

# PROTECT OUR KIDS COMMISSION REPORT

*December 1, 2015*

# PROTECT OUR KIDS COMMISSION

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## LETTER FROM THE COMMISSION CHAIR

December 1, 2015

The findings and recommendations in this report reflect a year of in-person meetings and robust collaboration between the members of the POK Commission, leadership of the Department of State Health Services (DSHS), and the Department of Family and Protective Services (DFPS), as well as numerous prevention advocates and Texas child welfare professionals. The report reflects careful consideration of the many complex issues surrounding child fatalities due to abuse or neglect, based on extensive research of state child fatality data, the 2012 Statewide Blue Ribbon Task Force, DFPS, surveys of child fatality review teams, and discussion at POK meetings.

The POK Commission was fortunate to have very competent and reliable staff support for the project from the Supreme Court Children's Commission. The POK Commission also benefitted from conducting its work simultaneously with the National Commission for the Elimination of Child Abuse and Neglect Fatalities led by Dr. David Sanders, Executive Vice President of System Improvement for Casey Family Programs.

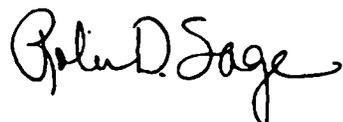
Included in this report is a summary of the national and state work currently underway, an inventory of evidenced-based and promising practices in Texas, and well-vetted recommendations regarding prevention, data collection, the state and local child fatality review team processes, and sustainability of the work already begun in Texas.

Throughout our work, the POK Commission gave due consideration to being as fiscally conservative as possible in making its recommendations. However, to measurably impact the number of child fatalities due to abuse and neglect, a commitment at the highest level is necessary. The significant investment of time and resources devoted to the POK Commission by the citizens who served and their recommendations should be given serious consideration by the Texas Legislature and child welfare stakeholders as the 85<sup>th</sup> Legislative Session approaches.

I would also like to express my gratitude to the Governor, Lieutenant Governor, the Speaker of the House, Representative Dawnna Dukes, Senator Jane Nelson, Representative Jodie Laubenberg, Commissioner John Specia, and Commissioner Kirk Cole for recognizing the need for this Commission and for the opportunity to assess the landscape of child fatalities in Texas, highlight the many initiatives and efforts already underway, and provide legislative, policy and practice recommendations that will strengthen Texas' response to and prevention of child fatalities caused by abuse or neglect.

Preventing child deaths from abuse or neglect is our duty and one that every Texan should take very seriously.

Sincerely,



Robin D. Sage, Chair

*Senior District Judge, Jurist in Residence*

*Supreme Court of Texas Permanent Judicial Commission for Children, Youth & Families*

## TABLE OF CONTENTS

Executive Summary .....	5
Recommendations and Strategies .....	6
Introduction.....	10
Background.....	11
Texas Data .....	11
National Efforts.....	13
Commission to Eliminate Child Abuse and Neglect Fatalities .....	13
Child Fatality Work in Texas.....	15
State Child Fatality Review Team .....	15
Sunset Advisory Commission.....	16
Department of Family and Protective Services.....	16
Department of State Health Services .....	19
Texas House of Representatives, Select Committee on Child Protection, Chaired by Representative Dawnna Dukes.....	19
The Texas Statewide Blue Ribbon Task Force .....	21
Children’s Justice Act Task Force .....	22
Cook Children’s Hospital Center for the Prevention of Child Maltreatment .....	22
The Texas Association for the Protection of Children.....	23
Commentary on the Recommendations .....	24
Conclusion .....	38
Appendices	

## EXECUTIVE SUMMARY

Senate Bill 66 from the 83rd Legislative Session created the Protect Our Kids Commission and charged it with the following:

1. Identify promising practices and evidence-based strategies to address and reduce fatalities from child abuse and neglect.
2. Develop recommendations and identify resources necessary to reduce fatalities from child abuse and neglect for implementation by state and local agencies and private sector and nonprofit organizations, including recommendations to implement a comprehensive statewide strategy for reducing those fatalities; and
3. Develop guidelines for the types of information that should be tracked to improve interventions to prevent fatalities from child abuse and neglect.

The POK Commission met seven times during the past year and divided into four workgroups (Child Fatality Review Teams, Prevention, Data, and Sustainability). The workgroups identified the following needs for the prevention of fatal child abuse and neglect:

### 1) **Child Fatality Review Teams (CFRT)**

Chronic under-resourcing for child fatality review teams has created (i) a lack of consistency in the data collected; (ii) significant delays in reviewing cases; (iii) volunteer CFRT member fatigue; and (iv) the need for training and staff assistance for data entry;

### 2) **Prevention**

The need for a state strategy to help direct how to best spend the state's limited resources for prevention along with improving the use of technology to most effectively identify areas in greatest need to inform future resource investment;

### 3) **Data**

The need for a multisystem solution for tracking data, specifically between the child welfare system, the health care system and day care providers, as well as an expansion of data collected to include near-fatalities to evaluate opportunities for enhanced detection, intervention, and/or reporting to Child Protective Services (CPS) prior to death; and

### 4) **Sustainability**

The need for a permanent, high-level advisory board to make recommendations regarding Texas' efforts for the prevention of child abuse and neglect.

The following recommendations and strategies were adopted by the POK Commission:

## Recommendations and Strategies

*Charge (1): Identify promising practices and evidence-based strategies to address and reduce fatalities from child abuse and neglect;*

- 1. DFPS, DSHS and the Prevention Advisory Board (described in Recommendation 3) should develop and maintain an inventory of the top evidence-based and promising practices addressing child abuse fatality prevention and cost per family, including population-based strategies currently in Texas and location and population-based strategies not in Texas.**
- 2. The State should prioritize prevention services using a geographic focus for families with the greatest needs.**
  - 2.1 DFPS Prevention and Early Intervention should develop a process to identify target geographic areas using multiple risk indicators of child abuse fatalities.
  - 2.2 DFPS Prevention and Early Intervention should map out geographically, the evidenced-based strategies and promising practices currently available in Texas and compare with the data and information analyzed from strategy 2.1 to determine whether service availability matches the level of need.
  - 2.3 DFPS Prevention and Early Intervention should determine gaps between areas served with high-risk and high-quality programs and areas underserved with high risk and low quality or no programs.
  - 2.4 DFPS Prevention and Early Intervention should consider implementing pilots in high and highest risk areas of the state with protocols for measuring effectiveness.
  - 2.5 The Legislature should develop a financing methodology for allotting resources to those areas with the highest need.

*Charge (2) part 1: Develop recommendations...including recommendations to implement a comprehensive statewide strategy for reducing those fatalities.*

- 3. The DFPS Commissioner should create a permanent, high-level advisory board to make recommendations regarding Texas' efforts for the prevention of child abuse and neglect for a state strategy to promote child safety and well-being through methods such as enhanced data collection and analysis, and expansion of evidenced based and promising practice programs. This Prevention Advisory Board should include representatives such as pediatricians, judges, agency representatives, prosecutors, medical examiners, provider groups, and policy experts in prevention, community advocacy or similar disciplines.**
  - 3.1 The Prevention Advisory Board should make recommendations using a population-based public health approach/model.
  - 3.2 The Prevention Advisory Board should make recommendations using a combination of targeted and universal prevention strategies.
  - 3.3 The Legislature should continue consolidation of child abuse prevention programs under DFPS, especially those serving duplicate targeted populations to improve service coordination.

3.4 While allowing for investment in promising practices, the Legislature should concentrate investment in evidenced-based strategies and discontinue prevention programs which fail to show measurable outcomes.

3.5 The Prevention Advisory Board should consider evidenced-based and promising practices for prevention programs and parent education programs as defined by Govt. Code, Sec. 1, Chapter 531, in structuring child abuse fatality prevention programming accountability and evidence-based measures.

3.6 The Prevention Advisory Board should research and make recommendations regarding the training of external stakeholders to identify, recognize, report and prevent child physical maltreatment and neglect, including expanded mandated training of medical professionals, child care workers, public and charter school staff, and higher education professionals with access to minors.

3.7 The Legislature should fund CPS staffing to allow DFPS to explore the following:

- a) Identifying high-frequency incident areas;
- b) Concentrating staffing levels, lowering caseloads, increasing expertise and specializing training to service high-risk catchment areas;
- c) Designating specialized units or caseworkers to conduct child fatality investigations based on expertise/tenure; and
- d) Developing non-DFPS community partner strategies for early recognition, reporting and prevention of fatalities.

**4. The State should make better use of the work of the State Child Fatality Review Team (SCFRT).**

4.1 The Legislature should amend Section 264.502 of the Texas Family Code to provide that the Speaker of the House, the Lieutenant Governor, and the Governor shall each appoint a liaison to serve on the SCFRT.

4.2 The Commissioner of DFPS should appoint the Chair of the SCFRT to serve as a standing member of the DFPS Prevention Advisory Board.

**5. The State should better support local Child Fatality Review Teams to ensure coordination, training, and consistency.**

5.1 The Legislature should fund Child Fatality Review Team Coordinators for each of the eleven DSHS Regions.

5.2 The Legislature should fund DSHS to improve CFRT training, coordination, data entry, and technical assistance to provide greater team consistency and alleviate the demands on volunteer team members.

5.3 The Legislature should amend the Code of Criminal Procedure Sections 49.10 (i) and 49.25 9(a) to eliminate “limited autopsies” for children younger than six years of age and require complete autopsies for children subject to inquest under Chapter 264 of the Texas Family Code.

5.4 The Legislature should set standards for required training and increase funding for Justices of the Peace and Medical Examiners specifically related to inquests, particularly for child deaths.

5.5 Local CFRTs should consider recruitment of members that reflect the diversity of the community and consider issues of disproportionality in child fatalities.

**6. The State should ensure that all Texas counties have a Child Fatality Review Team.**

6.1 The Legislature should amend Section 264.505 of the Texas Family Code to allow adjacent counties of any population size to form joint CFRTs and require each county to participate in a CFRT.

**7. The State should expedite the CFRT case review process.**

7.1 CFRT members designated by Section 264.505 of the Texas Family Code should actively participate in their local CFRTs and timely provide necessary information.

7.2 The Legislature should require for child autopsies that Medical Examiners' Offices follow professional standards issued by the National Association of Medical Examiners regarding timeliness and appropriately fund the offices so they have adequate resources to meet timeliness standards for all autopsies.

7.3 The Legislature should amend Section 264.505 to require local registrars to create expedited processes to notify CFRTs of child deaths within 120 days.

7.4 The Legislature should require DSHS to allow CFRTs electronic access to preliminary death certificates in the new electronic registration system to be launched 01/01/2018.

*Charge (2) part 2: Develop recommendations and identify resources necessary to reduce fatalities from child abuse and neglect for implementation by state and local agencies and private sector and nonprofit organizations . . .*

**8. The Prevention Advisory Board and DFPS should look for funding sources in addition to state general revenue, including federal and local government, and private funding streams to increase prevention programs.**

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

**9. The State should evaluate currently available child fatality data resources (CPS and CFRT data) and develop strategies to include near-fatalities.**

9.1 The State should develop a more specific definition for the near-fatality designation to facilitate a more consistent appraisal by physicians.

9.2 The State should expand current combined database to include near-fatalities, where child maltreatment is determined by CPS to have caused the near-fatality.

**10. The Legislature should extend the types of data tracked to enhance research and understanding.**

10.1 DFPS should track and analyze the following specific types of CPS data in a manner that will enable further research to reduce recurrence and create predictive analytics:

- a) Prior contact with CPS including number of referrals and disposition of each prior referral, including: (a) Priority None or Administrative Closure, (b) Differential Response (call screened out), (c) Alternative Response provided, (d) Investigated and ruled Unable to Complete, Unable to Determine, Ruled Out, or Reason to Believe.
- b) Disposition of Reason-To-Believe (RTB) cases resulting in (a) referral to family-based services, (b) inclusion of a safety plan, (c) services were offered to family, types of services and compliance/completion, and (d) removal of the child.

**11. DSHS and DFPS should determine how to better use available data to inform a public health approach to preventing child fatalities and continue to support the work already underway in the “Strategic Plan to Reduce Child Abuse and Neglect Fatalities.”**

## INTRODUCTION

No child in Texas should die from abuse or neglect. Child death from abuse and neglect is preventable. Some solutions require overarching, statewide systemic change, while others require more simple changes at the local level. All solutions designed to prevent child abuse and neglect involve a public health approach.

Preventing child maltreatment death cannot be relegated to DFPS exclusively. In fact, during fiscal years 2010 – 2013, slightly over half of child abuse and neglect fatalities involved children and perpetrators that were unknown to DFPS.<sup>1</sup> Because most of the children dying of child maltreatment are pre-school age<sup>2</sup>, the medical community, day care providers, law enforcement, first responders and other key stakeholders must work together to form a more effective safety net for families at risk. This approach would lead to opportunities for earlier interventions and, ultimately, prevention of child maltreatment deaths.

Developing strategies to prevent child deaths involves a multi-system analysis of information to address key questions: What are the child, family, and community-level risk factors associated with child fatalities? Were there missed opportunities within the safety net to prevent fatalities such as inadequate detection, intervention, or noncompliance? What are the most effective intervention strategies for families at risk? What are the best ways to prevent child fatalities? Efforts to address many of these questions are currently underway. For example, DFPS is assessing risk factors with predictive analytics to identify cases most likely to experience a particular outcome and to inform strategies for targeting limited resources. This report provides recommendations to enhance current efforts and to improve future endeavors to address these questions and save children from preventable deaths.

A problem of this magnitude cannot be addressed without an ongoing community effort. Everyone, from the neighbor who notices suspicious injuries on an infant's face to the medical examiner that carefully documents each injury in a child homicide victim, has a role to play in understanding and preventing child deaths. As suggested by this report, combining data bases may enhance our understanding of why children die in Texas and inform prevention strategies. Over the past few years, the Texas child welfare system has benefitted greatly from a deeper and more robust collaboration with state partners. A permanent, high-level advisory board would ensure that statewide efforts to prevent and eliminate child fatalities due to abuse or neglect are coordinated and sustained.

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<sup>1</sup> DEP'T. OF FAMILY AND PROTECTIVE SERVICES and DEP'T OF STATE HEALTH SERVICES, Strategic Plan to Reduce Child Abuse and Neglect Fatalities 1 (March 2015).

<sup>2</sup> DEP'T. OF FAMILY AND PROTECTIVE SERVICES: A Better Understanding of Child Abuse and Neglect Fatalities 4 (March 2015).

## BACKGROUND

The POK Commission was statutorily-created to study the relationship between CPS, child welfare services, and the rate of child abuse and neglect fatalities. The POK Commission was directed to report such findings to the Legislature and make recommendations regarding legislative and administrative changes.

The POK Commission established four workgroups to accomplish these tasks: Prevention, Data, Child Fatality Review Teams, and Sustainability. The work of each group was shared and reviewed at each of the seven meetings of the POK Commission between October 2014 and November 2015. The recommendations were developed by the workgroups and adopted by the POK Commission as a whole.

## TEXAS DATA

In March 2015, the DFPS Office of Child Safety released *A Better Understanding of Child Abuse and Neglect Fatalities* which included analysis of administrative and individual case reviews from FY2010 through FY2013.

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*DFPS reports that over the last ten years, an average of 220 children a year have died due to abuse or neglect.*

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### Key Findings

- There were 156 confirmed abuse/neglect fatalities in 2013 which reflected a 26% decrease from 2012.<sup>3</sup> Note, however, that some of the decline may be related to 2012 enhanced DFPS disposition guidelines that were developed to ensure consistent dispositions on child fatalities.<sup>4</sup>
- Confirmed physical abuse/intentional trauma fatalities have decreased by 35% since 2010.<sup>5</sup>
- Confirmed neglect related fatalities have decreased by 31% since 2010.<sup>6</sup>
- Neglect fatalities most commonly involve drowning, unsafe sleep, car and firearm accidents.<sup>7</sup>

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<sup>3</sup> *Id.*

<sup>4</sup> *Id.* at 9.

<sup>5</sup> *Id.* at 4.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

## Victims

- In 2013, 81% of fatalities caused by abuse or neglect involved children three years old or younger.<sup>8</sup>
- 58% of the victims were male.<sup>9</sup>
- The largest percentage of children who die from abuse or neglect were Hispanic;<sup>10</sup> however, African American children die at a per capita rate that is disproportionately higher compared to their overall representation in the Texas child population.<sup>11</sup>

## Perpetrators

- Physical abuse fatalities most commonly involved blunt force trauma inflicted by a father or boyfriend.<sup>12</sup>
- Parents are the most common perpetrators in fatal child abuse or neglect investigations.<sup>13</sup>
- In a slight majority of child abuse and neglect fatalities, the child or perpetrator had no prior history with CPS.<sup>14</sup> However, national research indicates that a prior report for child maltreatment before the age of five to CPS is a significant risk factor whether the report is substantiated or not.<sup>15</sup>

When the POK Commission began studying child fatalities, much work was already underway at both the national and state level. The Statewide Blue Ribbon Task Force, the State Child Fatality Review Team, the House Select Committee on Child Abuse Fatalities, the DFPS Office of Child Safety, the Children's Justice Act Task Force, and TexProtects are some of the organizations who have examined child fatality issues extensively. Each of these groups of experts has made recommendations, some of which have not yet been implemented. The POK Commission reviewed these reports and concluded that several of the recommendations were worthy of implementation and would effectively help address child fatalities. Thus, many of those recommendations are included in this report to highlight this excellent work.

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*"We can all agree: One death from child abuse or neglect is one too many."*

*Dr. David Sanders, Chairman, Commission to Eliminate Child Abuse and Neglect Fatalities*

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<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *Id.* at 16.

<sup>12</sup> *Id.* at 4.

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> COMM'N. FOR THE ELIMINATION OF CHILD ABUSE AND NEGLECT FATALITIES, Draft Themes and Recommendations (June 2015).

## NATIONAL EFFORTS

### *Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF)*

The CECANF was created by the federal Protect Our Kids Act of 2012 to develop a national strategy and recommendations to reduce fatalities across the country resulting from child abuse and neglect.<sup>16</sup> The CECANF plans to accomplish this by:

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

The CECANF is composed of 12 members, six appointed by the president and six appointed by Democratic and Republican leaders of the House and Senate. CECANF has conducted several meetings around the country, heard from numerous experts, and has exhaustively studied the issues related to child fatalities. The CECANF is in the final phase of reviewing the work of its subcommittees and developing recommendations for its report. It will conclude its work and issue its report in 2016. Because of its national and even international scope and resources, CECANF was able to explore areas that the Texas POK Commission was unable to address. This POK Commission looks forward to the release of that national report and would recommend that Texas carefully consider the CECANF report and recommendations when it is released. Preliminary themes from CECANF include:

#### **1. Collective Responsibility for Safety**

The primary government agency responsible for protecting children from child abuse and neglect is county or state-run CPS. A narrow focus on the CPS agency alone has not proven to be enough to eliminate child abuse and neglect fatalities.

#### **2. Leadership and Accountability**

Leadership at every level is necessary to create a sense of urgency, sustain attention, drive a collective approach, and shelter this effort from competing priorities.

#### **3. Measurement and Classification**

The ability to accurately count the number of children who die from child abuse and neglect is critical to know whether interventions designed to decrease fatalities are working and whether the resources being provided to address this problem are adequate based on the magnitude of the problem.

#### **4. Implementing Stronger Child Protection Methods**

A collective commitment to more effective identification, assessment, and treatment of children and families at risk will strengthen child safety. This commitment must include CPS agencies and other key partners (e.g., law enforcement, domestic violence services, substance abuse, mental health, health care, public health, education, and others).

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<sup>16</sup>Protect our Kids Act of 2012, Pub. L. No. 112-275 (2013) available at [www.gpo.gov/fdsys/pkg/PLAW-112publ275/pdf/PLAW-112publ275.pdf](http://www.gpo.gov/fdsys/pkg/PLAW-112publ275/pdf/PLAW-112publ275.pdf).

## **5. Developing New Tools and Strategies to Apply What We Know**

Continually expand the cutting edge of the capacity to analyze data and employ resources based on the findings to protect vulnerable children.

## **6. Considerations for Specific Communities**

Preventing child maltreatment fatalities in communities disproportionately affected: American Indian /Alaska Native, African American and military communities.<sup>17</sup>

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<sup>17</sup> COMM’N. FOR THE ELIMINATION OF CHILD ABUSE AND NEGLECT FATALITIES, *Not One More Death From Child Abuse and Neglect: A 21st Century Strategy for Protecting Our Kids*, CECANF Final Report: Proposed Outline (October 2015) available at <https://eliminatechildabusefatalities.sites.usa.gov/files/2015/08/DRAFT-Final-Report-Outline-9.21.pdf>.

# CHILD FATALITY WORK IN TEXAS

## State Child Fatality Review Team (SCFRT)

The SCFRT is a multidisciplinary group of statutorily-defined experts from DSHS, law enforcement, the medical community, DFPS, children's advocacy organizations, the court system, the behavioral health community, and more. The SCFRT was created in 1995<sup>18</sup> to:

1. Develop an understanding of the causes and incidences of child deaths in Texas;
2. Identify procedures with the agencies represented on the SCFRT to reduce the number of preventable child deaths; and
3. 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.<sup>19</sup>

The SCFRT is a great resource for the State of Texas. By making use of interested and experienced volunteers, Texas has tapped into an inexpensive, but effective way to accomplish this vital work.

The SCFRT produces a report with legislative recommendations every two years.<sup>20</sup> The most recent report from 2013 included several recommendations that were important to the work of this POK Commission:

1. Investigate options for more timely delivery of death certificates to local CFRTs, as well as strategies for improved data collection and data entry of those child deaths that local teams review;
2. Provide funding for annual training for Texas CFRTs; and
3. Promote and support work towards the goal that all Texas counties have an independent CFRT or participate in a multi-county CFRT to review and document all deaths of children less than 18 years of age.<sup>21</sup>

The SCFRT also identified in its 2013 report several areas for improvement:

1. **CFRT Coverage:** Texas does not have CFRTs in every county. There are currently 73 CFRTs covering 200 counties (79 percent). The SCFRT has a goal of 100 percent coverage. Development of a CFRT is voluntary rather than required.
2. **Data Collection Capacity:** CFRTs do not review all child deaths. In 2013, CFRTs reviewed and data-entered 1,787 of the 3,296 deaths (54.2 percent) that corresponded to counties with CFRTs. The voluntary nature of local CFRTs makes it difficult to enforce levels of participation.
3. **Data Collection and Entry:** There is room for improvement in data collection and entry. CFRTs have varying capacity in their understanding of what information needs to be collected and recorded. More monitoring and training is needed to increase their competencies.

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<sup>18</sup> Tex. Family Code § 264.502 (West 2015).

<sup>19</sup> *Id.* at § 264.503.

<sup>20</sup> *Id.*, See also, STATE CHILD FATALITY REVIEW TEAM, 2013 Annual Report available at

<https://www.google.com/webhp?sourceid=chrome-instant&ion=1&espv=2&ie=UTF-8#q=scftr%20report%20texas>.

<sup>21</sup> SCFRT 2013 Annual Report, *supra* note 20 at 8.

4. **Standardization of Information Collected:** Infant death scene investigations are not standardized in Texas. There is a protocol designed by the Centers for Disease Control and Prevention (CDC) to standardize information collected at the infant death scene. More outreach to and training of law enforcement, Justices of the Peace, CPS caseworkers, Emergency Medical Services (EMS), and others responding to these deaths is needed.
5. **Training:** CFRT members need ongoing training. CFRT members are volunteers with a wide range of professional expertise. All team members need orientation and training to increase their competence in reviews and to keep abreast of the most current research and best-practices in child death prevention. A CFRT-specific annual conference is needed.<sup>22</sup>

## Sunset Advisory Commission

In 2014, the Sunset Advisory Commission reviewed DFPS. The Sunset Commission, made up of five Senators, five Representatives and two members of the public, researches and analyzes if an agency's functions are needed and how the agency can work better. The Sunset Commission conducts public hearings and makes recommendations. Finally, the full Legislature considers Sunset recommendations and makes final determinations about whether the agency either continues with the improvements or is abolished.<sup>23</sup>

The Sunset Staff Report on DFPS, issued in July 2015, stated: “. . . the Sunset review focused on identifying management improvements and opportunities to streamline operations to help DFPS better focus on the day-to-day aspects of its difficult work.”<sup>24</sup> The Sunset Commission made many recommendations for DFPS, two of which are specifically relevant to the POK Commission:

1. CPS Does Not Capture Comprehensive Information to Adequately Assess How Well It Is Protecting Children.
2. DFPS Should Elevate the Importance of Its Prevention and Early Intervention Efforts and Better Use Existing Data to Evaluate Program Effectiveness.<sup>25</sup>

## Department of Family and Protective Services

In March 2015, DFPS issued two reports specifically addressing child fatalities:

1. *DFPS and DSHS Strategic Plan to Reduce Child Abuse and Neglect Fatalities*, and
2. *DFPS A Better Understanding of Child Abuse and Neglect Fatalities*.

The Strategic Plan outlined the collaboration between DSHS and DFPS “to reduce abuse and neglect fatalities by providing timely, coordinated, and evidence-based services to families and communities in need.”<sup>26</sup> These two agencies combined data on birth records, death records, and community-level risk indicators to:

1. Understand the prevalence of abuse and neglect fatalities within the population;

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<sup>22</sup> *Id.* at 9.

<sup>23</sup> SUNSET ADVISORY COMM’N, , <https://www.sunset.texas.gov/how-sunset-works> (last visited Oct. 26, 2015)

<sup>24</sup> SUNSET ADVISORY COMM’N, Staff Report with Final Results DFPS 1 (July 2015).

<sup>25</sup> *Id.* at 5.

<sup>26</sup> Strategic Plan, *supra* note 1 at 1.

2. Identify communities that are high risk for specific types of abuse and neglect fatalities; and
3. Explore which risk factors in the family are associated with abuse and neglect.<sup>27</sup>

The DFPS/DSHS Strategic Plan includes action items related to sleep-related deaths, physical abuse, enhanced data analysis and collaboration, and ongoing statewide collaboration to continue the joint DFPS/DSHS commitment to promote healthy mothers and healthy babies.<sup>28</sup>

DFPS also partnered with federal agencies and national advocates to use national data and practice to inform the Strategic Plan. Within DFPS, various divisions partner to investigate, review, analyze and prevent child fatalities, including:

1. Child Protective Services
2. Child Care Licensing and Adult Protective Services
3. Prevention and Early Intervention Division
4. Office of Child Safety

### ***Prevention and Early Intervention Division (PEI)***

As recommended by the Sunset Advisory Commission, DFPS elevated its PEI program to report directly to the agency's Commissioner thereby allowing the PEI program to maintain a connection to both the agency's critical child welfare function as well as community and public health partners who participate in broader prevention efforts.

DFPS PEI Division is currently in the process of producing a five-year strategic plan designed to help support the use of evidence-based and promising practice work in communities across Texas. As part of this effort, DFPS has brought together members from various disciplines to help craft the five-year strategic plan. This includes members from the legal system, law enforcement, advocacy groups, faith-based community, medical community, higher education, providers of prevention services, state and local governments, and school districts. By statute, this group is tasked with building a strategic plan that will:

1. Identify methods to leverage other sources of funding or provide support for existing community-based prevention efforts;
2. Include a needs assessment that identifies programs to best target the needs of the highest risk populations and geographic areas;
3. Identify the goals and priorities for the department's overall prevention efforts;
4. Report the results of previous prevention efforts using available information in the plan;
5. Identify additional methods of measuring program effectiveness and results or outcomes;
6. Identify methods to collaborate with other state agencies on prevention efforts; and
7. Identify specific strategies to implement the plan and to develop measures for reporting on the overall progress toward the plan's goals.<sup>29</sup>

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<sup>27</sup> *Id.*

<sup>28</sup> *Id.* at 2-3.

<sup>29</sup> Tex. Fam. Code § 265.005 (West 2015).

DFPS also created the Office of Child Safety under PEI to focus on child maltreatment fatalities data and research. Better use of data and partner involvement in the agency's prevention strategy will improve programs serving at-risk families.<sup>30</sup>

### *Office of Child Safety (OCS)*

The goals of the OCS are to:

1. Develop strategic recommendations to bring together local agencies, private sector, non-profits, and government programs to reduce child abuse and neglect fatalities.
2. Produce consistent, transparent, and timely review of child fatalities and serious injuries by independent experts outside any specific program;
3. Assess root causes of child fatalities to provide guidance on the most effective prevention changes as well as improvements in child welfare practices;
4. Operate with the understanding that many systems impact outcomes for children and that prevention and intervention efforts will involve many sectors and non-traditional partners; and
5. Work closely with the DSHS and others to share data and information.

In October 2104, DFPS released the DFPS Report to the Sunset Advisory Commission, and described the OCS as excerpted below:

*Abuse/neglect fatalities as well as near fatal events occur in every program within DFPS. Historically, CPS, Adult Protective Services (APS), and Child Care Licensing (CCL) have been independently responsible for identifying and addressing issues relating to the fatality. There has not been a centralized mechanism for insuring an independent case review, coordination of efforts, development of an agency perspective of systemic issues, or for targeting prevention efforts to reduce fatalities. This has resulted in fragmented responses from the agency as well as a perception that the agency is unable to provide unbiased reviews of its own work. An Office of Child Safety will instill a laser-focused and objective approach needed to research systemic problems, identify areas of prevention and intervention, initiate enhancements to practice, and bolster increased collaboration opportunities among DFPS, DSHS, other agencies and stakeholders. With this new office leading the charge, Texas can be a model for other states and a national leader in addressing child fatalities and serious injury.<sup>31</sup>*

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<sup>30</sup> Strategic Plan, *supra* note 1.

<sup>31</sup> TEX. DEP'T. OF FAMILY AND PROTECTIVE SERVICES, Report to The Sunset Advisory Commission: Child Protective Services Transformation October 2014 *available at* [https://www.sunset.texas.gov/public/uploads/files/reports/CPS\\_Transformation.pdf](https://www.sunset.texas.gov/public/uploads/files/reports/CPS_Transformation.pdf).

## Department of State Health Services

DSHS supports the prevention of child death in various important roles:

1. Maintains vital records including death certificates in the Vital Statistics Unit;
2. Provides support and coordination for the SCFRT and for the local CFRTs;
3. Provides support and collaborates to prevent child deaths due to injury through workgroups, national initiatives, conferences, training, and activities to address the Maternal Child Health Title V Block Grant national performance measures; and
4. Partners with DFPS in the *Strategic Plan to Reduce Child Abuse and Neglect Fatalities*.

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

The 83rd Legislative Session (2013) created the House Select Committee on Child Protection, which was chaired by Representative Dawanna Dukes. This Select Committee held four public hearings and heard from national and local experts. On September 30, 2014, the public hearing was focused solely on fatalities. The portions of the charge of the House Select Committee that are most relevant to the POK Commission are:

1. Monitor the ongoing efforts of the National Commission to Eliminate Child Abuse and Neglect Fatalities;
2. Assess the efficacy of ongoing prevention and early intervention efforts that target resources to families at-risk;
3. Consider ways to encourage consistent, transparent, and timely review of abuse and neglect fatalities;
4. Monitor ongoing efforts to enhance the use of data to improve outcomes; and
5. Consider strategies to ensure better coordination and collaboration among local agencies, faith-based organizations, the private sector, non-profits, and law enforcement to reduce the incidence of abuse and neglect fatalities.<sup>32</sup>

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<sup>32</sup> HOUSE SELECT COMMITTEE ON CHILD PROTECTION, Interim Report to the 84<sup>th</sup> Legislature 9 (Dec. 2014).

The House Select Committee made many recommendations, including:

**Prevention and Early Intervention:**

1. DFPS should explore the use of evaluative indicators associated with clients served through PEI programs who are found to have subsequent confirmed cases with Child Protective Services to support efforts to provide the most intensive services targeted to the highest risk clients;
2. DFPS should include strategies in their annual updates to the Senate Committee on Finance, Senate Committee on Health and Human Services, House Committee on Appropriations and the House Committee on Human Services to expand the Project Help Through Intervention (HIP), the birth match program that offers voluntary services to families to increase protective factors, and the Health Outcomes from Prevention and Early Support (HOPES), a program that contracts with community-based organizations to provide prevention services;
3. DSHS should identify opportunities to improve the report by CFRTs while monitoring the impact of services gaps in areas without teams; and
4. DFPS and DSHS should collaborate to identify additional funding opportunities to address individual and community-level factors that contribute to parental substance abuse and domestic violence.<sup>33</sup>

**Investigation:**

1. DFPS should improve tracking CPS investigations in Information Management Protecting Adults and Children in Texas (IMPACT), the computer application used by DFPS staff for case management, by using a broader family model that seamlessly links other cases to the current household composition including sibling groups, paramours, and relatives. DFPS should consider extending the retention rate of records to improve child safety.
2. DFPS should track the incidence of subsequent investigations and use of agency services for children involved in unable-to-determine CPS cases.<sup>34</sup>

**Information Sharing:**

1. The committee supports ongoing efforts of DFPS to modernize the IMPACT database that will advance transparency for stakeholders involved in the care of foster children while reducing discrepancies that lead to duplicative or erroneous record keeping.

On November 4, 2015, the House of Representatives also released the following interim charge:

Examine the Department of Family and Protective Services' policies and procedures, including prevention measures and resources, dedicated to eliminating child abuse and fatalities within the foster care system.<sup>35</sup>

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<sup>33</sup> *Id.* at 17.

<sup>34</sup> *Id.*

<sup>35</sup> TEXAS HOUSE OF REPRESENTATIVES, Interim Committee Charges, (Nov. 2015) *available at* <http://www.house.state.tx.us/media/pdf/interim-charges-84th.pdf>.

## *The Texas Statewide Blue Ribbon Task Force (BRTF)*

The BRTF was appointed and reappointed during the 81st and 82nd Legislative Sessions to bring together experts to assess, evaluate and create a strategic plan to address child abuse and neglect in Texas.<sup>36</sup> Chaired by Dr. Christopher Greeley, the BRTF held dozens of hearings, received testimony from stakeholders and experts across the state and researched and collected materials from numerous other states undergoing child abuse prevention focused programming. In 2011, the BRTF made recommendations regarding the following:

1. **Permanent Commission**

Expand and support child abuse and neglect prevention efforts by creating a permanent commission to provide continued and consistent advice on prevention strategies, ensure the state maximizes federal matching of the state general revenue and dedicated funds currently allocated and promote flexibility in utilizing funding from private foundations and organizations.

2. **Evidence of Effectiveness**

Focus investments in evidence-based programs and strategies for the prevention of child abuse and neglect, giving priority to strong evidence-based or evidence-informed programs that have undergone rigorous evaluation of efficacy

3. **Home Visitation Supporting Parenting and Child Development**

As one of the most important and effective methods in preventing child abuse and neglect, home visitation programs such as Nurse-Family Partnership should be maintained and expanded across the state. Other evidence-based home visitation strategies should be embraced and supported throughout the state.

4. **Investment**

Support and increase funding for prevention services.<sup>37</sup>

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<sup>36</sup> THE TEXAS STATEWIDE BLUE RIBBON TASK FORCE, Final Report (August 2011).

<sup>37</sup> *Id.* at 3.

## Children's Justice Act Task Force (CJA)

The CJA receives a federal grant to improve the investigation prosecution and judicial handling of cases of child abuse and neglect. Every three years, CJA conducts a comprehensive evaluation and writes an assessment.<sup>38</sup>

In its May 2015 Assessment, the CJA made the following relevant recommendations:

### 1. Multidisciplinary Team Response and Coordination

Use a multidisciplinary team (MDT) approach to child abuse, which is a child-centered approach and provides a coordinated, joint response facilitating cooperation across disciplines, preventing unintentional working at cross purposes and allowing for consistency from case to case. An MDT approach also improves the system's efficiency by eliminating duplicative efforts.

### 2. Improve the Quality and Consistency of Data Collection, Investigation, and Death Certification by:

- a. Reviewing existing CFRTs and promote increased standardization as well as data collection capacity;
- b. Providing regular training and tools to law enforcement and prosecutors, including developments in the law and latest advancements in investigative and forensic techniques; and
- c. Following impending CECANF recommendations related to:
  - i. Standardized, cross-system data sharing on child fatalities;
  - ii. Standardized best practice guidelines for child death scene investigation, death certification, and child autopsy protocols

## Cook Children's Hospital Center for the Prevention of Child Maltreatment (Cook Children's Center)

The Cook Children's Center is a Tarrant County nonprofit organization that provides training for doctors and first responders to recognize possible signs of abuse and neglect. The Cook Children's Center developed an online training to help Cook's 4,000 clinical employees detect risk factors and identify signs of drug exposure, failure to thrive, neglect and physical or sexual abuse.<sup>39</sup> Community-based education is also available to families of every socio-economic class.

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<sup>38</sup> TEXAS CHILDREN'S JUSTICE ACT TASK FORCE, Texas Children's Justice Act Three Year Assessment 2015-2018 (May 2015) available at <http://www.yourhonor.com/web/images/pdfs/CJA/2015CJAAssessment.pdf>.

<sup>39</sup> Susan Schrock, *Cook Children's New Center Focuses on Child Abuse*, Fort Worth Star Telegram, July 22, 2014, available at <http://www.star-telegram.com/living/health-fitness/article3866257.html>.

The Cook Children’s Center is also studying what prevention programs are available in communities where abuse and neglect are mostly likely to occur. By doing so, areas of greatest need can be targeted with the best and most efficient use of resources.<sup>40</sup>

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*“No one wants to think that someone is abusing a child.  
Sometimes the findings can be rather subtle.  
If a child is coming in with these subtle findings,  
we want to heighten clinicians’ awareness and then  
interaction can happen sooner.”*

*Dr. Janye Coffman, Medical Director, Cook Children’s Center  
for the Prevention of Child Maltreatment*

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### *The Texas Association for the Protection of Children (TexProtects)*

TexProtects is a non-profit focused on reducing and preventing child abuse and neglect through research, education, and advocacy. TexProtects made the following recommendations during the past legislative session that were especially relevant to the work of the POK Commission:

1. Ensure a report is produced that reflects all child fatality investigations completed annually based on number of reports, abuse or neglect disposition, not exclusively those fatalities given the disposition of Reason to Believe-Fatal (RTB-Fatal). This measurement would provide a clearer understanding of all fatalities where abuse or neglect was involved but may not have conclusively caused the child’s death. It will also provide data on how many “Unable to Determine” fatalities occur in Texas annually.
2. Ensure a report is produced measuring the number of child fatalities where DFPS had previous referrals, previously investigated the family and include substantiated and unsubstantiated history in this report.
3. Ensure that all Reason to Believe/Near Fatal cases where the child subsequently dies (through DSHS records) are re-disposed as RTB-Fatal.

Many Texas experts have studied child maltreatment fatalities and have given the state a wealth of information and recommendations. Each of the previous efforts informed and guided the work of the POK Commission.

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<sup>40</sup> Research reveals the following as ten factors often present in child maltreatment and child maltreatment deaths: young children, domestic violence, drug use, bruises on soft parts of the child’s body, untreated mental illness, multiple social stressors with no safety net, lack of education, bizarre “punishments”, prior allegations of abuse or domestic violence, and presence of an unrelated male. Dyann Daley, M.D., *Tarrant County is No. 1 in Child Abuse*, Checkup Daily, A Cook Children’s Newsroom, April 29, 2015, available at <http://www.checkupnewsroom.com/tarrant-county-is-no-1-in-child-abuse/>.

## COMMENTARY ON THE RECOMMENDATIONS

*Charge (1): Identify promising practices and evidence-based strategies to address and reduce fatalities from child abuse and neglect;*

- 1. DFPS, DSHS and the Prevention Advisory Board (described in Recommendation 3) should develop and maintain an inventory of the top evidence-based and promising practices addressing child abuse fatality prevention and cost per family, including population-based strategies currently in Texas and location and population-based strategies not in Texas.**

Commentary:

Historically, DFPS and DSHS have been the state agencies responsible for tracking and investigating child fatalities. In Recommendation 3, the POK Commission has suggested that a Prevention Advisory Board be appointed to work with these agencies to assist in setting future policies and implementing recommendations along with legislative directives. Funding for prevention programs should be allocated by priorities set by the Prevention Advisory Board.

The vast research on the most effective prevention programs and those showing efficacy and promise should inform the State's decisions related to investing in targeted and population-based cost-effective prevention strategies. Appendix A is an inventory of the top evidence-based and promising practices as of September 1, 2015 compiled by TexProtects with technical assistance from the PEI Division of DFPS.

- 2. The State should prioritize prevention services using a geographic focus for families with the greatest needs.**

- 2.1 DFPS Prevention and Early Intervention should develop a process to identify target geographic areas using multiple risk indicators of child abuse fatalities.**

Commentary:

By gathering data on certain known risk factors, DFPS can determine what geographic areas are more likely to have child fatalities occurring within them. Information including these factors is currently being kept in law enforcement and other governmental databases, such as the Women, Infant and Child Program (WIC). Agencies keeping this data should cooperate in the exchange of relevant data. High risk areas should be identified from relevant data.

- 2.2 DFPS Prevention and Early Intervention should map out geographically, the evidenced-based strategies and promising practices currently available in Texas and compare with the data and information analyzed from strategy 2.1 whether service availability matches the level of need.**

Commentary:

Once the high risk geographic areas are identified, efforts at prevention of child fatalities should be targeted. To determine whether the high risk areas are receiving such services and reveal any gaps, a map should be created to show the of areas needing services compared with the areas in which services are located.

**2.3 DFPS Prevention and Early Intervention should determine gaps between areas served with high-risk and high-quality programs and areas underserved with high risk and low quality or no programs.**

Commentary:

With limited state resources, Texas should identify child abuse fatality risk catchment areas of the state utilizing “terrain risk mapping” based on risk indicators or variables that correlate with high risk of fatalities. Overlaying the risk mapping with current evidence-based programs geographically will help focus future resource allocation. Appendix B shows county-level risk as well as the demand or need for home visiting prevention services compared to state supply of home visiting services (from all funding sources) as of 2013.<sup>41</sup>

**2.4 DFPS Prevention and Early Intervention should consider implementing pilots in high and highest risk areas of the state with protocols for measuring effectiveness.**

Commentary:

DFPS’s current HOPES program could serve as incubator sites or pilot projects for testing efficacy to inform future expansion efforts. For each of the HOPES sites, evaluations should measure effectiveness of the interventions and utilize cost-benefit findings to inform future expansion of the most effective pilots.

**2.5 The Legislature should develop a financing methodology for allotting resources to those areas with the highest need.**

Commentary:

While the state general revenues should be part of the funding formula for cost-effective prevention programs, the agencies and the legislature should leverage state funds with private funders (including foundations and private equity investors), as well as maximize local and federal funding streams.

*Charge (2): Develop recommendations...including recommendations to implement a comprehensive statewide strategy for reducing those fatalities.*

**3. The DFPS Commissioner should create a permanent, high-level advisory board to make recommendations regarding Texas’ efforts for the prevention of child abuse and neglect for a state strategy to promote child safety and well-being through methods such as enhanced data collection and analysis, and expansion of evidenced based and promising practice programs. This Prevention Advisory Board should include representatives such as pediatricians, judges, agency representatives, prosecutors, Medical Examiners, provider groups, and policy experts in prevention, community advocacy or similar disciplines.**

Commentary:

While DFPS should be accountable for implementation of a child abuse prevention strategy, they need not be solely responsible for creating, developing, monitoring and evaluating a child safety strategy. DFPS can leverage volunteer leaders in the field of child protection, including key professionals noted under Recommendation 3. These proposed Prevention Advisory Board members would bring access to numerous research, judicial, medical, law enforcement, policy, and program provider resources that are well-equipped to create a statewide prevention strategy

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<sup>41</sup> TEXPROTECTS, Risk Assessment & Families Served with Home Visiting (March 2015).

in cooperation with DFPS. A Prevention Advisory Board can help advise DFPS about “state-of-the-art” prevention initiatives and assist with sustaining and developing funding in addition to state general revenue.

**3.1 The Prevention Advisory Board should make recommendations using a population-based public health approach/model.**

**3.2 The Prevention Advisory Board should make recommendations using a combination of targeted and universal prevention strategies.**

Commentary:

Not all families who demonstrate a level of risk need intensive services. To implement a comprehensive system of services that meet the varying needs of families and targets funding in the most effective manner, the Prevention Advisory Board should recommend a combination of both targeted services for higher-risk families who need more intensive services, in addition to primary or universal prevention messaging that are beneficial to all families. These “lighter touch” protective factors may include universal messaging on safe infant sleep, reducing drowning or hot-car risks, as well as the availability of a hotline for help in dealing with an incessantly crying infant that resists soothing. See Appendix A for a variety of both universal and targeted prevention services currently in and out of Texas.

**3.3 The Legislature should continue consolidation of child abuse prevention programs under DFPS, especially those serving duplicate targeted populations to improve service coordination.**

Commentary:

Traditionally, child abuse prevention programs have been implemented by Health and Human Services Commission (HHSC), DSHS or DFPS. The Legislature should take steps to ensure that these programs are administered through one agency to avert duplicative overhead costs and to more effectively coordinate critical services to high risk Texas families.

**3.4 While allowing for investment in promising practices, the Legislature should concentrate investment in evidenced-based strategies and discontinue prevention programs which fail to show measurable outcomes.**

Commentary:

Texas’ expenditures on preventing child abuse fatalities should be concentrated in programs that are evidence-based according to randomized controlled trials. Ongoing assessment is necessary as studies emerge on efficacy of various programs. Programs that are innovative and have yet to attain the evidence-based level of efficacy, but which show positive outcomes in less rigorous research methodologies such as pre and post testing, are also worthy of investment, to the extent they have research demonstrating promise of effectiveness across a broad demographic or population. Programs that lack any evaluation need not be entirely discounted and may be best suited for evaluation funding. If after evaluation, programs are found to be ineffective, government resources should be re-directed to programs with higher levels of proven effectiveness. Ratings of efficacy must be continually updated based on the latest research findings. See Appendix A for a list of prevention programs in Texas with ratings denoting the evidence level for each program.

**3.5 The Prevention Advisory Board should consider evidenced-based and promising practices for prevention programs and parent education programs as defined by Govt. Code, Sec. 1, Chapter 531, in structuring child abuse fatality prevention programming accountability and evidence-based measures.**

Commentary:

In 2013, the Texas Legislature passed SB 426, the Home Visiting Accountability and Expansion Act that amended Chapter 531 of the Texas Government Code to define the terms “evidence-based” and “promising program”, as well as identifying the impact outcomes or goals, which programs must achieve.<sup>42</sup> A similar bill was passed in the 84<sup>th</sup> Legislature for parent education programs. Both are good models that the state can utilize in structuring and measuring the effectiveness of child abuse fatality prevention programming.

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*“Prevention is so much cheaper than intervention and treatment.”*

*Julie Evans, Executive Director, Alliance For Children*

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**3.6 The Prevention Advisory Board should research and make recommendations regarding the training of external stakeholders to identify, recognize, report and prevent child physical maltreatment and neglect, including expanded mandated training of medical professionals, child care workers, public and charter school staff, and higher education professionals with access to minors.**

Commentary:

Building upon Texas Education Code Sections 11.252 and 38.004, which mandated that all primary and secondary educational employees and childcare employees are trained in recognition, reporting and prevention of child maltreatment, the Legislature should explore training of medical professionals and staff to improve diagnosis, recognition and reporting of child maltreatment.<sup>43</sup> The legislature should also explore how the training of these “mandatory reporters” is recorded and reported to the legislature annually.

**3.7 The Legislature should fund CPS staffing to allow DFPS to explore the following:**

- a) **Identifying high-frequency incident areas;**
- b) **Concentrating staffing levels, lowering caseloads, increasing expertise and specializing training to service high-risk catchment areas;**
- c) **Designating specialized units or caseworkers to conduct child fatality investigations based on expertise/tenure; and**
- d) **Developing non-DFPS community partner strategies for early recognition, reporting and prevention of fatalities.**

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<sup>42</sup> Tex. Gov’t. Code § 531.983 (West 2015).

<sup>43</sup> Texas Educ. Code §§ 11.252, 38.004 (West 2015).

Commentary:

As noted above, risk terrain modeling technology allows identification of geographical areas that show high per capita incidents of child maltreatment over time. In addition to targeting prevention resources to these high risk catchment areas, DFPS might address these “hot spots” of maltreatment incidents and risks by exploring innovative staffing model approaches such as concentrating a higher number of staff with the most casework expertise in highest risk areas. DFPS may also consider reducing caseworker caseloads in high-incident areas similar to current CPS specialized staffing strategies related to intensive Family Based Safety Services, substance abuse, and family violence. Where feasible, DFPS should consider expanding specialized units to investigate child fatalities, such as those currently co-located with Children’s Advocacy Centers.

**4. The State should make better use of the work of the State Child Fatality Review Team (SCFRT).**

Commentary:

The SCFRT was statutorily-created in 1995 to develop strategies to improve child death data collection and analysis, to develop position statements on child safety issues, and to research and develop a report every two years with recommendations for the Texas Legislature, CPS, DSHS, and local CFRTs. The SCFRT recommendations are created by experts in child fatality review and the SCFRT is a valuable source of information on child fatalities in Texas.

**4.1 The Legislature should amend Section 264.502 of the Texas Family Code to provide that the Speaker of the House, the Lieutenant Governor, and the Governor shall each appoint a liaison to serve on the SCFRT.**

Commentary:

The Texas Family Code Section 264.502 (a) mandates that the state registrar of vital statistics, the DSHS Title V Director, and the DFPS Commissioner shall serve as permanent SCFRT members.<sup>44</sup> This section should be amended to include legislative liaisons.

**4.2 The Commissioner of DFPS should appoint the Chair of the SCFRT to serve as a standing member of the DFPS Prevention Advisory Board.**

Commentary:

These strategies set out in 4.1 and 4.2 will help institutionalize a stronger connection between the SCFRT, the Legislature, and DFPS and, thereby, bring greater awareness to the work of the SCFRT.

**5. The State should better support local Child Fatality Review Teams to ensure coordination, training, and consistency.**

Commentary:

Local child fatality review teams are volunteers from many specialties and agencies who conduct retrospective reviews of child deaths in their respective regions. The teams may meet quarterly, monthly or as needed. Some CFRTs review all child deaths, while others focus on non-natural deaths. In 2013, there were 73 active CFRTs covering 200 of Texas’ 254 counties, and 94 percent of Texas children lived in a county where child deaths are reviewed. A total of 3,625 children died in Texas in 2011. Of that number, there were 3,296 child deaths that corresponded to counties with CFRTs, yet only 54.2 percent of the 3,296 child deaths were reviewed and

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<sup>44</sup> Tex. Fam. Code § 264.502(a) (West 2015).

documented. The SCFRT in its last report recommended that all Texas counties participate in child fatality review and that 100 percent of child deaths be reviewed and recorded to fully understand the circumstances and risks leading to a child death, identify trends, and implement effective prevention activities.<sup>45</sup>

**5.1 The Legislature should fund Child Fatality Review Team Coordinators for each of the eleven Department of State Health Services (DSHS) Regions.**

Commentary:

In addition to attending meetings, the volunteer members of the CFRTs gather, review, and enter the child death data, often outside of normal work hours and without any support. The individuals that serve on child fatality review teams are to be commended for their work and should be supported in a manner that allows these teams to better identify and gather information that will improve intervention and prevention strategies to reduce child maltreatment deaths. One full-time employee in each of the eleven DSHS Health Regions serving as a staff member to support the local CFRTs would dramatically impact the effectiveness and consistency of the CFRTs' work by providing meeting coordination, training, and data entry assistance. Regional support could also help to ensure that counties without current CFRT coverage can join an existing CFRT or become part of a new CFRT. (See Appendix C). Three critical goals would be met: (1) regions with rural teams would receive more technical assistance and coordination of multiple teams; (2) regions with urban teams would receive assistance to work the high volume of cases; and (3) the state would gain more complete, consistent and meaningful data for preventing child fatalities. This recommendation echoes the SCFRT recommendation in its last report "that DSHS continue to promote and support the development of CFRTs in counties without teams and to focus on promoting more robust data collection, review, and entry by the local CFRTs."<sup>46</sup>

**5.2 The Legislature should fund DSHS to improve CFRT training, coordination, data entry, and technical assistance to provide greater team consistency and alleviate the demands on volunteer team members.**

Commentary:

The child fatality review process is overseen and supported by DSHS in various ways. A State CFRT Coordinator, employed by DSHS through the Division for Family and Community Health Services, in the Office of Title V and Family Health, supports the SCFRT in its quarterly meetings and activities and provides support and training to the local teams. The SCFRT Coordinator works to create processes and procedures for effective reviews and data collection. Also, DSHS staff provides analysis and interpretation of the CFRT-collected child death data. DSHS has developed a statewide conference for CFRT members and injury prevention professionals to keep current with the process, research, and best practices in injury prevention and the prevention of child deaths.<sup>47</sup> DSHS also conducts regional trainings with local CFRTs that focus on collecting data, conducting reviews, and implementing effective injury prevention activities at the local level. Local Children's Advocacy Centers may be an additional resource to assist with CFRT work.

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<sup>45</sup> SCFRT 2013 Annual Report, *supra* note 20.

<sup>46</sup> *Id.* at 45.

<sup>47</sup> *Id.*

**5.3 The Legislature should amend the Code of Criminal Procedure Sections 49.10 (i) and 49.25 to eliminate “limited autopsies” for children younger than six years of age and require complete autopsies for children subject to inquest under Chapter 264 of the Texas Family Code.<sup>48</sup>**

Commentary:

Currently, the death of any child under the age of six is required to be immediately reported to the medical examiner or, in counties without a Medical Examiner, a Justice of the Peace (JP).<sup>49</sup> An exception under the Texas Family Code to this requirement is when the death is a result of a motor vehicle accident.<sup>50</sup> A reportable death requires the JP or Medical Examiner to conduct an inquest, which is an investigation into the cause and circumstances of a death and a determination as to whether the death was caused by an unlawful act or omission.<sup>51</sup> Exceptions to the autopsy requirement include expected deaths due to a congenital or neoplastic disease or a death caused by an infectious disease.<sup>52</sup> Under certain circumstances, consent for an autopsy is not required, and objections to an autopsy do not apply to required autopsies.

Texas Code of Criminal Procedure, Article 49.01, defines “Autopsy” as “a post mortem examination of the body of a person, including X-rays and an examination of the internal organs and structures after dissection, to determine the cause of death or the nature of any pathological changes that may have contributed to the death.”<sup>53</sup>

Article 49.10(i) of the Code of Criminal Procedure is leading some JPs to interpret the required depth of autopsy differently. Article 49.10 (i) permits a JP to forego a “complete autopsy” and order analysis of only “body fluids, tissues, or organs in order to determine the nature and cause of death.” In other words, the JP has some discretion in determining if a complete autopsy is necessary. The POK Commission found evidence that several JPs interpret this statute to mean that the limited autopsy allowed by Article 49.10 is an acceptable autopsy even though it is not a “complete autopsy.” Medical Examiners have the same discretion to order a limited autopsy in Article 49.25, Section 9(A).<sup>54</sup> Both sections should be amended to be eliminate the limited autopsy exception for children subject to inquest under Chapter 264 of the Texas Family Code.

Some Texas counties have difficulties funding the cost of complete autopsies for children. Depending on the complexity, autopsies for children typically cost around \$2,500 to \$4,000. Sudden Infant Death Syndrome (SIDS) cases may be more expensive if genetic testing is required. However, counties may be reimbursed up to \$500 for the cost of an autopsy performed where the primary cause of death is SIDS.<sup>55</sup> There are two problems with this reimbursement statute: (1) “SIDS” is an outdated term that is rarely used today. Many jurisdictions do not qualify for reimbursement for cases of sudden unexplained infant death because of this limited and outdated terminology; and (2) \$500 is a fraction of the cost. Funding restraints have led to some counties using private contractors rather than the

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<sup>48</sup> Tex. Code of Crim. Proc. §§ 49.10(i), 49.25 (West 2015).

<sup>49</sup> Tex. Fam. Code § 264.513 (West 2015).

<sup>50</sup> *Id.*

<sup>51</sup> Tex. Fam. Code § 264.514; Tex. Code of Crim. Proc. § 49.01(2) (West 2015).

<sup>52</sup> Tex. Fam. Code § 264.514 (West 2015).

<sup>53</sup> Tex. Code of Crim. Proc. § 49.01(1) (West 2015).

<sup>54</sup> *Id.* at § 49.25 9(A) (West 2015).

<sup>55</sup> Tex. Admin. Code Title 25, Part 1, Chapter 37, Subchapter H Rule 37.173 (West 2015).

Medical Examiners' offices which has made consistency more challenging.<sup>56</sup> Other states have addressed this issue with legislation mandating protocols for autopsies of children under the age of three for pathologists who are not certified by the American Board of Pathology in Forensic Pathology and who are providing autopsy services to coroners and Medical Examiners.<sup>57</sup>

#### **5.4 The Legislature should set standards for required training and increase funding for Justices of the Peace and Medical Examiners specifically related to inquests, particularly for child deaths.**

Commentary:

JPs receive 80 hours of initial training upon taking office with four hours related to inquests. After that, no training is required on inquests or child death investigations. Required periodic training and funding for these trainings would create opportunities for education on important aspects of child death investigations such as: 1) medical information for first responders; 2) the importance of forensically competent death scene investigating; 3) community resources to assist families; and 4) the value of timely communication between the Justices of the Peace, coroners or Medical Examiners and the public health department.

The CDC states: "By definition, Sudden Infant Death Syndrome (SIDS) should be used as a cause of death only after a thorough examination of the death scene, a review of the clinical history, and performance of an autopsy fail to find an explanation for the death. Yet, we know that some Sudden Unexplained Infant Death (SUID) cases are not investigated and, when they are, investigation data are not collected and reported consistently."<sup>58</sup>

The CDC has developed protocols for death scene investigations of sudden unexplained deaths of children under the age of three. States such as California, New Jersey and Washington have mandated that the CDC or similar protocols be developed and applied.<sup>59</sup> One tool in the CDC protocol is the Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF). It was designed to assist investigative agencies to better understand the circumstances and factors contributing to unexplained infant deaths. The SUIDIRF is important for several reasons:

- Contains 25 questions that Medical Examiners and coroners should ask before beginning an autopsy.
- Guides investigators through the steps involved in an investigation.
- Allows investigators to document their findings easily and consistently.
- Improves classification of SIDS and other SUIDs by standardizing data collection.
- Produces information that researchers can use to recognize new health threats and risk factors for infant death so that future deaths can be prevented.<sup>60</sup>

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<sup>56</sup>Texas Children's Justice Act Three Year Assessment, *supra* note 38 at 46.

<sup>57</sup>Wash. Rev. Code Ann. §43.103.100 (2011).

<sup>58</sup>Center for Disease Control, <http://www.cdc.gov/sids/trainingmaterial.htm> (last visited Oct. 26, 2015).

<sup>59</sup>NAT'L DIST. ATTORNEYS ASSOC., NAT'L CENTER FOR PROSECUTION OF CHILD ABUSE, *Autopsies in Child Death Cases* (2011).

<sup>60</sup>CDC website, *supra* note 58.

**5.5 Local CFRTs should consider recruitment of members that reflect the diversity of the community and consider issues of disproportionality in child fatalities.**

Commentary:

To better understand the complex dynamics involved in any child fatality, particularly the diverse experiences a community's members, CFRTs would benefit from participants that reflect the diversity of the community in terms of race, class, and experience.

According to the DFPS March 15, 2015 Report, children of Hispanic heritage represent the largest percentage of child abuse and neglect fatalities in Texas. However, the child per capita rate of fatal abuse/neglect for African American children is disproportionately higher compared to their overall representation in the Texas child population. See Appendix E for the per capita rates by ethnicity for confirmed child abuse or neglect fatalities.<sup>61</sup> Nationally, more than 85 percent (86.8%) of child fatalities were composed of children from White (39.3%), African-American (33.0%), and Hispanic (14.5%) descent. Using the number of victims and the population data to create rates highlights some racial disparity. The rate of African American child fatalities (4.52 per 100,000 African-American children) is approximately three times greater than the rates of White or Hispanic children (1.53 per 100,000 White children and 1.44 per 100,000 Hispanic children).<sup>62</sup>

HHSC is actively working with state and federal agencies, universities, private groups, communities, foundations, and offices of minority health to decrease or eliminate disparities among racial, multicultural, disadvantaged, ethnic, and regional populations.

**6. The State should ensure that all Texas counties have a Child Fatality Review Team.**

**6.1 The Legislature should amend Section 264.505 of the Texas Family Code to allow adjacent counties of any population size to form joint CFRTs and require each county to participate in a CFRT.**

Commentary:

Currently, the Texas Family Code states that a county with a population of less than 50,000 may join an adjacent county or counties to establish a CFRT. Appendix C is a map showing the Texas counties currently without CFRT participation. The SCFRT made the following recommendation in their 2013 Report: "promote and support work towards the goal that all Texas counties have an independent CFRT or participate in a multi-county CFRT to review and document all deaths of children less than 18 years of age."<sup>63</sup>

**7. The State should expedite the CFRT case review process.**

Commentary:

Currently there are many obstacles in the child fatality review process including: (1) local policy that ongoing criminal cases will not be discussed until a criminal case is fully resolved; (2) delayed autopsy results; and (3) delayed receipt of death certificates by the CFRTs.

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<sup>61</sup> A Better Understanding, *supra* note 2 at 4, 16.

<sup>62</sup> U.S. DEP'T OF HEALTH & HUMAN SERVICES, ADMIN. FOR CHILDREN YOUTH AND FAMILIES, Children and Maltreatment 2013 56 (2013) available at <https://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf>.

<sup>63</sup> SCFRT 2013 Annual Report, *supra* note 20 at 45.

**7.1 CFRT members designated by Section 264.505 of the Texas Family Code should actively participate in their local CFRTs and timely provide necessary information.**

Commentary:

Some Texas counties have local policies that law enforcement and prosecutors are not to discuss cases at child fatality review meetings if there is an ongoing criminal case. This Commission urges the Legislature to clarify that all CFRT members should fully participate in their local teams in a timely manner to allow the fatality review process to be the most effective in preventing child fatalities.

**7.2 The Legislature should require for child autopsies that Medical Examiners' Offices follow professional standards issued by the National Association of Medical Examiners regarding timeliness and appropriately fund the offices so they have adequate resources to meet timeliness standards for all autopsies.**

Commentary:

The National Association of Medical Examiners (NAME) began promulgating practice standards in the 1970s, resulting in protocols such as the Accreditation Checklist, a tool used in the peer review system to improve office or system performance through objective evaluation and constructive criticism. In 2005, NAME also developed Forensic Autopsy Performance Standards, a framework that defines the fundamental services rendered by professional forensic pathologists.<sup>64</sup> These professional standards will improve timeliness and consistency of autopsies.

**7.3 The Legislature should amend Section 264.505 to require local registrars to create expedited processes to notify CFRTs of child deaths within 120 days.**

Commentary:

Some CFRTs obtain faster notification of child deaths by receiving notice from their local registrars rather than waiting up to a year to receive finalized death certificates from DSHS. Faster notification will help expedite the review process in many cases. In its last report, the SCFRT recommended “faster notification of child deaths by receiving notice from County Registrars instead of waiting to receive a death certificate from DSHS (this could be accomplished legislatively or by training on successful models).” From the same SCFRT report, “Delayed reviews preclude timely local prevention efforts to address identified risks for child injury and death and frustrate team members.”<sup>65</sup>

**7.4 The Legislature should require DSHS to allow CFRTs electronic access to preliminary death certificates in the new electronic registration system to be launched 01/01/2018.**

Commentary:

Certificates of Death are currently produced from the Texas Electronic Registrar (TER), a DSHS system that is older both in terms of technology and infrastructure. The Sunset Advisory Commission directed DSHS to replace TER with a new system that will be operational by 01/01/2018.<sup>66</sup> The POK Commission recommends that the new system should be designed to allow CFRTs direct access to preliminary death certificates.

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<sup>64</sup>THE NAT'L ASSOC. OF MEDICAL EXAMINERS, <http://www.thename.org/> (last visited 11/04/15).

<sup>65</sup> SCFRT 2013 Annual Report, *supra* note 20 at 45.

<sup>66</sup> SUNSET ADVISORY COMM'N, Staff Report with Final Results, DSHS (July 2015).

*Charge (2) part 2: Develop recommendations.... and identify resources necessary to reduce fatalities from child abuse and neglect for implementation by state and local agencies and private sector and nonprofit organizations*

- 8. The Prevention Advisory Board and DFPS should look for funding sources in addition to state general revenue, including federal and local government, and private funding streams to increase prevention programs.**

Commentary:

The Prevention Advisory Board and DFPS should continue to review the following prospective funding sources to maximize funding or matching opportunities for child abuse prevention programs through Temporary Aid or Needy Families (TANF), Maternal, Infant, and Early Childhood Home Visiting (MIECHV), Title V, Medicaid 1115 Waiver, Medicaid Texas Health Steps, the Child Abuse Prevention Trust Fund, Community Based Child Abuse Prevention (CBCAP), and other federal, state or local government funds. The State should also explore leveraging private foundation investments and other private funding shown in emerging innovative financing methods such as “Pay for Success” contracts. Such financing would allow the state to enter into contracts with private entities to scale up the most effective programs with measurable cost savings for taxpayers.

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

- 9. The State should evaluate currently available child fatality data resources (CPS and CFRT data) and develop strategies to include near-fatalities.**

- 9.1 The State should develop a more specific definition for the near-fatality designation to facilitate a more consistent appraisal by physicians.**

Commentary:

Because the near-fatality designation requires physician input, a more specific definition for “near-fatality” would improve consistency in how this designation is made. The Child Abuse Prevention and Treatment Act (CAPTA) definition of near fatality: “... an act that, as certified by a physician, places the child in serious or critical condition”<sup>67</sup> may be problematic in that “serious” (e.g., broken leg) injuries and “critical” (requiring life-saving measures) injuries are not typically equivalent and not further defined in the CAPTA definitions. To achieve useful data, an elaborated definition that is generally clear and acceptable to most physicians should be developed. For example, a near fatality could be considered an injury or condition that would have likely resulted in the death of the child had they not received life-saving medical intervention such as CPR. In addition, DFPS should develop criteria for CPS investigative workers indicating which cases require physician assessment for near-fatality designation. DFPS, in partnership with several child abuse pediatricians, has recently developed more detailed guidance for both DFPS staff and medical professions to use to support a consistent definition and identification of a near-fatality, which it will release to field staff in December 2015.

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<sup>67</sup> The Child Abuse Prevention and Treatment Act P.L. 93-247, 42 U.S.C. §§ 2(b)(6)) (1974), as amended by Pub. L. No. 111-320, the CAPTA Reauthorization Act of 2010 *available at* <http://www.acf.hhs.gov/sites/default/files/cb/capta2010.pdf>

**9.2 The State should expand current combined database to include near-fatalities, where child maltreatment is determined by CPS to have caused the near-fatality.**

**10. The Legislature should extend the types of data tracked to enhance research and understanding.**

This recommendation is supported by the work of the Sunset Advisory Commission. From its Staff Report on DFPS:

*CPS Does Not Capture Comprehensive Information to Adequately Address How Well It Is Protecting Children.*

*DFPS needs accurate and complete data to evaluate the effectiveness of CPS interventions in addressing child abuse and neglect. Identification of trends can guide CPS practices and policies, because they help the agency evaluate and improve its decision-making to keep children safe in future cases. . . Capturing a broader spectrum of information and analyzing it in a more meaningful way would allow the agency to evaluate its performance in a more holistic manner and better target its limited resources to services that are most successful at preventing future child abuse or neglect.<sup>68</sup>*

**10.1 DFPS should track and analyze the following specific types of CPS data in a manner that will enable further research to reduce recurrence and create predictive analytics:**

- a) **Prior contact with CPS including number of referrals and disposition of each prior referral, including:(a) Priority None or Administrative Closure (call screened out), (b) Alternative Response provided, (c) Investigated and ruled Unable to Complete, Unable to Determine, Ruled Out, or Reason to Believe.**
- b) **Disposition of Reason-To-Believe (RTB) cases resulting in (a) referral to family-based services, (b) inclusion of a safety plan, (c) services were offered to family, types of services and compliance/completion, and (d) removal of the child.**

Commentary:

Support efforts to prolong the length of time records are maintained by CPS, such that Reason-to-Believe with removal, Reason to Believe with Disposition of RTB for Sustained Perpetrator, Reason-to-Believe without a removal, Unable to Determine, Unable to Complete, and Ruled Out with risk factors indicated, and Ruled Out with risk factors controlled case records are retained by CPS for 50 years, 20 years, 20 years, 5 years, and 5 years, respectively, following case closure. Retaining records for DFPS' exclusive use will allow the department to identify repeat referrals that may go undetected under current record retention schedules, and will improve safety measures and provisions in subsequent referrals and investigations. Tracking data regarding services families are referred to and whether those services were utilized and their efficaciousness will inform future compliance monitoring, discontinuation of ineffective interventions and expansion of effective interventions that have shown to reduce child fatalities in reunification and family preservation cases.

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<sup>68</sup> Staff Report DFPS, *supra* note 24 at 5.

**11. DSHS and DFPS should determine how to better use available data to inform a public health approach to preventing child fatalities and continue to support the work already underway in the "Strategic Plan to Reduce Child Abuse and Neglect Fatalities."**

Commentary:

In the "Strategic Plan to Reduce Child Abuse and Neglect Fatalities," data was combined from DFPS, DSHS, birth records, death records and community-level risk indicators, providing a broader view of child fatalities that is child-centric and focused on preventable deaths, consistent with a public health approach. In addition, specific focus areas for intervention are identified and action plans are elaborated based on identified areas of need. This report represents a commendable step forward in understanding why children die in Texas. Recommendations to enhance this data base are provided below.

The separate data bases maintained by DSHS and DFPS are still useful for tracking trends over several years and should continue to be reported every year. Most children dying of child maltreatment are under three years of age. There are two primary safety nets these children may encounter prior to their death: health care system and day care settings. Current and future databases should incorporate information about medical care and daycare use by these children and their caretakers to evaluate opportunities for enhanced detection, intervention, and/or reporting to CPS prior to death.

While the data from the DFPS-Child Fatality Review Data (DFPS-CFR), birth records, death records, and community-level risk indicators (for example, concentration of poverty, education levels, or mobility), have provided significant areas to address child maltreatment fatalities, additional sources of data can provide for a richer analysis and collaboration between a variety of agencies and stakeholders. Additional data elements should include healthcare system involvement, daycare utilization, utilization of prevention services, and law enforcement data. Examples of additional data elements include:

**1) Health care and child care services used or accessed by families with child fatalities occurring during the child's first three years of life.**

The DFPS/DSHS Strategic Plan describes WIC enrollment among families with child maltreatment fatalities. Accessing additional sources of data, such as the Texas Health Care Information Collection (THCIC), Early Childhood Intervention (ECI), immunization registry, and data from Medicaid to determine whether and when such services were accessed by families with child maltreatment fatalities would enhance understanding of opportunities to intervene and prevent child fatalities. Infants and children with disabilities and compromised health, including prematurity and low birth weight are at greater risk for fatal maltreatment, and may be accessing health care more frequently than low-risk children. In addition to health services accessed on behalf of infants and children, maternal health services accessed in the perinatal period may provide opportunities to identify family violence and mental illness contributing to child risk. Currently, there is no reliable method to track use of day care by families with young children, although this data is sometimes collected by DFPS investigators, mechanisms to record and track this data should be explored. One study found that young children living in a home with an unrelated male were 50 times more likely to die than children living in homes with two biological parents. The role for protective day cares for at-risk families may be further elucidated if this data is collected and analyzed.

**2) Law enforcement data involving violent and drug-related crimes among family members of young children.**

This information is generally accessed by DFPS, but mechanisms for consistently recording and tracking law enforcement data should be explored. The purpose of gathering this data would be to determine whether children should be further assessed (medically or otherwise) when certain types of crimes are reported among adults in the household.

**3) Utilization of preventive programs, particularly home visitation programs that are 1) offered but not utilized by at-risk families, 2) offered, utilized, but ended prematurely, 3) offered and utilized by at-risk families and 4) not offered/not utilized by at-risk families. These would include DFPS/PEI services, CPS Family Based Safety Services, and home visitation programs (tracked by DSHS and/or DFPS). The goals of collecting this data are to determine capacity for preventing child fatalities and to establish what barriers prevent families from utilizing or accessing these services.**

To improve consistency of data collected and allow for real-time data analysis, the elements identified for this robust data analysis should be automated by their respective agencies and available for ongoing comparison.

## CONCLUSION

The leaders of the State of Texas appointed experts to the POK Commission to make recommendations about reducing child fatalities due to abuse or neglect. The members of the POK Commission donated their time and resources to study, examine, and research this tragic problem and offer solutions. It is now incumbent on state leaders to undertake the responsibility to invest the resources of the state to prevent fatalities.

The members of the POK Commission strongly believe that child fatalities are preventable. Texas children should be allowed to grow up in safe, loving environments. Texas must establish a commitment at the highest levels to focus on child abuse and neglect fatalities. By improving the exchange of information across databases, strengthening the ways our communities review child fatalities, and using that information for earlier intervention, Texas can provide that protection to its children.

The recommendations contained in this report provide a guide for the changes and improvements needed for a safer Texas. To move these recommendations beyond the page, it is imperative that they receive Legislative and Executive Branch support, because only then can Texas say it has done everything possible to Protect Our Kids.

APPENDIX A

	Age Range of Children	Target Population/ Eligibility Criteria	Service Intensity/ Duration	Brief Descriptor of Program Goals/Curriculum/Outcomes	In Texas? Families Served <sup>i</sup>	Currently funded by PEI or other state agency?	Cost/client	Levels of Evidence Support					
								Cost Benefit: ROI <sup>ii</sup>	Blue Prints <sup>iii</sup>	OJDP <sup>iv</sup>	CEBC <sup>v</sup>	UofH EBP Score <sup>vi</sup>	Other Endorsements
<b>Prevention Programs in Texas</b>													
<b>Community-Based Child Abuse Prevention (DFPS)</b>	All	Parents of children of all ages	n/a	Goal is to urge parent to use prevention services in their communities and to strengthen prevention efforts in communities. Services include respite, education of caregivers, home visiting, and father services. Uses Help for Parents, Hope for Kids campaign.	Yes-837 in 2014 <sup>vii</sup>	Yes-PEI	\$2.3 million appropriated for year 2015 <sup>viii</sup>	n/a	n/a	n/a	n/a	n/a	n/a
<b>Exchange Parent Aide (HV program)</b>	Birth to 12	Families with children ages birth to 12 who are considered at risk for abuse and/or neglect	1-2 weekly home visits continuing for at least one year	Goal is to replace patterns of abusive behavior with effective skills for nonviolent parenting; reduce child abuse and neglect. No specific curriculum; services are family-centered and focus on child safety, problem solving skills, parenting skills, and social support.	50 in 2013 <sup>ix</sup>	No	\$3,000 annual cost per family <sup>x</sup>	n/a	n/a	n/a	Rating: 3	n/a	n/a
<b>Family Connections (HV program)</b>	Birth to 17	Families at risk for child maltreatment with children from birth to 17	At least one hour per week for at least three months	FC is a multifaceted, community-based service program that works with families in their homes and in the context of their neighborhoods to help them meet the basic needs of their children and prevent child maltreatment. Nine practice principles guide FC interventions: ecological developmental framework; community outreach; individualized family assessment and tailored interventions; helping alliance; empowerment principles; strengths-based practice; cultural competence; outcome-driven service plans with SMART goals; and a focus on the competence of the practitioner. Individualized family intervention is geared to increase protective factors, decrease risk factors, and target child safety, well-being, and permanency outcomes. At least one study has found fewer substantiated and unsubstantiated reports of CA/N; at least two studies have found improvement in safety of environment.	Yes	No	\$1,466 per family (\$8,035 when administrative costs included) <sup>xvi</sup>	n/a	n/a	n/a	Rating: 3	n/a	n/a

Nurse-Family Partnership (HV program)	Prenatal to age 2	Low-income, first-time moms willing to receive a home visit by the end of the 28th week of pregnancy	Approximately 64 home-visits for 60-75 minutes (weekly, every other week, then monthly)	Goals are (1) Improve: (a) pregnancy outcomes, (b) child health and development, and (c) economic self-sufficiency of the family, (2) Reduce domestic violence, (3) Promote father involvement. Visit-by-visit guidelines available, but nurses use variety of developmental screening and diagnostic tools to tailor program to fit unique needs of family. Outcomes in child abuse and neglect reduction.	2850 in 2013 <sup>ix</sup>	Yes-HHSC NFP and THVP	\$4,100 average annual cost per family <sup>xiii</sup>	Pacific Institute estimates: Net savings per child, through age 5: \$3,270 and age 9: \$8,036	Model	Exemplary	Rating: 1	33 [YWCA of Metropolitan Dallas]	NREPP-SAMHSA-3.5 (for child maltreatment) <sup>xi</sup>
								5: \$3,270					
								9: \$8,036					
												Crime Solutions rating-Effective; Promising Practice Network rating: Proven <sup>xiv</sup>	
Nurturing Parenting Program (HV program)	Birth to 18	Parents and children- target all families at risk for abuse and neglect with children ages 0-18	Sessions runs 2 to 3 hours once a week for 12 to 45 weeks. Programs can be implemented in groups or home sites. Program features activities to foster positive parenting skills and self-nurturing, home practice exercises, family nurturing time.	Targets families with children birth to age 18 who are at risk for child abuse or neglect. There are two general Nurturing Parenting Programs that specifically target children birth to age 5 and that can be delivered primarily in the home: (1) Nurturing Program for Parents and their Infants, Toddlers and Preschoolers and (2) Nurturing Skills for Families Program. In both, home visitors engage in activities to promote positive parenting skills, self-nurturing, and child brain development. Goals are: Decrease level of new offenses, increases level of self esteem, improve level of family bonding, improve parent-child communication. Increase level of problem solving/conflict resolution skills, increase knowledge regarding parenting, and decrease level of family violence. Outcomes: Positive change in parenting and child-rearing attitudes of parents: expectations more appropriate, increased empathic awareness of child's needs, decreased use of corporal punishment and decrease in parent-child role reversal.	778 in 2013 <sup>ix</sup>	No	\$1,072 to \$1,597 per caregiver <sup>xv</sup>	Benefit-cost ratio is at least .87 <sup>xv</sup>	n/a	n/a	Rating:3 (for children 5-12)	n/a	NREPP-SAMHSA 2.9-3.2
Healthy Families America (HV program)	Prenatal to age 5	Recruited prenatally or soon after birth; other requirements site specific (e.g., low-income)	Weekly home visits until child is at least 6-months- old; then home visits occur less often until child is age 3 to 5	Goals are: (1) Build and sustain community partnerships to engage overburdened families, (2) Strengthen parent-child relationship, (3) Promote child health and development, (4) Enhance overall family functioning by reducing risk and increasing protective factors. Site not required to use a specific curriculum, but must use some research-based curriculum.	643 in 2013	No	\$3,214-\$3,892 annual cost per family <sup>xvi</sup>	Women in NY returned of \$0.15 for every dollar invested; women in the highest risk group (RRO) produced a \$3.16 return per dollar; <sup>xvii</sup> WSIPP estimates: Long-term net loss of \$2,011 after accounting for costs; \$0.56 return per dollar	n/a	Effective	Rating: 1 (child well-being); 4 (prevention of CA/N)	29 [HF San Angelo, Inc; Parenting Center], 26 HFA	Crime Solutions rating-Promising; Promising Practices-Proven [HF New York]

<b>Parenting Awareness and Drug Risk Education (PADRE; TX DSHS Program)</b>	All ages, including prenatal	Fathers with a child under 6, referred by DFPS	15-week parenting group plus case management	Goals is to help fathers become well-equipped to handle parenting. Curriculum includes a fatherhood group and case management to address unique needs, referrals, crisis management, and parenting skills.	Yes; Nine sites in FY 2014 <sup>xviii</sup>	Yes, DSHS	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
<b>Period of Purple Crying</b>	Newborn infant	Prior to hospital discharge; parents of newborns	Curriculum includes: 10 min. DVD and ~5 min. follow-up conversation with medical personnel; DVD and brochure then provided to caregivers to take home and share with others	Goals are (1) Reduce child abuse, especially incidents of Abusive Head Trauma (AHT), (2) Reduce caregiver frustration due to excessive crying, (3) Increase caregiver knowledge of AHT and Shaken Baby Syndrome (SBS). Curriculum disbursed in three doses. Dose 1: Initial caregiver education, provided at hospital/birthing facility; Dose 2: Reinforcement through home visiting, physicians and public health practices; Dose 3: Media campaign on Shaken Baby Syndrome and Abusive Head Trauma.	Yes - Currently trying to implement statewide through budget rider in 84th. Currently operating in approximately 40 hospitals statewide <sup>xix</sup>	No	\$4.50 per family <sup>xx</sup>	n/a	n/a	n/a	Rating: 3	n/a	n/a	
<b>Parents as Teachers (HV program)</b>	Prenatal to kindergarten entry	Sites can determine specific eligibility requirements for enrollment	At least 12 home visits annually; families with 2 or more high need characteristics receive 24 visits for at least two years	Goals are: (1) Increase parent knowledge of early childhood development and improve parenting practices, (2) Provide early detection of developmental delays and health issues, (3) Prevent child abuse and neglect, (4) Increase children's school readiness and school success.  Curriculum includes: Personal visit plans, Guided planning tools, Individualization for families, Toolkit to facilitate interactions.	6968 families in 2013 <sup>ix</sup>	Yes-HHSC Texas Home Visiting Program	\$2,652 average annual cost per family <sup>xxi</sup>	WSIPP estimates: \$765 benefits minus costs, \$1.18 benefit to cost ratio	n/a	No	Rating: 3	29 [Family Care Connection] also 25, 26	Promising Practices Network rating: Promising	
<b>Positive Parenting Program (Triple-P) (HV component)</b>	Birth to 16	Parents or caregivers of a child ages birth to 9-16 (depending on location) who are at risk for child maltreatment	Varies depending on needs of family; Home visits may consist of one consultation to more than 10 visits	Goals are: (1) Promote: (a) family independence and health, (b) non-violent, protective and nurturing environments, and (c) child development, growth, health and social competencies, (2) Reduce child abuse, mental illness, behavior problems, delinquency and homelessness, (3) Enhance parent competence, resourcefulness and self-sufficiency. Flexible curriculum offered at five different levels of intervention; Services may be delivered individually, face-to-face, in group meetings, with telephone assistance, or self-directed	195 in 2013 <sup>ix</sup>	No	\$5,306 average total cost per family <sup>xxii</sup>	PPP pays for itself by averting .5% of child conduct disorder; total cost savings of \$12,466,502 projected for Houston pilot; Rate of ROI: 8%; <sup>xxiii</sup> WSIPP estimates: Long-term net return of \$722 per person; \$6.06 return per dollar	Promising	Effective	Rating: 1	n/a	NREPP-SAMHSA Rating 2.9-3.0; Crime solutions rating: Effective; Promising Practices Network Rating: Promising	
<b>The CenteringPregnancy and CenteringParenting Models</b>	Pregnancy Model: Prenatal; Parenting Model: Postpartum and infancy	Pregnancy Model: Pregnant women; Parenting Model: Mothers of Infants	Pregnancy Model: Ten sessions; Parenting Model: Eight to nine sessions. Overall 12-24 months for combined programs	Both models emphasize assessment, education, and support in order to empower women to make healthy lifestyle choices for themselves and their babies. Women are placed in small groups; the Pregnancy model groups women according to gestational age.	In Texas, 32 CenteringPregnancy sites, 1 CenteringParenting site <sup>xxiv</sup>	No	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
<b>Post-Partum Pregnant Intervention Program (PPI) (TX DSHS program)</b>	Prenatal to infancy	Pregnant and postpartum women of all ages who have a risk factor of substance abuse	Varies	Goals are to reduce fetal and infant exposure to alcohol and substance use and to encourage a healthy lifestyle for mothers. Services include substance abuse assessment, counseling, referrals, home visits, individual and group crisis counseling, and education in reproductive health, child development, family violence prevention, and parenting.	19 programs as of 2014 <sup>xxv</sup>	Yes-DSHS	n/a	n/a	n/a	n/a	n/a	n/a	n/a	

<b>Parenting Wisely</b>	3-18 years	Children in homes and children in residential care; Ages 3-18	n/a	CBCAP-Easy to use, affordable, interactive parenting skills education programs. Interactive CD-ROM, evidence based VHS and DVD's, online training, and a variety of parent education programs to address the needs of parents at all stages. Outcomes-Eyberg Child Behavior Inventory, the Parent Daily Report, Beck Depression Inventory, Child Behavior Checklist. reduced family violence, improved impulsive and hyperactive behavior, improved parental communication and problem solving skills, increases in knowledge of good parenting principles and skills.	14 programs in TX in 2012	Yes-PEI in 2012	n/a	n/a	n/a	Promising	Rating: 3	17 (Greater Port Arthur Chamber of Commerce)	NREPP-SAMHSA 2.7 (parenting); Promising Practices Network: Other Reviewed Programs
<b>Project HOPES: Healthy Outcomes through Prevention and Early Support</b>	0-5	At-Risk Families	n/a	Project HOPES is a new effort that will contract with community-based organizations to provide child abuse and neglect prevention services that target families with children between 0-5 years of age. Contracts will be awarded in targeted counties and will include a home-visiting program component as well as other services that will meet the needs of the target county and should include collaborations between child welfare, early childhood education, and other child and family services. Goal is to prevent child abuse and neglect and strengthen families in the following six areas of protective factors: nurturing and attachment, knowledge of child development, parental resilience, social connections, concrete supports, and social and emotional competence.	Yes - began in 2014, in 8 communities: Cameron, Hidalgo, Ector, El Paso, Gregg, Potter, Travis, Webb <sup>xxvi</sup>	Yes-PEI	\$1.5 million total spent in FY 2014 <sup>xxvii</sup>	n/a	n/a	n/a	n/a	n/a	n/a
<b>Project HIP: Helping through Intervention and Prevention</b>	at birth	Families who have previously had rights terminated after 2008 and currently have an infant, families with a newborn who previously lost a child due to CA/N, foster youth who are pregnant or have a newborn of less than 4 months	n/a	Project HIP is a new effort that provides voluntary services to families that will increase protective factors and prevent abuse of infants. The program provides an extensive family assessment, home visiting programs that include parent education and basic needs support to targeted families. Eligible families are those who have previously had their parental rights terminated due to child abuse and neglect in year 2008 or later who currently have a newborn child, families who have previously had a child die with the cause identified as child abuse or neglect in year 2008 or later who have a newborn child, or current foster youth who are pregnant or who have given birth in the last four months	Yes - Began in 2014	Yes-PEI	\$1.4 million total spent in FY 2014 <sup>xxvii</sup>	n/a	n/a	n/a	n/a	n/a	n/a
<b>Parents Anonymous</b>	All ages	Everyone; All ages	1.5-2 hours per week; parents can attend as often as they wish	CBCAP-Support group that encourages parents to play active roles in the development of their children through support and educative knowledge. Parents meet in a group run by a PA facilitator. Parents practice new behaviors at home and discuss results in the group each week. The group is free, open-ended, and ongoing (once weekly). Children meet in a separate group involving activities and skills while parents are meeting. Outcomes-reduced child maltreatment, reduced risk factors, increased protective factors.	Yes	Yes-PEI in 2012	n/a	n/a	n/a	n/a	Rating: 3	18 [Children's Advocacy Center of Tom Green County] Also 11	n/a
<b>Parent-Child Interaction Therapy</b>	Ages 2 to 7	Children ages 2 to 7 who suffer from behavioral problems and parent-child relationship problems	Hour-long weekly sessions for an unlimited time, typically 14 weeks	Aims to restructure the parent-child relationship and provide the child with a secure attachment to the parent. Parents are treated with their children, skills are behaviorally defined, and all skills are directly coached and practiced in parent-child sessions. Therapists observe parent-child interactions through a one-way mirror and coach the parent using a radio earphone. Live coaching and monitoring of skill acquisition are cornerstones of the program. WSIPP reports statistically significant decrease in child abuse and neglect.	Yes	No	\$1,551 average total cost per family <sup>xxxi</sup>	WSIPP estimates: \$4.62 per participant benefit to cost ratio; \$5,617 total benefits minus cost per participant	Promising	Effective	Rating: 1	n/a	NREPP-SAMHSA 3.1-3.9; Crime Solutions Rating: Effective

<b>Structured Decision-Making</b>	Birth to 17	Families in child welfare system	Assessment only	Goal is to promote safety and well-being in children in welfare system while reducing subjectivity in assessments of cases. SDM is a systematic approach: Social workers use specific evaluation tools to make decisions for cases. WSIPP reports a statistically significant decrease in child abuse and neglect; In Michigan, a 12-month follow-up evaluation was done in 1995 to compare the outcomes for cases in SDM counties and non-SDM counties. The study showed that in counties using SDM, there were 27 percent fewer new referrals for treated cases, 54 percent fewer new substantiations, 40 percent fewer children removed from the home and placed in foster care, and 42 percent fewer child injuries warranting medical assistance--as compared to formerly treated cases in counties not using SDM.	Yes	Yes-CPS	n/a	n/a	n/a	Promising	Rating: 3	n/a	Crime Solutions Rating: Promising
<b>Safecare (Augmented) (HV program)</b>	Birth to age 5	Families at risk of with history of child abuse and/or neglect/birth to age 5	Weekly or biweekly home visits delivered over 15-18 weeks for 60-90 minutes each	Goals are to improve: (1) infant and child health care, (2) home safety, and (3) parent-child interactions, to prevent and address the factors associated with child maltreatment by targeting parents at risk for child abuse and neglect. Home visitors follow structured protocols that cover three modules –health, home safety, parent-child/infant interactions–each in 5-7 sessions.	PEI began program in 2014	Yes-PEI	\$6,263 average total cost per family (for general SafeCare program) <sup>xxviii</sup>	WSIPP estimates (for general Safecare program): Total benefits after costs is \$1,399; \$14.65 benefits per dollar	n/a	n/a	Rating: 2 [Safecare program], 3 [HV]	n/a	n/a
<b>24-7 Dads</b>	Birth to 17	Fathers and father figures of children from birth to age 17	Weekly 2-hour groups for 12 weeks	Goal is to teach parenting skills to fathers in order to change their attitudes, improve their knowledge and abilities, and increase their self-awareness, compassion, and responsibility.	PEI funding	Yes-PEI	Initial costs are \$399-650 per curriculum kit, \$3,999-\$4,999 to train a trainer; Materials are \$8 per family. (4)	n/a	n/a	n/a	Not Rated	n/a	n/a
<b>Safe Environment for Every Kid (SEEK)</b>	Birth to 5	Families at risk for child maltreatment with children from birth to age 5	Assessment of family at pediatric appointment; referral to outside care	Goals are to improve pediatric care, prepare professionals, identify families with risk factors for child maltreatment, strengthen families, support parents, promote child health and safety, prevent child abuse and neglect. Pediatrician is trained in identifying risk factors; assessment is completed at appointment.	Yes	No	\$5.12 per family <sup>xxix</sup>	n/a	n/a	n/a	Rating: 1	n/a	n/a
<b>Public Awareness Campaigns</b>													
<b>Help for Parents, Hope for Kids (DFPS Special Initiative)</b>	All	Parents of children of all ages	n/a	Child abuse prevention awareness campaign and website that directs parents to community resources for parenting skills, counseling, substance abuse recovery, jobs, child care, basic needs, family violence, and legal aid. Website also includes video testimonials of parents breaking the cycle of abuse. Goal is to prevent child abuse and neglect by reducing parents' stressors.	Yes	Yes-PEI	\$2.4 million campaign <sup>xxx</sup>	n/a	n/a	n/a	n/a	n/a	n/a
<b>Pool Safely (Consumer Product Safety Initiative)</b>	All	All users of pools and spas or those in the vicinity of them	n/a	Partners with various programs to distribute materials in order to prevent drowning by educating the public about pool safety.	Materials used in TX	Yes-PEI	n/a	n/a	n/a	n/a	n/a	n/a	n/a
<b>Room to Breathe (DFPS special initiative)</b>	Infants	Families and caregivers of infants; service providers to this population	n/a	Safe Sleep practice campaign to reduce sleep-related deaths in infants; includes training curriculum for service providers of families with infants and web resources.	Yes	Yes-PEI	n/a	n/a	n/a	n/a	n/a	n/a	n/a

<b>Safe to Sleep Campaign</b>	Infants	Caregivers, child care providers, and relatives of infants	n/a	Outreach activities in targeted communities to educate those who care for infants on reducing the risk of SIDS and other sleep-related causes of death. Since the beginning of the campaign, SIDS rates have declined by 50 percent.	Materials used in TX	Yes-PEI	n/a						
<b>Watch Kids Around Water (DFPS special Initiative)</b>	n/a	Parents, child care providers, and residential child care providers	n/a	Water safety campaign to prevent drownings; involves public service announcements and safety tips.	Yes	Yes-PEI	n/a						

**Out of State Programs**

<b>Homebuilders</b>	<b>Birth to 17</b>	Families with children at imminent risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities.; Ages birth-17	4-6 weeks of intensive services; therapist is available 24 hours a day for crisis intervention	Homebuilders is a brief service intervention for families where children are at imminent risk for removal. Goals are to reduce child abuse and neglect, family conflict, and child behavior problems; and to teach families the skills they need to prevent placement or successfully reunify with their children. The program was directed at building collaborative relationships with parents, strengthening communication, problem-solving and parenting skills, addressing concrete needs (e.g., food, shelter, employment), and providing in-home support when the family was reunified. There are no charges for these services, and families are offered counseling and education to ensure the safety of the child/ren within the home. The program is delivered in home.	No	No	Total avg. costs/family: \$3,288 <sup>xxxi</sup>	WSIPP estimates: Benefit to cost ratio is \$2.11; total benefits minus cost is \$3,655	n/a	Promising	Rating:2 (1 is best on 1-5 scale)	21 (Catholic Charities, Diocese of Fort Worth)	NREPP-SAMHSA Rating: 2.9 (out-of-home placement); Crime Solutions Rating: Effective
<b>Multi-Systemic Therapy for Child Abuse and Neglect</b>	6 to 17	Families in CPS system due to physical abuse or neglect where child is still living with parents or may reunify	Family interacts with therapist multiple times per week for about seven months	Goals are to reduce abuse and neglect, reduce out-of-home placement, improve parenting, improve family mental health, and increase social support. A team of 3 therapists, a crisis caseworker, a psychiatrist, and a supervisor works with the family using various treatment modalities.	No	n/a	n/a	n/a	n/a	Promising	Rating: 2	n/a	Crime Solutions Rating: Promising
<b>Chicago Child Parent Centers</b>	Preschool to Elementary School	Families in high poverty neighborhoods with children from preschool to elementary school	One to two years	Based in schools, these centers offer support to families in neighborhoods of high poverty in order to promote stable education from preschool through early elementary and to support parents to get involved in children's education. WSIPP has reported statistically significant decreases in child abuse and neglect as a result of this intervention.	No	n/a	Preschool: \$5,597/year; School-age: \$2,010/year; Extended: \$5,163/year <sup>xxxii</sup>	Preschool program: return to society of \$10.83 per dollar (net benefits per participant of \$83,708). Benefits to public: \$7.20 per dollar. School-age program: societal return of \$3.97 per dollar and \$2.11 public return. Extended intervention program (4 to 6 years): societal return of \$8.24 and public return of \$5.21. <sup>xxxii</sup>	n/a	Promising	n/a	n/a	Crime Solutions Rating: Promising; Promising Practices rating: Proven

Upstate New York Shaken Baby Syndrome Education Project	Infants	Parents of infants	Parents introduced to materials in the hospital and asked to sign a commitment understanding it; additional materials provided at follow-up doctor's visit	Goals are to educate parents about infant crying, dangers of shaking, how to calm a baby, reduce frustration, how to select other caregivers, and reduce frequency of abusive head trauma. Reports reduction of 50% of shaken baby syndrome in initial project, and another 10% in following years. This was a pilot program that has been replicated in other states, including Pennsylvania and Connecticut.	No	n/a	n/a	n/a	n/a <sup>xxiii</sup>	n/a	Rating: 3	n/a	n/a
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<sup>i</sup> For programs that list a specific number of families for 2013, this information was gathered from the 2013 TexProtects home visiting survey of home visiting programs in Texas: Phillips, S., Wilson, A., McClure, M., & Decker, E. (2015). Home Visiting in Texas: Current and Future Directions 2.0 2013-2014 Evaluation Outcomes and Data Update.

<sup>ii</sup> All WSIPP estimates: Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). Return on investment: Evidence-based options to improve statewide outcomes, April 2012 (Document No. 12-04-1201). Olympia: Washington State Institute for Public Policy. Retrieved from [http://www.wsipp.wa.gov/ReportFile/1102/Wsipp\\_Return-on-Investment-Evidence-Based-Options-to-Improve-Statewide-Outcomes-April-2012-Update\\_Full-Report.pdf](http://www.wsipp.wa.gov/ReportFile/1102/Wsipp_Return-on-Investment-Evidence-Based-Options-to-Improve-Statewide-Outcomes-April-2012-Update_Full-Report.pdf)

<sup>iii</sup> Programs are rated as "Model" or "Promising." University of Colorado Boulder Center for the Study and Prevention of Violence Institute of Behavioral Science. (2012-2015). Blueprints for violence prevention. Retrieved from <http://www.blueprintsprograms.com/>

<sup>iv</sup> Programs are rated as "Exemplary," "Effective," or "Promising." U.S. Department of Justice Office of Justice Programs. (2015). Programs. Retrieved from <http://www.ojjdp.gov/>.

<sup>v</sup> Programs are rated 1-5, with 1 indicating strongest research evidence and 5 indicating evidence that is concerning for the wellbeing of families. California Evidence-Based Clearinghouse. (2015). Program Registry. Retrieved from <http://www.cebc4cw.org/home/>

<sup>vi</sup> This scale ranges from 9-33; higher numbers indicate stronger evidence support; the mean rating was 23.1. Steinberg, C. S., et al. (August, 2009). Report to the Interagency Coordinating Council for Building Healthy Families and the Department Of Family and Protective Services. Evaluation Elements 1-6 Final Report; The Office of Community Projects, The Graduate College of Social Work, University of Houston.

<sup>vii</sup> Texas Department of Family and Protective Services. (n.d.). DFPS 2014 Data Book. Retrieved from [https://www.dfps.state.tx.us/documents/about/Data\\_Books\\_and\\_Annual\\_Reports/2014/DataBook14All.pdf](https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2014/DataBook14All.pdf)

<sup>viii</sup> Texas Department of Family and Protective Services. (2013). New prevention and intervention initiatives [Powerpoint slides]. Retrieved from [http://www.dfps.state.tx.us/documents/Prevention\\_and\\_Early\\_Intervention/powerpoints/PEI%20Project%20HOPES%20community%20meeting%20Webb%20County.pdf](http://www.dfps.state.tx.us/documents/Prevention_and_Early_Intervention/powerpoints/PEI%20Project%20HOPES%20community%20meeting%20Webb%20County.pdf)

<sup>ix</sup> Phillips, S., Wilson, A., McClure, M., & Decker, E. (2015). Home Visiting in Texas: Current and Future Directions 2.0 2013-2014 Evaluation Outcomes and Data Update.

<sup>x</sup> The National Exchange Club. (2012). Exchange Parent Aide program implementation. Retrieved from <http://preventchildabuse.com/pa-implementation.shtml>.

<sup>xi</sup> NREPP-SAMHSA ratings: Research quality rated on a scale from 0.0 to 4.0; higher numbers indicate stronger support. SAMHSA's National Registry of Evidence-based Programs and Practices. (2015). Retrieved from <http://www.nrepp.samhsa.gov/>

<sup>xii</sup> Miller, T. R. (2009). Estimated Medicaid costs and offsetting federal cost-savings of Nurse-Family Partnership. Calverton, MD: Pacific Institute for Research and Evaluation. Retrieved from [http://www.nursefamilypartnership.org/assets/PDF/Journals-and-Reports/PIRE\\_May\\_2009](http://www.nursefamilypartnership.org/assets/PDF/Journals-and-Reports/PIRE_May_2009).

<sup>xiii</sup> Karoly, L. A., Kilburn, M. R., & Cannon, J. S. (2005). Early childhood interventions: Proven results, future promise. Santa Monica, CA: RAND Corporation. Retrieved from [http://www.rand.org/pubs/monographs/2005/RAND\\_MG341.pdf](http://www.rand.org/pubs/monographs/2005/RAND_MG341.pdf).

<sup>xiv</sup> Crime Solutions ratings: Programs are rated as "Effective," "Promising," or "No Effects." Crime Solutions. Office of Justice Programs. (n.d.). Programs. Retrieved from <http://crimesolutions.gov/>

<sup>xv</sup> Maher, E. J., Corwin, T. W., Hodnett, R., & Faulk, K. (2012). A cost-savings analysis of a statewide parenting education program in child welfare. Research on Social Work Practice. Retrieved from <http://rsw.sagepub.com/content/22/6/615.short>

<sup>xvi</sup> Administration for Children and Families, U.S. Department of Health and Human Services. (n.d.). Home visiting evidence of effectiveness. Retrieved from <http://homvee.acf.hhs.gov/implementations.aspx>

<sup>xvii</sup> DuMont, K., Kirkland, K., Mitchell-Herzfeld, S., Ehrhard-Dietzel, S., Rodriguez, M. L., Lee, E., . . . Green, R. (2010). Final report: A randomized trial of Healthy Families New York (HFNY): Does home visitation prevent child maltreatment? Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/232945.pdf>.

<sup>xviii</sup> Lakey, D., Texas Department of State Health Services. (2014). *Presentation to select committee on child protection* [PowerPoint slides].

<sup>xix</sup> National Center on Shaken Baby Syndrome, personal communication, 2015.

<sup>xx</sup> Center for Child and Family Health, UNC. (2012). The Period of PURPLE Crying: keeping babies safe in North Carolina. Injury Prevention Research Center and the National Center for Shaken Baby Syndrome: Summary Report to participating hospitals, July 2012.

<sup>xxi</sup> Administration for Children and Families, U.S. Department of Health and Human Services. (n.d.). Home visiting evidence of effectiveness. Retrieved from <http://homvee.acf.hhs.gov/implementations.aspx>

<sup>xxii</sup> Mathematica Policy Research. (2014). Costs of early childhood home visiting: An analysis of programs implemented in the supporting Evidence-Based Home Visiting to Prevent Child Maltreatment Initiative. Princeton, NJ: A. Burwick, H. Zaveri, L. Shang, K. Boller, D. Daro, D. A. Strong. Retrieved from [http://www.mathematica-mpr.com/~media/publications/PDFs/Earlychildhood/EBHV\\_costs.pdf](http://www.mathematica-mpr.com/~media/publications/PDFs/Earlychildhood/EBHV_costs.pdf)

<sup>xxiii</sup> Correa, N., Quintal, L., Sanborn, R., Begley, C., Franzini, L., Giardino, A., . . . Tortolero, S. (2012). The state of parent education in Houston, Texas: An opportunity to strengthen family well-being, prevent child maltreatment, and prepare children for a brighter future. Houston, TX: Children at Risk. Retrieved from <http://childrenatrisk.org/wp-content/uploads/2012/01/The-State-of-Parent-Education-in-Houston-Report.pdf>.

<sup>xxiv</sup> Centering Healthcare Institute. (n. d.). Locate centering sites. Retrieved from <https://centeringhealthcare.secure.force.com/WebPortal/LocateCenteringSitePage>

<sup>xxv</sup> Texas Department of State Health Services, personal communication, November 4, 2014.

<sup>xxvi</sup> Texas Department of Family and Protective Services. (2013). New prevention and intervention initiatives [Powerpoint slides]. Retrieved from [http://www.dfps.state.tx.us/documents/Prevention\\_and\\_Early\\_Intervention/powerpoints/PEI%20Project%20HOPES%20community%20meeting%20Webb%20County.pdf](http://www.dfps.state.tx.us/documents/Prevention_and_Early_Intervention/powerpoints/PEI%20Project%20HOPES%20community%20meeting%20Webb%20County.pdf)

<sup>xxvii</sup> Texas Department of Family and Protective Services. (n.d.). DFPS 2014 Data Book. Retrieved from [https://www.dfps.state.tx.us/documents/about/Data\\_Books\\_and\\_Annual\\_Reports/2014/DataBook14All.pdf](https://www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2014/DataBook14All.pdf)

<sup>xxviii</sup> Mathematica Policy Research. (2014). Costs of early childhood home visiting: An analysis of programs implemented in the supporting Evidence-Based Home Visiting to Prevent Child Maltreatment Initiative. Princeton, NJ: A. Burwick, H. Zaveri, L. Shang, K. Boller, D. Daro, D. A. Strong. Retrieved from [http://www.mathematica-mpr.com/~media/publications/PDFs/Earlychildhood/EBHV\\_costs.pdf](http://www.mathematica-mpr.com/~media/publications/PDFs/Earlychildhood/EBHV_costs.pdf)

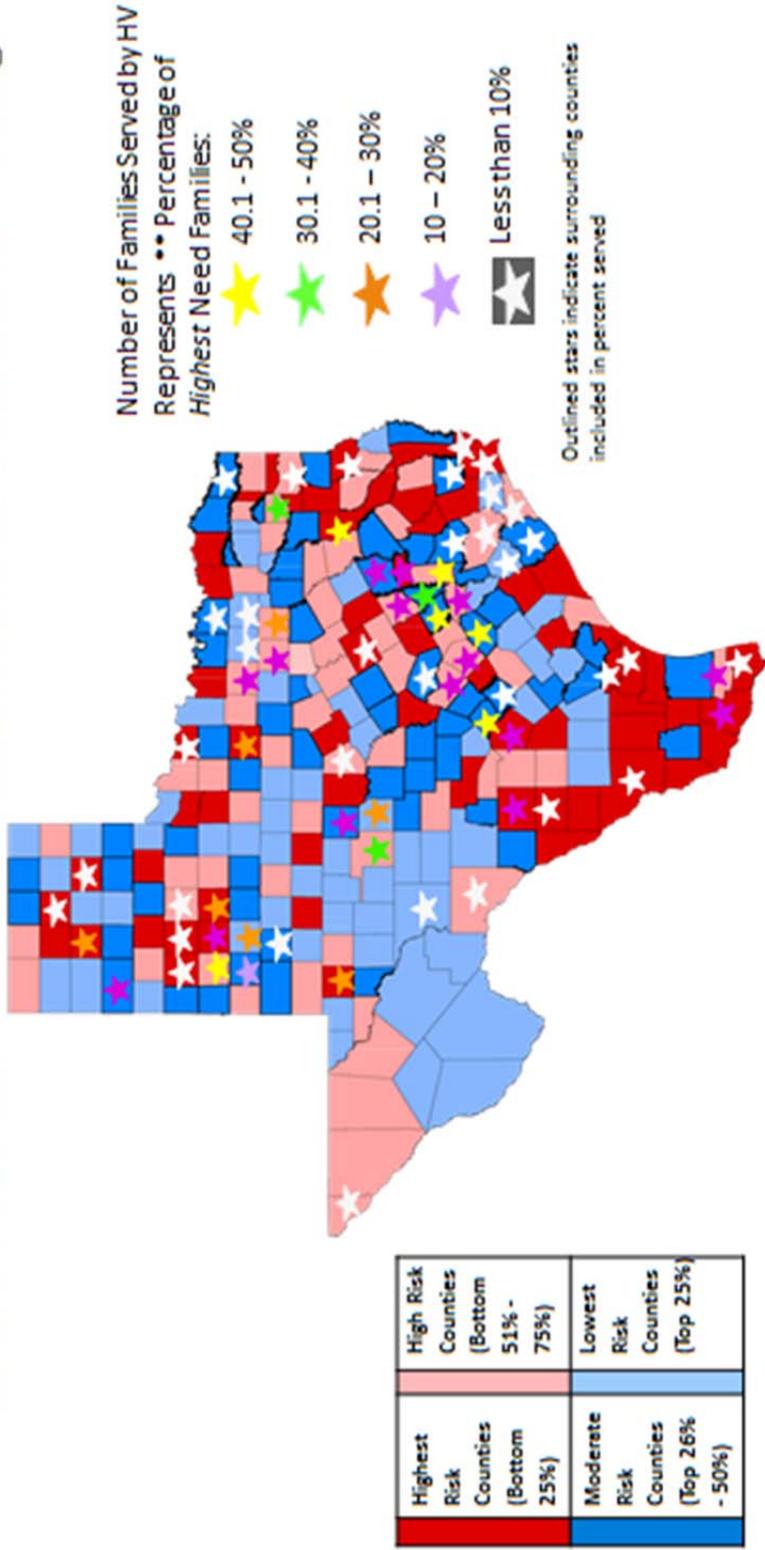
<sup>xxix</sup> University of Maryland School of Medicine. (2012) SEEK: Safe Environment for Every Kid. Retrieved from [http://theinstitute.umaryland.edu/seek/resources/SEEK\\_Overview.docx](http://theinstitute.umaryland.edu/seek/resources/SEEK_Overview.docx)

<sup>xxx</sup> Texas Department of Family and Protective Services. (2012). New campaign prevents child abuse with a helping hand for parents [Press Release]. Retrieved from [http://www.dfps.state.tx.us/About\\_DFPS/News/2012/2012-07-02\\_help\\_and\\_hope.asp](http://www.dfps.state.tx.us/About_DFPS/News/2012/2012-07-02_help_and_hope.asp)

<sup>xxxi</sup> Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). Return on investment: Evidence-based options to improve statewide outcomes, April 2012 (Document No. 12-04-1201). Olympia: Washington State Institute for Public Policy. Retrieved from [http://www.wsipp.wa.gov/ReportFile/1102/Wsipp\\_Return-on-Investment-Evidence-Based-Options-to-Improve-Statewide-Outcomes-April-2012-Update\\_Full-Report.pdf](http://www.wsipp.wa.gov/ReportFile/1102/Wsipp_Return-on-Investment-Evidence-Based-Options-to-Improve-Statewide-Outcomes-April-2012-Update_Full-Report.pdf)

<sup>xxxii</sup> Reynolds, A. J., Temple, J. A., White, B. A., Suh-Ruu, O., & Robertson, D. L. (2011). Age-26 cost-benefit analysis of the child-parent center early education program. Child Development, 82(1). Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3817956/>

# TexProtects Risk Assessment & Families Served with Home Visiting

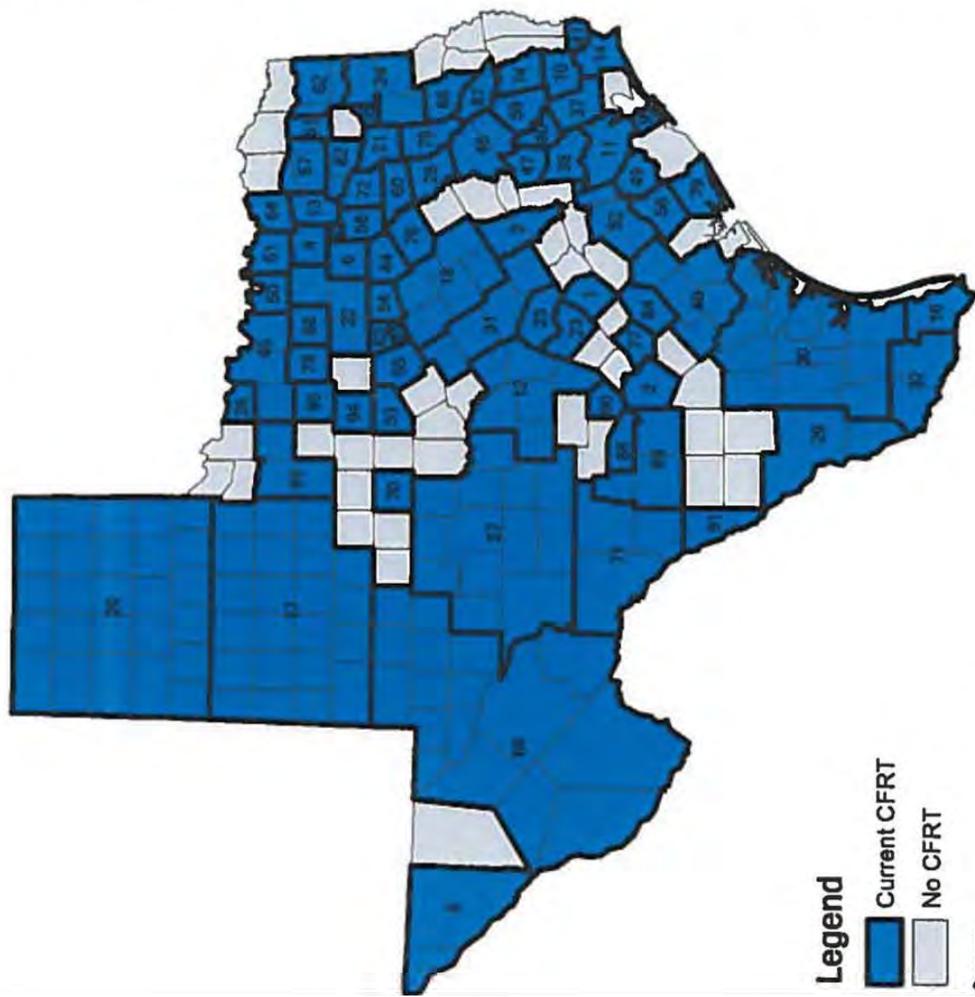


The suggested risk rankings are derived from a geographic risk assessment completed by TexProtects in 2014 based on the following covariates reflecting 5 year data (2009-2013): rates of domestic violence, substance abuse, teen pregnancy, child abuse and neglect related fatalities, child abuse confirmed incidents and child poverty. These six variables were selected due to their strong correlation to child maltreatment. The counties were accorded a final risk ranking based on an aggregate of each risk variable and then divided into quartiles. The red counties represent the top 25% highest-risk counties and the light blue represent the bottom 25% lowest-risk Texas counties. Superimposed over the geographic risk assessment is the percentage of families being served by home visiting in each county denoted by the stars, comparing the need for services versus current supply. The supply of home visiting services was collected through TexProtects' statewide 2013 home visiting data survey. The percentage of families served compared to the need was calculated by the number of families in highest-risk compared to the capacity of home visiting slots in that county. For the purpose of the assessment, "highest-risk" was defined as families with children under the age of 6 (standard ages served with home visiting and other child abuse prevention services) at or below 50% of the Federal Poverty Level for a family of four. Poverty is a proxy for families needing services because of its significant correlation to a multitude of other risk factors. However, some families in poverty could benefit more than others, and other families not in poverty are in high need of services. TexProtects' initial risk assessment was performed on each of Texas 264 counties. It should be noted that there have been very few risk assessments completed on a more localized or concentrated geographical area. Future geographic risk assessments should assess risk at a more concentrated level, such as U.S. Census tracks or by zip code, to inform a more refined and targeted resource allocation strategy.

# APPENDIX C

## Child Fatality Review Teams 2015

- Child Fatality Review Teams: 54 = Johnson
- 28 = Anderson
- 87 = Angelina
- 88 = Bandera
- 1 = Bastrop
- 2 = Bexar
- 3 = Brazos
- 16 = Cameron/Willacy
- 62 = Cass/Morris/Marion
- 31 = Central Texas
- 75 = Cherokee
- 30 = Coastal Bend
- 4 = Collin
- 52 = Colorado/Austin/Waller
- 27 = Concho Valley
- 50 = Cooke
- 6 = Dallas
- 53 = Eastland
- 8 = El Paso
- 44 = Ellis
- 55 = Erath
- 64 = Fannin
- 49 = Fort Bend
- 9 = Galveston
- 84 = Gonzales
- 51 = Grayson
- 35 = Gregg
- 77 = Guadalupe
- 10 = Hardin
- 11 = Harris
- 18 = Heart of Texas
- 60 = Henderson
- 32 = Hidalgo/Starr
- 12 = Hill
- 63 = Hood
- 57 = Hopkins/Franklin/Delta
- 46 = Houston/Trinity
- 13 = Hunt
- 78 = Jack
- 14 = Jefferson
- 58 = Kaufman
- 90 = Kendall
- ? = Kerr
- 37 = Liberty
- 79 = Matagorda
- 91 = Maverick
- 38 = Montgomery
- 66 = Nacogdoches
- 76 = Navarro
- 45 = North Texas Tri-County
- 41 = Orange
- 20 = Panhandle
- 59 = Polk
- 85 = Rockwall
- 93 = Rolling Plains
- 80 = San Jacinto
- 21 = Smith
- 92 = Somervell
- 17 = South Plains
- 71 = South Texas Tri-County
- 40 = Southeast Region
- 89 = Southwest Texas
- 94 = Stephens
- 22 = Tarrant
- 70 = Taylor
- 69 = Texas "J"
- 61 = Titus/Camp
- 23 = Travis
- 24 = Tri-County
- 74 = Tyler
- 72 = Van Zandt
- 47 = Walker
- 29 = Webb
- 56 = Wharton
- 26 = Wichita
- 25 = Williamson
- 68 = Wise
- 82 = Wood/Rains
- 95 = Young



Sources:  
 - State Child Fatality Review Coordinator, 2015  
 Prepared by: Office of Program Decision Support, 2/17/2015, (r)

## APPENDIX D

### Per Capita Rate (per 100,000 Children) by Ethnicity for Confirmed Child Abuse or Neglect Fatalities FY2010

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Total Child Population	810,543	2,322,661	3,317,777	414,843	6,865,824
Number of Fatalities	46	78	85	18	227
Per Capita Rate of Fatality	5.68	3.36	2.56	4.34	3.31

### FY2011

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	811,081	2,317,712	3,389,573	433,811	6,952,177
Number of Fatalities	51	59	104	17	231
Per Capita Rate of Fatality	6.29	2.55	3.07	3.92	3.32

### FY2012

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	809,036	2,332,640	3,415,186	439,490	6,996,352
Number of Fatalities	56	70	73	13	212
Per Capita Rate of Fatality	6.92	3.00	2.14	2.96	3.03

### FY2013

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	819,438	2,327,549	3,509,752	464,760	7,121,499
Number of Fatalities	40	48	60	8	156
Per Capita Rate of Fatality	4.88	2.06	1.71	1.72	2.19

Sources: Texas State Data Center; DFPS Data Warehouse Report FT\_06