CHILD FATALITY REVIEW IN TEXAS

PROCEDURE MANUAL

TEXAS Health and Human Services
Texas Department of State Health Services

Contents

INTRODUCTION

In 1995, the Texas Legislature amended **Chapter 264** of the Texas Family Code (TFC) by adding the State Child Fatality Review Team (SCFRT) Committee and Investigation Statute. The Texas Legislature created the SCFRT Committee and established procedures for operating local child fatality review teams (CFRTs) and reporting and investigating child fatalities. The SCFRT Committee works with local CFRTs throughout Texas and makes recommendations to the governor and legislature about reducing the number of preventable child fatalities. Today, local CFRTs cover areas with over 95% of the state's population.

One of the primary reasons for conducting child fatality reviews throughout the U.S. has been to identify, and ultimately prevent, child fatalities caused by abuse and neglect. Fatalities caused by injury are not only preventable but can also uncover undetected cases of abuse and neglect. Texas, like most states, has opted for a broader fatality review process that addresses child fatality from a public health perspective. Teams are encouraged to review all cases of child fatality in their coverage area, including natural deaths, and provide recommendations to prevent future deaths. By adopting this public health approach, the underreporting of maltreatment-related fatalities is systematically addressed. Further, there can be a better understanding and greater awareness of all causes of child fatality at the local, state, and national level to assist in prevention initiatives.

Local CFRTs in Texas 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. The efforts of local CFRTs, the SCFRT Committee, and others who support the establishment and implementation of an integrated system of child fatality review is evidence of Texas' commitment to protect and raise children in a healthy and safe environment.

BACKGROUND

Texas' first local CFRT started in Dallas in 1992 with a one-year pilot project overseen and funded by the Children's Justice Act (CJA) Grant Project, a federal grant project administered by the Texas Department of Protective and Regulatory Services, now known as the Texas Department of Family and Protective Services (DFPS). In 1994, CJA formed a statewide committee of professionals with expertise in child protection, health, and safety issues to embark on the difficult process of examining the child fatality response system in Texas and make recommendations for legislation.

The CJA CFRT committee found a need to improve the process for reporting child fatalities, death certification, and training for professionals in child death investigations. They found little consistency among child death investigation procedures; variances in local capacity, data processes and child safety resources; and disparities among access to qualified professionals. Although there were many similarities among communities, unique circumstances existed in every community in their response to cases of child death.

The committee also found that data on the incidence and causes of child fatality was inconsistent and that standardized definitions to record this data did not exist. The discrepancy between the numbers of child maltreatment-related fatalities recorded by Child Protective Services (CPS) and the state Bureau of Vital Statistics illustrated the problem with not having a coordinated data collection system. The reason for many child fatalities being classified as injuries or unexplained fatalities may be because of the lack of knowledge and training about child abuse and neglect.

On Sept. 1, 1995, the amendment of Chapter 264 of the TFC established a SCFRT committee and standardized the data collection system. The purpose of the SCFRT Committee as outlined in Section 264.503 of the TFC is to:

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

The legislature directed the Department of Protective and Regulatory Services, now known as DFPS, the Department of Health, now known as the Texas Department of State Health Services (DSHS), and the Children's Trust Fund of Texas Council to work together as a support system for the SCFRT Committee.

Currently, DSHS is responsible for assisting the SCFRT Committee with developing model protocols for reporting and investigating child fatality; establishing and training local CFRTs; and collecting and reviewing child fatality data. The state injury prevention coordinator is the liaison for SCFRT Committee activities through the Office of Injury Prevention.

CHILD FATALITY REVIEW TEAMS

Local CFRTs are working groups of community partners. They review child deaths on a local level from a public health perspective. Reviewing a child's death helps identify strategies to decrease preventable child deaths. Local CFRTs vary in size and the number of counties for which they review child deaths. Some teams review deaths for only one county. Regional teams review deaths for two or more counties.

GOALS

The goals of CFRTs are to:

- Improve the response to child fatalities
- Provide accurate information about how and why Texas children are dying
- Reduce the number of preventable risks and deaths among children by establishing an effective review and standardized data collection system for all child fatalities that will inform local programming

OBJECTIVES

Members on local CFRTs strive to:

- Assure an accurate record of child fatalities by age, location, cause, manner, and circumstance
- Support adequate child death investigation and certification
- Enable multi-agency collaboration, cooperation, and communication at the state and local levels regarding child fatalities
- Enhance the general awareness of child fatality through providing insight and understanding about how and why children die
- Identify system-based barriers to child health and safety that, when removed, will ultimately reduce the number of preventable child fatalities
- Develop recommendations for community prevention initiatives

PURPOSE OF THE PROCESS

- To accurately identify and record the cause of every child fatality
- To collect uniform and accurate statistics about child fatality
- To identify circumstances surrounding child fatality that could prevent future fatalities and inform preventive efforts

- To promote collaboration and coordination among participating agencies
- To implement cooperative protocols to investigate child fatalities
- To provide a confidential forum for agencies to meet and discuss common issues or resolve conflicts
- To recommend necessary changes in legislation, policies, and procedures to the SCFRT Committee
- To identify and address public health issues

TEAM LEADERSHIP

Each local CFRT selects a presiding officer, team coordinator, and data entry coordinator prior to the first fatality review meeting. These leadership roles may be filled by any team member; one member may fill multiple positions and these positions may also rotate among team members. Teams may specify terms for the presiding officer and coordinators and revisit these terms periodically.

The following are common duties of the presiding officer, team coordinator, and data entry coordinator. Each CFRT should discuss and appoint members to the following roles.

Presiding officer duties:

- Serves as the team leader
- Responsible for scheduling and chairing 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
- Ensures the team operates according to the protocols developed by DSHS as 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 report form
- Enters data in the online case report system for cases reviewed

CFRT MEMBERSHIP

Local CFRT members are comprised of representatives from the agencies responsible for child death investigations, death certification, medical procedures, social services, or any resulting legal action. Members should be able to provide case information, prevention measures, and other expertise related to reviewed cases of child fatality. The following is a list of suggested members for local CFRTs:

- A criminal prosecutor involved in prosecuting crimes against children
- A sheriff
- Medical examiner or justice of the peace
- 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 child protective services specialist
- A sudden infant death syndrome (SIDS) family service provider
- A neonatologist
- A child advocate
- A chief juvenile probation officer
- A child abuse prevention specialist

Local CFRTs may add or adjust team members to fit their community resources and needs. Each member provides the team with information from their records, serves as a liaison to their professional counterparts, provides definitions of their profession's terminology, interprets the procedures and policies of their agency, and explains the legal responsibilities or limitations of their profession. Members also assist with providing referrals for services or providing direct aid to surviving family members.

Additional team members may be added as reviews reveal gaps in information and there is a need for additional team representation. For example, local child care licensing representatives may be added to a team that is repeatedly reviewing deaths occurring in child care facilities and needs information regarding licensing standards. As agencies have special programs which relate to team activities, it may be appropriate to have more than one agency representative on the team.

Member Designees and Meeting Attendance

Team members may designate another representative of their agency to serve as a back-up member for them at meetings that they are unable to attend. Members must recognize the need to attend meetings regularly to offer the expertise and knowledge which initially determined their selection. Regular attendance and participation help establish trust among team members. Agencies or members who are consistently unable to attend meetings may be contacted by the presiding officer to select another member to represent that agency on the team.

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:

- They are directly involved in a death scheduled for review
- They are needed to provide information on team-related activities

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

Regional Child Fatality Review Teams

Local CFRTs may choose to review deaths in more than one county; these teams are called regional CFRTs. Regional CFRTs are encouraged when establishing a team in counties with a population of 50,000 or less. When forming these teams, organizers should consider what agencies or facilities are involved in child death response in multiple counties. Counties covered by a regional CFRT should have many of the following areas of jurisdiction or responsibility in common: state health and human services region, district attorney's office, medical examiners' jurisdiction, hospital district, or emergency medical services (EMS)/firefighters district.

Each county covered by a regional CFRT should have a member representative on the team. An agency regional director or other professional whose jurisdiction or responsibilities include the county would fulfill this requirement.

To ensure adequate community involvement in regional CFRTs, at least one representative from a member agency or auxiliary member of the county where the illness, injury, or event occurred that caused the child's death should be present during

the fatality review. This allows regional CFRTs to receive information from professionals directly involved in the case being reviewed, while strengthening the team's relationship with various local agencies in counties where fatalities occurred. Establishing and maintaining this relationship is crucial in achieving prevention, training, and education objectives for regional CFRTs.

STARTING A CHILD FATALITY REVIEW TEAM

STEPS TO ESTABLISHING A TEAM

Establish Team Organizer(s)

To establish a multi-agency, multi-disciplinary local CFRT in a community, a team organizer or organizers must be willing to commit the time and effort required to form a team. Teams have been initiated in Texas by a variety of professionals, including physicians, prosecutors, medical examiners, law enforcement personnel, justices of the peace, public health officers, CPS workers, and child advocates.

Contact the State Injury Prevention Coordinator

The team organizer(s) should contact the DSHS state injury prevention coordinator at cfrt@dshs.texas.gov to request CFRT information and membership recruiting materials. Team organizer(s) may also request county- or region-specific mortality data for a specified time period to assist with planning for future fatality review meetings.

Contact an Operational Child Fatality Review Team

Team organizer(s) may contact the presiding officer of an operating team and request permission to attend one of their meetings. The operational team should have at least one year's experience in conducting child fatality reviews. Observing a team can help provide insight about how teams operate. It may also provide suggestions on recruiting potential team members. If the team organizer(s) do not know of an established local CFRT, they should reach out to the state injury prevention coordinator for assistance.

Contact the Local Agencies

Using the suggestions from the team membership section as a guide, develop a list of prospective members. The team organizer(s) should contact the directors of the potential member agencies and professions to discuss establishing a local CFRT. When recruiting team members, the team organizer(s) should request the highest possible level of agency staff join the team. These individuals should have the authority to implement necessary changes and to obligate the agency to cooperative projects and protocols. If the agency director is unavailable, a lower-level staff member with the knowledge and experience of direct and routine involvement with child fatality should be designated to represent the agency. Agency staff will provide the team with essential

input. The team should be comprised of professionals with both executive and specialized responsibilities.

Schedule a Stakeholders Meeting

The stakeholders meeting provides team members and community stakeholders an opportunity to meet to discuss team organization and operation prior to the first case review meeting. This meeting should be held only if most people invited are able to attend. Invite the state injury prevention coordinator to attend this meeting. Additionally, a team member from an established CFRT may be invited to attend this meeting.

Conduct a Stakeholders Meeting

- *Introduce potential members and review roles.* Team organizer(s) lead a discussion of the role of each agency and profession as well as the benefits to participating agencies.
- *Review and discuss statute and provide an overview of child death revie*w. The state injury prevention coordinator can discuss the CFRT authorizing statute, Chapter 264, Subchapter F of the TFC, and provide pertinent information related to child death review in Texas to meeting attendees.
- *Select a presiding officer, team coordinator, and data entry coordinator*. Team members should discuss the responsibilities of each leadership role and select team members to fill each position.
- *Determine future meetings.* If necessary, set a time, date, and location for another organizational meeting. All organizational issues should be addressed prior to beginning child fatality reviews. If no additional organizational meetings are required, schedule the first child fatality review meeting. Attendance will be higher if a regular time and place is agreed upon for meetings.
- *Select additional team members.* Compile a list of other potential team members and develop a plan for enlisting their participation. Include a time frame for completing contacts.
- *Discuss and sign the team Inter-Agency Agreement.* Each attendee should sign the inter-agency agreement. A copy of the signed inter-agency agreement should be kept by the team organizer(s) and should be scanned and emailed to the state injury prevention coordinator.

- *Address questions and issues.* The team organizer(s) should allow time for each person attending to participate, ask questions, and express concerns. If the team organizer(s) do not immediately have answers to questions, team members should agree to get answers or find out what other teams are doing regarding an issue and report back to the group in an agreed upon timeframe. The state injury prevention coordinator can be a resource for these answers.
- *Meeting minutes.* The team organizer(s) should compose and distribute meeting minutes to attendees and request the initial organizational team members review the meeting minutes to ensure they were accurately recorded. Include any agreements reached and suggestions for future actions in the minutes.

MAINTAINING A CHILD FATALITY REVIEW TEAM

Once a local CFRT has been established and the procedures for operation are thoroughly understood, maintenance of the team is essential. The following are recommendations for maintaining a functional review team.

MEMBER COMMITMENT

Participate and Be Prepared for Meetings

Fatality review meetings require commitment, regular attendance, and active participation of all team members. Members should become acquainted with the questions on the data collection forms to ensure they bring the correct records to fatality review meetings.

Keep Regular Schedules for Meetings

Establishing regularly scheduled meetings provides team members the ability to make long-term schedule plans and allows for better attendance. Canceling scheduled meetings diminishes a team's ability to gather information and hinders the cooperative networking of its members. A CFRT can only achieve its objectives by meeting routinely and regularly. If teams do not have deaths to review on a regular basis, meeting quarterly to discuss issues related to child safety in the community and plan for community safety initiatives and activities can assist a team in remaining connected.

Provide an Educational Element to Team Meetings

Keeping members informed of team-related training, changes in laws regarding their professions, and new child death or injury prevention programs should be an integral part of the operation of every local CFRT meeting. Periodically scheduling brief presentations and providing informative handouts will enhance a team's ability to accomplish its objectives.

MAINTAIN NETWORKS

Use the Texas Network of CFRTs

Contact other local CFRTs for suggestions about how that team handled a problem or to obtain input on innovative team efforts. For a list of local CFRT presiding officers and

team coordinators, please visit the Texas Child Fatality Review website (dshs.texas.gov/mch/cfrt).

Use the SCFRT Committee

The resources of the agencies responsible for the SCFRT Committee, according to the roles specified in Chapter 264, Subchapter F of the TFC, are readily available to assist local CFRTs. Teams should also provide recommendations to the SCFRT Committee regarding the needs of local communities and teams.

Provide Other Members with Support

Each professional brings their perspective, professional knowledge, and expertise to a local CFRT. It is support, not criticism, that will encourage change and allow for improvements. Although most teams collaborate well, sometimes disagreements between members is unavoidable. Teams should consider establishing ground rules for meetings to minimize any negative effects on the team. The presiding officer can then reinforce the rules to support productive exchanges and discourage dialogue which is disruptive to the review process. Each member must acknowledge and respect the professional role of every participating representative.

MAINTAIN THE VISION AND COMMITMENT

Do Not Lose Sight of The Team's Purpose and Objectives

Local CFRTs should review the stated purpose of a CFRT and its goals and objectives annually to provide direction to the team and remind members why the team was originally formed.

Team Membership is a Long-Term Commitment

Local CFRTs are not ad-hoc committees collecting data on child deaths for a designated period. Rather, each team is a panel of professionals dedicated to establishing a better understanding of the causes of child deaths in their community. Discovering the patterns that cause or contribute to preventable child deaths is an ongoing process. Patterns change over time within a community. The aggregate knowledge acquired and shared by members provides teams with a structure for achieving effective results.

A CFRT is Both a Message to the Community and a Message from the Community

By participating on a team, local professionals with the responsibility of the protection, health, and safety of their community's children communicate a pledge to better understand child deaths and to support the necessary steps to eliminate obstacles hindering their integrated response.

CHILD FATALITY REVIEW TEAM MEETINGS

MEETING PREPARATION

Receipt of Death Certificate Information

- The DSHS Vital Statistics System provides death certificate information to the state injury prevention coordinator who then sends the death certificate information via encrypted email to local CFRT leadership.
- If a team has questions about death certificate information, the presiding officer or the coordinator should contact the state injury prevention coordinator at cfrt@dshs.texas.gov.
- To obtain additional death certificate information for fatality review meetings, presiding officers may contact their local registrars. Most counties have more than one registrar; and each city in a county may have its own office of vital statistics, with the county clerk recording deaths for unincorporated areas. The state registrar can provide presiding officers with a list of local registrars for their area. All local registrars are required by law to submit their certificates to the state registrar. Contact the state injury prevention coordinator for details.

Distribution of Death Certificate information to Team Members

- Death certificate information is password protected and should be shared with team members through a secure process, either by encrypted email or through another secure method.
- The team coordinator should share death certificate information with team members for cases that are scheduled to be reviewed approximately two weeks before each scheduled review meeting to allow team members time to gather their agency's information about the child and family.

Fatality Review Meeting Information

To make fatality review meetings effective, team members are encouraged to bring case-specific information to each meeting for cases scheduled to be reviewed. Team members should know prior to each meeting which cases are to be reviewed and bring the appropriate information for each case. This information may include:

- Case-specific information on the death of the child, including records relating to the child, family, investigation, services, and agency responses to the death.

- Data on other deaths or injuries like the death being reviewed. These data may show trends that will help the team in advocating for necessary changes in state policies or procedures.
- Information on local and state resources, services, programs, and policies relevant to the prevention of this type of death and the delivery of services.

REVIEWABLE DEATHS

It is recommended that teams review all child deaths, regardless of cause, for children younger than age 18.

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

Reviews are required only for those deaths in which a birth certificate was issued. A birth is considered viable and live if the attending medical personnel determines that a birth certificate is appropriate. If a birth certificate is not issued and a determination of "stillbirth" is made, a review is not conducted by the team.

Teams can prioritize reviews by establishing review criteria, if needed.

In-depth Reviews

In-depth reviews are conducted for injury deaths and sudden and unexpected infant deaths. These deaths generally require a more extensive discussion by the team to discover the circumstances surrounding the death.

Categories of deaths which may require a more extensive review:

- Homicide
- Injuries
- Suicide
- Undetermined
- Sudden or unexpected deaths, including SIDS deaths
- All medical examiner cases
- All cases with previous CPS involvement
- All cases investigated by law enforcement

Expedited Reviews

Expedited reviews of deaths occur when cases are not reviewed by all team members. A local CFRT can develop a subcommittee of team members to examine the pertinent information of a case or group of cases prior to a fatality review meeting.

Cases may receive expedited reviews if:

- The case is non-controversial, i.e. circumstances of death are not out of the ordinary
- There is no additional information other than that contained on the death certificate
- A full review is unlikely to yield new specific prevention strategies

If the subcommittee determines that additional information is needed, it can recommend that the case be brought to a fatality review meeting for a full review.

Follow-up Reviews

Cases may need to be reviewed at more than one meeting for several reasons:

- The results of the investigations are incomplete at the first review
- Members may wish to obtain additional information from their agency
- A team member or auxiliary member with significant information is absent
- The case continues to progress and needs to be updated

REVIEW PROCESS

Confidentiality Agreement

Each team member and meeting attendee must sign a confidentiality agreement prior to each fatality review meeting. This agreement should be kept at each meeting by the presiding officer or team coordinator. A sample confidentiality agreement is provided in the Team Resources section of this manual.

Share all Case Information

Team members share the information from their agency related to the reviewed death. After each team member has shared their case information, there may be time for questions, however, if the team identifies gaps in the case information, it may be best to table further discussion until the next meeting.

Discuss the Investigation

Team members discuss information about the investigative agency and death scene investigation if applicable. This discussion is meant to determine if all information the team needs related to the circumstances of the death are available or if more information or further investigation is needed.

Discuss the Delivery of Services

Team members 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 any recommendations to improve the delivery of these services in the future.

Identify risk factors

Team members identify risk factors to determine how to prevent future deaths. Risk factors may fall under the following categories:

- Health
- Social
- Economic
- Behavioral
- Environmental
- Systemic (agency policies and procedures)
- Product safety

Was the Death Preventable?

This question should be considered for each reviewed case, as it allows team members a chance to participate in a discussion related to possible prevention recommendations and learn from the expertise of other team members.

VIRTUAL CHILD FATALITY REVIEW MEETINGS

Local CFRTs may meet and conduct meetings via virtual platforms if team leadership determines that this is an effective strategy for the team. As with in-person meetings, 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. A virtual or hybrid meeting model may be established if

this promotes increased attendance at team meetings and allows for engaged and productive conversations among team members.

CHILD FATALITY REVIEW TEAM DATA

DATA OVERVIEW

The review of a child's death can inform community efforts to prevent other child deaths. It is important for local CFRTs to systematically collect data and report on their findings. When data is analyzed over time, risk factors or trends in child injury and safety can be identified. The collection of findings from fatality review meetings 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.
- The SCFRT Committee review data and findings provided by local CFRTs and state datasets to identify trends and major risk factors and inform recommendations for state policy and practice improvements.
- The SCFRT Committee and local CFRTs use the reports to demonstrate the effectiveness of their reviews and gain support for community interventions.

NATIONAL FATALITY REVIEW CASE REPORTING SYSTEM

Case Report Form

The case report form can be found at ncfrp.org/wp-content/uploads/NCRPCD-Docs/CDR_CRS_v5-1.pdf. The data entry coordinator completes the case report form for all deaths reviewed by a local CFRT within 30 days of a completed review. This form 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. When a death review is complete, tabulation and analysis of the data from the case report will provide:

- Comprehensive information on the child, the family, and the child's supervisor at the time of incident
- Risk factors identified in the death
- Descriptions of the investigation activities conducted because of the death
- Descriptions of services provided or needed as a result of the death
- Recommendations for additional services or referrals
- Recommendations and actions taken for the prevention of future deaths

- Factors affecting the quality of the case review meetings

This data is tabulated and analyzed by DSHS for inclusion in reports on child fatality review for either local or state distribution. The data elements in the form can be helpful to guide discussion, however, it is not recommended that the case report form be completed during meetings as this may inhibit the flow of discussion.

Logging into the Online Case Report System

The online case report system is located at **data.ncfrp.org/**.

The state injury prevention coordinator provides usernames and passwords for the online case report system. Logins to the online case report system can be requested for the presiding officer, team coordinator, and data entry coordinator. To request login information, email the new user's name, organization, contact information, and local CFRT name to the state injury prevention coordinator at **cfrt@dshs.texas.gov**.

Priority Variables

The National Center for Fatality Review and Prevention started a data quality initiative to improve consistency and quality of data being entered into the case report system. Because the case report form is an extensive document, priority variables are indicated on the online case report form by an orange star. Guidance for each priority variable can be found by clicking on the "?" next to each priority variable question on the online case report form.

PREVENTION

OVERVIEW

According to Chapter 264 of the TFC, Section 264.506, one of the purposes of a CFRT is to "initiate prevention measures as indicated by the review team findings." An important aspect of child fatality review is to improve health and safety initiatives for children to reduce the number of preventable child deaths. Focusing child fatality review efforts on prevention provides meaning and purpose for meetings 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 they're developed through collaborative efforts of local team members who represent a variety of agencies.

STEPS TO DEVELOPING RECOMMENDATIONS FOR A REVIEWED DEATH

Determine if the Death was Preventable

Discussing the preventability of a death following a case review can provide 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 then determine which factors they believe they can modify or impact within the community.

Determine the Best Strategy for Prevention

The Spectrum of Prevention is a helpful tool for teams 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 provided recommendation(s). Please share these recommendations with the state injury prevention coordinator (cfrt@dshs.texas.gov) when the team completes them. Please use the sample recommendations template for guidance.

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 long-term solutions. Combining strategies may increase the effectiveness of a team's proposed initiatives.

Act or Share the Findings

Local CFRTs should share findings with the appropriate agencies or individuals who are best positioned to act.

RECOMMENDATIONS FOR THE BIENNIAL SCFRT REPORT

Prevention initiatives developed by local CFRTs are submitted to the SCFRT Committee for consideration for inclusion into the SCFRT biennial report. The report contains aggregate child fatality data from local CFRTs, recommendations to prevent child fatalities and injuries, and recommendations to DFPS on CPS operations based on input from the SCFRT Committee. Recommendations related to changing current statute, increasing public education, and strengthening existing systems are shared with the governor, lieutenant governor, and the speaker of the Texas House of Representatives no later than April 1 of each even-numbered year.

INFORMATION SHARING

Local CFRTs are essential to improving the response to a child's death. A team may request information and records regarding a deceased child as necessary to carry out the purpose and duties of the team. Background and current information from the records of team member agencies and other sources may be needed to assess circumstances of the death.

Information from a fatality review meeting can contribute to the outcome of a pending investigation. Team members should use knowledge and expertise provided in confidential fatality review meetings to gather additional input for pending investigations.

A standing request for records and information may be developed by a team to facilitate the gathering of information required to conduct a fatality review. It should be addressed to the "custodian of the records" or the agency director and include the review team 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. Some teams have numerous hospitals in the county or counties they cover; this request format may enhance a team's ability to gather required medical information. Please use the sample request for records and information for guidance.

CONFIDENTIALITY

- Records acquired by local CFRTs to conduct a fatality review are exempt from disclosure under the Open Records Law, Chapter 552 of the Government Code.
- Data and information collected regarding the death of a child shared at a fatality review meeting are confidential.
- A report or statistical compilation of a fatality review is a public record subject to the Open Records Law, Chapter 552 of the Government Code if it does not include the identification of an individual.
- A team member may not disclose any information that is confidential.
- Information, documents, and records of the CFRT are confidential and are not subject to subpoena or discovery and may not be introduced into evidence in any civil or criminal proceedings.

- Information that would otherwise be available from other sources are exempt because they are included in a fatality review meeting.
- The CPS member of a team may not disclose information from Texas DFPS records that would identify an individual who reported an allegation of child abuse and neglect.

The confidentiality agreement is required to be signed by CFRT members and other meeting attendees and should be kept in each meeting's records by the presiding officer or team coordinator.

MEDIA RELATIONS

It is important that local CFRTs establish an effective working relationship with the media. Involving the media is fundamental to the team's ability to promote public awareness and educate the public regarding child deaths.

As the team representative, the presiding officer may contact various local media and provide them with information regarding the establishment of the team, its purpose, and information about team operations. Any agency team member may make a public statement about the general purpose or nature of the child fatality review process if the statement does not identify a specific case or person. The presiding officer may continue to provide the media with statistics and reports relating to team activities. All information that is confidential, as specified by state statute, cannot be disclosed to the media. Frequently, the objectives and review process are misunderstood by representatives of the media. The presiding officer and CFRT members are responsible for reinforcing the concept of the team as "not a fault-finding panel." Media are not allowed to attend local CFRT meetings but may attend SCFRT Committee meetings.

Interacting with media can serve as an essential component for the CFRT to accomplish its prevention strategies.

TEAM RESOURCES

SAMPLE INTERAGENCY AGREEMENT

Team members should sign the interagency agreement when a new CFRT is formed or when a new member joins the team. If a new member joins the team, only the new member will need to sign the interagency agreement. The interagency agreement should be kept by the presiding officer or coordinator and a copy forwarded to the DSHS state injury prevention coordinator.

Sample Child Fatality Review Team Interagency Agreement

Name of CFRT:

This cooperative agreement is made between each of the following agencies:

District Attorney's Office	**Medical Examiner/Justice of the Peace**
Name	Name
Signature	Signature
Sheriff Department	**DFPS- Child Protective Services**
Name	Name
Signature	Signature
Police Department	**City/County Health Department**
Name	Name
Signature	Signature

Add Agency Name

Name	Signature

WHEREAS, the parties are vested with the authority to promote and protect the public health and safety and to provide services which improve the well-being of children and their families.

WHEREAS, the parties agree that they are mutually served by the establishment of a multi-agency, multi-professional child fatality review team, and that the outcome of such reviews will be the identification of preventable child deaths and recommendations for intervention and prevention strategies.

WHEREAS, the objectives of a child fatality review team are agreed to be:

Promote cooperation, communication, and coordination among agencies involved in responding to child deaths.

- Assure the accurate inventory of child fatalities by age, location, cause, manner, and circumstance.
- Support adequate child death investigation and certification.
- Implement investigative guidelines and recommendations for child fatalities.
- Improve recognition of child deaths from abuse and neglect, genetic diseases, inadequate medical care, and public health dangers through analysis of patterns and trends in child fatalities.
- Enhance the general awareness of child deaths through the understanding of how and why children die.
- Identify system-based impediments to child health and safety that, when removed, will ultimately reduce the number of preventable child deaths.
- Initiate local prevention efforts to reduce the number of preventable child deaths as indicated by team findings.

WHEREAS, the parties agree the Child Fatality Review Team membership be comprised of, but not limited to, the following professionals:

- Criminal prosecutor
- Medical examiner/justice of the peace
- Physician
- Child protective services
- Sheriff
- Police
- Public health representative
- Mental health provider
- Child advocate
- EMS personnel
- Juvenile probation officer
- Domestic violence advocate

WHEREAS, the parties agree the review process requires case specific sharing of records and that confidentiality is inherent in many of the involved reports, there will be clear measures taken to protect confidentiality.

NOW THEREFORE, it is agreed that all team members will sign a confidentiality agreement which prohibits any unauthorized dissemination of information beyond the purpose of the review process. Data will be submitted by the team to the Texas Department of State Health Services where it will be maintained for the purpose of establishing a state central registry for child fatalities with standardized, non-identified aggregate data from child fatality review teams throughout Texas.

Sample Confidentiality Agreement

Confidentiality Agreement

The confidentiality agreement is signed by all CFRT members at each meeting.

Name of CFRT Member	Signature of CFRT Member	Agency

Sample Request for Records Form

This form may be used by a CFRT to facilitate the gathering of information required to conduct a fatality review.

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

Date

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

REQUEST FOR RECORDS

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 the incidence of preventable child deaths.

We are currently scheduled to review the following case:

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

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

- ☐ History and physical
- ☐ Discharge summary
- ☐ Investigative report
- ☐ Emergency Department record
- ☐ EMS Run sheet

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

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

PREVENTION RESOURCES

To assist with the development of these efforts, local, state, and national programs that address specific prevention needs for the health, safety, and well-being of children and families are available to all teams (see the resource list below). These programs exist in both the public and private sector and may be sponsored by various religious, community, professional and/or government organizations. Some are short-term projects with temporary funding. Others are established programs with documented results and a proven track record.

THE SPECTRUM OF PREVENTION

The Spectrum of Prevention is a tool for teams to use 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: https://www.preventioninstitute.org/tools/spectrum-prevention-0.

Child Fatality Review Team Prevention Recommendations Template

This template should be used by Child Fatality Review Teams (CFRTs) to outline CFRT recommendation(s) and their justification.

Team	Recommendation	Justification

General Information

The Texas Department of State Health Services (DSHS) Maternal and Child Health Unit comprises three branches. The following three branches aim to improve the health of women of childbearing age, infants, children, adolescents, and children with special health care needs as well as prevent injury and death to Texans through surveillance and data-driven support.

- **Healthy Texas Mothers and Babies Branch** focuses on parents-to-be, new parents, and infants.
- **Child and Adolescent Health Branch** focuses on children ages 1-12 and adolescents ages 10-24 including children and youth with special health care needs.
- **Office of Injury Prevention** gathers data to prevent injury and death to Texans through surveillance and data-driven support.

Our Goals

DSHS' Maternal and Child Health work is advanced through collaboration; partnerships with national and state agencies, organizations, and universities; and surveillance of injury and fatality to inform programming. The goal of these collaborations is to harness the expertise of multidisciplinary professionals who share an interest in optimizing health and reducing preventable injury throughout all Texas populations.

Our Mission

Maternal and Child Health coordinates efforts that address different levels of health prevention and promotion. We use proven strategies, data, and research to:

- Increase health-promoting behaviors
- Strengthen professional support
- Improve community systems
- Reduce the barriers to healthy lifestyle choices
- Ensure professionals use data and research to make decisions that will improve safety and health

Contact Information

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Maternal and Child Health Child Fatality Review

dshs.texas.gov/mch/cfrt