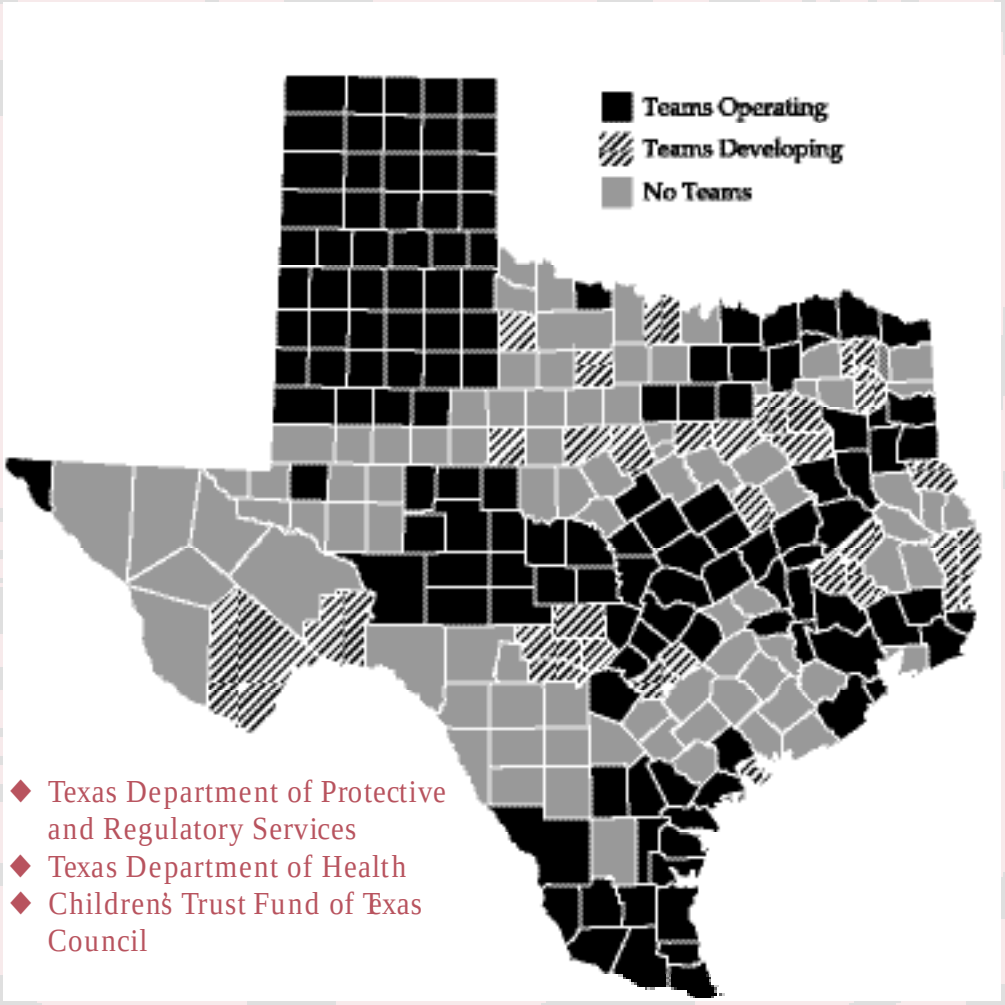
State Child Fatality Review Team Committee

Child Fatality Review Team Operating Procedures



- Texas Department of Protective and Regulatory Services
- Texas Department of Health
- Children's Trust Fund of Texas Council

“Never doubt that a small
group of thoughtful,
committed citizens
can change the world;
indeed it is the
only thing that ever has.”

—Margaret Mead

Child Fatality Review Team Operating Procedures

July 2001

State Child Fatality Review Team Committee

Child Fatality Review Team Operating Procedures

Contents

Child Fatality Review Team Operation Procedures

I. Introduction

In 1995, the Texas Legislature amended Chapter 264 of the Family Code (TFC), by adding the State Child Fatality Review Team Committee and Investigation statute. It created the State Child Fatality Review Team Committee, and established procedures for the operation of local child fatality review teams and the reporting and investigation of child deaths. The State Committee provides oversight to the local teams and makes recommendations to the governor and legislature regarding reducing the number of preventable child deaths. Local review teams now cover over 80 percent of the state's population.

One of the primary reasons for the implementation of child fatality review teams throughout the United States has been to identify and ultimately prevent child deaths caused by abuse and neglect. However, Texas, like most states, has opted for a broader death review process that addresses all preventable child deaths from a public health perspective. The top five leading causes of death for Texas children in 1998 were 1) perinatal conditions, 22.7%; 2) unintentional injuries, 22.1%; 3) congenital anomalies, 16.3%; 4) violence, 7.0%; and 5) malignant neoplasms, 4.2%. These causes account for nearly 7 of every 10 child deaths in the state. Injuries are not only preventable, but are also the category where undetected abuse and neglect related deaths are most likely to be hidden. By adopting this public health approach, not only can the "under-reporting" problem of maltreatment related deaths be systematically addressed, but a better understanding and greater awareness of all the causes of child deaths can be realized on the local, state and national level.

Our state is a national leader in the social conditions and demographics associated with poor child health and safety issues: poverty, unemployment, substandard education, juvenile violence rate, lack of available health care, teen pregnancy, and a large minority population. Texas also has one of the fastest growing birth rates and largest child populations in the nation. Review team membership is composed of the professionals that face this situation daily, and recognize that responding to all child fatalities is the responsibility of the state and the community. The efforts of local teams, the State Committee, and others who have supported the establishment and implementation of an integrated system of child death review is evidence of Texas' commitment to protect and raise its children in health and safety.

II. Background

A. The Need For Review Teams

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

The CJA Child Fatality Review Team Committee found a need to improve reporting of child deaths, death certification, and training for professionals in child death investigations. They found that too often, there was little or no investigation done when a child died suddenly and unexpectedly. Community resources and standards varied in their response to child deaths. Because some counties rarely experienced a child fatality, when it did occur, they were ill-prepared to respond adequately.

Although there were many similarities, unique circumstances existed in every community in response to child deaths. There were no standardized procedures for most professionals involved in responding to child fatalities. Autopsies were not routinely performed. Because very few counties in Texas have a medical examiner, long distances complicated their availability.

Data on the incidence and causes of child deaths was inconsistent and inaccurate. Standardized definitions to record data did not exist. The discrepancy between the number of child maltreatment related deaths recorded by Child Protective Services and the state Bureau of Vital Statistics illustrated the problem with not having a coordinated data collection system. The lack of knowledge and training about child abuse or neglect may account for a large number of child fatalities being classified as injuries or unexplained deaths.

B. Legislation

The legislation which establishes an effective review and standardized data collection system became effective Sept. 1, 1995. To assist the State Child Fatality Review Team Committee in achieving it's purpose as outlined in Section 264.503 of the TFC— develop an understanding of the causes and incidence of child deaths, identify procedures within the agencies represented to reduce the number of preventable child deaths, 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 — the legislature directed the Department of Protective and Regulatory Services, the Department of Health and the Children's Trust Fund of Texas Council to work together as a support system for the State Committee. Section 264.503 of the TFC outlines the duties of the three state agencies in this regard. Protective and Regulatory Services is responsible for assisting the State Committee in the development of model protocols for reporting and investigating child deaths, data collection, and the establishment and training of review teams. The Texas Department of Health collects data from local teams and performs annual statistical studies thereby, creating for the first time in Texas, a central registry of child fatalities. The Children's Trust Fund of Texas Council is responsible for promoting public education regarding child deaths and the public's role in their prevention.

III. Child Fatality Review Teams

A. Goal

The goal of child fatality review teams is to improve the response to child fatalities, provide accurate information on how and why Texas children are dying, and ultimately reduce the number of preventable child deaths by establishing an effective review and standardized data collection system for all child fatalities.

B. Objectives

1. Assure an accurate inventory of child fatalities by age, location, cause, manner and circumstance.
2. Support adequate child death investigation and certification.
3. Implement investigation guidelines and recommendations for child fatalities.
4. Enable multi-agency collaboration, cooperation, and communication at the state and local levels regarding child fatalities.
5. Through analysis of patterns and trends in child fatalities, improve the recognition of child deaths from
   a) abuse and neglect;
   b) genetic diseases;
   c) inadequate medical care; and
   d) public health dangers.
6. Enhance the general awareness of child death through the understanding of why and how children die.
7. Identify system-based impediments to child health and safety, that, when removed, will ultimately reduce the number of preventable child deaths.
8. Develop community prevention initiatives from the findings of child fatality review teams.

C. Purpose of the Review Process

1. To accurately identify and record the cause of every child death.

   If the accuracy of child death determinations is to be improved, there must be a coordinated approach to the investigation and documentation of the death from the various agencies. Sharing of information is essential. Prior to the completion of the death certificate, a thorough scene investigation, as well as background checks for criminal history and prior reports of child abuse must be conducted by law enforcement and child protective services. Many deaths will require a review of the child's medical history. Teams provide a forum for ensuring relevant information is shared and available to use in making a determination of why a child died and better understanding all the factors contributing to the death. Because of the team's multi-disciplinary membership, reviews encourage the improved accuracy of death certificates.

2. To collect uniform and accurate statistics on child deaths.

   For each child death reviewed, local teams complete a data collection form with information provided from the records of team members. This data is submitted to the state's central registry for child fatalities maintained in the Texas Department of Health's Bureau of Vital Statistics. The pooling of information from the local teams will provide better epidemiologic data on the causes of death and the most accurate and thorough information ever collected on child fatalities in Texas.

3. To identify circumstances surrounding deaths that could prevent future deaths and initiate preventive efforts.

Local teams will use the data they collect to identify and implement actions needed to reduce the number of preventable child deaths. Each child fatality review team will use their local data on which to base their preventative efforts, for assessing limited resources, and for promoting awareness and education on the management and prevention of child deaths in the community. The State Committee is available for assistance in these efforts.

For example, the Williamson County Team reviews found a lack of knowledge in the care of newborns. The team initiated Baby Steps: Maternal and Newborn Visit Program, a public health project of the city and county health districts. Working in partnership with local families, physicians and hospitals, the project's goal is to ensure a healthy beginning for all children in the community.

4. To promote collaboration and coordination among the participating agencies.

Interagency communication is crucial in the review of child deaths. Communication between agencies must be maintained on a formal and informal basis. Feedback is useful in assessing intervention on a case-by-case basis and can be used to discuss successes and problems in coordination among agencies and professionals. It can also identify gaps in services and barriers to effective investigations. By agreeing on common goals, developing a clear understanding of professional roles and responsibilities, maintaining open communication, developing procedures for intervention and collaboration, and instituting procedures for feedback, team members strengthen their working relationships with other agencies. Information regarding agency procedures, relevant programs and child death training needs are exchanged regularly at team meetings. The outcome is a better use of limited resources and an enhanced ability to fill gaps in services in the area covered by the team.

5. To improve criminal investigation and prosecution of child death cases.

As law enforcement, medical examiners, physicians, child protective services workers, and others exchange information, the quality of child death investigations improves. Evidence processing in child maltreatment-related fatalities requires specialized investigation techniques. Investigators must be well trained specifically in handling child deaths. Discussions at multi-agency team meetings frequently alert members to the need for adequate autopsies, child death investigation training and expert knowledge related to child deaths. Barriers to improved investigations can be identified and eliminated.

6. To implement cooperative protocols for the investigation of child deaths.

Child death investigations may vary greatly. The use of investigation protocols by team members will provide consistency, guide intervention and standardize practice. With clearly defined roles, responsibilities and standardized procedures to follow, coordination and collaboration problems are less likely to arise.

7. To improve communication among agencies and the timely notification of agencies when a child dies.

Many times the agencies mandated to investigate and respond to child deaths are not notified in a timely or reliable way. Establishment of a local team often ensures that reliable and timely methods of notification of child deaths are followed within the community. Because of the team, some members have found that reporting laws regarding child deaths are more

closely followed. Members have discovered that they are receiving referrals and exchanging case information with some agencies for the first time.

8. To provide a confidential forum for agencies to meet and discuss common issues or resolve conflicts.

Maintenance of open relationships between agency personnel in a confidential setting improves all aspects of services provided for children and their families. Teams are protected by state law regarding the exchange of information or discussions held during a review team meeting. This protection provides an opportunity to openly discuss specific issues which may have been previously considered imprudent.

9. To propose needed changes in legislation, policies and procedures.

Over time, a team may see recurring issues in policy or practice within an agency. The appropriate team member can then address the issue within his or her own agency. Aggregate information from local team data will provide the basis for the annual report of the State Child Fatality Review Team Committee. Addressed to the governor, lieutenant governor and the legislature, this report will identify needed policy changes at the state level and include recommendations for changes in laws that will reduce the number of preventable child deaths.

10. To identify and address public health issues.

The review system provides agencies the opportunity to identify patterns and trends of child deaths in their region. Many of these deaths will not be a result of intentional abuse or involve criminal activity, but rather will fall in the category of public health issues. Identification of these patterns and trends will provide the information required for local and state efforts to educate the public, make recommendations for change, design intervention approaches, and pool resources to address the need.

D. Membership

1. Core Team Membership

Core members are representatives from the agencies responsible for child death investigations, death certification, or any resulting legal action. They are:

a) police

b) sheriff

c) child protective services

d) criminal prosecutor

e) medical examiner or justice of the peace

f) pediatrician

2. Additional Members

Additional members are determined depending on community resources and needs. The may include any of the following:

a) emergency medical services personnel

b) mental health provider

c) juvenile probation officer

d) public health professional

e) child educator

f) sudden infant death syndrome family services provider

g) victim's assistance representative

h) child advocate

i) fire fighter

j) neonatologist

Other members may be determined as reviews reveal gaps in information that indicate a need for additional team representation. For example, local child-care licensing representative was added to teams who were repeatedly reviewing deaths occurring in child-care facilities and needed information regarding licensing standards. Because agencies have special programs which relate to team activities, it may be appropriate to have more than one agency representative on the team.

3. Auxiliary Members

To facilitate completing reviews in a timely manner, teams may designate "auxiliary" members. These team members are not permanent members and therefore, do not regularly receive team notices. They attend meetings only when 1) they were directly involved in a death scheduled for review or, 2) to provide information on team related activities. Auxiliary members provide valuable information to the team without increasing the number of permanent team members.

E. The Roles of Team Members

The roles of the team members can be flexible to meet the needs of a particular community. The individual abilities of members should be used to form the most effective team possible.

Each member provides the team with information from their records, serves as a liaison to their professional counterparts, provides definitions of their profession's terminology, interprets the procedures and policies of their agency, and explains the legal responsibilities or limitations of their profession. They also assist in making referrals for services or providing direct aid to surviving family members.

All team members must have a clear understanding of their own and other professional's and agencies' roles and responsibilities in response to child fatalities. Additionally, members need to be aware of and respect the expertise and resources offered by each profession and agency. The integration of these roles is the key to a community having a well coordinated child fatality response system.

1. Medical Examiner or Justice of the Peace

All information regarding suspicious or unnatural child deaths is received by medical examiners or justices of the peace. However, all child deaths under age 6, regardless of the cause must be reported to the medical examiner or justice of the peace according to Chapter 264 of the Family Code. If a county has a medical examiner (ME) system, justices of the peace (JP) are not involved in child deaths, and medical examiners make the determination of cause of death. Justices of the peace have the authority of a medical examiner in counties without a medical examiner. There are usually several justices of the peace in a county, but only one medical examiner for several adjacent counties. Guided by state law requirements, justices of the peace routinely request medical examiners to perform an autopsy to aid them in making cause of death rulings.

When reviewing suspicious or unnatural deaths, the medical examiner or justice of the peace provides the team with information regarding how the determination of cause of death was reached. If an autopsy was performed, a summary of the report is included. They educate team members in areas relating to cause of death rulings.

The medical examiner or justice of the peace also assists the team because of their access to records from the other investigating agencies and because of their ongoing working relationship with law enforcement, EMS, hospitals, and CPS.

2. Law Enforcement

Law enforcement members provide information on criminal investigations of child deaths reviewed by the team. They also check the criminal histories of the child and/or family members and suspects in the child death cases. To ensure sufficient representation, both the sheriff's department and the police department in the largest jurisdiction are needed as team members. The law enforcement team members act as liaisons between the team and other local law enforcement departments. They assist with persuading officers from other agencies to participate in reviews when there is a death in that jurisdiction. Law enforcement officers are usually the best trained team members on scene investigations and interrogations, essential skills required in determining how a child died. Their expertise provides useful information and training to other members.

3. Child Protective Services (CPS)

The CPS member has the legal authority and responsibility to investigate and provide protection to siblings that might be at risk. As a team member, they provide detailed information on the family and the worker's investigation into the child's death. CPS members also have prior agency contact information including 1) reports of neglect or abuse on that child or siblings and 2) CPS services previously or currently being provided to the family.

They may be able to provide the team with information regarding the family's history and the psychosocial factors that influence family dynamics such as unemployment, divorce, previous deaths, history of domestic violence, history of drug abuse, and previous abuse of children. When reviews indicate the need, CPS may provide services to the surviving family members. Their knowledge on issues related to child abuse and neglect cases is essential to an effective team.

4. Prosecutor

Prosecutors educate the team on criminal law and provide information about criminal and civil actions taken against those involved in the child deaths reviewed. They also provide the team with explanations regarding when a case can or cannot be pursued and information about previous contacts with family members and criminal prosecutions of suspects in a child death.

5. Public Health

Public health agencies facilitate and coordinate preventive services needed to assist the community with education and community awareness programs. Public health members provide the team with vital records, epidemiological profiles of families for early risk detection and prevention of child deaths, and help educate members on the public health services available in the county. Public health doctors or nurses help identify public health issues that arise in child deaths and also provide medical explanations to the team. If the child was treated in a local public health facility, they can provide medical histories and explanations of previous treatments.

6. Pediatrician

The pediatrician provides the team with medical explanations and the perspective of having knowledge gained from routinely examining children who present with a variety of medical conditions. They can access medical records at hospitals and from other doctors. If the pediatrician testifies regularly in child abuse trials, his or her expert opinion regarding medical evidence can be useful. It is preferable if the pediatrician team member has experience in treating victims of child abuse and neglect. If a pediatrician is unavailable, teams may select a physician who specializes in family practice or has a general practice.

7. Mental Health

The mental health representative provides information and insight regarding psychological issues related to the child, the family, the perpetrator, and the event that caused the child's death. They make suggestions when counseling or other mental health service referrals may be appropriate.

8. EMS/Fire Fighter

Fire fighters provide information about investigations of fire-related deaths and education regarding preventing these deaths. EMS is frequently first at the scene and observes critical information regarding the scene and circumstances of a child's death, including the behavior of witnesses. The EMS report can also be useful in determining the position of the body at death and other scene elements that may have changed before an investigator arrived..

9. Child Advocate

Child advocates represent a variety of local child advocacy programs. Texas CASA and child advocacy center directors or interviewers are excellent candidates for team members. These individuals offer the team organizational ability, excellent communication and negotiation skills, and understand the role of each of the team members and participating agencies.

10. Chief Juvenile Probation Officer

The juvenile probation officer provides information regarding crimes involving older children. A large number of teenagers die from gunshot or stab wounds inflicted by other adolescents. Gang related shootings are frequent in some communities, along with drug and alcohol related deaths of teenagers. Teenage suicide numbers increase each year. Records from juvenile workers assist in the reviews of these deaths.

11. Sudden Infant Death Syndrome (SIDS) Family Service Provider

SIDS account for a large number of infant deaths. Sudden infant death syndrome family service providers educate the team on various issues related to SIDS deaths. The counseling of surviving family members in a SIDS death is a much needed component of the community child death response.

What contributes to these deaths and, therefore, how to prevent them continues to puzzle the professionals handling these cases. As team members, SIDS family service providers offer the most up -to-date information and assistance available regarding this issue.

12. Child Educator

The child educator provides the team with information from school records regarding children and families. School records include academic performance, participation in school and extra-curricular activities, absenteeism, and other indicators of a child's well-being. As educators, these team members offer the perspective of professionals who regularly observe child health, growth and development.

F. Regional Review Teams

1. Regional review teams consist of representatives from more than one county and are encouraged when establishing teams in counties consisting of populations of 55,000 or less.

In forming these teams, organizers should consider what agencies or facilities involved in child death response are shared by the counties. It is preferable that the counties have many of the following areas of jurisdiction or responsibility in common: state health and human services region, criminal prosecutor's jurisdiction, medical examiners' jurisdiction, hospital district, and/or EMS/firefighters district.

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

3. To ensure that the review team concept of community involvement is met, at least one representative from a core member agency of the county where the illness/injury or event occurred that caused the child's death should be present during the review. This allows the regional team to receive information from the professionals directly involved with the death, while strengthening the team's relationship with the various local agencies in the counties covered by the team. Establishing and maintaining this relationship is crucial if the team's prevention, training and education objectives are to be achieved.

IV. Steps To Establishing a Team

A. Team Organizers

To establish a multi-agency, multi-disciplinary child fatality review team in your community, one of the professionals composing team membership must be willing to commit the time and effort required to form a team. Teams have been initiated in Texas by physicians, prosecutors, medical examiners, law enforcement, justices of the peace, public health officers, CPS workers, and child advocates. Teams are not mandated in Texas, but are created through individual efforts and the voluntary cooperation of the agencies and professionals involved with child deaths.

B. Contact State Review Team Coordinator

The team organizer contacts the State Child Fatality Review Team Coordinator at the Texas Department of Protective and Regulatory Services for team information and membership recruiting materials. The community's local political climate and relationships between the heads of core agencies will strongly impact the approach taken to forming the team. Each community should adapt the approach most suitable to their unique characteristics.

C. Study Team Materials

The team organizer becomes thoroughly familiar with review team operation through the informational materials. Any supplemental information regarding other professions and how they function should also be studied.

D. Contact Operating Review Team

Team organizer contacts the presiding officer of an operating team and requests to attend their meeting. The team contacted should have been conducting reviews for at least a year. Observing a team will answer many questions regarding how teams operate. It may also provide suggestions on recruiting potential team members.

E. Contact the Local Core Member Agencies

The team organizer contacts the directors of the core member agencies and professions to discuss establishing a team. It is important that organizers become familiar with each agency's role and the need for their participation on the team before meeting with the various agencies. In recruiting team members, request the highest possible level of staff from each participating agency to join the team. These individuals have the authority to implement changes if necessary, and to obligate the agency to cooperative projects and protocols. If the agency director is not available, a lower level staff member with the knowledge and experience of direct and routine involvement with child deaths should be designated to represent the agency. These agency staff provide the team with essential input. The team should be comprised of professionals with both executive and specialized responsibilities.

F. Schedule an Organizational Meeting

After all core agencies have been contacted, the team organizer schedules an organizational meeting. Provide two or three weeks notice and offer a choice of dates and times for the meeting. Hold the meeting only if most of those invited are able to attend. Several organizational meetings may be necessary before teams can actually begin reviewing deaths.

G. Conducting an Organizational Meeting

1. Present the basic information concerning the purpose and operation of a local child fatality review team. You may request the attendance of the State Child Fatality Review Team Coordinator and/or a team member from an operating team to discuss team operations.

2. Discuss the role of each agency and profession and the benefits to participating agencies.

3. Allow time for each person attending to express concerns or raise issues. Make sure each person has an opportunity to ask questions and participate.

4. You may not have the answers to all the initial questions. Agree to get answers or find out what other teams are doing regarding a particular issue and report back to the group.

5. Discuss and complete these steps:

   a) Discuss the child fatality review team authorizing statute, Chapter 264, Subchapter F of the Texas Family Code; the inter-agency and confidentiality agreements and the team data collection forms.

   b) Compile a list of other potential team members and develop a plan for enlisting their participation. Include a time frame for completing contacts.

   c) If necessary, set a time, date, and location for another organizational meeting. All organizational issues should be addressed prior to beginning child death reviews.

   d) If no additional organizational meetings are required, schedule the first meeting to review deaths. Attendance will be higher if a regular time and place is agreed upon for meetings.

   e) Agree on what materials will be compiled and distributed to team members at the first review meeting. Materials should include some basic information about child fatality review teams, the authorizing legislation, the data collection form, and the preliminary agreements made at the initial meeting.

   f) Compose and distribute minutes of the organizational meeting to core members. Contact the core members to ensure the minutes were accurately recorded. The minutes should include any agreements reached and suggestions for future actions.

   g) Follow-up with core members to ensure delegated tasks are completed before the first team meeting of reviews is held.

   h) The team organizer contacts the State Child Fatality Review Team Coordinator for team recognition. The Bureau of Vital Statistics will not distribute death certificates to teams without the authorization of the State Child Fatality Review Team Coordinator.

V. Team Operation Procedures

A. Reviewable Deaths

1. A team reviews all child deaths regardless of cause for children under age 18.

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

3. More extensive in-depth reviews are conducted for sudden and unexpected deaths. These deaths generally require a more intensive discussion by the team to discover the circumstances surrounding the death.

4. Because of the large numbers of child deaths in their county, some large urban teams have prioritized their reviews by establishing review criteria.

5. Reviews are to be conducted by the team which covers the county where the illness/injury or event occurred which, according to the death certificate, caused the child's death. The deceased child may or may not be a resident of the county covered by the team. Because death certificates are distributed based upon the county of residence, please review "Transfer and Forms Procedures" located in the Attachments section of this guide.

B. Information Sharing

1. Teams are not a mechanism for criticizing or second-guessing any agency's decision. They are a mechanism for the essential information sharing required if the system's response to child fatalities is to be improved.

2. A team may request information and records regarding a deceased child as necessary to carry out the purpose and duties of the team. Background and current information from the records of team members and other sources may be needed to assess circumstances of the death.

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

4. A standing request for records and information may be developed by the team to facilitate the gathering of information required to conduct a death review. It should be addressed to the "custodian of the records" or the agency director and include the review team authorizing statute, information regarding the team operation and purpose, and a copy of the team's interagency agreement. These requests are particularly useful for acquiring information from agencies that do not have a representative on the team. Some teams have numerous hospitals in the county or counties covered by the teams; this request would enhance the team's ability to gather required medical information.

5. When reviewing deaths of children who were or are residents of another county, team members should contact the agency which corresponds to theirs and request information regarding the deceased child for the review.

C. Confidentiality

1. Records acquired by the team to conduct a review are exempt from disclosure under the Open Records Law, Chapter 552 of the Government Code.

2. Data collected and information regarding the death of a child at a review team meeting are confidential.

3. A report or statistical compilation of a review team is a public record subject to the Open Records Law, Chapter 552 of the Government Code if it does not permit the identification of an individual.

4. A team member may not disclose any information that is confidential.

5. Information, documents and records of the team are confidential and are not subject to subpoena or discovery and may not be introduced into evidence in any civil or criminal proceedings.

6. Information that would otherwise be available from other sources are immune because they were included in a review team meeting.

7. The child protective services member of a team may not disclose information from the Texas Department of Protective and Regulatory Services records that would identify an individual who reported an allegation of child abuse and neglect.

D. Presiding Officer

The team selects a presiding officer at the organizational meeting prior to the first meeting when reviews are conducted. The presiding officer may be any of the team members and serves as presiding officer at the discretion of the team. Teams may decide to specify terms for the presiding officer and rotate the position among the members.

E. Duties of the Presiding Officer

1. The presiding officer is responsible for calling and chairing the team meetings.

2. The duties of the presiding officer include:

   a) sending notices of meetings to the team members

   b) obtaining the names of the children to be reviewed and compiling the summary information for distribution to team members

   c) distributing the information in b); it should be prepared approximately two weeks before each scheduled meeting to allow team members time to gather their agency's information about the child and family

   d) submitting the data reports to the state Bureau of Vital Statistics not later than the 30th day after the date the review is completed

   e) ensuring the team operates according to the protocols developed by the Texas Department of Protective and Regulatory Services, as adapted by the team.

F. Member Designees and Meeting Attendance

1. Team members may designate another representative of their agency to replace them at meetings they are unable to attend. Team members must recognize the need to attend meetings regularly to offer the expertise and knowledge which initially determined their selection.

2. Agencies of members who are consistently unable to attend meetings may be contacted by the team's presiding officer to select another member to represent them on the team.

G. Obtaining the Names for Team Reviews

1. The Bureau of Vital Statistics in the Texas Health Department will provide death certificates to the team's presiding officer and birth certificates for children born in Texas and under two years of age. Because it is the legal document required to certify death and bury a body, the death certificate is the basis for a review. The birth certificate includes an expanded lower section with medical information regarding the mother and newborn that is extremely useful for reviews.

2. Because of the length of time involved in the filing process, there is usually an eight week delay period from the date of the child's death until the time the presiding officer will receive the death certificate.

3. To obtain birth certificates, presiding officers must submit a request in writing to the state registrar at the state Bureau of Vital Statistics. The request must include the deceased children's names and the date of the meeting for which the birth certificates are required.

4. To obtain names earlier for review meetings, presiding officers may contact their local registrars. Most counties have more than one registrar; and each city in a county may have its own office of vital statistics, with the county clerk recording deaths for unincorporated areas. The State Registrar can supply presiding officers with a list of local registrars for their area. All local registrars are required by law to submit their certificates to the State Registrar.

H. Child Death Information and Distribution for a Review Meeting

The presiding officer compiles summary information for each death to be reviewed. It is required by team members to search their files and obtain the necessary data for a review. Most of this information is available from the death certificate and the medical examiner's records.

For confidentiality purposes, the death certificates and birth certificates are not distributed to the members until the meeting.

I. Child Fatality Summary Information

1. Deceased child's name.
2. Child's ethnicity, age, and gender.
3. Child's date of birth and date of death.
4. Mother's name and address (both maiden and current is usually required for background checks and prior CPS involvement). If you cannot obtain mother's name, then use father's name or legal guardian's name and address.
5. Cause of death - may be pending when the list is initially written. Cause of death is the specific reason the child died: car accident, blunt force head injury, gunshot, pneumonia, etc.
6. Manner of death - is the category of the death; natural, homicide, suicide, accidental or undetermined.
7. Brief description of what may have occurred, i.e. "child found face down in bassinet"

J. Record Keeping

The team will not maintain records of case discussions. Basic information will be kept for purposes of informing the team members of the deaths to be reviewed; and the data collection form may be kept or not kept by the team. The team's presiding officer maintains a list of issues raised during the meetings.

VI. Procedures for Conducting a Child Death Review Meeting

A. Members Agree To Confidential Discussions

Each member agrees to keep meeting discussions and information confidential. This is essential for each agency to be able to fully participate in the meetings. A confidentiality agreement signed by team members and required for other meeting attendees should be kept at each meeting by the presiding officer.

B. Members Provide Information

Each team member provides information from their agency's records and, when appropriate, distributes them to other members.

C. Categories Of Deaths Requiring Extensive Review:

1. Homicide
2. Injuries
3. Suicide
4. Undetermined
5. Sudden or unexpected deaths, including SIDS
6. All medical examiner cases
7. All cases with previous CPS involvement
8. All cases investigated by law enforcement

D. Data Collection And Time Required For Reviews

Deaths will vary in the amount of time required for completion of a review. Each member presents their agency's investigation and/or historical information on the cases and families. To ensure an adequate review has been conducted and the appropriate questions asked, the data collection form serves as the agenda for a review. Not all questions are applicable for each death. Information that is not available can be just as valuable to the review process as what is available. The lack of information regarding the circumstances of a death serves the team by focusing their attention to what information was needed, but unavailable. Such awareness eventually allows the team through its members, team reports and prevention efforts to address these issues.

E. Review Discussion

The presiding officer ends every review with a question that is on the data collection form, "After hearing all the information regarding this child's death, was this a preventable death?" If, the answer is "yes," the team is asked to identify possible interventions. At the end of the meeting, each member may discuss any issues raised during the meeting.

F. Record Meeting Issues

The presiding officer maintains a record of issues from team discussions. The team will need to periodically review these issues and develop a plan for addressing and monitoring what actions are taken on each issue.

G. Follow-up Reviews

Cases may need to be discussed at more than one meeting for several reasons: the results of the investigations are incomplete at the first review, members may wish to obtain additional information from their agency, a team member or auxiliary member with significant information is absent, or the case continues to progress and needs to be updated.

H. Expedited Reviews

Expedited reviews are for those deaths which are not reviewed by the complete fatality review team. A team member or group of members examines the pertinent information of a case prior to the team meeting. If the case appears to be non-controversial, i.e. circumstances of death are not out of the ordinary, there is not additional information other than that contained on the death certificate, or a full review will probably not yield new specific prevention strategies, the case may receive an expedited review.

I. Referrals

Referrals for appropriate services are an opportunity for the team to assess and address an immediate need. A “referral list” should be compiled by the team of programs or agencies that can provide services identified by the team. Referrals are usually handled by the team member professionally associated with the program or agency providing the service. Any team member may assist with making a referral. The team should discuss how the referral will be made and who will be responsible for handling it.

VII. Agency Conflict Resolution

Participating agencies may have individuals with concerns or disagreements regarding specific cases. Reviews are not opportunities for others to criticize or second guess an agency's decision regarding a case. Issues with the procedures or policy of a particular agency are sometimes identified; however, that agency's team member is responsible for any further action taken on the issue by his or her agency.

Teams are not peer reviews. They are designed to look at the system issues, not the performance of individuals. The team review is a professional process aimed at improving the system that responds to child deaths.

Most agencies involved in the teams do not have an internal review process; Child Protective Services conducts multi-agency reviews of child fatalities in which there has been prior contact with the agency. Some hospitals conduct internal reviews for child deaths. For most agencies, review teams provide a forum that previously did not exist for reviewing their actions, policies and procedures.

When conflict continues to occur among members, the presiding officer should intervene at the meeting to allow the review to progress. By contacting the members outside the meeting, the presiding officer may discuss the issues and assist with resolving the conflicts. Sometimes disagreement is both productive and appropriate, but disruption of the review is not acceptable. Members should always be encouraged to conduct the reviews in a professional manner.

VIII. Media Relations

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

The presiding officer should contact the various local media and provide them with information regarding the establishment of the team, its purpose and operation. The presiding officer should continue to provide the media with statistics and/or reports relating to the team's activities. All information that is confidential as specified by state statute is not to be disclosed to the media. Frequently , the objectives and review process is misunderstood by representatives of the media. The presiding officer and members are responsible for reinforcing the concept of the team as "not a fault-finding panel".

Viewing the media as an essential component for the team to accomplish its prevention strategies allows the team members to interact with media representatives in a manner that better serves the community, and allows the team to function effectively.

IX. Maintaining A Review Team

A team follows three stages of development to achieve its goal of reducing the number of preventable child deaths in the community: organizational, operational, and the implementation of prevention efforts and strategies from team findings. Once a team has been established and the procedures for operation are thoroughly understood, maintenance of the team is essential. The following are recommendations for maintaining a functional review team:

A. Respect Team Agreements

For the team to operate effectively, it is essential that team agreements be recognized and followed by the members.

B. Participate And Be Prepared For Meetings

Reviews require the regular attendance and participation of its members. Members should become acquainted with the questions on the data collection forms to facilitate their own record preparation.

C. Keep Regular Schedules For Meetings

Establishing regularly scheduled meetings provides members with the ability to make long term schedule plans and allows for better attendance. Cancelling scheduled meetings diminishes the team's ability to gather information and hinders the cooperative networking of the members. A team can only achieve its objectives by meeting routinely and regularly.

D. Provide An Educational Element To Team Meetings

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

E. Use The Texas Network of Review Teams

Regular contact with other teams for suggestions regarding how they handled a problem or to obtain input on innovative team efforts is often helpful.

F. Use The Professional Associations Represented On Teams

Professional associations can answer questions regarding many aspects of the responsibilities and statutes that govern a profession.

G. Use The State Child Fatality Review Team Committee

The resources of the agencies responsible for the State Child Fatality Review Team Committee, according to the roles specified in Chapter 264, Subchapter F of the Family Code, are readily available to assist teams. Teams provide input to the State Committee regarding the needs of local communities and teams.

H. Provide Other Members With Support

Each profession brings to the team their perspective, professional knowledge and expertise. It is support, not criticism, that will encourage change and allow for improvements. Disagreement between members is sometimes unavoidable, but if handled inappropriately, it could affect the team's ability to function effectively. It is the responsibility of the presiding officer to reinforce productive exchanges and discourage dialogue which is disruptive to the review process. Each member must acknowledge and respect the professional role of each participating agency.

Improvements will come through cooperative effort, not coercion.

I. Do Not Lose Sight Of The Team's Purpose And Objectives

A periodic review of the stated purpose of the team and its goal and objectives will provide direction to the team and remind members why the team was originally formed.

J. Team Membership Is A Long-Term Commitment

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

K. A Team Is Both A Message To The Community And A Message From The Community.

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

X. Prevention

According to Chapter 264 of the Family Code, Section 264.506, one of the purposes of a review team is to "initiate prevention measures as indicated by the review team findings." To assist with the development of these efforts, local, state, and national programs that address specific prevention needs for the health, safety and well-being of children and families are available to teams. These programs exists in both the public and private sector and may be sponsored by various religious, community, professional and/or government organizations. Some are short-term projects with temporary funding. Others are established programs with documented results and a proven track record.

A. Compile and Maintain A Record of Programs

Each team should compile and maintain a record of these prevention programs. It will allow the team to 1) make appropriate referrals for services indicated by a specific review. and 2) identify public awareness and prevention education needs of the community.

The presiding officer should schedule a meeting designed to discuss programs or services that exist in the county or region that will assist the team in compiling its referral list. This meeting will also help the team identify what services do not exist, but are needed. Once the list has been compiled, team members should keep the team informed of programs that develop within their agencies and of others they become aware of outside their agency.

B. Contact the Program

By contacting the various service providers, team members will receive information regarding the specifics of their programs. Services and assistance may include medical care, education, professional therapeutic and crisis intervention services, information and referrals, food, medical supplies or equipment, and child health and/or safety equipment. These programs may also serve the team by forming the basis for coalitions and partnerships that create the foundation for the team's prevention efforts.

Inviting representatives of these programs to inform the team regarding their mission, target clients and the delivery of their services will facilitate the team's ability to make appropriate referrals.

C. Types of Program Resources

Types of programs for referrals and assistance include:

SIDS Family Counseling
Teen Pregnancy Prevention
Suicide Prevention and Counseling
Firearm Safety
Crime Victim's Assistance
Gang Prevention and Intervention
Substance Abuse Counseling and Education
Drowning Prevention
Seat Belt Safety
Domestic Violence Intervention
Teen Driving Safety
Bicycle Safety
Fire Safety
Prenatal Medical Care
Parenting Skills
Infant and Child Day Care Programs
Child Abuse and Neglect Prevention Programs
Poison Control
Child Safety Seat Loaner Programs

XI. Resources

Team members should contact the numerous agencies and organizations that have established prevention programs for assistance and information. This list includes only a few of the groups that can assist teams.

A. National Organizations

SAFE KIDS Coalition

US Health and Human Services Department

US Department of Justice– Juvenile Crime Prevention Department

SIDS National Clearinghouse- McLean, Virginia

National Committee to Prevent Child Abuse, 1-800-CHILDREN

National Center on Child Abuse and Neglect

Annie B. Casey Foundation

Centers for Disease Control and Prevention– Atlanta, Georgia

National Committee to Prevent Child Abuse– Chicago, Illinois

B. State Organizations

Texas Department of Protective and Regulatory Services

Children's Trust Fund of Texas Council

Texas Department of Health

Texas Youth Commission

Texas Department of Mental Health and Mental Retardation

Services to At-Risk Youth (STAR)

C. Professional Associations:

Professional associations are created to provide assistance, training, and information for their members. As a resource, they can offer teams updates on changes to laws that affect various professions, and information regarding training and programs that relate to team activities.

American Academy of Pediatrics

National Medical Examiner's Association

Texas Pediatric Society

Texas Medical Association

Texas Hospital Association

American Bar Association's Center on Children and the Law

Texas State Bar Association

County and District Attorney's Association

Justices of the Peace and Constables Association

Texas Police Association

Texas Sheriff's Association

American Professional Society on the Abuse of Children

Child Welfare League of America

National Institute for Mental Health

XII. Attachments

A. Sample Interagency Agreement

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

_____
District Attorney's Office

_____
Sheriff's Department

_____
Police Department

_____
Medical Examiner / Justice of the Peace

_____
TDPRS-Child Protective Services

_____
City / County Health Department

(Please add any additional agencies, etc.)

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

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

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

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

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

- criminal prosecutor
- medical examiner / justice of the peace
- physician
- child protective services
- sheriff
- police
- public health representative
- mental health provider
- child advocate
- EMS personnel
- juvenile probation officer

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

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

B. Review Team Sample Confidentiality Agreement

The purpose of a child fatality review team is to conduct a thorough examination of each child death in _____County(ties) by the _____County Child Fatality Review Team.

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

The undersigned agree to abide by the terms of this confidentiality agreement.

Name	Agency

Transfer Forms and Procedures

Child Fatality Review Team Case Transfer Procedures

Currently, the statute pertaining to the review procedure for child deaths (TFC 264.508) states:

1. The review team of the county in which the injury, illness, or event that was the cause of death of the child occurred, as stated on the child's death certificate shall review the death.

Because death certificates are distributed based upon county of residence, the following transfer procedure was created to facilitate the referral of death certificates to those counties responsible for the review of a death. It is hoped that this procedure will also open lines of communication between teams and allow for the exchange of information relating to the review of child deaths.

A. Deaths Due to Injury

1. Upon receipt of the death certificates, the presiding officer or team coordinator examines section 41e of the certificate of death to determine geographical location of injury.

2. If the injury occurred in a county outside the jurisdiction of a particular team, the death certificate is then forwarded to the appropriate team through the following mechanism:

   a. The Child Fatality Review Team Transfer/Return Form is completed and forwarded with the death certificate to: (1) the appropriate team, and (2) Child Fatality Review Specialist, Bureau of Vital Statistics.

   b. A copy of the death certificate and transfer/return form should also be retained by the team originally receiving the death certificates.

3. If there is not a team in the county where the injury occurred, a copy of the death certificate should be returned to the Bureau of Vital Statistics using the Child Fatality Review Team Transfer/Return Form with the date of return.

B. Natural Deaths

1. This group of deaths should continue to be reviewed based upon county of residence since much of the information pertaining to the child's social and medical history will be found in the county where the child resided.

2. If assistance is needed in obtaining medical records for deaths occurring in counties other than the county of residence, Child Fatality Review Teams in the county where the death occurred can help facilitate the request and transfer of records.

Child Fatality Review Team Transfer/Return Form

Circle One: Transfer Return

County of Injury: _____

County of Death: _____

Death Certificate received by: _____team

Death Certificate transferred to: _____team

Date transferred/returned:_____

For a transfer, please attach a copy of the death certificates and forward copies to (1) the appropriate team, and (2) the Texas Bureau of Vital Statistics at the following address:

Child Fatality Review Specialist
Bureau of Vital Statistics
Texas Department of Health
1100 West 49th Street
Austin, TX 78767-3199

For a return, please attach a copy of the death certificate and forward to the Texas Department of Health, Bureau of Vital Statistics at the above address.

STATE OF TEXAS

CERTIFICATE OF BIRTH

BIRTH NUMBER

SAMPLE

NEWBORN

1. Name — First / Middle / Last
2. Date of Birth
3. Sex
4a. Place of Birth - County
4b. City or Town (If outside city limits, give precinct no.)
5. Time of Birth
6a. If Plurality (Single, Twin, Triplet, etc)
6b. If Plural Birth, Was It 1st, 2nd, 3rd, etc.
7a. Place of Birth ☐ Clinic / Doctor's Office ☐ Licensed Birthing Center ☐ Hospital ☐ Residence ☐ Other (Specify):
7b. Name of Hospital or Birthing Facility (Not Institution, Do Not Use Acronyms)

ATTENDANT/ CERTIFIER

8a. Attendant's Name and Mailing Address
8b. Certifier - *I certify that this child was born alive at the place and time and on the date as stated.*
Signature and Title
Date Signed
8c. ☐ MD ☐ DO ☐ CNM ☐ Midwife ☐ Other (Specify):
8d. ☐ Attendant ☐ Facility Administrator / Designee ☐ Other (Specify):

MOTHER

10. Name — First / Middle / Maiden Surname
11. Date of Birth
12. Birthplace (State or Foreign Country)
13a. Residence - State
13b. County
13c. City or Town
13d. Street Address or Rural Location
13e. Inside City Limits ☐ Yes ☐ No
14. Mother's Mailing Address (*If Same As Residence, Enter Zip Code Only*)

FATHER

15. Name — First / Middle / Last
16. Date of Birth
17. Birthplace (State or Foreign Country)

REGISTRAR

18a. Registrar's File Number
18b. Date Received by Local Registrar
18c. Signature of Local Registrar

CONFIDENTIAL INFORMATION FOR MEDICAL AND PUBLIC HEALTH USE - THE FOLLOWING INFORMATION WILL NOT BE SHOWN ON CERTIFIED COPIES

19a. Mother Married? ☐ Yes ☐ No
19b. I consent for my baby's immunization information to be included in the statewide Immunization Registry and to share the immunization information with registered providers. ☐ Yes ☐ No
19c. SSN for your new baby? ☐ Yes ☐ No
19d. SSN of Mother
19e. SSN of Father

SIGNATURES

20. Signature of Parent – I have reviewed the information above and I swear that it is correct.
21. Father's mailing address (If Same as Mother enter 'Same')

MOTHER

22. Race (For example: American Indian, black, white, etc.)
23. Hispanic Origin, If Yes, Specify (Mexican, Cuban, Puerto Rican, etc.)
24. Education - highest grade completed (0 - 17+)
25a-b. Usual Occupation (homemaker, lawyer, teacher, clerk, programmer, actor, realtor, artist, nurse, etc.)
25c-d. Type of Business / Industry (banking, retail, consulting, education, farming, government, manufacturing, etc.)
22a. Mother
23a. ☐ Yes ☐ No Specify:
24a. Mother
25a. Mother
25c. Mother

FATHER

22b. Father
23b. ☐ Yes ☐ No Specify:
24b. Father
25b. Father
25d. Father

PREGNANCY HISTORY

LIVE BIRTHS		OTHER PREGNANCY OUTCOMES
26a. Now Living: Number ____ ☐ None	26b. Now Dead: Number ____ ☐ None	26c. Number ____ ☐ None

26d. Date of Last Live Birth
26e. Date Last Other Pregnancy Ended
26f. Mother's Medicaid Number

27. Source of Prenatal Care (check all that apply)
☐ Hospital Clinic ☐ Public Health Clinic ☐ Private Physician ☐ Midwife ☐ Nurse ☐ Unknown ☐ Other (specify):

28. Hepatitis B Immunization Given ☐ Yes ☐ No
29. Birthweight: G. or LB. OZ.
30. Date Last Normal Menses Began
32. Clinical Estimate of Gestation (Weeks)
33. Prenatal Care Began During 1st, 2nd, 3rd, etc. month. Specify:
34. Number of Prenatal Visits
35a. HIV Test Done Prenatally ☐ Yes ☐ No
35b. HIV Test Done at Delivery ☐ Yes ☐ No
35c. Serologic Test Done at Delivery ☐ Yes ☐ No

37a. Mother Transferred Prior to Delivery ☐ No ☐ Yes (Specify Facility):
37b. Infant Transferred After Delivery ☐ No ☐ Yes (Specify Facility):
37c. Hospital Use

38a. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply) 1 ☐ Anemia (Hct.<30/Hgb.<10) 2 ☐ Cardiac disease 3 ☐ Acute or chronic lung disease 4 ☐ Diabetes
5 ☐ Hydramnios / Oligohydramnios 6 ☐ Hemoglobinopathy 7 ☐ Hypertension, chronic 8 ☐ Hypertension, pregnancy-associated 9 ☐ Eclampsia 10 ☐ Incompetent cervix
11 ☐ Previous infant 4000+ grams 12 ☐ Previous preterm or small - for - gestational-age infant 13 ☐ Preterm labor 14 ☐ Renal disease 15 ☐ Blood group isoimmunization
16 ☐ Preterm rupture of membranes (<24 hrs.) 17 ☐ STD 18 ☐ Zidovudine administered during pregnancy 19 ☐ NONE
20 ☐ Other (Specify): 21 ☐ UNKNOWN

38b. OTHER RISK FACTORS FOR THIS PREGNANCY (Complete all items) ☐ Yes ☐ No Tobacco use during pregnancy ____ Average number of cigarettes per day
☐ Yes ☐ No Alcohol use during pregnancy ____ Average number of drinks per week ____ 6a. Weight gained during pregnancy

38c. OBSTETRIC PROCEDURES (Check all that apply) 1 ☐ Amniocentesis 2 ☐ Electronic fetal monitoring 3 ☐ Induction of labor 4 ☐ Augmentation of labor 5 ☐ Tocolysis
6 ☐ Ultrasound 7 ☐ NONE 8 ☐ Other (specify): ____

38d. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)
1 ☐ Fever (>100° F. or 38° C) 2 ☐ Meconium, moderate / heavy 3 ☐ Premature rupture of membrane (>12 hours) 4 ☐ Abruptio placenta 5 ☐ Placenta previa
6 ☐ Other excessive bleeding 7 ☐ Seizures during labor 8 ☐ Precipitous labor (<3 hours) 9 ☐ Prolonged labor (>20 hours) 10 ☐ Dysfunctional labor
11 ☐ Breech / Malpresentation 12 ☐ Cephalopelvic disproportion 13 ☐ Cord prolapse 14 ☐ NONE 15 ☐ Other (specify): ____

38e. METHOD OF DELIVERY (Check one of 1 - 4.)
1 ☐ Vaginal 2 ☐ Vaginal birth after previous C-section 3 ☐ Primary C-section 4 ☐ Repeat C-section
Check 5 and/or 6 if applicable
5 ☐ Forceps 6 ☐ Vacuum

38f. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)
1 ☐ Anemia (Hct. <39/Hgb. < 13) 2 ☐ Fetal alcohol syndrome 3 ☐ Hyaline membrane disease / RDS 4 ☐ Meconium aspiration syndrome 5 ☐ Assisted ventilation <30 min
6 ☐ Assisted ventilation ≥30 min 7 ☐ Seizures 8 ☐ Sepsis 9 ☐ UMBG pH < 7.2 10 ☐ NONE 11 ☐ Other (specify): ____

38g. CONGENITAL ANOMALIES OF CHILD (Check all that apply)
1 ☐ Anencephalus 2 ☐ Spina Bifida / Meningocele 3 ☐ Hydrocephalus 4 ☐ Microcephalus 5 ☐ Other central nervous system anomalies ____ (specify)
6 ☐ Heart malformations 7 ☐ Other circulatory / respiratory anomalies ____ (specify) 8 ☐ Rectal atresia / stenosis
9 ☐ Tracheo-esophageal fistula / Esophageal atresia 10 ☐ Omphalocele / Gastroschisis 11 ☐ Other gastrointestinal anomalies ____ (specify)
12 ☐ Malformed genitalia 13 ☐ Renal agenesis 14 ☐ Other urogenital anomalies ____ (specify) 15 ☐ Cleft lip / palate 16 ☐ Polydactyly / Syndactyly
17 ☐ Limb reduction(s) 18 ☐ Club foot 19 ☐ Diaphragmatic hernia 20 ☐ Other musculoskeletal / integumental anomalies ____ (specify)
21 ☐ Down's syndrome 22 ☐ Other chromosomal anomalies ____ (specify) 23 ☐ NONE 24 ☐ Other: ____ (specify)

WARNING: THE PENALTY FOR KNOWINGLY MAKING A FALSE STATEMENT IN THIS FORM CAN BE 2-10 YEARS IN PRISON AND A FINE OF UP TO $5000.

STATE COPY
VS-111 REV. 8/99

556101

STATE OF TEXAS — CERTIFICATE OF FETAL DEATH

STATE FILE NO.

FETUS

1. Name — First / Middle / Last
2. Date of Delivery
3. Sex
4a. Place of Delivery - County
4b. City or Town (If outside city limits, give precinct no.)
5. Time of Delivery
6a. Plurality (Single, Twin, Triplet, etc.)
6b. If Plural, Delivered (1st, 2nd, 3rd, etc.)
7a. Place of Delivery ☐ Clinic / Doctor's Office ☐ Licensed Birthing Center ☐ Hospital ☐ Residence ☐ Other (Specify)
7b. Name of Hospital or Birthing Center (If not institution, Give Street Address)

MOTHER

8. Name — First / Middle / Maiden Surname
9. Date of Birth
10. Birthplace (State or Foreign Country)
11a. Residence - State
11b. County
11c. City or Town
11d. Street Address or Rural Route Number
11e. Inside City Limits ☐ Yes ☐ No
12. Mother's Mailing Address (If Same As Residence, Enter Zip Code Only)
13. Informant — Signature & Relationship

FATHER

14. Name — First / Middle / Last
15. Date of Birth
16. Birthplace (State or Foreign Country)

ATTENDANT/CERTIFIER

17a. Attendant's Name and Mailing Address
18a. Certifier – To the best of my knowledge, fetal death was delivered at the time, date, and place as shown and fetal death was due to the cause(s) as stated
Signature and Title
Date Signed
17b. ☐ MD ☐ DO ☐ CNM ☐ Midwife ☐ Other (Specify)
18b. ☐ Attendant ☐ Facility Administrator / Designate ☐ Other (Specify)

DISPOSITION

19. METHOD OF DISPOSITION
☐ BURIAL
☐ CREMATION
☐ REMOVAL FROM STATE
☐ DONATION
☐ OTHER (SPECIFY)
20a. PLACE OF DISPOSITION (Name of Cemetery, Crematory or Other Place)
20b. Section / Block / Lot / Unknown ☐
21. LOCATION (City, State)
22. SIGNATURE OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH
23. DATE OF DISPOSITION
24. NAME & ADDRESS OF FUNERAL HOME

CAUSE OF FETAL DEATH

25. PART I — Fetal or maternal condition directly causing fetal death. (Do not enter terms such as stillbirth, prematurity, or cardiac arrest.) Fetal and/or maternal conditions, if any, giving rise to the immediate cause (a) stating the underlying cause last.
IMMEDIATE CAUSE (Enter only one cause per line for (a), (b), (c).)
(a)
DUE TO, OR AS A POSSIBLY CONSEQUENCE OF:
(b)
DUE TO, OR AS A POSSIBLY CONSEQUENCE OF:
(c)
Specify fetal or maternal

PART II — Other significant conditions of fetus or mother contributing to fetal death but not resulting in the underlying cause.
26. Fetus died before labor, during labor or delivery, unknown, (Specify)
27a. Was an autopsy performed? ☐ Yes ☐ No
27b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☐ No

REGISTRAR

28a. Registrar's File Number
28b. Date Received by Local Registrar
28c. Signature of Local Registrar

CONFIDENTIAL INFORMATION BELOW — FOR MEDICAL AND HEALTH USE ONLY — THIS SECTION MUST BE FILLED OUT

29. Race (For example, American Indian, black, white, etc.)	30. Hispanic Origin, If Yes, Specify (Mexican, Cuban, Puerto Rican, etc.)	31. Education - highest grade completed (0 - 17+)	32a. Usual Occupation (homemaker, student, teacher, clerk, programmer, attorney, realtor, artist, nurse, etc.)	32b-d. Type of Business / Industry (banking, retail, consulting, education, tourism, government, manufacturing, etc.)
29a. Mother	30a. ☐ Yes ☐ No Specify:	31a. Mother	32a. Mother	32b. Mother
29b. Father	30b. ☐ Yes ☐ No Specify:	31b. Father	32a. Father	32b. Father

PREGNANCY HISTORY

LIVE BIRTHS		LIVE PREGNANCIES
33a. Now Living: Number ☐ None	33b. Now Dead: Number ☐ None	33c. Number ☐ None
33d. Date of Last Live Birth	33e. Date of Last Other Pregnancy Ended	

34. Source of Prenatal Care (check all that apply) ☐ Hospital Clinic ☐ Public Health Clinic ☐ Private Physician ☐ Midwife ☐ None ☐ Unknown ☐ Other (specify):
35. Mother Married ☐ Yes ☐ No
36. Weight of Fetus — G. or Lb. Oz.
37. Date Last Normal Menses Began
38. Clinical Estimate of Gestation (Weeks)
39. Mother Transferred Prior to Delivery ☐ No ☐ Yes (Specify Facility):
40. Prenatal Care Began: During 1st, 2nd, 3rd, etc. month. Specify:
41. Number of Prenatal Visits
42a. HIV Test Done Prenatally ☐ Yes ☐ No
42b. HIV Test Done at Delivery ☐ Yes ☐ No
43. Serologic Test Done at Delivery ☐ Yes ☐ No

WARNING

The penalty for knowingly making a false statement in this document is [illegible] in prison and a fine of up to $10,000. (Health and Safety Code, Sec. 10[illegible])

44a. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply) 1 ☐ Anemia (Hct. <30/Hgb. <10) 2 ☐ Cardiac disease 3 ☐ Acute or chronic lung disease 4 ☐ Diabetes 5 ☐ Hemoglobinopathy 6 ☐ Hemoglobinopathy 7 ☐ Hypertension, chronic 8 ☐ Hypertension, pregnancy-associated 9 ☐ Eclampsia 10 ☐ Incompetent cervix 11 ☐ Previous birth 4000+ grams 12 ☐ Previous preterm or small - for - gestational age infant 13 ☐ Preterm labor 14 ☐ Renal disease 15 ☐ Blood group isoimmunization 16 ☐ Premature rupture of membranes (>37 hrs.) 17 ☐ IUGR 18 ☐ Zidovudine administered during pregnancy 19 ☐ NONE 20 ☐ Other (specify): 21 ☐ UNKNOWN

44b. OTHER RISK FACTORS FOR THIS PREGNANCY (Complete all items)
☐ Yes ☐ No Tobacco use during pregnancy — Average number of cigarettes per day
☐ Yes ☐ No Alcohol use during pregnancy — Average number of drinks per week
lbs. Weight gained during pregnancy

44c. OBSTETRIC PROCEDURES (Check all that apply)
1 ☐ Amniocentesis 2 ☐ Electronic fetal monitoring 3 ☐ Induction of labor 4 ☐ Augmentation of labor 5 ☐ Tocolysis 6 ☐ Ultrasound 7 ☐ NONE 8 ☐ Other (specify):

44d. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)
1 ☐ Febrile (>100° F. or 38° C.) 2 ☐ Meconium, moderate / heavy 3 ☐ Premature rupture of membrane (>12 hours) 4 ☐ Abruptio placenta 5 ☐ Placenta previa 6 ☐ Other excessive bleeding 7 ☐ Seizures during labor 8 ☐ Precipitous labor (<3 hours) 9 ☐ Prolonged labor (>20 hours) 10 ☐ Dysfunctional labor 11 ☐ Breech / Malpresentation 12 ☐ Cephalopelvic disproportion 13 ☐ Cord prolapse 14 ☐ NONE 15 ☐ Other (specify):

44e. METHOD OF DELIVERY Check one of 1 - 4
1 ☐ Vaginal 2 ☐ Vaginal birth after previous C-section 3 ☐ Primary C-section 4 ☐ Repeat C-section
Check 5 and/or 6 if applicable
5 ☐ Forceps 6 ☐ Vacuum

44f. CONGENITAL ANOMALIES OF FETUS (Check all that apply)
1 ☐ Anencephalus 2 ☐ Spina bifida / Meningocele 3 ☐ Hydrocephalus 4 ☐ Microcephalus 5 ☐ Other central nervous system anomalies (specify) 6 ☐ Heart malformations 7 ☐ Other circulatory / respiratory anomalies (specify) 8 ☐ Rectal atresia / stenosis 9 ☐ Tracheo-esophageal fistula / Esophageal atresia 10 ☐ Omphalocele / Gastroschisis 11 ☐ Other gastrointestinal anomalies (specify) 12 ☐ Malformed genitalia 13 ☐ Renal agenesis 14 ☐ Other urogenital anomalies (specify) 15 ☐ Cleft lip / palate 16 ☐ Polydactyly / Syndactyly 17 ☐ Limb reduction(s) 18 ☐ Club foot 19 ☐ Diaphragmatic hernia 20 ☐ Other musculoskeletal / integumental anomalies (specify) 21 ☐ Down's syndrome 22 ☐ Other chromosomal anomalies (specify) 23 ☐ NONE 24 ☐ Other (specify)

STATE COPY
VS-113 REV. 1/97

SAMPLE

36583

STATE OF TEXAS — CERTIFICATE OF DEATH — STATE FILE NUMBER

Texas Department of Health — Bureau of Vital Statistics

1. NAME OF DECEASED (a) FIRST (b) MIDDLE (c) LAST | (d) MAIDEN | 2. SEX | 3. DATE OF DEATH

4. DATE OF BIRTH | 5. AGE (IN YEARS) | IF UNDER 1 YR. MO DAYS | IF UNDER 1 DAY HOURS MIN | 6. BIRTH PLACE (CITY & STATE OR FOREIGN COUNTRY) | 7. SOCIAL SECURITY NO.

8. RACE | 9a. WAS THE DECEDENT OF HISPANIC ORIGIN? ☐ YES ☐ NO | 9b. IF YES, SPECIFY (MEXICAN, CUBAN, PUERTO RICAN, ETC.) | 10. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ YES ☐ NO | 11. EDUCATION (SPECIFY HIGHEST GRADE COMPLETED, ELEM. OR SECONDARY (0-12) COLLEGE (13-16, 17+)

12. MARITAL STATUS ☐ MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED | 13. SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME) | 14a. DECEDENT'S USUAL OCCUPATION | 14b. KIND OF BUSINESS OR INDUSTRY

15a. RESIDENCE STREET ADDRESS | 15b. CITY OR TOWN

15c. COUNTY | 15d. STATE | 15e. ZIP CODE | 15f. INSIDE CITY LIMITS ☐ YES ☐ NO

16. FATHER'S NAME | 17. MOTHER'S MAIDEN NAME

18. PLACE OF DEATH (CHECK ONLY ONE)

HOSPITAL: ☐ INPATIENT ☐ ER/OUTPATIENT ☐ DOA | OTHER: ☐ NURSING HOME ☐ RESIDENCE ☐ OTHER (SPECIFY)

19. COUNTY OF DEATH | 20. CITY OR TOWN (IF OUTSIDE CITY LIMITS, GIVE PRECINCT NO.) | 21. NAME OF HOSPITAL OR INSTITUTION (If not in institution, show street address)

22. INFORMANT — SIGNATURE & RELATIONSHIP | 23. MAILING ADDRESS OF INFORMANT

24. METHOD OF DISPOSITION
☐ BURIAL
☐ CREMATION
☐ REMOVAL FROM STATE
☐ DONATION
☐ OTHER (SPECIFY)

25. PLACE OF DISPOSITION (NAME OF CEMETERY, CREMATORY OR OTHER PLACE)

26. LOCATION (CITY, STATE)

27. SIGNATURE OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH

25b. Section ____ Block ____ Lot ____ Space ____ Unknown ☐

28. DATE OF DISPOSITION

29. NAME & ADDRESS OF FUNERAL HOME

30. CERTIFIER

☐ CERTIFYING PHYSICIAN — TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE TIME, DATE AND PLACE, AND DUE TO THE CAUSE(S) AND MANNER AS STATED.

☐ MEDICAL EXAMINER ☐ JUSTICE OF THE PEACE — ON THE BASIS OF EXAMINATION AND/OR INVESTIGATION, IN MY OPINION, DEATH OCCURRED AT THE TIME, DATE, PLACE, AND DUE TO THE CAUSE(S) AND MANNER AS STATED.

31. SIGNATURE & TITLE OF CERTIFIER | 32. DATE SIGNED MO DAY YEAR | 33. TIME OF DEATH M.

34. PRINTED NAME & ADDRESS OF CERTIFIER

CAUSE OF DEATH

35. PART 1 ENTER THE DISEASES, INJURIES OR COMPLICATIONS THAT CAUSED THE DEATH. DO NOT ENTER THE MODE OF DYING, SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE ON EACH LINE. | Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ____ DUE TO (OR AS A LIKELY CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in death) LAST

b. ____ DUE TO (OR AS A LIKELY CONSEQUENCE OF):

c. ____ DUE TO (OR AS A LIKELY CONSEQUENCE OF):

d. ____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART 1 (i.e., substance abuse, diabetes, smoking, etc.) | 36a. AUTOPSY? ☐ YES ☐ NO | 36b. AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☐ YES ☐ NO

37. DID TOBACCO USE CONTRIBUTE TO DEATH ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

38. DID ALCOHOL USE CONTRIBUTE TO DEATH ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

39. WAS DECEDENT PREGNANT AT TIME OF DEATH ☐ YES ☐ NO ☐ UNK; WITHIN LAST 12 MO ☐ YES ☐ NO ☐ UNK

40. MANNER OF DEATH
☐ NATURAL
☐ ACCIDENT
☐ SUICIDE
☐ HOMICIDE
☐ PENDING INVESTIGATION
☐ COULD NOT BE DETERMINED

41a. DATE OF INJURY | 41b. TIME OF INJURY M. | 41c. INJURY AT WORK ☐ YES ☐ NO | 41d. PLACE OF INJURY — AT HOME, FARM, STREET, FACTORY, OFFICE, ETC. (SPECIFY)

41e. LOCATION (STREET AND NUMBER, CITY OR TOWN, STATE)

41f. DESCRIBE HOW INJURY OCCURRED

42a. REGISTRAR FILE NO. | 42b. DATE RECEIVED BY LOCAL REGISTRAR | 42c. SIGNATURE OF LOCAL REGISTRAR

VS-112 REV. 9/95

The penalty for knowingly making a false statement in this form can be ... years in prison and a fine of up to $10,000. (Health and Safety Code, Sec. 195, 1vs9)

Statutes

Statutes

Chapter 264 of the Family Code was amended in the 74th Legislature by Subchapter F, which created the state child fatality review team committee, procedures for the operation of local child fatality review teams and the reporting and investigation of child deaths under age 6.

Article 49.04 and 49.10 of the Code of Criminal Procedure was also amended regarding inquests and autopsies.

Subchapter F. Child Fatality Review and Investigation

§ 264.501 Subchapter F. Definitions.

In this subchapter:

(1) "Autopsy" and "inquest" have the meanings assigned by Article 49.01, Code of Criminal Procedure.

(2) "Bureau of vital statistics" means the bureau of vital statistics of the Texas Department of Health.

(3) "Child" means a person younger than 18 years of age.

(4) "Committee" means the child fatality review team committee.

(5) "Council" means the Children's Trust Fund of Texas Council.

(6) "Department" means the Department of Protective and Regulatory Services.

(7) "Health care provider" means any health care practitioner or facility that provides medical evaluation or treatment, including dental and mental health evaluation or treatment.

(8) "Meeting" means an in-person meeting or a meeting held by telephone or other electronic medium.

(9) "Preventable death" means a death that may have been prevented by reasonable medical, social, legal, psychological, or educational intervention. The term includes the death of a child from:

(A) intentional or unintentional injuries;

(B) medical neglect;

(C) lack of access to medical care;

(D) neglect and reckless conduct, including failure to supervise and failure to seek medical care; and

(E) premature birth associated with any factor described by Paragraphs (A) through (D).

(10) "Review" means a reexamination of information regarding a deceased child from relevant agencies, professionals, and health care providers.

(11) "Review team" means a child fatality review team established under this subchapter.

(12) "Unexpected death" includes a death of a child that, before investigation:

(A) appears to have occurred without anticipation or forewarning; and

(B) was caused by trauma, suspicious or obscure circumstances, sudden infant death syndrome, abuse or neglect, or an unknown cause.

§ 264.502. Committee.

(a) The child fatality review team committee is composed of:

(1) a person appointed by and representing the state registrar for the bureau of vital statistics;

(2) a person appointed by and representing the director of protective services for families and children of the department;

(3) a person appointed by and representing the director of the bureau of epidemiology of the Texas Department of Health;

(4) a person appointed by and representing the executive director of the council; and

(5) individuals selected under Subsection (b).

(b) The members of the committee who serve under Subsections (a)(1) through (4) shall select the following additional committee members:

(1) a criminal prosecutor involved in prosecuting crimes against children;

(2) a sheriff;

(3) a justice of the peace;

(4) a medical examiner;

(5) a police chief;

(6) a pediatrician experienced in diagnosing and treating child abuse and neglect;

(7) a child educator;

(8) a child mental health provider;

(9) a public health professional;

(10) a child protective services specialist;

(11) a sudden infant death syndrome family service provider;

(12) a neonatologist;

(13) a child advocate; and

(14) a chief juvenile probation officer.

(c) Members of the committee selected under

Subsection (b) serve two-year terms that expire on February 1 of each even-numbered year.

(d) Members selected under Subsection (b) must reflect the geographical, cultural, racial, and ethnic diversity of the state.

(e) An appointment to a vacancy on the committee shall be made in the same manner as the original appointment.

(f) Members of the committee shall select a presiding officer from the members of the committee.

(g) The presiding officer of the committee shall call the meetings of the committee, which shall be held at least quarterly.

(h) A member of the committee is not entitled to compensation for serving on the committee but is entitled to reimbursement for the member's travel expenses as provided in the General Appropriations Act. Reimbursement under this subsection for a person serving on the committee under Subsection (a)(1) or (3) shall be paid from funds appropriated to the Texas Department of Health. Reimbursement for other persons serving on the committee shall be paid equally from funds appropriated to the department and funds appropriated to the council.

§ 264.503. Purpose and Duties of Committee and Specified State Agencies.

(a) The purpose of the committee is to:

(1) develop an understanding of the causes and incidence of child deaths in this state;

(2) identify procedures within the agencies represented on the committee to reduce the number of preventable child deaths; and

(3) 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.

(b) To ensure that the committee achieves its purpose, the department, the council, and the Texas Department of Health shall perform the duties specified by this section.

(c) The department shall:

(1) recognize the creation and participation of review teams;

(2) promote and coordinate training to assist the review teams in carrying out their duties;

(3) assist the committee in developing model protocols for:

(A) the reporting and investigating of child fatalities for law enforcement agencies, child protective services, justices of the peace and medical examiners, and other professionals involved in the investigations of child deaths;

(B) the collection of data regarding child deaths and

(C) the operation of the review teams; and

(4) develop and implement procedures necessary for the operation of the committee.

(d) The council shall promote education of the public regarding the incidence and causes of child deaths, the public role in preventing child deaths, and specific steps the public can undertake to prevent child deaths. The committee shall enlist the support and assistance of civic, philanthropic, and public service organizations in the performance of the duties imposed under this subsection.

(e) The Texas Department of Health shall:

(1) collect data under this subchapter and coordinate the collection of data under this subchapter with other data collection activities; and

(2) perform annual statistical studies of the incidence and causes of child fatalities using the data collected under this subchapter.

(f) The committee shall issue annual reports on the committee's activities, including findings and recommendations relating to each purpose and duty of the committee described by this section. Not later than December 1 of each even-numbered year, the committee shall publish the report and submit a copy of the report to the governor, lieutenant governor, and speaker of the house of representatives.

§ 264.504. Meetings of Committee.

(a) Except as provided by Subsections (b), (c), and (d), meetings of the committee are subject to the open meetings law, Chapter 551, Government Code, as if the committee were a governmental body under that chapter.

(b) Any portion of a meeting of the committee during which the committee discusses an individual child's death is closed to the public and is not subject to the open meetings law, Chapter 551, Government Code.

(c) Information identifying a deceased child, a member of the child's family, a guardian or caretaker of the child, or an alleged or suspected perpetrator of abuse or neglect of the child may not be disclosed during a public meeting.

(d) Information regarding the involvement of a state or local agency with the deceased child or another person described by Subsection (c) may not be disclosed during a public meeting.

(e) The committee may conduct an open or closed meeting by telephone conference call or other electronic medium. A meeting held under this subsection is subject to the notice requirements applicable to other meetings. The notice of the meeting must specify as the location of the meeting the location where meetings of the committee are usually held. Each part of the meeting by telephone conference call that is required to be open to the public shall be audible to the public at the location specified in the notice of the meeting as the location of the meeting and shall be tape-recorded. The tape recording shall be made available to the public.

(f) This section does not prohibit the committee from requesting the attendance at a closed meeting of a person who is not a member of the committee and who has information regarding a deceased child.

§ 264.505. Establishment of Review Team.

(a) A multidisciplinary and multiagency child fatality review team may be established for a county to review child deaths in that county. A review team for a county with a population of less than 50,000 may join with an adjacent county or counties to establish a combined review team.

(b) Any person who may be a member of a review team under Subsection (c) may initiate the establishment of a review team and call the first organizational meeting of the team.

(c) A review team may include:

(1) a criminal prosecutor involved in prosecuting crimes against children;

(2) a sheriff;

(3) a justice of the peace or medical examiner;

(4) a police chief;

(5) a pediatrician experienced in diagnosing and treating child abuse and neglect;

(6) a child educator;

(7) a child mental health provider;

(8) a public health professional;

(9) a child protective services specialist;

(10) a sudden infant death syndrome family service provider;

(11) a neonatologist;

(12) a child advocate; and

(13) a chief juvenile probation officer.

(d) Members of a review team may select additional team members according to community resources and needs.

(e) A review team shall select a presiding officer from its members.

§ 264.506. Purpose and Duties of Review Team.

(a) The purpose of a review team is to decrease the incidence of preventable child deaths by:

(1) providing assistance, direction, and coordination to investigations of child deaths;

(2) promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities;

(3) developing an understanding of the causes and incidence of child deaths in the county or counties in which the review team is located;

(4) recommending changes to agencies, through the agency's representative member, that will reduce the number of preventable child deaths; and

(5) advising the committee on changes to law, policy, or practice that will assist the team and the agencies represented on the team in fulfilling their duties.

(b) To achieve its purpose, a review team shall:

(1) adapt and implement, according to local needs and resources, the model protocols developed by the department and the committee;

(2) meet on a regular basis to review child fatality cases and recommend methods to improve coordination of services and investigations between agencies that are represented on the team;

(3) collect and maintain data as required by the committee; and

(4) submit to the bureau of vital statistics data reports on deaths reviewed as specified by the committee.

(c) A review team shall initiate prevention measures as indicated by the review team's findings.

§ 264.507. Duties of Presiding Officer.

The presiding officer of a review team shall:

(1) send notices to the review team members of a meeting to review a child fatality;

(2) provide a list to the review team members of each child fatality to be reviewed at the meeting;

(3) submit data reports to the bureau of vital statistics not later than the 30th day after the date on which the review took place; and

(4) ensure that the review team operates according to the protocols developed by the department and the committee, as adapted by the review team.

§ 264.508. Review Procedure.

(a) The review team of the county in which the injury, illness, or event that was the cause of the death of the child occurred, as stated on the child's death certificate, shall review the death.

(b) On receipt of the list of child fatalities under Section 264.507, each review team member shall review the member's records and the records of the member's agency for information regarding each listed child.

§ 264.509. Access to Information.

(a) A review team may request information and records regarding a deceased child as necessary to carry out the review team's purpose and duties.

Records and information that may be requested under this section include:

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

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

(A) a birth certificate;

(B) law enforcement investigative data;

(C) medical examiner investigative data;

(D) juvenile court records;

(E) parole and probation information and records; and

(F) child protective services information and records.

(b) On request of the presiding officer of a review team, the custodian of the relevant information and records relating to a deceased child shall provide those records to the review team.

(c) This subsection does not authorize the release of the original or copies of the mental health or medical records of any member of the child's family or the guardian or caretaker of the child or an alleged or suspected perpetrator of abuse or neglect of the child which are in the possession of any state or local government agency as provided in Subsection (a)(2). Information relating to the mental health or medical condition of a member of the child's family or the guardian or caretaker of the child or the alleged or suspected perpetrator of abuse or neglect of the child acquired as part of an investigation by a state or local government agency as provided in Subsection (a)(2) may be provided to the review team.

§ 264.510. Meeting of Review Team.

(a) A meeting of a review team is closed to the public and not subject to the open meetings law, Chapter 551, Government Code.

(b) This section does not prohibit a review team from requesting the attendance at a closed meeting of a person who is not a member of the review team and who has information regarding a deceased child.

(c) Except as necessary to carry out a review team's purpose and duties, members of a review team and persons attending a review team meeting may not disclose what occurred at the meeting.

(d) A member of a review team participating in the review of a child death is immune from civil or criminal liability arising from information presented in or opinions formed as a result of a meeting.

§ 264.511. Use of Information and Records; Confidentiality.

(a) Information and records acquired by the committee or by a review team in the exercise of its purpose and duties under this subchapter are confidential and exempt from disclosure under the open records law, Chapter 552, Government Code, and may only be disclosed as necessary to carry out the committee's or review team's purpose and duties.

(b) A report of the committee or of a review team or a statistical compilation of data reports is a public record subject to the open records law, Chapter 552, Government Code, as if the committee or review team were a governmental body under that chapter, if the report or statistical compilation does not contain any information that would permit the identification of an individual.

(c) A member of a review team may not disclose any information that is confidential under this section.

(d) Information, documents, and records of the committee or of a review team that are confidential under this section are not subject to subpoena or discovery and may not be introduced into evidence in any civil or criminal proceeding, except that information, documents, and records otherwise available from other sources are not immune from subpoena, discovery, or introduction into evidence solely because they were presented during proceedings of the committee or a review team or are maintained by the committee or a review team.

§ 264.512. Governmental Units.

The committee and a review team are governmental units for purposes of Chapter 101, Civil Practice and Remedies Code. A review team is a unit of local government under that chapter.

§ 264.513. Report of Death of Child.

(a) A person who knows of the death of a child younger than six years of age shall immediately report the death to the medical examiner of the county in which the death occurs or, if the death occurs in a county that does not have a medical examiner's office or that is not part of a medical examiner's district, to a justice of the peace in that county.

(b) The requirement of this section is in addition to any other reporting requirement imposed by law, including any requirement that a person report child abuse or neglect under this code.

(c) A person is not required to report a death under this section that is the result of a motor vehicle accident. This subsection does not affect a duty imposed by another law to report a death that is the result of a motor vehicle accident.

§ 264.514. Procedure In the Event of Reportable Death.

(a) A medical examiner or justice of the peace notified of a death of a child under Section 264.513 shall hold an inquest under Chapter 49, Code of Criminal Procedure, to determine whether the death is unexpected.

(b) The medical examiner or justice of the peace shall immediately notify an appropriate local law enforcement agency if the medical examiner or justice of the peace determines that the death is unexpected, and that agency shall investigate the child's death.

§ 264.515. Investigation.

(a) The investigation required by Section 264.514 must include:

(1) an autopsy, unless an autopsy was conducted as part of the inquest;

(2) an inquiry into the circumstances of the death, including an investigation of the scene of the death and interviews with the parents of the child, any guardian or caretaker of the child, and the person who reported the child's death; and

(3) a review of relevant information regarding the child from an agency, professional, or health care provider.

(b) The review required by Subsection (a)(3) must include a review of any applicable medical record, child protective services record, record maintained by an emergency medical services provider, and law enforcement report.

(c) The committee shall develop a protocol relating to investigation of an unexpected death of a child under this section. In developing the protocol, the committee shall consult with individuals and organizations that have knowledge and experience in the issues of child abuse and child deaths.

Section 3 Subsection (a) Article 49.04 Code of Criminal Procedure, is amended to read as follows:

(a) A justice of the peace shall conduct an inquest into the death of a person who dies in the county served by the justice if:

(8) the person is a child who is younger than six years of age and the death is reported under Chapter 264, Family Code.

Section 4 Subsection (e) Article 49.10, Code of Criminal Procedure, is amended to read as follows:

(a) A justice of the peace shall order an autopsy performed on a body if:

(1) the deceased was a child younger than six years of age and the death was reported under Chapter 264, Family Code.

For additional copies of this manual, more information or assistance with forming a team in Texas contact:

Texas Department of Protective and Regulatory Services
P.O. Box 149030
Austin, Texas 78714-9030
(512) 438-4963
(512) 438-3782 FAX

What Are Review Teams?

Child fatality review teams are multi-disciplinary, multi-agency panels that review all child deaths regardless of the cause. Members include law enforcement, prosecutors, physicians, medical examiners, justices of the peace, public and mental health professionals, EMS, and child protective services and child advocates. By sharing information, team members discover the circumstances surrounding children's deaths. They identify gaps or breakdowns in agency services designed to protect children, and work to revise agency procedures and professional investigation protocols.

These teams are uniquely qualified to understand what no single agency or group working alone can: how and why children are dying in their community.

Because of the team's efforts, child fatalities are more accurately recorded and needed prevention initiatives can be developed. The ultimate result of a child death review system is an improved response to all child fatalities.