TEXAS
Department of Family
and Protective Services

Fiscal Year 2023
Child Maltreatment Fatalities and Near Fatalities Annual Report

March 2024

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Executive Summary

With over 7 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. Child fatalities decreased by 34 percent between FY 2020 and FY 2023. This includes decreases in physical abuse, physical neglect, and neglectful supervision. Tragically, preventable fatalities such as unsafe sleep fatalities that involved substance use as well as drownings continued at rates similar to the prior year.

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. More than half of all child maltreatment fatalities in FY2023 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.

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

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

Based on administrative data and individual case reviews for confirmed child abuse and neglect related fatalities during FY 2023, the following trends and areas for review have been identified:

General Findings

- In FY 2023, 164 children died due to abuse and neglect in Texas (Table 1).
- In most of these cases – 139 – there was no Child Protective Investigation (CPI) 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).
- There were decreases in most causes of child fatalities including in physical abuse, neglectful supervision, and neglect. (Figure 3).

- There continues to be a high number of physical abuse fatalities after an all-time low in FY 2017--but in the vast majority of those cases, abuse in the family was never reported to Child Protective Services (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 decreased from 997 in FY 2022 to 690 in FY 2023 (Figure 2).
- Confirmed neglect-related fatalities account for 56 percent of child maltreatment fatalities (Figure 4).
- The most common causes of fatalities involving neglect were drowning, unsafe sleep, and physical neglect and medical neglect fatalities (Figure 7, 8).
- In FY 2023, Texas had 85 confirmed abuse and neglect-related near fatalities (Figure 36).

Victims

- Based on the confirmed child abuse and neglect-related fatalities over the past 10 fiscal years, children 3 years of age and younger were almost 80 percent of all confirmed child abuse and neglect fatalities; however, the past three years have had a marked increase in child fatalities involving older children. In FY 2023, children 3 years of age and younger made up 70.7 percent of confirmed child abuse and neglect fatalities. Male children made up more than half of all confirmed child abuse and neglect-related fatalities (Figure 9, 10).
- During FY 2023, 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).
- 66 percent of children who died from abuse or neglect in FY 2023 were too young for school and not enrolled in day care. Six 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 53 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

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
- deaths of children living with their families, or deaths where the child is in DFPS conservatorship and in non-foster care kinship placements (Child Protective Services placements).

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

In abuse and neglect investigations, investigators are required by law to establish a preponderance of evidence 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. To track and report on these fatalities, DFPS utilizes case dispositions from every investigation.

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

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

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

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

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

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

Near Fatality Investigations

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

As there is no universal definition of "serious" or "critical" condition, DFPS worked with child abuse pediatricians from around the state to help provide common, clarifying guidance for both staff and medical professionals to utilize. A near fatality consists of an act of abuse or neglect to

a child who, without imminent medical intervention, would likely have died as a result of the maltreatment. "Imminent medical intervention" must be performed by a licensed medical professional and requires some form of:

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

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

Investigation Dispositions for Near Fatalities

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

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

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

Findings: Investigating Child Abuse and Neglect Related Fatalities

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

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

	FY2019	FY2020	FY2021	FY2022	FY2023
Child Population of Texas	7,437,514	7,515,129	7,594,941	7,675,490	7,757,746
Number of Intakes Assigned for Investigation or Alternative Response by CPI	242,103	224,288	253,054	273,415	264,464
Number of Investigated Child Fatalities	772	826	964	997	690
Number of fatalities where abuse/neglect was confirmed	235	251	199	182	164
Child Fatality Rate per 100,000 Children	3.16	3.34	2.62	2.37	2.11
National Rate for Equivalent Federal Fiscal Year[2]	2.48	2.50	2.63	2.73	***

Source: Data from US Census Bureau; Texas State Data Center; DFPS Data Books FY2010-FY 2023; 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 2023 – estimates were updated during FY2019 for population from 2010 through 2019.

*** Child Maltreatment 2023 is scheduled to be released after the publishing of this report. National rates were recalculated in Child Maltreatment 2022 report.

The number of child fatalities that were investigated by DFPS decreased from 997 in FY2022 to 690 in FY2023 (30.8 percent decrease). This decrease comes after a policy/practice change was implemented in September 2022. Intakes that involve a child fatality but include no explicit concern for abuse and neglect are sent to the field as a Case Related Special Request to ensure the reporter or first responders had no concern for abuse or neglect. If there are any concerns for abuse or neglect, the child fatality is then sent to CPI investigators for a full investigation. This practice change reflects a similar routing process that was in place from FY2013 through

February 2020 where practice required that when SWI received an intake regarding a child fatality but there was no clear allegation of abuse or neglect, the intake was reviewed by a screener before assignment as a full investigation. This process ensures that reports assigned to field staff for full investigation meet DFPS jurisdiction to investigate.

The distribution of case dispositions for child fatality investigations conducted over the last 10 years are presented in Table 2 - Percentage of Child Fatality Investigations by Disposition. The percent of confirmed child abuse and neglect-related fatalities have varied between 17.37 percent and 30.44 percent in the past five years, with FY 2023 at 23.77 percent of all investigated fatalities being related to maltreatment.

Table 2. Percentage of Child Fatality Investigations by Disposition

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

*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

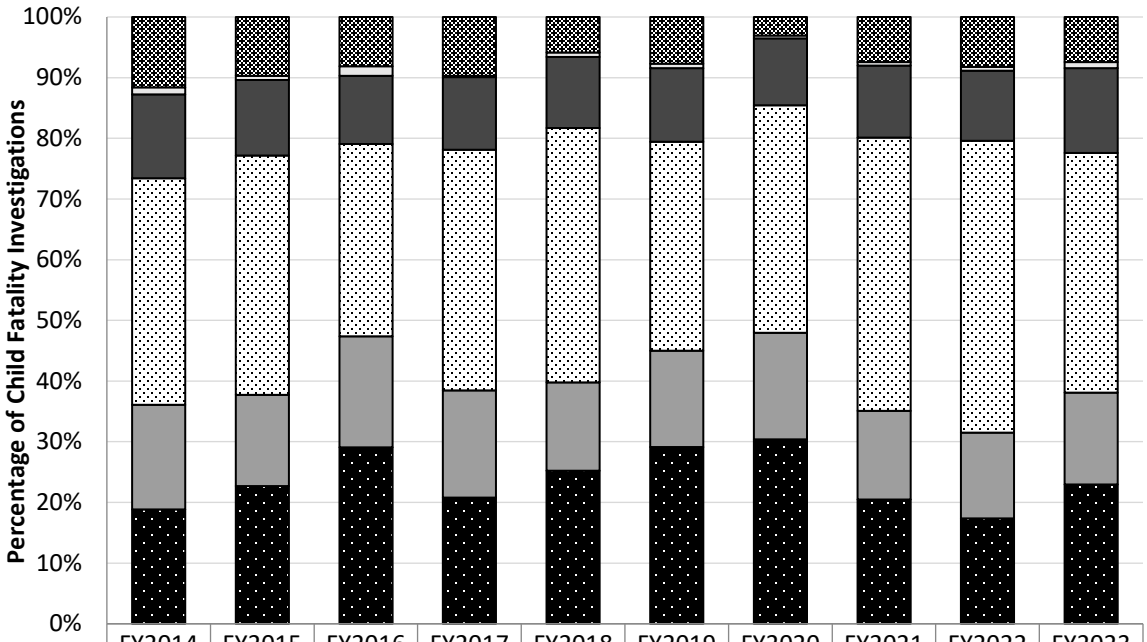
It is important to note that starting September 1, 2021, Texas Family Code, Section 261.001 provided an updated definition for neglect that requires both the presence of blatant disregard as well as either a resulting harm or an immediate danger:

> "an act or failure to act by a person responsible for a child's care, custody, or welfare evidencing the person's blatant disregard for the consequences of the act

or failure to act that results in harm to the child or that creates an immediate danger to the child's physical health or safety…"

Since FY 2022 was the first year with this expanded definition for neglect, it will take time to see if this is part of the decrease in the percent of investigations where the child fatality was confirmed to be due to fatal abuse or neglect.

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



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

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

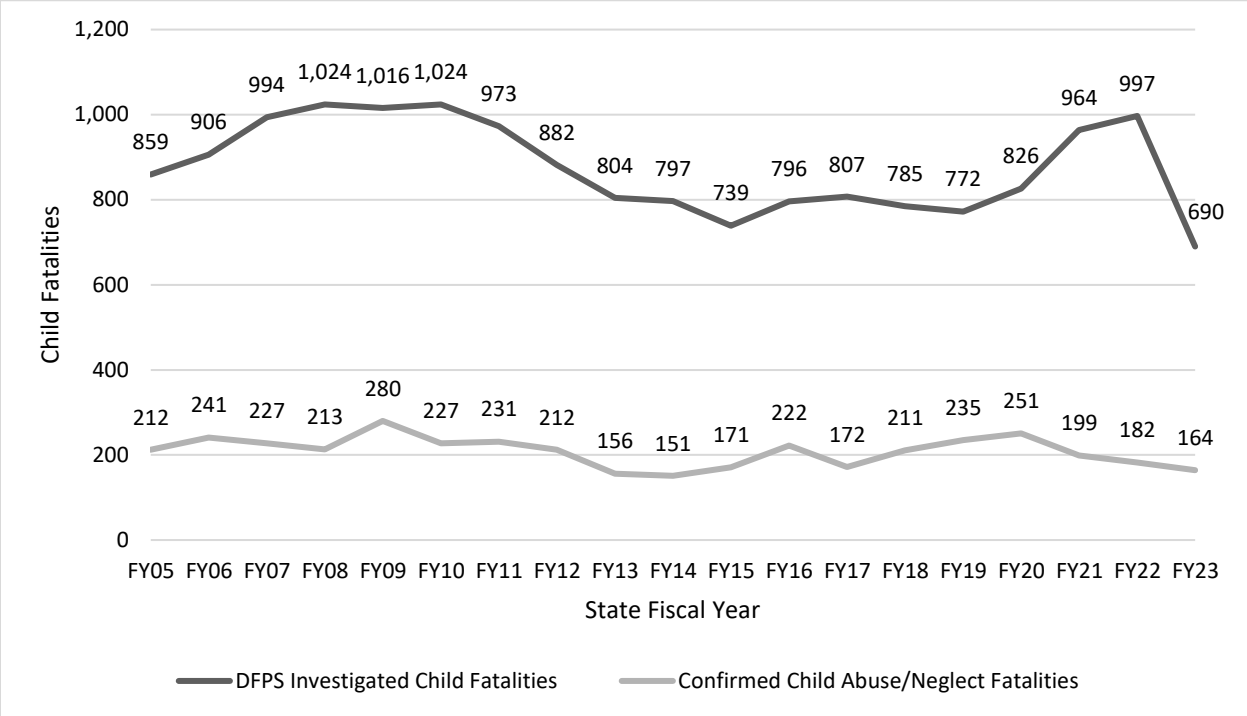
DFPS works in collaboration with other partners such as medical examiners, law enforcement, and DFPS Special Investigators to ensure thorough child fatality investigations. Additional training has been provided to CPI staff on various topics to support more thorough

investigations: contacting reporters, utilizing collateral contacts, family engagement, building a support network, and assessing safety throughout the investigation.

Several factors help support case dispositions:

- Increased understanding by the general public and first responders on what child fatalities should be reported to DFPS for investigation;
- Ongoing training within CPI to provide additional education on best practices for investigating child fatalities and properly dispositioning cases;
- Utilization of Special Investigators to investigate child fatalities and locate families if the primary investigator is unable to locate the family or surviving siblings;
- Collaborating with medical professionals to determine the nature and extent of the maltreatment; and
- Increased collaboration and multidisciplinary team staffing between law enforcement, medical examiners, Child Protective Investigations, and Child Protective Services.

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



Source: DFPS Data Warehouse Report FT_06

In FY 2023, DFPS investigated 690 possible child abuse and neglect-related fatalities. That number peaked in FY 2008 and FY 2010 at 1,024 investigated child fatalities. (Figure 2).

Ensuring Consistency in Dispositions

Guidelines are utilized by CPI 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.

The overall number of child fatality investigations may also reflect random fluctuation. The number of child abuse and neglect fatalities spiked in FY 2009 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 (HHSC), 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]

FY 2023 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 is collected from IMPACT and individual case reads where the child's death was caused by abuse or neglect which is distinguished with the disposition of reason to believe - fatal.

General Findings

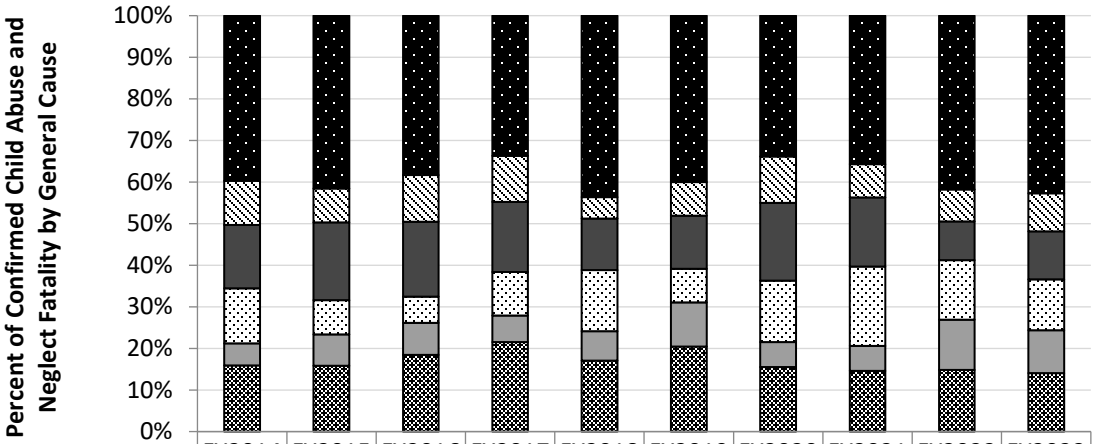
- In FY 2023, 164 children died due to abuse and neglect in Texas (Table 1).
- In most of these cases – 139 – there was no Child Protective Investigation (CPI) or ongoing services stage open at that time, so there was no regular monitoring of the family occurring that could have protected the child (Figure 24).
- There were decreases in most causes of child fatalities including in physical abuse, neglectful supervision, and neglect. (Figure 3).
- There continues to be a high number of physical abuse fatalities after an all-time low in FY 2017--but in the vast majority of those cases, abuse in the family was never reported to Child Protective Services (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 decreased from 997 in FY 2022 to 690 in FY 2023 (Figure 2).
- Confirmed neglect-related fatalities account for 56 percent of child maltreatment fatalities (Figure 4).
- The most common causes of fatalities involving neglect were drowning, unsafe sleep, and physical neglect and medical neglect fatalities (Figure 7, 8).
- In FY 2023, Texas had 85 confirmed abuse and neglect-related near fatalities (Figure 36).

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

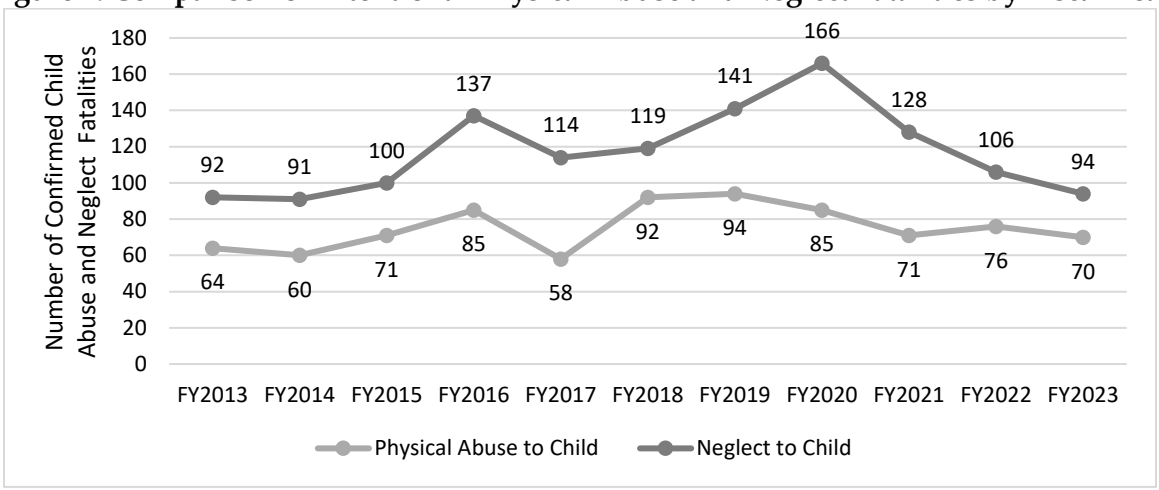


	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023
Physical Abuse - Blunt Force Trauma & Intentional Homicide	60	71	85	58	92	94	85	71	76	70
Vehicle related	16	14	25	19	11	19	28	16	14	15
Unsafe sleep	23	32	40	29	26	30	47	33	17	19
Other*	20	14	14	18	31	19	37	38	26	20
Neglectful Supervision	8	13	17	11	15	25	15	12	22	17
Drowning	24	27	41	37	36	48	39	29	27	23

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

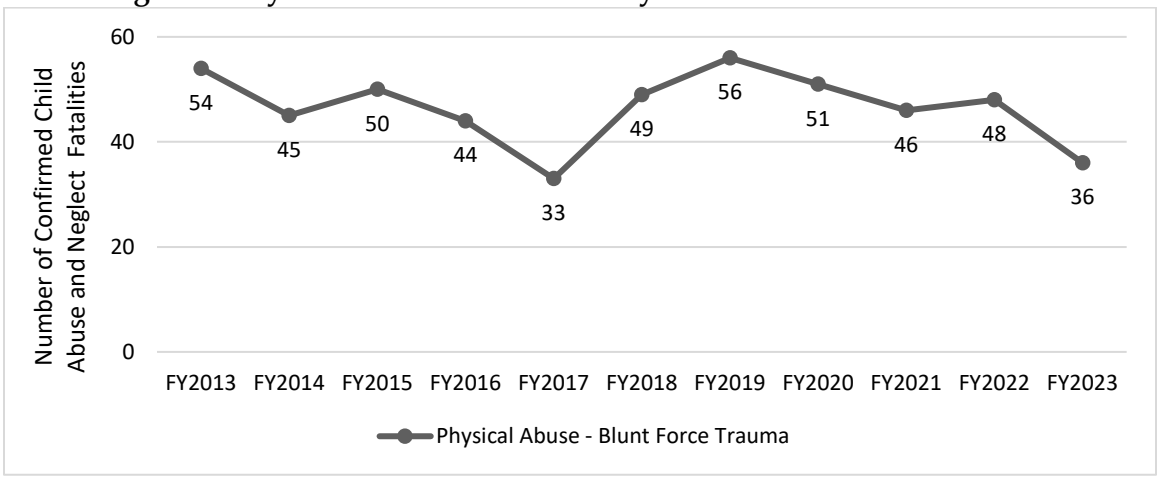
Source: DFPS individual case reviews

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



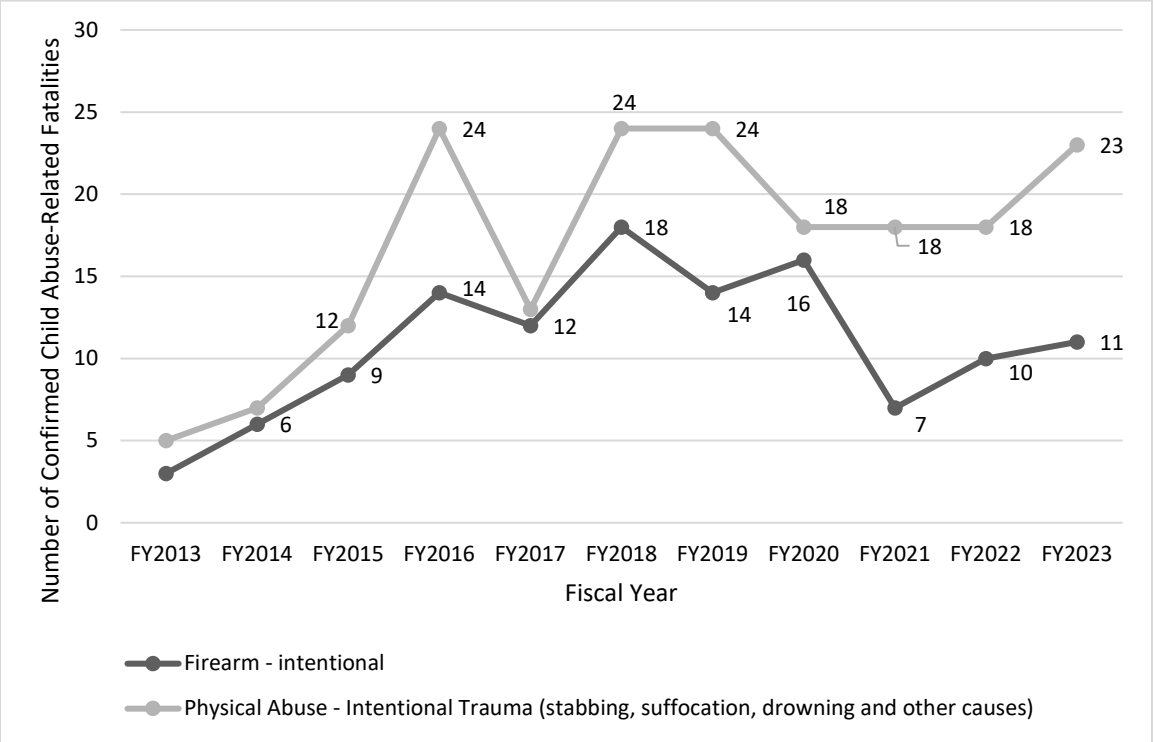
Source: DFPS individual case reviews

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



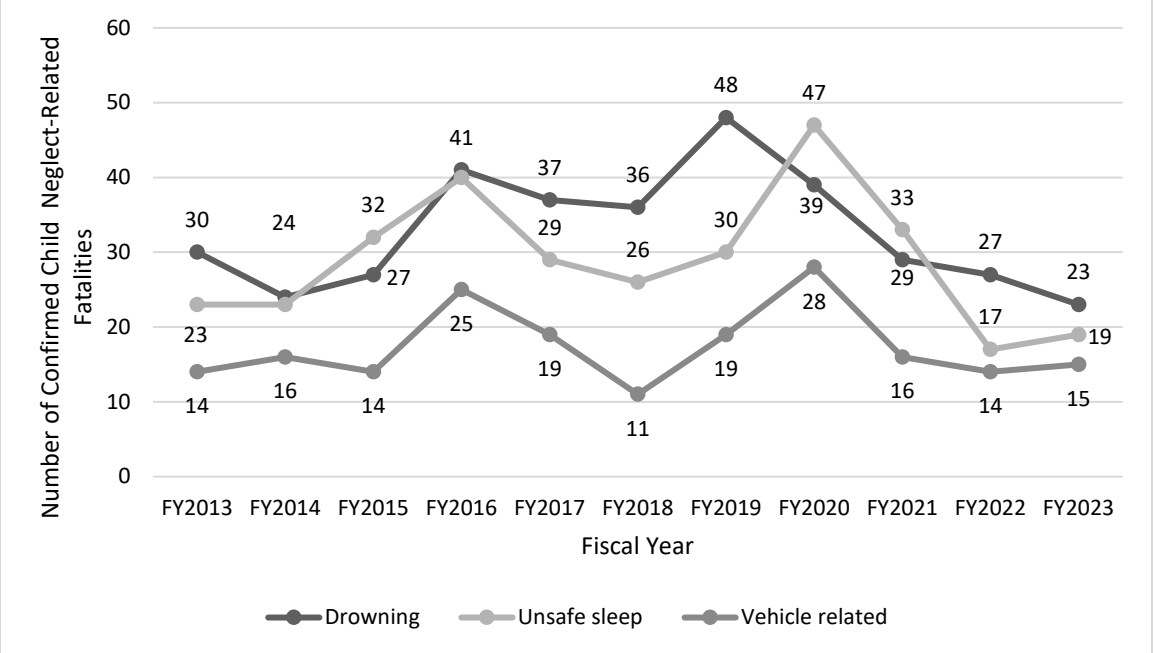
Source: DFPS individual case reviews

Figure 6. Intentional Physical Abuse to Child by Cause



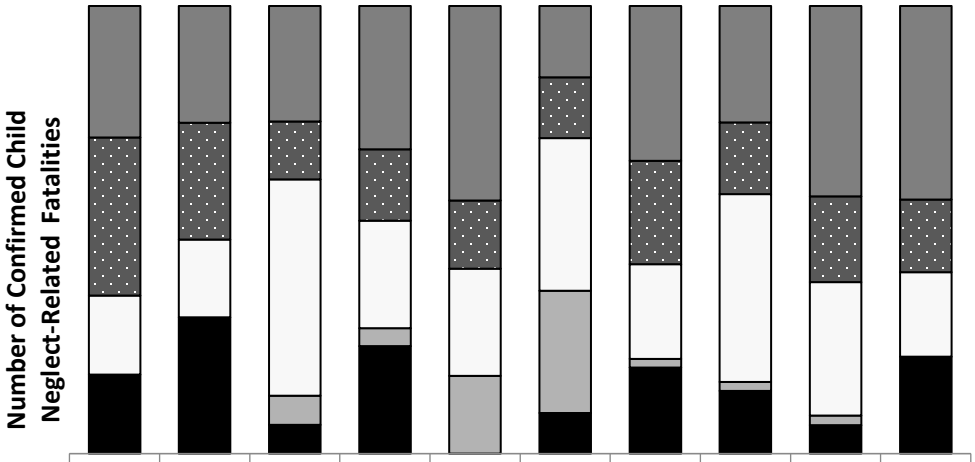
Source: DFPS individual case reviews

Figure 7. Neglect-Related Child Fatality by Cause



Source: DFPS individual case reviews

Figure 8. Neglect-Related Child Fatality by Cause



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

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

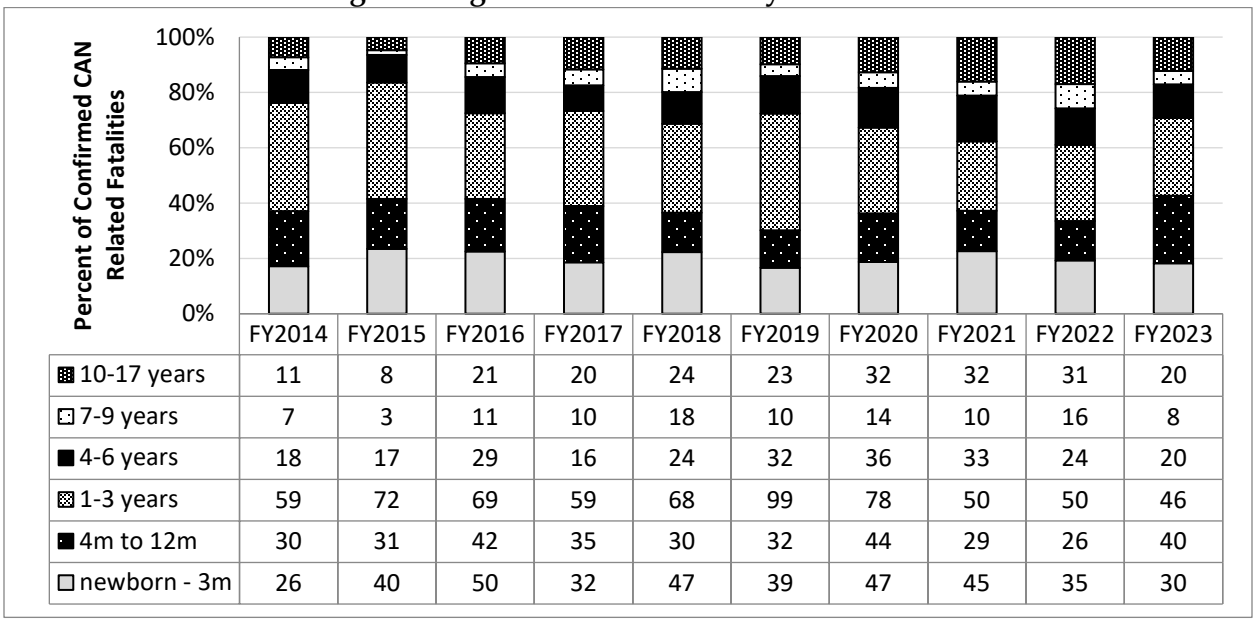
Victim Demographic Characteristics - Age, Gender, Ethnicity

Victims

- Based on the confirmed child abuse and neglect-related fatalities over the past 10 fiscal years, children 3 years of age and younger were almost 80 percent of all confirmed child abuse and neglect fatalities; however, the past three years have had a marked increase in child fatalities involving older children. In FY 2023, children 3 years of age and younger made up 70.7 percent of confirmed child abuse and neglect fatalities. Male children made up more than half of all confirmed child abuse and neglect-related fatalities (Figure 9, 10).
- During FY 2023, 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).

- 66 percent of children who died from abuse or neglect in FY 2023 were too young for school and not enrolled in day care. Six children were being cared for by illegal day care operations (Page 25).

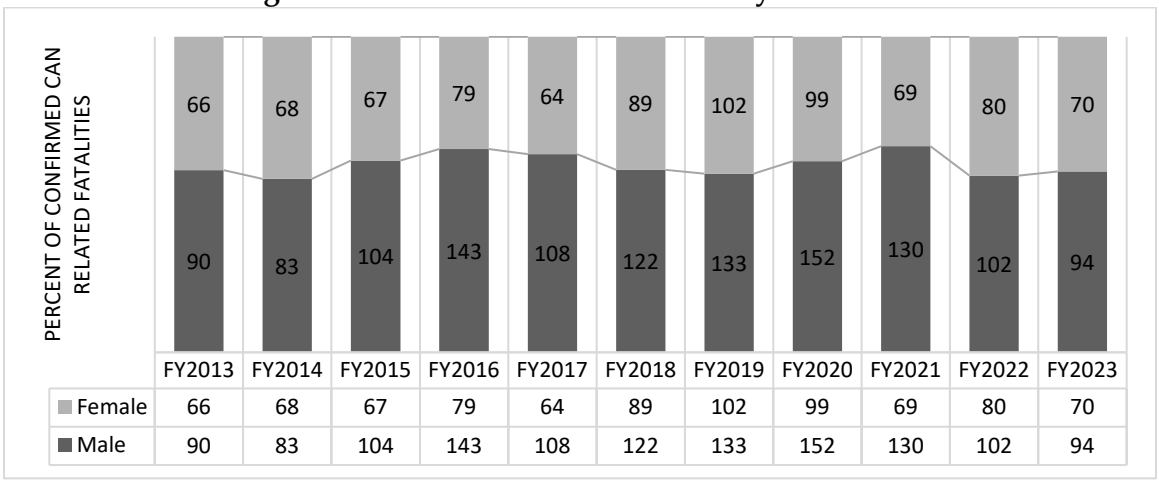
Figure 9. Age of Child at Death by Fiscal Year



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

Source: DFPS Data Warehouse Report FT_06

Figure 10. Gender of Deceased Child by Fiscal Year



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

Source: DFPS Data Warehouse Report FT_06

When reviewing the ethnicity of the victim, it is important to view fatalities in context of the child per capita rate for Texas. In FY 2023, 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 (DSHS) to address child fatalities from a public health approach.

Table 3. FY2023 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	927,124	2,332,313	3,839,288	659,021	7,757,746
Number of Fatalities	51	46	57	10	164
Per Capita Rate of Fatality	5.50	2.1	1.51	1.67	2.11

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

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

The United States Center for Disease Control and Prevention defines risk factors for child maltreatment as characteristics associated with child maltreatment.[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 FY 2023, 29 percent of child maltreatment fatalities involved a child with special medical needs or medical concerns.

Table 4. FY2023 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	FY2023 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality
None/Unknown	116 Fatalities
Asthma	3 Fatalities • Physical Abuse (3)
ADD/ADHD	11 Fatalities • Physical Abuse (3) • Medical Neglect (2) • Suicide (3) • Neglectful Supervision (3)
Anxiety/Depression	3 Fatalities • Suicide (3)
Autism	6 Fatality • Physical Abuse (3) • Neglectful Supervision (3)
Bipolar Disorder	2 Fatalities • Suicide (2)
Cerebral Palsy	1 Fatality • Medical Neglect (1)
Developmental Disability/Delay	5 Fatalities • Physical Abuse (2) • Neglectful Supervision (2) • Medical Neglect (1)
Diabetes	2 Fatalities • Physical Abuse (2)
Downs Syndrome	2 Fatalities • Physical Abuse (1) • Neglectful Supervision (1)
Feeding Tube	1 Fatality • Medical Neglect (1)

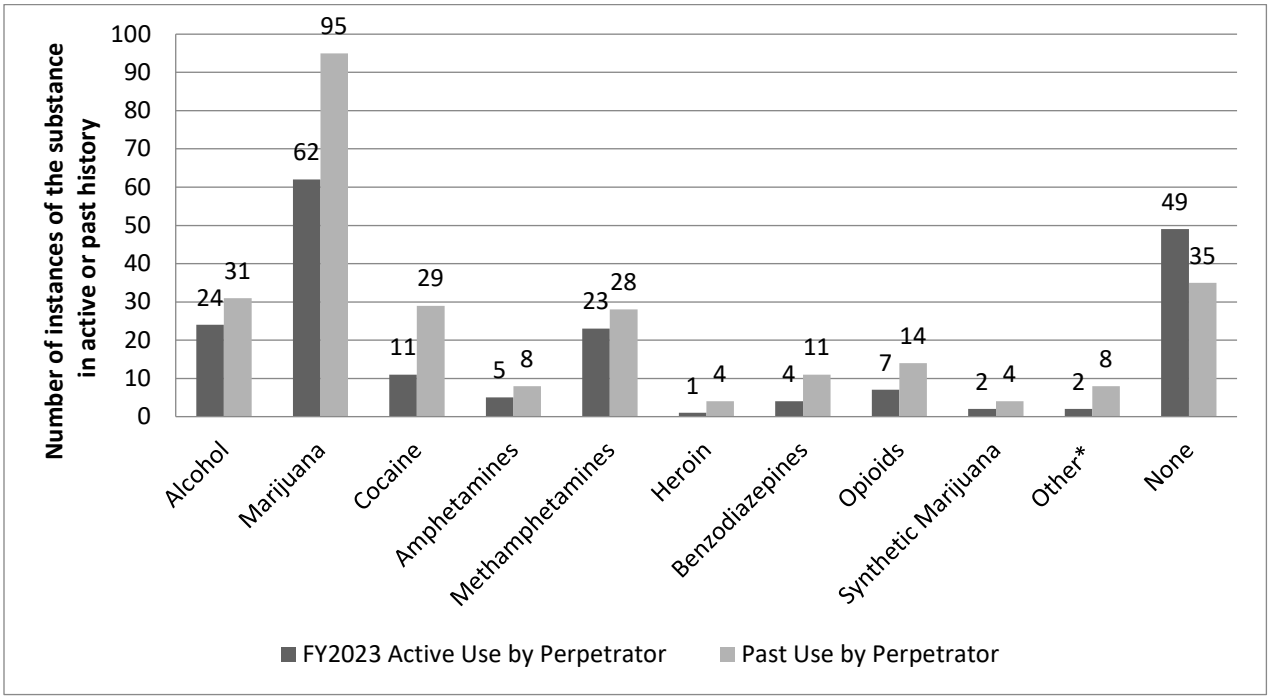
Identified Special Need	FY2023 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality
Infant Drug Addiction/Prenatal Drug Exposed	13 Fatalities • Unsafe Sleep (3) • Physical Abuse (2) • Neglectful Supervision (5) • Drowning (3)
Intellectual Disability	4 Fatalities • Medical Neglect (2) • Physical Abuse (2)
Learning Disability	2 Fatality • Neglectful Supervision (1) • Physical Abuse (1)
Medically Complex	3 Fatality • Medical Neglect (2) • Physical Abuse (1)
Oppositional Defiant Disorder	1 Fatality • Medical Neglect (1)
Physical Disability	3 Fatalities • Neglectful Supervision (2) • Medical Neglect (1)
Speech Impairment	4 Fatalities • Physical Abuse (1) • Medical Neglect (2) • Neglectful Supervision (1)
Other—premature birth, heart conditions, other medical concerns	15 Fatalities • Physical Abuse (7) • Neglectful Supervision (7) • Drowning (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 FY 2023, 114 of the 164 child fatalities caused by abuse or neglect involved a parent or caregiver actively using a substance and/or under the influence of at least one substance that affected the ability to care for the child. In the tables and chart below, the substance abuse is described by type and if it was reported. While methamphetamine use and alcohol use was

identified in 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 95 of the cases.

Figure 11. FY 2023 Confirmed Child Abuse or Neglect Fatality by Substance Abuse by Perpetrator



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

Table 5. FY 2023 Confirmed Child Abuse or Neglect Fatality by Co-Occurring Substance Abuse by Perpetrator

Co-Occurring Substances	Active	Past History
Alcohol and Marijuana	9	21
Cocaine and Marijuana	6	25
Cocaine and Alcohol	6	9
Benzodiazepines and Marijuana	3	11
Methamphetamines and Marijuana	12	25
More than two substances	13	34

Mental Health Concerns as Risk Factor

During the review of confirmed child fatalities due to abuse and neglect, cases were reviewed for a documented history of mental health concerns and if there were concerns for mental

health at the time of the child fatality. In FY 2023, 64 percent of child fatalities involved a parent/caregiver who reported active mental health concerns.

Table 6. FY2023 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*	**104**	**105**
• Bipolar Disorder	22	26
• Depression	39	49
• Anxiety	32	41
• Postpartum Depression	3	6
• Post-Traumatic Stress Disorder	10	10
• Schizophrenia	6	9
• Substance abuse disorder	10	11
• ADD/ADHD	14	20
• Other**	13	16
• Unknown Diagnosis – Reported by Individual	4	
No	**60**	**59**

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

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 FY 2023, there was active domestic violence present in the home environment for 68 families. A history of domestic violence was identified in 96 case reviews. For the 50 child fatalities where the family had a history of domestic violence and reported active concerns for domestic violence, 60 percent of those fatalities were due to physical abuse.

Table 7. FY 2023 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	**16**	**42**	**50**
No	**40**	**17**	**44**
Unknown (not identified in case read)	**8**	**4**	**8**

Source: DFPS individual case reviews

School and Day Care Enrollment as Protective Factor

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

FY 2023 Confirmed Child Abuse and Neglect Fatalities:

- In 108 of the 164 child fatalities due to abuse or neglect, the child was not enrolled either in a day care or in school. In 14 case reviews, the status of the child being in school or day care was unknown. In 3 case reviews, the children were home schooled.
- In 25 of the 164 child fatalities due to abuse or neglect, the child was enrolled in day care or school. Eight of the fatalities occurred when school was out of session for the summer or winter break.
- In six of the 164 child fatalities due to abuse or neglect, the child was being cared for by a caregiver that should have been registered or licensed through HHSC but was not.

Table 8. FY 2023 Child Abuse and Neglect Related Fatalities - By County

County	Region	Child Abuse/Neglect Related Fatalities	Children in DFPS Conservatorship at Time of Fatality*
Anderson	04	1	
Angelina	05	1	
Archer	02	1	
Bee	11	1	
Bell	07	8	
Bexar	08	14	1
Bowie	04	1	
Brazos	07	1	
Brooks	11	1	
Brown	02	1	
Caldwell	07	1	
Cameron	11	1	
Camp	04	1	
Cherokee	04	1	
Collin	03	7	
Coryell	07	1	
Cottle	02	1	
Dallas	03	13	
Denton	03	1	
Ector	09	1	
El Paso	10	4	
Ellis	03	3	3
Falls	07	1	
Fort Bend	06	5	
Galveston	06	1	
Guadalupe	08	1	
Hale	01	1	
Hardin	05	1	
Harris	06	23	
Hays	07	1	
Henderson	04	3	
Hidalgo	11	3	
Hudspeth	10	1	
Jefferson	05	4	
Kaufman	03	1	

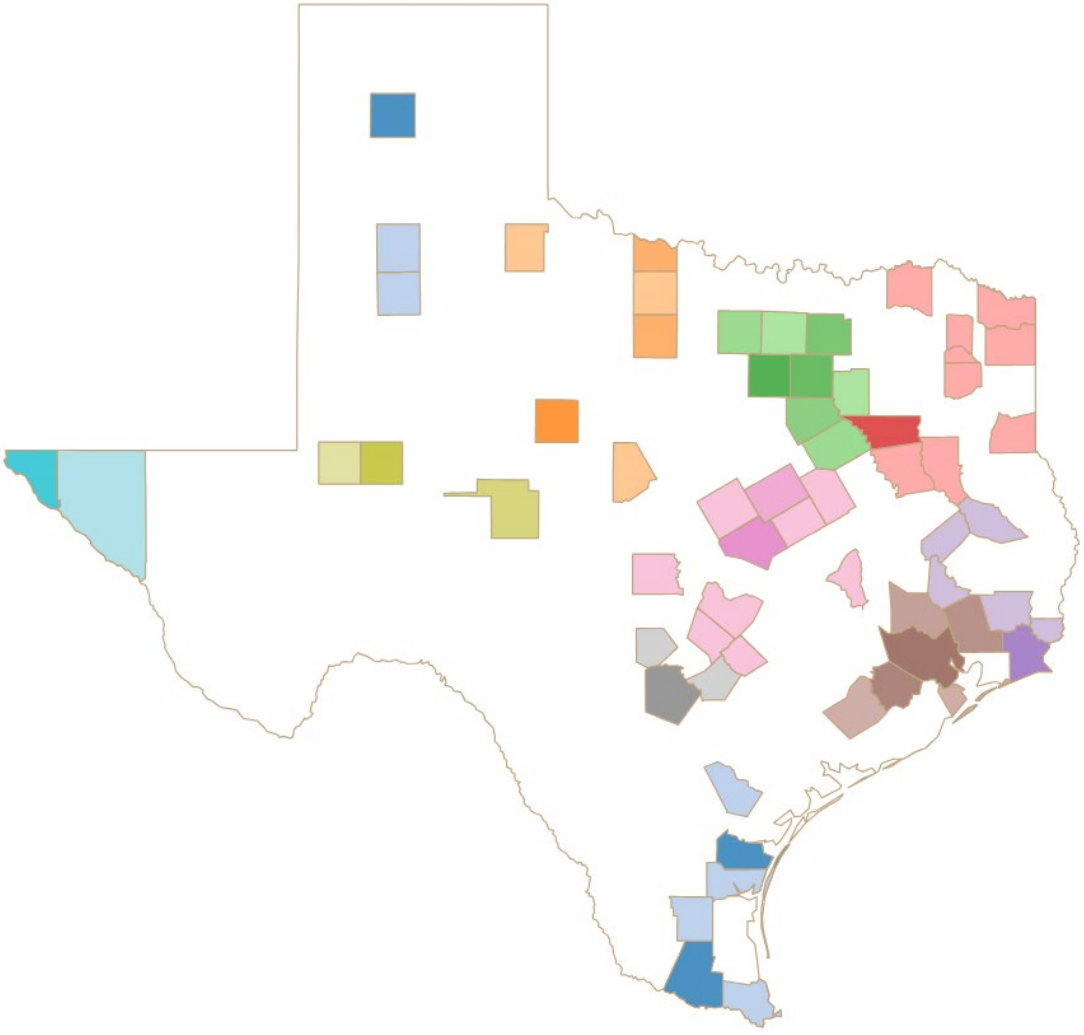
County	Region	Child Abuse/Neglect Related Fatalities	Children in DFPS Conservatorship at Time of Fatality*
Kendall	08	1	1
Kleberg	11	1	
Lamar	04	1	
Liberty	06	3	
Limestone	07	1	
Llano	07	1	
Lubbock	01	1	
McLennan	07	2	
Midland	09	4	
Montgomery	06	2	
Navarro	03	2	
Nueces	11	2	
Orange	05	1	
Potter	01	3	
San Jacinto	05	1	
Tarrant	03	14	
Taylor	02	2	
Titus	04	1	
Tom Green	09	2	
Travis	07	1	
Trinity	05	1	
Wharton	06	1	
Wichita	02	2	
Wise	03	2	
Young	02	3	
Total		164	5

* Two fatalities occurred while the child was in DFPS Conservatorship; however, the fatal injuries were caused prior to the child entering foster care and were caused by the child's parent or caregiver.

Does not include corrections or updates, if any that may subsequently be made to DFPS data.

Includes child fatalities investigated and confirmed by Child Protective Investigations – Field Division (169), Child Day Care Investigations (4), Residential Child Care Investigations (0), and Adult Foster Care (1)

FY2023 Child Abuse and Neglect Related Fatalities - By Region



FY 2023 Confirmed Child Abuse and Neglect Related Fatalities - Case Review Data

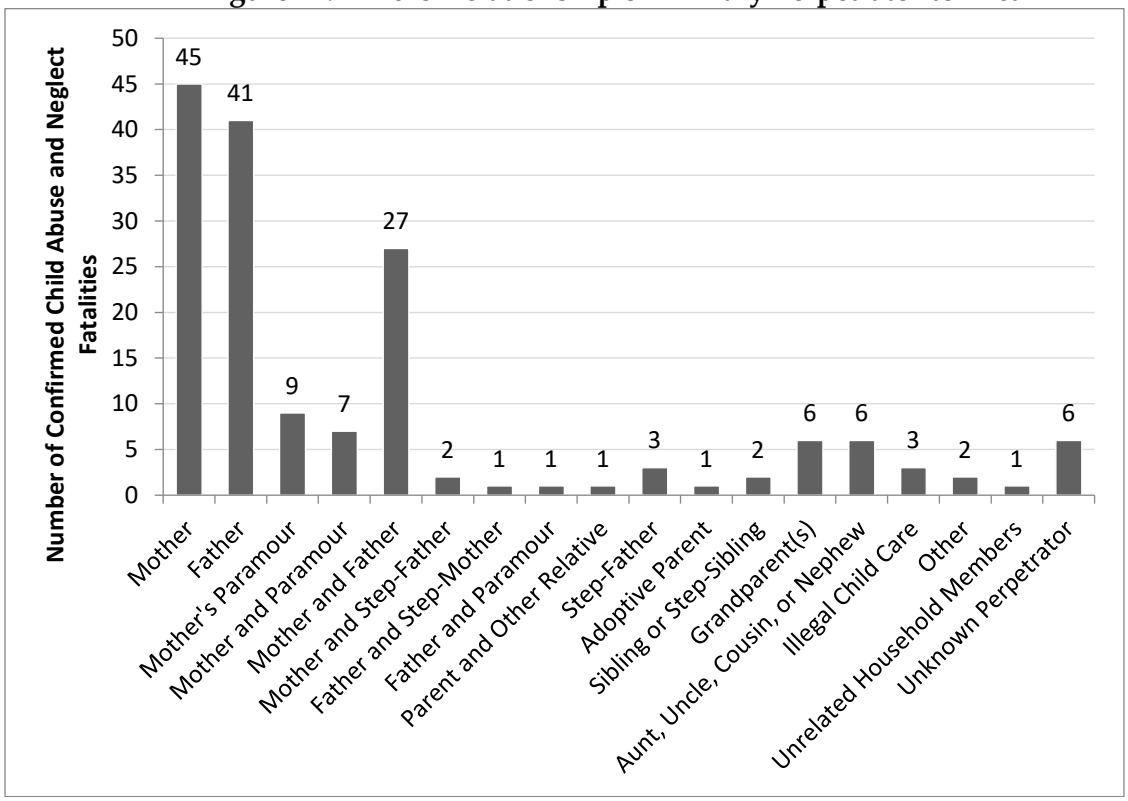
Based on the confirmed child abuse and neglect fatalities that occurred during FY 2023, several key demographic areas allow for specialized targeting of prevention and intervention in child abuse and neglect cases. Data from these fatalities tells us that these parents would benefit from support, education, and targeted campaigns. Communities can use this data to strategically message and target available resources for families and caregivers.

FY 2023 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 53 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).

Figure 12. FY2023 Relationship of Primary Perpetrator to Victim

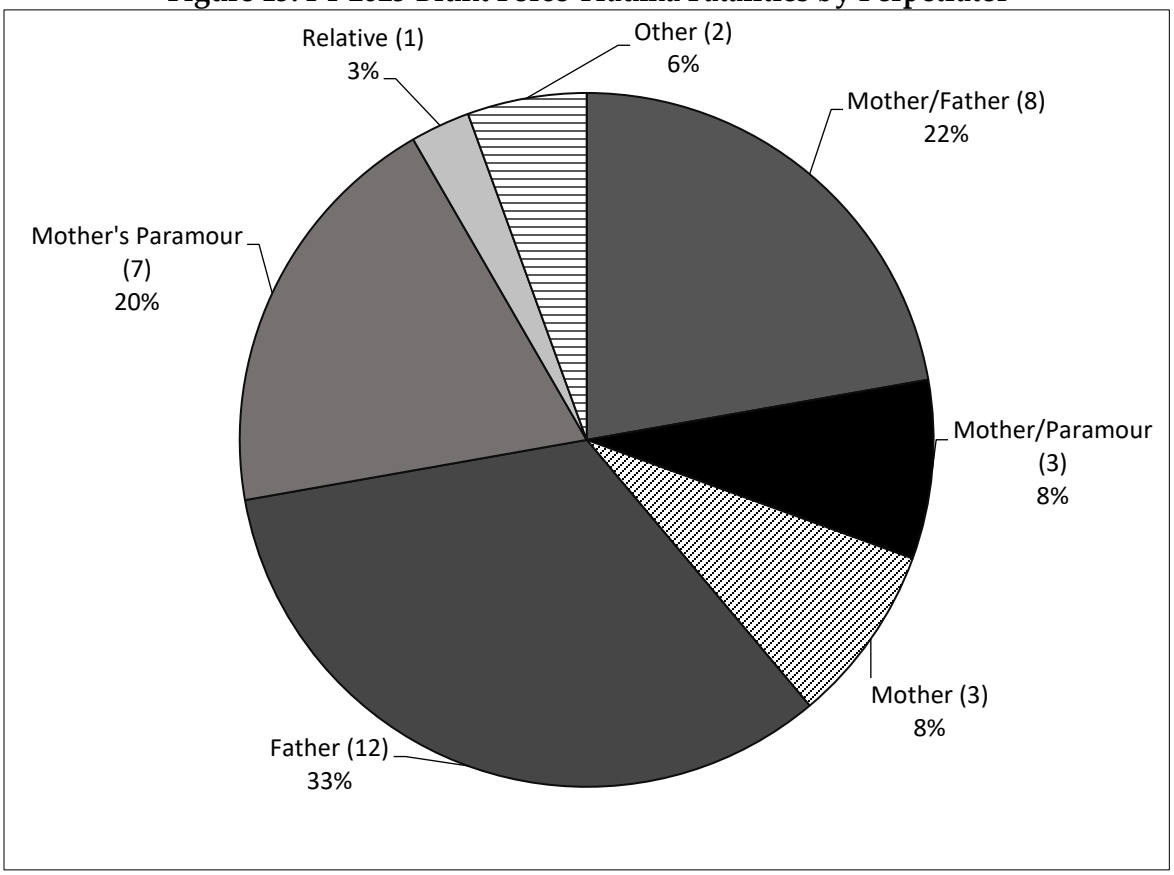


Source: DFPS individual case reviews

FY 2023 Primary Perpetrator, Child Age and Cause of Death

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

Figure 13. FY 2023 Blunt Force Trauma Fatalities by Perpetrator

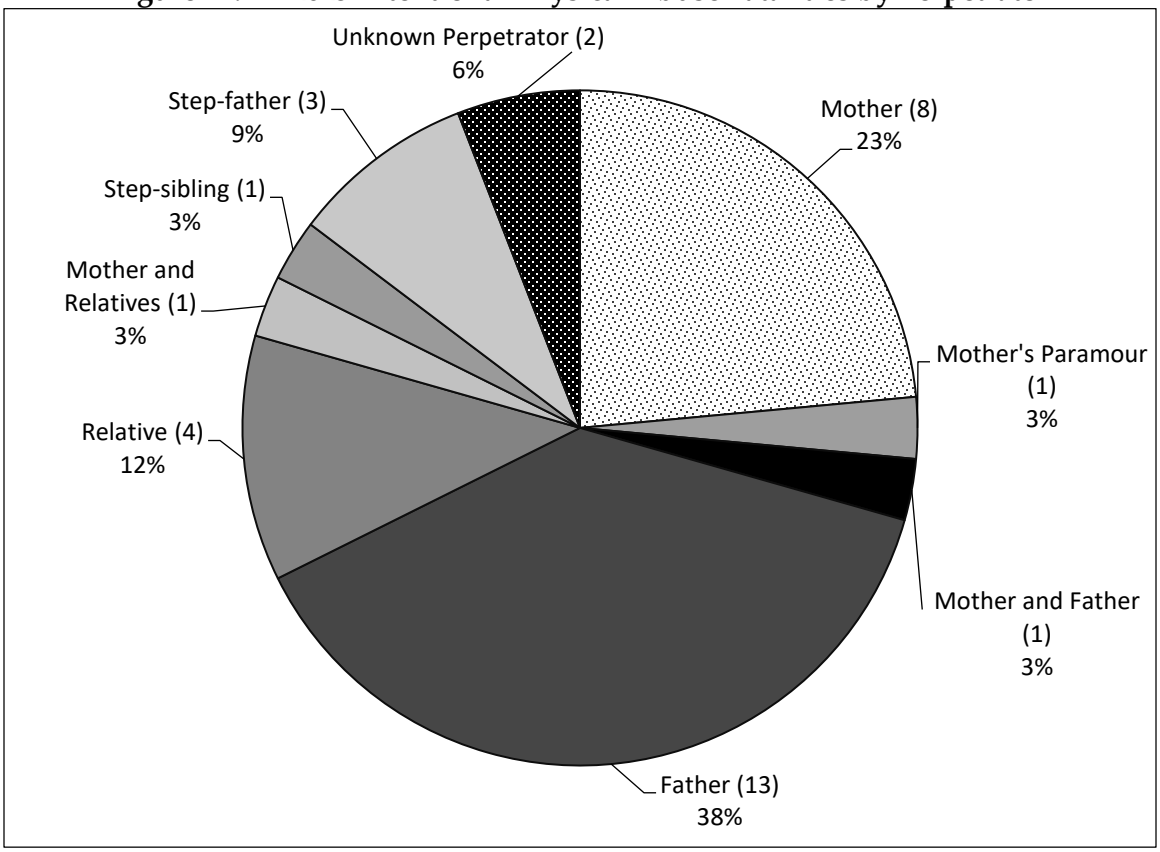


Number of victims: 36 children

Age range of victims: Newborn to 14-year-old youth. 33 children were younger than one year old; 91.7% were age three or younger

Finding: Usually involve young children being physically abused by the father or a boyfriend (83.3%)

Figure 14. FY 2023 Intentional Physical Abuse Fatalities by Perpetrator

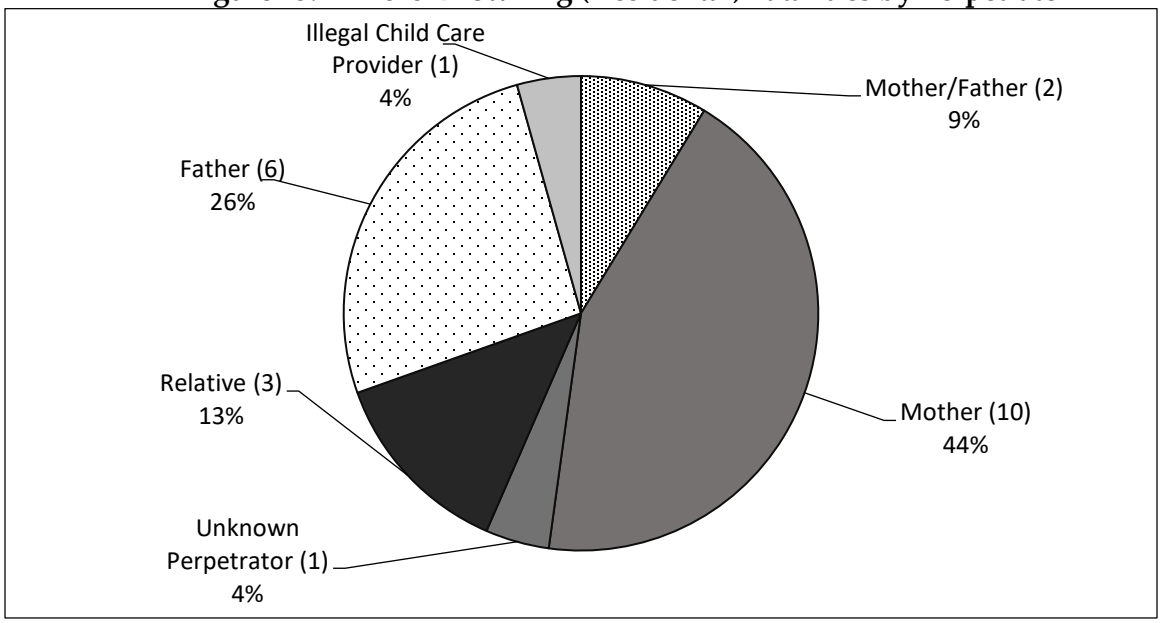


Number of victims: 34 children

Age range of victims: Newborn to 17-year-old youth. 70 percent were children age four and older

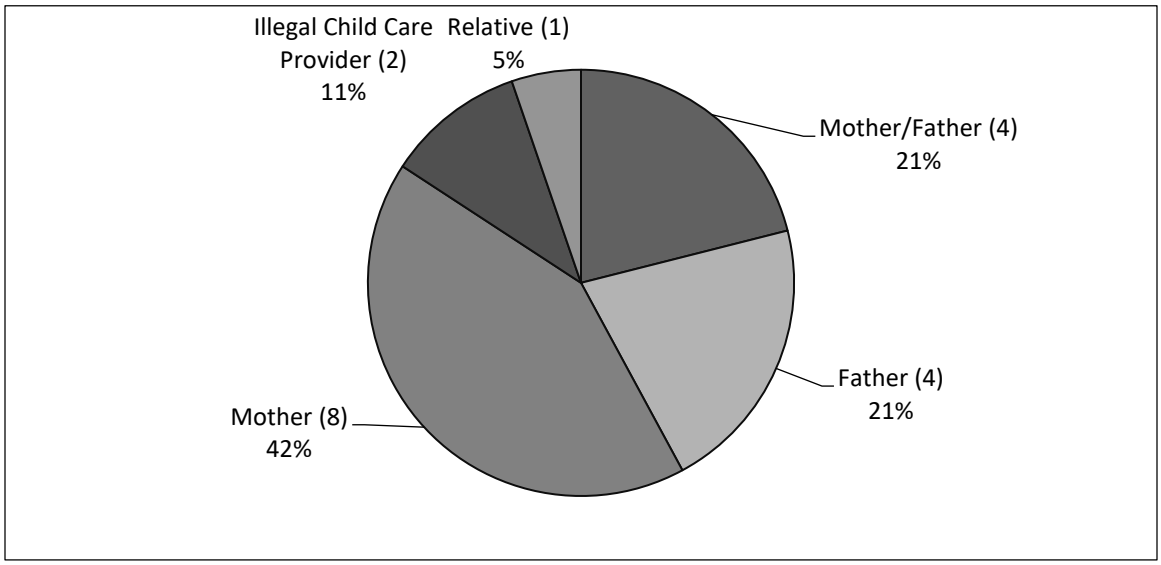
Finding: Usually involved children with primary perpetrator as mother (32%), father or step-father (44%).

Figure 15. FY 2023 Drowning (Accidental) Fatalities by Perpetrator



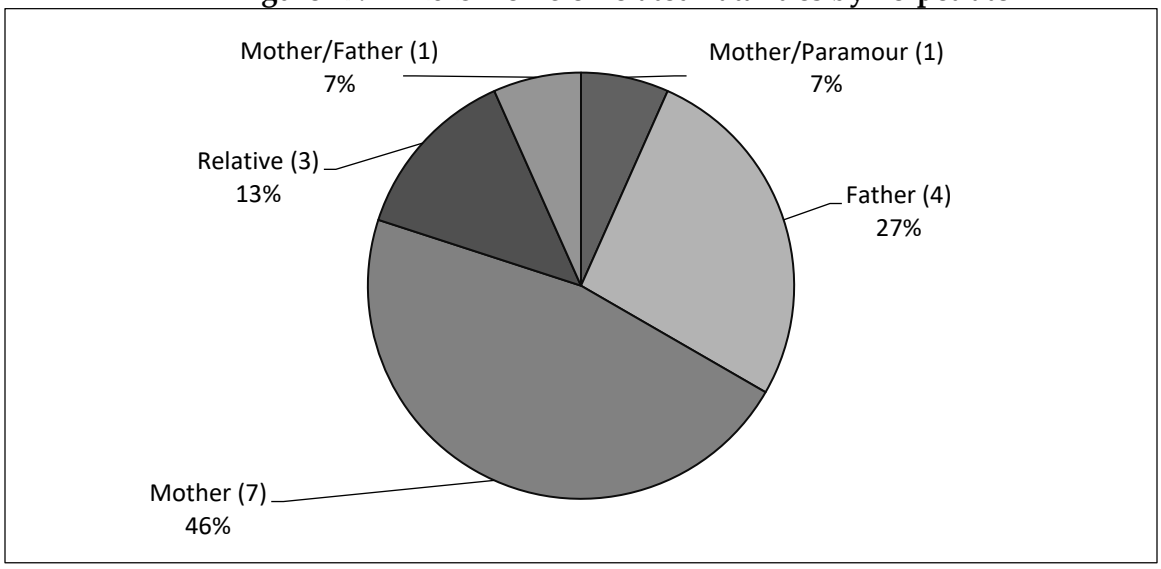
Number of victims: 23 children
Age range of victims: Newborn to 5-year-old child. Nineteen children were 3 years old and younger (82.6%).
Finding: Usually involve young children with mother as primary perpetrator (53%).

Figure 16. FY 2023 Unsafe Sleep Fatalities by Perpetrator (includes bed-sharing and unsafe sleep environments)



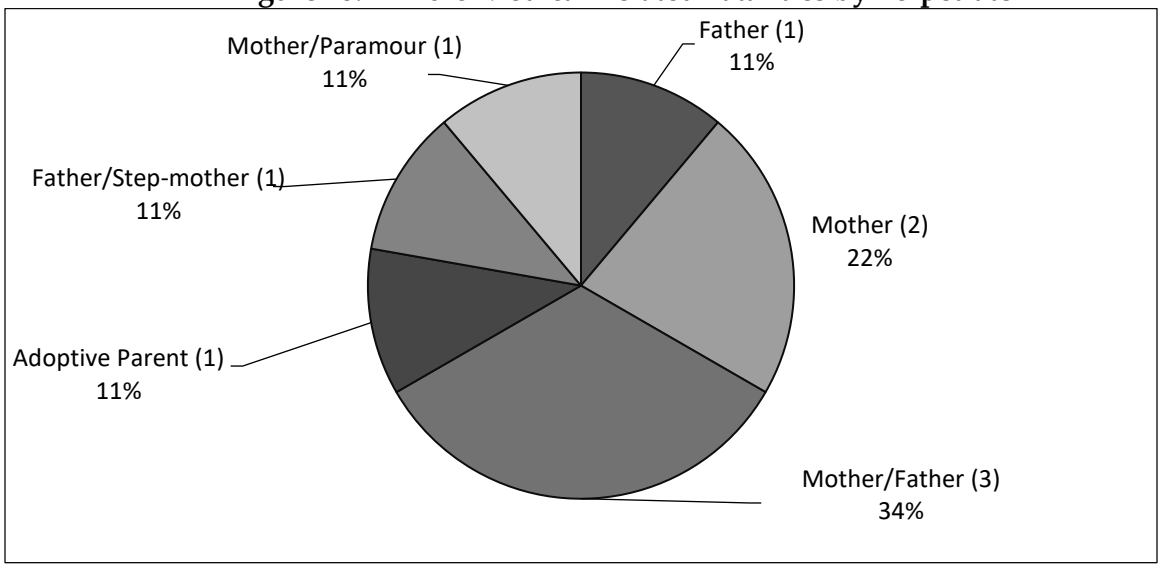
Number of victims: 19 children
Age range of victims: Newborn old to 1 year old
Finding: Involved infants with primary perpetrator generally the mother, father, or both mother and father.

Figure 17. FY 2023 Vehicle Related Fatalities by Perpetrator



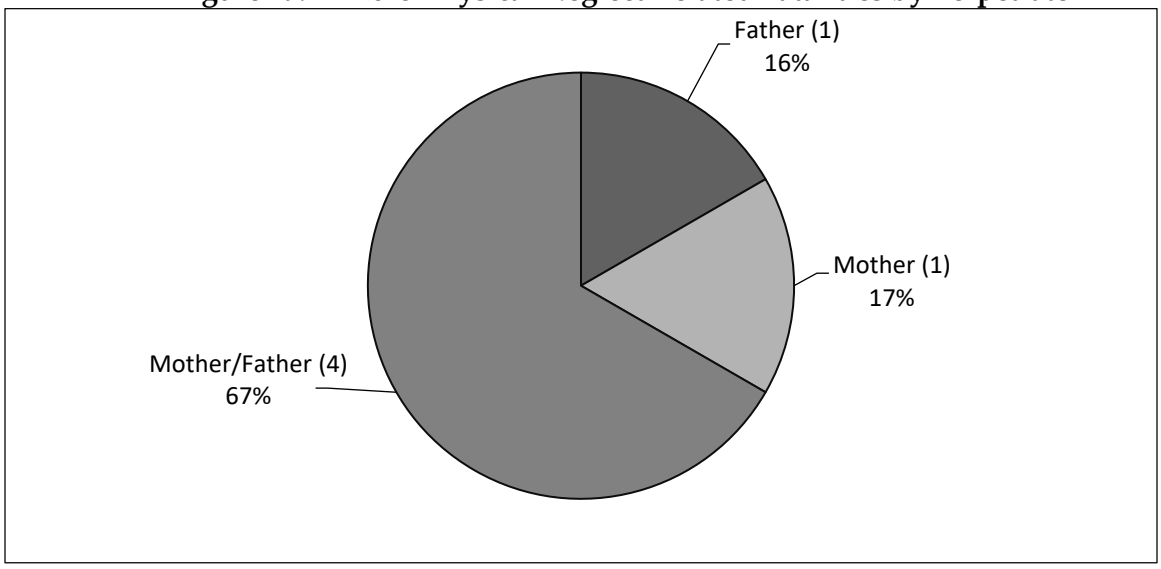
Number of victims: 15 children
Age range of victims: Newborn to 10 years old
Finding: Usually happens while in care of the mother (46%). Six children died after being left in a vehicle.

Figure 18. FY 2023 Medical Related Fatalities by Perpetrator



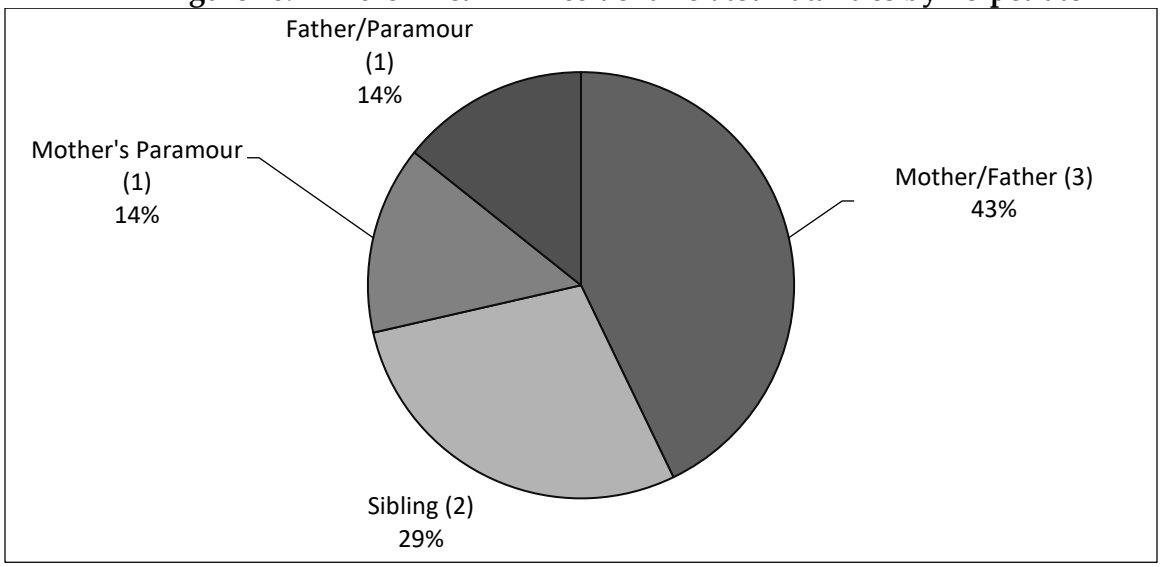
Number of victims: 9 children
Age range of victims: newborn to 10 years old
Finding: Usually happens while in care of the mother (66.7%).

Figure 19. FY 2023 Physical Neglect Related Fatalities by Perpetrator



Number of victims: 6 children
Age range of victims: Four-month old to 2 years old
Finding: Usually happens while in care of the mother (83.3%).

Figure 20. FY 2023 Firearm - Accident Related Fatalities by Perpetrator

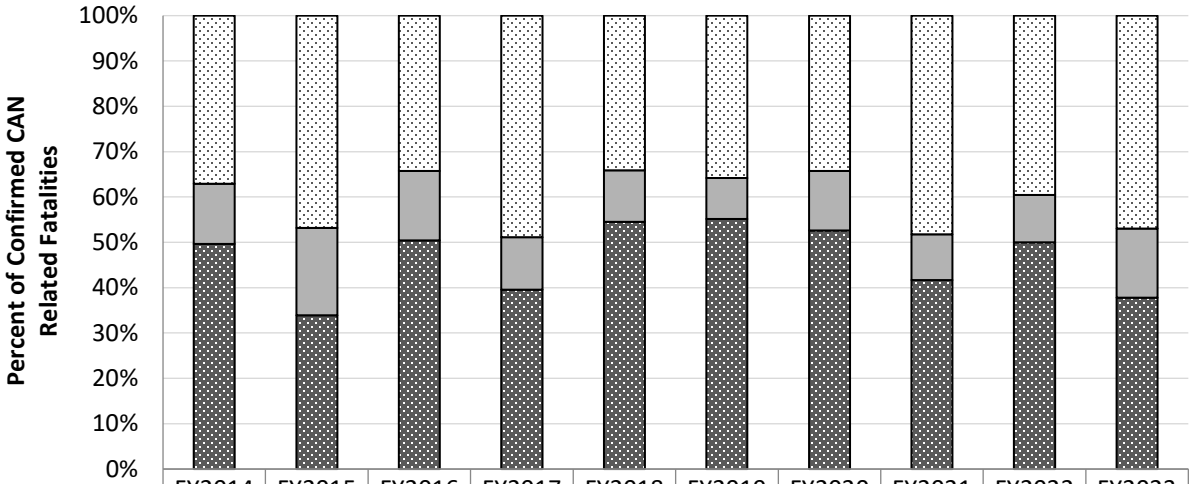


Number of victims: 7 children
Age range of victims: 8 months old to 14 years old
Finding: Usually happens while in care of a parent (50%).

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 15.2 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 37.8 percent of confirmed child fatalities, CPI or CPS had been involved with the child or the perpetrator in the past.

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



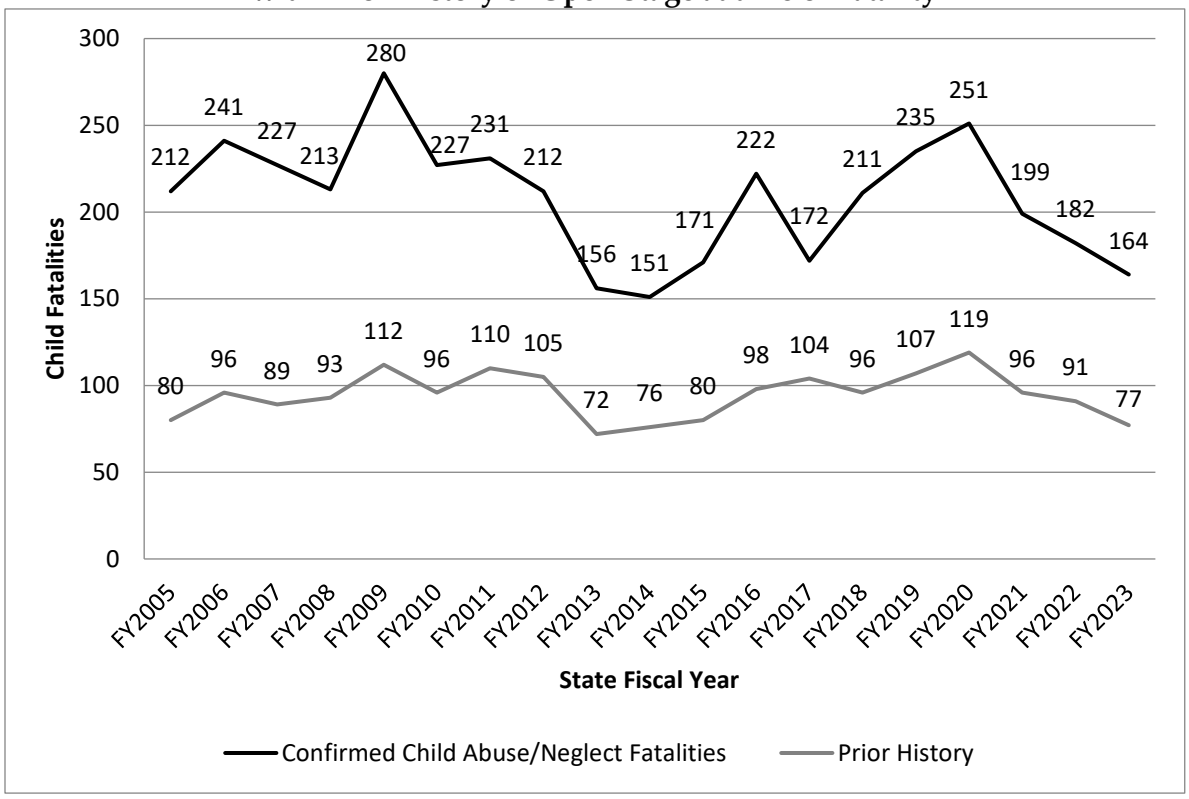
	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023
Prior History	56	80	76	84	72	83	86	96	72	77
Open Stage	20	33	34	20	24	21	33	20	19	25
No Prior History	75	58	112	68	115	128	132	83	91	62

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 FY 2023 often consisted of unsafe sleeping arrangements (7 fatalities) or physical abuse (13 fatalities.)

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



Source: DFPS Data Warehouse Report FT_06

For FY 2023, based on Figures 22-24, the following themes are noted:

- In 25 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.
    - One of the children was involved in an Alternative Response stage and a new incident of abuse or neglect occurred leading to the fatality.
        - Initial contact was completed timely in the Alternative Response stage.
        - There was only one worker assigned.
        - There were no parental child safety plans in place in the investigations. Assessments were completed timely.
    - Seventeen of the children were in an active investigation and a new incident of abuse or neglect occurred leading to the fatality.

        - Initial contacts were completed in the 15 open investigations; eight of the initial contact were completed timely.
        - In eight investigations, there was only one worker assigned; in eight investigations, there were two workers assigned during the open stage; and in one investigation, there were three or more workers assigned.
        - There were no parental child safety plans in place in the investigations. The risk and safety assessment were completed timely in nine of the investigations.
        - Starting caseloads: 6 with 15 or fewer cases; 5 with 11-20 cases; 5 with more than 20 cases. For one investigation, the starting caseload was unknown.
    - Four 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 all four of the FBSS cases, there was only one worker assigned.
        - Safety plans were in place in three of the open FBSS cases.
        - Caseloads for the staff at the time of the fatality: 4 with 15 or less cases.
        - In the FBSS cases, two families were offered substance abuse testing or assessment, mental health services. Counseling, parenting, and domestic violence services were offered. At the time of the fatalities, three families were partially compliant, and one family was fully compliant with services.
    - Three of the children were in an active Conservatorship (CVS) stage and in a kinship placement when a new incident of abuse or neglect occurred leading to the fatality.
        - Initial contacts in open CVS were completed timely and the children were being seen timely.
        - In all three of the fatalities, there was only one worker assigned.
        - Safety plans were in place in three of the open FBSS cases.
        - Caseloads for the staff at the time of the fatality: 3 cases.

- For child fatalities with prior history (77 children), the majority had only one worker assigned during the family's last involvement with DFPS (79.7 percent) and caseloads were often at 20 cases or fewer per staff member assigned.
    - Ten families had two workers assigned and one family had four workers assigned.
    - Starting caseloads: 21 with 10 or fewer cases; 27 with 11-20 cases; 14 with more than 20 cases; 6 were unknown due to the age of the history.

    - Ending caseloads: 24 with 10 or fewer cases; 16 with 11-20 cases; 10 with more than 20 cases; 21 were unknown due to the age of the history or the staff member being in transition between units.
- In the 77 child fatalities with prior history:
    - 27 families had prior involvement with Family Based Safety Services (FBSS).
        - 27 families had prior involvement with FBSS after an investigation concluded.
        - 19 families had a prior safety plan that required the parents, significant other or the designated perpetrator to have supervised contact with the children. 95 percent of safety plans were documented as being followed during the family's involvement with DFPS.
        - On average, families were seen monthly, with their involvement in FBSS ranging from 3 months to one year. In general, initial visits were completed timely as the policy and practice is to work collaboratively with Child Protective Investigations and the family to engage in FBSS services at case transfer. On average, families had twelve or more visits with the FBSS caseworker.
        - Services offered in the previous or open stage include:
            - Counseling for family, individual, or group: 17 cases
            - Daycare or respite care: 1 case
            - Domestic violence shelter or counseling: 5 cases
            - Drug testing or treatment: 22 cases
            - Infant or early childhood screening or development services: 3 cases
            - Mental health (psychological testing, mental health assessment or treatment, referral to local mental health authority): 13 cases
            - Parenting skills / evidence-based parent education: 17 cases
    - 89 percent of families that had been involved with FBSS were reportedly fully compliant or partially compliant with their service plan.

Figure 23. FY 2023 Department of Family and Protective Services (DFPS) Data on Child Abuse and Neglect Related Fatalities Statewide

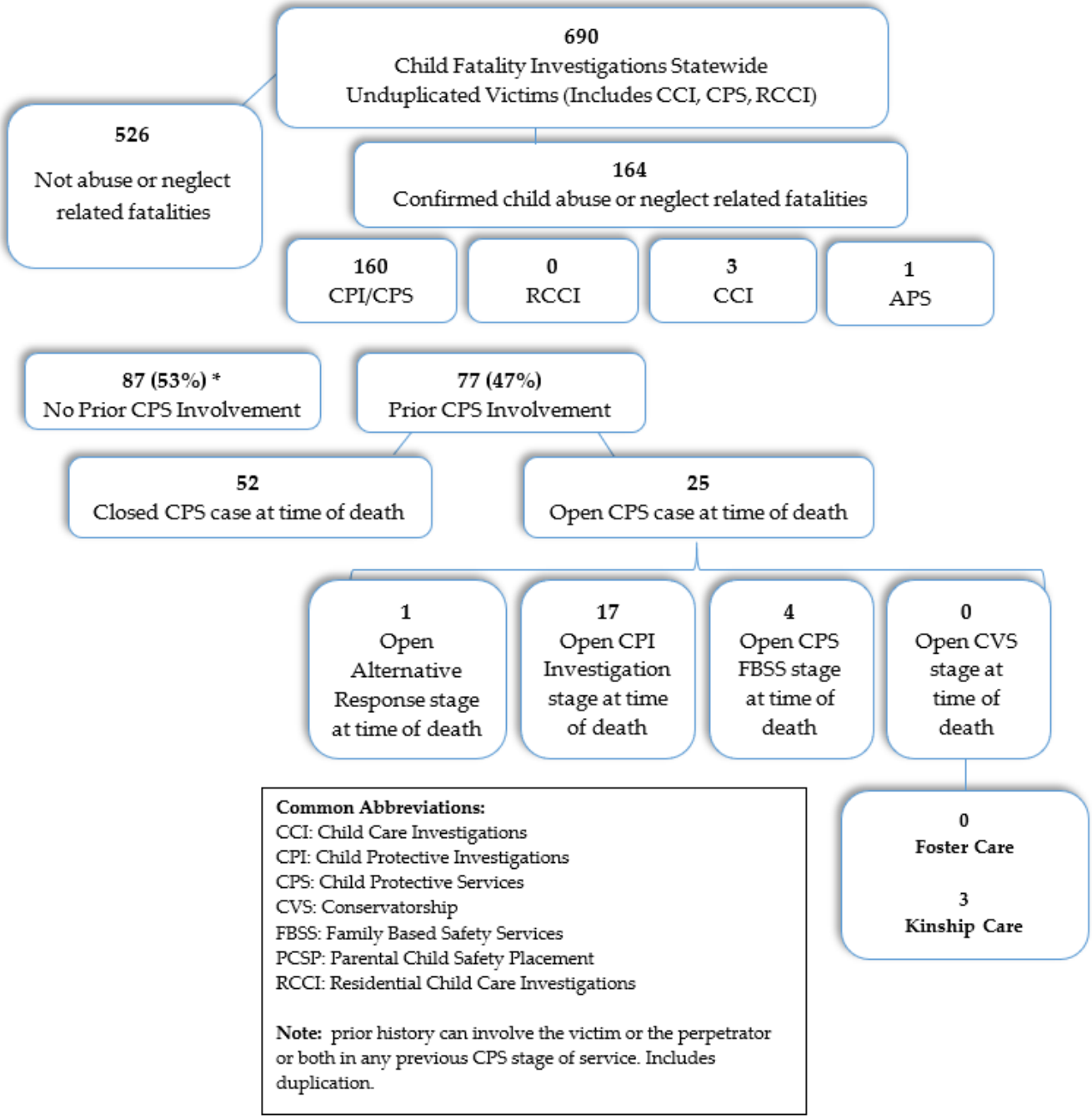
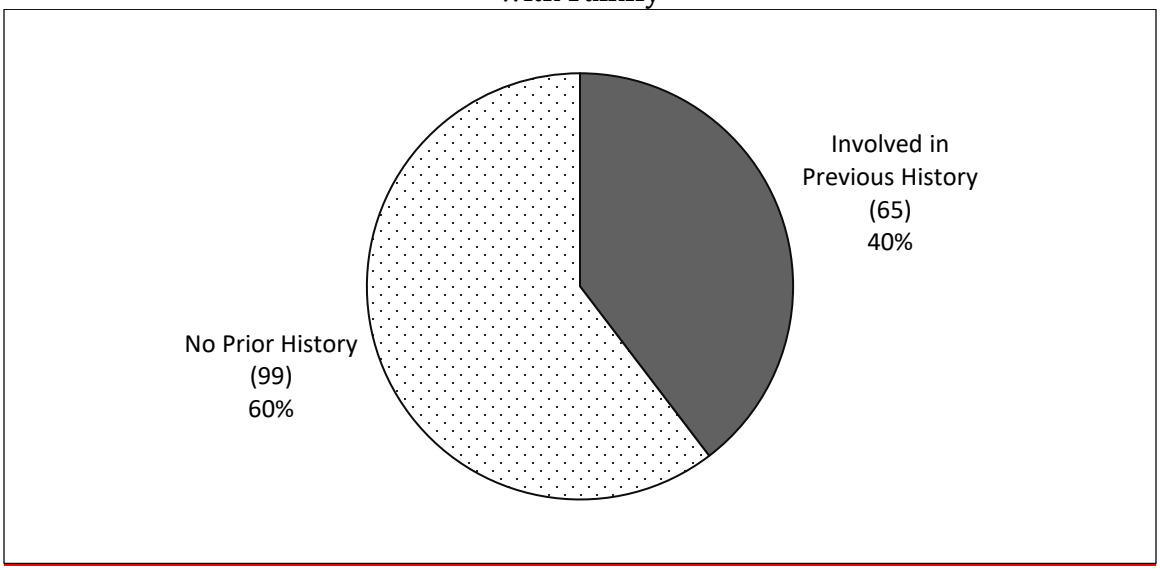


Figure 24. FY 2023 Prior History by Child/Perpetrator with Previous Involvement

Type of Previous History	Total Count
Child has previous history or open stage (perpetrator was not known to CPS)	16
Perpetrator has previous history or open stage (Child was not known to CPS)	19
Both child and perpetrator have previous history or open stage	49
Total with previous history or open stage	77

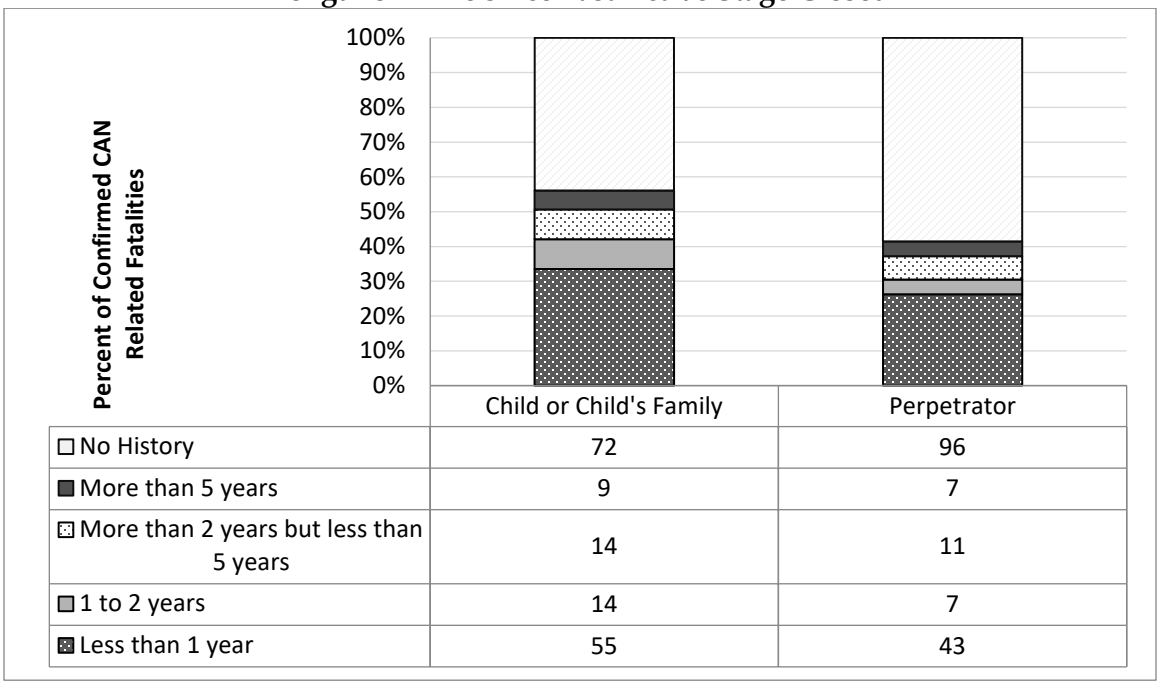
Source: DFPS individual case reviews – includes history that may be purged from IMPACT but referenced in case narrative.

Figure 25. FY 2023 Prior History Where Deceased Child was Present in Previous Involvement with Family



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

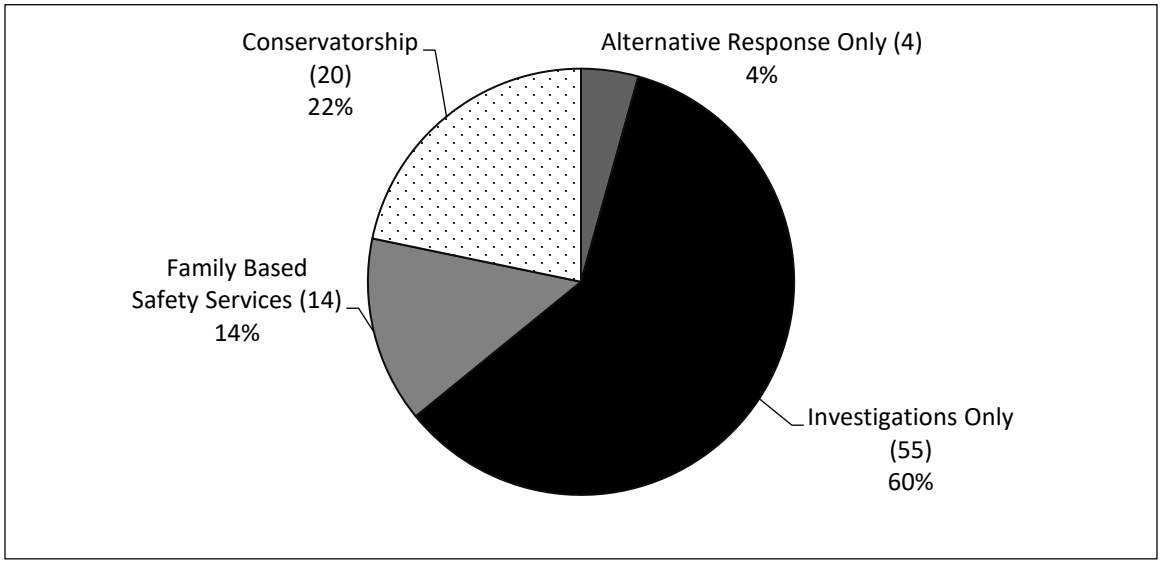
Figure 26. FY 2023 CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Length of Time since Last Active Stage Closed



	Child or Child's Family	Perpetrator
No History	72	96
More than 5 years	9	7
More than 2 years but less than 5 years	14	11
1 to 2 years	14	7
Less than 1 year	55	43

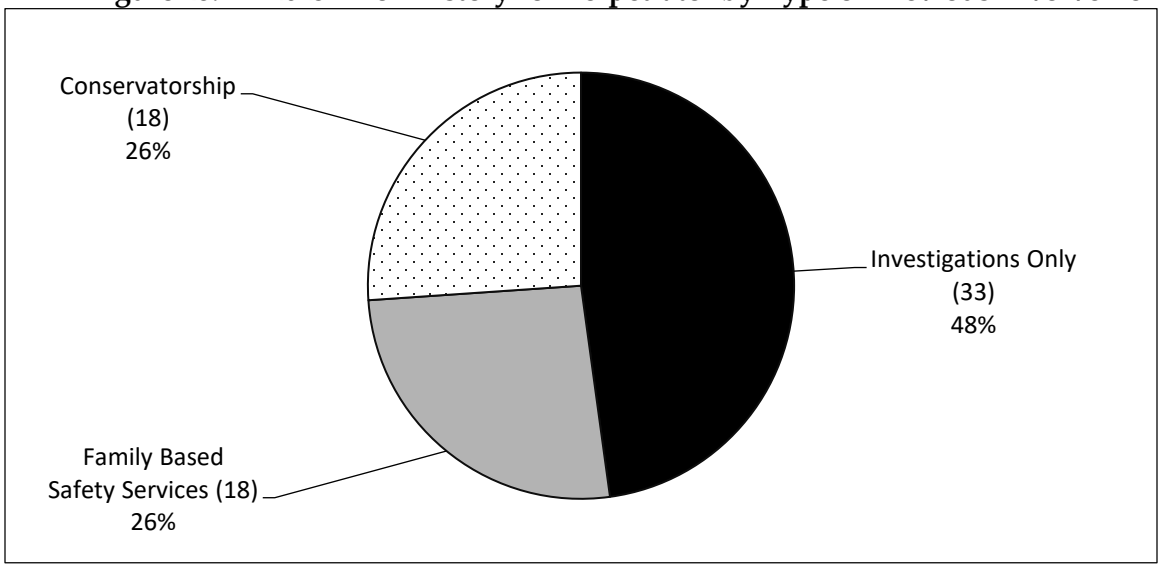
Source: DFPS individual case reviews

Figure 27. FY 2023 Prior History for Child or Child's Family by Type of Previous Involvement



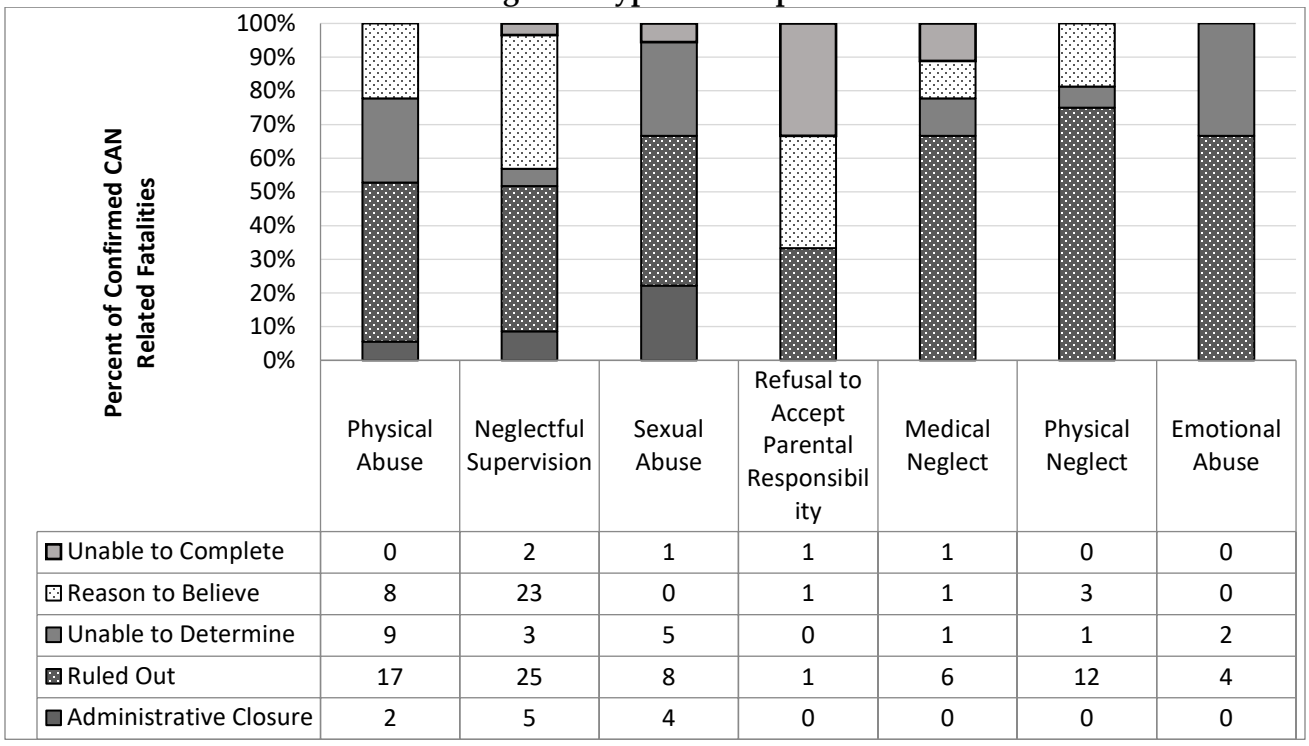
Source: DFPS individual case reviews

Figure 28. FY 2023 Prior History for Perpetrator by Type of Previous Involvement



Source: DFPS individual case reviews

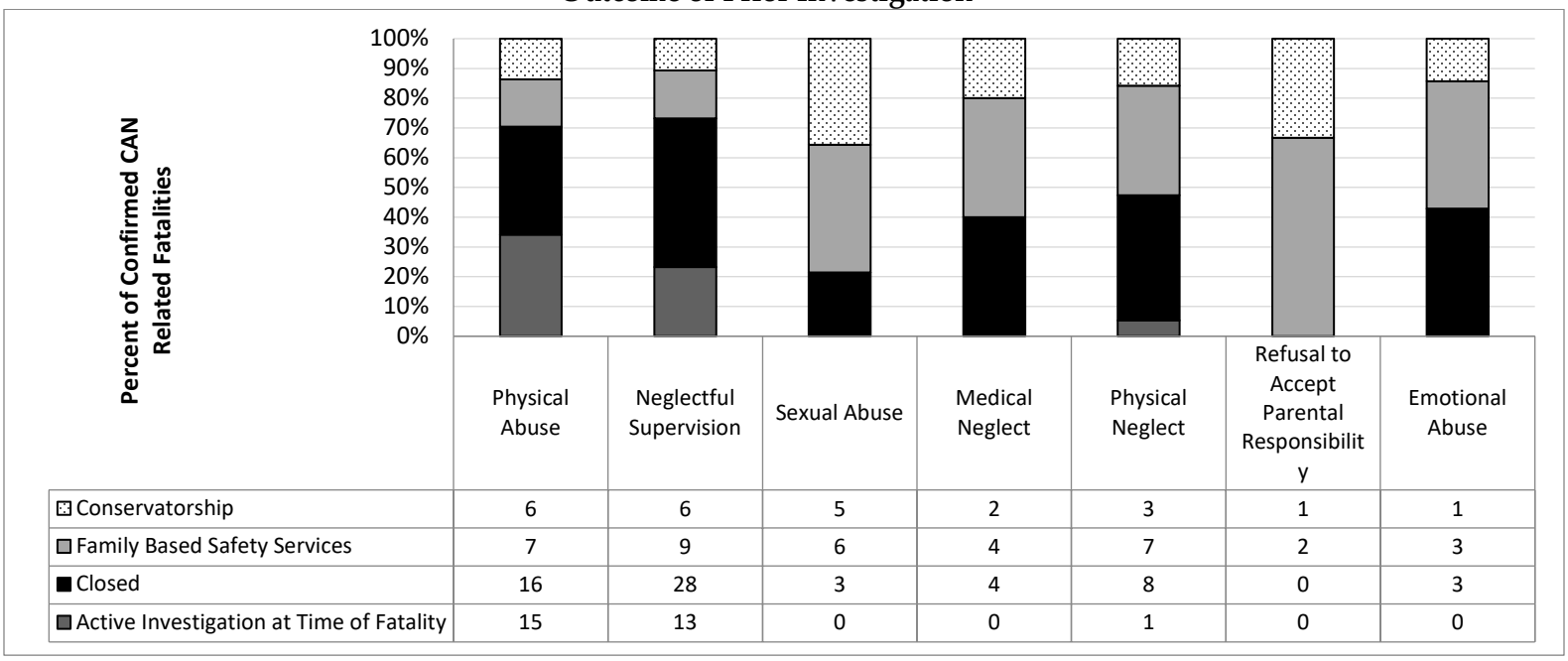
Figure 29. FY 2023 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or Child's Family in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Refusal to Accept Parental Responsibility	Medical Neglect	Physical Neglect	Emotional Abuse
Unable to Complete	0	2	1	1	1	0	0
Reason to Believe	8	23	0	1	1	3	0
Unable to Determine	9	3	5	0	1	1	2
Ruled Out	17	25	8	1	6	12	4
Administrative Closure	2	5	4	0	0	0	0

Source: DFPS individual case reviews

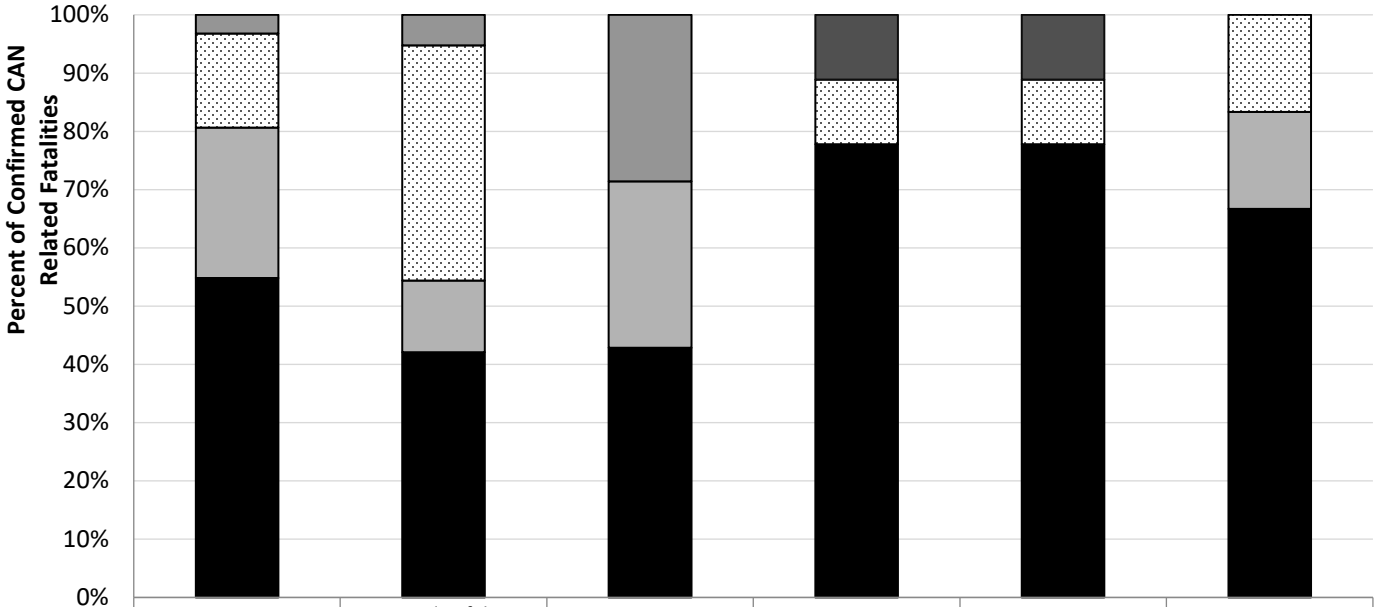
Figure 30. FY 2023 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or the Child's Family in the Two Years Prior to Fatality, by Outcome of Prior Investigation



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Medical Neglect	Physical Neglect	Refusal to Accept Parental Responsibility	Emotional Abuse
Conservatorship	6	6	5	2	3	1	1
Family Based Safety Services	7	9	6	4	7	2	3
Closed	16	28	3	4	8	0	3
Active Investigation at Time of Fatality	15	13	0	0	1	0	0

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

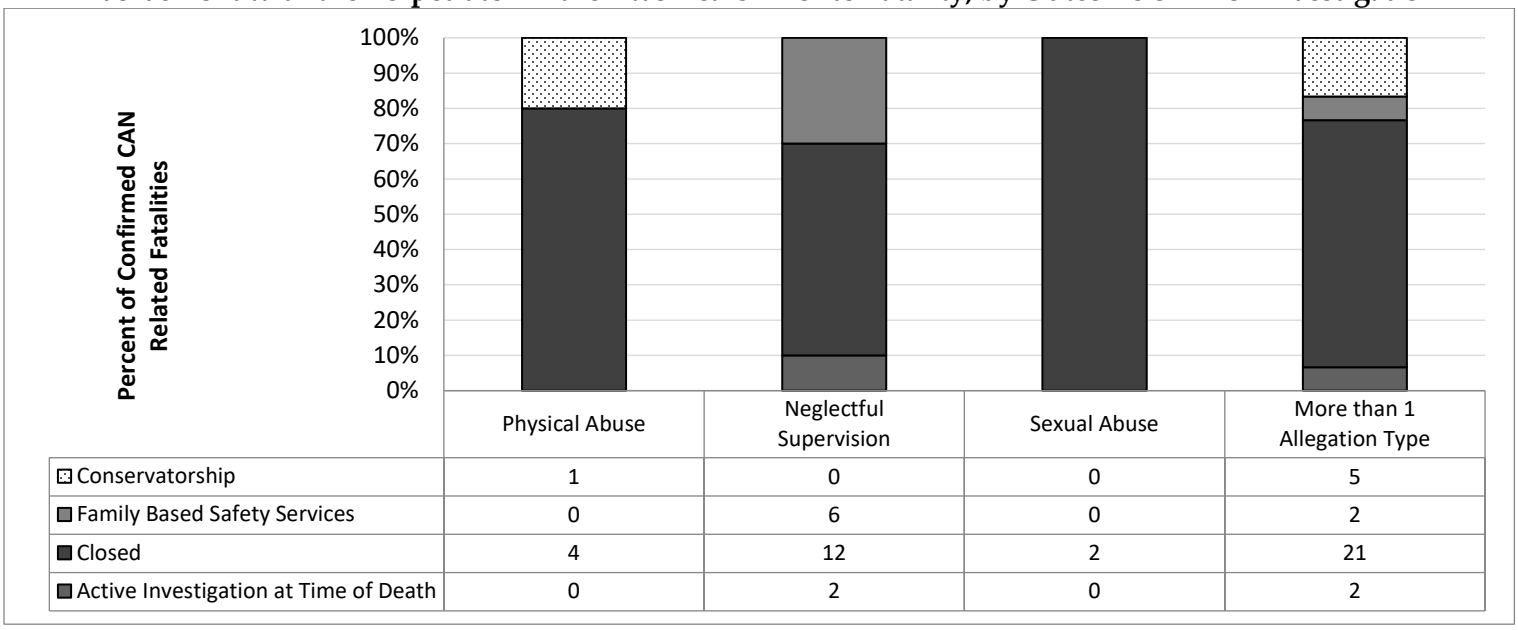
Figure 31. FY2023 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Perpetrator in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Medical Neglect	Physical Neglect	Emotional Abuse
Administrative Closure	1	3	2	0	0	0
Unable to Complete	0	0	0	1	1	0
Reason to Believe	5	23	0	1	1	1
Unable to Determine	8	7	2	0	0	1
Ruled Out	17	24	3	7	7	4

Source: DFPS individual case reviews

Figure 32. FY 2023 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	Sexual Abuse	More than 1 Allegation Type
Conservatorship	1	0	0	5
Family Based Safety Services	0	6	0	2
Closed	4	12	2	21
Active Investigation at Time of Death	0	2	0	2

Source: DFPS individual case reviews

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

Table 9. FY 2023 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**	**4**	**2**	**11**	**7**	**25**
Prior Neglectful Supervision Allegation	**8**	**7**	**3**	**14**	**6**	**38**
Prior Sexual Abuse Allegation	**1**	**2**	**1**	**7**	**1**	**12**
Prior Medical Neglect Allegation	**2**	**2**	**0**	**3**	**1**	**8**
Prior Physical Neglect Allegation	**2**	**3**	**0**	**2**	**3**	**10**
Prior Emotional Abuse Allegation	**1**	**1**	**0**	**1**	**2**	**5**
Prior Refusal to Accept Parental Responsibility	**0**	**1**	**0**	**0**	**0**	**1**
Total Child Fatalities with History with Child or Child's Family	**6**	**11**	**4**	**19**	**9**	**49**
No Prior History or History Greater than Two Years	*18*	*8*	*11*	*50*	*28*	*115*
Overall Total	*24*	*19*	*15*	*69*	*37*	*164*

Source: DFPS individual case reviews

Table 10. FY 2023 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**	**5**	**2**	**11**	**8**	**27**
Prior Neglectful Supervision Allegation	**5**	**11**	**3**	**15**	**5**	**39**
Prior Sexual Abuse Allegation	**1**		**0**	**2**	**1**	**4**
Prior Medical Neglect Allegation	**2**	**3**	**0**	**2**	**1**	**8**
Prior Physical Neglect Allegation	**2**	**3**	**0**	**1**	**3**	**9**
Prior Emotional Abuse Allegation	**1**	**1**	**0**	**1**	**1**	**4**
Total with History	**6**	**9**	**3**	**19**	**10**	**47**
No Prior History or History Greater than Two Years	*18*	*10*	*12*	*50*	*27*	*117*
Overall Total	*24*	*19*	*15*	*69*	*37*	*164*

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 FY 2023, there were 25 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.

1. Jackson was involved in an open Alternative Response (AR) case at the time of the fatality. The case was initiated on May 2, 2023, due to concerns of neglectful supervision of Jackson. During the case, Jackson died on May 3, 2023. Jackson was found unresponsive with a gunshot wound.
2. Jace was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on July 12, 2022, due to concerns of neglectful supervision and physical neglect of Jace and his siblings. During the investigation, Jace died on September 10, 2022 after being found unresponsive with serious signs of physical trauma.
3. Amir was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on May 8, 2023, due to concerns of neglectful supervision of Amir and his sibling. During the investigation, Amir died on May 13, 2023, after being found unresponsive in an unsafe sleep environment.
4. Stone was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on January 3, 2023, due to concerns of neglectful supervision of Stone. Another intake was received on January 24, 2023, regarding concerns of medical neglect of Stone. During the investigation, Stone died on February 22, 2023, after being found unresponsive in an unsafe sleep environment.
5. Ariyan was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on February 8, 2023, due to concerns of physical abuse and neglectful supervision of Ariyan and her siblings. Another intake was received on March 13, 2023, regarding concerns of neglectful supervision of Ariyan and her siblings. During the investigation, Ariyan died on March 13, 2023 after being involved in a motor vehicle accident.
6. Gentry was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on May 30, 2023, due to concerns of neglectful supervision and physical neglect of Gentry and his siblings. Another intake was received on June 15, 2023 due to additional concerns of physical neglect and

neglectful supervision of Gentry and his siblings. During the investigation, Gentry died on June 15, 2023 after being found unresponsive in an unsafe sleep environment.

7. Chanel was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on October 6, 2022, due to concerns of medical and physical neglect of Chanel. Another intake was received on October 15, 2022, regarding concerns of sexual abuse and neglectful supervision of Chanel and her sibling. During the investigation, Chanel died on October 16, 2022. Chanel was brought to a hospital by her mother with serious signs of physical trauma.
8. Quintavious was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on August 17, 2022, due to allegations of domestic violence between the parents in the presence of the children. During the investigation, Quintavious died on October 22, 2022. Quintavious was found unresponsive with serious signs of physical trauma.
9. Kenzlie was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on December 13, 2022, due to concerns of neglectful supervision of Kenzlie. Another intake was received on January 7, 2023, regarding additional concerns of neglectful supervision and physical abuse of Kenzlie. During the investigation, Kenzlie died on January 7, 2023 after being found unresponsive in an unsafe sleep environment.
10. Briella was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on September 27, 2022 alleging that there was a domestic violence incident in the home while Briella and her siblings were present. During the investigation Briella died on May 1, 2023. Briella was found unresponsive, taken to a hospital, and was found to have multiple injuries. Briella died due to blunt force injuries.
11. Isaiah was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on June 17, 2023, due to concerns of neglectful supervision of Isaiah. A second intake was received on July 15, 2023, and a third intake on July 28, 2023, both with additional concerns of neglectful supervision of Isaiah. During the investigation, Isaiah died on June 28, 2023 after being found unresponsive in an unsafe sleep environment.
12. Elizabeth was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on September 29, 2022, alleging medical neglect and neglectful supervision. During the investigation, Elizabeth died on February 24, 2023. Elizabeth was found unresponsive while in the care of her parents. Elizabeth died due to drug ingestion.
13. Zevaya was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on March 16, 2023, due to concerns of physical abuse of Zevaya. Another intake was received on March 20, 2023, regarding

additional concerns of physical abuse of Zevaya. During the investigation, Zevaya died on March 20, 2023. Zevaya is alleged to have died as a result of physical abuse.

14. Za'Maia was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on January 20, 2023 due to concerns of physical neglect of Za'Maia. During the investigation, Za'Maia died on March 20, 2023 after being found unresponsive with serious signs of malnutrition. Za'Maia died as a result of malnutrition and dehydration.
15. Rosalinda was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on December 1, 2022, alleging concerns of neglectful supervision by Rosalinda's parents as they engaged in domestic violence. A second intake was received on February 13, 2023, also alleging domestic violence. During the investigation, a third intake was received on April 12, 2023, alleging Rosalinda's parents engaged in domestic violence involving a gun and Rosalinda was accidentally shot. Rosalinda died on April 12, 2023, from a gunshot wound.
16. Shaheen was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on August 1, 2023, alleging neglectful supervision when Shaheen's sibling drowned at a family member's home. During the investigation, Shaheen and his sibling died on August 28, 2023 from gunshot wounds.
17. Mateen was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on August 1, 2023, alleging neglectful supervision when Mateen's sibling drowned at a family member's home. During the investigation, Mateen and her sibling died on August 28, 2023 from gunshot wounds.
18. Fletcher was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on May 16, 2023, alleging concerns of neglectful supervision. During the investigation, Fletcher died on June 11, 2023, after being found unresponsive. Fletcher died as a result of physical abuse.
19. Prince was involved in an open CPS family based safety services (FBSS) case at the time of the fatality. The FBSS stage was open on May 31, 2023 due to concerns of neglectful supervision of Prince. During the FBSS case, Prince died on July 3, 2023. Prince was found unresponsive in an unsafe sleep environment.
20. Sky was involved in an open family based safety services (FBSS) stage at the time of the fatality. The FBSS stage was opened on November 7, 2022 due to concerns of neglectful supervision of Sky. During the FBSS stage, Sky died on February 24, 2023. Due to prematurity, Sky was on oxygen 24 hours a day. Sky was found unresponsive as a result of not being provided required oxygen.
21. Joselyn was involved in an open CPS family-based safety services (FBSS) case at the time of the fatality. The FBSS stage was opened on September 14, 2022, due to concerns of neglectful supervision of the child. During the FBSS stage, Joselyn died on January 10, 2023; the child drowned in a bathtub.

22. Yana was involved in an open CPS family based safety services (FBSS) case at the time of the fatality. The FBSS stage was open on February 22, 2023 due to concerns of neglectful supervision of Yana and her siblings. During the FBSS case, Yana died on March 29, 2023 after being found unresponsive in an unsafe sleep environment.
23. Legend was involved in an open CPS conservatorship (CVS) case at the time of the fatality. Legend entered foster care on July 1, 2022. On September 2, 2022 Legend was placed with a relative. Legend died on March 3, 2023. The fatality investigation was initiated on March 4, 2023 as Legend had been found unresponsive. Legend died as a result of blunt force trauma.
24. Ayden was involved in an open CPS conservatorship (CVS) case at the time of the fatality. Ayden entered foster care on July 1, 2022. On September 2, 2022 Ayden was placed with a relative. Ayden died on March 3, 2023. The fatality investigation was initiated on March 4, 2023 as Ayden had been found unresponsive. Ayden died as a result of blunt force trauma.
25. Alayiah was involved in an open CPS conservatorship (CVS) case at the time of the fatality. Alayiah entered foster care on July 1, 2022. On September 2, 2022 Alayiah was placed with a relative. Alayiah died on March 3, 2023. The fatality investigation was initiated on March 4, 2023 as Alayiah had been found unresponsive. Alayiah died as a result of blunt force trauma.

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

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

Further analysis and individual case readings in these types of investigations are a useful tool to inform strategies to prevent child fatalities and ensure consistency in investigations in which a child fatality has occurred. These cases continue to have similar demographics in FY 2023 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 FY 2023, there were 104 child fatalities where the death was not related to abuse or neglect, but the investigation found abuse or neglect had occurred in the home.
- 67 child fatalities where the death was not related to abuse or neglect had some form of prior history, with 63 percent of those cases occurring in the past two years.
- Most child fatalities that were not found to be abuse or neglect related are due to health-related issues, followed by deaths determined by the medical examiner as unable to determine.
    - The cause of death in 52 of the confirmed cases were: natural, health-related, accidental suffocation, vehicle-related, drowning, and sudden unexplained infant death.
    - In one case, the youth died by suicide and six children died due to trauma unrelated to abuse or neglect.
    - The other investigations involved a fatality where the cause of death was undetermined.

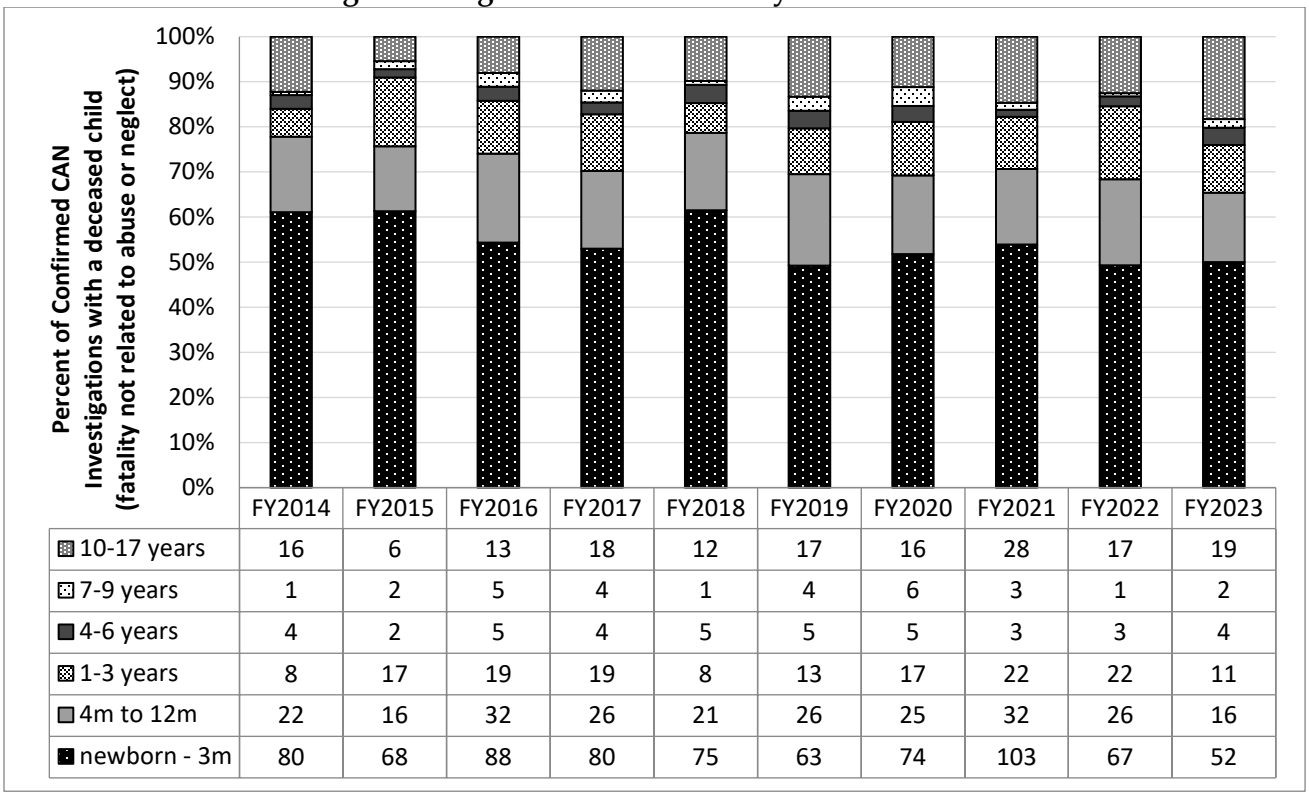
Victim Children

- 10 of the 104 children were previous alleged victims but allegations were not confirmed in prior cases.
- 13 of the 104 children were previously confirmed victims in prior cases.
- 9 of the 104 children were involved in Family Based Safety Services previously and three had been involved in DFPS conservatorship.

Perpetrators

- 18 of the confirmed perpetrators were previously alleged perpetrators but allegations were not confirmed in prior cases.
- 38 of the confirmed perpetrators were previously confirmed perpetrators in prior cases.

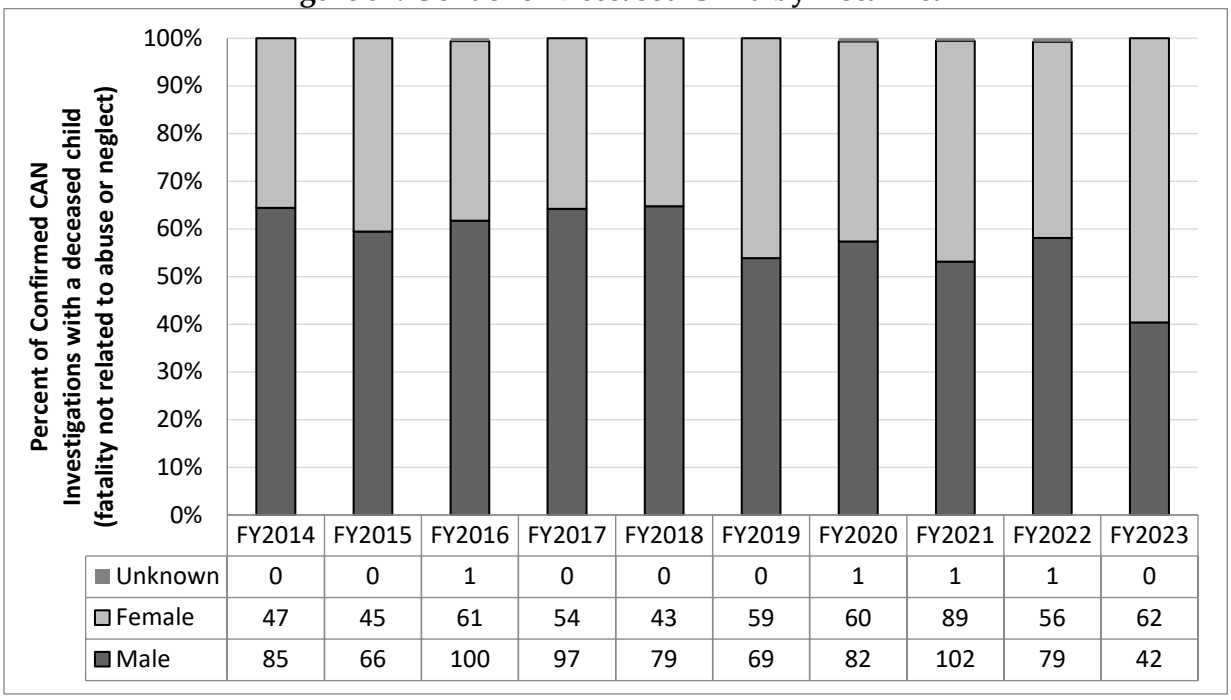
Figure 33. Age of Child at Death by Fiscal Year



	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023
10-17 years	16	6	13	18	12	17	16	28	17	19
7-9 years	1	2	5	4	1	4	6	3	1	2
4-6 years	4	2	5	4	5	5	5	3	3	4
1-3 years	8	17	19	19	8	13	17	22	22	11
4m to 12m	22	16	32	26	21	26	25	32	26	16
newborn - 3m	80	68	88	80	75	63	74	103	67	52

Source: DFPS Data Warehouse Report ft_12

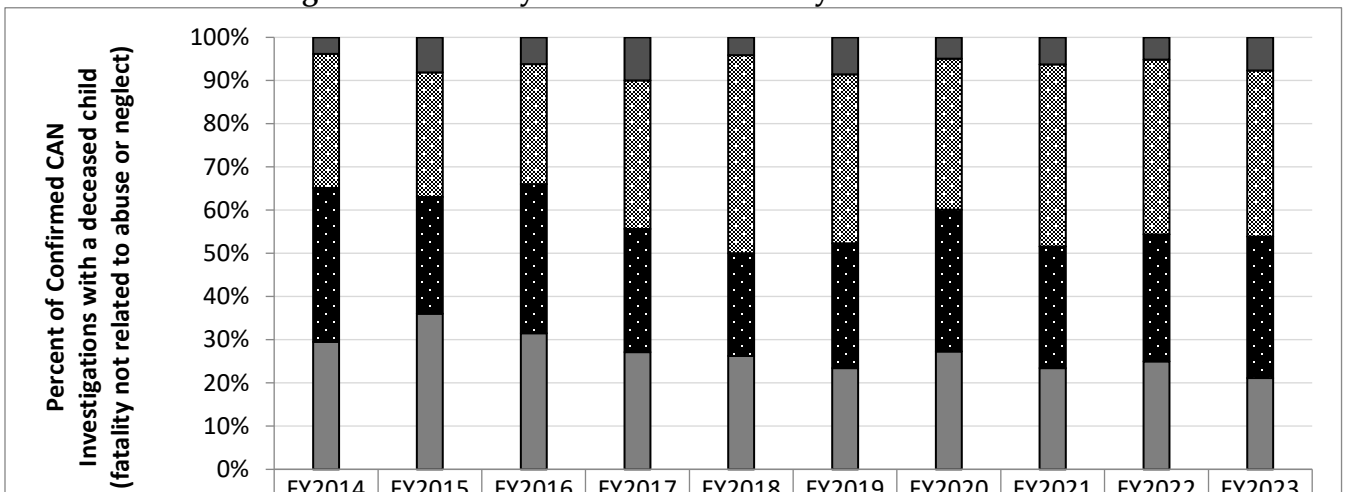
Figure 34. Gender of Deceased Child by Fiscal Year



	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023
Unknown	0	0	1	0	0	0	1	1	1	0
Female	47	45	61	54	43	59	60	89	56	62
Male	85	66	100	97	79	69	82	102	79	42

Source: DFPS Data Warehouse Report ft_12

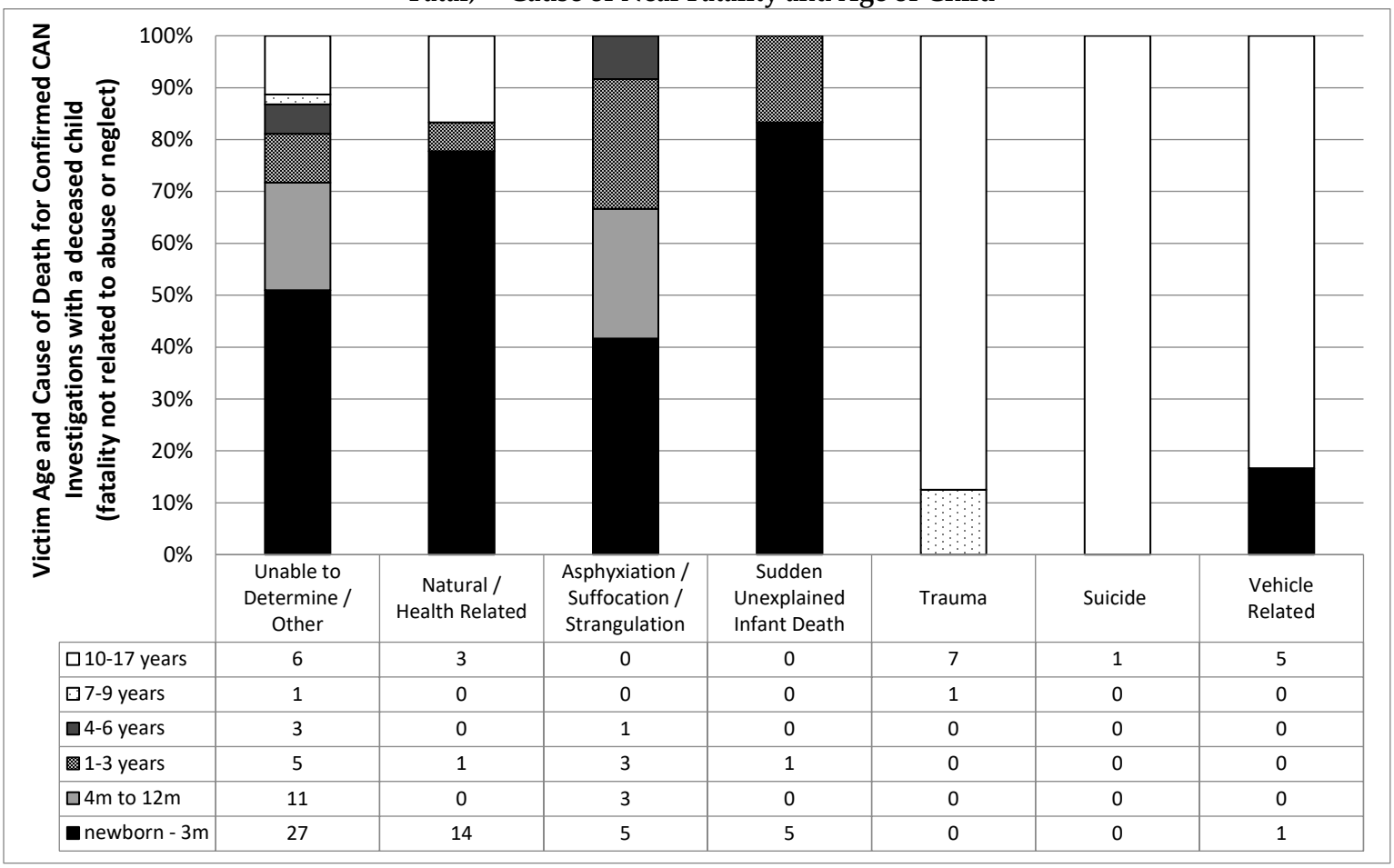
Figure 35. Ethnicity of Deceased Child by Fiscal Year



	FY2014	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023
Other	5	9	10	15	5	11	7	12	7	8
Hispanic	41	32	45	52	56	50	50	81	55	40
African American	47	30	56	43	29	37	47	54	40	34
Anglo	39	40	51	41	32	30	39	45	34	22

Source: DFPS Data Warehouse Report ft_12

Figure 36. FY 2023 - Investigated Child Fatalities that were not Abuse and Neglect Related Fatality but Maltreatment Confirmed in Investigation (RTB with Severity Type Other than Fatal) -- Cause of Near Fatality and Age of Child



	Unable to Determine / Other	Natural / Health Related	Asphyxiation / Suffocation / Strangulation	Sudden Unexplained Infant Death	Trauma	Suicide	Vehicle Related
10-17 years	6	3	0	0	7	1	5
7-9 years	1	0	0	0	1	0	0
4-6 years	3	0	1	0	0	0	0
1-3 years	5	1	3	1	0	0	0
4m to 12m	11	0	3	0	0	0	0
newborn - 3m	27	14	5	5	0	0	1

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 2022 (the most recent year reported for all states), the Texas rate was 2.37 confirmed child abuse and neglect related fatalities per 100,000 compared to a national average of 2.73 confirmed child abuse and neglect related fatalities per 100,000. It is important to note that for federal reporting, not all states report data and child

fatalities are reported during the federal fiscal year in which the death was determined to have been caused by maltreatment which is not necessarily the year in which the child died. Additionally, there are not common reporting and definition requirements when calculating child fatalities and it has been estimated that as many as 50 percent to 60 percent of child deaths resulting from abuse or neglect are not recorded as such.[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.

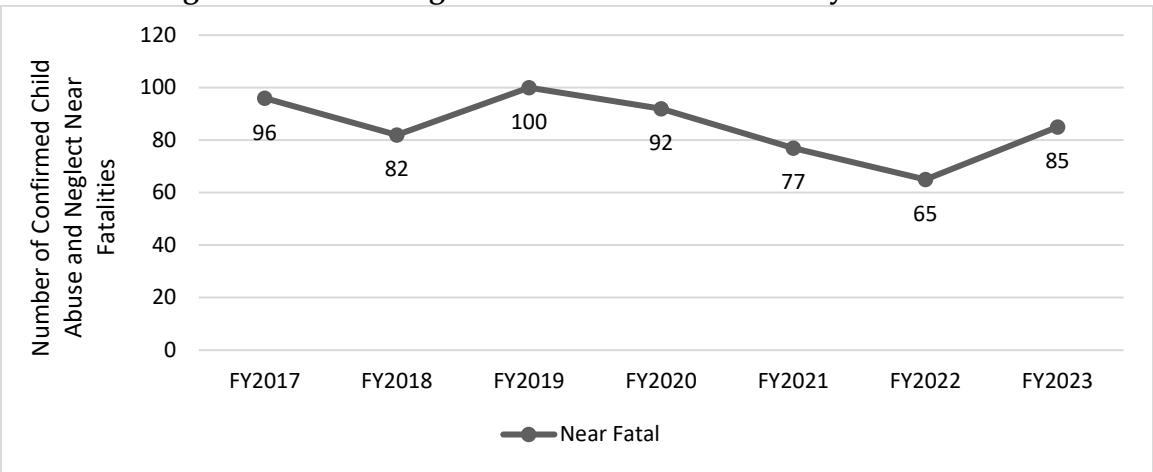
Near Fatalities

In FY2023, Texas had 85 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 45 percent of the near fatalities in FY2023.

During FY2023, children aged three and younger accounted for 75 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 49 percent. Male children made up more than 50.5 percent of all confirmed near fatalities.

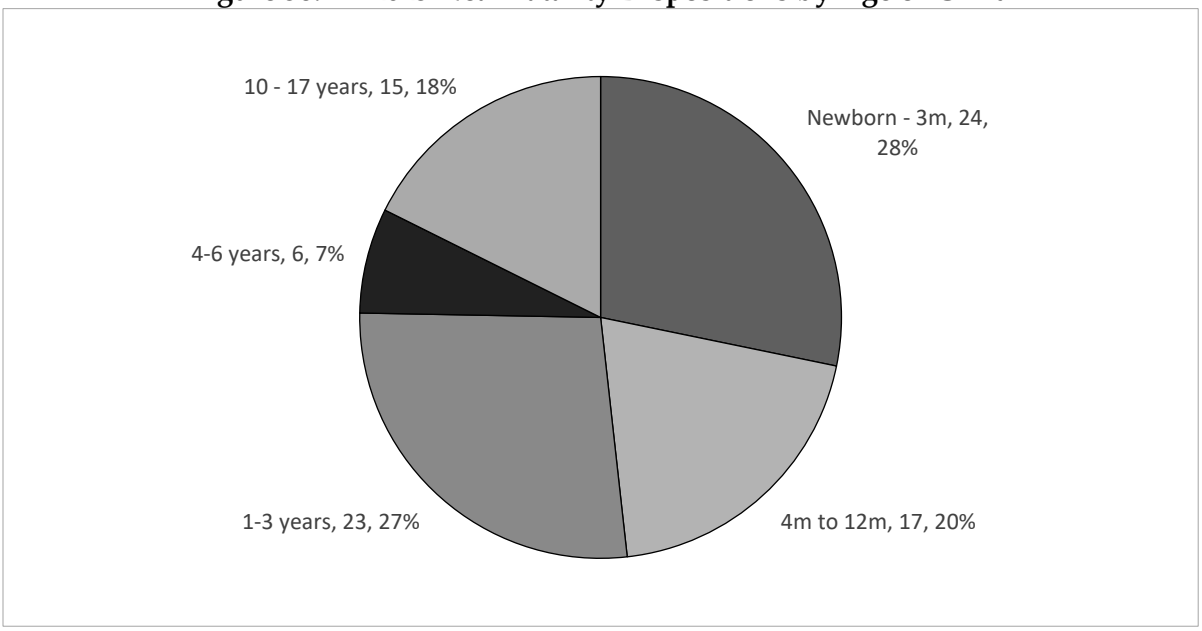
The highest number of abuse and neglect-related near fatalities was Region 3 (Dallas/Ft. Worth) with 30 near fatalities followed by Region 8 (San Antonio) with 21 near fatalities, and Region 7 (Austin) with 8 near fatalities.

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



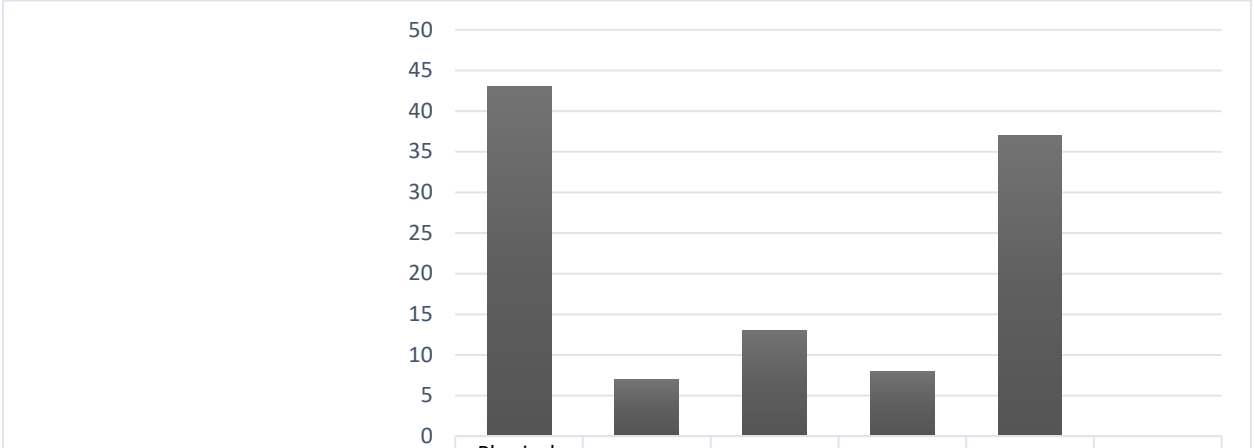
Source: DFPS individual case reviews

Figure 38. FY 2023 Near Fatality Dispositions by Age of Child



Source: DFPS individual case reviews and Data Warehouse nf_01

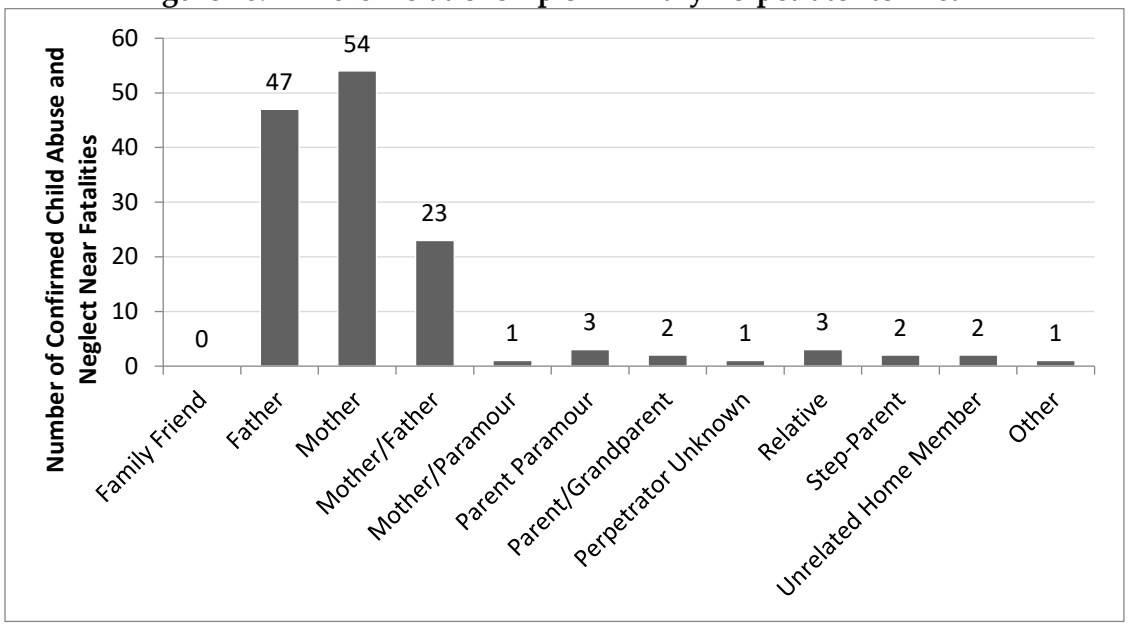
Figure 39. FY 2023 – Near Fatality Dispositions by Cause



	Physical Abuse - Blunt Force & Inflicted Trauma	Vehicle Related	Medical Neglect	Non-Fatal Drowning	Neglectful Supervision	Other*
General Cause of Confirmed Child Abuse or Neglect Fatalities in FY2022 - Statewide	43	7	13	8	37	0

** Other includes medical neglect, physical neglect, attempted suicide, premature birth due to drug use, and abandonment at birth. One near fatality may have multiple near fatal allegations and dispositions. Source:* DFPS individual case reviews

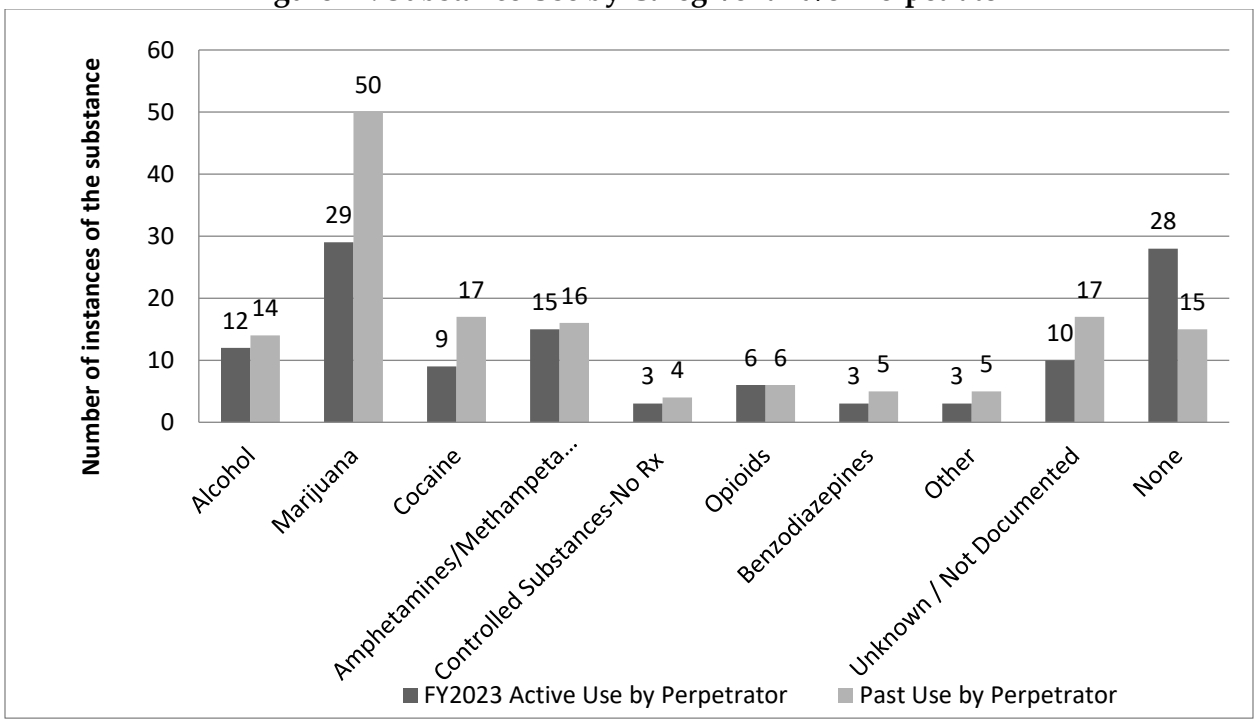
Figure 40. FY 2023 Relationship of Primary Perpetrator to Victim



Source: DFPS individual case reviews

Note: Number of victims: 85; however, in many cases more than one functional perpetrator was identified.

Figure 41. Substance Use by Caregiver and/or Perpetrator



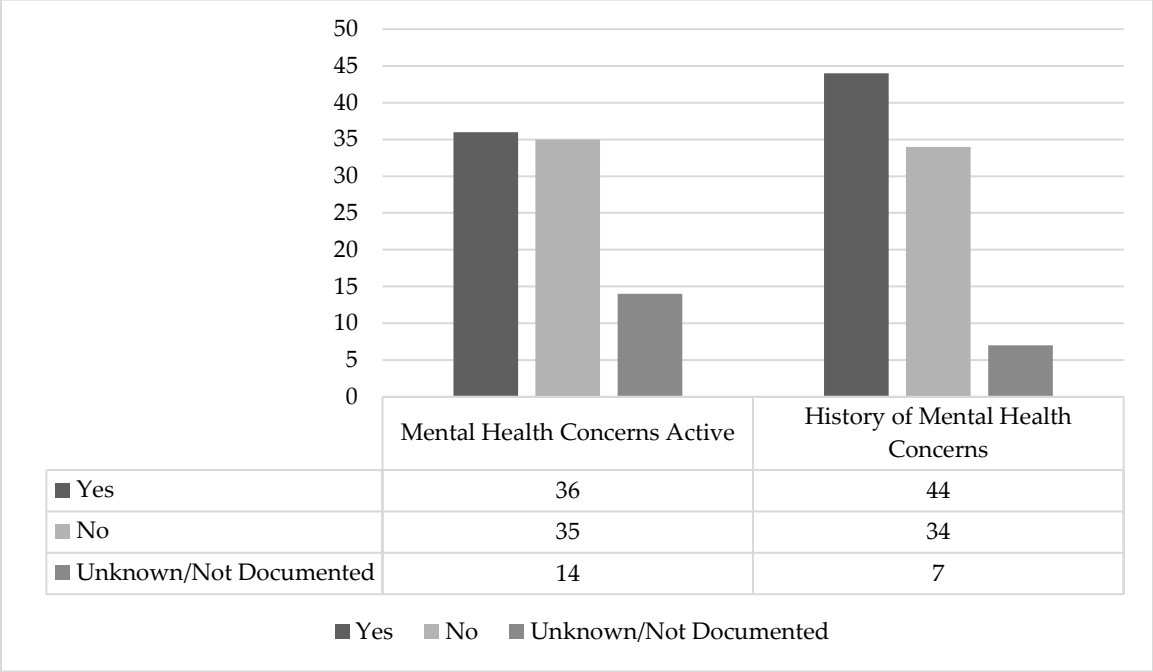
Source: DFPS individual case reviews

Table 11. FY 2023 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	**33**	**45**	**19**
No	**43**	**35**	**-**
Unknown (not identified in case read)	**9**	**5**	**-**

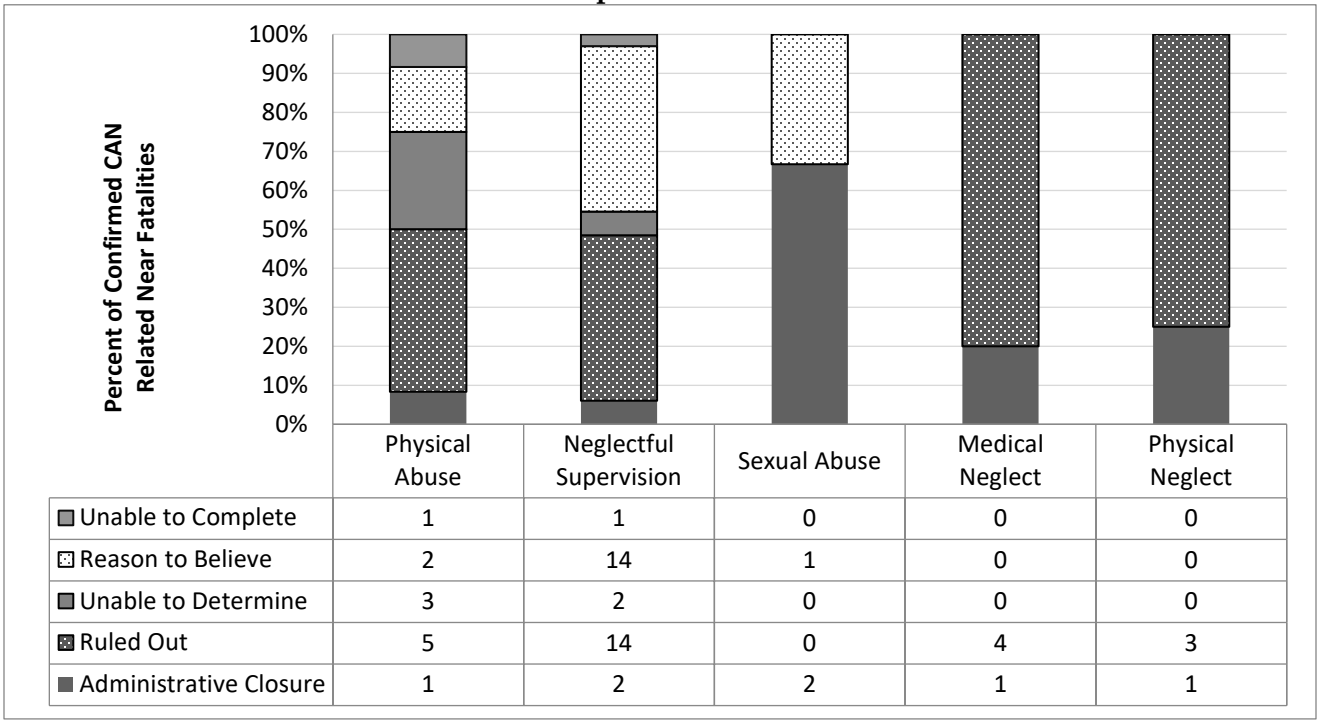
Source: DFPS individual case reviews

Figure 42. FY 2023 Mental Health for Caregivers and/or Perpetrator



Source: DFPS individual case reviews

Figure 43. FY 2023 CPS History for Confirmed Near Fatalities – CPS Involvement with the Child or Child's Family in the Two Years Prior to Near Fatality, by Prior Allegation Type and Disposition



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Medical Neglect	Physical Neglect
Unable to Complete	1	1	0	0	0
Reason to Believe	2	14	1	0	0
Unable to Determine	3	2	0	0	0
Ruled Out	5	14	0	4	3
Administrative Closure	1	2	2	1	1

Source: DFPS individual case reviews

In 32 near fatalities, the family had prior history with the department.

- 23 families had prior investigations that were closed without ongoing DFPS involvement.
- 13 families had an open stage of service: Seven open investigations, four in DFPS Conservatorship, and two with Family Based Safety Services. 100-percent of initial contacts were completed timely. All near fatality cases had one worker assigned per stage.
- 19 families had prior FBSS involvement. 17 of the families had a safety plan in place during the involvement. 94-percent of families reportedly complied or partially complied with their safety plan during services.
    - On average, families were seen monthly, with their involvement in FBSS ranging from three months to one-year. In general, initial visits were made timely as the policy and practice is to work collaboratively with Investigations and the family to engage in FBSS services at case transfer.
        - Services offered in the previous or open stage include:
            - Counseling for family, individual, or group: 13 cases

- Daycare or respite care: 2 cases
- Domestic violence shelter or counseling: 8 cases
- Drug testing or treatment: 16 cases
- Education or training (ARD, supplies, referrals for GED, vocational ed, etc.): 1 case
- Family support services (food stamps, TANF, etc.): 1 case
- Household needs (utilities, household items, furniture, etc.): 1 case
- Mental health (psychological testing, mental health assessment or treatment, referral to local mental health authority): 6 cases
- Parenting skills / evidence-based parent education: 12 cases

- In 5 of the 32 near fatalities, the family had prior involvement through DFPS Conservatorship.
- In 32 of the 44 cases with prior history, initial contacts were made timely in 72.72 percent of the qualifying investigations.

Statewide Internal and External Child Fatality Review

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

Child Safety Review Committee - DFPS Review Team with External Stakeholders

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

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

The State Committee is a multidisciplinary group comprised of members throughout Texas.[13] Its mission is to reduce the number of preventable child deaths and its purpose is threefold:

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

DSHS publishes an annual report from the SCFRT. The most recent report is the State Child Fatality Review Team Committee Biennial Report – April 2022.[14]

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

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

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

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

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

Protect Our Kids Commission

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

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

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

National Initiatives and Program Improvement

Federal Commission for the Elimination of Child Abuse and Neglect Fatalities

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

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

Endnotes

[1] 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 2022*. Available at https://www.acf.hhs.gov/cb/report/child-maltreatment-2022

[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:
https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html

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

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

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