Department of Family and Protective Services and Department of State Health Services Strategic Plan to Reduce Child Abuse and Neglect Fatalities

A report from the Department of Family and Protective Services
and Department of State Health Services

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Executive Summary

A child fatality is the most tragic consequence of abuse and neglect. It is a loss not only to the family but to the child's community and Texans overall. Texas is striving to build a more robust safety net to protect the most vulnerable in society by coordinating inititaives though prevention and early invention services that reach the entire population. The Texas Department of Family and Protective Services (DFPS) and the Texas Department of State Health Services (DSHS) are charged with addressing the health and safety needs of all Texans, be it through improving health overall or addressing safety, and wellbeing for children, youth, families, and adults across the state. Given that 53% of all abuse and neglect fatalities from calendar year 2010 to 2012 had no prior involvement with Child Protective Services (CPS), it is clear that preventing abuse and neglect fatalities is not a charge that DFPS should be facing alone. Rather, efforts to address and reduce these deaths must be strategically focused on the entire population to reach vulnerable children outside of the CPS system and involve coordinated effort between agencies.

Directed and thorough analysis of abuse and neglect fatalities can lead to understanding the types of abuse and neglect cases that are occurring and where they are occurring. Also, these analyses can help explain the underlying risks that exist in families and communities. Understanding these risks can help guide and direct intervention programs and identify unmet needs so that programs can be developed and coordinated between agencies to better protect vulnerable children. The collaboration between DFPS and DSHS aims to use these results to guide a strategic plan to coordinate support services between DSHS and DFPS. The ultimate goal of this plan is to reduce abuse and neglect fatalities by providing timely, coordinated, and evidence-based services to families and communities in need.

Major Findings

DSHS and DFPS have partnered to analyze and link DFPS-Child Fatality Review Data (DFPS-CFR) with other data sources including birth records, death records, and community-level risk indicators (for example, concentration of poverty, education levels, or mobility). The focus of these analyses is three-fold:

(1) to understand the prevalence of abuse and neglect fatalities within the population;
(2) to identify communities that are high risk for specific types of abuse and neglect fatalities; and
(3) to explore which risk factors in the family are associated with abuse and neglect.

Comparing confirmed child abuse and neglect fatalities to all non-natural child fatalities

- 14.5% of all child fatalities without an underlying medical cause were confirmed child abuse and neglect.
- 7.7% of all sleep-related deaths were confirmed child abuse and neglect deaths.
- 6.1% of all motor vehicle deaths were confirmed child abuse and neglect deaths, with 64% of the abuse neglect motor vehicle fatalities being either pedestrian deaths (an unsupervised child being hit by a vehicle) or children left in hot cars.

Community Disparities

- The San Antonio/New Braunfels, Midland/Odessa, and Beaumont/Port Arthur areas had higher-than-expected number of abuse and neglect sleep-related deaths.
- The Dallas/Fort Worth area had a higher-than-expected number of children dying in hot cars.

Point of Contact Identified for Referral

- According to birth certificate information, 65% of the mothers involved in a confirmed child abuse or neglect fatality were enrolled in the Nutrition Program for Women, Infants, and Children (WIC) during their pregnancies.

Risks at Birth

- Many of the risk factors identified for abuse and neglect fatalities are also known risks for domestic violence.
- Infants who died from sleep-related abuse and neglect were likely to have a mother who smoked during pregnancy.

Strategic Plan

Activities related to four major areas identified by the data analysis are currently under way to address child fatalities, including child abuse and neglect, from a public health perspective.

- Motor vehicle-related fatalities, focusing on hyperthermia or "hot car death" prevention efforts in the Dallas/Fort Worth area
- Motor vehicle-related fatalities, focusing on pedestrian fatalities statewide
- Sleep-related fatalities, statewide and focusing on the San Antonio/New Braunfels, Beaumont/Port Arthur, and Midland/Odessa areas
- Physical abuse-related fatalities statewide

Each of the four major areas are part of the strategic plan to deliver a consistent, comprehensive, and evidence-based action plan to address child fatalities, including those that are caused by abuse or neglect. Additionally, two areas have been identified to strengthen ongoing analysis and project coordination between DFPS and DSHS.

Focus Area	Action Plan	Inter-Agency Coordination
Motor Vehicles: Hyperthermia Focus Area: Dallas/Fort Worth	• Develop hyperthermia educational materials (DSHS). • Identify and develop partnerships to distribute and promote prevention messages. • Increase temperature gauge demonstrations. • Use billboards in targeted markets.	DSHS Safe Rider Program and DFPS Prevention and Early Intervention Division
Motor Vehicles: Pedestrian Focus Area: Statewide	• Assist local Child Fatality Review Team (CFRT) efforts to address motor vehicle/pedestrian safety. • Use Safe Rider Program (child safety seat program) to promote motor vehicle/pedestrian safety. • Develop a child motor vehicle workgroup to plan and assess child motor vehicle death prevention activities in Texas. o Review DSHS/DFPS findings as well as	DSHS Office of Title V and Family Health, DFPS Prevention and Early Intervention Division, and DSHS Safe Rider Program

	data that may be available through local review processes. o Assess current child pedestrian safety programs being conducted and/or educational materials being distributed in Texas. o Develop evidence-based recommendations for child pedestrian death prevention strategies to implement throughout Texas.	
Sleep-Related Focus Area: San Antonio/New Braunfels, Beaumont/Port Arthur, and Midland/Odessa areas, and statewide	• Conduct Education and Referral Pilot in WIC Clinics. • Conduct community assessment and planning. • Create Safe Sleep Workgroup (statewide). • DSHS will work with the State Child Fatality Review Team Committee (SCFRT) and local CFRTs to enhance death scene data collection to increase identification and improve classification of sleep-related deaths (statewide).	DSHS/DFPS Interagency
Physical Abuse Focus Area: Statewide	• Create an Intimate Partner Violence Workgroup to review screening and referral process for community providers. • Coordinate this initiative with the Task Force on Domestic Violence created pursuant to HB 2620 of the 83rd Legislature, Regular Session. • Identify, review, and catalog national intimate partner violence materials, health and human services, enterprise resources, and service providers • Coordinate with local partners to develop targeted strategies to address screening during prenatal/postnatal care for intimate partner violence.	DSHS/DFPS Interagency
Enhanced Data Analysis and Collaboration Focus Area: Statewide	• Improve identification, classification and data collection. • Conduct evaluation of impact of strategic initiatives. • Expand data collaboration to include child abuse and neglect cases not resulting in a fatality.	DSHS/DFPS Interagency
Ongoing Collaboration Focus Area: Statewide	Continue the joint DSHS-DFPS commitment to promote healthy mothers and healthy babies including examining: • The impact of the state's investment in home-visitation programs; • The promising practices of Centering Prenatal Care and mother-child attachment models	DSHS/DFPS Interagency

	such as Circles of Security; and • Innovative local initiatives such as Cook Children's Hospital's newly formed Center for the Prevention of Child Maltreatment and the use of the Period of Purple Crying shaken-baby prevention program by Dell Children's Hospital and Texas Children's Hospital.	

Overview

In April 2014, DFPS Commissioner Judge John Specia and DSHS Commissioner Dr. David Lakey brought together their respective agencies to proactively address child fatalities. Almost half of all confirmed child abuse and neglect fatalities are in families that had no previous involvement with DFPS, highlighting the importance of population-based strategies to reduce these deaths. By taking into consideration the entire population to understand, analyze, and build comprehensive strategies to target child abuse and neglect fatalities, DFPS and DSHS can leverage resources, programs, and community collaborations to target specific issues and geographical areas based on their individual needs. By combining data from DFPS with the population-based data systems available to DSHS, a broader picture of influencing factors and possible intervention points can be determined for all child fatalities, including those caused by abuse and neglect.

The goal of this collaboration is not to predict which children in the care of DFPS are at risk of suffering from an abuse and neglect-related fatality. Rather, the goal is to identify risk factors that are associated with child abuse and neglect fatalities as a means to identify warning signs so that services can be provided to the family before a crisis occurs. By using rich data to drive the coordination of prevention efforts and resources, the joint project is designed to reduce preventable child deaths and ensure a clear, consistent response to child fatalities by strategically providing timely, coordinated, and evidence-based services to families and communities in need.

The analyses presented in the report follow an approach that is informed by the public health literature in the United States and other countries. This approach is built on the recognition that risk factors for abuse and neglect are multi-faceted and can be measured across multiple levels of influence: the individual within a family can carry risk, the family can carry risk, and the community can have risk. It is important to understand each level to develop a plan to address these fatalities. The analyses within this report have three main objectives: (1) to understand the prevalence of child abuse and neglect fatalities within the population; (2) to identify communities that are high-risk for specific types of child abuse and neglect fatalities; and (3) to explore family-level risk factors that are associated with child abuse and neglect.

Current System

Texas provides specific health and human services through five agencies, including DSHS and DFPS. These agencies are responsible for meeting the health and safety needs of children, youth, families, and adults across the entire state.

DSHS oversees programs such as disease prevention, family and community health services, environmental and consumer safety, regulatory programs, and mental health and substance abuse prevention and treatment programs. In regard to child fatalities, DSHS has traditionally addressed child fatalities from a public health approach of disseminating prevention activities through maternal and child health programs and safety campaigns. These prevention efforts are developed from and informed by surveillance and research efforts in the agency, as well as through data gathered on birth and death records. Additionally, DSHS provides support to the State Child Fatality Review Team (SCFRT) and local Child Fatality Review Teams (CFRTs), which are multidisciplinary groups comprised of members throughout Texas. SCFRT's mission is to reduce the number of preventable child deaths, regardless of cause, and its purpose is threefold:

- To develop an understanding of the causes and incidence of child deaths in Texas;
- To identify procedures within the agencies represented on the SCFRT to reduce the number of preventable child deaths; and
- To promote public awareness and make recommendations to the Governor and the Legislature for changes in law, policy, and practice to reduce the number of preventable child deaths.

DFPS works with communities to protect children, the elderly, and people with disabilities from abuse, neglect, and exploitation. It also works to protect the health and safety of children in daycare, as well as foster care and other types of 24-hour care. This work is achieved through prevention and early intervention services, investigations, services and referrals, and regulation of specific types of care providers. Through the Texas Family Code, DFPS is the investigator of child fatalities that are suspected to be from abuse and neglect. In September 2014, DFPS established the Office of Child Safety to address child fatalities and serious injuries through thorough case review, data analysis, practice recommendations and collaboration with local agencies, private sector, non-profits, and government programs to reduce child abuse and neglect fatalities. Additionally, DFPS works in partnership and serves as a member of the SCFRT, as well as with local CFRTs. DFPS also leads the Child Safety Review Committee, which provides recommendations for action to DFPS based on review of confirmed child abuse and neglect related fatalities. This group comprises internal and external stakeholders including law enforcement, medical professionals, early childhood education, and Court Appointed Special Advocates (CASA).

Data and resources from both agencies have helped each agency address child fatalities. However, it is through this project that both DFPS and DSHS have collaborated to focus on reducing child abuse and neglect fatalities. Utilizing a public health approach to prevent all child fatalities allows both agencies to:

- understand child deaths at the local level;
- collect and analyze data to better understand risks to children; and
- inform local and statewide activities to reduce preventable child deaths.

Analysis of Child Abuse and Neglect Fatalities

A major component of the collaboration between DFPS and DSHS centers on data sharing. The literature on the epidemiology of child abuse and neglect is clear that multiple data sources must be linked in order to understand both individual and social risk. This literature has shown that there are strong ties between several risks that public health tries to mitigate and child abuse and neglect. For example,

poverty is a strong predictor of child abuse and neglect. It has been shown that children in families with an annual income of less than $15,000 are 14 times more likely to be abused and 44 times more likely to be neglected as compared to children in families with an annual income of $30,000 or more[1]. Children with young mothers are more likely to suffer fatal child maltreatment[2]. Also, evidence-based prenatal and infancy support programs, such as home visits by nurses, have been shown to have to fewer verified cases of child abuse and neglect among participating families[3].

DFPS provided case-specific data of confirmed child abuse and neglect fatalities from Fiscal Year (FY) 2010 through (FY) 2013. The Office of Program Decision Support within the DSHS Division for Family and Community Health Services then matched this data set to information in its system, based on calendar year. This level of data linking helped identify the official cause and manner of death on the death certificate and provided information to complete geo-coding to allow community-based analysis of where the child lived, such as concentration of poverty, level of education, crime levels, and access to nutritious food, among other information. Additionally, a sub-set of cases of children younger than 3-years old were linked with the child's birth certificate. The birth certificate contains several important pieces of information that enhance analyses of these fatalities, such as presence or absence of paternity, adequate prenatal care, tobacco use during pregnancy, mother's and father's educational level, and a host of other maternal and infant characteristics. This linking also facilitated geo-coding cases based on the mother's residence at the time of birth, which was used to link to a variety of sources about poverty, community risks and other factors.

Major Findings and Action Plans

Summary of Major Findings

The analyses presented in this report follow an approach that is informed by the public health literature in the United States and other countries. The analysis includes 4,723 child fatalities between 2010 and 2013, of which 14.5% (686) were confirmed abuse and neglect related deaths. For this report, child fatalities include all non-natural deaths to a child younger than 18 years old. These child fatalities include accidents, homicides, suicides and all unknown or undetermined causes of death.

Through the rest of the report, all numbers presented in parentheses are the actual number of children who died between calendar year 2010 and the end of 2012. This report presents specific analyses that are the basis for the recommendations that will strengthen the coordination between DFPS and DSHS.

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[1] Sedlack, A.J., & Broadhurst, D.D. *Executive summary of third national incidence study of child abuse and neglect.* Administration of Children and Families. Available at: https://www.childwelfare.gov/pubs/statsinfo/nis3.cfm (Accessed on March 5, 2014.)

[2] Stiffman, N.M., et al. Household composition and risk of fatal child maltreatment. *Pediatrics, 109*(4): 615-621. April 2002.

[3] Olds, D.L. Preventing child maltreatment and crime with prenatal and infancy support of parents: The nurse-family partnership. *Journal of Scandinavian Studies in Criminology and Crime Prevention, 9*(S1): 2-24. December 2008. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2946620/**.** (Accessed on March 5, 2014.)

Major Finding: Motor Vehicle Related Fatalities - Hyperthermia

Findings and Conclusions

In Texas, child fatalities from hyperthermia are an unfortunate seasonal reality and are completely preventable. Hyperthermia (24) due to the child being left in a hot car accounts for 32% of motor vehicle-related child abuse and neglect fatalities (75). Additionally, 75% of all child deaths due to hyperthermia (32) were attributed to child abuse or neglect. A significantly greater than expected number of the child abuse and neglect fatalities related to hyperthermia occurred in the Dallas/Fort Worth area. While DFPS has had a major campaign to address hyperthermia deaths, it has often been targeted to childcare providers rather than caregivers.

Action Plan and Service Coordination

Proposed Hyperthermia Prevention activities will be targeted to Dallas, Fort Worth and other cities/media markets where fatalities due to heat exposure have occurred.

Action Plan	Inter-Agency Coordination

• Develop hyperthermia prevention educational materials and distribute through the Safe Riders information and referral request line.
• Develop a partnership with the statewide Hyperthermia Task Force and seek other public/private partnerships to promote messages for hyperthermia prevention.
• Purchase vehicle temperature gauge displays for distribution to DSHS regional offices, Texas Department of Transportation (TxDOT) traffic safety specialists, and other events
• Purchase billboard space in cities/markets where recent hyperthermia deaths have occurred.
• DSHS-DFPS Collaboration to:
    o Identify community organizations and distribute educational material statewide; and
    o Receive and use temperature gauge displays in hyperthermia demonstrations.
	DSHS Safe Rider Program and DFPS Prevention and Early Intervention Division

Major Finding: Motor Vehicle Related Fatalities - Pedestrian

Findings and Conclusions

Data analysis found that 64% of confirmed child abuse and neglect fatalities related to motor vehicles were hyperthermia (24) or pedestrian deaths (24). The pedestrian fatalities often involved a child who was unsupervised and entered the roadway or who was playing in a driveway where someone backed

out. At times, these events occurred while the caregiver was under the influence of alcohol or drugs, or unable to supervise the child.

Action Plan and Service Coordination

While hyperthermia fatalities were disproportionally found in the Dallas/Fort Worth areas, pedestrian fatalities occur statewide. Because of this trend, the CFRTs located throughout the state have been identified as a possible resource for addressing this specific finding.

Action Plan	Inter-Agency Coordination
• DSHS Office of Title V and Family Health will develop a cross-program child motor vehicle workgroup in coordination with the State Child Fatality Review Team Committee to plan and assess child motor vehicle death prevention activities in Texas. An initial project of the workgroup will be to examine child pedestrian deaths. The workgroup will: o Review state and local data and current child pedestrian safety programs being conducted statewide/in targeted areas. o Develop evidence-based recommendations for child pedestrian death prevention strategies to implement in targeted areas and statewide. o Partner with Safe Riders distribution and education sites statewide/in targeted areas to promote MV/Pedestrian Safety.	DSHS Office of Title V and Family Health, DFPS Prevention and Early Intervention Division, and DSHS Safe Riders Program

Major Finding: Sleep-Related Fatalities

Findings and Conclusions

Sudden unexplained infant-death that occurs during sleep (SIDS/SUID) is the second-leading category of death in cases where child abuse and neglect has been substantiated. It is also one of the leading causes of death among all infants in Texas. Between 2010 and 2012, 7.7% of all sleep related deaths (1,449) were found to be child abuse and neglect-related fatalities (112). The greatest number of child abuse and neglect sleep-related infant fatalities occurred in the San Antonio/New Braunfels area. There were also a greater than expected number of cases in both Beaumont/Port Arthur and in Midland/Odessa.

The cases that were matched to birth data also showed that smoking during pregnancy was a risk factor for sleep-related child abuse and neglect-related fatalities. Smoking during pregnancy is also a leading modifiable risk factor for *all* sleep-related infant deaths. The prevalence of tobacco use among pregnant women is significantly higher than the state average (4.7%) in Beaumont/Port Arthur (12.8%) and in Midland/Odessa (8.0%).

One of the major questions leading into these analyses was whether or not these high-risk families could be reached and targeted for intervention before they became involved with CPS. Of the child abuse and neglect cases linked to the birth file (329), 65% of mothers were receiving WIC services during pregnancy (214). Additionally, 72% of these mothers had their deliveries paid for by Medicaid. However, the rate of utilization of prenatal services was lower than the general public, with only 49% of women attending an adequate number of prenatal care visits. These results suggest that WIC may be a valuable component in the safety net services able to reach these families.

Child fatalities that are alleged to be from abuse or neglect must be reported to DFPS for investigation. Additionally, the local CFRTs review the majority of child fatalities in Texas, regardless of abuse or neglect allegations. One group of child fatalities that can be caused by abuse or neglect, but are often not reported, are those where co-sleeping (shared sleep surface/bed) is involved and other factors such as substance abuse may be present. The reason data is not reported is often due to a lack of information being gathered at the death scene.

Action Plan and Service Coordination

Action Plan	**Inter-Agency Coordination**
• WIC staff in Local Agencies serving Greater San Antonio, Beaumont/Port Arthur, and Midland/Odessa will participate in a pilot project to assess feasibility and efficacy of implementing safe sleep activities in the WIC setting. Activities will include: o WIC clinic staff will be trained on evidence-based information about safe sleep environments and recommended strategies for risk reduction of sleep-related deaths. o To address the specific risk factor of prenatal smoking and to reduce child health risks associated exposure to environmental tobacco smoke, WIC clinic staff will be trained to implement an Ask/Advise/Refer brief tobacco-cessation intervention with participants, and Quitline posters will be displayed in local WIC clinics. • Coordinate with key public health and prevention partners in each of the three targeted communities to identify local stakeholders in child abuse and neglect and in risk reduction for sleep-related deaths. • Convene partners and stakeholders for "listening session" meetings in each of the three targeted communities. • Plan, implement and evaluate community-specific strategic actions in each of the three targeted communities for prevention and risk reduction of sleep-related deaths	DSHS Nutrition Services Section (Texas WIC), DSHS Office of Title V and Family Health and DFPS Prevention and Early Intervention Division

- Coordinate across agencies to align messaging and strategies related to safe sleep environments and risk reduction for sleep-related infant deaths. - Develop activities to increase statewide access to consistent, comprehensive, and evidence-based information. - Work with the SCFRT Committee and local CFRTs to enhance death scene data collection to increase identification and improve classification of sleep-related deaths.	

Major Finding: Physical Abuse

Findings and Conclusions

Among child fatalities without a clear medical cause from 2010 to 2012, 6.4% were ruled as child abuse or neglect homicides (304); and over half of all child homicides (575) were determined to be abuse- or neglect-related. Many of these homicide cases (129) were linked to the child's birth record. In-depth analyses of the birth data showed that many of the factors in the Texas data that put the infant at risk for a child abuse and neglect fatality are also risks identified in the research literature for domestic violence. Domestic violence prior to and during pregnancy is a strong predictor of violence in the home once the child is born. It is critical to address violence in home both prior to conception and once the mother is pregnant.

Surveillance data gathered through the *Pregnancy Risk Assessment Monitoring Survey* at DSHS has shown that women receiving Medicaid during pregnancy (58.4%) were significantly more likely to report being screened for domestic violence than non-Medicaid clients (46.3%). While these screening results are encouraging, these data also show that only half of the women who reported incidences of abuse during pregnancy also reported being screened for domestic violence. Given the apparent shared risks, one way to address physical abuse among infants is to strengthen support and screening for domestic violence during pregnancy.

Action Plan and Service Coordination

Action Plan	Inter-Agency Coordination
• Form a DSHS-DFPS Interagency Workgroup to focus on the Intimate Partner Violence screening and referral process across community providers and develop a consistent, comprehensive and evidence-based strategic plan. • Coordinate initiative with the Task Force on Domestic Violence created pursuant to HB 2620 of the 83rd Legislature, Regular Session, which is working with a broader group of partners to address these same issues. • Identify, review and catalog existing national materials, relevant health and human services enterprise programmatic resources, and service providers. • Coordinate local partners to develop targeted strategies to address screening for intimate partner violence during prenatal/postnatal care.	DSHS Office of Title V and Family Health and DFPS Prevention and Early Intervention Division

Major Finding: Data Analysis and Ongoing Collaboration

Findings and Conclusions

During this initial phase of data sharing, resource mapping, and collaboration of intervention efforts to address child abuse and neglect fatalities, specific issues were noted that would strengthen ongoing action items. One of these issues was to strengthen data sharing between DFPS and DSHS. The analyses in this initial phase were based on data from confirmed child abuse and neglect fatalities. While focusing on fatalities helps target a specifically tragic outcome, there remains a gap in knowledge about preventing abuse and neglect generally.

Future data sharing must still include all fatalities resulting from abuse or neglect, but should be expanded to include all cases where abuse or neglect occurred and identify cases where the child suffered a near fatal injury or where a serious injury did not occur.

These data will be utilized to examine local level risk factors in greater depth to help in identifying specific areas of need.

While the four major areas for current intervention have been identified and action plans for each are under way, it is also essential to conduct ongoing evaluations to determine the impact of these strategic initiatives.

Additionally, DFPS and DSHS are committed to providing support and partnering with other agencies and stakeholders who also want to reduce child fatalities through prevention and intervention

strategies. By promoting research and initiatives in Texas communities to support healthy mothers and healthy babies, DFPS and DSHS can reach exponentially more families. This work includes examining and working in partnership with:

- in-home visitation programs, and
- the promising practices of Centering Prenatal Care and mother-child attachment models such as Circles of Security; and innovative local initiatives such as Cook Children's Hospital's newly-formed Center for the Prevention of Child Maltreatment and the use of the Period of Purple Crying (shaken-baby prevention program) by Dell Children's Hospital and Texas Children's Hospital.

Conclusion

The first wave of data analysis has provided several beneficial touchstones for work between the agencies to address child fatalities. While this analysis was based on confirmed child abuse and neglect fatalities, future collaboration will look at near fatalities, serious injuries and general child abuse and neglect. This ongoing work will allow both agencies to further pinpoint particular geographic areas and specific risk factors that need targeted services and outreach. With these data, DFPS and DSHS can continue to collaborate with families, stakeholders, law enforcement, the medical community, service providers, community agencies, and other governmental agencies to address the specific issues identified in their area and reduce the unnecessary deaths of our children, our future.