Protect Our Kids Commission Meeting

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

Texas Hospital Association
1108 Lavaca Street,
Austin, TX 78701

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January 16, 2015
10:00 am – 2:00 pm

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MEETING AGENDA

10:00a.m. Opening Remarks
Judge Robin Sage, Chair
Commissioner Reports

10:25a.m. Brief Review of the Charge to POK Commission

10:30a.m. Jane Burstain, Ph.D., Senior Policy Analyst
Department of Family and Protective Services

11:00a.m. Tammy Sajak, M.P.H, Director Title V and Family Health
Department of State Health Services

11:15 a.m. Madeline McClure, J.D., Executive Director
TexProtects

11:30p.m. Commissioner Feedback
Nancy Kellogg, M.D., Marian Sokol, Ph.D., Eric Higginbotham, M.D.

12:00p.m. Lunch

12:15 p.m. Commissioner Discussion

1:45 p.m. Public Comment
Next Steps

Tab 1

Protect Our Kids Commission

GOVERNOR PERRY APPOINTEES

The Honorable Robin D. Sage, Presiding Officer
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DSHS COMMISSIONER LAKEY APPOINTEES

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Tab 2

S.B. No. 66

AN ACT

relating to studying the causes of and making recommendations for reducing child fatalities, including fatalities from the abuse and neglect of children.

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

SECTION 1. Subsections (b) and (c), Section 264.502, Family Code, are amended to read as follows:

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

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

(2) a sheriff;

(3) a justice of the peace;

(4) a medical examiner;

(5) a police chief;

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

(7) a child educator;

(8) a child mental health provider;

(9) a public health professional;

(10) a child protective services specialist;

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

(12) a neonatologist;

(13) a child advocate;

(14) a chief juvenile probation officer;

(15) a child abuse prevention specialist;

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

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

(18) an emergency medical services provider; and

(19) a provider of services to, or an advocate for, victims of family violence.

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

SECTION 2. Subsection (f), Section 264.503, Family Code, is amended to read as follows:

(f) [~~The committee shall issue a report for each preventable child death. The report must include findings related to the child's death, recommendations on how to prevent similar deaths, and details surrounding the department's involvement with the child prior to the child's death.~~] Not later than April 1 of each even-numbered year, the committee shall publish a report that contains aggregate child fatality data collected by local child fatality review teams, recommendations to prevent child fatalities and injuries, and recommendations to the department on child protective services operations based on input from the child safety review subcommittee. The committee shall [~~compilation of the~~

~~reports published under this subsection during the year,~~] submit a copy of the report [~~compilation~~] to the governor, lieutenant governor, speaker of the house of representatives, Department of State Health Services, and department[~~,~~] and make the report [~~compilation~~] available to the public. Not later than October 1 of each even-numbered year, the department shall submit a written response to [~~on~~] the committee's recommendations [~~compilation from the previous year~~] to the committee, governor, lieutenant governor, [~~and~~] speaker of the house of representatives, and Department of State Health Services describing which of the committee's recommendations regarding the operation of the child protective services system the department will implement and the methods of implementation.

SECTION 3. (a) The Protect Our Kids Commission is composed of six members appointed by the governor, one of whom shall be designated as presiding officer, three members appointed by the lieutenant governor, three members appointed by the speaker of the house of representatives, one member with experience in behavioral health and substance abuse appointed by the commissioner of the Department of State Health Services, one member who represents the Department of Family and Protective Services appointed by the commissioner of the department, and one member who represents the Office of Title V and Family Health of the Department of State Health Services appointed by the office director.

(b) Each member appointed to the commission must have experience relating to the study of the relationship between child protective services and child welfare services and child abuse and

neglect fatalities.

(c) In making appointments to the commission, each appointing authority shall make every effort to select individuals whose expertise is not already represented by other members of the commission and who reflect the geographical, cultural, racial, and ethnic diversity of the state.

(d) Members of the commission serve without compensation and are not entitled to reimbursement for expenses.

(e) The commission shall study the relationship between child protective services and child welfare services and the rate of child abuse and neglect fatalities.

(f) 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.

(g) The commission may accept gifts and grants of money, property, and services from any source to be used to conduct a function of the commission.

(h) Not later than December 1, 2015, the commission shall submit to the governor, lieutenant governor, and speaker of the house of representatives a report containing:

(1) the commission's findings and a complete explanation of each of the commission's recommendations;

(2) proposed legislation necessary to implement the recommendations made in the report; and

(3) any administrative recommendations proposed by the commission.

(i) The commission is not subject to Chapter 2110, Government Code.

(j) The Protect Our Kids Commission is abolished and this section expires December 31, 2015.

SECTION 4. The members of the child fatality review team committee under Subsection (a), Section 264.502, Family Code, responsible for selecting the additional members of the committee required by Subsection (b), Section 264.502, Family Code, as amended by this Act, shall make those appointments not later than November 1, 2013.

SECTION 5. This Act takes effect September 1, 2013.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 66 passed the Senate on March 13, 2013, by the following vote: Yeas 31, Nays 0; and that the Senate concurred in House amendment on May 23, 2013, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 66 passed the House, with amendment, on May 20, 2013, by the following vote: Yeas 147, Nays 0, two present not voting.

Chief Clerk of the House

Approved:

Date

Governor

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.

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

Tab 3

PROTECT OUR KIDS COMMISSION

MEETING SUMMARY

October 24, 2014
10:00 am – 2:00 pm

Legislative Conference Center
Texas Capitol Extension, E2.002

The Protect Our Kids Commission held its initial meeting on October 24, 2014, to introduce the Commissioners and begin information-gathering with presentations from key stakeholders including the Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS), the Dallas County Medical Examiner's Office, and the Texas Center for the Judiciary.

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

Judge John Specia, Commissioner of DFPS
DFPS has recently released its plan for organizational transformation based on recommendations by The Stephen Group (TSG), a consulting firm based out of New Hampshire and the Texas Sunset Commission. According to TSG findings, caseworkers only spend about 26% of their time in the field. DFPS Transformation strategies include technology upgrades and streamlined decision making processes to "buy back" time for caseworkers to spend with children and families. Commissioner Specia is focused on workforce stabilization through expanded training, more detailed screenings for compatibility at hiring, and improved employee mentoring. More prevention dollars will be funneled toward the Zero to Three Population where over half of the child fatalities occur.

Sasha Rasco, Director of Prevention and Early Intervention
Sasha Rasco educated the POK Commission on the establishment of an Office of Child Safety at DFPS that is on-par with Child Protective Services and Adult Protective Services. Currently, DFPS Prevention and Early Intervention (PEI) has contracts with community-based programs and agencies to provide a variety of services that help prevent abuse, neglect, delinquency, and truancy of Texas children. Some key points of her presentation were as follows:

Texas Family Code Sec. 265.002. PREVENTION AND EARLY INTERVENTION SERVICES DIVISION.
"Prevention and early intervention services" means programs intended to provide early intervention or prevent at-risk behaviors that lead to child abuse, delinquency, running away, truancy, and dropping out of school.

Child Abuse and Neglect Prevention Services focuses on strengthening the following six protective factors:

1. Nurturing and Attachment
2. Knowledge of Child Development
3. Parental Resilience
4. Social Connections
5. Concrete Supports
6. Social and Emotional Competence of the Child

Texas Family Code Sec. 265.004. USE OF EVIDENCE-BASED PROGRAMS FOR AT-RISK FAMILIES.
(a) To the extent that money is appropriated for the purpose, the department shall fund evidence-based programs offered by community-based organizations that are designed to prevent or ameliorate child abuse and neglect. … (b) The department shall place priority on programs that target children whose race or ethnicity is disproportionately represented in the child protective services system. (c) The department shall periodically evaluate the evidence-based abuse and neglect prevention programs to determine the continued effectiveness of the programs.

Project HOPES: Healthy Outcomes through Prevention and Early Support.
The goal of Project HOPES is to establish flexible, community-based child abuse and neglect prevention programs in select communities, targeting families of children ages 0-5 who are at-risk for abuse and neglect.

During the 83rd Legislature, $19 million was set aside for other at-risk prevention programs that include:
• Only programs that are evidence-based or promising practices.
• Community-based programs located throughout the state.
• Performance measures that gauge program effectiveness.
• Programs with a focus on children ages 0-17.
• Public private collaboration that enhances state resources to reach more children, youth, and families.

The benefit of the Project HOPES will be to reduce the abuse and neglect of children by empowering local communities, to build effective prevention services and coalitions through financial resources, data-driven procurement, and offering the flexibility to choose the evidence-based programs that meet the needs of the local community. The counties targeted for HOPES are:

•Potter (Amarillo)	•Gregg (Longview)	•Hidalgo (McAllen)
•Cameron (Harlingen)	•Travis (Austin)	•El Paso (El Paso)
•Webb (Laredo)	•Ector (Odessa)	

The new **Office of Child Safety** will have overall project management responsibility for cross-program initiatives that address preventable child fatalities, serious injuries and increase overall child safety. Current initiatives that will move under this division for project management include:

•Critical Case Management (CCM) is a cross-divisional, internal process of review of critical cases, often child fatality cases, looking for trends;
•HHSC fatality reviews;
•Project HIP (Help Through Intervention and Prevention– match birth records with records on families with a child fatality determined to be caused by abuse or neglect or a termination of parental rights) and ongoing legislative initiatives including the DFPS Safety Plan for Children in Foster Care, HIP •the DFPS and DSHS Strategic Plan to Reduce Child Abuse and Neglect Fatalities; The estimated number of referrals for this program in calendar year 2014 is 1502.
•the Protect Our Kids Commission; and
•the Federal Commission for the Elimination of Child Abuse and Neglect Fatalities.

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.

Actions Central to DSHS

- Providing timely data regarding child abuse/neglect fatalities in Texas
- Addressing the role that substance abuse plays in homes where children are at risk
- Recognizing the critical role providers play and giving them additional resources to deal with these complex issues

Child Fatality Review Teams

- Statewide effort to conduct retrospective reviews of child deaths through volunteer-based, Child Fatality Review Teams (CFRTs)
- Led by DSHS, in coordination with DFPS and other state agencies
- Public health strategy to:
    - Understand child deaths through multidisciplinary review on the local level;
    - Collect and analyze data to better understand risks to children; and
    - Inform local and statewide activities to reduce preventable child deaths
- Two Components:
    - Local Child Fatality Review Team (76 CFRTs cover 203 of the 254 Texas counties)
    - State Child Fatality Review Team (SCFRT) – make recommendations to reduce preventable child death including motor vehicle, drowning and abuse and neglect

Medical Child Abuse Resources and Education System (MEDCARES)
$2.5 million in funds are awarded annually to hospitals, academic health centers, and health care facilities with expertise in pediatric health care and a demonstrated commitment to developing basic and advanced programs and centers of excellence to develop and support regional initiatives to improve the assessment, diagnosis and treatment of child abuse and neglect. MEDCARES encourages the training and hiring of Child Abuse Pediatrics (a relatively new subspecialty):

•Specialized child abuse providers improve timely and accurate diagnoses, provide treatment and give support to investigations
•Medical services include comprehensive medical evaluations in an inpatient or outpatient setting
•Provides specialized equipment to handle medical and forensic exams
•Provides education and training to health care providers, community partners and the public

Need for Substance Abuse Services for DFPS Clients

•Drug overdose deaths exceed motor vehicle-related deaths in 29 states and Washington D.C.
•Abuse of prescription painkillers costs an estimated $53.4 billion a year in lost productivity, medical costs and criminal justice costs
•Only 1 in 10 Americans with a substance abuse disorder receives treatment

Texas Health Steps Online Provider Education Program for physicians and other health care providers on:

- Recognizing, Reporting and Preventing Child Abuse
- Infant Safe Sleep
- Intimate Partner Violence Training

Dr. Reade Quinton, Deputy Chief Medical Examiner in Dallas County

Dr. Quinton works closely with the Dallas Children's Advocacy Center, the Dallas County Child Death Review Team, and the Texas State Child Fatality Review Team. He is the Incoming President of the State Child Fatalities Review Team and led the POK Commission in a discussion about:

Local CFTs

•Volunteers
  –Many specialties and agencies
  –May include multiple hospitals and multiple police/sheriff jurisdictions
•Retrospective reviews (some may be a year after the death)
•May meet quarterly, monthly, or as needed
•May include all causes of death or focus on non-natural causes
•May identify individual case errors
•Facilitate local prevention initiatives
  –Water safety
  –Booster seats
  –Safe sleep
•Draft recommendations yearly to SCFRT
•Input data into the National Case Reporting System

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)

Heidi Penix, Director of Texas Children's Justice Act
The Children's Justice Act (CJA) is a federal grant awarded to each state to operate programs designed to improve the child protection system, especially in the areas of child sexual abuse, child abuse and neglect related fatalities, the investigation and prosecution of abuse and neglect cases, and cases involving children with disabilities.

Section 107(d) of CAPTA requires the CJA State Task Force to undertake a comprehensive review of the investigative, administrative and judicial handling of cases of child abuse and neglect and to make training and policy recommendations in the CJA categories. The State Task Force assessment (review, evaluation, and recommendations) is required at three year intervals.

The most recent assessment found broad variation in how child death cases are handled because of inconsistent training and resources:

- Lack of definitive medical evidence
- Misunderstanding about what an autopsy can and cannot do
- Autopsy standards vary widely – no mandated standards and protocols
- Lack of basic training on child abuse/neglect investigation for law enforcement
- No required standardized training on death investigations for Justices of the Peace
- No required standardized training on death investigations for first responders
- No required use of SUIDI protocol
- Joint investigations between law enforcement/cps are not happening as required

CJA's Next Steps

- Improve consistency of data collection
- Standardized protocols for first responders on child death investigations
- Death investigation training for JPs
- Joint training for law enforcement & CPS
- CAC access to IMPACT
- Infant and child death autopsy protocol

Judge Sage announced she would circulate a proposed set of ground rules to govern the procedure of the Commission and asked the Commissioners to provide feedback on the ground rules. The Commission will consider adoption of those rules thereafter.

Future Meetings will be:
January 16, 2015
March 6, 2015
May 11, 2015

Meeting adjourned.

Tab 4

Survey of Current Child Fatality Work in Texas

(This survey of child fatality work in Texas reflects our current knowledge of work in other organizations and will be revised as POK Commissioners, meeting presenters, and other partners make additions to the developing work.)

(1) Department of Family and Protective Services (DFPS)

On October 22, 2104, DFPS released the DFPS Report to the Sunset Advisory Commission, excerpted below:

Office of Child Safety

Abuse/neglect fatalities as well as near fatal events occur in every program within DFPS. Historically, CPS, Adult Protective Services (APS), and Child Care Licensing (CCL) have been independently responsible for identifying and addressing issues relating to the fatality. There has not been a centralized mechanism for insuring an independent case review, coordination of efforts, development of an agency perspective of systemic issues, or for targeting prevention efforts to reduce fatalities. This has resulted in fragmented responses from the agency as well as a perception that the agency is unable to provide unbiased reviews of its own work. An Office of Child Safety will instill a laser-focused and objective approach needed to research systemic problems, identify areas of prevention and intervention, initiate enhancements to practice, and bolster increased collaboration opportunities among DFPS, Department of State Health Services (DSHS), other agencies and stakeholders. With this new office leading the charge, Texas can be a model for other states and a national leader in addressing child fatalities and serious injury.

Initiative	**Implementation**	
	Status	**Comments**
Establish Office of Child Safety to house the child fatality review process within the Prevention and Early Intervention Division. This office will support independent data analysis, identification of systematic issues, and support cross-program (CPS, APS, CCL) initiatives to address preventable child fatalities, serious injuries and increase overall child safety. Policies and procedures for both investigations and reviews will Be centralized and made available to all staff and the general public.	**In Progress**	• April 30, 2014 – DFPS trained staff on new policies and protocol guidebook including child fatality process logic model, guided checklists, use of real time information to inform staff actions, and improved tracking of recommendations and action items in line with operational review recommendations. • Sept. 1, 2014 – DFPS created the Office of Child Safety and will fill three new positions by Nov. 1, 2014. • Nov. 30, 2014 – DFPS will produce draft DFPS/DSHS strategic plan to reduce abuse/neglect fatalities.

Prevention and Early Intervention
The Sunset Advisory Commission recommended prioritizing prevention programming at DFPS, which until recently, has been a contracting function within CPS Purchased Client Services. Elevating Prevention and Early Intervention (PEI) to report directly to the Commissioner allows prevention to administer programs that maintain a connection to both the agency's critical child welfare function and with community and public health partners who participate in broader prevention efforts. PEI will benefit from data and research provided by the Office of Child Safety. Better use of data and partner involvement in the agency's prevention strategy will improve programs serving at-risk families.

Initiative	**Implementation**	
	Status	**Comments**
Reorganize DFPS' organizational structure to elevate Prevention and Early Intervention efforts as a direct report to the Commissioner. Also, better use existing data to focus on programmatic outcomes, and develop a comprehensive strategic plan for PEI programs.	**In Progress**	• Sept. 1, 2014 – DFPS leadership approved plan to reorganize and the new structure will be in place by November 1, 2014. • Oct. 31, 2014 – DFPS will develop a final plan for completing the five-year strategic plan including methods to involve stakeholders in the planning process.

(2) TexProtects is a non-profit focused on reducing and preventing child abuse and neglect through research, education, and advocacy. Founder and Executive Director Madeline McClure is a POK Commissioner and will be able to expand on this, but initial research reveals that TexProtects has made the following legislative recommendations:

- Ensure a report is produced of all child fatality investigations completed annually based on disposition, not exclusive to those dispositioned Reason to Believe. This measurement would not only provide a clear understanding of all fatalities where abuse or neglect was involved but may not have conclusively caused the child's death but also provide data on how many Unable to Determine fatalities occur in Texas annually. DFPS can still produce a separate report of Reason to Believe/Fatal cases.
- Ensure a report is produced measuring the number of child fatalities where DFPS had previously investigated the family and include substantiated and unsubstantiated history in this report.
- Ensure that all Reason to Believe/Near Fatal cases where the child subsequently dies (through DSHS records) are re-disposed as RTB/Fatal.

(3) The Texas State Child Fatality Review Team (SCFRT) is a governmental unit authorized by the Civil Practice and Remedies Code to:

- Develop an understanding of the causes and incidence of child deaths in Texas;
- Identify procedures with the agencies represented on the SCFRT to reduce the number of preventable child deaths; and
- Promote public awareness and make recommendations to the governor and legislature for changes in law, policy and practice to reduce the number of preventable child deaths.

The SCFRT made several recommendations in their Texas Child Fatality Review Annual Report 2013. The first five recommendations related to motor vehicle and swimming pool safety. The remainder of their recommendations are as follows:

RECOMMENDATIONS FOR CPS OPERATIONS:

Provide quarterly update reports to the SCFRT on two significant projects related to the prevention of child death: Project HIP (Help Through Intervention and Prevention) and the work of the Protect Our Kids Commission.

Project HIP background: Since 2009, the SCFRT has annually recommended that DFPS conduct a feasibility study to see how Texas could implement an electronic system to identify new births to parents who had a child die of maltreatment or who had parental rights terminated due to abuse or neglect. This system was seen as a proactive mechanism to provide support services or intervention to protect vulnerable infants from abuse or neglect. In 2013, DFPS and DSHS worked together to develop Project HIP, the Texas system to be implemented in 2014.

The SCFRT recommends that DFPS provide quarterly reports to the SCFRT on Project HIP implementation. The reports will include finalization of service provider contracts; numbers and geographic location of birth matches; response rates to the identification of infants born of parents who had prior child deaths due to abuse and/or neglect or termination of parental rights; number of cases referred to DFPS from the birth-match process; parental receptivity to services offered; and any issues arising in implementation. The SCFRT wants to follow how the system addresses and prevents child abuse and neglect.

The SCFRT recommends that DFPS keep the SCFRT informed on the progress of the time limited Protect Our Kids Commission at SCFRT quarterly meetings. The SCFRT also recommends that DFPS facilitate connections where appropriate between the commission and the SCFRT. Given that the SCFRT is dedicated to understanding all child deaths and determining how to prevent them, the work of the commission and the potential for SCFRT consultation and collaboration is of great interest to the SCFRT as a means for engaging more partners and systems in child death prevention.

RECOMMENDATIONS FOR THE DSHS:

Investigate options for more timely delivery of death certificates and birth abstracts to the local CFRTs, as well as strategies for improved data collection and data entry of those child deaths that teams review.

The SCFRT recommends that DSHS staff investigate options for direct electronic transfer of vital statistics data into the online database. Texas Child Fatality Review has historically had data collection and entry challenges. Texas has never had CFRTs in all 254 counties, and for this reason, many deaths go without review. Because of the volume of deaths and the lengthy process for finalizing death certificates, Texas CFRTs have conducted retrospective child death reviews. Department staff studied and streamlined distribution processes to facilitate more timely distribution of death certificates to the teams. Even with strides made in quicker distribution, reviews of child deaths are still typically conducted up to two years after the deaths, particularly in urban counties where the volume of child deaths has made it difficult to close the gap to one year retrospective review. Delayed reviews preclude timely local prevention efforts to address identified risks for child injury and death and frustrate team members. In October 2013, the NCRPCD launched a new version of the nationwide online child death review database. The new database version offers features that could facilitate quicker team access to death certificate/birth abstract data.

Provide funding for annual training for Texas CFRTs.

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

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

In 2013, there were 73 active CFRTs covering 200 of Texas' 254 counties, and 94 percent of Texas children lived in a county where child deaths are reviewed. A total of 3,625 children died in Texas in 2011. Of, the 3,296 child deaths that corresponded to counties with CFRTs, 54.2 percent of 2011 child deaths were reviewed and documented. To fully understand the circumstances and risks leading to a child death, identify trends, and implement effective prevention activities, the SCFRT recommends that all Texas counties participate in CFR and that 100 percent of child deaths be reviewed and recorded. It is recommended that DSHS continue to promote and support the development of CFRTs in counties without teams and to focus on promoting more robust data collection, review, and entry by the local CFRTs Texas Child Fatality Review Annual Report 2013.

(4) Texas House of Representatives, Select Committee on Child Protection, Chaired by Representative Dawnna Dukes

This Select Committee which has met four times since July 1, 2014, has a broader mission than child fatalities, but focused on fatalities on September 30, 2014. The Committee heard from national and local experts to:

- Monitor the ongoing efforts of the National Commission to Eliminate Child Abuse and Neglect Fatalities.
- Consider ways to encourage consistent, transparent, and timely review of abuse and neglect fatalities.
- Consider strategies to ensure better coordination and collaboration among local agencies, faith-based organizations, the private sector, non-profits, and law enforcement to reduce the incidence of abuse and neglect fatalities.
- Assess the efficacy of ongoing prevention efforts that target resources to families at risk.

On December 1, 2014, the House Select Committee submitted its Interim Report. The recommendations relating to the work of the POK Commission are as follows:

RECOMMENDATIONS

Prevention and Early Intervention

1. DFPS should explore the use of evaluative indicators associated with clients served through Prevention & Early Intervention programs who are found to have subsequent confirmed cases with Child Protective Services to support efforts to provide the most intensive services targeted to the highest risk clients.

2. DFPS should include strategies in their annual updates to the Senate Committee on Finance, Senate Committee on Health and Human Services, House Committee on Appropriations and the House Committee on Human Services to expand the HIP and HOPES preventative projects to additional areas and populations identified as high risk.

3. The Department of State Health Services (DSHS) should identify opportunities to improve the report by Child Fatality Review Teams while monitoring the impact of services gaps in areas without teams.

4. DFPS and DSHS should collaborate to identify additional funding opportunities to address individual and community-level factors that contribute to parental substance abuse and domestic violence.

Investigation

1. DFPS should improve tracking Child Protective Services investigations in IMPACT by using a broader family model that seamlessly links other cases to the current household composition including sibling groups, paramours, and relatives. The Department should consider extending the retention rate of records to improve child safety.

2. DFPS should track the incidence of subsequent investigations and use of agency services for children involved in ‘unable-to-determine’ Child Protective Services cases.

3. DFPS should strengthen location efforts for children labeled as missing who are alleged victims with an open CPS investigation and those who are under the direct supervision of DFPS, including children in foster care and Family Based Safety Services (FBSS). The Department should also expand the Children's Advocacy Centers of Texas pilot program with Statewide Intake and law enforcement in order to safeguard cases from being overlooked in the system.

Workforce

1. DFPS should extend caseworker retention strategies to include timely annual reviews and merit-based advancement opportunities.

2. DFPS should pilot a differential salary for Child Protective Services caseworkers based on the local job market, the extent to which caseworker salaries meet the cost-of-living expenses, and other factors related to location.

3. DFPS should expand caseworker co-location with Child Advocacy Centers that has been shown to support caseworker retention.

4. DFPS should implement recommendations made by various stakeholders to restructure tasks of caseworkers in a manner that maintains child safety, maximizes time spent with the child, acknowledges workload over caseload, and better reflects the ability to successfully manage workload.

5. DFPS should track higher education indicators that assist in evaluating worker retention by the type of degree held and participation in the Title IV-E University Degree and Stipend Program. The committee supports additional opportunities for caseworkers to receive student loan repayment assistance.

Information Sharing

1. The committee supports ongoing efforts of DFPS to modernize the IMPACT database that will advance transparency for stakeholders involved in the care of foster children while reducing discrepancies that lead to duplicative or erroneous record keeping.

2. DFPS should consider extending read-only access to IMPACT for Child Placing Agency caseworkers and coordinators in fiscal years 2016 and 2017.

3. DFPS should bridge components of IMPACT and CLASS databases to improve the investigative abilities of Residential Child Care Licensing and Child Protective Services to respond in a timely manner to complaints of abuse and/or neglect made by children in care.

4. The committee supports the DFPS initiative to simplify the policies and procedures manual that can be easily employed by caseworkers.

5. DFPS should strengthen efforts associated with the Texas Faith Based Model by evaluating the cost-effectiveness of the Care Portal in meeting the local needs of children and families through direct services provided by the faith community.

6. DFPS should implement recommendations made by the Internal Audit Division to phase in implementation of a revised risk assessment tool that utilizes empirically-driven predictive analytics to monitor contracts across DFPS offices and Child Placing Agencies.

Tab 5

Protect Our Kids Commissioner Feedback

Commissioner	Questions/Comments regarding the work of the POK	CECANF Categories	What additional information do you need?	Ground Rules	Funding possibilities
Dr. Marian Sokol	I heard stated several times that most deaths are occurring in very young children, and that majority are neglect. In addition to assuring that the "Room to Breathe"/Safe Sleep			First, the ground rules are fine and fair. And, yes, the dates for the next several meetings are on my calendar.	Also, travel costs are not an issue for me, as I often drive from San Antonio to Austin to work on child advocacy issues. Still, I would be in favor of helping anyone who has to fly or pay lodging, if that becomes a barrier to their participation.
	In hearing about the creation of a new Office on Child Safety at DFPS, I am very hopeful. But what is, or will be, the capacity? In reading the material I see that 3 people will be hired. Is this the team that will lead the workforce stabilization effort? How can we help it succeed? And what can we do to transition from an antiquated data collection system so that CPS workers can spend time with families?				
	I heard mixed messages about whether or not the CFRTs are adequate in terms of covering the state of Texas. Do we need more; or do we need to improve the efficacy of those we have? It does not seem reasonable to have to wait 4 to 6 months before information is provided to the teams. What can we do to get timely reviews?				
	We consistently hear that parental drugs and alcohol are a major reason for removal of children from the home, and the trigger that leads to abuse and fatalities. How can we create more family drug courts or baby courts to hold parents accountable? In terms of briefings, can someone help explain the status of predictive analytics? What do we know about "near fatalities" and serious injuries in terms of predictive information?				
	With regard to rural communities, I heard Commissioner Specia (whom I highly respect) state that basic health, affordable child care services, and public housing are priority issues/problems. Without these low level Maslow hierarchy needs met, I would imagine that frustration and anger will continue to evoke anger that will be targeted at innocent children. What …if any…if our role with regard to advocating for changes that are this "rooted" or systemic?				
Dr. Nancy Kellogg	1. Questions	I am fine with subcommittees as she suggests, but feel like I would need a lot more information before I could pick which subcommittee(s) best match my interest/expertise and bring a summary back to the Commission on any of these items.	1. Additional information that may be helpful:	I am fine with the Ground Rules as written	No need for funding to cover my expenses
	a. Recommendations and resources necessary to reduce **abuse** fatalities will likely differ from recommendations and resources necessary to reduce **neglect** fatalities; data collection and tracking for each will be different as well. Will the Commission only focus on guidelines, recommendations and resources common to both?		a. Reviewing the CFRT case reporting system forms(Dr. Quinton had these)		
	b. While it may be easier to determine whether abuse caused or contributed to a child's death, more structured definitions may be needed to determine whether neglect caused or contributed to a child's death. For example, under which circumstances would supervision neglect contribute to a drowning death? Does this depend on the age of the child? Whether the parent was intoxicated? The length of time the child was not watched by the parent? The presence or absence of enclosed fencing around a pool? Similar questions apply to a child found dead while co-sleeping with a parent.		b. Reviewing currently available data (from CFRT and CPS) for child maltreatment deaths in Texas: i. Are cases differentiated: abuse/neglect caused death vs. abuse/neglect contributed to death?		
	c. While charge 3 to the Commission is to develop guidelines for the types of information that should be tracked(and therefore analyzed for trends and risk factors), we are also asked to develop recommendations and resources necessary to reduce fatalities-before we have collected and analyzed the data we are recommending to be tracked. If we implement interventions to reduce child maltreatment fatalities *and* make changes to the current data collection simultaneously, then it will be hard to track whether the interventions changed fatality rates because we would be tracking data differently.				

Protect Our Kids Commissioner Feedback

Commissioner	Questions/Comments regarding the work of the POK	CECANF Categories	What additional information do you need?	Ground Rules	Funding possibilities
Dr. Nancy Kellogg	d. Are we going to look at near-fatalities? It may be a bit too soon as this was implemented in the CPS data system only recently. Additionally, this designation requires a physician determination yet at a meeting in September 2014 *none* of the members of the Texas Pediatric Society Committee on Child Abuse had heard about this, nor was it clear how to define a near-fatality. e. Do we have sufficient/accurate data **now** to identify a target population for POK Commission charges 1 and 2? Would this be data from CFRTs and from CPS death reviews? Can the information from both be merged somehow for common cases? f. There was much discussion by the Federal Commission on how child maltreatment cases are identified and counted, and the challenges associated with achieving uniform, child-centered definitions. The Federal Commission may make recommendations about what data to collect and how- for all states. Will we need to coordinate these recommendations with the recommendations from the Texas Commission? 2. Comments on Interventions/Prevention a. Such interventions can be universal (such as PSAs on safe sleep) or targeted (focused on parents or children with risk factors based on evidence/data). Many interventions discussed today concern parenting education and classes and providing resources for families, focusing on building resilience and strengths. Some families will not be compliant with these services, or may only participate to the extent that it "gets CPS off my back." It seems improving early recognition of signs of abuse or neglect is also needed. Today it was mentioned that about 50% of the child maltreatment fatalities had prior CPS history and one of the presenters in Florida indicated a report to CPS within the first 5 years of life significantly elevated risk of death. CPS is just one safety net/filter. Could we look also look at how often/whether a child saw a physician, whether a domestic violence/dispute report was made to the child's home, whether any caregiver of the child had any drug or alcohol-related charges, and whether the child was enrolled in a daycare during the time he or she was alive? Education in recognition of signs of child abuse/neglect for these other safety filters may increase earlier recognition of child maltreatment, preventing deaths. b. I think the Federal Commission is working on this, but it would be nice if any HIPAA obstacles could be cleared to enable folks to collect various kinds of data related to child maltreatment death, as it is considered critical to public health monitoring.		c. We heard about some universal prevention approaches such as media campaigns about water safety, safe sleep. These are easy to do, but how effective are they? What is the best way to disperse information and how often? Do we have data that shows effectiveness of such interventions? (for example, reduction in drownings in the 1-2 months following media blast in April?)		
Dr. Eric Higginbotham	Now that I have a better idea of how the SCFRT and local CFRTs work (or fail to work) I would be interested to see how granular the data can become and be used. My specific reason for wanting this would be to better identify the areas with high levels of abuse and neglect so that interventions can be targeted to those communities. I would also be interested in seeing if there is any use of focusing interventions with this type of data that is on-going in the country so that we could adopt those practices. I would defer to Dr. Quinton (Deputy Chief Medical Examiner, Southwestern Institute of Forensic Sciences) and Ms. Sajak (Office of Title V and Family Health Director, Texas DSHS) who best could speak to these issues or requests.	I think the recommendation to divide the work in proposed 6 buckets make the most sense and is in alignment with federal work being done. Small group work that is presented to the large committee seems the quickest way to get this done.	Granular data to better identify the areas with high levels of abuse and neglect so that interventions can be targeted to those communities.	The ground rules seem straight forward. In some of the medical committees I work on we usually have a ground rule on when work is to be completed… I don't know if that needed here for not.	I would support finding funds to help those that need to have travel costs defrayed. I luckily live here in Austin so I will not incur travel expenses.

Tab 6

SUMMARIZED RECOMMENDATIONS
OF THE U. S. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

1: Our Nation must establish a national commitment at the highest levels to understand the scope and nature of fatal child abuse and neglect.

2: Federal and State agencies must significantly increase research efforts on serious and fatal child abuse and neglect.

3: The supply of professionals qualified to identify and investigate child abuse and neglect fatalities should be increased.

4: There must be a major enhancement of joint training by government agencies and professional organizations on the identification and investigation of serious and fatal child abuse and neglect.

5: States, military branches, and Indian Nations should implement joint criminal investigation teams in cases of fatal child abuse and neglect.

6: States and the Joint Commission on Accreditation of Health Care Organizations should adopt requirements to assure that all hospitals with pediatric services have Suspected Child Abuse and Neglect (SCAN) teams.

7: All states should enact legislation establishing child autopsy protocols. Federal funding for autopsies of children who die unexpectedly should be available under Medicaid.

8: States should take steps to ensure that all children have access to available, necessary medical care when they are at risk of serious injury or death.

9: States should enact "felony murder or homicide by child abuse" statutes for child abuse and neglect.

10: The Secretary of Health and Human Services and the U. S. Attorney General should work together to assure there is an ongoing national focus on fatal child abuse and neglect and to oversee an ongoing process to support the national system of local, State, and Federal child abuse and neglect fatality review efforts.

11: A national-level effort should ensure that services and training materials on fatal child abuse and neglect are made available to all states.

12: All States should have State level Child Death Review Teams. Such teams should also be established within the military branches, Indian Nations and territories,

13: Child Death Review Teams should be established at the local or regional level within states.

14: Model legislation should be enacted to address confidentiality

15: States and communities should assure that the religious community is included in efforts to prevent child abuse and neglect fatalities.

16: All child and family programs must adopt child safety as a major priority.

17: All relevant State and Federal legislation must explicitly identify child safety as a goal.

18: The decision to remove children from their homes or initiate family preservation services should be made by a team.

19: Family preservation services should be available in every jurisdiction. Intensive family preservation services should be available in every jurisdiction as an option.

20: States should use guidelines when considering family preservation services.

21: An array of primary prevention services and supports, including home visiting, must be made available to all families.

22: Family support services funding should be used for prevention programs aimed at families with infants and toddlers.

23: State and local agencies should design prevention programs for men. Programs should integrate services on child abuse and domestic violence and address the need for interagency training.

24: Expedited TPR should be developed in every State.

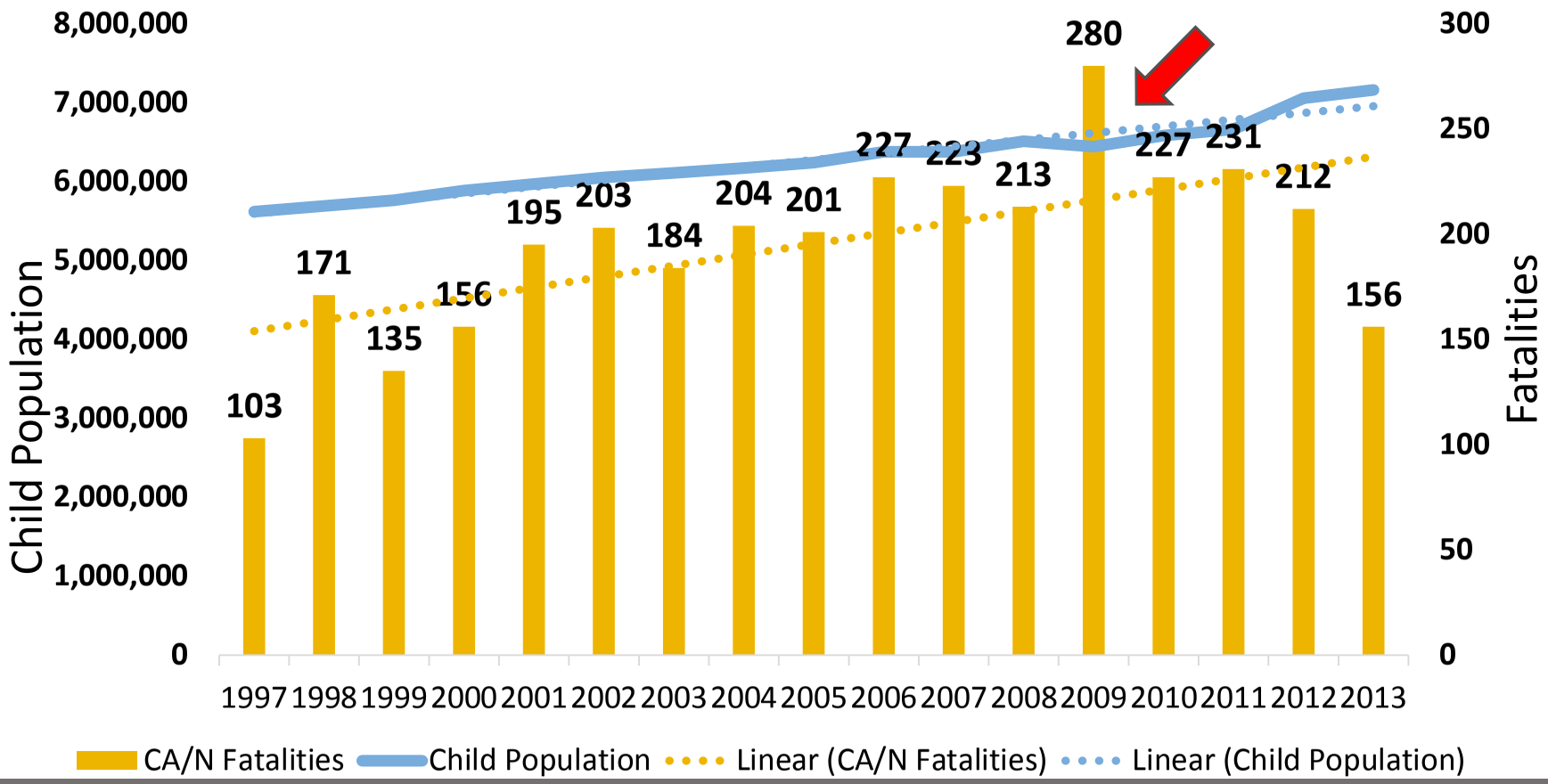
25: A broad public prevention campaign should be developed to address serious and fatal child abuse and neglect.

26: Regulatory measures should be adopted to reduce environmental dangers.

Insert Tab 7

DFPS Reported Fatalities vs. Child Population

Between 1997 and 2013, child fatalities grew at nearly 3x child population growth.



Fatality Count and Recommendations

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:

Recommendation:

- 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.

Fatality Count and Recommendations

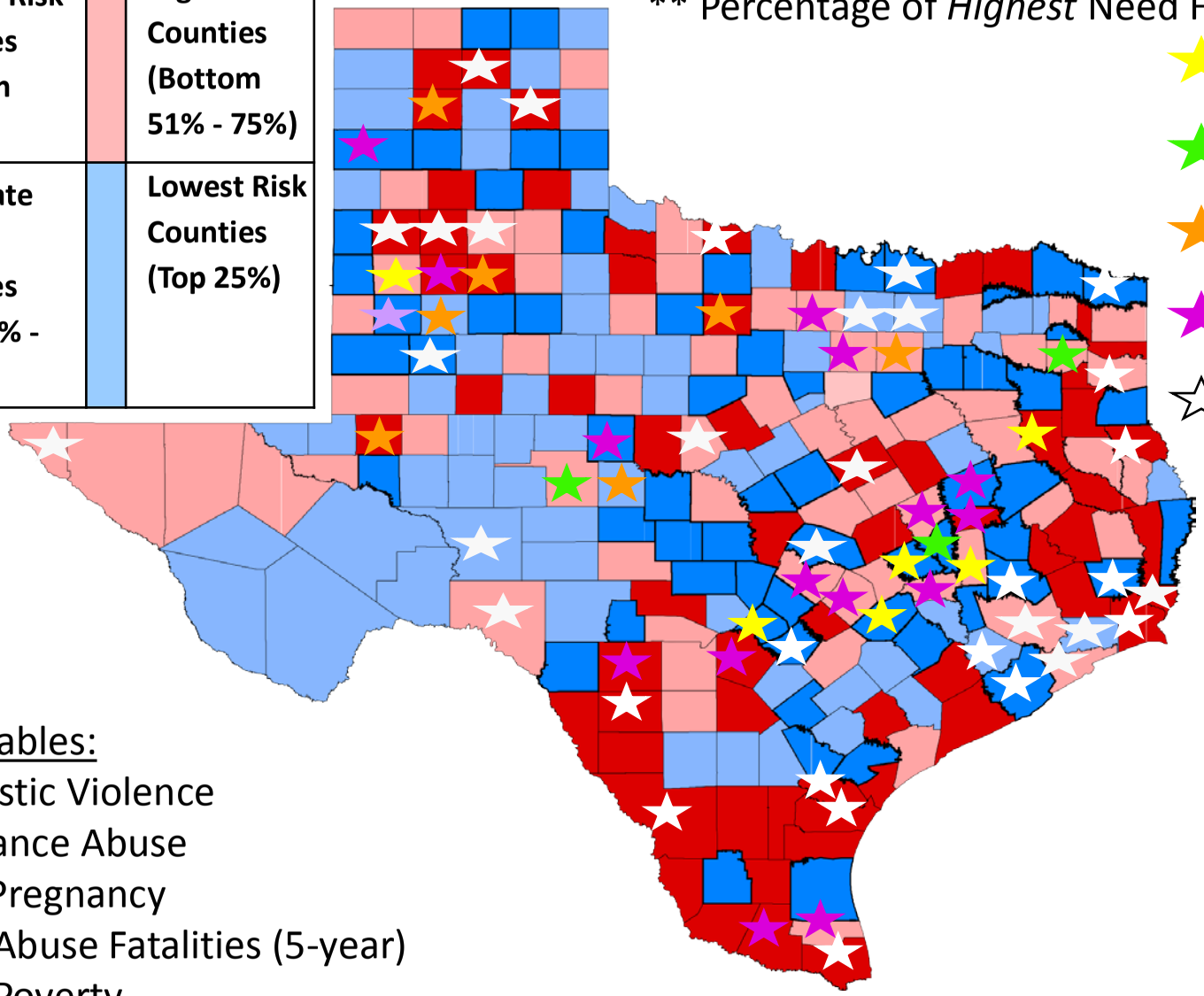
Track Fatalities with prior reports of abuse by:

- 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.

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%



Risk Variables:

1) Domestic Violence
2) Substance Abuse
3) Teen Pregnancy
4) Child Abuse Fatalities (5-year)
5) Child Poverty

Prevention as a Strategy

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)

Child Protection Wheel: Prevention Touch Points