

**Texas Child Fatality Review Teams**  
**Biennial Report**  
**2000–2001**

**Contents**

- I. Acknowledgments
- II. Open Letter from a State Trooper
- III. Letter from the Chair
- IV. Definition of Child Fatality Review Team
- V. Overview of Child Deaths in Texas
  - A. Infant Mortality (SIDS)
  - B. Motor Vehicle Crashes
  - C. Violence
- VI. Additional Local Team Activities
- VII. State Committee Accomplishments
- VIII. Recommendations for State Policy Makers
  - Appendix A — State Committee Members
  - Appendix B — Child Deaths Reviewed by Team
  - Appendix C — Texas Child Fatality Review Teams Contact Sheet

## Acknowledgments

The Texas Child Fatality Review Team State Committee would like to gratefully acknowledge past members of the committee for their devoted service to the children of Texas.

These are:

Brad Alpert, Associate Professor, University of Texas Health Science Center-Houston

John Chacon, Executive Director, Children's Trust Fund of Texas Council

Craig Crabtree, Associate Professor, Texas Tech University

Dennis Perrotta, State Epidemiologist, Texas Department of Health (TDH)

Sarah Webster, Child Protective Services Director, Texas Department of Protective and Regulatory Services (PRS)

Fred Rich, Sergeant, Dallas Police Department

The committee would also like to commend Regina Patridge for her services as the Child Fatality Review Team Coordinator and Colleen McCall as the Chair of the State Committee.

Pursuant to §264.503 of the Texas Family Code, this report is to be submitted to the governor, lieutenant governor, and speaker of the house of representatives.

This report was written and edited by John Hellsten, TDH epidemiologist, and Katherine Keenan, Child Fatality Review Team Coordinator, PRS Child Protective Services, with individual contributions as noted throughout the report.

The report was sponsored by The Texas Department of Health and The Texas Department of Protective and Regulatory Services.

Questions about this report should be directed to:

Sheriff Jack Ellett,  
Chair of the State Child Fatality Review Team Committee  
Att: Katherine Keenan  
State Child Fatality Review Team Coordinator  
Texas Department of Protective and Regulatory Services  
P.O. Box 149030  
Austin, Texas 78714-9030

Or by e-mail to: [Katherine.Keenan@tdprs.state.tx.us](mailto:Katherine.Keenan@tdprs.state.tx.us)

## Open Letter from a State Trooper

Do any of these statements sound familiar?

*“We’re only going down the street to the convenience store.”*

*“She thinks she’s too old to buckle up.”*

*“He will stop crying if I can hold him on my lap.”*

They are all common excuses parents give for not buckling their children in appropriate child safety seats or safety belts. Despite increased public awareness, child safety seat and safety belt usage rates among children are still alarmingly low. Unfortunately, motor vehicle crashes remain the leading cause of unintentional injury-related death for children.

As a parent of three children, I am thankful that Texas has state laws requiring children to be properly restrained. There have been times in the past that perhaps one of my kids was questioning whether they should wear their safety belt. Well, I would let them know that we as parents loved them and wanted them to have a safe ride in the vehicle. Secondly, I reminded them that this was one of the rules of the house. And last, I would inform them that this is one of the laws in Texas enforced by police officers. Being a state trooper myself, my children understand fully the meaning of this. So as one can see, the child safety restraint laws in Texas do help parents out in getting children to adopt the buckle up habit.

Police officers across the state investigate far too many vehicle crashes involving improperly restrained children being critically injured or even worse, losing their life. Nothing saddens officers more and tears at them emotionally than to see a young child injured or killed in a car crash. The impact is compounded when it is determined that the child was not properly restrained.

A significant majority of Americans favor strong enforcement of laws that require all children to be buckled up. In fact, numerous parents rely on the laws as a tool and guideline to help keep their kids safe. Even if you are a safe driver, you cannot control the other drivers’ behavior or eliminate the possibility of a crash. You can, though, reduce the risk that your children will be seriously injured or killed by buckling them in properly. It’s an easy habit to become addicted to. Just maybe, the single most important thing you can do to protect your children is to buckle them up the right and legal way every time. It works!

*Paul S. Waggener, Senior Trooper, Safety Education Service, Texas Department of Public Safety (DPS)*

## Letter from the Chair

When the 74<sup>th</sup> Texas Legislature created an organized approach to child fatality review, our hope was that we could begin to understand more about why almost 4,000 children in Texas die each year and thus implement strategies to reduce child deaths. Since 1995, we have seen the formation of 43 local child fatality review teams and now have much more data about child deaths than ever before. Has it made a difference? Yes!

Child fatality review teams help us pinpoint where intervention could have made a difference. The data they submit help us understand leading causes of child deaths. For several years, the State Committee has pushed for stronger enforcement and enactment of child passenger safety laws, as well as measures that gradually introduce teens to the stresses of driving. Motor vehicle crashes continue as a leading cause of death for Texas children, and one that is considered preventable in almost all circumstances. We are proud of local team efforts that assisted in changing Texas laws and believe these efforts are effective in saving children's lives.

When local teams meet with the State Committee at our annual network meeting, it is always energizing for us to see the fervor local citizens develop when the cause is preventing child deaths. Every community in Texas deserves to have a local team looking at why their children are dying. We are not there yet, but over the next two years we hope to have teams that cover 100 percent of Texas counties. We plan to look at the best methods for ensuring coverage and for keeping the child fatality review process vital in Texas.

I am proud to have served as the Chair for this committee during the past two years. I consider it a privilege to have been a part of the State Committee, where our mission is to ultimately reduce the number of preventable child deaths.

Colleen McCall  
Chair of the State Child Fatality Review Team  
September 2000 – August 2002

## **Definition of Child Fatality Review Team**

### **What is a Child Fatality Review Team?**

A child fatality review team (CFRT) is a multi-disciplinary, multi-agency panel that reviews all child deaths regardless of the cause. Local teams identify gaps in service and coordination among all agencies represented on the team, and focus on developing community programs and activities to reduce the incidence of preventable child deaths.

Texas Family Code §264.505

### **Who are the team members?**

The core members include a:

- Criminal prosecutor for crimes against children;
- Sheriff;
- Justice of the peace or medical examiner;
- Police chief;
- Pediatrician experienced in diagnosing and treating child; abuse and neglect;
- Child educator;
- Child mental health provider;
- Public health professional;
- Child protective services specialist
- Sudden infant death syndrome family service provider;
- Neonatologist;
- Child advocate;
- Chief juvenile probation officer.

Other members may be selected by the core membership according to community resources and needs.

Texas Family Code §264.505

### **What happens during a review?**

During the review, teams explore what each member agency knows about the child, family, and circumstances surrounding the death. Information shared by team members is confidential by law. Data are collected and sent to the Texas Department of Health for compilation and analysis. Aggregate data from CFRTs are used to identify statewide trends and prevention strategies likely to reduce preventable child deaths.

### **What impact do communities report from participation in child fatality review?**

On a local level, teams identify trends and prevention strategies. Teams initiate community awareness campaigns and events such as seat belt/car seat safety

demonstrations and distribution, suicide prevention programs, shaken baby prevention programs, and other activities targeted to the communities' identified needs.

In addition to identifying factors that contributed to the specific deaths reviewed, benefits mentioned by local teams include improved working relationships and communication among member agencies, and improved investigation skills and evidence protection procedures.

Most importantly, child fatality review teams help reduce child deaths in their communities. The results from a recent study indicate that overall child death rates, in particular the mortality rates from Sudden Infant Death Syndrome (SIDS), have shown greater decline in Texas communities with CFRTs than in those communities without a team. The study also suggests that local review teams are helping to more accurately identify the cause of death.<sup>1</sup>

### **How do the teams use their data to help reduce preventable deaths?**

- Distribute materials to new mothers about dangers of co-sleeping;
- Outreach to young mothers and pregnant teenagers about the importance of pre-natal care;
- Shaken baby prevention/information packets distributed to expectant mothers;
- Water safety campaigns;
- Motor vehicle safety efforts, including a program to distribute free booster seats designed for school-age children, and teen driving safety programs;
- 4-Wheeler safety campaign;
- Publication of annual reports that community agencies use to target prevention efforts;
- Suicide prevention programs;
- Gun safety programs; and
- Identifying safety risks, including child abuse, during training offered to Head Start employees.
- Fire safety programs

### **What are CFRTs accomplishing in my community?**

Every year, the teams that contract with PRS send a report detailing their activities. Not every community or every accomplishment can be fully explored in this report. This report includes a brief summary to demonstrate the profound effect local teams have on reducing preventable child death. While each team responds with a wide variety of prevention efforts, the responses cluster primarily in three subject areas:

- Reduction of preventable deaths caused by motor vehicle crashes;
- Accurate identification of cause of death for infants and prevention efforts that attempt to reduce infant mortality;

---

<sup>1</sup>Migala, Witold. Impact Analysis of Texas Child Fatality Review Teams on Incidence and Select Cause of Death Determination. 2001, presented at TCFRT Network Meeting.

- Improvements in the coordination and quality of service delivery for child death investigations and prevention efforts;

## Overview of Child Deaths in Texas

Data for this report are derived from three sources: death certificates, child fatality review team reports, and population estimates. Death certificates, collected by the TDH Bureau of Vital Statistics, record virtually all deaths and collect a variety of information about the decedent and the death. Analyses of death certificate information are particularly useful for establishing demographic (e.g., age, sex, and race) and geographic patterns of for particular causes of death, as well as identifying trends over time.

Reports from child fatality review teams are also collected by the TDH Bureau of Vital Statistics and compiled into the Texas Child Death Registry. These reports contain pertinent and significant information on each child and the circumstances of death that is useful for developing prevention activities and evaluating the effectiveness of prevention programs.

Population estimates are provided by the Texas A&M University State Data Center and are available by age, race, sex, and geographic areas for specific years. For purposes of this report, these estimates are used to calculate mortality rates. Rates standardize the number of deaths by the size of the population and enable comparisons across time and geographic areas. It should be noted, however, that rates computed from small numbers of incidents may be unreliable and difficult to interpret from year to year.

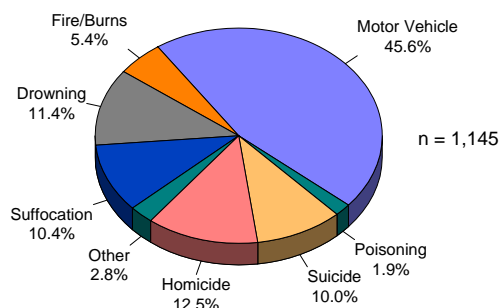
### **Child Mortality**

On average, 10 children less than 18 years of age died every day during the two years covered by this report: 3,783 deaths during 2000 and another 3,883 during 2001. The majority of these deaths were babies who did not see their first birthday (infant mortality comprises 55 percent of all child deaths) and most of these babies died during the first month of life. The leading causes of infant mortality include perinatal conditions, congenital anomalies, and Sudden Infant Death Syndrome (SIDS).

Injuries are the leading cause of death after children reach their first birthday. Although child mortality rates from motor vehicle crashes are declining, these still account for nearly half of all childhood injury deaths. Violence, either self-inflicted or inflicted by another, remains a leading cause of death for young children and teens. Each week, on average, five children die violently. Most of these violence-related deaths are due to a gunshot wound and are preventable.

## Child Injury Deaths

2000



Source: Texas Department of Health, Bureau of Vital Statistics

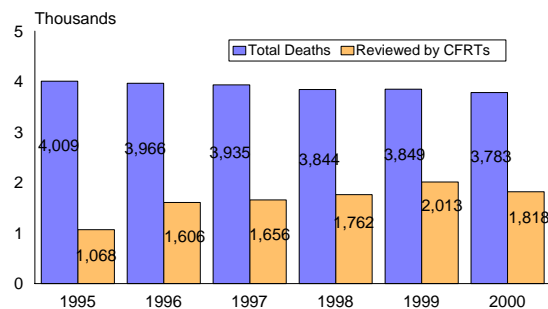
### Data from Child Fatality Review Teams

Teams are expected to complete an extensive data report on each child death reviewed. This includes information about the family and living situation; prior history including health events, abuse/neglect investigations, and school or legal problems; and specific information about the circumstances of death. These data are sent to the TDH Bureau of Vital Statistics to be compiled annually.

Approximately half of all child deaths in Texas were reviewed by a local child fatality review team in the years covered by this report. For injury deaths, this proportion increases to 60 to 65 percent of the injury deaths.

## Child Deaths Reviewed

1995-2000



Source: Texas Department of Health, Bureau of Vital Statistics

The overwhelming majority (85 percent) of all injury deaths reviewed were considered to be preventable. Team members identified two particular areas in which the death of a child might be averted: the use of safety precautions or a safety device (seat belt, personal flotation device, firearms locked, etc.) and improvement in parenting skills, particularly supervision of children. Changes in the community were also noted as ways to help prevent child deaths. Most notably, these included an increase in the availability

of prevention education programs and legislative action, particularly regarding child restraints in motor vehicles.

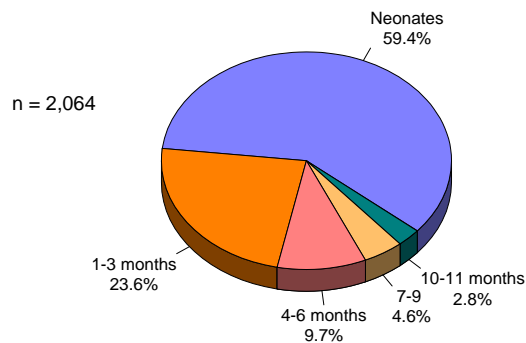
More detailed information regarding specific causes of child death is available through the TDH Bureau of Vital Statistics Web page at [www.tdh.state.tx.us/bvs/chfatal.htm](http://www.tdh.state.tx.us/bvs/chfatal.htm)

## Infant Mortality

Infant mortality is defined as the death of a child before his or her first birthday. There is an old adage that suggests that the health and success of a country may be measured by its infant mortality rate. If this is the case, Texans can be proud that over the past year significant strides have been made to address the state's infant mortality rate. In summer 2002, funding from Senate Bill 55, 77th Texas Legislature, provided for a statewide education initiative targeting infant mortality in Texas. The Infant Mortality Prevention Education Project was developed to provide education and training resources on infant mortality to a network of community-based programs. The program will concentrate its education efforts on losses in four major areas including Perinatal, Sudden Infant Death Syndrome, Unintentional Injury, and Physical Child Abuse and Neglect. Despite many of our efforts, 2,064 baby Texans did not celebrate their first birthdays in 2000.

### Infant Deaths by Age

2000



Source: Texas Department of Health, Bureau of Vital Statistics

The following identifies the top five causes of infant mortality in our state:

1. Perinatal conditions.
2. Congenital malformations
3. Sudden Infant Death Syndrome
4. Injuries
5. Diseases of the respiratory system

Perinatal Conditions are responsible for almost half of all Texas infant deaths. This statistic has increased nationally over the last decade even though technology has prolonged infant life. Babies are born alive who a decade ago would likely have been still births. Babies "saved" by this technology do not account for all of the deaths in this category. The rate of low birth weight or pre-term births among African-American mothers continues to be significantly higher than that of the general population. Hispanic mothers in some areas of Texas are up to 1.5 times more likely to deliver their babies prematurely. The reasons for this propensity towards prematurity and low birth weight are unclear; however, babies whose mothers have higher levels of education seem to fair better in all cultures. Teen mothers continue to lose their babies at higher rates than

the general population, and the mortality rate for babies born to teen mothers is 10.8 per 1,000 live births. Recent studies indicate that stress may be a significant contributor to poor birth outcomes, especially in high-risk women.

The state continues to need programs that can address the diverse needs of the populations at greatest risk for premature birth and low birth weights. They should include a combination of the unique health and social problems common to these populations. Good and early pre-natal care and alcohol, drug, and smoking avoidance are still critical components to programs that will increase infant survivability.

Congenital malformations still account for a significant number of losses. The life span for these Texans is contingent upon the degree or type of abnormality. Addressing this issue is difficult because there is often no known reason for the malformations. However, efforts can still be made to identify genetic risk factors when they exist, and provide accompanying education to parents, when appropriate, to avoid reoccurrence.

Sudden Infant Death Syndrome (SIDS) is the leading cause of death among infants from 1 month to 1 year old. SIDS is the sudden or unexpected loss of an apparently healthy infant, which remains unexplained after a complete medical history, death scene investigation, and autopsy. Though SIDS still has no known cause or cure, researchers are identifying commonalities among its victims that may eventually lead to identifying a cause or cure. Minority babies seem to be at greatest risk for SIDS. Current statistics indicate that the number one killer for Native American infants is SIDS, and African-American babies are 2.2 times more likely to die of SIDS than their white counterparts. Though these statistics might suggest some genetic links, researchers are unclear about why these populations seem to be more greatly affected. Texas has a relatively small Native American community, but the state needs efforts to address their specific SIDS educational needs and distinct cultural perspective. The state also still needs programs that provide education on risk reduction strategies and current information on the latest SIDS research. As new SIDS research data (such as information released this year regarding the increased risk associated with changing a baby's sleep position) becomes more available, programs offering high levels of SIDS specific knowledge will be even more vital. Programs targeting at-risk parents and other caregivers such as grandparents are also widely needed.

Unintentional injuries still account for too many of our infant losses. In 2000, 28 infant deaths were caused by unintentional suffocation. These kinds of losses have a long-term impact on the community because of the guilt and blame associated with each unnecessary death. Public education is our biggest hope for reducing the numbers of deaths resulting from unintentional injuries. Efforts such as public service announcements, billboards, and community-based programs that reiterate safety precautions are critical.

Diseases of the respiratory system are the fifth cause of death for Texas infants. National indicators suggest that respiratory ailments are on the rise for all age groups. In Texas, infants have encountered a broad spectrum of respiratory ailments from pneumonia, to diseases of the lungs, to asthma. Unfortunately, despite the growing need in this area, new treatment modalities for respiratory conditions are relatively limited. Researchers have stopped short of drawing a link between clean air issues and respiratory diseases; however, the most we can do to address the clean air problem seems prudent. Texas has been one of the states most criticized for its clean air issues.

Early identification and treatment of respiratory conditions are the strongest allies in reducing this infant mortality statistic. Ensuring that adequate health care is made available to all of our babies is also still one of our greatest challenges.

*Sandi Wiggins, Executive Director, North Texas SIDS Alliance*

## **What Are Some Local Teams Doing to Prevent Infant Deaths?**

### **Anderson/Cherokee County Child Fatality Review Team**

Based upon the results of their child death reviews, the Anderson/Cherokee County Child Fatality Review Team approached hospitals in both counties about distributing information on Shaken Baby Syndrome and SIDS to new mothers.

### **Ector County Child Fatality Review Team**

The Ector County Child Fatality Review Team noticed that a large majority of their county's deaths of premature infants were associated with one or more of the following factors:

- Little or no prenatal care
- Teenaged mother
- Mother has limited education
- Alcohol, tobacco, or other drug use during pregnancy

As a result, the team is working with the local school district to add an in-service program to educate teachers about these statistics along with strategies for preventing teenage pregnancies and information about where students can go for help. The team is also working with prenatal clinics and Planned Parenthood to increase community awareness about the importance of regular prenatal care visits.

### **Jefferson County Child Fatality Review Team**

The Jefferson County Child Fatality Review Team developed a program and trained volunteers to go into local birthing centers to talk to new parents about Shaken Baby Syndrome and SIDS. The program includes watching and receiving a:

- Video on Shaken Baby Syndrome;
- Resource list to cope with feeling overwhelmed; and
- Tips on reducing the likelihood of SIDS

The team participates in seatbelt and car safety seat checks and is developing, along with their representative, legislation related to fetal drug exposure.

### **McClennan County Child Fatality Review Team**

The McClennan County Child Fatality Review Team has recently updated its data collection process in order to research the reasons for deaths and the areas of the county with the most deaths. The team is developing training for pregnant teens and teen mothers on the importance of prenatal care. Each member of the team has noted that the process of reviewing child fatalities improves the ability to gather the information needed to improve the quality of reviews over time.

### **Panhandle Child Fatality Review Team**

The Panhandle Child Fatality Review Team covers a large rural area and serves 26 counties: Armstrong, Briscoe, Carson, Childress, Collingsworth, Dallam, Deaf Smith, Donley, Gray, Hall, Hansford, Hartley, Hemphill, Hutchinson, Lipscomb, Moore, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, and Wheeler.

The team tailors its prevention efforts to the findings of its reviews. Currently, the team has developed a brochure that addresses crib dangers and safe sleeping recommendations. The team plans to publish its annual report in the local newspaper which has a circulation of 26 counties.

### **South Plains Child Fatality Review Team**

The South Plains Team covers 22 counties: Bailey, Borden, Cochran, Cottle, Crosby, Dawson, Dickens, Floyd, Gaines, Garza, Hale, Hockley, Kent, King, Lamb, Lubbock, Lynn, Motley, Scurry, Stonewall, Terry, and Yoakum counties.

The team has been instrumental in developing training for child-care centers regarding safe sleeping arrangements for children. The team is working on a public service announcement for the prevention of overlay/asphyxiation death.

The team has provided training for their community regarding:

- Shaken Baby Syndrome, and
- Munchausen's Syndrome.

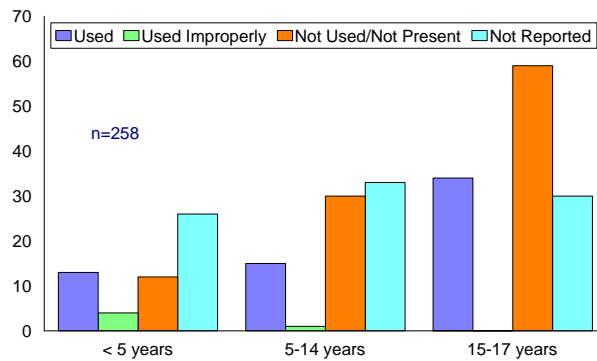
### **Wichita County Child Fatality Review Team**

The Child Fatality Review Team in Wichita County is coordinated through Patsy's House, the Children's Advocacy Center in Wichita County. Team members began to notice a trend in the child fatalities. Again and again, deaths were reviewed in which infants died while sleeping in unsafe conditions. In response, the team began to work with the media and the local hospital to distribute information about safe sleeping arrangements for infants. These community education efforts were so effective that people started to drop off cribs at the advocacy center for distribution to families in need. This response from the community was totally unexpected, but as news of the available cribs spread, more people came to Patsy's House to either drop off or pick up cribs. The team has responded by formalizing the crib exchange program.

## Motor Vehicle Crashes

More than 500 Texas children die every year from motor vehicle crashes, making this the leading cause of injury death. This is particularly evident among teens ages 15 to 17 years whose motor vehicle mortality rates are four times those of younger children. Child fatality review teams reviewed more than half these deaths during 2000 to 2001 and concluded that only about one of every three children who died in motor vehicle crashes was properly restrained. Alcohol and/or illicit substance use was involved in at least 20 percent of the motor vehicle deaths, and this proportion doubled in the cases in which the child was the driver. Despite increased public awareness and the fact that Texas has state laws requiring children to be properly restrained, child safety seat and safety belt usage rates among children are still alarmingly low. Unfortunately, motor vehicle crashes remain the leading cause of unintentional injury-related death for children.

**Restraint Use by Age**  
Motor Vehicle Fatalities, Year 2000



Source: Texas Department of Health, Child Death Registry

## **What Are Some Local Teams Doing To Prevent Motor Vehicle Fatalities?**

### **Anderson/Cherokee County Child Fatality Review Team**

After several fatalities related to the use of 4-wheelers by children, the Anderson Cherokee County Child Fatality Review Team successfully arranged for improved safety policies at a local 4-wheeler trail park.

The team conducts public safety workshops on a regular basis and recently purchased “fatal vision goggles” to demonstrate the effect of driving under the influence of alcohol. The team is currently developing a website that would cover safety issues for parents including topics such as suicide, 4-wheeler safety, and swimming pool safety.

### **Bowie County Child Fatality Review Team**

The Bowie County Child Fatality Review Team participated with DPS, Life Net EMS services, and Wadley Regional Trauma Center in motor vehicle safety programs such as “Operation Prom Night” (drinking and driving prevention), car seat distributions and checks, and other community safety issues.

### **Coastal Bend Child Fatality Review Team**

The Coastal Bend Child Fatality Review Team covers 13 counties: Aransas, Bee, Brooks, Duval, Jim Wells, Jim Hogg, Kenedy, Kleburg, Live Oak, Nueces, McMullen, Refugio, and San Patricio. In partnership with Driscoll Children’s Hospital and the Regional Advisory Council on Trauma of Coastal Bend, the team helped to greatly increase the number of car seats, especially booster seats, and bicycle helmets available to low-income families in the Coastal Bend area. The Corpus Christi Police Department received a seat belt grant, which, in connection with the booster seat giveaway and car seat classes for eligible low-income parents, has increased overall awareness of child passenger safety and the number of seats in use.

### **Collin County Child Fatality Review Team**

The Collin County Child Fatality Review Team participates in the “Buckle Up” program presented by the local Fire Department.

### **Hardin County Child Fatality Review Team**

The Hardin County Child Fatality Review Team has reviewed several deaths of teenagers resulting from poor driving skills and failure to wear seat belts. The team has sponsored seatbelt and car seat awareness with the community and schools, teaching teens the impact of speeding and not wearing seatbelts. The review team's effectiveness has increased by involving representatives from Juvenile Probation, DPS, the Sheriff's Department, and victim's assistance programs. The team is present at all local festivals and health fairs.

### **Orange County Child Fatality Review Team**

The Orange County Child Fatality Review Team held a seatbelt safety campaign when school reconvened in September 2002. The team is newly developed and in the process of gathering information to determine the prevention strategy and target area they want to address in the future.

### **Panhandle County Child Fatality Review Team**

Team members are working at the state level and through state professional societies and Associations with legislators to implement and strengthen child passenger safety laws. Local team members are involved in the local Safe Kids Coalition to provide car seat safety checks, education, and free car/safety seats to underserved populations.

### **Smith County Child Fatality Review Team**

The Smith County Child Fatality Review Team was involved, along with State Representative Leo Berman, in supporting the legislation to pass the graduated driver's license. The team is active in numerous community awareness meetings and health and safety fairs to advance the prevention of child fatalities based upon the findings of their reviews.

### **Travis County Child Fatality Review Team**

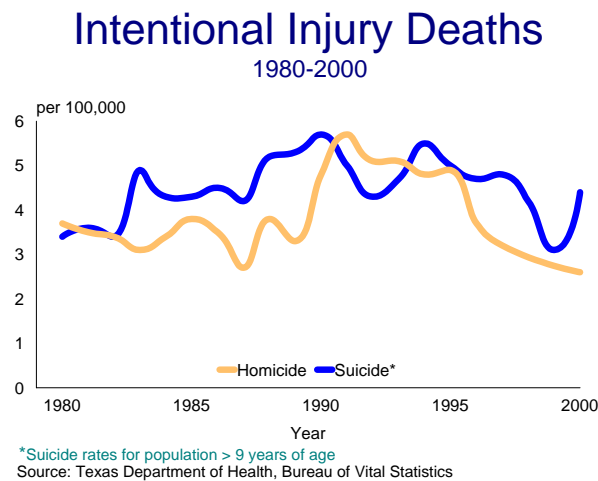
Each year the Travis County Child Fatality Review Team has a press conference to release their annual report. In 2002, comments from several local elected officials confirmed and strengthened the need for prevention of motor vehicle crashes in particular and safety belt use. Through foundation funds, the team placed three half-page ads in the *Austin American-Statesman* promoting proper use of seat belts. The team reports that EMS services have made changes to preserve evidence in child fatality/near fatality cases. The team has hosted a focus group regarding the value of collaboration with the medical community and provided a mock trial for children to educate them about child abuse.

### **Tri County Child Fatality Review Team**

The Tri County Child Fatality Review Team covers Panola, Rusk, and Harrison counties. The team is involved in child safety seat inspections, motor vehicle crash prevention education in schools, media coverage on water safety, overlay prevention information on infants, and other prevention issues.

## Violence

Each year in Texas, 200 to 250 children die from suicide and homicide. While the homicide rates have declined nearly 50 percent since 1995, child suicide rates are higher today than 20 years ago despite a recent decline. The accessibility of firearms to our children and teens has contributed to the large number of violent deaths in Texas each year. At least 50 percent of the homicide deaths and nearly 60 percent of the suicide deaths are due to a gunshot wound.



The decline in homicide deaths in past years is encouraging. We believe that many things have contributed to this decline. Stricter enforcement and prosecution of those who commit crimes with firearms and programs such as the EXILE have helped. Teen curfew laws and community policing efforts may also be credited with decreasing teenage violence. Improvements in the medical community to treat gunshot victims have saved many lives that would have been lost in the past. Information gained by our Child Fatality Review Teams across Texas has enabled us to establish preventive measures in our communities.

Texas needs a comprehensive effort from a variety of disciplines, such as the one used to lower the child homicide rate, in order to address child suicide. Suicide is a complex phenomenon, often resulting from an interaction between physiological, psychological, and social factors. Prevention efforts that address only one of these components are generally not effective in reducing suicidal behaviors. Following the model prevention plan established by the Surgeon General's office, the Texas Suicide Prevention Plan Steering Committee has proposed a comprehensive plan which includes three main areas: Awareness, Intervention, and Methodology (AIM).

Awareness (**A**) of suicide as a preventable problem is the first step needed to address the issue. Educational efforts regarding the risk and protective factors for suicide not only help involve more people in prevention, but also help reduce the social stigma associated with seeking mental health and substance abuse services. The interventions (**I**) developed for suicide prevention need to be comprehensive and community-based.

This includes training of educators, health care providers, the faith-based community, and lay people to recognize suicide risk factors and take appropriate actions. Prevention interventions range from efforts to instill resiliency factors in a child before suicidal behavior occurs, securing appropriate mental health and social services, and crisis intervention and post-intervention services during and after a suicidal act. The methodology **(M)** component involves expanding the scientific knowledge about the extent of suicidal behavior and what is effective in suicide prevention. The extent of child suicide deaths is adequately captured through death certificates, but the numbers of suicide attempts are rough estimates. Texas needs more and better efforts towards capturing the incidence of all suicidal behaviors to target and evaluate prevention efforts.

## **What Are Some Local Teams Doing To Prevent Violent Deaths?**

### **Statewide**

Child Fatality Review Teams prepare their members to better differentiate among the possible causes of death whether fatalities result from natural causes of death, unintentional injuries, or intentional injuries. Team members are better equipped to recognize child abuse or neglect when it is present. The review process itself is not intended to change the determined cause of death in the case reviewed. Instead, the formal training offered to team members and the process of the review itself teaches members what to look for in their own disciplines so that violent deaths are more likely to be identified than to be attributed to another cause.

### **Montgomery County Child Fatality Review Team**

Team members developed a suicide prevention program called "Reflections." This program offers an opportunity for teenagers to talk with each other about their concerns. Adults are present but do not enter into the conversations. Local media have published suicide statistics to raise community awareness of the problem.

### **Anderson/Cherokee Counties Child Fatality Review Team**

The team has conducted training on Shaken Baby Syndrome and other forms of child abuse to several community agencies. One of the team members, a Texas Ranger, attended a forensic training program that specialized in fatalities. The team is developing a website that will include information about suicide as well as safety issues.

### **Bexar County Child Fatality Review Team**

The team has over 20 member agencies that work together to take the information learned at the reviews and provide prevention efforts in the community. Key in this role are injury prevention specialists and trauma coordinators who attend this meeting. These individuals promote injury prevention efforts locally and in the South Texas area. Members of our team are engaged in research and injury prevention activities addressing issues such as Sudden Infant Death Syndrome, Youth Suicide, Non-Accidental Trauma, and Motor Vehicle-related injuries and fatalities. The chair of the team is currently involved in the planning of a child abuse conference that will be held in San Antonio in the fall of 2003.

### **Collin County Child Fatality Review Team**

The team members were able determine accurately the cause of death in a situation that might have been mistaken for homicide without the benefit of expertise and effective interdisciplinary interventions of team members involved in the investigation. The team facilitates effective communications between the emergency room and CPS. The team distributes child death/injury prevention and documentation guides to law enforcement and CPS so that death scene investigations are more effective and evidence is preserved.

### **Galveston County Child Fatality Review Team**

The county has experienced a high number of fatal and near fatal injuries in 2001. In response, the District Attorney's office has designated a reporting plan in which the on-call DA is notified as soon as CPS or law enforcement is aware of a serious or fatal injury to a child.

### **Coastal Bend Child Fatality Review Team**

Two cases thought to be SIDS were later identified as homicides because of advanced training and interagency cooperation among members. The perpetrators were successfully apprehended and confessed. The team is planning training for law enforcement in the smaller counties on SIDS and Shaken Baby Syndrome.

### **Panhandle Child Fatality Review Team**

The team conducts gun safety programs in the schools and for community organizations.

### **McClennan County Child Fatality Review Team**

Death scene investigations result in more information because of advanced training and cooperation among agencies.

### **Jefferson County Child Fatality Review Team**

The team hosted Child Injury and Death Investigation Training with 86 professionals in attendance. The attendees were from law enforcement, Child Protective Services, the District Attorney's office, fire rescue and investigators, and EMS first responders.

### **Travis County Child Fatality Review Team**

The team trains pediatric residents using a "mock trial." The goal is to improve the identification and reporting of child abuse in the medical community and to improve evidence collection procedures.

### **Tarrant County Child Fatality Review Team**

In 2000, there were 358 child deaths in Tarrant County. At the regular monthly meetings, team members review an average of 12 cases of unexpected deaths in which there were autopsies by the medical examiner. The remaining deaths are reviewed by the core membership at quarterly meetings.

Tarrant County has helped develop a training curriculum for investigating Shaken Baby Syndrome, Abusive Head Trauma, and SIDS. This training includes videos and workbooks that detail how to investigate scenes of child abuse and neglect while illustrating what constitutes evidence and how to preserve, collect, and evaluate the use of this evidence. A pocket card with 200 interview questions was designed and 5,000 copies are ready to be distributed to law enforcement.

In addition, the team offers training on child death investigation geared to the specific audiences such as law enforcement, fire service, EMS, hospital staff, and first responders. The team also coordinated with other victim groups for public awareness campaigns for the prevention of child abuse.

### **Wichita County Child Fatality Review Team**

Wichita County has had several cases of child homicides in the past year including two infants who died from abusive head trauma. These cases are difficult to prove, but through advanced training and interagency cooperation, both individuals believed to be responsible have been charged, and it is expected that these cases will come to trial in the next year.

## **Additional Local Team Activities**

Teams all over Texas report that working together as a team improves the accuracy of cause-of-death determinations. In cases in which the cause of death was difficult to accurately determine, member agencies were able to call upon their colleagues to sort out situations that might have been misidentified without collaboration. Whether a team is reviewing a death that appeared accidental but was determined to be a homicide or a death resulting from natural causes that could easily have been mistaken for an intentional injury, the benefit of multidisciplinary teams is clear.

### **Collin County Child Fatality Review Team**

Pocket-sized laminated cards developed by the State Committee that detail questions and observations of death scene investigations helped contribute to more accurate determinations of the cause of death. These Death/Injury Interview and Documentation Guides were distributed to law enforcement and CPS investigators by the Collin County Child Fatality Review Team. These reminder cards are very helpful because child fatality investigations may occur infrequently, or turnover may reduce the number of experienced staff.

### **Concho Valley Child Fatality Review Team**

The Concho Valley Child Fatality Review Team covers 13 counties: Coke, Concho, Crockett, Irion, Kimble, McCullough, Menard, Reagan, Runnels, Schleicher, Sterling, Sutton, and Tom Green.

The training provided through a contract with CPS increases the expertise of those conducting investigations. This training, supported this year by the Children's Trust Fund, results in improved, more thorough investigations and ideas for prevention programs. The team is always looking for ways to prevent future fatalities and shares these ideas with Partners in Prevention, a program within the Children's Advocacy Center of Tom Green County, which is where the team meets.

### **Dallas County Child Fatality Review Team**

The Dallas County Child Fatality Review Team issues a child death and infant mortality report each year. The team presents the results of the reports at a community forum. This report is instrumental in helping community groups to focus their attention on a particular area needing attention. The Safe Kids Coalition, Child Abuse Prevention Coalition, and other agencies use the data to target prevention efforts to the population most affected by a particular problem.

Dallas County has a large number of child fatalities each year. In 2000, there were 408 fatalities. All medical examiner certified deaths receive a full review, and deaths certified by an attending physician receive an expedited review. The average number of deaths reviewed at each monthly meeting is 38.

### **Hill Country Child Fatality Review Team**

The Hill Country Child Fatality Review Team covers 6 counties: Blanco, Burnet, Lampasas, Llano, Mason, and San Saba. Over time, reviewing child fatalities has helped each member agency see the role of the others and understand what they contribute to the review process. This type of collaboration has improved the communication among agencies. Now, law enforcement contacts CPS whenever a child dies. In this way, if there is history of abuse or neglect, protection of siblings is better served. The team is involved in training those who conduct child death investigations. The team is also involved in raising public awareness about issues of child safety with various community organizations, including the community religious leaders.

### **Houston/ Harris County Child Fatality Review Team**

There are 28 different police departments and four major hospitals represented on the Houston/Harris County Child Fatality Review Team. Working together to review child fatalities has resulted in improved communication among law enforcement, hospitals, CPS, and the Medical Examiner. As the result of member agencies participation in regular training and improved working relationships among member agencies, child fatality investigations have improved significantly. Due largely to the efforts of the team, every child younger than 6 years of age who dies suddenly or unexpectedly in Harris County receives a law enforcement scene investigation.

There were 581 child fatalities in Harris County in 2000. Although the team cannot review all these deaths, it reviews all intentional and non-intentional unexpected deaths. During each monthly meeting, the team reviews approximately 45 deaths. Natural deaths of children occurring within 24 hours or more at four of the largest area hospitals are reviewed by physicians who are team members. The team also maintains an informative website, produces a child fatality report, and regularly releases data on local child fatality incidence to community agencies.

### **Galveston County Child Fatality Review Team**

Because of a high number of fatal and near fatal injuries in 2001, the Galveston County Child Fatality Review Team, at the direction of the District Attorney's office, initiated a reporting plan in which the on-call DA is notified as soon as CPS or law enforcement is aware of a serious or fatal injury to a child. The team has been active in community speaking engagements on child abuse prevention.

### **Montgomery County Child Fatality Review Team**

The Montgomery County Child Fatality Review Team has noted improved communication among member agencies. In addition, the team has been active in suicide prevention and as a result has seen an increase in mental health services available in the area. The team is involved in the use of media to educate the public on suicide statistics. The team has developed a program called "Reflections" that provides a place for youth to safely discuss their problems in the presence of trusted adults who do not intrude on the discussion. The team is also involved in efforts to prevent motor vehicle crashes and conduct research on the number and frequency of Trisomy 13 deaths in the county.

## **Bexar County Child Fatality Review Team**

The team developed and distributed its first Bexar County Child Fatality Report. This report can be viewed at the following website: <http://sthrc.uthscsa.edu/stiprc> . The Bexar County Team strives to incorporate agencies that will have an impact on injury prevention. The team has developed a close working relationship with the South Texas Injury Prevention and Research Center. This center is a nonprofit corporation that is made up of a consortium of injury prevention specialists. The center aims to reduce injury related death and disability on the people of South Texas through a combination of education, research, intervention programs, public policy modification, and economic improvement of our communities. The chair of the team is currently involved with the center's educational, intervention, and research activities. The chair has personally taped television segments in Spanish on Child Abuse and SIDS awareness for "A Su Salud," one of the center's programs.

## **State Committee Accomplishments**

The purpose of the Texas Child Fatality Review Team State Committee is to develop an understanding of the causes and incidence of child death, identify procedures within committee agencies to reduce the number of preventable child deaths, promote public awareness, and make recommendations to elected officials for changes in law, policy, and practices in order to reduce the number of preventable child deaths. During 2000 and 2001, the State Committee has engaged in a number of activities designed to fulfill these purposes.

### **Held Annual Network Conferences With More Than 700 Attendees During the Last 2 Years**

Texas has the longest running annual conference for child fatality review in the United States and each year welcomes people from across the nation to learn more about reducing the number of preventable child deaths. Topics have covered a diverse area related to child deaths, including child death scene investigation, suicide prevention, SIDS prevention, child abuse, and child passenger safety. Attendees have overwhelmingly regarded the conferences as being pertinent to their profession, extending their knowledge about relevant issues and providing helpful prevention ideas. Opportunities for local team members to present team activities and share successes and difficulties and the ensuing discussions have been of particular benefit.

### **Increased the Number of Local Child Fatality Review Teams**

State committee members have strategized and used professional contacts to further the creation of local child fatality review teams in Texas. Agency staff have led community organizational meetings to discuss the importance of local teams and demonstrate how a team forms and operates. The overwhelming majority of metropolitan areas are now served by a local team, and the challenge is to reach out to rural areas that may have only one or two child deaths annually. Achieving 100 percent coverage for all counties of Texas is a high priority for the State Committee within the next two years.

### **Played an Integral Role in Creating the Texas Suicide Prevention Plan Steering Committee**

The insignificant decline in child suicide rates during recent years prompted members of the State Committee and agency staff to promote awareness of the issue throughout the state and mobilize people for action. After a statewide forum in May 2000 brought together more than 100 professionals and concerned individuals to discuss the issues, the Texas Suicide Prevention Plan Steering Committee was created. This multidisciplinary group was charged with creating a coordinated and comprehensive statewide plan for suicide prevention. The steering committee has made recommendations to the interim House Human Services Committee and is currently seeking stakeholder input on the proposed Texas Suicide Prevention Plan.

### **Assisted with the Formulation and Implementation of SB 55**

Senate Bill 55, 77th Texas Legislature, provides for the development and implementation of a statewide education program to prevent infant mortality. Authored by Senator Judith Zaffirini, co-author of the enabling child fatality review legislation, this bill was formulated with input and support from the State Committee. Members from the State Committee and local teams have been instrumental in creating this comprehensive education program designed to decrease the number of preventable infant deaths.

## Recommendations for State Policy Makers

In September 2001, the Texas Child Fatality Review Team State Committee developed a strategic plan of operation. This plan, which was established to guide the activities of the State Committee for the next two years, has four main goals to help reduce the number of preventable child deaths. These goals are:

- 1) Establish coverage of 100 percent of Texas counties with child fatality review teams;
- 2) Accurately identify and prioritize prevention strategies;
- 3) Develop and implement a comprehensive state plan for child death prevention; and
- 4) Evaluate and improve the effectiveness of Texas child fatality review teams.

To help accomplish these goals, the State Committee encourages the Texas Legislature take the following actions:

- 1) Enact legislation requiring jurisdictions to have a child fatality review team to review all deaths of Texas children less than 18 years of age;
- 2) Provide funding for a full-time child fatality review team state coordinator;
- 3) Provide a means by which to develop and implement a comprehensive state plan for child death prevention;
- 4) Support and enact enhanced automobile restraint/seatbelt legislation;
- 5) Adopt all recommendations of the Texas Suicide Prevention Plan Steering Committee including a mandate to develop a comprehensive, coordinated suicide prevention plan.

## Appendix A

### Texas Child Fatality Review Team Committee State Committee Members

<p>Jack Ellett State Child Fatality Review Team Chair, Sheriff, Panola County 314 West Wellington Carthage, TX 75633 (903) 693-0333 Fax (903) 694-9028 email: <a href="mailto:SGTFIELDS@JUNO.COM">SGTFIELDS@JUNO.COM</a></p>	<p>Rose E. Benham, MSSW Director, Child Protective Services Texas Dept. of Protective &amp; Regulatory Services P.O. Box 149030 Austin, TX 78714-9030 512-438-3312 Fax 512-438-3782</p>
<p>Gloria Black Ed.D, LMSW-AP Program Administrator Services to Children Youth and Families Texas Education Agency 1701 N. Congress Ave. Austin, TX 78701 (512) 463-9713 Fax (512) 463-4584 <a href="mailto:gblack@tea.state.tx.us">gblack@tea.state.tx.us</a></p>	<p>Susan Bryant Traffic Safety Section Director Traffic Operations Division Texas Department of Transportation Attn: TRF-TS 125 East 11<sup>th</sup> street Austin, TX 78701-2483 (512) 416-3167 Fax (512) 416-3349 <a href="mailto:SBRYANT@dot.state.tx.us">SBRYANT@dot.state.tx.us</a></p>
<p>Paige Dinn 214 Ohio Corpus Christi, TX 78404 (361) 888-4512 <a href="mailto:JRDinn@aol.com">JRDinn@aol.com</a></p>	<p>Alice Gong, M.D. University of Texas Health Science Center Pediatrics-Neonatology MSC 7812 7703 Floyd Curl Drive San Antonio, TX 78229-3900 (210) 567-5227 Fax (210) 567-5169 <a href="mailto:Gong@uthscsa.edu">Gong@uthscsa.edu</a></p>
<p>Joseph Hamilton Captain, Texas Highway Patrol Texas Department of Public Safety 6502 S. New Braunfels Ave. San Antonio, TX 78223 (210) 531-2203 Fax (210) 531-2205 <a href="mailto:joseph.hamilton@txdps.state.tx.us">joseph.hamilton@txdps.state.tx.us</a></p>	<p>Judge Judy Schier Hobbs Justice of the Peace Williamson County 109 West 5th Street P.O. Box 588 Taylor, TX 76754 512-352-2161 Fax 512-352-8956 <a href="mailto:jhobbs6785@aol.com">jhobbs6785@aol.com</a></p>

<p>George Kerr, M.D.  Professor  School of Public Health  University of Texas Health Science Center  PO Box 20186  Houston, TX 77225  (713) 500-9276 Fax (713) 500-9264  <a href="mailto:Gkerr@utsph.sph.uth.tmc.edu">Gkerr@utsph.sph.uth.tmc.edu</a></p>	<p>Eric N. Levy, MD, FAAP, FCCP  Director - Pediatric Critical Care Medicine  Associate Professor of Pediatrics  Amarillo Area Healthcare Specialist, LLP  P.O. Box 51688  Amarillo, TX 79159-1688  (806) 468-4326 Fax (806) 468-4360  <a href="mailto:elevynd@amaonline.com">elevynd@amaonline.com</a></p>
<p>Colleen McCall, LMSW-AP, LPC  Regional Director  Texas Dept. of Protective &amp; Regulatory  Services  6200 I-40 West, MC 005-1  Amarillo, TX 79106  (806) 354-5303 Fax (806) 354-5359  <a href="mailto:Colleen.McCall@tdprs.state.tx.us">Colleen.McCall@tdprs.state.tx.us</a></p>	<p>Skip Oertli, Ph.D  Chief, Bureau of Epidemiology  Texas Department of Health  1100 West 49th Street  Austin, TX 78756  (512) 458-7111 Fax (512) 458-7689  <a href="mailto:Ernest.Oertli@tdh.state.tx.us">Ernest.Oertli@tdh.state.tx.us</a></p>
<p>Denise Oncken, J.D.  Chief, Child Abuse Division  Harris County District Attorney's Office  201 Fannin, 2nd Floor  Houston, TX 77002-1901  (713) 755-5546 Fax (713) 755-8181  <a href="mailto:oncken_denise@dao.co.harris.tx.us">oncken_denise@dao.co.harris.tx.us</a></p>	<p>Debra Owens  Chief and State Registrar  Bureau of Vital Statistics  Texas Department of Health  1100 West 49th Street  Austin, TX 78756-3199  (512) 458-7366 Fax (512) 458-7130  <a href="mailto:debra.owens@tdh.state.tx.us">debra.owens@tdh.state.tx.us</a></p>
<p>Juan Parra, M.D.  Associate Professor of Pediatrics  University of Texas Health Science Center  7703 Floyd Curl Drive  San Antonio, TX 78229  (210) 562-5344 Fax (210) 562-5319  <a href="mailto:parraj@uthscsa.edu">parraj@uthscsa.edu</a></p>	<p>Elizabeth Peacock, M.D.  Travis County Medical Examiners Office  P. O. Box 1748  Austin, TX 78767  (512) 473-9599 Fax (512) 473-9044  <a href="mailto:Peacock@co.travis.tx.us">Peacock@co.travis.tx.us</a>  <a href="mailto:epeacock@austin.rr.com">epeacock@austin.rr.com</a></p>
<p>David Reilly  Chief Probation Officer  Bexar County  235 E. Mitchell Street  San Antonio, TX 78210-1822  (210) 531-1813  <a href="mailto:dreilly@co.bexar.tx.us">dreilly@co.bexar.tx.us</a></p>	<p>Teddy Thomas  Sergeant, Homicide Division  Houston Police Department  1200 Travis  Houston, TX 77002  (713) 308-3993 Fax (713) 308-3986  <a href="mailto:Teddy.Thomas@CityofHouston.net">Teddy.Thomas@CityofHouston.net</a></p>
<p>Sandi Wiggins</p>	

<p>North Texas SIDS Alliance  1401 Airport Freeway – Suite 118  Bedford, TX 76021  (800) 650-7437 Fax (817) 283-1526  <a href="mailto:sandiliwiggins@aol.com">sandiliwiggins@aol.com</a></p>	
<p>Child Fatality Review Team Staff Member  John Hellsten, Ph.D.  Texas Department of Health  Bureau of Epidemiology  1100 W. 49th street  Austin, TX 7876  512-458-7268 Fax (512) 458-7689  <a href="mailto:john.hellsten.@tdh.state.tx.us">john.hellsten.@tdh.state.tx.us</a></p>	<p>Child Fatality Review Team Staff Member  Katherine Keenan, LMSW-ACP  State Coordinator for the Child Fatality  Review Team  Texas Dept. of Protective &amp; Regulatory  Services  P.O. Box 149030  Austin, TX 78714-9030  (512) 438-4174 Fax (512) 438-3782  <a href="mailto:Katherine.Keenan@tdprs.state.tx.us">Katherine.Keenan@tdprs.state.tx.us</a></p>

**Appendix B  
Child Deaths Reviewed by Team\***

	2000			2001		
	#Death Certs*	# Reports	%	#Death Certs*	# Reports	%
<b>No Team</b>	687			602		
<b>Team</b>						
Anderson / Cherokee	15	8	53.3%	18	9	50.0%
Bastrop	15	8	53.3%	13	6	46.2%
Bexar**	257	257	100.0%	263	246	93.5%
Bowie	14	1	7.1%	17	0	0.0%
Brazoria	30	12	40.0%	33	17	51.5%
Brazos	20	20	100.0%	20	28	140.0%
Cameron / Willacy	53	19	35.8%	71	3	4.2%
Central Texas	87	0	0.0%	94	0	0.0%
Coastal Bend	71	71	100.0%	103	92	89.3%
Collin	73	24	32.9%	95	0	0.0%
Comal	9	0	0.0%	12	1	8.3%
Concho Valley	34	34	100.0%	32	34	106.3%
Dallas	408	376	92.2%	476	431	90.5%
Ector	31	17	54.8%	20	18	90.0%
El Paso	124	0	0.0%	122	0	0.0%
Galveston	55	36	65.5%	58	28	48.3%
Gregg	29	0	0.0%	29	0	0.0%
Grimes	16	0	0.0%	7	7	100.0%
Hardin	8	8	100.0%	8	0	0.0%
Harris	581	327	56.3%	641	641	100.0%
Hays	8	0	0.0%	14	0	0.0%
Hill	22	0	0.0%	13	13	100.0%
Hunt	12	0	0.0%	11	0	0.0%
Jefferson	53	41	77.4%	52	36	69.2%
Leon / Madison	8	8	100.0%	8	4	50.0%
Liberty	17	1	5.9%	20	0	0.0%
McLennan	34	19	55.9%	43	32	74.4%
Montgomery	64	0	0.0%	49	57	0.0%
Orange	17	14	82.4%	21	19	90.5%
Panhandle	102	84	82.4%	93	80	86.0%
Robertson	1	0	0.0%	4	0	0.0%
Smith	43	2	4.7%	47	28	59.6%
South Plains	101	72	71.3%	92	34	37.0%
Starr / Hidalgo	141	2	1.4%	129	0	0.0%
Tarrant	358	142	39.7%	373	139	37.3%
Travis	121	115	95.0%	138	125	90.6%
Tri-County	28	18	64.3%	21	14	66.7%

Victoria	18	14	77.8%	22	22	100.0%
Webb	47	3	6.4%	54	2	3.7%
Wichita	32	13	40.6%	22	0	0.0%
Williamson	35	32	91.4%	32	30	93.8%
<b>Total</b>	<b>3192</b>	<b>1818</b>	<b>57.0%</b>	<b>3992</b>	<b>2139</b>	<b>53.6%</b>

\* Note: These data are being reviewed and are subject to change.