Protect Our Kids Commission
Meeting

Friday, October 24, 2014
10:00 am – 2:00 pm

Legislative Conference Center
Texas Capitol Extension
E2.002
Austin, TX 78701

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10:00 am – 2:00 pm

Legislative Conference Center
Texas Capitol Extension, E2.002

MEETING AGENDA

10:00 a.m. Opening Remarks / Introductions – Judge Robin Sage, Chair

10:45 a.m. Discussion of Senate Bill 66 and Charge to POK Commission

11:00 a.m. Presentation from Department of Family and Protective Services, Sasha Rasco, Director of Prevention and Early Intervention

11:30 a.m. Presentation from Department of State Health Services, Tammy Sajak, MPH, Director Title V and Family Health

12:00 p.m. Lunch

12:15 p.m. Presentation from State Child Fatality Review Team, Reade Quinton, M.D., Deputy Chief Medical Examiner, Office of Dallas County Medical Examiner

12:45 p.m. Texas Children's Justice Act, Heidi Penix, CJA Grant Administrator

1:15 p.m. Group Discussion / Public Comment

1:45 p.m. Assignments / Next Steps

Tab 1

Protect Our Kids Commission

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Tab 2

S.B. No. 66

AN ACT

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

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

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

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

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

(2) a sheriff;

(3) a justice of the peace;

(4) a medical examiner;

(5) a police chief;

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

(7) a child educator;

(8) a child mental health provider;

(9) a public health professional;

(10) a child protective services specialist;

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

(12) a neonatologist;

(13) a child advocate;

(14) a chief juvenile probation officer;

(15) a child abuse prevention specialist;

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

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

(18) an emergency medical services provider; and

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

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

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

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

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

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

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

neglect fatalities.

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

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

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

(f) The commission shall:

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

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

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

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

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

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

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

(3) any administrative recommendations proposed by the commission.

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

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

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

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

President of the Senate

Speaker of the House

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

Secretary of the Senate

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

Chief Clerk of the House

Approved:

Date

Governor

Tab 3

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

The commission shall:

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

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

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

Tab 4

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

The CECANF was charged with:

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

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

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

Tab 5

COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MEETING MINUTES
Washington, D.C.
February 24, 2014

"This is not just a body-count commission, as tragic as that count may be. This is not about death, but life, and the type of life we want these children to have—one free of abuse and neglect."

--U.S. Rep. Lloyd Doggett, 35th District, Texas. Doggett was the sponsor of the Protect Our Kids Act of 2012, which created the Commission to Eliminate Child Abuse and Neglect Fatalities

The initial meeting of the Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) took place in Washington, D.C., on February 24, 2014. Commissioners introduced themselves and set the stage for working together during the next two years.

BACKGROUND

This first meeting covered the history that led to the creation of CECANF: Why is this commission necessary, and why now? There is little national awareness of the magnitude of the problem of child deaths from abuse or neglect. Data collection often is incomplete, incompatible, and not accessible in a single place. Deaths from abuse or neglect are most likely undercounted. There is not enough known about what works to prevent fatalities and how successful programs and strategies operate. This was the backdrop to the founding of the commission.

Several conferences and reports, including a U.S. Government Accountability Office (GAO) report on the inadequacy of data, led to the passage of the Protect Our Kids Act of 2012, which created CECANF. This legislation had strong bipartisan support and is based on the premise that deaths from abuse or neglect are preventable. The act charges the commission with making recommendations within two areas of focus: (1) improving policy and practice to reduce fatalities, and (2) measuring the true extent of fatalities and using data to inform policy decisions to prevent them.

Expectations

Commissioners articulated their expectations for CECANF and for their recommendations. Goals included the following:

- Increased understanding of the problem at the national level
- Uniform and cross-system data collection

- Effective, comprehensive, cross-system approaches to address the problem
- More effective strategies for jurisdictions to keep children from falling between the cracks
- Recommendations that can be turned into practical, fundable national policies
- More attention to prevention of abuse and neglect as a strategy
- An analysis of what is working and what is not
- Increased emphasis on community involvement
- Engagement of tribal communities to be part of the solution
- *Elimination* of deaths from abuse or neglect, not just reduction of deaths.

The commission has an historic opportunity to make a difference—in federal, state, and local policy, and more specifically in the lives of thousands of children and families. CECANF can be the hub for local commissions also working to prevent fatalities, but this commission's focus is on looking at *national* policy and funding streams.

The Commission's Charge Under the Protect Our Kids Act of 2012

CECANF reports directly to Congress and to the president. The foundation of their charge is that deaths from child abuse or neglect are preventable. A better understanding of the data and of the extent of the problem can lead to improved policy and practice. Specifically, the legislation charges the commission with the following:

- Examining the effectiveness of existing policies, practices, and services, specifically those funded under titles IV and XX of the Social Security Act
- Recognizing the importance of cross-system work
- Analyzing demographic trends
- Improving data collection in general and across systems
- Producing recommendations that are feasible and implementable around improvement of practice and policy to prevent fatalities, improvement of measurements, and use of data to review policy and research

SPEAKER PRESENTATIONS

The commission heard from experts who outlined the intent of the legislation that created CECANF and offered an overview of previous panels, commissions, reports, and recommendations about preventing fatalities from child abuse or neglect. These speakers set the stage for future discussions of what is currently known about the problem and its context. The speakers urged the commission to discuss mental health as a factor, to look at the barriers to preventing fatalities, to look for the red flags that could predict future

violence in order to stop it, and to suggest ways to prioritize services for those most in need of help.

CECANF Commissioners Theresa Covington and Michael Petit

Commissioners Covington and Petit both worked to build momentum for CECANF through their involvement with child death review panels. They pointed out that children die from abuse or neglect in states and jurisdictions across the country, but there is little urgency to address the problem at a national level. CECANF will do that.

Research about effective programs exists, but it has never risen to the level of informing legislation and implementation. A 2009 report by the Every Child Matters Education Fund pointed out that the existing data often is in different places, which has contributed to undercounting the actual number of children who have died from abuse or neglect. Children and families often are known to more than one system, but the systems do not communicate and families do not get help when they need it.

U.S. Rep. Dave Camp of Michigan commissioned a report from GAO on undercounting of deaths from abuse or neglect and held a hearing at the House Committee on Ways and Means. There was strong, bipartisan support, from both members and staff, for legislation to address the problem. This support led to the Protect Our Kids Act of 2012, sponsored by Rep. Lloyd Doggett of Texas.

Kurt Heisler, Research Analyst, Office of Data, Analysis, Research, and Evaluation; Administration on Children, Youth and Families (ACYF), U.S. Department of Health and Human Services (HHS)

The federal effort to collect child abuse and neglect data goes back decades with the Child Abuse Prevention and Treatment Act (CAPTA), which established a national database. The National Child Abuse and Neglect Data System (NCANDS) grew from that act. States submit data every 12 months to NCANDS via a web portal that allows HHS to report out in a uniform manner, despite differences in state laws and terminology.

Heisler described the reporting process, starting from the first allegation of abuse or neglect. In cases of child fatalities, HHS asks the state or jurisdiction to report on involvement of other systems, such as the district attorney or medical examiner's office, and to indicate whether its report includes data from these other systems. States and jurisdictions have different reporting requirements, which has an impact on the understanding of fatalities across states. California, for example, only reports out after cases have been audited.

In addition, participation in NCANDS is voluntary, not mandatory. If states choose to accept CAPTA funding for programs, however, they are obligated to report their data. Despite the fact that data is self-reported and voluntary, Heisler says that NCANDS is generally reliable and shows trends similar to other reports of abuse and neglect data.

Under CAPTA, states report:

- The number of fatalities due to abuse or neglect
- The number of those fatalities that involve children who were in foster care
- The number of fatalities that involve children with prior child protective services (CPS) involvement, including the number abused by parents or principal caretakers after reunification

The Child and Family Services Improvement and Innovation Act of 2011 required states to describe in their child welfare plans the data sources they use for reporting child deaths, including state statistics, child death review teams, law enforcement agencies, and offices of medical examiners or coroners. States are not required to consult all of these sources, however; they are only required to list the sources they used. States do not routinely collect reports on near fatalities or cases not involved with CPS.

Catherine Nolan, Director, Office on Child Abuse and Neglect; Children's Bureau, ACYF, HHS

Nolan focused her presentation on pre-CECANF commissions and federal efforts to address child fatalities. She included a recent history of relevant federal legislation and agencies dedicated to child welfare. The oldest of these agencies is the Children's Bureau, which includes an office focused on child abuse and neglect. The Children's Bureau, Nolan explained, is the focal point for collaborative efforts and special initiatives to prevent abuse and neglect and oversees NCANDS reporting, the Child and Family Services Reviews, and examination of child fatality review teams.

She cited a 1995 report by the U.S. Advisory Board on Child Abuse and Neglect—*A Nation's Shame: Fatal Child Abuse and Neglect in the United States*—that exposed the lack of knowledge about the scope of fatalities and offered 26 recommendations to improve investigations, services, and training. Expansion of child death review teams to all 50 states was one significant result of this call to action. The recommendations also included increasing primary prevention, expanding home-based services, and integrating child abuse and domestic violence services.

Nolan cited numerous studies and federal programs to investigate child deaths and prevent fatalities. They include the following:

- A report by the Maternal and Child Health Bureau (MCH) under HHS offered advice to the federal government to guide consistency of fatality reviews. (MCH later provided funding for the National Center for Child Death Review.)
- The Children's Justice Act of 1986 provides grants to states to improve handling of child abuse and neglect cases in general, including fatalities where abuse or neglect is suspected. Sixteen states use these funds for child death reviews.
- The Child and Family Services Improvement and Innovation Act of 2011 provides grants to state child welfare agencies for community-based prevention

efforts, including shaken baby syndrome prevention programs and safe sleep education in the community.

- The Child and Family Services Reviews include a focus on safety outcomes for each state.
- A study by a private contractor examined best practices for fatality reviews, including cross-system participation and data collection. This report concluded that child deaths and near fatalities are sentinel events and clear markers of the health and safety of a community. Recommendations focused on public education, improvement of policy and practice, and agency collaboration.

Commissioners responded with questions about funding, prevention and the barriers to prevention, outcomes of programs funded so far, data beyond NCANDS, and much more. They were setting the stage.

Rep. Lloyd Doggett, Texas

Rep. Doggett sponsored the Protect Our Kids Act. He talked about the situation in Texas, which leads the nation in having the highest incidence of child fatalities from abuse or neglect. He called on the commission to deliver a blueprint for change in Texas and throughout the country. He pointed out that CECANF's mandate includes examination of federal, state, and local policies and resources.

Doggett advised the commissioners not to limit their horizons, but to go where the evidence takes them in formulating their recommendations. Ultimately, he pointed out, this is a commission not about death, but about life. He said that he hopes the commission will not wait two years to provide evidence of their progress but will provide Congress with interim recommendations. Doggett asked them to help Congress learn how to use existing resources more effectively and to identify actions that can be taken without legislative activity, but he added that if they see the need for additional funding, they should make that recommendation. He invited the commission to meet in San Antonio, where the child fatality problem is significant and where many people and a lot of resources are focused on it.

LOOKING AHEAD AND DEVELOPING A WORK PLAN

Commissioners discussed plans for their work together during the next two years. The following issues emerged for inclusion in an initial work plan:

- **Defining the scope of the problem.** What do we know now about the extent of the problem, and how do we get additional information to fill the gaps and help inform the commission's recommendations? A list of questions will be compiled and sent to the Administration for Children and Families for response.
- **Identifying states or jurisdictions that have experienced success in reducing fatalities from abuse or neglect.** What can we learn from them? What can we

learn from failures in other jurisdictions? This work will include states, counties, and tribes and will look at community-based prevention efforts implemented in states and counties where fatalities have decreased. The commission wants to hear directly from jurisdictions that have made advances in solving the problem. Where are the best practices?

- **Looking at the issues as they affect subpopulations.** How can we ensure inclusion of tribal populations in terms of data and resources?
- **Funding and sharing cross-system information**. This includes information from and about the role of the courts.
- **Strengthening the connections between state and local programs.**
- **Understanding the challenges of confidentiality rules and regulations.**
- **Looking at the cost of reforms.**
- **Setting a bold agenda and actionable goals.** These will be ongoing after the commission's work is finished.

The commissioners agreed to start with what the commission needs to know right now and to make these questions a priority for discussion during the next several meetings, while looking for exemplary programs. Commission Chair David Sanders proposed developing a draft work plan to be discussed at the next meeting.

 5/23/2014

COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

TEXAS PUBLIC MEETING HIGHLIGHTS—JUNE 2-3, 2014

The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) held a state public meeting in San Antonio, Texas on June 2 and 3, 2014. The meeting was held at the University of Texas at San Antonio's downtown campus. This brief provides highlights from the meeting, including key presentation points on the following:

- **Counting child abuse and neglect fatalities**, including what is counted, the data tools utilized, and why reliable data matters
- The legislative history and foundation of **federal child protection policy and funding**, including Congress' interest in promoting child safety
- An interdisciplinary view of **Texas child protection policy and practice**—what is working and what needs improvement

A summary and transcript of the meeting will be available on the Commission's website at https://eliminatechildabusefatalities.sites.usa.gov/

COUNTING: WHAT, HOW, AND WHY

Commissioners heard thought-provoking presentations from nationally recognized public-health researchers and practitioners, Drs. Rachel Berger and Sam P. Gulino, on the subject of how deaths are determined to be the result of child maltreatment.

Dr. Berger provided examples to illustrate how counts of maltreatment fatalities vary by state due to different definitions—definitions that are often not child-centric. She also demonstrated that state counts are influenced, in part, by who determines the cause of death (e.g., medical examiner, child protective services [CPS]) as well as by the varying standards of evidence required in each state. Cultural norms also come into play, particularly when determining whether certain types of preventable deaths (e.g., drowning of a very young child, unsafe sleep, or access to a loaded unsecured gun) should be attributed to child neglect.

Citing earlier work around standardized coding of abusive head trauma, Dr. Berger suggested an approach whereby both a "broad operational definition" and a "narrow definition" of child maltreatment fatalities might be developed. The broad definition would ensure a more accurate count of deaths, providing more data for prevention purposes, while the narrower definition recognizes that it may not serve the public interest to substantiate or pursue criminal charges in every case.

Finally, Dr. Berger addressed the issue of counting near fatalities due to child abuse and neglect, which also is influenced by varied definitions. She noted that reliably measuring these incidents is important to increase the amount of data available and improve prevention efforts. Timely and

effective medical intervention is often the only difference between a fatality and a near fatality; many of the children who experience a near fatality are affected by the same risk factors as children who die.

Dr. Gulino, who serves as the chief medical examiner for the city of Philadelphia and leads that city's child abuse fatality and near-fatality review team, addressed the various tools and data systems used to track child maltreatment fatalities. According to Dr. Gulino, the National Child Abuse and Neglect Data System (NCANDS) may not capture all deaths due to maltreatment. There are a number of reasons that a child maltreatment death might not be identified by child welfare agencies at the state level or reported to NCANDS. These include reporting laws, evidentiary standards, child maltreatment definitions, and agency resources for investigations.

Other sources of data include death certificates, law enforcement, medical codes, and child death review teams. Limitations of death certificates include inconsistent qualifications and training for those investigating and certifying deaths; errors in the International Classification of Diseases (ICD) coding; and language that is sometimes subjective, emotional, or even political. However, death certificate data may be the most promising because every child who dies gets a death certificate. Dr. Gulino illustrated complications that can arise as a result of some jurisdictions utilizing coroners (elected officials who may not be required to have any prior training in medicine, forensic science, or death investigation) in place of medical examiners, who are medical doctors trained in forensic pathology. One solution would be to require coroners to work with and defer to a forensic pathologist in determining cause and manner of death.

Dr. Gulino spoke favorably of child death reviews undertaken by local teams. He did note, however, that not all of these teams contribute their data to the national child death review case reporting system, teams can have widely varying expertise and knowledge about child maltreatment, and definitions of child abuse and neglect fatalities are not applied consistently. He suggested that child death review may provide a mechanism to improve the national count, if it is coupled with other data sources. Dr. Gulino proposed two steps to improve counts: (1) create more specific, uniform definitions for child maltreatment deaths, and (2) develop a tool to improve decision-making in difficult cases, such as those involving inadequate supervision.

Finally, both Dr. Berger and Dr. Gulino discussed the challenge of classifying neglect-related child deaths. Each agency that comes into contact with a child who has died may apply a different operational definition when determining whether the death was neglect-related. These operational definitions are specific to each agency's function and the specific laws, regulations, and standards regulating practice. Each is also influenced by the perception of societal norms regarding acceptable parenting practices. The definitions also may be in direct conflict with one another. For example, a death certified by a medical examiner or coroner as an accident may be prosecuted if the district attorney feels the actions of the parent showed reckless disregard for the child's welfare. Conversely, a death determined to be neglect-related by a child welfare agency may fail to meet the legal threshold for criminal prosecution.

FEDERAL POLICY AND FUNDING

Emilie Stoltzfus from the nonpartisan Congressional Research Service provided Commissioners with an historical perspective on federal child protection policy in America. To begin, she noted child safety as a paramount goal of federal child welfare policy and congressional intent. With respect to federal programs dedicated for child welfare purposes, she pointed out that the majority of funds are invested in support services that are made available when children are removed and placed in out-of-home care; funds for prevention or in-home family strengthening are more limited.

Stoltzfus then described various federal child welfare goals, programs, and funding sources (e.g., title IV-E, title IV-B, CAPTA), noting that there is limited explicit focus within these policies related to child fatalities. In providing a legislative history of congressional action relating to child protection, she provided a broad overview of the 100-year history of the Children's Bureau, dating back to 1912, and noted how the original mandate of the Bureau was to address infant mortality and ensure that every child receives a birth certificate. Stoltzfus also covered recently enacted programs relevant to the Commission's work, including a description of the Maternal, Infant, and Early Childhood Home Visiting program and its goals "to prevent child injuries, child abuse, neglect, or maltreatment, and reduce emergency department visits." She described a number of other federal funding streams relating to child protection and reviewed congressional committees of jurisdiction.

Although much of the oversight and funding to prevent, investigate, and treat child maltreatment is administered by agencies within the U.S. Department of Health and Human Services (HHS), there are programs that involve intergovernmental coordination, such as between HHS and the Department of Justice. Most notably, funding from the federal Victims of Child Abuse Act requires a partnership to improve practice and award funding to support children's advocacy centers, train judges, and connect abused children with a court appointed special advocate (CASA).

Commissioners' discussion with Stoltzfus reinforced the importance of examining a broad range of systems that play a role in supporting child health and safety, including programs that support parents in caring for their children. These include public health programs, Medicaid, and the Individuals with Disabilities Education Act (IDEA). Stoltzfus cited several examples of child welfare legislation requiring partnerships between agencies but also described challenges in the coordination, collaboration, and measurement of services for children and families

TEXAS POLICY AND PRACTICE

Throughout the two-day meeting, Commissioners heard a variety of perspectives regarding child protection policy and practice in Texas. Speakers included U.S. Congressman Lloyd Doggett, State Senator Carlos Uresti, Judge John Specia, heads of state agencies, and community-based providers of services to children and families. Although their experiences and presentations were diverse, individually and collectively they illustrated the nuances of data measurement and the challenges of conducting child death reviews statewide with some consistency.

Many speakers suggested that child abuse and neglect fatalities were decreasing in Bexar County, where the meeting took place, even as they struggled to identify a specific program or strategy that might be contributing to such a decline.

Commissioners heard about a number of positive developments in Texas, including the following:

- Licensing of the subspecialty of child abuse pediatricians who are available to CPS investigators and expansion of trauma centers in children's hospitals. One presenter suggested that fatalities may be decreasing because children with severe injuries are getting better medical help faster and therefore may be near fatalities not included in fatality data.
- Memoranda of understanding (MOUs) between children's advocacy centers, law enforcement, district attorneys' offices, and CPS, as well as with almost every children's hospital in the state and numerous mental health providers.
- Public awareness campaigns around issues such as drowning.

Taking positive efforts to scale was a concern expressed by participants. Speakers urged the Commission to support flexibility in federal funding, specifically through title IV-E, so that federal

matching funds can be used for preventive services. They urged lifting the cap on IV-E funds and addressing the need for cost neutrality. The goal of these suggestions is to provide more funding for prevention services to address risk factors at the front end, rather than being forced to intervene only when problems are likely to be more serious and children need to be removed. Speakers also called for more treatment programs to address mental health issues, including substance abuse and postpartum depression, and more funding for trauma-informed care and home-visiting programs.

COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

FLORIDA PUBLIC MEETING HIGHLIGHTS—JULY 10, 2014

The Commission to Eliminate Child Abuse and Neglect Fatalities held a state public meeting in Tampa, Florida on July 10, 2014, from 8:00 a.m. to 4:30 p.m. at the Children's Board of Hillsborough County. The meeting was for Commissioners to gather national and state-specific information regarding child abuse and neglect fatalities. More than 200 people joined by phone or in person. This brief provides highlights from the meeting, including key presentation points on the following:

- The **use of data** to understand risk and enhance prevention efforts
- Balancing **confidentiality** with the need for transparency and accountability
- **Florida strategies** that are working well and opportunities for further improvement

A summary of the meeting will be available on the Commission's website at https://eliminatechildabusefatalities.sites.usa.gov/

USE OF DATA

Commissioners heard from Drs. Emily Putnam-Hornstein and Richard Barth, nationally recognized researchers in the field of child abuse and neglect, on strategies for using data to better understand risk factors for child abuse and neglect fatalities. Citing a population-level study based on multiple sources of data from California, Dr. Putnam-Hornstein provided an overview of the risk factors for fatal child maltreatment. Key findings included the following:

- A previous report to child protective services (CPS), regardless of disposition, significantly elevated the risk of death during a child's first five years of life.
- A previous report to CPS was significantly associated with a child's risk of both unintentional and intentional death.

Dr. Putnam-Hornstein also discussed specific barriers to obtaining a more accurate count of child abuse and neglect-related fatalities and the need to link multiple sources of data to enhance surveillance, front-end decision-making, and cost-effective research and evaluation. She proposed predictive risk modeling as a way that child welfare agencies might use the vast amounts of data now available to supplement clinical judgment and improve decision-making about child safety and service provision.

Dr. Barth spoke on the use of birth match in three states, and on issues related to deaths of children who were in foster care or who had been adopted. Birth match programs use an automated data system to alert CPS to births of children to parents who have previously had a termination of parental rights or who have been previously convicted of killing a child. Birth match is used in

Maryland, Michigan, and Minnesota to identify and provide timely intervention in cases of newborns at high risk of maltreatment. Although all states have the option to share birth records with child welfare agencies, very few currently exercise this option.

Dr. Barth also talked about children who have died while in foster care or after being adopted. He indicated a lack of procedures to systematically collect information on the deaths of these children, a process that is critically important for understanding how the number of fatalities can be reduced. He made a number of recommendations, including adding a requirement to the Child Abuse Prevention and Treatment Act (CAPTA) for states to report on these fatalities and creating a standardized home study for foster and adoptive parents that reflects known risk factors for maltreatment and filicide.

CONFIDENTIALITY

Howard Davidson, J.D., director of the American Bar Association's Center on Children and the Law, presented on the federal framework governing access to CPS records and other relevant data in the case of child maltreatment fatalities. He informed Commissioners that CAPTA provisions have evolved from the law's original (1974) focus on confidentiality to a broader mandate for information sharing beginning with the 1996 reauthorization; however, this mandate has yet to be fully spelled out in U.S. Department of Health and Human Services policy. Davidson then made specific recommendations for improving state laws on permissible and mandatory disclosures. He also discussed the legal issues related to information sharing among social service agencies for ensuring child safety and preventing child abuse and neglect fatalities.

Commissioners then heard a panel discussion on Confidentiality, Transparency, Accountability, and the Media. Panelists included Florida Rep. Gayle Harrell, who listed steps that Florida has taken to strike an appropriate balance between transparency and confidentiality, including the establishment of child death review teams and a state website that reports to the public on child deaths. Other panelists included representatives from the Florida judiciary, DCF, and the media. Panelists spoke about ways that transparency regarding child deaths may help support prevention efforts. A discussion between Commissioners and panelists touched on the following:

- Ways to further interagency collaboration while respecting the need for confidentiality
- Who is actually protected by confidentiality provisions—children and families or the system
- The role of immunity in creating greater transparency

FLORIDA STRATEGIES

A panel of representatives from Florida discussed how predictive analytics is being employed in the state through a process called Rapid Safety Feedback (RSF). RSF is designed to flag key risk factors that could gravely impact a child's safety in open child welfare cases. Key risk factors identified included children who are 3 years old or younger receiving in-home services, and the presence of a paramour in the home. Other risk factors RSF identifies include the following:

- Young parents
- Intergenerational abuse
- Substance abuse
- Mental illness

- Domestic violence history

Since RSF was implemented in Hillsborough County, there have been no child fatalities due to child abuse and neglect in the county. Florida DCF has now implemented RSF statewide.

Other notable features of the Florida child welfare system that presenters identified as promising or effective practices include the following:

- Appointment of a statewide child fatality specialist
- A coordinated system of child protection and child abuse death review teams (multidisciplinary, community-based, medically directed)
- Close collaboration between state and tribal child welfare systems (Seminole tribe)
- A community-based system that promotes a high level of collaboration at a local level
- Close relationships between child protective services and law enforcement (including six counties where the sheriff's office is the contractor providing child protective investigations)
- Enhanced laws and community training to increase reporting
- Community education and free devices (e.g., door alarms, smoke detectors) to help prevent common causes of death, including unsafe sleep and drowning
- Co-location of domestic violence specialists within child protection units

Challenges or areas for further improvement identified by presenters included the following:

- Retaining/recruiting adequate medical staff and assessing children's long-term health needs
- Need for safety planning with adults in the home other than parents (e.g., paramours) who may pose a risk to children
- Lack of uniform investigation procedures
- Primary focus on keeping families together rather than on child safety

One of the final speakers was a woman from Florida Youth SHINE who entered foster care at age 12 with her younger brother. She aged out of foster care at the age of 18 after living in at least 10 group homes and one foster home. She was separated from her bother and not allowed to contact him after he was adopted from foster care. She spoke to Commissioners about the impact of being separated from her sibling and the lack of family stability on her ability to form and maintain healthy relationships, handle life's difficulties, and become a loving parent. She indicated that many of the child abuse and neglect deaths in Florida involved young parents who had themselves been in foster care, suggesting that a critical prevention strategy is to provide safe, stable, and nurturing relationships for children in foster care.

COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MICHIGAN PUBLIC MEETING HIGHLIGHTS—AUGUST 28, 2014

The Commission to Eliminate Child Abuse and Neglect Fatalities held a public meeting in Plymouth, Michigan on August 28, 2014, from 8:00 a.m. to 4:30 p.m. at the Inn at St. John's. The purpose of this meeting was to gather national and state-specific information regarding child abuse and neglect fatalities. More than 200 people attended via teleconference or in person. This brief provides highlights from the meeting, including key presentation points on the following:

- State and federal data collection strategies
- Counting child maltreatment fatalities in Michigan
- Fatality reviews in Michigan
- Prevention strategies

U.S. Representatives Dave Camp (R–Mich.) and Sandy Levin (D–Mich.) were both present to discuss the history of the Protect Our Kids Act of 2012, which passed with strong bipartisan support. Rep. Camp praised the Commission's deliberate and careful focus on the issue and expressed his belief that this work represents a real opportunity to identify effective strategies in data collection, information sharing, and prevention, and to "change the status quo" by reducing child deaths. Rep. Levin asked the Commission to advise Congress as to whether the current level and distribution of appropriations for up-front preventive services is adequate to help families with the greatest needs.

The meeting also included brief presentations by a parent advocate and a foster youth, who offered recommendations from their own experience with the child welfare system. Both asked the Commissioners to recommend increased funding for prevention services to support families in building protective factors *before* a crisis occurs. The parent advocate also described how she learned to navigate the child welfare system when her own children were removed, the importance of agency communication, and why parent voices are essential in policy and practice decisions.

A full transcript and meeting minutes will be available on the Commission's website at https://eliminatechildabusefatalities.sites.usa.gov/

STATE AND FEDERAL DATA COLLECTION STRATEGIES

This panel of experts discussed the complexities and uncertainties of our national data on child abuse and neglect fatalities (including issues around inconsistent definitions) and provided recommendations to improve our understanding of the scope and classification of child fatalities due to abuse and neglect.

- **Amy Smith Slep, Ph.D.,** of New York University presented work that was the result of a collaboration between herself, Dr. Richard Heyman, and the U.S. Air Force. To try and improve the consistency in decision-making about which cases of child maltreatment should be substantiated (e.g., counted), they developed standardized child maltreatment definitions, conducted field testing of the definitions and a computerized decision tool, and

then performed a dissemination trial. Use of the finalized tool resulted in 90 percent reliability (e.g., agreement) as to which cases of suspected maltreatment—not specifically fatalities—should be substantiated. The computerized tool is currently being used in practice throughout the Defense Department to make decisions about substantiation.

- **Patricia Schnitzer, Ph.D.**, an epidemiologist at the University of Missouri, argued for redefining child abuse and neglect fatalities as a public health issue rather than a child protective services (CPS) issue. In a public health model, fatalities are "counted" as child abuse and neglect fatalities when they meet standardized/operationalized definitions; these definitions may or may not match those established by different agencies (e.g., CPS, legal). Therefore, a given death can be counted by the public health system as a fatality but not included in the current federal counting system (NCANDS). The counting is independent of any single agency. Dr. Schnitzer also recommended including at least two categories (e.g., *definite* and *probable*) to allow for a level of uncertainty. In a public health model, there is an emphasis on collection of data about risk factors. Importantly, a public health model allows for inclusion of all deaths, not only those known to CPS. Dr. Schnitzer indicated that the public health model is, scientifically, the best model for developing intervention and prevention strategies, and that it allows for improved monitoring of trends over time.
- **Steve Wirtz, Ph.D.**, an epidemiologist with the California Department of Public Health, discussed California's response to some of the counting issues the Commission has been hearing about. SB39 requires welfare agencies to count (and treat) any child death as a maltreatment fatality if any one of three agencies—CPS, law enforcement, or the medical examiner—determines that the death was due to child maltreatment. He strongly suggested that including near fatalities in review efforts would broaden our understanding of the risk factors and causes and inform prevention efforts. Dr. Wirtz suggested that changes could be made to existing systems such as NCANDS and NVDRS to obtain the case-specific risk information needed to inform prevention efforts. He also supported the role of child death review teams (CDRTs) to serve as multi-agency, multidisciplinary forums for reviewing and classifying child deaths and proposed funding a feasibility study to adapt the Air Force's current classification system for use by CDRTs.
- **Vincent Palusci, M.D., M.S.**, a professor of pediatrics at NYU Langone Medical Center, reinforced the call to look at child abuse and neglect fatalities as a public health issue. He emphasized the role of medical professionals, particularly pediatricians with expertise in child abuse, in improving identification and prevention strategies. He also argued for changes to HIPAA to enhance information-sharing. He recommended that CAPTA funding be expanded to require reviews and extend them beyond child welfare. Finally, he suggested an important role for CDRTs and recommended incorporating linked fatality-specific data elements into NCANDS and CDC data.

The panel presentation was followed by a demonstration and discussion of the Air Force tool and further discussion about the implications of looking at child maltreatment fatalities as a public health issue.

COUNTING FATALITIES IN MICHIGAN

Steve Yager, director of the state's Children's Services Administration (CSA), provided a high-level overview of the process of investigating and counting child maltreatment fatalities in Michigan, as governed by the state's Child Protection Law. Other speakers provided more in-depth views of specific elements of the system; these included representatives from CDRTs, medical examiners' offices, and a county prosecutor's office.

Panel members highlighted recent, promising changes in Michigan, including the following:

- A centralized intake system for reports of child death is providing greater consistency and quality control for investigation decisions.
- In many cases, law enforcement, CPS, and medical examiners' offices have protocols and informal relationships that support joint investigations.
- Strong local child death reviews allow DHS to collect comprehensive child-specific data.
- The state's new SACWIS system captures cause of death for individual child victims.
- The state is beginning to implement predictive analytics.

Presenters also identified the following areas where further improvements are needed:

- A more standardized approach to identifying cases for review
- Better strategies for defining, identifying, and tracking deaths due to neglect
- Funding to support further collaboration among law enforcement, CPS, and medical examiners when conducting investigations, as well as to fund more prosecutions
- Ongoing training to improve the quality of investigations by medical examiners' offices and child death review teams
- Public service announcements to increase reporting by the public

FATALITY REVIEWS IN MICHIGAN

A panel of speakers provided the Commissioners with an overview of the many different entities performing child death reviews in Michigan, including local and state advisory teams, citizens review panels, the Office of Children's Ombudsman, and the Office of the Family Advocate with DHS, as well as fetal and infant mortality reviews and the Domestic and Sexual Violence Prevention and Treatment Board. Several presenters emphasized the breadth of data used by these teams in making their determinations, including interviews with caseworkers and frontline staff in addition to case files from CPS, mental health, education, substance abuse, and law enforcement.

All 83 Michigan counties currently have local child death review teams. The state advisory team reviews local findings and makes annual recommendations to policymakers to prevent future deaths. Beginning in September 2014, the Office of Children's Ombudsman is authorized by new legislation to issue recommendations for how the state's legal and medical systems, in addition to CPS, can improve their ability to prevent child fatalities.

Presenters noted that many of their teams' recommendations have resulted in positive changes, including standardization of death scene investigations, improved safe sleep policy and practice, enhanced investigation of SUIDs, training for mandated reporters, a suicide prevention/depression management initiative for older youth in foster care, and mandatory training for child welfare workers on threatened harm assessment and safety planning. Michigan has reported a decline in child deaths during the past two years. Although Commissioners were cautioned that this cannot yet be interpreted as a trend, presenters did suggest an enhanced focus on safety within the state.

Panel members offered some recommendations to further improve the ability of child death review teams to reduce fatalities. These included the following:

- Increase federal funding to support child death review.
- Support greater collaboration with domestic violence agencies to enhance effectiveness of the community's approach in cases where this is a factor.

- Employ a public health approach to understanding and preventing child maltreatment deaths.
- Use public education to change cultural practices around neglect (e.g., unsafe sleep).

PREVENTION STRATEGIES

The Commission heard from a panel of state stakeholders about efforts to prevent child maltreatment fatalities. Stacie Bladen, acting deputy director of CSA, presented on Michigan's use of birth match, an automated system to identify children born to families who previously lost rights to a child or committed an egregious act of abuse and neglect. An automatic case assignment is made that requires workers to make an immediate contact to assess the safety and well-being of the infant, evaluate the risk of maltreatment, and provide services to protect children from harm.

Several presenters urged the Commission to recommend increased financial support for early, comprehensive, and sustainable prevention services. Specific approaches that panel members indicated are showing promise in Michigan include:

- Home visitation programs
- Use of a protective-factors framework
- The Period of PURPLE Crying program to prevent shaken baby syndrome
- Safe sleep education efforts
- Quality child care, including Head Start and Early Head Start
- Holistic, accessible, community-based services to families (e.g., Promise Neighborhoods)
- Tribal consultation meetings and agreements
- Culturally competent policies, procedures, training, and resources

A final panel presented brief overviews of their organizations' involvement in reducing child abuse and neglect fatalities and offered recommendations that they believed would help to reduce fatalities in the future. Some speakers reinforced points made earlier in the day (e.g., the need for community collaboration). Additional recommendations included the following:

- Integrate a health-equity lens within the Commission's analysis and recommendations.
- Do not rule out solutions that may be more difficult but will have longer-lasting results.
- Although greater emphasis is typically placed on physical abuse, keep in mind the lifelong detrimental effects of toxic stress and neglect.
- Encourage treatment of child maltreatment death as a national health emergency on the level of heart disease.
- Invest resources to build alliances with courts, business, faith communities, education systems, and other nontraditional partners for the purpose of prevention.
- Support universal use of valid, empirically supported assessment tools for structured decision-making.
- Make multidisciplinary teams (already required by CAPTA) a reality "on the ground."

Tab 6

Survey of Current Child Fatality Work in Texas

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

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

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

Office of Child Safety

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

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

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

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

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

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

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

- Develop an understanding of the causes and incidence of child deaths in Texas;
- Identify procedures with the agencies represented on the SCFRT to reduce the number of preventable child deaths; and
- Promote public awareness and make recommendations to the governor and legislature for changes in law, policy and practice to reduce the number of preventable child deaths.
- The SCFRT made several recommendations to the 84th Legislature.

The following seem the most closely-related to the work of this POK Commission:

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

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

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

Protect our Kids Commission background: This commission, incorporated into the CFRT legislation in the 83rd legislative session, is a two-year appointed commission that will study child abuse fatalities and their prevention. The commission is charged to (1) identify promising practices and evidence-based strategies to address and reduce child abuse and neglect fatalities; (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; (3) develop recommendations to implement a comprehensive statewide strategy for reducing those fatalities; and (4) develop guidelines for the types of information that should be tracked to improve interventions to prevent fatalities from child abuse and neglect. DFPS is charged with support of the commission.

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

partners and systems in child death prevention. Texas Child Fatality Review Annual Report 2013.

RECOMMENDATIONS FOR THE DEPARTMENT OF STATE HEALTH SERVICES

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

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

Provide funding for annual training for Texas CFRTs.

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

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

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

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

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

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