Texas Child Fatality Data and Recommendations

As Required by

Texas Family Code, Section

264.503(f)

State Child Fatality Review

Team Committee

April 2020

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Executive Summary

The State Child Fatality Review Team Committee (committee) biennial report is prepared in compliance with Texas Family Code, Section 264.503(f). The report contains aggregate child fatality data from local child fatality review teams (CFRTs), recommendations to prevent child fatalities and injuries, and recommendations to the Department of Family and Protective Services (DFPS) on child protective services operations based on input from the committee.

The committee works with local CFRTs to provide recommendations about injury prevention activities. Recommendations relate to changing current statute, increasing public education, and how best to strengthen existing systems.

To support the committee in developing this report, the Department of Health Services (DSHS) calculated child fatality statistics from death data files. These statistics are based on the most currently available data – 2016 finalized death files. Data for more recent years have yet to be finalized.

In 2016, the Texas child death rate remained consistent with previous years. There were 3,858 child deaths in Texas in 2016, and active local CFRTs reviewed 1,244 (approximately 32 percent) of the total child deaths.

Recommendations to the Governor and Legislature

1. Repeal of Texas Education Code, Section 1001.112. This statute allows a parent, legal guardian, step-parent, or grandparent to provide a driver education course to eligible minors 16-18 years of age.
2. Pass legislation that requires new residential swimming pools to have a circumferential isolation pool fence installed that is at least four feet in height and completely separates the house and play area of the yard from the pool.
3. Amend Texas Family Code, Section 261.102 to require professionals to report to DFPS all cases of children less than six years old who have died due to unexplained or non-natural causes, excluding motor-vehicle occupant deaths unless there is suspicion of alcohol or substance use.
4. Fund CFRT Coordinators in each of the DSHS Public Health Service Regions as recommended by the Protect Our Kids Commission.
5. Amend Texas Transportation Code, Section 545.412 to create an additional offense related to rear-facing child passenger restraint systems.

Recommendation to DFPS

1. Establish a dedicated and secure DFPS Hotline 800 number for all medical personnel to reduce wait-times for mandated medical professionals during critical and often time-sensitive interactions with potential child abuse situations.

1. Introduction

Per Texas Family Code, Section 264.503(f), the State Child Fatality Review Team Committee (committee) is required to report aggregate child fatality data collected by local CFRTs and recommendations from the committee and local CFRTs to prevent child fatalities and injuries. The committee is also required to provide recommendations to the Department of Family and Protective Services (DFPS) on child protective services operations based on input from the child safety review subcommittee. The child safety review subcommittee is an internal DFPS committee that meets quarterly to discuss recommendations to improve DFPS practices and prevent child deaths.

The report is made to the Governor, Lieutenant Governor, and the Speaker of the House of Representatives no later than April 1 of each even-numbered year.

To satisfy the requirements of statute, the following report presents:

- Committee recommendations to the Governor and the Legislature on preventing child fatalities and injuries,
- General child fatality statistics based on 2016 finalized death data files, and
- Aggregate child fatality data collected by local CFRTs.

2. Background

Child fatality review is a public health strategy used to understand child deaths through multi-disciplinary review at the local level. Deaths are reviewed and data are collected and analyzed to best understand risks to children. Child fatality review is practiced in each state in the United States and in other countries.

In 1995, Texas enacted legislation establishing the State Child Fatality Review Team Committee (committee) and authorized counties to form local and regional Child Fatality Review Teams (CFRT).

Committee members serve three-year terms and are a multi-disciplinary group of professionals representing law enforcement, the medical community, child advocacy organizations, the court system, the behavioral health community, and other state agencies. Committee members are also required to be members of their local CFRT.

During the 85th Legislature, Regular Session, 2017, House Bill 1549 added three permanent members to the committee: a member appointed by and representing the Speaker of the House of Representatives; a member appointed by and representing the Lieutenant Governor; and a member appointed by and representing the Governor. For a complete list of committee membership, see Appendix A. House Bill 1549 made other substantial changes to statute that defines the committee and local CFRT structure and activities. These changes are outlined below in Appendix B.

The committee meets quarterly to:

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

Local CFRTs are volunteer-based and organized by county or multi-county geographic areas. Membership mirrors that of the committee. Local CFRTs conduct retrospective reviews of deaths of children 17 years of age or younger in their geographic areas.

As of December 2019, there were 83 active local CFRTs covering 211 of the 254 Texas counties resulting in 94 percent of Texas children residing in a county where child deaths are reviewed. In 2016, there were 3,858 child deaths in Texas in 2016 and active local CFRTs reviewed 1,244 (approximately 32 percent) of the total child deaths.

Since the 2018 Legislative Report, the local CFRT death certificate distribution process changed considerably at both the state and local level due to the requirement for DSHS to provide local CFRTs with electronic access to preliminary death certificates. Previously, death certificates were distributed by mail at an 18-to 24-month delay after the death occurred.

The electronic death certificate distribution process has evolved and improved during the past two years. The process started with teams primarily accessing the death certificate information from the NCFRP online case report system. After receiving local CFRT feedback regarding data needed from the death certificate to conduct a complete review, the electronic case distribution was expanded and improved. Local CFRTs currently receive a secure electronic spreadsheet with death certificate information. As of December 2019, local CFRTs received death certificate information through July 2019.

3. State Child Fatality Review Team Committee Recommendations

Local Child Fatality Review Teams (CFRTs) receive death certificate information from the Department of State Health Services (DSHS) to identify child deaths that occurred in their community. The local CFRTs then conduct a retrospective review of deaths of children 17 years of age or younger in their geographic areas. Team members collect and provide information that corresponds to their disciplines and specific questions from the National Center for Fatality Review and Prevention (NCFRP) database at the review meeting. Members meet to share what each member knows about the cases being reviewed, such as incident circumstances, and to identify risk factors. A major purpose of these reviews is to determine if a child's death was preventable.[1]

Local CFRTs enter the data collected during reviews in the NCFRP database. The data collected and lessons learned from local CFRT fatality reviews inform recommendations to the State Child Fatality Review Team Committee (committee), which are submitted to DSHS. The committee reviews, discusses, and votes on each recommendation submitted by local CFRTs. Recommendations are included in the biennial report and are used to inform local and statewide prevention activities with the aim of reducing preventable deaths.

The most recent year for which all local CFRTs have completed their review of child fatality cases is 2016. Their review and recommendations – in addition to other research conducted by the committee - form the basis of the committee's recommendations in this report. A DSHS analysis of 2016 death data files is also presented in Appendix C. Aggregate data from local CFRTs are presented in Appendix D.

Local CFRTs submitted 14 recommendations for the committee to review for this report. Each recommendation was voted on by the committee at the quarterly meeting on November 15, 2019. The below recommendations were approved by the committee.

[1] Per the NCFRP database, a child's death is considered to be preventable if an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death.

Recommendations to the Governor and Legislature

Recommendation 1: Repeal of Texas Education Code, Section 1001.112 Parent-Taught Driver Education which allows a parent, legal guardian, step-parent, or grandparent to provide a driver education course to eligible minors 16-18 years of age.

Motor vehicle crashes are the leading cause of unintentional injury death for youth in the United States (U.S.) from 10-24 years of age.[2] The Centers for Disease Control and Prevention (CDC) reported in 2017 that 2,364 teens in the U.S. aged 16-19 were killed in motor vehicle crashes.[3] This statistic translates to six teens per day dying in motor vehicle crashes. Males had a two times higher rate of motor vehicle crash death than females 16-19 years of age in 2017.[4]

In Texas, 106 youth ages 15-17 years died in a motor vehicle crash in 2016. Local CFRTs reviewed 56 of those crashes and found that 36 percent of the deaths were the driver of the vehicle and 28.5 percent were the passenger. Speed and reckless driving were the top two factors identified by local CFRTs as contributing to the motor vehicle crashes for the 15-17-year-old age group.

The National Highway Traffic Safety Administration and Texas Transportation Institute published a study in April 2007 called *Parent-Taught Driver Education in Texas: A Comparative Evaluation*.[5] The study reported that nearly 40 percent of the 218,054 driver education certificates issued in Texas in 2004-2005 were from parent-taught driver education (PTDE), and PTDE youth were obtaining driver's permits at a slightly younger age.

Although the study cites few self-reported differences in driving knowledge and skills related to the type of driver education, the study reviewed driving records and found that PTDE drivers demonstrated lower driving knowledge early in their training, inferior driving skills compared to their professionally-trained peers, and a lower rate of passing the state-administered driving test on the first attempt.

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[2] Centers for Disease Control and Prevention (CDC). Ten Leading Causes of Death and Injury. US Department of health and Human Services; https://www.cdc.gov/injury/images/lc-charts/leading_causes_of_death_by_age_group_unintentional_2017_1100w850h.jpg; Accessed 9 Jan. 2020.

[3] Centers for Disease Control and Prevention (CDC). Teen Drivers Fact Sheet. US Department of health and Human Services; https://www.cdc.gov/motorvehiclesafety/teen_drivers/teendrivers_factsheet.html. Accessed 9 Jan. 2020.

[4] Institute of Highway Safety (IIHS). Fatality Facts 2018: Teenagers. https://www.iihs.org/topics/fatality-statistics/detail/teenagers. Accessed 13 Jan 2020.

[5] U.S. Department of Transportation, National Highway Traffic Safety Administration. "Parent-Taught Driver Education in Texas: A Comparative Evaluation." (2007). (Report No. DOT HS 810 760). Parent-Taught Driver Education in Texas: A Comparative Evaluation, www.nhtsa.gov/sites/nhtsa.dot.gov/files/parent-taught_driver_ed.pdf. Accessed 6 Dec. 2019.

Furthermore, PTDE novice drivers committed more traffic offenses and were in more crashes after receiving their full license. When supervision is eliminated (full licensure), then PTDE students were involved in more traffic convictions and increasingly serious motor vehicle crashes.

Given the increased risk of serious injury and death experienced by minor drivers and their passengers, and the lack of any requirement for parents who teach driver education to demonstrate driving knowledge, skills, or Department of Public Safety monitoring, the committee recommends repealing legislation allowing for parent- or guardian-taught driver education.

Recommendation 2: Pass legislation that requires new residential swimming pools have a circumferential isolation pool fence installed that is at least four feet in height and completely separates the house and play area of the yard from the pool.

Drowning is the leading cause of injury death in children one to four years of age and the second leading cause of unintentional injury death among children five to nine years of age in the U.S.[2] In 2017, over 800 children and adolescents, ages 0-17 years, died in the U.S. due to drowning.[6]

In 2016, there were 67 children 1-4 years of age who died due to drowning in Texas. There were 33 children in this age group who died in a swimming pool due to drowning, and local CFRTs reviewed 54 percent of the deaths. Local CFRTs recorded that only 22 percent of the reviewed cases indicated a pool fence at the incident scene.

In 2019, the American Academy of Pediatrics (AAP) updated drowning prevention recommendations for families, including installation of a four-sided, four-foot tall fence with self-closing and self-latching gates that completely isolates the pool from the house. The AAP also recommended that policymakers pass state or local legislation or building code that mandates new and existing residential pools have a four-sided isolation fence.[7]

Research has shown that nearly half of swimming pool drownings and near drownings occur in a home or private swimming pool, and at least 80 percent of

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[6] Centers for Disease Control and Prevention (CDC). WISQARS (Web-based Injury Statistics Query and Reporting System). US Department of Health and Human Services; https://webappa.cdc.gov/cgi-bin/broker.exe; Accessed 9 Jan. 2020.

[7] Pediatrics: Official Journal of the American Academy of Pediatrics. "Prevention of Drowning." *Prevention of Drowning/American Academy of Pediatrics*, 1 May 2019, https://pediatrics.aappublications.org/content/143/5/e20190850.

children have access to the pool from the house or yard. Four-sided isolation fencing around the pool itself is part of a multi-layered method to prevent a child's access to the pool.[8]

Currently in the U.S., 25 states have a law in place in regards to pool fences. Some states use the 2009 International Residential Code or 2009 International Building Code, which specifies the requirements of swimming pool fences.

Recommendation 3: Amend Texas Family Code, Section 261.102 to report to the Department of Family and Protective Services (DFPS) all children less than six years old who have died due to unexplained or non-natural causes, excluding motor-vehicle occupant deaths unless there is suspicion of alcohol or substance use.

The current law states that professionals must report a death to Child Protective Services (CPS) at DFPS if they have a belief that the child has been abused or neglected. Due to the lack of notification and investigation by CPS, child deaths resulting from possible abuse and/or neglect may be under-reported and services to the families are not offered. Therefore, the committee recommends amending the existing Texas Family Code, Section 261.102 to include reporting all children less than six years old that have died due to unexplained or non-natural causes, excluding motor-vehicle occupant deaths unless there is suspicion of alcohol or substance use to DFPS in order to better identify possible cases of abuse and/or neglect.

A precedent for reporting child deaths exists in the Texas Family Code, Section 263.513, which states that a person who knows of the death of a child younger than six years old must report it to the Medical Examiner or Justice of the Peace in the county in which the death occurred, regardless of whether the death was alleged to be the result of abuse or neglect.

Implementation of this recommendation will ensure that all children who die unexpectedly that are less than six are investigated by DFPS. This recommendation has the possibility to increase the number of investigations and services offered to families at the time of a child's death in addition to improving the continuity of reporting among agencies.

[8] Injury Prevention Web. "Isolation Fences Around Residential Swimming Pools." *Injury Prevention Policy*, www.safetypolicy.org. Accessed 6 Dec. 2019.

Recommendation 4: Fund Child Fatality Review Team Coordinators in each of the DSHS Public Health Service Regions as recommended by the Protect Our Kids Commission (POK Commission).

The Children's Justice Act pilot project in Bexar County and Burnet County was conducted to provide support for this recommendation. The pilot, which ended in August 2019, hired two CFRT Coordinators, one in a rural and one in an urban region of Texas, to provide guidance and training to their local CFRT to increase the quality of the data reported and the quantity of the cases reviewed. Preliminary results showed that Burnet County entered 78 percent of cases for 2018 and Bexar County increased data entry by 92.5 percent from 2015 to 2018. Bexar County Juvenile Justice Department found that having a local CFRT Coordinator for their county team increased stakeholder participation and increased data entry. They applied for the Children's Justice Act grant in 2019 and, given the success of the pilot, were awarded the grant to continue housing the Bexar County CFRT Coordinator.

The committee supports the POK Commission recommendation to fund a CFRT Coordinator in each Public Health Service Region. Local CFRT Coordinators, presiding officers, and data entry coordinators are members who serve as volunteers on their review teams. Funding a local CFRT Coordinator in each of the Public Health Service Regions will increase the potential for consistency in local CFRT function throughout the state.

The POK Commission met seven times in 2015 and divided into four workgroups (CFRT, Prevention, Data, and Sustainability). One of the recommendations and strategies that were adopted by the POK Commission was for the legislature to fund CFRT Coordinators for each of the DSHS Regions.

The recommendations contained in the 2015 POK Commission Report provide a guide for the changes and improvements needed for a safer Texas.[9]

Recommendation 5: Amend Texas Transportation Code, Section 545.412 to create an additional offense related to rear-facing child passenger restraint systems using the following language:

- Current language: *A person commits an offense if the person operates a passenger vehicle, transports a child who is younger than eight years of age,*

[9] Protect Our Kids Commission Report. "Protect Our Kids Commission Report - December 1, 2015." Protect Our Kids Commission Report, www.texaschildrenscommission.gov/media/1141/pdf-report-pok-commission-december-2015.pdf. Accessed 9 Dec. 2019.

unless the child is taller than four feet, nine inches, and does not keep the child secured during the operation of the vehicle in a child passenger safety seat system according to the instructions of the manufacturer of the safety seat system.

- Proposed additional language: *A person commits an offense if the person operates a passenger vehicle, transports a child* **under two years of age**, *and does not keep the child secured during the operation of the vehicle in a rear-facing child passenger safety seat system according to the instructions of the manufacturer of the safety seat system.*

The AAP, the CDC, and the National Highway Traffic Safety Administration (NHTSA) recommends that children should use a rear-facing car safety seat (CSS) for as long as possible but at least until they reach the highest weight or height allowed by their CSS's manufacturer.[10, 11, 12] This varies in age but can usually cover children from birth to age two to four years.[11] Most convertible CSS will allow children two years or more to ride rear-facing.[10]

In a rear-facing CSS, the harness cradles and moves with a child to reduce the stress to a child's head and neck.[12]

There has been a substantial increase in scientific evidence on which to base recommendations for best practices in child passenger safety. Current estimates of child restraint effectiveness indicate that child safety seats reduce the risk of injury by 71 to 82 percent and reduce the risk of death by 28 percent when compared with children of similar ages in seat belts.[10]

In Texas, there were 86 deaths to children less than 8 years of age in motor vehicle crashes in 2016, and local CFRTs reviewed 43 percent of those deaths.

Recommendations to the Department of Family and Protective Services

Recommendation 1: A dedicated and secure DFPS Hotline 800 number for all medical personnel in order to reduce wait time for mandated medical

[10] Pediatrics Official Journal of the American Academy of Pediatrics. "Child Passenger Safety." Child Passenger Safety/American Academy of Pediatrics, 1 November 2018, www.pediatrics.aappublications.org/content/142/5/e20182460.

[11] Centers for Disease Control and Prevention. "Child Passenger Safety: Get the Facts - Prevention." Child Passenger Safety: Get the Facts/Motor Vehicle Safety, www.cdc.gov/motorvehiclesafety/child_passenger_safety/cps-factsheet. Accessed 9 Dec. 2019

[12] National Highway Traffic Safety Administration. "Car Seat Recommendations for Children." Car Seat Recommendations for Children – NHTSA, 21 March 2011, www.nhtsa.gov/sites/nhtsa.dot.gov/files/nhtsacarseatrecommendations.pdf.

professionals during critical, and often time-sensitive interactions with potential child abuse situations.

The committee recommends that DFPS establish a dedicated hotline for all medical personnel in order to reduce wait time for mandated medical professionals during critical, and often time-sensitive interactions with potential child abuse situations. A dedicated hotline would decrease wait times to reporting of abuse and neglect concerns by trained and vetted medical professionals.

Currently, medical personnel in Texas do not have a dedicated child abuse hotline (800 number) like law enforcement agencies to report abuse and neglect to DFPS. Medical personnel use the public child abuse hotline that is used by schools, other professional organizations, and private citizens. Per DFPS statewide intake reports of abuse/neglect by agency, medical personnel (84,776) were the highest reporters to statewide intake, followed by schools (66,168), and law enforcement (56,664).[13]

In 2018, DFPS received 467,282 calls on the public child abuse hotline. The average hold time was 11.9 minutes. DFPS answered 307,942 of those calls, with an average hold time of 13.8 minutes. There were 159,340 calls abandoned or 34.1 percent of the total calls.

In comparison, in 2018, DFPS received 67,947 calls on the dedicated law enforcement hotline, with an average hold time of 1.6 minutes. DFPS answered 64,293 of those calls, with an average wait time of 1.6 minutes. There were 3,654 calls abandoned or 5.4 percent of the total calls.

Having a dedicated child abuse hotline has decreased the average hold time for law enforcement professionals to 1.6 minutes compared to 13.8 minutes for the pubic child abuse hotline. Medical professionals are seeing patients in hospitals, clinics, and private practices. CFRT members, both local and state, report that it can be a struggle to wait to report abuse and neglect to DFPS using the public child abuse hotline while balancing the needs of their patients.

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[13] Texas Department of Family and Protective Services. “Statewide Intake: Source of Abuse/Neglect Report.” *Child Protective Services (CPS) Data and Statistics-DFPS*, https://www.dfps.state.tx.us/About_DFPS/Data_Book/Statewide_Intake/Source_of_Reports.asp. Accessed 9 Dec. 2019.

4. Conclusion

Child Fatality Review is a unique process that brings together multi-disciplinary professionals to discuss how and why Texas children are dying. This report is based on the data collected and recommendations made by local CFRTs, as well as the research, recommendations, and advocacy of the committee. Committee members participate in their local CFRT reviews and work to bring the topics discussed in local reviews to the attention of the state committee.

The State Child Fatality Review Team Committee (committee) made five recommendations to the Governor and Legislature concerning actions to increase children's safety in Texas. Recommendations include legislation around pool fences, strengthening motor vehicle legislation, funding support staff in the regions and modifying how deaths are reported to CPS. One recommendation was also made to the Department of Family and Protective Services for the addition of a dedicated hotline for medical personnel.

This report would not be possible without the dedication and input of the members of the committee and the local CFRT Coordinators, Presiding Officers, and respective team members. The diverse range of professionals who volunteer as members of the local CFRTs give the child fatality review process its multi-disciplinary perspective and add immeasurably to the goal of understanding child death and reducing risk to Texas children.

List of Acronyms

Acronym	Full Name
AAP	American Academy of Pediatrics
CDC	United States Center for Disease Control and Prevention
CFRT	Child Fatality Review Team
CPS	Child Protective Services
CCS	Car Safety Seat
DFPS	Department of Family and Protective Services
DSHS	Department of State Health Services
NCFRP	National Center for Fatality Review and Prevention
NHTSA	National Highway Traffic Safety Administration
POK	Protect Our Kids
PTDE	Parent-Taught Driver Education

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Appendix B. Legislative Changes

In 2017, during the regular session of the 85th Legislature, House Bill 1549 made substantial changes to statute that defines the committee and local CFRT structure and activities. Below is a list of the changes:

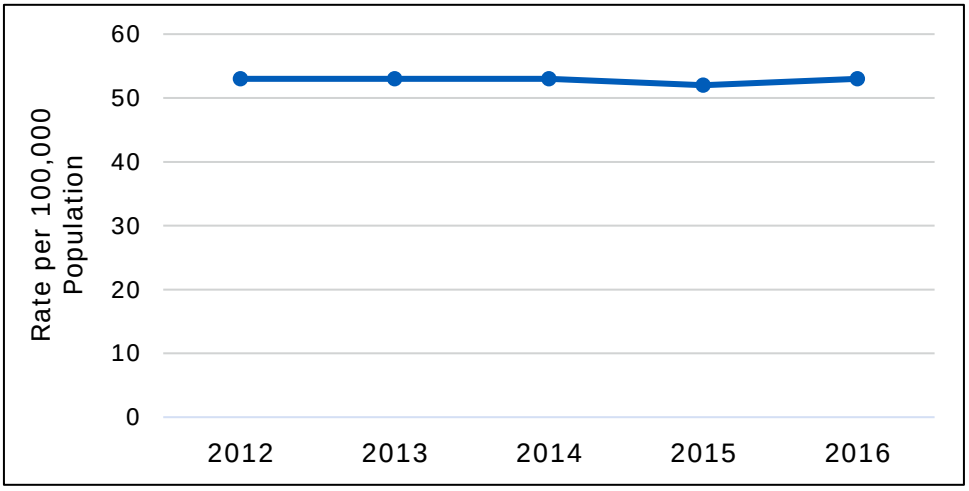
- The addition of three legislative appointees to the committee.
- A rule that committee members must be a member of the local CFRT where they reside unless they are an appointed representative of a state agency.
- The DSHS must evaluate CFRT data to create public health strategies.
- Training must be identified and made available for Justices of the Peace and Medical Examiners regarding inquests in child death cases.
- Deletion of the population requirement of 50,000 to join counties for local CFRTs.
- A local CFRT must reflect the diversity of the county's population.
- A local CFRT must review and analyze the collected data to identify demographic trends in child fatality review cases, including if there was a disproportionate number of child fatalities in specific population groups or geographic areas.
- DSHS shall provide a local CFRT with electronic access to the preliminary death certificate for a deceased child.
- The Commissioner's Court of a county shall adopt regulations relating to the timeliness for conducting an inquest into the death of a child. The regulations adopted under this subsection must be as stringent as the standards issued by the National Association of Medical Examiners unless the Commissioner's Court determines that it would be cost prohibitive for the county to comply with those standards.
- The Medical Examiner or Justice of the Peace shall notify the appropriate county CFRT of the child's death not later than the 120th day after the date the death is reported.

Appendix C. Analysis from 2016 Death Certificates

Data presented in this report represent state-level trends from death certificate data for child deaths that occurred in Texas in 2016, regardless of the child's residence. Currently, 2016 is the most recent year for which the Department of State Health Services' (DSHS) Center for Health Statistics has finalized death data files. Data for 2017 and beyond are not currently finalized and will not be used in the following analysis to ensure consistent and accurate reporting.

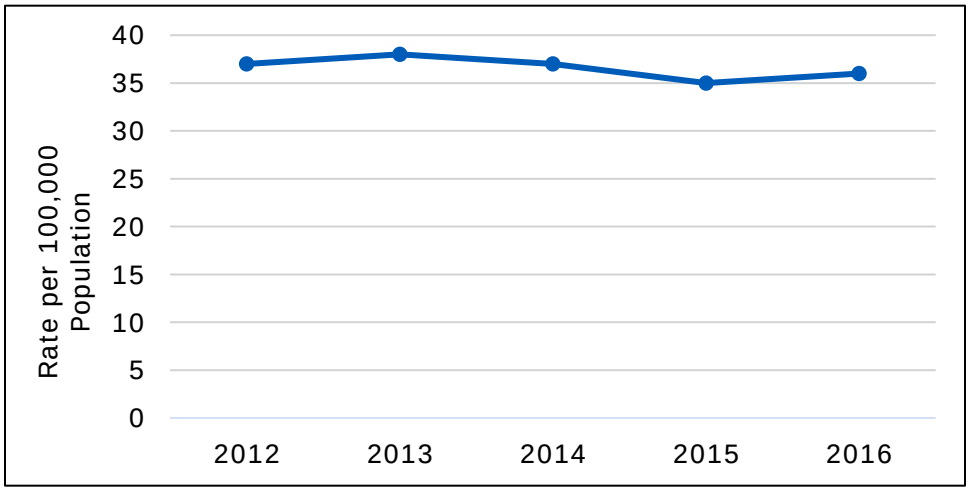
Figure 1 shows the mortality rate in Texas for all child deaths for children 0-17 years of age between 2012 and 2016. The rates of total child deaths in Texas were consistent during the specified time period.

Figure 1. Texas Child Death Rate, All Causes of Death, 0-17 Years, 2012-2016[i]



[i] Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates
Center for Health Statistics, DSHS Death Data Files 2016
Prepared by: Office of Injury Prevention, 1/2020

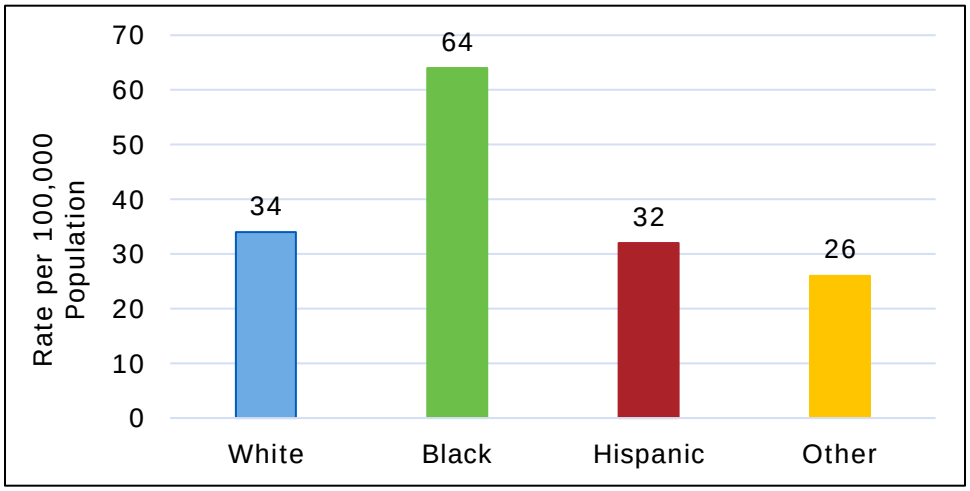
Figure 2. Texas Child Death Rate, Natural Cause of Death, 0-17 Years, 2012-2016[i]



[i] Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2016
Prepared by: Office of Injury Prevention, 1/2020

Natural child deaths were at the lowest rate in five years in 2015. The rates of natural child deaths in Texas were consistent during the specified time period (Figure 2).

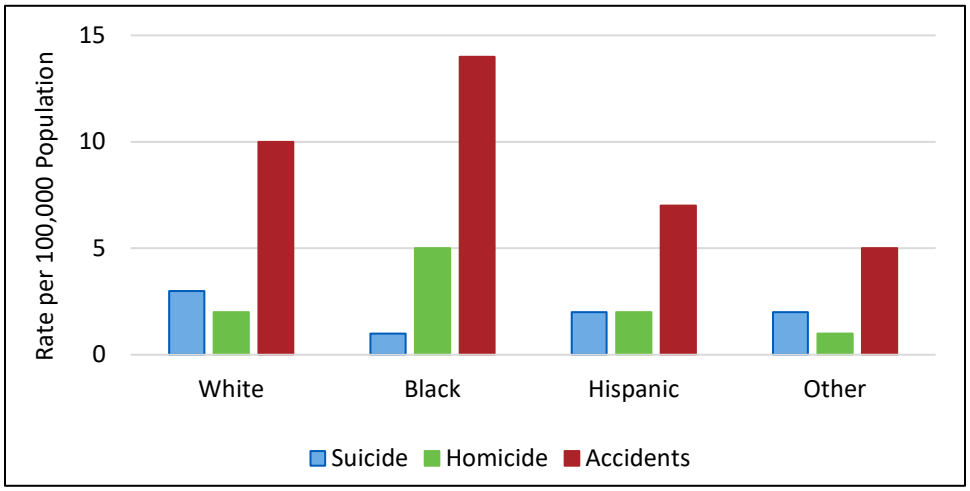
Figure 3. Natural Child Death Rate by Race/Ethnicity, Texas, 0-17 Years, 2016[i]



[i] Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2016
Prepared by: Office of Injury Prevention, 1/2020

Natural causes include death due to prematurity, congenital anomalies, cancer, and infectious diseases. In 2016, Black children were nearly two times more likely to die of natural causes than any other race/ethnicity (Figure 3), primarily due to prematurity.

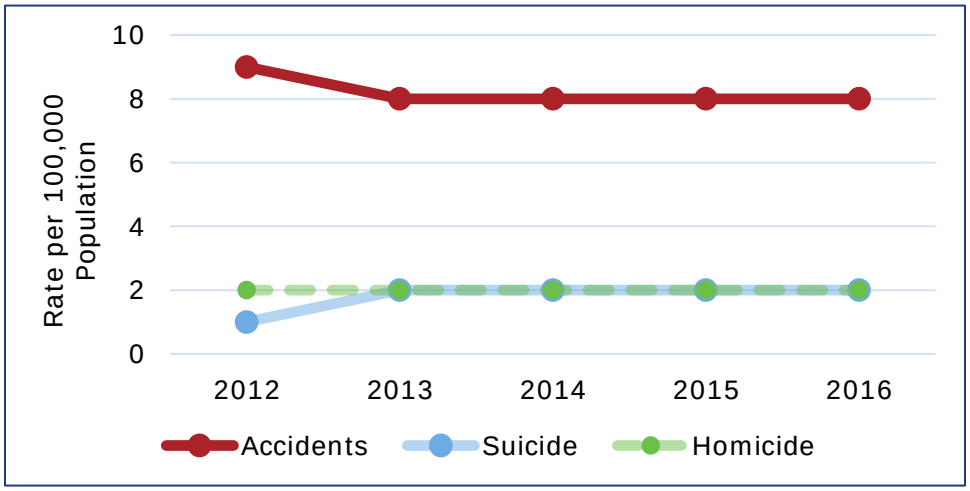
Figure 4. Injury Child Death Rate by Race/Ethnicity, Texas, 0-17 Years, 2016[i]



[i] Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates
Center for Health Statistics, DSHS Death Data Files 2016
Prepared by: Office of Injury Prevention, 1/2020

The injury child death rates (Figure 4), which consists of homicides, suicides and accidents, were considerably lower than the natural child death rates (Figure 3). In 2016, Black children died of homicide and accidents at a higher rate than any other race/ethnicity (Figure 4). White children died of suicide at a higher rate than any other race/ethnicity (Figure 4).

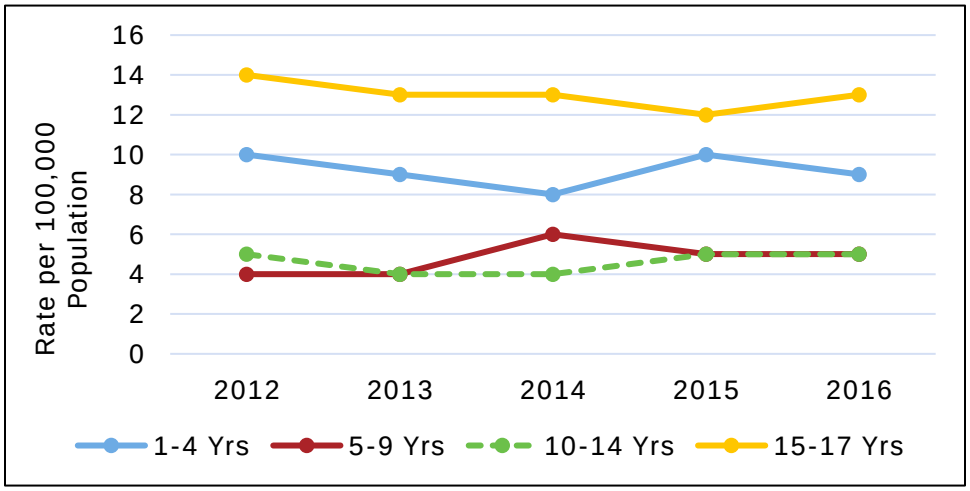
Figure 5. Trends in Injury Child Death Rates by Manner of Death, Texas, 0-17 Years, 2012-2016[i]



[i] Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates
Center for Health Statistics, DSHS Death Data Files 2016
Prepared by: Office of Injury Prevention, 1/2020

The rate of accidental death for children 0-17 years of age in Texas remains at least four times higher than homicide or suicide deaths between 2012 and 2016 (Figure 5). Accidental deaths include deaths due to motor vehicle injuries, drowning, choking, and other causes of death. Accidental deaths remained constant from 2013 to 2016 (Figure 5).

Figure 6. Trends in Accidental Child Death Rates by Age Groups, Texas, Ages 1-17 Years, 2012-2016[i]



[i] Source: Office of the State Demographer, Texas State Data Center, Texas Population Estimates Center for Health Statistics, DSHS Death Data Files 2016
Prepared by: Office of Injury Prevention, 1/2020

Accidental child death rates increased slightly among youth aged 15-17 years from 2015 to 2016 (Figure 6). There was a decrease in accidental death rates between 2015 and 2016 among children 1-4 years (Figure 6).

Appendix D. Data from Child Fatality Review Teams

Texas CFRT data was downloaded from the National Center for Fatality Review and Prevention (NCFRP) Case Reporting System on 01/21/2020. Deaths occurring in 2016 were abstracted from this dataset, checked for duplicates, and imported into SAS software. All data was previously collected by local CFRTs and with no additional data added.

Texas death data was extracted from the Texas Department of State Health Services mortality file for 2016, ages 0-17 years-old, on 01/21/2020. All data was previously collected with no additional data added. This dataset was imported into SAS software for analysis.

All frequency analyses and tabulations for both datasets were performed in SAS software, version 9.4.

Table 1. Comparison of Child Fatality Cases Reviewed, Death Certificates and CFRT Data by Manner of Death, Texas, Ages 0-17 years, 2016[i]

Manner of Death	Death Certificate	Reviewed	Percent Reviewed
Natural	2,601	573	22%
Accident	613	313	51%
Homicide	154	85	55%
Suicide	150	85	57%
Other[ii]	340	187	55%
Total	**3,858**	**1,243**	**32%**

[i] Source: Child Fatality Review Team Death Data Files 2016
Prepared by: Office of Injury Prevention Epidemiology, 1/2020

[ii] Includes records with manner of death coded as undetermined, unknown, or pending

Table 2. Comparison of Child Fatality Cases Reviewed, Death Certificates and CFRT Suicide by Age Group, Texas, Ages 10-17 years, 2016[i]

Age Group	Death Certificate	Reviewed	Percent Reviewed
10-14 years	36	19	53%
15-17 years	113	65	58%
Total	**149**	**84**	**56%**

[i] Source: Child Fatality Review Team Death Data Files 2016
Prepared by: Office of Injury Prevention Epidemiology, 1/2020

Table 3. Comparison of Child Fatality Cases Reviewed, Death Certificates and CFRT Homicide by Age Group, Texas, Ages 0-17 years, 2016[i]

Age Group	Death Certificate	Reviewed	Percent Reviewed
0-4 years	63	36	57%
5-9 years	17	11	65%
10-14 years	14	6	43%
15-17 years	60	32	53%
Total	**154**	**85**	**55%**

[i] Source: Child Fatality Review Team Death Data Files 2016
Prepared by: Office of Injury Prevention Epidemiology, 1/2020

Table 4. Comparison of Child Fatality Cases Reviewed, Death Certificates and CFRT Accidental Deaths by Age Group, Texas, Ages 0-17 years, 2016[i]

Age Group	Death Certificate	Reviewed	Percent Reviewed
0-4 years	245	137	56%
5-9 years	99	33	33%
10-14 years	108	52	48%
15-17 years	161	91	57%
Total	**613**	**313**	**51%**

[i] Source: Child Fatality Review Team Death Data Files 2016
Prepared by: Office of Injury Prevention Epidemiology, 1/2020

Table 5. Comparison of Child Fatality Cases Reviewed, Death Certificates and CFRT Other Causes by Age Group, Texas, Ages 0-17 years, 2016[i]

Age Group	Death Certificate	Reviewed	Percent Reviewed
0-9 years[ii]	320	173	54%
10-14 years	8	5	63%
15-17 years	12	9	75%
Total	**340**	**187**	**55%**

[i] Source: Child Fatality Review Team Death Data Files 2016
Prepared by: Office of Injury Prevention Epidemiology, 1/2020
[ii] Age groups are combined to reduce suppression

Table 6. Comparison of Child Fatality Cases Reviewed, Death Certificates and CFRT Natural by Age Group, Texas, Ages 0-17 years, 2016[i]

Age Group	Death Certificate	Reviewed	Percent Reviewed
0-4 years	2143	488	23%
5-9 years	173	23	13%
10-14 years	164	36	22%
15-17 years	121	26	21%
Total	**2,601**	**573**	**22%**

[i] Source: Child Fatality Review Team Death Data Files 2016
Prepared by: Office of Injury Prevention Epidemiology, 1/2020