

HOUSTON/HARRIS COUNTY CHILD FATALITY REVIEW TEAM

2004-2005
CHILD FATALITY REPORT

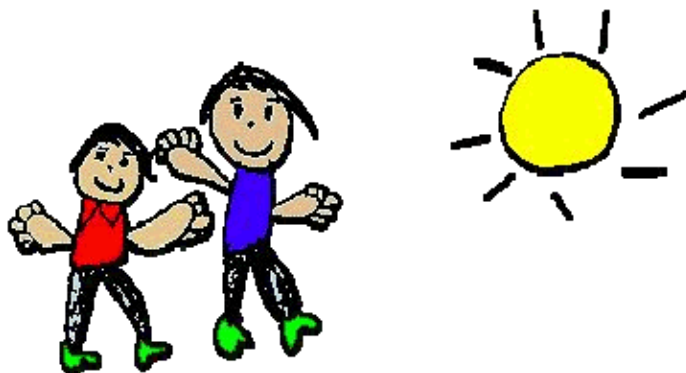


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The primary source of the statistics presented in this report is the data collected, reviewed, and compiled by the Houston/Harris County Child Fatality Review Team (HHCCFRT). Deaths are recorded by the place of occurrence for injuries and by the place of residence for natural deaths. Mortality rates are calculated on Federal Census population figures

We would like to acknowledge Dr. Albert Chu, M.D., forensic pathologist for the Harris County Medical Examiner’s Office for his written contribution to the section on SUID/SIDS.

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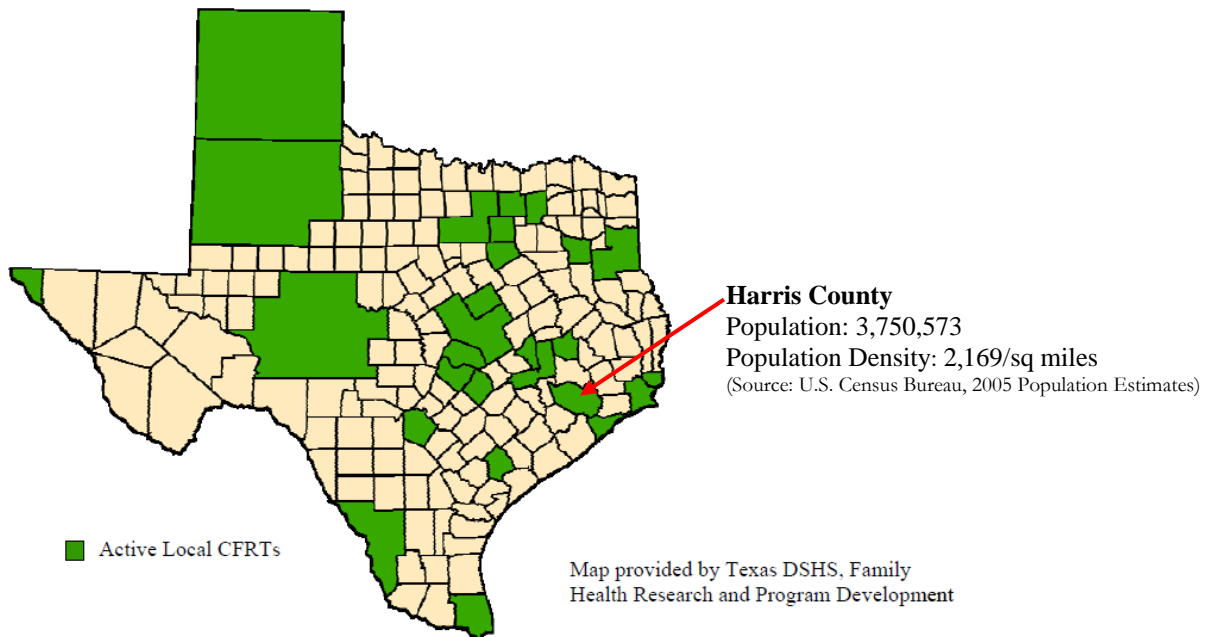
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WHAT IS CHILD FATALITY REVIEW?

Approximately 4,000 children die annually in Texas, but although many agencies have a role in responding to a child's death, there is no single agency that tracks or assesses the circumstances surrounding these deaths. As a result, it is difficult to identify the risk factors that may have adversely affected the child's chance for survival. Over the past twenty years, states across the nation have established child fatality review teams to identify risk factors so that policies can be developed and funds targeted for prevention initiatives. Currently, all 50 states have some form of systematic child death review and data collection mechanism. Texas has been involved with the development of child death review since 1992. In 1995, the Texas Legislature legitimized these efforts by amending Chapter 264 of the Family Code with the Child Fatality Review Team and Investigation statute. During 2005, there were 27 local review teams that cover 95 out of 254 Texas counties. In 2005, 17% of all Texas child deaths (0-17 years) occurred in Harris County.

The Houston/Harris County Child Fatality Review Team (HHCCFRT) has been in operation since April of 1994. The HHCCFRT is a local, multi-disciplinary, multi-agency team whose purposes are to 1) conduct a review of records and information pertaining to each child under the age of 18 years who dies in Harris County; 2) compile and analyze these data to identify patterns or trends in the deaths; and 3) contribute to the development and implementation of interventions designed to prevent or reduce the incidence of these needless deaths.

Figure 1. Active Child Fatality Teams, 2005



TEAM OPERATIONS

The large volume of cases in Houston and Harris County make it necessary for the HHCCFRT to establish certain criteria to prioritize reviews. A case is reviewed if it is the death of a resident of the City of Houston or unincorporated Harris County, or if it is a death due to an injury that occurred within the boundaries of Houston or Harris County regardless of residence. Stillbirths are not reviewed. Cases requiring extensive review are: injury deaths which include child abuse homicides and suicides; all cases investigated by law enforcement and/or child protective services; sudden or unexpected deaths, including Sudden Infant Death Syndrome (SIDS), and deaths of undetermined manner with a “co-sleeping”, or bed sharing indication.

The HHCCFRT meets monthly, reviewing a prioritized list of 20-40 cases at each meeting. In addition to deaths reviewed in the meetings, member physicians associated with Texas Children’s Hospital, Children’s Memorial Hermann Hospital, Ben Taub Hospital, and Lyndon Baines Johnson Hospital review natural deaths of children greater than 24 hours old that occurred in their respective hospitals.

The team coordinator compiles summary information for each death to be reviewed. These summaries are provided to the other team members who then search their files and obtain the necessary data for a review. Each member presents his or her agency’s investigation and/or historical information on the cases and families. Prevention efforts, interventions and other key issues raised by the review are discussed during the meeting, and then stakeholders and community advocates are alerted to areas where their efforts would best make the most impact. The HHCCFRT is also tasked to make recommendations based on information gleaned from review to the State Child Fatality Review Committee. This committee then compiles these recommendations to be presented to the Governor, making an impact on laws and policies related to Texas infant/child safety issues.

The review process adheres to strict rules of confidentiality.* Team members may not disclose any confidential information outside of the team. Records generated by the team may not be introduced into evidence in any civil or criminal proceedings.

* Due to confidentiality regulations, categories of deaths that have a total of less than five cases may not be disclosed therefore totals and rates are not provided in the report for these cases.



HOUSTON/HARRIS COUNTY OVERVIEW

Table 1. Child Fatalities in 2004-2005

Summary	2004	Rate*	2005	Rate*
Total Deaths	662	64.4	708	68.3
Gender	2004	Rate*	2005	Rate*
Male	380	72.3	414	78.2
Female	282	56.1	293	57.8
Race/Ethnicity	2004	Rate*	2005	Rate*
White	136	44.9	156	53.0
African Amer.	207	103.9	218	110.3
Hispanic	298	63.4	314	64.5
Other**	21	37.7	20	34.8
Age	2004	Rate*	2005	Rate*
<1 Year	448	677.3	446	665.4
1-4 Years	73	29.6	76	30.1
5-9 Years	36	13.3	48	17.7
10-14 Years	46	16.3	45	16.1
15-17 Years	59	36.2	93 [†]	55.7 [†]

* Rate is per 100,000 specified populations unless otherwise noted.

** Other is a combined category that includes Asian Americans, American Indians, and other ethnicities that are represented by small population numbers in Houston/Harris County.

[†] The significant increase in the number of 15-17 year-old deaths can be attributed to the significant increase in homicidal and suicidal deaths, as well as slight increase in motor vehicle crash deaths, for this age category during 2004-05.

LEADING CAUSES OF DEATH

Leading Causes of Death in 2004

Injury deaths claimed the most lives of Houston/Harris County children in 2004. Motor vehicle crash injuries, which will be discussed later in this report, caused the largest number of child fatalities in our community.

Infant deaths from severe congenital anomalies and from conditions such as prematurity, extreme prematurity, necrotizing enterocolitis, chorioamnionitis, and hydrops fetalis arising in the perinatal period are the second and third leading causes of death. For this report, a death during the perinatal period is defined as the death of an infant less than 28 days old who weighed greater than or equal to 500 grams at birth. In order to illustrate more reliable information in the tables showing the leading cause of deaths (from Table 2 to Table 8), the deaths of infants who died before the 28th day of life and whose weights were less than 500 grams or unknown were excluded.

Table 2. Leading Cause of Death (birth – 17 years), 2004

2004	Harris County		Texas	
Cause of Death	Number of Deaths	Rate	Number of Deaths	Rate
Injury	135	13.1	1016	16.3
Congenital Malformation	117	11.4	639	10.4
Perinatal Condition	79	7.7	952	15.4
Infection	70	6.8	91	1.5
Cancer	31	3.0	168	2.7
Undetermined (Co-sleeping)*	26	2.5	N/A	N/A
SIDS	22	2.1	208	3.4

In 2004, there were 201 infants who died from perinatal conditions, among these, 122 infant deaths were excluded due to low or unknown birth weight: 67 infants with birth weight less than 500 grams and 55 infants with unknown birth weights. The remaining 79 out of the 201 were counted for the number of deaths due to perinatal conditions.

*Please note: co-sleeping was not the cause of death, only an indicator factor coinciding with the “Undetermined” manner and cause of death.

Leading Causes of Death in 2005

In 2005, injuries caused the most child deaths. The majority of these injury deaths occurred in motor vehicle crashes. Deaths from perinatal conditions and severe congenital anomalies were the second and third leading causes of death.

Table 3. Leading Cause of Death (birth – 17 years), 2005

2005	Harris County		Texas	
Cause of Death	Number of Deaths	Rate	Number of Deaths	Rate
Injury	163	15.7	1003	16.1
Perinatal Condition	116	11.2	952	15.3
Congenital Malformation	108	10.4	627	10.1
Infection	80	7.7	95	1.5
Undetermined (Co-sleeping)	36	3.5	N/A	N/A
Cancer	32	3.1	183	2.9
Undetermined	24	2.3	N/A	N/A

The same exclusion criteria were adapted for 2005 infant deaths from perinatal conditions. Among 213 infant deaths from perinatal conditions, 97 deaths were excluded because while those infants died before their 28th day of life their birth weights were less than 500 grams or unknown. The remaining 116 deaths represent the number of deaths from perinatal conditions.

Figure 2. Manner of Non-natural & Undetermined Causes of Death among Harris County Children (Birth - 17 Years of Age), 2004-2005

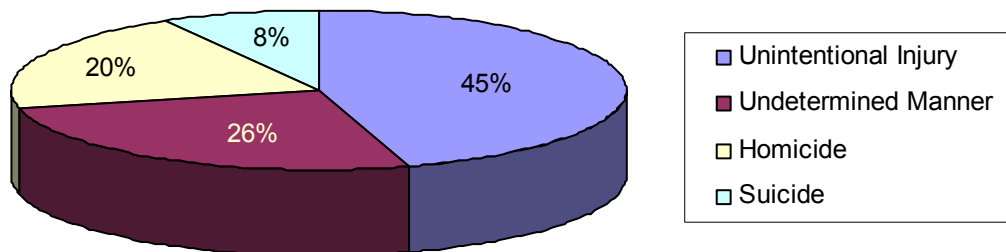


Table 4. Leading Cause of Death for Infants (0-11 months), 2004-2005

Rank	Cause of Death	Number of Deaths	Rate
1	Perinatal Conditions	188	141.2
2	Congenital Malformation	172	129.2
3	Infection	112	84.1
4	Undetermined (Co-sleeping)	60	45.1
5	SIDS	40	30.0

Table 5. Leading Cause of Death for Children (1-4 years), 2004-2005

Rank	Cause of Death	Number of Deaths	Rate
1	Injury	62	12.4
2	Congenital Malformation	24	4.8
3	Infection	19	3.8
4	Cancer	18	3.6
5	Respiratory Disease	7	1.4

Table 6. Leading Cause of Death for Children (5-9 years), 2004-2005

Rank	Cause of Death	Number of Deaths	Rate
1	Injury	31	5.7
2	Cancer	17	3.1
3	Congenital Malformation	16	3.0
4	Infection	7	1.3
5	Metabolic Disease	<5	N/A

Table 7. Leading Cause of Death for Children (10-14 years), 2004-2005

Rank	Cause of Death	Number of Deaths	Rate
1	Injury	40	7.1
2	Cancer	18	3.2
3	Congenital Malformation	11	2.0
4	Circulatory Disease	8	1.4
5	Infection	6	1.1

Table 8. Leading Cause of Death for Children (15-17 years), 2004-2005

Rank	Cause of Death	Number of Deaths	Rate
1	Injury	120	36.4
2	Cancer	8	2.4
3	Infection	6	1.8
4	Nervous System Disease	<5	N/A
5	Circulatory Disease	<5	N/A

DEATHS FROM NATURAL CAUSES

Natural causes of death contributed to 71% of all child deaths in 2004-2005. There were 490 natural deaths in 2004 and 479 natural deaths in 2005, for a combined two-year total of 1365 child deaths. The largest number of natural deaths occurred among infants (758 deaths, 78% of all natural deaths), followed by children ages 1-4 years (80 deaths, 8%).



Table 9. Natural Death by Gender

Gender	2004		2005	
	Number	Rate	Number	Rate
Male	273	51.9	264	49.9
Female	217	43.2	214	42.2
Total	490	47.6	479*	46.1

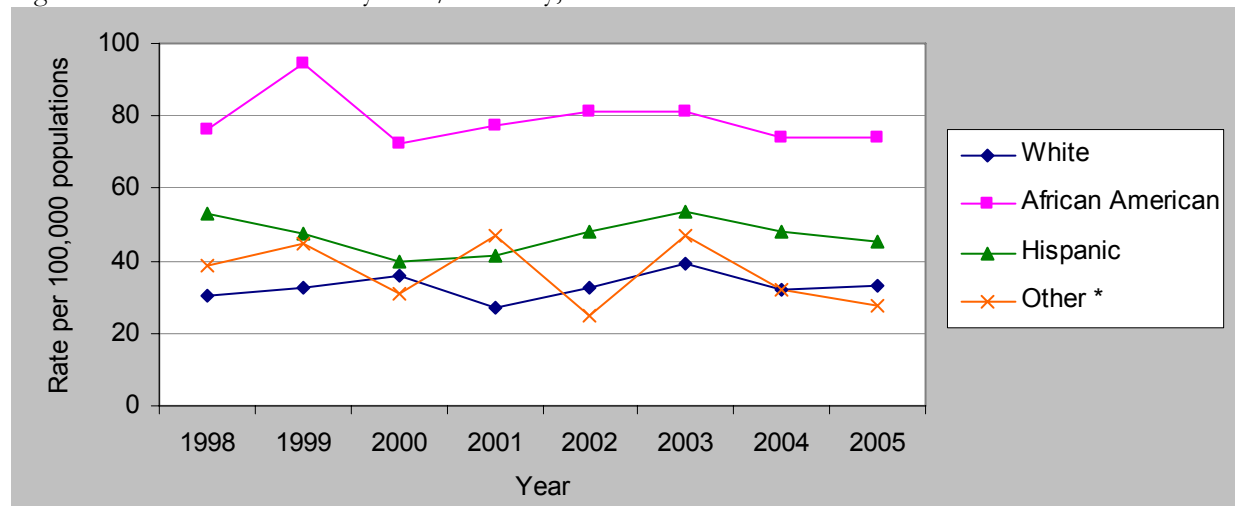
* There was a death whose gender was not determined due to extreme prematurity.

The number of male children who died from natural causes exceeds that of female children in both 2004 and 2005. The rate difference between genders reduced slightly from 8.7 in 2004 to 7.7 in 2005.

Table 10. Natural Death by Race/Ethnicity

Race/Ethnicity	2004		2005	
	Number	Rate	Number	Rate
White	97	32.0	97	32.9
African American	148	74.3	146	73.9
Hispanic	227	48.3	220	45.2
Other	18	32.3	16	27.9

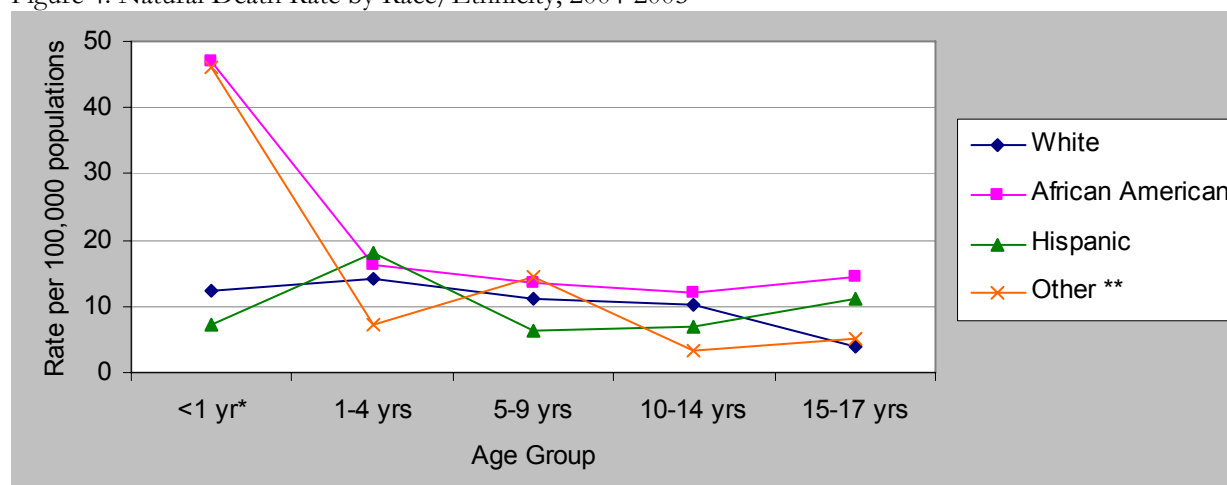
Figure 3. Natural Death Rate by Race/Ethnicity, 1998-2005



* The fluctuation of mortality rate among Other race may be attributed to small population numbers.

The rate of natural deaths among African American children was more than double that of children from the White and Other racial groups in 2004-2005. Hispanic children also had a higher natural death rate than White children. These persistent racial disparities in the rate of children dying have been observed in Houston/Harris County since data collection began, with the most evident rate disparities seen via the infant mortality rate. In Figure 3 the fluctuation of mortality rate among the Other race category may be attributed to small population numbers.

Figure 4. Natural Death Rate by Race/Ethnicity, 2004-2005

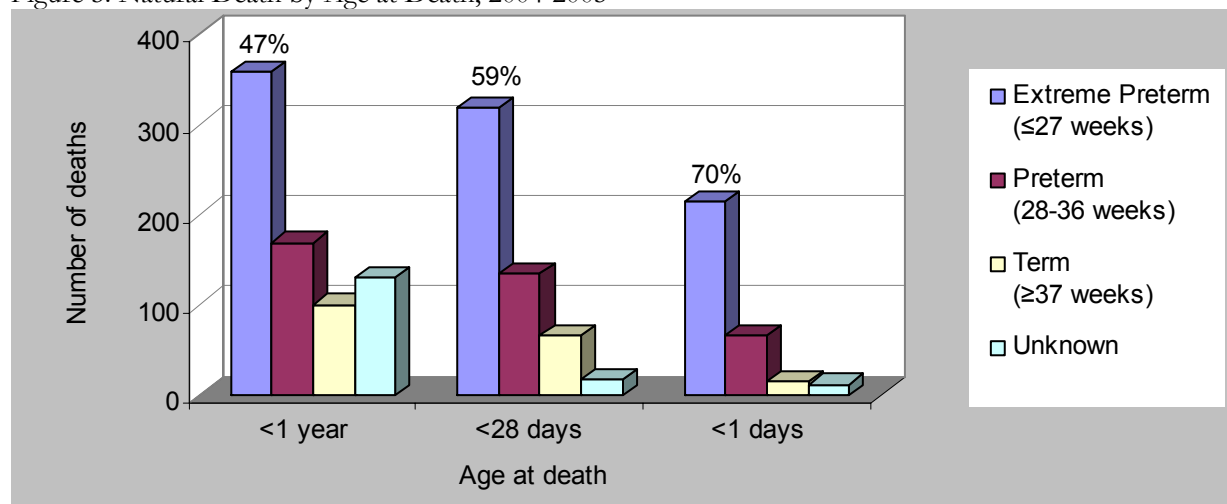


* Death Rate per 1,000 live births.

** High incidence of Other infant mortality rate may be due to small population numbers.

Of the 969 children who died as a result of natural causes in 2004-2005, 55% died before their 28th day and 32% did not survive for more than 24 hours. Of newborns who died within 28 days, 84% had a gestational age of less than 37 weeks. Immaturity and low birth weight of newborns due to preterm delivery were the most significant contributing factors of infant mortality. Among infants who died at <1 day, the proportion of extreme preterm births is significantly higher. Among infants who died at <1 day, the proportion of extreme preterm births is significantly higher.

Figure 5. Natural Death by Age at Death, 2004-2005



Sudden Unexpected Infant Death (SUID)

The term "sudden unexpected infant death" refers to infant deaths (1 to 12 months of age) that occur suddenly and without an obvious cause. It is estimated that approximately half of these deaths are categorically labeled sudden infant death syndrome (SIDS). In Harris County, cases of sudden unexpected infant death not falling within the criteria for the SIDS label are classified as "Undetermined".

Sudden Infant Death Syndrome (SIDS)

A subset of sudden unexpected infant deaths, the diagnosis of SIDS is primarily a diagnosis of exclusion that should not be diagnosed in the presence of other possible causes of death, potentially significant autopsy findings, or atypical circumstances. SIDS is defined as the death of an infant less than 12 months of age that cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and review of the clinical history.

SIDS remains one of the leading circumstances of death among infants 1 to 12 months of age. Risk factors include: African American and American Indian race/ethnicity, age less than 6 months, household member smoking, and prone (stomach) sleep position. The prevention strategies recommended by the Infant Mortality Risk Reduction Work Team of the National SIDS & Infant Death Program Support Center (NSIDPSC) include:

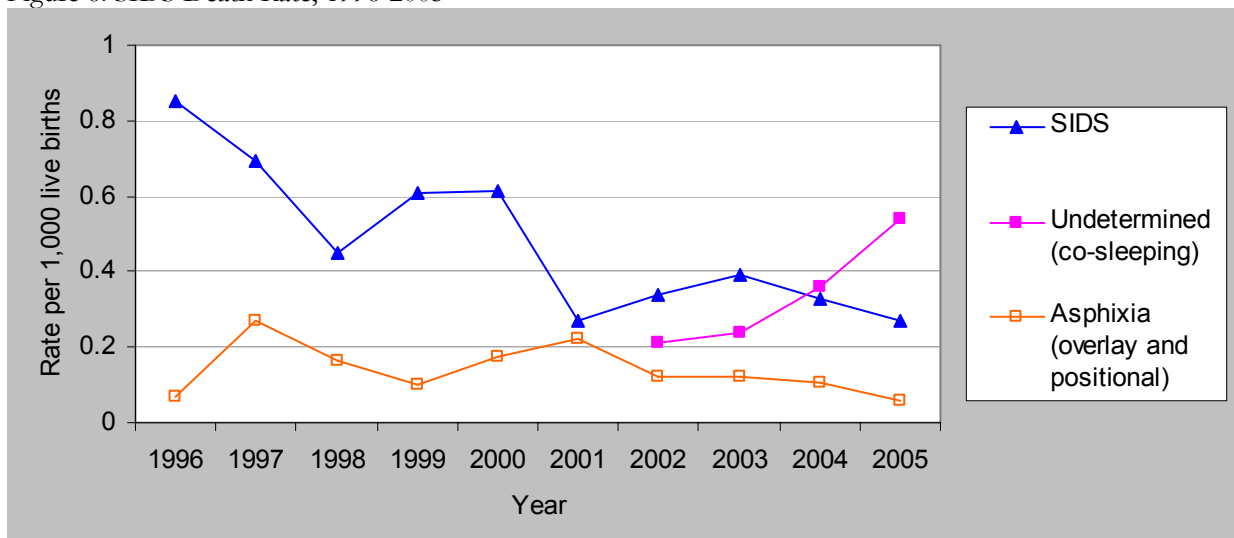
- Always place the baby on his back to sleep. If he falls asleep while playing on his stomach, turn him over on his back to continue his rest.
- Place the baby on a firm mattress and remove all pillows, quilts, comforters, bumper pads, wedges or positioners, sheepskins, stuffed toys, and other soft items from the crib.
- Do not place the baby to sleep on a waterbed, sofa or chair, soft mattress, sleeping bag, pillow, or any other soft surface.
- Do not allow babies to share a crib, even if they are siblings or twins.
- Ask the parents to provide a sleeper garment. Dress the baby in it for sleep instead of covering him with a blanket or comforter.
- Make sure that the baby's head stays uncovered while he sleeps.
- Do not let babies sleep in a room where smoking is allowed (even if no one smokes while the babies are in the room).
- Make the families you serve aware of the steps you take to reduce the risk of SIDS while caring for their children.

Since 1990, the overall rate of SIDS in the United States has declined by more than 50 percent. This appears to be mostly due to two main factors: 1) efforts to encourage supine (back) infant sleep positioning and 2) changes in the classification of SIDS.

In 1992, the American Academy of Pediatrics initiated its "Back to Sleep" campaign, which recommended that infants be placed on their backs during sleep. Between 1992 and 1999, the total SIDS rate in the United States dropped from 1.2 per 1000 live births to 0.67 per 1000 live births, with an accompanying decrease in the overall infant mortality rate.

More recently, the decline in SIDS has continued but the overall infant mortality rate has remained stable, suggesting that the current trend is more likely due to changes in the classification of sudden unexpected infant deaths. With improved investigation of infant deaths and increasing recognition of the potential hazards of unsafe sleeping environments, a decline in the diagnosis of SIDS with a concomitant increase in other causes of death (including undetermined and asphyxial deaths) has occurred. It has been estimated that greater than 90 percent of the drop in SIDS rates nationwide between 1999 and 2001 can be attributed to changes in classification alone (Malloy MH, MacDorman M. Changes in the classification of sudden unexpected infant deaths: United States, 1992-2001. *Pediatrics* 2005;115:1247-53). Data from Houston/Harris County are consistent with reported nationwide trends. Since “Undetermined” & “Undetermined (co-sleeping)” have been used as a classification of death, the rates of asphyxial deaths and SIDS have decreased significantly.

Figure 6. SIDS Death Rate, 1996-2005



During 2004-2005, 40 infants were ruled as SIDS cases in Houston/Harris County. Males had a slightly higher SIDS death rate per 1,000 live births. In contrast to decreasing figures in the total number of SIDS deaths, however, the number of SIDS deaths recorded for the Hispanic population and the Other race/ethnic groups were nearly equal. As in the years 2002-2003, African American infants maintain a higher rate of SIDS death than White and Hispanic infants. Seventy percent of SIDS deaths occurred between 2-4 months of age, and the months of April and May had the highest number of SIDS deaths.

Table 11. SIDS by Gender

Gender	2002-2003		2004-2005	
	Number	Rate*	Number	Rate*
Male	26	0.39	22	0.32
Female	22	0.34	18	0.27
Total	48	0.36	40	0.30

* Rate is per 1,000 live births in Harris County.



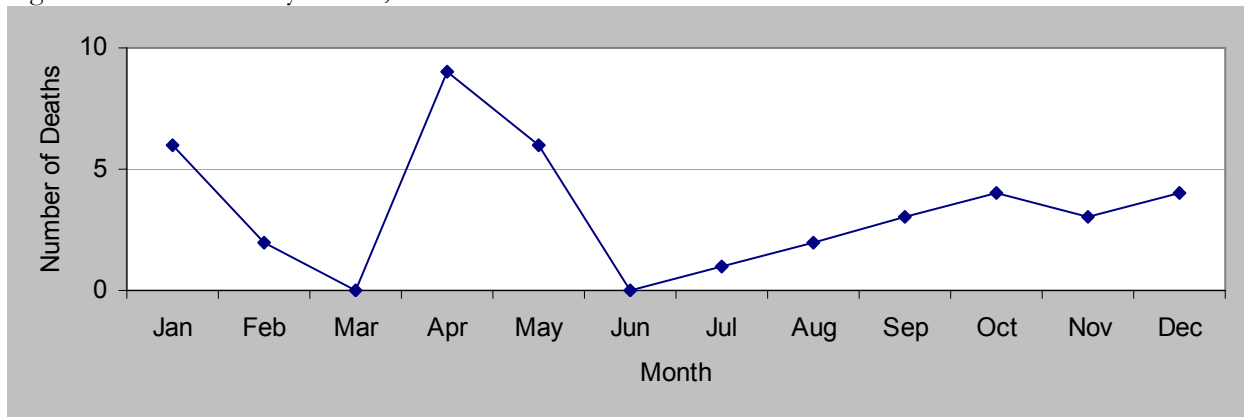
Table 12. SIDS by Race/Ethnicity

Race/Ethnicity	2002-2003		2004-2005	
	Number	Rate*	Number	Rate*
White	16	0.45	9	0.26
African American	15	0.66	12	0.51
Hispanic	15	0.23	15	0.22
Other	<5	N/A	<5	N/A



* Rate is per 1,000 live births in Harris County.

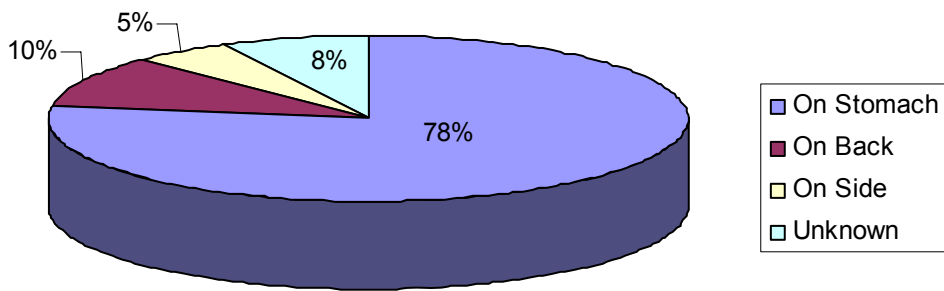
Figure 7. SIDS Deaths by Month, 2004 -2005



Data from Houston/Harris County also support the national findings on risk in the areas of infant age, gender, and maternal prenatal care. The average gestational age for infants who died of SIDS in 2004-2005 was 38 weeks, and the average birth weight was 2146 grams for the deaths with known gestational age and birth weight. Of the 40 infants who died of SIDS, 43% had experienced recent cough, fever, congestion, and/or flu-like symptoms.

The American Academy of Pediatrics recommends that to reduce the risk of SIDS, healthy babies should be put down to sleep on their backs. In Harris County during 2004-2005, there were 37 SIDS deaths in which the sleeping position of the infant was known. At the time of discovery, the majority of these infants, 78%, were sleeping on the stomach, 10% were on the back, and 5% were on one side.

Figure 8. SIDS Deaths by Position at the Time of Discovery, 2004 -2005



INTENTIONAL INJURIES - HOMICIDES

Homicides contributed to 39 child deaths in 2004 and 47 child deaths in 2005. Firearm-related homicides resulted in 48% of these deaths, and since 2000-2001, this has increased by 41%. Other mechanisms included drowning, strangulation, malnourishment/neglect, scalding, and being left in a hot car, as well as failure by the caregiver to seek necessary medical care. Nineteen of the murdered children (22%) had at least one prior involvement with Children’s Protective Services (CPS) and 13 of the perpetrators (15%) had a previous history with CPS.

The majority of the homicides were committed using a gun, usually a handgun. Striking, that resulted in blunt force trauma, with or without shaking the child, was the second leading mechanism of injury.

Table 13. Homicide by Mechanism

Mechanism	2002-2003	2004-2005
Gun Shot Wound	51	41
Struck/Shaken/Thrown	25	29
Cut/Stab Wound	5	<5
Drowning	<5	<5
Other	27	9

According to the Child Trends DataBank, homicide is currently the leading cause of injury deaths among infants in the United States, and homicide risk is greater during the first year of life than in any other year before age 17. In Harris County, the homicide death rate showed the same trend during 2004-2005. Infants had the highest homicide rate among children 0-16 years, with the homicide death rate decreasing as the children grow older until age 11. However, after age 16, the homicide death rate increases dramatically showing that 17 year-olds had the highest death rate due to homicide, most likely due to gang-related violence.

Figure 9. Homicide Rate by Age, 2004-2005

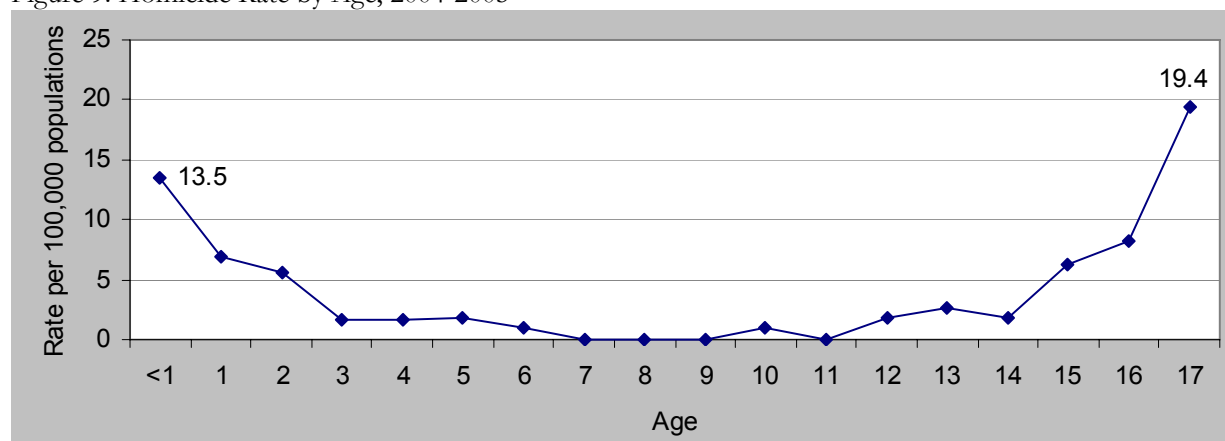


Figure 10. Percentage of Homicide Cases by Age Group, 2004-2005

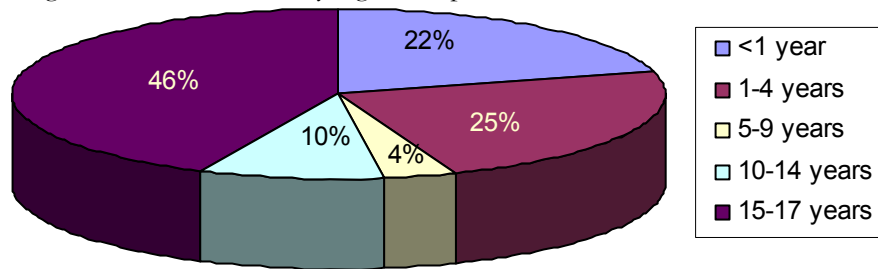


Table 14. Homicide by Gender

Gender	2002-2003		2004-2005	
	#	Rate	#	Rate
Male	69	6.7	63	6.0
Female	43	4.4	23	2.3
Total	112	5.5	86	4.2

Table 15. Homicide by Race/Ethnicity

Race/Ethnicity	2002-2003		2004-2005	
	#	Rate	#	Rate
White	12	1.9	12	2.0
African American	44	11.0	37	9.3
Hispanic	52	5.9	37	3.9
Other	<5	N/A	0	0.0

The rate of male homicide deaths in 2004-2005 was significantly higher than that of female deaths at 6.0 to 2.3 per 100,000 populations. The total homicide death rate declined in all race/ethnicity groups in 2004-2005, but the discrepancies between racial groups remained almost the same. African American children had a higher rate of homicide deaths than any other race/ethnicity group while Hispanic children comprised the largest total number of homicide fatalities in 2004-2005.

Because information was not available about the perpetrators in many of these homicide cases, the following information about perpetrators is an incomplete depiction. However, it does begin to give some idea of who these perpetrators were and therefore may be considered valuable information nonetheless. Documentation existed on known criminal history of the perpetrator in 5 of the 86 homicide cases. Twelve homicide cases were known to be gang-related. In seven of the 86 cases, revenge toward the victim was documented as the precipitating factor. In six homicides the victim tested positive for either alcohol or illegal substances.

Table 16. Homicide by Perpetrator

Perpetrator	2002-2003	2004-2005
Parents (including foster parents and guardians)	40	28
Parent's Significant Other	12	8
Friend/Acquaintance	15	5
Other person known to victim (Babysitter, Relatives, etc.)	13	6
Person unknown to victim	22	20
Information unavailable	10	19

The most common location of homicide proved to be the child's home at 43% of all locations.

Table 17. Homicide by Location

Location	2000-2001	2002-2003	2004-2005
Child's Home	49	56	37
Parking Lot	5	10	14
Street	7	9	10
Other Residence	5	19	5
Other	14	18	20

Combined data gathered by the Houston/Harris County Child Fatality Review Team from 1996-2005 show that the number of children who are murdered in Harris County reaches a peak during the late summer months of July, August, and September. The majority of the murders are committed between the time periods 12 noon to 6:00 pm and from 6:00 pm to 12 midnight.

Figure 11. Homicide by Month, 1996-2005

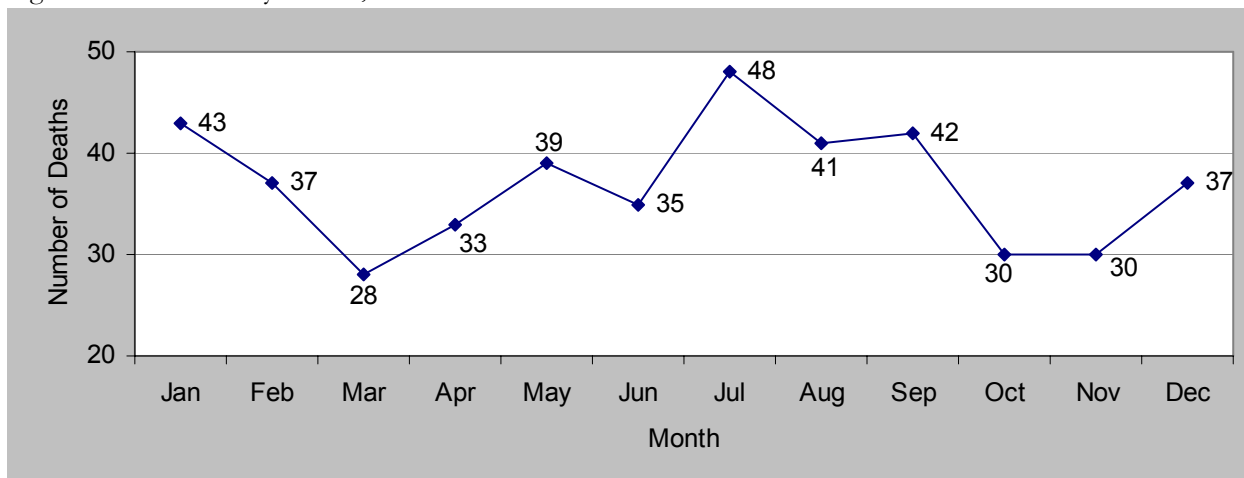
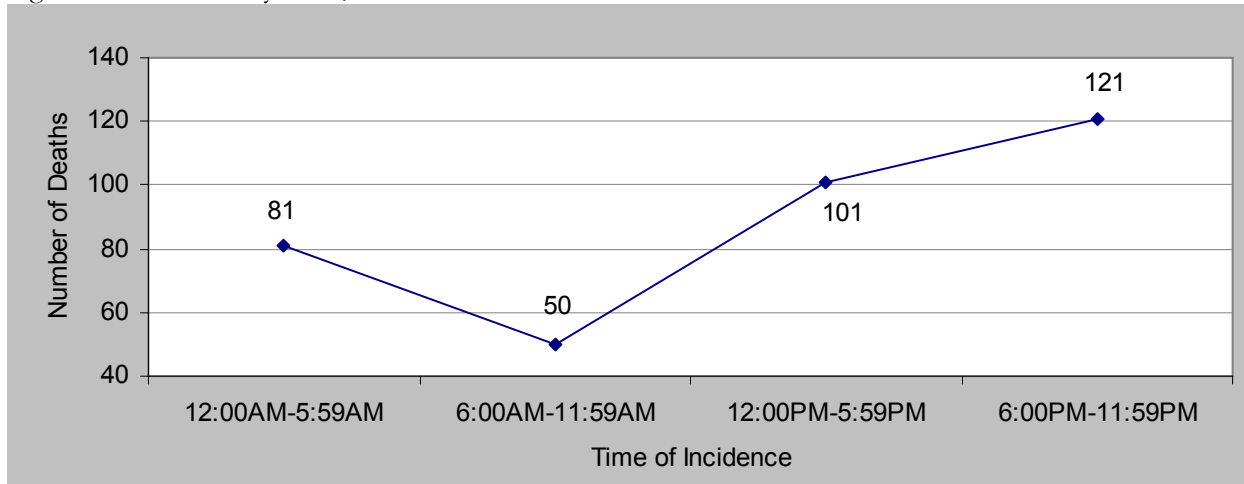


Figure 12. Homicide by Time, 1996-2005



CHILD ABUSE HOMICIDES

There is a subset of homicides that are a result of child abuse/maltreatment of children aged 0-11 years. Child abuse/maltreatment homicides include the child being beaten, shaken, thrown, struck with an object or with hands or feet, drowned, shot, malnourished, left in a hot car (all by the caregiver), as well as failure by the caregiver to seek necessary medical care. There were 23 such deaths in 2004 and 21 in 2005. The majority of child abuse deaths (77%) occurred in the child's home, and in 55% of these homicides, one or both biological parents inflicted the injury. The parent's intimate partner was the perpetrator in 23% of the deaths. The average age of the perpetrator was 26 years. In 17% of these homicides, the perpetrator was under the influence of alcohol and/or illegal substances. Some of the events directly leading up to the fatal injuries included crying child, disciplining or toilet training of child, playing in a bathtub without supervision, and revenge against another person.

Table 18. Child Abuse Homicide by Perpetrator

Perpetrator	Number	%
Biological parent	24	55%
Parent's intimate partner or Step-parent	11	25%
Other caretaker	11	25%
Information unavailable	<5	N/A

Figure 13. Child Abuse Homicide by Age, 2004-2005

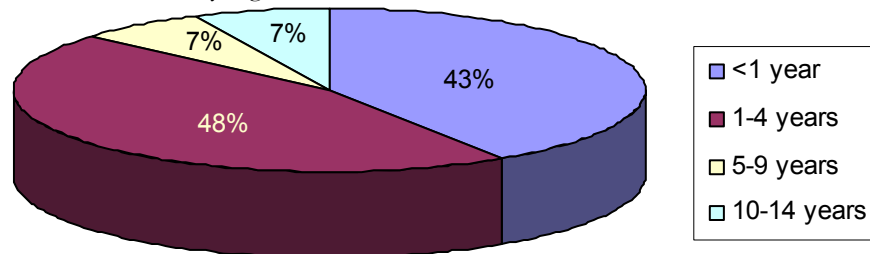


Figure 14. Methods of Child Abuse Homicides, 2004-2005

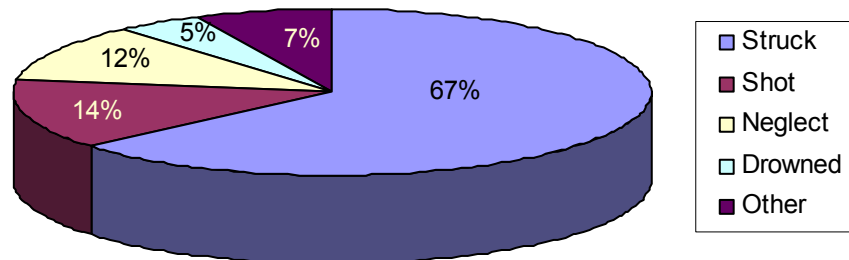


Table 19. Child Abuse Homicide by Gender

Gender	2002-2003		2004-2005	
	#	Rate	#	Rate
Male	31	3.0	27	3.8
Female	25	2.5	17	2.5
Total	56	2.8	44	3.2

Table 20. Child Abuse Homicide by Race/Ethnicity

Race/Ethnicity	2002-2003		2004-2005	
	#	Rate	#	Rate
White	8	1.3	7	1.8
African American	23	5.7	22	8.6
Hispanic	23	2.6	15	2.2
Other	<5	N/A	0	0.0

FIREARM HOMICIDES

Firearms were used in 48% of all child fatality homicides perpetrated in Harris County during 2004-2005. Children of Hispanic ethnicity were the victims in 51% of the cases; however African American children were killed with a firearm at a higher rate. Teens from 15-17 years of age comprised 78% of firearm homicide victims, and from known information, at least 26% of these homicides were gang-related. Revenge toward the victim was known for 10% of the firearm homicides. Thirty two percent of all firearm homicides took place between the evening hours of 6:00 pm and midnight. No seasonal trend in homicide deaths was observed during 2004-2005.

A handgun was the firearm of choice, used in 93% of these homicides. Among the suspects of known identity, the average age of suspects was 23 years, 96% were male, and individuals of Hispanic ethnicity committed 54% of the firearm homicides.

Table 21. Firearm Homicide by Gender

Gender	2002-2003		2004-2005	
	Number	Rate	Number	Rate
Male	35	3.4	33	3.1
Female	16	1.6	8	0.8
Total	51	2.5	41	2.0



Table 22. Firearm Homicide by Race/Ethnicity

Race/Ethnicity	2002-2003		2004-2005	
	Number	Rate	Number	Rate
White	5	0.8	6	1.0
African American	15	3.7	14	3.5
Hispanic	30	3.4	21	2.2
Other	<5	N/A	0	0.0

Table 23. Firearm Homicide by Location

Mechanism	2002-2003	2004-2005
Child's Home	13	5
Other Residence	11	<5
Parking Lot	8	14
Street	9	<5
Other	10	16

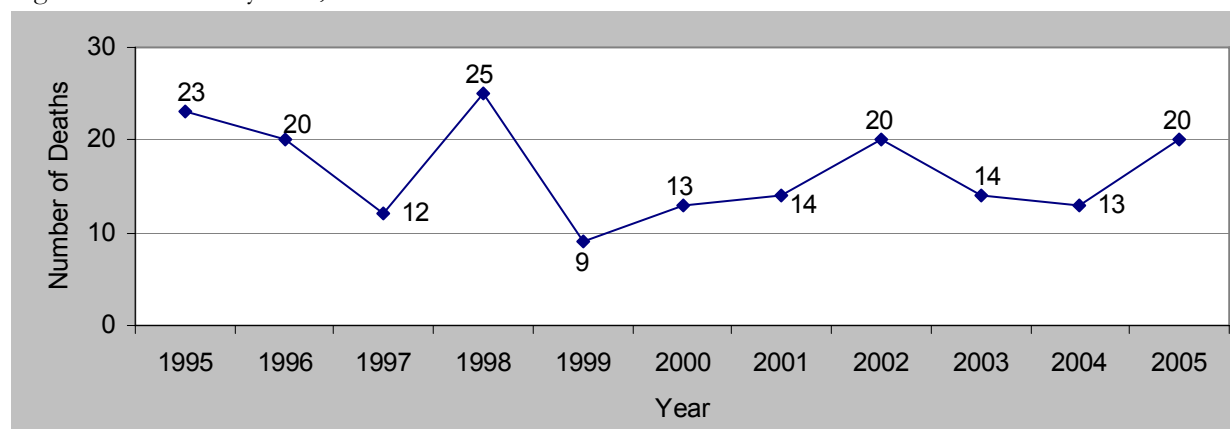
Table 24. Firearm Homicide by Perpetrator

Perpetrator	2002-2003	2004-2005
Parents	6	<5
Friend/Acquaintance	15	<5
Other	7	<5
Person unknown to victim	18	16
Information unavailable	5	16

INTENTIONAL INJURIES - SUICIDES

Suicide deaths are the visible outcome of an unknown number of suicide attempts each year in Harris County. In 1998, Harris County experienced the highest number (25) of child suicides in the history of the HHCCFRT. By contrast, the number for 1999 was only 9, the lowest number recorded by the HHCCFRT. The number of child suicide deaths declined between 2002 and 2004 then increased again in 2005.

Figure 15. Suicides by Year, 1995-2005



The highest rate of child suicide in Houston/Harris County was found among White males: 3.3 deaths per 100,000 populations. Overall, males complete suicide twice as often as females. White children have a higher rate of death by suicide than African American and Hispanic children. As seen in Figure 16, half of the suicides occurred among 16-17 years olds. For the years 2004-2005, the youngest age of death by suicide in Houston/Harris County was 13 years old. In years past, however, there have been deaths by suicide as young as nine years old.

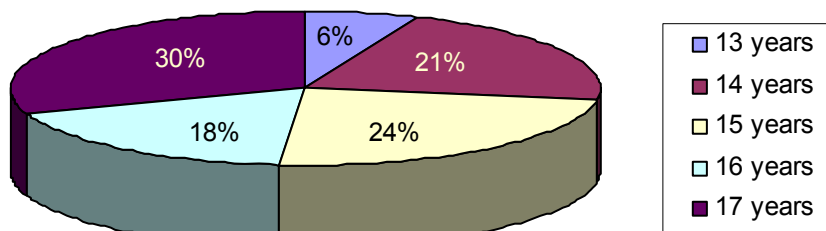
Table 25. Suicide Deaths by Gender

Gender	2002-2003		2004-2005	
	#	Rate	#	Rate
Male	24	2.3	22	2.1
Female	10	1.0	11	1.1
Total	34	1.7	33	1.6

Table 26. Suicide Deaths by Race/Ethnicity

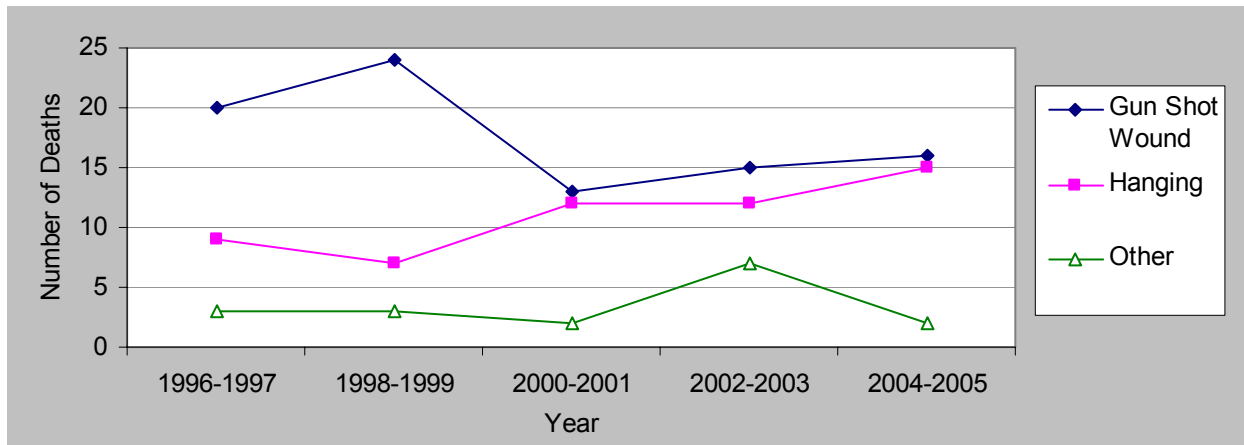
Race/Ethnicity	2002-2003		2004-2005	
	#	Rate	#	Rate
White	19	3.0	15	2.5
African American	<5	N/A	6	1.5
Hispanic	12	1.4	12	1.3
Other	0	0.0	0	0.0

Figure 16. Suicide Deaths by Age, 2004-2005



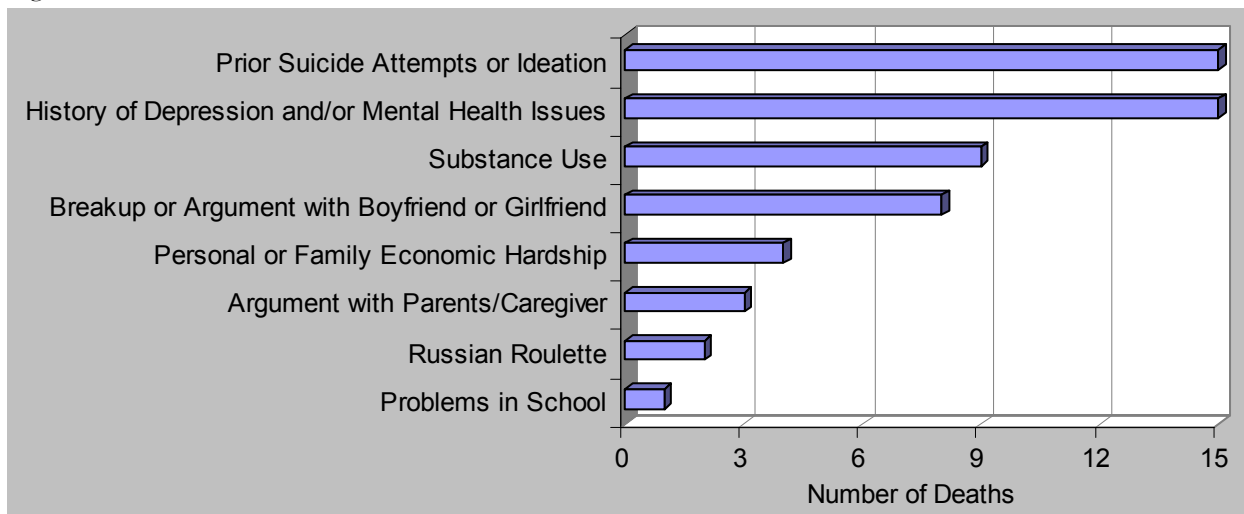
The most common mechanism of suicide before 2000 was from gun shot wounds. However, there is an increasing trend of suicides by hanging; almost half of the children who completed suicide in 2004-2005 died from asphyxiation due to hanging. Still, of the 33 suicide deaths, 48% (16 deaths) were from firearm injuries—handguns were used in 12 cases and rifles were used in 4 cases. Eighty one percent of suicides from gun shot wounds were male children. The gun owner was not known in half of the completed firearm suicides, however, of the known firearm owners, 88% (7 cases) were a parent.

Figure 17. Completed Suicides by Mechanism



Many factors can contribute to a child attempting or completing suicide. The contributing factors listed in Figure 18 are routinely documented during the HHCCFRT meetings. A combination of these factors was often documented in a single suicide case. Of the 2004-2005 cases, almost half of the children who completed suicide talked about previous suicidal attempt(s) and/or ideations to someone close to them. Common mental health issues these children had were ADHD, bipolar disorder, and depression. Twenty one percent of the suicide cases tested positive for either alcohol or illegal substances. The majority of the suicides (91%) occurred in the child's home.

Figure 18. Suicide Factors, 2004-2005



UNINTENTIONAL INJURY DEATH

Unintentional injuries caused 83 child deaths in 2004 and 94 child deaths in 2005. Of these 144 unintentional injury deaths, motor vehicle crashes were responsible for 54% of all unintentional injury deaths. Drowning and complications due to near drownings accounted for 19% of all unintentional injury deaths. There were <5 unintentional firearm deaths among children in Harris County during 2004-2005.

Table 27. Unintentional Injury Deaths by Mechanism

Mechanism	2000-2001	2002-2003	2004-2005
Motor Vehicle Crash	100	104	96
Drowning	32	18	33
Poison/Overdose	11	12	17
Asphyxia	38	25	13
Fire	10	6	10
Other	14	14	8
Total	205	179	177



Males were significantly more likely to experience an unintentional fatal injury than were females. For race/ethnicity, African Americans have consistently shown the highest unintentional injury death rate. A steadily decreasing pattern has occurred in the Other race/ethnicity groups since 2000, even though the data is not available in the table below due to confidentiality regulations.

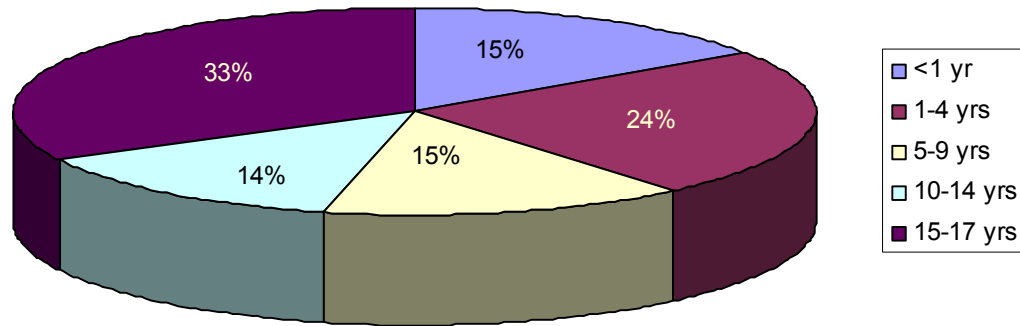
Table 28. Unintentional Injury Deaths by Gender

Gender	2004		2005		Total	
	Number	Rate	Number	Rate	Number	Rate
Male	56	10.7	51	9.6	107	10.1
Female	27	5.4	43	8.5	70	6.9
Total	83	8.1	94	9.1	177	8.6

Table 29. Unintentional Injury Deaths by Race/Ethnicity

Race/Ethnicity	2004		2005		Total	
	Number	Rate	Number	Rate	Number	Rate
White	24	7.9	23	7.8	47	7.9
African American	21	10.5	26	13.2	47	11.8
Hispanic	35	7.4	43	8.8	78	8.1
Other	<5	N/A	<5	N/A	5	4.4

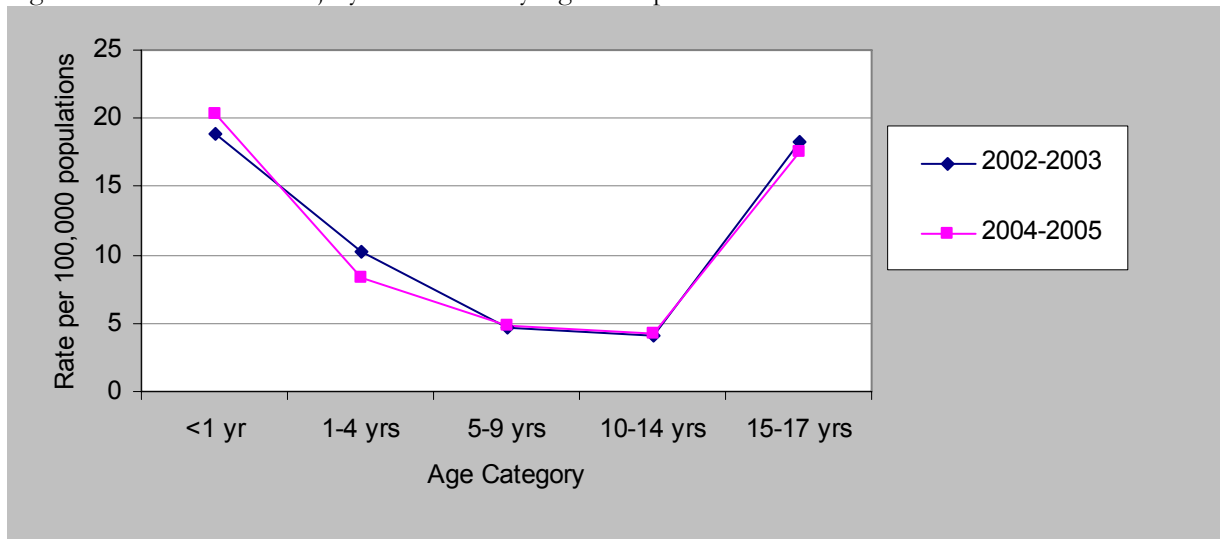
Figure 19. Proportion of Unintentional Injury Death by Age Group, 2004-2005



As seen in Figure 18, almost one third of unintentional injury deaths occurred among the 15-17 year old age group (33%); the 1-4 year old age group was the second largest group in unintentional deaths (24%).

However, the death rates from 2004-2005 HHCCFRT data showed that the age group proportionately at greatest risk for unintentional injury is infants <1 years old. The risk lessens as the children grow older and have more control over their movements and activities. Compared to 2002-2003, the difference in risk of unintentional injury between <1 yr of age and 1-4 years became more pronounced in 2004-2005. The risk increases again as the children move in to the 15-17 year old category when they begin to drive motor vehicles.

Figure 20. Unintentional Injury Death Rate by Age Group



UNINTENTIONAL INJURY - MOTOR VEHICLE CRASH

Motor vehicle crashes (MVC) were the cause of 96 unintentional injury deaths during the years 2004-2005 in Harris County. This figure comprises 53% of all unintentional injury deaths among children 0-17 years of age. The majority of the MVC injuries occurred on streets rather than highways or interstates. The overall death rate due to fatal MVC reduced from 5.1 per 100,000 in 2002-2003 to 4.6 in 2004-2005. The death rate of males due to MVC, however, remains higher than that of females.

Table 30. MVC Death by Gender

Gender	2002-2003		2004-2005	
	Number	Rate	Number	Rate
Male	65	6.3	61	5.8
Female	39	3.9	35	3.5
Total	104	5.1	96	4.6

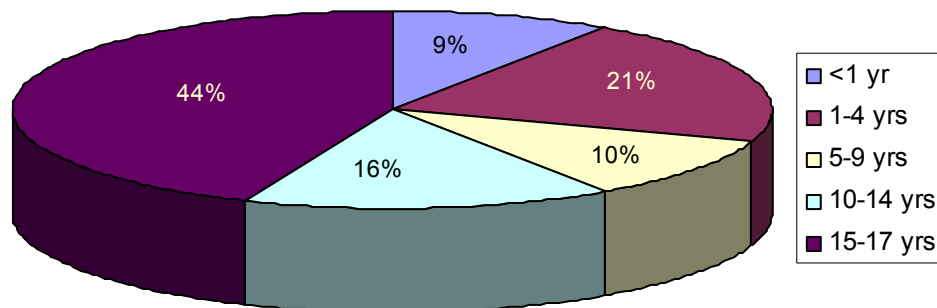


Table 31. MVC Death by Race/Ethnicity

Race/Ethnicity	2002-2003		2004-2005	
	Number	Rate	Number	Rate
White	28	4.4	22	3.7
African American	20	5.0	14	3.5
Hispanic	50	5.7	58	6.1
Other	6	5.7	<5	N/A

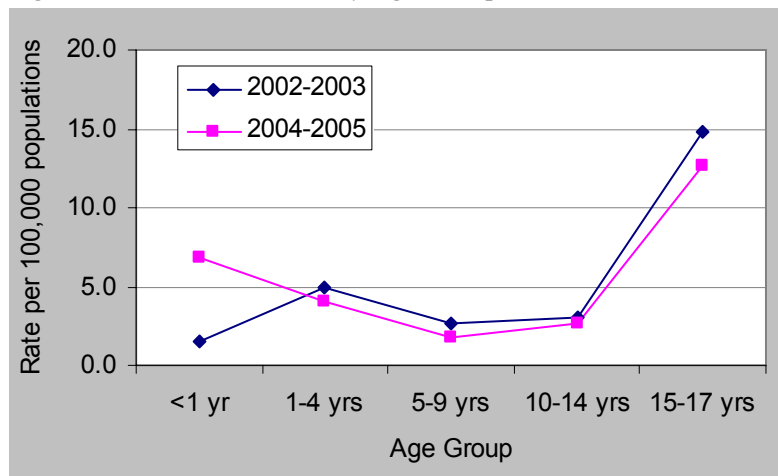
The highest rate of motor vehicle crash deaths in 2004-2005 occurred among Hispanic children; historically and until now their rates continue to increase: 5.0 in 2000-2001, 5.7 in 2002-2003, and 6.1 in 2004-2005. In contrast, the rate of African American children, who had the highest rate of motor vehicle crash deaths in 2000-2001, plummeted from 6.2 in 2000-2001 to 3.5 in 2004-2005.

Figure 21. MVC Deaths by Age Group, 2004-2005



Based on the rate and proportion of MVC deaths by age group, 15-17 year-olds had the highest risk for MVC death. As they started driving, they were more likely to be exposed to risky situations such as distraction, inexperienced driver, and peer pressure to remain unrestrained. Among the 42 deaths of 15-17 years olds, 12 were the driver and 23 were the passenger at the time of the crash, and of these only eight were restrained correctly.

Figure 22. MVC Death Rate by Age Group



Compared to 2002-2003, the MVC death rate for <1 year olds showed considerable increase in 2004-2005. Improper installation of infant car seats may have been a big contributing factor in <1 year old MVC deaths. Of those MVC deaths identified as being correctly restrained, the proportion is lowest in the <1 year olds. Overall, 54% were identified as restrained incorrectly or unrestrained at the time of injury, among 67 deaths of driver or passenger at the time of the crash.



Included in the 96 MVC deaths are 20 pedestrians and fewer than five bicyclists. Of the pedestrians and bicyclists, 14 were hit in the street, five in driveways, and five in a variety of other locations such as garages, parking lots, and rail road tracks. Neglectful supervision contributed to all of the deaths that occurred in a driveway (backing over the child), to most that occurred in parking lots, and to some deaths in the roadway. Among those pedestrians and bicyclists, eight deaths occurred between 2:00 PM and 5:00 PM.

Table 32 MVC Death by Restraint Usage at Injury

Restraint Usage	2002-2003	2004-2005
Restrained correctly	18	17
Restrained inappropriately	<5	<5
Unrestrained	36	34
Unknown	14	12
Seat belt not present	<5	<5

Table 33 MVC Number of Death by Position

Position at Injury	2002-2003	2004-2005
Driver	20	12
Passenger	50	55
Pedestrian	24	20
Bicyclist	7	<5
Other	<5	5

Table 34. MVC Death by Child Occupied Vehicle

Type of Vehicle	2002-2003		2004-2005	
	Number	%	Number	%
Car	45	43%	48	65%
SUV/Van/Jeep	15	14%	9	12%
Pick-up Truck	6	6%	<5	N/A
Bicycle/Motorcycle	13	13%	7	9%
Unknown	25	24%	6	8%



Table 35. MVC Death by Other Vehicle Involved

Type of Other Vehicle Involved	2002-2003		2004-2005	
	Number	%	Number	%
Car	29	41%	24	39%
SUV/Van/Jeep	20	28%	12	20%
Pick-up Truck	15	21%	15	25%
Other (Bus, Train)	5	7%	<5	N/A
Unknown	<5	N/A	7	11%

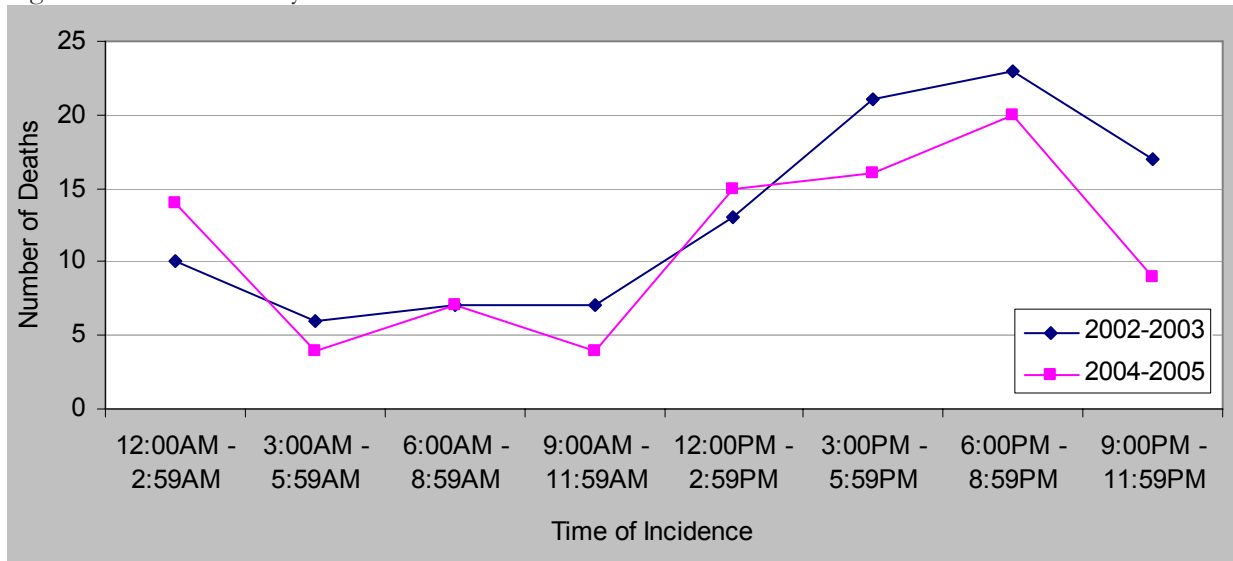
When a second vehicle was involved in the collision which resulted in the death of a child in Harris County, the driver of the other vehicle involved was a male in 62% of the cases, and White in 61% of the cases. The average age of the driver in the second vehicle was 36 years (ranged from 18 to 61).

Many factors contributed to a motor vehicle crash resulting in a child's death. Some of these factors recorded by the HHCCFRT include: weather conditions, driver's inexperience, excessive speed, failure to obey traffic laws, inattentiveness, and substance use. A high rate of speed is the most frequent contributing factor in motor vehicle crash deaths: 44% of MVC deaths occurred while one of the vehicles involved in the collision was racing, chasing, or speeding over the limit. Use of alcohol and/or illegal substances was identified as a contributing factor among 19% of reviewed motor vehicle crashes in which a child was killed. However, if the data for all MVC were available, use of these substances might be a larger factor.



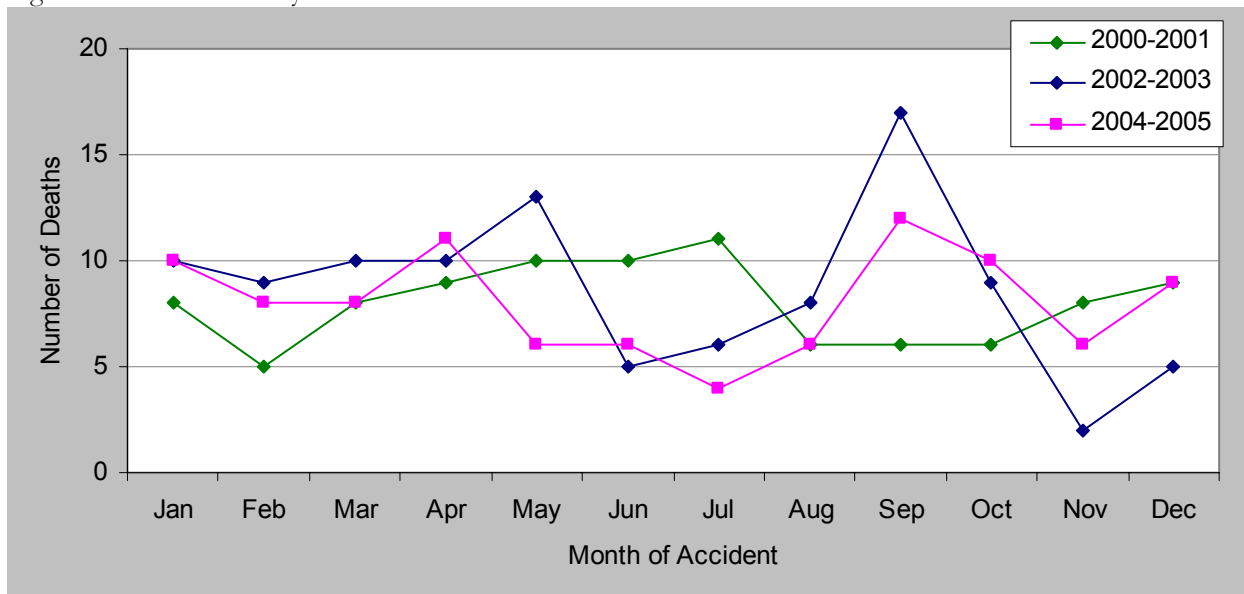
MVC deaths in Houston/Harris County during 2004-2005 were more likely to occur in the afternoon: 53% were between 12:00 pm and 9:00 pm. The time of incidences, however, varies slightly by age groups. Among school aged children (5-17 years old), time of MVC death had a much higher incidence between 3:00 pm to 9:00 pm. Sixty three percent of MVC deaths among 1-4 year old children occurred between 12:00 pm and 6:00 pm. For 15-17 year old children, unlike other age groups, the risk of MVC death between 12:00 am and 3:00 am was the same as late afternoon.

Figure 23. MVC Death by Time of Incidence



During 2004-2005, the months of April, September and October had larger numbers of child deaths due to motor vehicle crashes. As shown in Figure 24, however, data compiled from 2000 to 2005 does not show a seasonal pattern.

Figure 24. MVC Death by Month of Incidence



UNINTENTIONAL INJURY - DROWNING

Drowning was the second leading cause of unintentional injuries that resulted in a child death during 2004-2005 in Houston/Harris County. Compared to 2002-2003, the number of deaths due to drowning doubled. There were 12 drownings in 2004 and 21 drownings in 2005. Male children were more likely to drown than female children. African American or White male children were at higher risk of drowning. In 2004-2005, the rate increase among African American and White children was much greater than those of Hispanic and Other race groups. The largest age group of children who drowned was the 1-4 year-olds (46%); the 5-9 year-old age group was the second largest group of drownings.

Table 36. Drowning Death by Gender

Gender	2002-2003		2004-2005	
	Number	Rate	Number	Rate
Male	11	1.1	20	1.9
Female	7	0.7	13	1.4
Total	18	0.9	33	1.6

Table 37. Drowning Death by Race/Ethnicity

Race/Ethnicity	2002-2003		2004-2005	
	Number	Rate	Number	Rate
White	5	0.8	13	2.2
African American	5	1.2	6	2.3
Hispanic	7	0.8	9	0.9
Other	<5	N/A	<5	N/A



Figure 25. Unintentional Drowning Death by Age, 2004-2005

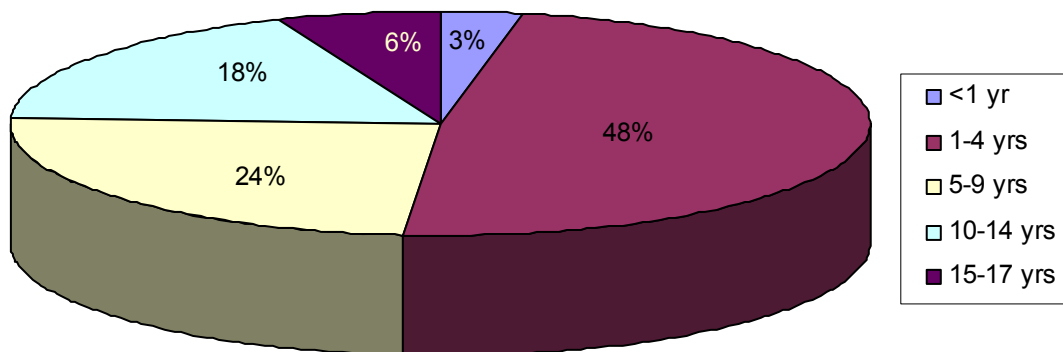
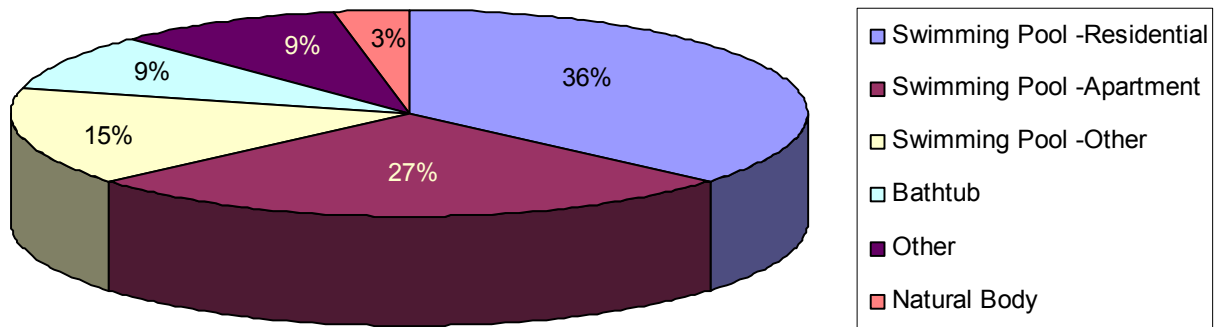


Figure 26. Unintentional Drowning Death by Location, 2004-2005



The majority of child drowning deaths in Houston/Harris County occurred in swimming pools. The proportion of drowning deaths in swimming pools increased from 66% in 2002-2003 to 79% in 2004-2005.

Twelve deaths occurred at residential pools, which comprised 46% of all swimming pool drowning deaths. Most residential pool deaths were 1-4 year old toddlers. This highlights the importance of four-sided fencing surrounding backyard pools, as well as careful supervision of children. Nine children died at apartment pools and fewer than five children died at community pools. The 5-9 year old group was at a much higher risk for apartment pool drowning than any other age group, while children 10 years or older were at high risk of community pool drowning. Bathtub drownings comprised 9% of the all drowning deaths. Other locations of drowning were a drainage ditch and an ordinary house planter.

In most of the drowning cases, the caregiver's failure to provide adequate supervision resulted in the fatality. The supervisor at the time of the incidence was a parent in 19 cases (58%) and relative/other adult in eight cases (24%); <5 deaths occurred under a lifeguard's supervision.



UNINTENTIONAL INJURY- POISON/OVERDOSE

During 2004-2005, poisoning and overdose were the third leading cause of unintentional injury death. In Houston/ Harris County, 17 children died as the result of an unintentional poisoning or overdose. There was no difference between the rate of male and female in the rate of death due to poisoning or overdose.

Table 38. Poisoning/Overdose Death by Gender

Gender	2002-2003		2004-2005	
	Number	Rate	Number	Rate
Male	8	0.8	9	0.9
Female	<5	N/A	8	0.8
Total	12	0.6	17	0.8

Table 39. Poisoning/Overdose Death by Race/Ethnicity

Race/Ethnicity	2002-2003		2004-2005	
	Number	Rate	Number	Rate
White	<5	N/A	6	1.0
African American	<5	N/A	5	1.3
Hispanic	6	0.7	6	0.6
Other	<5	N/A	0	0.0

Various substances were associated with poison/overdose deaths. Alprazolam (Xanax) and methadone were the most frequently used substances among these deaths. Hydrocodone, oxycodone, carisoprodol, difluorochloromethane (Freon huffing), sertraline, benzotropine, cocaine, and alcohol were also included in the list of substances. Among adolescents aged 15-17 years, the mortality rate for this type of death was 3.3 per 100,000. Most of these adolescents consumed tobacco regularly and had a history of drug use.

There were <5 infant deaths caused by complications of maternal substance abuse (illicit drug or prescription drug).



UNINTENTIONAL INJURY- ASPHYXIA

The number of child deaths due to unintentional asphyxia (smothering, strangulation and choking) consistently declined from 38 deaths in 2000-2001 to 13 deaths in 2004-2005 in both gender and race/ethnicity categories for Houston/Harris County. As explained previously in the SIDS section, some of this decline may be attributed to a change in classification criteria for unintentional asphyxia to “undetermined” due to lack of concrete evidence suggesting something otherwise.

Smothering included suffocation by blanket, bag, or other object over the face, overlay of another person on the child, or the child being wedged between two surfaces. For 2004-2005, all 13 asphyxial deaths were infants (under one year old). Most of these deaths were the result of unsafe sleep situations and/or neglectful supervision. Sixty nine percent of asphyxial deaths occurred while children were sleeping with their parents or siblings (i.e. bed sharing). Wedging between two surfaces, e.g. mattress and headboard or wall, comprised 54% of the unintentional asphyxial deaths in Houston/Harris County.

Table 40. Asphyxia Death by Gender

Gender	2002-2003		2004-2005	
	Number	Rate	Number	Rate
Male	16	1.5	7	0.7
Female	9	0.9	6	0.6
Total	25	1.2	13	0.6

Table 41. Asphyxia Death by Race/Ethnicity

Race/Ethnicity	2002-2003		2004-2005	
	Number	Rate	Number	Rate
White	<5	N/A	<5	N/A
African American	10	2.5	<5	N/A
Hispanic	11	1.2	5	0.5
Other	<5	N/A	<5	N/A

Even though the overall rate of asphyxia was cut in half from 2002-2003 to 2004-2005, differences between gender and race/ethnic groups remain unchanged. Males kept a slightly higher mortality rate than females, and the rate for African Americans was twice as high as those for Whites and Hispanics.

It should be noted that young children can choke on a variety of items including hot dog pieces, crackers, nuts, candy, balloons, and small toys as recorded in previous years by the team. However, no choking deaths were reported in 2004-2005.

UNDETERMINED MANNER/CAUSE OF DEATH

In Houston/Harris County, cases that do not fulfill the diagnostic criteria for SIDS and that do not have a clearly identifiable cause of death are classified as “undetermined.” The largest subset of this category included infant deaths that occurred in the setting of bedsharing/co-sleeping with adults/others. Because an accidental suffocation by overlay could not be determined and/or excluded, these cases are classified as “undetermined (co-sleeping).”

Of note, other factors identified in a single case may have precluded documentation of bedsharing, or bedsharing was not documented in the case investigation. In these cases, the cause of death was classified simply as “undetermined” (without the “co-sleeping” designation). Therefore the record of "undetermined (co-sleeping)" cases may well underestimate the true prevalence of bedsharing associated deaths. Other examples of cases classified as “undetermined” included those with autopsy findings of uncertain significance, an unsafe sleeping environment (other than bedsharing), a history of prior abuse, or unexplained infant deaths in the same family.

In Houston/Harris County, 94 child deaths were ruled as undetermined in cause of death during 2004-2005. Infants comprised 86 of these deaths (91%). Sixty of these infants had been sleeping with at least one other person in an adult bed (i.e., bedsharing or co-sleeping). The proportion of bedsharing within each race/ethnic group was higher in African American and Hispanic populations.

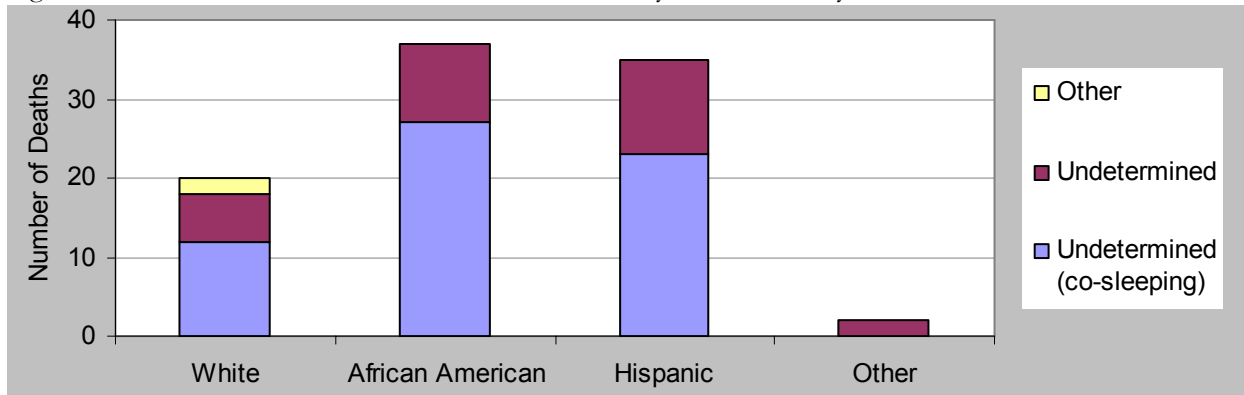
Table 42 Undetermined Death by Gender

Gender	2002-2003		2004-2005	
	#	Rate	#	Rate
Male	29	2.8	57	5.4
Female	18	1.8	37	3.7
Total	47	2.3	94	4.6

Table 43 Undetermined Death by Race/Ethnicity

Race/Ethnicity	2002-2003		2004-2005	
	#	Rate	#	Rate
White	15	2.4	20	3.3
African American	18	4.5	37	9.3
Hispanic	13	1.5	35	3.7
Other	<5	N/A	<5	N/A

Figure 27. Number of Undetermined Manner of Death by Race/Ethnicity, 2004-2005



CONCLUSIONS

The fatality data presented in this report, unless otherwise specified in the text, was gathered by the Houston/Harris County Child Fatality Review Team through the child fatality review process. The team was able to work together in 2004-2005 to promote communication and coordination among the agencies involved through the review of 669 child deaths. In many cases the team was also able to:

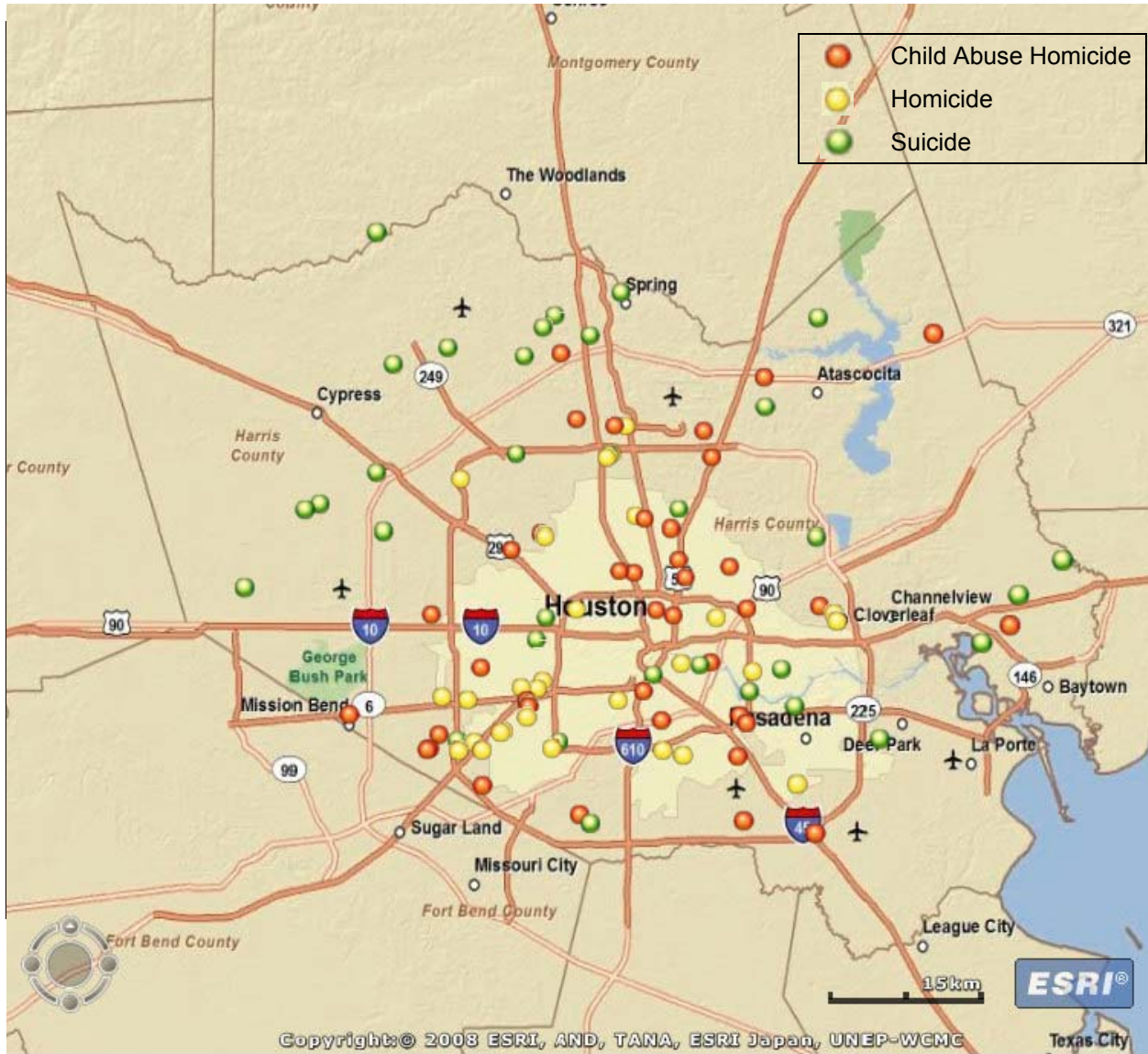
- ❖ Assist / redirect in a criminal investigation
- ❖ Initiate/assist in a Children's Protective Services investigation
- ❖ Assist in the Medical Examiner's investigation
- ❖ Assist prosecution in case preparation

Certain child deaths are unavoidable. Many, however, can be prevented. It is the goal of the Houston/Harris County Child Fatality Review Team to identify these preventable deaths and work toward decreasing them by:

- ❖ Providing assistance, direction, and coordination to the investigation of child deaths
- ❖ Promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities
- ❖ Developing an understanding of the causes and incidences of child deaths in Harris County
- ❖ Recommending changes to agencies that will improve the collection of data surrounding these deaths thereby reducing the number of preventable deaths.
- ❖ Providing data collected from review to policy makers, child advocacy groups and grassroots educators.
- ❖ Participating in activities to promote child safety in the community.



Appendix A. Map of Intentional Injury Deaths, 2004-2005



Appendix B. Map of Unintentional Injury Deaths, 2004-2005



Houston/Harris County Child Fatality Review Team Agencies

Ben Taub Hospital — Harris County Hospital District
Children’s Protective Services in Harris County
The Children’s Assessment Center
Children’s Memorial Hermann Hospital
City of Houston Department of Health & Human Services
City of Houston Fire Department/Emergency Medical Services
City of Houston Police Department
City of Houston Vital Statistics
Harris County District Attorney’s Office
Harris County Medical Examiner’s Office
Harris County Public Health & Environmental Services
Harris County Fire Marshal’s Office
Harris County Juvenile Probation Department
Harris County Sheriff’s Department
Lyndon Baines Johnson Hospital— Harris County Hospital District
The Mental Health and Mental Retardation Authority
Neighborhoods Centers Inc., Sunny Futures Healthy Start Program
SafeKids Greater Houston
Texas Children’s Hospital
Texas Department of Protective and Regulatory Services
University of Texas Medical School Pediatrics

Participating area Police Departments include Baytown, Bellaire, Deer Park, Friendswood, Galena Park, Hedwig Village, Humble, Jacinto City, Jersey Village, Katy, Lakeview, La Porte, Memorial Villages, Missouri City, Morgan’s Point, Nassau Bay, Pasadena, Pearland, Seabrook, Shoreacres, South Houston, Southside Place, Spring Valley, Stafford, Tomball, Webster, West University Place

It is the sincere hope of the Houston/Harris County Child Fatality Review Team that the information presented here will provide direction for program and policy development to the many agencies and community based organizations concerned with the well being of children in our community.