TEXAS
Department of Family
and Protective Services

Fiscal Year 2024
Child Maltreatment Fatalities and Near Fatalities Annual Report

February 28, 2025

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Executive Summary

Protecting children and helping them reach their greatest potential begins at home for the over 7 million children in Texas. Family members, neighbors, schools, and communities all serve as a safety net. When that safety net is not effective, allegations of abuse, neglect or exploitation are investigated by the Texas Department of Family and Protective Services to ensure safety of Texas children. The number of reports made to the Texas Department of Family and Protective Services (DFPS) Statewide Intake Hotline alleging abuse, neglect or exploitation of children decreased by 12.2 percent between fiscal year 2023 and fiscal year 2024, and during that same period, child fatalities reported to the DFPS Statewide Intake Hotline decreased by 14.9 percent. Allegations of abuse or neglect related to child fatalities including neglectful supervision, physical abuse, and other (includes medical neglect, physical neglect, premature birth due to drug use, abandonment at birth), all saw decreases in fiscal year 2024. Preventable fatalities related to confirmed abuse or neglect, such as unsafe sleep fatalities that involved substance use as well as drownings, also experienced a decline from the previous fiscal year.

To address child maltreatment before it starts and protect children from future harm, DFPS works in partnership with communities to provide a complete continuum of prevention and intervention programs. These partnerships with families, communities, service providers, law enforcement, and the medical community allow DFPS to utilize a public health framework to address fatal and near fatal child maltreatment.

Specifically, through analyzing and addressing trends in child abuse and neglect fatalities, DFPS continually improves policy and practices for investigations, interventions, and services provided to children, youth, and families to address child safety. This work also contributes to partnerships between DFPS and the community to proactively address child safety and well-being through prevention efforts *before* families are in crisis.

Many are familiar with safety campaigns embedded in a public health framework, especially in Texas: *Click it or Ticket, Turn Around…Don't Drown, Move Over or Slow Down.* These messages have become part of the norms in our society to help keep us safe, whether it is wearing your seatbelt, avoiding high water crossings, or giving space on the road to first responders. Similarly, child safety messages continue to play a pivotal role in reducing child fatalities and near fatalities. To address fatal and near-fatal child maltreatment, families must be supported in their parenting experience through universal messages and services on topics such as: ensuring support for new parents; understanding expected child development; selecting a caregiver; education around the *ABCs of Safe Sleep*, water safety, and vehicle safety; and community supports for major risk factors such as substance abuse, domestic violence, and mental health.

We have seen communities take on these issues directly--from water safety outreach, to working to ensure all birthing hospitals in a community are safe sleep certified, and even partnering with parent education resources to connect parents with the support they need. For children to remain safe, and thrive, it takes community collaboration to build support networks and resources, while normalizing a parent's ability to seek help and engage families before tragedy strikes.

Child maltreatment fatalities are generally thought of as either physical abuse or unavoidable accidents. But in nearly every child maltreatment fatality, someone or some system could have intervened and prevented the child's death. By utilizing a proactive, public health approach, DFPS continues to work with communities to improve child safety by increasing the awareness of the community, service providers, and local leaders about the scope and problems associated with child maltreatment. These efforts include consistent messaging about water safety, safe sleep practices, and caregiver selection. DFPS policies surrounding discussing safe sleep practices, supporting family preservation efforts, and connecting families to services have been strengthened to support building a stronger safety net for families that come to the attention of the agency.

DFPS produces this annual report in accordance with Texas Family Code, Section 261.204, to support internal and external work to address risk factors associated with child maltreatment and support ongoing work to increase resiliency within the community and reach positive outcomes for Texas children. Tasked with systematically investigating and addressing child maltreatment fatalities, DFPS is extremely aware of the risk factors that lead to child fatalities—young, vulnerable children often left with caregivers or in dangerous situations. The co-occurrence of substance abuse, domestic violence, and mental health concerns with child maltreatment is prevalent. It requires intensive coordination and collaboration between DFPS, other state agencies, and community providers so that families can be supported.

Together with efforts by other state agencies to address child fatalities and child maltreatment, this report can inform the development of prevention and early intervention programs and intervention strategies if abuse and neglect is suspected as well as to support child safety in regulated childcare settings.

Evolving Child Protection Landscape

Consistent with national research on child protection and childhood trauma[1], the State of Texas recognizes that separating a child from his or her parent is a traumatic experience that can adversely affect wellbeing. While separation of a parent from a child is sometimes necessary, DFPS policy and practice have shifted in recent years to recognize that children should remain in the home with their parent or parents whenever they can be safe in that environment. As a result, and consistent with nation-wide trends[2], the number of children in substitute care in Texas has decreased from 26,164 on August 31, 2021 to 16,035 on August 31, 2024[3].

Legislative Changes

In recognition of the seriousness of the impact that a finding of abuse or neglect can have on a family, the State of Texas has revised its policy and practice. Findings in child fatality investigations are determined based on the definitions of abuse and neglect as defined by Texas Family Code, Section 261.001(4). Beginning in FY 2022, the definition for Neglect changed to "…an act or failure to act by a person responsible for a child's care, custody, or welfare evidencing the person's blatant disregard for the consequences of the act or failure to act that results in harm to the child or that creates an immediate danger to the child's physical health or safety…". As a result, the number of child fatalities that met the definition for neglect has declined since FY 2021, a trend which continued into FY 2024. This definition change did not impact determination of a finding of abuse in physical abuse cases.

Practice Changes

Prior to September 2022, when SWI received an intake regarding a child fatality that falls under DFPS jurisdiction, it was assigned as a full investigation. This practice involved DFPS in families lives even when there was no indication abuse or neglect contributed to the child's death. This practice unnecessarily retraumatized a family already dealing with the death of a child. As a result, beginning in September 2022, intakes that involve a child fatality but include no explicit concern for abuse and neglect are first sent to the field as a Case Related Special Request instead of a full investigation, to confirm whether the reporter or first responders had any concern for abuse or neglect. If there are any concerns for abuse or neglect, the child fatality is then sent for a full investigation. This practice change, as well as legislative changes to the definition of neglect, has resulted in a decrease in the number of fatality investigations DFPS conducts. This process ensures that reports assigned to field staff for full investigation involve allegations of abuse and meet DFPS jurisdiction to investigate.

In recognition of the gravity of a child fatality, in September 2023, DFPS Special Investigators assumed primary responsibility for all child fatality investigations and case-related special requests. Special Investigators are DFPS staff who have previous law enforcement experience.

This change enhanced the collaboration between DFPS and law enforcement and helped to ensure appropriate and consistent response to affected families.

As an additional measure to ensure consistency with the implementation of changes to the Texas Family Code, Section 261.001, DFPS implemented a process to further certain investigations closed with a disposition of reason to believe for neglect with a fatal severity code. These cases include investigations such as drownings and unsafe sleep related deaths. This process, initiated for fiscal year 2024, includes an additional level of review and has been applied to investigation case closures meeting the specified criteria.

Based on administrative data and individual case reviews for confirmed child abuse and neglect related fatalities during FY 2024, the following trends and areas for review have been identified:

General Findings

- In FY 2024, 99 children died due to abuse and neglect in Texas (Table 1). Of those deaths:
    - 61 children died as a result of neglect. The change in the definition of neglect and corresponding policy and practice changes impacted the number of fatalities DFPS determined occurred as a result of neglect.
    - 38 children died as a result of abuse. This determination was not impacted by the revised definition of neglect.
- In 56.5 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had prior history with CPS (Figure 21, 22). This history could have occurred at any point in the child or perpetrator's lifetime.
- The lowest incident of physical abuse related deaths were substantiated in FY 2024 since FY 2017 (Figure 4). Physical abuse related deaths are not impacted by the change in the definition of neglect, and the FY 2024 decrease correlates with a decrease in the number of allegations of physical abuse reported to DFPS, which decreased by 12.6 percent between FY 2023 and FY 2024.
- Confirmed neglect-related fatalities account for 57.5 percent of child maltreatment fatalities (Figure 4).
- The most common causes of fatalities involving neglect were drowning, and unsafe sleep (Figure 7, 8).
- In FY 2024, Texas had 77 confirmed abuse and neglect-related near fatalities (Figure 37).

Victims

- Based on the confirmed child abuse and neglect-related fatalities over the past 10 fiscal years, children 3 years of age and younger were almost 80 percent of all confirmed child abuse and neglect fatalities; however, the past three years have had a marked increase in child fatalities involving older children. In FY 2024, children 3 years of age and younger made-up 70.7 percent of confirmed child abuse and neglect fatalities. Male children

represented a slight majority of confirmed child abuse and neglect-related fatalities (Figure 9, 10).

- During FY 2024, Hispanic children accounted for the largest percentage of children who died from abuse or neglect. The per capita rate for African American children who die from maltreatment continues to be higher than any other ethnicity in Texas. That is also true across the United States (Table 3).
- 67.6 percent of children who died from abuse or neglect in FY 2024 were too young for school and not enrolled in day care. One child was being cared for by a day care operation that was not registered or licensed through HHSC (Page 25).

Perpetrators

- Physical abuse in fatalities most commonly involved blunt force trauma or intentional trauma inflicted by a father or mother (Figures 13-15).
- In all confirmed cases of abuse and neglect, parents continue to be the most common perpetrators (Figure 12).
- When the perpetrator or the child was previously known to DFPS in the two years prior to fatality, the child fatality is often related to physical abuse or neglectful supervision. (Table 9, 10).

Definitions: Child Abuse and Neglect Fatalities and Near Fatalities Investigation Dispositions

Child Fatality Investigations

DFPS is required under the Texas Family Code to investigate child fatalities where allegations of abuse or neglect are present. Investigations are carried out to determine if abuse and/or neglect occurred and, if applicable, whether the fatality was caused by abuse or neglect.[4]

DFPS investigates child abuse or neglect fatalities based on where the child was living at the time of death and when there is an allegation of abuse or neglect either at the time of the death or if the death is suspected to be caused by abuse or neglect. This includes investigations in a variety of settings:

- day care settings (Child Care Investigation settings);
- deaths of children in regulated care placements (Residential Child Care Investigation settings), including children in DFPS conservatorship in foster care placements; and
- deaths of children living with their families, or deaths where the child is in DFPS conservatorship and in non-foster care kinship placements (Child Protective Services placements).

An investigation will be completed if a child dies while in DFPS conservatorship, either from natural causes, or injuries sustained before coming into foster care or when potentially a foster parent is involved at the time of death. If the investigation determines that the death is related to abuse or neglect, it is counted as a confirmed child abuse or neglect fatality.

In child abuse investigations, allegations of abuse and neglect must be determined by a preponderance of the evidence. To show a "preponderance of the evidence" means there is sufficient evidence to prove that the determination is more likely true than not. Sometimes this is referred to as the "51 percent" standard.

The data used in this report were compiled from the IMPACT case reporting system as well as from individual case reviews completed on confirmed child abuse and neglect-related fatalities.

Investigation Dispositions for Child Fatalities

Texas Family Code, Section 261.203, states that "if, after a child abuse or neglect investigation is completed, the department determines a child's death was caused by abuse or neglect, the department shall promptly release" specific information. To track and report on these fatalities, DFPS utilizes case dispositions from every investigation.

Reason to Believe (RTB) - Based on a preponderance of evidence, staff concludes that abuse or neglect has occurred. For fatalities that have a disposition of RTB, a severity code as outlined below must be determined.

- **RTB-Fatal** - Staff determine that there is enough evidence to support a finding that abuse or neglect caused or contributed to the death (e.g., when a parent physically assaults a child and the child dies from the injuries).
- **RTB - without the severity code of fatal** - Staff determine there is sufficient evidence to support a finding of abuse or neglect, but not enough evidence that it caused or contributed to the death (e.g., child was malnourished but died in a car accident).

Ruled Out (RO) - Staff determine, based on available information that it is reasonable to conclude that the abuse or neglect has not occurred. "Available information," in the context of the "ruled out" disposition, is evidence that the worker gathered through the required and supplemental actions taken to conduct a thorough or an abbreviated investigation.

Unable to Complete (UTC) - Before staff could draw a conclusion, the persons involved in the allegation moved and could not be located, or the family refused to cooperate with the investigation. (CPI investigations only)

Unable to Determine (UTD) - Staff conclude there is not a preponderance of evidence that abuse or neglect occurred, but it is not reasonable to conclude that abuse or neglect has not occurred. The family did not move and become unable to locate before the worker could draw a conclusion about the allegation. (CPI Investigations only)

Preliminary Investigations/Administrative Closure (ADMIN) - Information received after a case was assigned for investigation reveals that continued intervention is unwarranted such as when there is no allegation of abuse or neglect or the fatality is not within DFPS jurisdiction.

Near Fatality Investigations

As set out in Texas Family Code, DFPS is required to investigate child abuse and neglect allegations. In some instances, the level of abuse or neglect caused the child to be in serious or critical condition. Texas Family Code §264.5031 defines a near fatality as a situation where a physician has certified that a child is in critical or serious condition, and a CPI investigator determines that the child's condition was caused by the abuse or neglect of the child or that abuse or neglect contributed to the child's condition.

As there is no universal definition of "serious" or "critical" condition, DFPS worked with child abuse pediatricians from around the state to help provide common, clarifying guidance for both staff and medical professionals to utilize. A near fatality consists of an act of abuse or neglect to a child who, without imminent medical intervention, would likely have died as a result of the

maltreatment. "Imminent medical intervention" must be performed by a licensed medical professional and requires some form of:

- Cardiopulmonary resuscitation (CPR) such as chest compressions, rescue breathing, removal of airway obstruction and/or intubation;
- Medical interventions or surgery to preserve brain function or to prevent impending circulatory collapse or respiratory failure.

In most circumstances, the child will have been admitted to an intensive care unit, including neonatal intensive care units, pediatric intensive care units, and trauma units.

Investigation Dispositions for Near Fatalities

If the investigator determines, after consulting with a licensed medical professional and/or child abuse pediatrician that the child was in serious or critical condition, and determines that abuse or neglect contributed to or was the cause of the medical condition, then the investigator would assign the following disposition:

> **Reason to Believe (RTB) with a severity code of Near Fatal** – Based on a preponderance of evidence, staff concludes that abuse or neglect has occurred. For all child abuse and neglect investigations that have a disposition of RTB, a severity code of Near Fatal must be applied if staff determine that there is enough evidence to support a finding that abuse or neglect caused the child to need medical intervention and they were in serious or critical condition according to a licensed medical professional.

Should the child subsequently die due to the injuries that were determined to be near fatal, the child maltreatment would be included in the total number of child maltreatment fatalities and not as a near fatality.

Findings: Investigating Child Abuse and Neglect Related Fatalities

Table 1 provides data regarding overall trends in child abuse and neglect in Texas. While the child population of Texas has continued to increase, the number of intakes assigned for investigation in general saw a decline from FY 2010 through FY 2013. In FY 2014, the number of intakes assigned for investigation began to rise, with FY 2022 being the highest in the past 10 years.

Table 1. Child Population and Reports of Child Abuse and Neglect

	FY2020	FY2021	FY2022	FY2023	FY2024
Child Population of Texas	7,515,129	7,594,941	7,675,490	7,757,746	7,843,350
Number of child abuse and neglect Intakes to the Texas Statewide Intake Hotline	279,128	293,898	317,928	317,977	293,950
Number of Intakes Assigned for Investigation or Alternative Response by CPI	224,288	253,054	273,415*	264,464*	232,176*
Number of Investigated Child Fatalities	**826**	**964**	**997***	**690***	**587***
Number of fatalities where abuse was confirmed	85	71	76	70	38
Number of fatalities where neglect was confirmed	166	128	106*	94*	61*
Number of fatalities where abuse/neglect was confirmed	**251**	**199**	**182***	**164***	**99***
Percentage of fatalities where abuse/neglect was confirmed	30.3%	20.6%	18.2%*	23.7%*	16.9%*
Child Maltreatment Fatality Rate per 100,000 Children	3.34	2.62	2.37	2.11	1.32
National Maltreatment Rate for Equivalent Federal Fiscal Year[5]	2.50	2.63	2.73	2.73	***

Source: Data from US Census Bureau; Texas State Data Center; DFPS Data Books FY2010-FY 2024; DFPS Data Warehouse Report FT_06; U.S. Department of Health and Human Services. Population Data Source: Population Estimates and Projections Program, Texas State Data Center, Office of the State Demographer and the Institute for Demographic and Socioeconomic Research, University of Texas at San Antonio. Current Population Estimates and Projections Data as of December 2024

*This data was impacted by the change in the definition of Neglect in Texas Family Code 261.001. The definitional change did not impact investigations or dispositions related to physical abuse.

*** Child Maltreatment 2024 is scheduled to be released after the publishing of this report. National rates were recalculated in Child Maltreatment 2023 report.

The distribution of case dispositions for child fatality investigations conducted over the last 10 years are presented in Table 2 - Percentage of Child Fatality Investigations by Disposition. The percent of confirmed child abuse and neglect-related fatalities have varied between 17.37 percent and 30.39 percent in the past five years. FY2024 registered a 16.85 percent of all investigated fatalities being related to maltreatment.

Table 2. Percentage of Child Fatality Investigations by Disposition

State Fiscal Year	Number of Investigated Child Fatalities	Reason to Believe and Fatality Confirmed for Abuse or Neglect* (RTB-Fatal)	Reason to Believe but Fatality not from Abuse or Neglect (RTB but not Fatal)	Ruled Out (RO)	Unable to Determine (UTD)	Unable to Complete (UTC)	Administrative Closure (Admin)
FY2014	797	18.94%	17.31%	37.51%	13.92%	1.12%	11.67%
FY2015	739	23.27%	15.01%	39.44%	12.48%	0.66%	9.69%
FY2016	796	28.94%	18.25%	31.55%	11.21%	1.83%	8.21%
FY2017	807	21.31%	17.65%	39.66%	11.97%	0.24%	9.67%
FY2018	785	25.18%	14.56%	41.89%	11.69%	0.72%	5.58%
FY2019	772	30.44%	16.58%	33.82%	11.92%	0.73%	7.54%
FY2020	826	30.39%	17.55%	37.53%	11.02%	0.48%	3.03%
FY2021	964	20.64%	14.73%	45.44%	11.93%	0.62%	7.47%
FY2022	997	17.37%	14.12%	48.09%	11.55%	0.67%	8.21%
FY2023	690	23.77%	15.65%	40.87%	14.49%	1.01%	7.68%
FY2024	587	16.85%	10.39%	51.95%	11.75%	2.04%	7.15%

*Count by child. All other dispositions are count by investigation. Count by investigation includes duplicated children and may include confirmation of abuse and neglect of a child that is not the deceased child. Additionally, a child may die in a home where there are multiple families being investigated due to the child fatality.

Source: DFPS Data Warehouse Report FT_01, FT_02, FT_06

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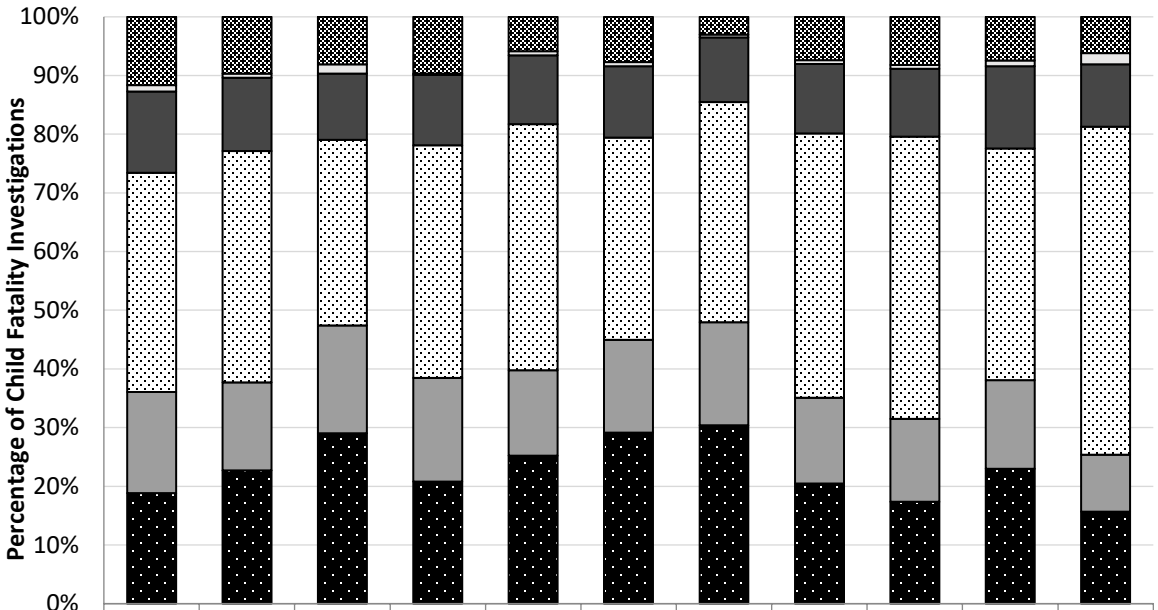
Figure 1. Percentage of Completed Child Fatality Investigations by Disposition per Fiscal Year



	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Administrative Closure	93	73	62	80	49	62	25	72	86	53	39
Unable to Complete	9	5	12	2	6	6	4	6	7	7	12
Unable to Determine	111	94	86	99	98	98	91	115	121	100	67
Ruled Out	299	297	242	328	351	278	310	438	504	282	353
Reason to Believe - Not Fatal*	138	113	140	146	122	128	145	142	148	108	61
Reason to Believe - Fatal*	151	171	222	172	211	235	251	199	182	164	99

* Count by Child, all other categories are count by investigation.
Source: DFPS Data Warehouse Report FT_01, FT_02, FT_06

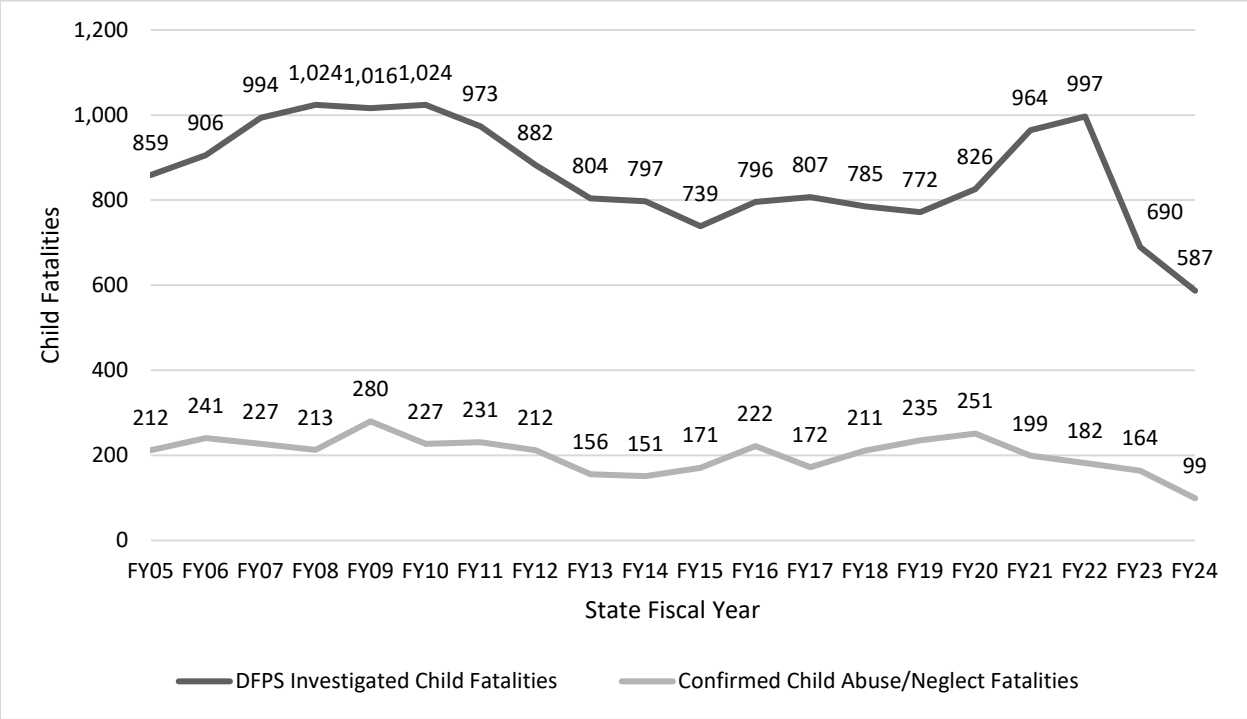
DFPS works in collaboration with other partners such as medical examiners, law enforcement, and DFPS Special Investigators to ensure thorough child fatality investigations. Additional training has been provided to CPI staff on various topics to support more thorough investigations: contacting reporters, utilizing collateral contacts, family engagement, building a support network, and assessing safety throughout the investigation.

Several factors help support case dispositions:

- Increased understanding by the general public and first responders on what child fatalities should be reported to DFPS for investigation;
- Ongoing training within CPI to provide additional education on best practices for investigating child fatalities and properly dispositioning cases;

- Utilization of Special Investigators to investigate child fatalities and locate families if the primary investigator is unable to locate the family or surviving siblings;
- Collaborating with medical professionals to determine the nature and extent of the maltreatment; and
- Increased collaboration and multidisciplinary team staffing between law enforcement, medical examiners, Child Protective Investigations, and Child Protective Services.

Figure 2. DFPS Investigated Child Fatalities and Confirmed Child Abuse/Neglect Fatalities



Source: DFPS Data Warehouse Report FT_06

In FY 2024, DFPS investigated 587 possible child abuse and neglect-related fatalities. That number peaked in FY 2008 and FY 2010 at 1,024 investigated child fatalities. (Figure 2).

FY 2024 Confirmed Child Abuse and Neglect-Related Fatalities

During the 81st Legislative Session, the Texas Legislature passed Senate Bill 1050 codifying Child Abuse Prevention and Treatment Act (CAPTA) reporting requirements and directing DFPS to provide specific information regarding all child fatalities alleged to be from abuse or

neglect as well as detailed information if DFPS "determines a child's death was caused by abuse or neglect."[9] During the 84th Texas Legislature, Senate Bill 949 was passed to support additional reporting elements for child fatality investigations. In the 85th Texas Legislature, House Bill 1549 included collecting additional details on near fatalities and child fatalities, including past utilization of Family Based Safety Services (FBSS) and the relationship between number of caseworker and caseloads in past history. The following data is collected from IMPACT and individual case reads where the child's death was caused by abuse or neglect which is distinguished with the disposition of reason to believe - fatal.

General Findings

- In FY 2024, 99 children died due to abuse and neglect in Texas (Table 1). Of those deaths:
    - 61 children died as a result of neglect. The change in the definition of neglect and corresponding policy and practice changes impacted the number of fatalities DFPS determined occurred as a result of neglect.
    - 38 children died as a result of abuse. This determination was not impacted by the revised definition of neglect.
- In 56.5 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had prior history with CPS (Figure 21, 22). This history could have occurred at any point in the child or perpetrator's lifetime.
- The lowest incident of physical abuse related deaths were substantiated in FY 2024 since FY 2017 (Figure 4). Physical abuse related deaths are not impacted by the change in the definition of neglect, and the FY 2024 decrease correlates with a decrease in the number of allegations of physical abuse reported to DFPS, which decreased by 12.6 percent between FY 2023 and FY 2024.
- Confirmed neglect-related fatalities account for 57.5 percent of child maltreatment fatalities (Figure 4).
- The most common causes of fatalities involving neglect were drowning, and unsafe sleep (Figure 7, 8).
- In FY 2024, Texas had 77 confirmed abuse and neglect-related near fatalities (Figure 37).

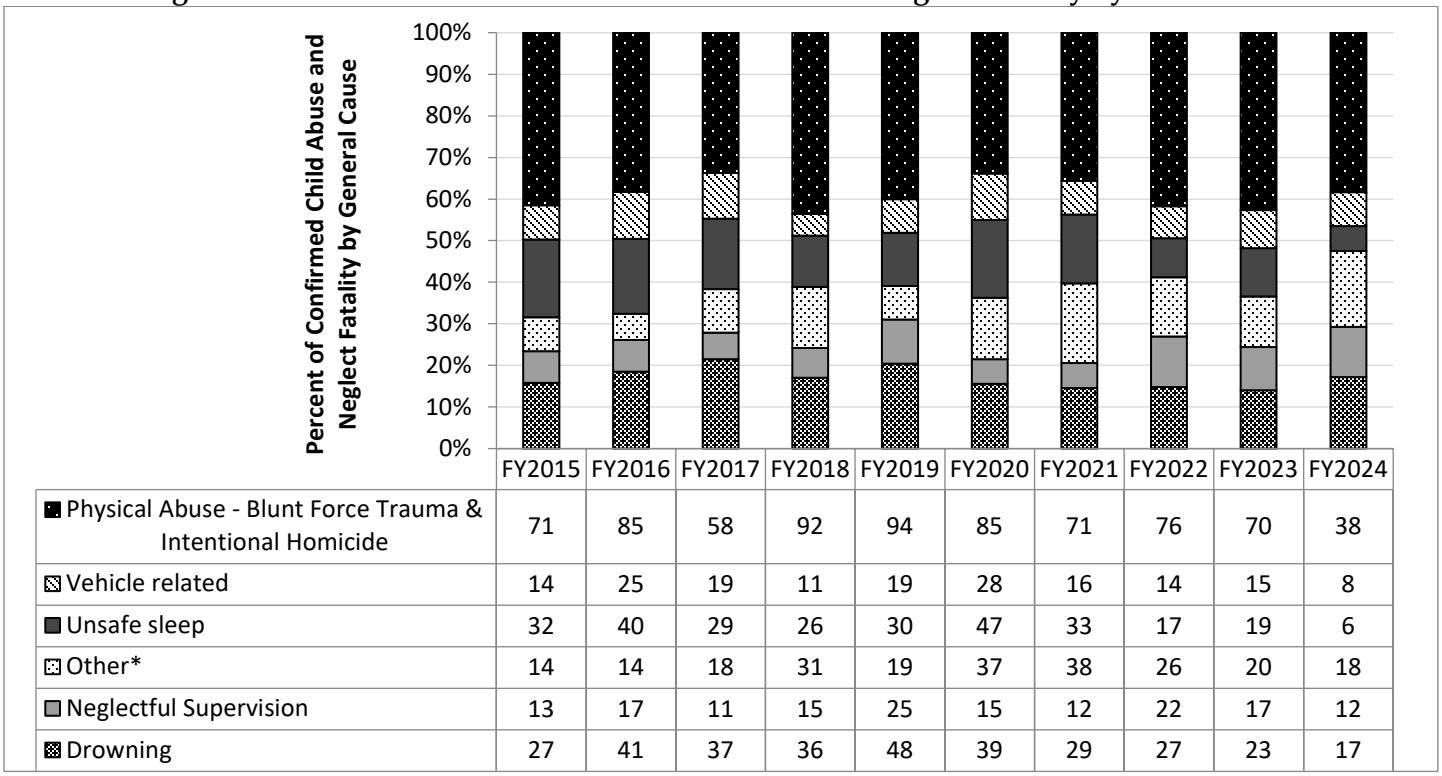
General Cause/Manner of Child Abuse or Neglect Fatality

Medical examiners and community-based child fatality review teams differentiate intentional/homicides and unintentional/accidental fatalities. In the data discussed below, child fatalities are divided into these categories to allow for common understanding and provide more information to target child abuse and neglect prevention efforts.

In this section, intentional deaths are defined as those where the perpetrator intended to cause harm or death to the child and are most often to be a confirmed allegation of physical abuse.

Unintentional deaths are those in which the level of inattention and/or impairment by the child's caregiver was enough to be considered neglect.

Figure 3. General Cause of Confirmed Child Abuse or Neglect Fatality by Fiscal Year

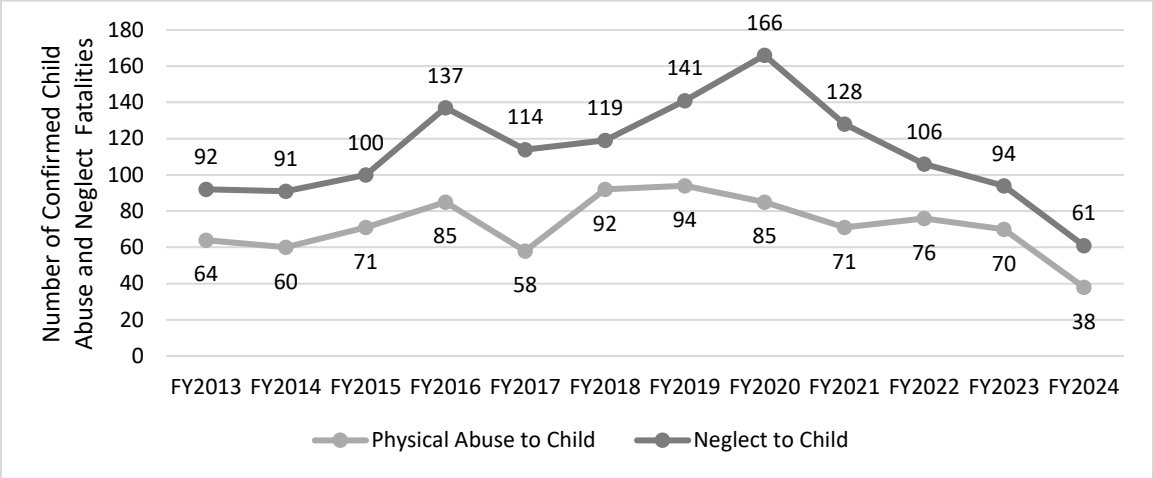


	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Physical Abuse - Blunt Force Trauma & Intentional Homicide	71	85	58	92	94	85	71	76	70	38
Vehicle related	14	25	19	11	19	28	16	14	15	8
Unsafe sleep	32	40	29	26	30	47	33	17	19	6
Other*	14	14	18	31	19	37	38	26	20	18
Neglectful Supervision	13	17	11	15	25	15	12	22	17	12
Drowning	27	41	37	36	48	39	29	27	23	17

*Other category includes medical neglect, physical neglect, and suicide.

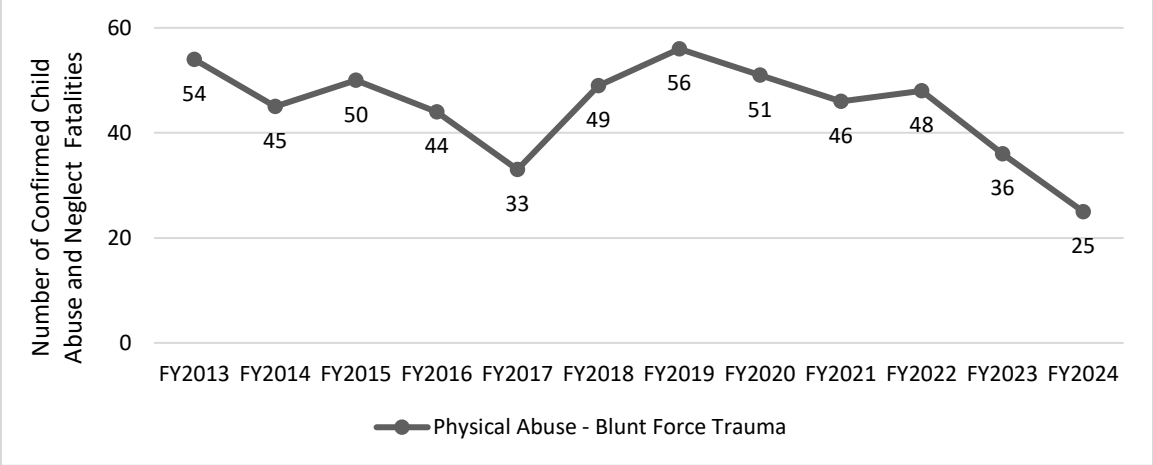
Source: DFPS individual case reviews

Figure 4. Comparison of Intentional Physical Abuse and Neglect Fatalities by Fiscal Year



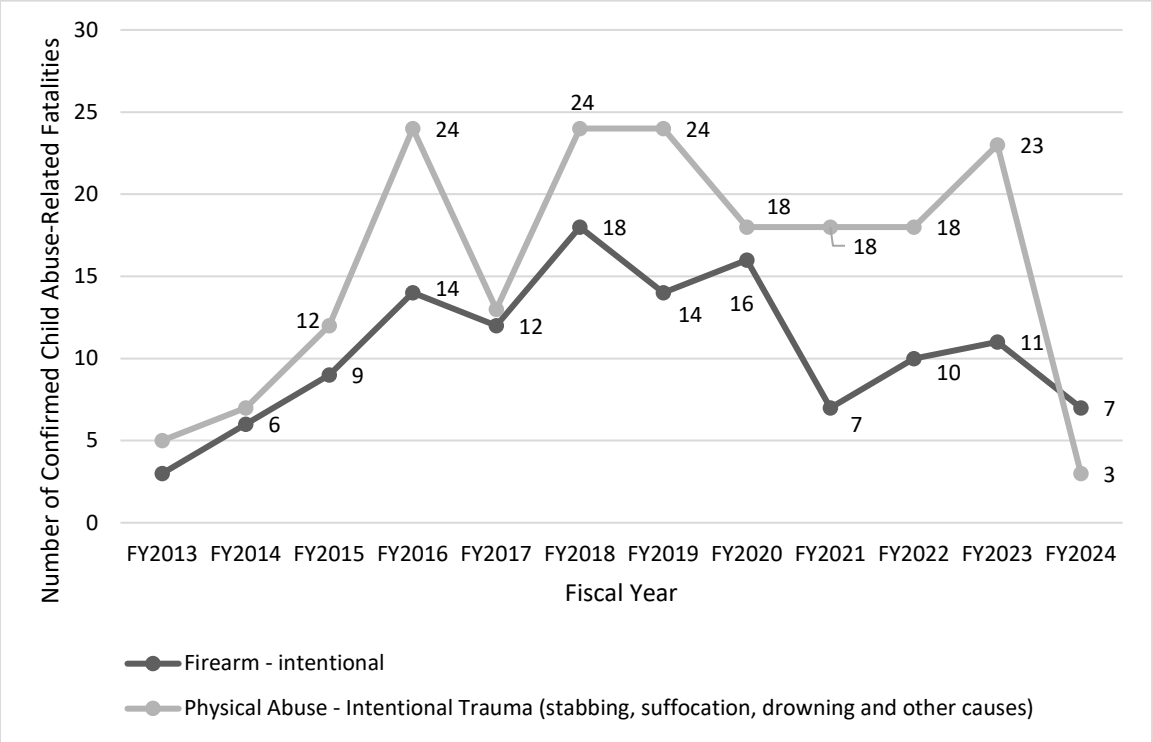
Source: DFPS individual case reviews

Figure 5. Physical Abuse Related Fatality: Blunt Force Trauma to Child



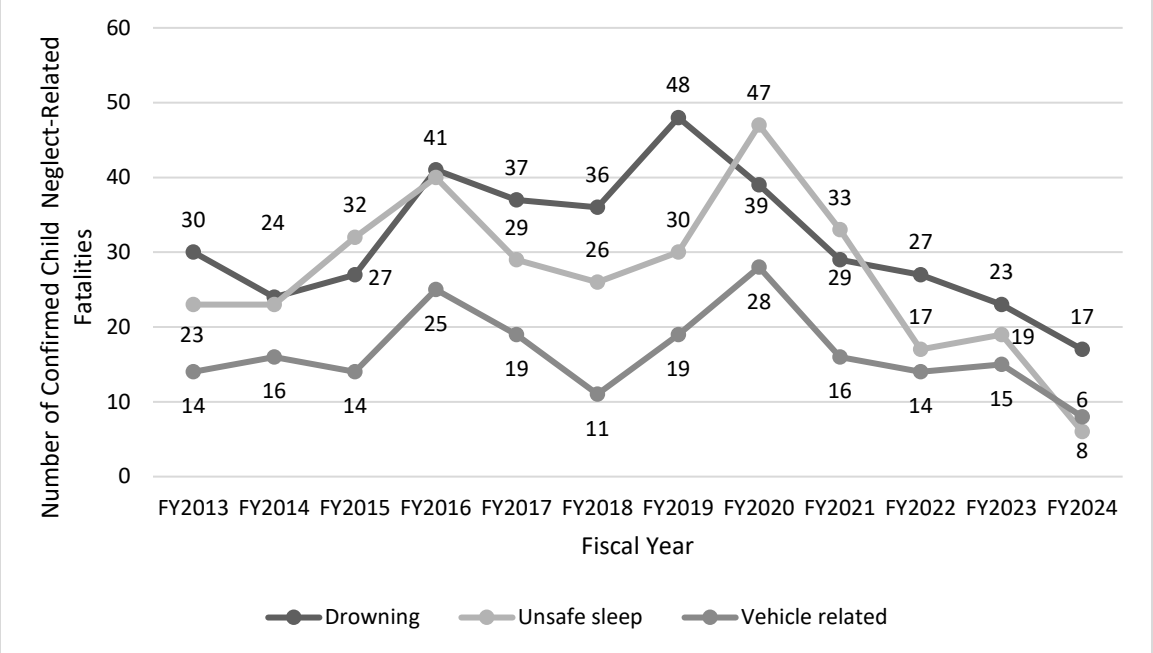
Source: DFPS individual case reviews

Figure 6. Intentional Physical Abuse to Child by Cause



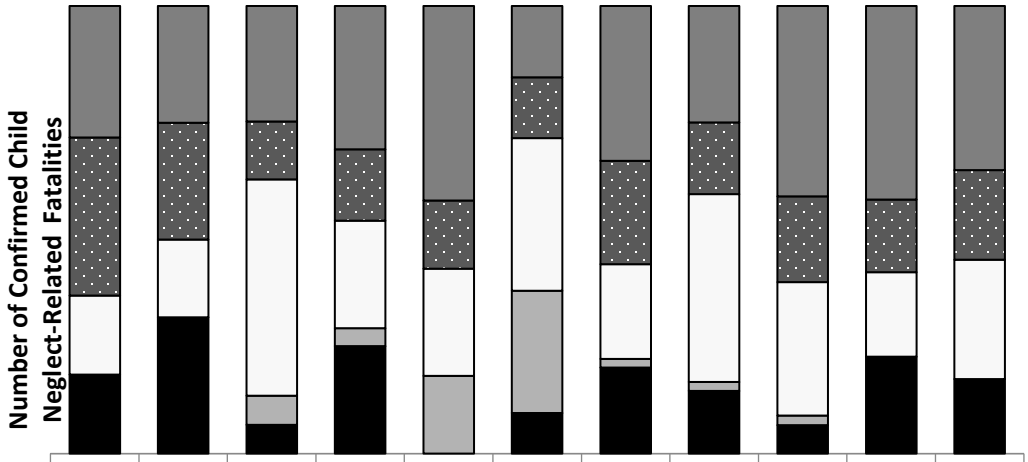
Source: DFPS individual case reviews

Figure 7. Neglect-Related Child Fatality by Cause



Source: DFPS individual case reviews

Figure 8. Neglect-Related Child Fatality by Cause continued*



	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Physical Neglect & Medical Neglect / Related to Medical Issue	5	6	8	8	20	7	18	13	20	16	11
Firearm - accidental	6	6	4	4	7	6	12	8	9	6	6
Neglectful Supervision - Other*	3	4	15	6	11	15	11	21	14	7	8
Fire	0	0	2	1	8	12	1	1	1	0	0
Accidental overdose / medication, alcohol, illegal substance	3	7	2	6	0	4	10	7	3	8	5

** Neglectful Supervision - Other includes choking, and suicide,*
Source: DFPS individual case reviews

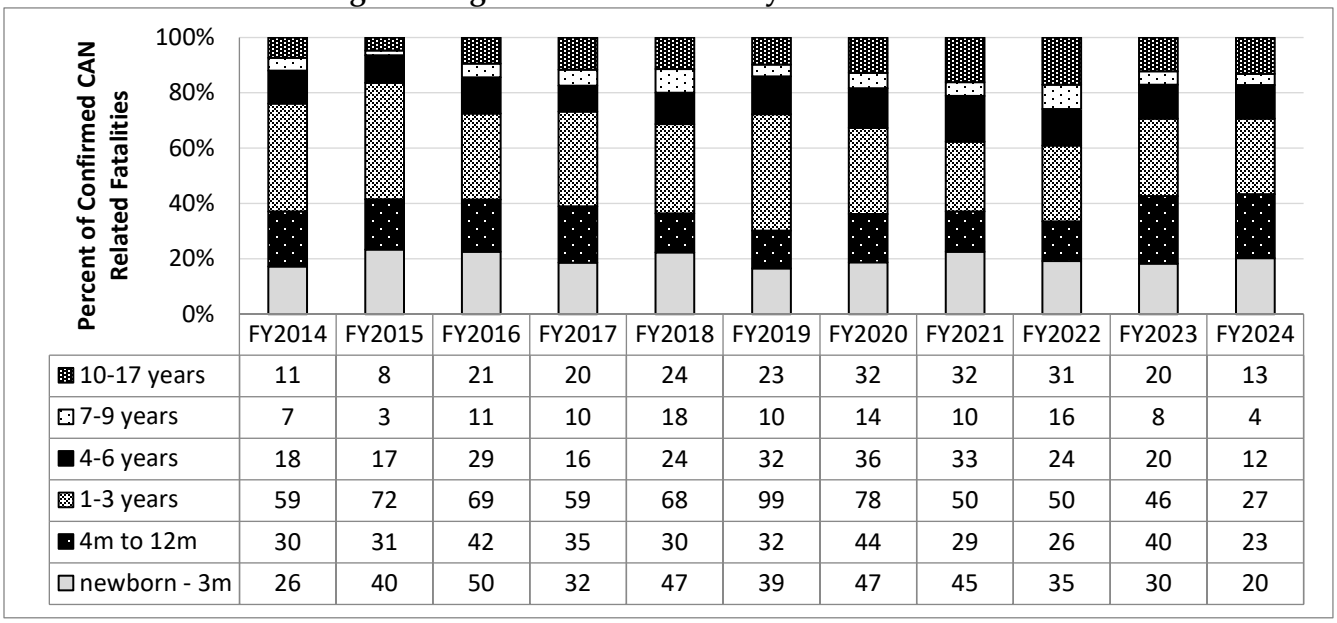
Victim Demographic Characteristics - Age, Gender, Ethnicity

Victims

- Based on the confirmed child abuse and neglect-related fatalities over the past 10 fiscal years, children 3 years of age and younger were almost 80 percent of all confirmed child abuse and neglect fatalities; however, the past three years have had a marked increase in child fatalities involving older children. In FY 2024, children 3 years of age and younger made-up 70.7 percent of confirmed child abuse and neglect fatalities. Male children represented a slight majority of confirmed child abuse and neglect-related fatalities (Figure 9, 10).
- During FY 2024, Hispanic children accounted for the largest percentage of children who died from abuse or neglect. The per capita rate for African American children who die from maltreatment continues to be higher than any other ethnicity in Texas. That is also true across the United States (Table 3).

- 67.6 percent of children who died from abuse or neglect in FY 2024 were too young for school and not enrolled in day care. One child was being cared for by a day care that was not registered or licensed by HHSC (Page 25).

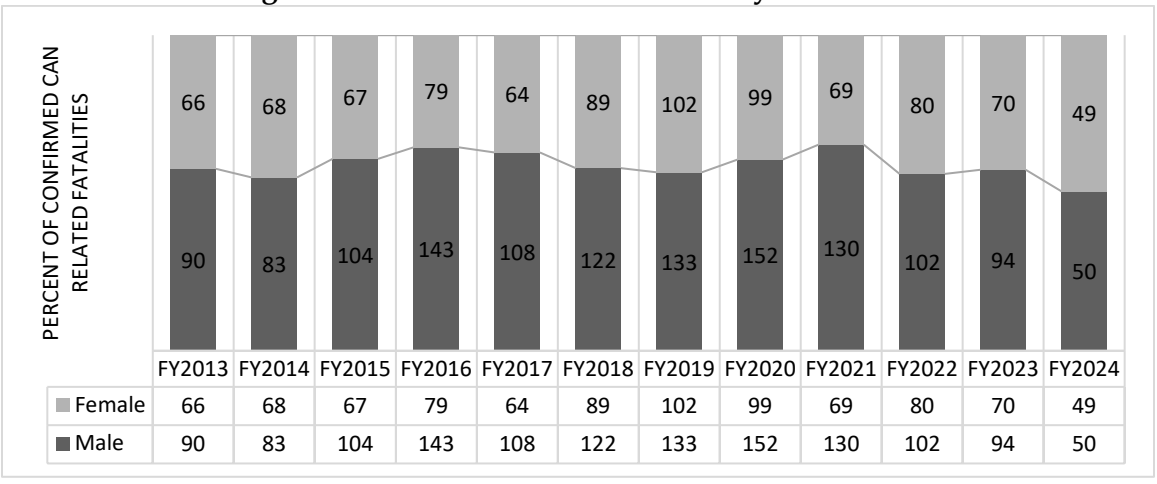
Figure 9. Age of Child at Death by Fiscal Year



	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
10-17 years	11	8	21	20	24	23	32	32	31	20	13
7-9 years	7	3	11	10	18	10	14	10	16	8	4
4-6 years	18	17	29	16	24	32	36	33	24	20	12
1-3 years	59	72	69	59	68	99	78	50	50	46	27
4m to 12m	30	31	42	35	30	32	44	29	26	40	23
newborn - 3m	26	40	50	32	47	39	47	45	35	30	20

Source: DFPS Data Warehouse Report FT_06

Figure 10. Gender of Deceased Child by Fiscal Year



	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Female	66	68	67	79	64	89	102	99	69	80	70	49
Male	90	83	104	143	108	122	133	152	130	102	94	50

Source: DFPS Data Warehouse Report FT_06

When reviewing the ethnicity of the victim, it is important to view fatalities in context of the child per capita rate for Texas. In FY 2024, children of Hispanic heritage represented the largest

number of child abuse and neglect fatalities. As in previous years, the child per capita rate of fatal abuse/neglect for African American children is disproportionally higher as compared to the overall Texas child population (Table 3). DFPS is actively working with state agencies, universities, private groups, communities, and stakeholders to address health and health access disparities for all populations. Part of this work includes cross-program work between DFPS and the Texas Department of State Health Services (DSHS) to address child fatalities from a public health approach.

Table 3. FY2024 Per Capita Rate (per 100,000 Children) by Ethnicity - Confirmed Child Abuse Neglect Fatalities

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non-Hispanic	Total
Child Population	939,258	2,338,055	3,883,787	682,250	7,843,350
Number of Fatalities	26	21	43	9	99
Per Capita Rate of Fatality	2.90	.94	1.16	1.38	1.32

Sources: Texas State Data Center; DFPS Data Book FY2023; DFPS Data Warehouse Report FT_06

Risk Factors and Protective Factors Involved in Confirmed Child Abuse or Neglect Fatalities

The United States Center for Disease Control and Prevention defines risk factors for child maltreatment as characteristics associated with child maltreatment.[10] These factors may or may not be direct causes but are often found in situations where children have been the alleged victim or confirmed victim of child maltreatment. The data contained in this report supports those same findings for risk factors—children who are three or under, history of child maltreatment, substance abuse, mental health concerns, and/or domestic violence in the home. Children with special needs or medical concerns also may be more at risk.

Although risk factors may remain consistent or fluctuate in a given family, protective factors also can affect child safety. Protective factors, such as parent support systems and parenting skills, help safeguard a family from risk factors associated with child maltreatment.

Special Needs & Medical Concerns as Risk Factor

In FY 2024, 22.2 percent of child maltreatment fatalities involved a child with special medical needs or medical concerns.

Table 4. FY2024 Confirmed Child Abuse Neglect Fatalities where Child had Special Medical Needs*

*Child may have more than one special medical need and appear more than once

Identified Special Need	FY2024 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality
None/Unknown	77 Fatalities
Asthma	1 Fatalities • Medical Neglect (1)
ADD/ADHD	4 Fatalities • Physical Abuse (1) • Neglectful Supervision (2) • Medical Neglect (1)
Anxiety/Depression	3 Fatalities • Medical Neglect (3)
Autism	1 Fatality • Neglectful Supervision (1)
Cerebral Palsy	2 Fatalities • Physical Neglect (1) • Physical Abuse (1)
Depression	3 Fatalities • Medical Neglect (3)
Developmental Disability/Delay	6 Fatalities • Physical Abuse (5) • Physical Neglect (1)
Failure to Thrive	5 Fatalities • Physical Abuse (3) • Neglectful Supervision (1) • Physical Neglect (1)
Feeding Tube	2 Fatality • Physical Abuse (1) Physical Neglect (1)
Infant Drug Addiction/Prenatal Drug Exposed	3 Fatalities • Physical Abuse (1) • Neglectful Supervision (1) • Physical Neglect (1)
Intellectual Disability	2 Fatalities • Medical Neglect (1) • Physical Neglect (1)
Medically Complex	1 Fatality

Identified Special Need	FY2024 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality
	• Physical Abuse (1)
Oppositional Defiant Disorder	1 Fatality • Neglectful Supervision (1)
Physical Disability	2 Fatalities • Neglectful Supervision (1) • Physical Neglect (1)
Speech Impairment	1 Fatalities • Neglectful Supervision (1)
Other—premature birth, heart conditions, other medical concerns	11 Fatalities • Physical Abuse (8) • Neglectful Supervision (1) • Physical Neglect (2)

Substance Use and Substance Abuse Disorder by Caregiver as Risk Factor
During the review of confirmed child fatalities due to abuse and neglect, cases were reviewed for a documented history of substance use (including inappropriate use of prescribed medications) and for active concerns for substance use at the time of the child fatality.

For FY2024, 60 of the 99 child fatalities caused by abuse or neglect involved a parent or caregiver actively using a substance and/or under the influence of at least one substance that affected the ability to care for the child. In the tables and chart below, the substance abuse is described by type and if it was reported. While methamphetamine use and alcohol use was identified in a total of 15 child fatalities, marijuana was the substance most identified as an active substance in child abuse and neglect-related fatalities and was identified as prior use in 28 of the cases.

Figure 11. FY 2024 Confirmed Child Abuse or Neglect Fatality by Substance Abuse by Perpetrator

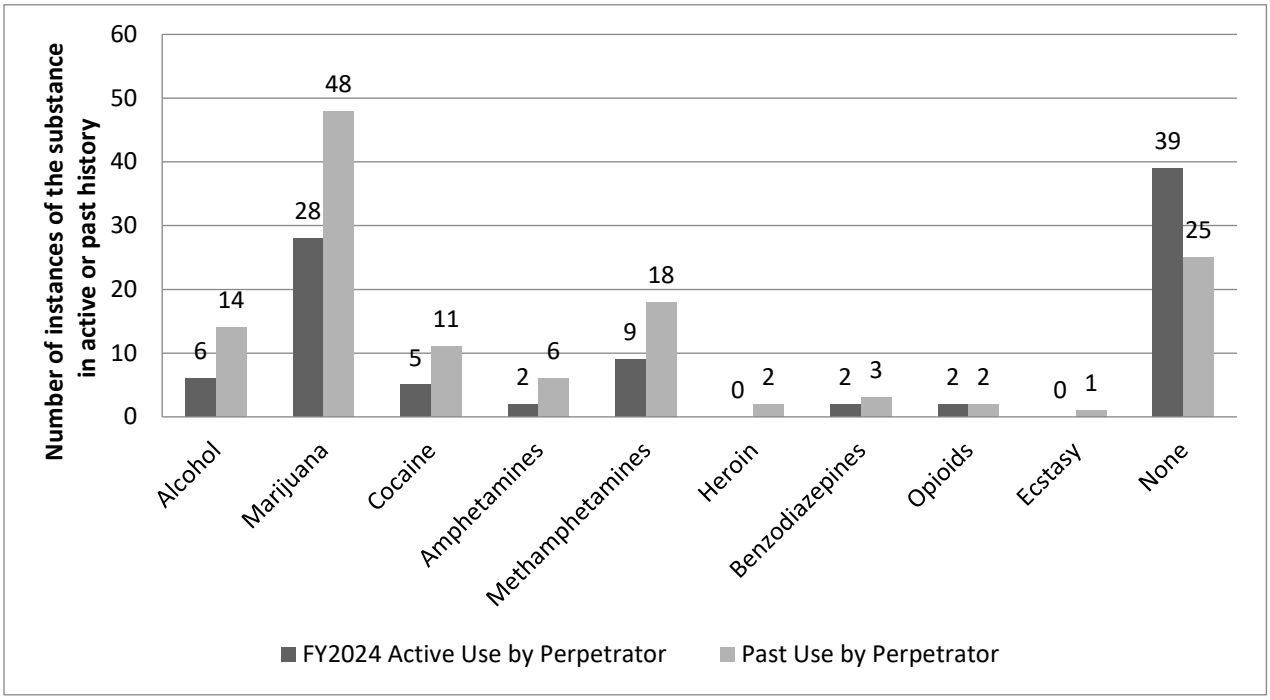


Table 5. FY 2024 Confirmed Child Abuse or Neglect Fatality by Co-Occurring Substance Abuse by Perpetrator

Co-Occurring Substances	Active	Past History
Alcohol and Marijuana	2	6
Cocaine and Marijuana	4	9
Cocaine and Alcohol	0	2
Benzodiazepines and Marijuana	1	3
Methamphetamines and Marijuana	3	13
More than two substances	1	13

Mental Health Concerns as Risk Factor

During the review of confirmed child fatalities due to abuse and neglect, cases were reviewed for a documented history of mental health concerns and if there were concerns for mental health at the time of the child fatality. In FY 2024, 53.5 percent of child fatalities involved a parent/caregiver who reported active mental health concerns.

Table 6. FY 2024 Mental Health Concerns both Active and in Past History for Perpetrator of Confirmed Child Abuse Neglect Fatalities

Mental Health Concern	Active	Past History
Total Number of Parents/Caregivers with Mental Health Concern*	**53**	**58**
• Bipolar Disorder	11	17
• Depression	22	29
• Anxiety	20	26
• Postpartum Depression	0	6
• Post-Traumatic Stress Disorder	5	6
• Schizophrenia	3	4
• Substance abuse disorder	6	7
• ADD/ADHD	7	9
• Other**	1	3
• Unknown Diagnosis – Reported by Individual	18	10
No	**46**	**41**

* Many may have more than one mental health concern and appear more than once.
**Other includes mood disorder, suicidal ideation, behavior disorder, oppositional defiance disorder and personality disorder.

Domestic Violence Concerns as Risk Factor

Domestic violence is often a precursor to child maltreatment and often an indicator to larger issues in the home. DFPS is working closely with staff, providers, and stakeholders to recognize and address domestic violence with the families involved with DFPS. Part of this work includes:

- employing a subject matter expert within CPS;
- developing training for all staff;
- providing guidance on how to investigate, disposition allegations, and provide services to families where domestic violence or intimate partner violence is a concern;
- strengthening connections between local providers and DFPS so that consultations about the danger in the home are more accurate and interventions can be improved;
- working closely with the Texas Council on Family Violence, DFPS is addressing barriers to provide more families with batterer intervention services statewide; and
- through the safety decision-making process and practice model, staff are trained on how to assess, provide services and work with families to ensure that case closure is based on behavioral change and establish safety plans with the family that are long-term and address day-to-day danger that might jeopardize child safety.

In FY 2024, DFPS Prevention and Early Intervention also funded several partnerships in the community with the local domestic violence intervention provider to provide direct services and outreach, including in the Austin, Waco, Victoria, and Amarillo areas.

During the review of confirmed child fatalities due to abuse and neglect, cases were reviewed for a documented history of domestic violence concerns and active concerns for domestic violence in the home at the time of the child fatality. As with other risk factors, there is concern that individuals are underreporting active domestic violence either to the department, law enforcement, or to community providers.

In FY 2024, there was active domestic violence present in the home environment for 35 families. A history of domestic violence was identified in 50 case reviews. For the 28 child fatalities where the family had a history of domestic violence and reported active concerns for domestic violence, 78.5 percent of those fatalities were due to physical abuse.

Table 7. FY 2024 Domestic Violence Concerns both Active and in Past History for Perpetrator Confirmed Child Abuse Neglect Fatalities

Domestic Violence Concern	Active	Past History	Both Active and Past History
Total Number of Parents/Caregivers Reporting Domestic Violence	**35**	**50**	**28**
No	**59**	**45**	**39**
Unknown (not identified in case read)	**5**	**4**	**3**

Source: DFPS individual case reviews

School and Day Care Enrollment as Protective Factor

With 70.7 percent of child fatalities involving children age three and younger, protective, and attentive parents and caregivers are critical to maintaining child safety. When a parent works, care for the child must be found; sometimes that care is a family member or friend, or commonly a day care provider. Finding good care for a child's needs is critical, especially when the primary parent/caregiver to the child is out of the home. School and day care also provide another adult outside the family the opportunity to be around the child regularly and be on the lookout for signs of abuse or neglect. Eighty percent of children who died due to abuse or neglect were not involved with either a registered or licensed day care or a school system that could have provided additional eyes and ears.

FY 2024 Confirmed Child Abuse and Neglect Fatalities:

- In 67 of the 99 child fatalities due to abuse or neglect, the child was not enrolled either in a day care or in school. In 4 case reviews, the status of the child being in school, or day care was unknown. In 4 case reviews, the children were home schooled.
- In 22 of the 99 child fatalities due to abuse or neglect, the child was enrolled in day care or school. Two of the fatalities occurred when school was out of session for the summer or winter break.
- In 1 of the 99 child fatalities due to abuse or neglect, the child was being cared for by a caregiver that should have been registered or licensed through HHSC but was not.

Table 8. FY 2024 Child Abuse and Neglect Related Fatalities - By County

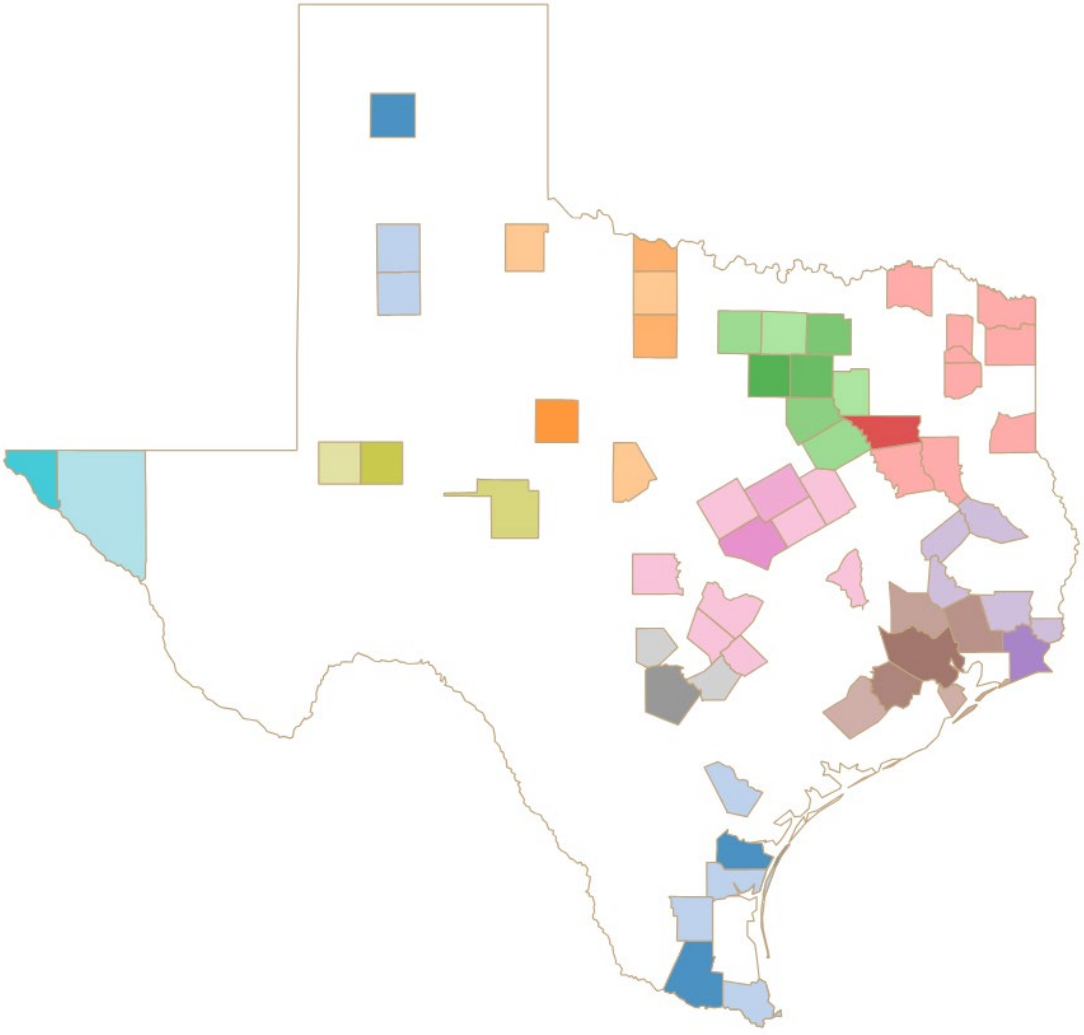
County	Region	Child Abuse/Neglect Related Fatalities	Children in DFPS Conservatorship at Time of Fatality*
Anderson	04	1	
Angelina	05	1	
Atascosa	08	1	
Bee	11	1	
Bell	07	2	
Bexar	08	5	
Brazoria	06	3	
Brazos	07	1	
Brown	02	1	
Camp	04	1	
Cherokee	04	1	
Collin	03	2	
Dallas	03	4	
Ector	09	2	
El Paso	10	3	
Ellis	03	1	
Falls	07	1	
Fannin	03	1	
Floyd	01	1	
Fort Bend	06	1	1
Frio	08	1	
Galveston	06	2	1
Grayson	03	1	
Grimes	07	1	
Harris	06	17	
Harrison	04	1	
Hidalgo	11	1	
Jefferson	05	2	
Johnson	03	2	
Karnes	08	1	1
Kaufman	03	1	
Kendall	08	1	1
Knox	02	1	
Lubbock	01	1	
Maverick	08	1	

County	Region	Child Abuse/Neglect Related Fatalities	Children in DFPS Conservatorship at Time of Fatality*
McLennan	07	4	
Midland	09	2	
Montgomery	06	3	
Nueces	11	2	
Orange	05	1	
Potter	01	3	
San Patricio	11	2	
Smith	04	1	
Tarrant	03	6	1
Tom Green	09	1	
Travis	07	5	
Wood	04	1	
Total		99	

* Of the five fatalities that occurred while the child was in DFPS Conservatorship, three were a result of fatal injuries caused prior to the child entering foster care and were caused by the child's parent or caregiver.

Does not include corrections or updates, if any that may subsequently be made to DFPS data.
Includes child fatalities investigated and confirmed by Child Protective Investigations – Field Division (98), Child Day Care Investigations (0), Residential Child Care Investigations (1), and Adult Foster Care (0)

FY2024 Child Abuse and Neglect Related Fatalities - By Region



FY 2024 Confirmed Child Abuse and Neglect Related Fatalities - Case Review Data

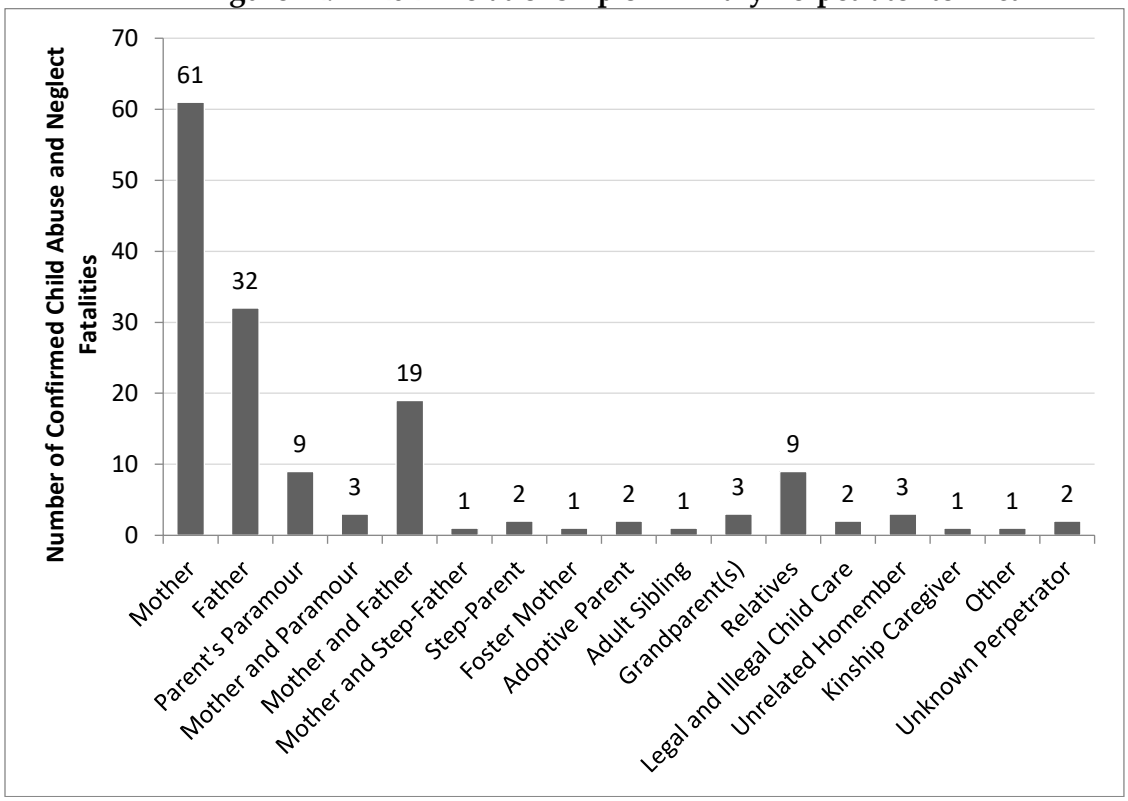
Based on the confirmed child abuse and neglect fatalities that occurred during FY 2024, several key demographic areas allow for specialized targeting of prevention and intervention in child abuse and neglect cases. Data from these fatalities tells us that these parents would benefit from support, education, and targeted campaigns. Communities can use this data to strategically message and target available resources for families and caregivers.

FY 2024 Perpetrator Demographic and Characteristics - Relationship and History

Perpetrators

- Physical abuse in fatalities most commonly involved blunt force trauma or intentional trauma inflicted by a father or mother (Figures 13-15).
- In all confirmed cases of abuse and neglect, parents continue to be the most common perpetrators (Figure 12).
- In 56.6 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had prior history with CPS (Figure 21, 22).
- When the perpetrator or the child was previously known to DFPS in the two years prior to fatality, the child fatality is often related to physical abuse or neglectful supervision. (Table 9, 10).

Figure 12. FY2024 Relationship of Primary Perpetrator to Victim



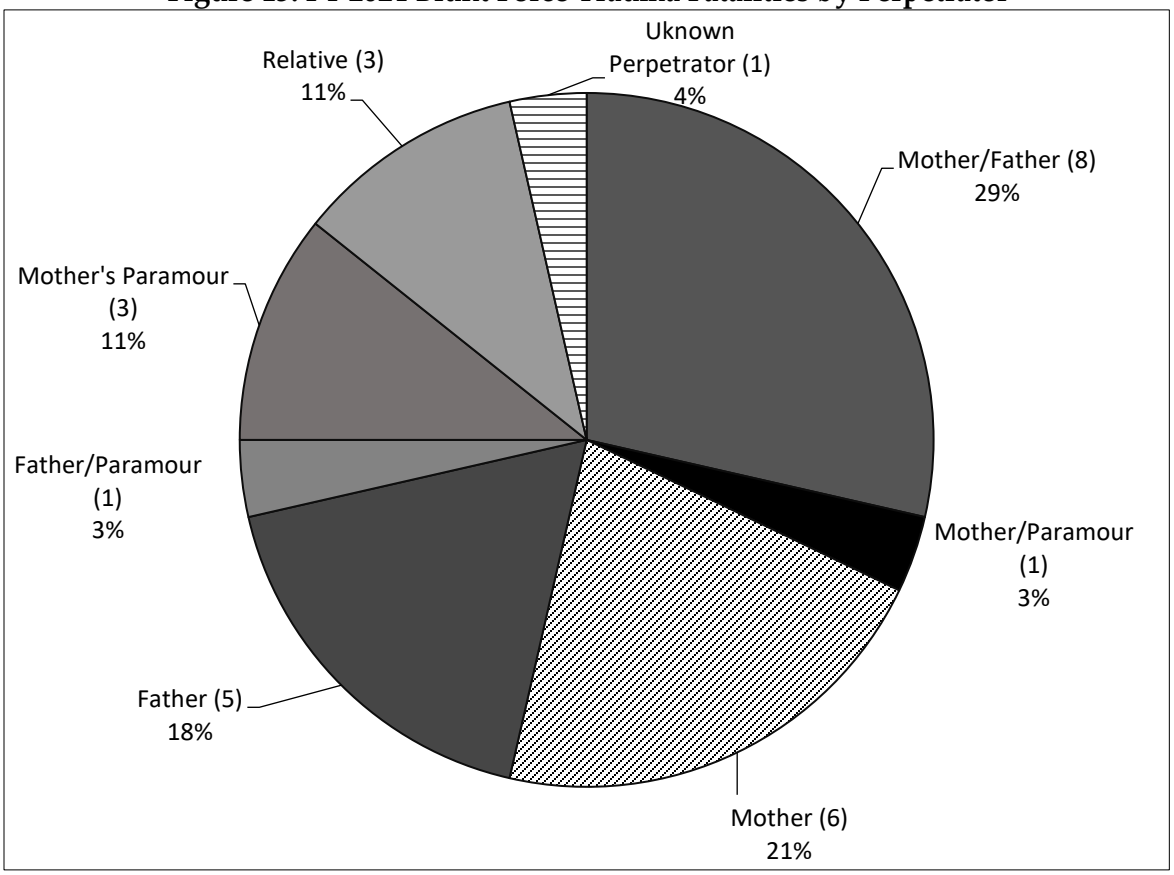
Source: DFPS individual case reviews.

*In some cases, there were multiple primary perpetrators per fatality victim.

FY 2024 Primary Perpetrator, Child Age and Cause of Death

This analysis looks for patterns in the child's age and the type of primary perpetrator. Only those where the cause/manner of death was identified in six or more abuse or neglect related fatalities are detailed below. All data in this section is based on case reviews.

Figure 13. FY 2024 Blunt Force Trauma Fatalities by Perpetrator



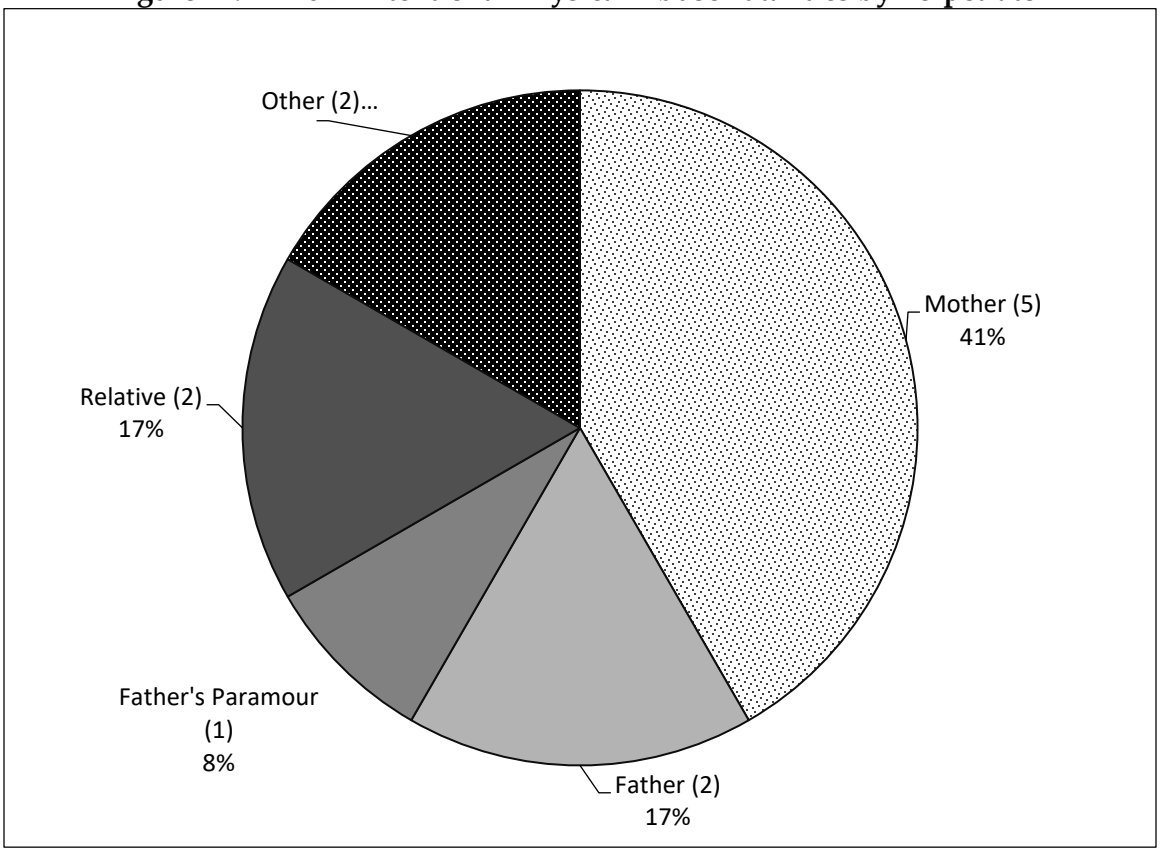
Number of victims: 25 children

Age range of victims: Newborn to 6-year-old youth. 20 children were younger than one year old; 92% were age three or younger

Finding: Usually involve young children being physically abused by the father or a mother (76%)

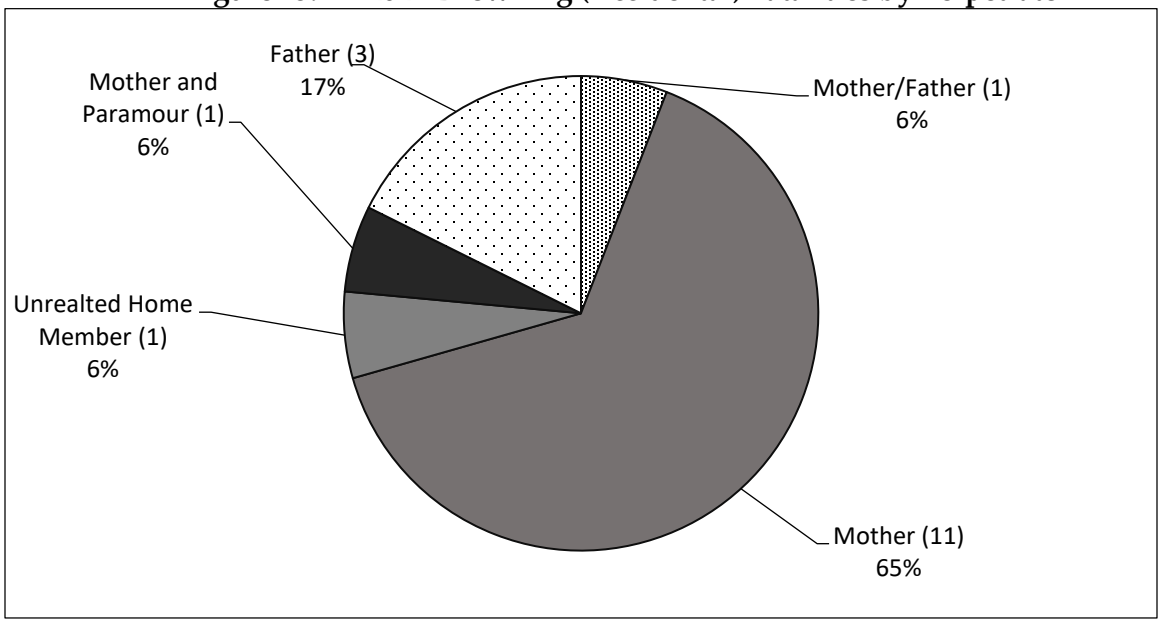
**One fatality had multiple relative perpetrators designated with RTB/FT.*

Figure 14. FY 2024 Intentional Physical Abuse Fatalities by Perpetrator



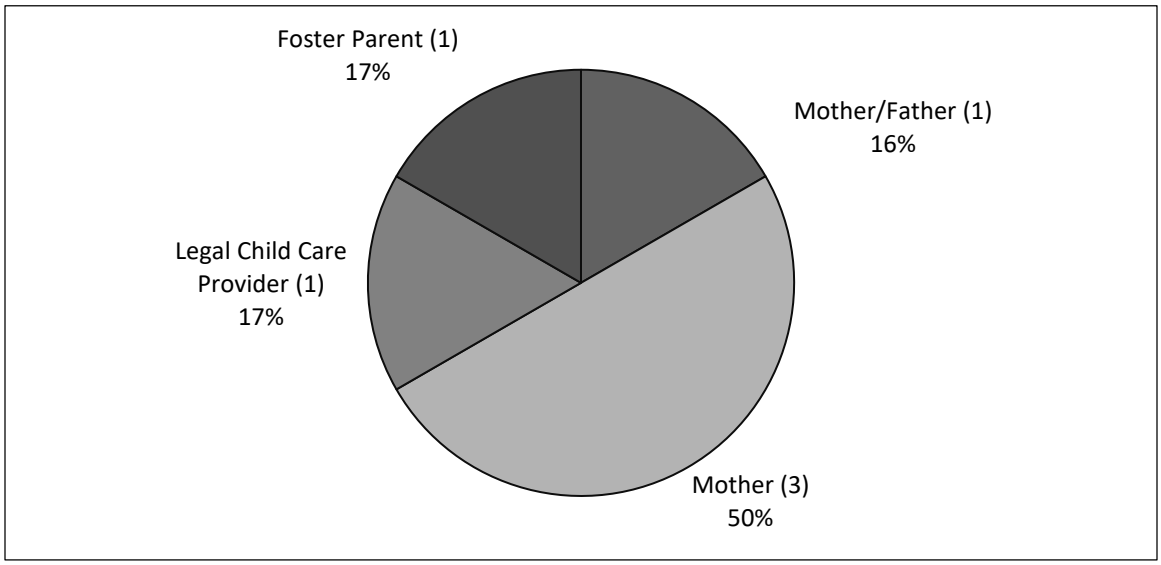
Number of victims: 12 children
Age range of victims: Newborn to 17-year-old youth. 66.6 percent were children age four and older
Finding: Usually involved children with primary perpetrator as mother (41.6%).
**Includes intentional drownings and intentional firearm deaths*

Figure 15. FY 2024 Drowning (Accidental) Fatalities by Perpetrator



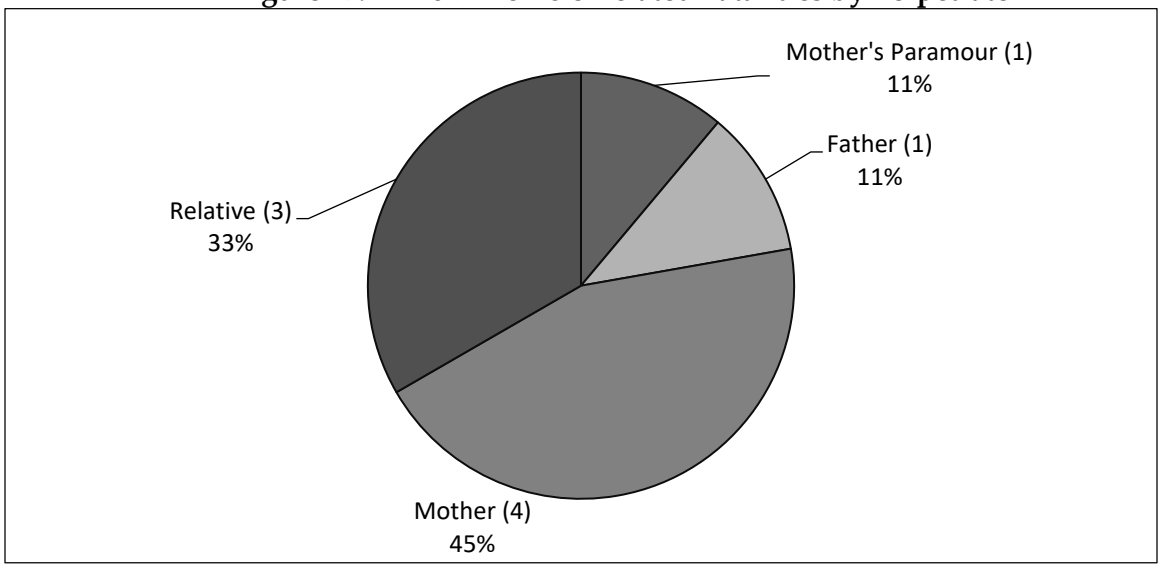
Number of victims: 17 children
Age range of victims: 4 months to 6-year-old child. Fifteen children were 3 years old and younger (88.2%).
Finding: Usually involve young children with mother as primary perpetrator (64.7%).

Figure 16. FY 2024 Unsafe Sleep Fatalities by Perpetrator
(Includes bed-sharing and unsafe sleep environments)



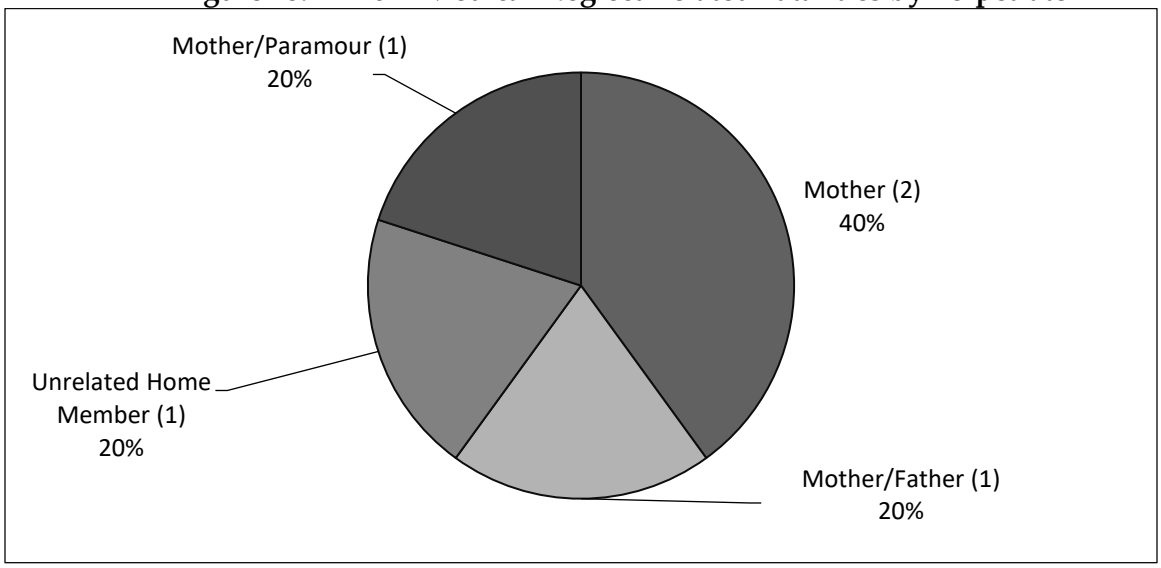
Number of victims: 6 children
Age range of victims: Newborn to 12 months
Finding: Involved infants with primary perpetrator, generally the mother.

Figure 17. FY 2024 Vehicle Related Fatalities by Perpetrator



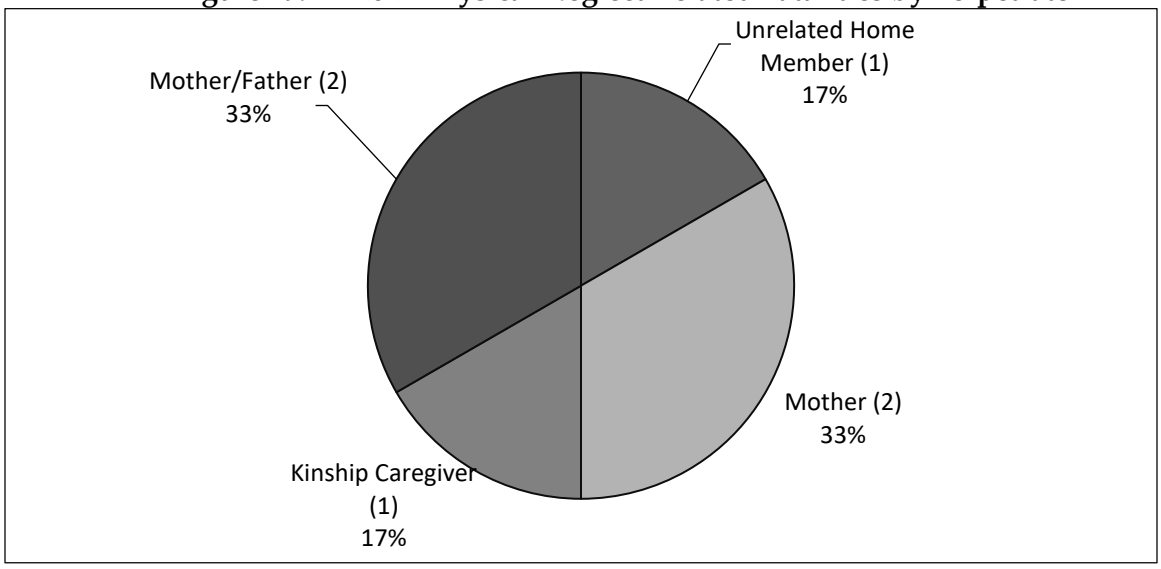
Number of victims: 9 children
Age range of victims: 4 months to 17 years old
Finding: Usually happens while in care of the mother (44.4%). Three children died after being left in a vehicle.

Figure 18. FY 2024 Medical Neglect Related Fatalities by Perpetrator



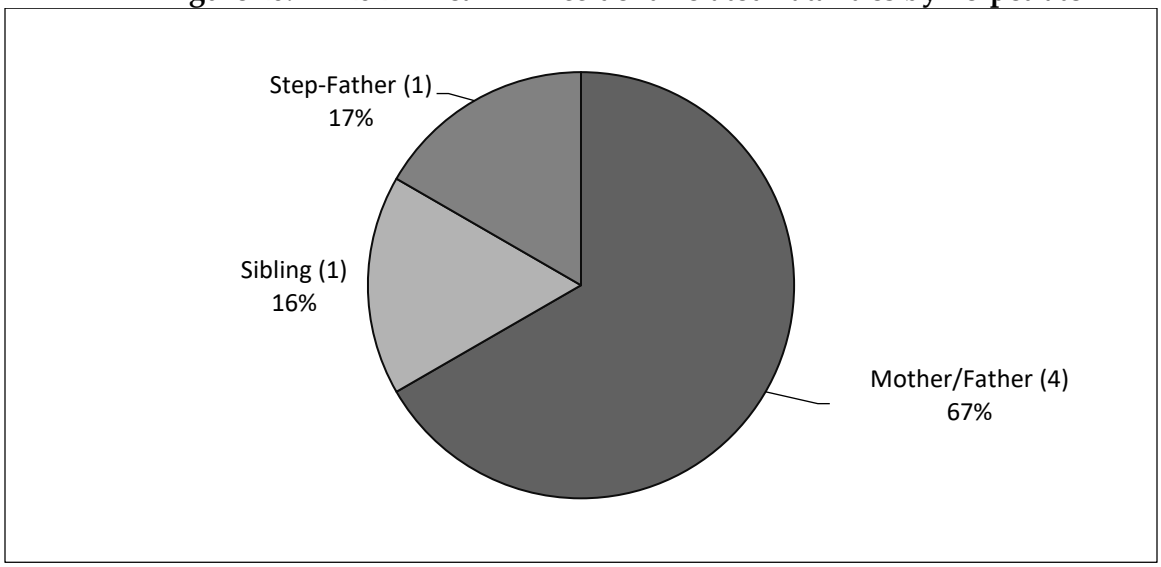
Number of victims: 5 children
Age range of victims: one to 17 years old
Finding: Usually happens while in care of the mother (40%).

Figure 19. FY 2024 Physical Neglect Related Fatalities by Perpetrator



Number of victims: 6 children
Age range of victims: Newborn to 6 years old
Finding: Usually happens while in care of one or both parents (66%).

Figure 20. FY 2024 Firearm - Accident Related Fatalities by Perpetrator

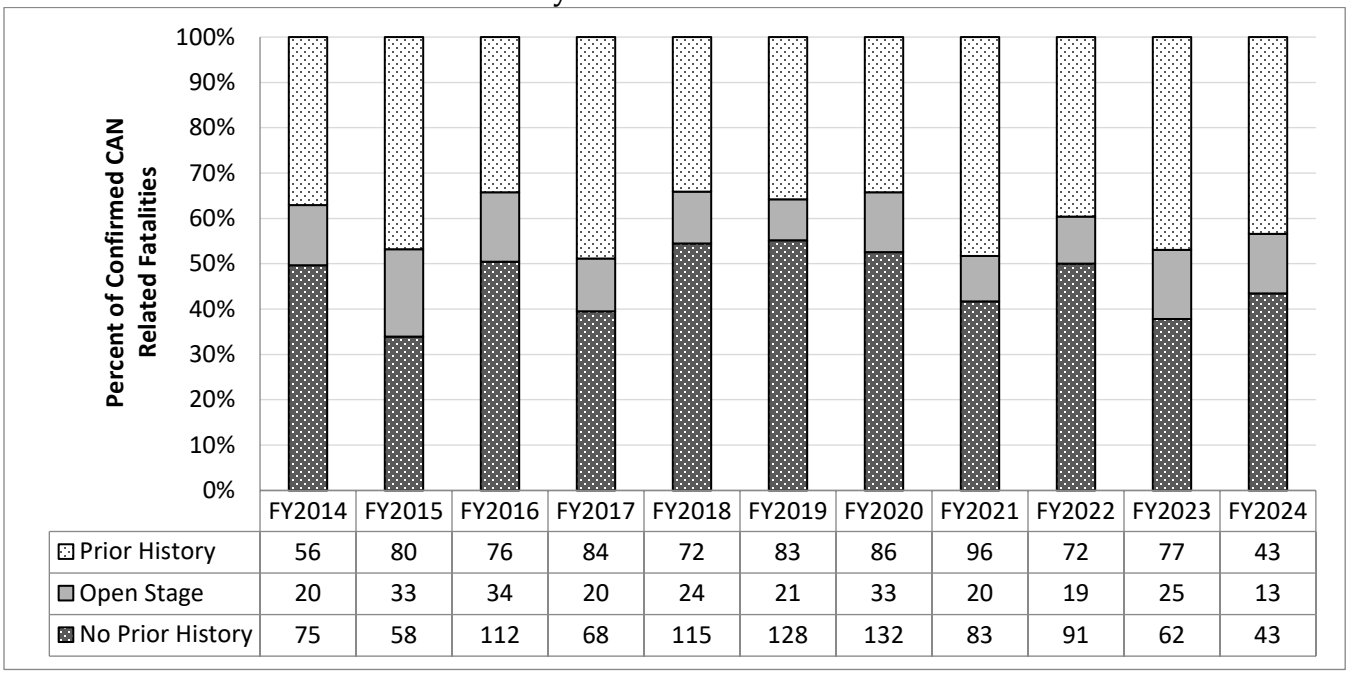


Number of victims: 6 children
Age range of victims: 4 months old to 17 years old
Finding: Usually happens while in care of a parent (67%).

Prior CPS History in Child Abuse and Neglect-Related Fatalities

To better understand fatalities, it is important to identify if families had prior involvement with DFPS. DFPS defines prior CPS history broadly – if the deceased child or a designated perpetrator in the fatality had been in a CPI investigation or received CPS services before the child's death. Under this definition, it counts as prior CPS history even if the last contact with CPS was several years before the death or was unrelated to the circumstances of the fatality. In 13.1 percent of the child abuse and neglect fatalities, CPI or CPS was involved with the family or the child at the time of the death. In 56.5 percent of confirmed child fatalities, CPI or CPS had been involved with the child or the perpetrator in the past.

Figure 21. CPI/CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Fiscal Year

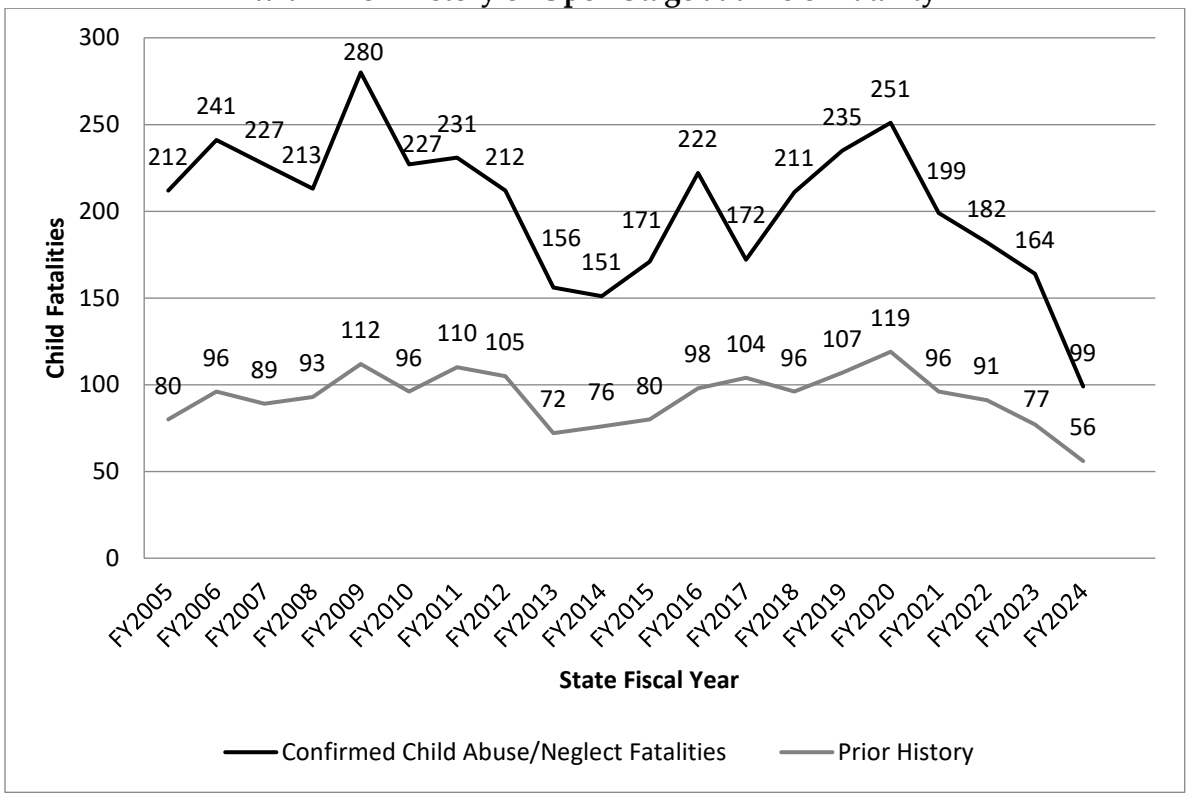


	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Prior History	56	80	76	84	72	83	86	96	72	77	43
Open Stage	20	33	34	20	24	21	33	20	19	25	13
No Prior History	75	58	112	68	115	128	132	83	91	62	43

Source: DFPS Data Warehouse Report FT_06

A child fatality may occur in an open case such as Investigations, Family Based Safety Services, or Conservatorship. Child abuse and neglect-related fatalities where the child died while CPS was involved with the family in FY 2024 often consisted of physical abuse (4 fatalities) and neglectful supervision (6 fatalities).

Figure 22. DFPS Investigated Child Fatalities and Confirmed Child Abuse/Neglect Fatalities with Prior History or Open Stage at time of Fatality



Source: DFPS Data Warehouse Report FT_06

For FY 2024, based on Figures 22-24, the following themes are noted:

- In 13 child fatalities, the child or the child's family was involved with CPI or CPS at the time of death and a new incident of abuse or neglect occurred.
    - Five of the children were in an active investigation and a new incident of abuse or neglect occurred leading to the fatality.
        - Initial contacts were completed in all 5 of the open investigations.
        - In four investigations, there was only one worker assigned; one investigation had two workers assigned during the open stage.
        - There were no parental child safety plans in place in the investigations. The risk and safety assessment were completed timely in four of the investigations.
        - Starting caseloads: 1 with 10 or fewer cases; 2 with 11-20 cases; 2 with more than 20 cases.
    - Five of the children were in an active Family Based Safety Services (FBSS) stage and a new incident of abuse or neglect occurred leading to the fatality.

        - Initial contacts in open FBSS were completed timely and the children were being seen timely.
        - In three of the FBSS cases, there was only one worker assigned. Two families had two workers assigned.
        - Safety plans were in place in three of the open FBSS cases.
        - Caseloads for the staff at the time of the fatality: Two with less than 10 cases and two had over 20 cases.
        - In the FBSS cases, four families were offered substance abuse testing or assessment. Two families were offered mental health services. Four of the FBSS cases were offered counseling, and parenting services. At the time of the fatalities, two families were partially compliant, and two families were fully compliant with services. One family was not compliant.

    - One child had active Investigation and FBSS stages at the time of the fatality. Initial contacts were made timely. The safety assessments and risk assessments were completed timely. The family had an active safety plan; they were not compliant.

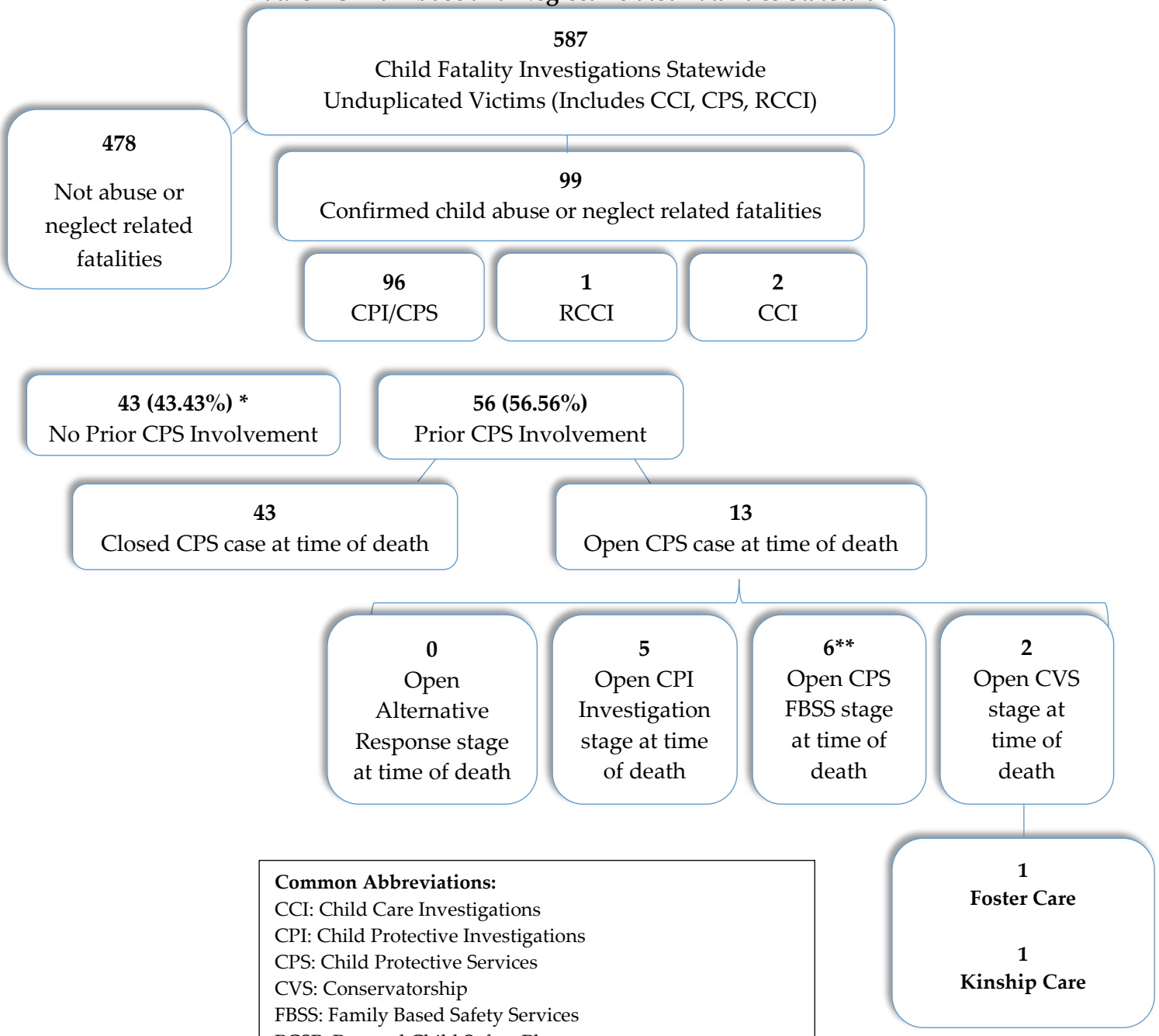
    - Two children were in an active Conservatorship (CVS) stage when a new incident of abuse or neglect occurred leading to the fatality. One of the children was in a Kinship placement.
        - Initial contact in one open CVS stage was completed timely. Both children were being seen timely.
        - In one of the fatalities, there was only one worker assigned. The other open CVS stage had 2 caseworkers assigned.
        - Caseloads for the staff at the time of the fatality: one had two and the other had five cases.

- For child fatalities with prior history (56 children), the majority had only one worker assigned during the family's last involvement with DFPS (75 percent) and caseloads were often at 20 cases or fewer per staff member assigned.
    - Eleven families had two workers assigned and three families had three workers assigned.
    - Starting caseloads: 29 with 10 or fewer cases; 17 with 11-20 cases; 13 with more than 20 cases.
    - Ending caseloads: 29 with 10 or fewer cases; 18 with 11-20 cases; 8 with more than 20 cases; 1 was unknown due to the age of the history or the staff member being in transition between units.

- In the 56 child fatalities with prior history:

- 25 families had prior involvement with Family Based Safety Services (FBSS).
  - 25 families had prior involvement with FBSS after an investigation concluded.
  - 21 families had a prior safety plan that required the parents, significant other or the designated perpetrator to have supervised contact with the children. 76.1 percent of safety plans were documented as being followed during the family's involvement with DFPS.
  - On average, families were seen monthly, with their involvement in FBSS ranging from 3 months to one year. In general, initial visits were completed timely as the policy and practice is to work collaboratively with Child Protective Investigations and the family to engage in FBSS services at case transfer. On average, families had twelve or more visits with the FBSS caseworker.
  - Services offered in the previous or open stage include:
    - Counseling for family, individual, or group: 16 cases
    - Daycare or respite care: 2 cases
    - Domestic violence shelter or counseling: 7 cases
    - Drug testing or treatment: 17 cases
    - Homemaker assistance: 1 case
    - Infant or early childhood screening or development services: 3 cases
    - Mental health (psychological testing, mental health assessment or treatment, referral to local mental health authority): 7 cases
    - Parenting collaboration group (CPS Local Parent Support Group): 1 case
    - Parenting skills / evidence-based parent education: 13 cases
- 87.5 percent of families that had been involved with FBSS were reportedly fully compliant or partially compliant with their service plan.

Figure 23. FY 2024 Department of Family and Protective Services (DFPS) Data on Child Abuse and Neglect Related Fatalities Statewide



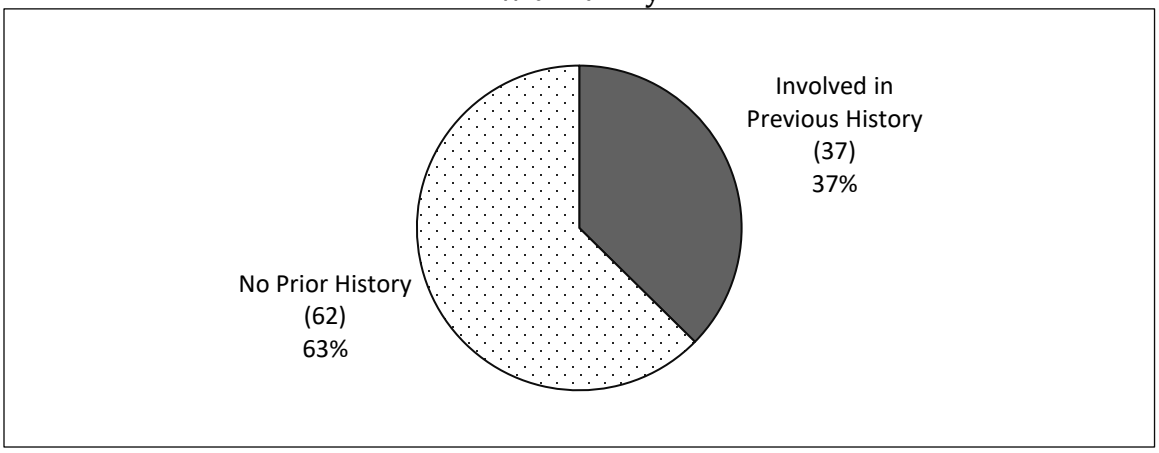
Common Abbreviations:
CCI: Child Care Investigations
CPI: Child Protective Investigations
CPS: Child Protective Services
CVS: Conservatorship
FBSS: Family Based Safety Services
PCSP: Parental Child Safety Placement
RCCI: Residential Child Care Investigations
Note: prior history can involve the victim or the perpetrator or both in any previous CPS stage of service. Includes duplication.
** One of the families with an open FBSS stage also had an open INV stage.

Figure 24. FY 2024 Prior History by Child/Perpetrator with Previous Involvement

Type of Previous History	Total Count
Child has previous history or open stage (Perpetrator was not known to CPS)	12
Perpetrator has previous history or open stage (Child was not known to CPS)	16
Both child and perpetrator have previous history or open stage	28
Total with previous history or open stage	56

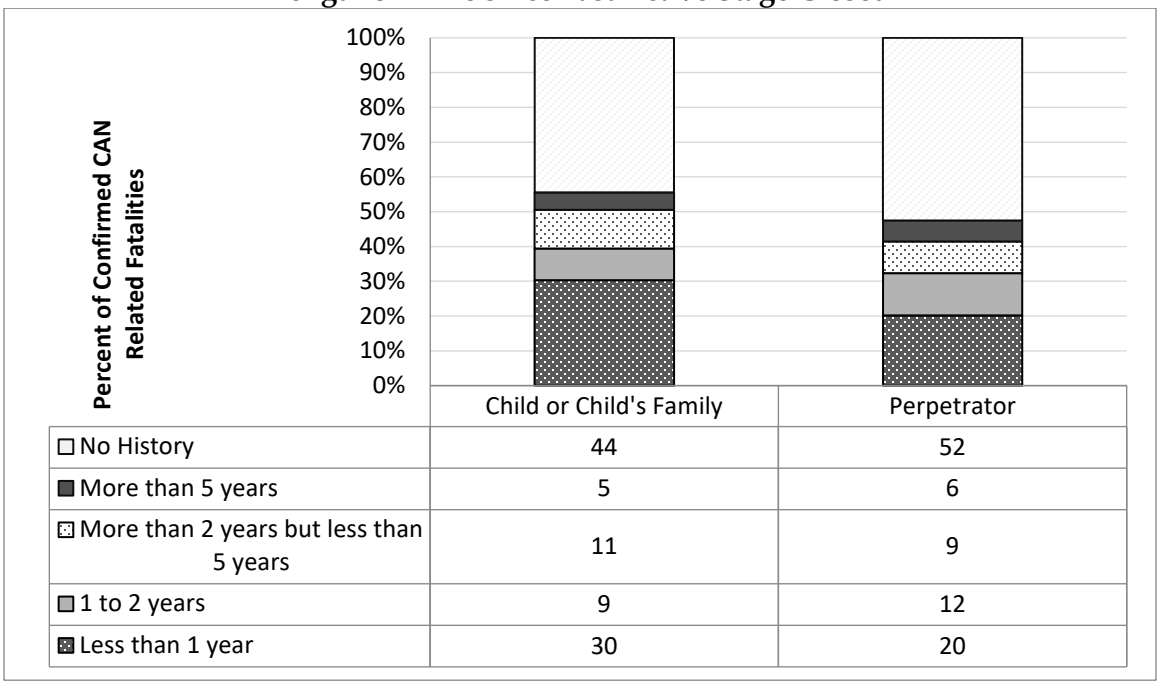
Source: DFPS individual case reviews

Figure 25. FY 2024 Prior History Where Deceased Child was Present in Previous Involvement with Family



Source: DFPS individual case reviews – includes history that may be purged from IMPACT but referenced in case narrative.

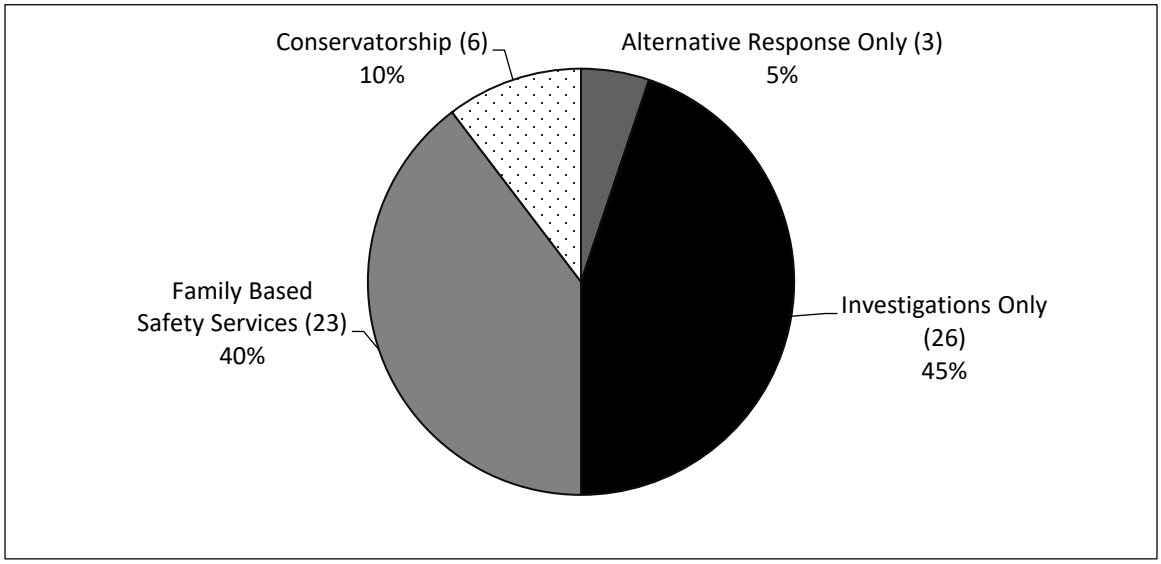
Figure 26. FY 2024 CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Length of Time since Last Active Stage Closed



	Child or Child's Family	Perpetrator
No History	44	52
More than 5 years	5	6
More than 2 years but less than 5 years	11	9
1 to 2 years	9	12
Less than 1 year	30	20

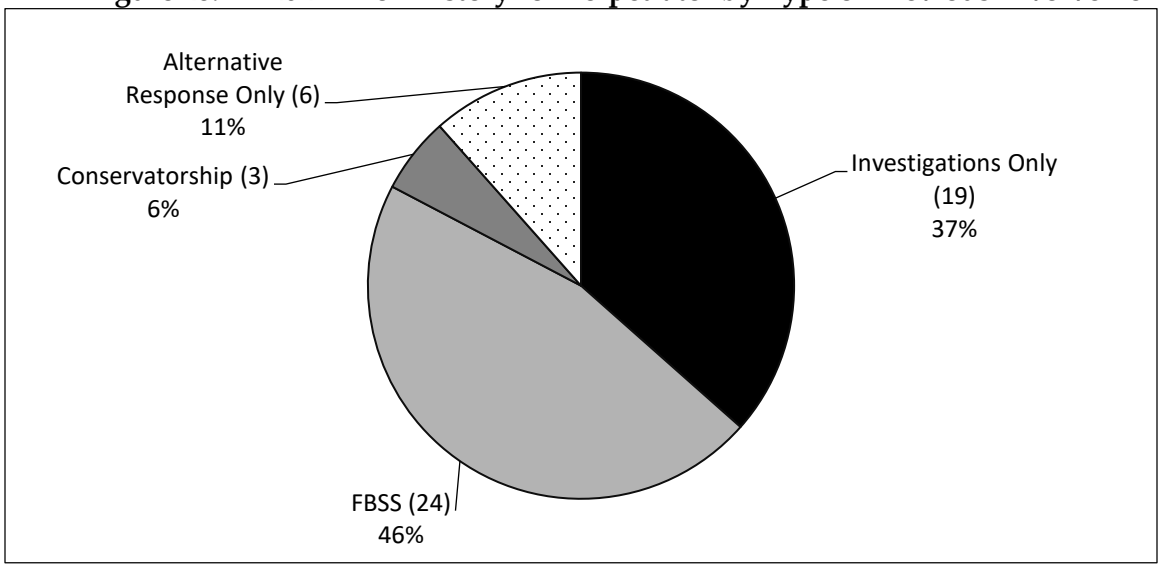
Source: DFPS individual case reviews

Figure 27. FY 2024 Prior History for Child or Child's Family by Type of Previous Involvement



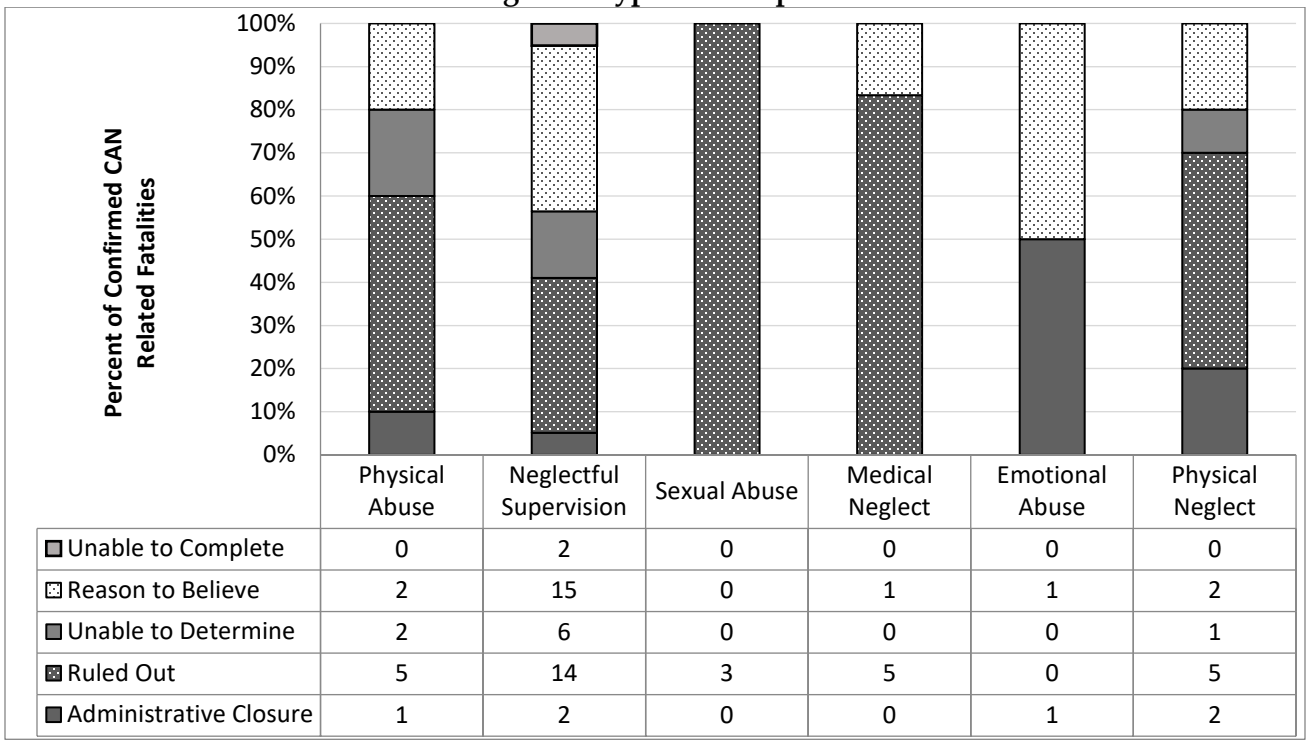
Source: DFPS individual case reviews; history may include more than one stage of service.

Figure 28. FY 2024 Prior History for Perpetrator by Type of Previous Involvement



Source: DFPS individual case reviews; history may include more than one stage of service

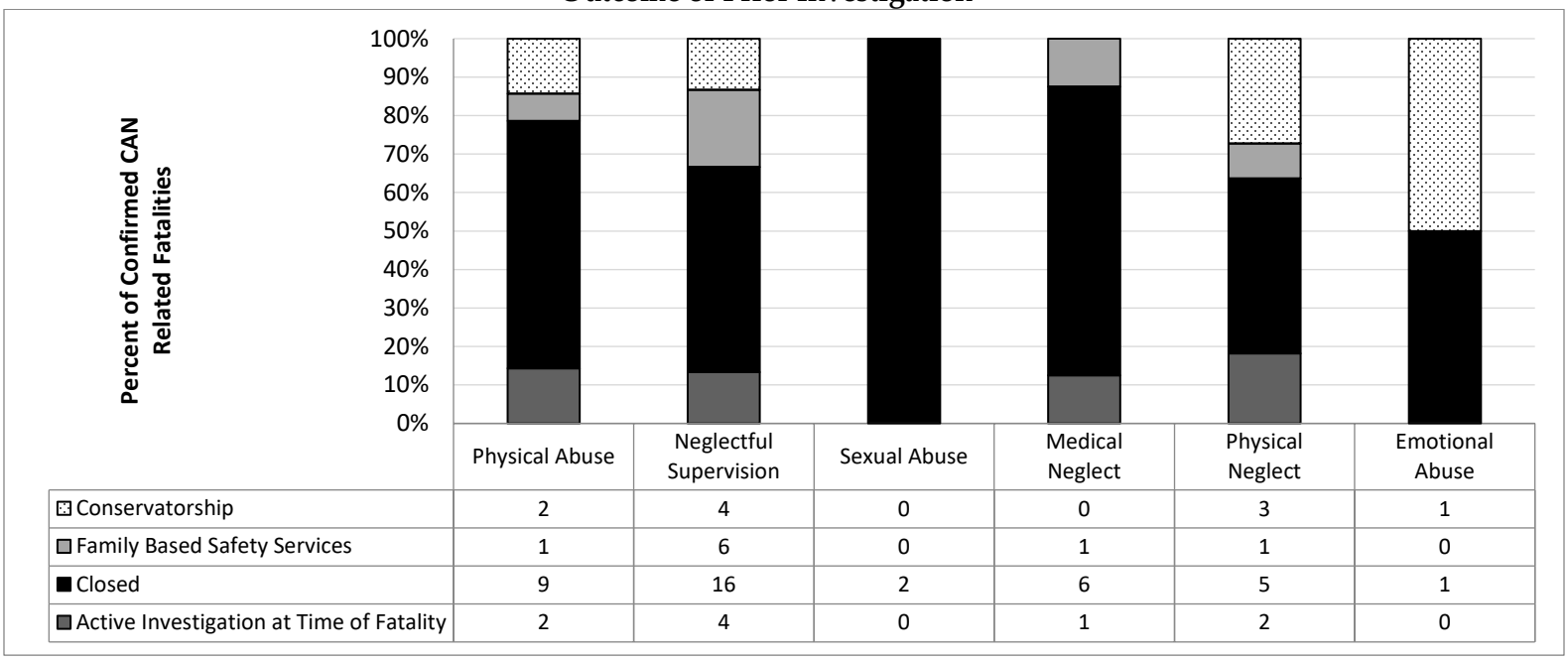
Figure 29. FY 2024 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or Child's Family in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Medical Neglect	Emotional Abuse	Physical Neglect
Unable to Complete	0	2	0	0	0	0
Reason to Believe	2	15	0	1	1	2
Unable to Determine	2	6	0	0	0	1
Ruled Out	5	14	3	5	0	5
Administrative Closure	1	2	0	0	1	2

Source: DFPS individual case reviews

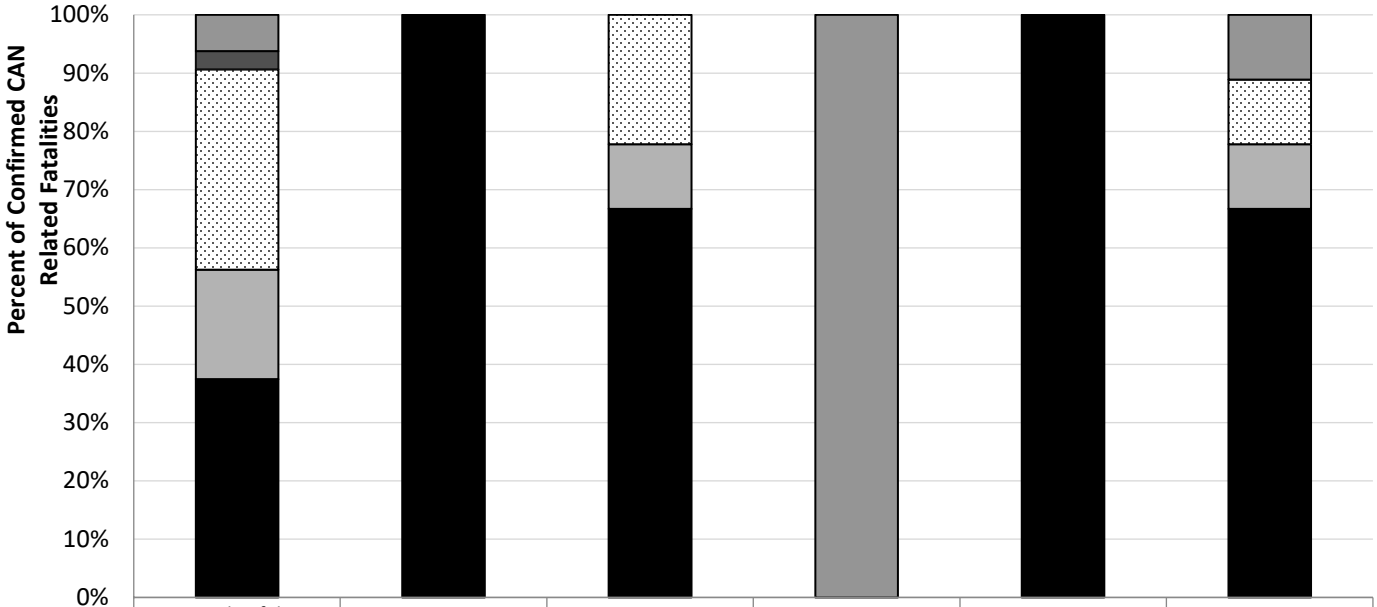
Figure 30. FY 2024 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or the Child's Family in the Two Years Prior to Fatality, by Outcome of Prior Investigation



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Medical Neglect	Physical Neglect	Emotional Abuse
Conservatorship	2	4	0	0	3	1
Family Based Safety Services	1	6	0	1	1	0
Closed	9	16	2	6	5	1
Active Investigation at Time of Fatality	2	4	0	1	2	0

Source: DFPS individual case reviews; an investigation may have more than one allegation type and disposition.

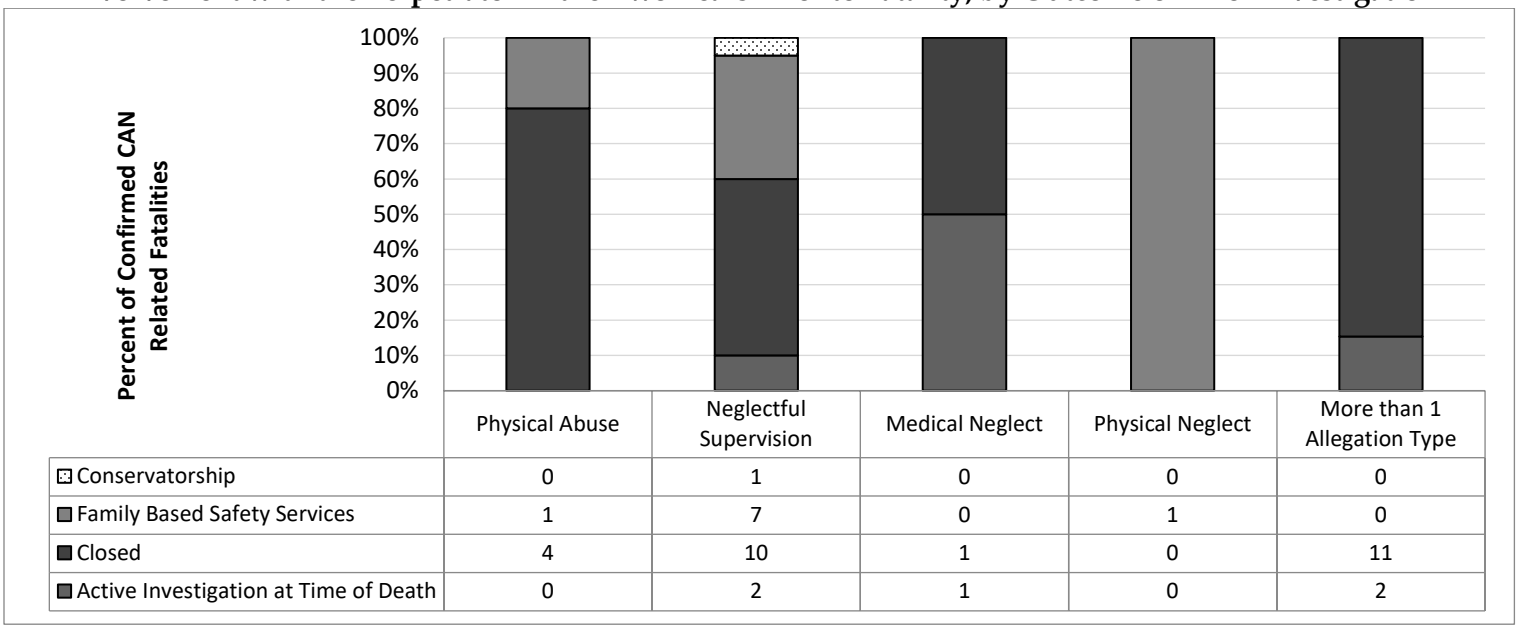
Figure 31. FY 2024 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Perpetrator in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



	Neglectful Supervision	Medical Neglect	Physical Abuse	Emotional Abuse	Sexual Abuse	Physical Neglect
Administrative Closure	2	0	0	1	0	1
Unable to Complete	1	0	0	0	0	0
Reason to Believe	11	0	2	0	0	1
Unable to Determine	6	0	1	0	0	1
Ruled Out	12	6	6	0	2	6

Source: DFPS individual case reviews; an investigation may have more than one allegation type and disposition.

Figure 32. FY 2024 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Perpetrator in the Two Years Prior to Fatality, by Outcome of Prior Investigation



	Physical Abuse	Neglectful Supervision	Medical Neglect	Physical Neglect	More than 1 Allegation Type
Conservatorship	0	1	0	0	0
Family Based Safety Services	1	7	0	1	0
Closed	4	10	1	0	11
Active Investigation at Time of Death	0	2	1	0	2

Source: DFPS individual case reviews

During the case review of confirmed child fatalities due to abuse and neglect, case history for two years prior to the fatality were reviewed. The prior allegation type was noted, regardless of overall disposition or outcome of the investigation involving the child or perpetrator.

Table 9. FY 2024 Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or Child's Family in the Two Years Prior to Fatality, by Prior Allegation Type and Cause of Fatality

	Drowning Related	Unsafe Sleep Related	Vehicle Related	Physical Abuse	Neglectful Supervision/ Other	Total
Prior Physical Abuse Allegation	**1**	**0**	**0**	**5**	**1**	**7**
Prior Neglectful Supervision Allegation	**6**	**4**	**3**	**10**	**5**	**28**
Prior Sexual Abuse Allegation	**0**	**0**	**0**	**2**	**0**	**2**
Prior Medical Neglect Allegation	**1**	**0**	**0**	**4**	**0**	**5**
Prior Physical Neglect Allegation	**0**	**1**	**0**	**4**	**0**	**5**
Total Child Fatalities with History with Child or Child's Family	**8**	**5**	**3**	**25**	**6**	**47**
No Prior History or History Greater than Two Years	*15*	*3*	*5*	*17*	*12*	*52*
Overall Total	*23*	*8*	*8*	*42*	*18*	*99*

Source: DFPS individual case reviews

Table 10. FY 2024 Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Perpetrator in the Two Years Prior to Fatality, by Prior Allegation Type and Cause of Fatality

	Drowning Related	Unsafe Sleep Related	Vehicle Related	Physical Abuse	Neglectful Supervision/ Other	Total
Prior Physical Abuse Allegation	**1**	**0**	**0**	**3**	**3**	**7**
Prior Neglectful Supervision Allegation	**4**	**3**	**2**	**9**	**6**	**24**
Prior Sexual Abuse Allegation	**0**	**0**	**0**	**1**	**0**	**1**
Prior Medical Neglect Allegation	**1**	**0**	**0**	**3**	**2**	**6**
Prior Physical Neglect Allegation	**0**	**1**	**0**	**5**	**2**	**8**
Prior Emotional Abuse Allegation	**0**	**0**	**0**	**0**	**1**	**1**
Prior Sex Trafficking	**0**	**0**	**0**	**1**	**0**	**1**
Abandonment	**0**	**0**	**0**	**0**	**1**	**1**
Total with History	**6**	**4**	**2**	**22**	**15**	**49**
No Prior History or History Greater than Two Years	*12*	*3*	*11*	*15*	*9*	*50*
Overall Total	*18*	*7*	*13*	*37*	*24*	*99*

Source: DFPS individual case reviews

Child Fatality Case Summary

As part of this annual report and ongoing program review, the Office of Child Safety conducts in-depth reviews for child fatalities occurring when the child is involved with DFPS in an open stage (Investigations, Family Based Safety Services, or Conservatorship) and death is confirmed to be caused by abuse or neglect.

In FY2024, there were 13 confirmed child fatalities due to abuse or neglect that occurred during an active stage of service with DFPS. For each of those children, a short description of the involvement is included below.

- Thalia was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on January 13, 2024, due to concerns of neglectful supervision. Another intake was received on March 4, 2024, due to concerns of neglectful supervision and physical abuse of Thalia and her sibling after Thalia was found unresponsive. Thalia died on March 4, 2024, as a result of physical neglect.

- Jackson was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on September 27, 2023, due to concerns of neglectful supervision and physical neglect of Jackson. Another intake was received on November 6, 2023, due to concerns of physical abuse of Jackson. During the investigation, Jackson died on November 6, 2023, after being found unresponsive with signs of physical trauma.

- Ailyn was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on June 27, 2023, alleging neglectful supervision of Ailyn's 2-year-old sibling who was able to leave the home and was found standing in a street. During the investigation, Ailyn died on October 11, 2023. Ailyn was left unsupervised outside and was struck by a vehicle in her driveway.

- Harmani was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on February 20, 2024, due to concerns of medical neglect. During the investigation, Harmani died on March 4, 2024. Harmani was found unresponsive and died of alcohol poisoning.

- Derek was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation opened April 18, 2024, due to concerns of neglectful supervision of Derek and neglectful supervision and physical abuse of another child in

the home. During the investigation, Derek died on May 19, 2024, after being found deceased at home. Derek died due to an overdose of an over-the-counter medication.

- Delilah was involved in open Child Protective Investigations (CPI) and open Family Based Safety Services (FBSS) stages at the time of the fatality. The investigation was initiated on October 14, 2023, alleging domestic violence that occurred in Delilah's presence. The FBSS stage was opened December 6, 2023. During the FBSS stage, Delilah died on December 13, 2023. Delilah was found unresponsive after co-sleeping with her mother and a friend, who were under the influence of illegal substances and alcohol.

- Amir was involved in an open CPS Family Based Safety Services (FBSS) case at the time of the fatality. The FBSS stage was opened on June 13, 2023, due to concerns of neglectful supervision of Amir. During the FBSS case, Amir died on September 23, 2023. Amir died as a result of malnutrition in conjunction with blunt force injuries.

- Aniyah was involved in an open CPS Family Based Safety Services (FBSS) case at the time of the fatality. The FBSS case was opened on October 23, 2023, due to concerns of neglectful supervision of Aniyah and her siblings. During the FBSS case, Aniyah died on August 24, 2024, after being found unresponsive in the bathtub. Aniyah died as a result of drowning.

- Kymbreal was involved in an open Family Based Safety Services (FBSS) case at the time of the fatality. The FBSS stage opened April 3, 2024, due to concerns of physical neglect of Kymbreal and a sibling. During the FBSS stage, Kymbreal died on August 27, 2024, after being found unresponsive at her home. Kymbreal died of a severe asthma attack.

- Elena was involved in an open CPS Family Based Safety Services (FBSS) case at the time of the fatality. The FBSS stage was opened on June 28, 2024, due to concerns of neglectful supervision of Elena. During the FBSS case, Elena died on August 1, 2024. The fatality investigation was initiated on this date as Elena had been found unresponsive in an unsafe sleep environment.

- Ayria was involved in an open CPS Family Based Safety Services case at the time of the fatality. The FBSS stage was opened on October 26, 2023, due to concerns of neglectful supervision of Ayria and her siblings. During the FBSS case, Ayria died on February 6, 2024. Ayria was hit by a motor vehicle while running in a motel parking lot and did not survive the injuries caused by the accident.

- Infant was involved in an open CPS conservatorship (CVS) case at the time of the fatality. Infant entered foster care on July 11, 2023, due to concerns for neglectful supervision. Infant died on October 25, 2023. The fatality investigation was initiated on this date as Infant had been found unresponsive in an unsafe sleep environment.

- Benson was involved in an open CPS conservatorship (CVS) case at the time of the fatality. Benson entered foster care on December 7, 2023. The fatality investigation was initiated on July 25, 2024, after Benson was found unresponsive and died on July 24, 2024. He was residing with a relative at the time of the incident. Benson died due to congenital anomalies complicated by drug toxicity.

Child Fatalities Not Caused by Abuse and Neglect but Abuse or Neglect Confirmed Overall

The Federal Child Abuse Prevention and Treatment Act (CAPTA) and Texas Family Code (Tex. Fam. Code), Section 261.203 and Tex. Fam. Code, Section 261.204) require that specific information about fatalities *caused by or the result of* abuse or neglect be reported. The Texas Family Code considers all other information to be confidential. (Tex. Fam. Code, Section 261.201) As a result, case specific details on child fatalities where abuse or neglect was not the cause of the fatality cannot be individually reported. Utilizing aggregate information to analyze child fatalities in which abuse or neglect occurred but did not cause the fatality can help target specific prevention and intervention services both in the community and by DFPS contractors. It is important to remember that dispositions in child fatality investigations are reviewed by several levels of management and rely heavily on medical personnel and law enforcement.

Further analysis and individual case readings in these types of investigations are a useful tool to inform strategies to prevent child fatalities and ensure consistency in investigations in which a child fatality has occurred. These cases continue to have similar demographics in FY 2024 as confirmed child fatalities caused by abuse and neglect in previous years: the victim is often three months of age or younger, and there is a component of neglectful supervision. Many situations involve premature delivery of a newborn child (unrelated to suspected abuse or neglect) alongside other concerns in the home that rise to the level of confirmed maltreatment.

General Findings

- In FY 2024, there were 61 child fatalities where the death was not related to abuse or neglect, but the investigation found abuse or neglect had occurred in the home.
- 43 child fatalities where the death was not related to abuse or neglect had some form of prior history, with 70 percent of those cases occurring in the past two years.
- Most child fatalities that were not found to be abuse or neglect related are due to health-related issues, followed by deaths determined by the medical examiner as unable to determine.
    - The cause of death in 27 of the confirmed cases were: health-related, accidental suffocation, vehicle-related, and sudden unexplained infant death.
    - Two children died due to poisoning/toxicity of illicit substances.
    - The other investigations involved a fatality where the cause of death was undetermined.

Victim Children

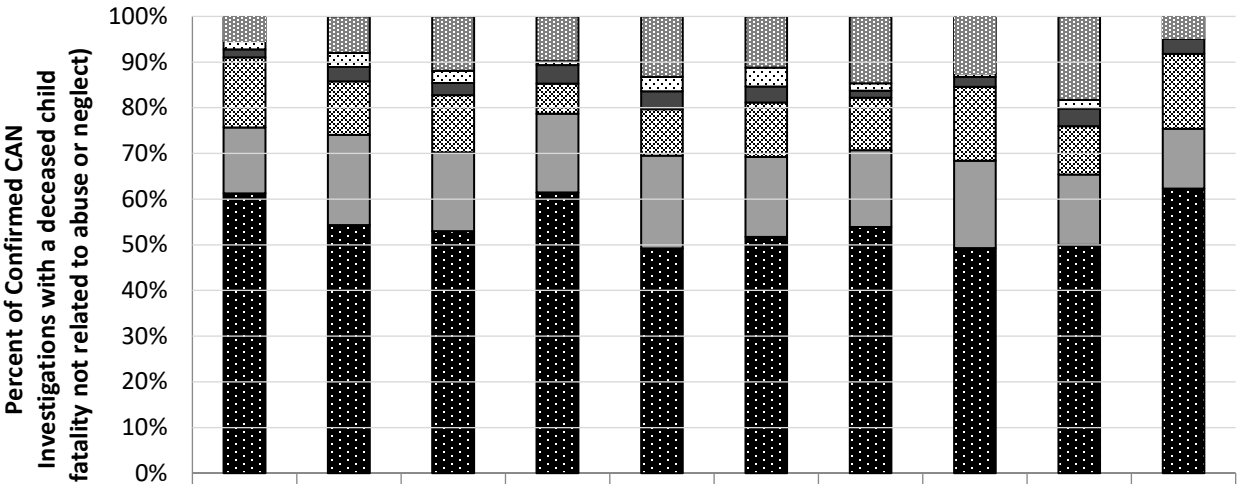
- 6 of the 61 children were previous alleged victims but allegations were not confirmed in prior cases.

- 6 of the 61 children were previously confirmed victims in prior cases.
- 8 of the 61 children were involved in Family Based Safety Services previously and three had been involved in DFPS conservatorship.

Perpetrators

- 11 of the confirmed perpetrators were previously alleged perpetrators but allegations were not confirmed in prior cases.
- 26 of the confirmed perpetrators were previously confirmed perpetrators in prior cases.

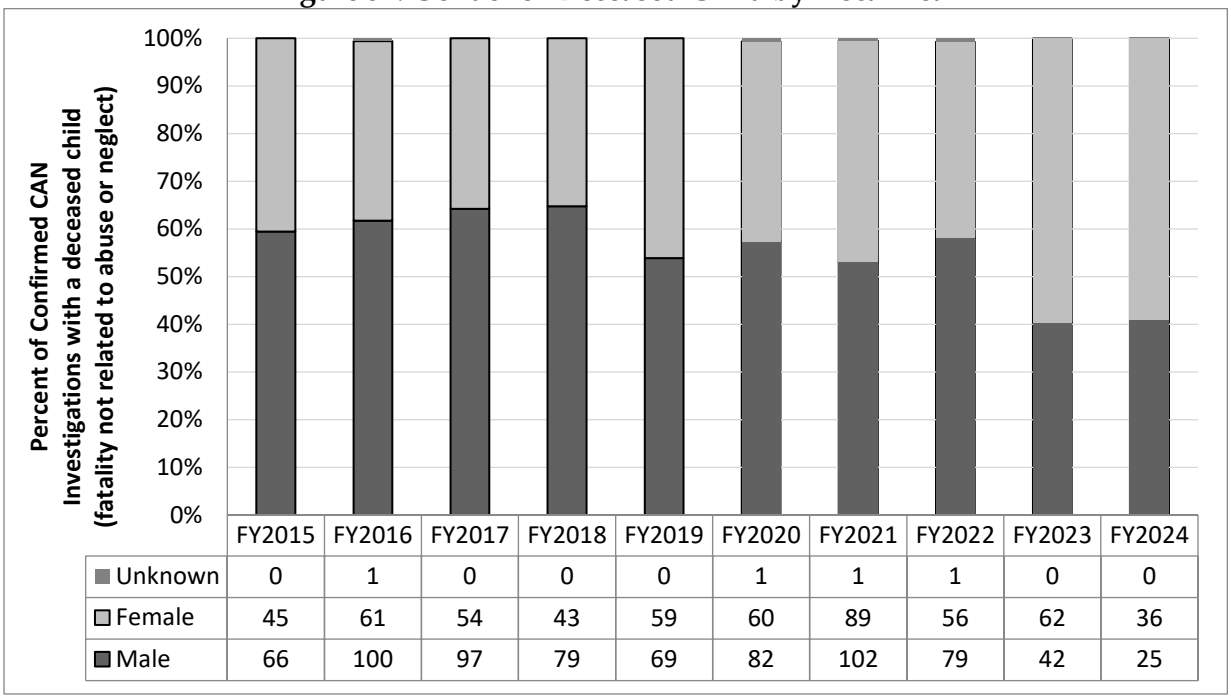
Figure 33. Age of Child at Death by Fiscal Year



	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
10-17 years	6	13	18	12	17	16	28	17	19	3
7-9 years	2	5	4	1	4	6	3	1	2	0
4-6 years	2	5	4	5	5	5	3	3	4	2
1-3 years	17	19	19	8	13	17	22	22	11	10
4m to 12m	16	32	26	21	26	25	32	26	16	8
newborn - 3m	68	88	80	75	63	74	103	67	52	38

Source: DFPS Data Warehouse Report ft_12

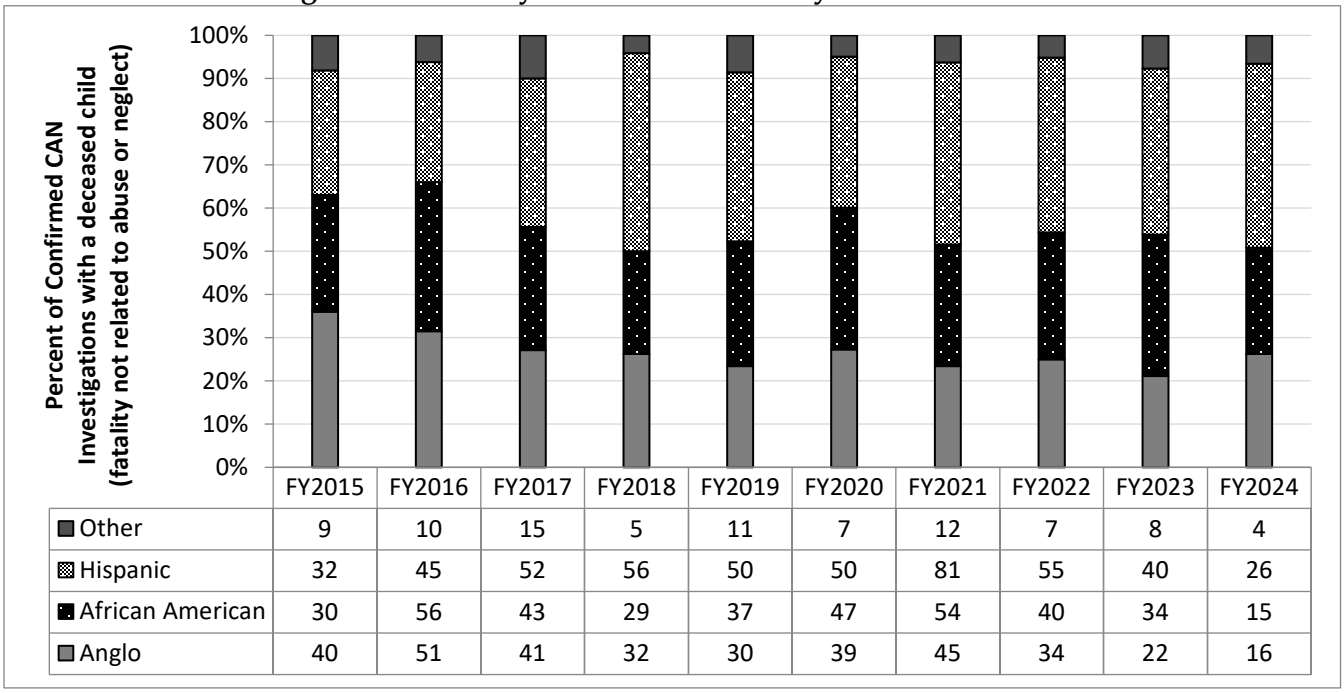
Figure 34. Gender of Deceased Child by Fiscal Year



	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Unknown	0	1	0	0	0	1	1	1	0	0
Female	45	61	54	43	59	60	89	56	62	36
Male	66	100	97	79	69	82	102	79	42	25

Source: DFPS Data Warehouse Report ft_12

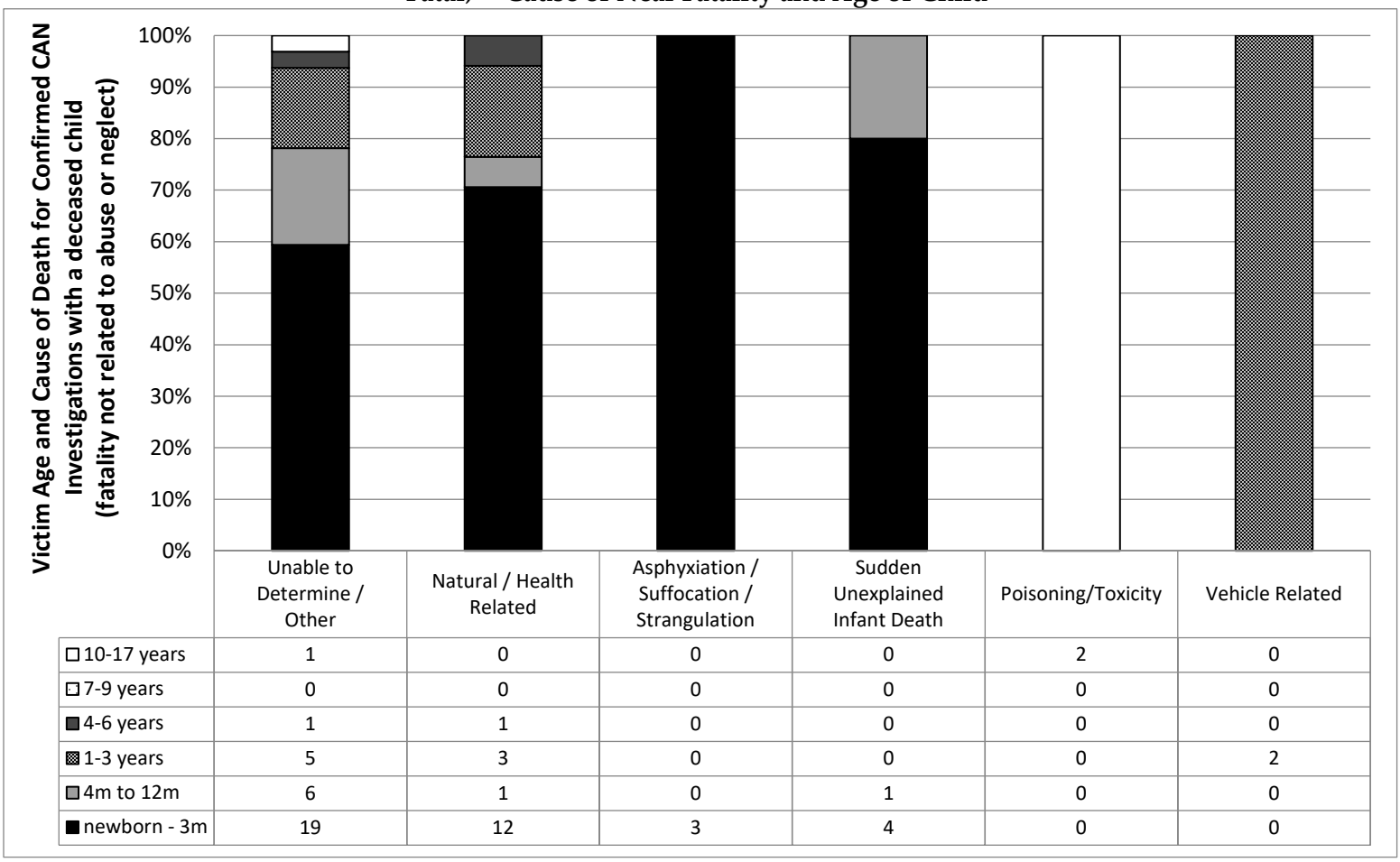
Figure 35. Ethnicity of Deceased Child by Fiscal Year



	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Other	9	10	15	5	11	7	12	7	8	4
Hispanic	32	45	52	56	50	50	81	55	40	26
African American	30	56	43	29	37	47	54	40	34	15
Anglo	40	51	41	32	30	39	45	34	22	16

Source: DFPS Data Warehouse Report ft_12

Figure 36. FY 2024 - Investigated Child Fatalities that were not Abuse and Neglect Related Fatality but Maltreatment Confirmed in Investigation (RTB with Severity Type Other than Fatal) -- Cause of Near Fatality and Age of Child



	Unable to Determine / Other	Natural / Health Related	Asphyxiation / Suffocation / Strangulation	Sudden Unexplained Infant Death	Poisoning/Toxicity	Vehicle Related
10-17 years	1	0	0	0	2	0
7-9 years	0	0	0	0	0	0
4-6 years	1	1	0	0	0	0
1-3 years	5	3	0	0	0	2
4m to 12m	6	1	0	1	0	0
newborn - 3m	19	12	3	4	0	0

Source: DFPS Data Warehouse Report ft_12

Child Fatalities in Texas within the National Context

Varying definitions of abuse and neglect among states: The Children's Bureau of the U.S. Department of Health and Human Services publishes *Child Maltreatment*[11], an annual report comprising data from the National Child Abuse and Neglect Data System (NCANDS). While this data allows for some comparison between the states that report, there are several areas where states differ in reporting such as inconsistent definitions of abuse/neglect, variation in the definition of previous history, and states limiting reportable child fatalities to only those children already known to or actively involved in the child welfare system.[12]

Texas' definition of abuse and neglect is broad: Texas addresses these issues by having very broad abuse and neglect definitions and mandatory reporting so that any child fatality alleged to involve abuse or neglect, either while the child was alive or as part of the fatality itself, is investigated and reported to NCANDS if the death is a confirmed child abuse or neglect related fatality. Texas is able to do this through:

- requiring any person who believes that a child has been or may be abused or neglected or has died of abuse or neglect to report his or her concerns, with a heightened reporting requirement for professionals; [13]
- investigating any report of child abuse or neglect allegedly committed by a person responsible for a child's care, custody, or welfare; [14]
- including in the definition of child abuse and neglect the use of a controlled substance[15] and defining medical neglect as the failure to *seek, obtain, or follow through* with medical care for the child;[16] and
- defining prior history very broadly.

Defining prior history: While other states limit prior history to those cases with previous investigations, direct service delivery, or conservatorship of the child within a certain time, Texas does not limit either the time or type of involvement when reporting history. Texas defines prior history as, at the time of the child fatality, either the deceased child or a designated perpetrator in the fatality had been in an investigation or received CPS services before the child's death. According to this definition, it counts as prior CPS history even if the last contact with CPS was several years before the death, the perpetrator was involved with a different family, the deceased child was not yet born, or if the history was completely unrelated to the circumstances of the fatality.

Per capita rate: Given the broad definitions in Texas, the Texas per capita rate for child abuse and neglect fatalities (rate per 100,000 children in the child population), has been higher than the national average. For federal fiscal year 2023 (the most recent year reported for all states), the Texas rate was 2.0 confirmed child abuse and neglect related fatalities per 100,000 compared to a national average of 2.73 confirmed child abuse and neglect related fatalities per 100,000. It is important to note that for federal reporting, not all states report data and child fatalities are

reported during the federal fiscal year in which the death was determined to have been caused by maltreatment which is not necessarily the year in which the child died. Additionally, there are not common reporting and definition requirements when calculating child fatalities and it has been estimated that as many as 50 percent to 60 percent of child deaths resulting from abuse or neglect are not recorded as such.[17] Some states do not even report at all; for example, in the annual federal *Child Maltreatment 2018* report, Massachusetts did not report on child fatalities and other states only report fatalities where they had been involved with the family within certain timeframes or only specific causes of death.

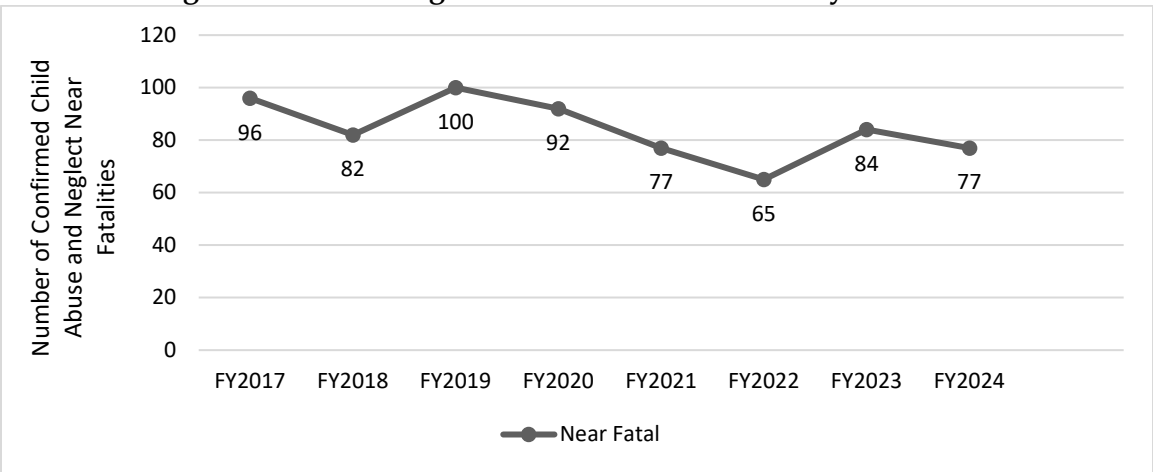
Near Fatalities

In FY 2024, Texas had 77 confirmed abuse and neglect-related near fatalities. The most common cause of abuse and neglect-related near fatalities involved physical abuse to include blunt force, inflicted trauma and abusive head injury, which accounted for 50.64 percent of the near fatalities in FY2024.

During FY 2024, children aged three and younger accounted for 79.2 percent of the confirmed child abuse and neglect-related near fatalities. Hispanic children comprised the largest percentage of children who experienced a near fatal incident due to abuse or neglect at 46.75 percent. Female children made up 53.2 percent of all confirmed near fatalities.

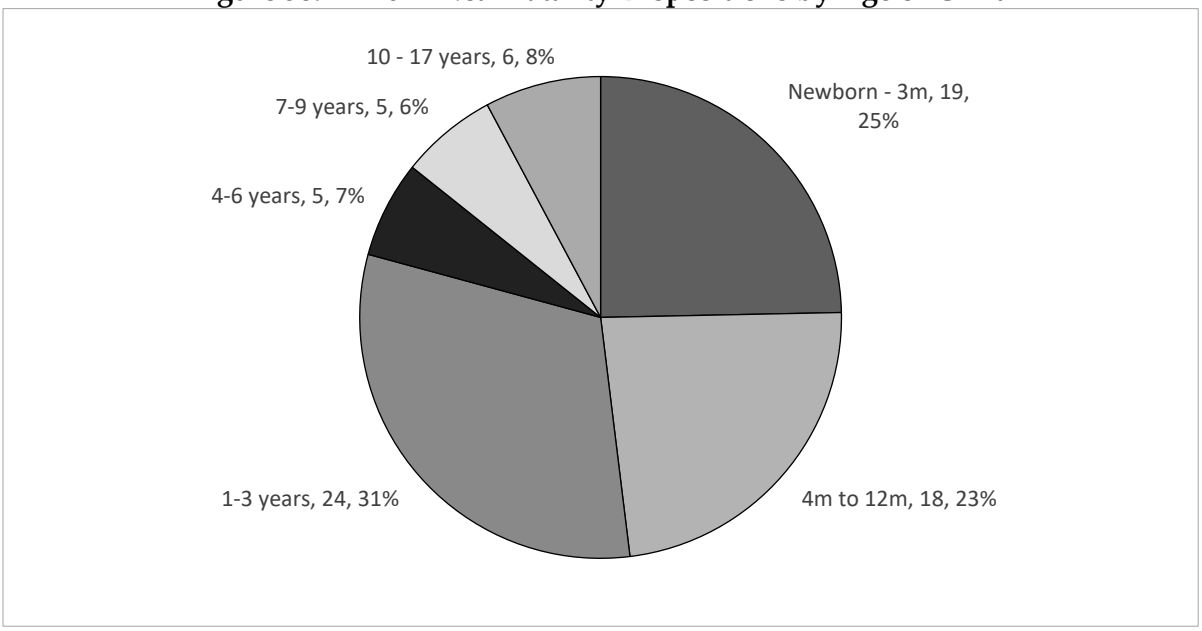
The highest number of abuse and neglect-related near fatalities were seen in Region 3 (Dallas/Ft. Worth) with 28 near fatalities. Region 8 (San Antonio) had 14, while Region 6 had 9 confirmed near fatalities.

Figure 37. Abuse/Neglect Related Near Fatalities by Fiscal Year



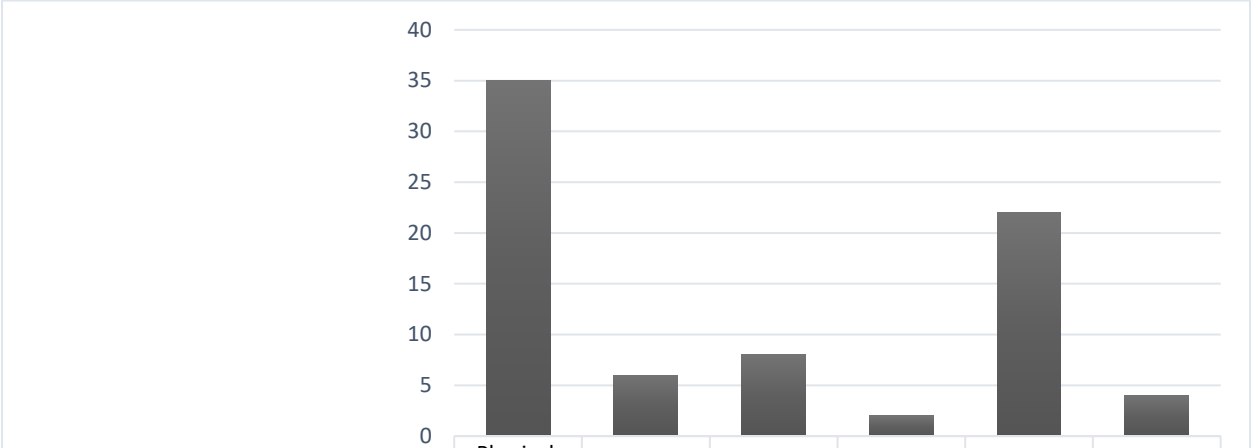
Source: DFPS individual case reviews

Figure 38. FY 2024 Near Fatality Dispositions by Age of Child



Source: DFPS individual case reviews and Data Warehouse nf_01

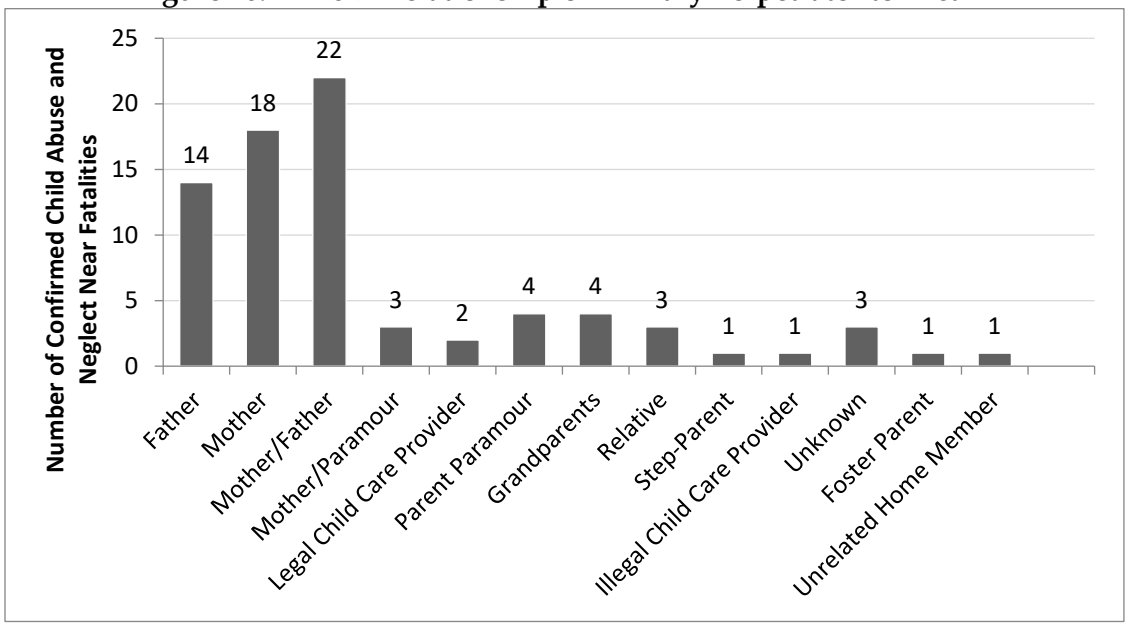
Figure 39. FY2024 –Near Fatality Dispositions by Cause



	Physical Abuse - Blunt Force & Inflicted Trauma	Vehicle Related	Medical Neglect	Non-Fatal Drowning	Neglectful Supervision	Physical Neglect
General Cause of Confirmed Child Abuse or Neglect Fatalities in FY2024 - Statewide	35	6	8	2	22	4

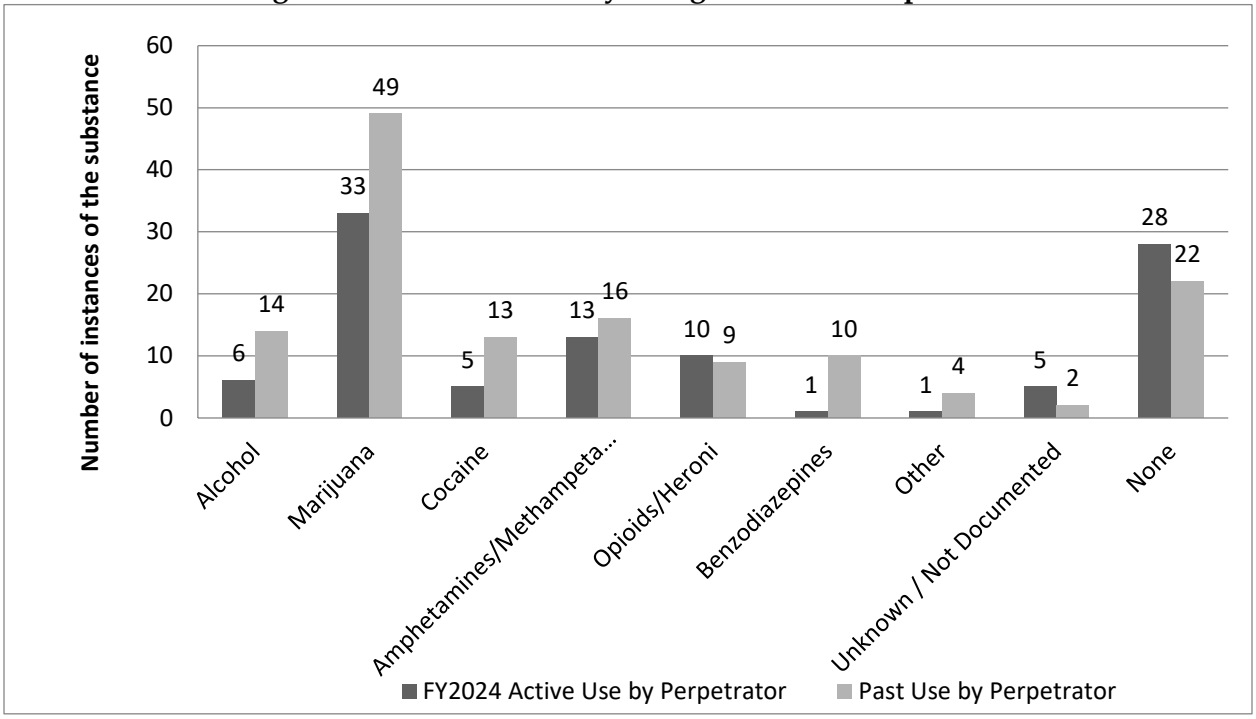
Source: DFPS individual case reviews

Figure 40. FY 2024 Relationship of Primary Perpetrator to Victim



Source: DFPS individual case reviews

Figure 41. Substance Use by Caregiver and/or Perpetrator



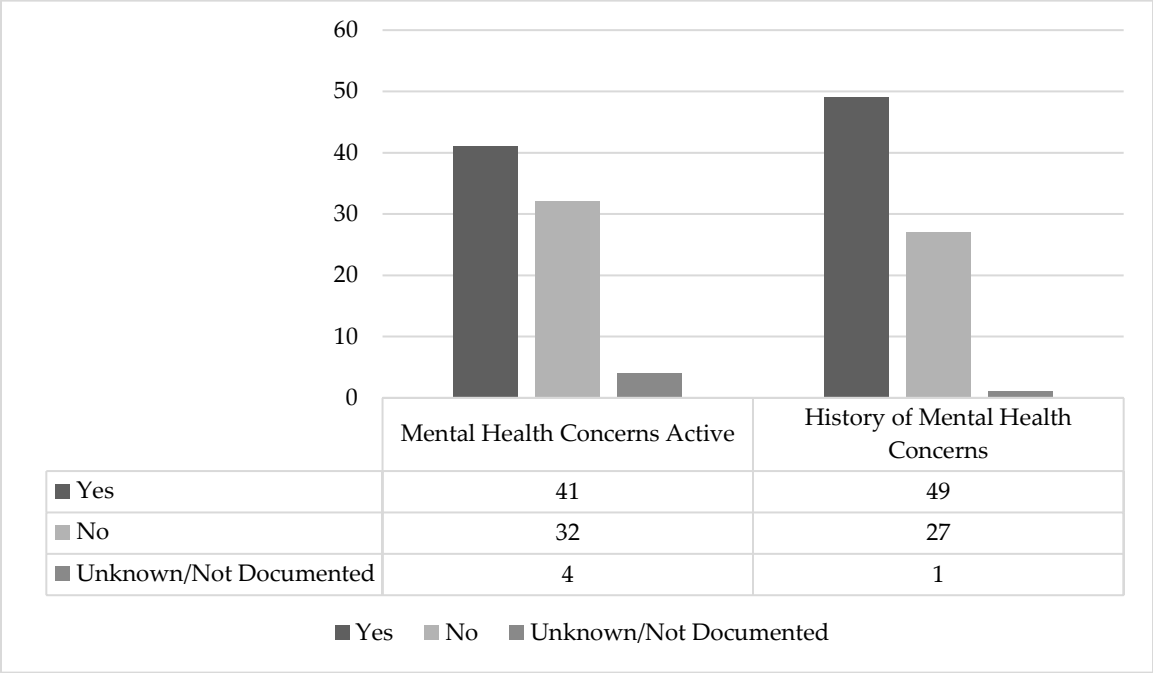
Source: **DFPS individual case reviews Note: Some individuals had multiple substances recorded in both active and history.**

Table 11. FY 2024 Active Domestic Violence Concerns for Caregiver and/or Perpetrator

Domestic Violence Concern	Active	Past History	Both Active and Past History
Total Number of Parents/Caregivers Reporting Domestic Violence	**31**	**37**	**19**
No	**44**	**36**	**-**
Unknown (not identified in case read)	**2**	**4**	**-**

Source: DFPS individual case reviews

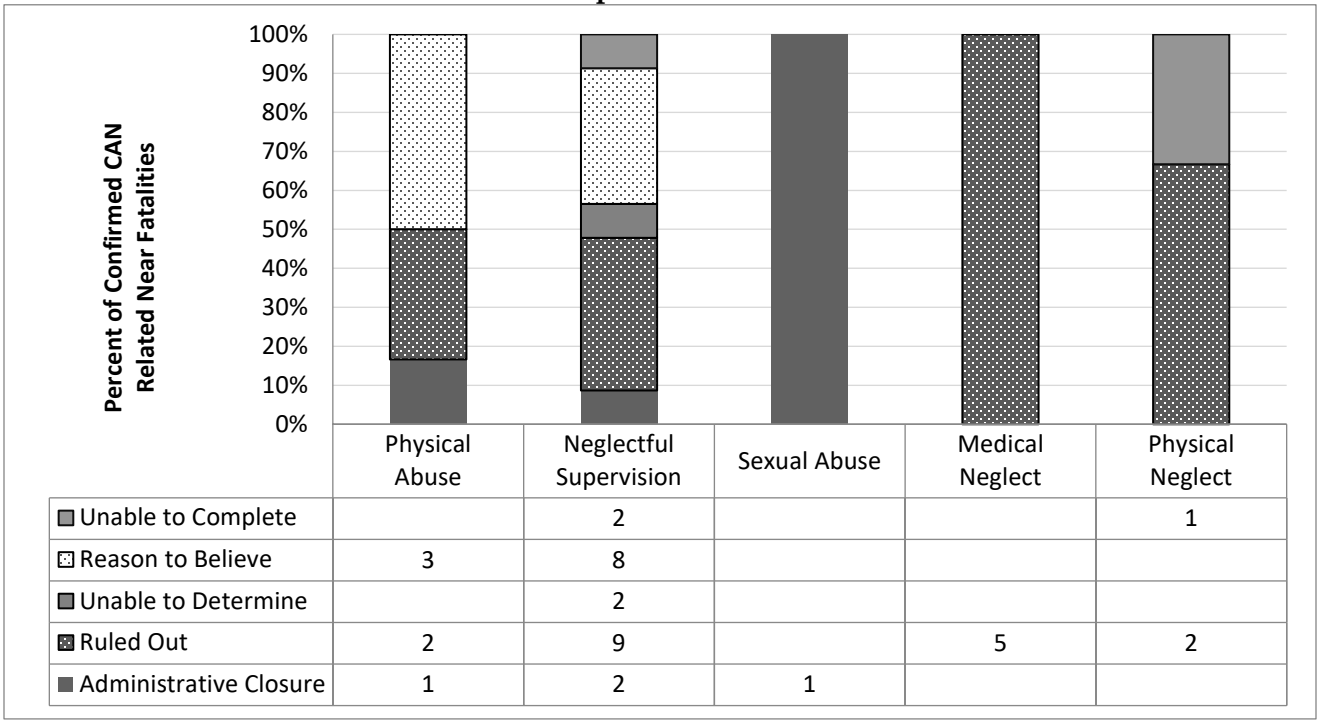
Figure 42. FY 2024 Mental Health for Caregivers and/or Perpetrator



	Mental Health Concerns Active	History of Mental Health Concerns
Yes	41	49
No	32	27
Unknown/Not Documented	4	1

Source: DFPS individual case reviews

Figure 43. FY 2024 CPS History for Confirmed Near Fatalities – CPS Involvement with the Child or Child's Family in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Medical Neglect	Physical Neglect
Unable to Complete		2			1
Reason to Believe	3	8			
Unable to Determine		2			
Ruled Out	2	9		5	2
Administrative Closure	1	2	1		

Source: DFPS individual case reviews

In 34 near fatalities, the family had prior history with the department.

- 9 families had prior investigations that were closed without ongoing DFPS involvement.
- 7 families had an open stage of service: Three open investigations, three had open FBSS stages, and one in DFPS Conservatorship. 100-percent of initial contacts were completed timely. Six of the near fatality cases had one worker assigned per stage, and one of the open FBSS stages had been assigned to three different caseworkers.
- 18 families had prior FBSS involvement. 16 of the families had a safety plan in place during the involvement. 87.5-percent of families reportedly complied or partially complied with their safety plan during services.
    - On average, families were seen monthly, with their involvement in FBSS ranging from three months to one-year. In general, initial visits were made timely as the policy and practice is to work collaboratively with Investigations and the family to engage in FBSS services at case transfer.
        - Services offered in the previous or open stage include:
            - Counseling for family, individual, or group: 11 cases
            - Daycare or respite care: 2 cases

- Domestic violence shelter or counseling: 1 case
- Drug testing or treatment: 14 cases
- Housing (rent, section 8, etc.): 1 case
- Infant or early childhood screening or development- 8 cases
- Mental health (psychological testing, mental health assessment or treatment, referral to local mental health authority): 7 cases
- Parenting skills / evidence-based parent education: 7 cases
- Physical health (medical and dental, i.e. Medicaid, TX Health Steps, CHIPS, TX Healthy Kids Corporation, local health resources, etc)- 1 case
- Support groups (Such as Parents Anonymous, AA, ALANON, etc)- 1 case

- In 6 of the 77 near fatalities, the family had prior involvement through DFPS Conservatorship.
- In 25 of the 34 cases with prior history, initial contacts were made timely in 73.5 percent of the qualifying investigations.

Statewide Internal and External Child Fatality Review

DFPS works collaboratively with communities and state agencies to reduce child abuse and neglect overall, with a focus on addressing child abuse and neglect-related fatalities. Also, several national and state efforts are currently under way to address child fatalities.

Child Safety Review Committee - DFPS Review Team with External Stakeholders

The Child Safety Review Committee (CSRC) examines issues that have implications for CPI or CPS policy and practice. It consists of internal and external stakeholders. The group reviews all information collected by each Regional Child Death Review Committee and makes recommendations to CPI and CPS based on those trends and patterns. Recommendations from the CSRC have included training and additional resources for working with families with active substance abuse, domestic violence/intimate partner violence, and children with special medical needs.

DSHS State Child Fatality Review Team Committee (SCFRT) - Volunteer Team with DFPS and DSHS membership

The State Committee is a multidisciplinary group comprised of members throughout Texas.[18] Its mission is to reduce the number of preventable child deaths and its purpose is threefold:

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

DSHS publishes an annual report from the SCFRT. The most recent report is the State Child Fatality Review Team Committee Biennial Report – April 2022.[19]

Local Child Fatality Review Teams (CFRT) - Volunteer Teams with DFPS and DSHS membership

CFRTs are multidisciplinary, multiagency working groups that review child deaths on a local level from a public health perspective. By reviewing circumstances surrounding child deaths, teams identify prevention strategies that will decrease the incidence of preventable child deaths by:

- Providing assistance, direction, and coordination to investigations of child deaths;
- Promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities;
- Developing an understanding of the causes and incidence of child deaths in the county or counties in which the team is located;

- Recommending changes to agencies, through the agency's representative member, that will reduce the number of preventable child deaths; and
- Advising the State Committee on changes to law, policy, or practice that will assist the team and the agencies represented on the team in fulfilling their duties.

Texas CFRTs vary in size and the number of counties for which they review child deaths. Several teams each review deaths for one county while others review deaths for two or more. The largest number of counties any single Texas team covers is 26.

Protect Our Kids Commission

During the 83rd Texas Legislature, Senate Bill 66 established the Protect Our Kids Commission and tasked the Commission with studying the relationship between CPS, child welfare services, and the rate of child abuse and neglect fatalities. The Commission identified necessary resources and developed recommendations to reduce child abuse and neglect fatalities that can be implemented at the local and state level. DFPS served as one of the 15 members on the Commission. Recommendations from the Protect Our Kids Commission include:

- Prioritize prevention services using a geographic focus for families with the greatest needs.
- Utilizing a DFPS advisory board to make recommendations for a state strategy to promote child safety and well-being.
- Supporting local Child Fatality Review Teams to ensure coordination, training, and consistency as well as better utilization of the State Child Fatality Review Team.
- Using data to inform a public health approach to preventing child fatalities

The Protect Our Kids Commission report is available at:
https://texaschildrenscommission.gov/media/zd2h5ywi/pdf-report-pok-commission-december-2015.pdf

National Initiatives and Program Improvement

Federal Commission for the Elimination of Child Abuse and Neglect Fatalities

Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF), is charged with developing a national strategy and recommendations for reducing child abuse and neglect fatalities. DFPS presented to CECANF in June 2014 at their first national meeting in San Antonio. This meeting was focused on gathering information related to federal policy's impact on the state/local level, current data and research, and policy/practice associated with child abuse and neglect fatalities. Texas continues to participate in CECANF's ongoing meetings and work closely with other states to help create a national standard in defining child abuse and neglect, requirements for reporting, and addressing child fatalities from a public health perspective.

The final report from the Federal Commission for the Elimination of Child Abuse and Neglect Fatalities is available at:
https://www.acf.hhs.gov/sites/default/files/documents/cb/cecanf_final_report.pdf

Endnotes

[1] Casey Family Programs. (2018). *Safe Children: How does investigation, removal, and placement cause trauma for children?* Retrieved from https://www.casey.org/media/SC_Investigation-removal-placement-causes-trauma.pdf.

[2] Administration for Children, Youth and Families. (2024). *Trends in Foster Care and Adoption: FY 2013-2022.* Retrieved from Trends in Foster Care and Adoption: FY 2013 – 2022 | The Administration for Children and Families.

[3] DFPS Data Warehouse SA_05, Warehouse Data as of: 12/07/2024, Report Run Date: 1/10/2025.

[4] DFPS will review and complete an investigation on any child who dies within DFPS conservatorship or an open stage of service such as investigations or family preservation when the fatality is alleged to be from abuse or neglect or had injuries previously investigated, and then subsequently succumbs to those injuries are included in the year of his or her death.

[5] U.S. Department of Health and Human Services, Administration of Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). *Child Maltreatment 2022*. Available at https://www.acf.hhs.gov/cb/report/child-maltreatment-2022

[6] Casey Family Programs. (2018). *Safe Children: How does investigation, removal, and placement cause trauma for children?* Retrieved from https://www.casey.org/media/SC_Investigation-removal-placement-causes-trauma.pdf.

[7] Administration for Children, Youth and Families. (2024). *Trends in Foster Care and Adoption: FY 2013-2022.* Retrieved from Trends in Foster Care and Adoption: FY 2013 – 2022 | The Administration for Children and Families.

[8] DFPS Data Warehouse SA_05, Warehouse Data as of: 12/07/2024, Report Run Date: 1/10/2025.

[9] See SB1050 enrolled bill at:
http://www.legis.state.tx.us/tlodocs/81R/billtext/html/SB01050F.htm

[10] See US Centers for Disease Control and Prevention at:
https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html

[11] *Child Maltreatment 2022*, https://www.acf.hhs.gov/cb/report/child-maltreatment-2022

[12] U.S. Government Accountability Office. (2011). *Child maltreatment: Strengthening national data on child fatalities could aid in prevention*. Retrieved from http://
www.gao.gov/new.items/d11599.pdf

[13] Tex. Fam. Code §261.102 Matters to be Reported, Section 261.101 Persons Required to Report; Time to Report.

[14] Tex. Fam. Code §261.301 Investigation of Report.

[15] Substance abuse is often a determining factor in child fatality cases, especially in situations where the child dies from positional asphyxiation or overlay from sharing a sleep surface with an intoxicated parent or in cases involving neglectful supervision of the child such as drowning, car accidents, and firearm fatalities.

[16] Tex. Fam. Code §261.001 Definitions

[17] Child abuse and neglect fatalities: Statistics and Interventions. Child Welfare Information Gateway. 2019. Available at: https://www.childwelfare.gov/pubs/factsheets/fatality/

[18] DSHS State Child Fatality Review Team Members, https://www.dshs.state.tx.us/mch/child_fatality_review.shtm?terms=SCFRT

[19] Texas Child Fatality Data and Recommendations – April 2022, https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/State_Child_Fatality_Review_Team_Committee_Biennial_Report_for_2022.pdf