to 13 years old

Finding: Usually happens while in care of someone other than mother

Figure 15. FY2013 Medical (including seizures) Fatalities by Perpetrator

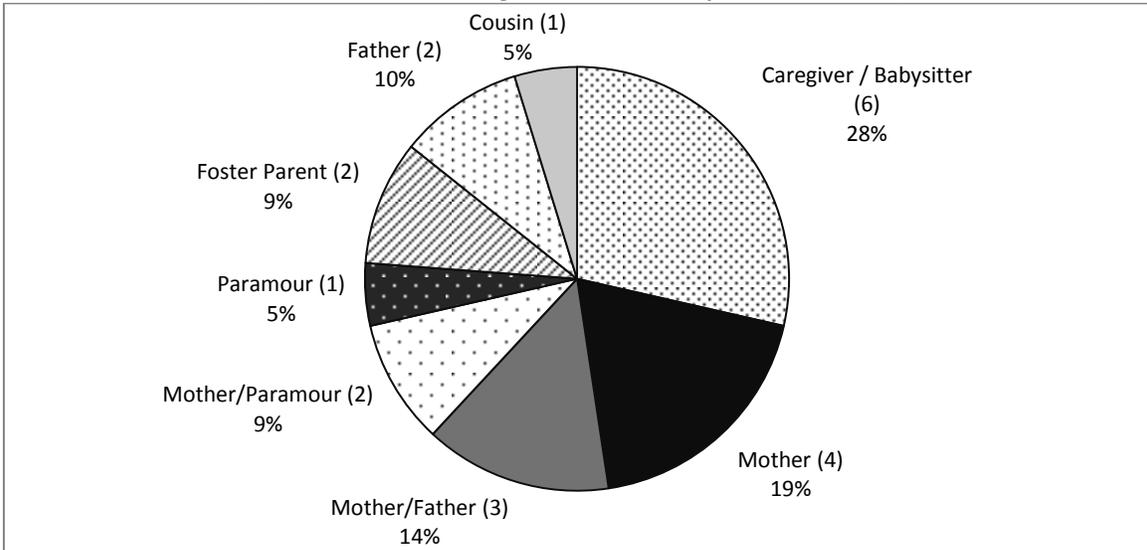


Number of victims: 8 children

Age range of victims: 3 months to 15 years old

Finding: Usually happens while in care of the mother (75 percent)

Figure 16. FY2013 Unsafe Sleep Fatalities by Perpetrator (includes bed-sharing and unsafe sleep environments)

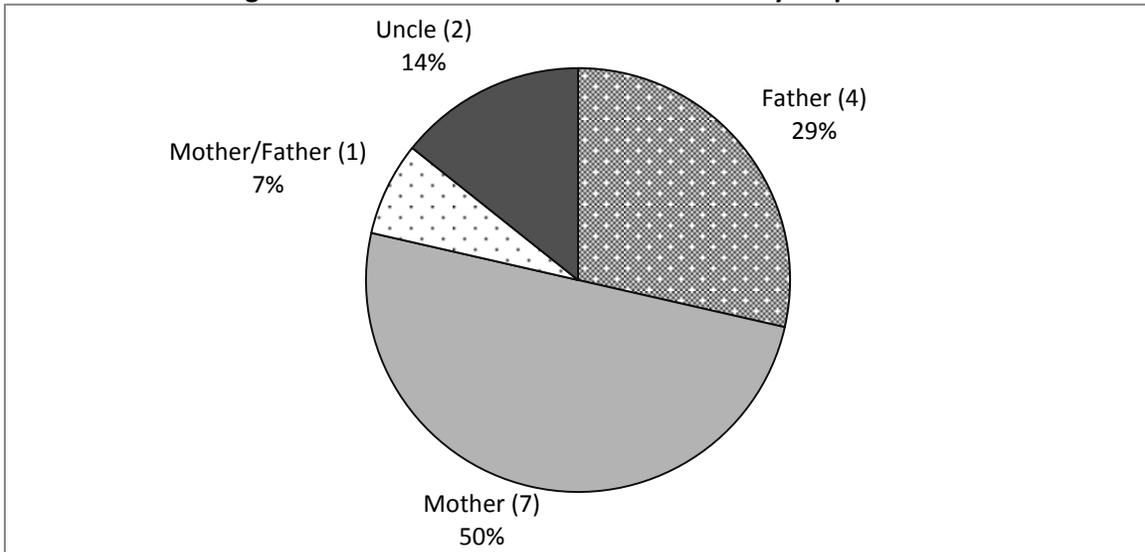


Number of victims: 21 children

Age range of victims: newborn to 1.5 years old

Finding: Generally involve infants but no patterns on primary perpetrator although likely involve the mother either by herself or with either the child's father or her paramour.

Figure 17. FY2013 Vehicle Related Fatalities by Perpetrator



Number of victims: 14 children

Age range of victims: 5 months to 13 years old

Finding: Usually happens while in care of the mother (57 percent)

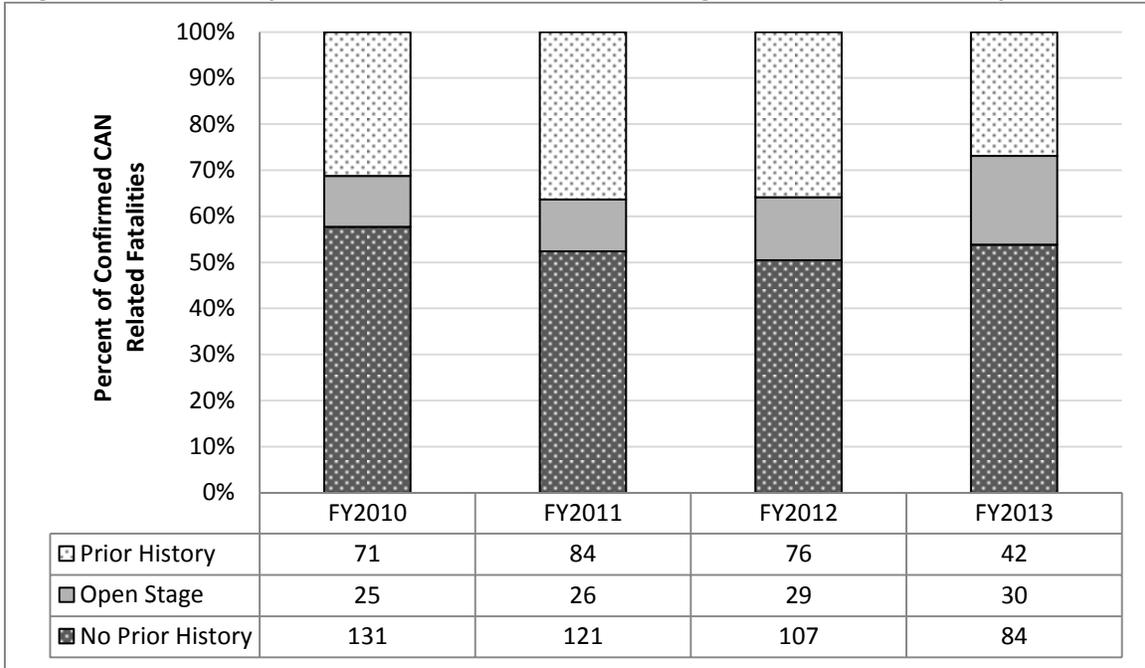
Prior CPS History in Child Abuse and Neglect-Related Fatalities

To better understand fatalities, it is important to identify cases with, and without, prior CPS history and the nature of the prior history. DFPS defines prior CPS history broadly – if the deceased child or a designated perpetrator in the fatality had been in a CPS investigation or received CPS services before the child's death. Under this definition, it counts as prior CPS history even if the last contact with CPS was several years ago or was unrelated to the circumstances of the fatality. Even under this broad definition, the majority of child abuse and neglect fatalities had no prior CPS history. In about 15 percent of the child abuse and neglect fatalities, CPS was involved with the family or the child at the time of the death. In the remaining 31 percent, CPS had been involved with the child or the perpetrator in the past.

Child abuse and neglect-related fatalities where the child died while CPS was involved with the family usually consisted of unintentional acts such as accidental drowning and unsafe sleep. It can be difficult to predict or foresee when or if these types of circumstances will occur. Preventing child fatalities centers primarily with educating caregivers about things such as proper supervision around water and safe sleep.

In contrast, over a third of child abuse and neglect-related fatalities where the child died and CPS had investigated or provided services to the child or perpetrator in the past involved intentional acts, such as blunt force trauma. A more detailed analysis is needed to explore whether physical abuse was involved in the prior CPS cases as well.

Figure 18. CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Fiscal Year

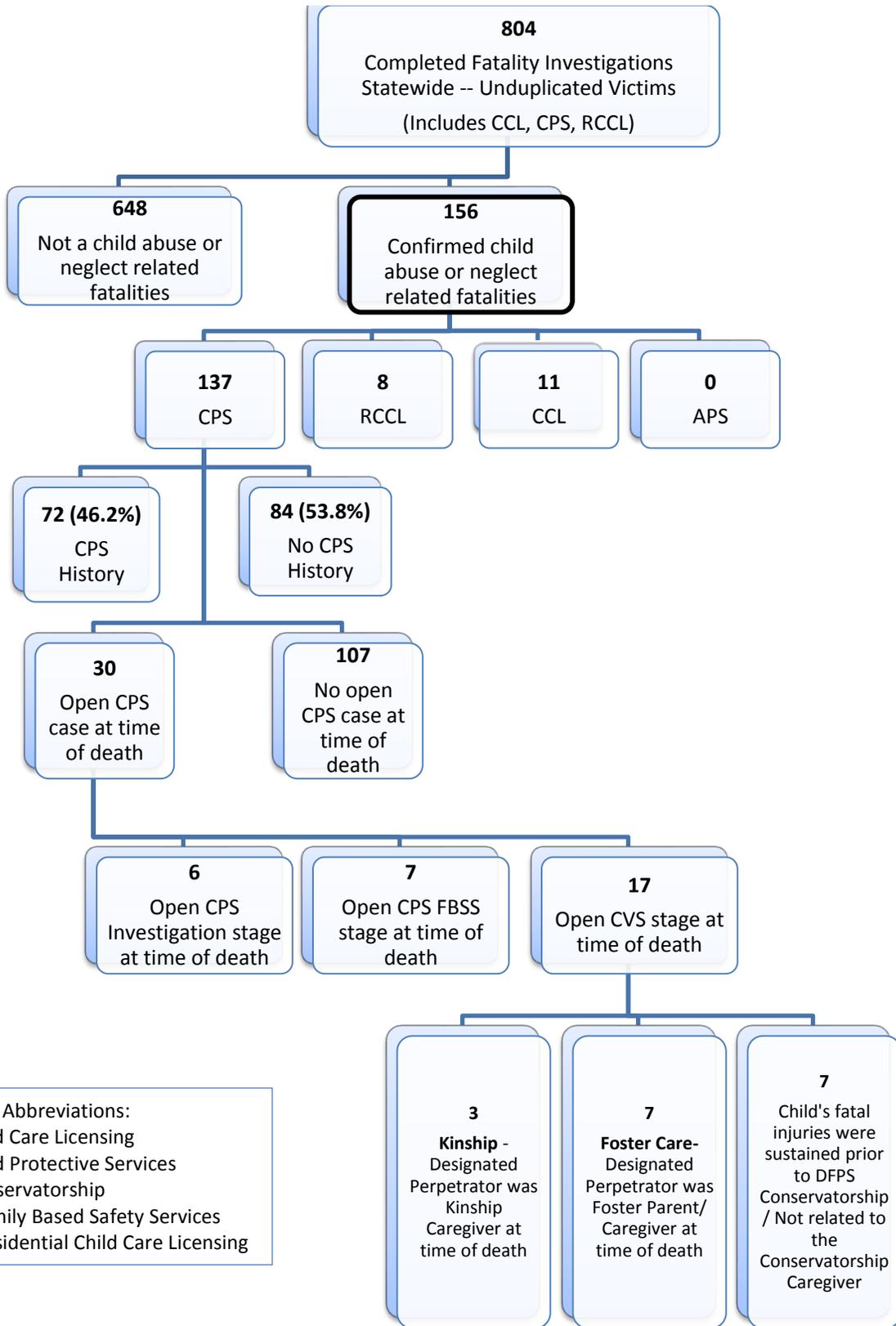


Source: DFPS Data Warehouse Report FT_06

Additionally, a child fatality may occur in an open stage of service such as Investigations, Family Based Safety Services, or Conservatorship. The majority of fatalities that occur in the Conservatorship stage of service are not found to abuse or neglect related but often due to terminal medical conditions that existed prior to DFPS intervention. Figure 19 uses FY2013 child abuse and neglect fatality investigation data to breakdown the overall number of child fatalities investigated and those where the abuse or neglect caused the child fatality. Comparing Figure 18 and Figure 19, the data show that there were 30 confirmed child abuse or neglect related fatalities with an open stage at the time of the fatality. Based on Figure 19, the following conclusions are noted:

- 30 children were involved with Child Protective Services at the time of their death.
 - 6 of the children were in an active investigation stage and a new incident of abuse or neglect occurred leading to the fatality
 - 7 of the children were in an active Family Based Safety Services stage and a new incident of abuse or neglect occurred leading to the fatality data
 - 17 of the children were in an active conservatorship stage at the time of the fatality
 - 3 of the children were being cared for in a kinship placement at the time and a new incident of abuse or neglect occurred leading to the fatality
 - 7 of the children were being cared for in a foster care placement and a new incident of abuse or neglect occurred leading to the fatality data
 - 7 of the children were brought into DFPS conservatorship having already suffered the fatal injuries and subsequently died while in care

**Figure 19. FY2013 Department of Family and Protective Services (DFPS)
Data on Child Abuse and Neglect Related Fatalities Statewide**



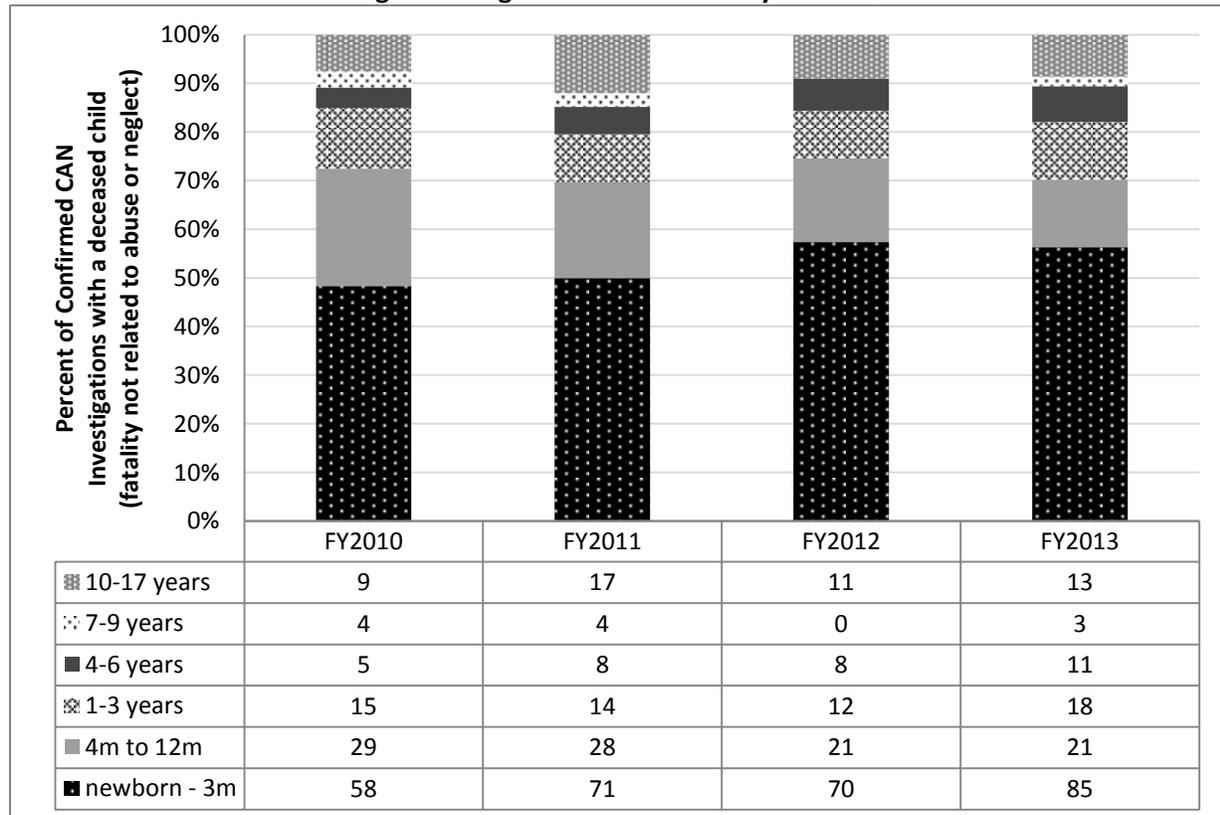
Common Abbreviations:
CCL: Child Care Licensing
CPS: Child Protective Services
CVS: Conservatorship
FBSS: Family Based Safety Services
RCCL: Residential Child Care Licensing

Child Fatalities Not Caused by Abuse and Neglect but Abuse or Neglect was Found In General

The federal Child Abuse Prevention and Treatment Act (CAPTA) and Texas Family Code (Tex. Fam. Code §261.203 and Tex. Fam. Code §261.004) require that specific information about fatalities *caused by or the result of* abuse or neglect be reported. Texas Family Code otherwise considers all other information to be confidential. (Tex. Fam. Code §261.201) As a result, we cannot currently report case specific details on child fatalities where abuse or neglect was not the cause of the fatality. However, analyzing child fatalities where there is a confirmation of abuse or neglect in the home even though it did not cause the fatality can help target specific prevention and intervention services both in the community and in those contracted by DFPS. It is important to remember that dispositions in child fatality investigations are reviewed by several levels of management in the region and rely heavily on input from medical personnel and law enforcement.

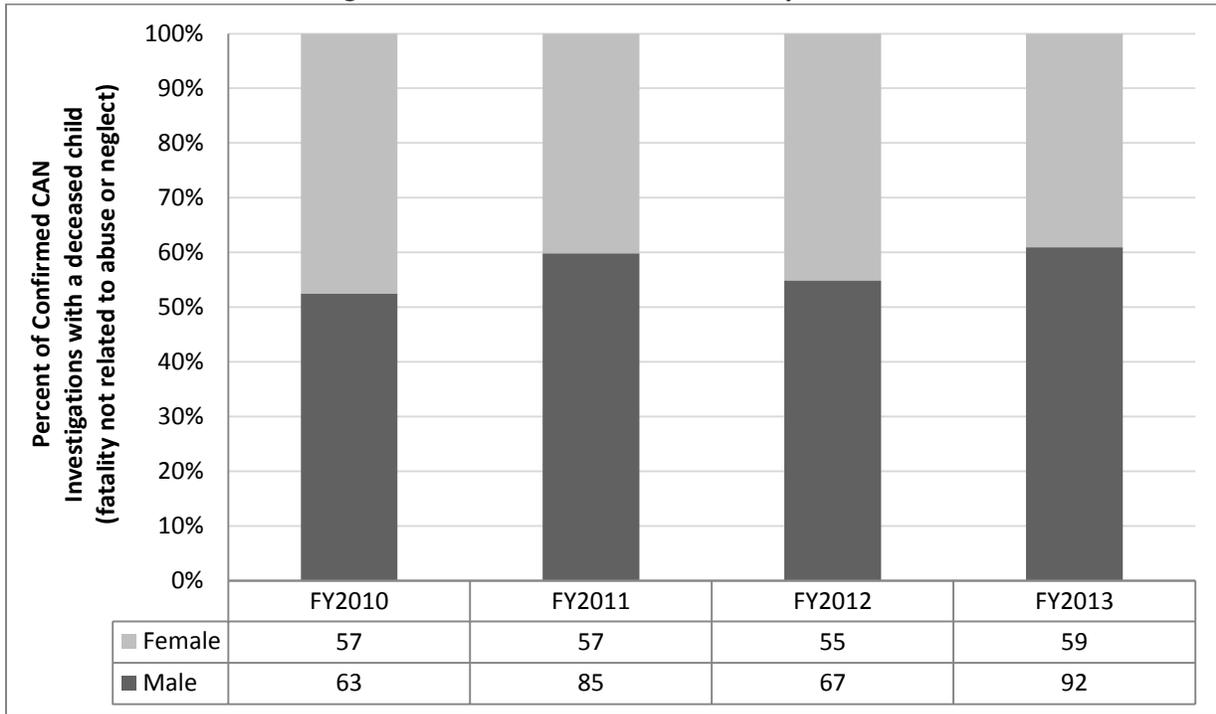
Further analysis and individual case readings in these types of investigations is needed to help inform strategies to prevent child fatalities in general and ensure consistency in decision making surrounding investigations where a child fatality has occurred. The Office of Child Safety will complete a review of cases where a child fatality occurred but was found to be caused by something other than abuse or neglect. This in-depth analysis is needed as these cases have similar demographics as confirmed child fatalities caused by abuse and neglect: the victim is often under one year old, Hispanic and male. One noted difference is that victims in this category are often three months of age or younger at the time of their death.

Figure 20. Age of Child at Death by Fiscal Year



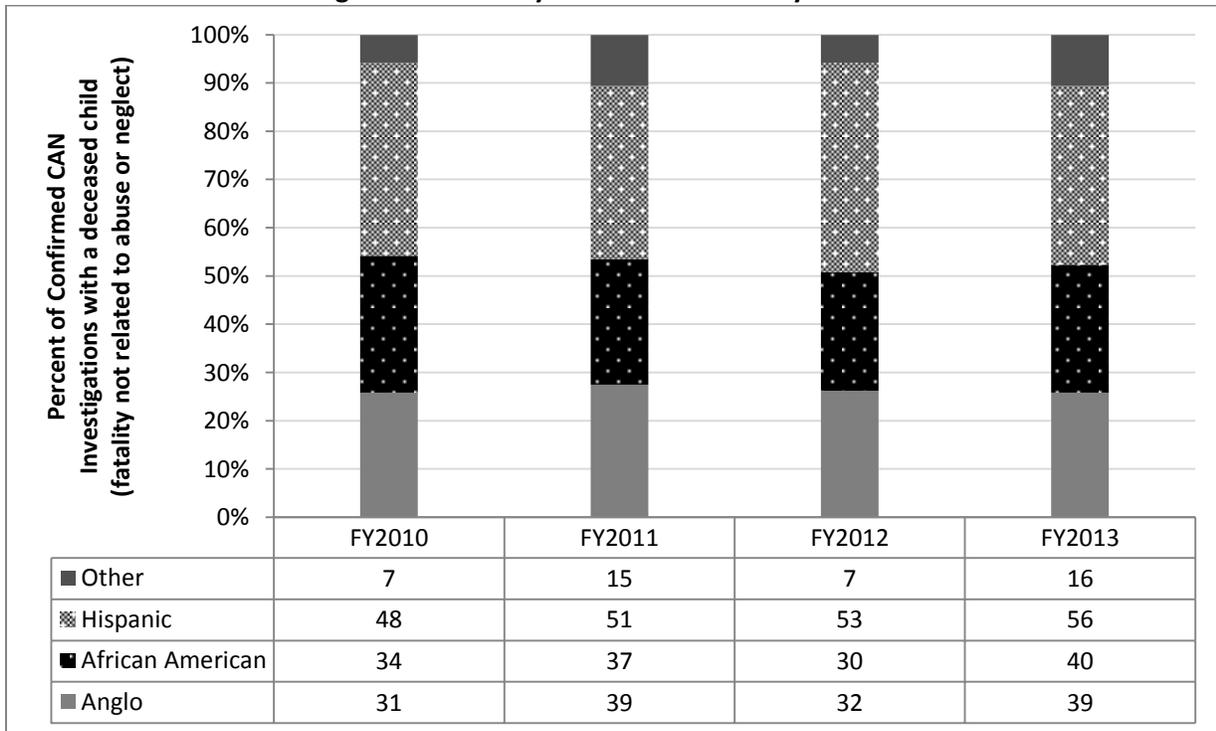
Source: DFPS DRIT Request

Figure 21. Gender of Deceased Child by Fiscal Year



Source: DFPS DRIT Request

Figure 22. Ethnicity of Deceased Child by Fiscal Year



Source: DFPS DRIT Request

Child Fatalities in Texas within the National Context

Varying definitions of abuse and neglect among states: The Children's Bureau of the U.S. Department of Health and Human Services publishes *Child Maltreatment*^{xv}, an annual report comprising data from the National Child Abuse and Neglect Data System (NCANDS).^{xvi} While this data allows for some comparison between the states that report, there are several areas where states differ in reporting such as inconsistent definitions of abuse/neglect, variation in the definition of previous history, and states limiting reportable child fatalities to only those children already known to or actively involved in the child welfare system.^{xvii}

Texas's definition of abuse and neglect is broad: Texas addresses these issues by having very broad abuse and neglect definitions and reporting structure so that any child fatality alleged to involve abuse or neglect, either while the child was alive or as part of the fatality itself, is investigated and reported to NCANDS if the death is a confirmed child abuse or neglect related fatality. Texas is able to do this through:

- requiring any person who believes that a child has been or may be abused or neglected or has died of abuse or neglect to report his or her concerns, with a heightened reporting requirement for professionals;^{xviii}
- investigating any report of child abuse or neglect allegedly committed by a person responsible for a child's care, custody, or welfare;^{xix}
- including in the definition of child abuse and neglect the use of a controlled substance^{xx} and defining medical neglect as the failure to *seek, obtain, or follow through* with medical care for the child;^{xxi} and
- defining prior history very broadly.

Defining prior history: While other states limit prior history to those cases that had previous investigations, direct service delivery, or conservatorship of the child within a certain timeframe, Texas does not limit either the timeframe or type of involvement when reporting history. Texas defines prior history as, at the time of the child fatality, either the deceased child or a designated perpetrator in the fatality had been in a CPS investigation or received CPS services before the child's death. Under this definition, it counts as prior CPS history even if the last contact with CPS was several years ago, the perpetrator was involved with a different family, the deceased child was not yet born, or if the history was unrelated to the circumstances of the fatality.

Per capita rate: Given the broad definitions in Texas, the Texas per capita rate for child abuse and neglect fatalities (rate per 100,000 children in the child population), has been higher than the national average. For federal fiscal year 2012 (the most recent year reported for all states), the Texas rate was 3.03 confirmed child abuse and neglect related fatalities per 100,000 compared to a national average of 2.2 confirmed child abuse and neglect related fatalities per 100,000. The higher rate is likely due in part to under-reporting in other states. For example, studies in Nevada and Colorado have estimated that as many as 50 percent to 60 percent of child deaths resulting from abuse or neglect are not recorded as such.^{xxii} Some states do not even report at all; in the annual federal *Child Maltreatment 2012* report, Idaho, Maine and Massachusetts did not report on child fatalities.

Delay in national reporting: National data comparisons for FY2013 will not be available until late December 2014 or early 2015. It is important to note that the number of confirmed child abuse and neglect related fatalities continued to decline in FY2013; it is likely that when the federal level data for FY2013 is released that Texas will be close to or below the national rate.

Initiatives & Program Improvement

Internal Initiatives and Program Improvement

DFPS Transformation is a rigorous self-improvement process that Child Protective Services (CPS) began in 2014 to transform itself into a better place to work and the most effective program possible. It is a bottom-up effort built on the knowledge and insights of front-line staff and led by both regional and state office staff. Transformation will improve child safety, build community collaboration, create a stable workforce, and build leadership.

As part of DFPS Transformation, DFPS has undertaken several initiatives designed to reduce child abuse and neglect overall, with a focus on addressing child abuse and neglect related fatalities. Additionally, several national and state efforts are currently underway to address child fatalities.

Streamlining Policy - CPS has begun streamlining and updating its current policy handbook – separating policy from best practice and improving the content, clarity, and accuracy of policy provisions. CPS has also created a better process for communicating policy changes in a more coordinated and effective manner, so that staff can more readily digest and understand agency policies.

Risk and Safety Assessments - Risk assessments and structured decision-making tools are being fully revised. The safety assessment tool will assist a caseworker during the first contact with a child and family, a critical opportunity to assess safety. The new risk assessment tool will be more objective and based on actuarial principles that have been scientifically accepted and adapted for Texas.

Utilizing Predictive Analytics - CPS is expanding the use of predictive analytics to address emerging problems, coordinate and improve fragmented quality assurance processes, and establish clear accountability for overseeing change in state office and in the regions. Currently, CPS is utilizing predictive analytics to improve child safety in Family Based Safety Services cases by piloting real time case reviews in high-risk cases. This pilot is set to expand statewide for Family Based Safety Services cases and then be replicated for Investigations.

Improving Case Transfer - The case transfer process between Investigations and FBSS staff has been simplified and can begin as soon as an investigator has identified that a family could benefit from ongoing services.

Prevention and Early Intervention - Office of Child Safety - In FY2015, DFPS established the Office of Child Safety to address child fatalities and serious injuries through thorough case review, data analysis, practice recommendations and collaboration with local agencies, private sector, non-profits, and government programs to reduce child abuse and neglect fatalities. The goals of the new Office of Child Safety are to:

- Produce consistent, transparent, and timely review of child fatalities and serious injuries by independent experts outside any specific program.

- Find root causes of child fatalities to provide guidance on the most effective prevention changes as well as improvements in child welfare practices;
- Operate with the understanding that many systems impact outcomes for children and that prevention and intervention efforts will involve many sectors and non-traditional partners;
- Work closely with the Department of State Health Services (DSHS) and others to share data and information; and
- Develop strategic recommendations to bring together local agencies, private sector, non-profits, and government programs to reduce child abuse and neglect fatalities.

The Office of Child Safety will conduct a review of child fatality investigations where the death was not found to be from abuse or neglect but that there was abuse or neglect found in general. Within the constraints of Texas Family Code 261.201 confidentiality, the Office of Child Safety will produce a report.

Prevention and Early Intervention - Public Awareness Campaigns

DFPS has several public awareness campaigns and services through Prevention and Early Intervention. Through these campaigns and resources, DFPS is able to provide information to the general population – not just those people who have been involved with the CPS system. These campaigns target specific issues that lead to child abuse and neglect, including fatalities. Campaigns include:

- Help and Hope on how to connect with community-based resources.^{xxiii}
- Room to Breathe on safe sleep practices for infants.^{xxiv}
- Watch Kids Around Water about drowning prevention.^{xxv}
- Look Before You Lock on preventing deaths in hot cars.^{xxvi}

Prevention and Early Intervention - Project HOPES

DFPS is increasing services through Prevention and Early Intervention. Project HOPES will establish flexible, community-based child abuse and neglect prevention programs in select communities targeting families of children ages 0-5 who are at high-risk for abuse and neglect and even more at-risk for abuse/neglect caused fatalities. Communities can propose evidence-based programming that meets the needs of their population. DFPS worked with external stakeholders to identify communities with high child abuse and neglect risk factors such as family violence, substance abuse, teen pregnancy, child fatalities, and child poverty. After identifying the high-need communities, those with an existing community services infrastructure that DFPS could leverage were chosen as the target for Phase I. The eight counties selected are Potter, Webb, Gregg, Ector, Cameron, Hidalgo, Travis, and El Paso Counties.

Prevention and Early Intervention - Project HIP

Project HIP is a new effort that provides both CPS interventions and voluntary prevention services to families to increase protective factors and prevent child abuse. The program provides an extensive family assessment, home visiting programs that include parent education and basic needs support to targeted families. Eligible families are those who have previously had their parental rights terminated due to child abuse and neglect in year 2008 or later who currently have a newborn child, families who have previously had a child die with the cause identified as child abuse or neglect in year 2008 or later who have a newborn child, or current foster youth who are pregnant or who have given birth in the last four months. CPS investigates the majority of new births in the first two categories initially.

Child Safety Review Committee

The Child Safety Review Committee (CSRC) examines issues that have implications for CPS policy and practice. It consists of internal and external stakeholders. The group reviews all information collected by each Regional Child Death Review Committee and makes recommendations to CPS based on those trends and patterns. Recommendations from the CSRC have included training and additional resources for working with families with active substance abuse, domestic violence/intimate partner violence, and children with special medical needs.

Statewide/External Initiatives and Program Improvement

DSHS State Child Fatality Review Team Committee (SCFRT)

The State Committee is a multidisciplinary group comprised of members throughout Texas.^{xxvii} Its mission is to reduce the number of preventable child deaths and its purpose is threefold:

- To develop an understanding of the causes and incidence of child deaths in Texas;
- To identify procedures within the agencies represented on the Committee to reduce the number of preventable child deaths; and
- To 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.

Local Child Fatality Review Teams (CFRT)

CFRTs are multidisciplinary, multiagency working groups that review child deaths on a local level from a public health perspective. By reviewing circumstances surrounding child deaths, teams identify prevention strategies that will decrease the incidence of preventable child deaths by:

- Providing assistance, direction, and coordination to investigations of child deaths;
- Promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities;
- Developing an understanding of the causes and incidence of child deaths in the county or counties in which the team is located;
- Recommending changes to agencies, through the agency's representative member, that will reduce the number of preventable child deaths; and
- Advising the State Committee on changes to law, policy, or practice that will assist the team and the agencies represented on the team in fulfilling their duties.

Texas CFRTs vary in size and the number of counties for which they review child deaths. Several teams each review deaths for one county while others review deaths for two or more. The largest number of counties a single Texas team covers is 26.

DSHS publishes an annual report from the SCFRT. The most recent report is: [FY2013 Annual Report](#)^{xxviii}

DFPS/DSHS Strategic Plan to Reduce Child Abuse and Neglect Fatalities

In April 2014, DFPS and DSHS combined efforts to address proactively child fatalities through the Strategic Plan to Reduce Child Abuse and Neglect Fatalities. Almost half of the confirmed child abuse and neglect fatalities have no previous involvement with DFPS, highlighting the importance of population-based strategies to reduce these deaths. By utilizing a public health approach to understand, analyze, and build a comprehensive approach to target child abuse and neglect fatalities, DFPS and DSHS

can leverage resources, programs, and community collaborations to target specific issues and geographical areas based on their individual needs. With the robust data systems available to DSHS, a broader picture of influencing factors and possible intervention points can be determined for all child fatalities, including those caused by abuse and neglect.

The collaboration between DFPS and DSHS has the specific aim of taking the results of an in-depth analysis of the risks that exist within families and communities that have experienced an abuse or neglect fatality and use those results to guide a strategic plan that coordinates support services between DSHS and DFPS. The ultimate goal of this plan is to reduce abuse and neglect fatalities by strategically providing timely, coordinated, and evidence-based services to families and communities in need.

Protect Our Kids Commission

During the 83rd Texas Legislature, SB66 established the Protect Our Kids Commission and tasked the Commission with studying the relationship between CPS, child welfare services, and the rate of child abuse and neglect fatalities. The Commission will identify necessary resources and develop recommendations to reduce child abuse and neglect fatalities that can be implemented at the local and state level. DFPS serves as one of the 15 members on the Commission. As an active member, DFPS is helping form and strategize recommendations for future implementation including:

- identification of best practices and evidence-based strategies to reduce child fatalities from abuse and neglect.
- development of recommendations for a comprehensive strategy to bring together local agencies, private sector, non-profits, and government programs to reduce child fatalities from abuse and neglect.
- development of guidelines for information that should be tracked to improve interventions to prevent child fatalities from abuse and neglect.

Statewide Child Fatality Disposition Review Team

The Statewide Child Fatality Disposition Review Team, comprised of regional and state office staff, currently is reviewing a sample of child fatality investigations with a variety of dispositions. This review is conducted to ensure statewide consistency in decision making with dispositions and severity types applied during a child fatality investigation.

National Initiatives and Program Improvement

Casey Family Programs - Child Safety Forums

Since 2010, DFPS has participated in Child Safety forums hosted by Casey Family Programs to address child fatalities. Forums are focused on bringing together researchers, policy makers, child welfare and public health leaders to address a variety of approaches to address child safety. Forums have included topics such as:

- Improving Child Safety and Reducing Child Maltreatment Fatalities
- Applying Public Health Approaches to Improve Safety and Prevent Child Fatalities
- Focusing on Child Protection
- Reframing Public Perception
- Application of Predictive Risk Modeling

Federal Commission for the Elimination of Child Abuse and Neglect Fatalities

Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF), is charged with developing a national strategy and recommendations for reducing child abuse and neglect fatalities. DFPS presented to CECANF in June 2014 at their first national meeting in San Antonio. This meeting was focused on gathering information related to federal policy's impact on the state/local level, current data and research, and policy/practice associated with child abuse and neglect fatalities. Texas continues to participate in CECANF's ongoing meetings and work closely with other states to help create a national standard in defining child abuse and neglect, requirements for reporting, and addressing child fatalities from a public health perspective.

Endnotes

ⁱ DFPS will review and complete an investigation on any child who dies within DFPS conservatorship or an open stage of service such as investigations or family preservation when the fatality is alleged to be from abuse or neglect or had injuries previously investigated, and then subsequently succumbs to those injuries are included in the year of his or her death.

ⁱⁱ FY2010 Population data from U.S. Census Bureau, Census 2010 Census Summary File 1. Available at: <http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>

ⁱⁱⁱ FY2011 and FY2012 data from Texas State Data Center, Texas Population Estimates; FY2013 data from Texas State Data Center, Texas Population Estimates. Available at:

<http://txsdc.utsa.edu/data/TPEPP/Index.aspx>

^{iv} U.S. Department of Health and Human Services, Administration of Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child Maltreatment 2012*, <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>

^v U.S. Department of Health and Human Services, Administration of Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2014). *Child Maltreatment 2013*, <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>

^{vi} See Statewide Blue Ribbon Task Force. Available at: <http://www.blueribbontaskforce.com/index.html>

^{vii} See State Child Fatality Review Team. Available at

http://www.dshs.state.tx.us/mch/child_fatality_review.shtm

^{viii} Wood, J.N., S.P. Medina, C. Feudtner, X. Luan, R. Localio, E.S. Fieldston, and D.M. Rubin. 2012. Local macroeconomic trends and hospital admissions for child abuse, 2000-2009. *Pediatrics*.

Available at: <http://pediatrics.aappublications.org/content/130/2/e358.full.pdf>

^{ix} See Medical Child Abuse Resources and Education System (MEDCARES). Available at <https://www.dshs.state.tx.us/mch/medcares.shtm/>

^x See Forensic Assessment Center Network. Available at: <http://facntx.org/Public/About.aspx>

^{xi} See DFPS Child Safety Resource Page. Available at:

http://www.dfps.state.tx.us/Child_Protection/Child_Safety/default.asp

^{xii} U.S. Department of Health and Human Services, Administration of Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2014). *Child Maltreatment 2013*. Available from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

^{xiii} See SB1050 enrolled bill at: <http://www.legis.state.tx.us/tlodocs/81R/billtext/html/SB01050F.htm>

^{xiv} See HHSC Center for the Elimination for Disproportionality and Disparities.

Available at: http://www.hhsc.state.tx.us/hhsc_projects/cedd/about/index.shtml

^{xv} *Child Maltreatment 2011*, <http://www.acf.hhs.gov/sites/default/files/cb/cm11.pdf>.

^{xvi} U.S. Department of Health and Human Services, Administration of Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child Maltreatment 2012*. Available from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.

^{xvii} U.S. Government Accountability Office. (2011). *Child maltreatment: Strengthening national data on child fatalities could aid in prevention*. Retrieved from <http://www.gao.gov/new.items/d11599.pdf>

^{xviii} Tex. Fam. Code §261.102 Matters to be Reported, Section 261.101 Persons Required to Report; Time to Report.

^{xix} Tex. Fam. Code §261.301 Investigation of Report.

^{xx} Substance abuse is often a determining factor in child fatality cases, especially in situations where the child dies from positional asphyxiation or overlay from sharing a sleep surface with an intoxicated parent or in cases involving neglectful supervision of the child such as drowning, car accidents, and firearm fatalities.

^{xxi} Tex. Fam. Code §261.001 Definitions

^{xxii} Child abuse and neglect fatalities: Statistics and Interventions. Child Welfare Information Gateway. 2010. Available

at: [http://www.odontologiapediatrica.com/img/Child Abuse and Neglect Fatalities. Statistics and Interventions \(en ingl%C3%A9s\)..pdf](http://www.odontologiapediatrica.com/img/Child_Abuse_and_Neglect_Fatalities_Statistics_and_Interventions_(en_ingl%C3%A9s)..pdf). (Accessed on February 3, 2014).

^{xxiii} DFPS Public Website, <http://www.helpandhope.org/index.html>

^{xxiv} DFPS Public Website, http://www.dfps.state.tx.us/Room_to_Breathe/default.asp

^{xxv} DFPS Public Website, http://www.dfps.state.tx.us/Watch_Kids_Around_Water/default.asp

^{xxvi} DFPS Public Website,

http://www.dfps.state.tx.us/Prevention_and_Early_Intervention/Vehicle_Safety/default.asp

^{xxvii} DSHS State Child Fatality Review Team Members,

<https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589985017>

^{xxviii} Texas Child Fatality Review Annual Report 2013,

<http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589987385>

Insert Tab 6

CFRT Workgroup

The CFRT Workgroup has met three times and has identified the following areas to focus on and continue researching and evaluating:

- A. Ways to alleviate strain, frustration and workload from CFRT members,
- B. The need for greater consistency in the review process, including obtaining autopsies,
- C. The need for increased training for Justices of the Peace and CFRT members,
- D. Shortening the time frame for cases to be reviewed, and
- E. Coverage of 100% of Texas counties.

Coordination, training and better consistency for CFRTs

Amy Bailey, DSHS State Coordinator for CFRTs, recently conducted a survey of CFRTs. Amy Bailey is still obtaining information from additional CFRTs but has shared the information she has obtained thus far with the workgroup on matters such as: how often teams meet, which deaths are reviewed, and whether the teams use the national case report.

Tammy Sajak of DSHS has noted that CFRTs have never had any funding at the local level, and it is truly remarkable what has been achieved with volunteer commitment only. Tammy Sajak and Amy Bailey have shared with the workgroup their concept of adding one full-time employee (“FTE”) to each of eight the Regional DSHS offices to serve as a staff member to support the local CFRTs. There are 11 Public Health Regions that are housed in 8 offices, with 3 regions sharing office locations. A map is attached hereto showing the 11 regions and 8 offices.

Tammy Sajak and Amy Bailey believe the investment of only a few employees statewide to support the CFRTs could dramatically impact the effectiveness and consistency of the CFRTs’ work by providing meeting coordination, training, and data entry assistance to local CFRTs and would ultimately help lead to better child fatality information and thereby better prevention efforts. It has been noted by Tammy Sajak and members of the workgroup that the needs of CFRTs vary between urban and rural teams, but two critical goals should be met: (1) regions with rural teams need more technical assistance and coordination of multiple teams; and (2) regions with urban teams need assistance to work the high volume of cases. The workgroup has also discussed whether DSHS or DFPS would be the best agency to hire the FTEs and whether each should be hired by the State Coordinator, Amy Bailey.

It is possible that regional support could also help to ensure that counties without current CFRT coverage can join an existing CFRT or become part of a new CFRT.

With the Legislature currently in session, the workgroup reached out to DSHS and DFPS to determine if either agency was in a position to make a budget request for these new FTEs. Both agencies had already submitted their budgets; accordingly, no opportunity existed to take action on this concept during the current Legislative session. The workgroup as a whole believes this concept is one to continue to evaluate and consider; however, the workgroup felt we did not have sufficient information about how it could be implemented in order for the POK Commission to take action during this current Session. It is a concept that we anticipate continuing to research and consider as a solution to several of the critical needs for CFRTs.

Autopsies

Currently, the death of any child under the age of 6 is required to be immediately reported to the medical examiner or, in counties without a medical examiner, a justice of the peace. An exception to this requirement is when the death is a result of a motor vehicle accident. A reported death requires the justice of the peace or medical examiner to conduct an inquest. One requirement of the inquest is an autopsy. Exceptions to the autopsy requirement are expected deaths due to a congenital or neoplastic disease. Under certain circumstances, a death caused by an infectious disease may also be exempted. Consent for an autopsy is not required, and the statutes allowing objections to an autopsy do not apply to required autopsies.

Judge McCown has raised the idea in a Commission meeting of requiring autopsies of all child deaths in Texas. The workgroup is working to determine the approximate number of additional autopsies which would be required each year if the age requirement were raised and the approximate cost which would be associated with requiring autopsies for all unexpected, non MVA child deaths.

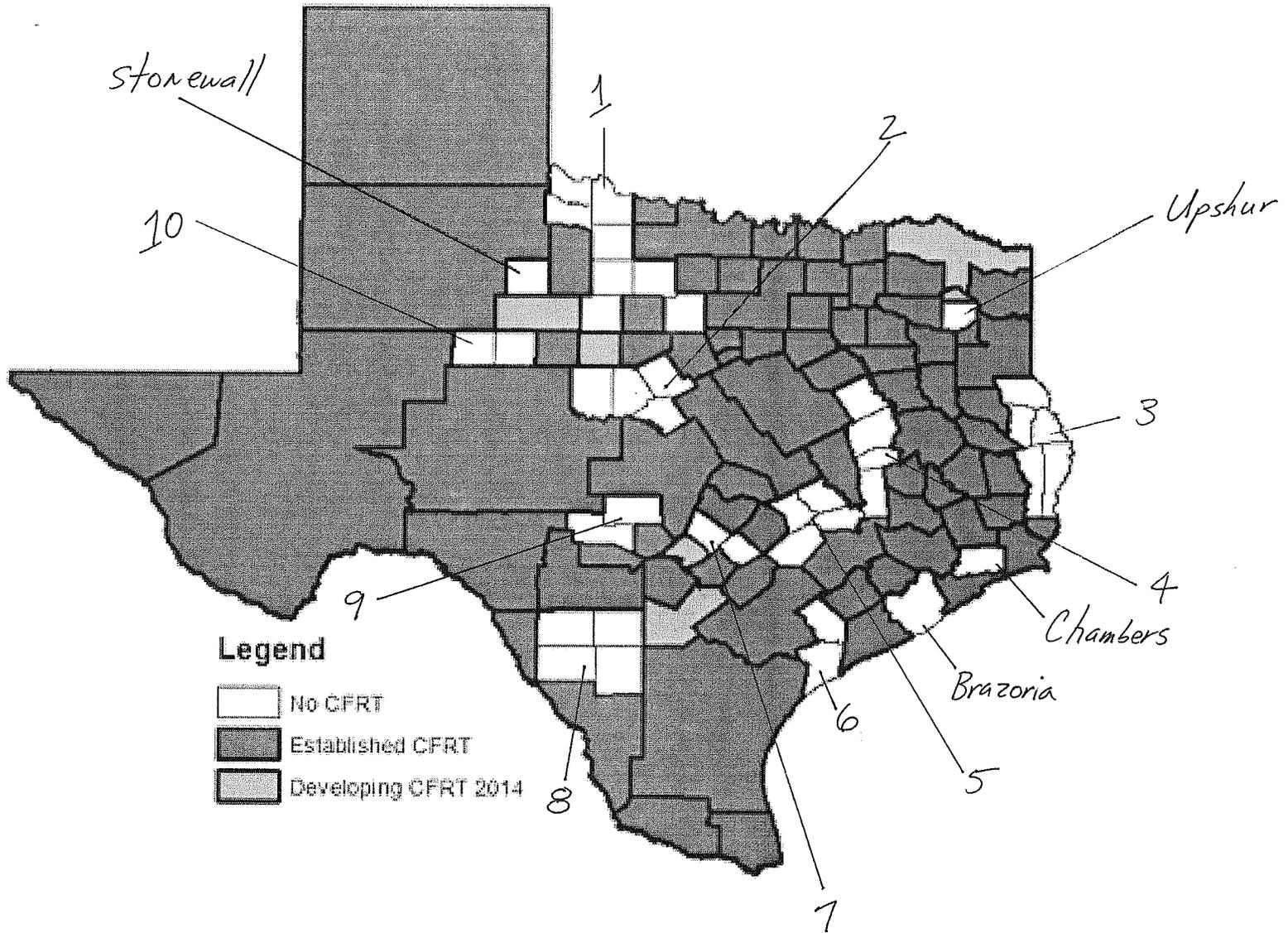
Shortening the time frame for cases to be reviewed

The workgroup has discussed obstacles which cause delays in the review and reporting process. These delays include matters such as: the amount of time required to obtain toxicology results, and thereby final autopsy results, and hesitancy by law enforcement and/or prosecutors to provide information on fatalities until a criminal case is fully resolved. Some CFRTs obtain faster notification of child deaths by receiving notice from County Registrars instead of waiting to receive a death certificate from DSHS. Faster notification may help expedite the review process in many cases. More information needs to be obtained and considered regarding the expense of this faster notification process as well as whether it would ultimately expedite the review process.

Coverage of 100% of Texas counties

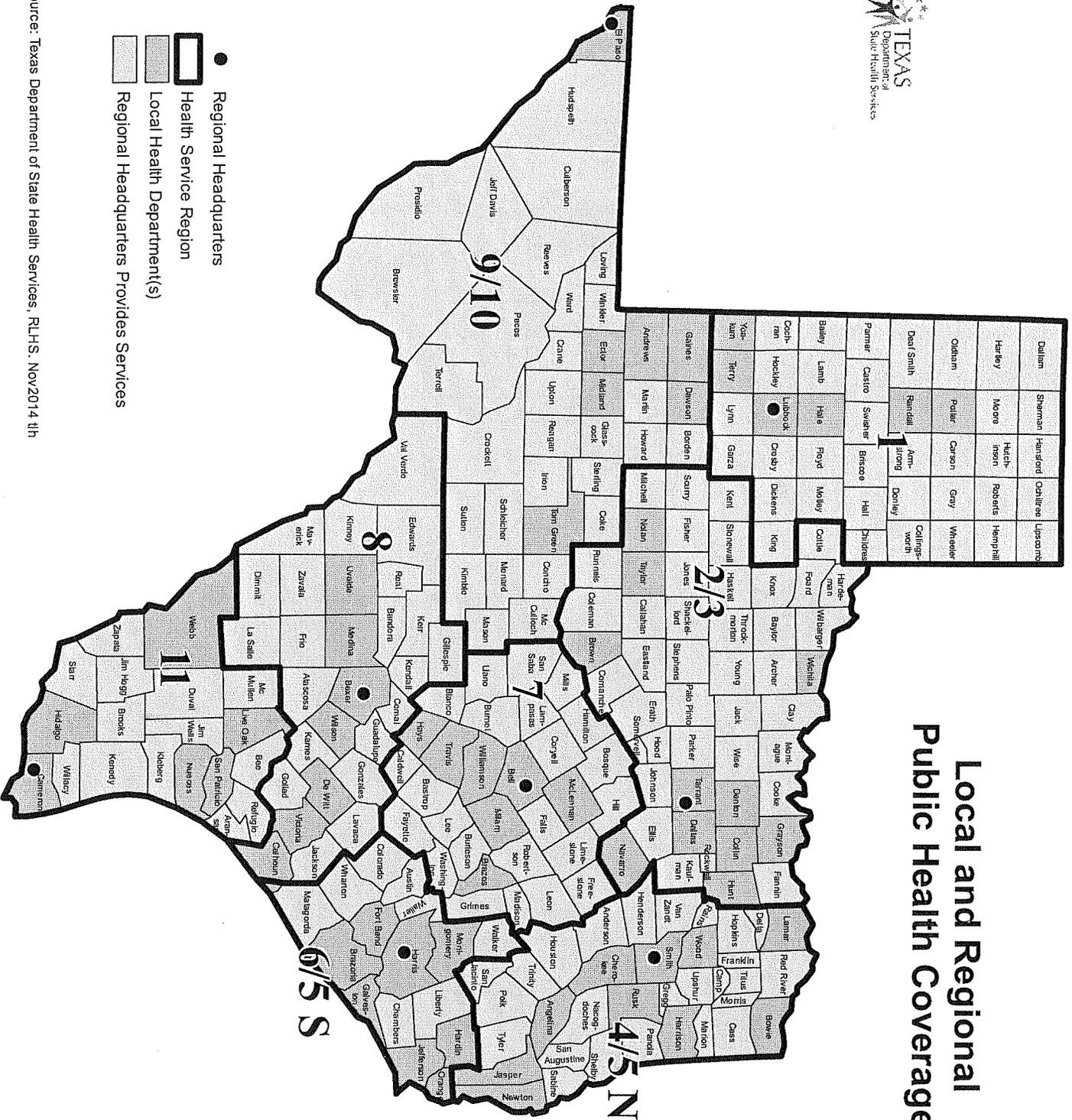
The workgroup has recently begun looking at the counties which are not part of a CFRT to evaluate whether 100% participation would significantly impact the information obtained by the State CFRT and thereby used to identify trends and prevention efforts.

Currently, a county with a population of less than 50,000 may join an adjacent county or counties to establish a CFRT. Attached to this summary is a map showing the Texas counties currently without CFRT participation. Also attached is a list of the counties without CFRT participation with the risk levels identified by Madeline McClure in her presentation to the Commission on January 16, 2015. The factors used to determine risk were: (1) domestic abuse, (2) substance abuse, (3) teen pregnancy, (4) child abuse fatalities, and (5) child poverty.





Local and Regional Public Health Coverage



Source: Texas Department of State Health Services, RLHS, Nov2014.tth

	Counties	Populations	Risk
Single Counties			
	Brazoria	324,769	Moderate
	Chambers	31,196	Low
	Stonewall	1,475	Low
	Upshur	39,995	High
Multi-County Areas			
1	Baylor	3,623	High
1	Foard	1,307	Highest
1	Hardeman	4,082	Low
1	Palo Pinto	27,856	Moderate
1	Throckmorton	1,601	Moderate
1	Wilbarger	13,258	High
1	Young	18,339	Highest
	<u>TOTAL</u>	<u>70,066</u>	
2	Brown	37,825	High
2	Coleman	8,675	Highest
2	Comanche	13,765	Highest
2	Mills	4,828	Low
	<u>TOTAL</u>	<u>65,093</u>	
3	Jasper	35,923	Highest
3	Newton	14,200	Moderate
3	Sabine	10,433	Low
3	San Augustine	8,818	High
3	Shelby	26,019	Highest
	<u>TOTAL</u>	<u>95,393</u>	
4	Freestone	19,515	Low
4	Grimes	26,783	High
4	Leon	16,803	Moderate
4	Madison	13,677	Highest
	<u>TOTAL</u>	<u>76,778</u>	
5	Burleson	17,291	Moderate
5	Fayette	24,695	Moderate
5	Lee	16,601	High
5	Washington	34,093	High
	<u>TOTAL</u>	<u>92,680</u>	
6	Calhoun	21,609	High
6	Jackson	14,255	Low
	<u>TOTAL</u>	<u>35,864</u>	

7	Caldwell	38,734	Highest
7	Hays	176,026	Moderate
	TOTAL	<u>214,760</u>	
8	Dimmit	10,461	Highest
8	Frio	17,702	High
8	La Salle	7,109	Low
8	Zavala	11,961	Highest
	TOTAL	<u>47,233</u>	
9	Gillespie	25,153	Moderate
9	Kerr	49,786	Highest
	TOTAL	<u>74,939</u>	
10	Mitchell	9,628	Low
10	Nolan	15,498	Highest
	TOTAL	<u>25,126</u>	

Insert Tab 7

Good Data Subcommittee

Charge 3: “Develop guidelines for the types of information that should be tracked to improve interventions to prevent fatalities from child abuse and neglect.”

On 3/17/15, TDFPS released a new report written jointly with TDSHS, “Strategic Plan to Reduce Child Abuse and Neglect Fatalities.” In this report, data was combined from DFPS, DSHS, birth records, death records and community-level risk indicators, which was one recommendation of this subcommittee. This combination of data has produced a broader view of child fatalities, is child-centric and focused on preventable deaths, consistent with a public health approach; this was another recommendation of the subcommittee. In addition, specific focus areas for intervention are identified and action plans are elaborated based on identified areas of need. This report represents a commendable step forward in understanding why children die in Texas.

The separate data bases maintained by TDSHS and TDFPS are still useful for tracking trends and should continue to be reported every year. It is important to acknowledge the hard work, time commitment, and dedication of the individuals that gather, review, and enter this data, many of whom are volunteers committed to saving children’s lives. Individuals that serve on child fatality review teams are to be commended for their work and particularly for the prevention strategies that have emerged from fatality reviews. Additional support for local CFRTs is needed to continue to identify and gather information that will improve intervention and prevention strategies to reduce child maltreatment deaths.

Current CFRT data collection should be evaluated for consistency and reliability to identify opportunities for improvement. This is also consistent with conclusions stated in the Strategic Plan to Reduce Child Abuse and Neglect Fatalities: “Improve identification, classification and data collection.” In addition, a parallel data base should be developed that includes child maltreatment deaths(Reason-to-believe fatal designation in TDFPS 3/17/15 report “A Better Understanding of Child Abuse and Neglect Fatalities”; abuse or neglect caused *or* contributed to the death), near fatalities(where abuse or neglect caused or contributed to the injury/condition) and preventable deaths(suicides, accidents, homicides, unknown, and undetermined causes of death; currently tracked with new combined data base). Most children dying of child maltreatment are under 3 years of age. There are 3 primary safety nets these children may encounter prior to their death: CPS, health care providers, and day cares. Current and future databases should incorporate information about medical care and daycare use by these children and their caretakers to evaluate opportunities for enhanced detection, intervention, and reporting to CPS prior to death. The Strategic Plan document indicates that most mothers involved in a confirmed child abuse or neglect fatality were enrolled in the Nutrition Program for Women, Infants and Children (WIC) during their pregnancies; in addition, risk factors for abuse and neglect may be identified during well- or sick-child visits and pre- and post-natal maternal health care visits. While re-referrals and child deaths are being tracked by CPS for families receiving in-home services, there are other in-home intervention and prevention services (NFP, HIPPY, SafeCare, Healthy Families/Precious Minds, Parents as Teachers, etc) and parent education programs (Period of Purple Crying, Triple P, etc) not directly affiliated with

CPS that may impact child maltreatment rates; data on CPS referrals and child deaths during and following these interventions should also be gathered and tracked.

Recommendations

1. Evaluate **currently** available child fatality data resources (CPS and CFRT data) and develop strategies to improve **completeness, consistency, validity and utility** by:
 - a. Evaluating mechanisms to ensure that all counties in Texas have CFRTs, and all unexpected infant/child deaths have autopsies and are reviewed. To improve consistency of data collected by CFRTs, definitions and indications for autopsies should be reviewed and training should be provided to ensure that CFRTs work from the same base level of knowledge and expectations. Mechanisms for- providing infrastructure and financial support for data collection by CFRTs are recommended and should be explored.
 - b. Reviewing current data collection methods and tools used for child maltreatment deaths to ensure that collection methods are standardized and terms are clearly understood and defined. For example, developing a more specific definition for a “near fatality” would facilitate a more consistent appraisal by physicians.
 - c. Add clearly defined criteria for “near fatalities” and “serious injuries” to be tracked by CPS, and address HIPAA regulations to allow this new, de-identified aggregated data, to be shared with the public.
2. Support efforts to prolong the length of time records are maintained by CPS, such that Reason-to-Believe with removal, Reason to Believe with Disposition of RTB for Sustained Perpetrator, Reason-to-Believe without a removal, Unable to Determine, Unable to Complete, and Ruled Out with risk factors indicated, and Ruled Out with risk factors controlled case records are retained by CPS for 50 years, 20 years, 20 years, 5 years, and 5 years, respectively, following case closure.
3. Evaluate enhancements to the new combined data base to include:
 - (a) near-fatalities and serious injuries due to child maltreatment;
 - (b) an expanded analysis of opportunities for preventing child maltreatment fatalities by improving earlier detection of risk, ensuring appropriate multidisciplinary case reviews when maltreatment is suspected, and assessing the impact of current community prevention programs on risk of child maltreatment fatalities.
4. Develop mechanisms to gather, analyze and track **new** information or data that may improve earlier detection of child maltreatment or risks related to child maltreatment and therefore impact (or prevent) child maltreatment fatality or near-fatality rates, such as:
 - (a) Utilization of pediatric health care, including
 - (1) number of well child examinations
 - (2) number and location (PCP office, ER, facility specializing in pediatric care) of sick visits

Commented [NK1]: I am unsure how this will help with “improving interventions to prevent child maltreatment fatalities” going forward since the data we currently track and the data we want to track in the future is very different than past data, so aggregating data will be difficult. In addition, this recommendation is currently in the December 2014 Interim Report to the 84th Legislature submitted by the House Select Committee on Child Protection.

- (3) prior injuries, growth percentiles (weight and height), development milestones documented in medical records
- (b) Utilization of day care facilities, including documented injuries or conditions concerning for physical neglect
- (c) Prior contact with CPS including number of referrals and disposition of each prior referral, including:

- (a) Priority None or Administrative Closure,
- (b) Differential Response (call screened out),
- (c) Alternative Response provided,
- (d) Investigated and ruled
 - i. Unable to Complete,
 - ii. Unable to Determine,
 - iii. Ruled Out or
 - iv. Reason to Believe

ii. Disposition of "Reason-To-Believe (RTB)cases resulting in:

- (a) referral to family-based services;
- (b) inclusion of a safety plan;
- (c) services were offered to family, types of services and compliance/completion;

(d) removal of the child

5. Develop mechanisms to gather, analyze and track **new** information or data that may improve interventions once child maltreatment is suspected and reported, including whether:

(a) intra-agency(CPS or law enforcement) or multidisciplinary(CAC) case reviews of serious or near-fatal injuries in children 3 and under impacts re-referrals to CPS and child death rates.

(b) services provided by CPS, such as Project HOPES and Project HIP impact (or prevent) child maltreatment fatality or near-fatality rates.

(c) child maltreatment fatalities or near-fatalities are found to be associated with *multiple* previous CPS referrals involving any of the children in the home (as in 1c, **above**).

2-3. Develop mechanisms to gather, analyze and track **new** information or data on whether various types of preventive services (such as parent education programs, in-home services, hospital-based programs) impact (or prevent) child maltreatment fatality and near-fatality rates. In addition to the predictive analytic data discussed in 1c, above, data from currently existing programs for families with young children may also guide prevention strategies. There are several in-home prevention programs and parent education programs throughout Texas, some well-known and with a strong evidence base that are not services contracted by CPS. Prevention services providers typically do not know if families receiving services are referred to CPS. Developing mechanisms for tracking whether such families participating in preventive services are referred to CPS or experience a child maltreatment death would be useful in evaluating whether these programs effectively prevent child abuse and death, particularly among at-risk families.

Commented [NK2]: Please note that the Putnam-Hornstein 2011 study that found previous CPS history was associated with an increased risk of both intentional and unintentional child fatalities in California did not address whether **multiple** referrals to CPS was associated with an increased risk of fatality. We need to first establish whether this is the case, then track granular data regarding previous referrals if it is....there is certainly potential for several areas of secondary analyses that could potentially emerge once the new combined data base (that would ideally include near fatality data as well) is established and analyzed. I think this would need to be a step-wise process

Insert Tab 8

Child Abuse Fatalities in Texas: Prevention Solutions

Presentation to the Protect Our Kids Commission

PREVENTION COMMITTEE

JAMYE COFFMAN MD

ANGELO GIARDINO MD

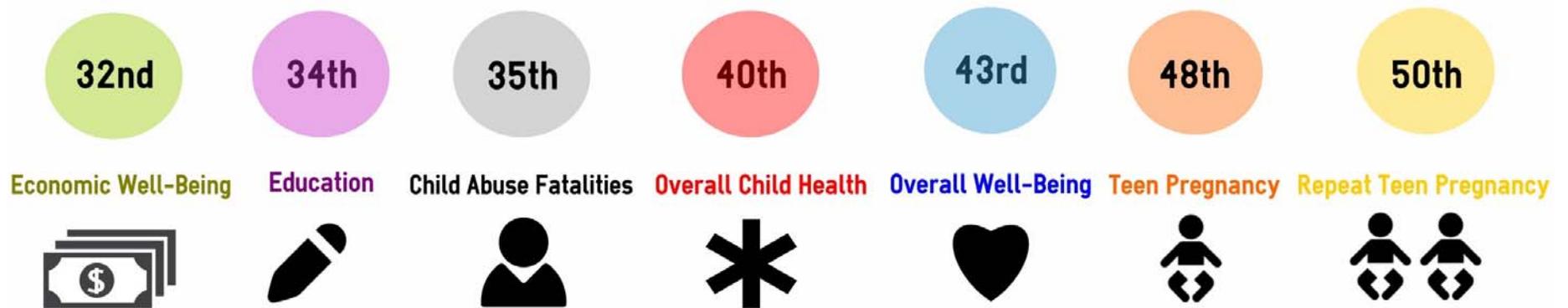
MADELINE MCCLURE

LUANNE SOUTHERN

MARCH 27, 2015

Why Texas Needs to Invest in Prevention

Texas Ranks...

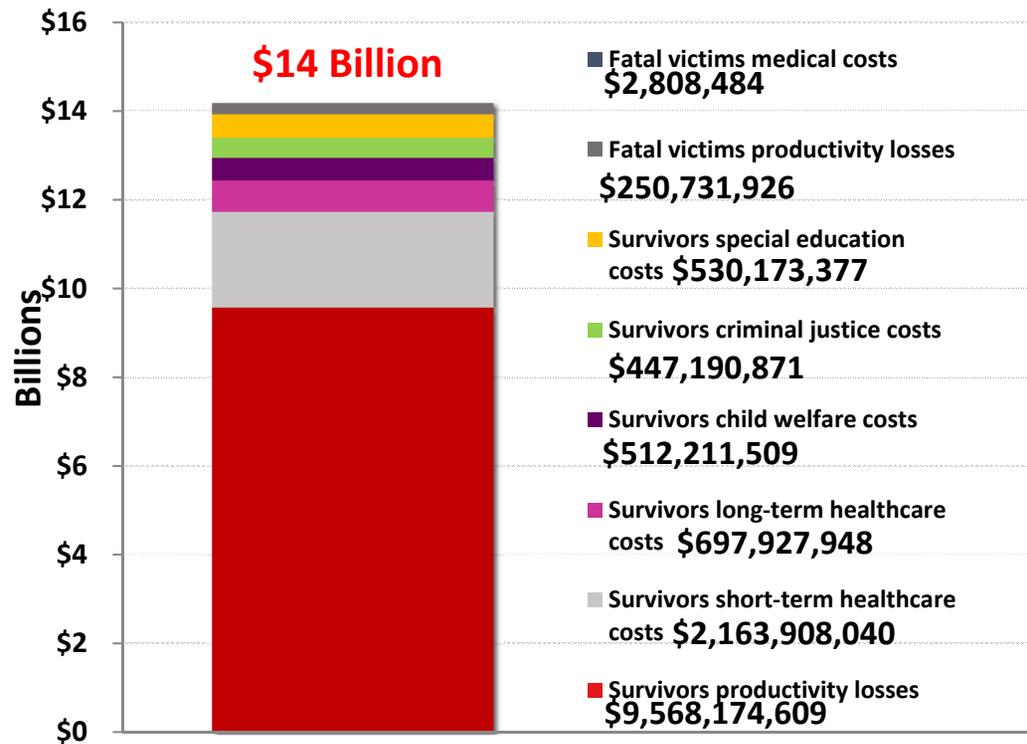


Sources: The Annie E. Casey Foundation. (2014). The 2014 Kids Count Data Book. Retrieved from <http://www.aecf.org/resources/the-2014-kids-count-data-book/>.

Guttmacher Institute. (2014). U.S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends by Age, Race and Ethnicity. Retrieved from <http://www.guttmacher.org/pubs/USTPtrends10.pdf>

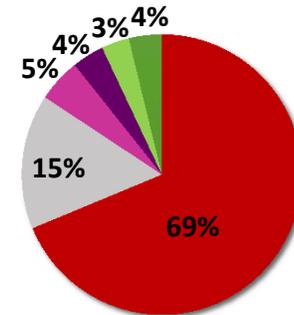
Lifetime Costs of Maltreatment in TX - \$14 Billion

TX lifetime cost from one year of child maltreatment



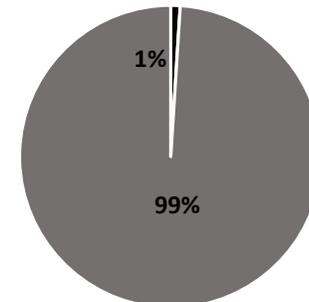
Average lifetime cost per survivor: 66,572

\$210,012

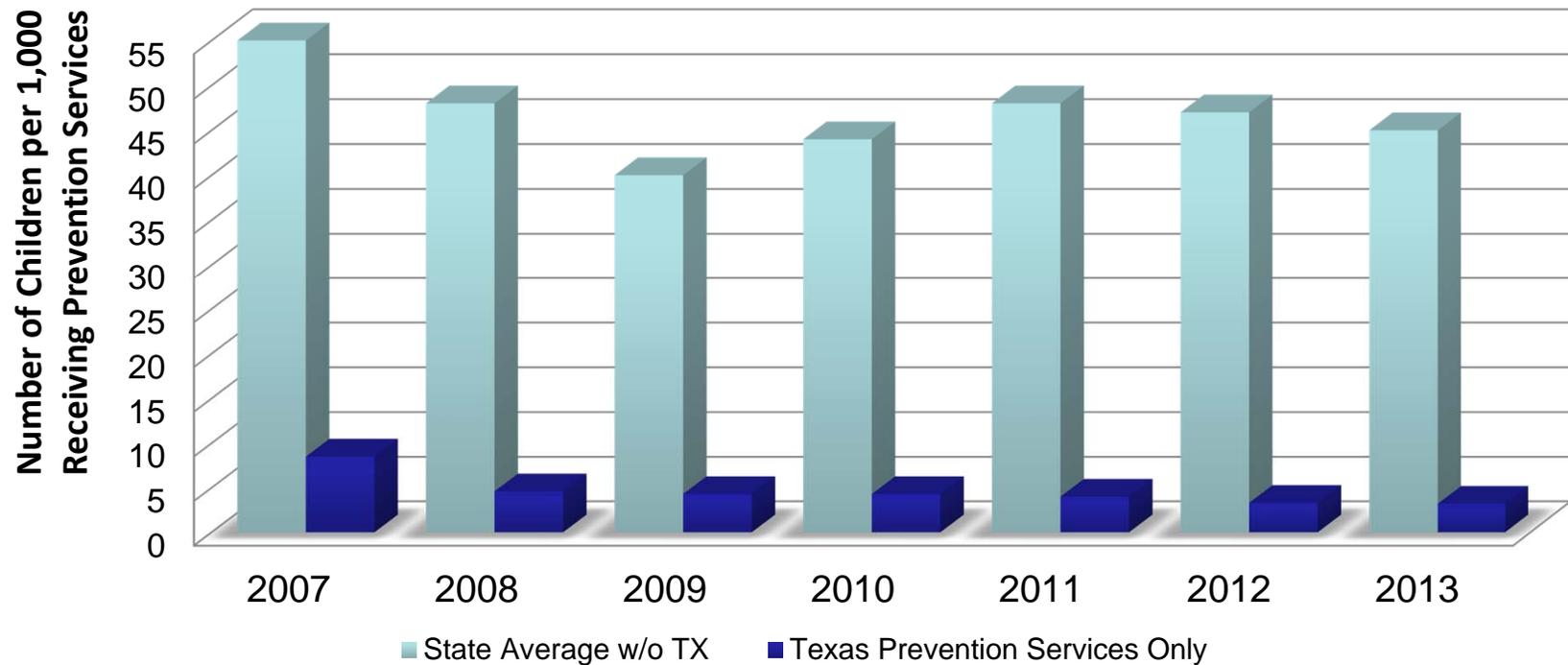


Average lifetime cost per fatal victim: 151

\$1,272,900

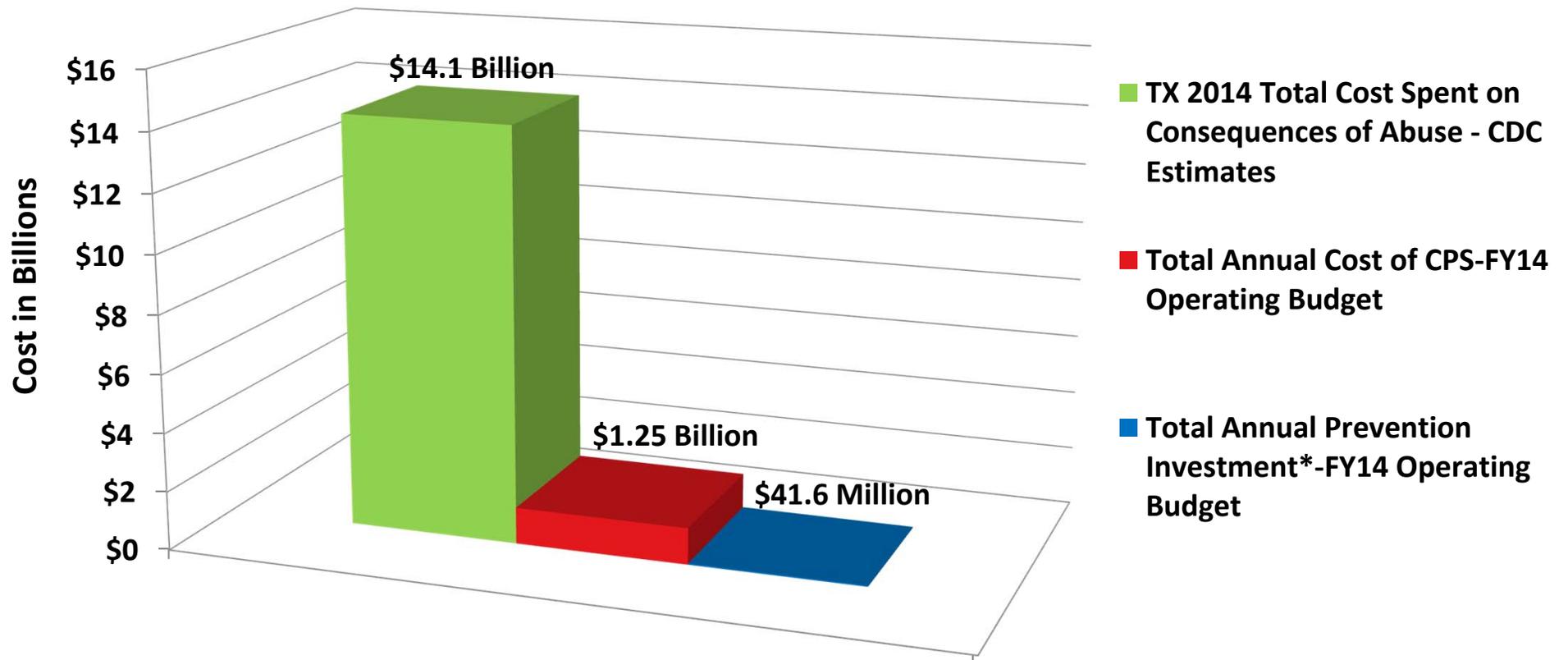


Child Abuse Prevention Services: Texas vs. US average*



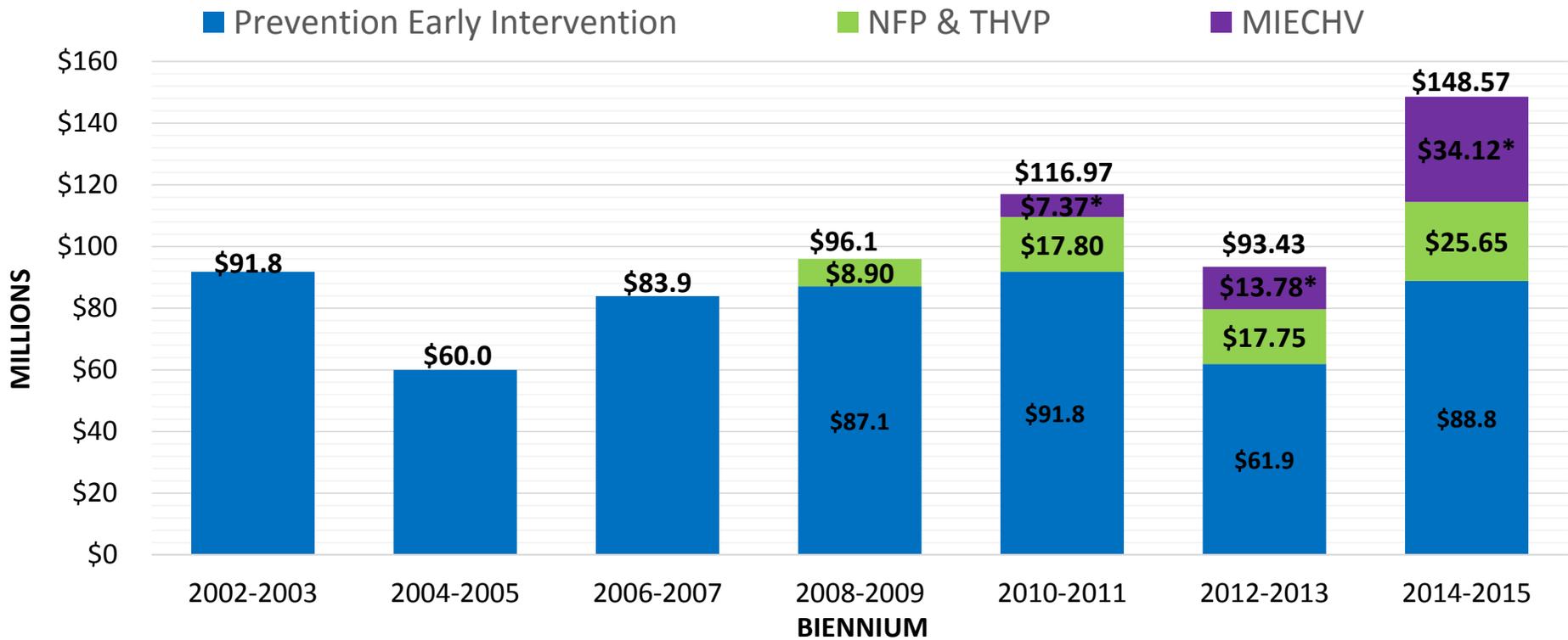
*US Dept. HHS, Administration for Children & Families, Child Maltreatment data books for each respective year, found at http://www.acf.hhs.gov/programs/cb/stats_research/
 Texas Child Abuse Prevention Services Only data found in DFPS Data Books from each respective year, found at http://www.dfps.state.tx.us/about/data_books_and_annual_reports/

Texas Child Abuse Costs vs. Prevention Investments

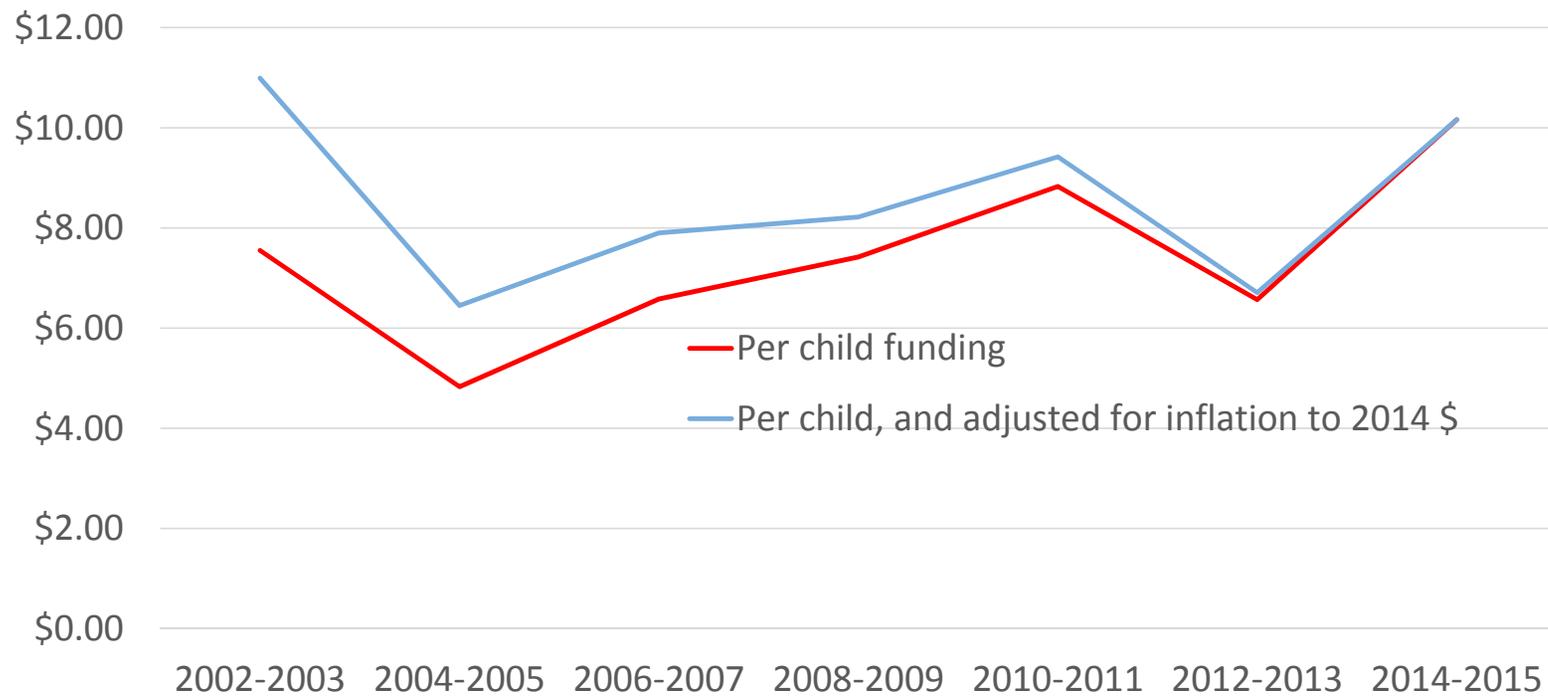


* Prevention Investment Includes FY14 Allocation for the Texas Home Visiting Program and Nurse-Family Partnership, and FY14 Budget for Key line items under the Prevention and Early Intervention Division (PEI) of DFPS including: At-Risk Prevention, Other At-risk Prevention, and Child Abuse Prevention Grants.

Texas' Prevention Investment



Prevention Funding, Adjusted for Texas Child Population Increase and Inflation (State/Local Govt. Implicit Price Deflator)



Child Fatality Prevent Framework:

Investing in EBP “Touchstones”- Developmental Trajectory

Universal Prevention Programs: Evidence Based Practices

- Triple P Level 1: Universal Messaging
- Period of Purple Crying / Other hospital-based post pregnancy education
- Triple P Level 2-4: Parenting Hot-line; Seminars; Parent Education

Universal: Promising Practices

- Child Development Education-Ob-Gyn CME / Distribution of EBP child development materials
- Recognizing and Reporting: Pediatricians/ ER professionals (school, university and child care professionals in statute)
- Child Development /Trauma-Impact Education-Junior High (permissive statute)

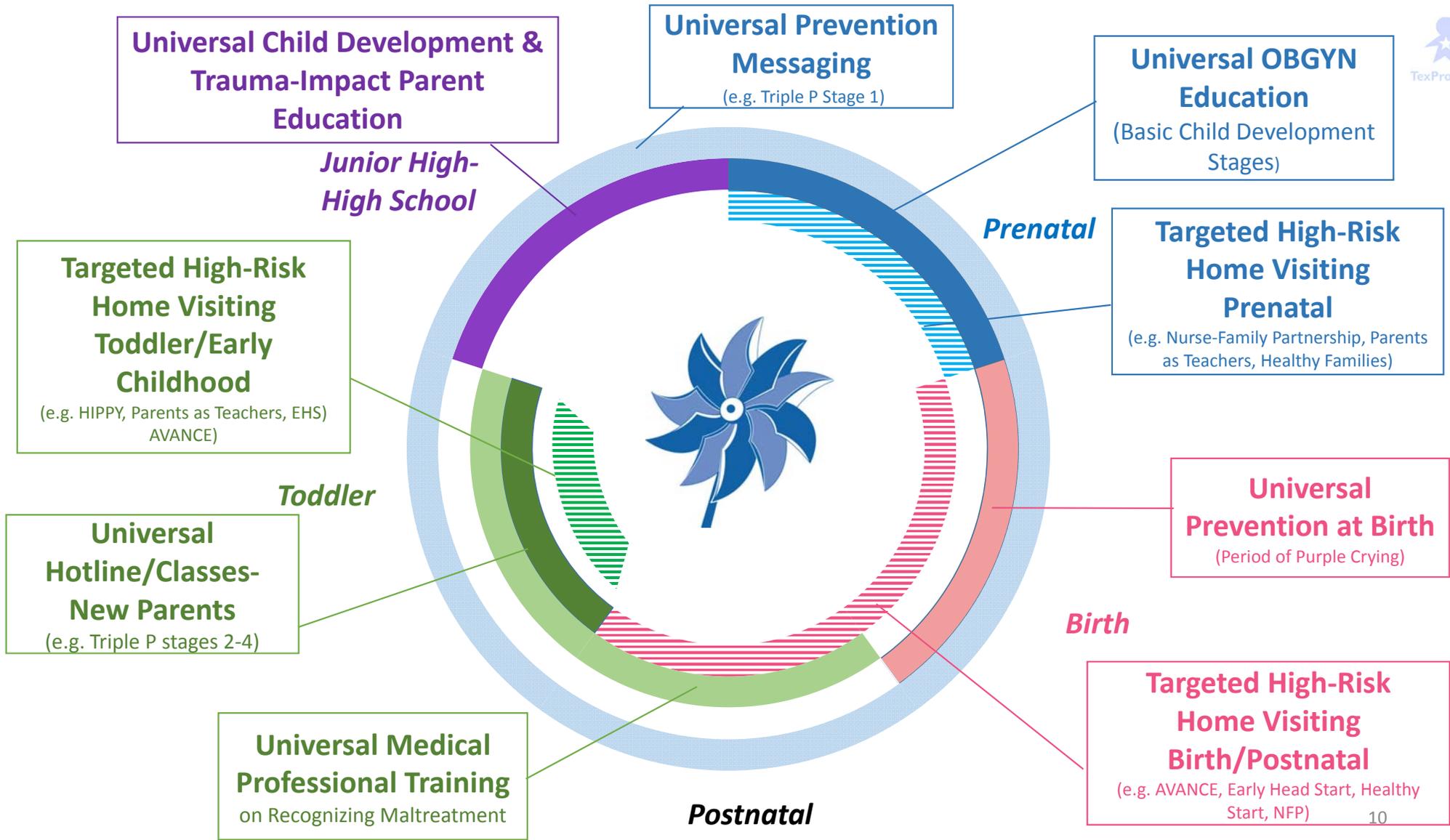
Child Fatality Prevent Framework: Investing in EBP “Touchstones”- Developmental Trajectory

➤ **Targeted Home Visiting Evidence Based Programs:**

- Nurse-Family Partnership
- Triple P (Stage 5)
- SafeCare
- Healthy Families
- Healthy Start
- Home Instruction for Parents of Pre-School Youth

➤ **Targeted Home Visiting Promising Practices:**

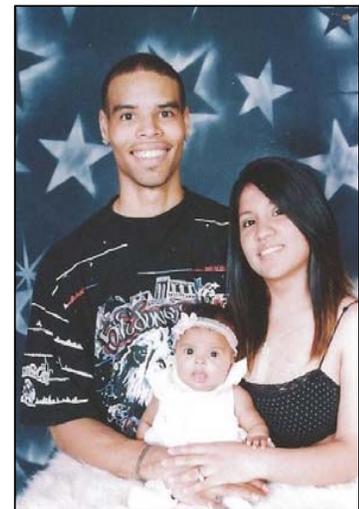
- AVANCE



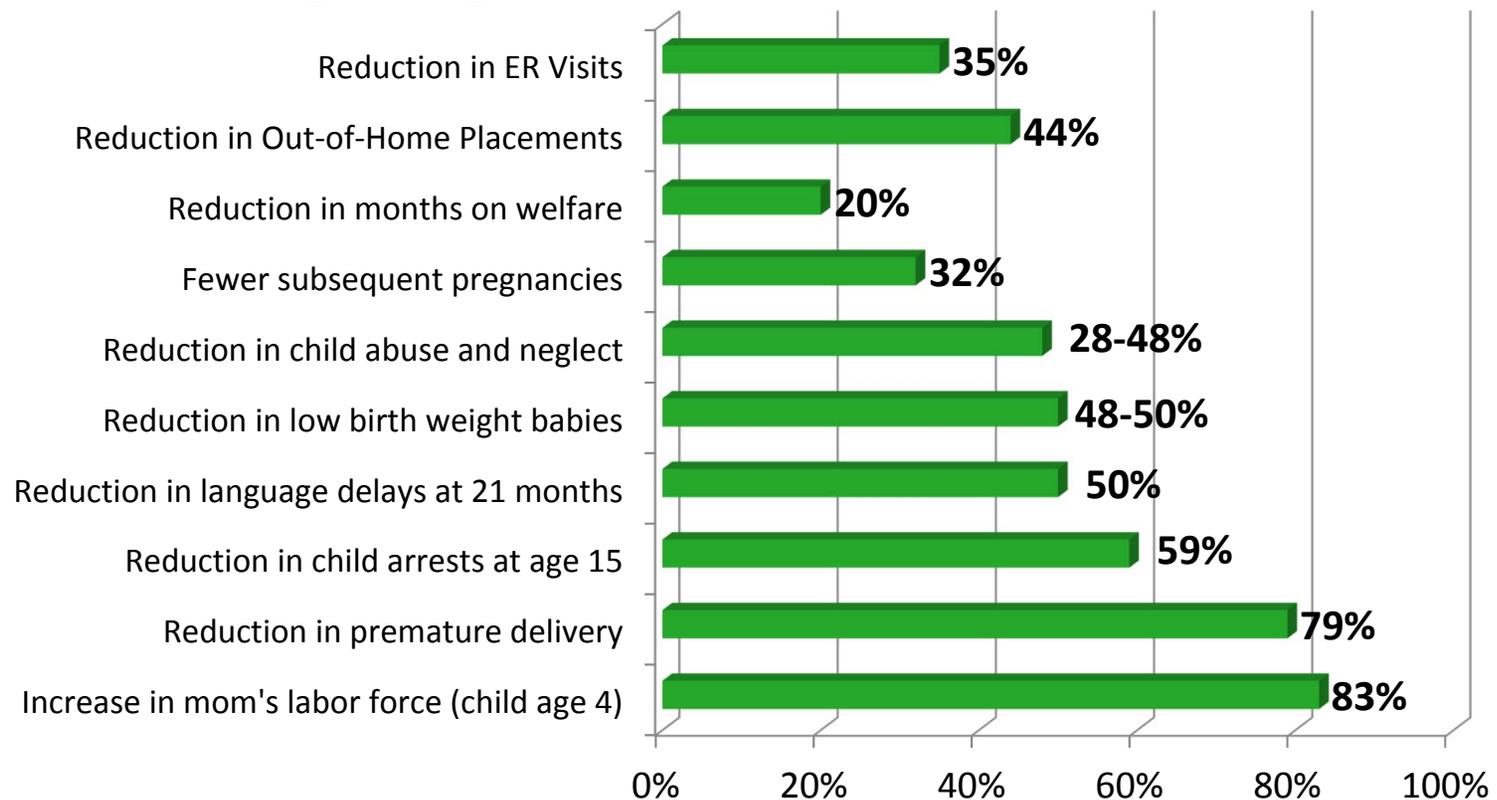
Family Support Home Visiting Programs

Trained personnel provide information, guidance, risk assessment, and parenting support in the home for families with young children

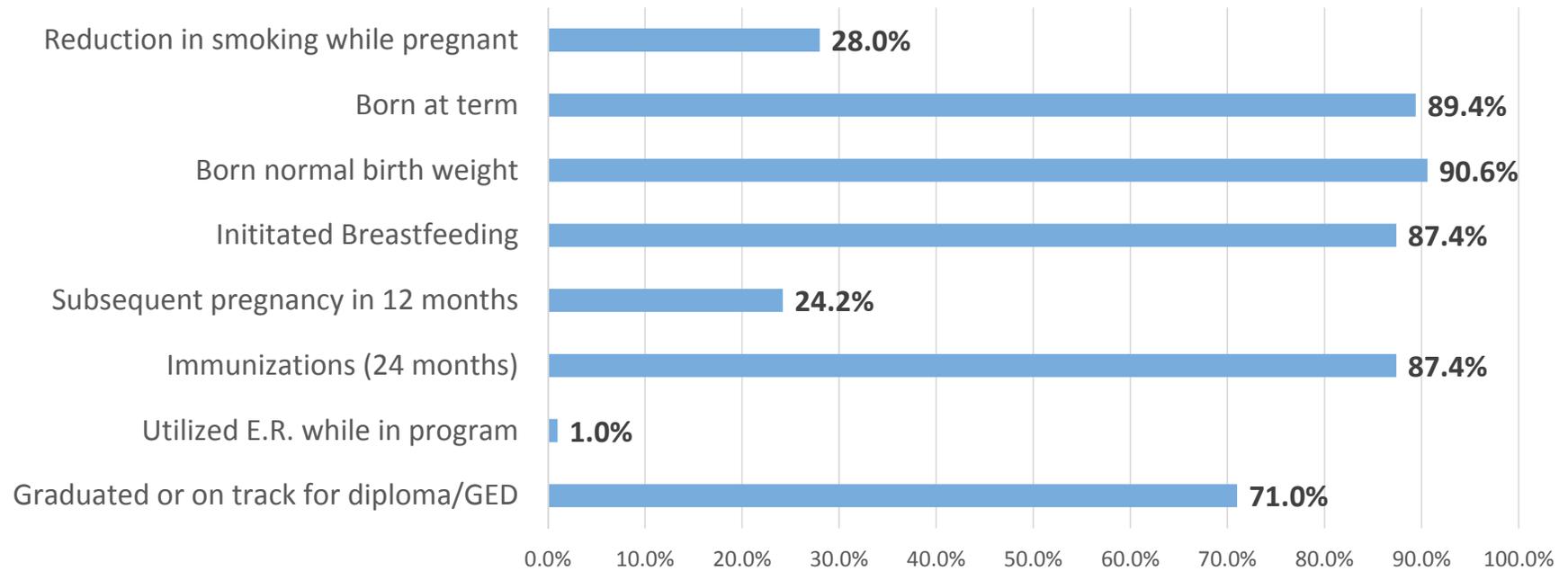
- Programs take a whole-family, or two generation approach
- Different model curricula for different clients
- Designed to improve a myriad of health, educational, safety and economic issues
- Targeted to specific at-risk groups
- Services delivered by trained professionals or paraprofessionals
- Spans from 6 months – 5 years
- Families enroll voluntarily



Outcomes Among Multiple Evidence-Based Home Visiting Programs

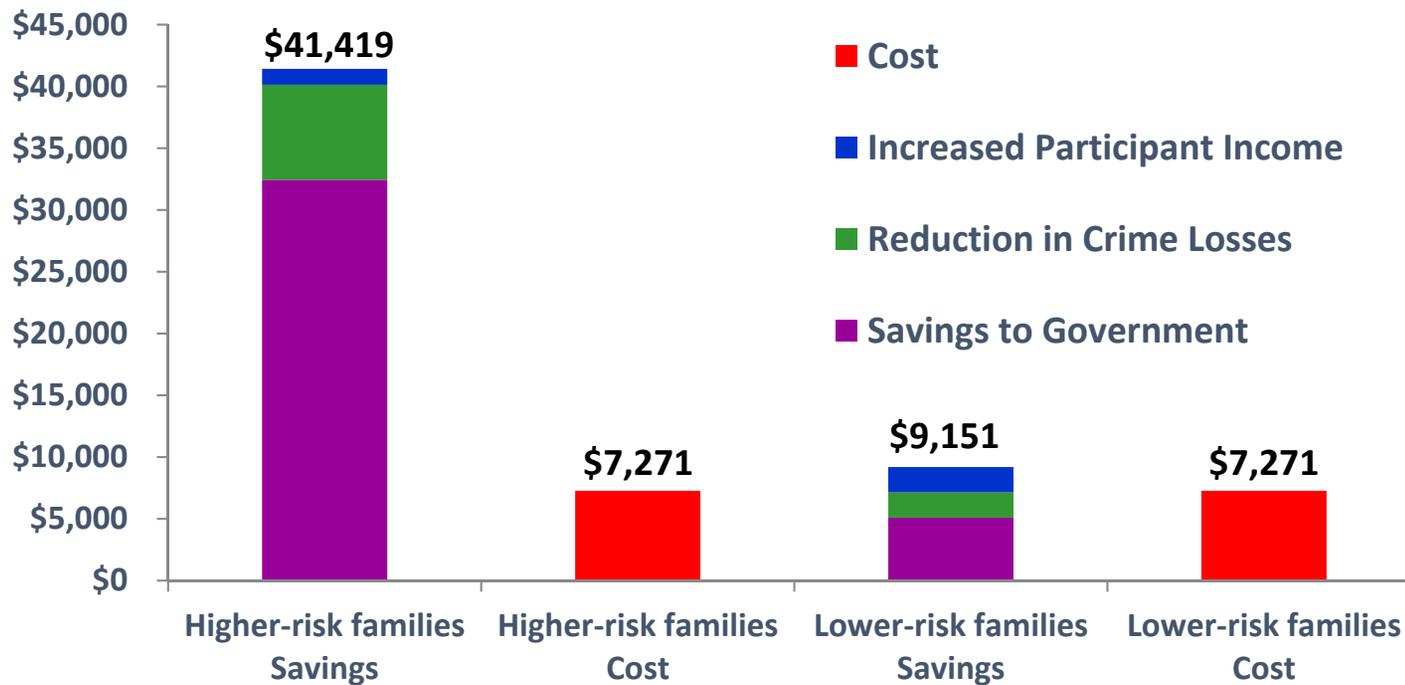


NFP Outcomes in Texas



NFP outcomes from Texas Nurse-Family Partnership Quarterly Report (December 31, 2014) *Cumulative Texas and National data from program inception to December 31, 2014.*

Home Visiting: A Sound Investment*



Karoly, L. A., Kilburn, M. R., & Canon, J. S. (2005). *Early childhood interventions: Proven results, future promise*. Santa Monica, CA: RAND Corporation.

Home Visiting Programs in Texas

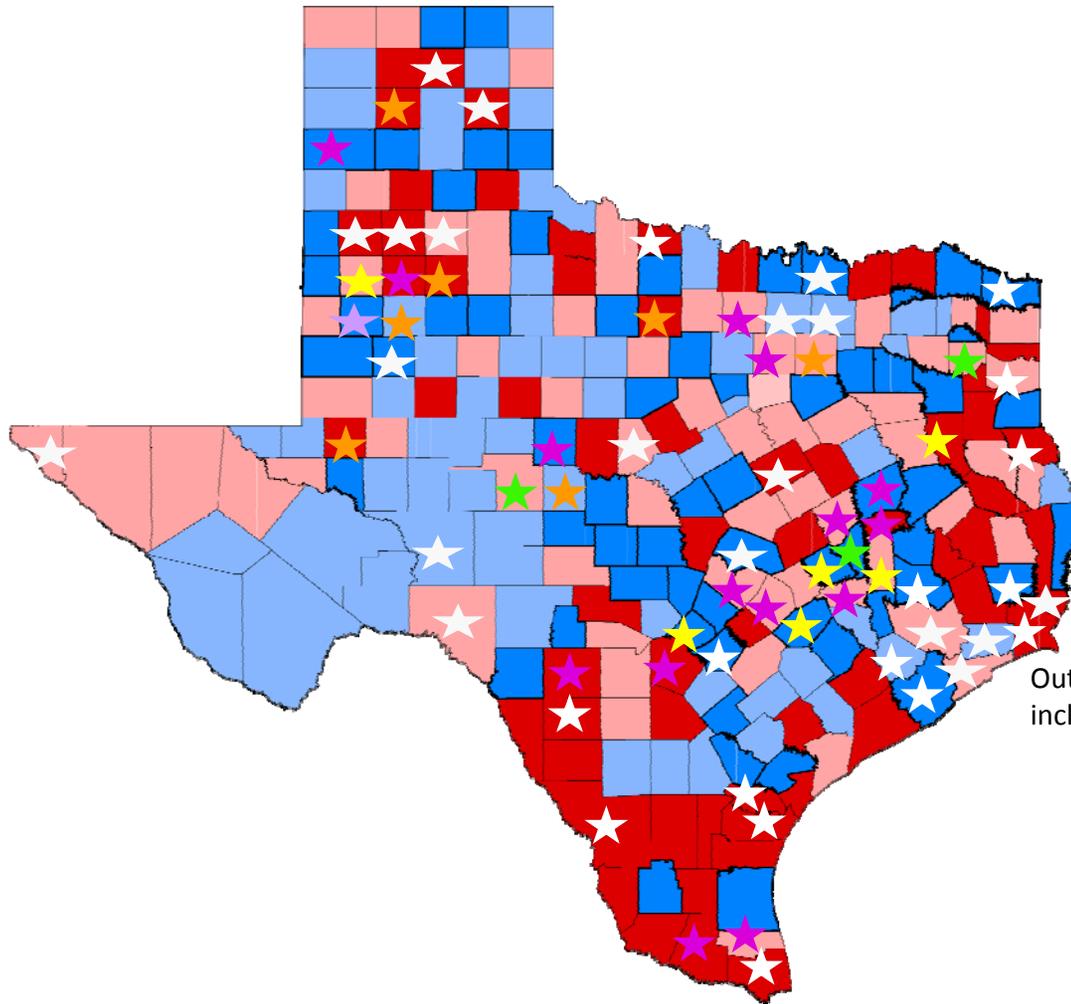
Program	2012 Families Served	2013 Families Served
AVANCE Parent-Child Education Program	5,235	6,674
Home Instruction for Parents of Preschool Youngsters	1,496	2,908
Parents As Teachers^	5,308	3,744
Nurse-Family Partnership	2,650	2,850
Early Head Start (home-based)	1,221	1,451
Healthy Start	1,580	1,123
Nurturing Parenting Program^	656	778
Healthy Families America	530	643
Family Connections	N/A	452
Systematic Training for Effective Parenting (home-based)	111	215
Positive Parenting Program	175	195
Parents and Children Together (PACT)^	126	126
Exchange Parent Aide	50	50
Expectant mother program	N/A	8
Family Connections	75	N/A
TOTAL	19,213	21,217

^ PAT is serving approximately 6,000 + families annually; not all families were captured in our county survey

TexProtects Risk Assessment & Families Served with Home Visiting



Highest Risk Counties (Bottom 25%)	High Risk Counties (Bottom 51% - 75%)
Moderate Risk Counties (Top 26% - 50%)	Lowest Risk Counties (Top 25%)



Number of Families Served by HV Represents ** Percentage of *Highest Need Families*:

- ★ 40.1 - 50%
- ★ 30.1 - 40%
- ★ 20.1 - 30%
- ★ 10 - 20%
- ★ Less than 10%

Outlined stars indicate surrounding counties included in percent served

Reducing Physical Abuse & Abusive Head Trauma Fatalities

- **The Period of PURPLE Crying** is a primary prevention program developed to educate new parents on infant crying, increase knowledge and safety behaviors, and ultimately, reduce AHT, which is the leading cause of CA/N fatalities in the U.S.
- Shaken Baby Syndrome (SBS) is the most common form of AHT
- Excessive crying is cited as most common reason for SBS/AHT perpetration
- On average, 191 Texas children are confirmed victims of AHT each year; of these 18 die of their injuries annually
- Estimated cost: \$1 million per case

Peak of Crying
Unexpected
Resists Soothing
Pain-like Face
Long Lasting
Evening

Outcomes of the Period of Purple Crying

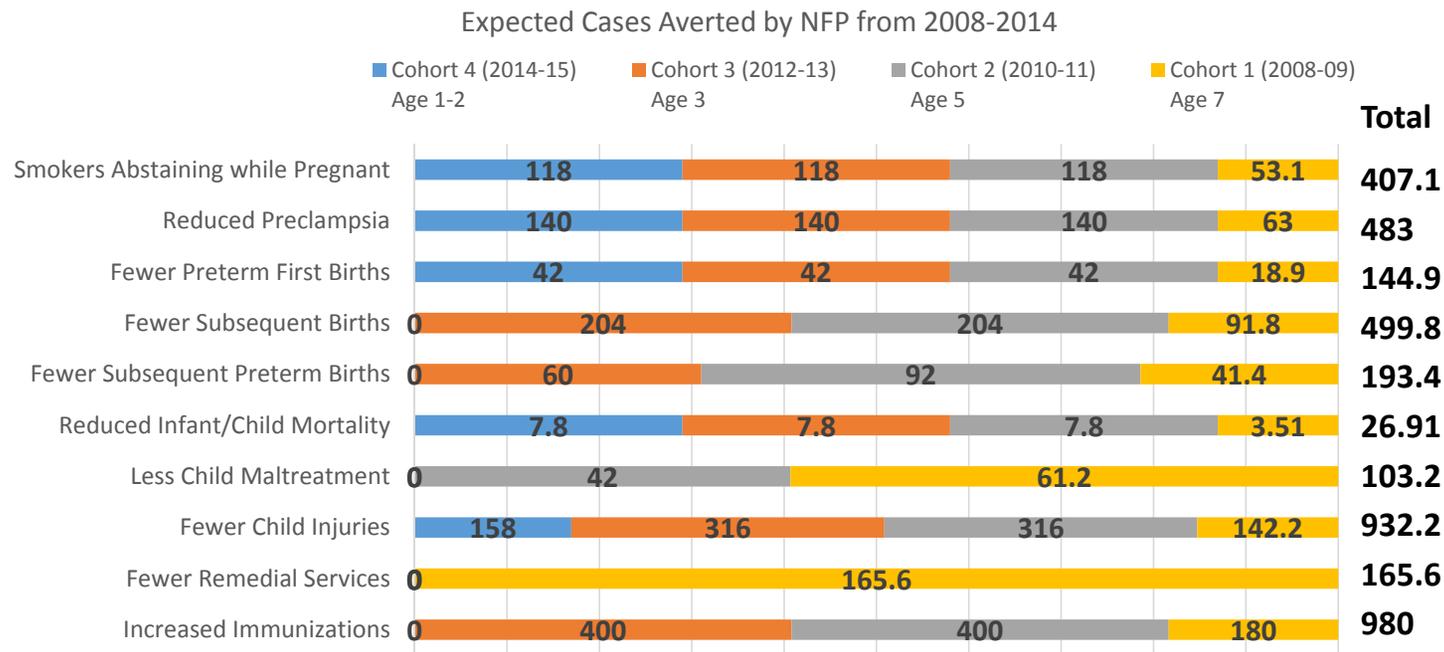
Studies in both the United States and Canada have indicated mothers:

- Understood more about normal infant crying
- Increased knowledge of the dangers of shaking infants
- Rise in walk-away behavior when frustrated, especially during periods of inconsolable crying
- Parents were more willing to share their education following the study
- Reduction in verified SBS occurrences unknown, but increase in knowledge suggests preventative modification of harmful behaviors
- Proven effective for both Spanish and English speaking mothers
- Suggested effectiveness also as a secondary prevention program

84th Session: Child Abuse/Neglect Fatality Prevention Priorities

1. Maintain and Expand State Home Visiting Funding- SFC-\$5mil NFP; HAC-\$16.1 mil pended
2. Child Fatality and Abusive Head Trauma Prevention Funding-DFPS Exceptional Item
3. Child Abuse Fatality Data Reporting-SB 949- Sen. Uresti
4. Establish prevention and family strengthening as elevated division under HHSC- Consolidation of existing prevention programs. SB200-Sen. Nelson; HB2304- Rep. Price
5. Support CPS ability to increase quality screening, response, investigation, services and focus on highest risk child abuse referrals (SB206 Sen. Schwertner; HB 2433-Rep. Burkett)
6. Establish Social Impact Financing-allow State to enter into a Social Impact Bond contract and pay out saved government funding under LBB and evaluator. (HB 3014 Rep. Parker)
7. Enhances awareness, screening, treatment, accessibility, and affordability of services for individuals with post-partum depression.
8. Increase minimum penalty for injury to a child in death or permanent disfigurement- remove probation as an option. SB 1418-Sen. Van Taylor and HB 3977-Rep. Dawanna Dukes

Outcomes and Expected Cases Averted from Texas' Investment in Nurse-Family Partnership



Calculations Based on Table 1: Expected Life Status and Financial Outcomes When First-Time Low-Income Mothers Receive NFP Services in Texas From Miller, Ted. (May 2014). Life Status and Financial Outcomes of Nurse-Family Partnership in Texas. Pacific Institute for Research and Evaluation.

Category of Savings	Total/family	2,650 Families	26,500 Families
TANF Payments	\$452	\$1,197,800	\$11,978,000
Medicaid Graduation	\$518	\$1,372,700	\$13,727,000
Reduced Costs if on Medicaid	\$2,024	\$5,363,600	\$53,636,000
Fewer Closely Spaced 2nd Births on Medicaid	\$2,811	\$7,449,150	\$74,491,500
Child Care, 2nd Births	\$36	\$95,400	\$954,000
Special Education	\$910	\$2,411,500	\$24,115,000
Confirmed Maltreatment	\$480	\$1,272,000	\$12,720,000
Other Maltreatment	\$24	\$63,600	\$636,000
Youth Arrests	\$1,652	\$4,377,800	\$43,778,000
Youth Crime	\$696	\$1,844,400	\$18,444,000
Youth Substance Abuse	\$0.24	\$636	\$6,360
State Savings by Year	\$9,604	\$25,450,600	\$254,506,000
Federal Savings by Year	\$13,118	\$34,762,700	\$347,627,000
Total Government Savings by Year	\$22,722	\$60,213,300	\$602,133,000
Cumulative Federal & State Medicaid Savings	\$13,572	\$35,965,800	\$359,658,000
Cumulative State Savings (Present Value)	\$7,475	\$19,808,750	\$198,087,500
Cumulative Federal Savings (Present Value)	\$10,788	\$28,588,200	\$285,882,000
Total Government Savings (Present Value)	\$18,263	\$48,396,950	\$483,969,500

Total Cost Savings by Category/Family from Miller, T. R. (May 2014). Cost Savings of Nurse-Family Partnership in Texas. Pacific Institute for Research and Evaluation.

References

Barr, R., Barr, M., Fujiwara, T., Conway, J., Catherine, N., & Brant, R. (2009). Do educational materials change knowledge and behavior about crying and shaken baby syndrome? A randomized controlled trial. *CMAJ, 180*(7), 727-733.

Bradshaw, J. (2010). Period of PURPLE Crying effective in changing knowledge and behavior in a home visiting program supporting high risk, first time mothers (Doctoral Dissertation). Retrieved from <http://dontshake.org/pdf/DrBradshawHomeVisitPURPLE.pdf>.

Chaffin, M., Hecht, D., Bard, D., Silovsky, J. F., & Beasley, W. H. (2012). A statewide trial of the SafeCare home-based services model with parents in child protective services. *Pediatrics, 129*(3), 509-515. doi: 10.1542/peds.2011-1840

Child and Adolescent Health Measurement Initiative (2013). "Overview of Adverse Child and Family Experiences among US Children." Data Resource Center, supported by Cooperative Agreement 1-U59-MC06980-01 from the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Available at www.childhealthdata.org. Revised 5/10/2013.

DuMont, K., Mitchell-Herzfeld, S., Greene, R., Lee, E., Lowenfels, A., Rodriguez, M., & Dorabawila, V. (2008). Healthy Families New York (HFNY) randomized trial: Effects on early child abuse and neglect. *Child Abuse & Neglect, 32*(3), 295-315. doi:10.1016/j.chiabu.2007.07.007

Garner, A. (2013). Translating Developmental Science into Healthy Lives: Realizing the Potential of Pediatrics [PowerPoint Slides].

Harden, B. J. (2014). Home Moments: Home Visiting to Address Toxic Stress [PowerPoint Slides]. Retrieved from https://s3.amazonaws.com/v3-app_crowdc/assets/events/LlcoEjkC8i/activities/Brenda_Jones_HardinPPT.original.1390919299.pdf.

References (Continued)

Laskey, A. Evaluation of the Period of PURPLE Crying through word of mouth. Retrieved from <http://dontshake.org/pdf/DrLaskeyEvalPURPLE.pdf>
MacMillan, H., Thomas, B., Jamieson, E., et al. (2005). Effectiveness of home visitation by public health nurses in prevention of the recurrence of child physical abuse and neglect: A randomized controlled trial. *Lancet*, 365 (9473), 1786-1793.

Maher, E. J., Marcynyszyn, L. A., Corwin, T. W. & Hodnett, R. (2011). Dosage matters: The relationship between participation in the Nurturing Parenting Program for infants, toddlers, and preschoolers and subsequent child maltreatment. *Children and Youth Services Review*, 33, 1426-1434. doi: 10.1016/j.chilyouth.2011.04.014

National Center on Shaken Baby Syndrome. (2009). Randomized controlled trials on the effectiveness of the PURPLE materials: Parallel studies in the state of Washington (USA) and the province of British Columbia (Canada) [online.] Retrieved from <http://www.dontshake.org/pdf/PURPLE-RandomizedControlledTrials.pdf>

Olds, D. L., Eckenrode, J., Henderson, C. R., Kitzman, H., Powers, J., Cole, R., . . . Luckey, D. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial. *Journal of the American Medical Association*, 278(8), 637-643.

Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). Population-based prevention of child maltreatment: The U.S. Triple P system population trial. *Prevention Science*, 10(1), 1-12. doi:10.1007/s11121-009-0123-3

Shonkoff, J., & Garner, A. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 129(1). 232-246.

U.S. Department of Health and Human Services, Administration on Children, Youth and Families. (2013). *Child maltreatment 2003-2012*. Washington, DC: US Government Printing Office. Retrieved from <http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment>.