PROTECT OUR KIDS COMMISSION

MEETING SUMMARY

January 16, 2015
10:00 am – 2:00 pm

Texas Hospital Association
1108 Lavaca Street, Suite 700
Austin, Texas 78701

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

Background

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

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

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

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

Welcome from the POK Chairperson, Judge Robin Sage

Speaker Presentations

Lisa Black, Assistant Commissioner of Child Protective Services, DFPS
Jane Burstain, Ph.D., Director of Systems Improvement, DFPS
Sasha Rasco, Director of Prevention and Early Intervention, DFPS
Kathryn Sibley, Legislative & Policy Analyst, DFPS

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

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

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

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

What do we mean when we say "data"?

1. Administrative data – collected from IMPACT; usually consists of data such as race, ethnicity, case action and disposition, region and county

2. Case read data – collected through reading individual cases. It is an important supplement to administrative data but is time-intensive to gather

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

There are two determinations in any fatality investigation:

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

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

<u>Dispositions</u>:
RTB = preponderance of evidence that abuse and neglect occurred
Ruled out = reasonable evidence that abuse and neglect did not occur
Unable to Complete = DFPS was unable to locate a principal
Unable to Determine = based on the information, DFPS was unable to determine whether it was RTB or Ruled Out

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

Q: Is every child death supposed to be reported to CPS?
A: Yes, but this does not always happen. It is typical for CPS to learn of at least one case for the first time at local CFRT meetings.
Some counties are using the Child Advocacy Centers to bridge the gap between the many disciplines involved.

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

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

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

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

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

Increases/Decreases
2009 deaths were higher
2013 deaths were lower

Q: Are these flukes? Are there explanations for the trends?
A: Nationally there has also been a drop in deaths and in the number of reports made since 2013.
DFPS did not find any systemic causes for the drop. DFPS will be looking deeper into the causes with the Office of Child Safety. An Annual Child Fatality Report will be produced.

Q: Are there comparisons between CFRT deaths and the DFPS disposition?
A: CFRT teams are often two years behind, so DFPS are often already dispositioned.

Currently underway is a DSHS/DFPS project to link data and look at cases real time.
Cases are re-disposed if for example, a near fatal child dies, then the disposition is adjusted.
Q: Where are those adjustments visible?
A: Data book is a frozen data set, but DFPS could share those updated numbers in another format.

Q: Was there a policy change or change in definitions in 2013 to explain the decrease in deaths?
A: No policy change or change in definition in 2013 to explain the change. No regional explanation either.

Q: Are these changes statistically significant? For example, if there are 7 million children in Texas, would an increase from213 to 280 be considered random by a statistician?
A: There are tools such as the Standardized Mortality Ratio to see if differences matter statistically.

Q: Is it possible that statewide numbers are not very helpful because of the great diversity among Texas counties? Should we be looking at regional data? Are there hotspots?
A: DFPS intends to look at the data at a regional basis.
When looking at the data, DFPS is looking for trends, but it is difficult to see trends when looking at such small numbers, especially when they have to be parsed out into even smaller categories because for example, deaths between teenagers and infants are so different.

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

Q: Wouldn't it be more meaningful to compare the number of abuse and neglect fatalities to the number of reports filed?
A: Yes, and DFPS is doing that.

Q: Has DFPS seen changes within the categories of dispositions? For example, the category of Reason to Believe seems like it would be more consistent then Unable to Determine. UTD might or might not be abuse, but it seems the RTB numbers would be more consistent.
A: No, DFPS has not seen a huge change within the categories.

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

Starting Sept 1, 2015 DFPS will be tracking near fatalities in the administrative data.
Q: What about serious injuries?
A: No, not at this time because medical expertise is not necessarily included in those cases, so it is more ambiguous and more difficult to track.

Other Trends:

Infants

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

Intentional Abuse

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

Co-sleeping and Unsafe Sleep

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

Prior CPS History

- Defined broadly – any CPS history (even if not confirmed) on deceased child or fatality perpetrators
- Of 28 physical abuse fatalities, 10 had some type of prior CPS history

- Of 13 co-sleeping/ unsafe sleep deaths involving parents, 7 had some type of prior CPS history
- Details of prior history are varied with no noticeable trend or pattern

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

DFPS Is Using Predictive Analytics to Improve Child Safety

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

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

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

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

Amy Bailey, State Child Fatality Review Team Coordinator, DSHS
Child Fatality Review is a multi-disciplinary, multi-agency group that meets under Chapter 264 of the Texas Family Code

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

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

The SCFRT meets quarterly:

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

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

- volunteer-based
- organized by county or multi-county geographic areas

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

Local Child Fatality Review Team Process and Data Collection

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

Data Collection Improvement Actions

Assessment of Local Team Capacity

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

DSHS Considerations for Increased Support of Local Teams

DSHS contract for:

- Data entry - local teams could enter information onto form and then send form to state and will not be required to enter into the national database, will help quality and timeliness
- Technical Assistance – answer calls from local teams
- CFRT Statewide Conference – it is a goal to do a 2016 conference, first of its kind
    - Data collection training
    - Injury prevention

- Funding for expanded data collection to teams
    - Sleep related deaths
    - Sudden unexplained death in the youth
- Explore possibility of local teams obtaining the preliminary death certificate from their County Registrar
    - Costs associated with providing the data
    - Barriers to the ability of the data to be shared

National Center for the Review and Prevention of Child Deaths

Data collection challenges:

- Caseload
- Volume of data per case

20 page CDR reporting form

- Variable participation among CFRTs
- Variable terminology (death certificates)

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

Q: Data form is huge, up to 300 questions per case. Is some of the data incomplete?
A: Yes. Perhaps we could develop a statewide protocol for a screening process.

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

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

Prevention Plans also from the DSHS/DFPS Collaboration:

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

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

Q: What about hiring a full time employee (FTE) for each region?
A: In the higher populated areas there is enough work for an FTE. In less populated areas, an FTE might need to cover multiple counties or teams.

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

Madeline McClure, Executive Director of TexProtects

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

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

Recommendations:

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

Track Fatalities with prior reports of abuse by:

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

Evidence-Based Home Visitation and Universal Prevention

Population-Level Examples:

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

Targeted Evidence-Based Home Visitation Examples:

Nurse-Family Partnership (NFP)

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

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

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

Dr. Nancy Kellogg

1. In regards to the first charge of this Commission, it is important to note that "the practices and evidence-based strategies to address and reduce fatalities" from abuse will likely differ significantly from "the

practices and evidence-based strategies to address and reduce fatalities from neglect. Deaths due to neglect are more common than those due to abuse. The strategies to prevent a 7 month old from drowning in a bathtub because they are left unattended is likely different than the strategies involved in preventing a 7 month old from being deliberately drowned because they were crying too much.

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

        Kathryn Sibley commented that DFPS is currently looking at FY 2013 and in process of getting the 2014 data, using same questions as CFRTs, prior history, prior review (CPS, CAC, multidisciplinary) DFPS is looking at things like whether interventions did not have an impact or if there wasn't any follow up, etc.)

        How do we engage other professionals and are there accountability measures in place?

CPS interviews a lot of people which is rich information that needs to be linked to CFRT reviews. We should also consider reallocation of resources, to spend more up front for example drug testing rather than after a child has died.

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

2. Deaths without CPS history: was the child in daycare or did they seek medical care? Were injuries or indicators of abuse/neglect noted in these settings? Are there opportunities to improve recognition in medical and daycare settings which are the predominant domains outside the home for children under 4 years of age. Emergency rooms, in particular, should be targeted as many families do not present for routine medical care in a PCPs office.

3. Are there risk factors/predictors of child maltreatment deaths that could be identified and treated to prevent deaths?

4. Would including data on serious injuries and/or near fatalities provide additional data and information regarding risk factors? (Would have to clearly define "serious" and "near fatality" first) Preliminary studies from Pennsylvania indicate that serious abuse and near fatality cases share a lot of similarities with child maltreatment deaths.

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

3. In regards to charge 2 for the Commission, recommendations to reduce child maltreatment deaths depend in part on what the data tells us:

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

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

b. Earlier recognition of abuse or neglect by health care professionals or daycare providers. If the data indicates that children dying of child maltreatment were seen in medical or daycare settings prior to death, then statewide strategies should support on-going education in the recognition and management of suspected abuse and neglect.

c. Impact of multidisciplinary case staffings/review on child maltreatment rates. There are numerous models statewide of how cases are selected, staffed and managed. There are CPS case managers in each region who may be resources for gathering data on how such case reviews impact child maltreatment fatalities

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

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

Future Meetings will be:

March 27, 2015
May 11, 2015

Meeting adjourned.