



Texas Child Fatality Review Team

Annual Report 2009

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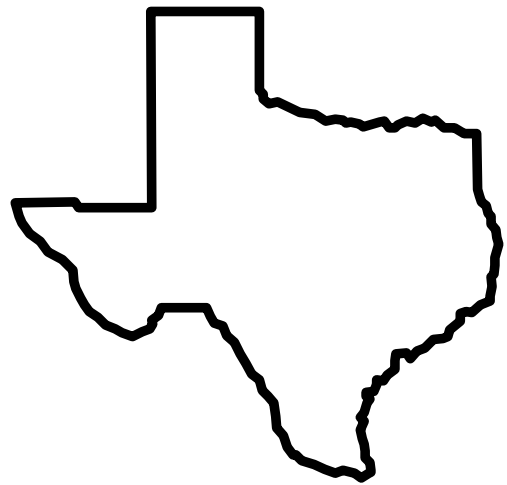
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# INTRODUCTION



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## ACKNOWLEDGEMENTS

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

- **Anna Madrigal**, M.A., Prevention and Early Intervention, Department of Family and Protective Services, who served in the Child Abuse Prevention Specialist role on the SCFRT.
- **Donna Norris**, M.A., Relief Nursery of Central Texas, who served in the Child Abuse Prevention Specialist role on the SCFRT.
- **Joy Rauls**, J.D., Children's Advocacy Centers of Texas, who served in the Child Advocate role on the SCFRT.
- **Charly Skaggs**, M.A., Williamson County Juvenile Services Department, who served in the Chief Juvenile Probation Officer role on the SCFRT.

This report is based on recommendations from the SCFRT committee and was written and compiled by the Texas Department of State Health Services (DSHS) staff from the Division for Family and Community Health Services, which includes Jamie Clark, M.S.P.H., Director, Office of Program Decision Support; Sharyn Parks Brown, Ph.D., M.P.H., Researcher; and Susan Rodriguez, Texas Child Fatality Review Coordinator. Paula Kirby, of the Center for Health Statistics, also contributed to the preparation of this report. This report would not be possible without the dedication and input of the members of the SCFRT (Appendix A) and the local Child Fatality Review Team (CFRT) coordinators, presiding officers and respective team members (Appendix B). The wide array of professionals who volunteer as members of their local teams give the child fatality review process its multi-disciplinary flavor and add immeasurably to the goal of understanding child death in Texas and reducing risk to Texas children. Their commitment to understanding and preventing child death is saluted.

The Office of Title V and Family Health, DSHS, provided generous funding for the one-day CFRT symposia conducted in each of the Health Service Regions. This opportunity to take specific CFRT and injury prevention training to the regions is greatly appreciated.

Questions about the report should be directed to:  
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## LETTER FROM THE CHAIR

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***“Our lives begin to end the day we become silent about things that matter.”***

***Martin Luther King, Jr.***



*Dr. Juan Parra*

The action plan for the establishment of child fatality review in Texas started 18 years ago. The visionaries of that time worked diligently to create a system to address an issue that should matter to all of us: keeping our children safe so that each child can reach their potential and achieve success. With this legacy in place, the members of the State Child Fatality Review Team (SCFRT) Committee, after much collegial discussion, collaborative work and consensus, present the 2009 Texas Child Fatality Review Team Annual Report.

Since our last report in 2008, the SCFRT Committee, along with collaborative partners, have accomplished the following:

- The review and revision of the Position Statements on Safe Sleep for Infants and Motor Vehicle Safety for Infants and Children by the SCFRT Committee. The SCFRT Committee completed the Position Statement on Water Safety for Children. The SCFRT Committee Position Statements continue to be shared with the general public and professionals at the local, state and national level and continue to receive positive comments and are used for injury prevention efforts.
- The publication of the 2008 Annual Report detailing our accomplishments and challenges, child fatality data and recommendations to our state government, Child Fatality Review Teams (CFRT), partnering agencies, professional colleagues and the general public.
- The continual growth and development of active teams in the state. This growth is due to the tireless efforts by the Child Fatality Review Coordinator, staff members of Department of State Health Services (DSHS) Office of Program Decision Support, the Office of Title V and Family Health, regional DSHS staff, Vital Statistics staff, SCFRT members and members of local CFRT. As of November 2009, there are now 57 active review teams across 179 counties, incorporating 88% of the target child population for review.
- The development and presentation of the Regional Child Fatality Review Symposium conducted in the summer of 2009 was a significant accomplishment by the Child Fatality Review Coordinator, DSHS staff, SCFRT Committee members, members of local CFRT and local community leaders. The symposia were conducted to improve the communication and visibility between the SCFRT Committee and DSHS staff with local CFRT, as well as to provide a better understanding of the purpose and processes of child fatality review. A one-day symposium was held in each of the eight DSHS Public Health Service Regions. The symposia were very well attended and positively evaluated by attendees.



They allowed local CFRT members, DSHS staff, SCFRT Committee members and community leaders to share successes and challenges, learn about resources across the region, state and the nation, and receive specific training on injury prevention for children.

- The SCFRT Committee, Child Fatality Review Coordinator and DSHS staff provided professionals and legislators with key information and support to help pass legislation that amended Transportation Code Section 545.412(a) relating to securing a child passenger in a motor vehicle. This legislation will help protect children up to 8 years of age, unless taller than 4 feet 9 inches, to reduce serious injury and fatalities.
- The SCFRT Committee continues to partner with the Children's Assessment Center of Houston to conduct our annual conference as part of the annual Protecting Texas Children Conference, which was held on April 26-28, 2010. The SCFRT hosted a pre-conference session on April 25, 2010, that will provide training on the principles and practices of injury prevention. Members of the SCFRT Committee serve on the planning committee for the conference.

As the newly appointed Chair of the SCFRT Committee, I recognize and applaud the commitment, leadership and accomplishments of all our past Chairs and the members of the SCFRT Committee, the Child Fatality Review Coordinator, DSHS staff, local CFRT members and all of our partners.

The SCFRT Committee will continue to seek opportunities and meet our challenges head on.

- We will complete, publish and disseminate three additional Position Statements: Suicide Prevention, Firearm Safety, and Fire and Burn Injury Prevention.
- We will work toward the establishment of new and active CFRT across the state.
- We will work closely with the Child Fatality Review Coordinator, DSHS staff and local CFRT members to improve the number of all types of fatalities reviewed as well as to improve the data collected and entered in the National Center on Child Death Review database.
- We will research, evaluate and act upon ways to improve the process of child fatality review.
- We will continue to report the information we learn and provide recommendations to our state government and partnering agencies and work with you to incorporate the information and recommendations in this report toward achieving our goal of eliminating preventable deaths of Texas children.

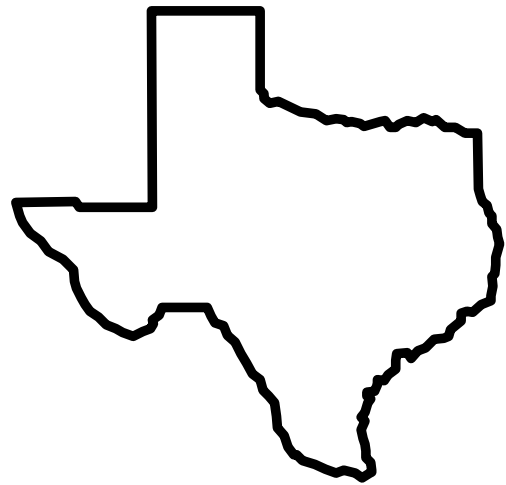
The SCFRT Committee welcomes comments on this annual report as we look forward to another year of dedicated work with all of our collaborative partners.



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



**CHAPTER 1**  
**OPERATIONS & ACTIVITIES**



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## OPERATIONS

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### **An Overview of Child Fatality Review in Texas**

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

#### **Role of the State Child Fatality Review Team Committee**

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

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

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

#### **Role of the Local Child Fatality Review Teams**

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

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

- providing assistance, direction and coordination in child death investigations;
- promoting cooperation, communication and coordination among agencies involved in responding to child fatalities;
- developing an understanding of the causes and incidence of child death in the county or counties in which the review team is located; and
- advising the SCFRT Committee on changes to law, policy or practice that will assist the team and the agencies represented on local teams in fulfilling their duties.



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

### **Legislative Authority and State Agency Involvement**

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

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

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

The role of the Coordinator is to:

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

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

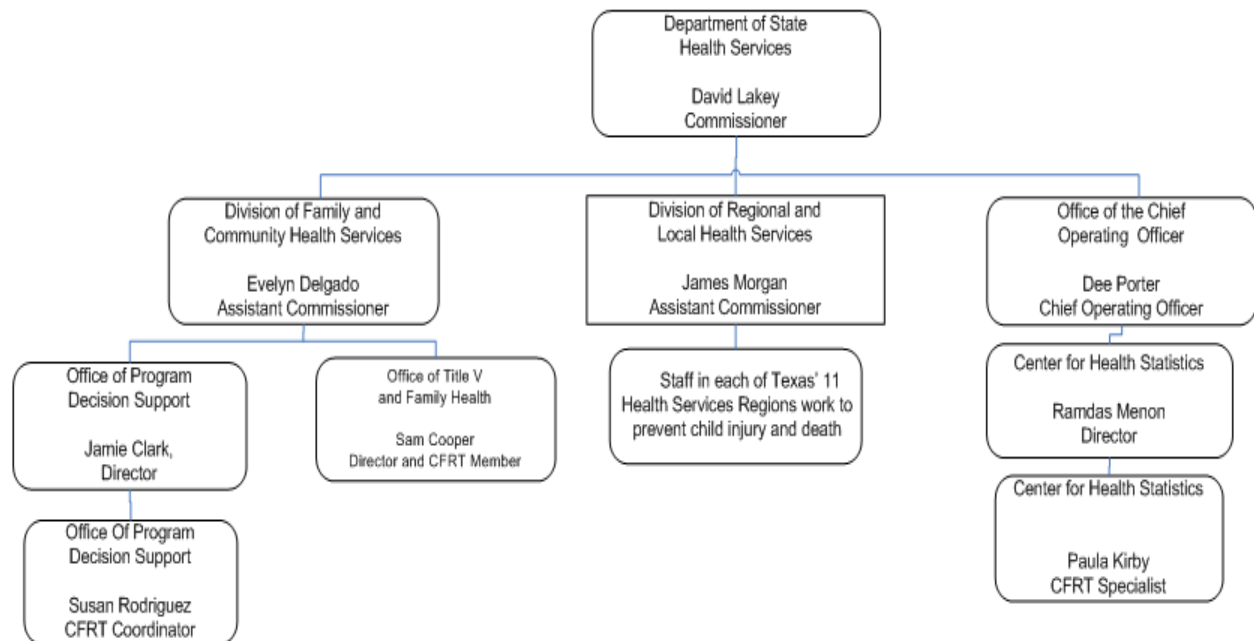
In mid-2007, with funding from the *Office of Title V and Family Health*, staff from each of the eight DSHS Health Service Regions was identified to focus on understanding the causes of child death and how those deaths may be prevented. In this role, regional staff assist in developing new CFRT and serve as the voice of public health and prevention on existing teams. DSHS regional staff has been trained on the Child Fatality Review (CFR) process and are working with the Texas CFR Coordinator to identify potential partners, convene community information meetings, organize new teams and work with teams and communities on prevention initiatives. The impact of a



statewide focus on CFR has been tremendous. Twenty-one new and returning teams were created through the cooperative efforts of regional and state DSHS staff and community members in 2008, and five new and returning teams in 2009, with 19 new teams in development. Regional DSHS staff working on CFRT and child injury prevention has increased the reach and scope of the program and has contributed to the goal of reviewing all Texas child deaths.

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

**Figure 1. DSHS Support of Child Fatality Review**



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## DATA AND LIMITATIONS

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Statistical analyses of data derived from local CFRT reviews are an important facet of the child fatality review process. Analyses of these data provide thorough and comprehensive understanding of the causes and circumstances surrounding child fatalities in Texas. Whereas information from the death certificate provides the demographic characteristics of child fatalities, only the more detailed information available from CFRT case reports can indicate the specific information regarding how, where, and under whose supervision an event occurred. This provides better understanding of the scope and nature of child fatalities in Texas that can be used to drive preventive interventions.

### Overview of Child Fatality Review Team Data

Data from the reviews conducted by local teams are entered into a multi-state database developed by the National Maternal and Child Health Center for Child Death Review in collaboration with state programs. Given the volume of deaths and the volunteer nature of local CFRT, teams may choose not to review all deaths. Many programs in the United States, including some Texas teams, do not review natural deaths with the exception of SIDS. It is important to consider this information when interpreting child death review data. Case selection depends on several factors such as geographic area, number of deaths, access to information and CFRT meeting frequency.

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

Missing and unknown values can limit CFRT data. Specific information about the circumstances of death is not always available for all reviewed deaths. Therefore, the number of cases in which the information was available is noted within each table and chart. These unknown values are difficult to interpret and may indicate the presence of social desirability bias (the inclination to underreport behaviors that are not consistent with current social recommendations). For example, a mother who has lost a baby to SIDS may not reveal that the infant was placed on his/her stomach to sleep or that there was smoking in the home, which are behaviors discordant with current public health recommendations. Since some reviews involve criminal proceedings, the prevalence of unknown values may indicate a person's desire to conceal aspects of the death that may be incriminating. Some reviews may have unknown values because the



information was not collected at the time of the death scene investigation. While it is impossible to know why values may be missing, it is important to consider the prevalence of unknown values when interpreting findings.

Another limitation of CFRT data is the absence of data collection and submission standards. There are local teams that do not review all of their deaths. They may choose to focus solely on injury deaths or may only submit to the national online database those injuries that are preventable. These practices introduce bias into the CFRT data. Increasing standardization and rigor in data collection continues to be a programmatic goal.

### **Participation in the Multi-State Child Death Review Data Collection System**

Texas has opted to input data into the National Child Death Review Data Collection System, based within the Michigan Public Health Institute, National Maternal and Child Health Center for Child Death Review. Inputting data into the multi-state child death review database benefits Texas CFR by: (1) implementing a nationally standardized form for data entry and (2) allowing for comparison with CFR data from other states. All local teams collect data on each child death reviewed using the multi-state data collection instrument and enter the data using the online web-based system.



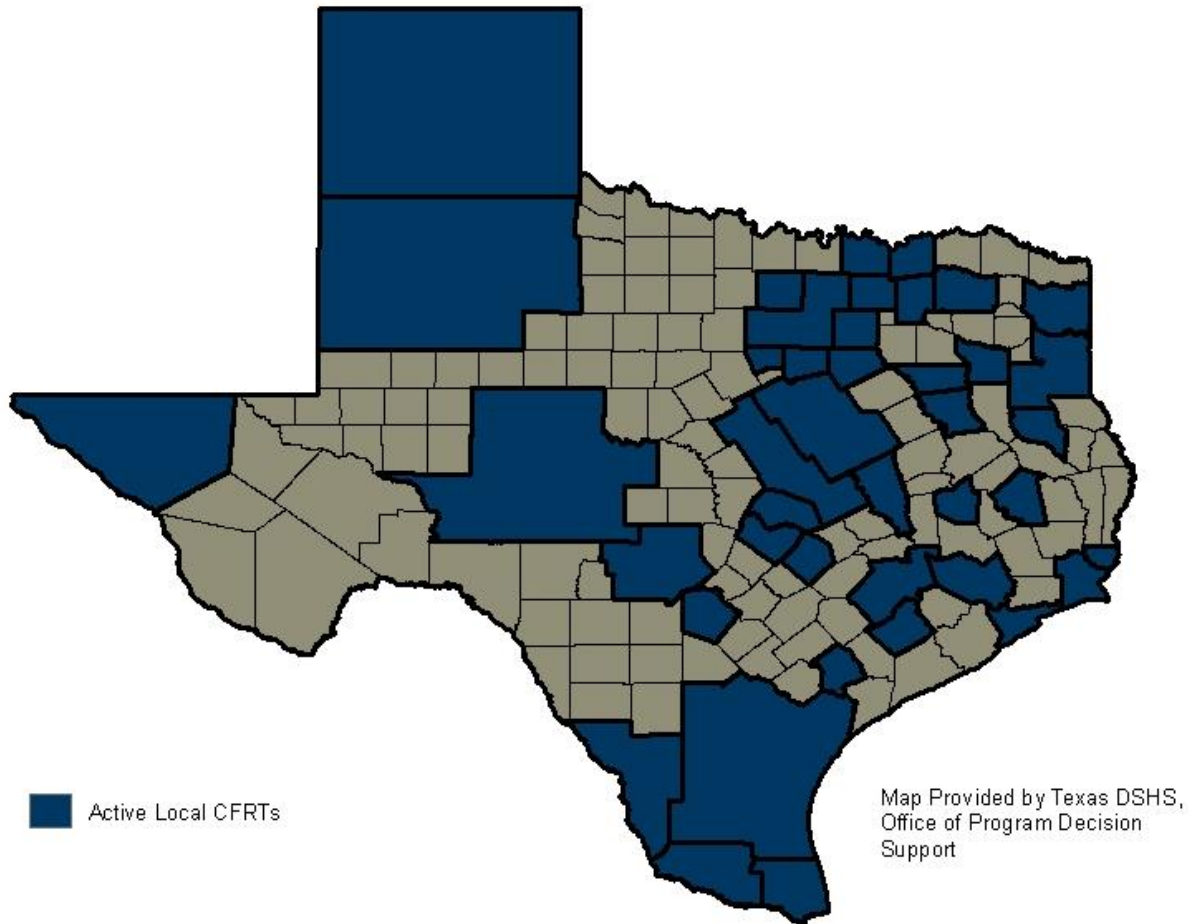
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## COVERAGE BY LOCAL CHILD FATALITY REVIEW TEAMS

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### Status of Child Fatality Review Teams Reviewing 2007 Child Deaths

#### Map 1. Active Teams Reviewing 2007 Child Deaths



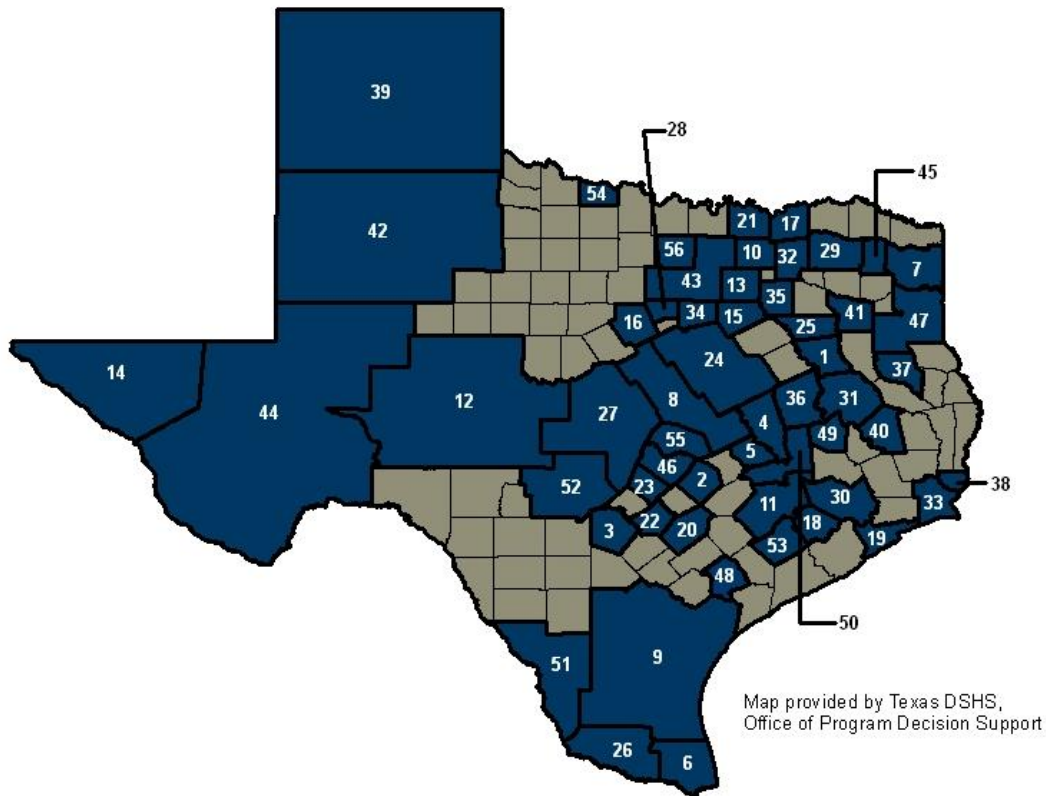
Forty-two active local teams, which include 138 of Texas' 254 counties, reviewed child deaths that occurred in 2007 (Map 1). More than three quarters of Texas' under-18 population resided in counties with CFRT that reviewed deaths occurring in 2007. Of the 4,077 child deaths occurring in 2007, 2,004 were reviewed (49.0%).



## Status of Child Fatality Review Teams in 2009

Map 2 and Table 1 identify the 56 local CFRT reviewing child deaths as of December 2009. The teams cover 178 of the 254 Texas counties.

**Map 2. Local Child Fatality Review Teams, 2009**



**Table 1. Local Child Fatality Review Teams in 2009**

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



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## TEXAS CHILD FATALITY REVIEW AT THE COMMUNITY LEVEL

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The overriding purposes of the local multi-disciplinary CFRT is to understand the contributing risk factors that lead to child deaths and to decrease the incidence of preventable child deaths. To best understand the deaths under review, the teams are comprised of subject matter experts from disciplines that interact with incidents of child fatality. This includes healthcare providers, Child Protective Services, law enforcement, the court system, physicians, child advocates and more. By sharing information within the confidential environment of the review team meeting, local team members are best equipped to understand risk factors involved in child deaths and to identify protective factors that could prevent future deaths.

The local CFRT in Texas have embraced the goal of reducing the number of preventable child deaths. They work to identify opportunities to take data to action through implementation of protective policies and interventions that contribute to reducing risks for childhood injury and death. The profiles below spotlight some of the prevention-oriented activities undertaken by different Texas teams in 2009.

### **Bastrop County Child Fatality Review Team**

This Central Texas team, led by the Children’s Advocacy Center of Bastrop, sees education as key to making the county a safer place for children. The team members have a commitment to making child safety information available to the members of their community. They collect articles and fact sheets about parenting and child safety and make them available in places where parents and other child caregivers gather, such as pediatricians’ offices, public libraries, schools and childcare centers.



### **Bexar County Child Fatality Review Team**

Under the leadership of ChildSafe Children’s Advocacy Center, the Bexar County team has focused on the high incidence of infant deaths due to unsafe sleep practices by forming a Safe Sleep Task Force. After conducting a data review of all 2007-2008 infant deaths, the Safe Sleep Task Force presented the data to the Director of the San Antonio Metropolitan Health District. The local health district has committed to working with the CFRT to further analyze the data and to develop a consistent education campaign to promote safe sleep for infants. Team members have also distributed 300 cribs, instructed on safe sleep practices to 996 participants of Baby University and conducted 10 safe sleep in-services. Additionally, team members have focused on the safety of children in and around vehicles, conducting 174 car safety seat inspections clinics, checking 3,252 car seats, and distributing 3,000 car safety seats.



### Coastal Bend Child Fatality Review Team

This 13-county team has made safe sleep for infants their prevention focus. After reviewing many infant deaths due to unsafe sleep practices, the team has partnered with Driscoll Children’s Hospital in Corpus Christi to start an Infant Safe Sleeping campaign. They distribute safe sleep brochures, postcards and magnets to in-patient families of infants. The team has also been a presence with safe sleep messages at two large community health fairs. They are soliciting grant funds to give out infant onesies with “**A**lone, on their **B**ack, in the **C**rib” on the garment. The team is also actively involved in the planning of the annual Rio Grande Valley Seminar in Forensic Sciences, and a team member was one of the injury prevention speakers at the summer CFRT symposium in McAllen.



*Coastal Bend CFRT members provide safe sleep information at Driscoll Children's Hospital.*

### Colorado/Austin/Waller Counties Child Fatality Review Team

This multi-county team is involved in a wide variety of child safety activities. The team distributed suicide prevention cards to all school nurses for broader distribution to students. The card included information on how to respond to a suicidal friend on one side and how to seek help if feeling suicidal on the other. The team participated in a third grade Safety Day, conducting presentations and activities on gun safety, seat belts, horse safety, snake awareness, water safety, fire safety and poison prevention. The team identified an area of Interstate 10 where multiple fatalities have occurred. Letters from the team to the Department of Public Safety and to the state representative for that area were sent to inform them of the dangers and to seek their cooperation in making that stretch of highway safer. Members of this team were actively involved in the planning of their summer CFRT symposium, serving as the gracious hosts of the day-long training event in Brookshire.



### Dallas County Child Fatality Review Team

This urban team, under the leadership of the Injury Prevention Center of Greater Dallas, has focused on conducting a population-based survey of infant bed sharing practices in Dallas County. Members of the team have made multiple presentations at national conferences to share the survey process and findings. The team was actively involved in the planning of the summer CFRT symposium in Fort Worth. The team chair and coordinator presented on the infant sleep survey to the attendees at the symposium. Team members made a presentation on “Home Injury Prevention” at a local high school. The team is also working closely with Child Protective Services to identify and study drug-endangered children in the county.



### Ellis County Child Fatality Review Team

Led by the Ellis County District Attorney’s Office, this team has focused their efforts on providing child safety information to their community. In August, the team was present at the 26<sup>th</sup> Annual National Night Out hosted by the Waxahachie Police Department at the Ellis County Expo Center. They distributed flyers on Safe Sleep for Babies, Youth Farm Safety and Teen Driver Safety. They feel that their presence at the event gave the team more exposure and let community members know that child fatality review is operating in Ellis County.

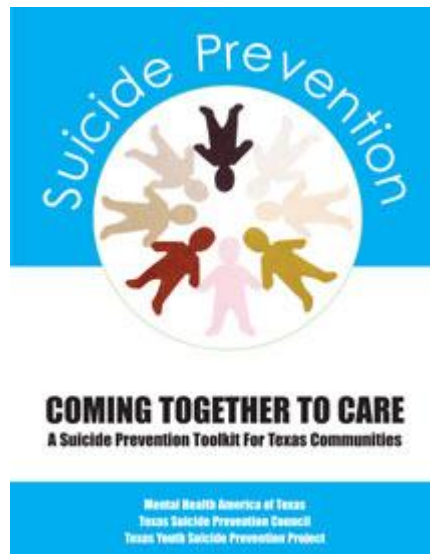


*Ellis County CFRT member, Judge Jackie Miller, Jr., Justice of the Peace, Pct.2, (L) passes out information at the National Night Out hosted by the Waxahachie Police Department.*



### **El Paso County Child Fatality Review Team**

This multi-county team in West Texas, led by the El Paso County District Attorney’s Office, prepares an annual report with focus on a particular risk to children in their area based on the reviewed child deaths. In 2009, the team focused on addressing the issue of infant safe sleep in their press conference to release the El Paso County CFRT Annual Report. Because of the extensive press coverage of their report, the risks to infants in unsafe sleep environments were highlighted in the media. Working with the local health department team member, the team produced a brochure in English and in Spanish on infant safe sleep. This brochure is being distributed to new parents throughout the area. CFRT members were involved in planning the summer CFRT symposium in Odessa, where they presented on their safe sleep initiative and on youth suicide prevention.



*Collaboration with Mental Health America of Texas ensured that all CFRT members attending the regional summer workshops received training on youth suicide prevention.*

### **Heart of Texas Child Fatality Review Team**

This multi-county team is led by the Heart of Texas Regional Advisory Council, an emergency healthcare network for the five-county region. In 2009, they had multiple activities designed to increase the health and safety of Central Texas children. A letter addressing SIDS and infant safe sleep practices was developed and sent to all childcare providers in the five counties. Team members participated in Hooray for Health, where they shared information on infant safe sleep and traffic safety. The team also addressed the issue of safe sleep for infants by distributing safe sleep information to new parents at the Adoption Day hosted by Baylor University Law School. The team coordinator was actively involved in the planning of the summer CFRT symposium in Waco, which was hosted by Hillcrest Baptist Medical Center.



## Houston/Harris County Child Fatality Review Team

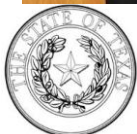
This urban team had multiple injury prevention activities in 2009. They marked their fourth year of partnering with the Safe Kids Greater Houston Water Safety Coalition to host the Annual April Pools Day Media Event. The Coalition received a proclamation from the City of Houston citing April as April Pools Month. They also received a resolution from Harris County recognizing their drowning prevention efforts. The event included a presentation from the Medical Examiner's Office on drowning statistics and a physician's presentation on the mechanisms of drowning. Additionally, the event included a parent's story of her child's drowning death and her resulting activism, demonstrations of CPR, proper fitting of personal flotation devices and a mock drowning/life-saving demonstration to illustrate the importance of swimming lessons and knowing CPR. Team members promoted child abuse prevention month in April, including giving a presentation of the Shattered Dreams program at an area high school. Team data were analyzed to learn more about perpetrators of child abuse deaths and a research paper was submitted as part of a HRSA grant application. Members of the team served on the planning committee for the summer CFRT symposium, where the SAFE KIDS team member presented on child safety in and around vehicles. Team members are also part of the Steering Committee for the annual Protecting Texas Children Conference.



*Above left, members of the April Pools Day Water Safety Coalition gather at the event; above right, a CPR demonstration was part of the program at the APD event.*



*Left, CFRT Team members El Buchanan, Harris Co. Medical Examiner's Office; Deonesia Gray, parent advocate; and Stephani Adams, CFRT Presiding Officer, Harris Co. Public Health & Environmental Services, receive the Commissioner's Court resolution proclaiming April, "April Pools Month" from Judge Ed Emmett.*



### Hidalgo/Starr Counties Child Fatality Review Team

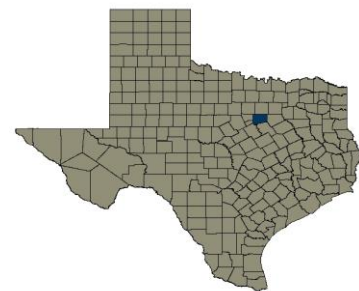
Members of this Rio Grande Valley team participated in a car safety seat clinic at the Edinburg Children’s Hospital. Working with Certified Passenger Safety technicians from the Hidalgo County Sheriff’s Office, they inspected child passenger safety seats for correct installation and provided car seats to those that needed replacement seats. Recommendations on child safety in and around vehicles were also provided. Members of the team participated in the planning and presentation of the summer CFRT symposium in Edinburg, which was hosted by Edinburg Children’s Hospital and held at South Texas College in McAllen.



*Scenes from the Child Passenger Safety Seat Clinic co-hosted by Edinburg Children’s Hospital, the Hidalgo County Sheriff’s Office and the Hidalgo/Starr Counties Child Fatality Review Team*

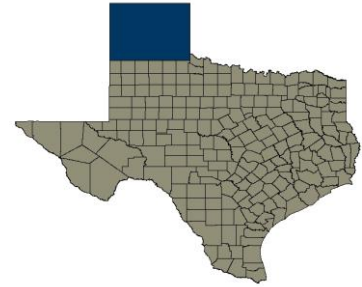
### Johnson County Child Fatality Review Team

This North Texas team, led by the Johnson County Children’s Advocacy Center, was highly motivated after reviewing two child deaths where texting while driving was a causal factor. They are working on a campaign to inform teens of the risks of texting while driving. They have developed a presentation that includes testimony of parents who have lost a teen in a related crash, a Power Point presentation on the risks of distracted driving and information from the law enforcement officers who respond to motor vehicle crashes. They will be piloting this presentation in two school districts. If it is well-received, the program will be offered in all county school districts. Team members also made a presentation on their campaign to promote safe sleep for infants at the summer CFRT symposium in Fort Worth.



### **Panhandle Child Fatality Review Team**

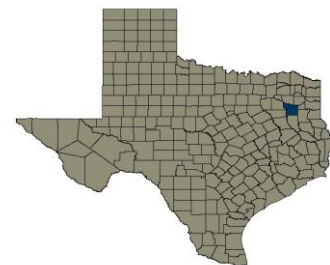
This 26-county team was actively involved in the planning and execution of the summer CFRT symposium in Amarillo. Members of the team served on the planning committee and handled symposium logistics. This included securing continuing education credits for the attendees, scheduling and setting up the training space at Northwest Texas Healthcare System, and arranging for lunch donated by Amarillo National Bank and Northwest Texas Healthcare System. The Texas Department of Transportation Traffic Safety Specialist who serves on the team provided training on Child Passenger Safety. Different members of the team representing law enforcement, the district attorney's office, justice of the peace and Child Protective Services, served on a panel discussing infant safe sleep. The team also made major strides in 2009, having reviewed 100 percent of all child deaths in the multi-county area.



*Left, Panhandle CFRT Coordinator, DSHS staff Don Nicholson, (middle left) serves steaks to symposium attendees; right, thanks to the Amarillo National Bank staff and their mobile grill pit, the donated lunch was prepared on site.*

### **Smith County Child Fatality Review Team**

This East Texas team is led by the Children's Advocacy Center of Smith County. Members of the team were actively involved in planning the summer CFRT symposium in Tyler. They secured the training space at Tyler Junior College and were hosts at the one-day training for teams in Health Service Region 4/5N.



### **South Plains Child Fatality Review Team**

This 22-county team, under leadership of the Child Advocacy Research Education (CARE) Center of the Texas Tech University Health Science Center Department of Pediatrics, is actively involved in the work of the South Plains Child Abuse Coalition. They participated in Lift a Life! events in three counties to honor the children whose lives had been impacted by child abuse and neglect. Each event featured a balloon release to raise awareness about child maltreatment in the South Plains area. Team members were also involved in planning the summer CFRT symposium in Amarillo.



### **Texas J Child Fatality Review Team**

This West Texas team is comprised of the 17 counties that make up the Texas J Regional Advisory Council for Trauma Service Area J. This new team was instrumental in planning and executing the summer CFRT symposium that was held in Odessa. The team hosted the training event at the Medical Center Hospital in Odessa.



### **Travis County Child Fatality Review Team**

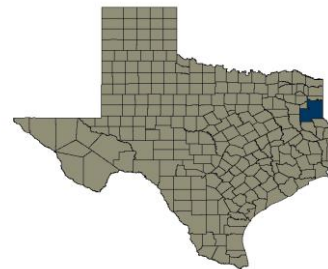
This Central Texas team prepares an annual report that is released at a press conference hosted by the Center for Child Protection. Their 2009 annual report focused on the causes of child death in 2008. The primary concern for the team was the number of asphyxiation or suffocation deaths, fourteen of which were infant deaths that occurred in unsafe sleep environments. Parallel to the release of their report, members of the team joined the Travis County Safe Kids Safe Sleep Coalition, which is developing an infant safe sleep campaign for the county. Two members of the team presented on the process of studying infant deaths in sleep environments and developing a safe sleep message for the community at the summer CFRT symposium in Waco. Their annual report is available here:

[http://www.centerforchildprotection.org/assets/Media\\_Publications\\_PDF/CFRT/cfrt-2008\\_4%20pages.pdf](http://www.centerforchildprotection.org/assets/Media_Publications_PDF/CFRT/cfrt-2008_4%20pages.pdf)



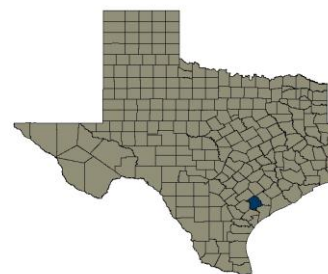
### **Tri-County Child Fatality Review Team**

This multi-county team in East Texas is under the leadership of Sheriff Jack Ellett, one of the original members on the SCFRT who continues to serve. In 2009, the team expanded its membership to include the director of a local Children’s Advocacy Center and two nurses with hospice. They found that the new members brought a wealth of information to the review process. Sheriff Ellett discusses injury prevention issues on his weekly radio show and in his column in the local paper in Carthage. He also presented on the history of Texas Child Fatality Review at the summer CFRT symposium in Tyler.



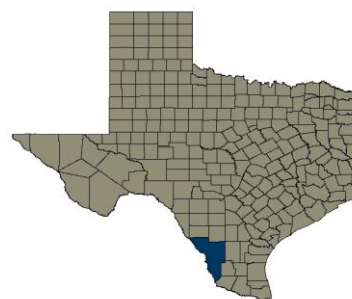
### **Victoria County Child Fatality Review Team**

This South Texas team has made safe sleep for infants their focus due to the number of infant deaths in unsafe sleep environments. They are developing a citywide event to provide education on safe sleep to childcare center workers, parents and infant caretakers. The plan includes distribution of literature, demonstrations and videos and pre- and post-tests for those attendees seeking continuing education credits. The team is also considering inviting adjacent counties without CFRT to join them to increase the reach of the review process and prevention activities.



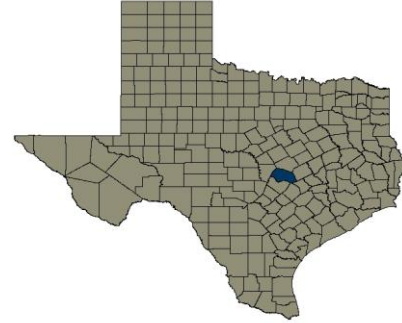
### **Webb/Zapata Counties Child Fatality Review Team**

In 2009-2010, this border team is focusing on preventing unintentional and intentional child deaths due to drug overdose. They formed a community group, Advocates for Child Death Prevention, and have engaged with local media, local school systems, Child Protective Services, chemical dependency counselors and city officials to plan a media campaign. They are holding focus groups in high schools to gather more information about student needs, their sense of connectedness to their families and communities, the role of the media in influencing student attitudes and general knowledge and attitudes about depression and suicide. They will also be engaging local students in scripting and producing 30- and 60-second outreach Public Service Announcements (PSA) in both English and Spanish.



## Williamson County Child Fatality Review Team

This team co-hosted their 1<sup>st</sup> Annual Central Texas April Pools Day in 2009. The county health department, the Central Texas Water Safety Coalition, the Williamson County CFRT and the Round Rock Express Baseball Team partnered to present the water safety event. The presentation included an educational program on cryptosporidiosis (a waterborne parasitic disease) and area pools, boater and flashflood safety and a mock drowning and rescue. The 19 participating agencies also provided written materials on a wide range of water safety topics to the attendees.



*Jennifer Jackson, Williamson County & Cities Health Department (L), and Judge Judy Schier Hobbs, Justice of the Peace, Pct. 4, Presiding Officer of the Williamson County Child Fatality Review Team, and member of the SCFRT Committee (R), flank Ron Morrison, County Commissioner, Pct. 4, as he opens the April Pools Day event at the Dell Diamond.*



*Life guards and EMS staff demonstrate measures they must take to stabilize the mock-drowning victim and prepare for transport by the Stat Air rescue helicopter.*



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## NOTABLE ACTIVITIES AND COLLABORATIONS IN 2009

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### Collaborating to Strengthen CFRT in Texas: 2009 CFRT Symposia

In August 2008, DSHS staff conducted a survey at the request of the SCFRT, to gauge connections and communication between local teams and the SCFRT. All local team coordinators were surveyed to learn how to better facilitate communication between the three key components of Texas Child Fatality Review: (1) between local CFRT and the SCFRT, (2) between local CFRT and the State Coordinator and (3) across local teams.

The response rate was high at 91.3 percent. The information was integral to creating and planning a forum for local coordinators to confer with the SCFRT and other teams.

- Local teams wanted a combination of face-to-face contact and conference call contact with the SCFRT. Their preference was for meetings in the regions.
- Nearly 55 percent of the respondents did not know or were unsure of the relationship between the local CFRTs and the SCFRT.
- Results showed that communication between the local teams and the SCFRT was in need of some nurturing and that there was very little interaction between local teams.
- Over 75 percent of respondents agreed that strengthened communication between the local teams, the SCFRT and the State Coordinator would improve the effectiveness of the local teams.

With funding through the Title V Maternal and Child Health Block Grant, the identified team needs were addressed by the creation of one-day Child Fatality Review workshops in each of the eight DSHS Health Service Regions. SCFRT members from the respective regions, DSHS regional staff from each region and local team members worked together to plan, promote and present the eight symposia. The workshops were designed with the following goals:

- Increase effective communication between the local teams, the SCFRT and the Coordinator;
- Improve understanding of the child fatality review process and the collection of quality data;
- Provide an opportunity to interact with other teams and to share successes and challenges;
- Provide an opportunity to learn about resources across the region, state and nation; and
- Offer training on injury prevention of motor vehicle crash deaths (Title V Block Grant performance measure), suicide (Title V Block Grant performance measure) and a topic of region's choice.

Extensive collaboration was required to plan the eight events, which were conducted in a 28-day period. The planning groups focused on using as many presenters as possible from the regions and local team membership, thus tapping into local expertise.



The planning groups formed a partnership with Merily Keller of Mental Health America-Texas to identify potential presenters on suicide prevention. She also served as trainer in those areas where a local speaker could not be identified. Through regular conference calls, each planning group identified speakers, free training space and donated lunches. Promotion and registration were done electronically. The planning groups made the eight symposia unique to the community and a community-wide effort.

Each workshop was divided into two sessions. The morning session was devoted to reviewing CFR best practices. These best practices include guidance on reviewing child fatalities, data entry and moving from data into prevention activities. This session was presented by the State Coordinator with assistance from the SCFRT members in attendance. The afternoon session featured training by local experts on the three injury prevention topics. Table 2 shows the unique character of each workshop.

**Table 2. 2009 Summer CFRT Symposia**

HSR	Date	Site/City	Special Training Topic	Attendees
1	7/16/2010	Northwest Texas Healthcare System, Amarillo	Safe Sleep for Infants Panel: law enforcement, justice of the peace, CPS, district attorney and pediatrician members of the Panhandle CFRT	50
2/3	8/4/2009	Tarrant County Health Department, Fort Worth	Safe Sleep for Infants Initiatives: Presentations by Dallas County and Johnson County CFRT members	53
4/5N	7/27/2009	Tyler Junior College, Tyler	Preventing Childhood Agricultural Injuries and Death	72
6/5S	7/23/2009	Brookshire Convention Center, Brookshire	Premature Birth: Causes and Prevention	67
7	7/21/2009	Hillcrest Baptist Medical Center, Waco	Safe Sleep for Infants Initiatives: Presentations by Travis County CFRT members and DSHS-DFPS Infant Health Workgroup Co-Chairs	47
8	7/31/2009	Texas Center for Infectious Disease, San Antonio	Safe Sleep for Infants Initiatives: Presentations by members of Bexar County CFRT Safe Sleep Task Force and State CFR Coordinator	37
9/10	7/29/2009	Medical Center Hospital, Odessa	Safe Sleep for Infants Initiatives: Presentations by members of the El Paso County CFRT and State CFR Coordinator	35
11	8/12/2009	South Texas College, McAllen	Premature Birth: Causes and Prevention	82

There were many positive results from the workshops. Team members who had never attended a CFRT conference before were able to receive invaluable training on best practices and injury prevention because the training occurred in their region. Members of different teams within each region had the opportunity to hear about the challenges and successes of other teams and to forge new connections for region-wide prevention activities. Members of the SCFRT were present to meet and connect with local team members. As the sessions were open to those interested in knowing more about



CFRT, contacts were made with community leaders interested in starting teams in counties without CFRT. The session on youth suicide prevention led to the organization of suicide prevention coalitions in several regions where there had been none. Feedback from attendees was overwhelmingly positive, with the majority expressing the need for annual workshops in the regions.

### Scenes from the symposium in Amarillo



*Left to right: Merily Keller and Esther Quine address the attendees on “Youth Suicide Prevention”; members of the South Plains CFRT as they wait for the steak dinner provided by the Northwest Texas Healthcare System and Amarillo National Bank; Gil Farren, Panhandle CFRT Presiding Officer, April Leming, The Bridge Children’s Advocacy Center and Panhandle CFRT member; and James Farren, Randall County District Attorney.*

### Scenes from the symposium in McAllen



*Upper left, clockwise: Karen Beard, Coastal Bend CFRT member, presents on “Preventing Motor Vehicle Crash Deaths”; attendees listen to Sonja Eddlemann, Coastal Bend CFRT Presiding Officer; Merily Keller speaks on suicide prevention; attendees in discussion, with Hidalgo/Starr Counties CFRT member, Robert Vela, making his point; Dr. John Hellsten, DSHS epidemiologist and SCFRT member (left) and Dr. Stan Fisch, Presiding Officer of the Cameron/Willacy Counties CFRT(right) listen as Dr. Juan Parra, pediatrician and SCFRT Chair (standing), addresses the group.*



## Ongoing Collaboration: SCFRT, CFRT Members, DSHS, and DFPS

There are numerous ways in which DSHS and DFPS collaborate to make Texas a healthier place for children. Historically, when DFPS had oversight over the CFRTs, DSHS was involved and responsible for the data collection and analysis, which was the basis for identifying and reducing risks to children through prevention initiatives. Now that DSHS has oversight of CFR, DFPS continues to be a critical partner in many different ways. DFPS is an important presence on the SCFRT Committee and on local teams, where caseworkers can provide critical insight into child deaths where there was a history of abuse or neglect. A subcommittee comprised of SCFRT members serve on the DFPS Child Safety Review Committee and submit annual recommendations on improving Child Protective Services (CPS) operations (see Chapter 2: Recommendations).

In 2009, the joint efforts on the topic of safe sleep for infants evolved into the creation of the Infant Health Workgroup. This workgroup is comprised of DFPS members from Child Protective Services, Child Care Licensing and Prevention and Early Intervention, plus DSHS staff from the Office of Program Decision Support (Women's and Perinatal Health Coordinator, Nurse Consultant and Child Fatality Review Coordinator). Given the number of infant deaths in sleep environments reviewed by the local teams and by CPS, as well as the diversity of opinion about the most effective practices and strategies for prevention, the issue of safe sleep is identified as one of mutual interest. In the 2006 Texas Child Fatality Review Team Annual Report, the data indicated that the rate of prior DFPS involvement among children who die of SIDS was at least ten percentage points greater than the rate among all other infant deaths each year from 2000 to 2004. DFPS began to informally tabulate cases where infants died in sleep environments, and brought their concerns about the issue to the SCFRT. The SCFRT also selected this topic for research. The SCFRT Position Statement on Safe Sleep for Infants (see Appendix E) was researched and written by a SCFRT subcommittee. The position statement was subsequently posted on the CFR website, as well as on the Texas Pediatric Society website, and has come to be a recognized expert resource on this topic.

As a result of the discussion in the SCFRT meetings, the Prevention and Early Intervention arm of DFPS partnered with DSHS to develop a targeted education and intervention pilot around safe sleep issues. The curriculum created by the workgroup will be launched and evaluated in three counties with high SIDS rates (Bell, Jefferson and Nueces). The curriculum will also be available online for anyone to download and present in their community in early summer 2010. The Infant Health Workgroup is also working with a social marketing firm to create an online training on safe sleep for infants for all CPS caseworkers. This online training, which will be mandatory for CPS caseworkers, will educate caseworkers on safe sleep practices, how to identify risks during home visits, how to talk with parents about changes necessary to keep their infants safe, and how to empower parents to make sure their changes are honored by other caregivers, such as grandparents and babysitters.



## Expanding Injury Prevention Activities

Collaboration at DSHS between the Division of Family and Community Health Services, Division of Mental Health and Substance Abuse and Division of Prevention and Preparedness led to the creation of an injury and violence prevention workgroup to explore opportunities for collaboration around injury prevention. Based on the collaboration of this workgroup, DSHS sought an assessment of the current injury and violence prevention efforts in the department. DSHS invited the State and Territorial Injury Prevention Directors Association (STIPDA) to send a State Technical Assessment Team (STAT) to assess injury prevention within the state health agency. The assessment focused on the core components of a successful state health department injury prevention program:

- infrastructure;
- data collection, analysis and dissemination;
- intervention design, implementation and evaluation;
- technical support and training; and
- public policy and advocacy.

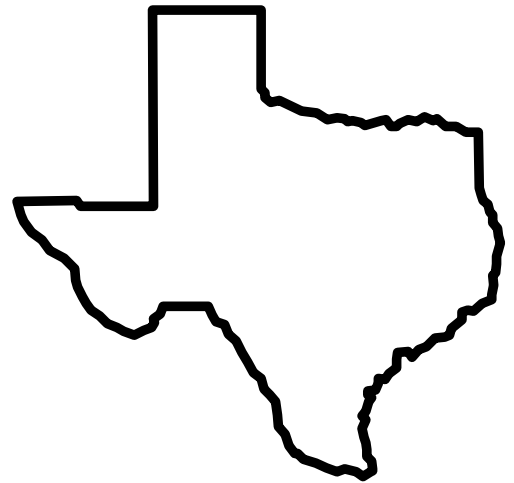
A team of injury prevention experts came to Texas for a five-day site visit in December 2008. During the visit, the team interviewed the staff and external partners involved in the state's injury prevention activities. They assessed the capacity of the program to conduct primary prevention. The SCFRT Chair and the Texas CFR Coordinator were interviewed about child fatality review as part of this process. The STAT team produced a report which described the status of injury and violence prevention in Texas and made recommendations for advancing injury and violence prevention in the state. The report is online at: [www.dshs.state.tx.us/injury/web%20stuff%20for%20posting/Texas%20STAT%20.pdf](http://www.dshs.state.tx.us/injury/web%20stuff%20for%20posting/Texas%20STAT%20.pdf)

As a result of the STAT visit and their recommendations, DSHS has made injury prevention a top priority. The CFR Coordinator is participating on the Tier-One Injury and Violence Prevention Workgroup. They are preparing an assessment and strategic plan for DSHS administration on how the agency can effectively improve injury and violence prevention across the life span.

In addition to this agency-wide initiative, the regional Maternal and Child Health staff continues to help develop CFRT and to serve on existing CFRT in their areas. Injury prevention is a focus of their work. They are working with the teams to better understand injury prevention and how to conduct meaningful prevention activities at the local level.



## CHAPTER 2 RECOMMENDATIONS



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## BACKGROUND AND INTRODUCTION

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

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

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

The recommendations offered are based on:

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

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



## Legislative Recommendations to Reduce Preventable Child Death in Texas

- A. Passage of legislation that requires new residential swimming pools to have a circumferential isolation pool fence installed that completely separates the house and play area of the yard from the pool. The fence should be at least four feet high and have a self-closing and self-latching gate that opens outward with latches that are out of the reach of children.**

According to the Centers for Disease Control and Prevention (CDC), more than one in four fatal drowning victims are children less than 15 years of age. Drowning is the second leading cause of unintentional injury deaths in children and young adolescents. For every child fatality from drowning, another four children receive emergency department care for nonfatal submersion injuries. Safe Kids Worldwide, an international nonprofit organization dedicated solely to preventing unintentional childhood injury, estimates that medical costs for each near-drowning victim can range from \$8,000 for initial medical care to more than \$250,000 for long-term care. The majority of toddler drowning cases occur in residential swimming pools. In a statement by the American Academy of Pediatrics (AAP) in 2003, it was estimated that circumferential isolation fencing could prevent 50-90 percent of drowning cases in young children. However, a national survey indicates that less than 30 percent of residential pool owners have a circumferential isolation fence around their pools. Legislation requiring circumferential isolation fencing around new residential swimming pools would prevent unnecessary drowning deaths and reduce the burden of health care costs associated with non-fatal submersions.

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

Each year, up to 100 children die from drowning in Texas and an estimated four times that number receive emergency care for nonfatal submersion injuries. Children ages one to four years have the highest drowning mortality rates and account for 45 percent of all child drowning deaths. Infants are at risk of drowning when left unsupervised for even seconds in the bathtub. Toddlers and young children are at greatest risk to drown in residential pools, hot tubs or water storage areas such as wells, cisterns and stock tanks. Young teens most often drown during water recreation activities such as swimming and boating. One study documenting seasonal variations for drowning deaths in children showed that two-thirds of drowning deaths in young children and adolescents occurred from May through August. April is targeted to bring attention to the prevention of water-related injuries before the peak season of water recreational



and sport activities. This will also designate an official time of the year where the state can annually promote the prevention of all types of water-related injuries.

**C. Mandate the following training topics be incorporated into all state-approved driver education courses and adopt an education campaign for all drivers to ensure the safety of children in and around motor vehicles.**

Children struck or injured by motor vehicles: According to 2007 data from the National Highway Traffic Administration (NHTSA), there were a total of 4,654 pedestrian fatalities of which 306 (7 percent) were children less than 15 years of age. It was also reported by NHTSA in 2007 that there were an estimated 70,000 pedestrians injured. Fourteen thousand were children less than 15 years of age. In the U.S. from 2001-2003, there were approximately 2,500 children and young adolescents annually receiving emergency room care for injuries after being struck by a motor vehicle. Additionally, there was an average of 229 children and young adolescents who died after being struck by a motor vehicle in a driveway or parking area. Nearly half of the children injured in these incidents were one to four years of age. CFRT in Texas have reviewed many tragic deaths where poor visibility prevented a parent, relative or friend from detecting a young child behind or in front of a motor vehicle. Passage of the Federal Cameron Gulbransen Kids Transportation Safety Act of 2007 requires the U.S. Department of Transportation to issue regulations related to power window safety, rearward visibility and rollaway prevention intended to reduce injuries and death of children occurring inside and near motor vehicles. In conjunction with this U.S. initiative and law, Texas should implement an education program for drivers about the deadly risks to small children around vehicles. It is also recommended that:

1. The Texas Department of Transportation (TxDOT) review public education and awareness campaigns, such as Spot the Tot campaign, and put in place a similar campaign for Texas. Spot the Tot is a campaign developed by the Utah Department of Health and Safe Kids Utah and has been expanded to a national campaign through Safe Kids USA.
2. All driver education courses provide training on the risks of injury for children in and around motor vehicles as well as incorporating this training into the Texas Department of Public Safety (DPS) Handbook.
3. TxDOT, DPS, Safe Kids coalitions in Texas, and other prevention organizations work in collaboration to track the effectiveness of the education campaign efforts and driver education programs to identify best practices and model programs.

Children as passengers in motor vehicles: Current Texas law requires children younger than eight years of age, unless taller than 4 feet 9 inches, to be in a child passenger safety system while riding in a motor vehicle. Children eight to seventeen years of age must be secured in a safety belt if occupying a seat in a vehicle that is so equipped. Safety experts recommend that all children under age 13 ride in the back seat.

To help reduce serious traumatic injuries to young children up to their eighth birthday, all drivers' education and the DPS Handbook should include information regarding proper installation and use of age-appropriate car safety seats systems. Research has



shown that young children restrained in age-appropriate child passenger safety seats have an 80 percent reduced risk of fatal injury than those who are unrestrained. A recent study published in *Pediatrics* by injury prevention researchers from the Children's Hospital of Philadelphia reported evidence that children ages four to eight who are restrained in the rear seat of a car in a belt-positioning booster seat are 45 percent less likely to be injured in a crash compared with children using a seat belt alone. In the United States, it is estimated that a \$46 child passenger safety seat generates, on average, \$1,900 in benefits to society and a \$31 booster seat generates \$2,200 in benefits to society. Using these estimated figures and the population for Texas children from birth to eight years of age, the benefits for Texas would exceed \$4 billion.

**D. Passage of legislation to amend Section 545.425 of the Transportation Code to address the risks of using wireless communication devices while driving.**

Current Texas law creates a statewide traffic offense for the use of a wireless communication device in a school zone unless the vehicle is stopped or exempted criteria are met. Cities, counties or any other political subdivisions wishing to enforce this prohibition must post a sign at the beginning of each school zone to inform drivers that use of a wireless communications device is prohibited and the operator is subject to a fine. The State Child Fatality Review Team (SCFRT) Committee recommends an amendment to the statute to eliminate the requirement to post a sign and require the restriction regardless of signage at the entrance of a school crossing zone. The requirement of posting signs is also an added expense to communities. Current legislation in the state limiting the use of wireless communication devices for motor vehicle operators under the age of 18 is in response to the known risk of the increased rate of motor vehicle crashes, injuries and fatalities for motor vehicle operators and pedestrians while using a wireless communication device.

**E. Passage of legislation requiring that an operator of a motor vehicle younger than 18 years of age cited for a moving violation must appear in court to settle the violation and must be accompanied by a parent or legal guardian.**

Current law does not require this recommendation. Required appearance in court means a young driver will be provided with information on safe driving practices. Presence of parents or guardians means they will be aware of the moving violation so they can monitor the safety employed by their young driver and impose added restrictions on their driving. Presence of parents or guardians also means they can be informed and advised on the option of revoking the driver's license of their young driver.

According to data from the Texas Department of Transportation's Crash Records Information System for 2008, drivers 15-17 years old were involved in 146 fatal crashes, 4,900 serious injury crashes and 7,325 crashes with other injuries. From this data, 27 drivers age 15-17 were killed in crashes.



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

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

At present, the core CFRT membership is comprised of volunteers. There is no consistent funding stream that provides the needed support and assistance for CFRT to conduct timely reviews of all child deaths and develop injury prevention initiatives.

Funding is needed for:

1. Developing new CFRT across the state to achieve 100 percent participation of counties in child fatality review;
2. Implementing an efficient method for distribution of death and birth records to the CFRT in a timely manner;
3. Providing training and support to CFRT membership to improve their skills in fatality review, data entry and in identifying high risk injury and fatality hazards in their community;
4. Implementing education campaigns on injury prevention by CFRT in their communities; and
5. Establishing a competitive grant funding source so that CFRT can develop and implement evidence-based community injury prevention projects.

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

At present, there are 57 active CFRT involving 179 counties incorporating 88 percent of the population of children and adolescents 0-17 years of age. To fully understand and review the circumstances leading to a child death and to fully address prevention initiatives effectively, the SCFRT Committee recommends that 100 percent of child deaths in Texas be reviewed and documented in a database system. A statutory requirement will reinforce Texas' commitment to child death review and prevention, and will ensure the further development of CFRT in Texas communities.

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



Child fatality review in Texas is becoming more thorough and sophisticated. The need for additional professional expertise on the SCFRT Committee has been identified.

- Emergency Medical Services (EMS) personnel are first responders at fatality and injury scenes. They can contribute in terms of scene information and investigation as well as in injury and fatality prevention efforts in Texas communities. Many county and regional CFRT have EMS represented for their reviews.
- Family violence poses a risk of injury to children and is too often a factor in child fatality cases reviewed by local teams. The addition of a Family Violence Service Provider will expand the expertise of the SCFRT Committee, which serves as a multi-disciplinary model to the local teams.
- Recent legislation added a representative from the newly created Department of Motor Vehicles (DMV) to the SCFRT Committee. The representative from the DMV replaced the previously designated SCFRT Committee member from TxDOT. Representation from TxDOT on the SCFRT Committee has been an invaluable asset. The experience, insight and innovative ideas of the TxDOT representative have led to successful initiatives for injury prevention as well as being a resource of information for the SCFRT Committee and local CFRT.

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

According to the Child Fatality Review statute, the purpose of the SCFRT Committee is to:

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

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

It is recommended to change the statute to state that the SCFRT Committee will publish an annual report that is submitted no later than April 1 of each year to the Governor,



Lieutenant Governor, Speaker of the House of Representatives, the Texas Department of Family and Protective Services (DFPS), the Texas Department of State Health Services (DSHS) and be made available to the public. The annual report shall contain aggregate child fatality data collected by local CFRT as well as recommendations to the Governor, State Legislators and DSHS to promote the prevention of fatalities and injuries to Texas children. Furthermore, the SCFRT Committee shall make recommendations to DFPS on CPS operations. Recommendations to DFPS are made by the SCFRT Committee and are based on recommendations of the SCFRT Committee's Child Safety Review Subcommittee. This subcommittee is charged to:

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

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



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## RECOMMENDATIONS ON CHILD PROTECTIVE SERVICES OPERATIONS

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### **A. Strengthen the communication between Child Protective Services, law enforcement and medical personnel about children at risk for abuse and neglect.**

It is recommended that CPS:

1. Evaluate the implementation of Family Code Section 261.3011 regarding Joint Investigation Guidelines and Training for CPS and law enforcement (SB 6 (79R)). It is also recommended that CPS identify potential barriers to collaboration amongst agencies that are involved in a child abuse investigation.
2. Evaluate the process and utilization of multi-disciplinary team collaborations by CPS in an effort to enhance information sharing and coordination among law enforcement, CPS, medical and mental health agencies. To the extent possible, identify how CPS partnerships with local children's advocacy centers, as defined in Family Code Section 264.401, are utilized to promote case coordination and information sharing.
3. Evaluate implementation of Family Code Section 261.3126 (SB 6 (79R)) regarding co-location of CPS and law enforcement investigators. It is required in each county, to the extent possible, to co-locate law enforcement and CPS investigators. In counties served by a Children's Advocacy Center (CAC), it is required, to the extent possible, to co-locate the investigators at the CAC facility. It is also recommended that CPS identify barriers and challenges to co-location as well as benefits to collaboration and information sharing achieved by counties where co-location of investigators exists.

### **B. Study and report on the feasibility of developing and implementing a system that would identify new births to parents whose parental rights have been terminated or who have had a child die of maltreatment. This recommendation also includes assessment of the living situation of the newborn and provision of support services as needed to the newborn in a high risk environment.**

It is recommended that CPS:

1. Study and report on the feasibility of working with the DSHS Vital Statistics Unit to develop a birth-match electronic system that will run electronic new birth registrations against a list of parents whose rights have been terminated or who have had a child die of maltreatment.
2. Study and report on the feasibility of automatically opening a case for investigation and provide support services for a newborn child identified by the birth-match electronic system.



**C. Incorporate childhood injury prevention training into the Basic Skills Training and the Protective Services Institute for Child Protective Services caseworkers.**

It is recommended that:

1. CPS caseworkers receive basic training about causes of childhood injuries, how to recognize risk factors for childhood injuries, and communicate effectively with parents about injury prevention. Unintentional injury is the leading cause of child death for children ages one through 17. There is a growing body of evidence that many unintentional childhood injuries are related to improper supervision.



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## RECOMMENDATIONS TO THE DEPARTMENT OF STATE HEALTH SERVICES

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**A. It is recommended that DSHS provide ongoing support for an Annual Child Fatality Review Conference for Texas Child Fatality Review Teams.**

CFRT operate in their own jurisdictions with oversight from the Child Fatality Review Coordinator at DSHS. In order to promote best practices in child fatality review and injury prevention, an annual gathering of the teams is essential. An annual conference is an efficient way to deliver consistent messages to all teams, as well as an opportunity for teams to share successes and challenges and be part of a statewide movement to protect Texas children. The partnership with the Children's Assessment Center of Houston to merge the annual child fatality review conference with their *Protecting Texas Children* conference has been very successful. The conference incorporates training particular to the needs for CFRT members and supports the value of multi-disciplinary work in protecting children. The conference is well-attended by CFRT members because the DSHS Office of Title V and Family Health funds the attendance for two members of each CFRT. It is recommended that DSHS continue to support annual training for CFRT members with active participation in the planning of the conference and funding of team member attendance.

**B. It is recommended that DSHS explore opportunities for local, state and federal funding for training and support of new and current community volunteers serving on local Child Fatality Review Teams.**

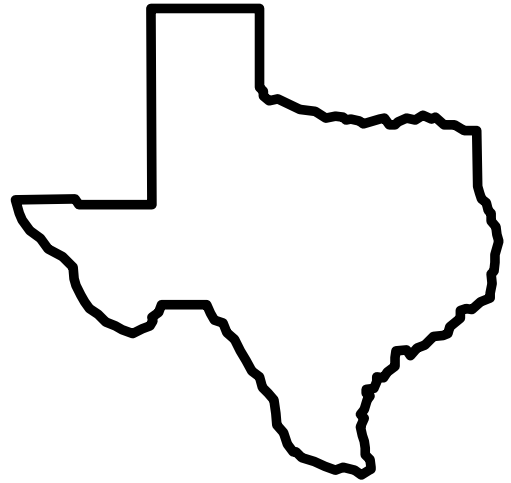
CFRT membership is made up exclusively of volunteers. Physicians, attorneys, law enforcement, social workers, educators and other child advocates donate their time to serve on the local teams. Adequate funding is essential to keep CFRT membership current with the latest training, education and implementation of best practices in injury prevention.

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

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



# CHAPTER 3 DATA & ANALYSIS



## GENERALIZABILITY OF CFRT DATA

The number of deaths reviewed by cause varies. The proportion of reviewed deaths for one cause may be significantly higher than other causes. While the proportion of deaths reviewed may be relatively low, the demographic characteristics of these deaths are similar enough to the “unreviewed” cases to generalize that the specific circumstances of death derived from the reviews accurately reflect child fatalities in Texas (Table 3).

**Table 3. Deaths Reviewed by CFRT, Total Deaths and Population 2007  
(0-17 Year Olds)**

	2007 CFRT		2007 Death Certificates <sup>1</sup>		2007 Population	
	Number	Percent <sup>2</sup>	Number	Percent <sup>2</sup>	Number	Percent <sup>2</sup>
<b>TEXAS</b>	2,004	100.0	4,077	100.0	6,438,744	100.0
<b>Race/Ethnicity</b>						
White	578	29.5	NA	NA	2,453,205	38.1
Black	451	23.0	NA	NA	812,483	12.6
Hispanic	871	44.5	NA	NA	2,936,814	45.6
Other	59	3.0	NA	NA	236,242	3.7
Not Stated	45	NA	NA	NA	-	NA
<b>Gender</b>						
Male	1,172	58.5	1,753	43.0	3,288,627	51.1
Female	830	41.5	2,324	57.0	3,150,117	48.9
Not Stated	2	NA	-	NA	-	NA
<b>Age Group</b>						
Infant	1,166	58.2	2,543	62.4	394,215	6.1
1-4 Years	274	13.7	495	12.1	1,512,285	23.5
5-9 Years	130	6.5	261	6.4	1,704,137	26.5
10-14 Years	139	6.9	294	7.2	1,721,492	26.7
15-17 Years	293	14.6	484	11.9	1,106,615	17.2
Not stated	2	NA	-	NA	-	NA

1. Death Certificates are based on deaths occurring to Texas residents, regardless of state of occurrence.

2. Percents are based on records with stated information.

CFRT Source: Texas Data from the National Center for Child Death Review, 2007.

Death Certificate Source: Texas Department of State Health Services, Vital Statistics Unit, 2007.

Population Source: Population Estimates and Projections Program, Texas State Data Center, Office of the State Demographer, Institute for Demographic and Socioeconomic Research, The University of Texas at San Antonio; 2007.



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## UNDERSTANDING MANNER OF DEATH

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Every death is assigned a manner of death. The four main manner of death classifications are natural, accident, suicide and homicide. When the justice of the peace or physician is unable to determine the manner, it is classified as undetermined. A death certificate can initially have a pending manner of death until the medical certifier can determine the specific manner. The manner of death and the cause of death are both determined by the medical certifier of death.

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



# MANNER OF DEATH: NATURAL

**Table 4. Natural Causes of Death by Race/Ethnicity, Age Group and Gender, 2007**

Race/Ethnicity	Number	Percent
Total	1,179	100.0
White	294	25.5
Black	266	23.0
Hispanic	554	48.0
Other	41	3.5
Not Stated	24	NA

Age group	Number	Percent
Total	1,179	100.0
Infant	900	76.4
1-4 Years	102	8.7
5-9 Years	65	5.5
10-14 Years	59	5.0
15-17 Years	52	4.4
Not stated	1	NA

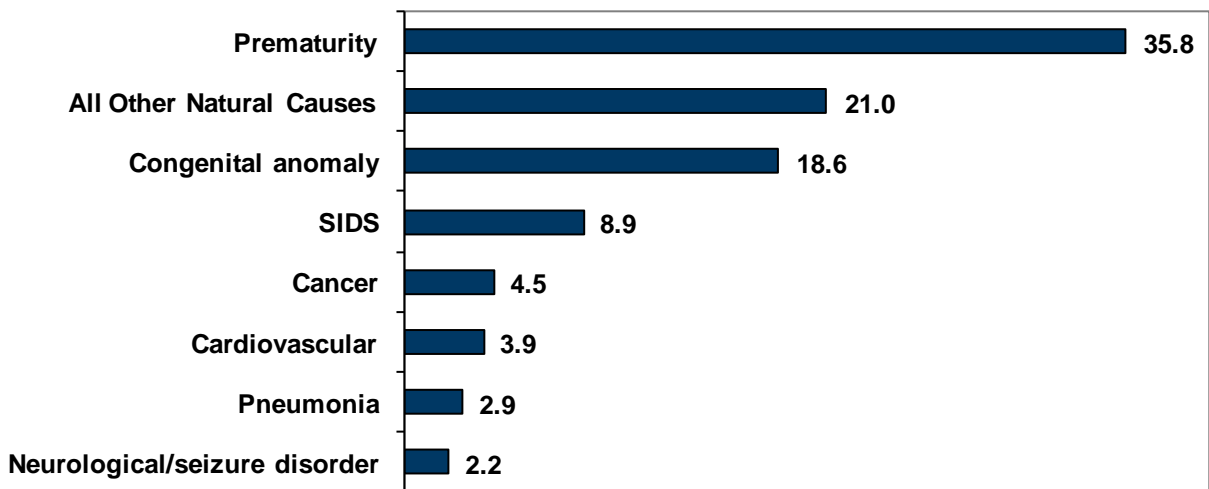
Gender	Number	Percent
Total	1,179	100.0
Male	642	54.5
Female	536	45.5
Not Stated	1	NA

Source: Texas Data from the National Center for Child Death Review, 2007

Table 4 reveals critical information about natural child deaths reviewed by local teams.

- 1,179 of the 2,004 deaths reviewed were natural deaths.
- Among the natural deaths reviewed, the majority of deaths were to infants (76.4 percent).
- More males (54.5 percent) than females (45.5 percent) died of natural deaths.
- Black children, representing 12.6% of the 2007 child population, make up 23.0% of all natural child deaths in Texas, revealing a distinct vulnerability for this population.

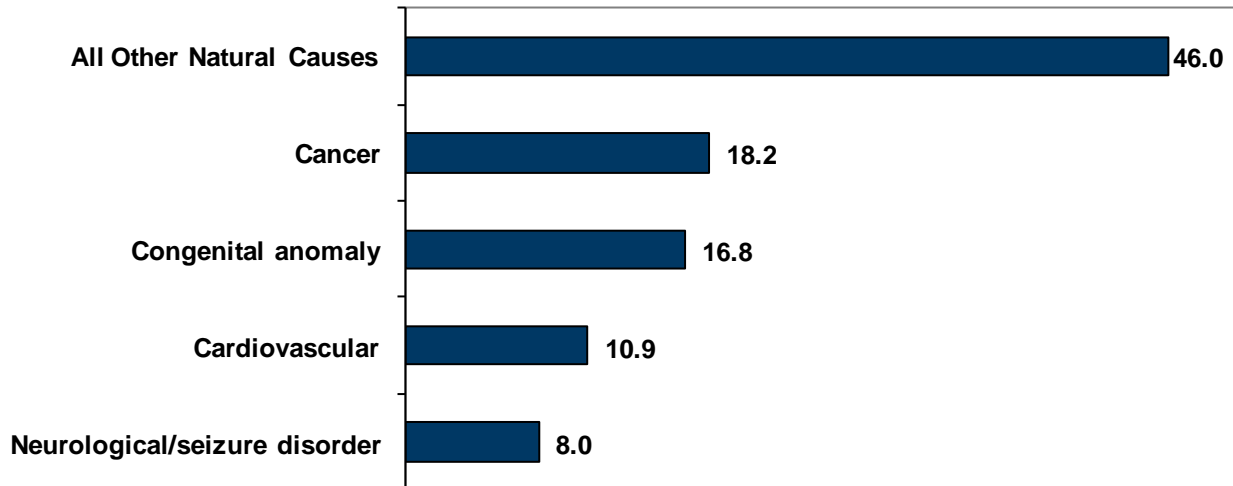
**Figure 2. Natural Manner of Death by Cause of Death 2007 (N = 1,168)**



Note: not all causes of natural death are listed due to the small number of deaths associated with specific causes of death. The percentages will not total to 100.0 percent.



**Figure 3. Natural Manner of Death for Children Aged 1-17 Years  
by Cause of Death, 2007 (N = 274)**



When specific causes of death are considered within the natural manner of death (Figure 2), even more is understood about the nature of natural deaths reviewed by local teams.

- Prematurity is the leading natural cause of death, accounting for 35.8 percent of all natural deaths.
- Sudden Infant Death Syndrome (SIDS) represents 8.9 percent of all natural deaths. For further discussion of SIDS, see page 54.
- Intervention with and education of women of child-bearing age, pregnant women and parents of newborns could potentially reduce the numbers of infants dying in Texas.
- Cancer accounted for 4.5 percent of all natural deaths reviewed by teams in 2007, but accounted for 18.2 percent of all natural deaths reviewed for decedents between the ages of one and 17 years old.



# MANNER OF DEATH: ACCIDENT

**Table 5. Accidental Causes of Death by Race/Ethnicity, Age Group, and Gender, 2007**

Race/Ethnicity	Number	Percent
Total	428	100.0
White	176	42.5
Black	74	17.9
Hispanic	153	37.0
Other	11	2.7
Not Stated	14	NA

Age group	Number	Percent
Total	428	100.0
Infant	71	16.6
1-4 Years	118	27.6
5-9 Years	52	12.2
10-14 Years	54	12.6
15-17 Years	133	31.1

Gender	Number	Percent
Total	428	100.0
Male	276	64.5
Female	152	35.5

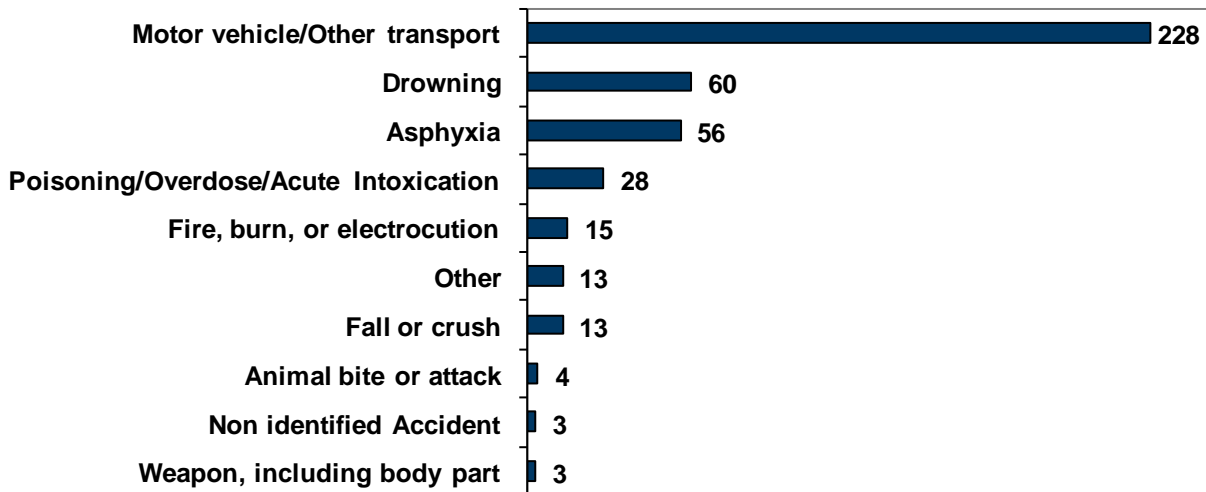
Source: Texas Data from the National Center for Child Death Review, 2007

Note: Percentages are rounded to the nearest tenth decimal point, total may not sum to 100.0 percent due to rounding.

Table 5 reveals critical information about accidental (or non-intentional) child deaths reviewed by local teams.

- Adolescents 15 to 17 years of age make up 31.1 percent of all accidental deaths. This age group constitutes only 14.6 percent of all child deaths reviewed (Table 3).
- Of the 293 2007 deaths reviewed of adolescents 15 to 17 years of age, 133 of those deaths were accidents.
- More males (64.5 percent) than females (35.5 percent) died of accidental deaths.
- Black children, representing 12.6 percent of the 2007 child population, make up 17.9 percent of all accidental child deaths in Texas, revealing a greater rate of accidental deaths for this population.

**Figure 4. Accidental Manner of Death by Cause of Death 2007 (N = 423)**



When specific causes of death are considered within the accident manner of death category (Figure 4), more is understood about the nature of these deaths reviewed by local teams.



- Motor vehicle crashes are the leading cause of accidental child deaths (53.9 percent). For more discussion on deaths in motor vehicle crashes, see page 60.
- Drowning is the second leading cause of accidental child deaths (14.2 percent). For more discussion on drowning deaths, see page 57.
- Asphyxia is the third leading cause of accidental deaths (13.2 percent). For more discussion on asphyxia deaths, see page 65.

Prevention efforts should focus on motor vehicle crashes and drowning deaths because they are the leading causes of accidental deaths among children in Texas. It is noteworthy that all of the legislative recommendations made by the State Child Fatality Review Team Committee (see page 31) address changes in law that would reduce motor vehicle and drowning deaths.



# MANNER OF DEATH: HOMICIDE

**Table 6: Homicide Causes of Death by Race/Ethnicity, Age Group, and Gender, 2007**

Race/Ethnicity	Number	Percent
Total	142	100.0
White	30	21.1
Black	47	33.1
Hispanic	62	43.7
Other	3	2.1

Age group	Number	Percent
Total	142	100.0
Infant	18	12.8
1-4 Years	41	29.1
5-9 Years	9	6.4
10-14 Years	16	11.3
15-17 Years	57	40.4
Not Stated	1	NA

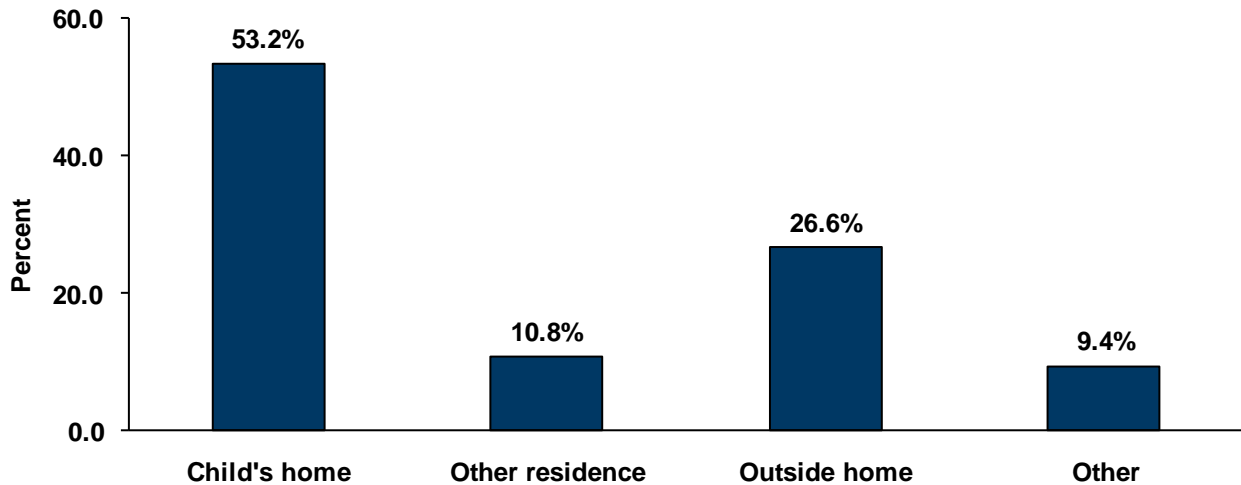
Gender	Number	Percent
Total	142	100.0
Male	98	69.0
Female	44	31.0

Source: Texas Data from the National Center for Child Death Review, 2007

Table 6 reveals critical information about homicide deaths reviewed by local teams.

- One hundred forty-two Texas children were murdered in 2007.
- More than twice as many males (69.0 percent) were murdered than females (31.0 percent).
- Young children, less than five years old, represent 41.9 percent of all child homicides.
- Black children, representing 12.6 percent of the 2007 child population, make up 33.1 percent of all homicides reviewed, revealing a much higher rate of homicide for this population.
- More information is needed to be able to determine risks to children and how to prevent homicide.

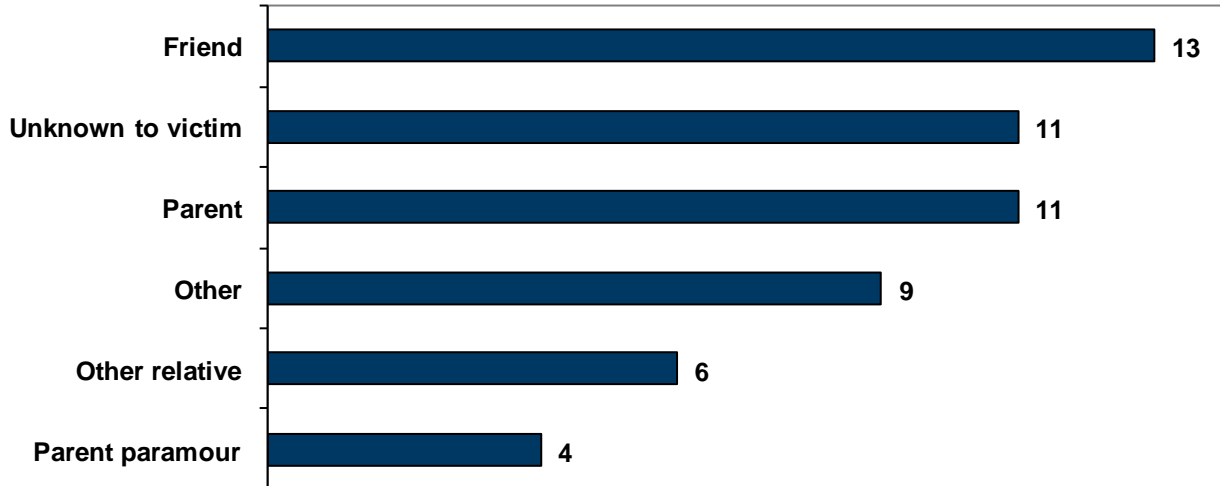
**Figure 5. Homicide Causes of Death by Place of Occurrence 2007 (N=139)**



Note: Place of death percentages are based on the number of records (139) with stated place of death for homicides. Three out of the 139 homicides did not have a place of death listed.



**Figure 6. Homicide Causes of Death by Perpetrator  
2007 (N=54)**



*Note: The perpetrator was unknown for 88 of the 142 homicides.*

Figures 5 and 6 reveal even more about the nature of homicides reviewed by local teams.

- More than half of the child homicides occurred in the home.
- The perpetrator was unknown for 88 of the 142 homicides and it is unclear if that is because the perpetrator was not identified by law enforcement or if the perpetrator information was not collected in the review process.
- Friends constituted the largest group of known perpetrators in reviewed homicides.

More discussion of homicides by firearm and asphyxia are found on pages 63-67.



# MANNER OF DEATH: SUICIDE

**Table 7. Suicide Causes of Death by Race/Ethnicity, Age Group, and Gender, 2007**

Race/Ethnicity	Number	Percent
Total	53	100.0
White	26	50
Black	3	5.8
Hispanic	21	40.4
Other	2	3.8
Not Stated	1	NA

Age group	Number	Percent
Total	53	100.0
10-14 Years	7	13.2
15-17 Years	46	86.8

Gender	Number	Percent
Total	53	100.0
Male	41	77.4
Female	12	22.6

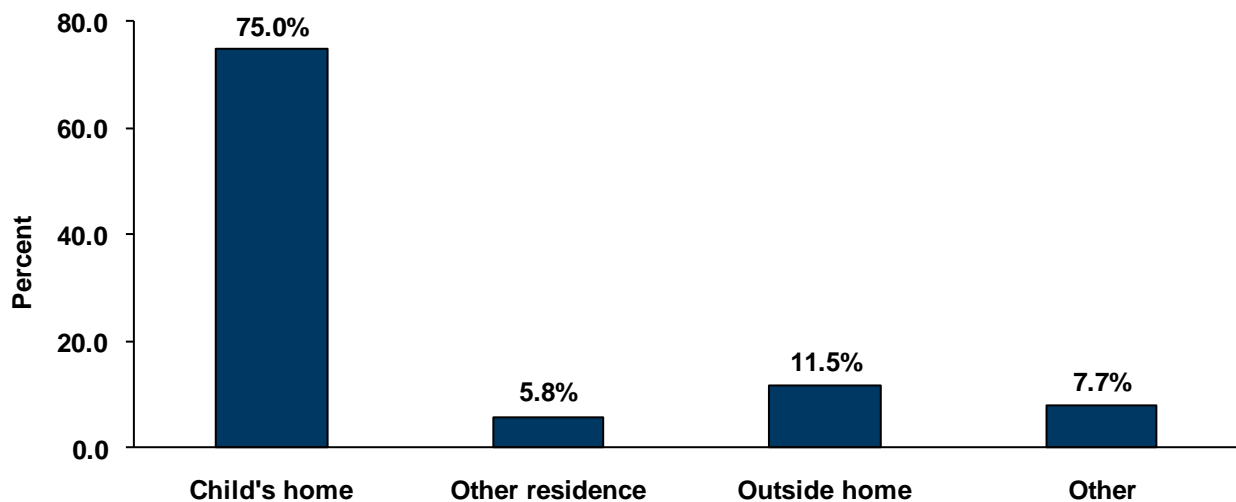
Source: Texas Data from the National Center for Child Death Review, 2007

Table 7 reveals critical information about suicides reviewed by local teams.

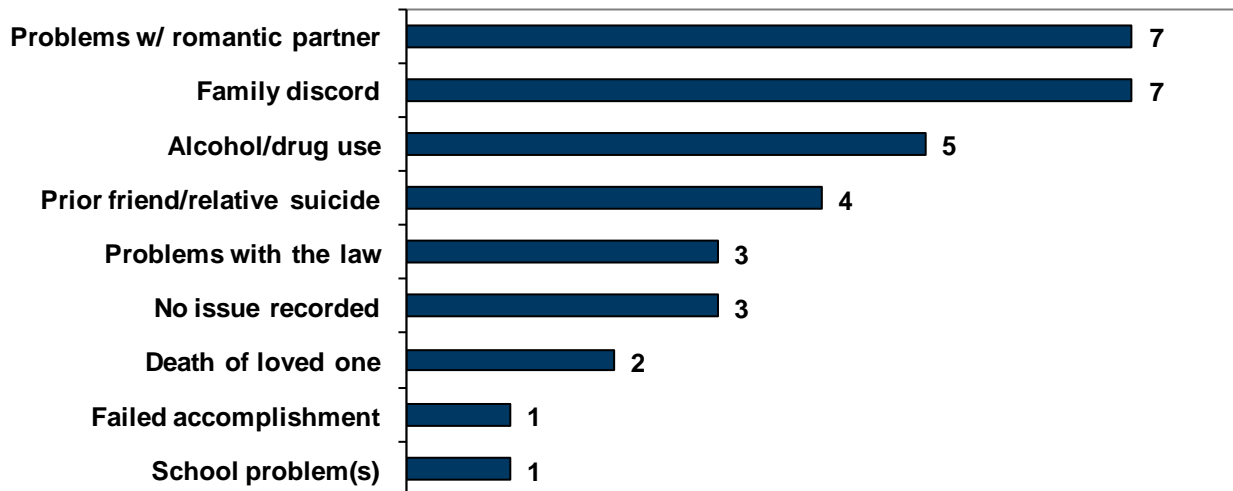
- Fifty-three children committed suicide in 2007.
- Of the 53 suicide deaths reviewed, 77.4 percent were committed by males.
- Seven of the 53 suicide deaths were committed by children 10 to 14 years of age.
- White children, representing 38.1 percent of the 2007 child population, committed half of the 2007 child suicides, compared with Hispanic children, who account for 45.6% of the population and had committed 40.4% of the total number of suicides.
- Suicide was relatively rare among black children. They account for 5.8 percent of all suicides reviewed.

More information is needed to be able to determine risks to children and how to prevent suicide.

**Figure 7. Suicide Causes of Death by Place of Occurrence 2007 (N=52)**



**Figure 8. Suicide Causes of Death by Contextual Factors  
2007**



*Note: More than one contextual factor can be listed for suicide.*

Figures 7 and 8 reveal more about the nature of suicides reviewed by local teams.

- The majority of suicides occurred in the home.
- True contextual factors of suicide are only known if the decedent leaves a note and if that note is shared in the review process.

Anecdotal evidence of what survivors report could have contributed to the suicide death are speculative and could reflect reporter bias.



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## UNDERSTANDING CAUSE OF DEATH

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All causes of death can be divided into natural causes and injuries. In this report, the only natural cause of death discussed is Sudden Infant Death Syndrome (SIDS). Injuries are further divided into unintentional and intentional injuries. The unintentional injuries discussed here are drowning and motor vehicle fatalities. Firearm and asphyxia deaths can be both intentional and unintentional injuries.



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## SUDDEN INFANT DEATH SYNDROME (SIDS)

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

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

**Table 8. Sudden Infant Death Syndrome (SIDS)  
by Race/Ethnicity, Age Group, and Gender, 2007**

Race/Ethnicity	Number	Percent
Total	123	100.0
White	47	38.2
Black	27	22.0
Hispanic	45	36.6
Other	4	3.3

Age group	Number	Percent
Total	123	100.0
<2 Months	37	30.3
2-4 Months	69	56.6
5-8 Months	15	12.3
9-12 Months	1	0.8
Not stated	1	NA

Gender	Number	Percent
Total	123	100.0
Male	66	53.7
Female	57	46.3

Source: Texas Data from the National Center for Child Death Review, 2007

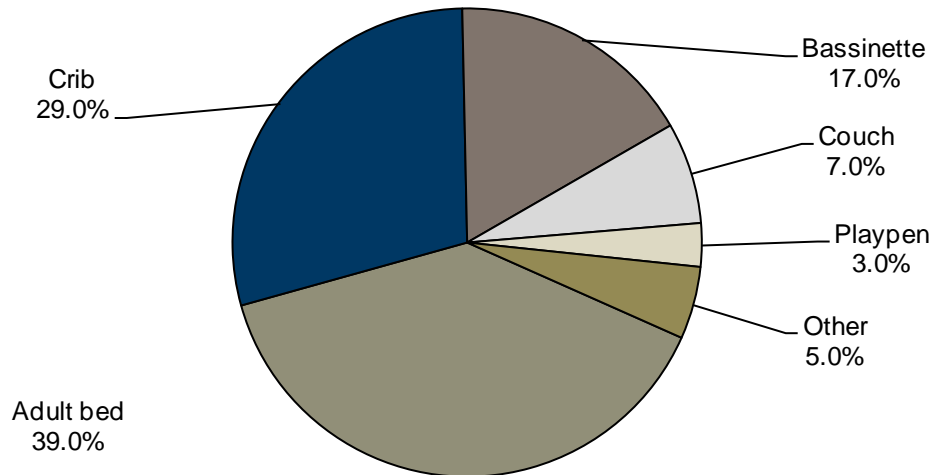
Generally, but not always, the infant is found dead after having been put to sleep and exhibits no signs of having suffered. SIDS is the leading cause of infant death in the postneonatal period (death between 28 and 365 days of life).

Data from the child fatality reviews of SIDS deaths gives insight into infants at higher risk.

- Infants between the ages of two and four months accounted for 56.6 percent of the SIDS deaths.
- Male infants represented 53.7 percent of those infants who died of SIDS.
- Black children, representing 12.6 percent of the 2007 child population, accounted for 22.0 percent of the SIDS deaths reviewed. This contrasts with Hispanic children, who account for 45.6 percent of the population and accounted for 36.6 percent of the total number of SIDS deaths. White children, representing 38.1 percent of the 2007 child population, accounted for 38.2 percent of SIDS deaths.

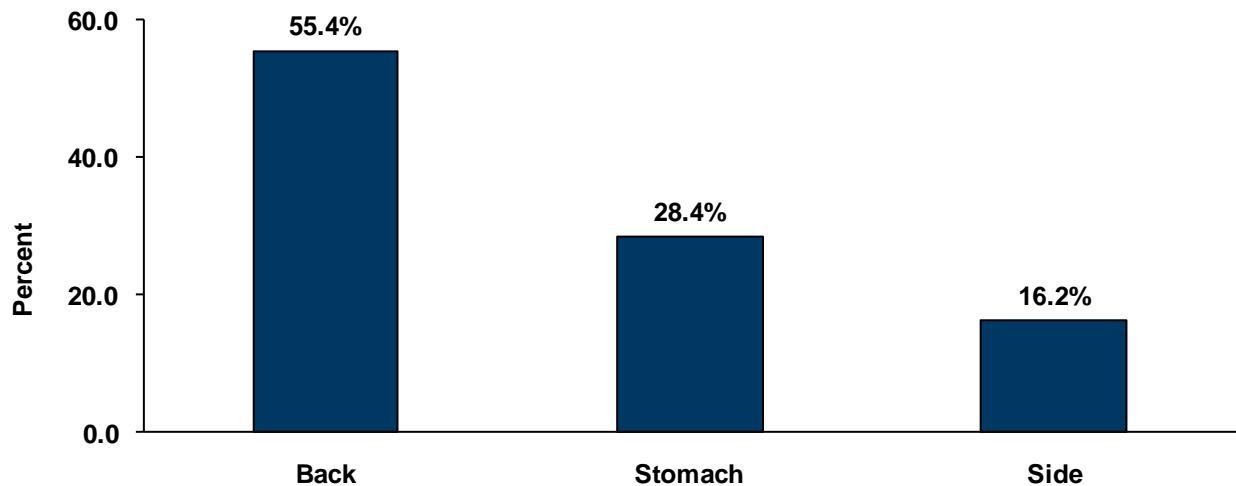


**Figure 9. SIDS by Sleeping Place  
2007 (N=100)**



*Note: Sleeping place percentages are based on the number of records (100) with stated sleeping place data. Twenty-three out of the 123 SIDS deaths did not have a sleeping place listed.*

**Figure 10. SIDS by Sleeping Placement  
2007, (N = 74)**



Further examination of SIDS cases gives more insight into preventive measures to reduce the risk of SIDS, as well as raises questions about what is not known.

- SIDS deaths occurred nearly at the same rate in adult beds and cribs.
- More than 40 percent of the SIDS deaths occurred with the infant sleeping on the stomach or the side.
- That infants die sleeping in the recommended supine position underscores the fact that SIDS deaths are due to a complex variety of factors and cannot be attributed to a single contributing factor.
- Sleeping place and sleeping placement were not identified in many cases, suggesting that the information was not collected at the death scene.



The implication for action from SIDS data is obvious. There is a need for consistent infant death scene investigation so that SIDS deaths can be more fully understood. Statewide implementation of the Sudden Unexpected Infant Death (SUID) investigation protocol promoted by the CDC would standardize investigations and contribute to greater understanding of SIDS and resultant prevention initiatives. There is need for consistent education about the risk factors for infants in sleep environments, and the protective factors that parents and caregivers can adopt to ensure safe sleep for infants.



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## DROWNING DEATHS

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Teams reviewed 64 drowning deaths for 2007. Several CFRT focused prevention activities on water safety; see pages 20 and 25 for additional information.

**Table 9. Drowning Deaths  
by Race/Ethnicity, Age Group, and Gender, 2007**

Race/Ethnicity	Number	Percent
Total	64	100.0
White	22	36.7
Black	18	30.0
Hispanic	17	28.3
Other	3	5
Not Stated	4	NA

Age group	Number	Percent
Total	64	100.0
Infant	3	4.7
1-4 Years	40	62.5
5-9 Years	7	10.9
10-14 Years	4	6.3
15-17 Years	10	15.6

Gender	Number	Percent
Total	64	100.0
Male	45	70.3
Female	19	29.7

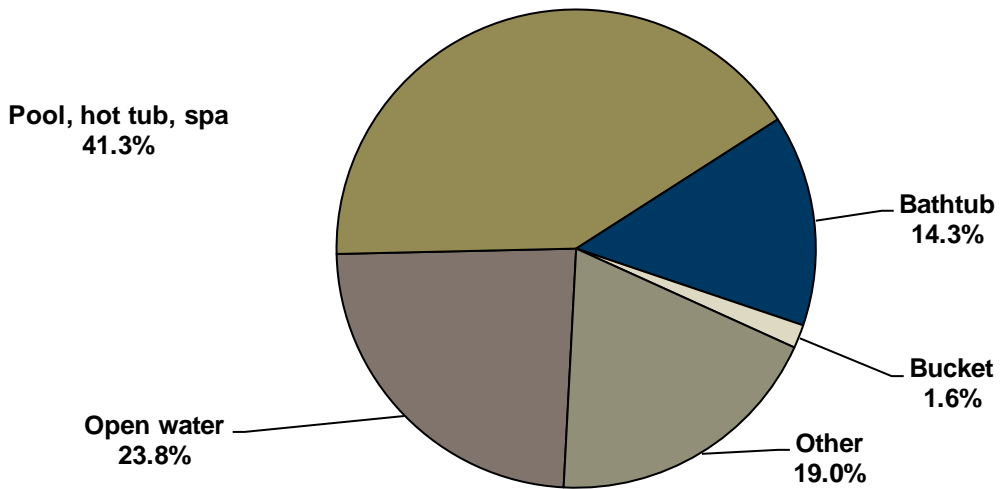
Source: Texas Data from the National Center for Child Death Review, 2007

Data from the child fatality reviews of drowning deaths give insight into which children are at higher risk.

- Children one to four years of age represent the largest percentage (62.5 percent) of the drowning deaths. Developmentally at this age, they are becoming mobile and are curious about exploring their environment, and consequently require heightened levels of supervision.
- Male children represent the majority (70.3 percent) of the drowning cases reviewed.
- Black children, representing 12.6 percent of the 2007 child population, accounted for 30.0 percent of the drowning deaths reviewed. This contrasts with Hispanic children, who represent 45.6 percent of the population and account for 28.3 percent of the total number of drowning deaths, and white children, who represent 38.1 percent of the population and account for 36.7 percent of total drowning deaths.

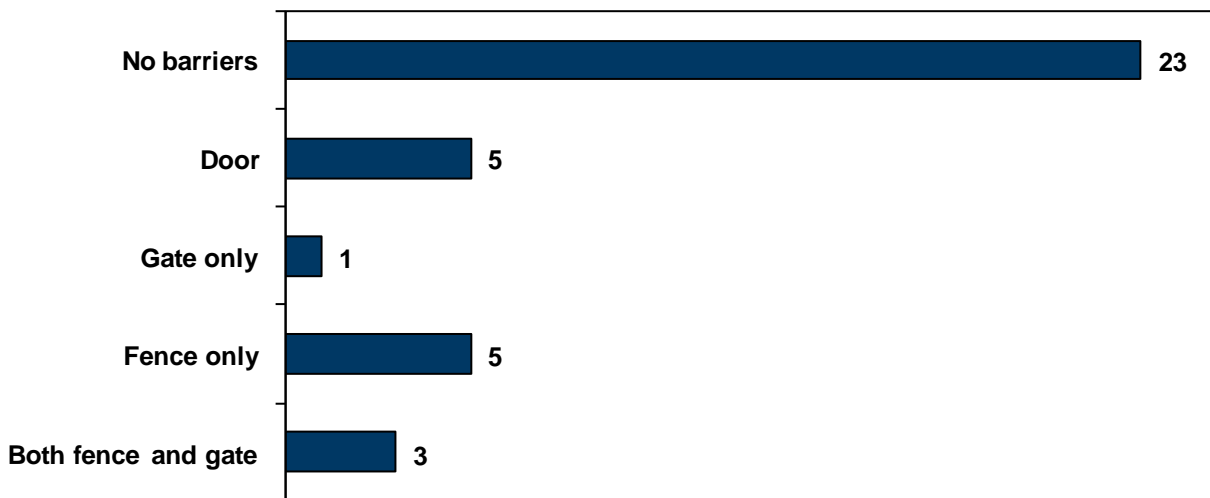


**Figure 11. Drowning Deaths by Place of Occurrence  
2007 (N=63)**



*Note: Location of drowning death percentages are based on the number of records (63) with stated location data. One drowning death did not have the location of drowning listed.*

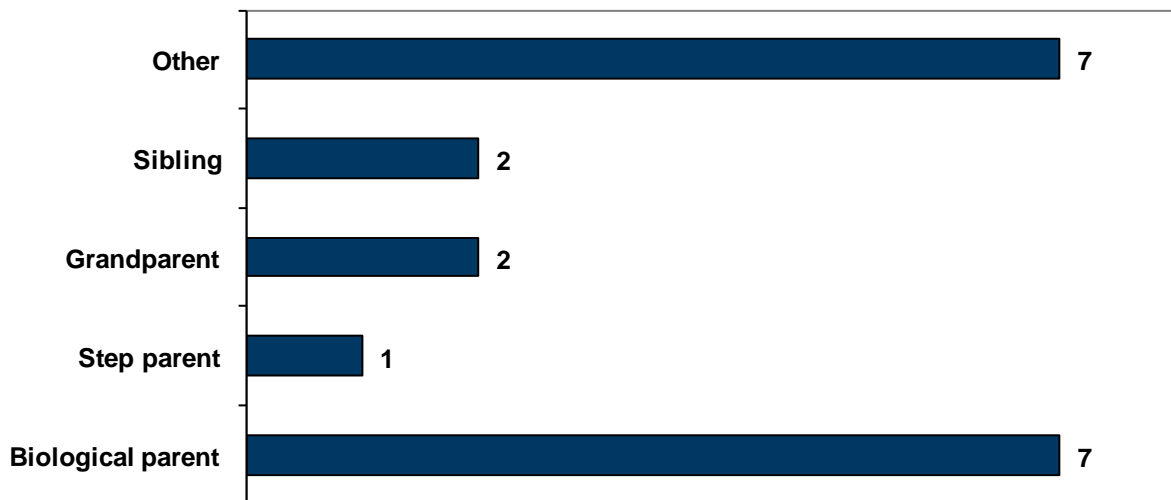
**Figure 12. Drowning Deaths by Water Access Barriers in Place  
2007 (N=54)**



*Note: Water access barriers in place for drowning deaths are based on the number of records (37) with stated barrier data. Water access barriers were unknown for 27 out of the 64 drowning deaths.*



**Figure 13. Drowning Deaths by Supervision Category  
2007 (N=26)**



*Note: Person supervising child for drowning death are based on the number of records (26) with stated supervision data. Person supervising child was unknown for 38 out of the 64 drowning deaths.*

Further examination of review data in Figures 12 and 13 yields more insight into preventive measures to reduce the risk of drowning. It also raises questions about what is not known or collected

- All bodies of water present drowning risk, but pools, hot tubs and spas pose the greatest risk.
- Lack of water access barriers was a predominant safety issue in the drowning deaths where that information was known. Information about barriers was not always reported in the deaths reviewed.
- Not all of the drowning deaths reviewed had information about supervision.

Of the 26 records with stated supervision data, which allows for multiple factors per supervisor, the following is known:

- 2 supervisors were asleep;
- 1 supervisor was drug impaired;
- 1 supervisor was alcohol impaired;
- 16 supervisors were distracted;
- 12 supervisors were absent; and
- None of the other questions regarding supervisor state were indicated in these deaths.

The implications for action from these drowning data are in line with the SCFRT Legislative Recommendation to Reduce Preventable Child Death in Texas addressing water access barriers (see page 33). This recommendation calls for circumferential isolation fencing of pools so that the yard and house are separated from the pool. But limiting access to bodies of water is not the sole solution, as supervision is also critical. Investigations of these deaths should include information about the level of supervision and the supervisor so that further risk factors can be identified. Community education initiatives about water safety for children and the need for supervision, such as the April



Pools Day events organized by CFRT in Harris and Williamson Counties, coupled with safety legislation, can go far in increasing awareness and reducing child drowning deaths in Texas.



## MOTOR VEHICLE FATALITIES

Teams reviewed 240 motor vehicle deaths for 2007. It is noteworthy that not all motor vehicle deaths have manner of death as accident. Of the motor vehicle deaths reviewed, one was deemed to be a suicide, four were designated as homicides and three were listed as undetermined.

**Table 10. Motor Vehicle Crash Deaths  
by Race/Ethnicity, Age Group, and Gender, 2007**

Race/Ethnicity	Number	Percent
Total	240	100.0
White	109	46.2
Black	36	15.3
Hispanic	86	36.4
Other	5	2.1
Not Stated	4	NA

Age group	Number	Percent
Total	240	100.0
Infant	11	4.6
1-4 Years	50	20.8
5-9 Years	37	15.4
10-14 Years	40	16.7
15-17 Years	102	42.5

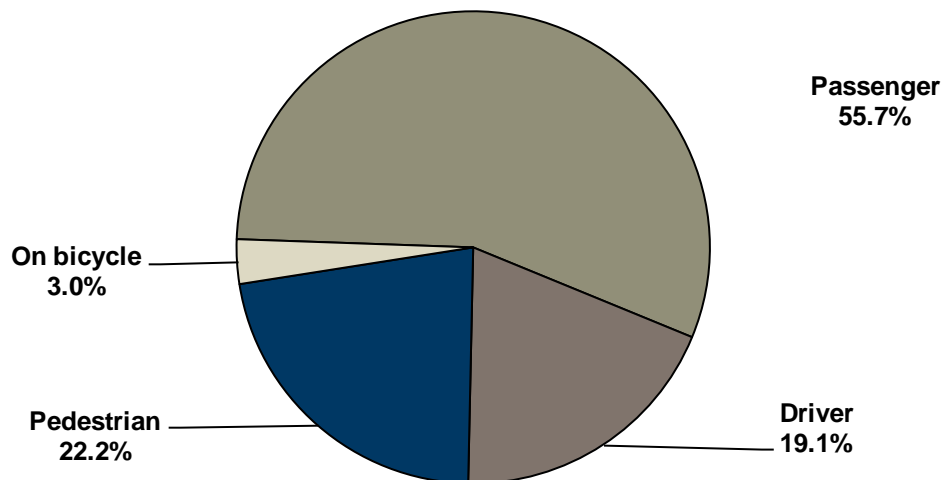
Gender	Number	Percent
Total	240	100.0
Male	152	63.3
Female	88	36.7

Source: Texas Data from the National Center for Child Death Review, 2007

Data from the child fatality reviews of motor vehicle deaths give insight into which children are at higher risk.

- While all age groups of children had motor vehicle fatalities, children ages 15-17 make up the largest percentage of these reviewed deaths (42.5 percent).
- Males (63.3 percent) represent the majority of the motor vehicle fatalities reviewed.
- Along race and ethnicity lines, percentages of deaths paralleled population data, with Hispanic children, representing 45.6 percent of the child population, accounting for 36.4 percent of the deaths.

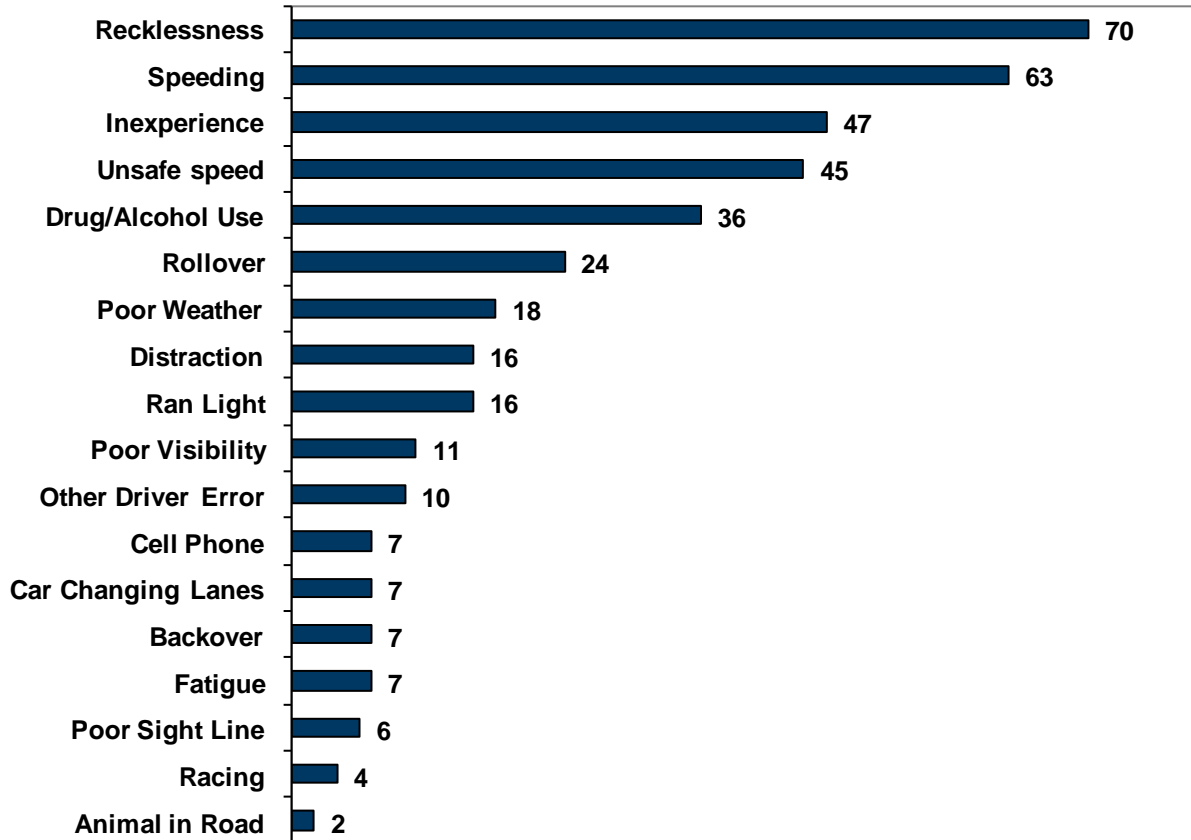
**Figure 14. Motor Vehicle Crash Deaths by Position of Child  
2007 (N=231)**



Note: Position of child percentages are based on the number of records (231) with stated position of child data. Nine out of the 240 motor vehicle accident deaths did not have the position of child listed.



**Figure 15. Motor Vehicle Crash Deaths by Cause Listed  
2007**

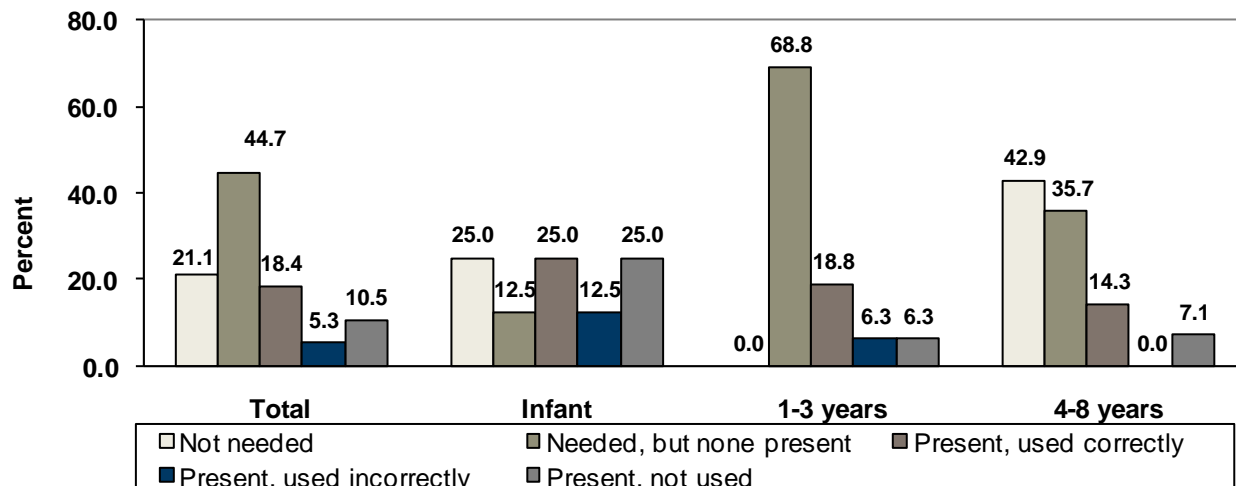


*Note: More than one cause of incident can be listed for motor vehicle accident deaths.*

Further examination of review data in Figure 15 yields more insight into factors that contribute to motor vehicle crashes and potential preventive measures to reduce the risks to children in motor vehicle-related crashes. Recklessness, speeding, inexperience, and drug or alcohol use top the list of causes for the motor vehicle crashes reviewed. These are issues that are best addressed through education of all drivers, with a focus on new drivers. The data also raises questions about what is not known or collected, such as reading or writing text messages while driving and presence of other passengers.



**Figure 16. Motor Vehicle Crash Deaths for Passengers by Car or booster seat usage for children <9 years old, 2007 (N=38)**



*Note: Car or booster seat percentages are based on the number of records (38) with stated car or booster seat data. Nineteen out of the 57 motor vehicle accident deaths to passengers aged less than nine years old did not have the car or booster seat usage listed.*

Data from the reviews related to use of age-appropriate child passenger safety seats (Figure 16) spotlights some of the challenges in prevention.

- Only 25% of infants were restrained in properly installed safety seats.
- A majority of the children ages one to three (68.8 percent) were not secured in a child passenger safety seat.
- A large number of the children ages four to eight (35.7 percent) were not secured in a child passenger safety seat.
- Only 38 of the 57 deaths reviewed had information about usage of a child passenger safety seat. It is not known if this information was not collected at the death scene or if it was not collected by the team.



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## FIREARM DEATHS

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Estimates suggest that there are over 250 million firearms in the United States (Jourdans F. Global study says civilians now hold 650 million small arms; about 270 million in U.S. August 10, 2007. www.ap.org). Given the prevalence of firearms and the likelihood that a child may encounter a firearm at home or when with a relative or neighbor, the safe storage of firearms is important to protect the lives of Texas' children. There were 95 firearm deaths reviewed for 2007.

**Table 11. Firearm Deaths  
by Race/Ethnicity, Age Group, and Gender, 2007**

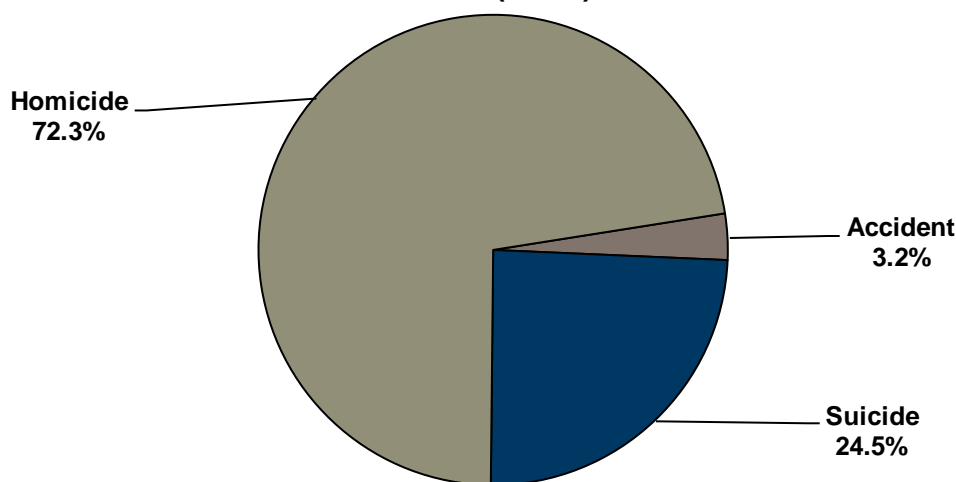
Race/Ethnicity	Number	Percent
Total	95	100.0
White	26	27.4
Black	24	25.3
Hispanic	43	45.3
Other	2	2.1

Age group	Number	Percent
Total	95	100.0
Infant	1	1.1
1-4 Years	3	3.2
5-9 Years	6	6.3
10-14 Years	19	20.0
15-17 Years	66	69.5

Gender	Number	Percent
Total	95	100.0
Male	75	78.9
Female	20	21.1

Source: Texas Data from the National Center for Child Death Review, 2007

**Figure 17. Firearm Deaths by Manner of Death  
2007 (N=95)**



Data from the child fatality reviews of firearm deaths give insight into risk factors.

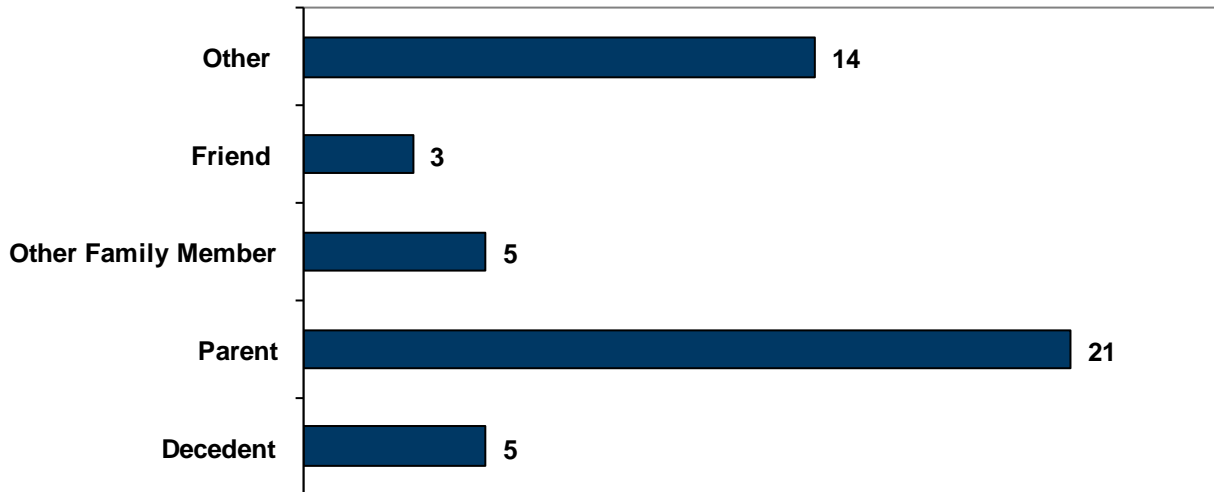
- Children ages 15-17 accounted for 69.5 percent of all the firearm deaths reviewed.
- Males (78.9 percent) represent the majority of the firearm fatalities reviewed.
- Black children, representing 12.6 percent of the child population in 2007, accounted for 25.3 percent of the firearm deaths, reflecting a higher risk for this population. Hispanic children, representing 45.6 percent of the 2007 child population, account for 45.3 percent of the total child deaths by firearms, while



white children, representing 38.1 percent of the population, account for 27.4 percent of total child deaths by firearms in 2007.

- The majority of the firearm deaths were homicides (72.3 percent). Suicides accounted for 24.5 percent, and accidental firearm deaths accounted for 3.2 percent of the reviewed deaths.

**Figure 18. Firearm Deaths by Owner of Firearm  
2007 (N=48)**



*Note: The owner of the firearm was unknown for 47 of the 95 firearm deaths.*

Figure 18 reflects what is known about the owner of the firearm in these deaths, which is related to the child safety issue of access. Information about the owner of the firearm was not available for half of the firearm fatalities reviewed.



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## ASPHYXIA DEATHS

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Asphyxia deaths were the third leading accidental cause of death for 2007.

**Table 12. Asphyxia Deaths  
by Race/Ethnicity, Age Group, and Gender, 2007**

Race/Ethnicity	Number	Percent
Total	95	100.0
White	33	36.7
Black	20	22.2
Hispanic	34	37.8
Other	3	3.3
Not Stated	5	NA

Age group	Number	Percent
Total	95	100.0
Infant	47	49.5
1-4 Years	16	16.8
5-9 Years	5	5.3
10-14 Years	5	5.3
15-17 Years	22	23.2

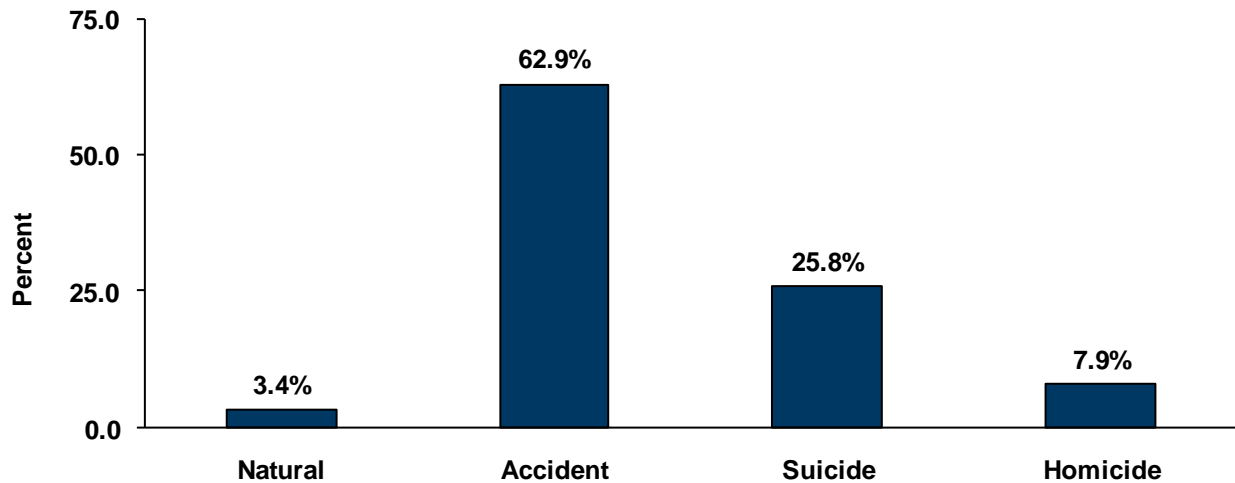
Gender	Number	Percent
Total	95	100.0
Male	59	62.1
Female	36	37.9

Source: Texas Data from the National Center for Child Death Review, 2007

Table 12 reveals critical information about asphyxia deaths reviewed by local teams.

- Ninety-five children died of asphyxia in 2007.
- Of the 95 asphyxia deaths reviewed, 49.5 percent were infants.
- Children ages 15-17 made up the second largest population, accounting for 23.2 percent of the asphyxia deaths.
- Males (62.1 percent) make up the majority of asphyxia deaths.

**Figure 19. Asphyxia Deaths by Manner of Death  
2007 (N=89)**



*Note: Manner of death percentages are based on the number of records (89) with stated manner of death data for asphyxia deaths. Six out of the 95 asphyxia deaths did not have a manner of death listed.*

The majority of asphyxia deaths were accidents (62.9 percent). Suicides accounted for 25.8 percent; natural asphyxia deaths accounted for 3.4 percent; and homicides accounted for 7.9 percent of the reviewed deaths.



**Figure 20. Asphyxia Deaths by Type  
2007 (N=93)**

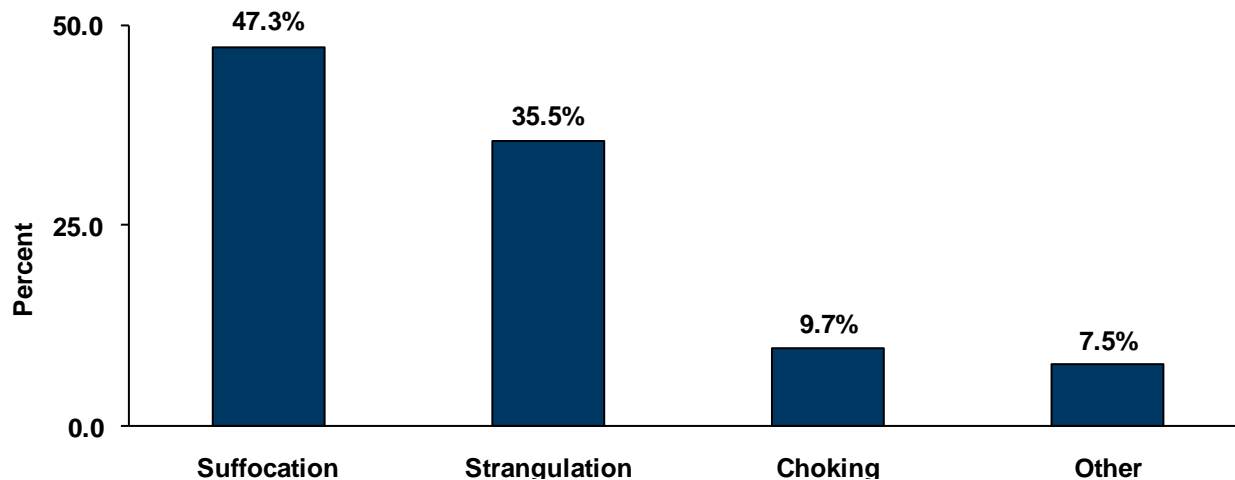
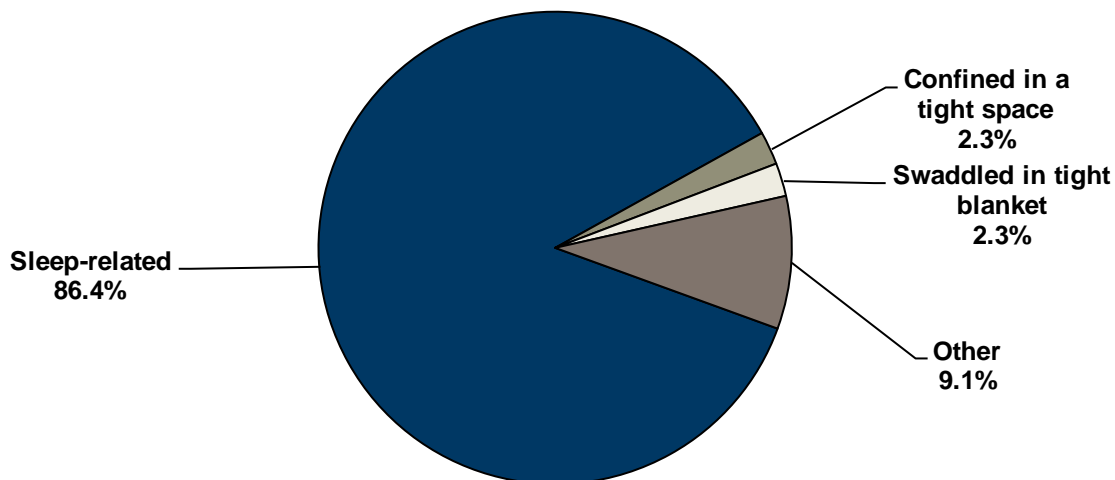
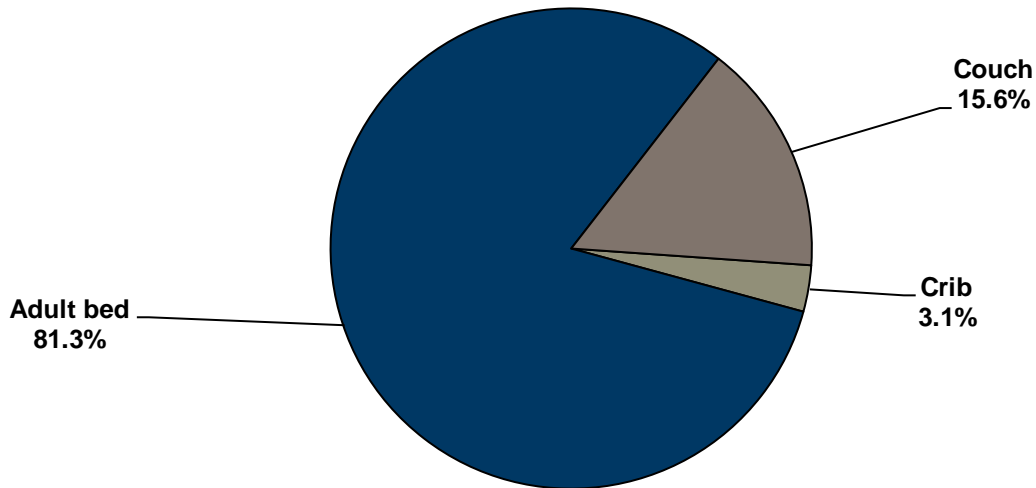


Figure 20 differentiates between the types of asphyxia deaths. Suffocation refers to an object or something in the environment that prevents breathing. Strangulation refers to an object compressing on the child's neck that prevents breathing. Choking refers to an object that blocks the airway and prevents breathing.

**Figure 21. Asphyxia Deaths Due to Suffocation by Action Causing Event  
2007 (N=44)**



**Figure 22. Asphyxia Deaths Due to Suffocation by Sleeping Place  
2007 (N=32)**



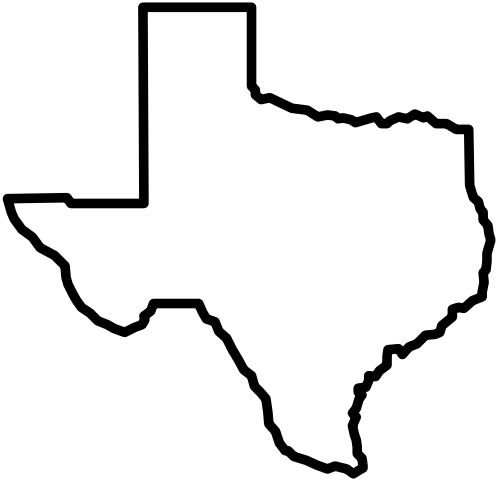
Figures 21 and 22 reveal more details about the infant suffocation deaths reviewed.

- A vast majority (86.4 percent) of asphyxia deaths due to suffocation were defined as sleep-related.
- The majority infant asphyxiation deaths are due to suffocation (81.3 percent) occurring in an adult bed. The couch (15.6 percent) is the second most common site of infant asphyxia death, followed by the crib (3.1 percent).

Prevention of asphyxia deaths of infants requires more focus on the tenets of safe sleep for infants. The SCFRT has issued a Position Statement on Safe Sleep for Infants (see Appendix E) which has been promoted widely in the pediatric community as an expert professional guideline for addressing sleep issues with parents of infants. There is an ongoing need in Texas for educating parents on this topic.



**APPENDIX A**  
**SCFRT COMMITTEE MEMBERS**



## State Child Fatality Review Team Committee Members

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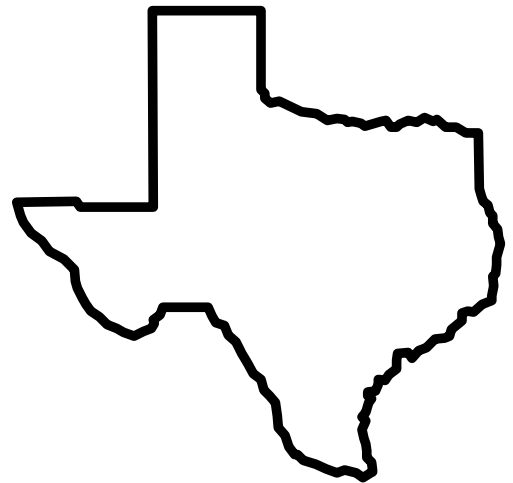
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**APPENDIX B**  
**ACTIVE LOCAL CHILD FATALITY**  
**REVIEW TEAMS, 2009**



## Texas Child Fatality Review Teams

Name	Service Area	Presiding Officer	Coordinator
Anderson County CFRT	Anderson County (Health Service Region 4/5N)	David Giles, EMT-P Asst. Director of EMS Palestine Regional Hospital 2900 South Loop 256 Palestine, TX 75801 (903) 731-5387 david.giles@lpnt.net	Anita Shook Department of State Health Services 100 W. Brazos St. Palestine, TX 75801 (903) 729-1116 anita.shook@dshs.state.tx.us
Bastrop County CFRT	Bastrop County (Health Service Region 7)	Cheryl Koch, Executive Director Children's Advocacy Center of Bastrop 1002 Chestnut St. P.O. Box 1098 Bastrop, TX 78602 (512) 321-6161 cherylcacbastrop@austin.rr.com	Mindy Graber Children's Advocacy Center of Bastrop 1002 Chestnut St. P.O. Box 1098 Bastrop, TX 78602 (512) 321-6161 mindycacbastrop@austin.rr.com
Bexar County CFRT	Bexar County (Health Service Region 8)	Vickie Ernst, Associate Director ChildSafe 7130 West US Hwy. 90 San Antonio, TX 78227-3515 (210) 675-9000 vickiee@childsafe-sa.org	Laurie Charles, R.N., SANE-A, CA/CPSANE SANE Program Coordinator 333 N. Santa Rosa San Antonio, TX 78207 (210) 704-3330 laurie.charles@christushealth.org
Brazos County CFRT	Brazos and Robertson Counties (Health Service Region 7)	Christopher C. Kirk Brazos County Sheriff 1700 Highway 21 West Bryan, TX 77803-1300 (979) 361-4150 chriskirk@highsheriff.com	Same as Presiding Officer
Burleson County CFRT	Burleson County (Health Service Region 7)	Tiffany Graves Burleson County Sheriff's Dept. Caldwell, TX (979)567-4343 tgraves@burlesoncounty.org	Pam Stetz, Social Worker Burleson St. Joseph Health Center 1101 Woodson Caldwell, TX 77836 (979)567-3245 pstetz@mail.st-joseph.org
Cameron/Willacy Counties CFRT	Cameron and Willacy Counties (Health Service Region 11)	Stanley I. Fisch, M.D. Harlingen Pediatrics Associates 321 South 21st Street Harlingen, TX 78550 (956) 425-8761 stan.fisch@gmail.com	Same as Presiding Officer

**Texas Child Fatality Review Teams (continued)**

Name	Service Area	Presiding Officer	Coordinator
Cass/Marion/Morris Counties CFRT	Cass, Marion and Morris Counties (Health Service Region 4/5N)	Judge Barbara McMillon Cass Co. Justice of the Peace Pct 1 P.O. Box 341 Linden, Texas 75563 (903)-756-5341 (903)-720-5277 (cell) judgemcmillon@att.net	Dora Whatley Department of State Health Services P.O. Box 300 Linden, Texas 75563 (903)756-7231 dora.whatley@dshs.state.tx.us
Central Texas CFRT	Bell, Coryell, Hamilton and Milam Counties (Health Service Region 7)	David Hardy, M.D., FAAP Pediatric Medical Consultant, Scott & White Hospital 2401 South 31st St. Temple, TX 76508 (254) 724-1199 dhardy@swmail.sw.org	Hilary Savage 2180 North Main St. Suite H6 Belton, TX 76513 (254) 770-2274 admin@tsa-l.com
Coastal Bend CFRT	Aransas, Bee, Brooks, Duval, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, and San Patricio Counties (Health Service Region 11)	Sonja Eddleman, R.N., CA/CP SANE, SANE-A, DABFN, CMI-III, CFN Driscoll Children's Hospital 3533 S. Alameda Corpus Christi, TX 78411 (361) 694-4240 Sonja.Eddleman@dchstx.org	Same as Presiding Officer
Collin County CFRT	Collin County (Health Service Region 2/3)	William Rohr, Medical Examiner Collin County Medical Examiner 700 B Wilmeth Road McKinney, TX 75069	Susan Schultz, LPC, LMFT Collin County Medical Examiner 700 B Wilmeth Road McKinney, TX 75069 susanschultz@mac.com
Colorado/Austin/Waller Counties CFRT	Colorado, Austin, and Waller Counties (Health Service Region 6)	Jennifer Leal Sealy Police Department 201 Second St. Sealy, TX 77474 (979) 885-3330 Jenniferleal2004@yahoo.com	Same as Presiding Officer
Concho Valley CFRT	Coke, Concho, Crockett, Irion, Kimble, Menard, McCulloch, Regan, Schleicher, Sterling, Sutton & Tom Green Counties (Health Service Region 9/10) Runnels County (Health Service Region 2/3)	Judge Eddie Howard, Justice of the Peace Tom Green County, Precinct 4 124 W. Beauregard San Angelo, TX 76903 (325) 659-6424 eddie.howard@co.tom-green.tx.us	Debra R. Brown, Executive Director Hope House Children's Advocacy Center of Tom Green County P.O. Box 5195 San Angelo, TX 76902 (325) 653-4673 drbrown@cactomgreen.org

**Texas Child Fatality Review Teams (continued)**

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Dallas County CFRT	Dallas County (Health Service Region 2/3)	Carrie Nie Injury Prevention Center of Greater Dallas 5000 Harry Hines P.O. Box 36067 Dallas, TX 75235 (214) 590-4461 cnie@parknet.pmh.org	Amy McSpadden Bailey Injury Prevention Center of Greater Dallas 5000 Harry Hines P.O. Box 36067 Dallas, TX 75235 (214) 590-4461 AMCSP1@parknet.pmh.org
El Paso County CFRT	El Paso, Hudspeth and Culberson Counties (Health Service Region 9/10)	Penny Hamilton Chief, Rape and Child Abuse Unit El Paso District Attorney's Office 500 E. San Antonio Ave., Suite 201 El Paso, TX 79901 (915) 546-2059 phamilton@epcounty.com	Donna Welch El Paso District Attorney's Office 500 E. San Antonio Avenue, Suite 201 El Paso, TX 79901 (915) 546-2059 ext 3701 dwelch@epcounty.com
Ellis County CFRT	Ellis County (Health Service Region 2/3)	Marlena Pendley, Investigator Ellis Co. District Attorney's Office 425 E. Ross Waxahachie, TX 75165 (972) 937-1870 Mar9763@aol.com	Same as Presiding Officer
Erath County CFRT	Erath County (Health Service Region 2/3)	Brett Thetford Director of Critical Care Services Texas Health Harris Methodist Hospital Stephenville 411 N. Belknap Stephenville, TX 76401 (254) 965-1548 BrettThetford@texashealth.org  Co-coordinators/Presiding Officers	Leslie Hughes Stephenville Fire Department 356 N. Belknap Stephenville, Texas 76401 (254) 918-1249 Office (254) 965-0402 Cell lhughes@ci.stephenville.tx.us  Co-coordinators/Presiding Officers
Fannin County CFRT	Fannin County (Health Service Region 2/3)	Richard Glaser, District Attorney Fannin County Courthouse 101 E. Rayburn Drive, Ste. 301 Bonham, Texas 75418 (903) 583-7448  reglaser@fanninco.net	Britney Martin Program Director Fannin County Children's Center 112 W. 5th St. Bonham, TX 75418 (903) 583-4339 Britney@fanninccc.org

**Texas Child Fatality Review Teams (continued)**

Name	Service Area	Presiding Officer	Coordinator
Fort Bend County CFRT	Fort Bend County (Health Service Region 6/5S)	Oshea Spencer Asst. DA, Child Abuse Division Fort Bend County District Attorney 301 Jackson St. Richmond, TX 77469 (281)238-4488 ospencer@co.fort-bend.tx.us	Same as Presiding Officer
Galveston County CFRT	Galveston County (Health Service Region 6/5S)	Louise Pound, Case Manager Advocacy Center for Children of Galveston County 5710 Avenue S1/2 Galveston, TX 77551 (409) 741-6000 lpound@sbcglobal.net	Same as Presiding Officer
Gonzales County CFRT	Gonzales County (Health Service Region 8)	Carol Villareal Infection Control Nurse Gonzales Healthcare Systems P.O. Box 587 1110 Sarah Dewitt Dr. Gonzales, TX 78629 (806) 672-7581 ext. 453 Bengita51@yahoo.com	Same as Presiding Officer
Grayson County CFRT	Grayson County (Health Service Region 2/3)	Martha Nuckols, Executive Director Children's Advocacy Center of Grayson County 910 Cottonwood Sherman, TX 75090 (903)957-0440 mnuckols@cacgc.org	Same as Presiding Officer
Guadalupe County CFRT	Guadalupe County (Health Service Region 8)	Paul Marsh Guadalupe County Children's Advocacy Center 424 N. River Seguin, TX 78155 (830) 303-4760 pmarsh@gccac.net	Same as Presiding Officer

**Texas Child Fatality Review Teams (continued)**

Name	Service Area	Presiding Officer	Coordinator
Hays County CFRT	Hays County (Health Service Region 7)	Melissa Rodriguez Roxanne's House Hays-Caldwell Women's Center P.O. Box 234 San Marcos, TX 78667 (512) 396-7276 mrodriguez@hcwc.org	Same as Presiding Officer
Heart of Texas CFRT	Bosque, Falls, Hill, Limestone, and McLennan Counties (Health Service Region 7)	Lori Boyett Hillcrest Hospital 100 Hillcrest Medical Blvd. Waco, TX 76712 (254) 202-2000 lboyett@hillcrest.net	Stephanie Alvey Heart of Texas Regional Advisory Council P.O. Box 8600 Waco, TX 76714 (254) 761-7890 salvey@heartoftexasrac.org
Henderson County CFRT	Henderson County (Health Service Region 4/5N)	Sheila Durden The Help Center 309 Royal St. Athens, TX 75751 (903) 675-4357 sdurden@thehelpcenter.org	Angela Rodriguez Department of State Health Services 708 E. Corsicana St. Athens, TX 75751 (903) 675-7742 (903) 675-3622 Fax angela.rodriguez@dshs.state.tx.us
Hidalgo/Starr Counties CFRT	Hidalgo and Starr Counties (Health Service Region 11)	M. Teresa Camacho, M.D., FAAP, MCCM, Medical Director of PICU Edinburg Regional Medical Center Children's Hospital 1102 W. Trenton Rd. Edinburg, TX 78539 (956) 421-2414 mateguia@aol.com	Martine Acosta, R.N. Trauma Coordinator Edinburg Regional Medical Center Children's Hospital 1102 W. Trenton Rd. Edinburg, TX 78539 (956)388-6519 martine.acosta@uhsrgv.com
Hill Country CFRT	Blanco, Burnet, Lampasas, Llano, Mills and San Saba Counties (Health Service Region 7)  Mason County (Health Service Region 9)	Deborah Keith, Executive Director Hill Country Children's Advocacy Center P.O. Box 27 Burnet, TX 78611 (512) 756-2607 hccac@tstar.net	Same as Presiding Officer

**Texas Child Fatality Review Teams (continued)**

Name	Service Area	Presiding Officer	Coordinator
Hood County CFRT	Hood County (Health Service Region 2/3)	Chief Mitch Galvan Granbury Police Department 116 W. Bridge St. Granbury, TX 76408 (817) 573-2648 galvan@granbury.org	Stephanie Williams Child Protective Services 1430 Southtown Dr Granbury, TX 76048 (817) 573-8612 stephanie.williams@dfps.state.tx.us
Hopkins/Franklin/ Delta Counties CFRT	Hopkins, Franklin and Delta Counties (Health Service Region 4/5N)	Becke Anderson Sulphur Springs Independent School District, Special Services 219 Ponder Sulphur Springs, TX 75482 (903) 885-6230 banderson@ssisd.net	Radona Adams Lakes Regional Mental Health Center 655 Airport Rd. Sulphur Springs, TX 75482 (903) 885-8611 x384 radonaa@lrmhmrc.org
Houston/Harris County CFRT	Harris County (Health Service Region 6/5S)	Stephani Adams Injury Surveillance Epidemiologist Harris Co. Public Health & Environmental Services 2223 West Loop South Houston, TX 77027 (713) 439-6137 sadams@hcphe.org	Jaennie Yoon Houston/Harris Co. CFRT Coordinator Harris Co. Public Health & Environmental Services 2223 West Loop South Houston, TX 77027 (713) 439-6003 jyoon@hcphe.org
Houston/Trinity Counties CFRT	Houston and Trinity Counties (Health Service Region 4/5N)	Krystal Patterson, R.N., B.S.N. Department of State Health Services 1034 South 4th Street Crockett, TX 75835 (936) 544-3559 krystal.patterson@dshs.state.tx.us	Linnea Robison 1034 S 4th St Crockett, TX 75835 (936) 545-0550 linnearobison@wildblue.net
Hunt Co. CFRT	Hunt County (Health Service Region 2/3)	Bret Freeman, R.N., CEN Trauma Coordinator Presbyterian Hospital of Greenville 4215 Joe Ramsey Blvd. Greenville, TX 75401 (903) 408-1412 bfreeman@hmhd.org	Tami Wooldridge Trauma Department Presbyterian Hospital of Greenville P.O. Drawer 1059 Greenville, TX 75403-1059 (903) 408-1627 twooldridge@hmhd.org

**Texas Child Fatality Review Teams (continued)**

Name	Service Area	Presiding Officer	Coordinator
Jefferson County CFRT	Jefferson County (Health Service Region 6/5S)	Marion Tanner The Garth House/Mickey Mehaffy Children's Advocacy Program 1895 McFaddin Beaumont, TX 77701 (409) 838-9084 mtanner@garthhouse.org	Janet Cooke Morris The Garth House/Mickey Mehaffy Children's Advocacy Program 1895 McFaddin Beaumont, TX 77701 (409) 838-9084 jmorris@garthhouse.org
Johnson County CFRT	Johnson County (Health Service Region 2/3)	Cathy Marchel Cleburne Chamber of Commerce 1511 W. Henderson P.O. Box 701 Cleburne, TX 76033 (817) 645-2455 cmarchel@cleburnechamber.com	Tammy King, Executive Director Johnson County Children's Advocacy Center 910 Granbury St. Cleburne, TX 76033 (817) 558-1599 (office) (817) 517-1689 (cell) cac@hyperusa.com
Kaufman County CFRT	Kaufman County (Health Service Region 2/3)	Laura Peace Kaufman County Juvenile Probation P.O. Box 1137 300 West Mulberry Kaufman, TX 75142 (972) 932-0320 ext. 3111 laurapeace@kaufmancounty.net	Sharna Ellis Kaufman Police Department 105 East Chestnut Kaufman, TX 75142 (972) 932-3094 ext. 109 sellis@kaufmantx.org
Madison/Leon Counties CFRT	Madison and Leon Counties (Health Service Region 7)	Dee Craft Leon County Sheriff's Office P.O. 278 Centerville, TX 75833 (903) 536-2749 dcraftleoncoso@gmail.com	Same as Presiding Officer
Nacogdoches County CFRT	Nacogdoches County (Health Service Region 4/5N)	Lisa King, Child Welfare Board 818 Park St. Nacogdoches, TX 75961 (936) 560-2338 Lking19@hotmail.com	Same as Presiding Officer
Orange County CFRT	Orange County (Health Service Region 6/5S)	Kim Hanks Garth House/Mickey Mehaffy Children's Advocacy Program 1895 McFaddin Beaumont, TX 77701 (409) 838-9084 khanks@garthhouse.org	Same as Presiding Officer

**Texas Child Fatality Review Teams (continued)**

Name	Service Area	Presiding Officer	Coordinator
Panhandle CFRT	Armstrong, Briscoe, Carson, Castro, Childress, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, and Wheeler Counties (Health Service Region 1)	Gil Farren Victim/Witness Coordinator Randall County Sheriff's Office 9100 S. Georgia Amarillo, TX 79118 (806) 468-5790 (sheriff's office) (806) 468-5570 (DA's office) gfarren@rc-sheriff.com	Don Nicholson Department of State Health Services WTAMU Box 60968 300 Victory Dr. Canyon, TX 79016 (806) 477-1106 (office) (806) 676-1512 don.nicholson@dshs.state.tx.us
Polk County CFRT	Polk County (Health Service Region 4/5N)	Jean LeBlanc Director, 258th & 411th Judicial District Polk County Juvenile Probation P.O. Box 1637 Livingston, TX 77351 (936) 327-6850 juvprob@livingston.net	Same as Presiding Officer
Smith County CFRT	Smith County (Health Service Region 4/5N)	Lea Rowe Children's Advocacy Center of Smith County 2210 Frankston Highway Tyler, TX 75701 (903) 533-1880 lea@cacsmythcounty.org	Same as Presiding Officer
South Plains CFRT	Bailey, Cochran, Crosby, Dawson, Dickens, Floyd, Garza, Hale, Hockley, King, Lamb, Lubbock, Lynn, Motley, Terry, and Yoakum Counties (Health Service Region 1) Borden and Gaines Counties (Health Service Region 9/10) Cottle, Kent, Scurry, and Stonewall Counties (Health Service Region 2/3)	Patti Salazar, R.N., SANE C.A.R.E. Center Texas Tech University Health Science Center Department of Pediatrics 6630 Quaker Avenue, Suite 202 Lubbock, TX 79413 (806) 743-7770 patricia.salazar@ttuhsc.edu	Same as Presiding Officer
Tarrant County CFRT	Tarrant, Denton and Parker Counties (Health Service Region 2/3)	Michael V. Floyd Senior Forensic Investigator Tarrant Co. Medical Examiner 200 Feliks Gwozdz Place Fort Worth, TX 76104-4919 (817) 920-5700 ext 120 mfloyd@tarrantcounty.com	Same as Presiding Officer

**Texas Child Fatality Review Teams (continued)**

Name	Service Area	Presiding Officer	Coordinator
Texas "J" CFRT	Andrews, Brewster, Crane, Ector, Glasscock, Howard, Jeff Davis, Loving, Martin, Midland, Pecos, Presidio, Reeves, Terrell, Upton, Ward and Winkler Counties (Health Service Region 9)	Judge Susan Redford Ector County Judge 300 N. Grant, Rm. 277 Odessa, TX 79741 (432) 498-4100 redfosm@co.ector.tx.us	Phyllis Craig-Blanco Trauma Services Medical Center Hospital 500 W. 4th St. Odessa, TX 79761 (432) 640-1190 pblanco@echd.org
Titus/Camp Counties CFRT	Titus and Camp Counties (Health Service Region 4/5N)	Peggy Helbert, Co-Presiding Officer Titus Regional Medical Center 2001 N. Jefferson Ave. Mt. Pleasant, TX 75455 (903) 577-6193 peggy.helbert@titusregional.com  Dr. Gerald Stagg, Co-Presiding Officer Pediatric Clinic 2001 N. Jefferson Ave., Suite 300 Mt. Pleasant, TX 75455 (903) 572-9823	Linda Thomas Department of State Health Services 1014 N. Jefferson Ave. Mt. Pleasant, TX 75455 (903)572-9877 linda.thomas@dshs.state.tx.us
Travis County CFRT	Travis County (Health Service Region 7)	Dayna Blazey, Assistant District Attorney Office of the District Attorney P.O. Box 1748 Austin, TX 78767 (512) 974-6830 dayna.blazey@ci.austin.tx.us	Sandra Martin, ED Center for Child Protection 8509 FM 969, Bldg 2 Austin, TX 78724 (512) 472-1164 smartin@centerforchildprotection.org
Tri-County CFRT	Harrison, Panola and Rusk Counties (Health Service Region 4/5N)	Sheriff Jack Ellett Panola Co. Sheriff's Department 314 W. Wellington St. Carthage, TX 75633 (903) 693-0333 jack.ellett@co.panola.tx.us	Sgt. Sarah Fields Panola County Sheriff's Department 314 W. Wellington St. Carthage, TX 75633 (903) 693-0333 sgtfields@hotmail.com
Victoria County CFRT	Victoria County (Health Service Region 8)	Adelaida Resendez, M.D. Pediatrician 110 Medical Dr. #103 Victoria, TX 77904-3101 (361) 572-0033	Gilda Miller, R.N.C. Citizens Medical Center 2701 Hospital Drive Victoria, TX 77901-5749 (361) 574-1777 gmiller@cmcvtx.org

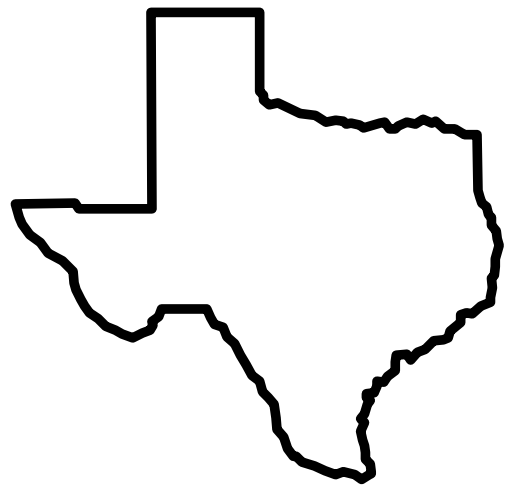
**Texas Child Fatality Review Teams (continued)**

Name	Service Area	Presiding Officer	Coordinator
Walker County CFRT	Walker County (Health Service Region 6/5N)	<p>Co-Presiding Officers: Raymond Teske, Jr., Ph.D. 304 Elkins Lake Huntsville, TX 77340 (936) 295-6274 rteske@suddenlink.net</p> <p>Nanette Anthony Victim's Services Coordinator Walker Co. District Attorney's Office 1036 11th St. Huntsville, TX 77340 (936) 435-4621 nanthony@co.walker.tx.us</p>	<p>Nanette Anthony Victim's Services Coordinator Walker Co. District Attorney's Office 1036 11th St. Huntsville, TX 77340 (936) 435-4621 nanthony@co.walker.tx.us</p>
Washington/Grimes Counties CFRT	Washington and Grimes Counties (Health Service Region 7)	<p>Marsha Doeblner Trinity Wellness Center 2111 South Day St. Brenham, TX (979) 830-5017 mdoeblner@trinitymed.org</p>	Same as Presiding Officer
Webb County CFRT	Webb and Zapata Counties (Health Service Region 11)	<p>Lupita Martinez Forensic Interviewer Children's Advocacy Center of Webb County 111 N. Merida Laredo, TX 78403-4128 (956) 712-1840 fi@caclaredo.org</p>	Same as Presiding Officer
Western Hill Country CFRT	Bandera, Gillespie, Kendall and Kerr Counties (Health Service Region 8)	<p>Judy Sullivan Kids' Advocacy Place P.O. Box 291722 Kerrville, TX 78029 (830) 895-4527 kap@ktc.com</p>	<p>Linda Lively Fredericksburg Police Dept. 1601 E. Main St. Fredericksburg, TX 78624 (830) 990-6264 llively@fbqtx.org</p>
Wharton County CFRT	Wharton County (Health Service Region 6/5N)	<p>Sharon Hill Department of State Health Services 5425 Polk St., Ste J, MC 1906 Houston, TX 77023-1497 (713) 767-3105 sharon.hill@dshs.state.tx.us</p>	Same as Presiding Officer

**Texas Child Fatality Review Teams (continued)**

Name	Service Area	Presiding Officer	Coordinator
Wichita County CFRT	Wichita County (Health Service Region 2/3)	Jacky Betts, R.N.-B.S.N.,LP Director of Trauma Hospital Preparedness & Safety United Regional Health Care System 1600 Eleventh Street Wichita Falls, Texas 76301 940/764-3631 phone jbetts@urhcs.org	Teressa Stephenson, R.N., B.S.N. Preventive Health Supervisor Wichita Falls-Wichita County Public Health District 1700 Third St. Wichita Falls, TX 76301-2113 (940) 761-7874 teressa.stephenson@cwftx.net  Linda Rodriguez-Ross, R.N., B.S.N. Wichita Falls-Wichita County Public Health District 1700 Third St. Wichita Falls, TX 76301-2113 (940) 761-7874 linda.rodriguez-ross@cwftx.net
Williamson County CFRT	Williamson County (Health Service Region 7)	Judge Judy Schier Hobbs Justice of the Peace, Pct. 4 211 W. 6th St. Taylor, TX 76574-3539 (512) 365-8922 jhobbs@wilco.org	Kim Reid Office of the Justice of the Peace, Pct. 4 211 W. 6th St. Taylor, TX (512) 238-2148 kreid@wilco.org
Wise County CFRT	Wise County (Health Service Region 3)	Amanda Lovette, M.D. Lovette Pediatrics 2014 Ben Merritt Dr., Suite B Decatur, TX 76234 (940) 627-8044 alovette@lovettepediatrics.com  Rex Hoskins Chief, Decatur Police Department 1601 South State Street Decatur, Texas 76234 (940) 627-1500 rhoskins@decaturpd.net	Co-coordinators: Paige DoByns, Alan Wilson, & Jerry DeMoss dobymsp@sheriff.co.wise.tx.us wilsona@sheriff.co.wise.tx.us demossj@sheriff.co.wise.tx.us Investigators, Crime Against Person Unit Wise County Sheriff's Office 200 Rook Ramsey Dr. Decatur, TX 76234 (940) 627-5971

**APPENDIX C:  
TEXAS FAMILY CODE**



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

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§ 264.501. DEFINITIONS. In this subchapter:

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

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

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

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

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

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

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

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

(A) intentional or unintentional injuries;

(B) medical neglect;

(C) lack of access to medical care;

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

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

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

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

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

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

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

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

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

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

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

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

(4) individuals selected under Subsection (b).

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

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

(2) a sheriff;

(3) a justice of the peace;

(4) a medical examiner;

(5) a police chief;

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

(7) a child educator;

(8) a child mental health provider;

(9) a public health professional;

(10) a child protective services specialist;

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

(12) a neonatologist;

(13) a child advocate;

(14) a chief juvenile probation officer;

(15) a child abuse prevention specialist;

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

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

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

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

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

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

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

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

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

Amended by:

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

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

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

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

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

(c) The department shall work cooperatively with:

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

(d) The Department of State Health Services shall:

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

for:

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

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

(C) the operation of the review teams;

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

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

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

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

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

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

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

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

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

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

Amended by:

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

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

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

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

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

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

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

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

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

Amended by:

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

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

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

(c) A review team may include:

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

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

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

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

Amended by:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) information and records maintained by any state or

local government agency, including:

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

records; and

(F) child protective services information and records.

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

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

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

Amended by:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (1) the disease was not acquired as a result of trauma or poisoning;
- (2) the infectious organism is identified using standard medical procedures; and
- (3) the death is not reportable to the Texas Department of Health under Chapter 81, Health and Safety Code.

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

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

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

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

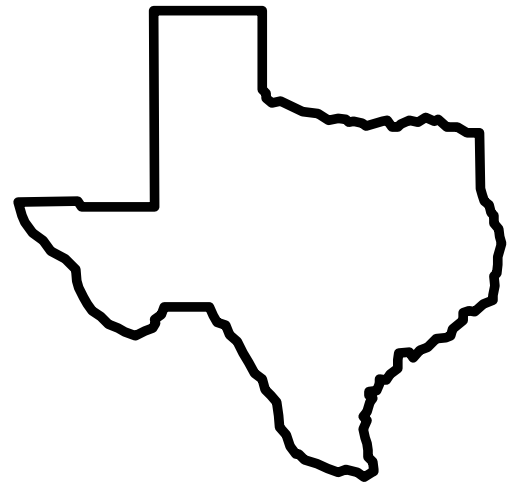
- (1) an autopsy, unless an autopsy was conducted as part of the inquest;
- (2) an inquiry into the circumstances of the death, including an investigation of the scene of the death and interviews with the parents of the child, any guardian or caretaker of the child, and the person who reported the child's death; and
- (3) a review of relevant information regarding the child from an agency, professional, or health care provider.

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

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

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

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



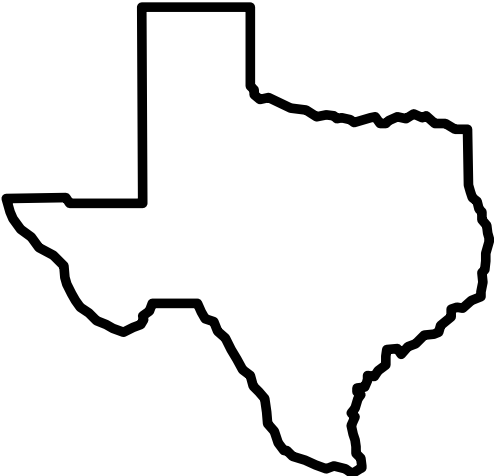
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## HOW TO START A CHILD FATALITY REVIEW TEAM IN YOUR COMMUNITY

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1. Anyone with a potential role as a member of a Child Fatality Review Team (CFRT) as defined by the legislation (see Appendix C) may convene a community meeting to discuss the child death review process, CFRT responsibilities and how the community can benefit from reviewing child deaths. The Texas Family Code states that a CFRT may include the following members (or their designees):
  - a. criminal prosecutor involved in the prosecution of crimes against children;
  - b. sheriff;
  - c. justice of the peace or medical examiner;
  - d. police chief;
  - e. pediatrician experienced in diagnosing and treating child abuse and neglect;
  - f. child educator;
  - g. child mental health provider;
  - h. public health professional;
  - i. child protective services specialist;
  - j. Sudden Infant Death Syndrome (SIDS) family services provider;
  - k. neonatologist;
  - l. child advocate;
  - m. chief juvenile probation officer; and
  - n. child abuse prevention specialist.
2. If you want to convene an information meeting about CFRT in your community, contact the Texas CFR Committee Coordinator, Susan Rodriguez ([susan.rodriquez@dshs.state.tx.us](mailto:susan.rodriquez@dshs.state.tx.us)) to schedule a presentation to describe the process and benefit to a community, to answer questions and to facilitate discussion about team formation and the steps for forming a multidisciplinary team in your community. The Coordinator provides materials to share with participants at the information meeting.
3. Invite representatives of all of the CFRT member disciplines to the convened information meeting.
4. Host the convened information meeting with the Texas CFR Coordinator. After receiving information and discussing how a team would benefit the safety of community children, the attendees and their respective agencies must commit to forming a team. The commitment to formation of a CFRT is formalized by:
  - a. a member agency volunteers to serve as Coordinator (who receives the death records from Texas Vital Statistics, schedules meetings, informs team members of the deaths they will be reviewing, and initiates requests for records);
  - b. a member volunteers to collect and submit the data on the online national child death review database (on many teams this is the Coordinator, but it can be another team member);
  - c. election of a Presiding Officer (who facilitates the CFRT meetings and serves as the voice of that team in the community);
  - d. all members and their respective agencies sign an Interagency Agreement to share information about the child deaths in the team meetings; and
  - e. all members and their respective agencies agree to honor confidentiality and sign a Confidentiality Statement.
5. Once steps 4a – 4e are completed, the Texas CFR Coordinator is notified and the team is formally recognized. Texas Vital Statistics begins supplying death certificates to the team for review.
6. The new team begins reviewing child deaths using the Case Report Tool. Teams must meet at least once a year. Depending upon the number of child deaths, teams typically meet quarterly, every other month or monthly.
7. The team Coordinator and/or other team member are set up to have access to the National Child Death Review Database so the data collected in the reviews can be entered in the secure online system.

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





## TEXAS STATE CHILD FATALITY REVIEW TEAM COMMITTEE POSITION STATEMENT: SAFE SLEEP FOR INFANTS

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

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

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

### **Recommended Healthy Practices for Parents**

It is recommended that:

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

### **Recommended Sleep Position**

It is recommended that:

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

### **Recommended Sleep Environment**

It is recommended that:

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

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

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

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

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

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

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

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Sources:

American Academy of Pediatrics:

A Child Care Provider's Guide to Safe Sleep, [www.healthychildcare.org/pdf/SIDSchildcaresafesleep.pdf](http://www.healthychildcare.org/pdf/SIDSchildcaresafesleep.pdf);

A Parent's Guide to Safe Sleep, [www.healthychildcare.org/pdf/SIDSparentsafesleep.pdf](http://www.healthychildcare.org/pdf/SIDSparentsafesleep.pdf)

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

First Candle: Important Safe Sleep Tips,

[www.firstcandle.org/new\\_exp\\_parents/new\\_exp\\_safesleeptips.html](http://www.firstcandle.org/new_exp_parents/new_exp_safesleeptips.html)

Indiana Perinatal Network & Baby First: [www.nd.edu/~jmckenna1/lab/pamphlets/safesleepv2.pdf](http://www.nd.edu/~jmckenna1/lab/pamphlets/safesleepv2.pdf).

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

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

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

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

June 2008, reviewed and renewed August 2009



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

November 2008, reviewed and revised October 2009

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

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

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

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

Observational data shows that children can drown in unusual conditions.

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

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

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

#### **ENVIRONMENT**

**Statement:** Drowning occurs in a variety of environments.

- **POOLS, HOT TUBS AND SPAS**

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

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

### **Recommendations:**

#### **Enticements:**

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

#### **Barriers:**

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

#### **Entrapment Protection:**

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

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

### **Recommendations:**

#### **Boating and Personal Watercrafts (PWC):**

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

### **Carbon Monoxide Poisoning:**

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

#### **Recommendations:**

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

- **HOMES:**

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

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

#### **Recommendations:**

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

### **SUPERVISION**

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

**Recommendations:**

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

**EDUCATION**

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

**Recommendations**

- **Swimming Instruction**

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

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

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

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

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

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

**Recommendations:**

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

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

### **General Resources**

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

### **The Home (pools and spas)**

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

### **Open Water (Playing or Swimming)**

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

### **Boating**

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