Texas Child Fatality Review Team

Annual Report 2006

TABLE OF CONTENTS

INTRODUCTION

LIST OF FIGURES, TABLES, MAPS, AND CHARTS

List of Figures

List of Tables

List of Maps

List of Charts

ACKNOWLEDGEMENTS

The Texas State Child Fatality Review Team (SCFRT) would like to gratefully acknowledge past SCFRT members for their dedicated service to the children of Texas.

- **Bruce Williams**, Sergeant, Homicide Division, Harris County Sheriff's Department
- **Jack Webster**, Captain, Department of Public Safety
- **George Kerr**, MD, University of Texas Health Sciences Center
- **Colleen McCall**, Department of Family and Protective Services
- **Skip Oertli**, Department of State Health Services
- **Sharon Derrick**, Harris County Public Health and Environmental Services

A special debt of gratitude is due to **Sheriff Jack Ellett** for his 3½ years of service as Chair of the State Child Fatality Review Team.

A new SCFRT Coordinator, Susan Rodriguez, joined the team in July 2006. Susan has many years of experience working in child abuse and neglect, domestic violence, volunteer management, and vital statistics, as well as expertise as a trainer, facilitator and conference planner. Special thanks are extended to Chan McDermott, Perinatal Health Coordinator for the Texas Department of State Health Services (DSHS), for her efforts as the interim SCFRT Coordinator during the hiring process for this position.

This report was written and edited by DSHS staff that includes Brian Castrucci, Director, Family Health Research and Program Development Unit; Susan Rodriguez, SCFRT Coordinator; Dr. John Hellsten, epidemiologist; Bobby Schiener, statistician; and Dr. Fouad Berrahou, State Title V Director. This report would not be possible without the dedication and input of the members of the SCFRT (Appendix A) and the local Child Fatality Review Team Coordinators (Appendix B), the presiding officers, and the respective members of each team. The wide array of professionals that range from district attorneys to pediatricians to EMS personnel to law enforcement to child protective services staff and other child advocates make for a comprehensive, multi-disciplinary approach to understanding child death in Texas, and they are saluted for their commitment to this important issue.

The Office of Title V and Family Health, Texas Department of State Health Services funded the development and production of this report.

Questions about the report should be directed to:

Denise Oncken, JD
Chair of the State Child Fatality Review Team Committee
Attn: Susan Rodriguez, State Child Fatality Review Team Coordinator
Texas Department of State Health Services
1100 W. 49th St.
Austin, TX 78756
(512) 458-7111 ext. 2311
susan.rodriguez@dshs.state.tx.us

LETTER FROM THE CHAIR

As one of the founding members of the SCFRT in the early 1990s and now as the newly elected SCFRT Chair, I have seen a number of changes. I have seen the Child Fatality Review Team (CFRT) initiative evolve, produce data, and provide insight into the causes of death for Texas children. I have seen energized and committed individuals across the state step forward to organize and serve on local teams to address issues specific to their communities and universal to us all: protecting children from injury and death. I experienced what happens when creative minds take data and paint a picture of why Texas children are dying. It has been inspiring to see how we as citizens can make a difference through understanding, education and legislation to protect our most vulnerable citizens. We have seen some results, but we have much more to do.

There have been periods since our inception when the initiative seemed to stall as teams lost momentum, critical team members and the sense of support from the State. The last legislative session introduced an unknown to the child fatality review process as the oversight of the program was shifted from the Department of Family and Protective Services (DFPS) to the Department of State Health Services (DSHS). Given the experiences of the past, I held my breath to see what awaited a program to which I am passionately dedicated.

I am pleased to report that Child Fatality Review is alive and well in Texas, and that the outlook for the future of this important volunteer-based program is bright. Reorganization of the SCFRT and local teams under the DSHS Office of Title V and Family Health, which is dedicated to maternal and child health as well as research, seems to be a good match. A full-time coordinator has been hired and already local CFRTs that fell into inactivity are being reinvigorated and beginning to conduct reviews. We are in the process of organizing some new teams and have a plan to raise the number of child fatalities reviewed to 100% before the end of the decade. There is a push to not only implement prevention programs but to measure their success. Death certificates are being supplied free of charge to the teams by the DSHS Vital Statistics Unit. There is a renewed emphasis on training of team members and the standardization of review processes. We are beginning to focus on the critical importance of learning from the data and putting evidence-based prevention programs into place. Texas teams have also joined teams from across the nation in collecting and storing the child fatality data in a uniform manner using an online system created by the National Center for Child Death Review, thus contributing not only to a greater understanding of child death in Texas but to child death in the United States.

I am optimistic about the future of Child Fatality Review in Texas. With consistent State support of dedicated staff and committed resources for training volunteer team members, we can take Child Fatality Review to a new level. We look to our State leadership to grant us the tools and resources to build an even stronger and more meaningful child fatality review process for Texas children, their families and communities.

Denise Oncken, JD
Chair, State Child Fatality Review Team

READING THIS REPORT

This report is divided into four chapters:

1. Operations & Activities
2. Recommendations
3. Prevention
4. Data & Analysis

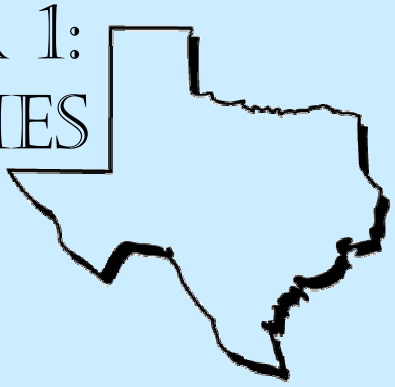
Chapter 1: Operations & Activities includes a thorough description of the child fatality review (CFR) process. This chapter addresses the legislative authority for the CFR process in Texas, a description of the data and the case reviews, and information on the number and distribution of teams.

Chapter 2: Recommendations includes policy and programmatic ideas that, if implemented, may improve our understanding of child death or contribute to the prevention of child death. These recommendations incorporate ideas from the local teams in addition to the expertise of the members of the SCFRT and are based on data found in *Chapter 4: Data & Analysis*.

Chapter 3: Prevention presents the findings from the local teams as to the preventability of each death and what changes at the personal and community levels could contribute to the prevention of future child deaths. The data presented in this section are the findings of the local teams, which are based on much of the data presented in *Chapter 4: Data & Analysis*. All data presented in this chapter was generated by local CFRTs.

Chapter 4: Data & Analysis is an overview of child death in Texas that includes mortality by county and data on Sudden Infant Death Syndrome (SIDS) and several causes of intentional and unintentional injury deaths (drowning, motor vehicle crashes, homicide, firearm injuries, and suicide). Trends in the data are presented along with information on gender, race/ethnicity, and age disparities. Information presented in this chapter includes data from local CFRTs as well as Texas Vital Statistics Unit.

CHAPTER 1:
OPERATIONS & ACTIVITIES



WHAT TO EXPECT IN THIS CHAPTER

This chapter describes the operation of child fatality review (CFR) in Texas, including a description of Chapter 264, Subchapter F of the Texas Family Code, the statutory authority for the CFR process in Texas, and the collaboration between DSHS and DFPS. An overview of the role of the local and state child fatality review teams (CFRTs) is provided along with the data sources and their limitations.

This chapter also provides a detailed description of the active and inactive CFRTs throughout Texas. Statistics pertaining to the population and number of deaths covered by the active teams are included along with a discussion of the number and proportion of cases reviewed over time.

Annually, local CFRTs are asked to provide highlights of the year's activities for inclusion in this report. This year seven teams provided information, which is included in this chapter. While highlighting their achievements, this section also shows the regional differences and challenges confronted throughout Texas.

Legislative Authority and State Agency Involvement

Senate Bill 6, passed by the 79th Texas Legislature, amended the Texas Family Code to move the oversight of the child fatality review process from the Department of Family and Protective Services (DFPS) to the Department of State Health Services (DSHS). DFPS retains a role in the child fatality review team process, as reflected in the legislation:

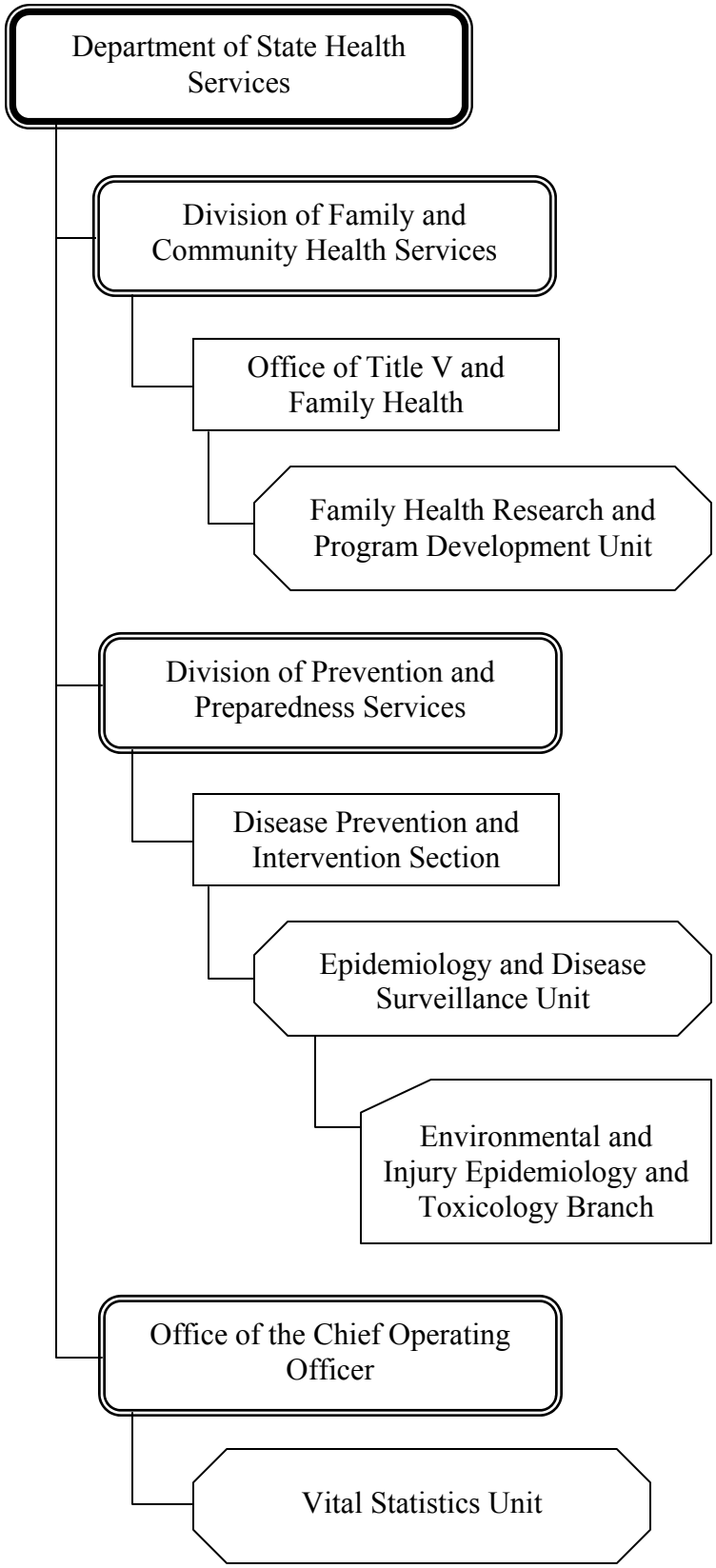
> *The [Department of Family and Protective Services] shall:*
> *(1) recognize the creation and participation of review teams; and*
> *(2) work cooperatively with the committee and with individual child fatality review teams.*
>
> *The Department of State Health Services shall:*
> *(1) promote and coordinate training to assist the review teams in carrying out their duties;*
> *(2) assist the committee in developing model protocols for:*
> *(A) the reporting and investigating of child fatalities for law enforcement agencies, child protective services, justices of the peace and medical examiners and other professionals involved in the investigations of child deaths;*
> *(B) the collection of data regarding child deaths; and*
> *(C) the operation of the review teams;*
> *(3) develop and implement procedures necessary for the operation of the committee; and*
> *(4) promote education of the public regarding the incidence and causes of child deaths, the public role in preventing child deaths, and specific steps the public can undertake to prevent child deaths.*

For DSHS to comply with the legislative mandate regarding CFRTs, multiple components of the agency must be involved in providing support and direction to the local teams (Figure 1). DSHS staff enhance child fatality review in Texas by working together to help teams collect and interpret child death data and turn knowledge into prevention initiatives.

The organizational home of the child fatality review process is within the *Division of Family and Community Health Services*, *the Office of Title V and Family Health*. Within that Office, the State Child Fatality Review Team (SCFRT) Coordinator is in the *Family Health Research and Program Development Unit*. The role of the SCFRT Coordinator is to:

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

Figure 1. DSHS Support of CFRT



Within the *Division of Prevention and Preparedness Services*, an epidemiologist from the *Environmental and Injury Epidemiology and Toxicology Branch* is dedicated to working with child fatality data. The epidemiologist

- serves as consulting staff to the SCFRT,
- produces quarterly and annual reports that are reviewed by members of the SCFRT,
- provides training on what Texas child fatality data say about preventable injury and death, and
- is instrumental in the annual analysis of child fatality data to inform this report.

The *Texas Vital Statistics Unit*, which is housed in the *Office of the Chief Operating Officer*, has traditionally played a significant role in the child fatality review process. The *Texas Vital Statistics Unit* is responsible for the annual distribution of over 3,000 death certificates and 1,500 birth transcripts to the local CFRTs. The absence of this information would severely limit the ability of local CFRTs to function.

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

Role of Child Fatality Review Team

Child Fatality Review Teams are multi-disciplinary and multi-agency groups of professionals who volunteer to regularly review child deaths in the designated area in order to reduce the number of preventable child deaths. Typically, CFRTs correspond to a given county, although the statute provides for multi-county teams in areas with a population of less than 50,000. The local team, in reviewing child deaths, is charged by the Texas Family Code with:

1) providing assistance, direction and coordination to investigations of child deaths;

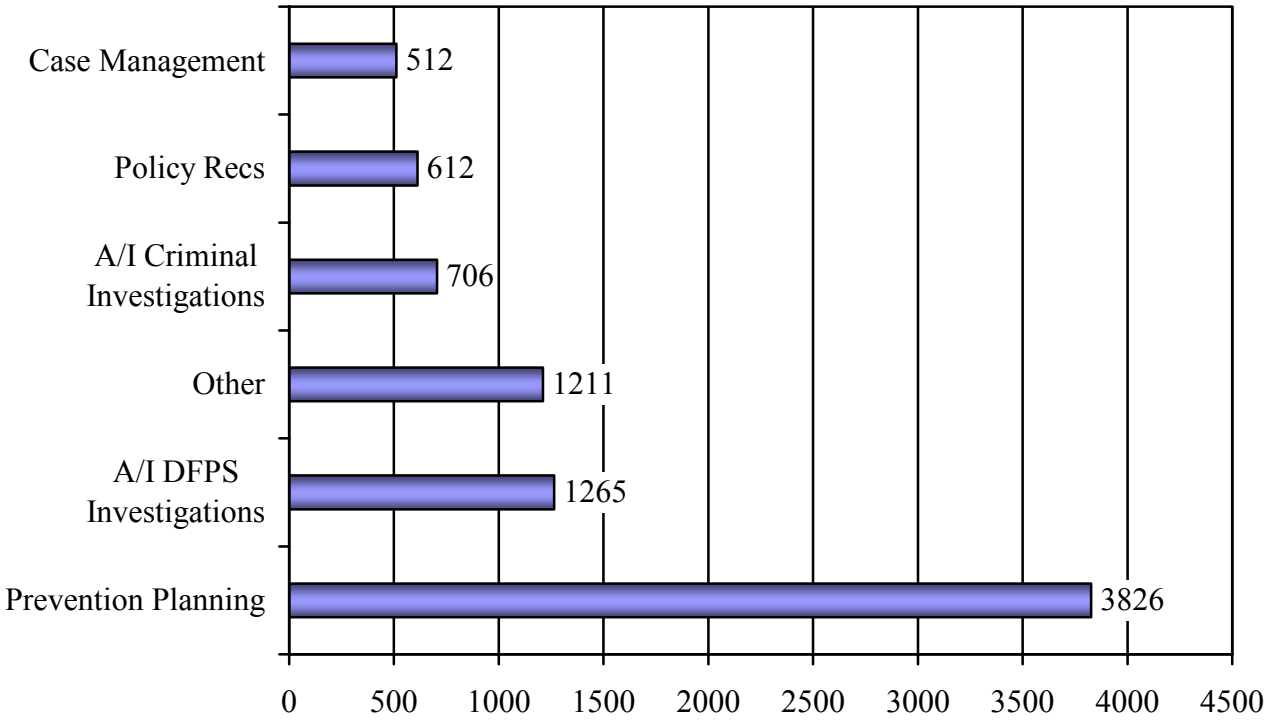
2) promoting cooperation, communication and coordination among agencies involved in responding to child fatalities;

3) developing an understanding of the causes and incidence of child death in the county or counties in which the review team is located; and

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

Ultimately, the role of the local CFRTs is to help prevent future child fatalities. The commitment to this role is seen in the distribution of review outcomes. Of the 12,275 child deaths reviewed between 1999 and 2004, 3,826 (31.2%) resulted in prevention planning (Chart 1).

Chart 1. Child Death Review Outcomes, 1999 through 2004



Note: A/I – Assist or Initiate

Source: Texas DSHS, Child Death Registry, 1999-2004

DATA AND LIMITATIONS

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

The two primary sources of data used in this report are (1) Vital Statistics Unit death certificates and (2) CFRT Reports, also known as the Child Death Registry. Information from death certificates includes demographic information about the child, county of residence, and the date and cause of the death. These data exist for all deaths occurring in Texas, which include both resident deaths and deaths that occurred in Texas to those who are not Texas residents. Annually, a final data file is prepared and serves as the official record of mortality in Texas. The most recent final file is for deaths occurring in calendar year 2003. Data included in this report from 2004 are provisional data. Provisional data are not final and are subject to change as death certificates arrive from other states for Texas residents or data entry errors are identified and corrected. Therefore, data presented in this report using 2004 death certificate data may change when a final file is issued. If changes in the final file alter interpretation, trends, or conclusions presented in this report using the provisional 2004 death certificate data, a section will be added to the 2007 Annual Report that will include corrections and updated data.

CFRT data have several limitations, one of which is missing or unknown values. Specific information about the circumstances of death was not always available for all reviewed deaths, therefore the number of cases in which the information was available is noted within each table and chart. These unknown values are difficult to interpret and may indicate the presence of social desirability bias (the inclination to underreport behaviors that are not consistent with current social recommendations). For example, a mother who has lost a baby to SIDS may not reveal that the infant was placed on his stomach to sleep, which is in contrast to public health recommendations. Since several reviews involve criminal proceedings, the prevalence of unknown values may indicate a person's desire to conceal aspects of the death that may be incriminating. While it is impossible to know why values may be missing, it is important to consider the prevalence of unknown values when interpreting findings.

Another limitation of CFRT data is the absence of data collection and submission standards. There are local CFRTs that do not review all of their deaths. They may choose to focus solely on injury deaths or may only submit to the Child Death Registry those injuries that are preventable. These practices introduce bias into the CFRT data. Increasing standardization and rigor in data collection is a programmatic goal. To this end, Texas has opted to input data into the National Child Death Review Data Collection System, based within the Michigan Public Health Institute, the home of the National Center for Child Death Review. Inputting data into the National Child Death Review Data Collection System will benefit Texas CFR by (1) implementing a nationally standardized form for data entry and (2) allowing for comparison with CFR data from other states.

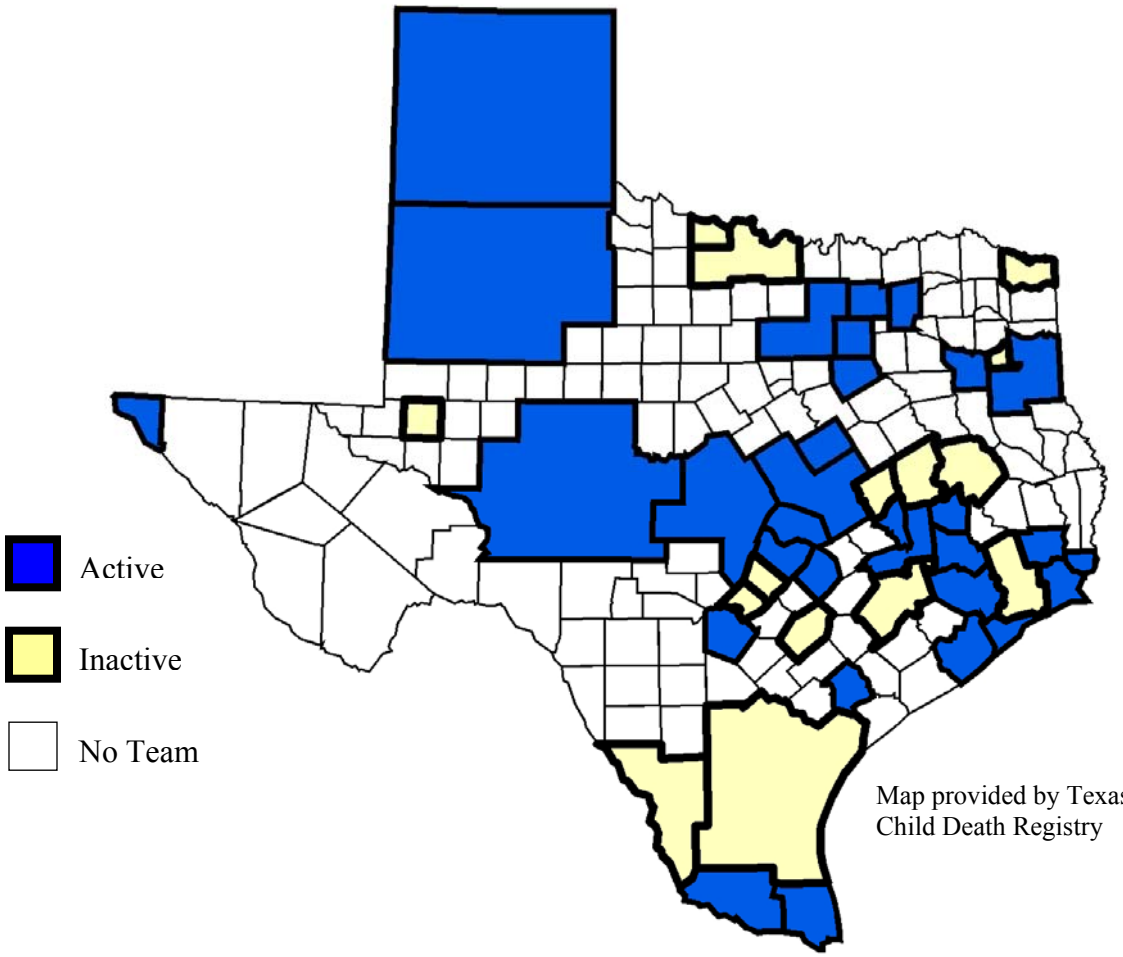
COVERAGE BY LOCAL CHILD FATALITY REVIEW TEAMS 2004 THROUGH 2006

The data presented in this report address mortality occurring before or during 2004. However, there have been changes in the location and number of teams between 2004 and 2006. The CFRT data presented in this report were collected by teams active during 2004. Team coverage is presented for 2006 because it provides the most current CFRT status available. Comparisons are made between 2004 and 2006 to demonstrate changes that may have occurred during this time period.

Status of Child Fatality Review Teams, 2006

As of August 2006, there were 31 active local CFRTs in Texas (Map 1). An active team is defined as any team reviewing at least one death annually. These teams encompass 106 of Texas' 254 counties. These counties include 76% of the under 18 population in Texas and a similar proportion of all deaths to children under the age of 18 years. In addition to the active teams, there are also 15 inactive teams encompassing 35 counties. Inactive teams are those that previously reviewed deaths, but are not currently conducting reviews.

Map 1. Active and Inactive Local Child Fatality Review Teams, 2006



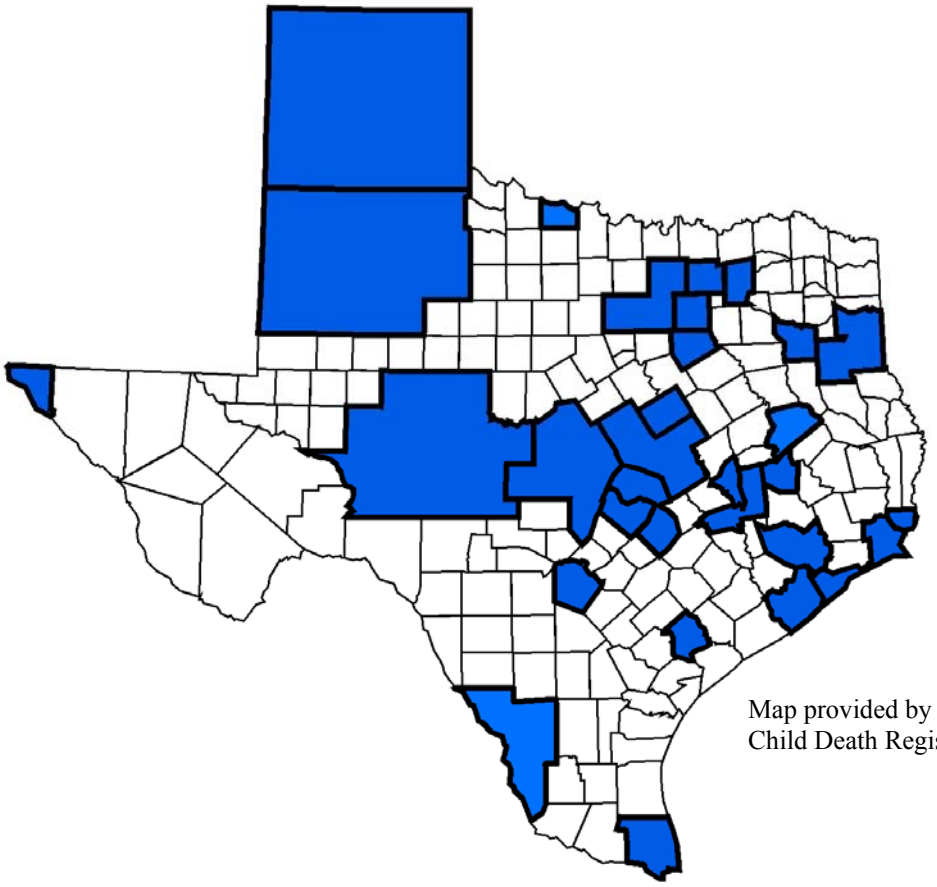
Map provided by Texas DSHS, Child Death Registry

Status of Child Fatality Review Teams, 2004

Active Teams

During 2004, there were 31 active child fatality review teams in 106 counties throughout Texas (Map 2). In 1995, when child fatality review was established in Texas, only 90 counties were covered. This represents a 17% increase.

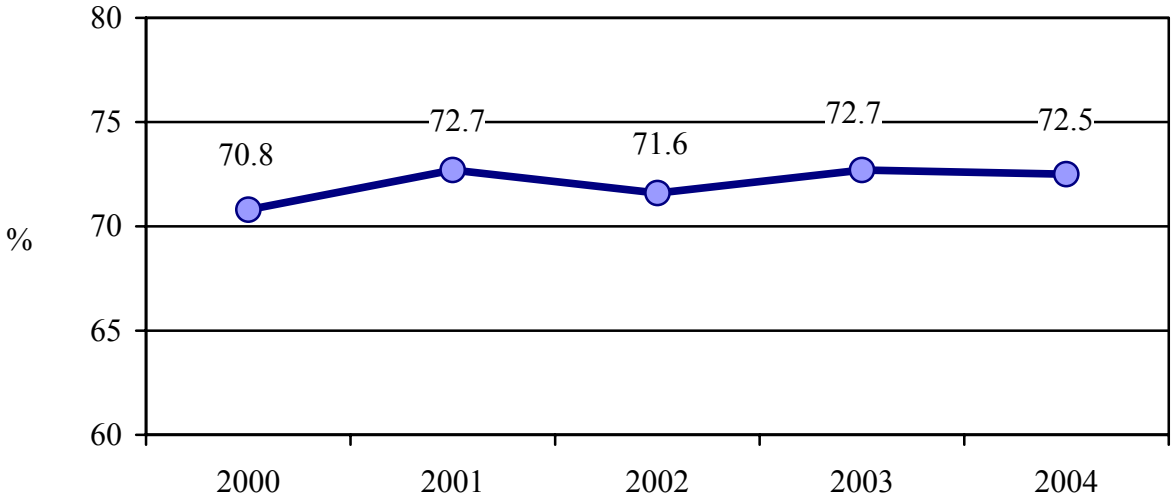
Map 2. Active Child Fatality Review Teams, 2004



Map provided by Texas DSHS, Child Death Registry

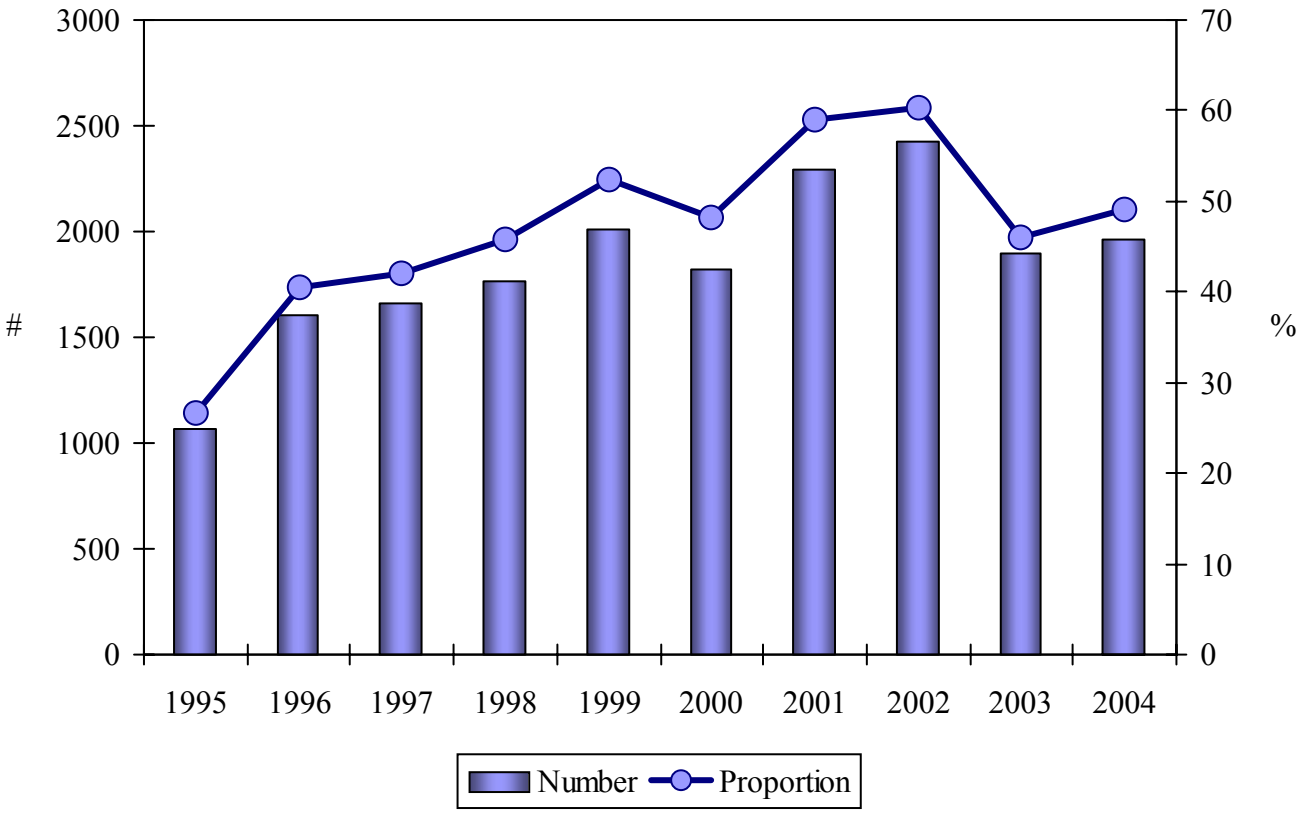
Of all deaths in 2004 occurring among children who were less than 18 years of age, 72.5% resided in counties with active local CFRTs, although not all deaths were reviewed (Chart 2). In 2004, 49.1% of all deaths were reviewed (1,966 reviewed out of 4,004 child deaths) (Chart 3). From initial calendar year 1995 to 2004, the proportion of reviewed deaths ranged from 26.6% in 1995 to 60.3% in 2002.

Chart 2. Proportion of Deaths among Children Less than 18 Years of Age Occurring in a County with an Active CFRT, 2000 through 2004



Source: Texas DSHS, Child Death Registry, 2000-2004

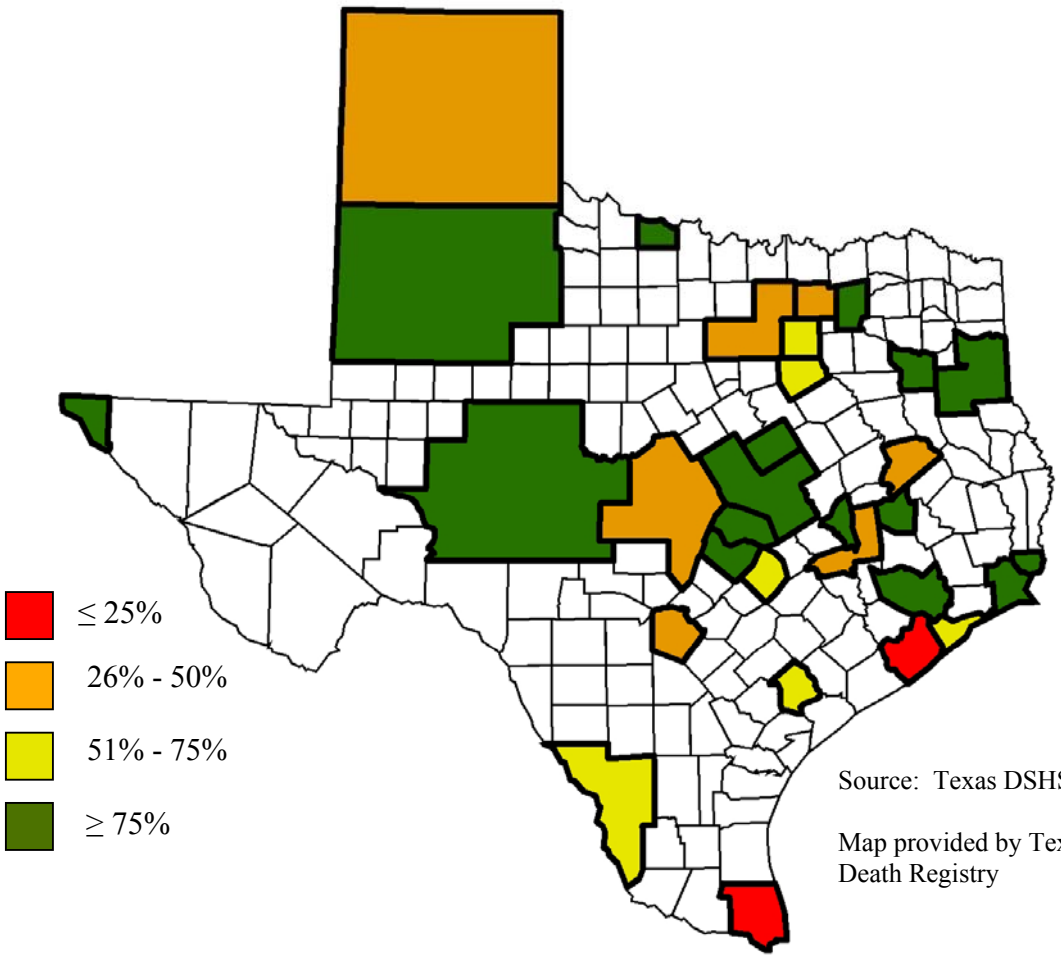
Chart 3. Number and Proportion of Child Deaths Reviewed, 1995 through 2004



Source: Texas DSHS, Child Death Registry, 1995-2004

The proportion of deaths reviewed by local teams ranges from 2% to over 100% across the 31 teams (Map 3).

Map 3. Proportion of Death Certificates Reviewed by Each Team, 2004



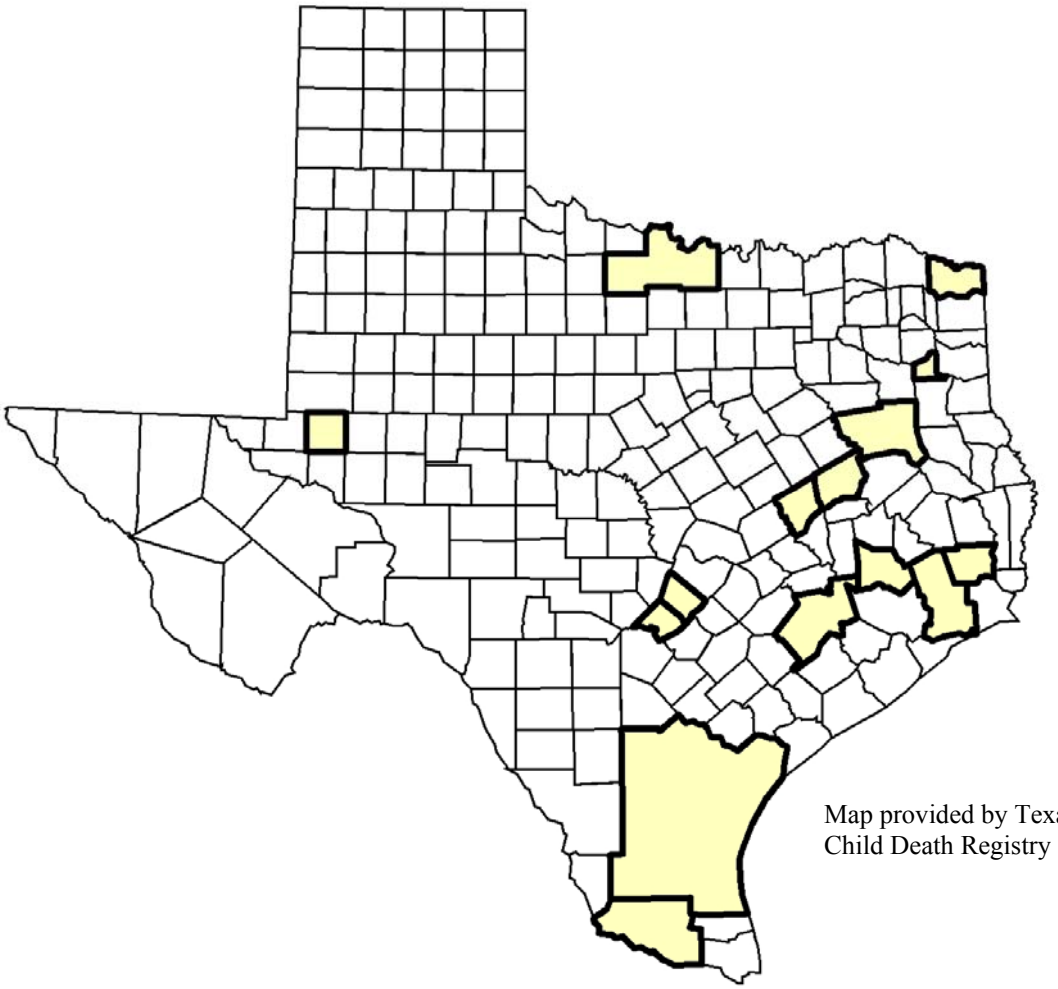
Source: Texas DSHS, VSU

Map provided by Texas DSHS, Child Death Registry

Inactive Teams

There are several teams that were active in the past, but, for a variety of reasons, did not review child fatalities in 2004 (Map 4). That year there were 15 inactive teams covering 34 counties, representing an additional 12.1% of all deaths to children less than 18 years of age.

Map 4. Inactive Child Fatality Review Teams, 2004



Map provided by Texas DSHS, Child Death Registry

Counties With No History of a CFRT

There are 114 counties that did not have a CFR process in place in 2004. These counties accounted for 15.4% of all deaths to children less than 18 years of age. It is a goal of the SCFRT and staff dedicated to CFR to reinvigorate the teams that have become inactive and to start new teams in targeted areas without a team.

SHINING THE SPOTLIGHT ON LOCAL CHILD FATALITY REVIEW TEAM ACCOMPLISHMENTS THROUGHOUT TEXAS

The Child Fatality Review Teams in Texas share two common goals of (1) understanding why Texas children are dying and (2) putting into place safeguards that will reduce the number of preventable child deaths. Yet each CFRT has its own regional character in what issues are tackled and the approaches taken. These teams are made up of committed professionals who volunteer their time, expertise and creativity to address prevention of child death in Texas. The following examples paint a picture of the unique approaches to a common problem.

Cameron/Willacy Counties Child Fatality Review Team

This Lower Rio Grande Valley team covers two counties in reviewing child fatalities. Dr. Stanley I. Fisch, a pediatrician, presides over a team that includes membership from law enforcement, Office of the District Attorney, Child Protective Services, Early Childhood Intervention, Texas Department of State Health Services, Shaken Baby Alliance, Valley AIDS Council and physicians from Valley Baptist Medical Center. The team invites other area professionals to attend when cases in review correspond to their expertise or experience. In addition to reviewing child deaths in their area, the team has taken on several efforts to prevent future child deaths and to strengthen the investigative system that first comes in contact with child fatalities. The efforts of the Cameron/Willacy Counties CFRT have created greater awareness among area justices of the peace and first reponders of the need for death scene investigation and autopsy in all cases of Sudden Unexpected Infant Death (SUID). Changes in how these investigations are conducted have led to more complete information for the District Attorney and Child Protective Services, as well as for the CFRT at the time of review. The team collaborated with Child Protective Services on a public awareness campaign about the danger of leaving children in closed vehicles in hot weather and led planning efforts to stage the annual Lower Rio Grande Valley Forensic Sciences Conference.

Collin County Child Fatality Review Team

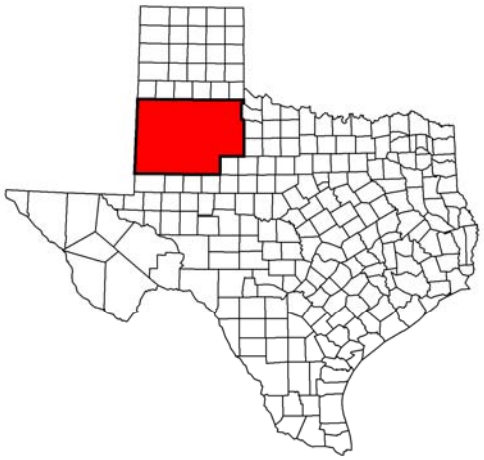
The Collin County Child Fatality Team is responsible for the review of all child deaths in this Metroplex county. The Collin County Children's Advocacy Center sponsors the team, with Jane Donovan as the team coordinator. This team is composed of Collin County Children's Advocacy Center staff, the Medical Examiner, Child Protective Services, local law enforcement entities, an epidemiologist, Office of the District Attorney, EMS staff, and nurses. On a daily basis the team is promoting the value and living the reality of close collaboration between agencies involved in child death due to its unique situation of having the Collin County Children's

Advocacy Center co-located with law enforcement and all Child Protective Services staff in Collin County. The Collin County CFRT, in collaboration with the Collin County Health Care Services and Community Preparedness, created a two-sided bookmark addressing water safety and car safety that is being distributed to visitors and clients at the Collin County Children's Advocacy Center and at community health fairs and speaking engagements to community groups.

Jefferson County Child Fatality Review Team

This Southeast Texas team reviews child fatalities that have occurred in Jefferson County. The team, coordinated by Carolyn Graham of The Garth House/Mickey Mehaffy Children's Advocacy Program in Beaumont, is comprised of members representing justices of the peace, Office of the District Attorney, area hospitals, law enforcement, fire departments, Juvenile Probation, Child Protective Services, mental health providers and physicians. The team coordinator is working with community leaders in neighboring Tyler and Newton counties to establish their own CFRTs.

South Plains Child Fatality Review Team



This Texas Panhandle multi-county team reviews child fatalities for 22 Texas counties (Bailey, Borden, Cochran, Cottle, Crosby, Dawson, Dickens, Floyd, Gaines, Garza, Hale, Hockley, Kent, King, Lamb, Lubbock, Lynn, Motley, Scurry, Stonewall, Terry and Yoakum). Patti Salazar, a sexual assault nurse examiner, of the Texas Tech University Health Science Center Department of Pediatrics coordinates the team, which includes members from the Medical Examiner's Office, Child Protective Services, the Lubbock Independent School District, law enforcement, the Children's Advocacy Center, Department of Public Safety, pediatricians, District Attorney's Office for multiple counties, and local health departments. The team collaborated with other agencies in the *Never Shake a Baby* campaign and was part of *Child Watch 2006* to promote awareness about child abuse and child death prevention. They are also part of the planning group for the implementation of the YWCA annual program, *Week Without Violence*.

Travis County Child Fatality Review Team

With unwavering focus on preventing deaths among the children of Travis County, the Travis County CFRT looks beyond statistics to identify patterns in child deaths and educate the community about how to prevent future deaths. The team, presided over by Assistant District Attorney Dayna Blazey, includes members from the Center for Child Protection, Child Protective Services, the Austin Police Department, Texas Department of Public Safety, Children's Hospital of Austin, Austin/Travis County EMS, Travis County Sheriff's Office, Austin/Travis County Local Registrar, physicians and the Medical Examiner's Office. Each April, national Child Abuse Awareness and Prevention Month, the team calls a press conference to share with the public the findings of the Travis County Child Fatality Review Team Annual Report. The Annual Reports issued by the team are available on the team's website at http://www.centerforchildprotection.org/CFRT.htm.

Victoria County Child Fatality Review Team

This team reviews child deaths in Victoria County. Gilda Miller, RN of Citizens Medical Center, serves as the team's coordinator. The team includes members from the Office of the District Attorney, law enforcement, physicians, justices of the peace, EMS personnel, the local registrar, Victims Assistance, the Texas Department of Public Safety, the Victoria Independent School District and Child Protective Services. The team spearheaded an initiative to establish a teen helpline with a focus on reducing teen suicide. The team enlisted media support and visited schools and youth homes to promote the availability of the helpline. Although the responsibility for the helpline has been assumed by a hotline service in Oklahoma, the team brought the issue to the attention of the public and created the service for area teens. The Victoria County CRT continues to work on coordinating training for area professionals (EMS, Department of Public Safety, both area hospitals and law enforcement) to conduct a car seat clinic for area parents. Once trained, these professionals will sponsor public events to inspect child car seats and educate parents about child safety while traveling.

Houston/Harris County Child Fatality Review Team

The Houston/Harris County CFRT reviews child deaths for Houston and the outlying Harris County area, encompassing many communities in the metropolitan area. Stephani Adams of Harris County Public Health and Environmental Services coordinates the team. Team membership includes law enforcement from Houston, Harris County, Pasadena and Baytown, as well as educators, the Office of the District Attorney, physicians, Houston Vital Statistics, Texas Children's Hospital staff, Child Protective Services, mental health providers, the Children's Assessment Center and the Office of the Medical Examiner. In addition to reviewing deaths in the most populous county in Texas, the team spearheaded a campaign to reduce incidence of water-related deaths and injuries to children in the 2006 swimming season. In collaboration with Houston Police Department Juvenile and Lake Patrol Divisions, Texas Children's Hospital, the Houston Fire Department, Harris County Public Health and Environmental Services, and the Safe Kids Greater Houston Water Safety Team, the team planned and executed a series of well-publicized events in its *April Pools Day* campaign. Events, held in Houston, greater Harris County and adjacent Galveston County, included an Aquatic Risk Management Seminar during which managers from area pools and water parks received updates on strategies and procedures to enhance pool safety and a refresher course on safety techniques. The *April Pools Day* event, held on April 1 at the YMCA Post Oak, demonstrated ways to keep children safe around bodies of water and showed parents and adults how to prevent and reduce water-related incidences of death and injuries. The team plans to make this an annual event. The Houston/Harris County CFRT also maintains a website at www.hd.co.harris.tx.us/opa/Child_Fatalit_Review_Team/Default.htm, where child death data is available to the public.

April Pools Day Event

CHAPTER 2: RECOMMENDATIONS

WHAT TO EXPECT IN THIS CHAPTER

As part of the requirements of Chapter 264, Subchapter F, Section 503 of the Texas Family Code, the SCFRT is tasked to "make recommendations to the governor and the legislature for changes in law, policy, and practice to reduce the number of preventable child deaths." In the 2002-2003 report, the State Child Fatality Review (SCFRT) made seven recommendations. Of these recommendations, three (42.8%) were implemented through governmental and/or State agency action. In this report, there are six recommendations made to the Governor and State Legislature organized into three sections – Preventing Abuse and Neglect, Sudden Infant Death Syndrome, and Child Fatality Review Operations.

Also as part of the requirements of the Texas Family Code, the SCFRT is tasked to "perform the functions and duties required of a citizen review panel" and provide "recommendations regarding the operation of the child protective services system." To fulfill this requirement, the SCFRT also provides recommendations to Department of Family and Protective Services (DFPS).

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

The recommendations offered are based on:

- data presented in this report,
- recommendations made by local teams, and
- the expertise and experience of the local CFRT members.

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

Child Abuse and Neglect Education Requirements

- **Require child abuse/neglect awareness education as part of licensure for all healthcare professionals practicing in Texas.** Healthcare professionals, such as physicians, dentists, therapists and nurses, have contact with children and need to be attuned to the physical and emotional signs that a child may be a victim of abuse or neglect. Requiring theses professionals to receive regular training on child abuse and neglect as part of license renewal will keep them informed and aware of this responsibility and should result in higher rates of detection of children at risk.

- **Require education on proper certification of death as part of licensure for all physicians practicing in Texas.** Understanding why children die is critically important in determining how to prevent future deaths. At present, there is wide disparity in how certain causes of death are used by physicians certifying death records. Requiring physicians to receive regular training on proper completion of death records as part of license renewal will result in improved data quality and enhanced understanding of why Texas children die.

Sudden Infant Death Syndrome

- **Expand funding for all autopsies of infants and children under six years of age.** Current law allows for reimbursement of child autopsies if the cause of death is SIDS. Because there is growing perception that this cause of death is improperly applied and the result of inadequate death scene investigation, it is recommended that reimbursement for infant autopsies should be expanded beyond the SIDS cause of death. This will lead to more accurate information about infant death and provide insight into how infant deaths can be prevented. Also, given the higher rate of infants whose families are involved with Child Protective Services who die with a cause of death of SIDS (Chart 7 on page 27), it is critically important that the cause of death be precise.

- **Allocate funding for creation of statewide Sudden Unexpected Infant Death (SUID) Prevention Program that includes mandatory SUID education prior to infant hospital discharge, incorporation of SUID education into well-baby visits with physicians, and into middle school and high school "Lifestyle" courses, as well as a home visiting program to monitor children at high risk.** Parents and caregivers need increased education about SUID. Funding would be required to distribute message broadly in hospitals prior to discharge, in doctors' offices and in schools. Infants identified as high risk (i.e., those whose families are involved with CPS, Chart 7 on page 27) and their parents will benefit greatly from home visitation and one-on-one education about prevention.

Child Fatality Review Operations

- **Require all Texas counties to have an independent CFRT or participate in a multi-county CFRT to review all deaths of children under 18 years of age.** At present, 49.1% of child deaths are reviewed by CFRTs (page 8). To fully understand child death in Texas and to address prevention efficiently, 100% child death review coverage is a goal. A statutory requirement will reinforce Texas' commitment to child death review and prevention and ensure development of teams in uncovered areas.

- **Amend statute to alter composition of SCFRT.** Amend statutory language to change the composition of the State Child Fatality Review Team Committee to include the Texas Department of Public Safety and the Texas Department of Transportation as required members of the SCFRT Committee, and add language allowing for additional members as needed. Membership in the State Committee and the local teams is defined by statute. As child death review matures in Texas, the need for more professional expertise has been identified. DPS also collects data related to child injury and fatality and would bring valuable additional information to the table. TxDOT has great expertise in doing preventive outreach to ensure that children are in car seats that are safe and properly installed, and would be valuable partners in prevention. The statute addressing membership in the State Committee should include language as found in the statutes defining local Review Team membership: "Members of a review team may select additional team members according to community resources and needs." (Texas Family Code, §264.505(d))

RECOMMENDATIONS ON CHILD PROTECTIVE SERVICES OPERATIONS

Focus on providing preventive services and close monitoring after the birth of a child to a family with an open CPS case. Infants have the highest risk of fatality, and their vulnerability is even greater when in a home already identified as high-risk. Special attention must be paid to these children and families. It is recommended that

- an updated risk assessment and Family Service Plan be completed within 30 days of the birth of a child to a family with an open case;
- weekly home visitation be mandatory for at least three months; and
- weekly home visitation includes education about infant care, infant development, SIDS risk reduction, other issues identified for the new infant and family, and assistance in accessing any necessary services, including appropriate child care to strengthen the infant's monitoring network.

Prepare and require CPS casework staff to do in-depth, comprehensive, well-researched home studies on potential relative placements for children and to provide extensive support, services and monitoring to ensure children's needs and safety are provided in relative placements. Relative placements for children are routinely sought for children who are unsafe in their own homes. Greater care needs to be taken to assess the appropriateness of the relative placement, with emphasis on the relative's commitment to the children's safety, the safety network, real limitations on parental contact and involvement, and the relative's ability to protect the children placed in the home. It is recommended that

- CPS staff provide additional support to kinship placements, especially those that are done voluntarily and are the basis of case closure without court intervention. These families critically need access to support services from CPS for a minimum of three months after the case is closed;
- CPS staff receive training to conduct thorough assessment of potential relative placements, with special care devoted to considering extended family for placement in cases where substance abuse is an issue;
- thorough risk assessment be conducted when considering relative placement; and
- relatives receive all information on the children's needs (including medical, social, psychological and special needs) and receive support services to meet those needs.

Follow and implement established CPS protocols for evaluation of drug-endangered children. With drug abuse at epidemic levels, it is urgent that there be specific strategies for evaluating and serving children who are living in a drug environment. Long-term impact of exposure to environmental toxins and drug-using caretakers upon developing children is yet to be fully understood. Implications are overwhelming for the range of services needed by these children, and CPS should be proactive in planning for these children's needs.

Implement intensive, ongoing training of CPS staff to meet the wide variety of family situations and children's needs. CPS staff are trained for basic performance of child protection duties, but the range of issues impacting families and children is constantly evolving, and training and professional skill-building of staff must be a constant and part of the job to keep pace and to protect children. It is recommended that ongoing professional training be required for CPS casework staff and supervisors. It is recommended that CPS supervisors conduct ongoing surveys of staff as to training needs. It is recommended that professional training be provided to CPS staff so they can increase their knowledge, understanding and skills in the following areas:

- conducting thorough risk assessments;
- assessment for risk of sexual abuse;
- domestic violence intervention and treatment;
- effectively working with medical professionals to understand and meet the medical and special needs of children;
- effectively working with children with substance abuse exposure and with families with substance abuse problems; and
- how to document thoroughly case notes so that subsequently assigned staff or supervisor may be able to understand the status of the case and be able to act quickly and appropriately as needed.

RECOMMENDATIONS TO THE DEPARTMENT OF STATE HEALTH SERVICES

Preparation of Local Teams

- **Develop multi-disciplinary training for local team members on the following topics: child death reviews, the new online child fatality recording system, working with local governments to enact ordinances that enhance child safety, and confidentiality.** Child death review is a complex process performed by committed volunteers. New issues related to child death review, data collection and developing community-based prevention programs are on the rise. In order for volunteer-based teams to do the best job possible, ongoing training must be offered.

- **Allocate funding ($7,500 per team per year) for training and support of new and current community volunteers serving on local Child Fatality Review Teams.** CFRTs are made up exclusively of volunteers. Physicians, attorneys, law enforcement, child protective service workers, mental health providers and others donate their time to serve on the local teams. In order to keep them current with training, funding is needed. When the teams had $5,000 funding for training through DFPS, more were engaged and active, and all teams attended the state-sponsored Annual CFRT Conference. The current level of funding for each team is $1,000, which is not sufficient to provide training and support to the teams. There has been a parallel decline in participation by teams that couldn't sustain on drastically reduced support. Increasing the training allotment for the teams would ensure that the team members are properly trained and that child death review in Texas is expanded.

- **Resume the Annual Child Fatality Review Conference for Texas teams.** CFRTs operate in their own jurisdictions under the oversight of the Child Fatality Review Coordinator at DSHS. In order to reinforce standard practices in child death review and prevention, an annual gathering of the teams is ideal. It is an efficient way to deliver consistent messages to all teams, as well as an opportunity for teams to share successes and challenges and be part of a statewide movement to protect Texas children. An annual conference was held in the past when the teams were organized under DFPS, and there are frequent requests from teams that DSHS reinstate this team-building practice.

- **Develop a Resource Library and technical assistance for local teams so that they can identify culturally and linguistically competent model programs for community-based injury prevention programs when planning local initiatives.** Local teams do a good job in reviewing deaths and submitting data. Putting together effective prevention programs is more of a challenge as many of the team members from the different disciplines do not have experience in doing this. Creation of a DSHS Resource Library, coupled with technical assistance from CFRT staff, will be a great help to local teams and their prevention initiatives. This will also facilitate the measurement of prevention initiative effectiveness and future recommendations about statewide implementation.

- **Develop training for local teams to structure prevention programs to measure program success and impact in their communities.** As stated above, development of prevention programs that really work is often beyond the scope of the CFRT team members. By training teams on how to structure programs and measure effectiveness, much can be learned about what works in different communities and how to be most efficient with prevention program dollars.

- **Facilitate communication between Child Fatality Review Teams to discuss trends and consult on common problems and successes.** All local teams have a designated coordinator. One of the frequent comments from the coordinators is that they feel somewhat isolated in their role and would benefit from more frequent contact with each other through conference calls and meetings. This effort to facilitate communications could also result in increased standardization of the process and improved data quality.

Data Quality Improvement

- **Incorporate Department of Public Safety data regarding child fatalities in motor vehicle crashes, in homicides, and in firearm fatalities with child fatality review data to flesh out a fuller picture of child death in Texas.** Meaningful child death review pivots on sharing of information from multiple disciplines. By adding a DPS member to teams as well as gaining access to DPS data on child deaths, a greater understanding of certain types of child death will be attained.

- **Facilitate access to investigative traffic reports to all local teams.** Investigative traffic reports, whether conducted by DPS or local officials, often contain critical information for child death reviews. Access to this information by the local teams will greatly increase insight into contributing factors to child deaths in motor vehicle crashes.

Child Death Prevention Initiatives

- **Allocate funding for community-based injury prevention projects and education of families and children based on child fatality data, review and analysis.** Child fatality review throughout Texas often reveals different issues in different communities. As a matter of process, the individual teams reviewing child deaths ask "was this death preventable?" and consider what can be done to prevent future deaths. According to patterns observed through child death review, different teams work within their communities to run education campaigns that will reduce child injury and death. Allocation of funding for campaigns tied to child fatality data would be a cost-effective investment in the safety of Texas kids.

- **Evaluate drowning prevention programs in preparation for a statewide water safety/drowning prevention and education campaign.** The Harris County CFRT ran the *April Pools Day* campaign in response to an increased number of deaths due to drowning reviewed by the team (page 15). Given that child drowning is an issue in Texas, evaluation of programs such as *April Pools Day* is critical to understanding which approaches will save lives.

CHAPTER 3: PREVENTION

WHAT TO EXPECT IN THIS CHAPTER

Throughout Texas there are local child fatality review teams (CFRTs) that meet on a regular basis to review child fatality cases and to make recommendations about how the participating agencies can improve coordination of services and investigations. In the review meeting, team members share information about the child, the family and the circumstances surrounding the death. The team then considers the following question:

- Was this death preventable?

If the death is determined to be preventable, the team then considers:

- "Could this death have been prevented with a change in the parents, change in the community, or change in the child?"

If the death was preventable with a change in the parents, community, and/or child, the team, using a predetermined list, indicates what changes could have contributed to the prevention of the death. The data collected about each child death were submitted to the Texas Department of State Health Services for compilation and analysis. From the knowledge and insight gleaned from the multi-disciplinary reviews, the teams initiate prevention measures in their communities.

This chapter presents these findings for cases reviewed between 1999 and 2004. All data reported in this chapter are self-reported beliefs of the team based on their review of the individual case reviews. Data on which these findings are based are presented, in part, in *Chapter 4: Data & Analysis*.

Information is presented for three categories: Sudden Infant Death Syndrome (SIDS), injuries, and suicide. Injuries are presented as a group because the recommendations are similar across causes of injury with the exception of suicide. In addition to being part of the injury group, suicide is presented individually because of the unique mental health aspects related to this cause of child death.

Overview of Preventable Deaths

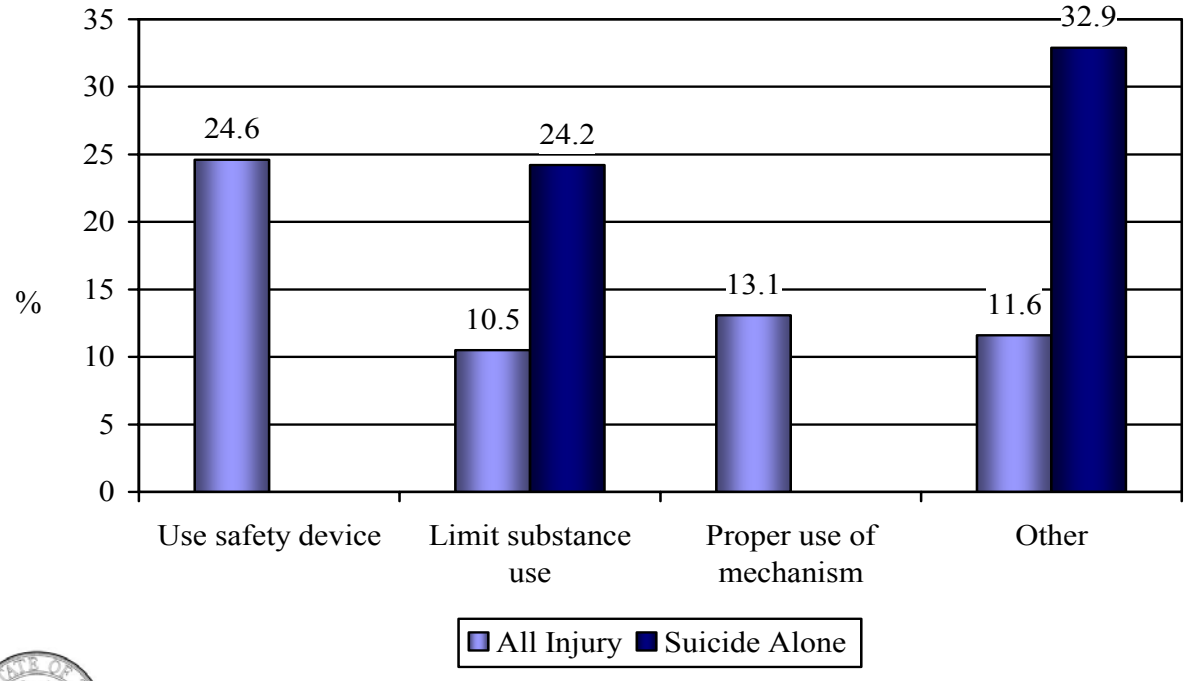
Among 12,275 child deaths reviewed between 1999 and 2004, 30% (3,654) were deemed to be preventable. Older children (15 to 17 years of age) accounted for the greatest proportion of preventable deaths (34.2%). Children under four years of age accounted for 39.9% (infants: 18.7%; ages one to four: 21.2%) of the preventable deaths.

If through a combination of policy, program, and intervention these child deaths could be prevented, the child mortality rate would decline significantly. Of the 1,966 cases reviewed in 2004, 522 were determined to be preventable. If the 4,004 child deaths in 2004 were reduced by 522, the child mortality rate would decline from 64.9 child deaths per 100,000 to 56.4 child deaths per 100,000, a decline of 13.1%.

Changes in the Child

Deaths that could be prevented through changes in the child are limited to deaths occurring by injury. Of the 470 preventable injury deaths, 44% (206) could have been prevented in part through some change in the child's behavior. Regarding unintentional injuries, this most often refers to the utilization of safety devices, such as seat belts and personal flotation devices. Thirty five percent of the motor vehicle occupant deaths to children 10 years of age and older might have been prevented if each child had buckled up. Through proactive intervention, suicide can be prevented. The most commonly identified changes to prevent suicide were to limit substance use and to seek help or counseling, which is included in the "other" category.

Chart 4. Changes in Child Behavior that May Contribute to Preventing Child Mortality, 1999 through 2004

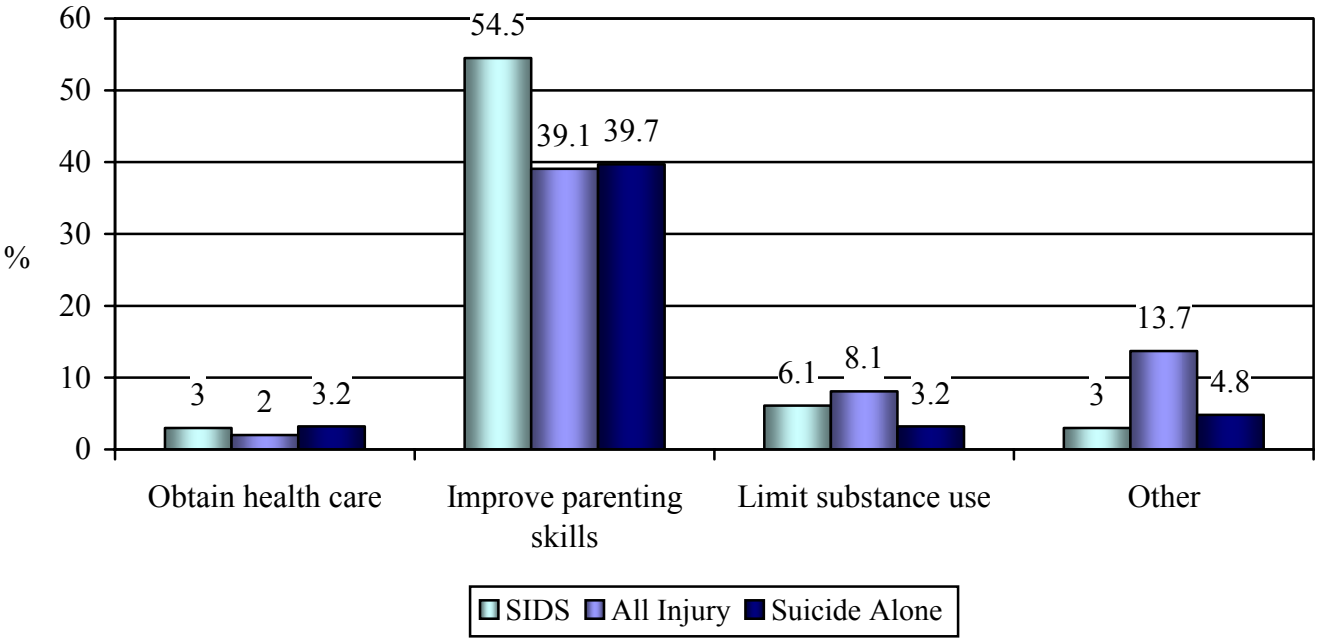


Changes in the Adult

Local teams concluded in their reviews of deaths from SIDS, injuries, and suicide that changes in the behavior of an adult could contribute to the prevention of these deaths. Specifically, "improved parenting skills" was identified as a prevention factor in more than 50% of SIDS deaths, nearly 40% of injury deaths, and 40% of suicide deaths. Improved parenting skills most often entails some form of supervision (for example, ensuring utilization of safety devices such as seatbelts, or bike helmets), more actively keeping the child from dangerous situations, or changes in parenting behavior (for example, placing a child on his/her back to sleep or not exposing children to environmental tobacco smoke).

Parents must be engaged in efforts to prevent child death. Several key behaviors that can contribute to the prevention of child death are in the control of the parents. Only 30% of the SIDS deaths reviewed indicated that the child was in the appropriate sleep position. Between 1999 and 2004, Texas CFRTs reviewed 745 SIDS deaths. In the majority of these reviews, behaviors that reduce the risk of SIDS were not being practiced. In reviews of firearm deaths, the firearm was stored appropriately in less than 10% of the deaths reviewed. Of the 40 drowning deaths of children less than 10 years of age, 24 (60%) were being supervised by at least one parent at the time of the drowning. In two out of three situations, the child was out of sight of the parent when the drowning occurred. If adults can improve their parenting by adopting behaviors that reduce the risk of childhood death, progress can be made to reduce child mortality.

Chart 5. Changes in Adult Behavior that May Contribute to Preventing Child Mortality, 1999 through 2004

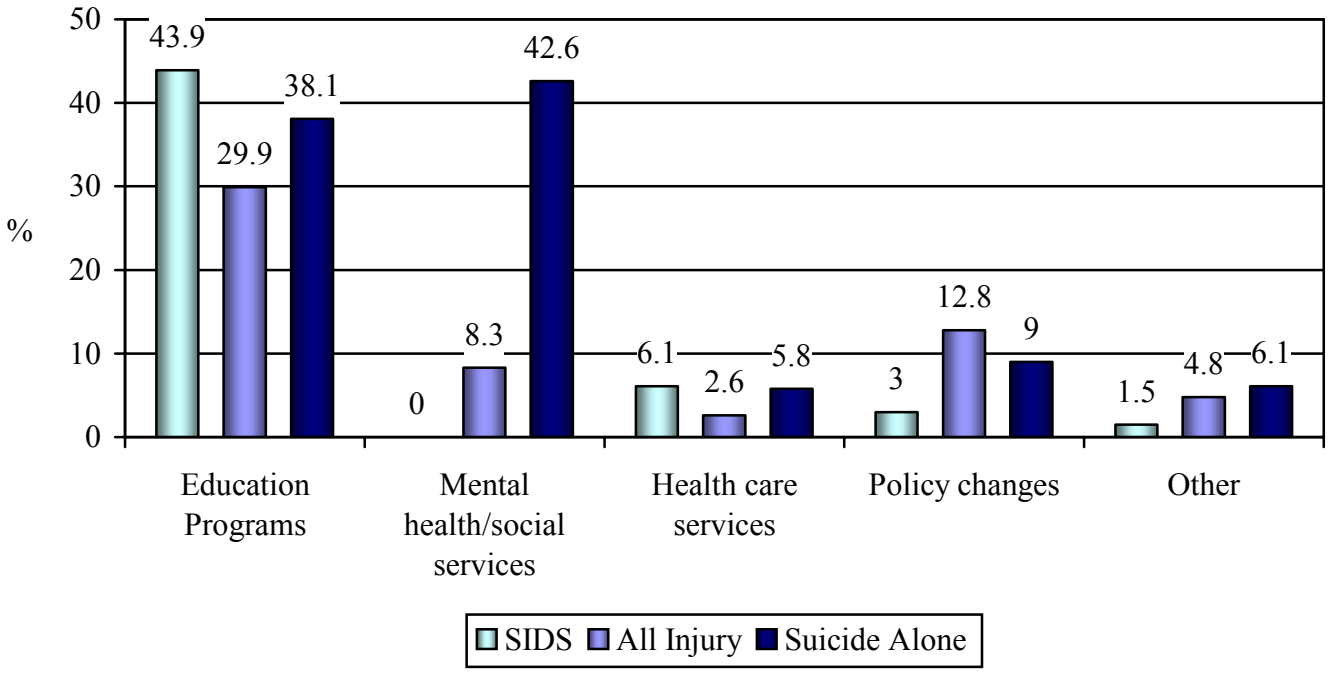


Changes in the Community

CFRTs reported that 30% of the SIDS deaths and more than 40% of the injury and suicide deaths could have been prevented through community-level education. In reviews of suicides, CFRTs recognized the need for increased mental health services. In 43% of the suicide cases reviewed, CFRTs concluded that expanded mental health/social services might have contributed to the prevention of the child's death.

These findings suggest a need for programs that educate communities about the risks of child death and prevention strategies. Expanded and improved community-level education may also help parents improve their knowledge of the risks to children and improve their parenting skills. While community health education often takes the form of classes or mass media messages, these messages should be delivered through multiple methods to ensure maximum coverage.

Chart 6. Changes at the Community Level that May Contribute to Preventing Child Mortality, 1999 through 2004



Targeting Disparities

Gender and racial/ethnic disparities were found across several of the causes of death. Males had higher rates of mortality from SIDS (page 35), drowning (page 38), motor vehicle crashes (page 40), homicide (page 43), firearm deaths (page 48), and suicide (page 45). The largest general disparity was found among firearm deaths, for which males had a four-fold higher rate than females.

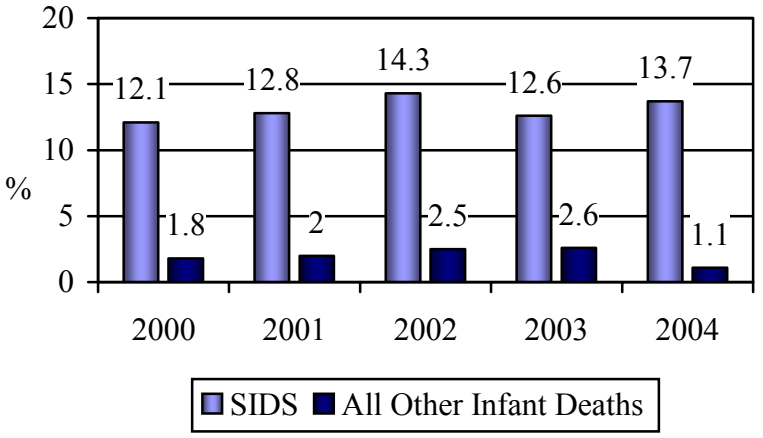
Black children had higher rates of death than all other races/ethnicities for SIDS, drowning, homicide, and firearm deaths. For motor vehicle crashes and suicide, White children had higher rates. Rates of SIDS and firearm deaths among Black children were double that of White children. For homicide, the rates among Black children were six times greater than White children and three times greater than Hispanic children.

These findings suggest a need for improved targeting of prevention activities and the continued creation of culturally sensitive messages. As greater attention is given to racial/ethnic health disparities, however, the gender differences identified in this report cannot be overlooked. Health educators and communication experts need to determine how best to reach young males to encourage them to change behavior that is potentially harmful.

SIDS and DFPS Involvement – An Opportunity for Action

Through their reviews, local CFRTs may have identified a leverage point where targeted education and intervention could have the greatest impact on SIDS prevention. CFRT data include information on a family's prior involvement with DFPS. In cases reviewed by local CFRTs, the rate of prior DFPS involvement among children who die of SIDS is at least 10 percentage points greater than the rate among all other infant deaths each year between 2000 and 2004 (Chart 7). These data suggest that increased education and intervention targeted to families with prior DFPS involvement may contribute to the prevention of SIDS deaths. Additional investigation of this relationship is warranted.

Chart 7. Prior Involvement with DFPS among Infants who Died of SIDS and All Other Causes, 2000 through 2004



Source: Texas DSHS, Child Death Registry, 1999-2004

While prior involvement with DFPS was indicated, when this involvement occurred is unclear. Additionally, prior DFPS involvement could range from an unsubstantiated report to confirmed abuse and neglect. This association, however, may be explained by a selection bias due to the method used by CFRTs to select cases for review. The presence of selection bias may lead to artificial increases in the proportion of SIDS deaths with DFPS involvement that were reviewed. However, while selection bias is possible, the representativeness of the cases reviewed reduces the likelihood that such bias was present (Table 1 through 3, pages 29 through 30).

CHAPTER 4:
DATA & ANALYSIS

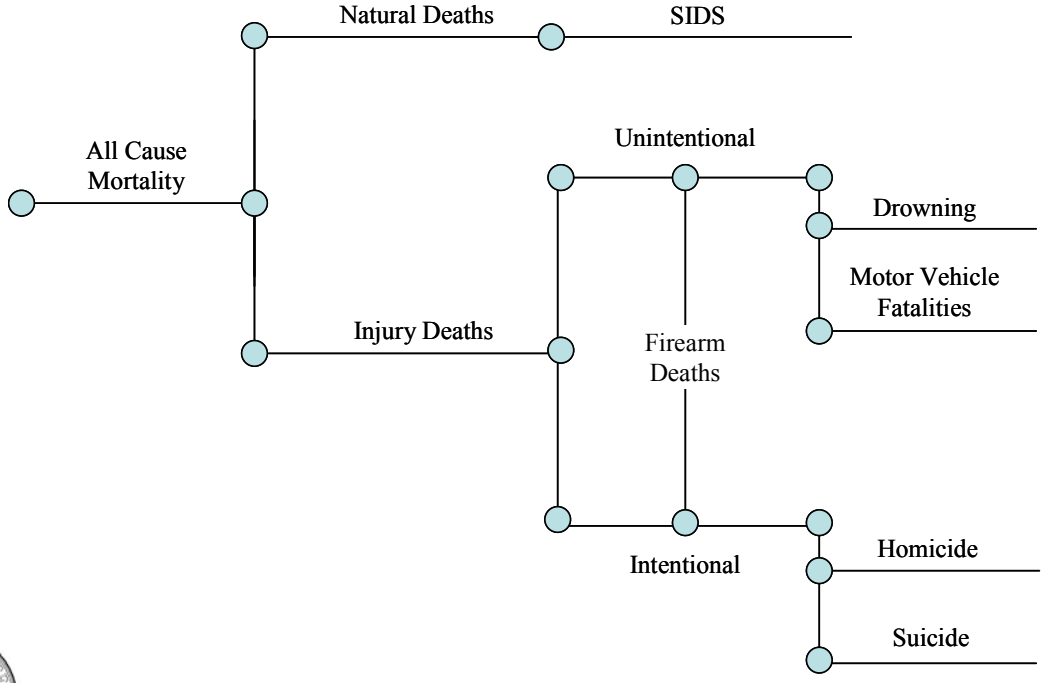
WHAT TO EXPECT IN THIS CHAPTER

This chapter includes detailed analyses of several leading causes of child mortality. After an overview of mortality trends in Texas, the chapter presents counts of an event and incidence rates for specific causes of death from death certificate information. Rates for specific causes of death (Tables 4 through 8) are calculated using population-level data provided by the Texas A&M State Data Center and queried using Epigram (Goldman DA. The EPIGRAM computer program for analyzing mortality and population data sets. *Public Health Reports*. 1994;109:118-124.). The data used in this report were last updated in November 2006. Included in Appendix C are the population-level data used to calculate the rates presented in this report.

For each cause of death, a general overview of child mortality is provided that includes trends over time and data on disparities by race/ethnicity, gender, and age, all of which is provided through the death certificate data file. These data are then followed by more detailed information derived from the CFRTs. Each chart and table cites the source of data. Data derived from death certificates are cited as *Texas DSHS, VSU* with the appropriate year(s) to follow. When CFRT data are used, the source reads *Texas DSHS, Child Death Registry* with the appropriate year(s) to follow. Specific information about the circumstance of death were not always available for all reviewed deaths, therefore the number of cases in which the information was available is noted within each table or chart.

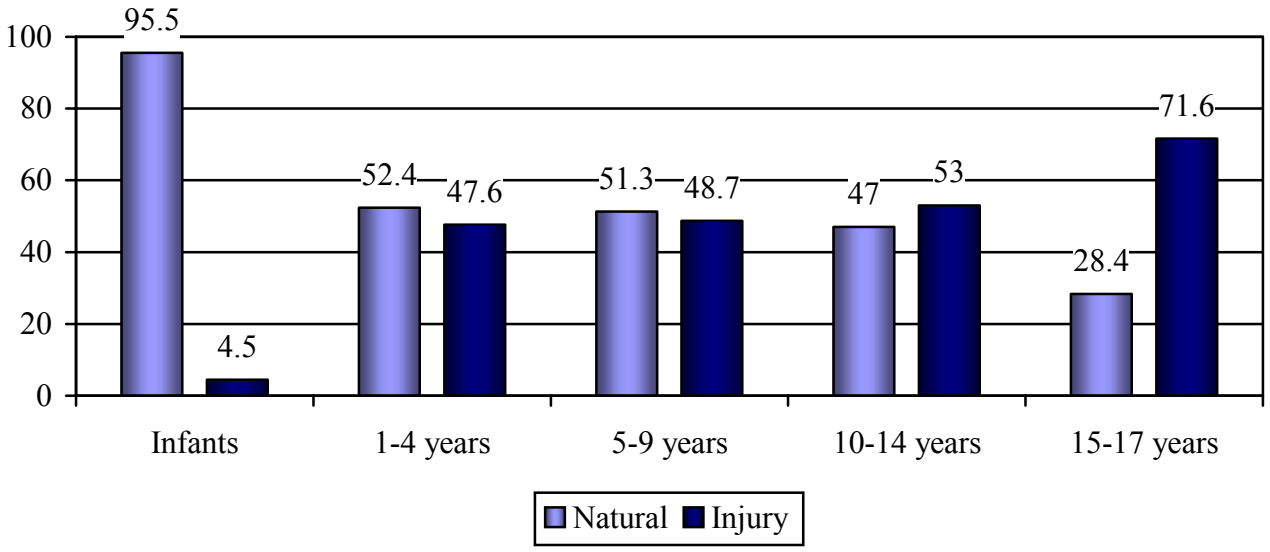
All causes of mortality can be divided into natural causes and injuries (Figure 2). In this report, the only natural cause of death presented is Sudden Infant Death Syndrome (SIDS). Injuries are further divided into unintentional and intentional injuries. The unintentional injuries presented here are drowning and motor vehicle crashes. The intentional injuries presented are homicide and suicide. Firearm deaths are presented separately because these deaths overlap with other causes of death and include both intentional and unintentional injuries.

Figure 2. Causes of Mortality Included in the 2004 CFRT Annual Report



The number of deaths due to injury has declined 14% in the last five years, whereas there were 330 more deaths due to natural causes in 2004 than in 2000. The leading cause of death changes with age, as injuries surpass natural causes after age 10 (Chart 8); of the 1,606 deaths among children 1-17 years of age, 57% were due to injuries.

Chart 8. Child Deaths by Cause and Age, 2004



The number of deaths reviewed by cause varies. The proportion of reviewed deaths for one cause may be significantly higher than other causes. While the proportion of deaths reviewed may be relatively low, the demographic characteristics of these deaths are similar enough to the "unreviewed" cases to lend some degree of confidence that the specific circumstances of death derived from the reviews accurately reflect child fatalities in Texas (Table 1 through 3).

Table 1. Comparing Reviewed Deaths to All Deaths, All Causes of Mortality, 2004

	2004 Child Population Estimates (%)	2004 Death Certificates (%)	2004 CFRT (%)	1999-2004 CFRT (%)
White	40.4	35.9	29.4	32.9
Black	12.6	20.3	19.6	22.4
Hispanic	43.6	41.7	34.6	39.4
Other	3.4	2.2	2.4	2.9
Male	51.1	57.3	57.8	58.0
Female	48.9	42.7	42.2	42.0
Infants	6.1	59.9	61.8	57.9
1-4 yrs	23.0	11.8	11.5	12.5
5-9 yrs	26.2	6.9	5.9	6.8
10-14 yrs	28.0	8.8	8.6	8.6
15-17 yrs	16.6	12.7	10.3	14.2

Table 2. Comparing Reviewed Deaths to All Deaths, Natural Causes of Mortality, 2004

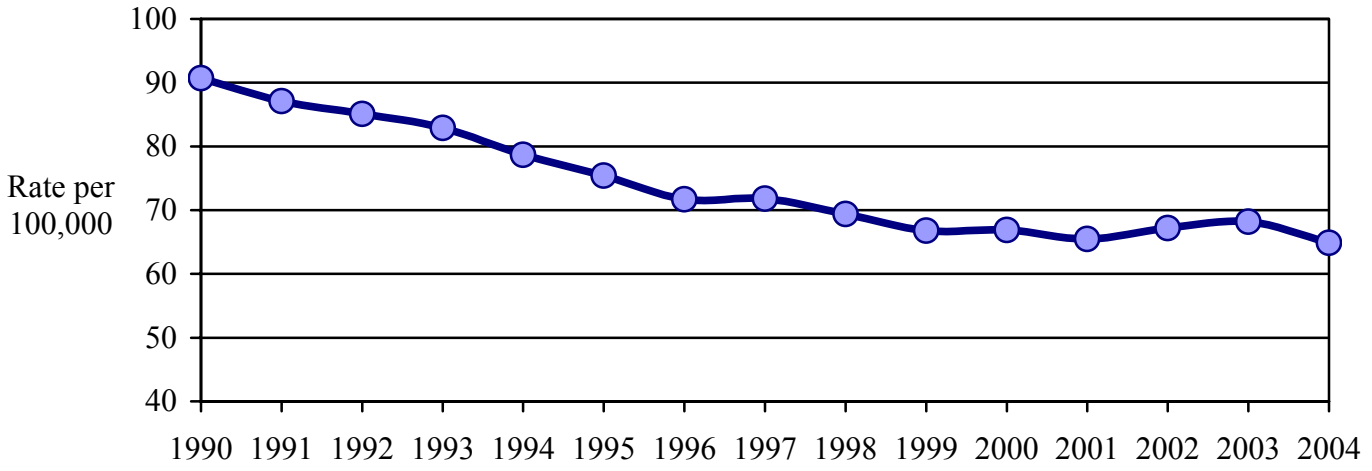
	2004 Death Certificates (%)	2004 CFRT (%)	1999-2004 CFRT (%)
White	33.1	25.9	29.8
Black	21.2	18.4	23.6
Hispanic	43.3	33.6	40.2
Other	2.4	2.5	2.9
Male	55.2	55.0	55.1
Female	44.8	45.0	44.8
Infants	76.6	78.8	75.6
1-4 yrs	8.3	7.7	8.7
5-9 yrs	4.8	4.1	4.9
10-14 yrs	5.5	5.7	5.9
15-17 yrs	4.8	3.6	5.0

Table 3. Comparing Reviewed Deaths to All Deaths, Injury Causes of Mortality, 2004

	2004 Death Certificates (%)	2004 CFRT (%)	1999-2004 CFRT (%)
White	44.2	39.1	40.2
Black	17.5	21.3	19.2
Hispanic	36.7	37.9	37.4
Other	1.6	2.3	3.0
Male	63.5	65.3	64.3
Female	36.5	34.7	35.7
Infants	10.6	14.9	14.4
1-4 yrs	22.0	21.9	21.9
5-9 yrs	13.3	11.2	11.6
10-14 yrs	18.3	16.5	15.7
15-17 yrs	35.7	35.5	36.4

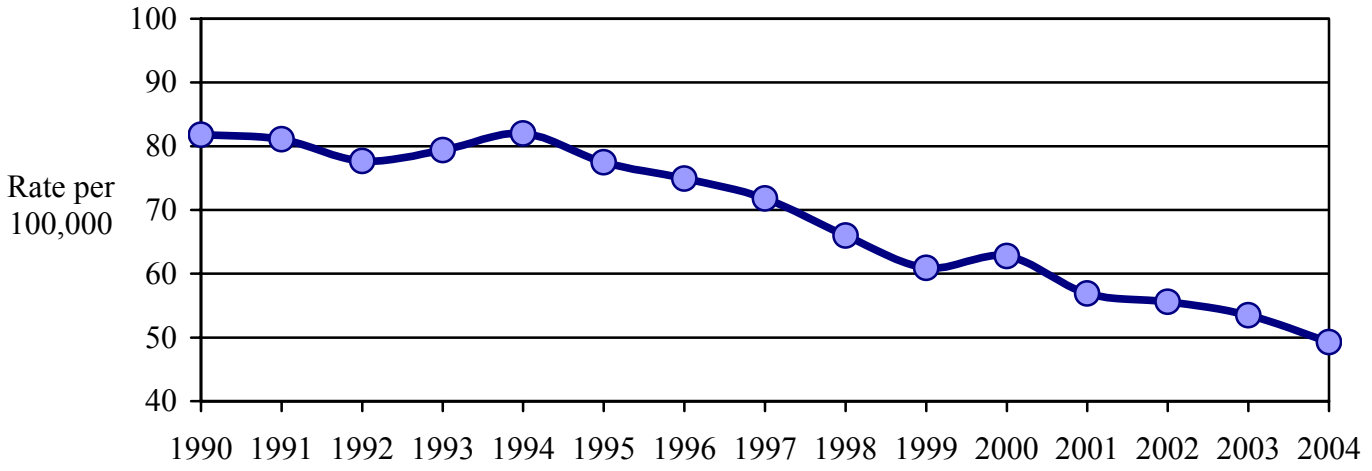
Every year more than 4,000 Texas children under the age of 18 years die. Over the course of time, the number and rate of child deaths has been substantially reduced. There were 4,407 deaths in 1990, a rate of 90.7 deaths per 100,000 children in the population. By the end of the decade, the rate had declined 26% (3,849 deaths, 66.8 deaths per 100,000 children in 1999). However, there has been little decline in the rate of child death during the first five years of the 21st century (Chart 9). This pattern of steady declines followed by a period of little to no change was also found when the data were stratified by gender and race/ethnicity. This pattern also was duplicated among each age group with the exception of children 15 to 17 years old among whom the rates continue to decline (Chart 10). Trends in mortality data by age, race/ethnicity, and gender can be found in Appendix D.

Chart 9. Trends in Child (0 through 17 years of age) Mortality, 1990 through 2004



Source: Texas DSHS, VSU, 1990-2004

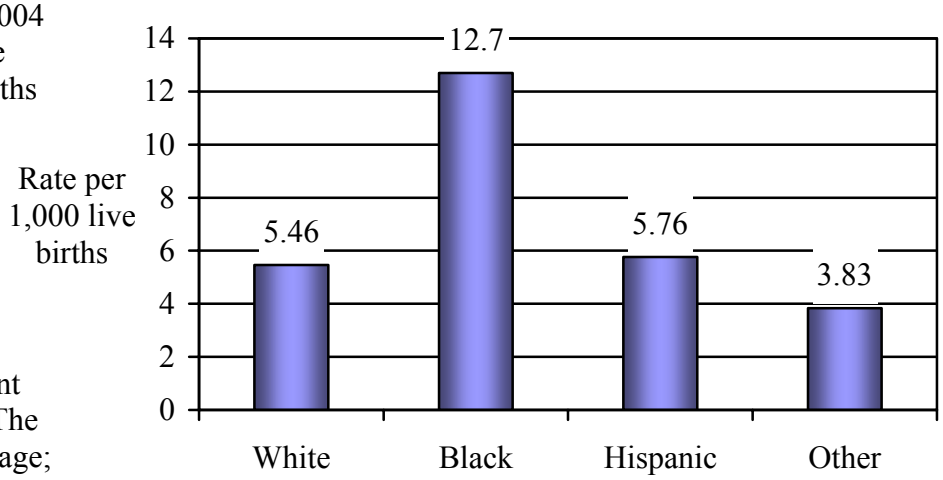
Chart 10. Trends in Child (15 through 17 years of age) Mortality, 1990 through 2004



Source: Texas DSHS, VSU, 1990-2004

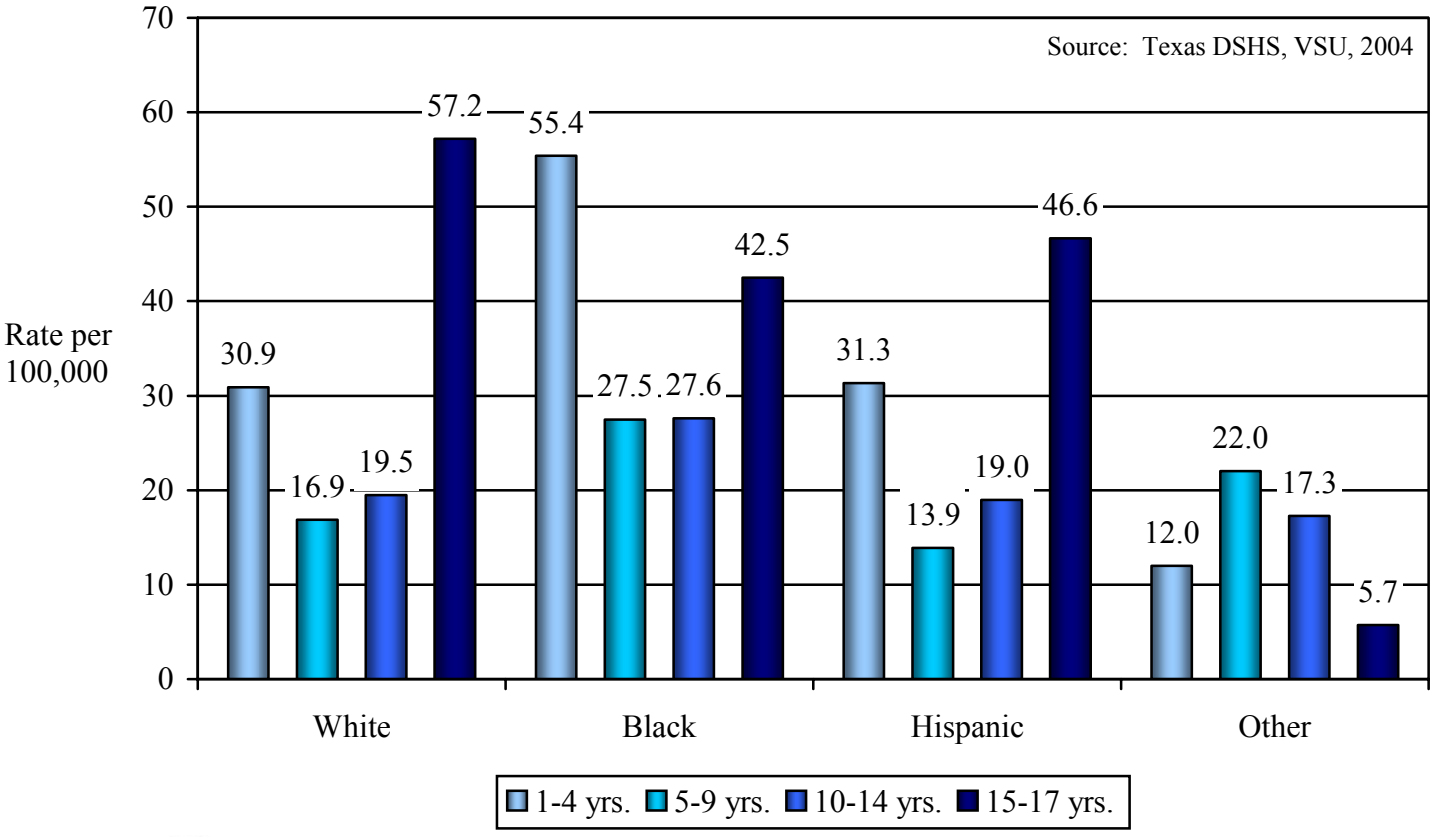
Among children ages 17 years and less, the majority of deaths occur among infants. Nearly 60% of the 4,004 child deaths in 2004 were to children less than one year of age. Many infant deaths occur during the first 28 days of life (neonatal period) from causes that are often difficult to prevent, such as perinatal conditions, prematurity, and congenital malformations. Males account for 57% of all child deaths. The risk for males increases with age; two out of three adolescent deaths (15 to 17 years of age) were male.

Chart 11. Infant Mortality Rates by Race/Ethnicity, 2004



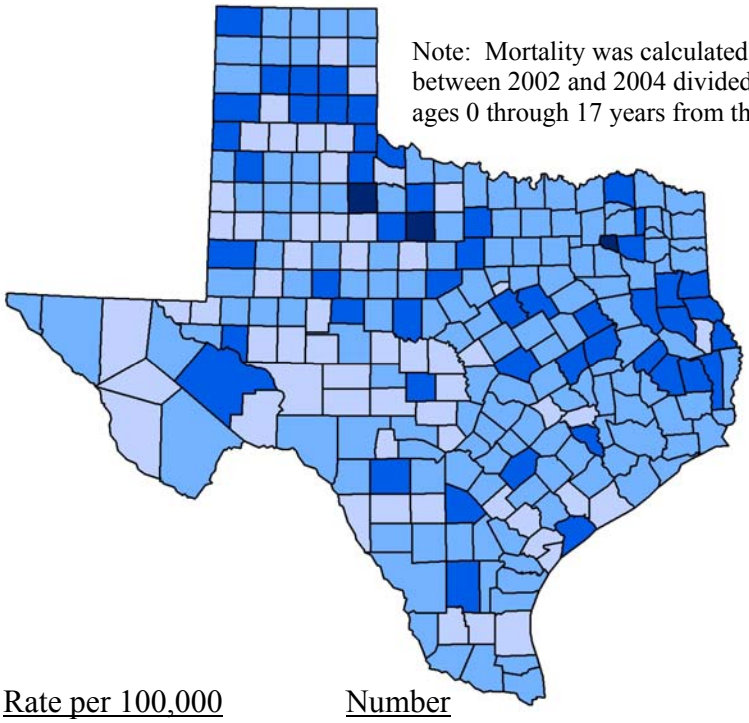
Black children are overrepresented among childhood deaths, particularly among the young. Black infant mortality rates are double those of other racial/ethnic groups (Chart 11). By the time of adolescence, however, the highest mortality rates are among White, non-Hispanics (Chart 12).

Chart 12. Child (Ages 1 through 17 years) Mortality Rates by Race/Ethnicity and Age, 2004



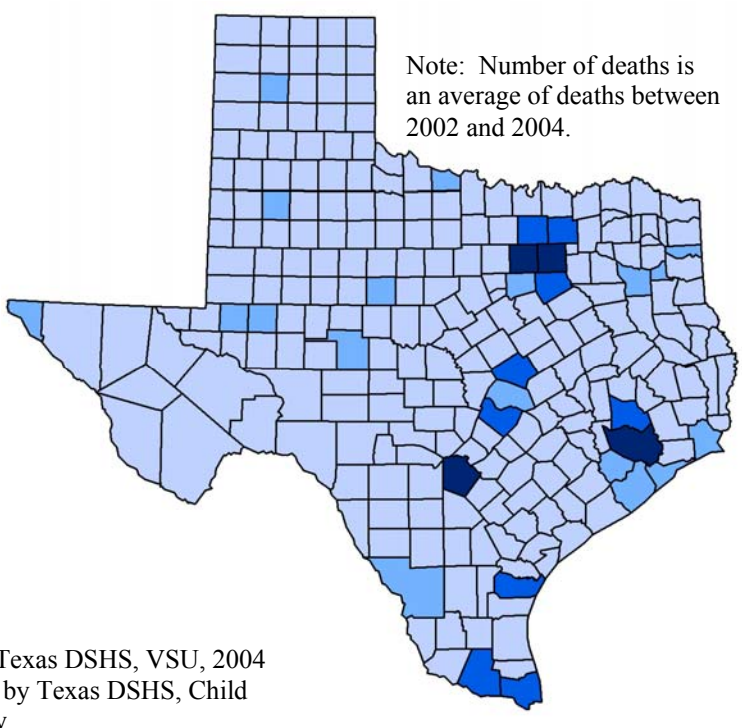
There are significant geographic differences in child mortality throughout Texas. Texas is geographically diverse, encompassing six of the United States' 21 largest cities (Houston – 4, San Antonio – 7, Dallas – 9, Austin – 16, Forth Worth – 19, El Paso – 21) as well as areas in West Texas that are classified as frontier. When analyzing child mortality patterns by geography, it is important to remember that a county with a relatively small population may have a high rate per 100,000 but a small number of deaths, while a large county may have a lower rate but significantly more deaths. Map 5 illustrates the geographic disparities in child mortality rates per 100,000 while Map 6 displays the number of child deaths per county. Of Texas' 254 counties, 41 (16%) had child mortality rates in excess of 100 child deaths per 100,000 population. However, generally, the population in these counties is relatively sparse. The average county population among these 41 counties was 5,172 children under 18 years of age compared to the average county size of 23,176 children less than 18 years of age throughout Texas. The counties with the highest mortality rates (Armstrong, Throckmorton, King, and Raines) each had an average of less than 10 deaths annually. However, the counties with the greatest numbers of deaths (Bexar, Tarrant, Dallas, and Harris) had mortality rates of 75.1 deaths per 100,000 or less. In 20 of the 254 Texas counties, the average number of deaths for 2002 through 2004 was zero.

Map 5. Average Child Mortality Rates by County, 2002 through 2004



Note: Mortality was calculated using an average of deaths between 2002 and 2004 divided by the number of children ages 0 through 17 years from the 2000 Census.

Map 6. Average Number of Deaths by County, 2002 through 2004



Note: Number of deaths is an average of deaths between 2002 and 2004.

Rate per 100,000	Number
0.0 – 42.9	0.0 – 18.3
43.0 – 89.4	18.4 – 51.3
89.5 – 178.9	51.3 – 130.3
179.0 – 399.2	130.3 – 688.3

Data source: Texas DSHS, VSU, 2004
Map provided by Texas DSHS, Child Death Registry

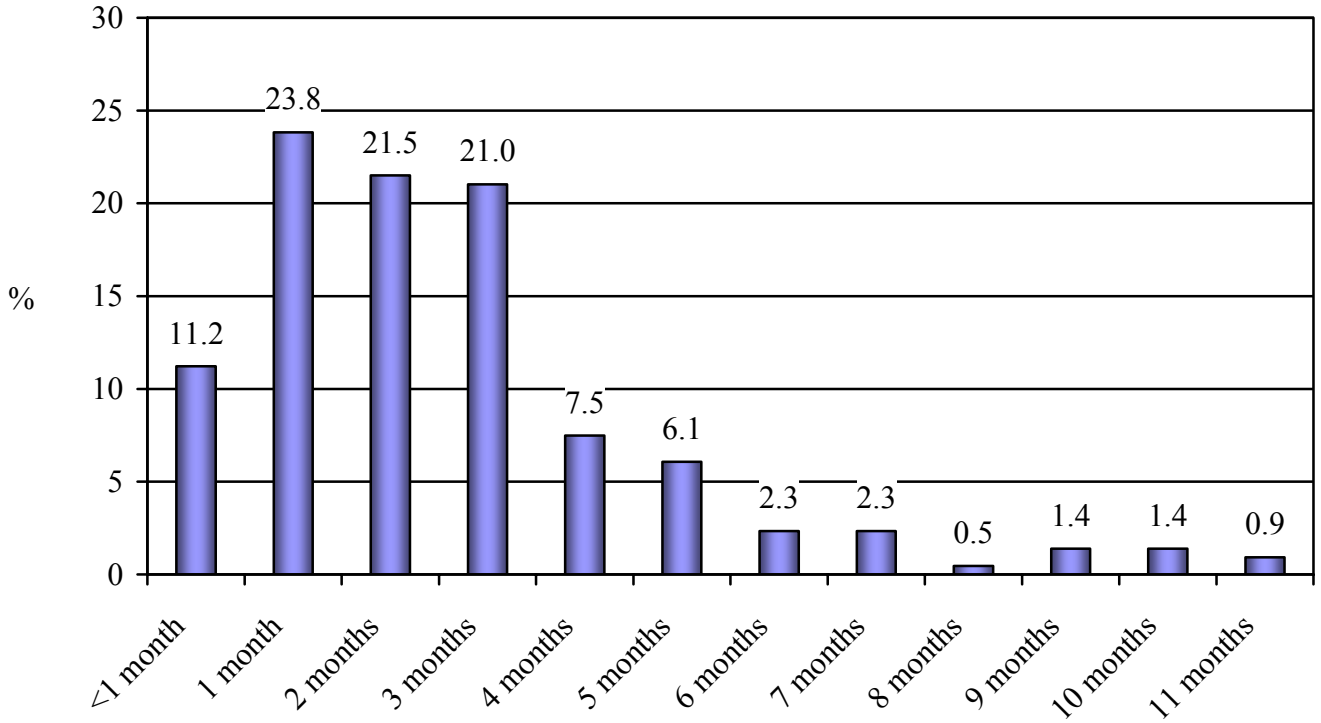
Sudden Infant Death Syndrome (SIDS)

Sudden Infant Death Syndrome (SIDS) is a definition of exclusion and should only apply to an infant whose death is sudden and unexpected, and remains unexplained after the performance of an adequate postmortem investigation that includes:

- an autopsy,
- investigation of the scene and circumstances of the death, and
- exploration of the medical history of the infant and family.

Generally, but not always, the infant is found dead after having been put to sleep and exhibits no signed of having suffered. SIDS is the leading cause of infant death in the postneonatal period (death between 29 and 365 days of life). In 2004, nearly 75% of all SIDS deaths occurred between one and three months of age (Chart 13).

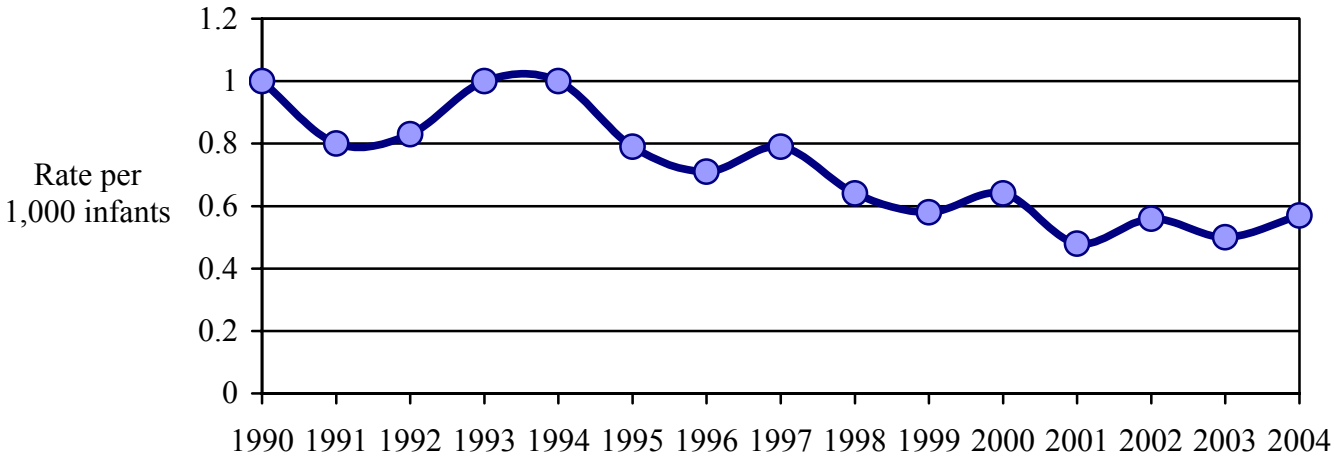
Chart 13. Age at Death among Infants who Died of SIDS, 2004



Source: Texas DSHS, VSU, 2004

SIDS rates in 2004 are 43% lower than they were in 1990 (Chart 14). While SIDS rates have declined, it is important to note that complex factors may be influencing this decline. In an *American Journal of Epidemiology* article (Shapiro-Mendoza CK, Tomashek KM, Anderson RN, Wingo J. Recent national trends in sudden, unexpected infant deaths: more evidence supporting a change in classification or reporting. 2006 Apr 15;163(8):762-9.), the authors noted that the decline in SIDS rates may not be reflective of an actual decline, but may be the result of medical examiners choosing other causes of death such as suffocation or undetermined.

Chart 14. SIDS Rates, 1990 through 2004

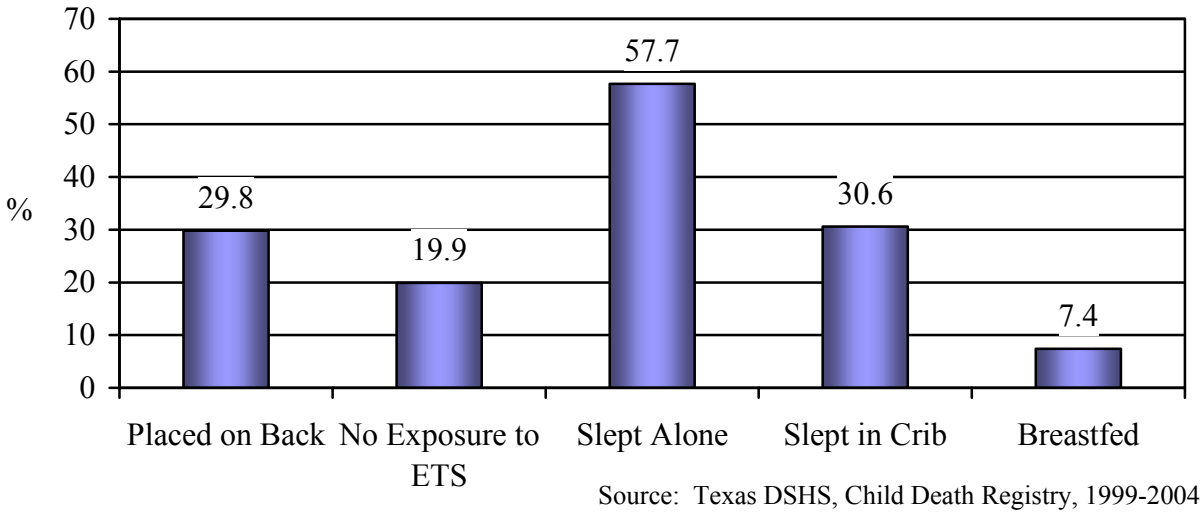


Source: Texas DSHS, VSU, 1990-2004

Consistent with national data, Black infants have the highest rate of SIDS (1.3 cases per 1,000), more than double the rate of Whites (0.62 per 1,000). Hispanics have the lowest SIDS rates in Texas with 0.38 cases per 1,000. SIDS rates among male infants (0.67 per 1,000) were higher than rates among female infants (0.46 per 1,000), which is also consistent with national trends.

Through their reviews, local CFRTs identified whether behaviors that are known to prevent SIDS were being practiced (Chart 15). These behaviors included placing the child to sleep on his/her back, not exposing the child to environmental tobacco smoke (ETS), sleeping alone, sleeping in a crib, and breastfeeding. Between 1999 and 2004, Texas CFRTs reviewed 745 SIDS deaths. In the majority of these reviews, behaviors that reduce the risk of SIDS were not being practiced.

Chart 15. Proportion of Cases Where Behavior was Confirmed, 1999 through 2004

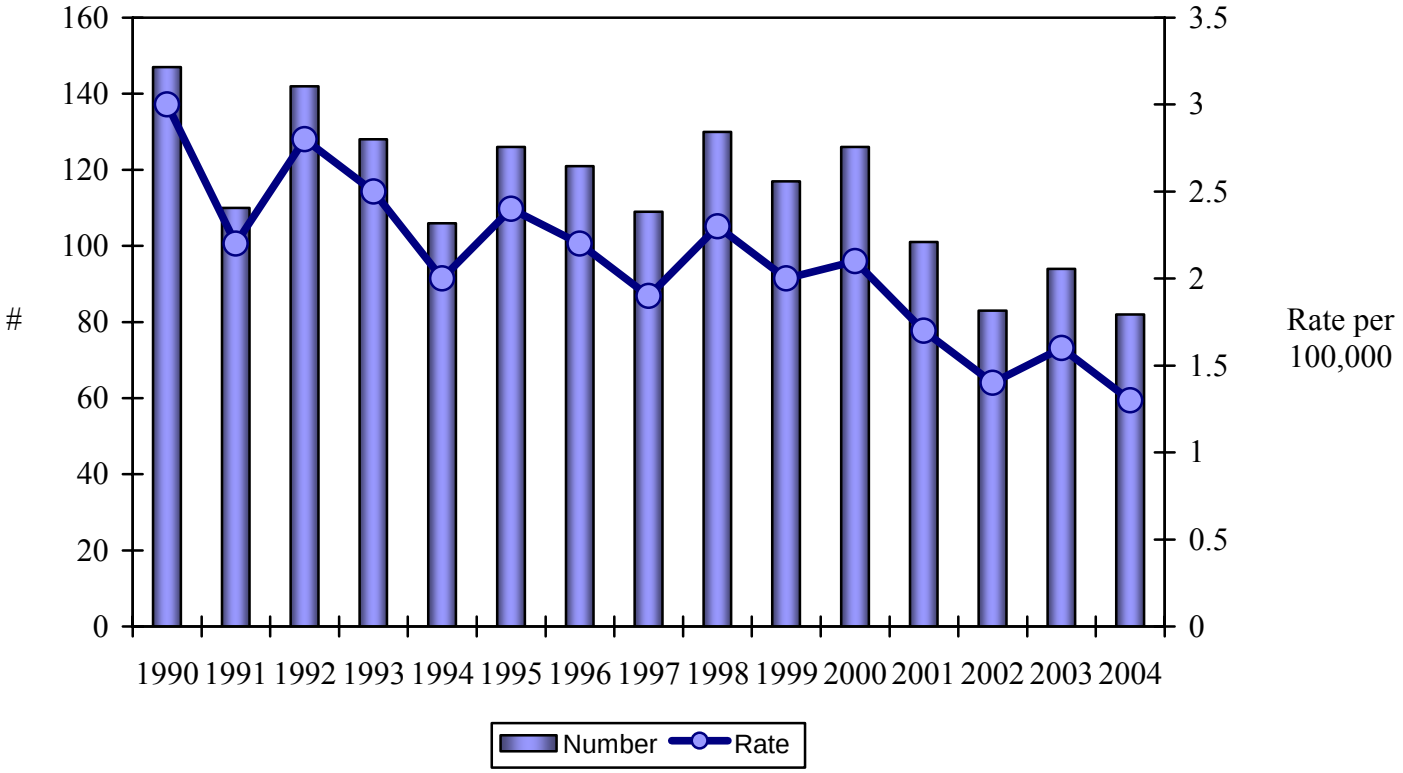


Source: Texas DSHS, Child Death Registry, 1999-2004

Drowning

The rate of deaths due to drowning has declined 56.7% from 3.0 deaths per 100,000 in 1990 to 1.3 deaths per 100,000 in 2004 (Chart 16). The number of drowning deaths and the rate of drowning deaths are each more than 60% higher among males than females (Table 4). Children ages one to four years had the highest number and rate of deaths due to drowning.

Chart 16. Number and Rate of Drowning Deaths, 1990 through 2004



Source: Texas DSHS, VSU, 1990-2004

Table 4. Sex, Race/Ethnicity, and Age of Children who Died of Drowning, 2004

Sex		
	#	Rate*
Male	52	1.6
Female	30	1.0

Race/Ethnicity		
	#	Rate*
White	38	1.5
Black	16	2.1
Hispanic	27	1.0
Other	1	---

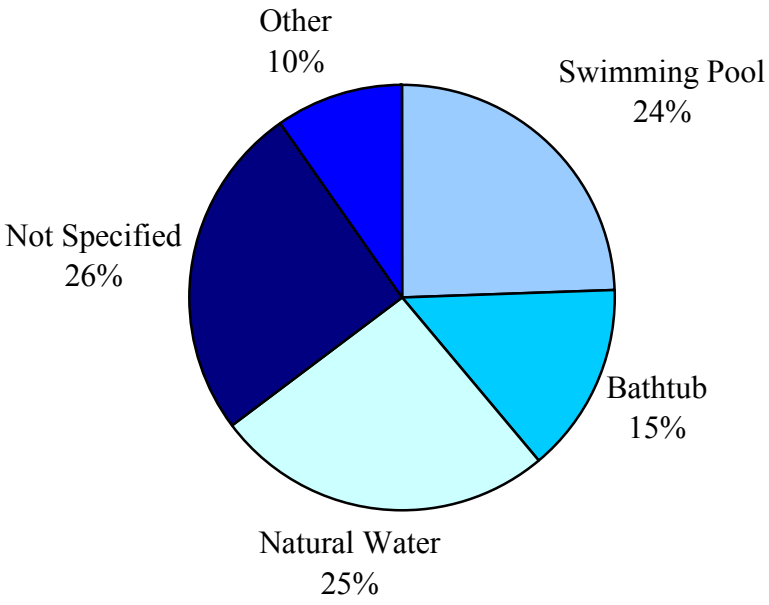
Age		
	#	Rate*
< 1 yr	6	1.6
1 – 4	43	3.0
5 – 9	10	0.6
10 – 14	11	0.6
15 – 17	12	1.2

* per 100,000
N = 82

Source: Texas DSHS, VSU, 2004

Almost one quarter of all drowning deaths occurred in a swimming pool. Another quarter occurred in natural bodies of water.

Chart 17. Location of Drowning Death, 2004

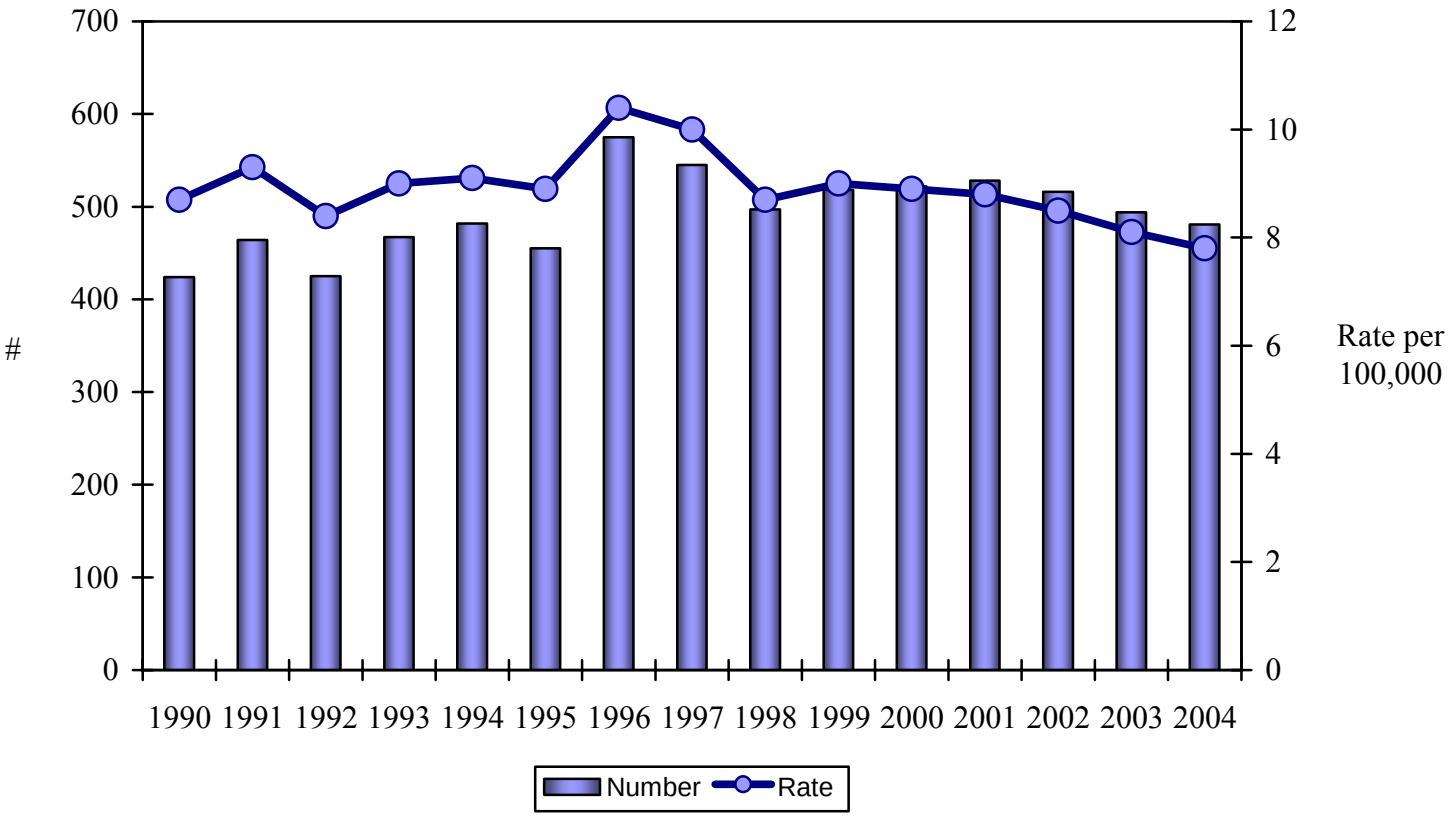


Source: Texas DSHS, VSU, 2004

Child Motor Vehicle Fatalities

In 2004, child motor vehicle fatalities were responsible for 12% of all childhood fatalities in Texas. The highest number and rate of child motor vehicle fatalities occurred in 1996, which was followed by a steady decline in the rate of child motor vehicle fatalities (Chart 18). While the rate of child motor vehicle fatalities has declined by 25.0%, the overall number of child motor vehicle fatalities has decreased by only 16.3%.

Chart 18. Number and Rate of Child Motor Vehicle Fatalities, 1999 through 2004



Source: Texas DSHS, VSU, 1990-2004

More males than females under the age of 18 years die in motor vehicle crashes in Texas (Table 5). Children 15 through 17 years of age have the highest rates of motor vehicle fatalities. The next highest rate by age was among children ages one through four years.

Table 5. Sex, Race/Ethnicity, and Age of Motor Vehicle Fatalities, 2004

Sex		
	#	Rate*
Male	289	9.2
Female	192	6.4

Race/Ethnicity		
	#	Rate*
White	236	9.5
Black	58	7.5
Hispanic	178	6.6
Other	9	4.3

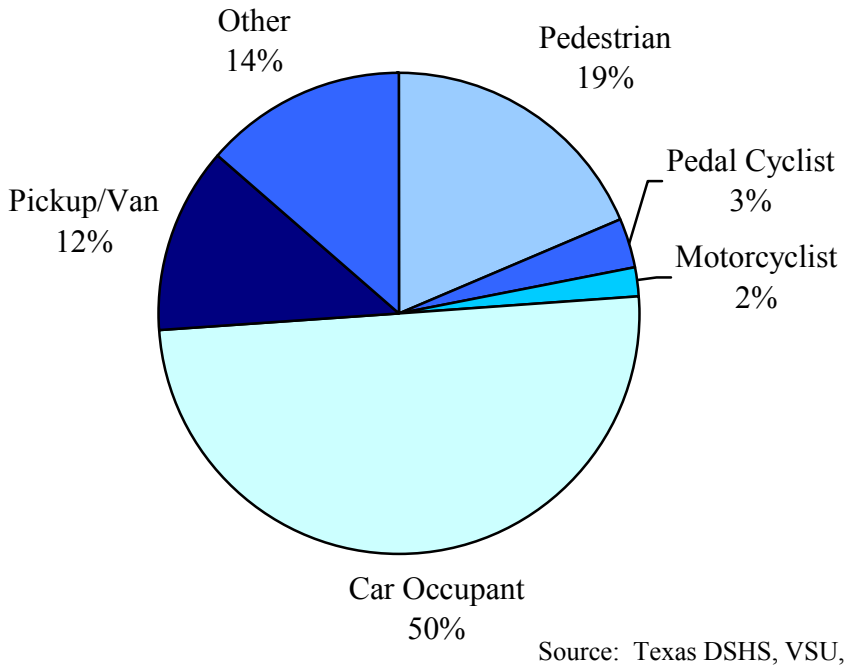
Age		
	#	Rate*
< 1 yr	18	4.8
1 – 4	103	7.3
5 – 9	79	4.9
10 – 14	102	5.9
15 – 17	179	17.4

*per 100,000
N = 481

Source: Texas DSHS, VSU, 2004

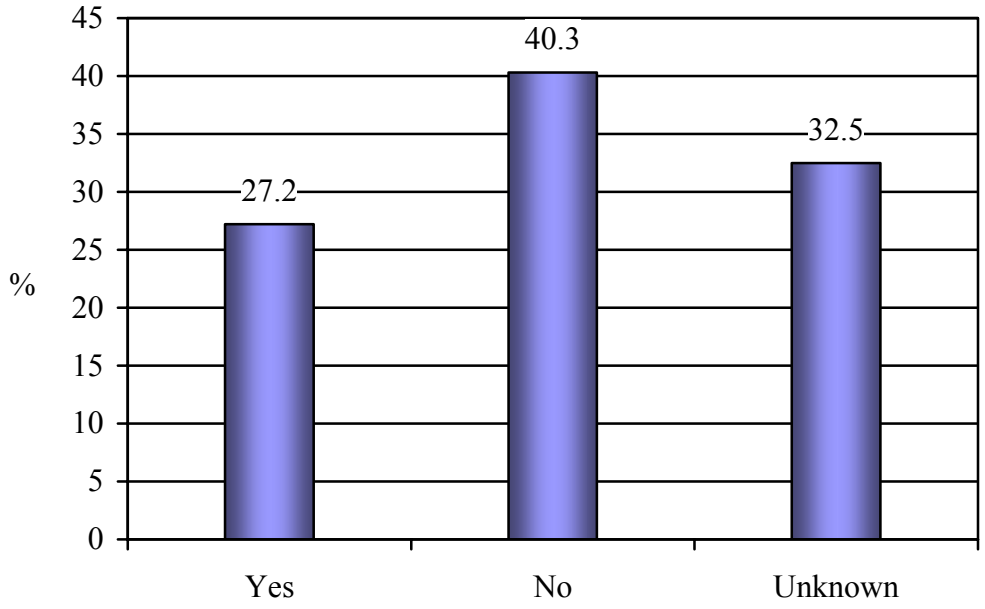
In half of all child motor vehicle fatalities, the fatality occurred to an occupant in a car. An additional 12% of fatalities were occupants in a pickup truck or van (Figure 19). Nearly one fifth of the children who died in motor vehicle fatalities were pedestrians. Among the 213 child motor vehicle fatalities reviewed in 2004, seat belt use could only be confirmed in 27.2% of the cases and the absence of seat belt use was confirmed in 40.3% of the cases reviewed (Figure 20).

Chart 19. Classification of Child Motor Vehicle Fatalities, 2004



Source: Texas DSHS, VSU, 2004

Chart 20. Seatbelt Use in Child Motor Vehicle Fatalities, 2004

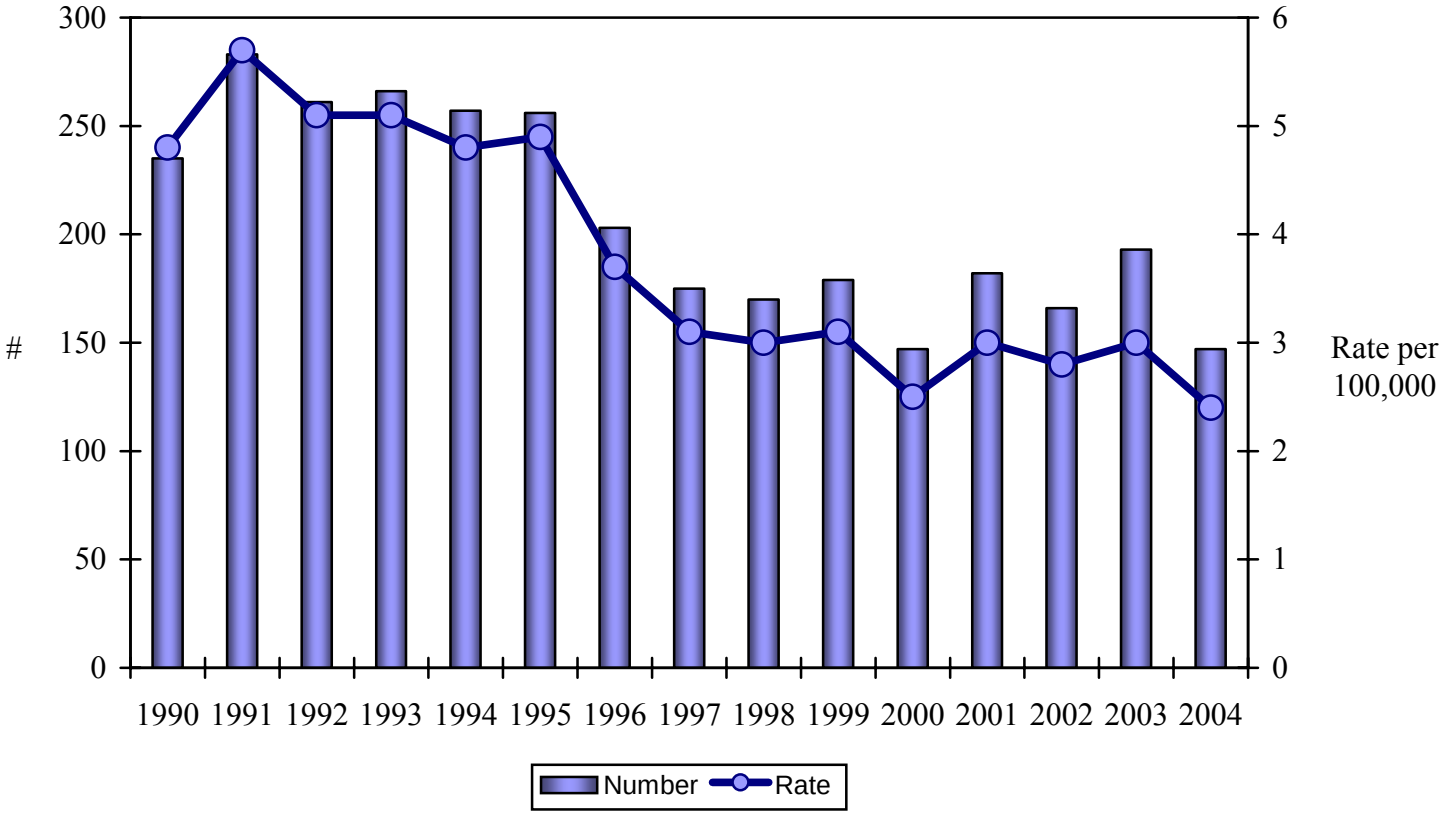


Source: Texas DSHS, Child Death Registry, 1999-2004

Child Deaths from Homicide

The rate and number of child deaths from homicide were highest in 1991 when there were 283 child deaths from homicide, a rate of 5.7 child deaths from homicide per 100,000 children (Chart 21). Between 1998 and 1995, there was a 38.8% decline in the rate of child deaths from homicide. In 2004, Texas had the lowest rate (2.4 child deaths from homicide per 100,000) and number of child deaths from homicide (147) since 1990.

Chart 21. Number and Rate of Child Deaths from Homicide, 1999 through 2004



Source: Texas DSHS, VSU, 1999-2004

There are gender and racial/ethnic disparities in the rate of child deaths from homicide in Texas. The rate of child deaths from homicide among males is 82.4% higher than among females (Table 6). The rate of child deaths from homicide among Blacks is 600% greater than the rate among Whites and 250% greater than the rate among Hispanics.

Table 6. Sex, Race/Ethnicity, and Age of Child deaths from homicide, 2004

Sex		
	#	Rate*
Male	97	3.1
Female	50	1.7

Race/Ethnicity		
	#	Rate*
White	28	1.1
Black	60	7.7
Hispanic	59	2.2
Other	0	---

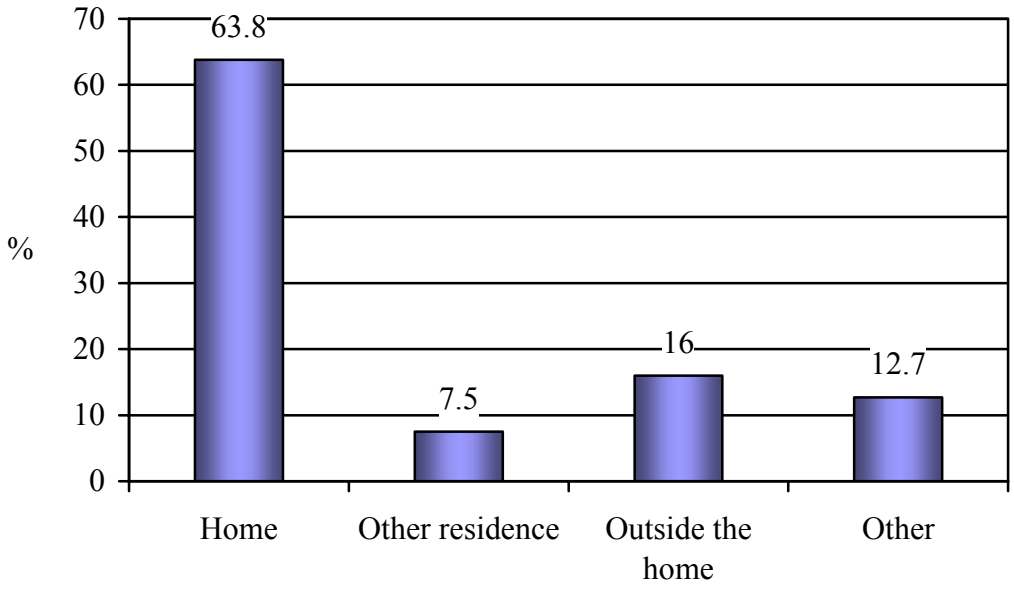
Age		
	#	Rate*
< 1 yr	30	8.0
1 – 4	32	2.3
5 – 9	15	0.9
10 – 14	20	1.2
15 – 17	50	4.9

*per 100,000
N = 147

Source: Texas DSHS, VSU, 2004

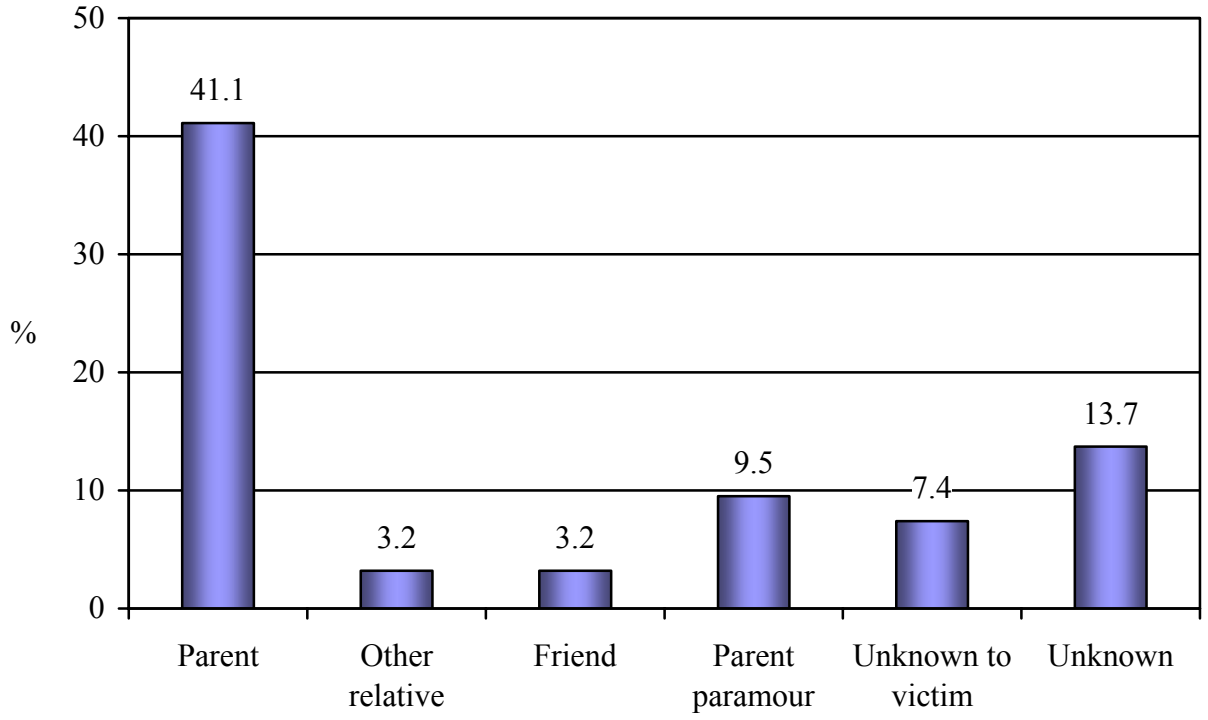
Of the 147 child deaths from homicide in 2004, local CFRTs reviewed 97. Of those deaths, the most common place of child deaths from homicide was in the child's own home and the parents were the most frequently identified assailants (Chart 22 and 23).

Chart 22. Location of Child deaths from homicide, 2004



Source: Texas DSHS, Child Death Registry, 2004

Chart 23. Assailant in Child deaths from homicide, 2004

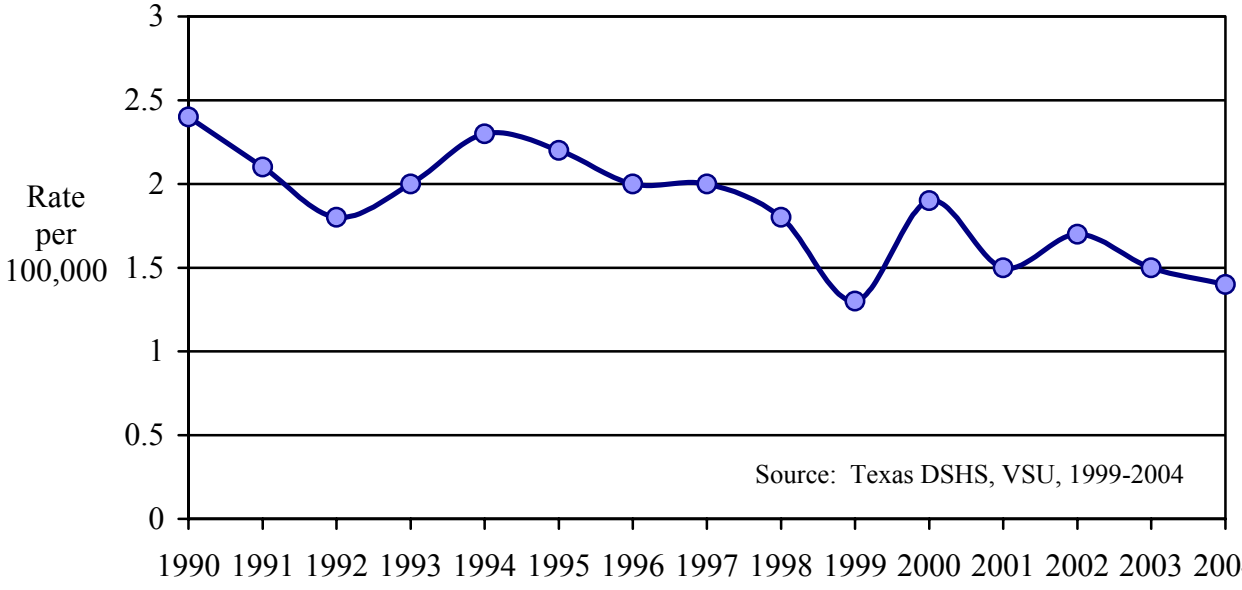


Source: Texas DSHS, Child Death Registry, 2004

Child Suicide

In Texas in 2004, there were 85 suicides. The 2004 rate of 1.4 suicide deaths per 100,000 is 7.7% higher than the lowest rate reached between 1990 and 2004, 1.3 suicide deaths per 100,000 (Chart 24).

Chart 24. Suicide Death Rates, 1990 through 2004



The rate of suicide deaths for males in 2004 was more than double that of females (Table 7). Suicide is also more common among White and Hispanic children than Black children. There were fewer than 10 suicide deaths among Black children while the number exceeded 30 among Hispanic children and 40 among White children. There were no suicides among children under the age of 10 years in 2004. The highest rate of death from suicide was found among children ages 15 to 17 years. Local CFRTs reviewed 51 of the suicides that occurred in 2004. More than 90% of child suicides occurred in the child's home (Chart 25). Depression, arguments with parents, alcohol or drug use, and school problems were each identified through the review process in more than 20% of the suicides reviewed as contextual factors that may have contributed to the suicide (Figure 26).

Table 7. Sex, Race/Ethnicity, and Age of Child Suicides, 2004

Sex		
	#	Rate*
Male	60	1.9
Female	25	0.8

Race/Ethnicity		
	#	Rate*
White	43	1.7
Black	8	1.0
Hispanic	34	1.3
Other	0	---

Age		
	#	Rate*
< 1 yr	0	---
1 – 4	0	---
5 – 9	0	---
10 – 14	20	1.2
15 – 17	65	6.3

*per 100,000
N = 85

Source: Texas DSHS, VSU, 2004

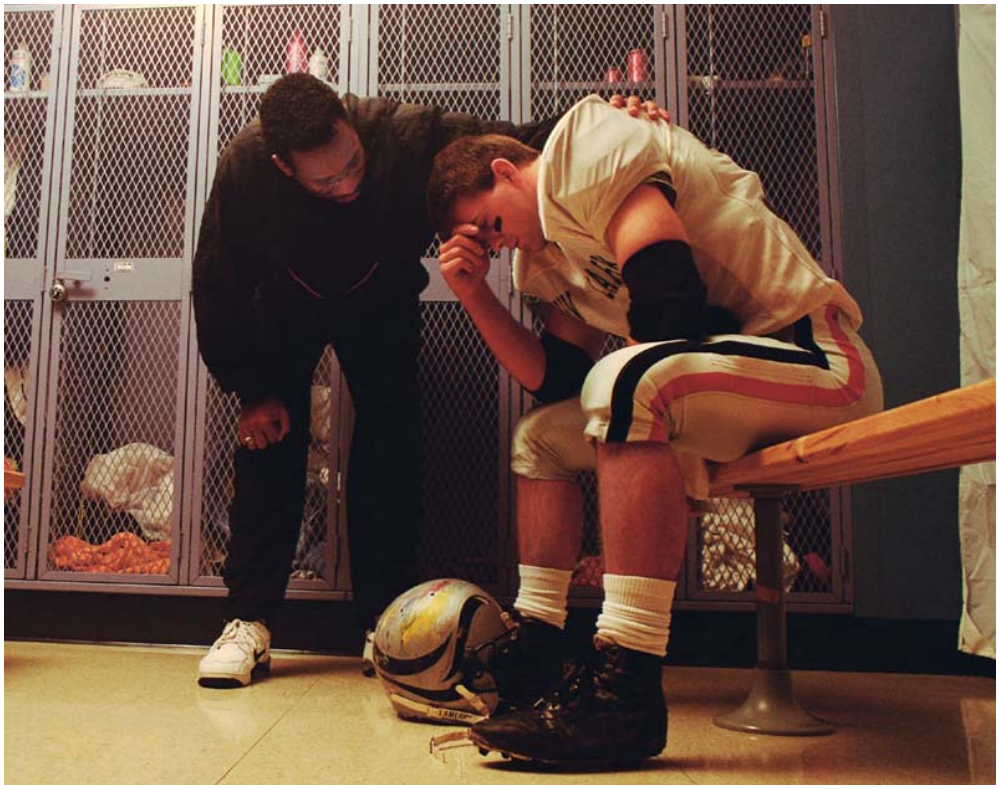
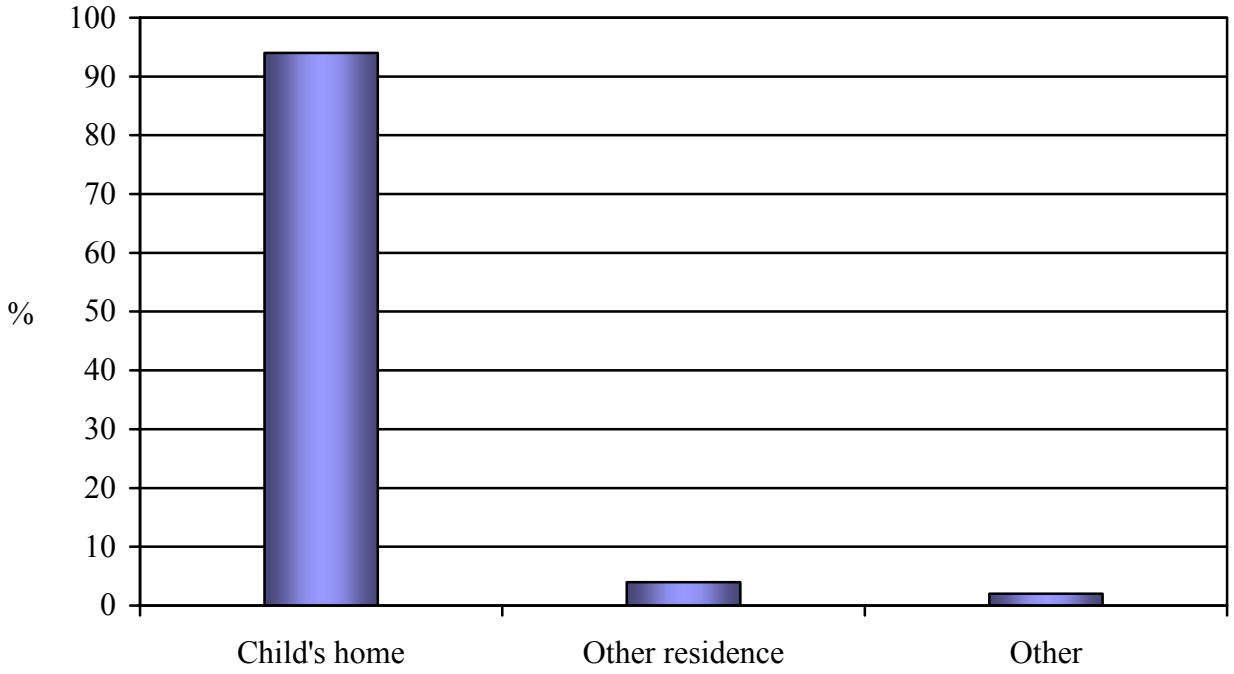
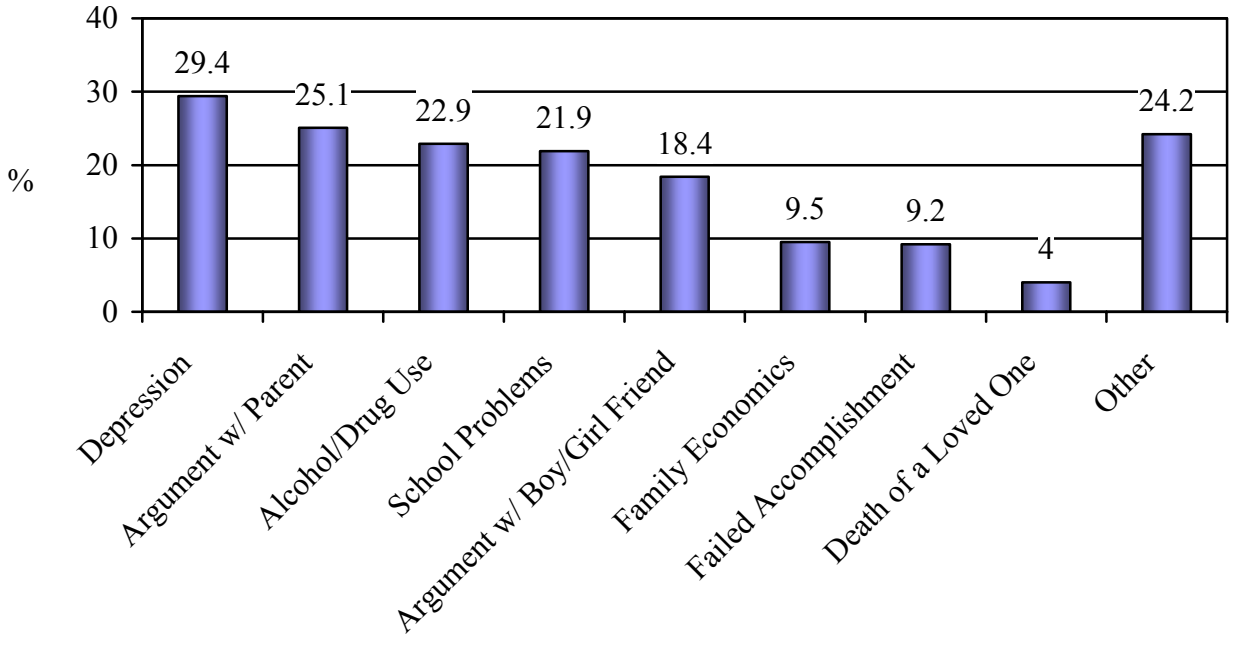


Chart 25. Location of Child Suicides, 2004



Source: Texas DSHS, Child Death Registry, 2004

Chart 26. Contextual Factors Surrounding Child Suicide, 1999 through 2004



Source: Texas DSHS, Child Death Registry, 2004

FIREARM DEATHS

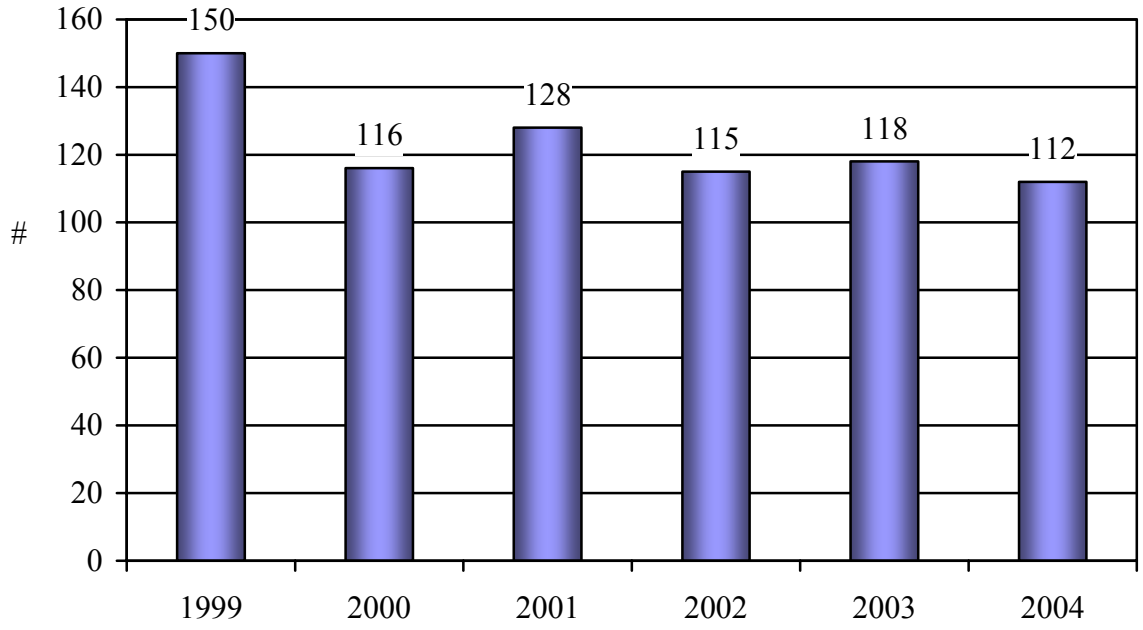
Estimates suggest that there are over 200 million firearms in the United States and that nearly half of all households have firearms. Given the prevalence of firearms and the likelihood that a child may encounter a firearm at home or when with a relative or neighbor, the safe storage of firearms is important to protect the lives of Texas' children.

Firearm deaths include four groups:

- unintentional deaths,
- suicides firearms,
- homicides firearms, and
- deaths of unknown intent.

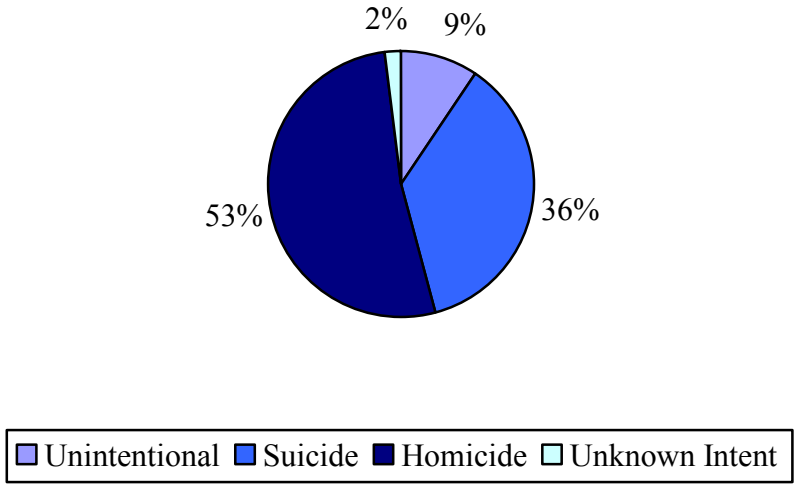
During 2004, there were 112 firearm deaths in Texas. After a decline in the number of firearm deaths in 2000, the number of these deaths has remained constant. Between 1999 and 2004, the number of firearm deaths was lowest in 2004 (Chart 27). Between 1999 and 2004, firearm deaths were primarily associated with suicides and homicides (Chart 28).

Chart 27. Number of Firearm Deaths, 1999 through 2004



Source: Texas DSHS, VSU, 1999 through 2004

Chart 28. Proportion of Firearm Deaths Attributed to Unintentional Death, Suicide, Homicide, and Unknown Intent, 1999 through 2004



Source: Texas DSHS, VSU, 1999 through 2004

The rate of firearm related deaths in 2004 was 383% higher among males than females (Table 8). Racial disparities were also found with rates of firearm related deaths among Blacks more than double the rates among Whites and Hispanics. Firearm deaths also have greater impact among 10 to 17 year olds than among children less than 10 years of age. Children 10 to 17 years old accounted for 89.9% of all firearm related deaths.

Table 8. Sex, Race/Ethnicity, and Age of Child Firearm Deaths, 2004

Sex		
	#	Rate*
Male	93	2.9
Female	19	0.6

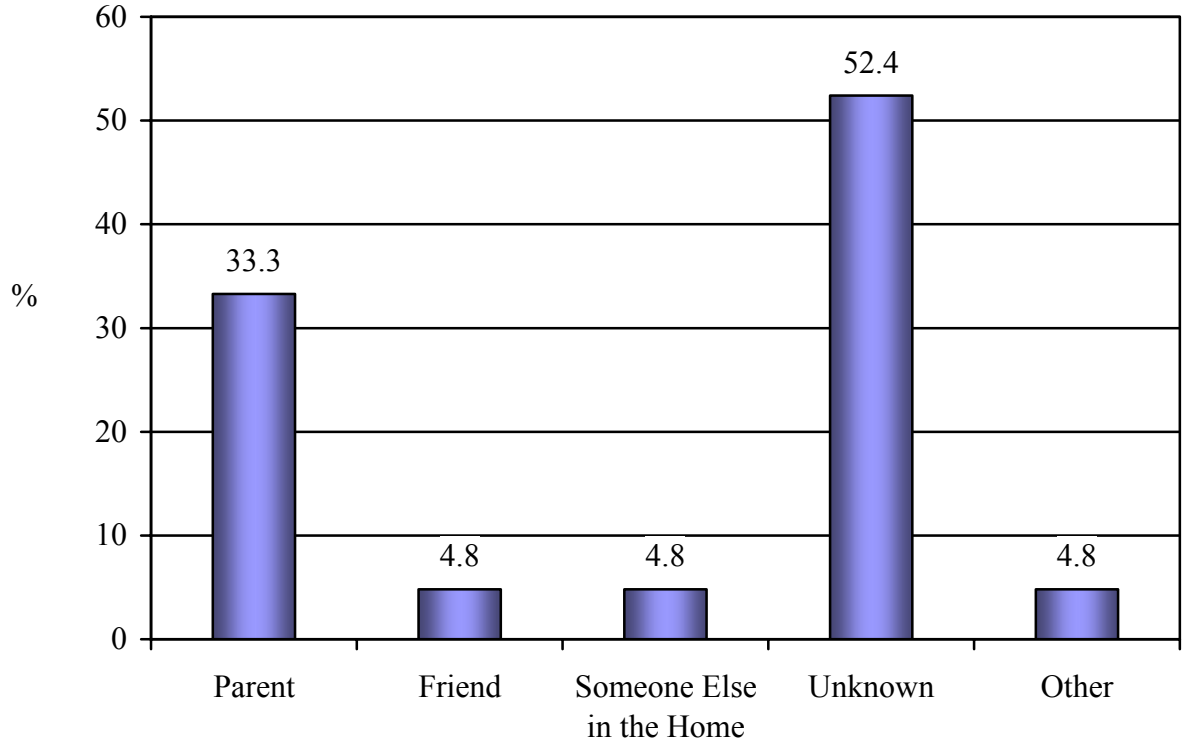
Race/Ethnicity		
	#	Rate*
White	42	1.6
Black	28	3.6
Hispanic	42	1.6
Other	0	---

Age		
	#	Rate*
< 1 yr	2	0.5
1 – 4	5	0.4
5 – 9	5	0.3
10 – 14	25	1.4
15 – 17	75	7.3

*per 100,000
N = 112

Of the 112 firearm deaths in Texas in 2004, 45 were reviewed by local CFRTs. Of the cases reviewed, the parent was identified as the owner of the firearm in one third (Chart 29). However, this information was frequently unknown.

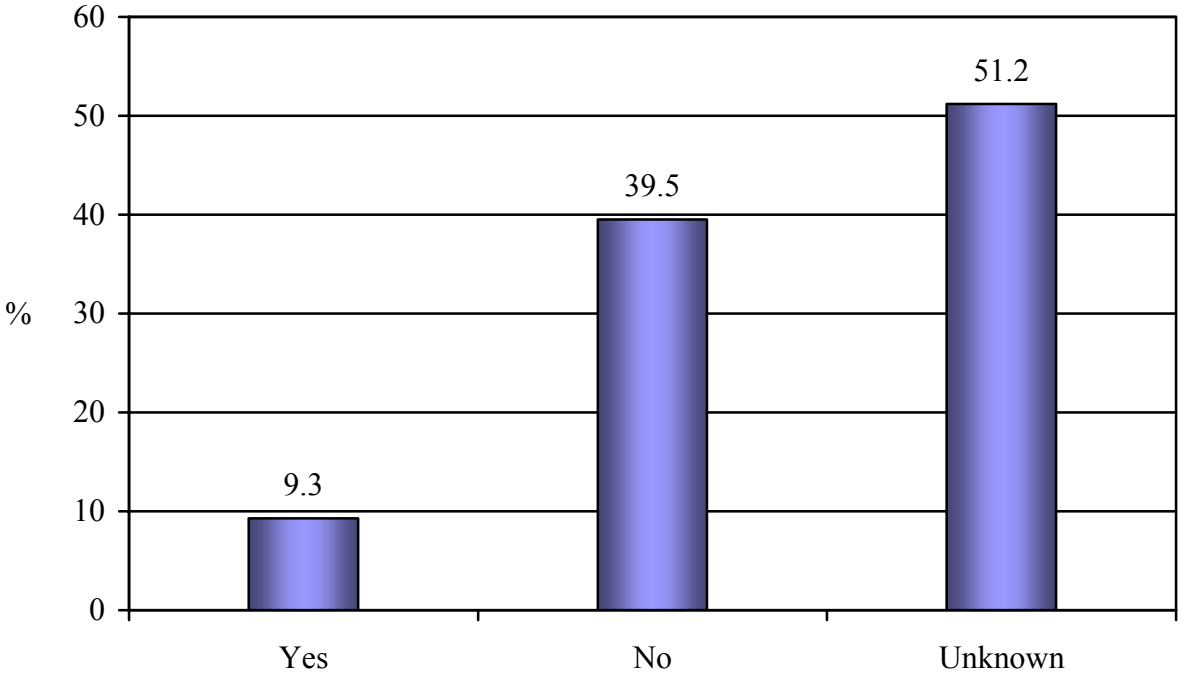
Chart 29. Owner of Firearm in Firearm Related Deaths, 2004



Source: Texas DSHS, Child Death Registry, 2004

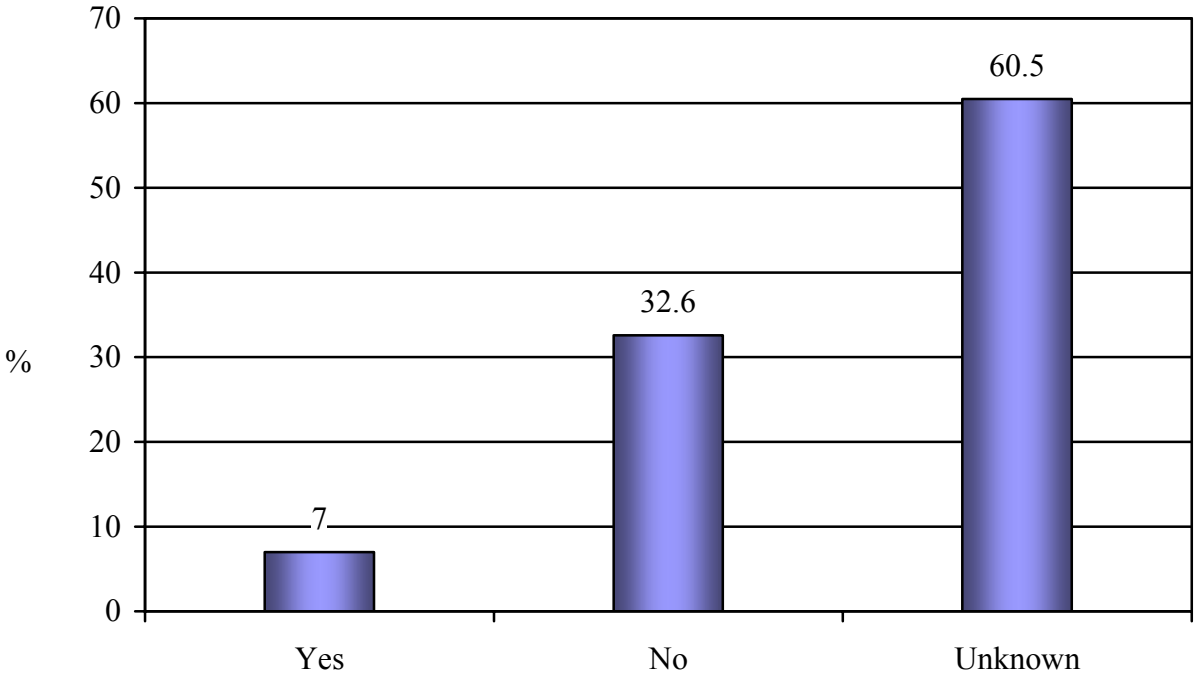
Injury prevention education messages targeting parents often focus on car seats, seat belts, life preservers, and bicycle helmets, but less on gun safety. To maximize gun safety and reduce the risk of accidental injury or death, firearms should be locked and stored unloaded. In the 45 firearm deaths reviewed by local CFRTs, the firearm was confirmed to be locked away in 9.3% of the cases (Chart 30). In one third of the cases reviewed, it was confirmed that the firearm was stored loaded (Chart 31). The firearm was known to be unloaded in only 7% of the cases reviewed.

Chart 30. Proportion of Locked Firearms, 2004



Source: Texas DSHS, Child Death Registry, 2004

Chart 31. Firearms Stored Unloaded, 2004



Source: Texas DSHS, Child Death Registry, 2004

APPENDIX A:
SCFRT COMMITTEE MEMBERS

DENISE ONCKEN, JD, SCFRT CHAIR
Chief, Child Abuse Division
Harris County DA's Office
201 Franklin, Suite 600
Houston, TX 77002
(713) 755-5546
Oncken_Denise@dao.co.harris.tx.us

KIM K. CHEUNG, MD, PHD
Pediatrician
University of Texas Health Science Center at Houston
Department of Pediatrics
Child Protective Services Clinic
6300 Chimney Rock
Houston, TX 77081
(713) 295-2579
kim.k.cheung@uth.rmc.edu

SHERIFF JACK ELLETT
Panola County Sheriff's Department
314 W. Wellington
Carthage, TX 75633
(903) 693-0333
jack.ellett@co.panola.tx.us

ALICE GONG, MD
Neonatologist
University of Texas Health Science Center at San Antonio
MC7812
7703 Floyd Curl Dr.
San Antonio, TX 78229-3900
(210) 567-5227
gong@uthscsa.edu

GERALDINE HARRIS, MLA
Chief and State Registrar
Texas Vital Statistics
Texas Department of State Health Services
1100 W. 49th St.
Austin, TX 78756
(512) 458-7366
geraldine.harris@dshs.state.tx.us

JUDGE JUDY SCHIER HOBBS
Justice of the Peace
Williamson County
P.O. Box 588
Taylor, TX 76574
(512) 365-8922
jhobbs@wilco.org

SERGEANT SANDRA HUTCHINSON
Austin Police Department
P.O. Box 689001
Austin, TX 78768
(512) 974-8511
Sandra.Hutchinson@ci.austin.tx.us

JOYCE JAMES
Assistant Commissioner
Child Protective Services
Department of Family and Protective Services
MC: E-157
P.O. Box 149030
Austin, TX 78751-9030
(512) 438-3312
joyce.james@dfps.state.tx.us

ERIC LEVY, MD
Director, Pediatric Critical Care Medicine
Associate Professor of Pediatrics
1301 Coulter
Suite 101
Amarillo, TX 79106
(806) 468-4326
elevymd@amaonline.com

LAUREL LINDSEY
Director of Investigations
Child Protective Services
Department of Family and Protective Services
MC: E-157
P.O. Box 149030
Austin, TX 78751-9030
laurel.lindsey@dfps.state.tx.us

ADA MCCLOUD
Program Coordinator
Children's Advocacy Centers of Texas
12325 Hymeadow Dr.
Bldg. 1-200
Austin, TX 78750
(512) 258-9920
amccloud@cactx.org

DONNA NORRIS
Child Abuse Prevention Specialist
Department of Family and Protective Services
MC: Y-956
8100-B Cameron Rd.
Austin, TX 78754
(512) 821-4731
donna.norris@dfps.state.tx.us

JUAN PARRA, MD, MPH
Associate Professor of Pediatrics
Medical Hispanic Center of Excellence
University of Texas Health Science Center at San Antonio
7703 Floyd Curl Dr.
Mail Code: 7808
San Antonio, TX 78229-3900
(210) 562-5344
parraj@uthscsa.edu

ELIZABETH PEACOCK, MD
Bexar County Medical Examiner
7337 Louis Pasteur Drive
San Antonio, Texas 78229-4565
(210) 335-4000
epeacock@austin.rr.com

WANDA PENA, LMSW-AP
State Child Safety Director
Department of Family and Protective Services
MC: E-157
P.O. Box 149030
Austin, TX 78751-9030
(512) 438-3303
guadalupe.pena@dfps.state.tx.us

TERRY PENCE
Texas Department of Transportation
125 E. 11th St.
Austin, TX 78701-2483
(512) 416-3167
tpence@dot.state.tx.us

LUCINA SUAREZ, PHD
Director
Epidemiology and Disease Surveillance Branch
Texas Department of State Health Services
1100 W. 49th St.
Austin, TX 78756
(512) 458-7111 ext. 6351
lucina.suarez@dshs.state.tx.us

LIEUTENANT STEVEN TELLEZ
Texas Department of Public Safety
6502 S. New Braunfels
San Antonio, TX 78223
(210) 531-2202
steven.tellez@txdps.state.tx.us

RAYMOND TESKE, PHD
Professor, Sam Houston State University
304 Elkins Lane
Huntsville, TX
(936) 295-6274
rteske@cox.net

JOHN VILLANACCI, PHD
Branch Manager
Environmental & Injury Epidemiology and Toxicology Branch
Texas Department of State Health Services
1100 W. 49th St.
Austin, TX 78756
(512) 458-7111 ext. 7269
john.villanacci@dshs.state.tx.us

SANDI WIGGINS, MPA
The Shaken Baby Alliance
4516 Boat Club Rd., Suite 114
Fort Worth, TX 75135
(817) 882-8687
swiggins@shakenbaby.com

Appendix B: Active Local Child Fatality Review Teams, 2004

Name	Service Area	Presiding Officer	Coordinator
Bastrop Co. CFRT	Bastrop County	Shelley Matthews, ED Children's Advocacy Center of Bastrop 1002 Chestnut St. P.O. Box 1098 Bastrop, TX 78602 (512) 321-6161 www.childrensadvocacycenter.org	Mindy Graber Children's Advocacy Center of Bastrop 1002 Chestnut St. P.O. Box 1098 Bastrop, TX 78602 (512) 321-6161 mindycacbastrop@austin.rr.com
Bexar Co. CFRT	Bexar County	Alicia Tezel, MD Alicia@assaca.com Alicia.tezel@christushealth.org	Laurie Charles, RN, SANE-A, CA/CPSANE SANE Program Coordinator 333 N. Santa Rosa San Antonio, TX 78207 (210) 704-3330 laurie.charles@christushealth.org
Brazoria Co. CFRT	Brazoria County	Jeri Yenne, District Attorney Brazoria County Courthouse 111 E. Locust, Suite 408A Angleton, TX 77515-4676 (979) 864-1230 jyenne@brazoria-county.com	Rhonda Harley Brazoria County Courthouse 111 E. Locust, Suite 408A Angleton, TX 77515-4676 (979) 864-1408 rhondah@brazoria-county.com
Brazos Co. CFRT	Brazos County	Christopher C. Kirk, Sheriff Brazos County Office of the Sheriff 300 E. 26th St., Suite 105 Bryan, TX 77803-5359 (979) 361-4150 chriskirk@highsheriff.com	Brenda Putz, Trauma Coordinator St Joseph's Regional Health Center 2801 Franciscan Dr. Bryan, TX 77802 (979)776-4917 bputz@mail.st-joseph.org
Cameron/Willacy Counties CFRT	Cameron and Willacy Counties	Stanley I. Fisch, M.D. Harlingen Pediatrics Associates 321 South 21st Street Harlingen, TX 78550 (956) 425-8761 sfisch@sbcglobal.net	Same as presiding officer
Central Texas CFRT	Bell, Coryell, Falls, Hamilton and Milam Counties	Michelle Farrell, Executive Director Children's Advocacy Center of Central TX 402 N. Main P.O. Box 145 Belton, TX 76513 (254) 939-2946 x1 caccted@hot.rr.com	Jennifer McDaniel Children's Advocacy Center of Central TX 402 N. Main P.O. Box 145 Belton, TX 76513 (254) 939-2946 x1 cacctvol@hot.rr.com

Name	Service Area	Presiding Officer	Coordinator
Collin Co. CFRT	Collin County	Jane Donovan, Community Educator Collin County Children's Advocacy Center 2205 Los Rios Blvd. Plano, TX 75074 (972) 633-6608 jdonovan@cacplano.org	Same as presiding officer
Concho Valley CFRT	Coke, Concho, Crockett, Irion, Kimble, Menard, McCulloch, Regan, Runnels,Schleicher, Sterling, Sutton & Tom Green Counties	Eddie Howard, Justice of the Peace Tom Green County, Precinct 4 124 W. Beauregard San Angelo, TX 76903 (325) 659-6424 eddie.howard@co.tom-green.tx.us	Debra R. Brown, Executive Director Hope House Children's Advocacy Center of Tom Green County 317 Koberlin P.O. Box 5195 San Angelo, TX 76902 (915) 653-4673 drbrown@wtxcoxmail.com
Dallas County Child Death & Infant Mortality Review Team	Dallas County	Martha Stowe, Executive Director Injury Prevention Center of Greater Dallas 5000 Harry Hines P.O. Box 36067 Dallas, TX 75235 (214) 590-4461 mstowe@parknet.pmh.org	Same as presiding officer
El Paso Co. CFRT	El Paso County	Jaime Esparza El Paso District Attorney's Office 500 E. San Antonio Avenue, Suite 201 El Paso, TX 79901 (915) 546-2059 jesparza@epcounty.com	Donna Welch, Paralegal El Paso District Attorney's Office 500 E. San Antonio Avenue, Suite 201 El Paso, TX 79901 (915) 546-2059 ext 3701 dwelch@epcounty.com
Ellis Co. CFRT	Ellis County	Marlena Pendley, Investigator Ellis County District Attorney's Office P.O. Box 2838 Waxahachie, TX 75168-2838 (972) 937-1870 marlena.eccac@ectisp.net	Same as presiding officer
Galveston Co. CFRT	Galveston County	Louise Pound, M.A., Case Manager Advocacy Center for Children of Galveston 5710 Avenue S1/2 Galveston, TX 77551 (409) 741-6000 lpound@sbcglobal.net	Same as presiding officer

Name	Service Area	Presiding Officer	Coordinator
Hill Country CFRT	Blanco, Burnet, Lampasas, Llano, Mason, Mills & San Saba Counties	Deborah Keith, Executive Director Hill Country Children's Advocacy Center P.O. Box 27 Burnet, TX 78611 (512) 756-2607 hccac@tstar.net	Same as presiding officer
Houston/Harris Co. CFRT	Harris County	Cindy Kilborn Chief Epidemiologist Harris County Public Health & Environmental Services 2223 West Loop South Houston, TX 77027 (713) 439-6160 ckilborn@harriscountyhealth.com	Stephani Adams, MPH Houston/Harris Co. CFRT Coordinator Harris Co. Public Health & Environmental Services 2223 West Loop South Houston, TX 77027 (713) 439-6137 sadams@harriscountyhealth.com
Houston/Trinity Counties CFRT	Houston & Trinity Counties	Sylvia Edwards, Crime Victim Assistant Crime Victims Services Houston County Courthouse Third Floor P.O. Box 1076 Crockett, TX 75835 dahcsde@yahoo.com	Same as presiding officer
Hunt Co. CFRT	Hunt County	Bret Freeman, RN, CEN (co-officer) Trauma Coordinator Presbyterian Hospital of Greenville 4215 Joe Ramsey Blvd. Greenville, TX 75401 (903) 408-1412 bfreeman@hmhd.org Patrick Schooler (co-officer) (908) 408-1428 pschooler@hmhd.org	Tamora Wooldridge TDPRS 2920 Lee St. P.O. Box 847 Greenville, TX 75403 (903) 455-7636 tamora.wooldridge@dfps.state.tx.us
Jefferson Co. CFRT	Jefferson County	Marion Tanner, Executive Director The Garth House/Mickey Mehaffy Children's Advocacy Program 1895 McFaddin Beaumont, TX 77701 (409) 838-9084 mtanner@garthhouse.net	Carolyn Graham, Volunteer Coordinator The Garth House/Mickey Mehaffy Children's Advocacy Program 1895 McFaddin Beaumont, TX 77701 (409) 838-9084 cgraham@garthhouse.net

Name	Service Area	Presiding Officer	Coordinator
McClennan Co. CFRT	McClennan County	Kerry Burkley, M. Div. Program Director Advocacy Center for Crime Victims and Children 2323 Columbus Ave. Waco, TX 76701 (254) 752-9330 ext. 101 kburkley@advocacycntr.org	Same as presiding officer
Orange Co. CFRT	Orange County	Kim Hanks, Interview Specialist Garth House Mickey Mehaffy Children's Advocacy Program, Inc. 1895 McFaddin Beaumont, TX 77701 (409) 838-9084 khanks@garthhouse.net	Same as presiding officer
Panhandle CFRT	Armstrong, Briscoe, Carson, Castro, Childress, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, & Wheeler Counties	Casie Stach City of Amarillo Department of Public Health P.O. Box 1971 Amarillo, TX 79105-1971 (806) 351-7324 casie.stach@ci.amarillo.tx.us	Same as presiding officer
Smith Co. CFRT	Smith County	Carol Langston, Executive Director Children's Advocacy Center of Smith Co. 2210 Frankston Hwy Tyler, TX 75701 (903) 533-1880 carollcac@cox-internet.com	Same as presiding officer
South Plains CFRT	Bailey, Borden, Cochran, Cottle, Crosby, Dawson, Dickens, Floyd, Gaines, Garza, Hale, Hockley, Kent, King, Lamb, Lubbock, Lynn, Motley, Scurry, Stonewall , Terry, & Yoakum Counties	Patti Salazar, SANE C.A.R.E. Center Texas Tech University Health Science Center Department of Pediatrics 6630 Quaker Avenue, Suite 202 Lubbock, TX 79413 (806) 743-7770 patricia.salazar@ttuhsc.edu	Same as presiding officer

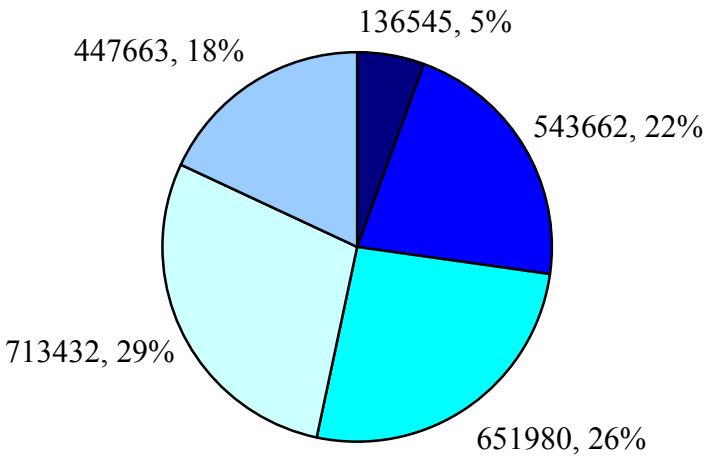
Name	Service Area	Presiding Officer	Coordinator
Tarrant Co. CFRT	Tarrant, Denton and Parker Counties	Michael V. Floyd, B.S., D-ABMDI Senior Forensic Investigator Tarrant County Medical Examiner's Office 200 Feliks Gwozdz Place Fort Worth, TX 76104-4919 (817) 920-5700 ext 120 mfloyd@tarrantcounty.com	Same as presiding officer
Travis Co. CFRT	Travis County	Dayna Blazey, Assistant District Attorney Office of the District Attorney c/o Rhonda Salinas P.O. Box 1748 Austin, TX 78767 (512) 974-6830 dayna.blazey@ci.austin.tx.us	Sandra A. Martin Center for Child Protection 1110 E. 32nd Street Austin, TX 78722 (512) 472-1164 smartin@centerforchildprotection.org
Tri-County CFRT	Harrison, Panola and Rusk Counties	Sheriff Jack Ellett Panola County Sheriff's Department 314 W. Wellington St. Carthage, TX 75633 (903) 693-0333 jack.ellett@co.panola.tx.us	Sarah Fields, Sergeant Panola County Sheriff's Department 314 W. Wellington St. Carthage, TX 75633 (903) 693-0333 sgtfields@hotmail.com
Victoria Co. CFRT	Victoria County	Adelaida Resendez, M.D. Pediatrician 110 Medical Dr. #103 Victoria, TX 77904-3101 (361) 572-0033	Gilda Miller, RNC, Nurse Manager Citizens Medical Center 2701 Hospital Drive Victoria, TX 77901-5749 (361) 574-1777 gmiller@cmcvtx.org
Walker Co. CFRT	Walker County	Nanette Anthony (co-presiding officer) Department of Family and Protective Services 7045 Hwy. 755 Huntsville, TX 77340 nanette.anthony@dfps.state.tx.us	Raymond Teske, Jr., Ph. D. (co-presiding officer) 304 Elkins Lake Huntsville, TX 77340 (936) 295-6274 rteske@cox.net
Washington/Grimes Counties CFRT	Washington & Grimes Counties	Marsha Doebler, Trauma Coordinator Trinity Community Medical Center of Brenham 700 Medical Parkway Brenham, TX 77833 (979) 830-5017 mdoebler@trinitymed.org	Same as presiding officer

Name	Service Area	Presiding Officer	Coordinator
Webb Co. CFRT	Webb & Zapata Counties	Guadalupe Martinez The Children's International Advocacy Center of Webb County 1302 Cedar Avenue Laredo, TX 78040 (956) 712-1840 advocate@caclaredo.org	Same as presiding officer
Wichita Co. CFRT	Wichita County	Kathryn McKinney, Executive Director Patsy's House Children's Advocacy Center 1411 Tenth St. Wichita Falls, TX 76301 (940) 322-8890	Same as presiding officer
Williamson Co. CFRT	Williamson County	Judge Judy Schier Hobbs Justice of the Peace, Pct. 4 211 W. 6th St. Taylor, TX 76574-3539 jhobbs@wilco.org	Same as presiding officer

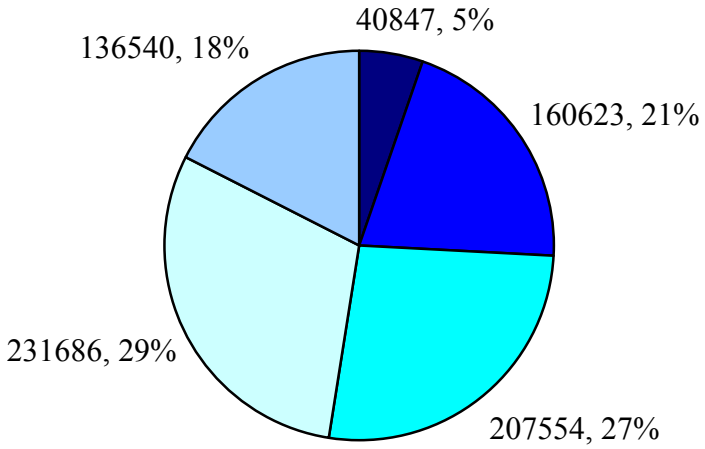
Appendix C: Population by Age, Race/Ethnicity, & Gender Texas, 2004

POPULATION BY RACE/ETHNICITY AND AGE, 2004

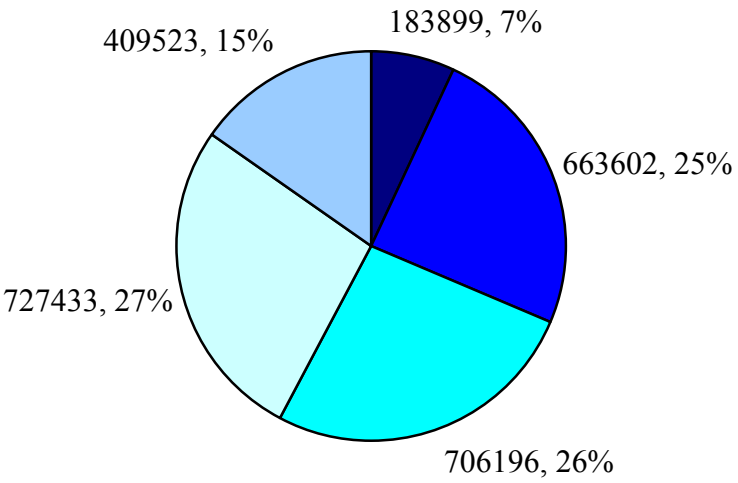
White (n = 2,493,282)



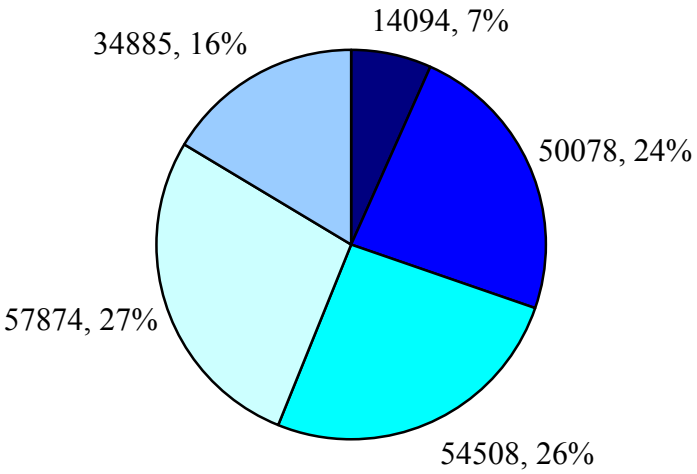
Black (n = 777,250)



Hispanic (n = 2,690,653)

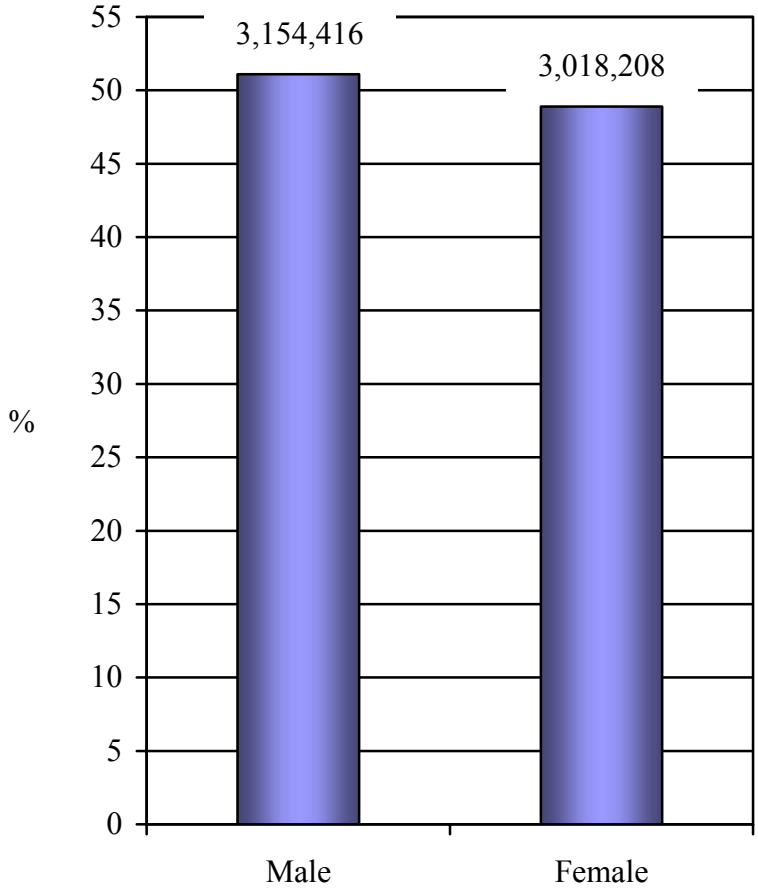


Other (n = 211,439)

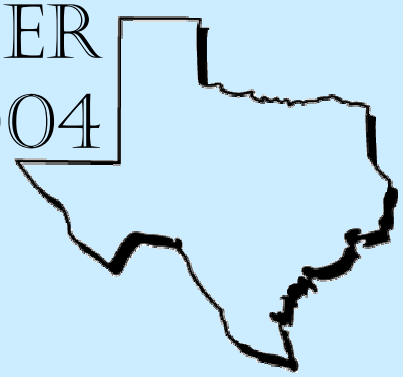


< 1 yr. | 1 – 4 yrs. | 5 – 9 yrs. | 10 – 14 yrs. | 15 – 17 yrs.

POPULATION BY GENDER, 2004

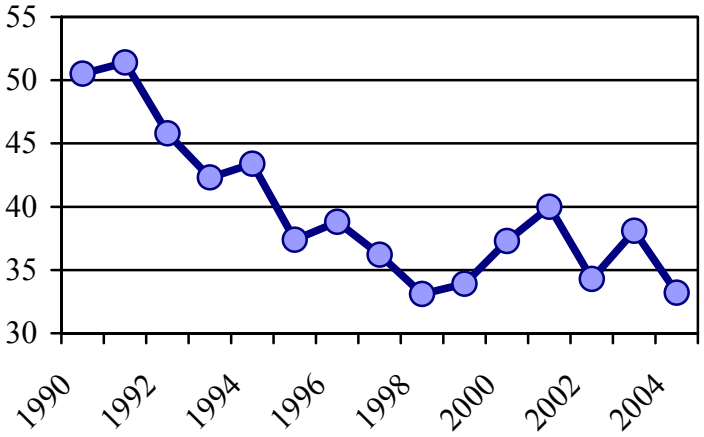


APPENDIX D:
TRENDS IN TEXAS CHILD DEATH BY AGE RACE/ETHNICITY, & GENDER 1990 THROUGH 2004

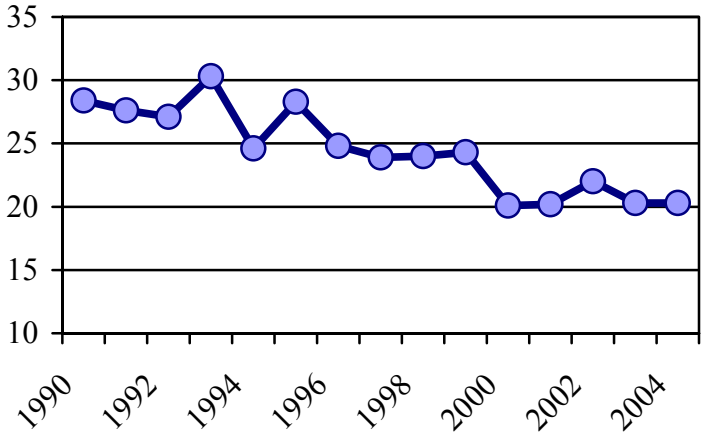


Trend of Texas Child Death by Age, 1990 through 2004

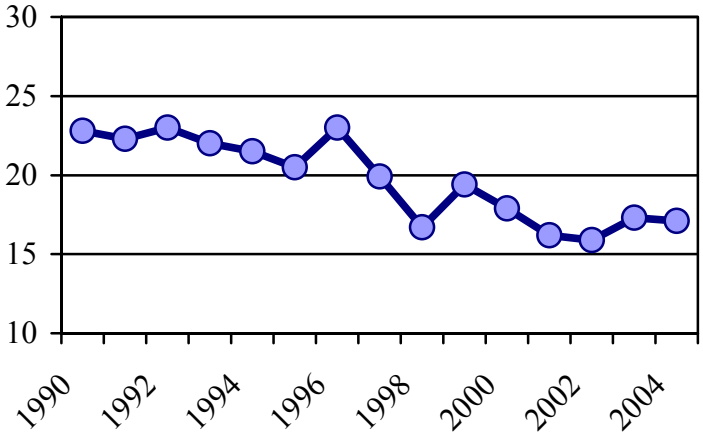
Ages 1 to 4 years



Ages 5 to 9 years

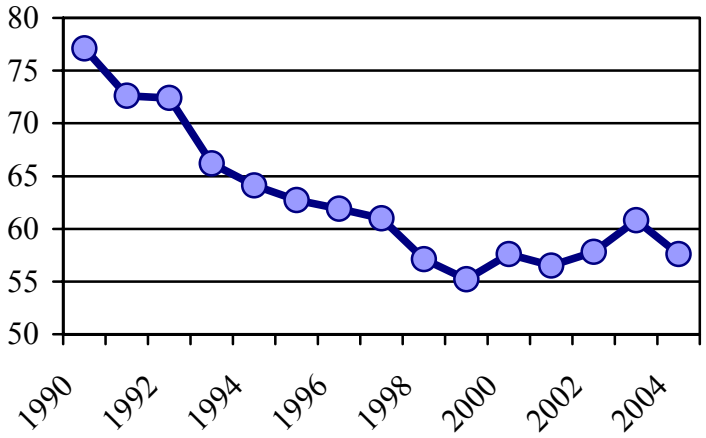


Ages 10 to 14 years

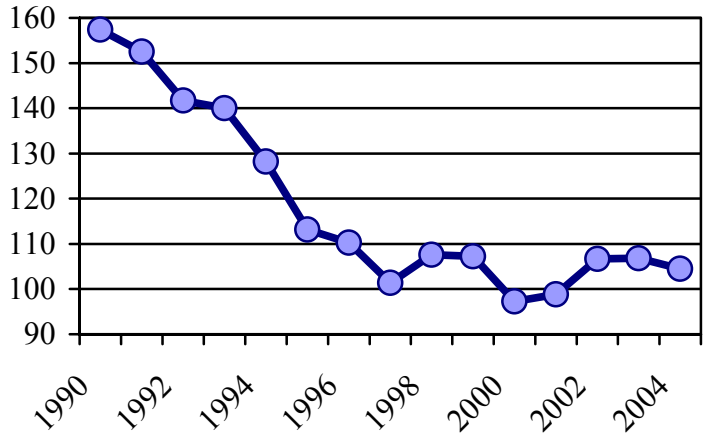


Trend of Texas Child Death by Race/Ethnicity, 1990 through 2004

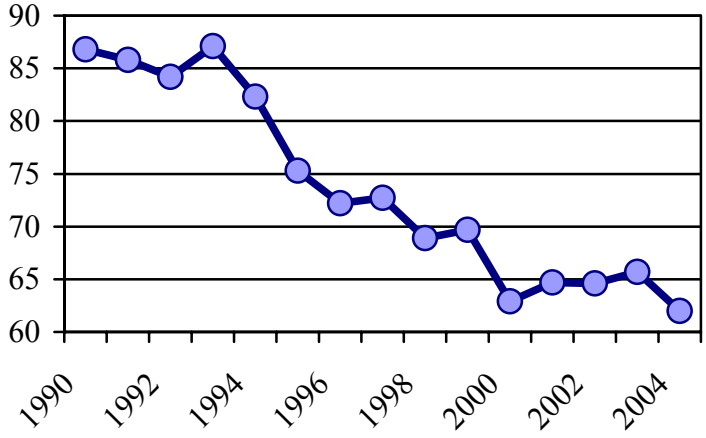
White



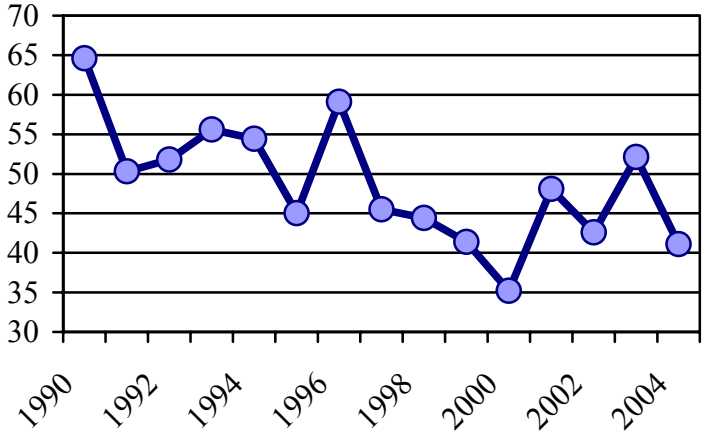
Black



Hispanic

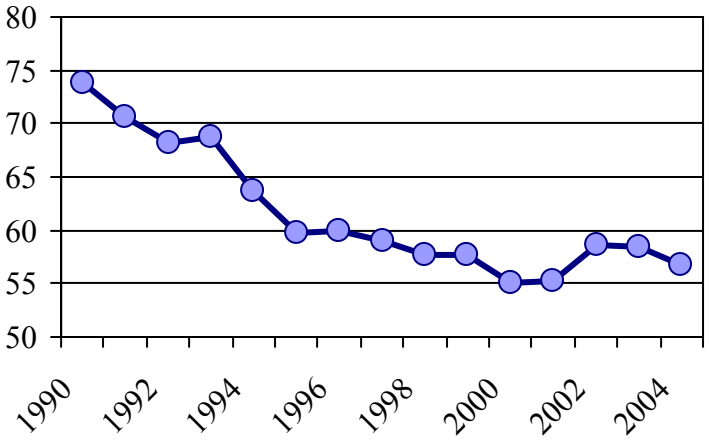


Other



Trend of Texas Child Death by Gender, 1990 through 2004

Female



Male