TEXAS
Department of Family
and Protective Services

Fiscal Year 2017
Child Maltreatment Fatalities and Near Fatalities Annual Report

March 1, 2018

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Executive Summary

With over seven million children in Texas, the safety net that exists to protect children and help them reach their greatest potential begins at home and includes family, neighbors, schools and communities. The Department of Family and Protective Services (DFPS), in partnership with law enforcement, the medical community, service providers and communities, is committed to providing a complete continuum of prevention and intervention programs that address child maltreatment. Specifically, through analyzing and addressing trends in child abuse and neglect fatalities, DFPS continually improves policy and practices surrounding 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.

Most significantly, the number of child fatalities decreased by 22.5 percent in FY 2017 compared to the previous year. Another finding – that in about half of the cases the family had no prior involvement with DFPS – highlights the importance of community in child protection. For children to remain safe, and to thrive, it takes community buy-in and collaboration, so that support networks can be built and families helped 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. Additionally, through Prevention and Early Intervention, DFPS uses prevention strategies to address the needs of families that are high risk for child maltreatment through a continuum of services such as home visiting, parent education, youth development and education, and support services.

The DFPS Office of Child Safety produces this annual report in accordance with Texas Family Code §261.204 to support internal and external work to address risk factors associated with child maltreatment, as well as to 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 and requires intensive coordination and collaboration between DFPS, other state agencies, and community providers so that families can be helped.

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. This new data can also be used 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 FY2017, the following trends and areas for review have been identified:

General Findings

- Texas had 172 confirmed child abuse and neglect-related fatalities in FY2017, a decrease of 22.5 percent compared to FY2016 (Figure 3).
    - The decrease in drownings statewide, unsafe sleep (both statewide, but specifically in Region 8), and vehicle-related fatalities were significant.
    - Physical abuse fatalities decreased by almost 32 percent. FY2017 had the lowest number of physical abuse fatalities since FY2010.
- The number of child fatalities investigated by DFPS increased from 796 in FY2016 to 807 in FY2017, the highest number of investigations in the past five years (Figure 2).
- Confirmed neglect-related fatalities historically account for almost 40 percent of child maltreatment fatalities, but in FY2017 were 34 percent (Figure 4).
    - The most common causes of fatalities involving neglect were drowning, unsafe sleep, and vehicle-related (Figure 7, 8).
        - Examples of vehicle-related deaths include: a child left in a hot car; a child unsupervised and struck by a vehicle; and a child riding in a car and the parent or caregiver driving was intoxicated or under the influence.

Victims

- Based on the confirmed child abuse and neglect-related fatalities over the past five fiscal years, children 3 years of age and younger were almost 80 percent of all 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 FY2017, 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).
- More than 57 percent of children who died from abuse or neglect in FY 2017 were too young for school and not enrolled in day care (as compared to 40 percent in FY2016.) Seven children were being cared for by illegal day care operations that were unknown to DFPS (Page 24).

Perpetrators

- Physical abuse-related fatalities most commonly involved blunt force trauma inflicted by a father or boyfriend (Figure 14, 15).
- Parents were the most common perpetrators of fatal child abuse and neglect (Figure 13).
- In about half of the confirmed child abuse and neglect fatalities, neither the children nor the perpetrator had prior history with CPS (Figure 20).

- Risk factors such as substance abuse, mental health concerns, and domestic violence were common factors in confirmed child abuse and neglect fatalities:
    - In FY2017, 52 percent of fatalities caused by abuse or neglect included a parent or caregiver actively using a substance and/or under the influence of one or more substances that affected their ability to care for the child (Figure 11, Table 5).
    - Almost 23 percent of child abuse and neglect fatalities involved a parent or caregiver with reported or confirmed mental health concerns (Table 7).
    - Active domestic violence concerns were identified in 17 percent of the child fatalities confirmed to be from abuse or neglect. In 40 percent of all child fatalities confirmed to be from abuse or neglect, families had a history of domestic violence (Figure 12).

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

Child Fatality Investigations

The Department of Family and Protective Services (DFPS) is required under the Texas Family Code to investigate child fatalities where allegations of abuse or neglect are present. Investigations are carried out to determine if abuse and/or neglect occurred and, if applicable, whether the fatality was caused by abuse or neglect.[1]

DFPS investigates child abuse or neglect fatalities based on where the child was living at the time of death. Adult Protective Services (APS) investigates deaths of children in APS-regulated placements. DFPS Investigations investigate deaths of children 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 Licensing settings); deaths of children in regulated care placements (Residential Child Care Licensing settings), including children in DFPS conservatorship in foster care placements; and/or deaths of children living with their families or who are in DFPS conservatorship and in non-foster care kinship placements (Child Protective Services approved placements). If a child dies while in DFPS conservatorship, either from natural causes, or injuries sustained before coming into foster care or when a potentially a foster parent is involved at the time of death, an investigation will be completed. If the investigation determines that the death is related to abuse or neglect, it is counted as a confirmed child abuse or neglect fatality.

In abuse and neglect investigations, investigators are required by law to establish a preponderance of evidence in order to confirm an allegation of abuse and neglect. "Preponderance of evidence" is a standard of proof in which the facts more likely than not occurred. Sometimes this is referred to as the "51 percent" standard, a more stringent standard than reasonable doubt but less stringent than clear and convincing evidence. For CPS investigations, child abuse and neglect is defined in Texas Family Code §261.101. For CCL and RCCL investigations, abuse and neglect is defined in Texas Family Code §261.401, and additional guidance is available in Texas Administrative Code 40 TAC §§745.8551– 745.8559.

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

Investigation Dispositions for Child Fatalities

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

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

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

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

Unable to Complete (UTC) - Before staff could draw a conclusion, the persons involved in the allegation moved and could not be located, or the family refused to cooperate with the investigation. (CPS 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. (CPS 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, The Department of Family and Protective Services (DFPS) is required to investigate child abuse and neglect allegations. In some instances, the level of abuse or neglect that caused the child to be in serious or critical condition. By Texas Family Code §264.5031, a near fatality is defined as a case where a physician has certified that a child is in critical or serious condition, and a caseworker determines that the child's condition was caused by the abuse or neglect of the child.

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 medical intervention, would likely have died as a result of the maltreatment. "Medical intervention:" requires some form of:

- cardiopulmonary resuscitation (CPR) such as chest compressions, rescue breathing, removal of airway obstruction and/or intubation;
- medications to stabilize cardiac or respiratory status, blood pressure or critical electrolytes; and/or
- surgery to preserve brain function or prevent blood loss/infection (abdominal trauma).

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 medical professional and/or child abuse pediatrician that the child was in serious or critical condition, and determines that abuse or neglect was the cause of the medical condition, then the investigator would assign the following disposition:

> **Reason to Believe (RTB) with severity 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 medical professional.

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

Findings: Investigating Child Abuse and Neglect Related Fatalities

Table 1 provides data regarding overall trends in child abuse and neglect in Texas. While the child population of Texas has continued to increase, the number of intakes assigned for investigation in general saw a decline from FY2010 through FY2013. In FY2014, the number of intakes assigned for investigation began to rise, with FY2017 being the highest in the past eight years.

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

	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Child Population of Texas	6,865,824	6,952,177	6,996,352	7,121,499	7,266,760	7,311,923	7,407,636	7,500,272
Number of Intakes Assigned for Investigation or Alternative Response by CPS	231,532	222,541	206,200	194,803	215,512	232,159	238,591	238,600
Number of Investigated Child Fatalities	1024	973	882	804	797	739	796	807
Number of fatalities where abuse/neglect was confirmed	227	231	212	156	151	171	222	172
Child Fatality Rate per 100,000 Children	3.31	3.32	3.03	2.19	2.10	2.34	2.99	2.29
National Rate for Equivalent Federal Fiscal Year[2]	2.10	2.10	2.18	2.09	2.14	2.26	2.36	***

Source: Data from US Census Bureau; Texas State Data Center; DFPS Data Books FY2010-FY 2017; 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 2017

*** Child Maltreatment 2017 is scheduled to be released in January/February 2019.

FY2017 saw a 22.5 percent decrease in child fatalities due to maltreatment over FY2016. Because child maltreatment fatalities are relatively low compared to overall child maltreatment rates and child population, it is difficult to single out causal factors independent of other concerns that impact child safety.

FY2017 had significant decreases in both physical abuse and neglect related fatalities as compared to FY2016.

- Decreases in unsafe sleep/co-sleeping fatalities by almost 30 percent
- Decreases in drownings after significant high in FY2016; decrease by almost 7 percent
- Decreases in homicides/physical abuse by almost 32 percent
- Decreases in vehicle related fatalities by 24 percent

Regarding child fatality investigations, the number of child fatalities reported to DFPS and investigated declined between FY2010 and FY2015. The total number of child fatalities investigated between FY2010 and FY2017 has decreased by more than 21 percent. The percent of confirmed child abuse and neglect-related fatalities have varied between 19 percent and 29 percent in the past five years, with FY2016 at almost 29 percent of all investigated fatalities being related to maltreatment. The distribution of case dispositions for child fatality investigations conducted in FY2010 through FY2017 are presented in Table 2 - Percentage of Child Fatality Investigations by Disposition.

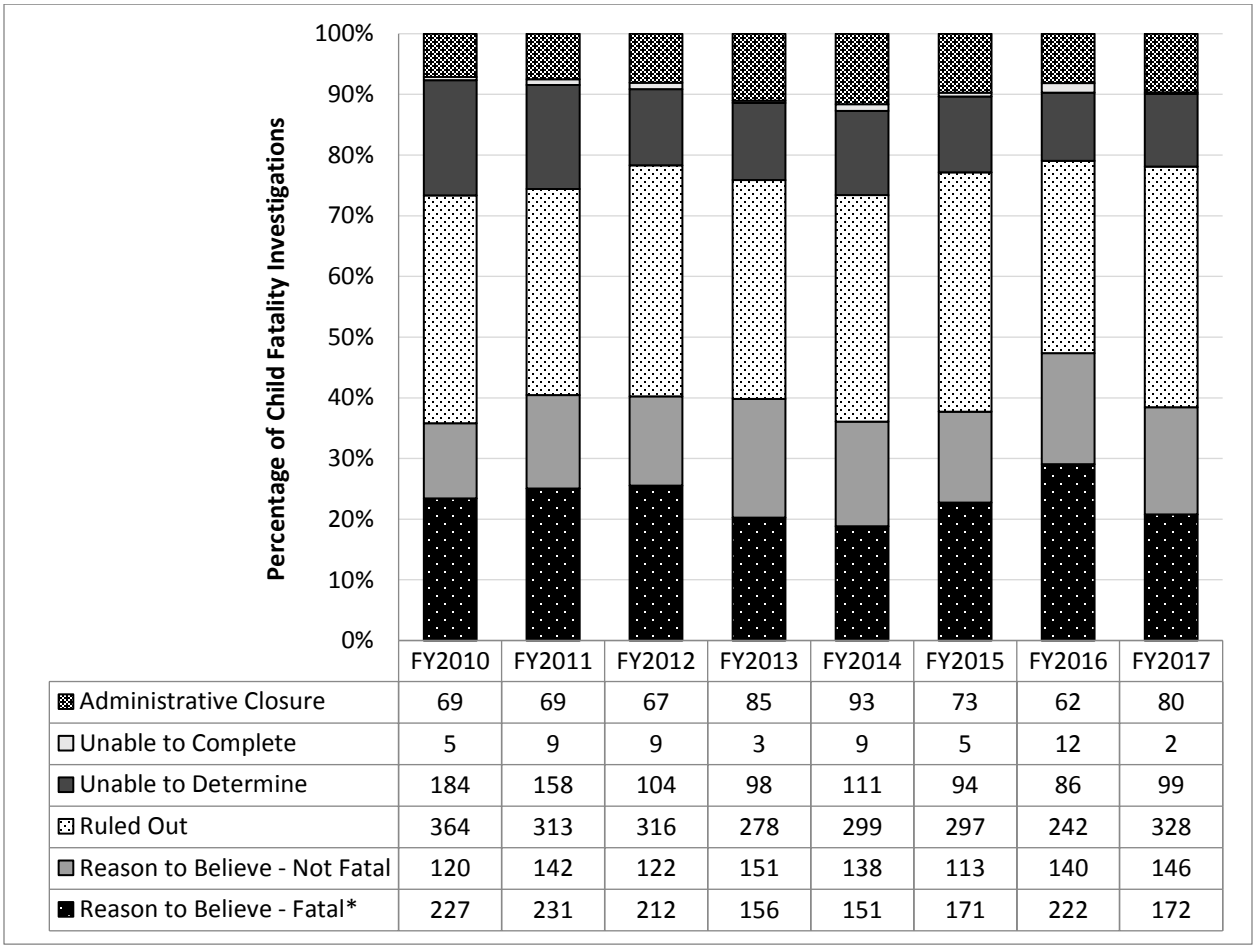
Table 2. Percentage of Child Fatality Investigations by Disposition

State Fiscal Year	Number of Investigated Child Fatalities	Reason to Believe and Fatality Confirmed for Abuse or Neglect* (RTB-Fatal)	Reason to Believe but Fatality not from Abuse or Neglect (RTB but not Fatal)	Ruled Out (RO)	Unable to Determine (UTD)	Unable to Complete (UTC)	Administrative Closure (Admin)
FY2010	1024	22.17%	11.72%	35.55%	17.97%	0.49%	6.74%
FY2011	973	23.74%	14.59%	32.17%	16.24%	0.92%	7.09%
FY2012	882	24.04%	13.83%	35.83%	11.79%	1.02%	7.60%
FY2013	804	19.40%	18.78%	34.58%	12.19%	0.37%	10.57%
FY2014	797	18.94%	17.31%	37.51%	13.92%	1.12%	11.67%
FY2015	739	23.27%	15.01%	39.44%	12.48%	0.66%	9.69%
FY2016	796	28.94%	18.25%	31.55%	11.21%	1.83%	8.21%
FY2017	807	21.31%	17.65%	39.66%	11.97%	0.24%	9.67%

*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. Multiple DFPS divisions such as Child Protective Services (CPS) or Residential Child Care Licensing (RCCL) may investigate a child fatality. Additionally, a child may die in a home where there are multiple families being investigated due to the child fatality.

Source: DFPS Data Request Intake and Tracking (DRIT) Request

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



	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Administrative Closure	69	69	67	85	93	73	62	80
Unable to Complete	5	9	9	3	9	5	12	2
Unable to Determine	184	158	104	98	111	94	86	99
Ruled Out	364	313	316	278	299	297	242	328
Reason to Believe - Not Fatal	120	142	122	151	138	113	140	146
Reason to Believe - Fatal*	227	231	212	156	151	171	222	172

* Count by Child, all other categories are count by investigation. *Source*: DFPS DRIT Request

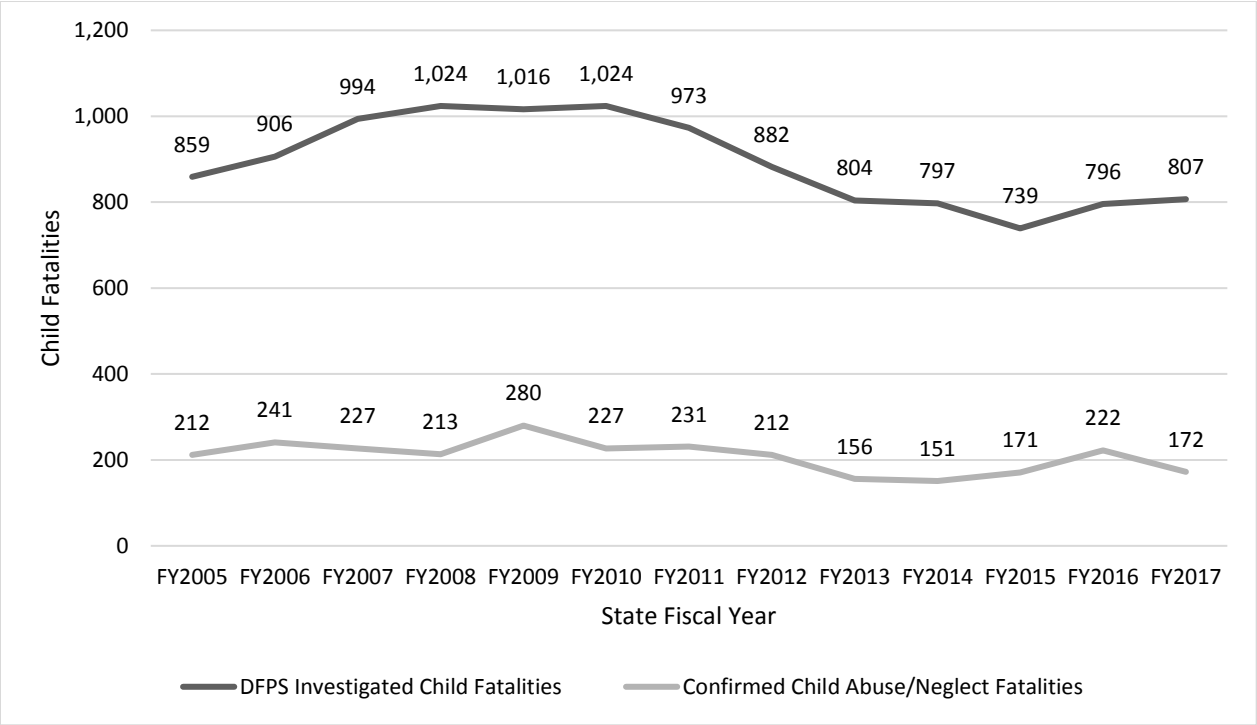
Since FY2010, there has been a decrease in cases closed with an unable to determine disposition. The decrease indicates more thorough investigations with the collaboration of partners such as medical examiners, law enforcement, and special investigators to determine the overall disposition of a fatality case based on critical needed information (Figure 1). Additional training has been provided to CPS investigation 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 Child Protective Services to provide additional education on best practice 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;

- Increased use of medical professionals, such as the Forensic Assessment Center Network and child abuse pediatricians, to determine the nature and extent of the maltreatment; and
- Increased collaboration and multidisciplinary team staffing between law enforcement, medical examiner, and Child Protective Services.

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



Source: DFPS Data Warehouse Report FT_06

In FY2017, DFPS investigated 807 possible child abuse and neglect-related fatalities. That number peaked in FY2008 and FY2010 at 1,024, with a decrease in the past five years until FY2016 (Figure 2).

Ensuring Consistency in Dispositions

Part of the overall trends in child abuse and neglect fatalities is related to more consistent disposition of fatalities. In FY2012, guidelines were provided to CPS staff to help ensure consistent dispositions on child fatalities involving co-sleeping, drownings, firearm accidents, suicides and children left in cars. In FY2013, CPS created the Statewide Child Fatality Disposition Review Team, comprised of regional and state office staff, to ensure consistency in child fatality investigations with a disposition of Reason to Believe-fatal for abuse or neglect. CPS also trained staff and management to strengthen information gathering, engage the family and support systems, and utilize information from professionals who have contact with the family. This has helped to determine and support consistent dispositions. In FY2015, the Statewide Child Fatality Disposition Review Team reviewed a random sample of all child fatality investigations from FY2013 to look at overall consistency in dispositions in those

investigations. These efforts allow the department to continue working with staff to support consistent dispositions statewide across all investigations, not solely those involving child fatalities.

Also, CPS has worked to ensure that reports assigned to field staff for full investigation meet DFPS jurisdiction to investigate. Before FY2013, a report that involved a child fatality but no clear abuse or neglect allegations was assigned as a Priority 1 investigation. This likely increased the number of child fatalities that were administratively closed or ruled out. In FY2013, CPS and DFPS Statewide Intake (SWI) worked to clarify what intakes regarding a child fatality should be sent to field staff for investigation. When SWI receives an intake regarding a child fatality but there is no clear allegation of abuse or neglect, the intake is now reviewed by a CPS screener before assignment as a full investigation.

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

FY2017 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 the 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. The following data are collected from IMPACT and individual case reads where the child's death was caused by abuse or neglect which is distinguished with the disposition of reason to believe - fatal.

General Findings

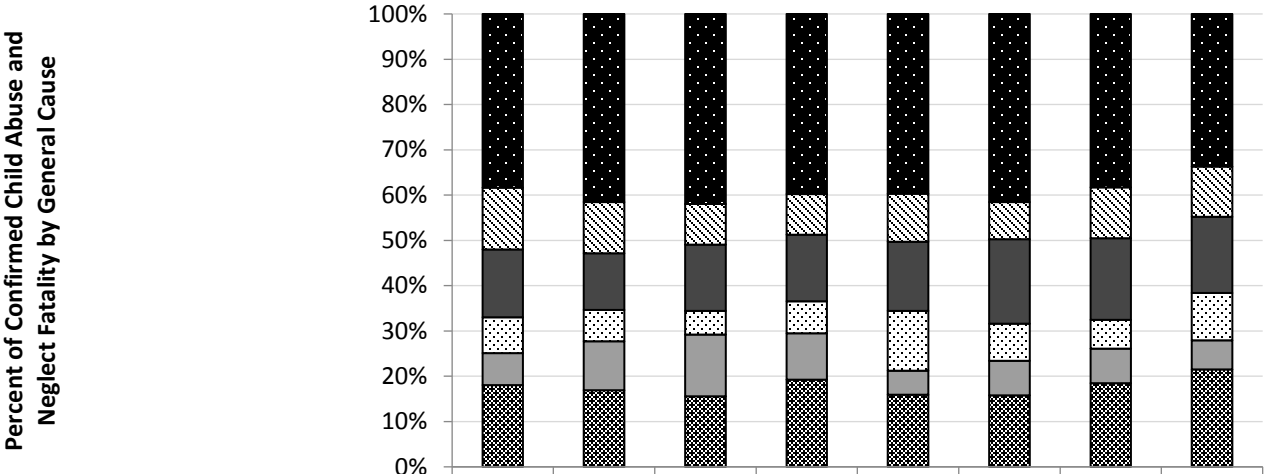
- Texas had 172 confirmed child abuse and neglect-related fatalities in FY2017, a decrease of 22.5 percent compared to FY2016 (Figure 3).
    - The decrease in drownings statewide, unsafe sleep (both statewide, but specifically in Region 8), and vehicle-related fatalities were significant.
    - Physical abuse fatalities decreased by almost 32 percent. FY2017 had the lowest number of physical abuse fatalities since FY2010.
- The number of child fatalities investigated by DFPS increased from 796 in FY2016 to 807 in FY2017, the highest number of investigations in the past five years (Figure 2).
- Confirmed neglect-related fatalities historically account for almost 40 percent of child maltreatment fatalities, but in FY2017 were 34 percent (Figure 4).
    - The most common causes of fatalities involving neglect were drowning, unsafe sleep, and vehicle-related (Figure 7, 8).
        - Examples of vehicle-related deaths include: a child left in a hot car; a child unsupervised and struck by a vehicle; and a child riding in a car and the parent or caregiver driving was intoxicated or under the influence.

General Cause/Manner of Child Abuse or Neglect Fatality

Medical examiners and community-based 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.

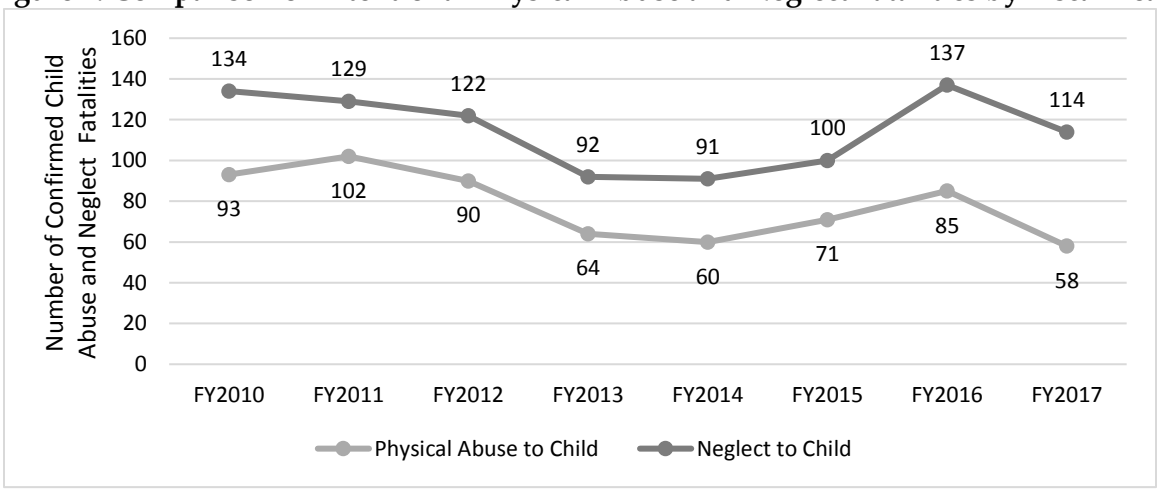
Figure 3. General Cause of Confirmed Child Abuse or Neglect Fatality by Fiscal Year



	FY10	FY11	FY12	FY13	FY14	FY15	FY16	FY17
Physical Abuse - Blunt Force Trauma & Intentional Homicide	87	96	89	62	60	71	85	58
Vehicle related	31	26	19	14	16	14	25	19
Unsafe sleep	34	29	31	23	23	32	40	29
Other*	18	16	11	11	20	14	14	18
Neglectful Supervision	16	25	29	16	8	13	17	11
Drowning	41	39	33	30	24	27	41	37

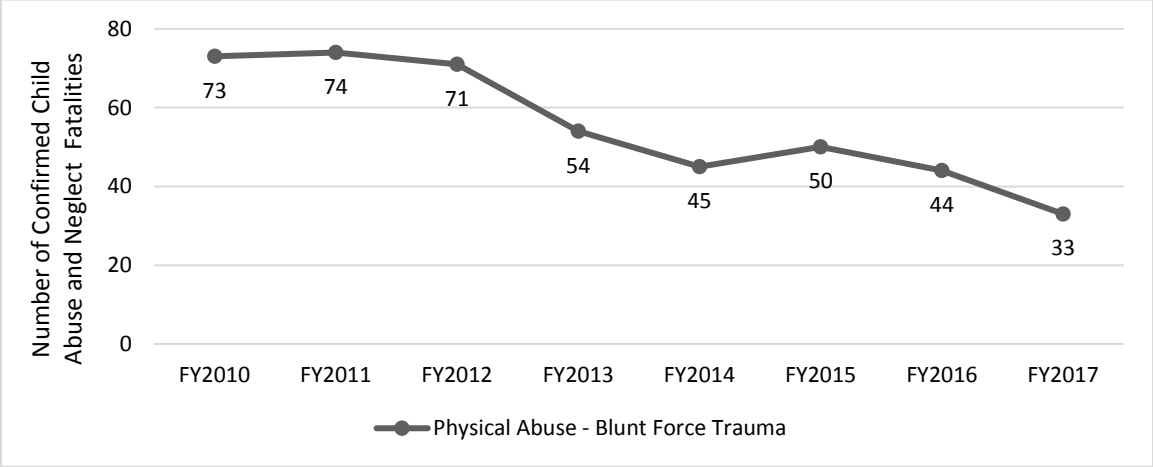
*Other category includes medical neglect, physical neglect, suicide, premature birth due to drug use, abandonment at birth.
Source: DFPS individual case reviews

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



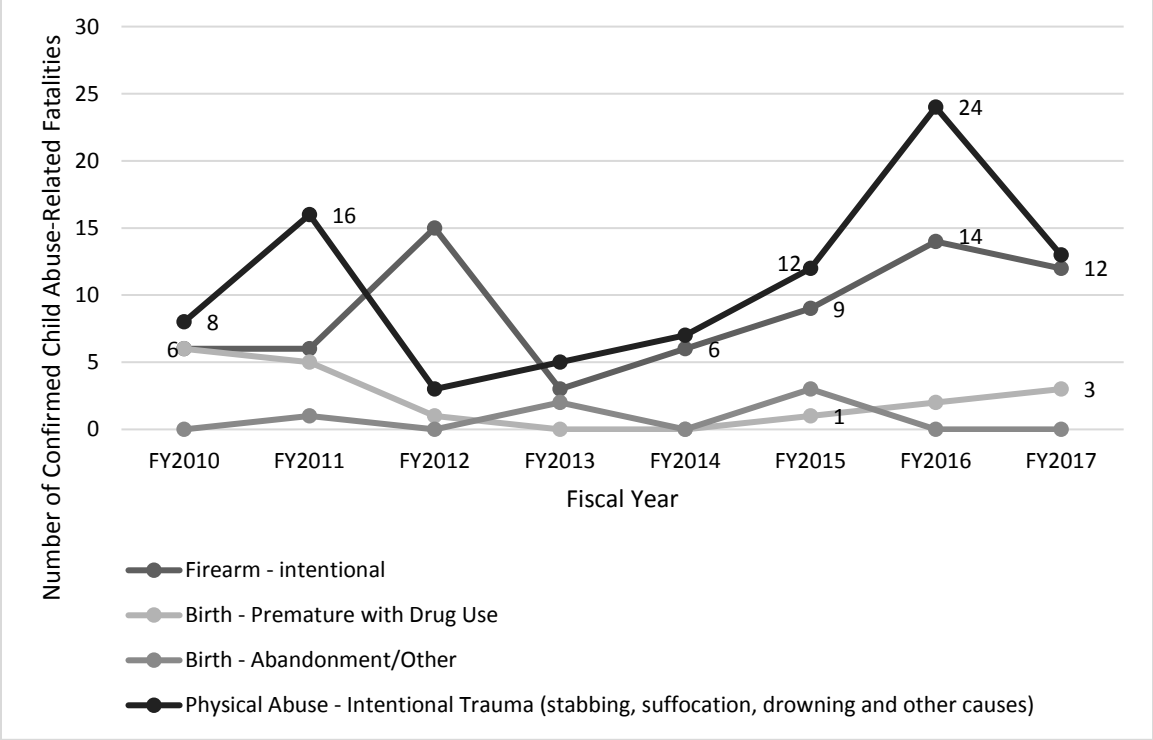
Source: DFPS individual case reviews

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



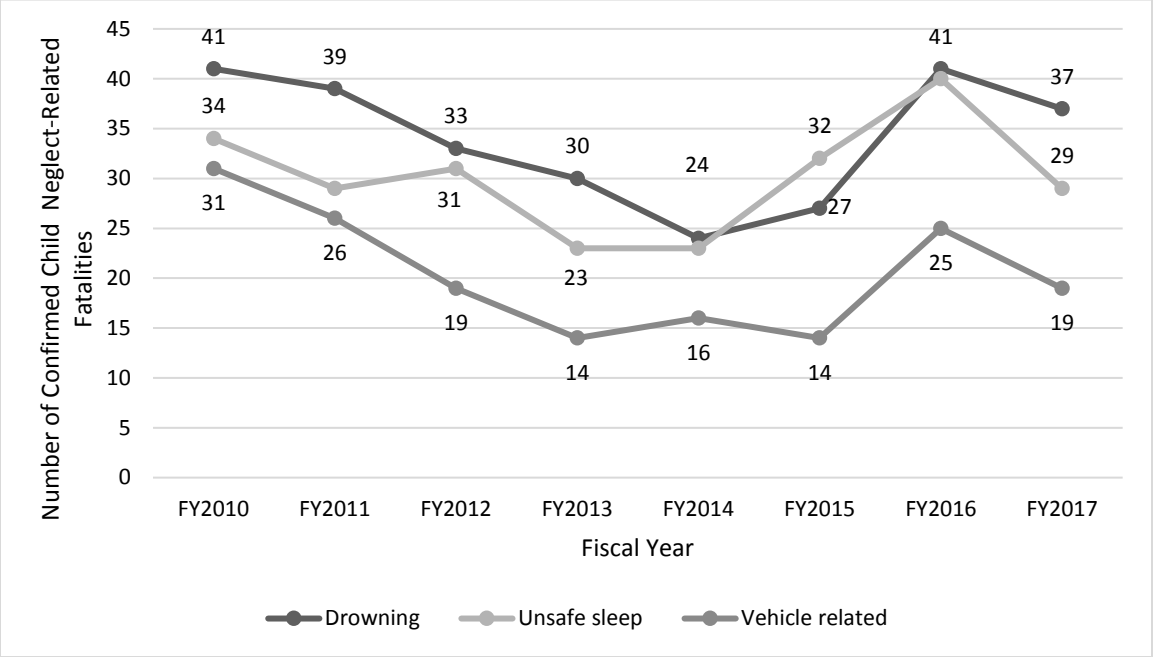
Source: DFPS individual case reviews

Figure 6. Intentional Physical Abuse to Child by Cause



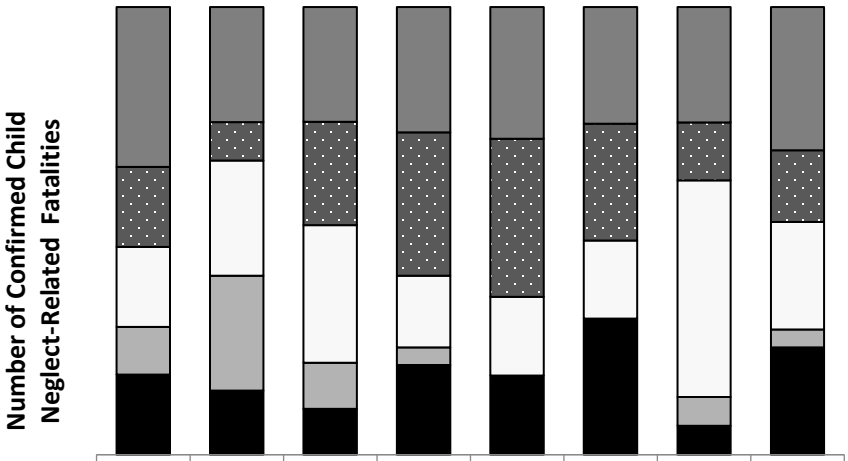
Source: DFPS individual case reviews

Figure 7. Neglect-Related Child Fatality by Cause



Source: DFPS individual case reviews

Figure 8. Neglect-Related Child Fatality by Cause



	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Physical Neglect & Medical Neglect / Related to Medical Issue	10	9	10	7	5	6	8	8
Firearm - accidental	5	3	9	8	6	6	4	4
Neglectful Supervision - Other*	5	9	12	4	3	4	15	6
Fire	3	9	4	1	0	0	2	1
Accidental overdose / medication, alcohol, illegal substance	5	5	4	5	3	7	2	6

** Neglectful Supervision - Other includes ATV accident, object falling on child, suicide, and dog attack*

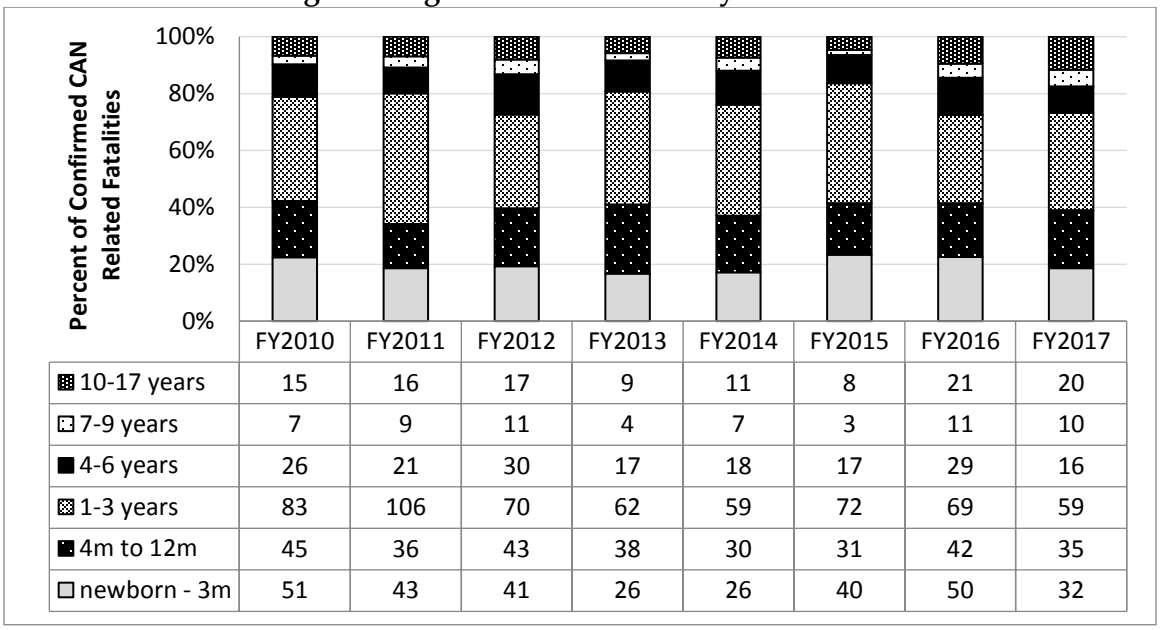
Source: DFPS individual case reviews

Victim Demographic Characteristics - Age, Gender, Ethnicity

Victims

- Based on the confirmed child abuse and neglect-related fatalities over the past five fiscal years, children 3 years of age and younger were almost 80 percent of all 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 FY2017, 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).
- More than 57 percent of children who died from abuse or neglect in FY 2017 were too young for school and not enrolled in day care (as compared to 40 percent in FY2016.) Seven children were being cared for by illegal day care operations that were unknown to DFPS (Page 24).

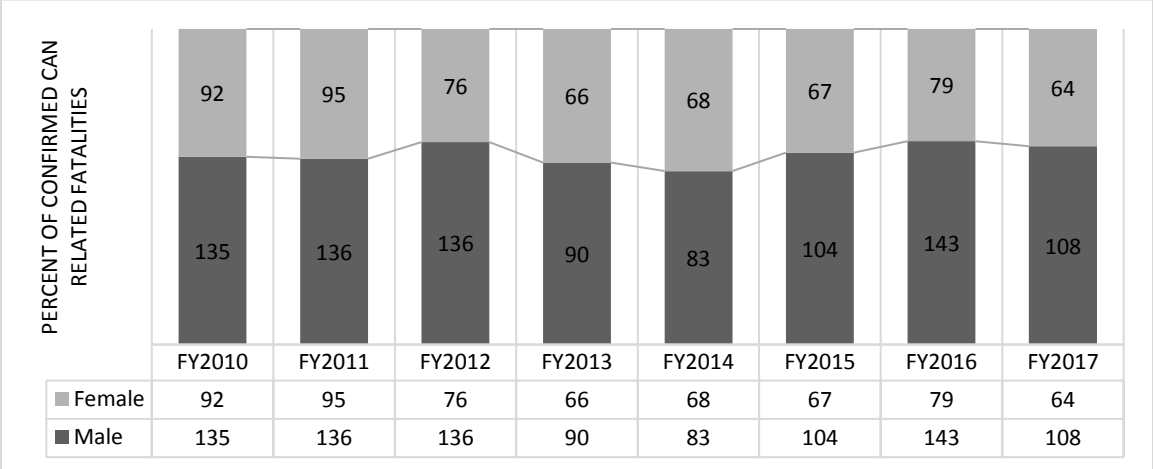
Figure 9. Age of Child at Death by Fiscal Year



	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
10-17 years	15	16	17	9	11	8	21	20
7-9 years	7	9	11	4	7	3	11	10
4-6 years	26	21	30	17	18	17	29	16
1-3 years	83	106	70	62	59	72	69	59
4m to 12m	45	36	43	38	30	31	42	35
newborn - 3m	51	43	41	26	26	40	50	32

Source: DFPS Data Warehouse Report FT_06

Figure 10. Gender of Deceased Child by Fiscal Year



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 FY2017, 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.[5] Part of this work includes cross-program work between DFPS and the Texas Department of State Health Services to address child fatalities from a public health approach.

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

FY2011

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	811,081	2,317,712	3,389,573	433,811	6,952,177
Number of Fatalities	51	59	104	17	231
Per Capita Rate of Fatality	6.29	2.55	3.07	3.92	3.32

FY2012

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	809,036	2,332,640	3,415,186	439,490	6,996,352
Number of Fatalities	56	70	73	13	212
Per Capita Rate of Fatality	6.92	3.00	2.14	2.96	3.03

FY2013

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	819,438	2,327,549	3,509,752	464,760	7,121,499
Number of Fatalities	40	48	60	8	156
Per Capita Rate of Fatality	4.88	2.06	1.71	1.72	2.19

FY2014

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	835,497	2,343,432	3,610,544	477,287	7,266,760
Number of Fatalities	34	57	54	6	151
Per Capita Rate of Fatality	4.07	2.43	1.50	1.26	2.08

FY2015

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	830,214	2,333,857	3,648,331	499,521	7,311,923
Number of Fatalities	35	51	67	18	171
Per Capita Rate of Fatality	4.21	2.18	1.84	3.6	2.33

FY2016

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	834,985	2,337,285	3,718,245	517,121	7,407,636
Number of Fatalities	56	74	81	11	222
Per Capita Rate of Fatality	6.71	3.17	2.18	2.13	3.0

FY2017

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	839,363	2,338,787	3,786,940	535,182	7,500,272
Number of Fatalities	40	57	58	17	172
Per Capita Rate of Fatality	4.77	2.44	1.53	3.18	2.29

Sources: Texas State Data Center; DFPS Data Books FY2010-FY 2017; 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.[6] 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 FY2017, eleven children who died from abuse or neglect had drug or alcohol exposure while in utero or an identified addiction at birth; the majority of these fatalities were due to neglectful supervision. However, three involved physical abuse to infants under four months of age. Eleven of the children who died due to abuse or neglect were identified to have learning and developmental disabilities, including five children diagnosed with autism and two children diagnosed with Downs Syndrome.

Table 4. 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	FY2017 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality
Drug or alcohol in utero exposure or addiction at birth	11 Fatalities • Neglectful Supervision – co-sleeping (1) • Medical Neglect (2) • Physical Abuse (5) • Neglectful Supervision – vehicle related (3) • Neglectful Supervision – drowning (1) • Birth – Premature Drug Use (2)
Asthma	1 Fatality • Medical Neglect (1)
Depression	3 Fatalities • Homicide (1) • Suicide (2)
ADD/ADHD	2 Fatalities • Homicide (1)

	• Suicide (1)
Autism	5 Fatalities • Neglectful supervision - drowning (1) • Physical Abuse (2) • Medical Neglect (1) • Physical Neglect (1)
Developmental disability/delay	3 Fatalities • Physical Abuse (1) • Physical Neglect (1) • Medical Neglect (1)
Other—Failure to Thrive, Downs Syndrome, Feeding Tube	5 Fatalities • Medical Neglect (3) • Physical Abuse (1) • Physical Neglect (1)

Substance Abuse 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 abuse (including inappropriate use of prescribed medications) and for active concerns for substance abuse at the time of the child fatality.

For FY2017, 90 of the 172 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. Marijuana was the substance most identified as an active substance in child abuse and neglect-related fatalities, representing over half of the cases. In terms of past history use, marijuana use by the parent or caregiver was noted in 44 percent of the 172 cases. In 20 child fatalities, methamphetamines and amphetamines were being actively used by the caregiver. Active use of heroin and opiates by the parent or caregiver was present in 6 of the 172 child fatalities and appears in prior history for 7 of the 172 child fatalities.

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

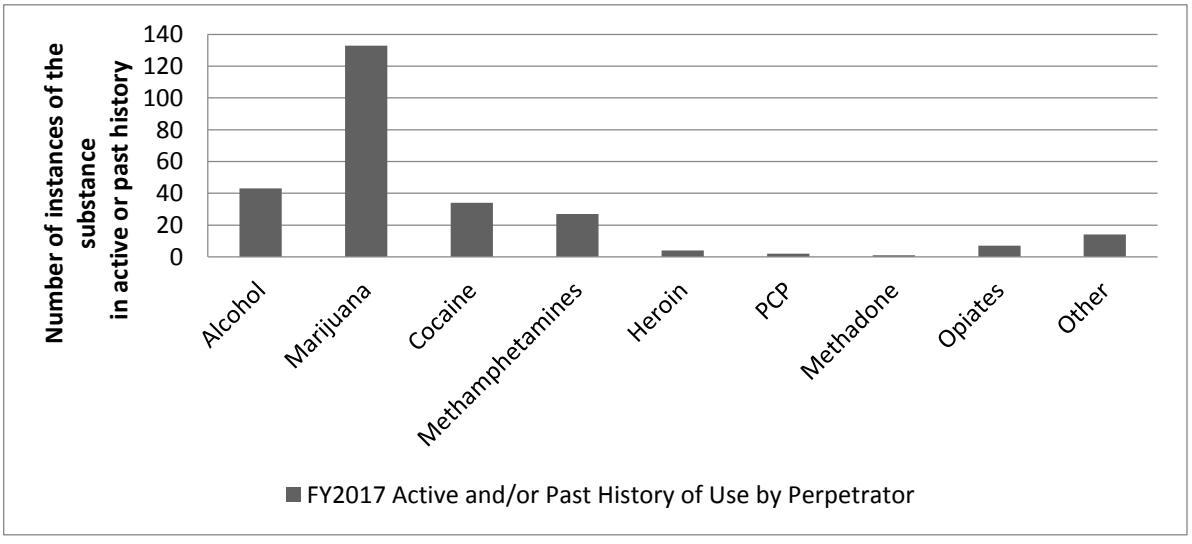


Table 5. Confirmed Child Abuse or Neglect Fatality by Substance Abuse by Perpetrator FY2017

Substance Abuse Concern	Active	Past History	Substance Abuse Concern	Active	Past History
Alcohol	23	20	**Methadone**	1	0
Marijuana	56	78	**Opiates**	2	4
Cocaine	16	19	**Synthetic Marijuana**	2	6
Methamphetamines	14	13	**Other**	16	3
Phencyclidine (PCP)	1	1	**Unknown**	26	31
Heroin	1	2	**No use**	56	50

Other: amphetamines (8 active, 0 past, Xanax (2 active, 2 past), benzodiazepines (2 active, 1 past), ecstasy (2 active, 3 past),

Table 6. Confirmed Child Abuse or Neglect Fatality by Co-Occurring Substance Abuse by Perpetrator -- FY2017

Co-Occurring Substances	Active	Past History
Alcohol and Marijuana	7	13
Marijuana and Cocaine	13	17
Cocaine and Alcohol	7	5
Cocaine and Methamphetamines	1	1
Methamphetamines and Marijuana	6	9
More than two substances	8	15

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 FY2017, 22.6 percent of child fatalities involved a parent/caregiver who reported active mental health concerns, significantly up from FY2016 where 9.5 percent of child fatalities involved a parent/caregiver who reported active mental health concerns.

Table 7. Mental Health Concerns both Active and in Past History for Perpetrator Confirmed Child Abuse Neglect Fatalities FY2017

Mental Health Concern	Active	Past History
Bipolar Disorder	5	6
Depression	12	19
Anxiety	6	4
Multiple Concerns/Co-occurring disorders	7	10
Postpartum Depression	2	4
Post-Traumatic Stress Disorder	5	4
Schizophrenia	1	1
Substance abuse disorder	-	-
ADHD	3	2
Unknown Diagnosis – Reported by Individual	15	9
No	104	102
Unknown (not identified in case read)	28	30

Domestic Violence Concerns as Risk Factor

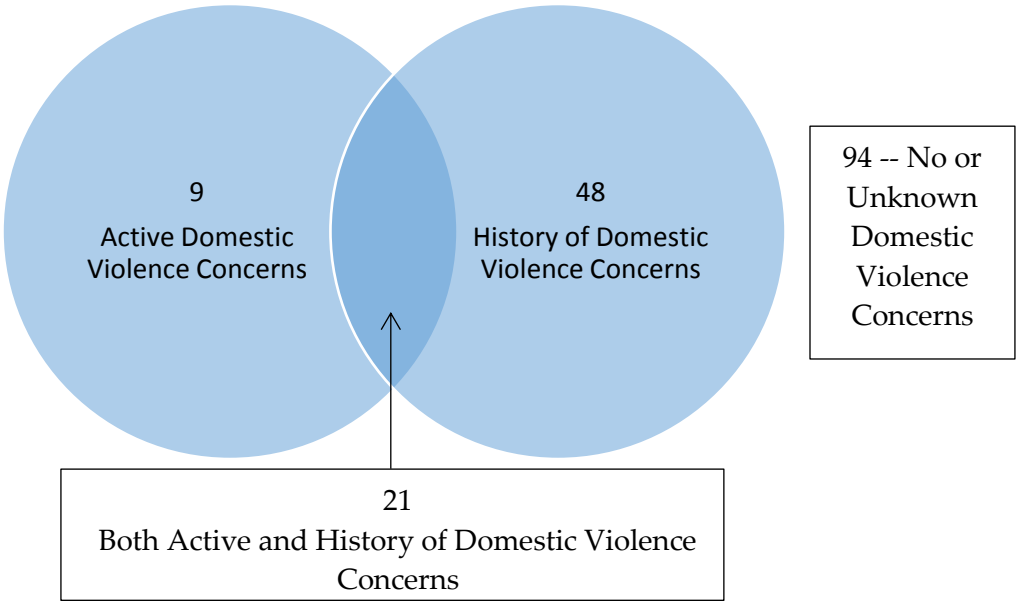
Domestic violence is often a precursor to child maltreatment and often an indicator to larger issues in the home. DFPS and CPS are working closely with staff, providers, and stakeholders to recognize and address domestic violence with the families involved with CPS. Part of this work includes:

- the hiring of a subject matter expert within CPS;
- development of training for all staff;
- guidance on how to investigate, disposition allegations, and provide services to families where domestic violence or intimate partner violence is a concern;
- strengthening connections between local providers and CPS 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, CPS 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 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. In FY2017, there was active domestic violence present in the home environment for 30 families. A history of domestic violence was identified in 69 case reviews. 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.

Figure 12. FY2017 Domestic Violence Concerns both Active and in Past History for Perpetrator Confirmed Child Abuse Neglect Fatalities



Source: DFPS individual case reviews

School and Day Care Enrollment as Protective Factor

With 73 percent of child fatalities involving children age three and younger, protective and attentive parents and caregivers are critical to protect children. 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 abuse or neglect. Almost 76 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.

FY2017 Confirmed Child Abuse and Neglect Fatalities:

- In 98 of the 172 child fatalities due to abuse or neglect, the child was not enrolled either in a day care or in school. In 33 case reviews, the status of the child being in school or day care was unknown.
- In 36 of the 172 child fatalities due to abuse or neglect, the child was enrolled in day care or school. Two of the fatalities occurred when school was out of session for the summer or winter break.
- In 7 of the 172 child fatalities due to abuse or neglect, the child was being cared for by a caregiver that should have been registered or licensed through DFPS but was not.
- In 3 of the 172 child fatalities due to abuse or neglect, the child was being cared for by a babysitter.

Table 8. FY2017 Child Abuse and Neglect Related Fatalities- By County

County	Region	Child Abuse/Neglect Related Fatalities	Child Abuse/Neglect Related Fatalities in Foster Care at Time*
Angelina	5	1	0
Bell	7	4	0
Bexar	8	8	0
Bowie	4	1	0
Brazoria	6	3	0
Brazos	7	1	0
Brown	2	1	0
Cameron	11	2	0
Camp	4	1	0
Cherokee	4	1	0
Collin	3	4	0
Coryell	7	1	0
Dallas	3	7	0
Dimmit	8	1	0
Eastland	2	1	0
El Paso	10	7	1
Ellis	3	2	0
Falls	7	1	0
Fannin	3	1	0
Fort Bend	6	1	0
Galveston	6	2	0
Gregg	4	1	0
Grimes	7	1	0
Guadalupe	8	2	0
Harris	6	30	1
Harrison	4	1	0
Hidalgo	11	9	0
Hill	7	1	0
Hood	3	1	0
Hunt	3	1	0
Jack	2	1	0
Jefferson	5	4	0
Johnson	3	4	0
Jones	2	1	0
Kerr	8	2	0
Lampasas	7	1	0
Liberty	6	2	0

County	Region	Child Abuse/Neglect Related Fatalities	Child Abuse/Neglect Related Fatalities in Foster Care at Time
Lubbock	1	1	0
Marion	4	1	0
Maverick	8	1	0
McLennan	7	2	0
Midland	9	1	0
Montague	2	1	0
Montgomery	6	3	0
Morris	4	1	0
Navarro	3	1	0
Nueces	11	4	0
Palo Pinto	3	1	0
Panola	4	2	0
Parker	3	3	0
Potter	1	4	0
Red River	4	1	0
Shelby	5	1	0
Smith	4	1	0
Starr	11	1	0
Tarrant	3	10	0
Taylor	2	1	0
Tom Green	9	2	0
Travis	7	7	0
Upshur	4	1	0
Victoria	8	1	0
Ward	9	1	0
Wheeler	1	1	0
Wichita	2	1	0
Williamson	7	1	0
Wise	3	1	0
Wood	4	1	0
State Total		172	2

Fatality Counts were frozen on 02/1/16. 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 Services (161), Adult Protective Services (2), Child Day Care Licensing (7), and Residential Child Care Licensing (2).

FY2017 Confirmed Child Abuse and Neglect Related Fatalities - Case Review Data

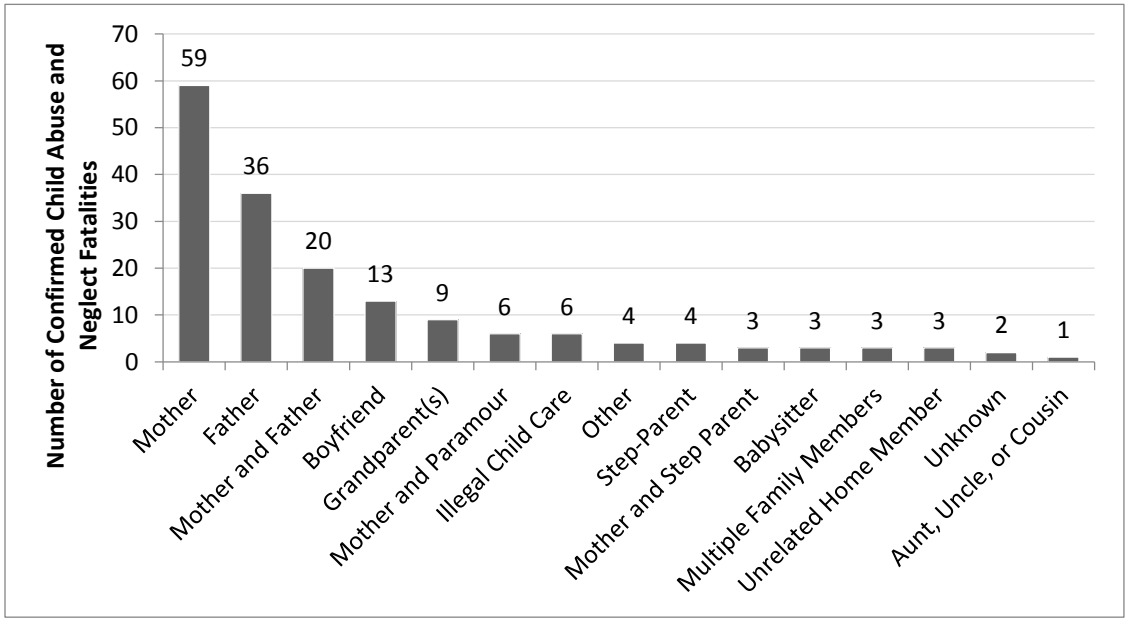
Based on the confirmed child abuse and neglect fatalities that occurred during FY2017, several key demographic areas allow for specialized targeting of prevention and intervention in child abuse and neglect cases. Data from these fatalities tells us that these parents would benefit from support, education and targeted campaigns. Communities can use this data to strategically message and target available resources for families and caregivers.

FY2017 Perpetrator Demographic and Characteristics - Relationship and History

Perpetrators

- Physical abuse in fatalities most commonly involved blunt force trauma inflicted by a father or boyfriend (combined represent 61 percent).
- In all confirmed cases of abuse and neglect, parents continue to be the most common perpetrators.
- 51.2 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had no prior history with CPS.

Figure 13. FY2017 Relationship of Primary Perpetrator to Victim

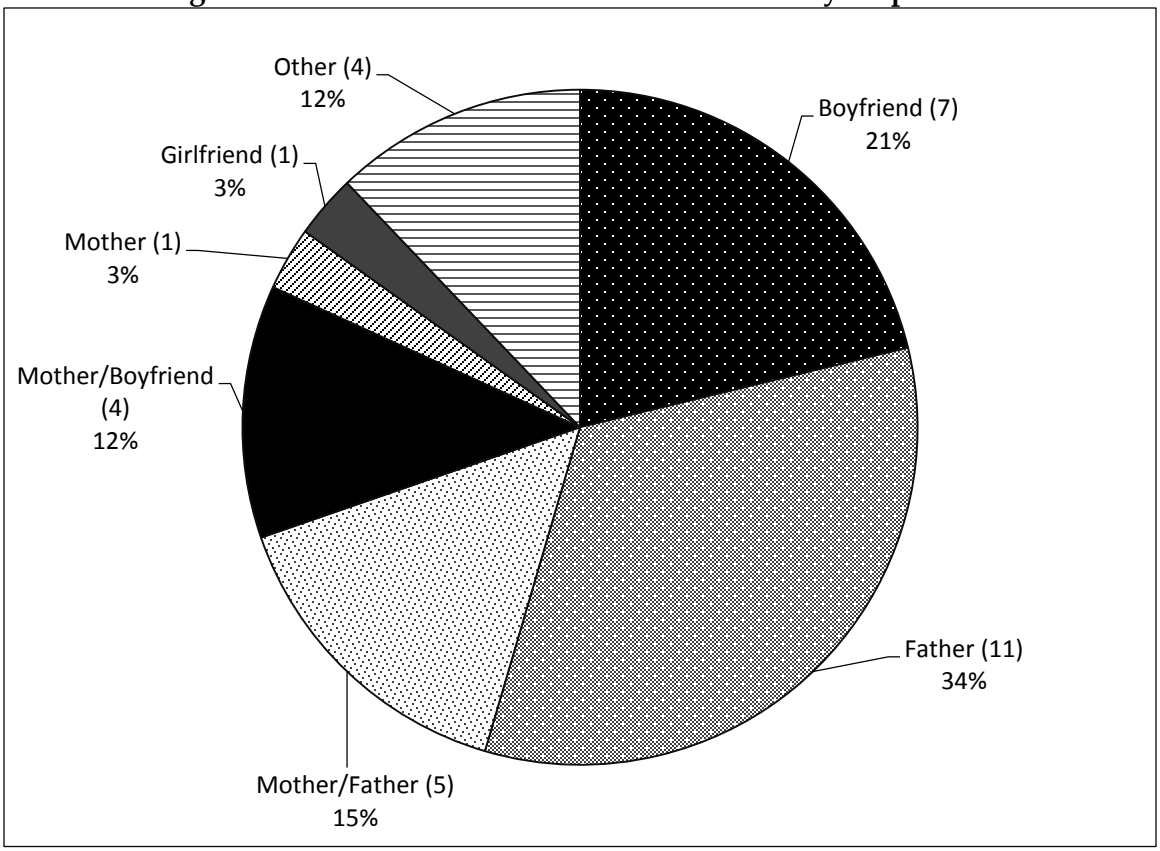


Source: DFPS individual case reviews

FY2017 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 causes of manner where six or more fatalities were confirmed as abuse or neglect related are detailed below. Other categories (such as suicide, house fire, physical neglect, medical neglect, neglectful supervision), each involved fewer than six children. All data in this section is based on case reviews.

Figure 14. FY2017 Blunt Force Trauma Fatalities by Perpetrator

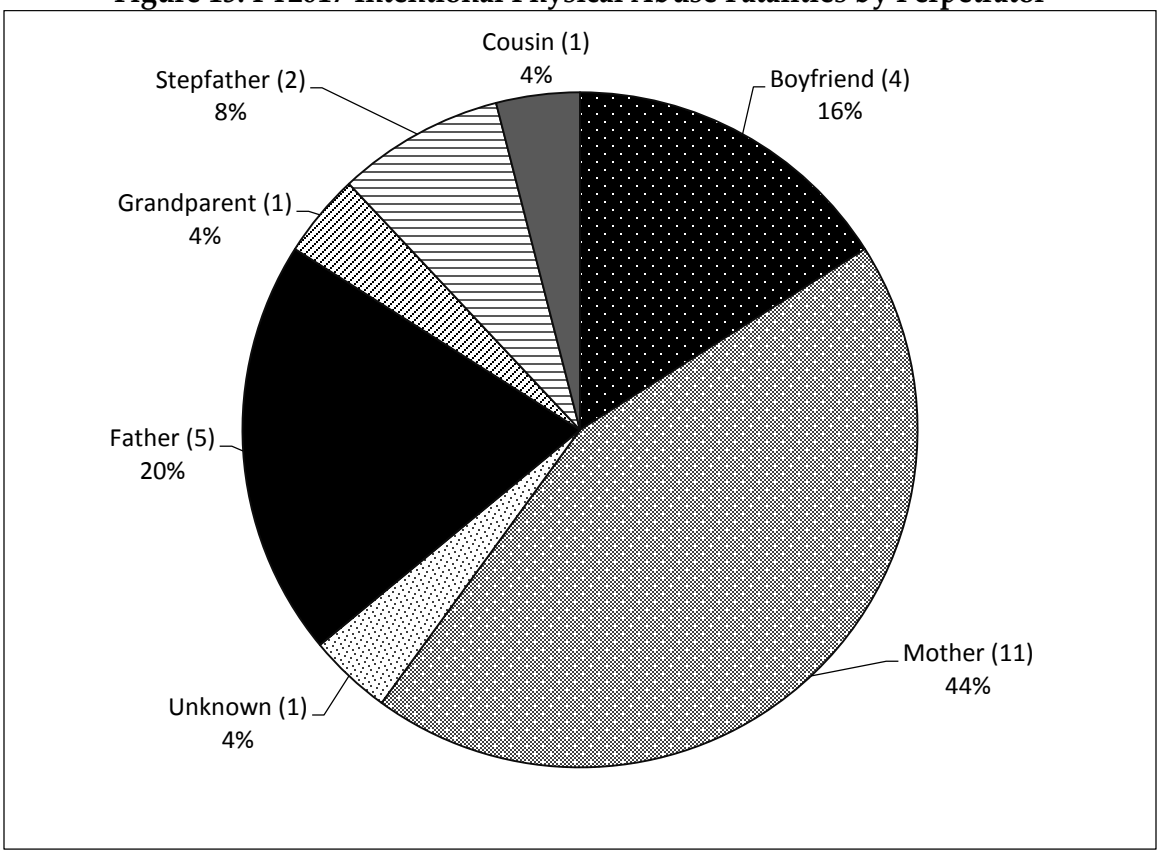


Number of victims: 33 children

Age range of victims: Newborn to four-year-old child. 20 children were younger than one year old; 73% were age two or younger

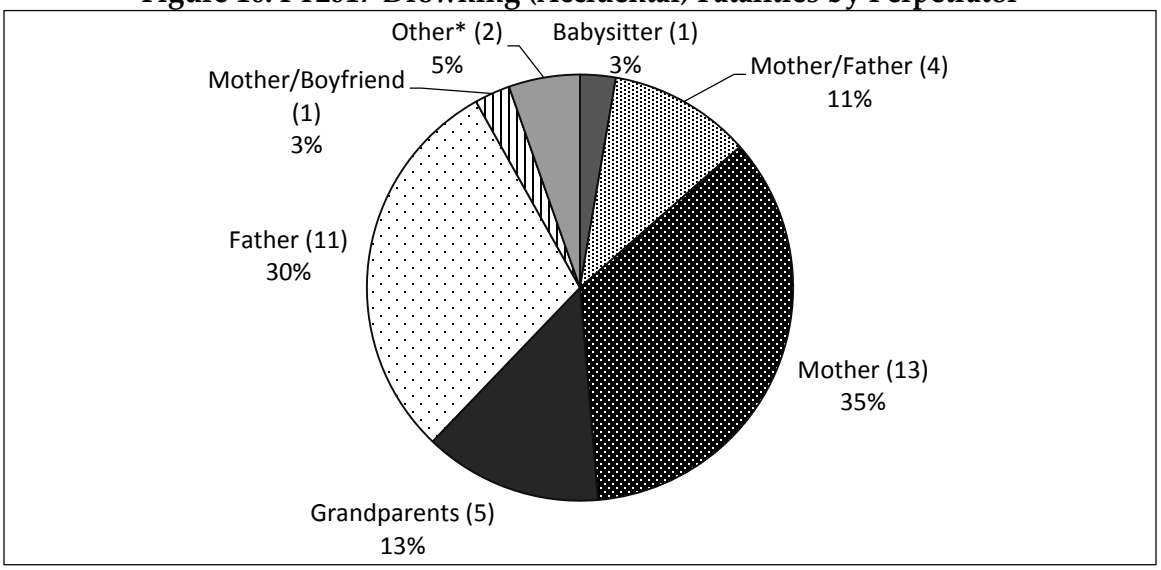
Finding: Usually involve young children being physically abused by the father (45%) or a boyfriend (33%)

Figure 15. FY2017 Intentional Physical Abuse Fatalities by Perpetrator



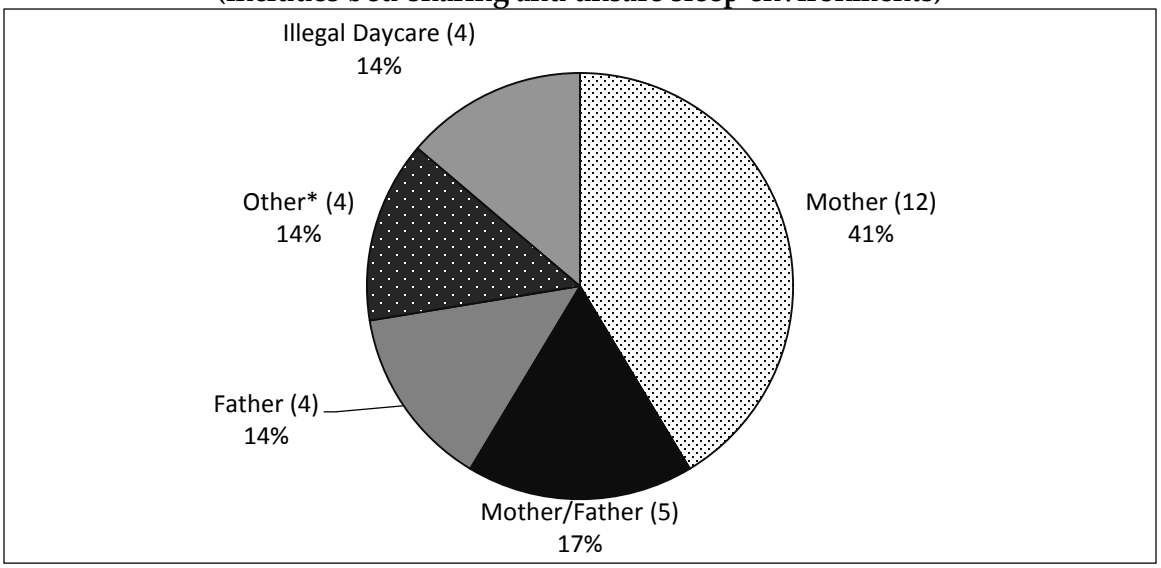
Number of victims: 25 children
Age range of victims: Newborn to 16-year-old youth. 16 children were age five and younger
Finding: Usually involved young children with primary perpetrator as mother (44%), father (20%), or boyfriend (16%).

Figure 16. FY2017 Drowning (Accidental) Fatalities by Perpetrator



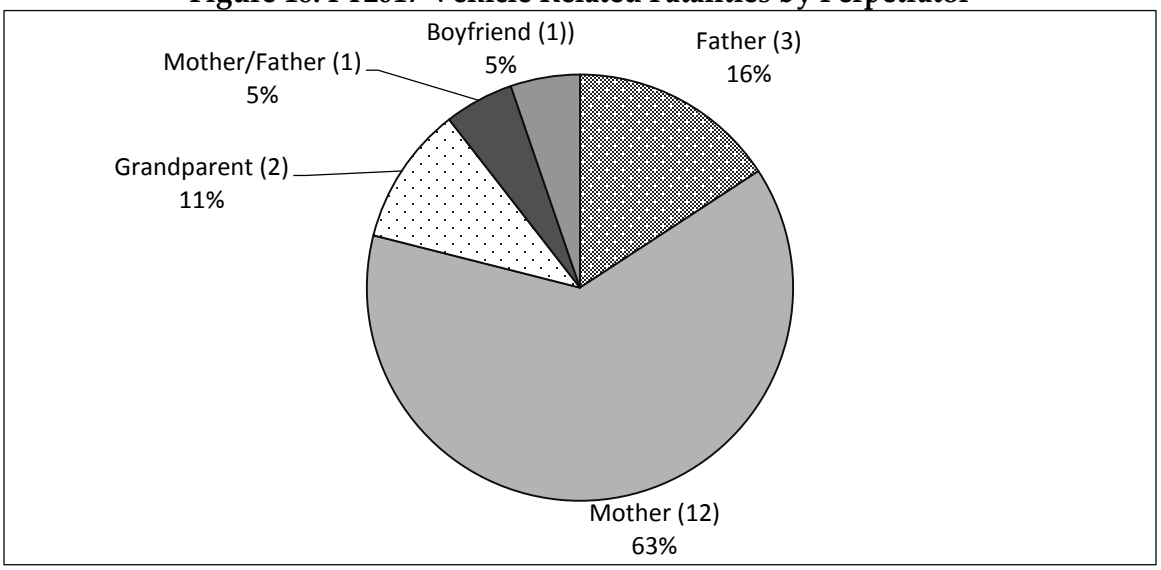
Number of victims: 37 children
Age range of victims: 8 months old to 6 years old. Thirty six children were 5 and younger (97%).
Finding: Usually involve young children with mother as primary perpetrator (35%)

Figure 17. FY2017 Unsafe Sleep Fatalities by Perpetrator (includes bed-sharing and unsafe sleep environments)



Number of victims: 29 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. Over half of unsafe sleep deaths occurred in a bed with an adult (79%) and six involved more than one other person in the bed with the child.

Figure 18. FY2017 Vehicle Related Fatalities by Perpetrator



Number of victims: 19 children

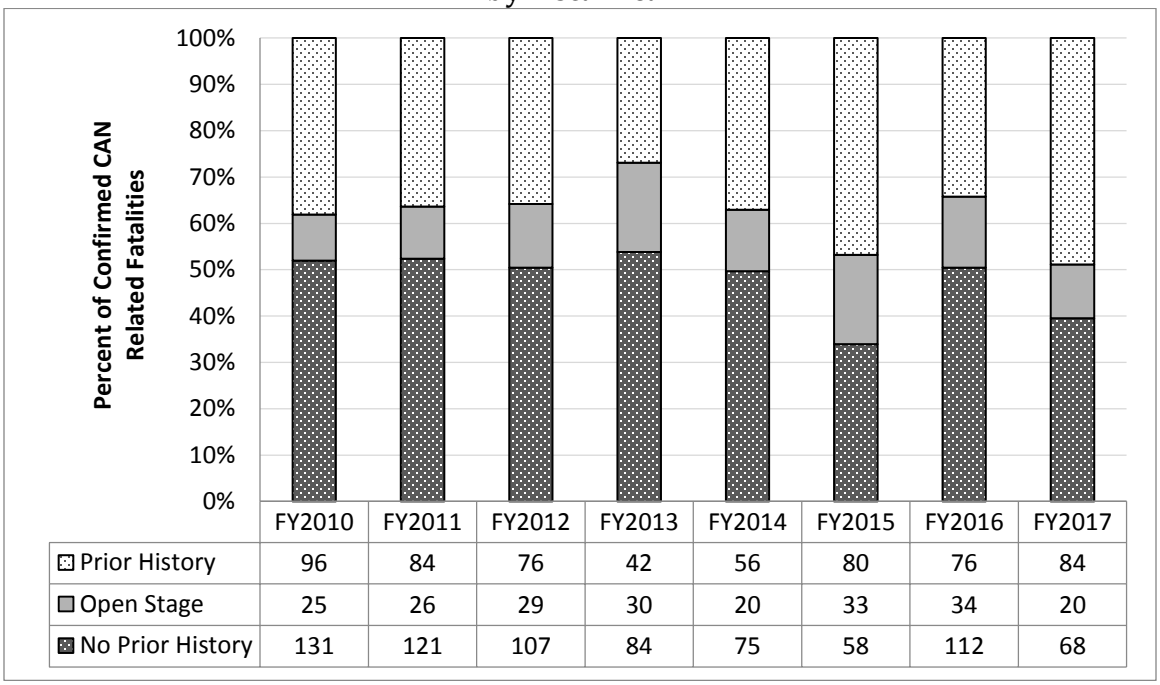
Age range of victims: 7 months old to 16 years old

Finding: Usually happens while in care of the mother (63%) or father (16%). There were eight fatalities due children being left in the vehicle (hyperthermia) and eight children who died as a result of a car accident where the driver was under the influence.

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 CPS. DFPS defines prior CPS history broadly – if the deceased child or a designated perpetrator in the fatality had been in a CPS 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 CPS history. In about 12 percent of the child abuse and neglect fatalities, CPS was involved with the family or the child at the time of the death. In 50.5 percent of confirmed child fatalities, CPS had been involved with the child or the perpetrator in the past.

Figure 19. CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Fiscal Year

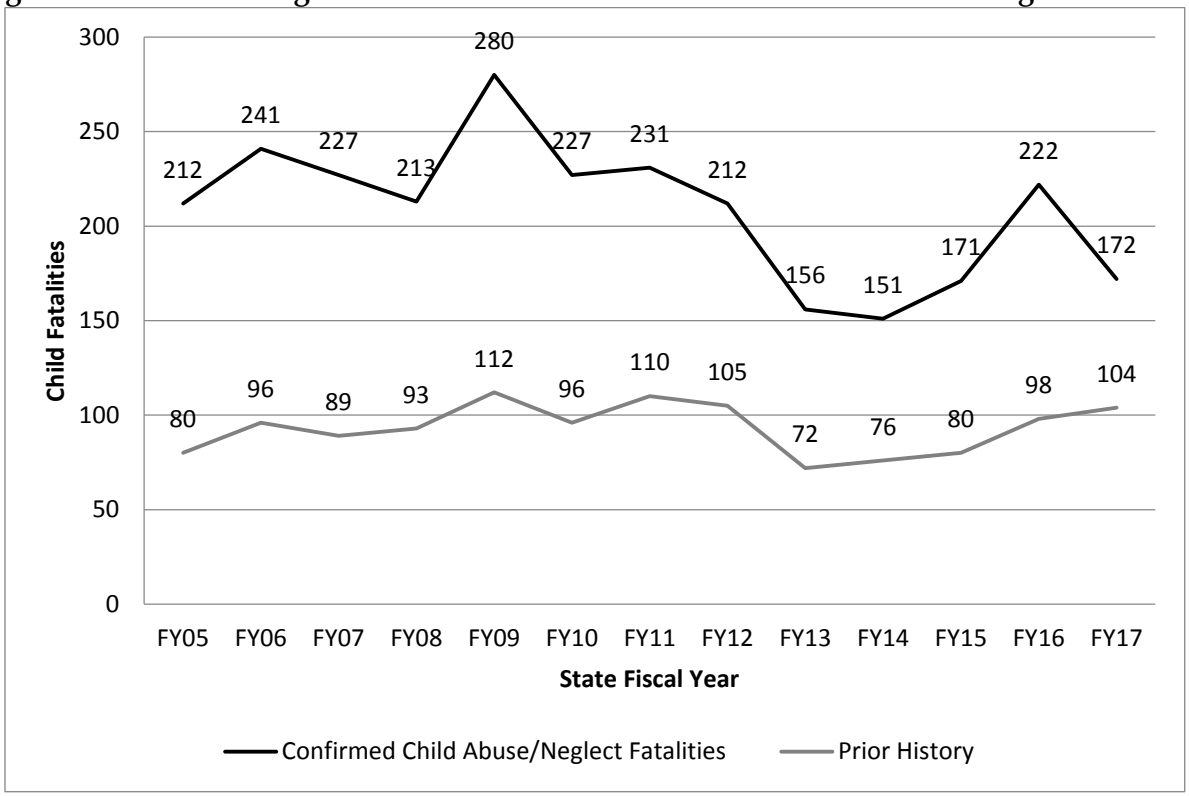


	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Prior History	96	84	76	42	56	80	76	84
Open Stage	25	26	29	30	20	33	34	20
No Prior History	131	121	107	84	75	58	112	68

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 FY2017 often consisted of neglectful supervision/unintentional acts (12 fatalities) and physical abuse fatalities such as blunt force trauma or intentional homicide (8 fatalities).

Figure 20. DFPS Investigated Child Fatalities and Confirmed Child Abuse/Neglect Fatalities



***Source*: DFPS Data Warehouse Report FT_06**

For FY2017, based on Figure 21, the following conclusions are noted:

- 20 children's families were involved with CPS at the time of death.
    - 10 of the children were in an active investigation and a new incident of abuse or neglect occurred leading to the fatality
    - Seven of the children were in an active Family Based Safety Services stage and a new incident of abuse or neglect occurred leading to the fatality
    - Three of the children or their family was involved in an active conservatorship stage at the time of the fatality
        - Two of the children were in foster care and a new incident of neglectful supervision occurred leading to the fatality
        - One youth was in DFPS conservatorship but in a ACF regulated placement and a new incident occurred at this placement that lead to the fatality
        - There were no fatalities in kinship care during FY2017.

Figure 21. FY2017 Department of Family and Protective Services (DFPS) Data on Child Abuse and Neglect Related Fatalities Statewide

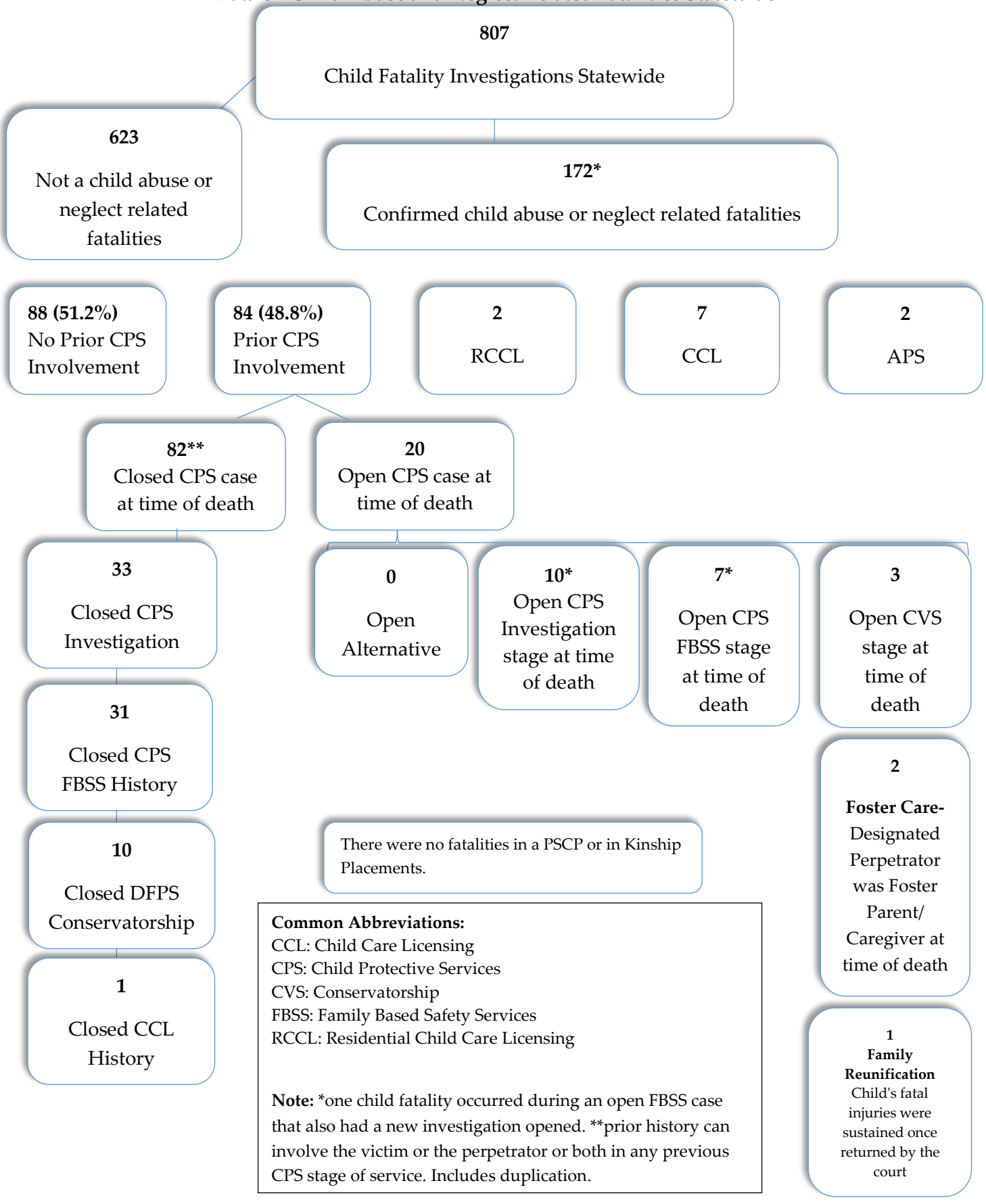
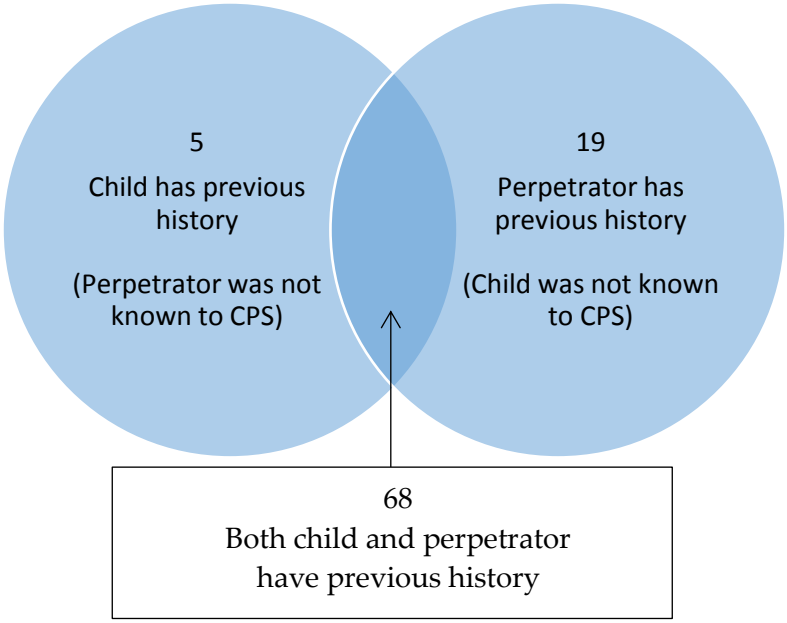
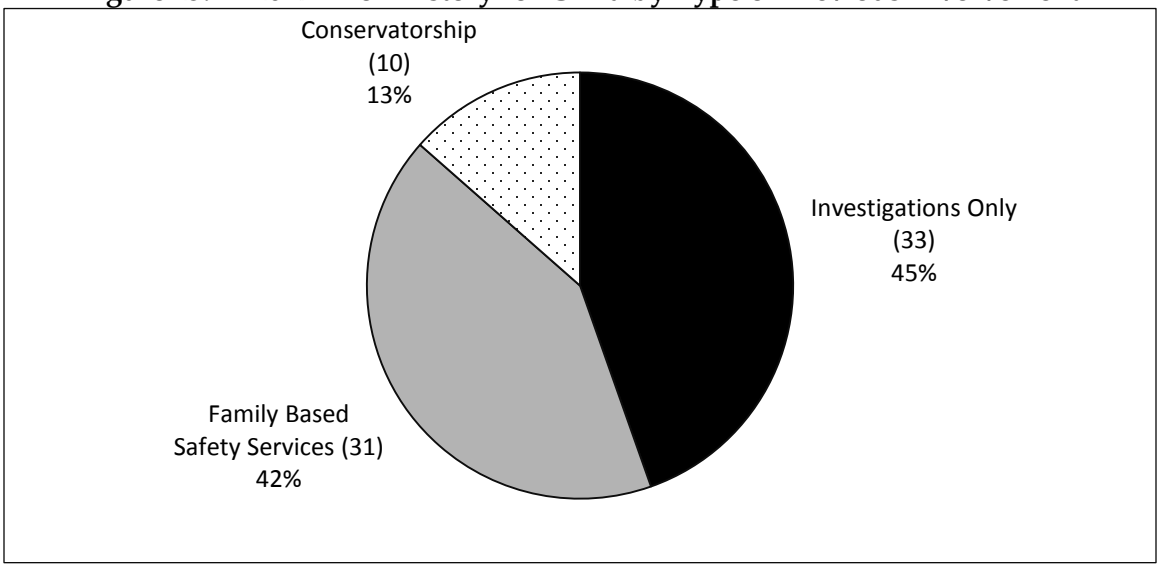


Figure 22. FY2017 Prior History by Child/Perpetrator with of Previous Involvement



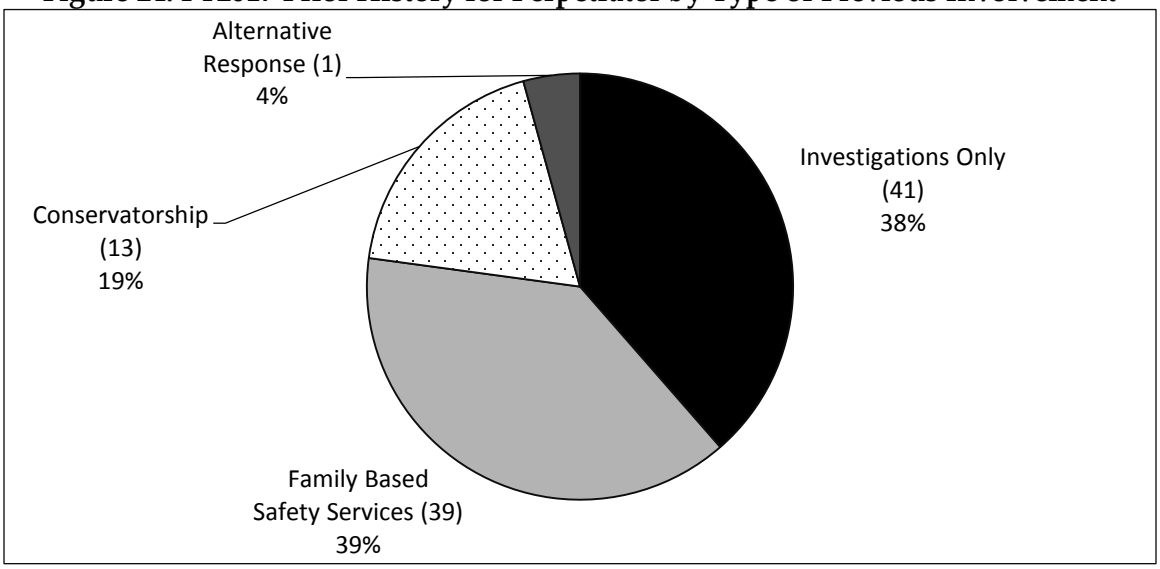
Source: DFPS individual case reviews – includes history that may be purged from IMPACT but referenced in case narrative.

Figure 23. FY2017 Prior History for Child by Type of Previous Involvement



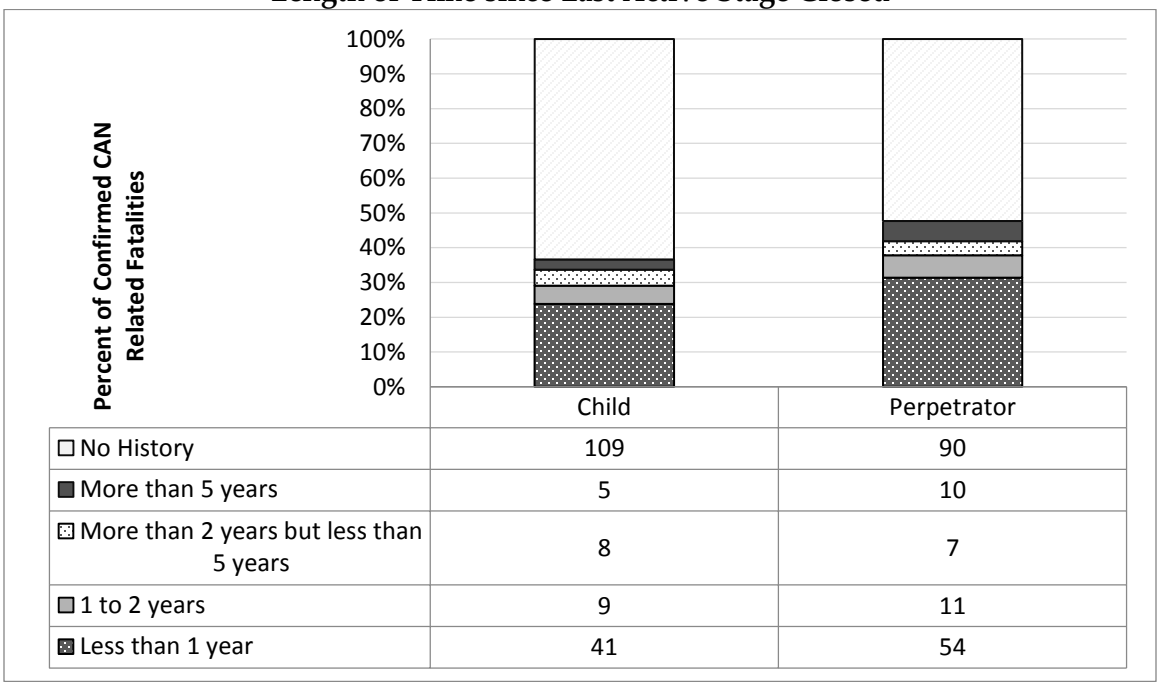
Source: DFPS individual case reviews

Figure 24. FY2017 Prior History for Perpetrator by Type of Previous Involvement



Source: DFPS individual case reviews

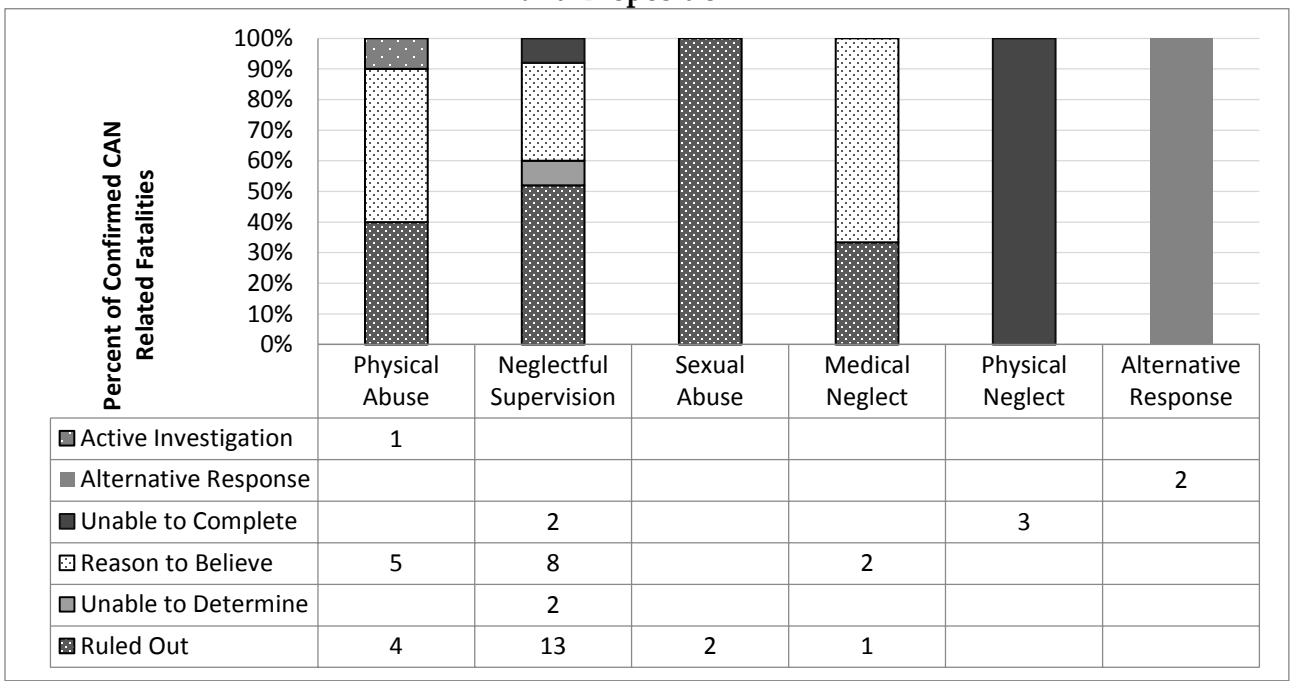
Figure 25. FY2017 CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Length of Time since Last Active Stage Closed



	Child	Perpetrator
No History	109	90
More than 5 years	5	10
More than 2 years but less than 5 years	8	7
1 to 2 years	9	11
Less than 1 year	41	54

Source: DFPS individual case reviews

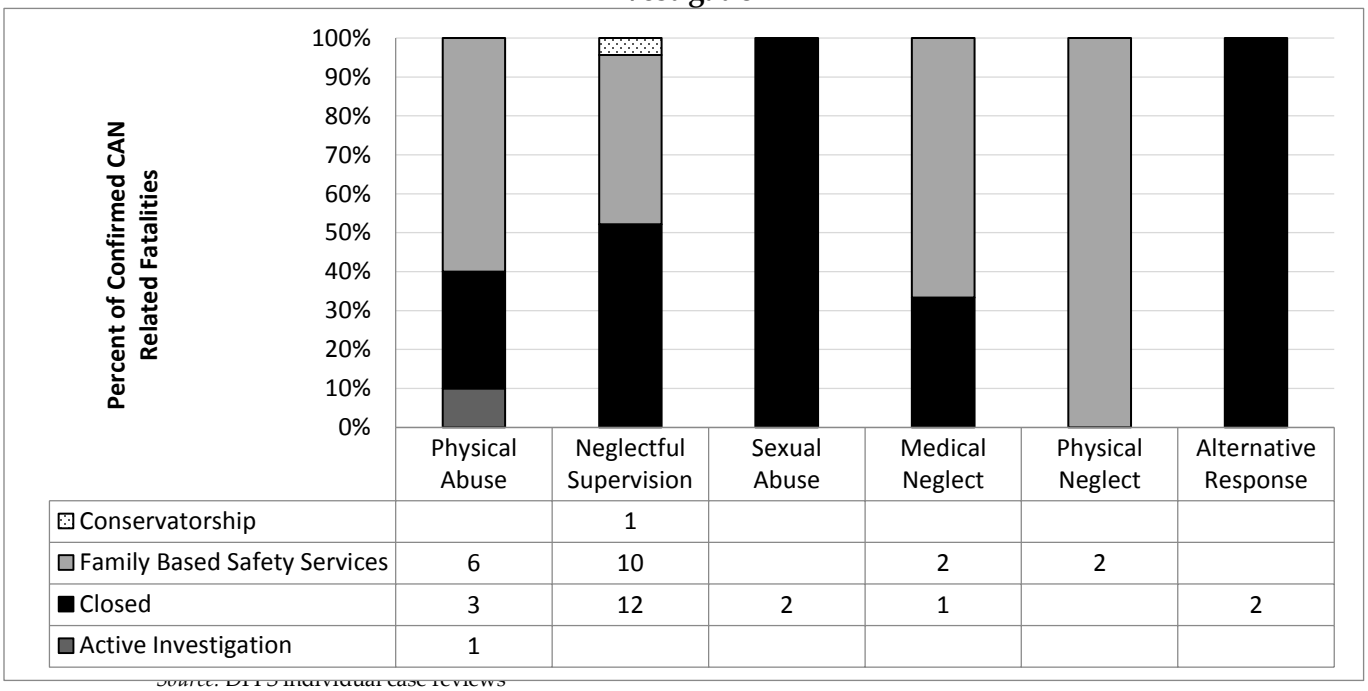
Figure 26. FY2017 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Medical Neglect	Physical Neglect	Alternative Response
Active Investigation	1					
Alternative Response						2
Unable to Complete		2			3	
Reason to Believe	5	8		2		
Unable to Determine		2				
Ruled Out	4	13	2	1		

Source: DFPS individual case reviews

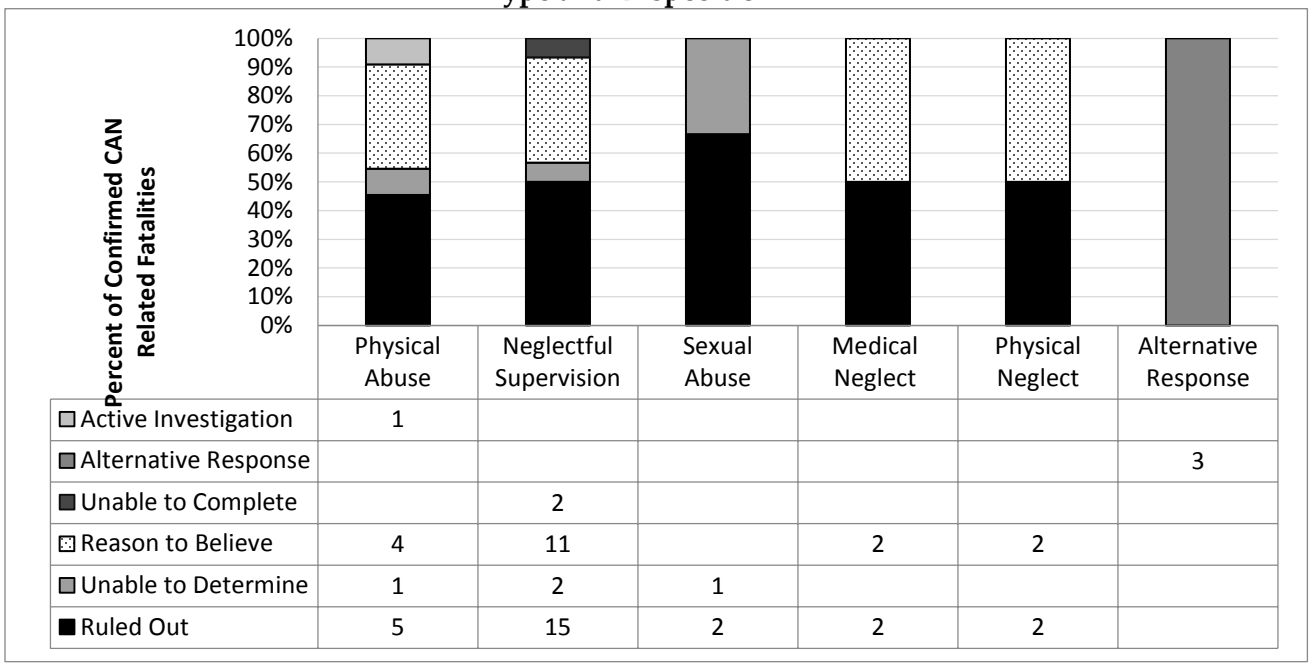
Figure 27. FY2017 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child in the Two Years Prior to Fatality, by Outcome of Prior Investigation



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Medical Neglect	Physical Neglect	Alternative Response
Conservatorship		1				
Family Based Safety Services	6	10		2	2	
Closed	3	12	2	1		2
Active Investigation	1					

Source: DFPS individual case reviews

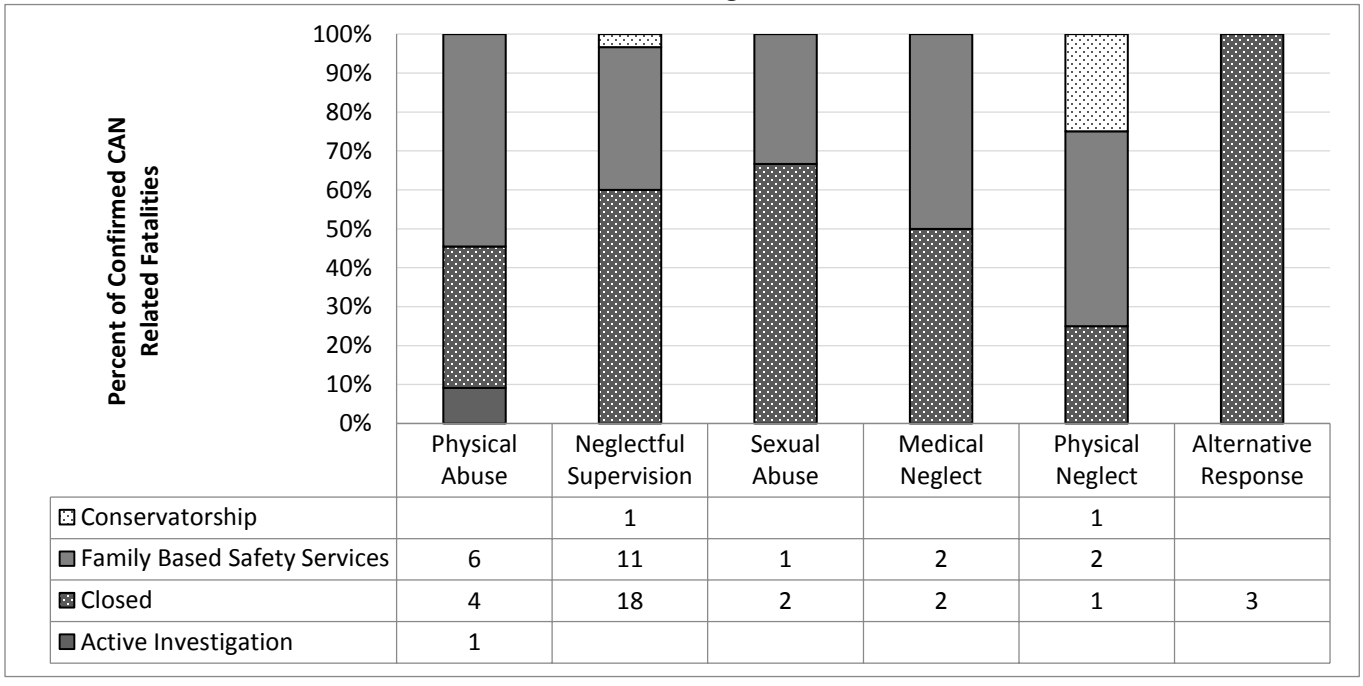
Figure 28. FY2017 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Perpetrator in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



	Physical Abuse	Neglectful Supervision	Sexual Abuse	Medical Neglect	Physical Neglect	Alternative Response
Active Investigation	1					
Alternative Response						3
Unable to Complete		2				
Reason to Believe	4	11		2	2	
Unable to Determine	1	2	1			
Ruled Out	5	15	2	2	2	

Source: DFPS individual case reviews

Figure 30. FY2017 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	Medical Neglect	Physical Neglect	Alternative Response
Conservatorship		1			1	
Family Based Safety Services	6	11	1	2	2	
Closed	4	18	2	2	1	3
Active Investigation	1					

Source: DFPS individual case reviews

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

With neglectful supervision as the cause for about 56 percent of all confirmed child abuse and neglect fatalities in FY2017, this pattern is also repeated in the subset of confirmed fatalities where the child or perpetrator had previous history with DFPS within the prior two years to the fatality.

- When the perpetrator or the child was previously known to DFPS in the two years prior to fatality, the child fatality is often related to physical abuse (45%) or one of three major neglectful supervision issues: drowning (9 fatalities), unsafe sleep (8 fatalities), or vehicle related (5 fatalities).
- When the child was previously known to DFPS in the two years prior to fatality because of prior physical abuse allegation, 40 percent were involved in a new incident of physical abuse which caused the fatality. In comparison, when the prior allegation was neglectful supervision, 48 percent were involved in a new incident of physical abuse which caused the fatality.
- When the perpetrator was previously known to DFPS in the two years prior to fatality because of prior physical abuse allegation, 36 percent were involved in a new incident of physical abuse which caused the fatality. In comparison, when the prior allegation was neglectful supervision, 50 percent were involved in a new incident of physical abuse which caused the fatality.

Table 9. FY2017 Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child in the Two Years Prior to Fatality, by Prior Allegation Type and Cause of Fatality

	Drowning Related	Unsafe Sleep Related	Vehicle Related	Physical Abuse	Other	Total
Prior Physical Abuse Allegation	3	-	2	4	1	10
Prior Neglectful Supervision Allegation	4	3	2	10	2	21
Prior Sexual Abuse Allegation	-	-	-	1	1	2
Prior Medical Neglect Allegation	1	-	-	2	-	3
Prior Physical Neglect Allegation	1	-	-	1	-	2
Prior Alternative Response	-	2	-	-	-	2
Total	9	5	4	18	4	40

Source: DFPS individual case reviews

Table 10. FY2017 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	Other	Total
Prior Physical Abuse Allegation	3	1	2	4	1	11
Prior Neglectful Supervision Allegation	5	4	3	15	3	30
Prior Sexual Abuse Allegation	-	1	-	1	1	3
Prior Medical Neglect Allegation	1	-	-	3	-	4
Prior Physical Neglect Allegation	2	-	-	2	-	4
Prior Alternative Response	1	2	-	-	-	3
Total	9	8	5	25	5	55

Source: DFPS individual case reviews

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

The Federal Child Abuse Prevention and Treatment Act (CAPTA) and Texas Family Code (Tex. Fam. Code §261.203 and Tex. Fam. Code §261.004) require that specific information about fatalities *caused by or the result of* abuse or neglect be reported. The Texas Family Code considers all other information to be confidential. (Tex. Fam. Code §261.201) As a result, case specific details on child fatalities where abuse or neglect was not the cause of the fatality cannot be individually reported. By 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 FY2017 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) and there are other concerns in the home that rise to the level of confirmed maltreatment.

General Findings

- In FY2017, there were 151 child fatalities where the death was not related to abuse or neglect, but the investigation found abuse or neglect had occurred in the home.
- 93 child fatalities where the death was not related to abuse or neglect had some form of prior history (61 percent).
- Most child fatalities that were not found to be abuse or neglect related are due to health related issues, followed by deaths determined by the medical examiner as unable to determine.

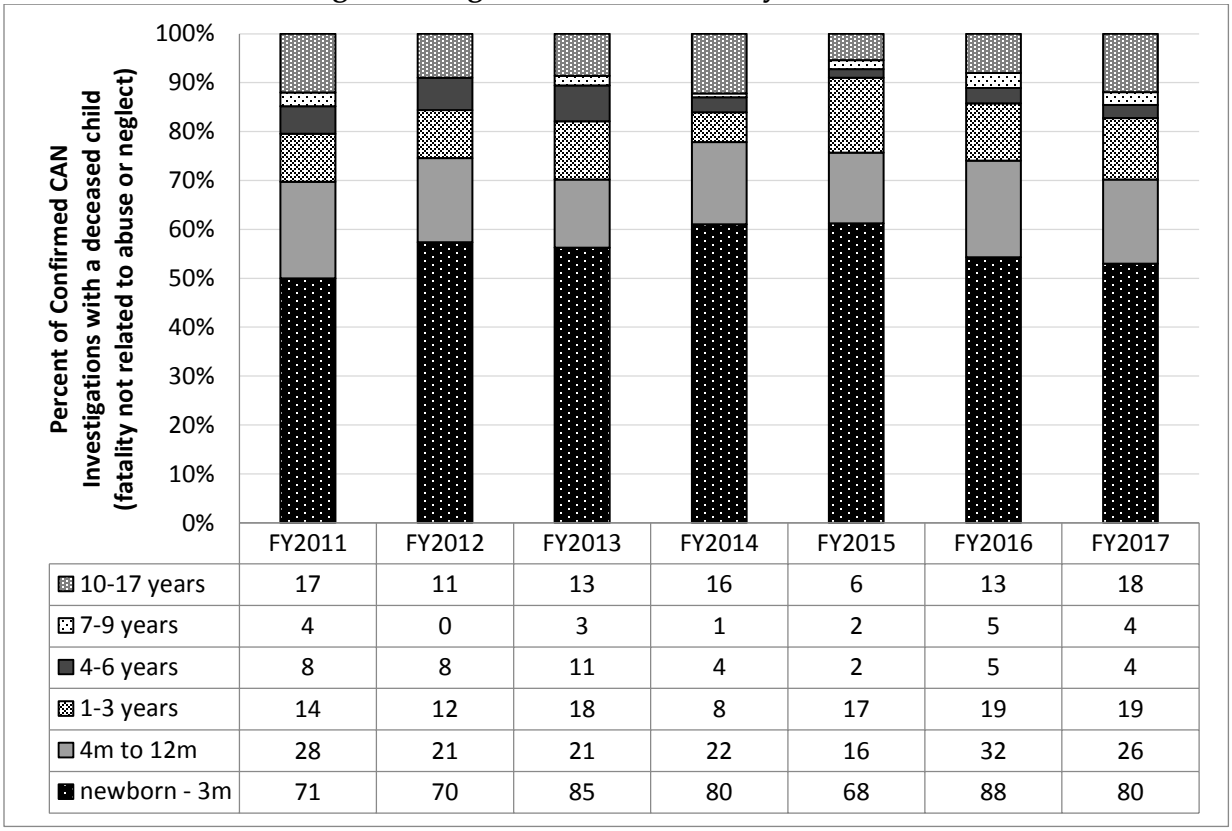
Victim Children

- 12 of the 151 children were previous alleged victims but allegations were not confirmed in prior cases.
- 23 of the 151 children were previously confirmed victims in prior cases.
- 29 of the 151 children were involved in Family Based Safety Services previously and 6 had been involved in DFPS conservatorship.

Perpetrators

- 31 of the confirmed perpetrators were previously alleged perpetrators but allegations were not confirmed in prior cases.
- 52 of the confirmed perpetrators were previously confirmed perpetrators in prior cases.
    - The cause of death in these 52 confirmed cases were: natural, health-related, undetermined, vehicle accident, accidental drowning

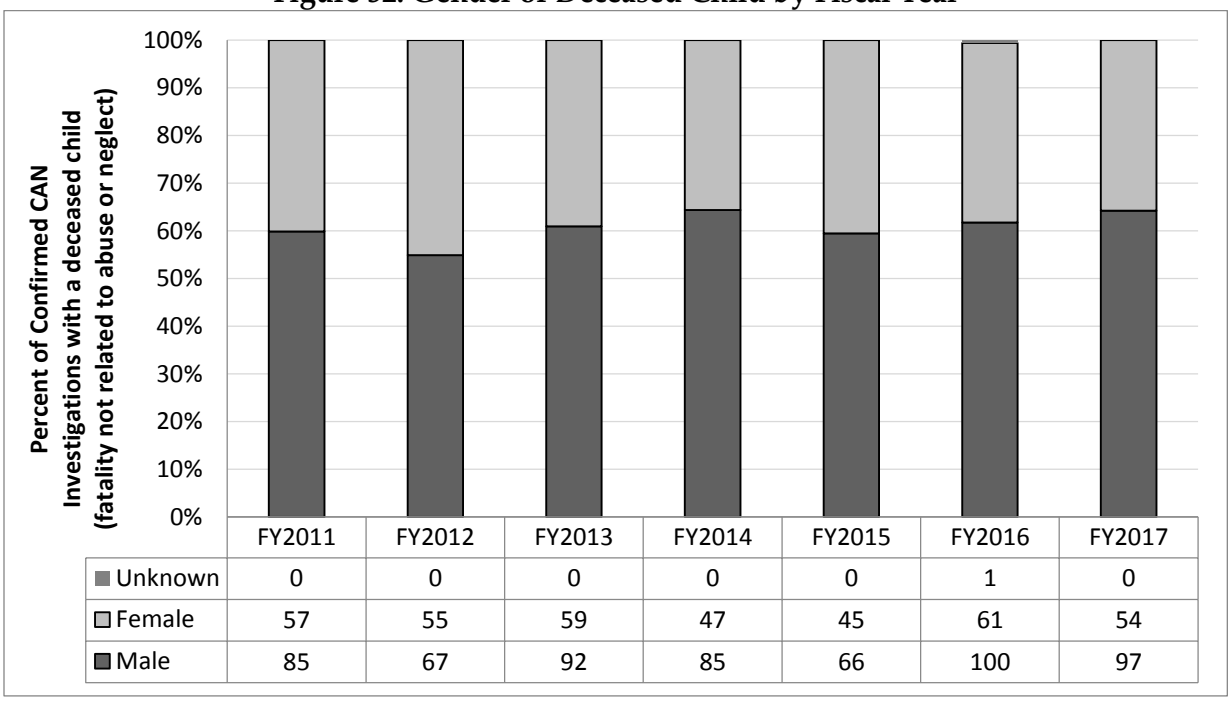
Figure 31. Age of Child at Death by Fiscal Year



	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
10-17 years	17	11	13	16	6	13	18
7-9 years	4	0	3	1	2	5	4
4-6 years	8	8	11	4	2	5	4
1-3 years	14	12	18	8	17	19	19
4m to 12m	28	21	21	22	16	32	26
newborn - 3m	71	70	85	80	68	88	80

Source: DFPS Data Warehouse

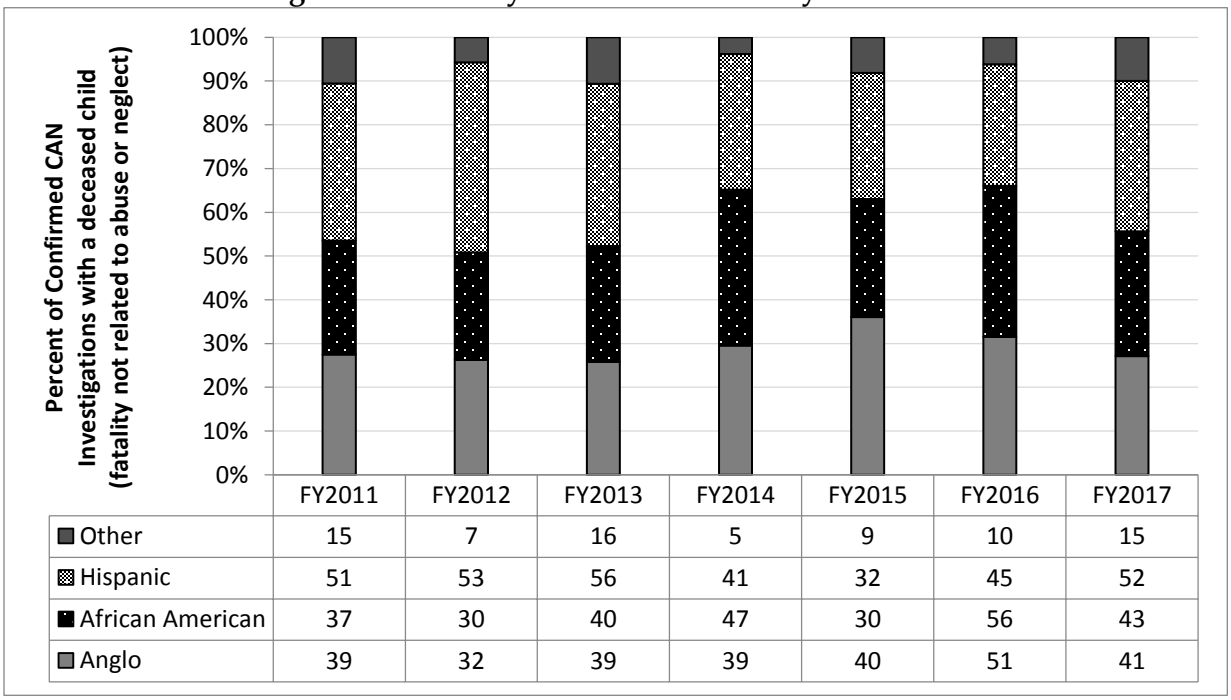
Figure 32. Gender of Deceased Child by Fiscal Year



	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Unknown	0	0	0	0	0	1	0
Female	57	55	59	47	45	61	54
Male	85	67	92	85	66	100	97

Source: DFPS DRIT Request

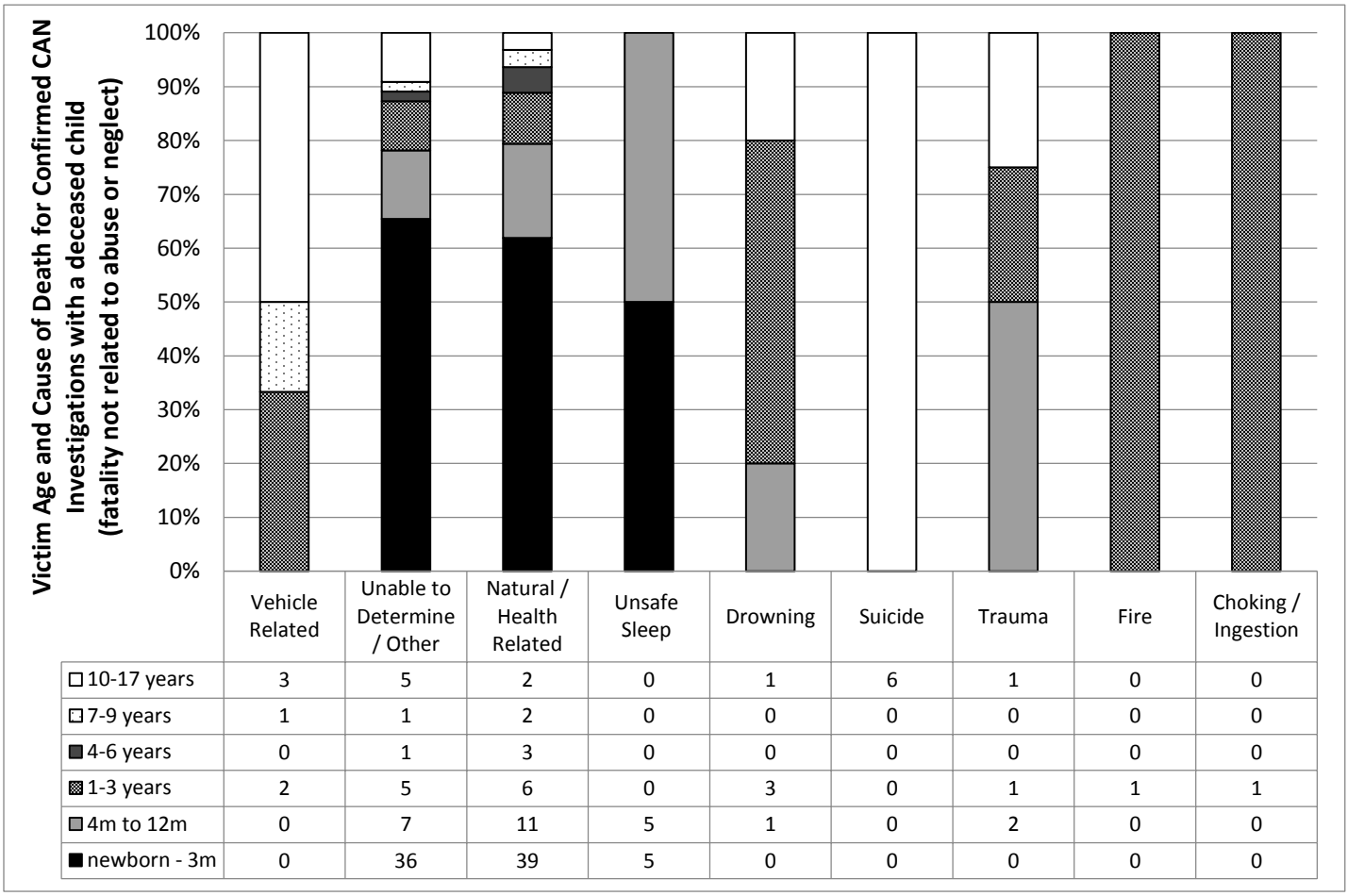
Figure 33. Ethnicity of Deceased Child by Fiscal Year



	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Other	15	7	16	5	9	10	15
Hispanic	51	53	56	41	32	45	52
African American	37	30	40	47	30	56	43
Anglo	39	32	39	39	40	51	41

Source: DFPS DRIT Request

Figure 34. FY2017 - 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 Fatality and Age of Child



	Vehicle Related	Unable to Determine / Other	Natural / Health Related	Unsafe Sleep	Drowning	Suicide	Trauma	Fire	Choking / Ingestion
10-17 years	3	5	2	0	1	6	1	0	0
7-9 years	1	1	2	0	0	0	0	0	0
4-6 years	0	1	3	0	0	0	0	0	0
1-3 years	2	5	6	0	3	0	1	1	1
4m to 12m	0	7	11	5	1	0	2	0	0
newborn - 3m	0	36	39	5	0	0	0	0	0

Source: DFPS DRIT Request

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*[7], an annual report comprising data from the National Child Abuse and Neglect Data System (NCANDS).[8] 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.[9]

Texas's 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;[10]
- investigating any report of child abuse or neglect allegedly committed by a person responsible for a child's care, custody, or welfare;[11]
- including in the definition of child abuse and neglect the use of a controlled substance[12] and defining medical neglect as the failure to *seek, obtain, or follow through* with medical care for the child;[13] 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 a CPS 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 2016 (the most recent year reported for all states), the Texas rate was 2.97 confirmed child abuse and neglect related fatalities per 100,000 compared to a national average of 2.36 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

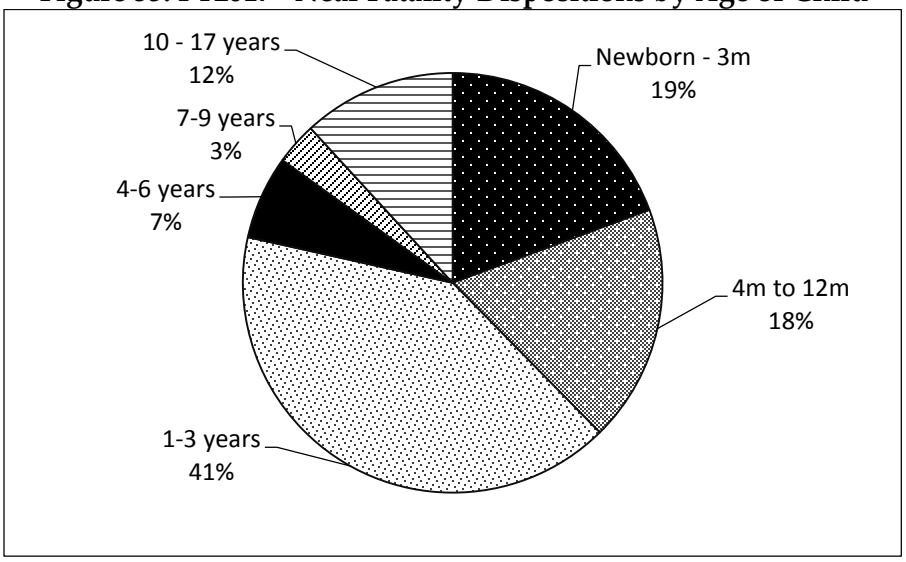
resulting from abuse or neglect are not recorded as such.[14] Some states do not even report at all; for example, in the annual federal *Child Maltreatment 2016* report, Maine and Massachusetts did not report on child fatalities and other states only report fatalities where they had been involved with the family within certain timeframes.

Near Fatalities & Future Reporting

In the 85th Texas Legislature, House Bill 1549 included collecting additional details on near fatalities and child fatalities. While these new requirements apply to FY2018 child fatality and near fatality case review, some details surrounding near fatalities is available for reporting. During FY2018, additional training and guidance will be provided to ensure all data elements are available for this report in FY2018.

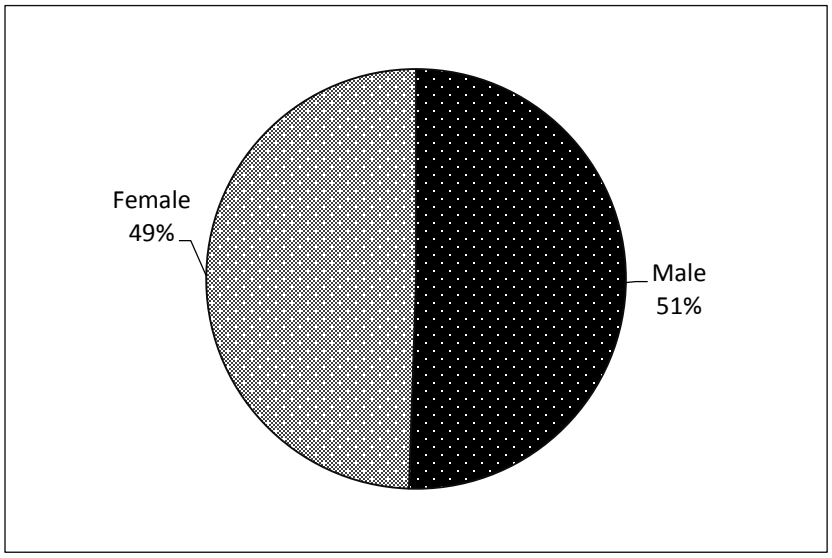
In FY2017, there were 96 near fatalities. Region 8 (San Antonio) had 38 near fatalities as compared to 13 in Region 6 (Greater Houston) and 12 in Region 3 (Dallas-Ft. Worth). This higher number is likely due to the close collaboration between the local hospital system, child abuse pediatricians, and DFPS in Region 8. . It is anticipated that with additional training in FY2018, near fatal dispositions will increase as DFPS Investigations collaborates with child abuse pediatricians and the Forensic Assessment Center Network to have consistent definitions and determinations when a child was in critical or serious condition due to abuse or neglect.

Figure 35. FY2017 –Near Fatality Dispositions by Age of Child



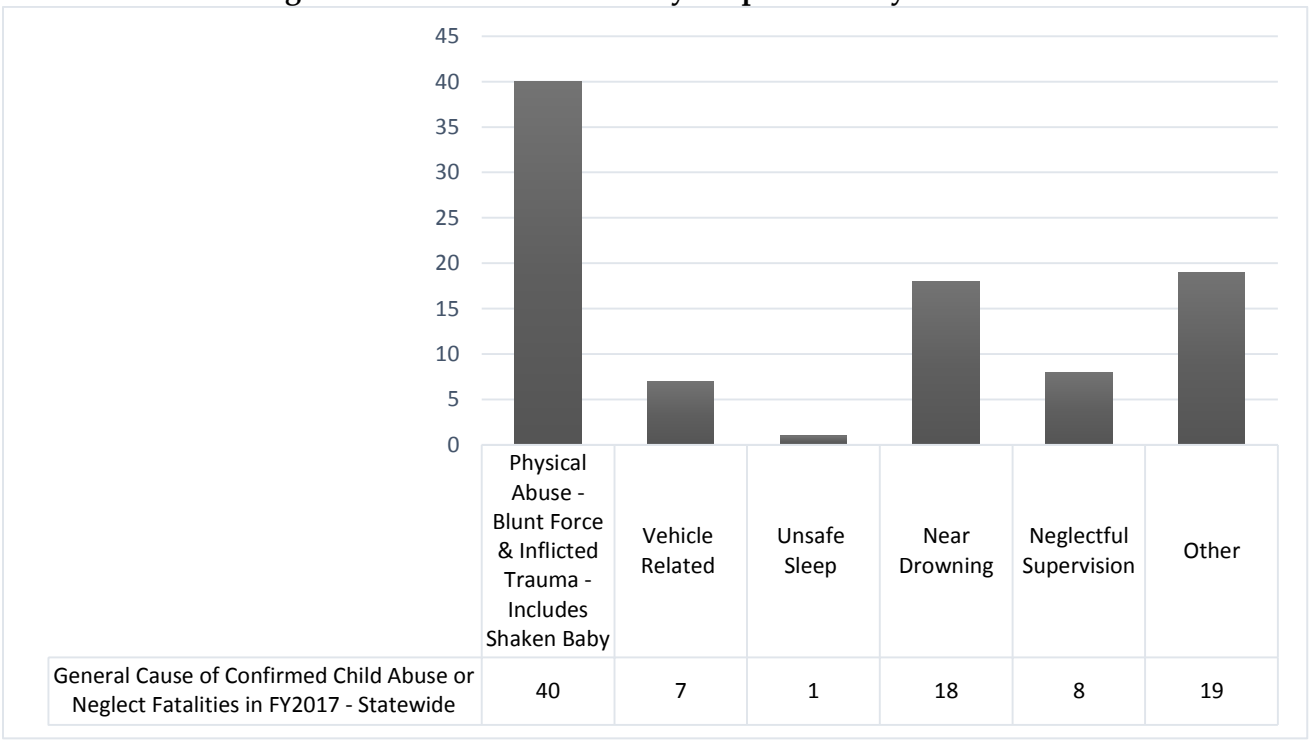
Source: DFPS individual case reviews

Figure 36. FY2017 –Near Fatality Dispositions by Gender of Child



Source: DFPS individual case reviews

Figure 37. FY2017 –Near Fatality Dispositions by Cause



	Physical Abuse - Blunt Force & Inflicted Trauma - Includes Shaken Baby	Vehicle Related	Unsafe Sleep	Near Drowning	Neglectful Supervision	Other
General Cause of Confirmed Child Abuse or Neglect Fatalities in FY2017 - Statewide	40	7	1	18	8	19

Source: DFPS individual case reviews

Future data elements required by Texas Family Code § 264.5032. Report on Child Fatality and Near Fatality Data will be included in the FY2018 Child Fatality and Near Fatality Annual Report. These elements surrounding near fatalities include:

(1) any prior contact the department had with the child's family and the manner in which the case was disposed, including cases in which the department made the following dispositions:

A. priority none or administrative closure;
B. call screened out;
C. alternative or differential response provided;
D. unable to complete the investigation;
E. unable to determine whether abuse or neglect occurred;
F. reason to believe abuse or neglect occurred; or
G. child removed and placed into substitute care.

(2) for any case investigated by the department involving the child or the child's family:

A. the number of caseworkers assigned to the case before the fatality or near fatality occurred; and
B. the caseworker's caseload at the time the case was opened and at the time the case was closed.

(3) for any case in which the department investigation concluded that there was reason to believe that abuse or neglect occurred, and the family was referred to family-based safety services:

A. the safety plan provided to the family;
B. the services offered to the family; and
C. the level of compliance with the safety plan or completion of the services by the family.

(4) the number of contacts the department made with children and families in family-based safety services cases.

(5) the initial and attempted contacts the department made with child abuse and neglect victims.

Prevention Programs

DFPS Prevention and Early Intervention Division (PEI) assists communities in identifying, developing, and delivering high quality prevention and early intervention programs designed to address risk factors and build protective factors within families in order to prevent or reduce juvenile delinquency and child maltreatment. Prevention services are provided through contracts with non-profit organizations and local governments located throughout Texas. With more than ten programs, two initiatives, multiple third-party program evaluations, and contractors serving all counties in Texas, PEI programs reached more than 64,000 families in FY2017. 99.7 percent of children and youth remained safe from maltreatment while receiving PEI services and more than 95 percent of youth engaged in services did not become involved with the juvenile justice system.

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

Childhood Programs (Primarily Serving Children 0-5)

- **Healthy Outcomes through Prevention and Early Support (HOPES)** promotes community collaboration through parent education, home visiting services, and other support services for families with children 5 years old and younger who are considered at risk for abuse and neglect. Counties were selected after identifying those at greatest risk for child maltreatment, focusing on risks most strongly tied to child abuse and neglect, such as domestic violence, substance abuse, teen pregnancy, child poverty, and child abuse fatalities.
- **Texas Home Visiting (THV)** supports the development and implementation of home visiting programs in at-risk communities across Texas and contributes to the development of a comprehensive early childhood system promoting maternal, infant, and early childhood health, safety, and development, as well as strong parent-child relationships in these communities.
- **Texas Nurse Family Partnership Program (TNFP)** was established by S.B. 156, 80th Legislature, Regular Session, 2007. This program is a voluntary, evidence-based program that helps transform the lives of vulnerable first-time mothers and their babies through regular home visitation by specially trained registered nurses. TNFP's mission is to empower first-time mothers living in poverty to successfully change their lives and the lives of their children through evidence-based nurse home visiting. Targeted services are designed to improve pregnancy outcomes by helping women engage in good preventive health practices, including getting prenatal care from their healthcare providers, improving their diet, and reducing their use of cigarettes, alcohol, and illegal substances and improve child health and development by helping parents provide responsible and competent care.
- **Safe Babies Evaluation** is an initiative and evaluation required by Budget Rider 39 from the 84th Legislature. The purpose of the project is to provide and evaluate hospital or clinic-based interventions that are designed to prevent maltreatment, especially abusive head trauma, in the first year after birth. Over 2,000 families will be provided prevention services and the evaluation will estimate the impact of abusive head trauma prevention efforts across the state.

Youth Programs

- **Services to At-Risk Youth (STAR)** provides family crisis intervention counseling, short-term emergency respite care, and individual and family counseling. This program is available in all counties in Texas.
- **Community Youth Development (CYD)** uses various approaches to prevent juvenile delinquency, including mentoring, youth employment programs, and recreational activities.
- **Statewide Youth Services Network (SYSN)** provides community and evidence-based juvenile delinquency prevention programs.
- **Texas Families Together and Safe (TFTS)** provides evidence-based, community-based programs designed to alleviate stress and promote parental competencies and behaviors that increase the ability of families to become self-sufficient and successfully nurture their children.

Family Programs

- **Community-Based Child Abuse Prevention (CBCAP).** CBCAP programs seek to increase community awareness of existing prevention services, strengthen community and parental involvement in child abuse prevention efforts, and encourage families to engage in services that are already available. CBCAP programs in FY2016 and FY2017 include:
    - Fatherhood Effects;
    - Basic parent education;
    - Respite care;
    - Home visiting, Education, and Leadership (HEAL);
    - Public awareness campaigns such as Safe Sleep and other special initiatives.
- **Community Based Family Services (CBFS)** serves families, who have been investigated by CPS but whose allegations are low priority or unsubstantiated, through community and evidence-based services.
- **Helping through Intervention and Prevention (HIP)** provides targeted families with an extensive family assessment, home visiting that includes parent education, and basic needs support. Families with a new child and a prior history of a confirmed child maltreatment fatality or termination of parental rights are eligible. Former foster youth and current foster youth who are expecting and/or are new parents may also access HIP services.
- **Military & Veterans Family Program (Military Families)** was established by HB 19 from the 84th Legislature to develop and implement a preventive services initiative targeted to serve military families and veterans. This program is currently in El Paso, San Antonio, and the Killeen/Belton area. The Military Families program is intended to address child abuse and neglect by providing prevention services based on the needs identified in a Community Needs Assessment and through collaboration with the local Family Advocacy Program office located on the targeted military installation. The

program seeks to increase protective factors of families served, thereby reducing the likelihood of a caregiver abusing a child and strengthening the resiliency of the family and community to prevent future maltreatment.

- **Texas Youth and Runaway Hotlines (TY&R)** is a 24-hour toll-free hotline offering crisis intervention, telephone counseling, and referrals to troubled youth and families. The hotline also includes text messaging and online chat to help support youth and families in need.

Prevention and Early Intervention - Public Awareness Campaigns

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

- Help and Hope on how to connect with community-based resources.[15]
- Room to Breathe on safe sleep practices for infants.[16]
- Watch Kids Around Water about drowning prevention.[17]
- Look Before You Lock on preventing deaths in hot cars.[18]
- Don't be in the Dark on selecting regulated child care.[19]

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

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

As part of this effort, DFPS and DSHS released the joint report "Strategic Plan to Reduce Child Abuse and Neglect Fatalities" in March 2015. This report identified certain risk factors and commonalities between confirmed child abuse and neglect fatalities including individual and

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

This work has been expanded in FY2017 and FY2018 to analyze child maltreatment, including fatalities, and build a public health approach between both agencies that addresses child maltreatment risk and protective factors.

The Office of Child Safety also hosts training sessions across the state. Topics presented at these training sessions are focused on issues surrounding child safety and addressing critical casework across various programs and stages of services. In FY2017, the Office of Child Safety held the annual Safety Summit to support Child Protective Services' Family Based Safety Services division works with high-risk families who have been investigated by Child Protective Services and an ongoing danger or safety concern to the child has been identified. This training addressed ongoing practice surrounding assessing, engaging, and supporting positive outcomes for families where maltreatment has already occurred and/or where the family is at high-risk for ongoing maltreatment. This included in-depth case mapping/critical thinking training designed to support CPS' practice model and the use of Signs of Safety. FBSS staff participated in 1.5 days of training which included trainers from Signs of Safety and then hands-on case mapping.

Initiatives & Program Improvement

Internal Initiatives and Program Improvement

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

Centralizing Investigations – In September 2017, DFPS centralized investigations under the DFPS Commissioner. The new division includes CPS investigations, CCL investigations (still separate from CPS investigations) and Special Investigators. The Investigation Division focuses on improving investigation practice and policy. It is responsible for developing policy and procedures consistent with best practices in child protective services as well as implementing legislative mandates.

Streamlining Policy - CPS has streamlined and updated its current policy handbook – separating policy from best practice and improving the content, clarity, and accuracy of policy. CPS has also created a better process for communicating policy changes in a more coordinated and effective manner, so that staff can more readily digest and understand agency policies.

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

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

Improving Case Transfer - The case transfer process between Investigations and FBSS staff has been simplified and can begin as soon as an investigator has identified that a family could benefit from ongoing services.

Statewide Internal and External Child Fatality Review Committees

Child Safety Review Committee - DFPS Review Team with External Stakeholders

The Child Safety Review Committee (CSRC) examines issues that have implications for CPS policy and practice. It consists of internal and external stakeholders. The group reviews all information collected by each Regional Child Death Review Committee and makes

recommendations to CPS based on those trends and patterns. Recommendations from the CSRC have included training and additional resources for working with families with active substance abuse, domestic violence/intimate partner violence, and children with special medical needs.

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

The State Committee is a multidisciplinary group comprised of members throughout Texas.[20] 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: Texas Child Fatality Review Biennial Report - April 2018[21]

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

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

- Providing assistance, direction, and coordination to investigations of child deaths;
- Promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities;
- Developing an understanding of the causes and incidence of child deaths in the county or counties in which the team is located;
- Recommending changes to agencies, through the agency's representative member, that will reduce the number of preventable child deaths; and
- Advising the State Committee on changes to law, policy, or practice that will assist the team and the agencies represented on the team in fulfilling their duties.

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

Protect Our Kids Commission

During the 83rd Texas Legislature, Senate Bill 66 established the Protect Our Kids Commission and tasked the Commission with studying the relationship between CPS, child welfare services, and the rate of child abuse and neglect fatalities. The Commission identified necessary

resources and developed recommendations to reduce child abuse and neglect fatalities that can be implemented at the local and state level. DFPS served as one of the 15 members on the Commission. Recommendations from the Protect Our Kids Commission include:

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

The Protect Our Kids Commission report is available at:
http://texaschildrenscommission.gov/media/46100/PDF-Report-POK-Commission-December-2015.pdf

National Initiatives and Program Improvement

Casey Family Programs - Child Safety Forums

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

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

Federal Commission for the Elimination of Child Abuse and Neglect Fatalities

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

The final report from the Federal Commission for the Elimination of Child Abuse and Neglect Fatalities is available at: https://eliminatechildabusefatalities.sites.usa.gov/

Endnotes

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

[2] U.S. Department of Health and Human Services, Administration of Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child Maltreatment 2012*, http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment

[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 HHSC Center for the Elimination for Disproportionality and Disparities.
Available at: http://www.hhsc.state.tx.us/hhsc_projects/cedd/about/index.shtml

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

[7] *Child Maltreatment 2011,* http://www.acf.hhs.gov/sites/default/files/cb/cm11.pdf.

[8] U.S. Department of Health and Human Services, Administration of Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). *Child Maltreatment 2012.* Available from http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment.

[9] 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

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

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

[12] 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.

[13] Tex. Fam. Code §261.001 Definitions

[14] Child abuse and neglect fatalities: Statistics and Interventions. Child Welfare Information Gateway. 2010. Available at: http://www.odontologiapediatrica.com/img/Child_Abuse_and_Neglect_Fatalities._Statistics_and_Interventions_(en_ingl%C3%A9s)..pdf.

[15] DFPS Public Website, http://www.helpandhope.org/index.html
[16] DFPS Public Website, http://www.dfps.state.tx.us/Room_to_Breathe/default.asp
[17] DFPS Public Website, http://www.dfps.state.tx.us/Watch_Kids_Around_Water/default.asp
[18] DFPS Public Website, http://www.dfps.state.tx.us/Prevention_and_Early_Intervention/Vehicle_Safety/default.asp
[19] DFPS Public Website, http://www.dfps.state.tx.us/Child_Care/Dont_Be_In_The_Dark/default.asp

[20] DSHS State Child Fatality Review Team Members, https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589985017

[21] Texas Child Fatality Review Biennial Report 2014-2015, https://www.dshs.texas.gov/mch/pdf/Texas-SCFRT-Biennial-Report_2014-2015.pdf