CHILD FATALITY REVIEW TEAM

OPERATIONS PROTOCOL

TEXAS Health and Human Services | Texas Department of State Health Services

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Introduction

What is Child Fatality Review?

Child Fatality Review is a prevention-focused process where multi-disciplinary teams meet to review individual child deaths to better understand how and why children die. Collected and reviewed child death information helps communities have a clearer understanding of underlying risk factors and inequities that they might not identify otherwise.

Child Fatality Review Legislation

In 1995, the Texas Legislature amended the **Texas Family Code (TFC), Chapter 264** by adding the Child Fatality Review and Investigation Statute. The Texas Legislature created the State Child Fatality Review Team (SCFRT) Committee and established procedures for local child fatality review team (CFRT) operations, child fatality reporting, and child death investigations.

The Texas Department of State Health Services (DSHS) developed this Child Fatality Review Protocol in accordance with **TFC, Section 264.503** to provide information regarding:

- Child fatality reporting and investigating for law enforcement agencies, child protective services (CPS), justices of the peace, medical examiners, and other professionals involved in child death investigations;
- Child death data collection; and
- CFRT operations.

Reporting and Investigating Child Fatalities

Under **TFC, Section 264.513**, any person who knows of the death of a child younger than age 6 shall immediately report the death to the medical examiner of the county in which the death occurs. If the death occurs in a county that does not have a medical examiner's office or is not part of a medical examiner's district, a person should report the death to that county's justice of the peace. This requirement is in addition to any other required reporting by law, including the requirement in **TFC, Section 261.101 (a)** that a person report child abuse and neglect to the Department of Family and Protective Services (DFPS) by calling the 24-hour toll-free abuse hotline at 1-800-252-5400.

Under **TFC, Section 264.513 (c)**, a person is not required to report the death of a child younger than age 6 that results from a motor vehicle accident to the medical examiner or justice of the peace. Following a death from a motor vehicle accident, the investigating law enforcement agent completes and submits an accident report notating the death to the State of Texas via The Texas Department of Transportation's Texas Peace Officer's Crash Report (Form CR-3).

Under **TFC, Section 264.514**, a medical examiner or justice of the peace notified of a death of a child under **TFC, Section 264.513** should hold an inquest under **Chapter 49, Code of Criminal Procedure**. Expected deaths due to congenital, neoplastic, or infectious disease do not require an inquest. A death caused by an infectious disease may be considered expected if:

- The disease was not acquired as a result of trauma or poisoning;
- The infectious organism is identified using standard medical procedures; or
- The death is not reportable to DSHS under **Chapter 81, Health and Safety Code**.

The inquest shall determine whether the death was unexpected or the result of abuse or neglect. **TFC, Section 261.001** defines the terms abuse and neglect. If the medical examiner or justice of the peace determines the death was unexpected or a result of abuse or neglect, they shall immediately notify an appropriate law enforcement agency, which shall investigate the child's death. This notification should occur not later than the 120th day after the date the death is reported and is based upon the jurisdiction where the death occurred.

TFC, Section 264.515 defines the investigation required by **TFC, Section 264.514**. The investigation must include:

- An autopsy, unless an autopsy was conducted as part of the inquest;
- An inquiry into the death's circumstances, including a death scene investigation and interviews with the parents of the child, any guardian or caretaker of the child, and the person who reported the child's death; and
- A review of relevant information about the child from any applicable records, including CPS records, emergency medical services (EMS) records, medical records, and law enforcement reports.

From this investigation, it is important to understand:

- Who was involved in the child death or has knowledge of the circumstances involved in the child death;
- What happened before, during, or after the child death occurred;
- When events related to the child death occurred to provide a timeline of the child death;
- Where the child death occurred and where evidence exists;
- Why the child death occurred and possible causes or reasons behind the child death; and
- How the child death occurred and how the who, what, when, and where of the death provide a hypothesis to conclude the investigation.

State Child Fatality Review Team Committee

The SCFRT Committee's purpose as outlined in **TFC, Section 264.503** is to:

- Develop an understanding of the causes and incidence of child fatality in Texas;
- Identify procedures within the agencies represented to reduce the number of preventable child fatalities;
- Promote public awareness; and
- Make recommendations to the governor and the legislature for changes in law, policy, and practice to reduce preventable child fatality numbers.

Not later than April 1 of each even-numbered year, the SCFRT Committee shall publish a report that contains aggregate child fatality data collected by local CFRTs, recommendations to prevent child fatalities and injuries, and recommendations to DFPS on CPS operations.

The SCFRT Committee is composed of:

1. A person appointed by and representing the state registrar of vital statistics;
2. A person appointed by and representing the commissioner of DFPS;
3. A person appointed by and representing the Title V director of the DSHS;
4. A person appointed by and representing the speaker of the house of representatives;
5. A person appointed by and representing the lieutenant governor;
6. A person appointed by and representing the governor
7. A criminal prosecutor involved in prosecuting crimes against children;
8. A sheriff;
9. A justice of the peace;
10. A medical examiner;
11. A police chief;
12. A pediatrician experienced in diagnosing and treating child abuse and neglect;
13. A child educator;
14. A child mental health provider;
15. A public health professional;

16. A CPS specialist;
17. A sudden infant death syndrome family service provider;
18. A neonatologist;
19. A child advocate;
20. A chief juvenile probation officer;
21. A child abuse prevention specialist;
22. A representative of the Department of Public Safety;
23. A representative of the Texas Department of Transportation;
24. An EMS provider; and
25. A provider of services to, or an advocate for, victims of family violence.

Local Child Fatality Review Teams

A local CFRT's purpose is to decrease preventable child fatality incidences by:

- Providing child fatality investigation assistance, direction, and coordination;
- Promoting cooperation, communication, and coordination among agencies involved in child fatality responses;
- Developing an understanding of child fatality causes and incidences in the county or counties in which the review team is located;
- Recommending agency changes, through the agency's representative member, that will reduce preventable child fatality numbers; and
- Advising on changes to law, policy, or practice that will assist the team and the agencies represented on the team in fulfilling their duties.

To achieve its purpose, a local CFRT shall:

- Adapt and implement, according to local needs and resources, the model protocols developed by DSHS and the SCFRT Committee;
- Meet on a regular basis to review child fatality cases and recommend methods to improve services and investigation coordination between agencies represented on the team;
- Collect and maintain data as required by the SCFRT Committee;
- Review and analyze the collected data to identify any child fatality case demographic trends, including whether there is a disproportionate number of child fatalities in a particular population, group, or geographic area; and
- Submit data reports on deaths reviewed to DSHS as specified by the SCFRT Committee.

A local CFRT shall initiate prevention measures as indicated by the team's findings.

Team Membership

In Texas, local CFRTs are created by the voluntary cooperation of individuals and agencies involved with child fatalities. Local CFRT membership is comprised of professionals who work in fields related to child mortality in their communities.

A local CFRT must reflect the diversity of the county or region's population and may include:

- A criminal prosecutor involved in prosecuting crimes against children;
- A sheriff;
- A justice of the peace or medical examiner;
- A police chief;
- A pediatrician experienced in diagnosing and treating child abuse and neglect;
- A child educator;
- A child mental health provider;
- A public health professional;
- A CPS specialist;
- A sudden infant death syndrome family service provider;
- A neonatologist;
- A child advocate;
- A chief juvenile probation officer; and
- A child abuse prevention specialist.

Local CFRTs may add or adjust team members to fit their community resources and needs or as information gaps become apparent during case review. For example, a CFRT may add a local child care licensing representative to the team if the CFRT repeatedly reviews deaths occurring in child care facilities and needs licensing standard information. If agencies have special programs which relate to team activities, it may be appropriate to have more than one agency representative on the team.

Local CFRT membership requires all team members' commitment, regular attendance, and active participation. Each member provides the team with information from their records, serves as a liaison to their professional counterparts, provides their profession's terminology definitions, interprets their agency's procedures and policies, and explains their profession's legal responsibilities or limitations. Members also assist with providing referrals for services or providing direct aid to surviving family members.

Members need to attend meetings regularly to offer the expertise and knowledge from their agency's perspective and help establish trust among team members. Team members may designate another representative from their agency to serve as a back-up member for meetings they are unable to attend. A team presiding officer may contact agencies or members who cannot consistently attend meetings to select another agency representative for the team.

Team Leadership

Local CFRTs select a presiding officer, team coordinator, and data entry coordinator from its members. Any team member may fill these leadership roles and one member may fill multiple positions. These positions may also rotate among team members. Teams may specify presiding officer and coordinator terms and revisit these term limits periodically.

Presiding officer duties

- Serves as the team leader.
- Schedules and chairs the team meetings.

Team coordinator duties

- Sends meeting notices to team members.
- Receives death certificate information for cases to be reviewed and distributes to team members prior to each fatality review meeting.
- Oversees team operations as outlined in DSHS protocols and adapted by the team.

Data entry coordinator duties

- Takes notes during team meetings.
- Requests information during team meetings that is pertinent to the completion of the case reporting system form.
- Enters reviewed case data into the online case report system.

Auxiliary Members

Local CFRTs may invite auxiliary members to attend meetings to provide additional valuable information. These auxiliary members are not permanent members and therefore do not regularly receive team notices. They attend

meetings only when a death scheduled for review directly involves them or they need to provide information related to a deceased child.

Examples of auxiliary members include homeless shelter staff, school personnel, or law enforcement representatives who do not normally attend meetings.

Review Procedure

Teams review all child deaths, regardless of cause, for children younger than age 18 according to the following criteria:

- Teams review natural fatalities of children who resided in their covered county or region.
- Teams review injury fatalities if the incident occurred in their covered county or region.

Teams shall follow these steps to complete a case review:

1. Gather and disseminate case information

The DSHS state injury prevention coordinator sends death certificate information via encrypted email to local CFRT leadership for cases assigned to each team. Death certificate information is password protected and CFRT leadership should share this information with team members through a secure process, either by encrypted email or through another secure method. Approximately two weeks before each scheduled review meeting, the team coordinator shall share death certificate information with team members for cases scheduled to be reviewed.

On receipt of the child fatality review list, each team member shall review their agency records for information regarding each listed child. This information may include:

- Case-specific information on the child's death, including records related to the child, family, investigation, services, and agency responses to the death.
- Data on other deaths or injuries similar to the death being reviewed. These data may show trends that will help the team advocate for necessary state policy or procedure changes.
- Information on local and state resources, services, programs, and policies relevant to the prevention of this type of death and the delivery of services.

2. Conduct a Fatality Review Meeting

Local CFRTs may meet and conduct meetings in person or via virtual platforms. A team may establish a virtual or hybrid meeting model if this promotes increased

meeting attendance and allows for engaged and productive conversations among team members.

Both in-person and virtual fatality review meetings are closed to the public and information identifying a deceased child, or the family members, may only be shared among team members or designated auxiliary members. Team members shall sign a confidentiality agreement prior to each fatality review meeting. The presiding officer or team coordinator should keep the completed agreements from each meeting. See **Appendix A** for a sample confidentiality agreement.

For each reviewed death, team members:

- Share their agency's case information. After team members share case information, they should address any case questions. If the team identifies case information gaps, it may be best to table further discussion until the next meeting.
- Discuss the investigative agency and death scene investigation information, if applicable. This discussion should determine if a team has all the information needed regarding the circumstances of the death or if the case requires further investigation.
- Discuss services delivered to the child, family members, or others (e.g., siblings, friends, schoolmates) prior to or following the death and whether the team has recommendations to improve future service delivery.
- Identify risk factors to determine how to prevent future deaths. Risk factors may fall under any of the following categories: health, social, economic, behavioral, environmental, systemic (agency policies and procedures), and product safety.
- Discuss whether each death was preventable. A team should consider this question for each reviewed case and engage in a discussion related to possible prevention recommendations.

3. Enter CFRT case review data

Teams submit case review data not later than the 30th day after the date of case review by entering data into the **National Fatality Review-Case Reporting System (NFR-CRS)**. This includes information about the child, caregivers, supervisors,

circumstances of the event leading to the death, investigation, and team findings related to services and prevention recommendations.

The DSHS state injury prevention coordinator provides usernames and passwords for the NFR-CRS. Team leaders may request an NFR-CRS account for any team member who assists with entering case review data. A team leader may request an account by emailing the new user's name, organization, contact information, and local CFRT name to the DSHS state injury prevention coordinator at **cfrt@dshs.texas.gov**.

The **National Center for Fatality Review and Prevention Case Reporting System form** contains all the NFR-CRS data elements and may help guide discussion during a case review. The data entry coordinator(s) should enter all case review information from the case reporting system form into the NFR-CRS, including information from records collected and reported by team members. Teams should pay close attention to entering priority variables, indicated in the NFR-CRS by an orange star.

- A question may be left blank if the team did not discuss/mention the information during a review meeting.
- A question may receive a response of "unknown" in situations when a team discussed a question or data point, but the information was not available to anyone on the team. If a team attempts to obtain information but cannot, those fields should be marked as "unknown."

Teams may find guidance for each NFR-CRS question by clicking on the "?" next to the question or reference the **NFR-CRS Data Dictionary**.

It is important for local CFRTs to systematically collect data and report their findings. The collection of fatality review meeting findings and the subsequent reporting of these findings can help:

- Local CFRTs identify any demographic trends in child fatality cases, including whether there is a disproportionate number of child fatalities in a particular population, group, or geographic area;
- Local CFRTs demonstrate the effectiveness of their reviews and gain support for community interventions; and

- The SCFRT Committee review local CFRT data and findings to identify trends and major risk factors that will inform state policy and practice improvement recommendations.

4. Develop Prevention Recommendations

According to **TFC, Section 264.506**, CFRT's should "initiate prevention measures as indicated by the review team findings." Focusing child fatality review meetings on prevention provides meaning and purpose and allows team members to discuss how these efforts can begin to prevent future child deaths. Prevention initiatives are more likely to be successfully adopted and implemented when developed through local collaborative multi-agency team member efforts.

Teams should take these steps to develop recommendations for a reviewed death:

- **Determine if the death was preventable** - Discussing a death's preventability during a case review provides a good basis for developing prevention initiatives related to the circumstances of the death.
- **Identify modifiable risk factors** - Local CFRTs should identify specific factors that caused the death and determine which factors they believe they can modify or impact within the community.
- **Determine the best strategy for prevention** - The Spectrum of Prevention, located in **Appendix B**, is a helpful team tool to use to create long-term community changes to prevent child deaths.
- **Write effective recommendations** - Local CFRTs should outline action-oriented recommendation(s) and appropriate justification, including the team's assessment on the types of deaths the members are trying to prevent. Teams should also plan to follow up on the recommendation(s).
- **Identify specific prevention initiatives** - Local CFRTs should identify specific activities that need to be implemented and review community resources to be sure that members are not replicating any ongoing activities. These initiatives will likely take time and are not quick and easy solutions. Combining strategies may increase a team's proposed initiatives' effectiveness.
- **Share team findings** - Local CFRTs should share findings with the appropriate agencies or individuals who are best positioned to act.

5. Share Prevention Recommendations for the SCFRT Biennial Report

Local CFRTs should submit their developed prevention initiatives and recommendations to the SCFRT Committee for consideration for inclusion into the SCFRT biennial report. Recommendations may relate to changing current statute, increasing public education, and strengthening existing systems. Teams should submit prevention recommendations to the DSHS state injury prevention coordinator (**cfrt@dshs.texas.gov**). See **Appendix C** for a sample CFRT prevention recommendations template.

CFRT Records Confidentiality and Retention

A local CFRT may request information and records regarding a deceased child as necessary to carry out the team's purpose and duties, including:

- Medical, dental, and mental health care information; and
- Any state or local government agency-maintained information and records including:
    - A birth certificate;
    - Law enforcement investigative data;
    - Medical examiner investigative data;
    - Juvenile court records;
    - Parole and probation information and records; and
    - CPS information and records.

On request of the local CFRT presiding officer, the custodian of the relevant information and records related to the deceased child shall provide those records at no cost to the team.

A standing request for records and information may be developed by a team to facilitate information gathering required to conduct a fatality review. It should be addressed to the "custodian of the records" or the agency director and include the CFRT authorizing statute and information regarding the team operation and purpose. These requests are particularly useful for acquiring information from agencies without a representative on the team. See **Appendix D** for a sample Request for Records and Information form.

Records Confidentiality

Records acquired by local CFRTs to conduct a fatality review are confidential and exempt from disclosure under the **Open Records Law, Government Code, Chapter 552**. Information, documents, and records otherwise available from other sources (e.g., police reports, hospital records) are not immune from subpoena, discovery, or introduction into evidence solely because they were presented during committee or review team proceedings or are maintained by a CFRT. A fatality review report or statistical compilation is a public record subject

to the **Open Records Law, Government Code, Chapter 552** if it does not include the identification of an individual.

A team member may not disclose any information that is confidential. All CFRT members and other meeting attendees shall sign a confidentiality agreement at each case review meeting, which should be kept in each meeting's records by the presiding officer or team coordinator.

Records Retention

Local CFRTs should enter case review records including case reports, case review notes, and team recommendations, into the NFR-CRS to securely store this information. Once teams enter case review records into the database, teams shall dispose of these records by securely shredding or deleting the records to appropriately protect the confidential information.

Appendix A: Child Fatality Review Team (CFRT) Confidentiality Agreement

CFRT Teams may use the attached template by double-clicking the paper clip icon or download at: dshs.texas.gov/injury-prevention/texas-child-fatality-review#CFRT

The purpose of the _____ **(*team name*)** Child Fatality Review Team is to conduct a thorough examination of each child death in _____ **(*name of county or counties*)** County.

In order to assure a coordinated response that fully addresses all systemic concerns surrounding child fatalities, all relevant data, including historical information concerning the deceased child and his or her family, must be shared at team reviews. Much of this information is protected from disclosure by the law, especially medical and child abuse/neglect information. Therefore, team reviews are closed to the public, and confidential information cannot be lawfully discussed unless the public is excluded. In no case should any team member or designee disclose any information regarding team decisions outside the team, other than pursuant to team confidentiality guidelines. Failure to observe this procedure may violate various confidentiality statutes that contain penalties. Any agency team member may make a public statement about the general purpose or nature of the child death review process, as long as it is not identified with a specific case.

The undersigned agree to abide by the terms of this Confidentiality Agreement.

CFRT Member's Name	CFRT Member's Signature	Agency

Appendix B: The Spectrum of Prevention

The Spectrum of Prevention is a Child Fatality Review Team (CFRT) tool to implement a multi-faceted approach to injury prevention initiatives.

Influencing Policy & Legislation	Developing strategies to change laws and policies to influence outcomes
Changing Organizational Practices	Adopting regulations and shaping norms to improve health and safety
Fostering Coalitions & Networks	Convening groups and individuals for broader goals and greater impact
Educating Providers	Informing providers who will transmit skills and knowledge to others
Providing Community Education	Reaching groups of people with information and resources to promote health and safety
Strengthening Individual Knowledge & Skills	Enhancing an individual's capability of preventing injury or illness and promoting safety

Adapted from Cohen L, Swift S. The spectrum of prevention: developing a comprehensive approach to injury prevention. Injury Prevention. 1999;5:203-207. For more information, please see: **preventioninstitute.org/tools/spectrum-prevention-0**.

Appendix C: Child Fatality Review Team (CFRT) Recommendations Template

CFRTs should use this template to outline CFRT recommendation(s) and their justification. CFRT Teams may use the attached template by double-clicking the paper clip icon or download at: **dshs.texas.gov/injury-prevention/texas-child-fatality-review#CFRT**

Team Name: _____

Recommendation	Justification

Appendix D: Records Request Form

This form may be used by a Child Fatality Review Team (CFRT) to facilitate the gathering of information required to conduct a fatality review. CFRT Teams may use the attached template by double-clicking the paper clip icon or download at: dshs.texas.gov/injury-prevention/texas-child-fatality-review#CFRT

Name of CFRT	
C/O Name	
Address	
Phone	
Fax	
Email address	

RECORDS REQUEST

Date	
Recipient Name	
Recipient Title	
Recipient Organization	
Recipient Street Address	
Recipient city, state, ZIP	

Dear Colleague:

Child Fatality Review Teams (CFRTs) are multi-disciplinary, multi-agency working groups that review child deaths on a local level from a public health perspective. In 1995, Texas enacted legislation establishing the State Child Fatality Review Team Committee (SCFRT) and authorizing counties to form local and regional CFRTs. By reviewing circumstances surrounding child deaths, teams identify prevention strategies that will decrease preventable child death incidences.

We are currently scheduled to review the following case:

Name	
Date of Birth	
Date of Death	
Resident Address	
Resident city, state, ZIP	
Mother's Name	

We request that you provide us a copy of the following records you might have pertaining to the child:

☐ History and physical
☐ Discharge summary
☐ Investigative report
☐ Emergency Department record
☐ Emergency Medical Services (EMS) Run sheet

You may legally furnish such records to us, in response to this request, pursuant to Texas Family Code (TFC), Section 264.509:

TFC, Sec. 264.509. ACCESS TO INFORMATION.

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

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

(2) Information and records maintained by any state or local government agency, including:

(A) A birth certificate;

(B) Law enforcement investigative data;

(C) Medical examiner investigative data;

(D) Juvenile court records;

(E) Parole and probation information and records; and

(F) Child protective services information and records.

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

If you need additional information about the Team or the case under review, please contact me. Thank you for your cooperation.

Sincerely,

Presiding Officer

Child Fatality Review Team

Child Fatality Review Websites

Texas Child Fatality Review

dshs.texas.gov/injury-prevention/texas-child-fatality-review

State Child Fatality Review Team Committee

dshs.texas.gov/injury-prevention/state-child-fatality-review-team-committee

National Center for Child Fatality Review and Prevention

ncfrp.org/

National Fatality Review Case Reporting System

data.ncfrp.org/Account/Login

Child Fatality Review Team Operations Protocol

dshs.texas.gov/injury-prevention/texas-child-fatality-review