TEXAS
Department of Family
and Protective Services

Fiscal Year 2021
Child Maltreatment Fatalities and Near Fatalities Annual Report

March 1, 2022

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Executive Summary

With over seven million children in Texas, the safety net that exists to protect children and help them reach their greatest potential begins at home. It includes family, neighbors, schools and communities. In FY2021, this safety net continued to face multiple stressors as COVID-19 impacted children, youth, and families in ways not previously experienced. Child fatalities decreased in FY2021 by twenty percent. This includes significant decreases in unsafe sleep, drownings, vehicle-related fatalities, as well as physical abuse fatalities. In this past year, Texas experienced one child left in a hot car, a number that puts in context that preventable child fatalities can be reduced over time through prevention messaging and diligent efforts in the community. The impact of the past two years on youth is also emerging in the data--in FY2021, thirteen youth died by suicide, a devastating loss for families and their community.

To address child maltreatment before it starts and protect children from future harm, the Texas Department of Family and Protective Services (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. Half

of all child maltreatment fatalities in FY2021 had no prior involvement with DFPS; this highlights the importance of community in child protection and well-being. 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. Additionally, through Prevention and Early Intervention, DFPS uses prevention strategies to address the needs of families at high risk for child maltreatment through a continuum of services such as home visiting, parent education, youth development, mentoring and education, and support services.

The DFPS Office of Child Safety produces this annual report in accordance with Texas Family Code §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 child care settings.

Based on administrative data and individual case reviews for confirmed child abuse and neglect related fatalities during FY2021, the following trends and areas for review have been identified:

General Findings

- In FY2021, 199 children died due to abuse and neglect in Texas (Table 1).
- In the vast majority of these cases – 177 – there was no CPI investigation or ongoing services stage open at that time, so there was no regular monitoring of the family occurring that could have protected the child (Figure 24).
- This year, 1 child died after being left in a hot car. This is down from a decade-high of eight children left in hot cars in FY2020 (Figure 3).
- There were decreases in the majority of causes of child fatalities including in physical abuse, vehicle-related, unsafe sleep, neglectful supervision, and drownings. There was an increase in the number of youth who died by suicide, increasing from eight fatalities in FY2020 to thirteen fatalities in FY2021 (Figure 3).
- There continues to be a high number of physical abuse fatalities after an all-time low in FY2017--but in the vast majority of those cases, abuse in the family was never reported to CPS, or CPS had not been involved with the family for two years, before the child fatally injured was born (Figure 4).
- The number of child fatalities investigated by DFPS increased from 826 in FY2020 to 964 in FY2021 (Figure 2).
- Confirmed neglect-related fatalities account for 64 percent of child maltreatment fatalities (Figure 4).
- The most common causes of fatalities involving neglect were drowning, unsafe sleep, and vehicle-related fatalities (Figure 7, 8).
- In FY2021, 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 ten fiscal years, children 3 years of age and younger were almost 80 percent of all confirmed child abuse and neglect fatalities; however, the past two years have had a marked increase in child fatalities involving older children. In FY2021, children 3 years of age and younger made up 64 percent of confirmed child abuse and neglect fatalities. In the past year, thirteen youth died by suicide. Male children made up more than half of all confirmed child abuse and neglect-related fatalities (Figure 9, 10).
- During FY2021, 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).
- 57 percent of children who died from abuse or neglect in FY 2021 were too young for school and not enrolled in day care. Three children were being cared for by illegal day care operations (Page 25).

Perpetrators

- Physical abuse in fatalities most commonly involved blunt force trauma or intentional trauma inflicted by a father or boyfriend (Figures 13-15).
- In all confirmed cases of abuse and neglect, parents continue to be the most common perpetrators (Figure 12).
- In 51.8 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had no 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 one of two major neglectful supervision issues: unsafe sleep or neglectful supervision. (Table 9, 10).

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

Child Fatality Investigations

The Department of Family and Protective Services (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.[1]

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/or deaths of children living with their families or who are in DFPS conservatorship and in non-foster care kinship placements (Child Protective Services placements). 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, an investigation will be completed. 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 abuse and neglect investigations, investigators are required by law to establish a preponderance of evidence in order to confirm an allegation of abuse and neglect. "Preponderance of evidence" is a standard of proof in which the facts more likely than not occurred. Sometimes this is referred to as the "51 percent" standard, a more stringent standard than reasonable doubt but less stringent than clear and convincing evidence.

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. In order 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 FY2010 through FY2013. In FY2014, the number of intakes assigned for investigation began to rise, with FY2021 being the highest in the past ten years.

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

	FY2017	FY2018	FY2019	FY2020	FY2021
Child Population of Texas	7,304,256	7,370,193	7,437,514	7,515,129	7,594,941
Number of Intakes Assigned for Investigation or Alternative Response by CPI	238,600	246,074	242,103	224,288	253,054
Number of Investigated Child Fatalities	807	785	772	826	964
Number of fatalities where abuse/neglect was confirmed	172	211	235	251	199
Child Fatality Rate per 100,000 Children	2.35	2.86	3.16	3.34	2.62
National Rate for Equivalent Federal Fiscal Year[2]	2.28	2.39	2.48	2.38	***

Source: Data from US Census Bureau; Texas State Data Center; DFPS Data Books FY2010-FY 2021; 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 2021 – estimates were updated during FY2019 for population from 2010 through 2019.

*** Child Maltreatment 2021 is scheduled to be released after the publishing of this report. National rates were recalculated in Child Maltreatment 2021 report.

Regarding child fatality investigations, the number of child fatalities reported to DFPS and investigated declined between FY2010 and FY2020 by 19 percent. In FY2021, there was a 16.7 percent increase in the number of child fatalities reported to DFPS for investigations. The percent of confirmed child abuse and neglect-related fatalities have varied between 21 percent and 30.4 percent in the past five years, with FY2021 at 20.64 percent of all investigated fatalities being related to maltreatment. The distribution of case dispositions for child fatality

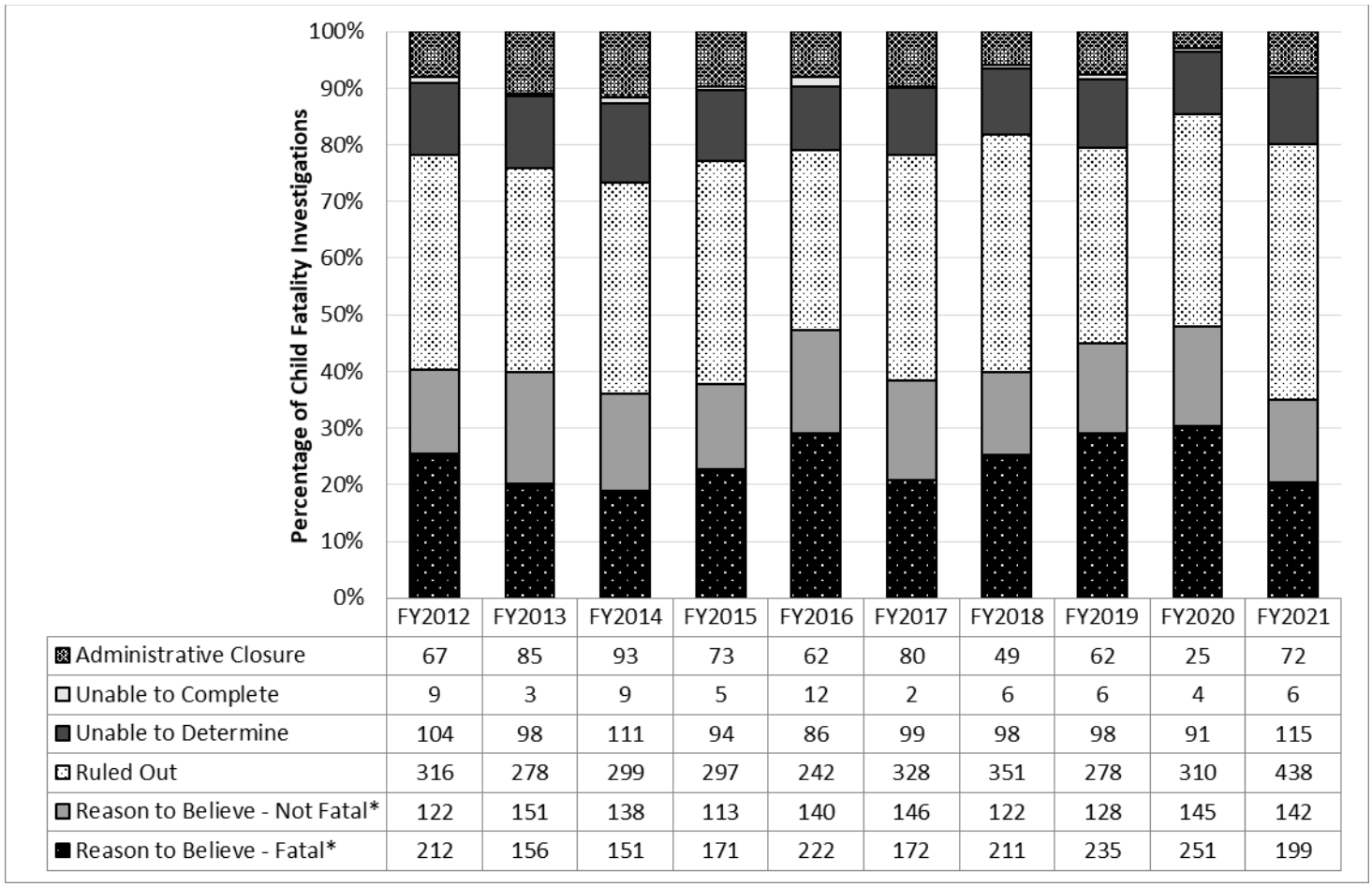
investigations conducted over the last ten years are presented in Table 2 - Percentage of Child Fatality Investigations by Disposition.

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)
FY2012	882	24.04%	13.83%	35.83%	11.79%	1.02%	7.60%
FY2013	804	19.40%	18.78%	34.58%	12.19%	0.37%	10.57%
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%

*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

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



	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Administrative Closure	67	85	93	73	62	80	49	62	25	72
Unable to Complete	9	3	9	5	12	2	6	6	4	6
Unable to Determine	104	98	111	94	86	99	98	98	91	115
Ruled Out	316	278	299	297	242	328	351	278	310	438
Reason to Believe - Not Fatal*	122	151	138	113	140	146	122	128	145	142
Reason to Believe - Fatal*	212	156	151	171	222	172	211	235	251	199

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

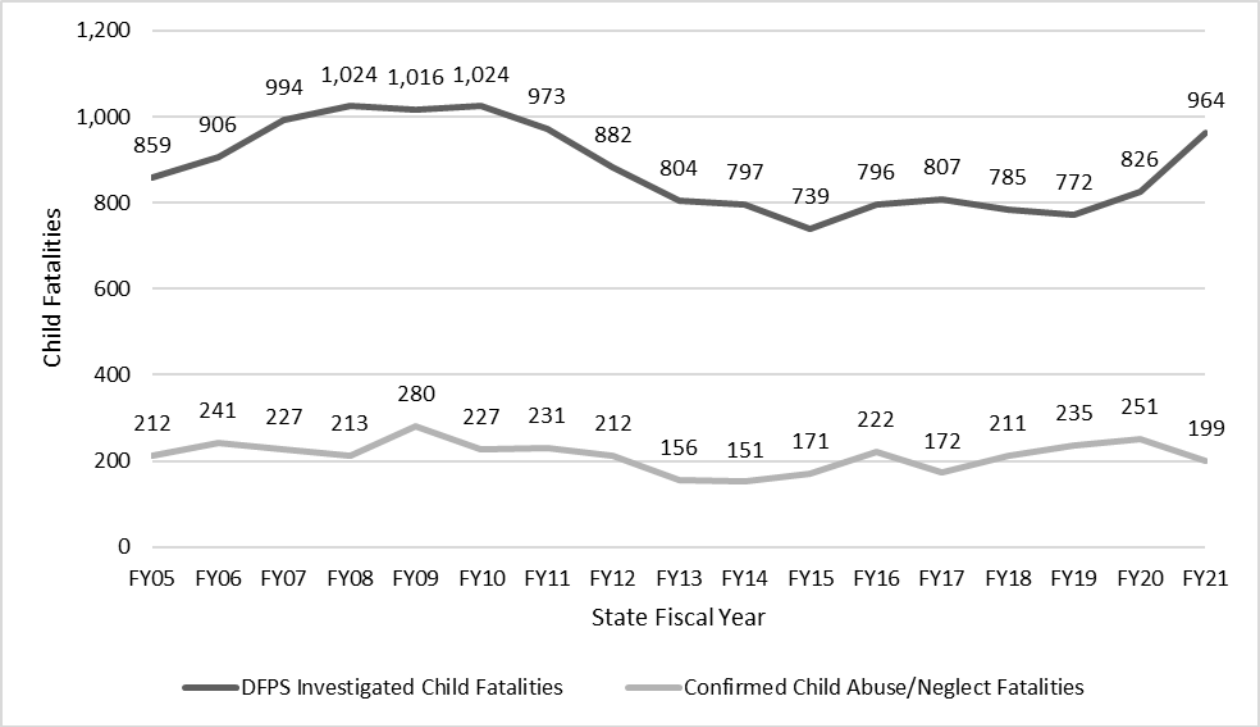
DFPS works in collaboration with other partners such as medical examiners, law enforcement, and DFPS Special Investigators to ensure thorough child fatality investigations. Additional training has been provided to Child Protective Investigations (CPI) staff on various topics to support more thorough 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 FY2021, DFPS investigated 964 possible child abuse and neglect-related fatalities. That number peaked in FY2008 and FY2010 at 1,024 investigated child fatalities. (Figure 2).

Ensuring Consistency in Dispositions

Part of the overall trends in child abuse and neglect fatalities is related to more consistent disposition of fatalities. In FY2012, guidelines were provided to CPI and CPS staff to help ensure consistent dispositions on child fatalities involving co-sleeping, drownings, firearm accidents, suicides and children left in cars. DFPS also continues to train staff and management to strengthen information gathering, engage the family and support systems, and utilize

information from professionals who have contact with the family. This has helped to determine and support consistent dispositions.
The overall number of child fatality investigations may also reflect random fluctuation. The number of child abuse and neglect fatalities spiked in FY2009 despite a slight decline in the number of reported deaths. After an exhaustive review of the fatalities through an independent analysis conducted by the Texas Health and Human Services Commission, the spike was attributed to a random increase in Harris County. No single factor was responsible for this increase. The following year, child abuse and neglect fatalities returned to previous lower levels, including Harris County (Figure 2). This same trend is true at the national reporting level with a spike in confirmed child abuse and neglect fatalities in Federal Fiscal Year 2009 and a return to lower levels in the following year.[3]

FY2021 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."[4] 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 are 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 FY2021, 199 children died due to abuse and neglect in Texas (Table 1).
- In the vast majority of these cases – 177 – there was no CPI investigation or ongoing services stage open at that time, so there was no regular monitoring of the family occurring that could have protected the child (Figure 24).
- This year, 1 child died after being left in a hot car. This is down from a decade-high of eight children left in hot cars in FY2020 (Figure 3).
- There were decreases in the majority of causes of child fatalities including in physical abuse, vehicle-related, unsafe sleep, neglectful supervision, and drownings. There was an increase

in the number of youth who died by suicide, increasing from eight fatalities in FY2020 to thirteen fatalities in FY2021 (Figure 3).

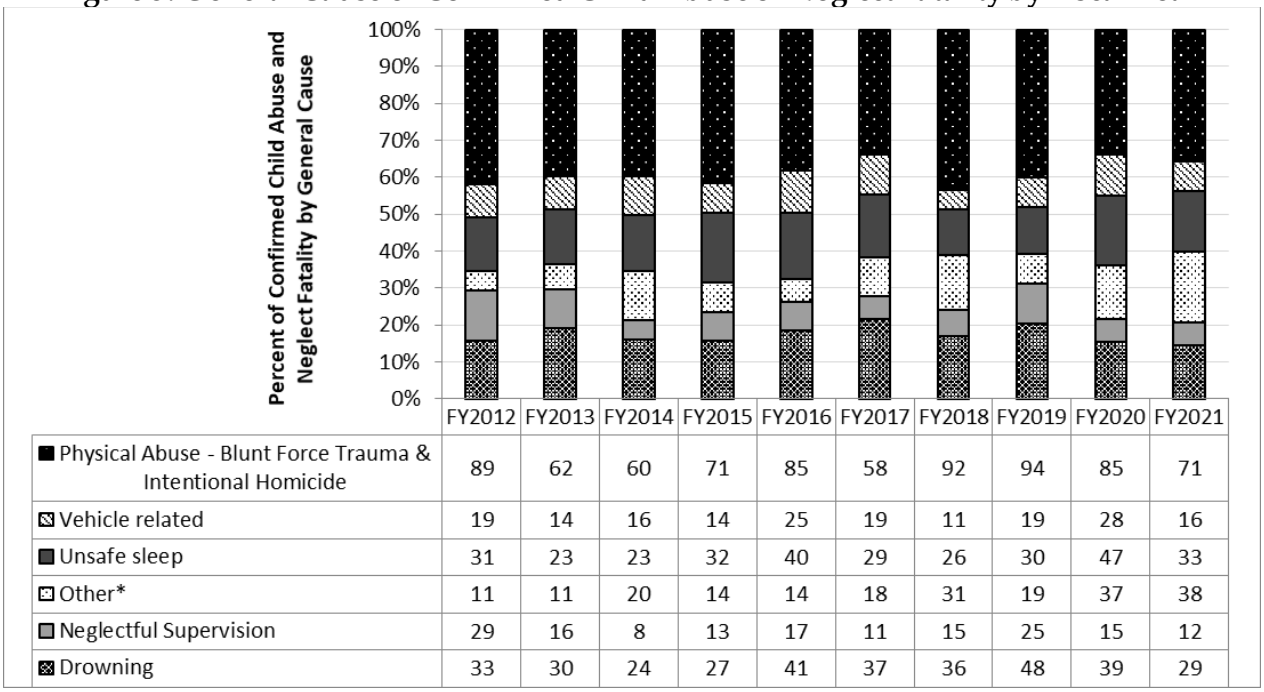
- There continues to be a high number of physical abuse fatalities after an all-time low in FY2017--but in the vast majority of those cases, abuse in the family was never reported to CPS, or CPS had not been involved with the family for two years, before the child fatally injured was born (Figure 4).
- The number of child fatalities investigated by DFPS increased from 826 in FY2020 to 964 in FY2021 (Figure 2).
- Confirmed neglect-related fatalities account for 64 percent of child maltreatment fatalities (Figure 4).
- The most common causes of fatalities involving neglect were drowning, unsafe sleep, and vehicle-related fatalities (Figure 7, 8).
- In FY2021, 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

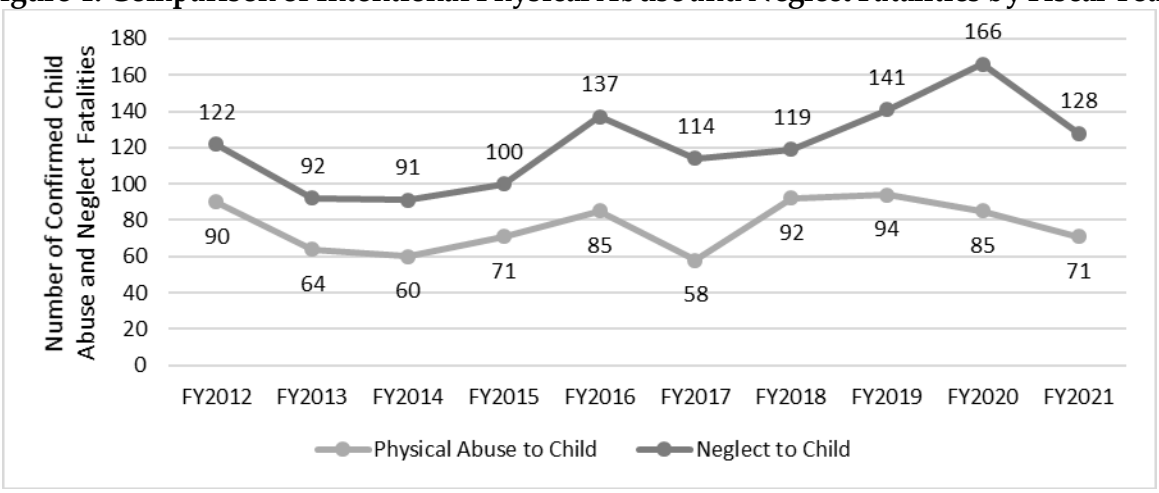


	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Physical Abuse - Blunt Force Trauma & Intentional Homicide	89	62	60	71	85	58	92	94	85	71
Vehicle related	19	14	16	14	25	19	11	19	28	16
Unsafe sleep	31	23	23	32	40	29	26	30	47	33
Other*	11	11	20	14	14	18	31	19	37	38
Neglectful Supervision	29	16	8	13	17	11	15	25	15	12
Drowning	33	30	24	27	41	37	36	48	39	29

*Other category includes medical neglect, physical neglect, suicide, premature birth due to drug use, abandonment at birth.

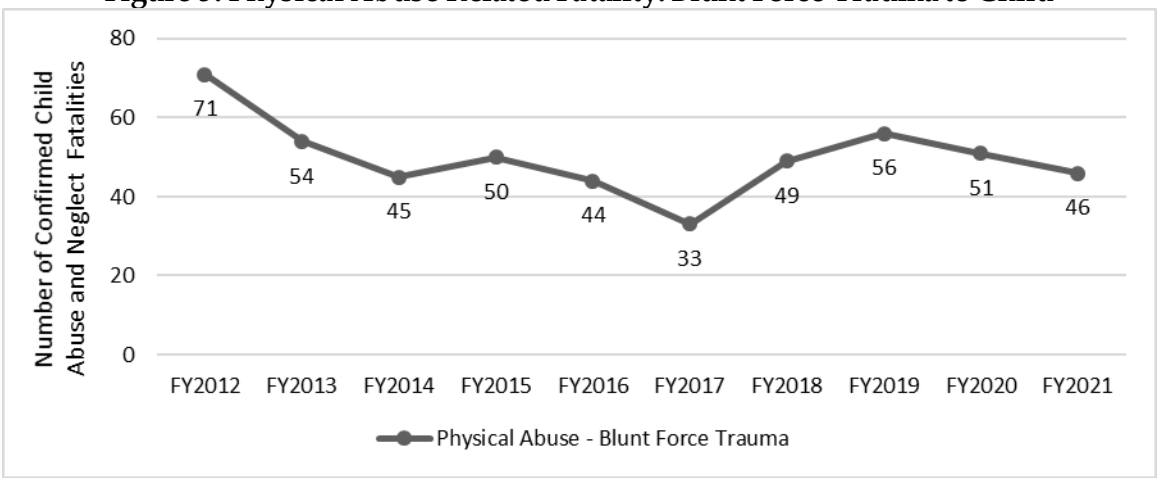
Source: DFPS individual case reviews

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



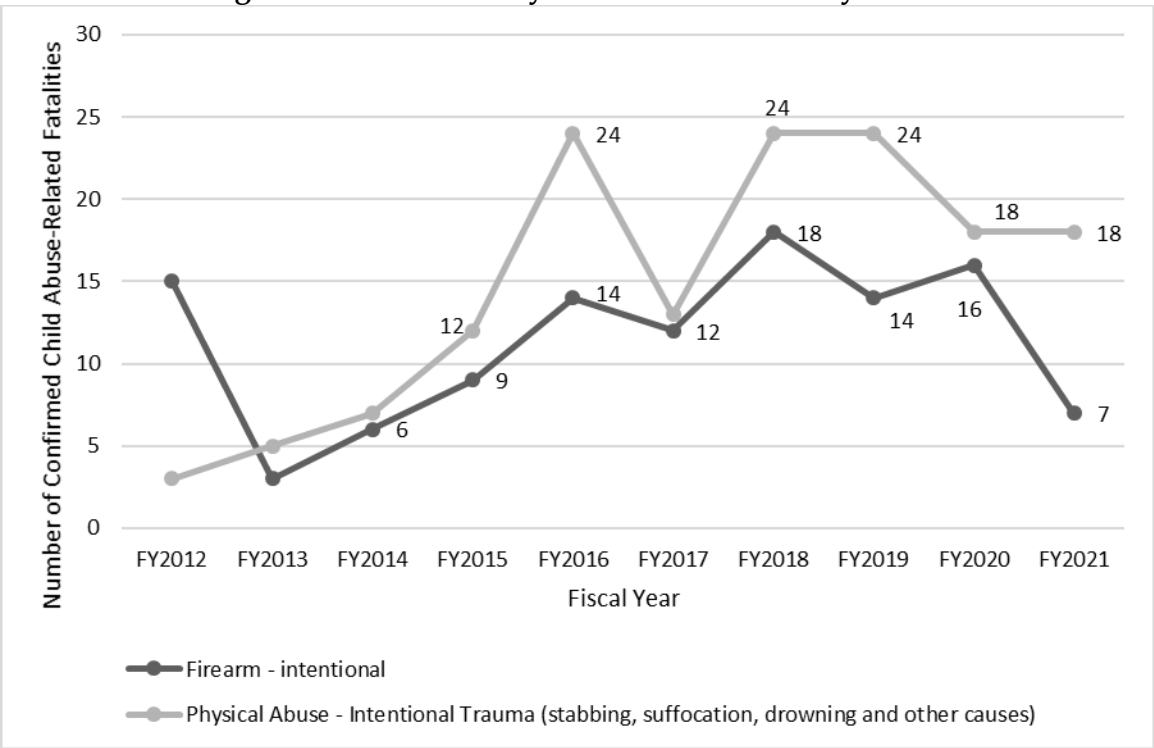
Source: DFPS individual case reviews

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



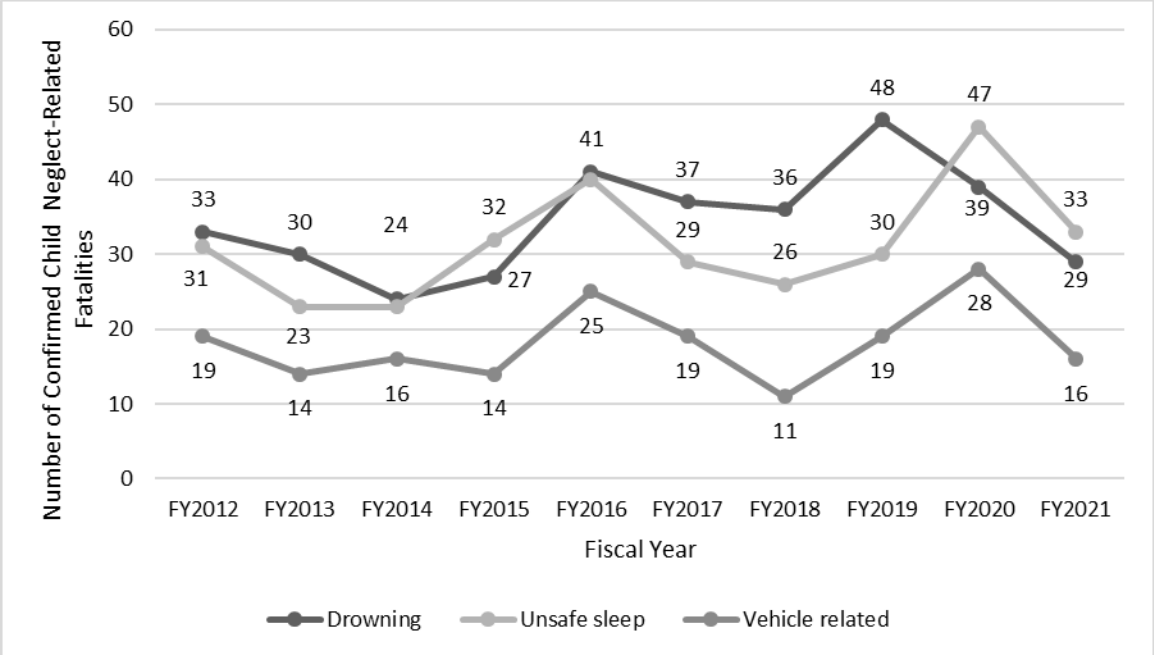
Source: DFPS individual case reviews

Figure 6. Intentional Physical Abuse to Child by Cause



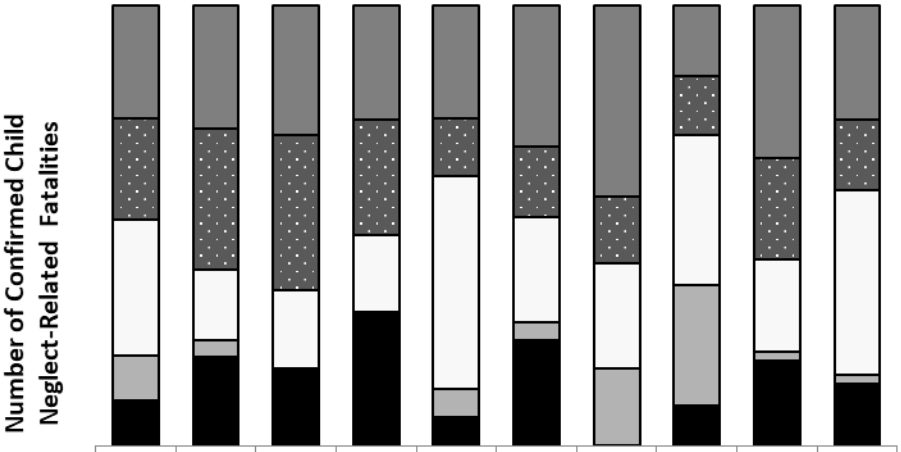
Source: DFPS individual case reviews

Figure 7. Neglect-Related Child Fatality by Cause



Source: DFPS individual case reviews

Figure 8. Neglect-Related Child Fatality by Cause



	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Physical Neglect & Medical Neglect / Related to Medical Issue	10	7	5	6	8	8	20	7	18	13
Firearm - accidental	9	8	6	6	4	4	7	6	12	8
Neglectful Supervision - Other*	12	4	3	4	15	6	11	15	11	21
Fire	4	1	0	0	2	1	8	12	1	1
Accidental overdose / medication, alcohol, illegal substance	4	5	3	7	2	6	0	4	10	7

** Neglectful Supervision - Other includes choking, suffocation, suicide, dog attack, and unable to determine.*
Source: DFPS individual case reviews

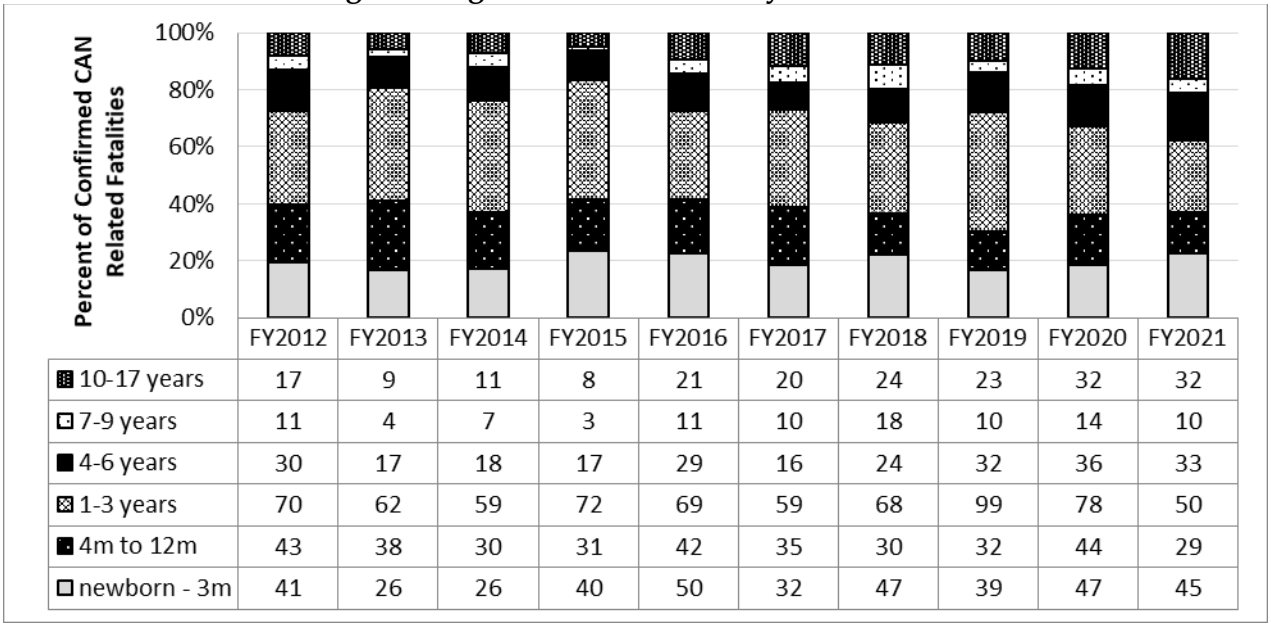
Victim Demographic Characteristics - Age, Gender, Ethnicity

Victims

- Based on the confirmed child abuse and neglect-related fatalities over the past ten fiscal years, children 3 years of age and younger were almost 80 percent of all confirmed child abuse and neglect fatalities; however, the past two years have had a marked increase in child fatalities involving older children. In FY2021, children 3 years of age and younger made up 64 percent of confirmed child abuse and neglect fatalities. In the past year, thirteen youth died by suicide. Male children made up more than half of all confirmed child abuse and neglect-related fatalities (Figure 9, 10).
- During FY2021, 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).

- 57 percent of children who died from abuse or neglect in FY 2021 were too young for school and not enrolled in day care. Three children were being cared for by illegal day care operations (Page 25).

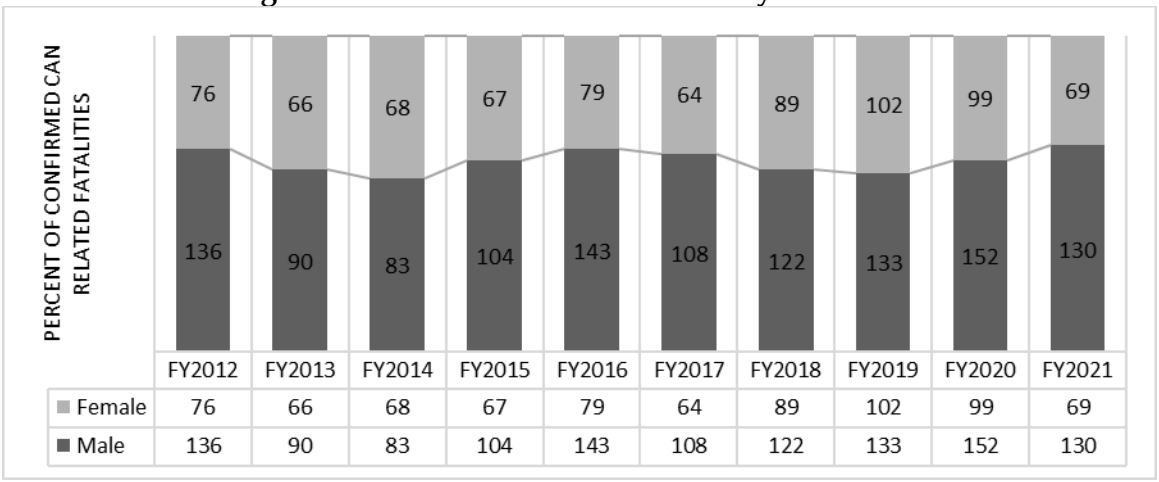
Figure 9. Age of Child at Death by Fiscal Year



	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
10-17 years	17	9	11	8	21	20	24	23	32	32
7-9 years	11	4	7	3	11	10	18	10	14	10
4-6 years	30	17	18	17	29	16	24	32	36	33
1-3 years	70	62	59	72	69	59	68	99	78	50
4m to 12m	43	38	30	31	42	35	30	32	44	29
newborn - 3m	41	26	26	40	50	32	47	39	47	45

Source: DFPS Data Warehouse Report FT_06

Figure 10. Gender of Deceased Child by Fiscal Year



	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Female	76	66	68	67	79	64	89	102	99	69
Male	136	90	83	104	143	108	122	133	152	130

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 FY2021, 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 among racial, multicultural, ethnic, and regional populations. Part of this work includes cross-program work between DFPS and the Texas Department of State Health Services to address child fatalities from a public health approach.

Table 3. FY2021 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	902,468	2,322,156	3,754,305	616,012	7,594,941
Number of Fatalities	58	52	68	21	199
Per Capita Rate of Fatality	6.43	2.24	1.81	3.41	2.62

Sources: Texas State Data Center; DFPS Data Book FY2021; 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.[5] 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 FY2021, 22 percent of child maltreatment fatalities involved a child with special medical needs or medical concerns.

Table 4. FY2021 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

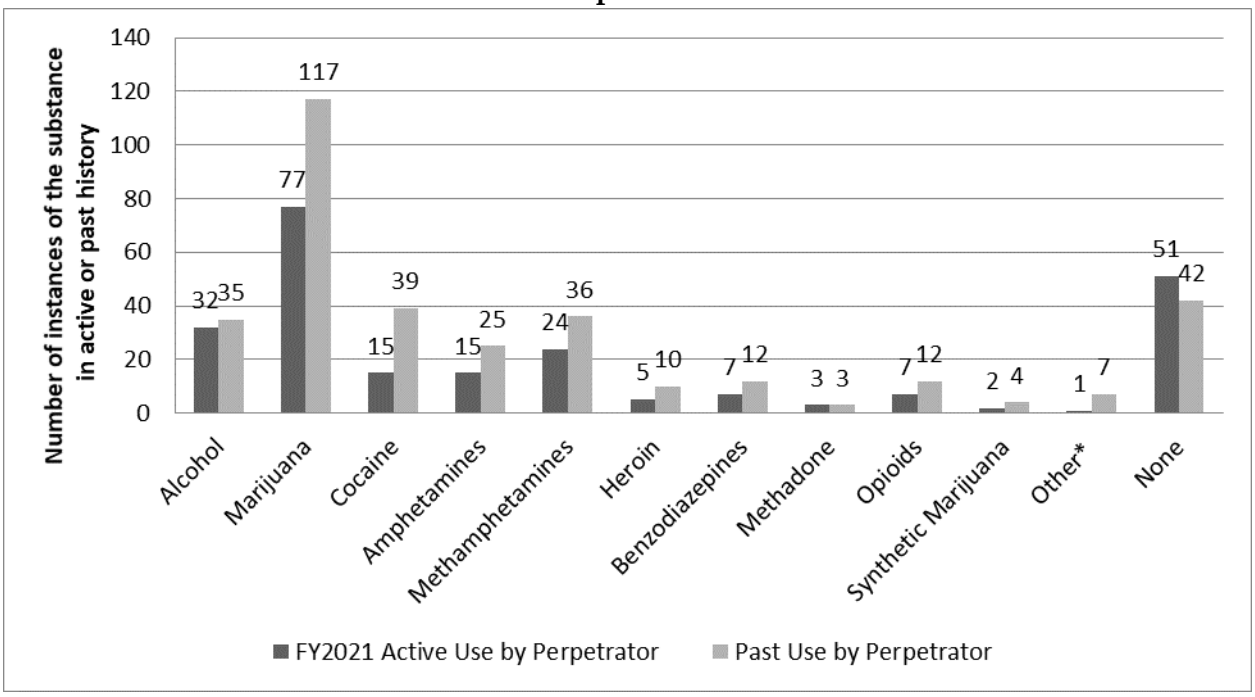
Identified Special Need	FY2021 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality
None/Unknown	150 Fatalities
Asthma	2 Fatalities • Physical Abuse (2)
ADD/ADHD	2 Fatalities • Physical Abuse (1) • Suicide (1)
Anxiety/Depression	10 Fatalities • Suicide (8) • Neglectful Supervision (2)
Autism	1 Fatality • Medical Neglect (1)
Bipolar Disorder	2 Fatalities • Suicide (2)
Cerebral Palsy	1 Fatality • Physical Abuse (1)
Developmental Disability/Delay	4 Fatalities • Physical Abuse (2) • Drowning (1) • Other – Accidental Overdose/Ingestion (1)
Diabetes	2 Fatalities • Medical Neglect (1) • Neglectful Supervision (1)
Downs Syndrome	3 Fatalities • Unsafe Sleep (2) • Physical Abuse (1)
Enuresis/Encopresis	1 Fatality • Physical Abuse (1)
Feeding Tube	2 Fatalities • Physical Abuse (2) • Other - Premature/Prenatal Substance Abuse (1)

Identified Special Need	FY2021 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality
Hearing Impaired	1 Fatality • Drowning (1)
Infant Drug Addiction/Prenatal Drug Exposed	12 Fatalities • Unsafe Sleep (3) • Physical Abuse (3) • Accidental Asphyxiation (2) • Other - Premature/Prenatal Substance Abuse (2) • Other – Accidental Overdose/Ingestion (2)
Intellectual Disability	2 Fatalities • Physical Abuse (2)
Learning Disability	1 Fatality • Suicide (1)
Medically Complex	2 Fatalities • Physical Abuse (2)
Mobility Impaired	1 Fatality • Physical Abuse (1)
Mood Disorder	3 Fatalities • Suicide (3)
Physical Disability	3 Fatalities • Drowning (1) • Physical Abuse (2)
Post-traumatic Stress Syndrome	2 Fatalities • Suicide (1) • Physical Abuse (1)
Psychotic Disorder	1 Fatality • Suicide (1)
Speech Impairment	2 Fatalities • Physical Abuse (1) • Medical Neglect (1)
Other—premature birth, heart conditions, other medical concerns	21 Fatalities • Premature/Prenatal Substance Abuse (1) • Unsafe Sleep (2) • Drowning (1) • Medical Neglect (5) • Physical Abuse (9) • Neglectful Supervision (2) • Suicide (1)

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 FY2021, 148 of the 199 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 was identified in 24 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 117 of the cases.

Figure 11. FY2021 Confirmed Child Abuse or Neglect Fatality by Substance Abuse by Perpetrator



***Other includes ecstasy, morphine, and Benadryl.**

Table 5. FY2021 Confirmed Child Abuse or Neglect Fatality by Co-Occurring Substance Abuse by Perpetrator

Co-Occurring Substances	Active	Past History
Alcohol and Marijuana	13	24
Cocaine and Marijuana	11	28
Cocaine and Alcohol	2	11
Benzodiazepines and Marijuana	4	9
Methamphetamines and Marijuana	16	31
More than two substances	16	40

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 FY2021, 42 percent of child fatalities involved a parent/caregiver who reported active mental health concerns compared to FY2016 where 9.5 percent of child fatalities involved a parent/caregiver who reported active mental health concerns.

Table 6. FY2021 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*		
• Bipolar Disorder	20	24
• Depression	43	57
• Anxiety	42	44
• Postpartum Depression	6	6
• Post-Traumatic Stress Disorder	12	12
• Psychosis	1	1
• Schizophrenia	9	10
• Substance abuse disorder	31	40
• ADD/ADHD	8	11
• Other**	7	19
• Unknown Diagnosis – Reported by Individual	7	6
No	**68**	**63**
Unknown (not identified in case read)	**47**	**38**

* Many may have more than one mental health concern and appear more than once.

**Other includes mood disorder, 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;
- development of training for all staff;
- 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.

DFPS Prevention and Early Intervention also funds 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 FY2021, there was active domestic violence present in the home environment for 50 families. A history of domestic violence was identified in 98 case reviews. For the 50 child fatalities where the family had a history of domestic violence and reported active concerns for domestic violence, 64 percent of those fatalities were due to physical abuse.

Table 7. FY2021 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	**50**	**98**	**39**
No	**101**	**75**	**63**
Unknown (not identified in case read)	**48**	**26**	**40**

Source: DFPS individual case reviews

School and Day Care Enrollment as Protective Factor

With 64 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. Fifty seven 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.

FY2021 Confirmed Child Abuse and Neglect Fatalities:

- In 114 of the 199 child fatalities due to abuse or neglect, the child was not enrolled either in a day care or in school. In 21 case reviews, the status of the child being in school or day care was unknown.
- In 53 of the 199 child fatalities due to abuse or neglect, the child was enrolled in day care or school. 10 of the fatalities occurred when school was out of session for the summer or winter break.
- In 3 of the 199 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.
- In 5 of the 199 child fatalities due to abuse or neglect, the child was being cared for by a relative or babysitter and 3 children were home schooled.

Table 8. FY2021 Child Abuse and Neglect Related Fatalities - By County

County	Region	Child Abuse/Neglect Related Fatalities	Child Abuse/Neglect Related Fatalities in DFPS Conservatorship at Time*
Angelina	05	1	
Armstrong	01	1	
Bastrop	07	2	
Bee	11	1	1
Bell	07	2	
Bexar	08	13	
Bowie	04	2	1
Brazoria	06	2	
Brazos	07	1	
Callahan	02	1	
Cameron	11	3	1
Cherokee	04	1	
Collin	03	2	
Colorado	06	2	
Comal	08	2	
Coryell	07	2	
Dallam	01	1	
Dallas	03	18	1
Denton	03	3	
Dimmit	08	1	
El Paso	10	9	
Ellis	03	1	
Falls	07	1	
Fort Bend	06	1	
Frio	08	1	
Galveston	06	2	
Grayson	03	1	
Gregg	04	1	
Grimes	07	1	
Guadalupe	08	1	
Harris	06	37	
Harrison	04	2	
Hays	07	1	
Henderson	04	2	

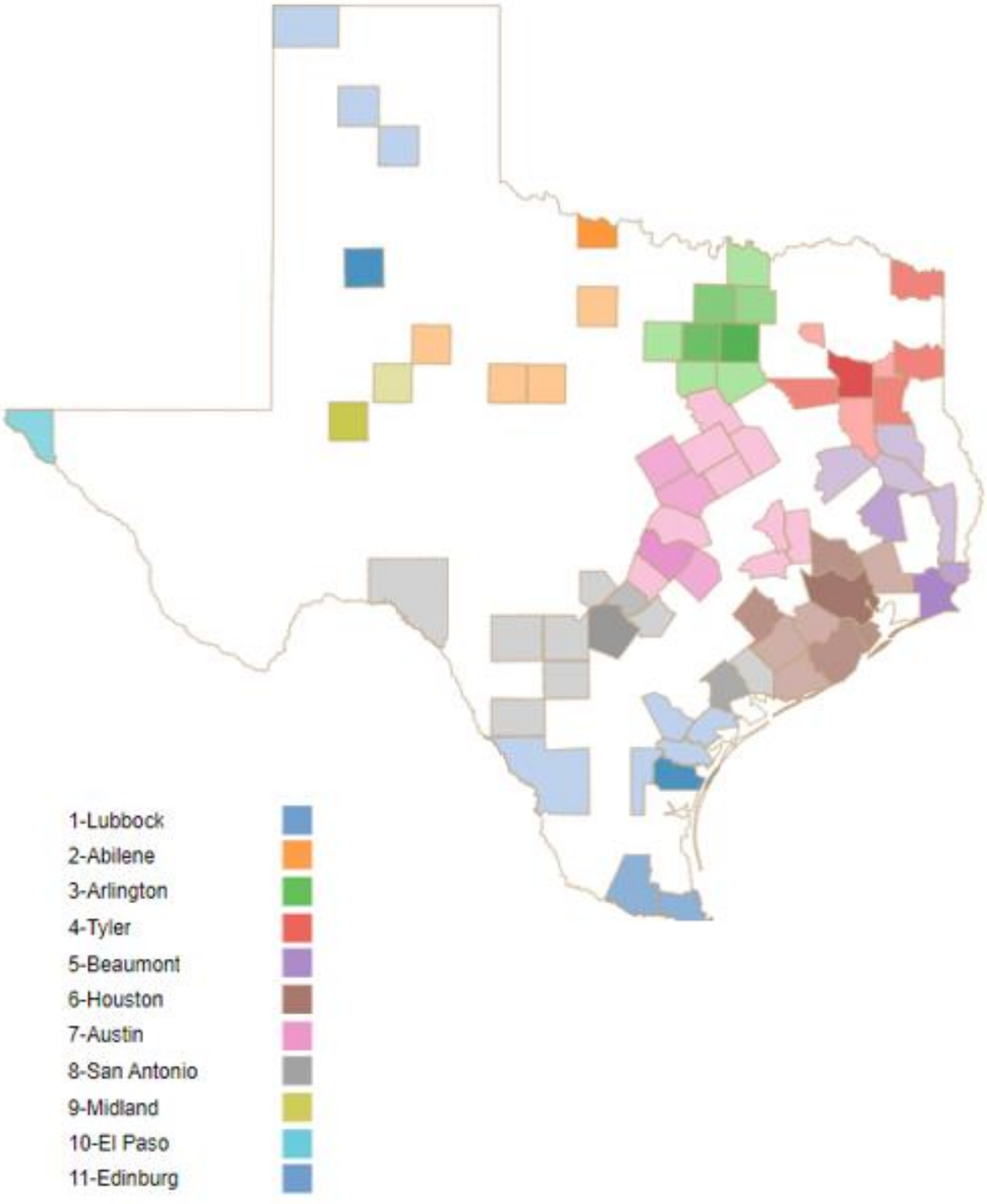
County	Region	Child Abuse/Neglect Related Fatalities	Child Abuse/Neglect Related Fatalities in DFPS Conservatorship at Time*
Hidalgo	11	3	
Hill	07	1	
Houston	05	1	
Howard	09	1	
Jackson	08	1	
Jasper	05	1	
Jefferson	05	4	
Jim Wells	11	1	
Johnson	03	1	
Kendall	08	1	
Liberty	06	1	
Limestone	07	1	
Lubbock	01	4	1
Matagorda	06	1	1
McLennan	07	1	
Medina	08	1	
Midland	09	2	
Montgomery	06	2	
Nacogdoches	05	1	
Nueces	11	4	
Orange	05	2	
Parker	03	1	
Polk	05	2	1
Potter	01	1	
Rains	04	1	
Refugio	11	1	
Rusk	04	2	
San Patricio	11	1	
Scurry	02	1	
Smith	04	4	
Tarrant	03	12	1
Taylor	02	1	
Travis	07	3	1
Uvalde	08	1	
Val Verde	08	1	

County	Region	Child Abuse/Neglect Related Fatalities	Child Abuse/Neglect Related Fatalities in DFPS Conservatorship at Time*
Victoria	08	3	
Washington	07	1	
Webb	11	1	
Wharton	06	1	
Wichita	02	2	
Williamson	07	1	
Young	02	1	1
Total		199	10

* Four fatalities occurred while the child was in DFPS Conservatorship: one fatality occurred while the child was in a foster care placement and three fatalities occurred while the child was in a kinship placement. In six fatalities, the fatal injuries were caused prior to the child entering foster care and were caused by the child's parent or caregiver.

Fatality Counts were frozen on 02/01/2022. 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 (192), Child Day Care Investigations (6), and Residential Child Care Investigations (1)

FY2021 Child Abuse and Neglect Related Fatalities - By Region



FY2021 Confirmed Child Abuse and Neglect Related Fatalities - Case Review Data

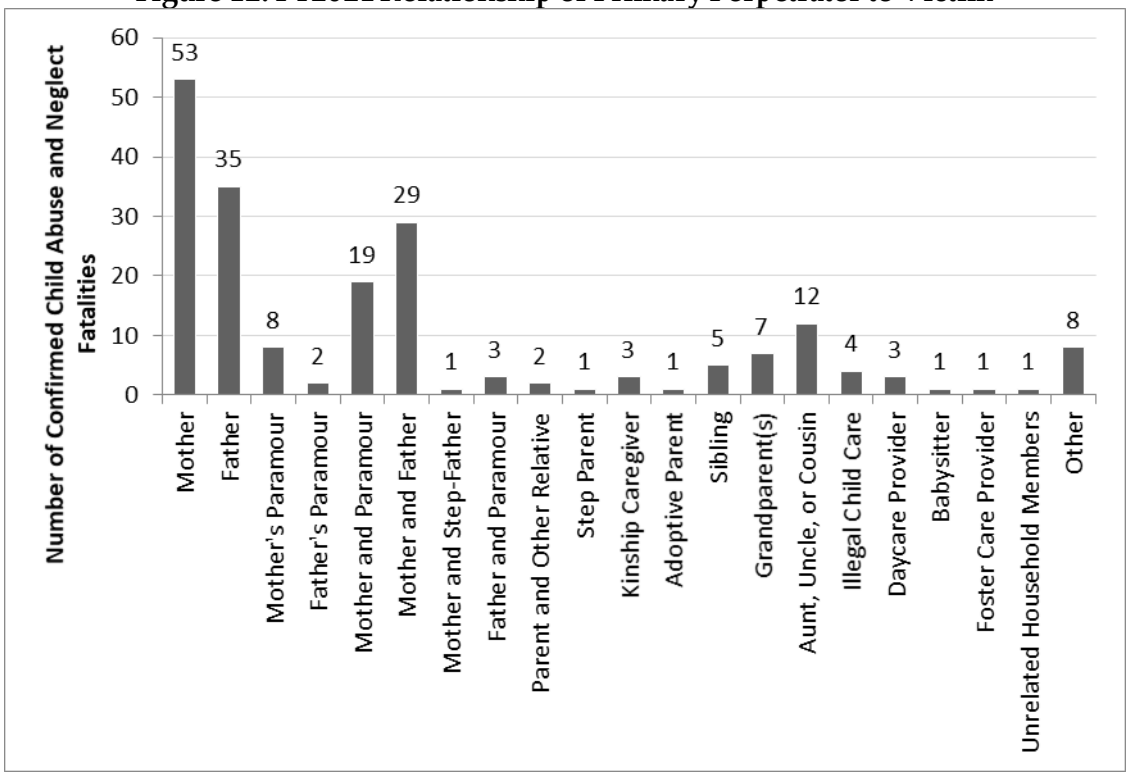
Based on the confirmed child abuse and neglect fatalities that occurred during FY2021 several key demographic areas allow for specialized targeting of prevention and intervention in child abuse and neglect cases. Data from these fatalities tells us that these parents would benefit from support, education and targeted campaigns. Communities can use this data to strategically message and target available resources for families and caregivers.

FY2021 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 boyfriend (Figures 13-15).
- In all confirmed cases of abuse and neglect, parents continue to be the most common perpetrators (Figure 12).
- In 51.8 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had no prior history with CPS (Figure 22, 23).
- 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 one of two major neglectful supervision issues: unsafe sleep or neglectful supervision. (Table 9, 10).

Figure 12. FY2021 Relationship of Primary Perpetrator to Victim

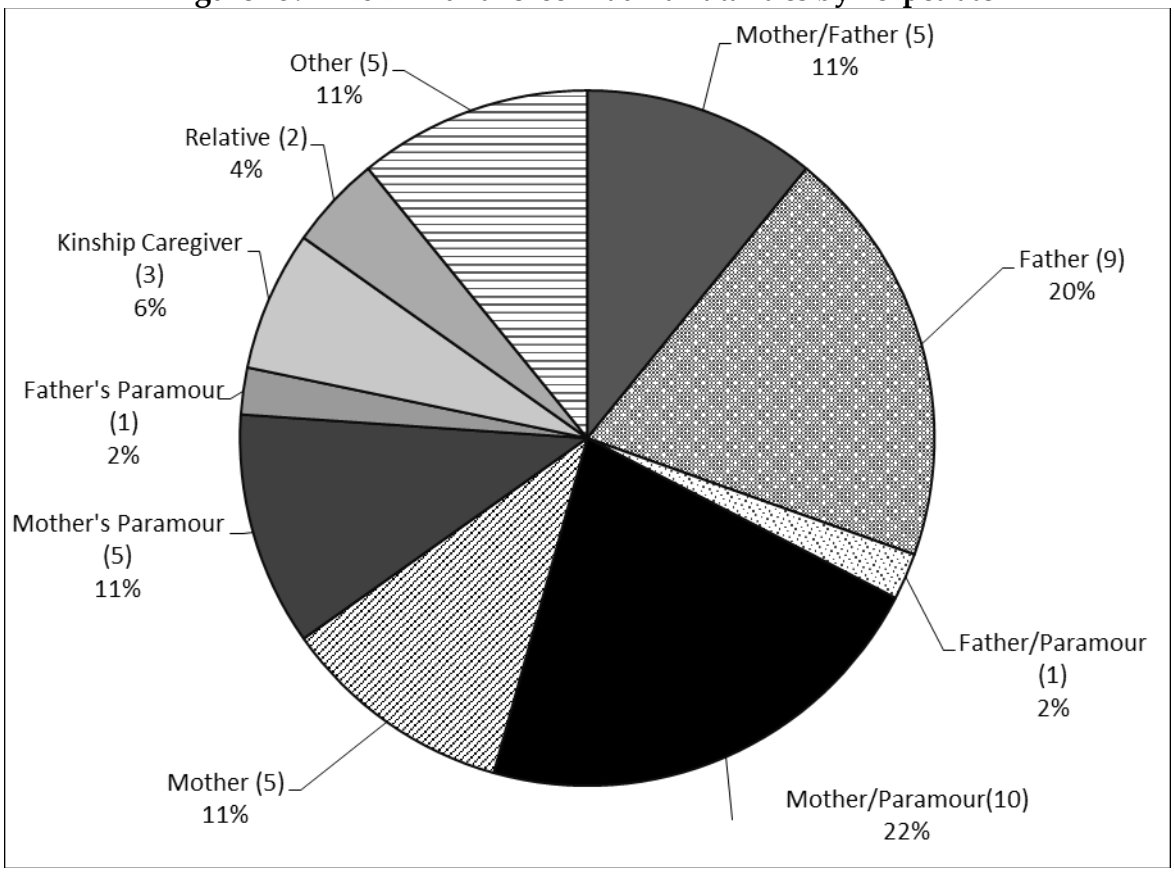


Source: DFPS individual case reviews

FY2021 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. FY2021 Blunt Force Trauma Fatalities by Perpetrator

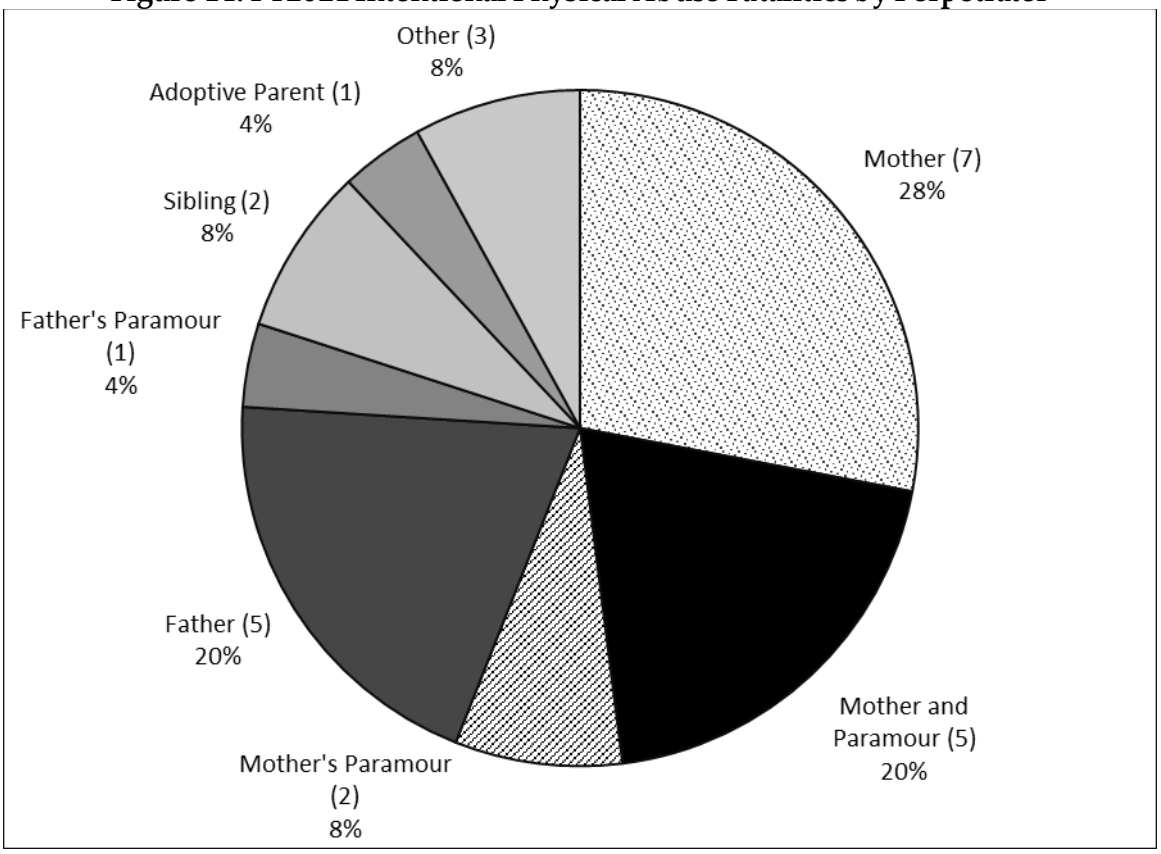


Number of victims: 46 children

Age range of victims: Newborn to 6-year-old child. 22 children were younger than one year old; 74% were age three or younger

Finding: Usually involve young children being physically abused by the father (31%) or a boyfriend (24%)

Figure 14. FY2021 Intentional Physical Abuse Fatalities by Perpetrator

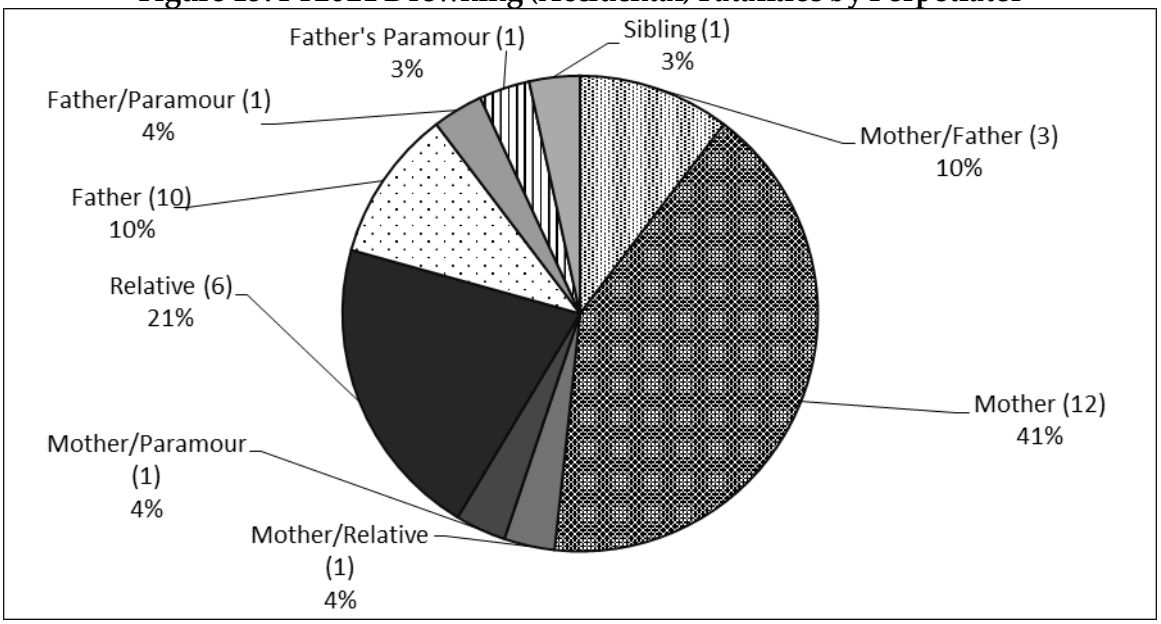


Number of victims: 25 children

Age range of victims: Newborn to 17-year-old youth. 56 percent were children age four and older

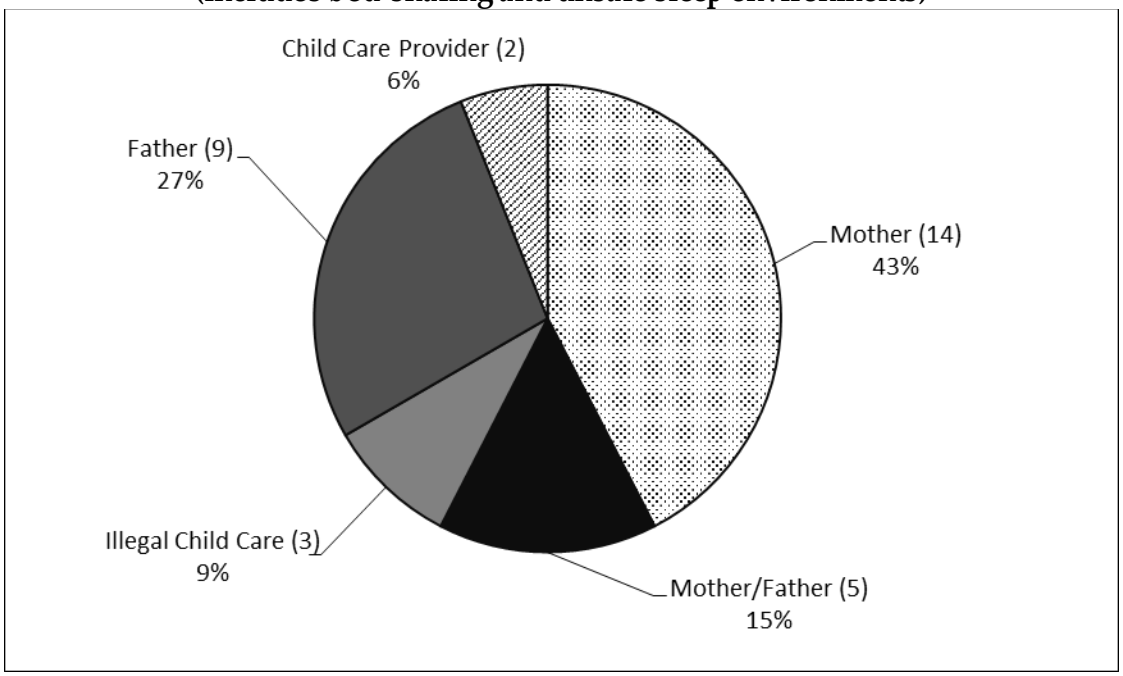
Finding: Usually involved children with primary perpetrator as mother (48%), father (20%).

Figure 15. FY2021 Drowning (Accidental) Fatalities by Perpetrator



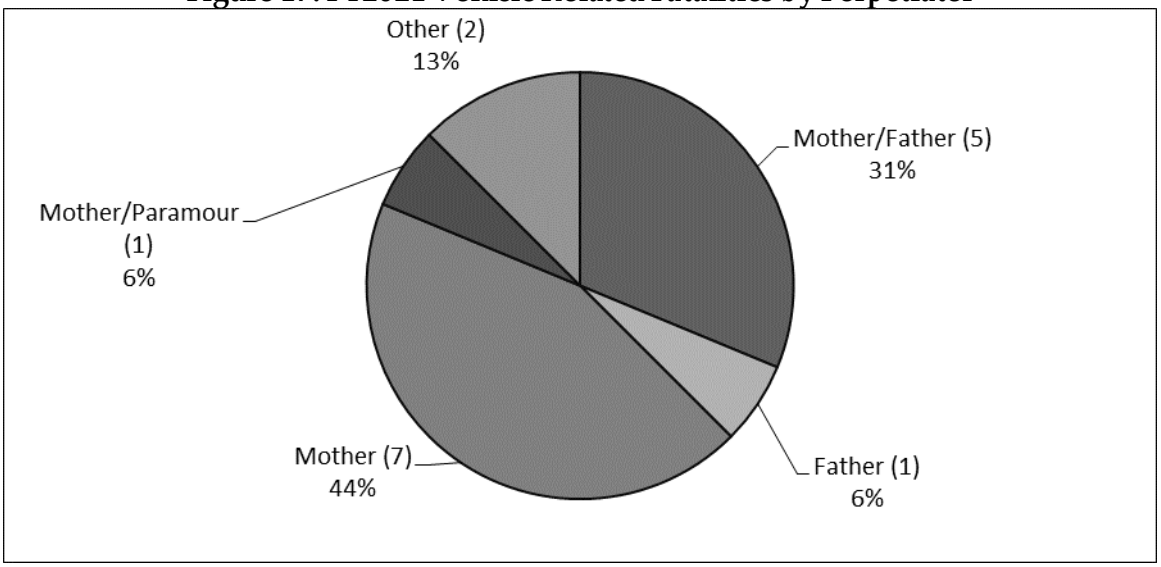
Number of victims: 29 children
Age range of victims: 4-month-old to 10-years-old. Twenty children were 3 years old and younger (69%).
Finding: Usually involve young children with mother as primary perpetrator (41%).

Figure 16. FY2021 Unsafe Sleep Fatalities by Perpetrator (includes bed-sharing and unsafe sleep environments)



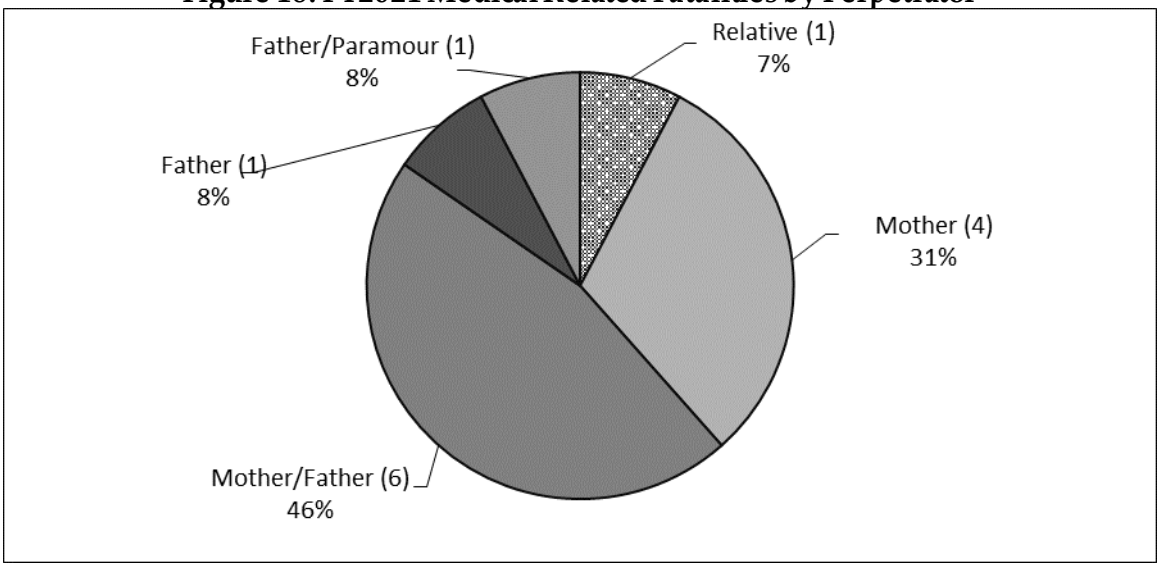
Number of victims: 33 children
Age range of victims: Newborn old to 1 year old
Finding: Involved infants with primary perpetrator generally the mother, father, or both mother and father.

Figure 17. FY2021 Vehicle Related Fatalities by Perpetrator



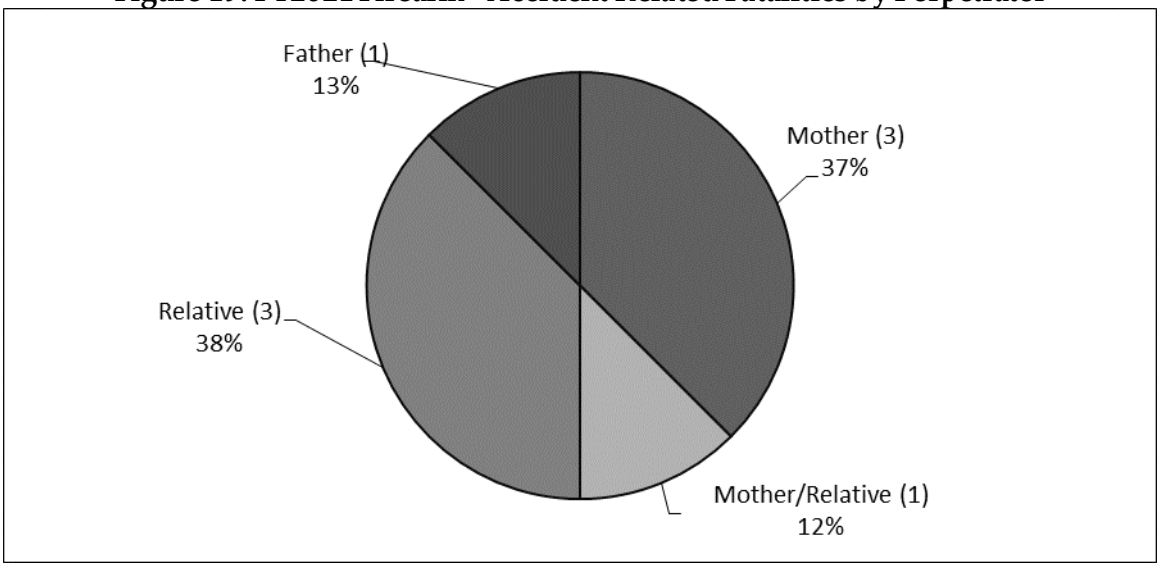
Number of victims: 16 children
Age range of victims: Newborn to 15 years old
Finding: Usually happens while in care of the mother (81%). One child died after being left in a vehicle. (Decrease from 9 hot car deaths in FY 2020.)

Figure 18. FY2021 Medical Related Fatalities by Perpetrator



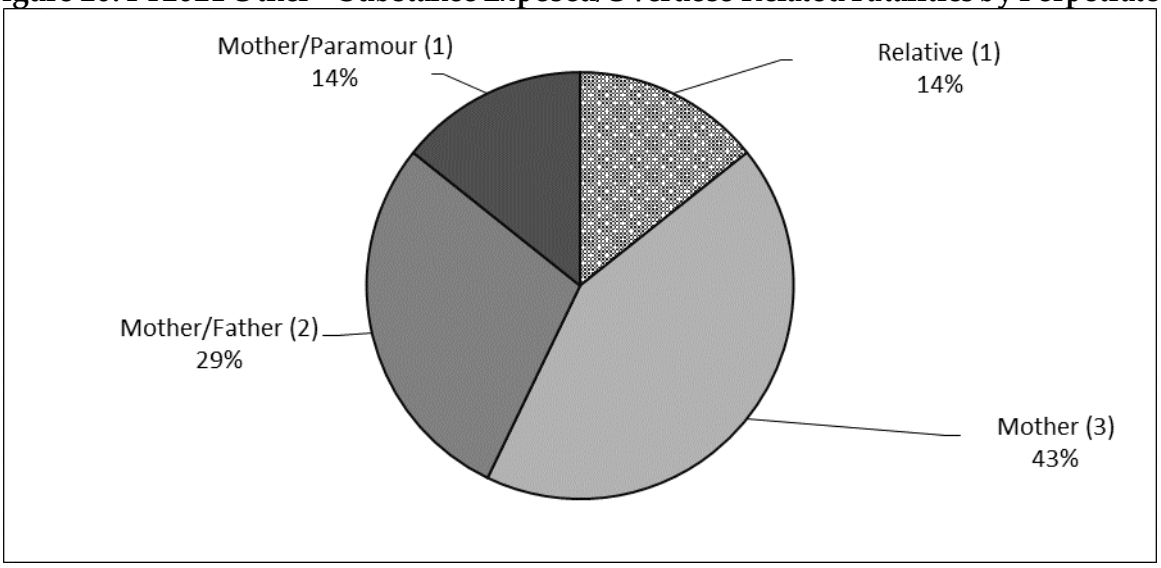
Number of victims: 13 children
Age range of victims: newborn to 16 years old
Finding: Usually happens while in care of the father (62%) or mother (77%).

Figure 19. FY2021 Firearm - Accident Related Fatalities by Perpetrator



Number of victims: 8 children
Age range of victims: 8 months old to 17 years old
Finding: Usually happens while in care of a parent (62%).

Figure 20. FY2021 Other – Substance Exposed/Overdose Related Fatalities by Perpetrator

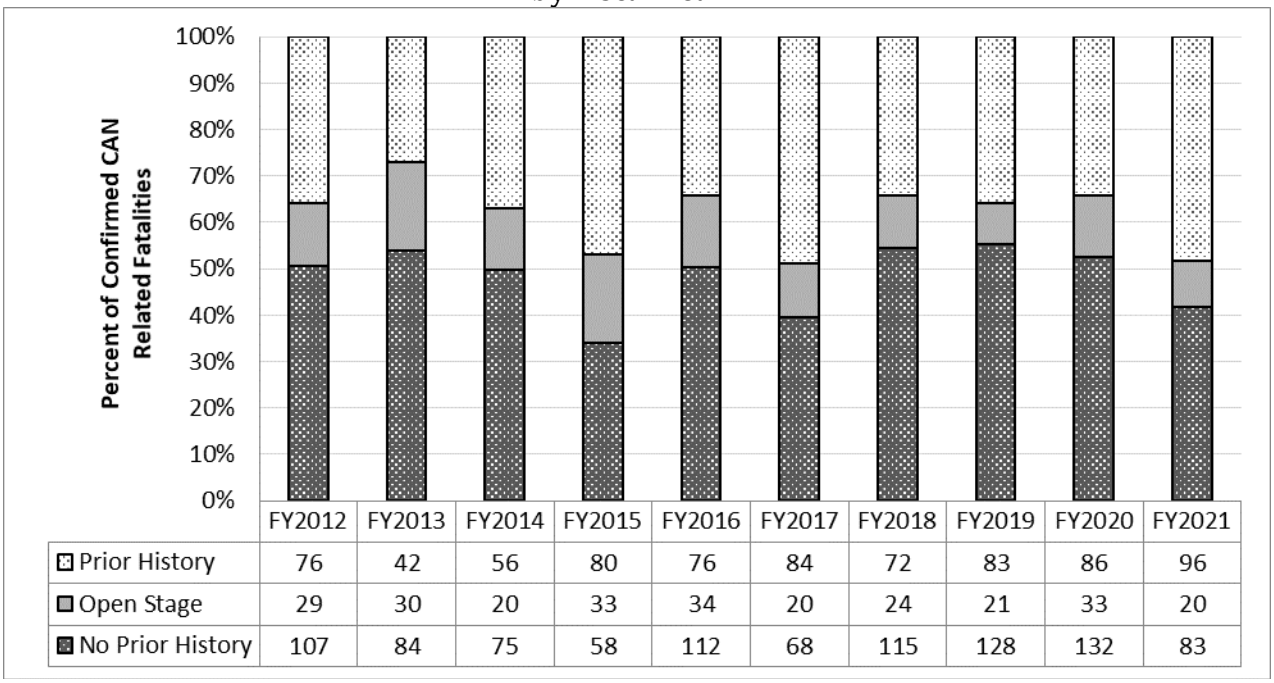


Number of victims: 7 children
Age range of victims: newborn to 8 years old
Finding: Since most involve substance exposure, four of the eleven child fatalities involved a newborn child.

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. Even under this broad definition, most child abuse and neglect fatalities had no prior CPI or CPS history. In 11 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 48.2 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



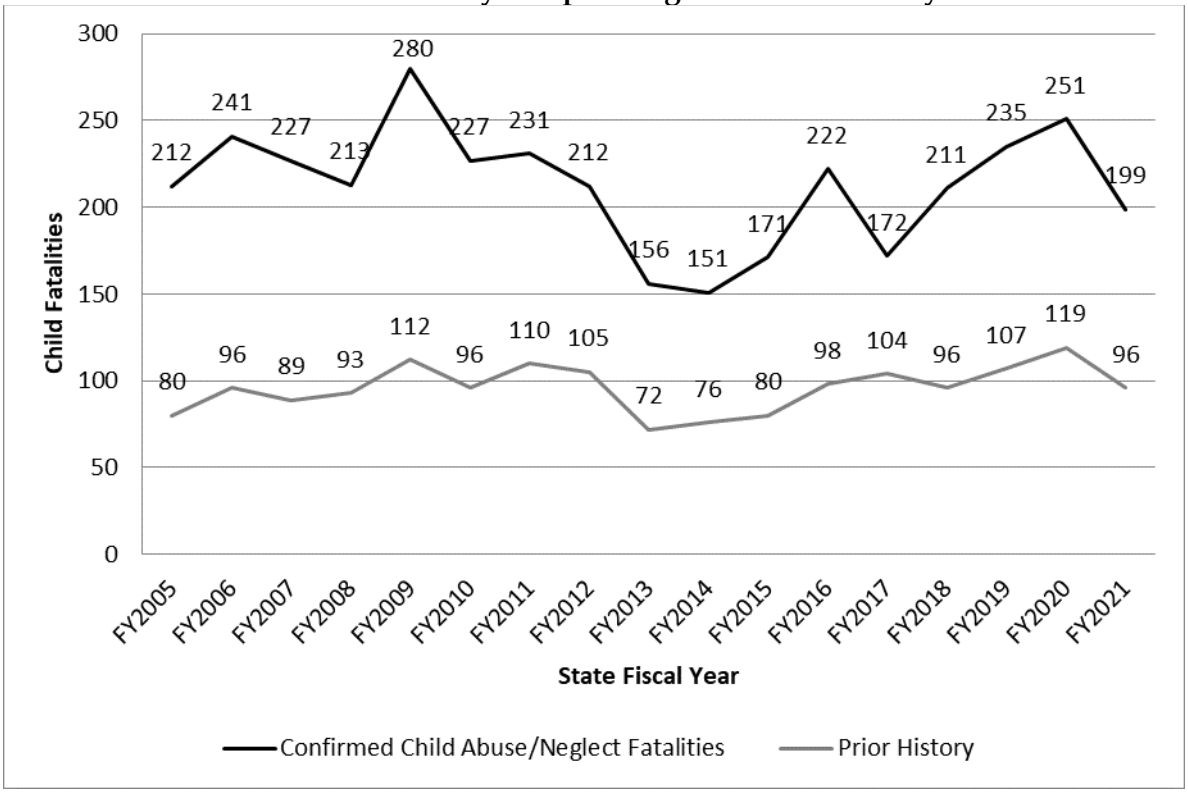
	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Prior History	76	42	56	80	76	84	72	83	86	96
Open Stage	29	30	20	33	34	20	24	21	33	20
No Prior History	107	84	75	58	112	68	115	128	132	83

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. Most fatalities that occur when a child is in DFPS conservatorship are not abuse or neglect-related, but from terminal medical conditions that existed prior to DFPS intervention. Child abuse and neglect-related fatalities where the child died while CPS was involved with the family in FY2021 often consisted of neglectful supervision/unintentional acts

(14 fatalities). Out of the 14 neglectful supervision/unintentional acts related fatalities, six died due to unsafe sleeping arrangements, three died due to medical neglect/physical neglect, two were vehicle-related, one died by drowning, one died from neglectful supervision, and one youth died by suicide.

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 FY2021, based on Figures 22-24, the following themes are noted:

- In 22 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.
    - Three children were in an open Alternative Response stage and a new incident of abuse or neglect occurred leading to the fatality.
        - Initial contact with the family was made timely and had two workers assigned to the Alternative Response stage.
        - No safety plans were in place. The risk and safety assessment were completed timely in two of the three cases.

- Thirteen of the children were in an active investigation and a new incident of abuse or neglect occurred leading to the fatality.
  - Initial contacts in open investigations were completed timely. In two investigations, initial contact had not been made and multiple attempted contacts were made in those investigations.
  - In seven investigations, there was only one worker assigned; in three investigations, there were two workers assigned during the open stage; and in two investigations, there were three or more workers assigned.
  - There were no parental child safety plans in place the investigations. The risk and safety assessment were completed timely in half of the investigations.
  - Starting caseloads: 2 with 15 or fewer cases; 9 with 11-20 cases; 2 with more than 20 cases.
- Two 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 one of the FBSS cases, there was only one worker assigned; in the other FBSS case, there had been two workers assigned during the open stage.
  - Safety plans were in place in one of the open FBSS cases.
  - Caseloads for the staff at the time of the fatality: 2 with less than 15 cases.
  - In both FBSS cases, the family was offered parenting, substance abuse assessments and ongoing services if needed. At the time of the fatalities, both of the families were partially compliant.
- Ten of the children or their family were involved in an active conservatorship stage at the time of the fatality.
  - Six children were in DFPS conservatorship at the time of their death, but the abuse or neglect that led to their death happened prior to being in DFPS conservatorship.
  - One youth was in a foster care placement and a new incident occurred that led to the fatality.
  - Three children were in kinship placements and a new incident of abuse or neglect occurred.
    - Initial contacts in open CVS cases were completed timely and the children were being seen timely.
    - In three of the CVS cases, there was only one worker assigned; in one of the cases, there were 2 caseworkers assigned to the case over time.
    - Caseloads for the staff at the time of the fatality were 10 cases or less.

- For children with prior history (74 children), the majority had only one worker assigned during the family's last involvement with DFPS (77 percent) and caseloads were often at 20 cases or fewer per staff member assigned.
    - Twelve families had two workers assigned, one family had three workers assigned and one family had four workers assigned.
    - Starting caseloads: 24 with 10 or fewer cases; 30 with 11-20 cases; 12 with more than 20 cases; 8 were unknown due to the age of the history.
    - Ending caseloads: 26 with 10 or fewer cases; 29 with 11-20 cases; 7 with more than 20 cases; 8 were unknown due to the age of the history or the staff member in transition between units.
- In the 96 child fatalities with prior history:
    - 38 families had prior involvement with Family Based Safety Services (FBSS).
        - 38 families had prior involvement with FBSS after an investigation concluded a reason to believe disposition.
        - 31 families had a prior safety plan that required the parents, significant other or the designated perpetrator to have supervised contact with the children. 67 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 fourteen or more visits with the FBSS caseworker.
        - Services offered in the previous or open stage include:
            - Counseling for family, individual, or group: 27 cases
            - Daycare or respite care: 4 cases
            - Domestic violence shelter or counseling: 4 cases
            - Drug testing or treatment: 24 cases
            - Infant or early childhood screening or development services: 3 case
            - Family support services/basic needs: 6 cases
            - Legal services: 1 case
            - Mental health (psychological testing, mental health assessment or treatment, referral to local mental health authority): 10 cases
            - Parenting skills / evidence-based parent education: 19 cases
            - Other (housing, referrals, transportation, community-based services): 9 cases
    - 84 percent of families that had been involved with FBSS were reportedly fully compliant or partially compliant with their service plan.

Figure 23. FY2021 Department of Family and Protective Services (DFPS) Data on Child Abuse and Neglect Related Fatalities Statewide

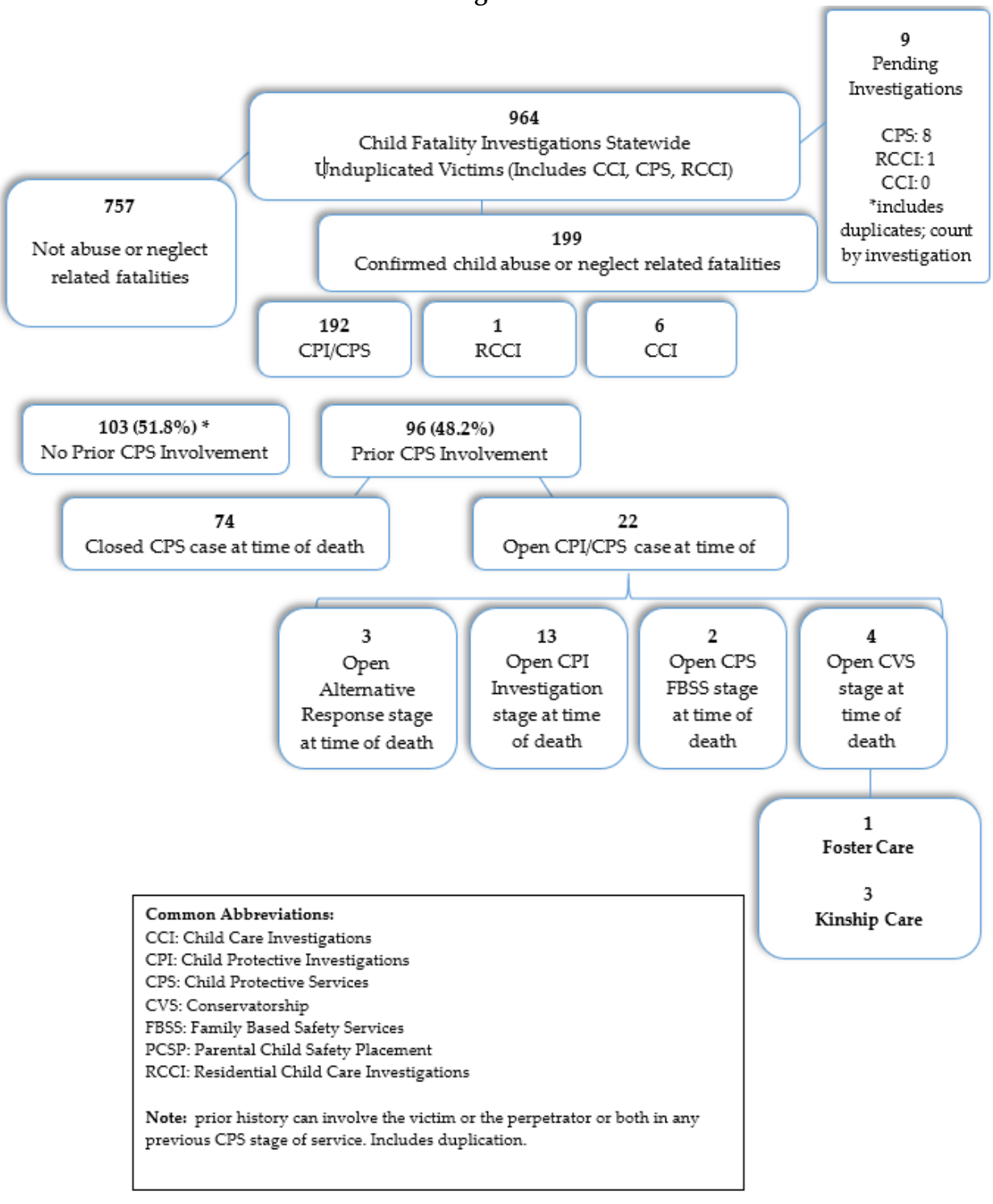
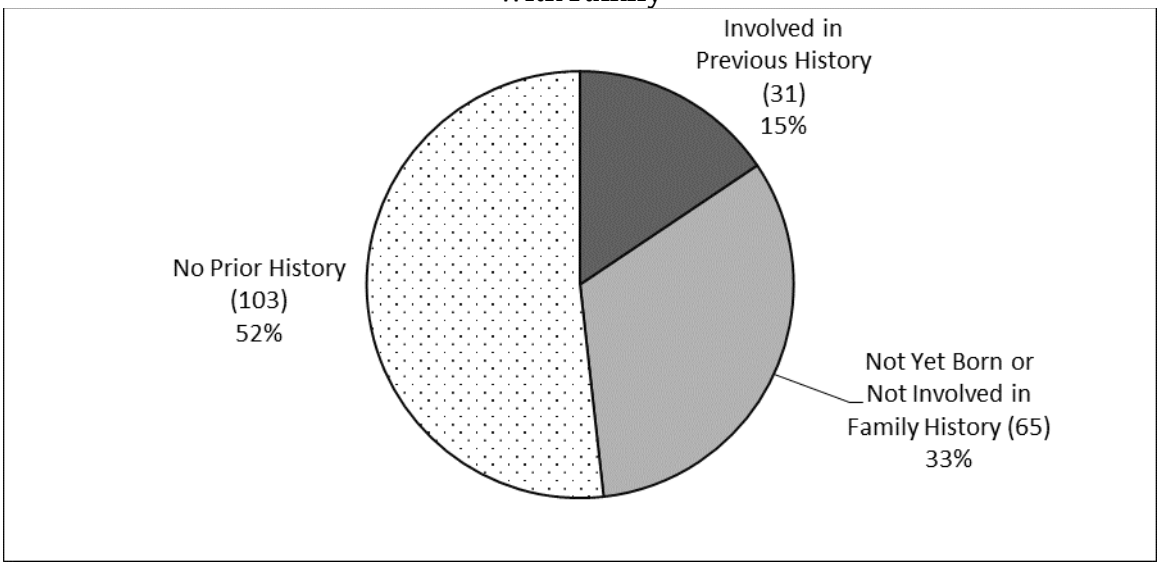


Figure 24. FY2021 Prior History by Child/Perpetrator with Previous Involvement

Type of Previous History	Total Count
Child has previous history or open stage (perpetrator was not known to CPS)	15
Perpetrator has previous history or open stage (Child was not known to CPS)	36
Both child and perpetrator have previous history or open stage	45
Total with previous history or open stage	96

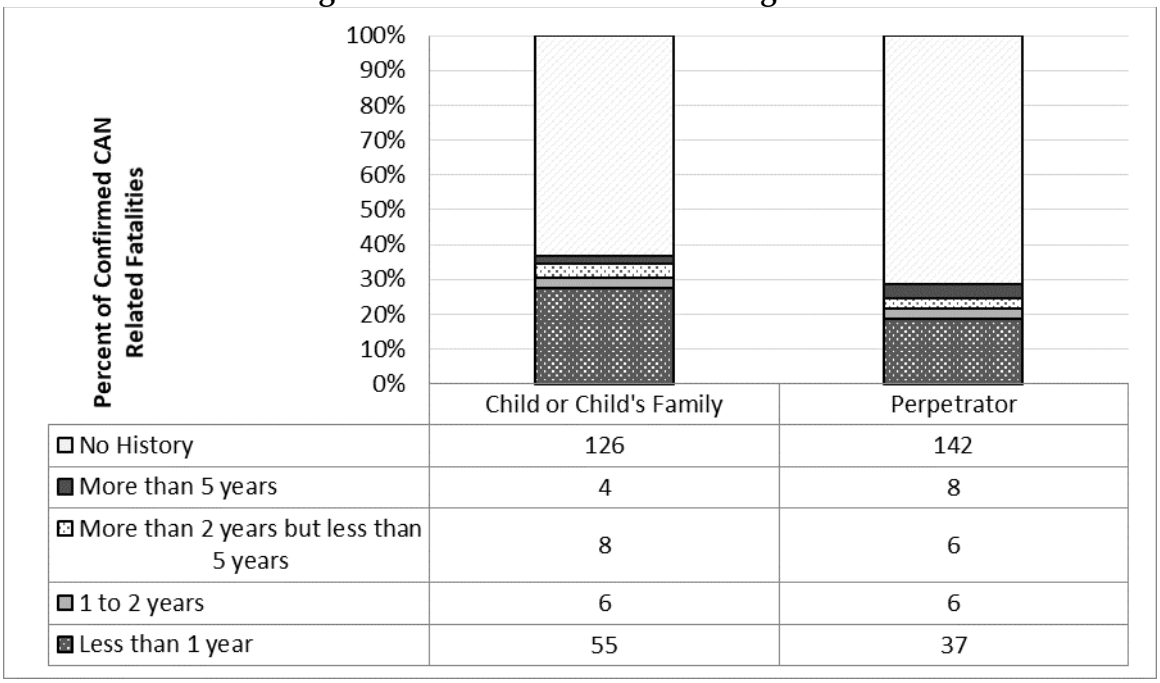
Source: DFPS individual case reviews – includes history that may be purged from IMPACT but referenced in case narrative.

Figure 25. FY2021 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.

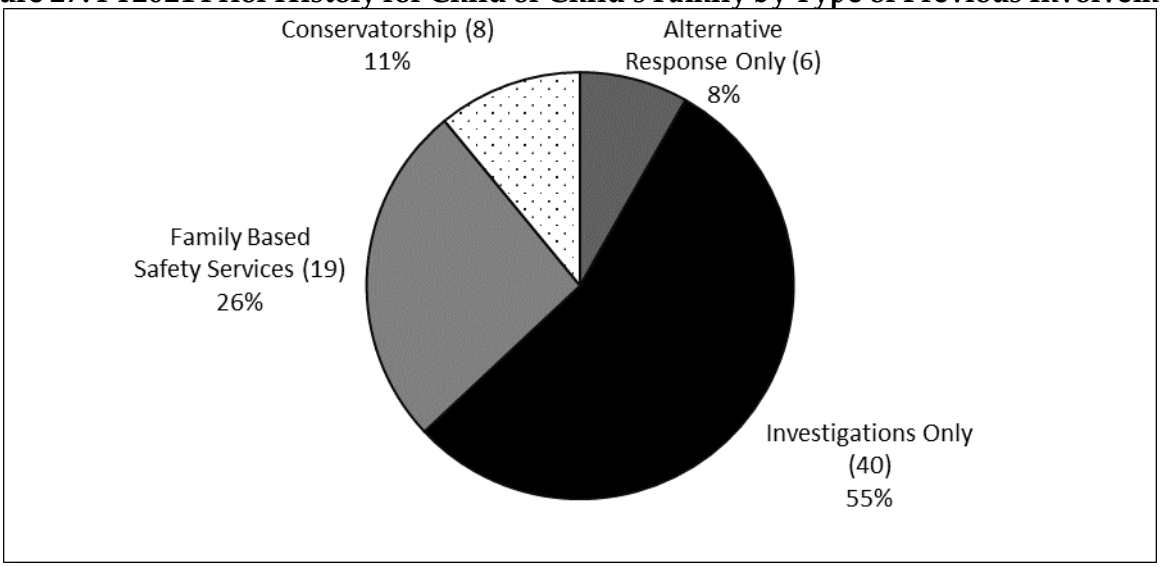
Figure 26. FY2021 CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Length of Time since Last Active Stage Closed



	Child or Child's Family	Perpetrator
No History	126	142
More than 5 years	4	8
More than 2 years but less than 5 years	8	6
1 to 2 years	6	6
Less than 1 year	55	37

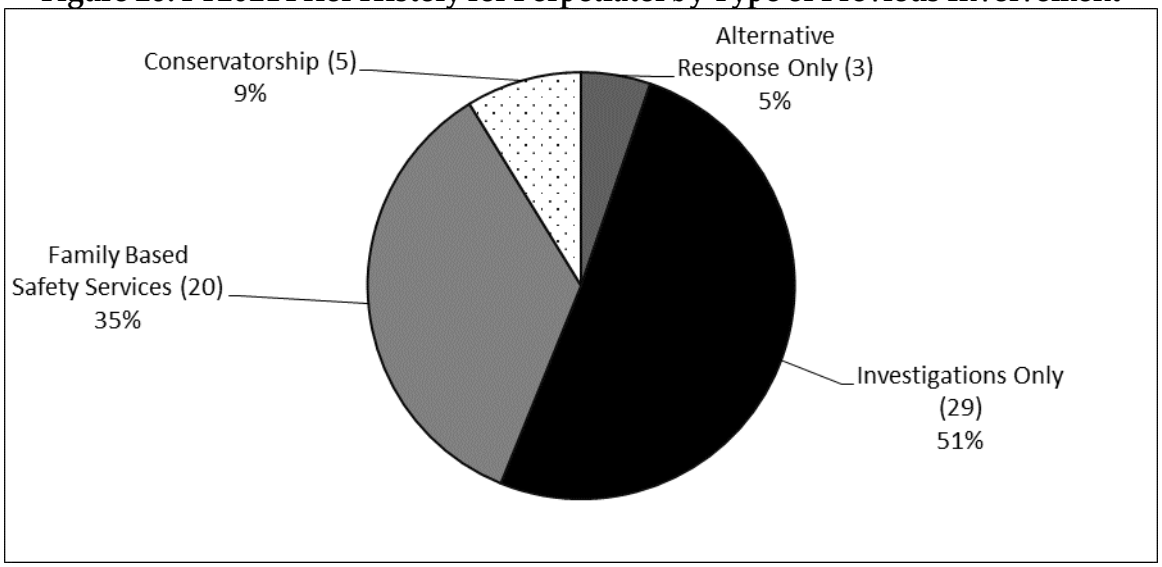
Source: DFPS individual case reviews

Figure 27. FY2021 Prior History for Child or Child's Family by Type of Previous Involvement



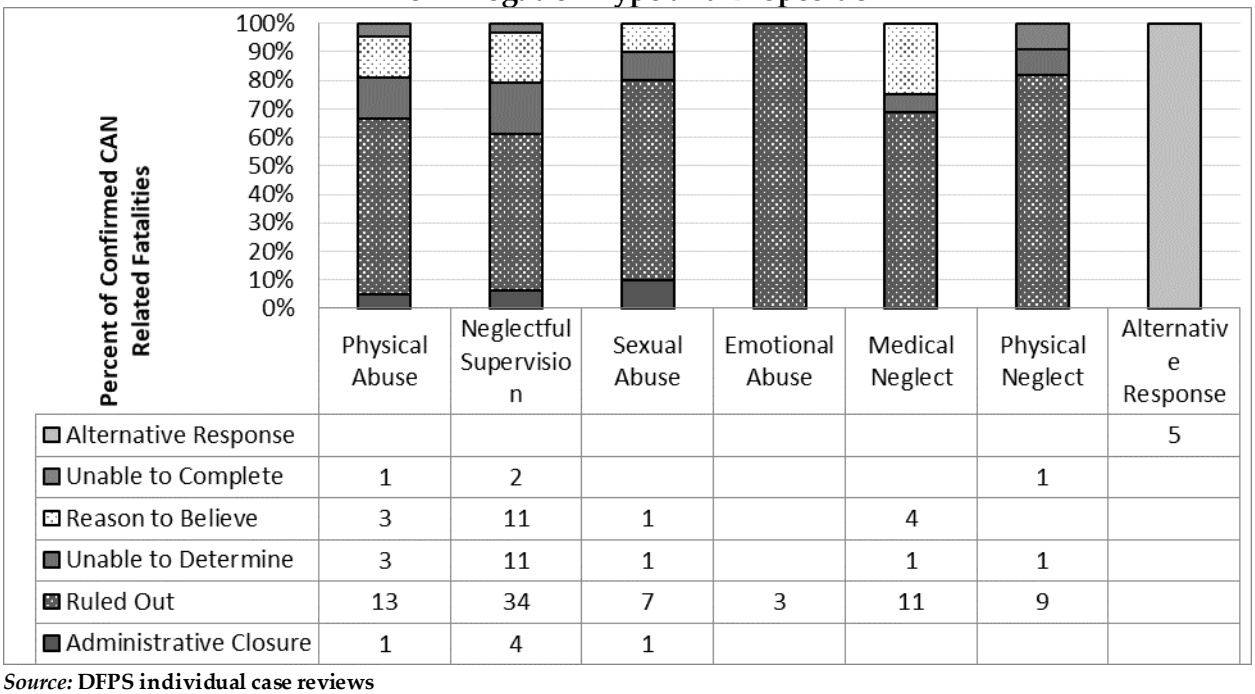
Source: DFPS individual case reviews

Figure 28. FY2021 Prior History for Perpetrator by Type of Previous Involvement



Source: DFPS individual case reviews

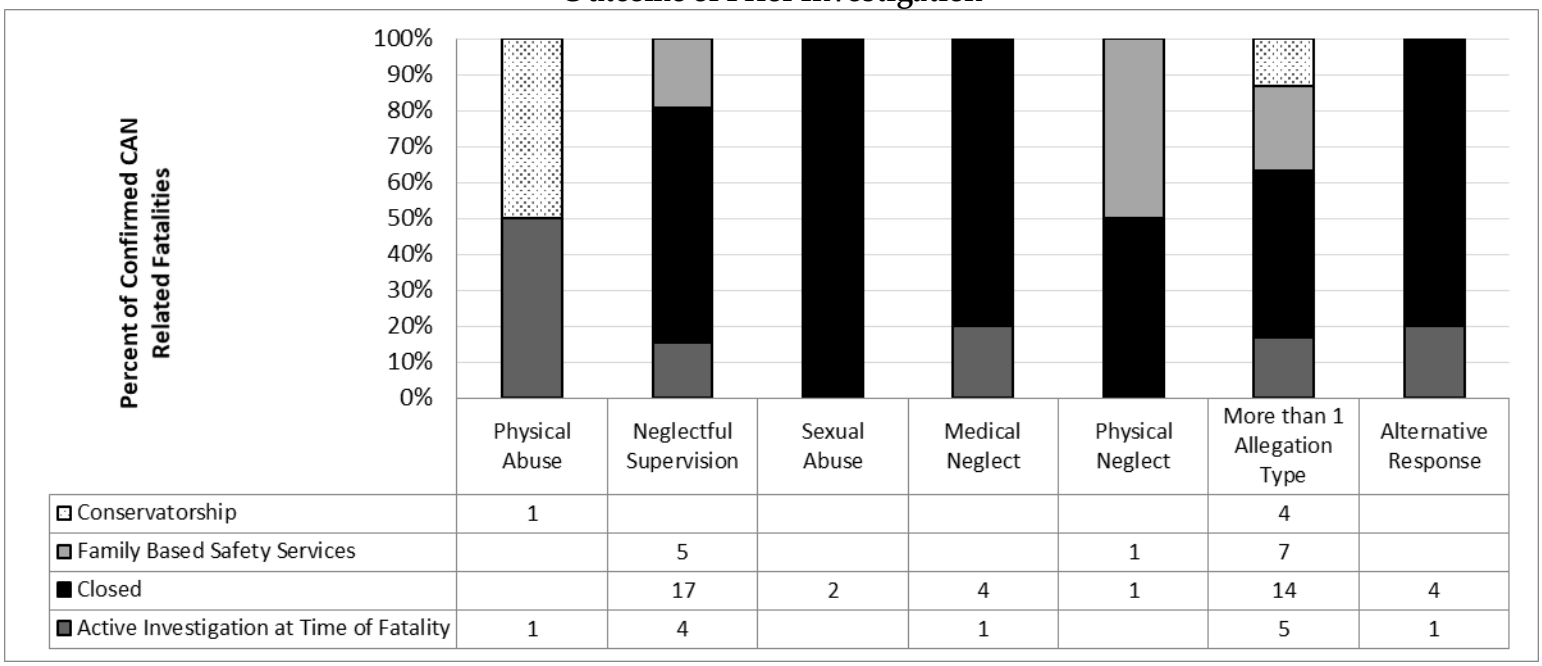
Figure 29. FY2021 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or Child's Family in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Emotional Abuse	Medical Neglect	Physical Neglect	Alternative Response
Alternative Response							5
Unable to Complete	1	2				1	
Reason to Believe	3	11	1		4		
Unable to Determine	3	11	1		1	1	
Ruled Out	13	34	7	3	11	9	
Administrative Closure	1	4	1				

***Source:* DFPS individual case reviews**

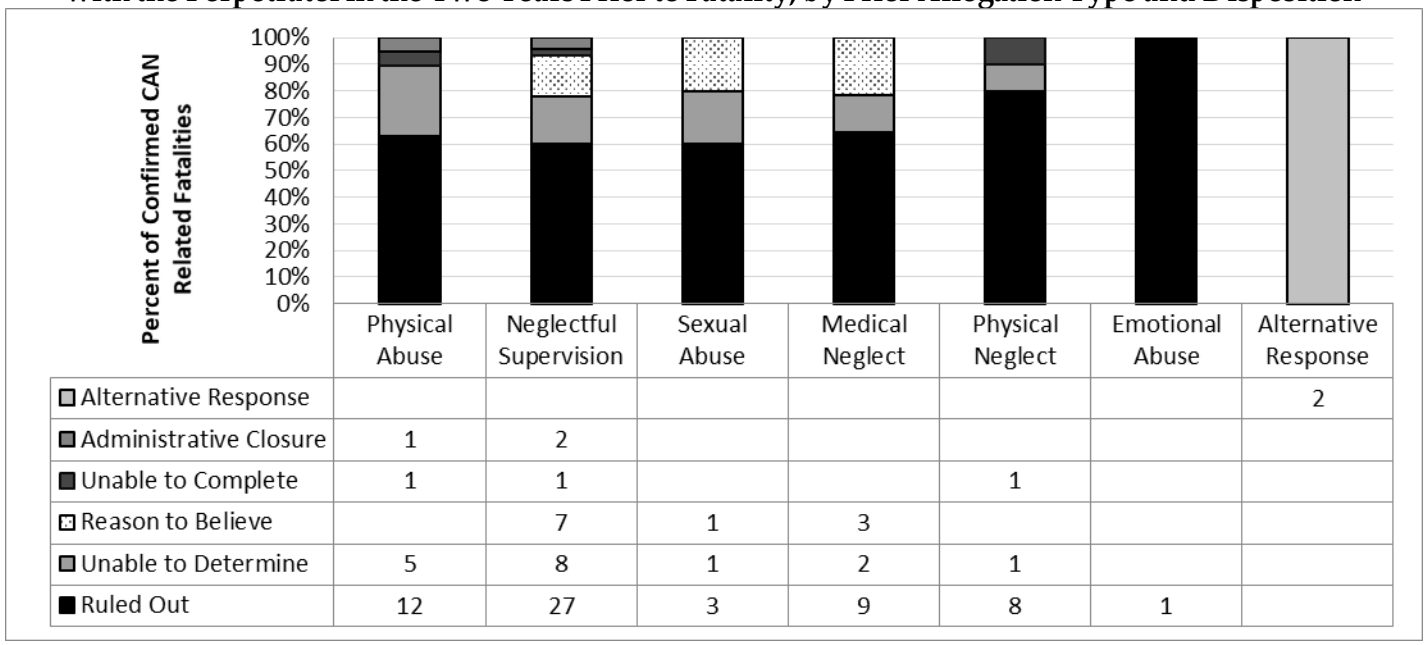
Figure 30. FY2021 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or the Child's Family in the Two Years Prior to Fatality, by Outcome of Prior Investigation



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Medical Neglect	Physical Neglect	More than 1 Allegation Type	Alternative Response
Conservatorship	1					4	
Family Based Safety Services		5			1	7	
Closed		17	2	4	1	14	4
Active Investigation at Time of Fatality	1	4		1		5	1

Source: DFPS individual case reviews

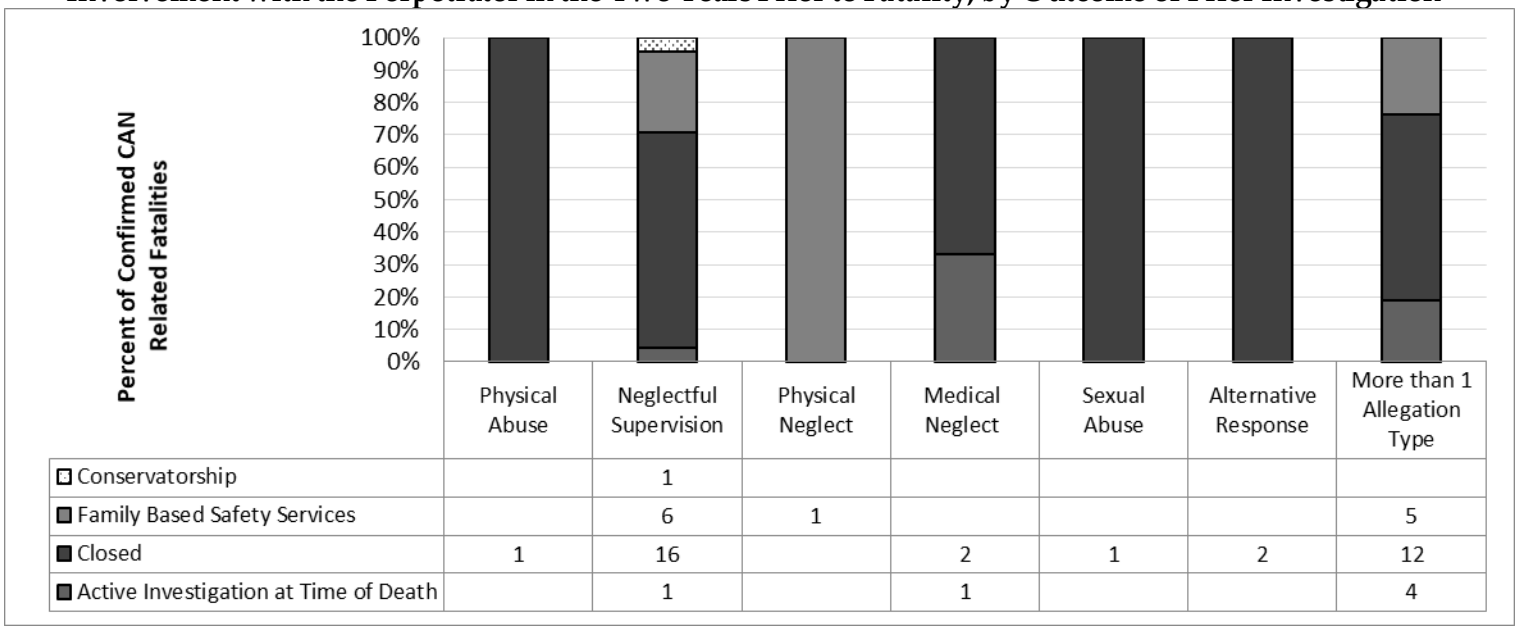
Figure 31. FY2021 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Perpetrator in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Medical Neglect	Physical Neglect	Emotional Abuse	Alternative Response
Alternative Response							2
Administrative Closure	1	2					
Unable to Complete	1	1			1		
Reason to Believe		7	1	3			
Unable to Determine	5	8	1	2	1		
Ruled Out	12	27	3	9	8	1	

Source: DFPS individual case reviews

Figure 32. FY2021 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	Physical Neglect	Medical Neglect	Sexual Abuse	Alternative Response	More than 1 Allegation Type
Conservatorship		1					
Family Based Safety Services		6	1				5
Closed	1	16		2	1	2	12
Active Investigation at Time of Death		1		1			4

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.

With neglectful supervision as the cause for 64 percent of all confirmed child abuse and neglect fatalities in FY2021, this pattern is also repeated in the subset of confirmed fatalities where the child or perpetrator had previous history with DFPS within the prior two years to the fatality.

- 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 one of three major neglectful supervision issues: vehicle-related, unsafe sleep, or neglect overall. Of note in FY2021, four youth who had prior involvement with DFPS in the past two years died by suicide. For context, in most fiscal years only one or two fatalities where a youth who died by suicide are considered due to abuse or neglect.
- When the *child* was previously known to DFPS in the two years prior to fatality because of prior physical abuse allegation, 47 percent were involved in a new incident of physical abuse which caused the fatality. In comparison, when the prior allegation was neglectful supervision, 32 percent were involved in a new incident of physical abuse which caused the fatality.
- When the *perpetrator* was previously known to DFPS in the two years prior to fatality because of prior physical abuse allegation, 47 percent were involved in a new incident of physical abuse which caused the fatality. In comparison, when the prior allegation was neglectful supervision, 26 percent were involved in a new incident of physical abuse which caused the fatality.

Table 9. FY2021 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**	**2**		**8**	**6**	**17**
Prior Neglectful Supervision Allegation	**7**	**7**	**2**	**15**	**10**	**47**
Prior Sexual Abuse Allegation				**5**	**3**	**8**
Prior Medical Neglect Allegation	**5**				**7**	**12**
Prior Physical Neglect Allegation	**2**	**2**		**4**	**3**	**11**
Prior Emotional Abuse Allegation					**3**	**3**
Prior Alternative Response		**1**		**1**	**2**	**5**
Total Child Fatalities with History	**15**	**12**	**2**	**33**	**34**	**96**
No Prior History or History Greater than Two Years	*14*	*21*	*14*	*38*	*16*	*103*
Overall Total	*29*	*33*	*16*	*71*	*50*	*199*

Source: DFPS individual case reviews

Table 10. FY2021 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**	**3**		**8**	**7**	**19**
Prior Neglectful Supervision Allegation	**9**	**14**	**2**	**15**	**16**	**56**
Prior Sexual Abuse Allegation				**2**	**2**	**4**
Prior Medical Neglect Allegation		**2**		**3**	**8**	**13**
Prior Physical Neglect Allegation	**2**	**2**		**3**	**5**	**12**
Prior Alternative Response		**1**		**1**		**2**
Total with History	**13**	**17**	**6**	**24**	**29**	**89**
No Prior History or History Greater than Two Years	*16*	*16*	*10*	*47*	*21*	*110*
Overall Total	*29*	*33*	*16*	*71*	*50*	*199*

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 FY2021, there were 22 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.

- Kyle, ten years old, was involved in an open Child Protective Investigation (CPI) Alternative Response (AR) case at the time of the fatality. The AR stage was initiated on September 25, 2020, alleging concerns of drug use. During the investigation the family could not be located. Kyle died on September 30, 2020 as a result of injuries from a vehicle accident.
- Haisley, two months old, was involved in an open Child Protective Investigation (CPI) case at the time of the fatality. The investigation was initiated on November 12, 2020, alleging there were weapons in the home accessible to children. During the investigation, Haisley died on November 21, 2020 while in the care of a babysitter. Haisley died as a result of unsafe sleep practices.
- Kalon, twelve years old, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on January 25, 2021, alleging that Kalon was not receiving required medical care. During the investigation, Kalon died on February 26, 2021 after being found unresponsive while in the care of a relative. Kalon died as a result of complications from a medical condition.
- Jacqueline, fourteen years old, was involved in an open Child Protective Investigation (CPI) Alternative Response (AR) case at the time of the fatality. The AR case was initiated on May 15, 2021 due to concerns of domestic violence and drug use. Jacqueline died on June 8, 2021 after being struck by a vehicle while walking on the highway under the influence of alcohol.

- Corraun, three months old, was involved in an open Child Protective Services (CPS) Family Based Safety Services (FBSS) case and an open Child Protective Investigation (CPI) case at the time of fatality. The family was receiving FBSS services to address ongoing mental health concerns in the home. The investigation was initiated on June 21, 2021 alleging physical neglect of Corraun. During the investigation, Corraun died on July 30, 2021 while in the care of a relative. Corraun died as a result of an illness.
- Noah, one month old, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on October 20, 2020, alleging drug use by Noah's parents and that they had not provided him prescription medication for bronchitis. During the investigation, Noah died on November 17, 2020. Noah was found having seizures and died due to physical abuse and medical neglect.
- Greyson, ten months old, was involved in an open Child Protective Investigations (CPI) case at the time of fatality. The investigation was initiated on December 16, 2020, alleging domestic violence and physical abuse. During the investigation, Greyson died on March 26, 2021. Greyson was found unresponsive after co-sleeping. Greyson died as a result of positional asphyxiation.
- Harmony, one year old, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on February 22, 2021 due to concerns of neglectful supervision when Harmony's sibling was born positive for amphetamines. Harmony and her sibling were placed with a relative. During the investigation, Harmony died on July 11, 2021 due to drowning.
- Kelly, fifteen years old, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on October 21, 2020 due to concerns of sex trafficking when a traffic stop was conducted and Kelly was found with two adult males after running away. During the investigation, Kelly ran away again and was dropped off at a hospital by two adult males, where she was found unconscious. Kelly died on November 4, 2020 due to from a medical condition.
- Gabriel, one month old, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on June 10, 2021, due to Gabriel's meconium testing positive for marijuana at his birth. During the investigation, Gabriel died on July 09, 2021, after being found unresponsive. Gabriel died of asphyxiation after co-sleeping.
- Cash, four years old, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on March 18, 2021, alleging that a person residing in the home was using drugs and caring for Cash. During the investigation, Cash died on May 15, 2021. Cash was found unresponsive with multiple stab wounds. Cash died as a result of homicide.

- Khalil, one year old, was involved in an open Child Protective Investigation (CPI) case at the time of the fatality. The investigation was initiated on September 4, 2020, alleging that persons responsible for the children's wellbeing were not providing adequate supervision, a clean home environment, and was under the influence of a mind-altering substance. During the investigation, Khalil died on September 19, 2020. Khalil was found unresponsive and taken to a hospital. The child was found to have multiple physical injuries and died due to physical abuse.
- Benjamin, four years old, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on July 21,2021 alleging physical abuse. During the investigation, Benjamin died on August 17, 2021. Benjamin was found unresponsive while at home and died as a result of malnourishment.
- Cathalina, two months old, was involved in an open Child Protective Investigation (CPI) case at the time of fatality. The investigation was initiated on December 18, 2020, alleging neglectful supervision and physical abuse of Cathalina. During the investigation, Cathalina died on February 22, 2021. Cathalina was found unresponsive and it is believed she died as a result of suffocation while co-sleeping.
- Keyontae, eight years old, was involved in an open Child Protective Investigations (CPI) Alternative Response (AR) case and an open Child Protective Services (CPI) case at the time of the fatality. The AR investigation was initiated on March 2, 2021, alleging concerns of physical abuse and the CPI investigation was initiated on March 04, 2021, alleging concerns of physical abuse and sexual abuse. During the investigations, Keyontae died on March 23, 2021. Keyontae was found unresponsive and had multiple injuries.
- Kentrell, a newborn, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on November 10, 2020, alleging that Kentrell was positive at birth for marijuana and his mother was positive for marijuana and amphetamines. During the investigation, the parents agreed to be supervised by a family member with Kentrell. Kentrell died on December 1, 2020 after being found unresponsive with concerns for unsafe sleep.
- Abelino, seven months old, was involved in an open Child Protective Services (CPS) Family Based Safety Services (FBSS) case at the time of the fatality. The FBSS stage was opened on July 11, 2020 due to concerns of neglectful supervision and drug usage. During the FBSS stage, Abelino died on January 21, 2021. Abelino was found unresponsive in his bassinet.
- Isabella, two years old, was involved in an open Child Protective Services (CPS) conservatorship case with an accompanying kinship stage at the time of the fatality. Isabella entered DFPS conservatorship on February 5, 2021. Isabella was previously

living with a relative during a Family Based Safety Services (FBSS) stage and when Isabella was removed, the court ordered Isabella to remain in the relative's home. The kinship stage opened February 12, 2021. The fatality investigation was initiated on February 16, 2021, due to concerns of physical abuse and physical neglect in the kinship home. Isabella died on February 18, 2021, from blunt force trauma.

- Zavian, sixteen years old, was involved in an open Child Protective Services (CPS) conservatorship case at the time of the fatality. Zavian entered DFPS conservatorship on October 7, 2020 and was placed at a residential treatment center (RTC) on January 25, 2021. Zavian died by suicide on February 26, 2021.
- Myles, three months old, was involved in an open Child Protective Services (CPS) conservatorship case with an accompanying kinship stage at the time of the fatality. Myles entered DFPS conservatorship on October 7, 2020, and was placed with fictive kin that same day. Myles died December 21, 2020, after being admitted to the hospital on December 16, 2020. An investigation was initiated on December 16, 2020, alleging physical abuse of Myles by a kinship caregiver due to numerous injuries reported at the time of his arrival to the hospital. Myles subsequently succumbed to his injuries while still in the hospital.
- Jensen, one year old, was involved in an open Child Protective Services (CPS) conservatorship case with an accompanying kinship stage at the time of fatality. Jensen entered DFPS conservatorship on February 13, 2020, and remained in the placement that was initiated on January 15, 2020, during the original investigation. Jensen died on February 15, 2021. The fatality investigation was initiated on February 12, 2021 as Jensen was reportedly found unresponsive after co-sleeping with this caregiver. Through the investigation, it was found that Jensen suffered inflicted blunt force trauma and died as a result of those injuries.

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 §261.203 and Tex. Fam. Code §261.004) 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 §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 FY2021 as confirmed child fatalities caused by abuse and neglect in previous years: the victim is often under a year old, male, and often there is a component of neglectful supervision. One continued difference is that victims in this category are often three months of age or younger at the time of their death. 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 FY2021, there were 192 child fatalities where the death was not related to abuse or neglect, but the investigation found abuse or neglect had occurred in the home.
- 129 child fatalities where the death was not related to abuse or neglect had some form of prior history, with 43.75 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.

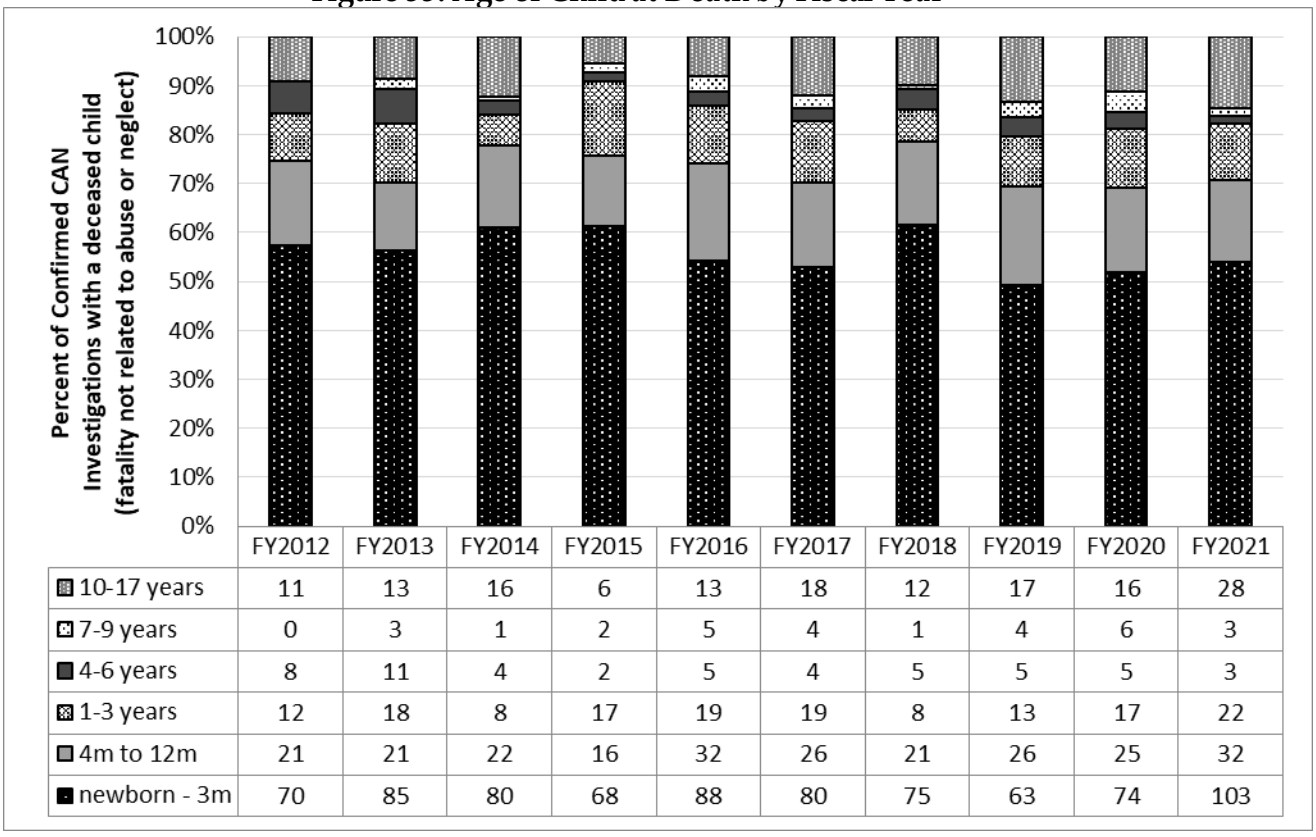
Victim Children

- 25 of the 192 children were previous alleged victims but allegations were not confirmed in prior cases.
- 23 of the 192 children were previously confirmed victims in prior cases.
- 21 of the 192 children were involved in Family Based Safety Services previously and 4 had been involved in DFPS conservatorship.

Perpetrators

- 35 of the confirmed perpetrators were previously alleged perpetrators but allegations were not confirmed in prior cases.
- 77 of the confirmed perpetrators were previously confirmed perpetrators in prior cases.
    - The cause of death in 73 of the confirmed cases were: natural, health-related, undetermined, accidental suffocation, fire, drowning, sudden unexplained infant death and unsafe sleep. In two cases, the youth died by suicide and two children died due to trauma unrelated to abuse or neglect.

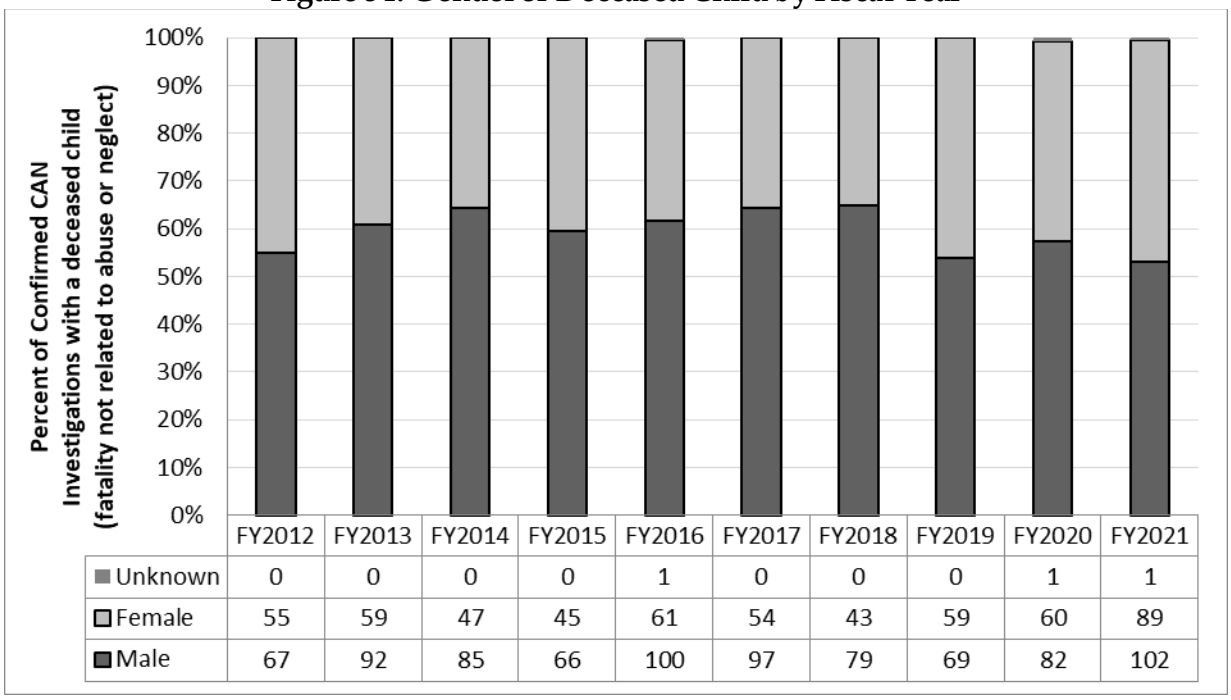
Figure 33. Age of Child at Death by Fiscal Year



	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
10-17 years	11	13	16	6	13	18	12	17	16	28
7-9 years	0	3	1	2	5	4	1	4	6	3
4-6 years	8	11	4	2	5	4	5	5	5	3
1-3 years	12	18	8	17	19	19	8	13	17	22
4m to 12m	21	21	22	16	32	26	21	26	25	32
newborn - 3m	70	85	80	68	88	80	75	63	74	103

Source: DFPS Data Warehouse Report ft_12

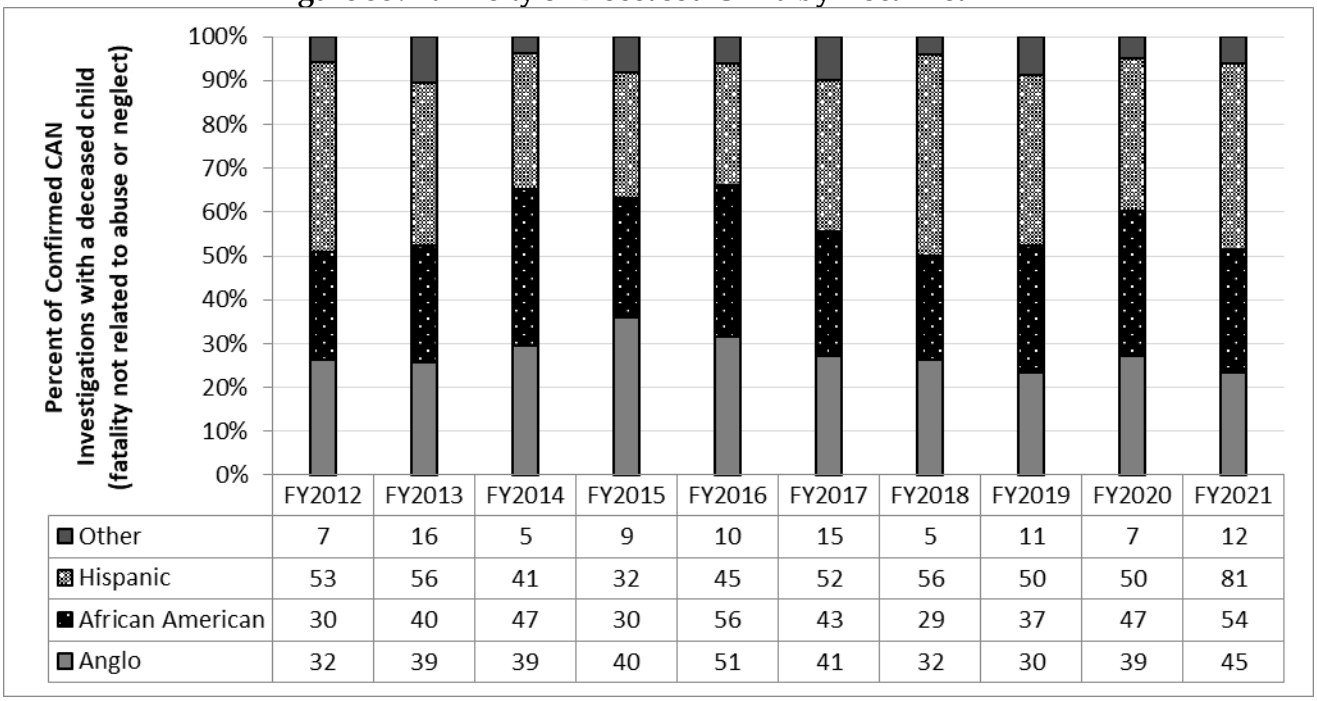
Figure 34. Gender of Deceased Child by Fiscal Year



	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Unknown	0	0	0	0	1	0	0	0	1	1
Female	55	59	47	45	61	54	43	59	60	89
Male	67	92	85	66	100	97	79	69	82	102

Source: DFPS Data Warehouse Report ft_12

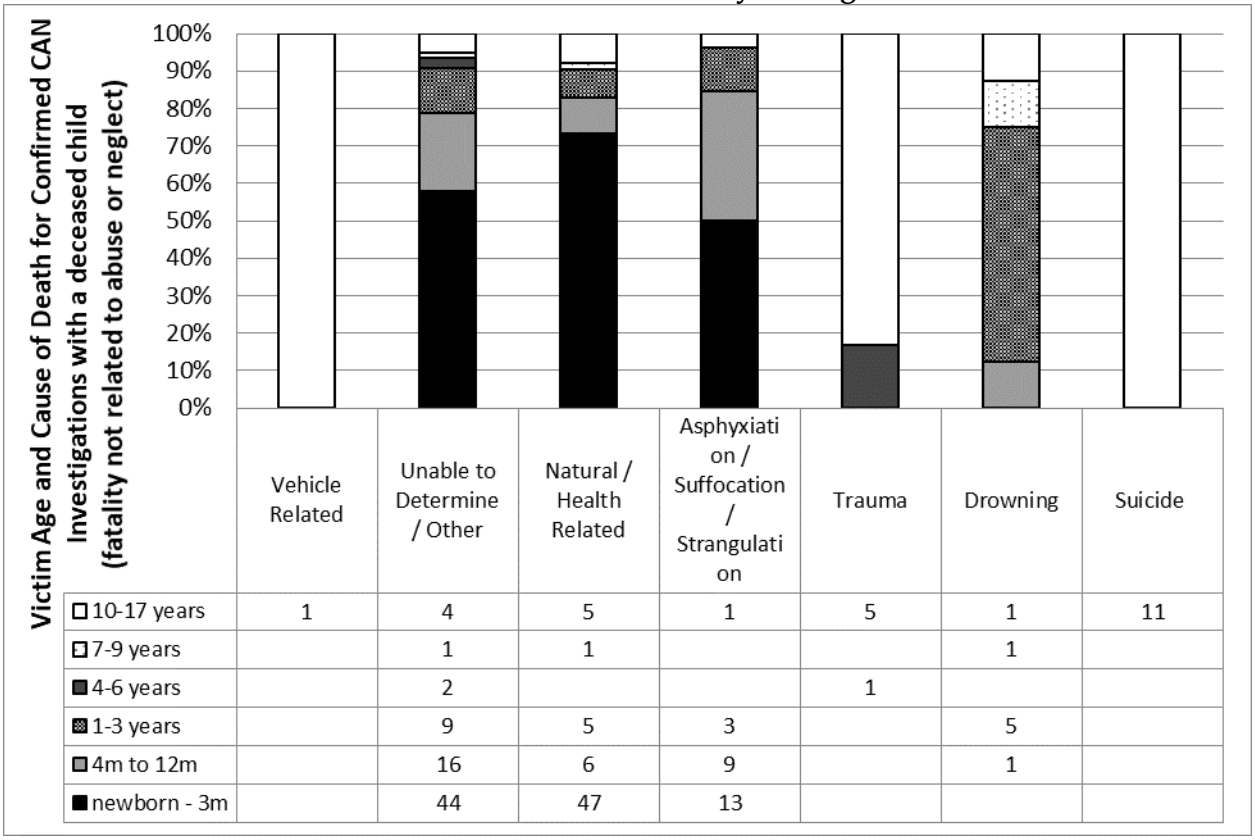
Figure 35. Ethnicity of Deceased Child by Fiscal Year



	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021
Other	7	16	5	9	10	15	5	11	7	12
Hispanic	53	56	41	32	45	52	56	50	50	81
African American	30	40	47	30	56	43	29	37	47	54
Anglo	32	39	39	40	51	41	32	30	39	45

Source: DFPS Data Warehouse Report ft_12

Figure 36. FY2021 - Investigated Child Fatalities that were not Abuse and Neglect Related Fatality but Maltreatment Confirmed in Investigation (RTB with Severity Type Other than Near Fatal) -- Cause of Near Fatality and Age of Child



Victim Age and Cause of Death for Confirmed CAN Investigations with a deceased child (fatality not related to abuse or neglect)	Vehicle Related	Unable to Determine / Other	Natural / Health Related	Asphyxiation / Suffocation / Strangulation	Trauma	Drowning	Suicide
10-17 years	1	4	5	1	5	1	11
7-9 years		1	1			1	
4-6 years		2			1		
1-3 years		9	5	3		5	
4m to 12m		16	6	9		1	
newborn - 3m		44	47	13			

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*[6], 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.[7]

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; [8]
- investigating any report of child abuse or neglect allegedly committed by a person responsible for a child's care, custody, or welfare; [9]
- including in the definition of child abuse and neglect the use of a controlled substance[10] and defining medical neglect as the failure to *seek, obtain, or follow through* with medical care for the child;[11] 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 2018 (the most recent year reported for all states), the Texas rate was 2.70 confirmed child abuse and neglect related fatalities per 100,000 compared to a national average of 2.39 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.[12] 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.

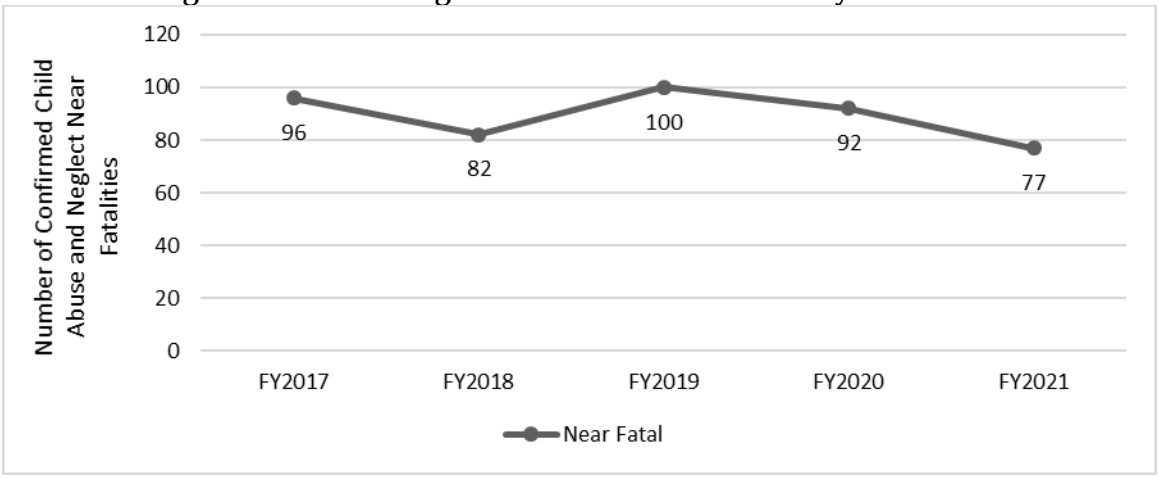
Near Fatalities

In FY2021, 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 also known as shaken baby syndrome, which accounted for 42 percent of the near fatalities in FY2021.

During FY2021, children age three and younger accounted for 65 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 48 percent. Female children made up 50.64 percent of all confirmed near fatalities. ******In FY2020, male children made up the majority of the near-fatal victims.

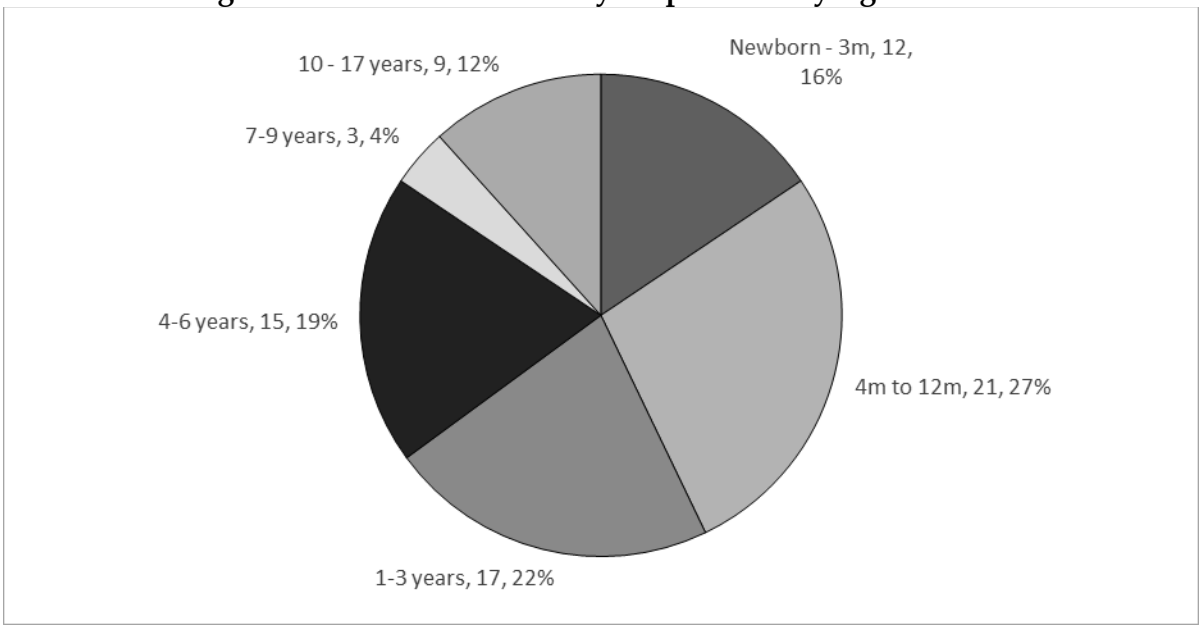
The highest number of abuse and neglect-related near fatalities were seen in Region 8 (San Antonio) with 19 near fatalities followed by Region 3 (Dallas/Ft. Worth) with 18 near fatalities, and Region 6 (Greater Houston) with 12 near fatalities.

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



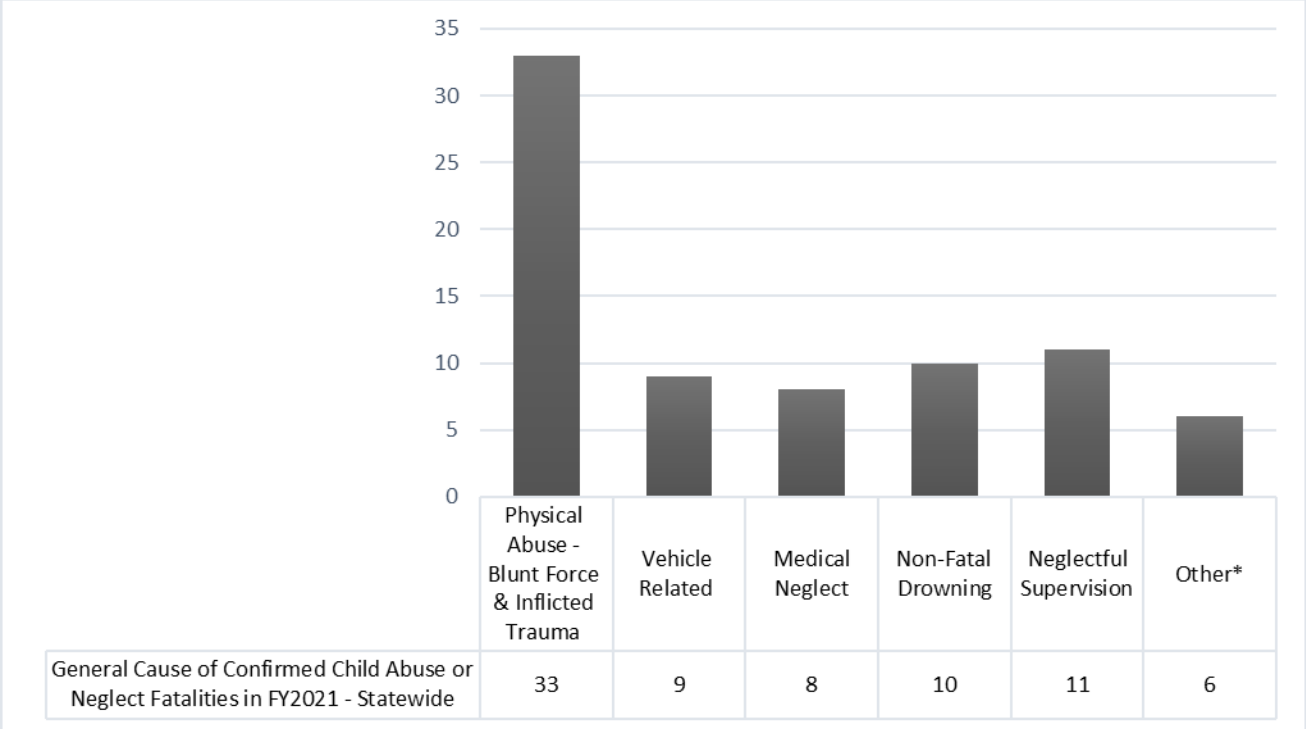
Source: DFPS individual case reviews

Figure 38. FY2021 Near Fatality Dispositions by Age of Child



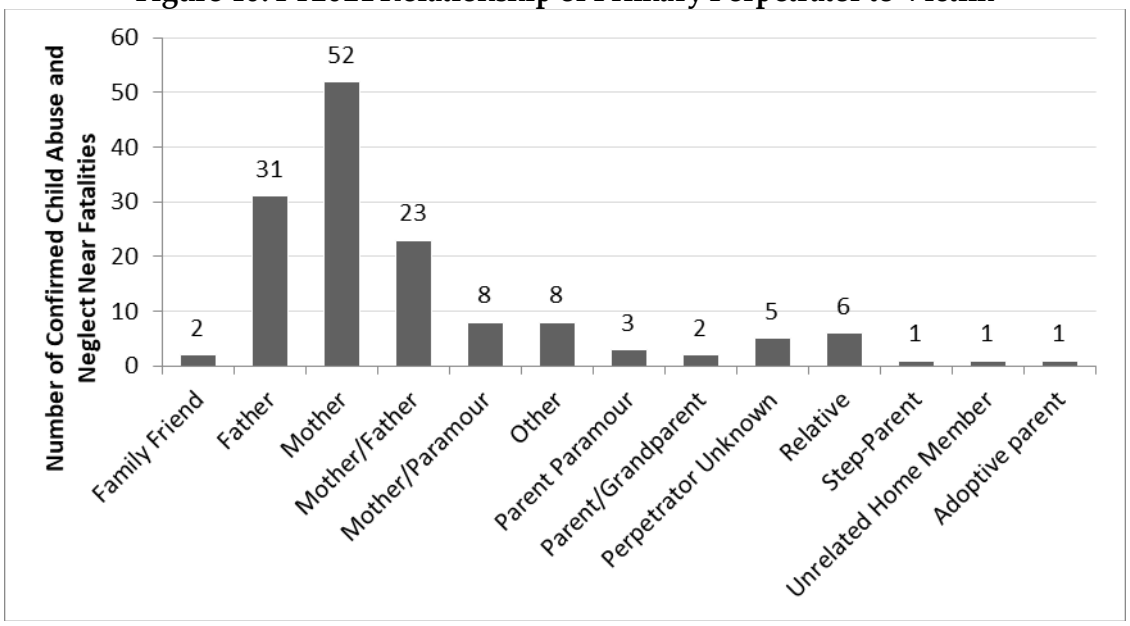
Source: DFPS individual case reviews and Data Warehouse nf_01

Figure 39. FY2021 –Near Fatality Dispositions by Cause



Other includes medical neglect, physical neglect, attempted suicide, premature birth due to drug use, and abandonment at birth.
***Source:* DFPS individual case reviews**

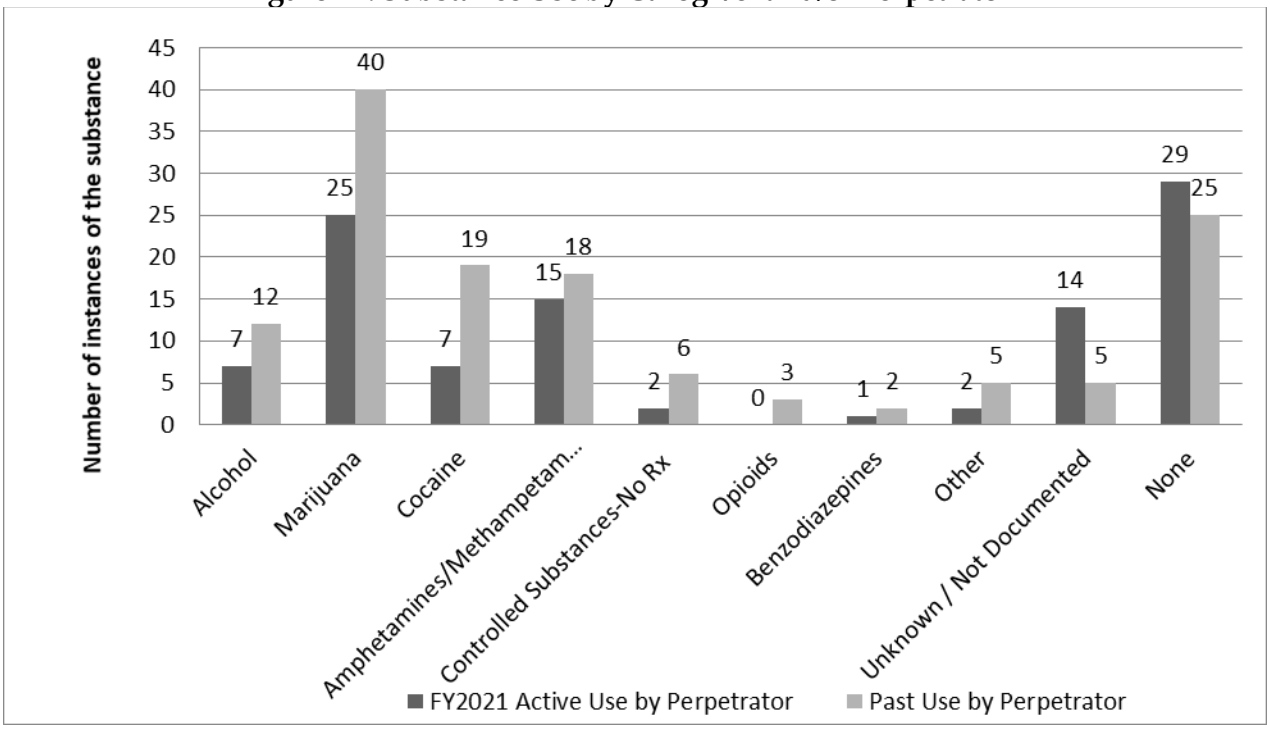
Figure 40. FY2021 Relationship of Primary Perpetrator to Victim



Source: DFPS individual case reviews

Note: Number of victims: 92; however, in many cases more than one functional perpetrator was identified.

Figure 41. Substance Use by Caregiver and/or Perpetrator



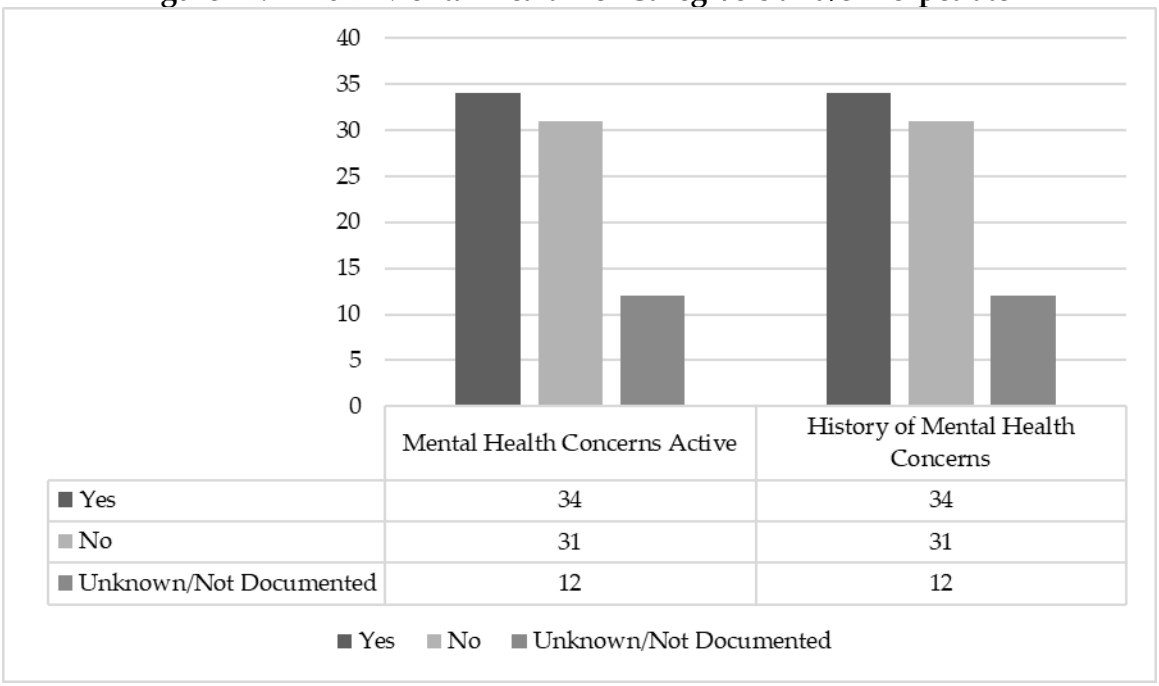
Source: DFPS individual case reviews

Table 11. FY2021 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	**26**	**42**	**21**
No	**44**	**30**	**-**
Unknown (not identified in case read)	**7**	**5**	**-**

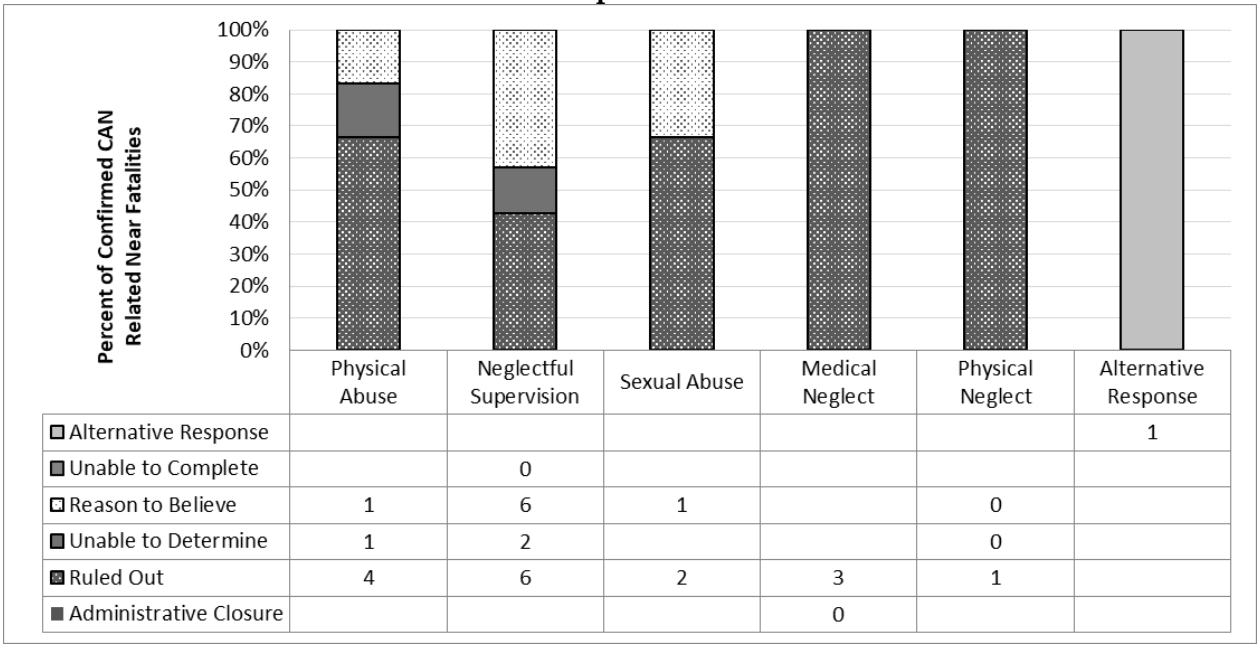
Source: DFPS individual case reviews

Figure 42. FY2021 Mental Health for Caregivers and/or Perpetrator



Source: DFPS individual case reviews

Figure 43. FY2021 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	Alternative Response
Alternative Response						1
Unable to Complete		0				
Reason to Believe	1	6	1		0	
Unable to Determine	1	2			0	
Ruled Out	4	6	2	3	1	
Administrative Closure				0		

Source: DFPS individual case reviews

In 37 near fatalities, the family had prior history with the department.

- 15 families had prior investigations that were closed without ongoing DFPS involvement.
- 6 families had an open stage of service: 3 open investigations, 1 open FBSS, and 1 was an open Alternative Response. 100 percent of initial contacts were completed timely. All 6 near fatality cases had one worker assigned per stage.
- 13 families had prior FBSS involvement. 9 of the families had a safety plan in place during the involvement. Fifty five 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 3 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: 4 cases
            - Daycare or respite care: 1 case
            - Domestic violence shelter or counseling: 2 cases
            - Drug testing or treatment: 5 cases

- Housing (rent, section 8, etc.): 1 case
- Infant or early childhood screening or development services: 3 cases
- Parenting skills / evidence-based parent education: 3 cases
- Interpreter/Translator services for limited English proficiency or hearing-impaired clients: 1 case

- In 5 of the 37 near fatalities, the family had prior involvement through DFPS Conservatorship.

In 28 of the 37 cases with prior history, initial contacts were made timely in 75.67 percent of the qualifying investigations.

Prevention Programs

DFPS Prevention and Early Intervention Division (PEI) assists communities in identifying, developing, and delivering high quality prevention and early intervention programs through contracts with community-based organizations, local governments, and school districts to provide services to promote positive outcomes for children, youth, families, and communities. PEI programs reached more than 57,000 families in FY2021. Ninety-eight percent of children and youth remained safe from maltreatment while receiving PEI services and more than 99 percent of youth engaged in services did not become involved with the juvenile justice system.

The current PEI-contracted programs include services for children, youth, and families.

Childhood Programs (Primarily Serving Children 0-5)

- **Healthy Outcomes through Prevention and Early Support (HOPES)** is a flexible community grant that funds a wide variety of innovative initiatives and supports for families with children 0-5 years of age. Supports typically include home-visiting services, as well as other supports that build protective factors such as parent support groups, maternal depression screening, early literacy promotion, case management, and other parent education. HOPES grants include collaborations with faith-based organizations and local providers of health care, child welfare, early childhood education, and other child and family services in the community.
- **Texas Home Visiting (THV)** a free, voluntary program through which early childhood and health professionals regularly visit the homes of pregnant women and families with children under 6 years of age. Through the use of evidence-based models, the program supports positive child health and development outcomes, increases family self-sufficiency, and creates communities where children and families can thrive. THV includes a broader set of funding that allows communities to select the model best suited for them. In addition to the funding appropriated through the Texas Legislature, THV is also funded through Maternal Infant Early Childhood Home Visiting (MIECHV), a federal grant that allows communities to choose among the following evidence-based home visiting models: Nurse-Family Partnership (NFP), Parents as Teachers (PAT), Home Instruction for Parents of Preschool Youngsters (HIPPY), and Healthy Families America (HFA). These funds also support the coordination of local and state early childhood coalitions to build comprehensive early childhood systems. The unique Texas model utilizes both service and system-level strategies to improve broad child and family outcomes.
- **Texas Nurse Family Partnership Program (TNFP)** is a free, voluntary program through which nurses partner with first-time mothers to improve prenatal care and provide one-on-one child development education and counseling. Families start the partnership with TNFP by their 28th week of pregnancy and can receive support until their child reaches 2 years of age.

- **Safe Babies Evaluation** is an initiative and evaluation required by Budget Rider 39 from the 84th Legislature. The purpose of the project is to provide and evaluate hospital or clinic-based interventions that are designed to prevent maltreatment, especially abusive head trauma, in the first year after birth. Over 2,000 families will be provided prevention services and the evaluation will estimate the impact of abusive head trauma prevention efforts across the state.

Youth Programs

- **Family and Youth Success (FAYS)** addresses family conflict and everyday struggles while promoting strong families and youth resilience. Every FAYS provider offers one-on-one coaching or counseling with a trained professional and group-based learning for youth and parents. FAYS programs also operate a 24-hour hotline for families having urgent needs. In some areas of the state FAYS only provides services to families with children 6-17 years of age.
- **Community Youth Development (CYD)** provides funding and technical assistance that affords community-based organizations the opportunity to foster positive youth development and build healthy families and resilient communities. CYD is a zip code-based program and provides services in zip codes with high incidences of juvenile crime. Communities prioritize and fund specific prevention services to address their community level needs.
- **Statewide Youth Services Network (SYSN)** creates a statewide network of youth programs aimed at positive youth development for youth ages 6 to 17. PEI funds allow state-level grantees to identify areas that may benefit from additional resources and target specific support to local communities to maintain the statewide network. Examples of service provided through SYSN include mentoring and youth skills development.

Family Programs

- **Fatherhood EFFECT** programs provide parent education and resources to fathers. Beginning in FY2020, Fatherhood EFFECT's scope expanded to include collaboration with community coalitions, encouraging organizations to increase the quality of supports targeted specifically at fathers and pivoting to explicitly include and support fathers across multiple programs in an organization or community.
- **Helping through Intervention and Prevention (HIP)** provides voluntary, in-home parent education using evidence-based or promising practice programs and other support services. This includes basic needs support to families with a newborn who are experiencing adversity. The HIP program increases protective factors for specialized families involved with the child welfare system. This includes currently pregnant, formerly pregnant, and parenting foster youth. The programs are designed to support

healthy, nurturing, and safe homes for children and ultimately promote positive outcomes for children and families.

- **Service Members, Veterans, and Families (SMVF) Program** provides support for families of children ages 0-17 in which one or both parents are serving, or have served, in the armed forces, reserves, or National Guard. Through parenting, education, counseling, and youth development resources, this program: builds on the strengths of both caregivers and children to promote strong families; partners with military and veteran caregivers to support positive parental involvement in their children's lives; partners with military and veteran caregivers to maximize their ability to give their children emotional, physical and financial support; and builds community coalitions focused on promoting positive outcomes for children, youth and families.
- **Texas Youth Helpline** is a 24-hour toll-free hotline offering crisis intervention, telephone counseling, and referrals to troubled youth and families. The hotline also includes text messaging and online chat to help support youth and families in need.

Prevention and Early Intervention - Public Awareness Campaigns

DFPS has several public awareness campaigns and services through Prevention and Early Intervention. Through these campaigns and resources, DFPS is able to provide information to the general population – not just those people who have been involved with the CPS system. These campaigns target specific issues that lead to child abuse and neglect, including fatalities. Campaigns include:

- Get Parenting Tips on how to connect with community-based resources.[13]
- Room to Breathe on safe sleep practices for infants.[14]
- Watch Kids Around Water about drowning prevention.[15]
- Look Before You Lock on preventing deaths in hot cars.[16]
- Don't be in the Dark on selecting regulated child care.[17]

Additional resources include:

- Videos: Animated and real-life videos for parents of all ages.[18]
- Local Support: Resources for concrete support in your area.[19]
- Free Downloads: Colorful resources, including an annual calendar with parenting tips for each month of the year.[20]

PEI has also developed a Community Toolkit. Understanding that there is no "one size fits all" approach for supporting all Texas communities, this toolkit is intended to offer a range of resources to support a collaborative approach to developing strategies that align the prevention of child maltreatment and the promotion of positive outcomes for Texas children, youth, and families.

PEI also houses the Office of Child Safety which independently analyzes individual child abuse and neglect fatalities, near fatalities and serious injuries as well as the risk factors and systemic issues involved. This involves reviewing state and national trends regarding child fatalities, near fatalities, and serious injuries in DFPS cases and in the general population as well as strategies that can be deployed by DFPS programs and by other state agencies and local communities. With the overarching goal of supporting implementation of prevention and intervention strategies to address and reduce fatal and serious child maltreatment, the Office of Child Safety is specifically tasked with:

- Producing consistent, transparent, and timely review of child fatalities and serious injuries by independent experts outside any specific program;
- Assessing root causes of child fatalities to provide guidance on the most effective prevention changes as well as improvements in child welfare practices;
- Operating with the understanding that many systems impact outcomes for children and that prevention and intervention efforts will involve many sectors and non-traditional partners;
- Working closely with the Department of State Health Services (DSHS) and others to share data and information; and
- Developing strategic recommendations to bring together local agencies, private sector, non-profits, and government programs to reduce child abuse and neglect fatalities.

As part of this effort, DFPS and DSHS released the joint report "Strategic Plan to Reduce Child Abuse and Neglect Fatalities" in March 2015. This report identified certain risk factors and commonalities between confirmed child abuse and neglect fatalities including individual and community risk factors for child abuse and neglect. Almost half of the confirmed child abuse and neglect fatalities have no previous involvement with DFPS, highlighting the importance of population-based strategies to reduce these deaths. By utilizing a public health approach to understand, analyze, and build a comprehensive approach to target child abuse and neglect fatalities, DFPS and DSHS can leverage resources, programs, and community collaborations to target specific issues and geographical areas based on their individual needs. The "Strategic Plan" provided recommendations to address child fatalities from a public health prospective in four broad areas such as fatalities surrounding vehicle safety (hyperthermia and pedestrian fatalities), safe sleep practices, and intimate partner violence.

This work has been expanded to analyze child maltreatment, including fatalities, and build a public health approach between both agencies that addresses child maltreatment risk and protective factors. During FY2022, data will be reanalyzed to look at any change in risk factors or community-specific issues that may have changed since the March 2015 "Strategic Plan to Reduce Child Abuse and Neglect Fatalities."

The Office of Child Safety also hosts training sessions across the state. Topics presented at these training sessions are focused on issues surrounding child safety and addressing critical junctures to prevent child fatalities such as safe sleep, water safety, supporting youth, and connecting families to upstream resources to help families thrive in their community.

PEI has made available other materials for community partners to help promote child safety across a variety of topics. This include hosting a Safe Sleep Awareness week and curating social media toolkits on a variety of topics such as safe sleep, water safety, mental health awareness and suicide prevention, and strengthening families/building healthy relationships.

Initiatives & Program Improvement

Internal Initiatives and Program Improvement

DFPS undertook several initiatives designed 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.

Centralizing Investigations – In September 2017, DFPS centralized investigations under the DFPS Commissioner. The division, referred to as Child Protective Investigations (CPI), includes Child Protective investigations (CPI), Child Care investigations (CCI), Residential Child Care investigations (RCI) and Special Investigators. The Investigation Division focuses on improving investigation practice and policy. It is responsible for developing policy and procedures consistent with best practices in child protective services as well as implementing legislative mandates.

Streamlining and Strengthening Policy – CPI and CPS have streamlined and updated current policy handbook – separating policy from best practice and improving the content, clarity, and accuracy of policy. CPI and CPS have also created a better process for communicating policy changes in a more coordinated and effective manner, so that staff can more readily digest and understand agency policies. Policy surrounding specific topics in child safety have been added or clarified, such as the requirement to assess and discuss safe sleep practices whenever there is a child under the age of one in the home and additional guidance on engaging families through Family Based Safety Services (FBSS). Policy and practice also allows for concurrent stages so that a family involved in an investigation with CPI can be served through FBSS as soon as it is identified that they can benefit from ongoing services to address child safety.

Risk and Safety Assessments - Risk assessments and structured decision-making tools are fully implemented. The safety assessment tool assists a caseworker during the first contact with a child and family, a critical opportunity to assess safety. The risk assessment tool is an objective tool to support safety interventions and based on actuarial principles that have been scientifically accepted and adapted for Texas.

Utilizing Predictive Analytics - DFPS is expanding the use of predictive analytics to address emerging problems, coordinate and improve fragmented quality assurance processes, and establish clear accountability for overseeing change in state office and in the regions. Examples of this work includes utilizing predictive analytics to improve child safety in Family Based Safety Services cases by conducting real time case reviews

in high-risk cases and additional staffings when a new intake is received on open stages of service.

Statewide Internal and External Child Fatality Review Committees

Child Safety Review Committee - DFPS Review Team with External Stakeholders

The Child Safety Review Committee (CSRC) examines issues that have implications for 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 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.[21] 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 Texas Child Fatality Data and Recommendations – April 2020.[22]

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:
http://texaschildrenscommission.gov/media/46100/PDF-Report-POK-Commission-December-2015.pdf

National Initiatives and Program Improvement

Casey Family Programs - Child Safety Forums

Since 2010, DFPS has participated in Child Safety forums hosted by Casey Family Programs to address child fatalities. Forums are focused on bringing together researchers, policy makers, child welfare and public health leaders to address a variety of approaches to address child safety. Forums have included topics such as:

- Improving Child Safety and Reducing Child Maltreatment Fatalities
- Applying Public Health Approaches to Improve Safety and Prevent Child Fatalities
- Focusing on Child Protection
- Reframing Public Perception
- Application of Predictive Risk Modeling

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://eliminatechildabusefatalities.sites.usa.gov/

Endnotes

[1] 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.

[2] 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 2020*. Available at https://www.acf.hhs.gov/cb/resource/child-maltreatment-2020

[3] U.S. Department of Health and Human Services, Administration of Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2014). *Child Maltreatment 2013.* Available from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment.

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

[5] See US Centers for Disease Control and Prevention at:
http://www.cdc.gov/violenceprevention/childmaltreatment/riskprotectivefactors.html

[6] *Child Maltreatment 2018,* https://www.acf.hhs.gov/cb/resource/child-maltreatment-2018

[7] 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

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

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

[10] 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.

[11] Tex. Fam. Code §261.001 Definitions

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

[13] DFPS Public Website, https://www.getparentingtips.com/

[14] DFPS Public Website, https://www.getparentingtips.com/babies/safety/ABCs-of-safe-sleep-for-babies/

[15] DFPS Public Website, https://getparentingtips.com/toddlers/safety/water-safety-for-kids/

[16] DFPS Public Website, https://getparentingtips.com/kids/safety/keeping-kids-safe-in-and-around-cars/

[17] DFPS Public Website, https://www.dfps.state.tx.us/child_care/search_texas_child_care/

[18] DFPS Public Website, https://www.getparentingtips.com/video-library.asp

[19] DFPS Public Website, https://www.getparentingtips.com/local-support/

[20] DFPS Public Website, https://www.getparentingtips.com/parenting-resources/

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

[22] Texas Child Fatality Data and Recommendations – April 2020, https://dshs.texas.gov/legislative/2020-Reports/Texas-Child-Fatality-Data-and-Recommendations-April-2020.pdf