



TEXAS
Department of Family
and Protective Services

Fiscal Year 2018
Child Maltreatment Fatalities
and Near Fatalities Annual Report

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Executive Summary

With over seven million children in Texas, the safety net to protect children and help them reach their greatest potential begins at home and includes family, neighbors, schools, and communities. It is through community partnerships that the Department of Family and Protective Services (DFPS) can protect children from harm by providing a complete continuum of prevention and intervention programs. These partnerships with law enforcement, the medical community, service providers, and families allow DFPS to utilize a public health framework to address fatal and near-fatal child maltreatment.

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

Many are familiar with safety campaigns that are embedded in a public health framework, especially in Texas: *Click it or Ticket, Turn Around...Don't Drown, Move Over or Slow Down*. These messages have become part of the public conversation in our society to help keep us safe—whether it is wearing your seatbelt, avoiding high water crossings, or giving space on the road to first responders. Similarly, the use of public child safety messages continue to play a pivotal role in reducing child fatalities and near fatalities. To address fatal and near fatal child maltreatment, it is important that we support the parenting experience through universal messages and services on: (1) understanding expected child development, (2) selecting a caregiver, (3) education around the *ABCS of Safe Sleep*, water safety, and vehicle safety, and (4) community supports for major risk factors such as substance abuse, domestic violence, and mental health.

We have seen communities take on these issues directly—from water safety outreach, to working to ensure all birthing hospitals in a community are safe sleep certified, and even partnering with parent education resources to connect parents with the support they need. The data over the past few years suggests that partnering with communities in a public health approach is working; child fatalities due to drownings, unsafe sleep, and vehicle-related fatalities continue to drop. But we must remain steadfast in this work to bring awareness to families, caregivers, and those expecting their first child. Inexplicably, in FY2018, the number of physical abuse fatalities increased significantly, after FY2017 was the lowest year for physical abuse fatalities in more than eight years.

Another finding in FY2018 is that in more than half (54.5 percent) of cases the family had no prior involvement with DFPS. This highlights the *absolutely critical* importance of community in child protection. For children to remain safe, and to thrive, it takes community collaboration, so that support networks, resources, and normalizing a parent's ability to seek help can be built and families engaged before tragedy strikes.

Child maltreatment fatalities are generally thought of as either physical abuse or related to neglect. 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 unsuitable 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 get the help they need.

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 FY2018, the following trends and areas for review have been identified:

General Findings

- Texas had 211 confirmed child abuse and neglect-related fatalities in FY2018, an increase of 22.7 percent compared to FY2017 (Table 1, Figure 3).
 - The increase in child maltreatment fatalities in FY2018 is predominately due to physical abuse fatalities which increased by 58 percent over FY2017. FY2017 had the lowest number of physical abuse fatalities since FY2010. In FY 2018 there were 92 physical abuse fatalities, compared to 58 in FY 2017. In 48 of those cases, DFPS had no knowledge of or involvement with the family. In 20 of those cases, the last contact with the family was at least two years before the death occurred. (Figure 1, Figure 3, Page 33).
 - Decreases continue in vehicle-related fatalities as well as in unsafe sleep and drownings.

- The number of child fatalities investigated by DFPS decreased from 807 in FY2017 to 785 in FY2018, continuing the overall downward trend since an all-time high in FY2010 (Figure 2).
- In 54.5 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had no prior history with CPS. (Figure 22)
- Confirmed neglect-related fatalities account for almost 56 percent of child maltreatment fatalities (Figure 4).
 - The most common causes of fatalities involving neglect were drowning, unsafe sleep, and physical/medical neglect (Figure 7, 8).
 - Vehicle-related deaths continue to decline by 42 percent in FY2018. 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 where the parent or caregiver driving was intoxicated or under the influence.
- In FY2018, Texas had 82 confirmed abuse and neglect-related near fatalities, a decrease of 14.6 percent compared to FY2017. The largest decrease was seen in non-fatal drownings which dropped 33.3 percent compared to FY2017 (Figure 38).

Victims

- Based on the confirmed child abuse and neglect-related fatalities over the past nine fiscal years, children 3 years of age and younger were almost 80 percent of all confirmed child abuse and neglect fatalities; however, in FY2018, children 3 years of age and younger made up 68 percent of child fatalities. Boys made up more than half of all confirmed child abuse and neglect-related fatalities (Figure 9, 10).
- During FY2018, 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, which is also a trend across the United States (Table 3).
- More than 56 percent of children who died from abuse or neglect in FY 2018 were too young for school and not enrolled in day care. Two children were being cared for by illegal day care operations that were unknown to DFPS (Page 23).

Perpetrators

- Physical abuse fatalities most commonly involved blunt force trauma or intentional trauma inflicted by a father or boyfriend (combined this represents 64 percent) (Figure 14, 15).
- In all confirmed cases of abuse and neglect, parents continue to be the most common perpetrators (Figure 13).
- In 54.5 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had no prior history with CPS. Since more than half of all perpetrators were unknown to CPS, it requires collaboration with families and communities to build a strong safety network that supports children, youth, and families. (Figure 22, 23).
- When the perpetrator or the child was previously known to DFPS in the two years prior to fatality, the child fatality is often related to physical abuse, related to neglectful supervision issues such as drowning and unsafe sleep, or issues related to physical neglect and medical neglect. (Table 8, 9).

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, it will be investigated. If DFPS 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 alleged 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 §261.001. 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, the investigation 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** – the investigation determines 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** – the investigation determines 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) – the investigation determines, 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 actions taken to conduct a thorough or an abbreviated investigation.

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

Unable to Determine (UTD) – The investigation concludes 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.

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, the investigator assigns 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. That trend has now reversed. In FY2014, the number of intakes assigned for investigation began to rise, with FY2018 being the highest in the past nine years.

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

	FY2014	FY2015	FY2016	FY2017	FY2018
Child Population of Texas	7,266,760	7,311,923	7,407,636	7,500,272	7,583,816
Number of Intakes Assigned for Investigation or Alternative Response by CPS	215,512	232,159	238,591	238,600	246,074
Number of Investigated Child Fatalities	797	739	796	807	785
Number of fatalities where abuse/neglect was confirmed	151	171	222	172	211
Child Fatality Rate per 100,000 Children	2.10	2.34	2.99	2.29	2.78
National Rate for Equivalent Federal Fiscal Year²	2.14	2.26	2.36	2.32	***

Source: Data from US Census Bureau; Texas State Data Center; DFPS Data Books FY2010-FY 2018; 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 2018.

*** Child Maltreatment 2018 is scheduled to be released in January/February 2020.

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 FY2018 are presented in Table 2 - Percentage of Child Fatality Investigations by Disposition.

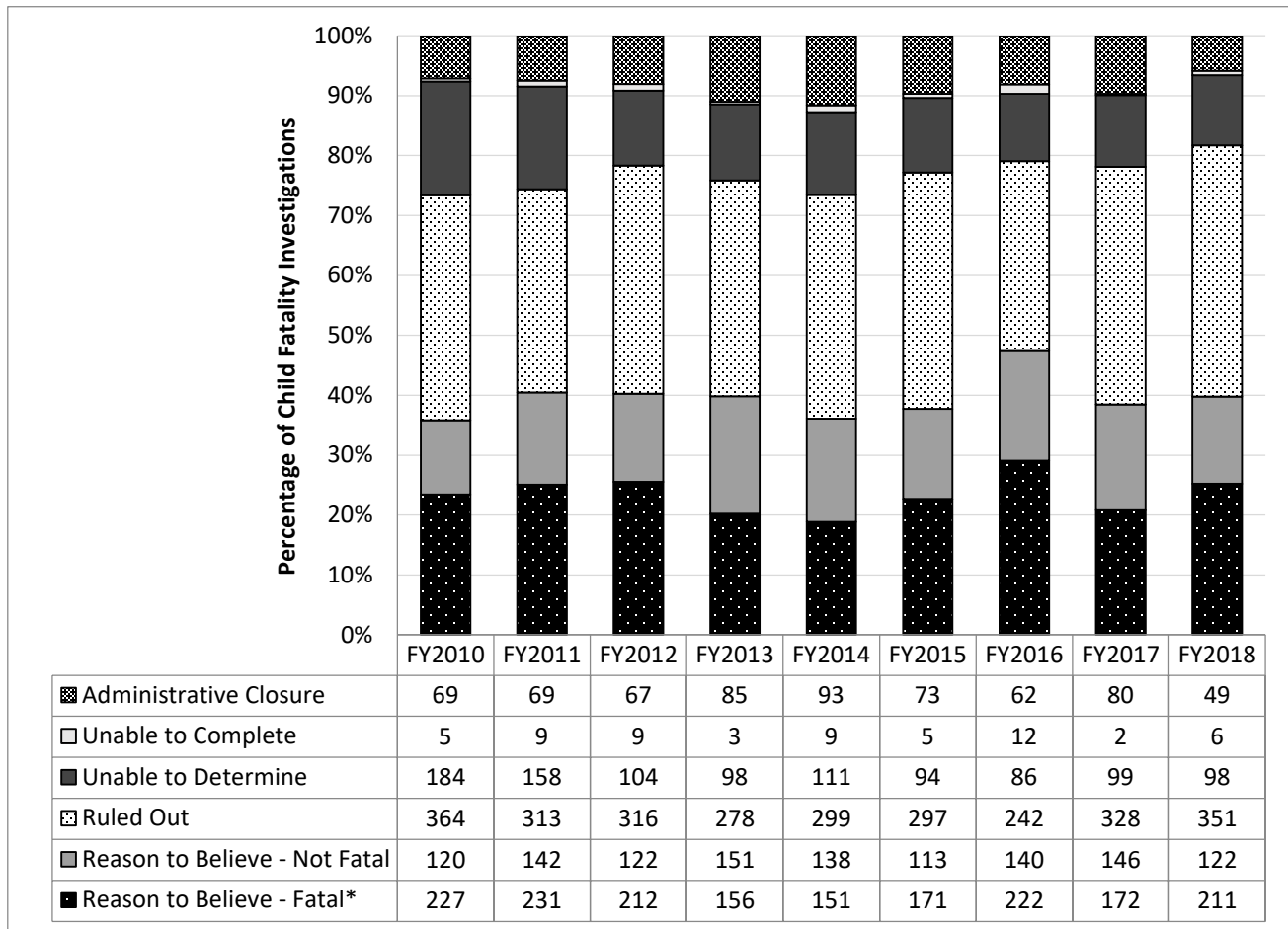
Table 2. Percentage of Child Fatality Investigations by Disposition

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%
FY2018	785	25.18%	14.56%	41.89%	11.69%	0.72%	5.58%

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

Source: DFPS Data Warehouse Report FT_01, FT_02, FT_06

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



* Count by Child, all other categories are count by investigation.

Source: DFPS Data Warehouse Report FT_01, FT_02, FT_06

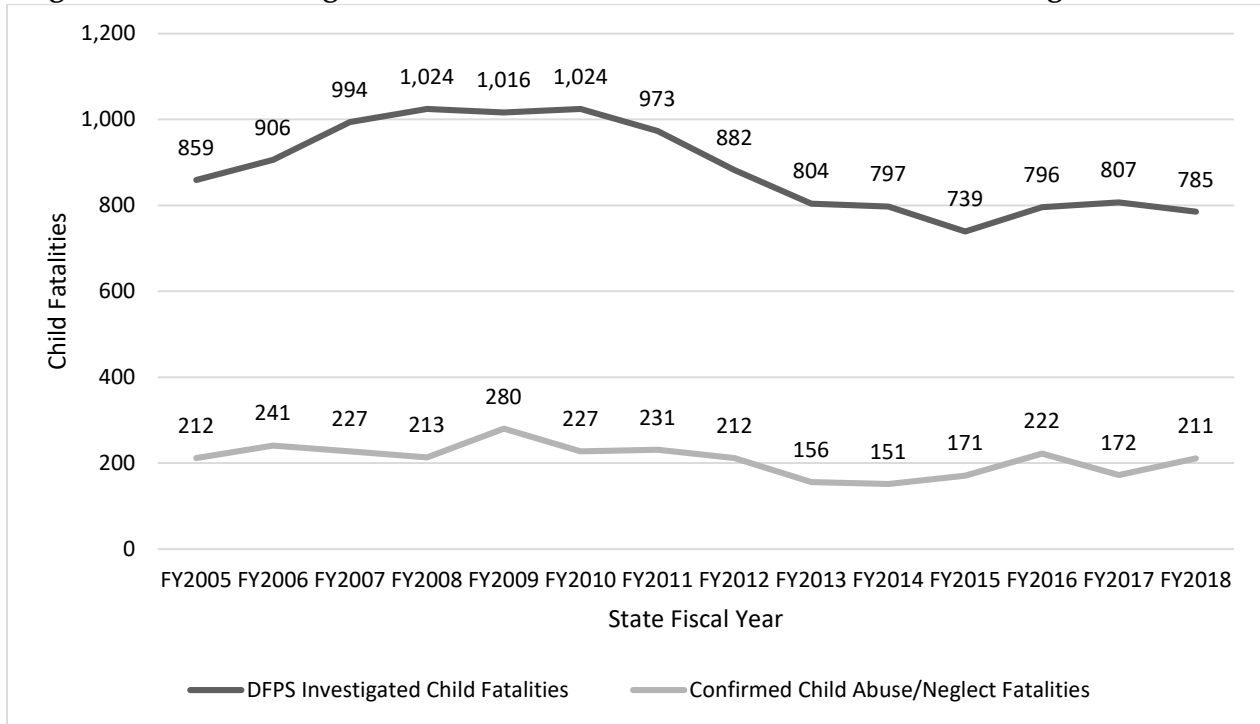
Since FY2010, there has been a decrease in cases closed with an unable to determine disposition. The decrease indicates more thorough investigations with the collaboration of partners such as medical examiners, law enforcement, and DFPS Special Investigators to determine the overall disposition of a fatality case based on critical needed information (Figure 1). Additional training has been provided to Child Protective Investigations (CPI) staff on various topics to support more thorough investigations: contacting reporters, utilizing collateral contacts, family engagement, building a support network, and assessing safety throughout the investigation.

Several factors help support case dispositions:

- Increased understanding by the general public and first responders on what child fatalities should be reported to DFPS for investigation;
- Ongoing training within Child Protective Investigations 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 (FACN) 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, Child Protective Investigations, and Child Protective Services.

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



Source: DFPS Data Warehouse Report FT_06

In FY2018, DFPS investigated 785 possible child abuse and neglect-related fatalities. That number peaked in FY2008 and FY2010 at 1,024, with an overall decreasing trend continuing through FY2018. (Figure 2).

Ensuring Consistency in Dispositions

A current trend in child welfare is the renewed focus on the accuracy of case dispositions following fatality investigations. In other words, did the investigation reach the appropriate conclusion? 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, better 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. These efforts allow the department to continue working with staff to support consistent dispositions statewide across all investigations, not solely those involving child fatalities.

The overall number of child fatality investigations may also reflect random fluctuation. The number of child abuse and neglect fatalities spiked to 280 in FY2009 despite a slight decline in the number of reported deaths. After an exhaustive review of the fatalities 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, the number of child abuse and neglect fatalities was 227, returning to previous lower levels, including in 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

FY2018 Confirmed Child Abuse and Neglect-Related Fatalities

During the 81st Legislative Session, the Texas Legislature passed Senate Bill 1050 codifying the federal 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. The agency was also directed to provide detailed information if DFPS "determines a child's death was caused by abuse or neglect."⁴ During the 84th Texas Legislature, Senate Bill 949 was passed to support additional reporting elements for child fatality investigations. In the 85th Texas Legislature, House Bill 1549 required DFPS to collect additional details on near fatalities and child fatalities.

General Findings

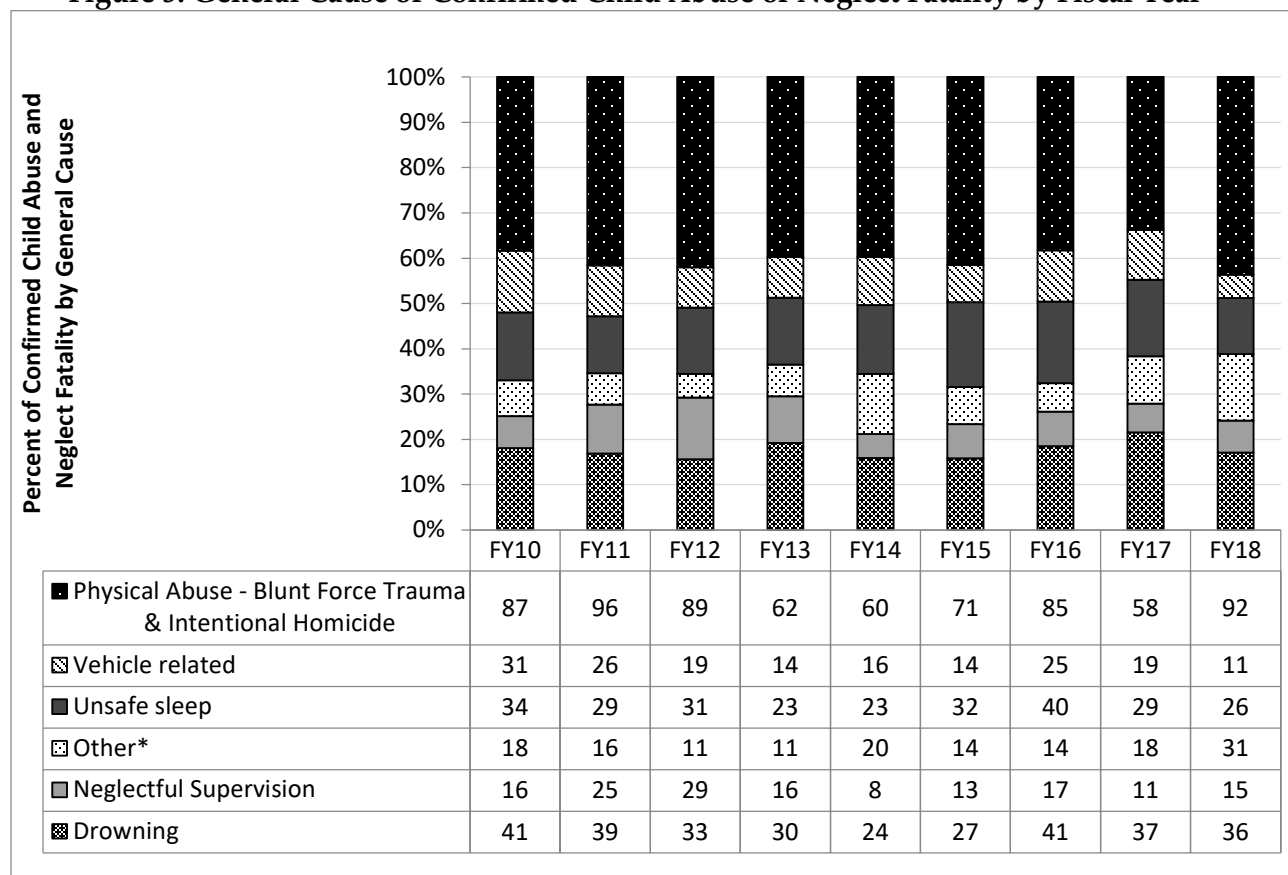
- Texas had 211 confirmed child abuse and neglect-related fatalities in FY2018, an increase of 22.7 percent compared to FY2017 (Table 1, Figure 3).
 - The increase in child maltreatment fatalities in FY2018 is predominately due to physical abuse fatalities which increased by 58 percent over FY2017. FY2017 had the lowest number of physical abuse fatalities since FY2010. In FY 2018 there were 92 physical abuse fatalities, compared to 58 in FY 2017. In 48 of those cases, DFPS had no knowledge of or involvement with the family. In 20 of those cases, the last contact with the family was at least two years before the death occurred. (Figure 1, Figure 3, Page 33).
 - Decreases continue in vehicle-related fatalities as well as in unsafe sleep and drownings.
- The number of child fatalities investigated by DFPS decreased from 807 in FY2017 to 785 in FY2018, continuing the overall downward trend since an all-time high in FY2010 (Figure 2).
- In 54.5 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had no prior history with CPS. (Figure 22)
- Neglect-related fatalities account for almost 56 percent of child maltreatment fatalities (Figure 4).
 - The most common causes of fatalities involving neglect were drowning, unsafe sleep, and physical/medical neglect (Figure 7, 8).
 - Vehicle-related deaths continue to decline and declined by 42 percent in FY2018. 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 where 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 child fatality review teams separate intentional/homicides and neglect-related fatalities. In the data below, child fatalities are divided into these categories to provide clarity and more information to be used to develop child abuse and neglect prevention efforts.

Intentional deaths are defined as those where the perpetrator intended to cause harm or death to the child and are most often physical abuse. Neglect-related deaths are often caused by inattention and/or impairment by the child’s caregiver.

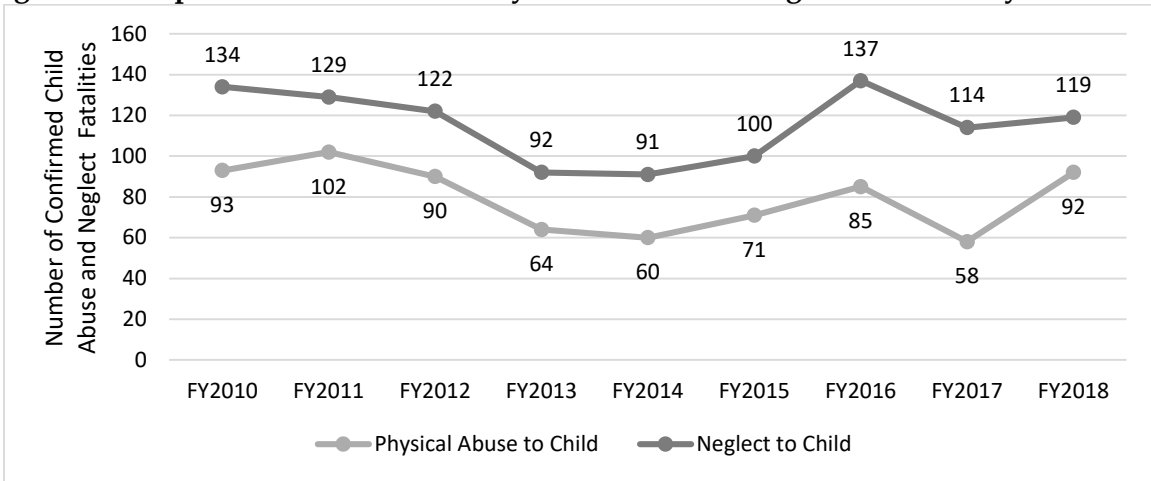
Figure 3. General Cause of Confirmed Child Abuse or Neglect Fatality by Fiscal Year



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

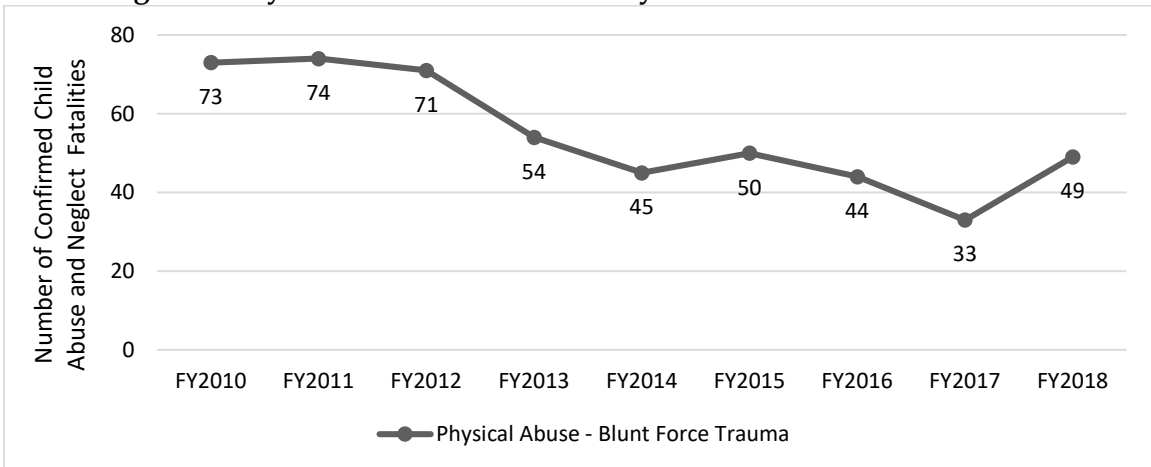
Source: DFPS individual case reviews

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



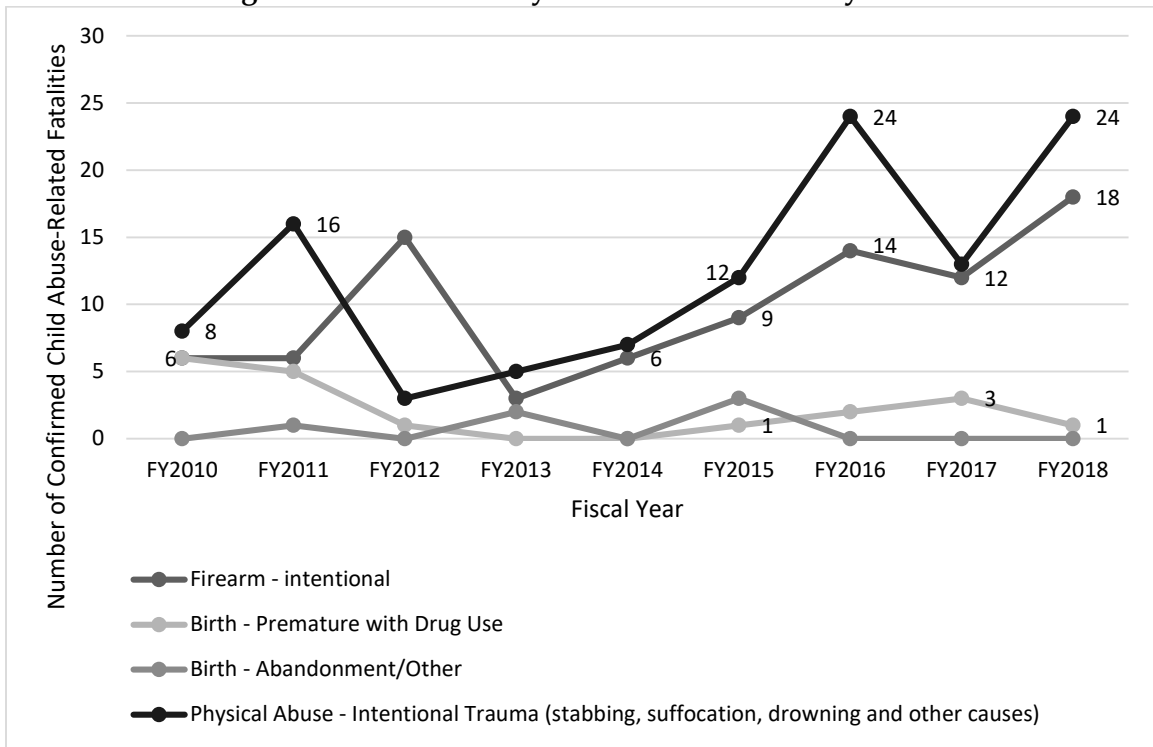
Source: DFPS individual case reviews

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



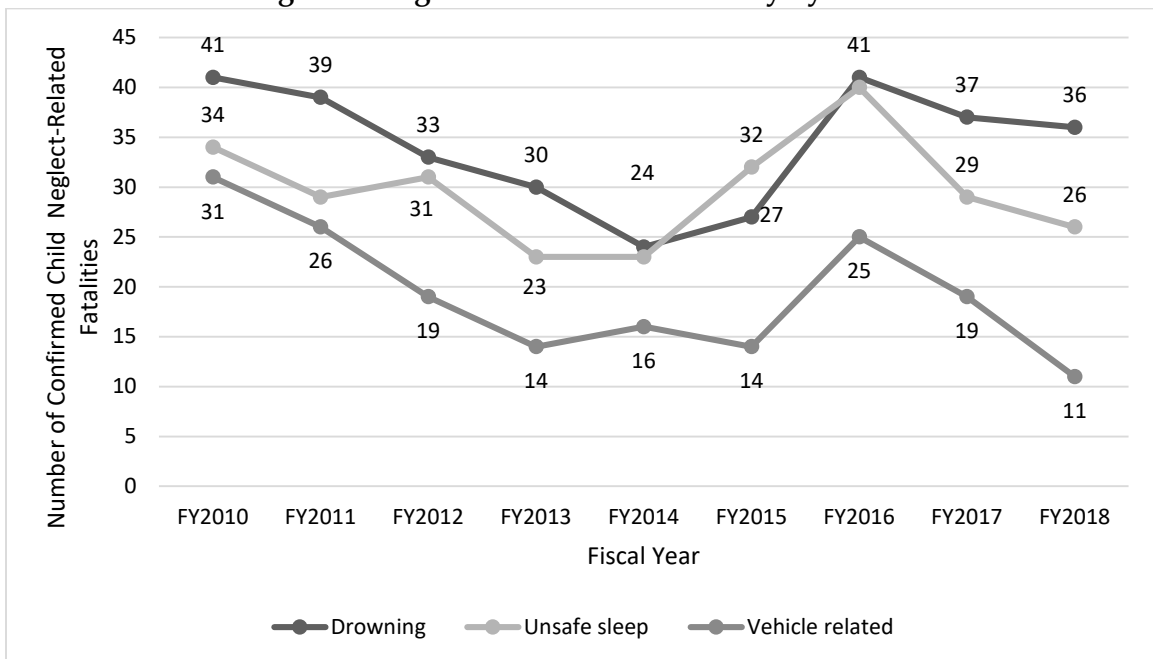
Source: DFPS individual case reviews

Figure 6. Intentional Physical Abuse to Child by Cause



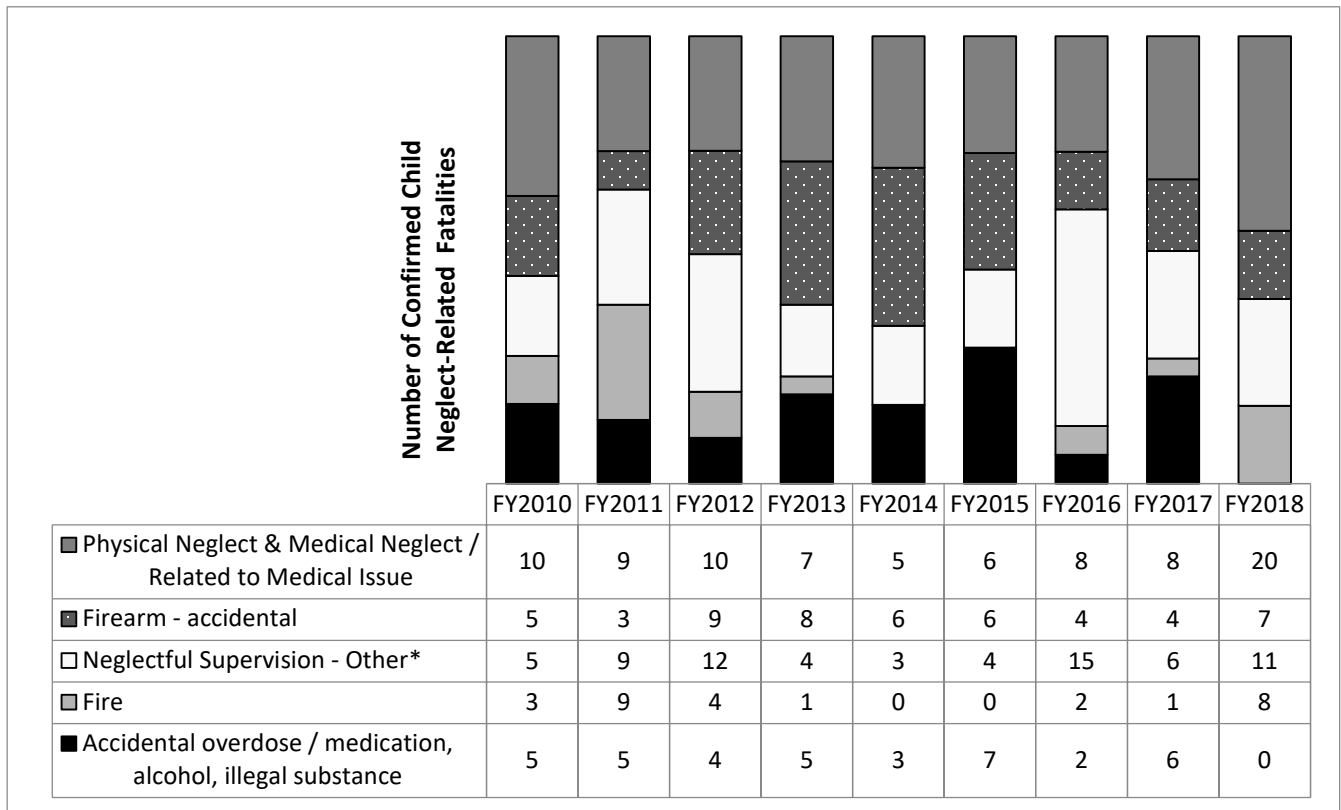
Source: DFPS individual case reviews

Figure 7. Neglect-Related Child Fatality by Cause



Source: DFPS individual case reviews

Figure 8. Neglect-Related Child Fatality by Cause



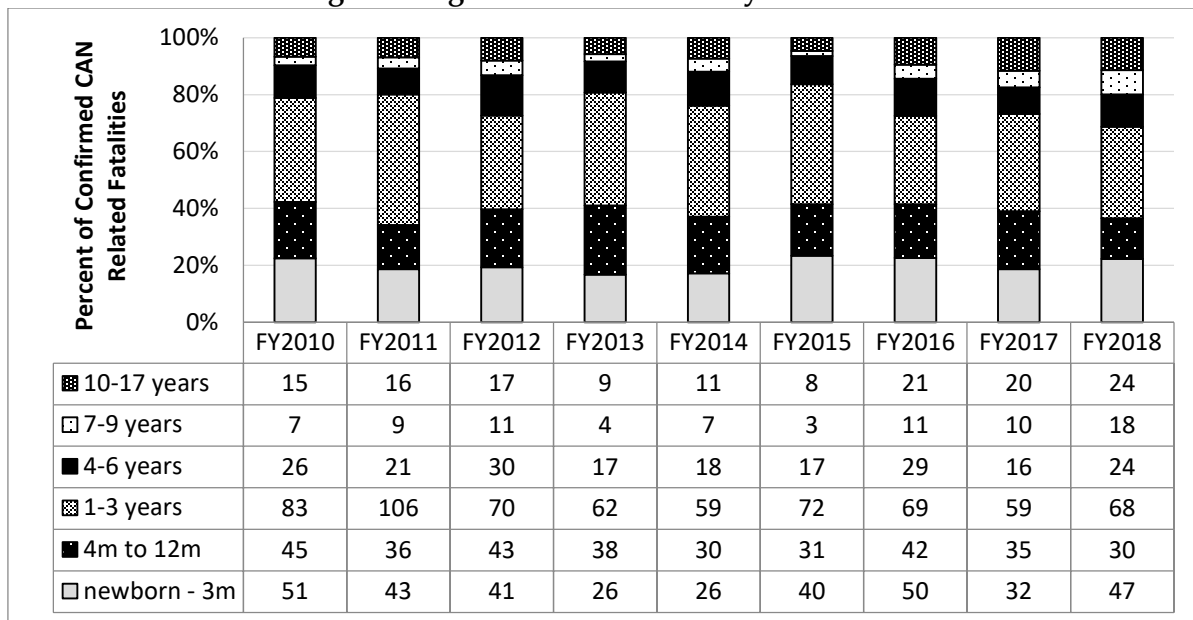
* Neglectful Supervision - Other includes ATV accident, object falling on child, suicide, and dog attack
 Source: DFPS individual case reviews

Victim Demographic Characteristics - Age, Gender, Ethnicity

Victims

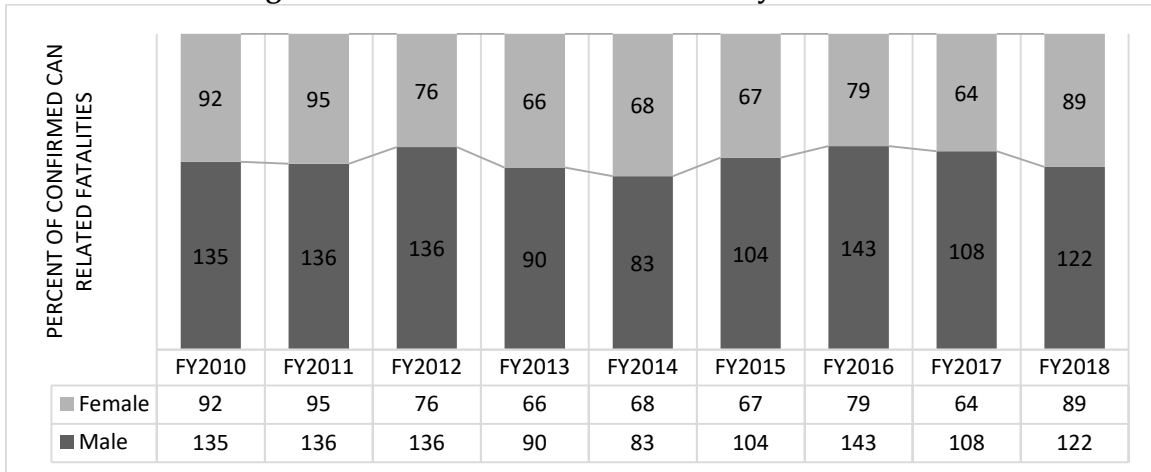
- Based on confirmed abuse and neglect-related fatalities over the past nine fiscal years, children three years of age and younger comprised almost 80 percent of all confirmed child abuse and neglect fatalities; however, in FY2018, children three years of age and younger made up 68 percent of child fatalities. Boys made up more than half of all confirmed child abuse and neglect-related fatalities (Figure 9, 10).
- During FY2018, 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 56 percent of children who died from abuse or neglect in FY 2018 were too young for school and not enrolled in day care. Two 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



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 the context of the child per capita rate for Texas. In FY2018, 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 disproportionately higher as compared to the overall Texas child population (Table 3). DFPS is actively working with state agencies, universities, private groups, communities, and stakeholders to address health and health access disparities among racial, multicultural, ethnic, and regional populations. Part of this work includes cross-program work between DFPS and the Texas Department of State Health Services to address child fatalities with a public health approach.

Table 3. FY2018 Per Capita Rate (per 100,000 Children) by Ethnicity - Confirmed Child Abuse Neglect Fatalities

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non Hispanic	Total
Child Population	841,943	2,338,026	3,851,190	552,657	7,583,816
Number of Fatalities	59	52	87	13	211
Per Capita Rate of Fatality	7.01	2.22	2.26	2.35	2.78

Sources: Texas State Data Center; DFPS Data Books FY2018; 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 (CDC) defines risk factors for child maltreatment as characteristics associated with child maltreatment.⁵ These factors may or may not be direct causes, but are often found in situations where children have been the alleged victim or confirmed victim of child maltreatment. The data contained in this report supports those same findings for risk factors—children who are three or under, history of child maltreatment, substance abuse, mental health concerns, and/or domestic violence in the home. Children with special needs or medical concerns also may be more at risk.

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

Special Needs & Medical Concerns as Risk Factor

In FY2018, 22 percent of child maltreatment fatalities involved a child with special medical needs or medical concerns. Eight 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. Four of the children who died due to abuse or neglect were diagnosed as failure to thrive and three children required feeding tubes.

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	FY2018 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality
None	164 Fatalities
Asthma	1 Fatality <ul style="list-style-type: none"> • Medical Neglect (1)
ADD/ADHD	3 Fatalities <ul style="list-style-type: none"> • Firearm – Accidental (1) • Suicide (1) • Medical Neglect (1)
Autism	5 Fatalities <ul style="list-style-type: none"> • Neglectful supervision - drowning (5)
Depression	1 Fatality <ul style="list-style-type: none"> • Suicide (1)
Developmental disability/delay	5 Fatalities <ul style="list-style-type: none"> • Physical Abuse (2) • Medical Neglect (3)
Diabetes	5 Fatalities <ul style="list-style-type: none"> • Medical Neglect (6)
Drug or alcohol in utero exposure or addiction at birth	8 Fatalities <ul style="list-style-type: none"> • Neglectful Supervision – co-sleeping (3) • Physical Abuse (2) Birth – Premature Drug Use (3)
Medically Fragile	5 Fatalities <ul style="list-style-type: none"> • Medical Neglect (2) • Physical Abuse (3)
Other – Failure to Thrive, Downs Syndrome, Feeding Tube	18 Fatalities <ul style="list-style-type: none"> • Neglectful Supervision (9) • Medical Neglect (2) • Physical Abuse (6) • Physical Neglect (1)

Substance Abuse by Caregiver as Risk Factor

During the review of confirmed child fatalities, 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 FY2018, 138 of the 211 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 actively being used by the perpetrator (85 cases) in child abuse and neglect-related fatalities. In 21 child fatalities, methamphetamines and amphetamines were being actively used by the caregiver.

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

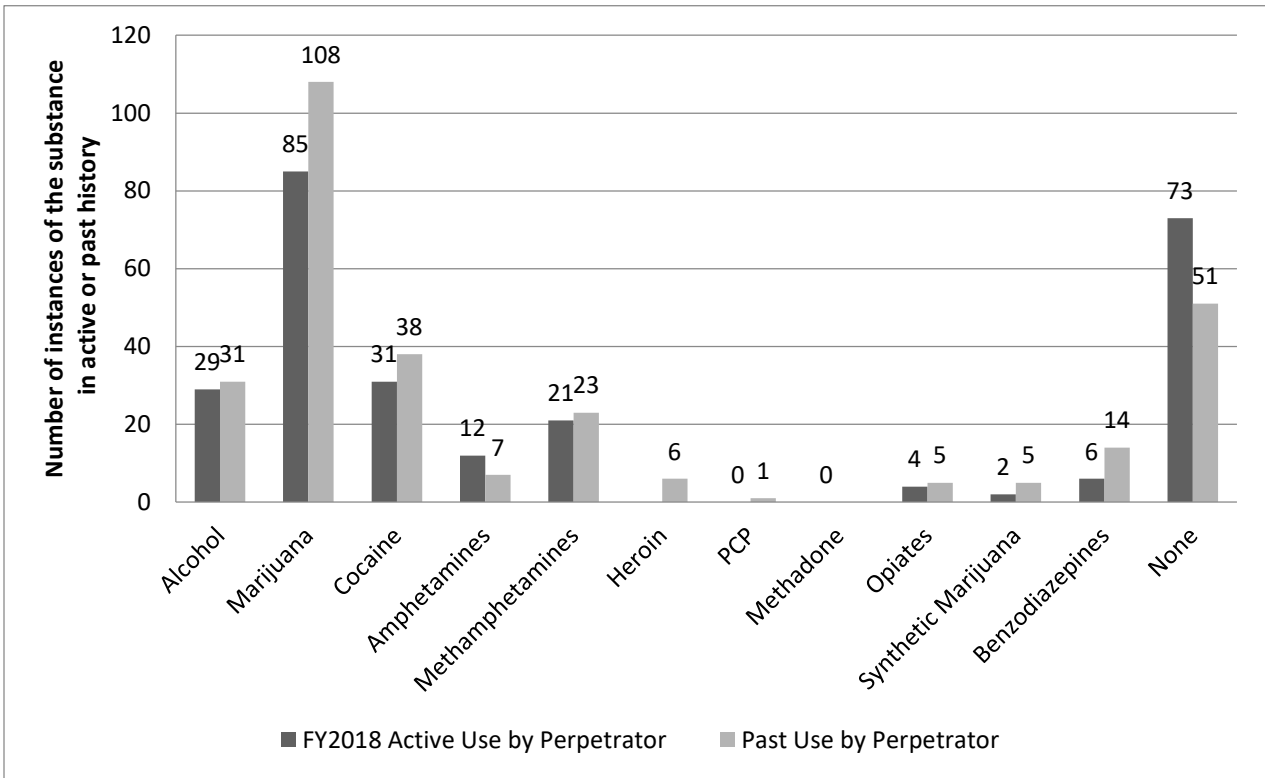


Table 5. Confirmed Child Abuse or Neglect Fatality by Co-Occurring Substance Abuse by Perpetrator -- FY2018

Co-Occurring Substances	Active	Past History
Alcohol and Marijuana	9	10
Marijuana and Cocaine	22	12
Cocaine and Alcohol	2	1
Cocaine and Methamphetamines	4	0
Methamphetamines and Marijuana	7	0
More than two substances	17	28

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 FY2018, 28.4 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 6. Mental Health Concerns both Active and in Past History for Perpetrator Confirmed Child Abuse Neglect Fatalities
FY2018**

Mental Health Concern	Active	Past History
Total Number of Parents/Caregivers with Mental Health Concern*	60	55
• Bipolar Disorder	13	13
• Depression	23	18
• Anxiety	18	13
• Postpartum Depression	0	2
• Post-Traumatic Stress Disorder	3	1
• Psychosis	0	1
• Schizophrenia	4	3
• Substance abuse disorder	1	1
• ADD/ADHD	3	5
• Unknown Diagnosis – Reported by Individual	21	23
No	102	109
Unknown (not identified in case read)	49	47

Domestic Violence Concerns as Risk Factor

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

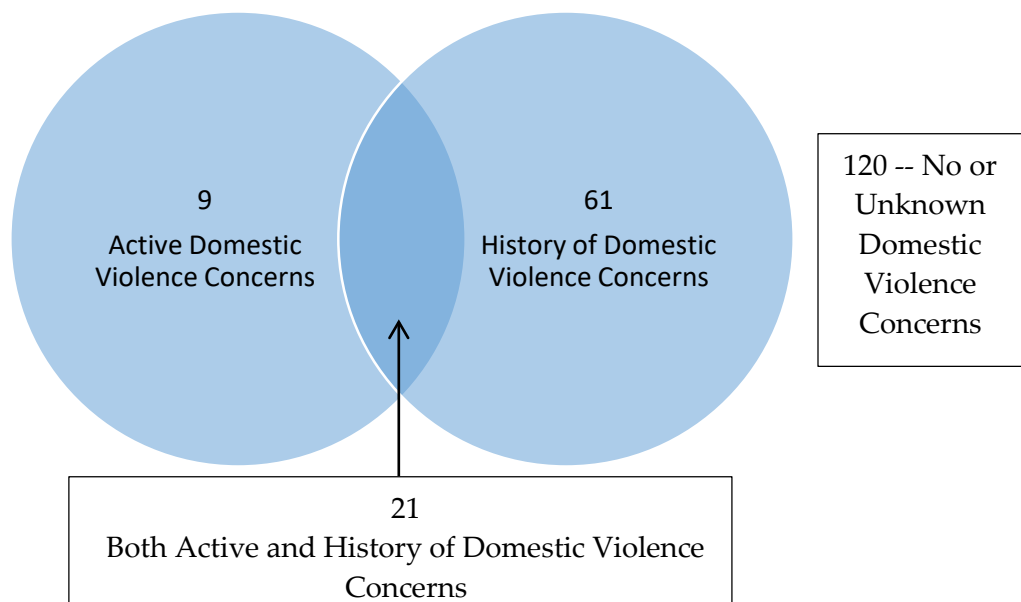
- the hiring of a subject matter expert within CPS;
- development of training for all staff;
- guidance on how to investigate, disposition allegations, and provide services to families where domestic violence or intimate partner violence is a concern;
- strengthening connections between local service providers and CPS so that reports of danger in the home are more accurate and interventions can be improved; and
- working closely with the Texas Council on Family Violence, CPS intends to provide more families with batterer intervention services.

DFPS Prevention and Early Intervention also funds several partnerships with local domestic violence intervention providers 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 concerns for domestic violence in the home at the time of the child fatality.

It is clear that domestic violence is underreported. In FY2018, there was active domestic violence present in the home environment for 30 families, and 90 percent of those families had a child fatality due to physical abuse. A history of domestic violence was identified in 82 case reviews; in 48 of those cases, the child’s death was due to physical abuse.

Figure 12. FY2018 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 68 percent of child fatalities involving children age three and younger, protective and attentive parents and caregivers are critical to keeping children safe. 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 other adults outside the family the opportunity to be around the child regularly and be on the lookout for abuse or neglect. More than half of children who died due to abuse or neglect were not involved with either a registered or licensed day care or a school system, where adults serve a critical role in a community's safety net and are required to report concerns of abuse or neglect.

FY2018 Confirmed Child Abuse and Neglect Fatalities:

- In 119 of the 211 child fatalities due to abuse or neglect, the child was not enrolled either in a day care or in school. In 27 case reviews, the status of the child being in school or day care was unknown.
- In 46 of the 211 child fatalities due to abuse or neglect, the child was enrolled in day care or school. Sixteen of the fatalities occurred when school was out of session for the summer or winter break.
- In two of the 211 child fatalities due to abuse or neglect, the child was being cared for by a caregiver that should have been registered or licensed through HHSC but was not.
- In one abuse/neglect fatality, the child was being cared for by a babysitter and one child was home schooled.

Table 7. FY2018 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	005	2	0
Aransas	011	1	0
Bastrop	007	2	0
Bell	007	1	0
Bexar	008	9	0
Bowie	004	1	0
Brazoria	006	4	0
Brazos	007	2	0
Collin	003	2	0
Comal	008	1	0
Cooke	003	3	0
Dallas	003	19	0
Denton	003	2	0
Ector	009	2	0
El Paso	010	4	0
Ellis	003	2	0
Fort Bend	006	2	0
Galveston	006	4	0
Gregg	004	3	0
Hardin	005	2	0
Harris	006	45	0
Harrison	004	1	0
Hays	007	2	0
Henderson	004	3	0
Hidalgo	011	6	0
Hunt	003	3	0
Hutchinson	001	1	0
Jackson	008	1	0
Jefferson	005	3	0
Jim Wells	011	2	0
Johnson	003	3	0
Kendall	008	0	0
Liberty	006	2	0
Lubbock	001	1	0
Maverick	008	1	0
McLennan	007	5	0
Midland	009	1	0

FY2018 Child Fatality and Near Fatality Annual Report

County	Region	Child Abuse/Neglect Related Fatalities	Child Abuse/Neglect Related Fatalities in Foster Care at Time
Montgomery	006	4	0
Nacogdoches	005	1	0
Navarro	003	1	0
Nueces	011	6	0
Orange	005	1	0
Palo Pinto	003	2	0
Parker	003	3	0
Potter	001	3	0
Rusk	004	0	0
Smith	004	2	0
Somervell	003	2	0
Tarrant	003	21	0
Taylor	002	1	0
Tom Green	009	2	0
Travis	007	3	0
Upshur	004	1	0
Val Verde	008	1	0
Victoria	008	1	0
Waller	006	1	0
Webb	011	3	0
Wharton	006	1	0
Willacy	011	1	0
Williamson	007	2	0
Total		211	0

Fatality Counts were frozen on 01/14/2019. Does not include corrections or updates, if any that may subsequently be made to DFPS data.

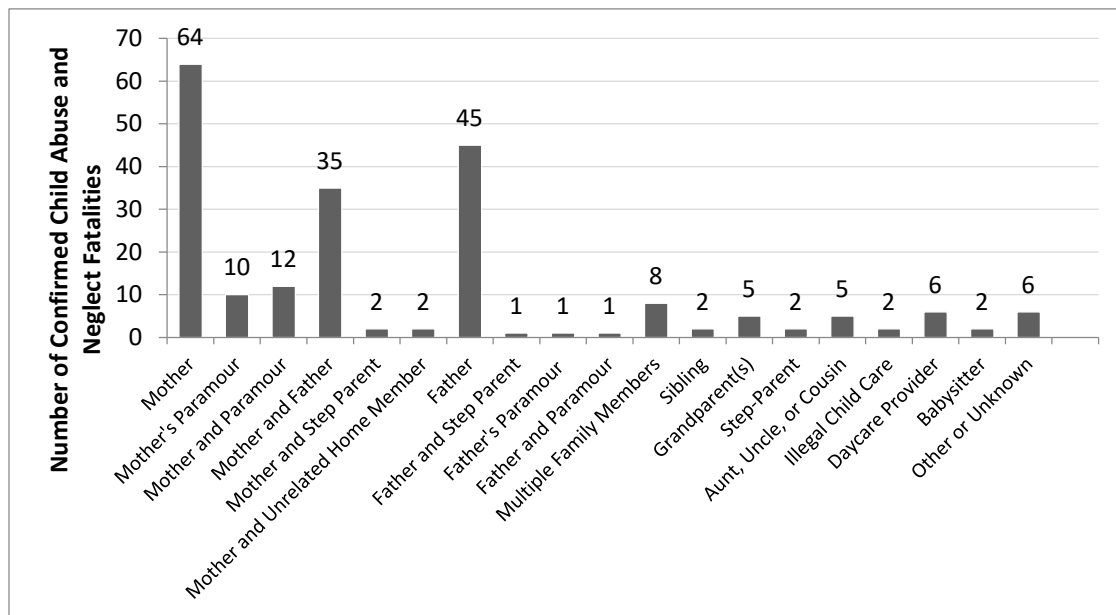
Includes child fatalities investigated and confirmed by Child Protective Investigations – Field Division (203) and Child Day Care Licensing (8).

FY2018 Perpetrator Demographic and Characteristics - Relationship and History

Perpetrators

- Physical abuse in fatalities most commonly involved blunt force trauma or intentional trauma inflicted by a father or boyfriend (combined represent 64 percent).
- In all confirmed cases of abuse and neglect, parents continue to be the most common perpetrators.
- In 54.5 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had no prior history with CPS. Since more than half of all perpetrators were unknown to CPS, it requires collaboration with families and communities to build a strong safety network that supports children, youth, and families.
- 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, related to neglectful supervision issues such as drowning and unsafe sleep, or issues related to physical neglect and medical neglect. (Table 8, 9).

Figure 13. FY2018 Relationship of Primary Perpetrator to Victim

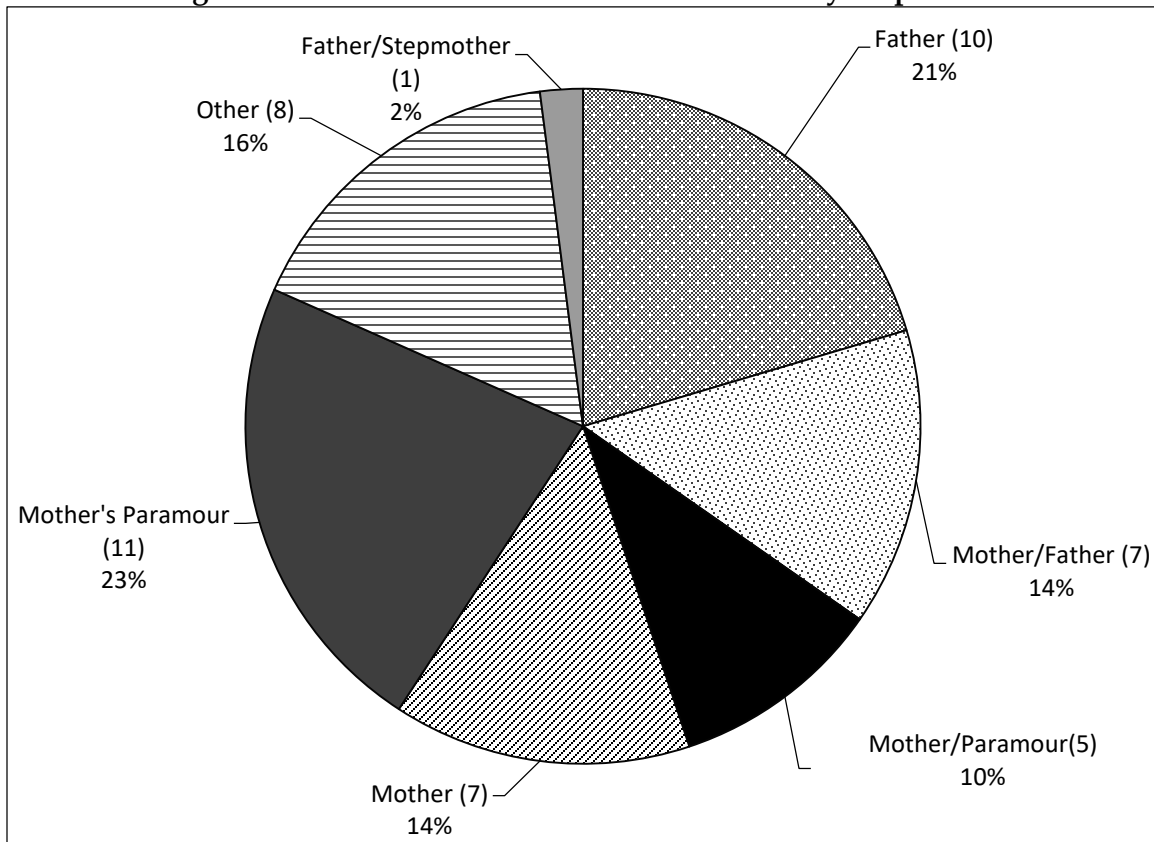


Source: DFPS individual case reviews

FY2018 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. FY2018 Blunt Force Trauma Fatalities by Perpetrator

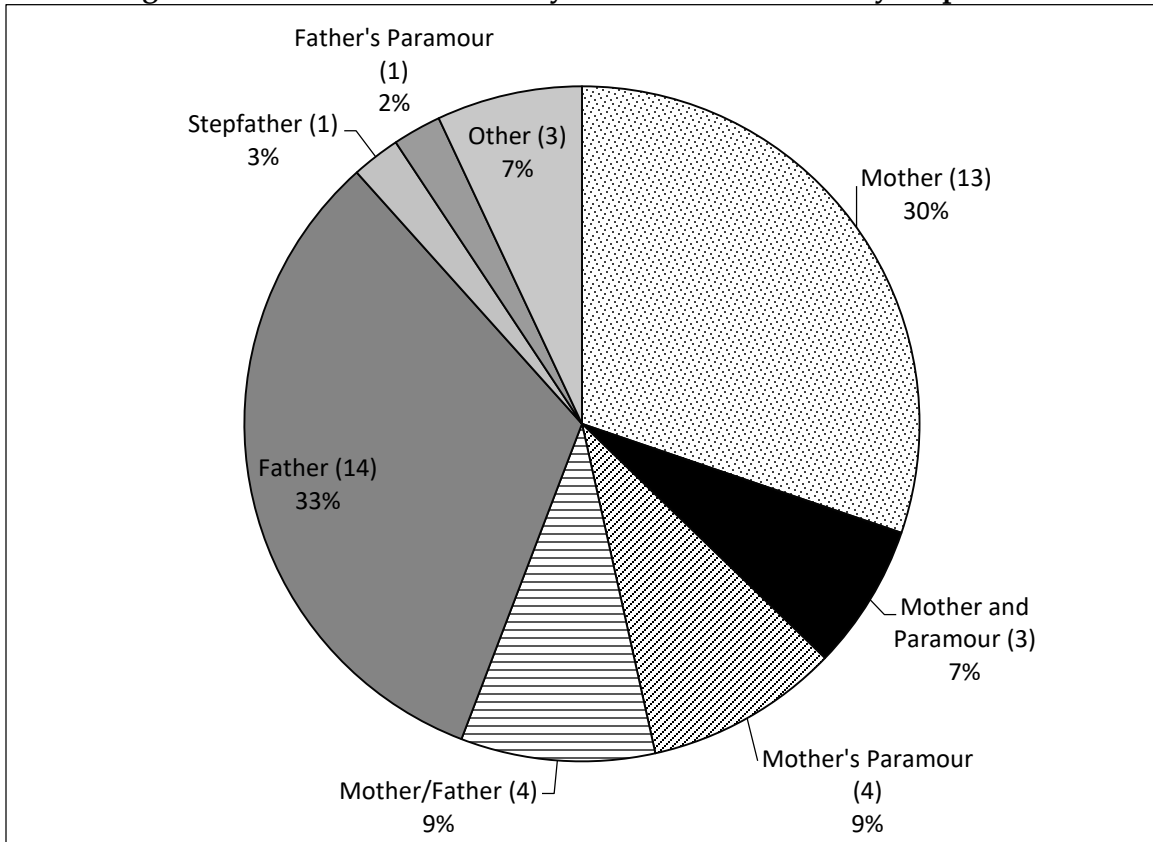


Number of victims: 49 children

Age range of victims: Newborn to 10-year-old child. 24 children were younger than one year old; 80% were age two or younger

Finding: Usually involve young children being physically abused by the father (37%) or a boyfriend (33%)

Figure 15. FY2018 Intentional Physical Abuse Fatalities by Perpetrator

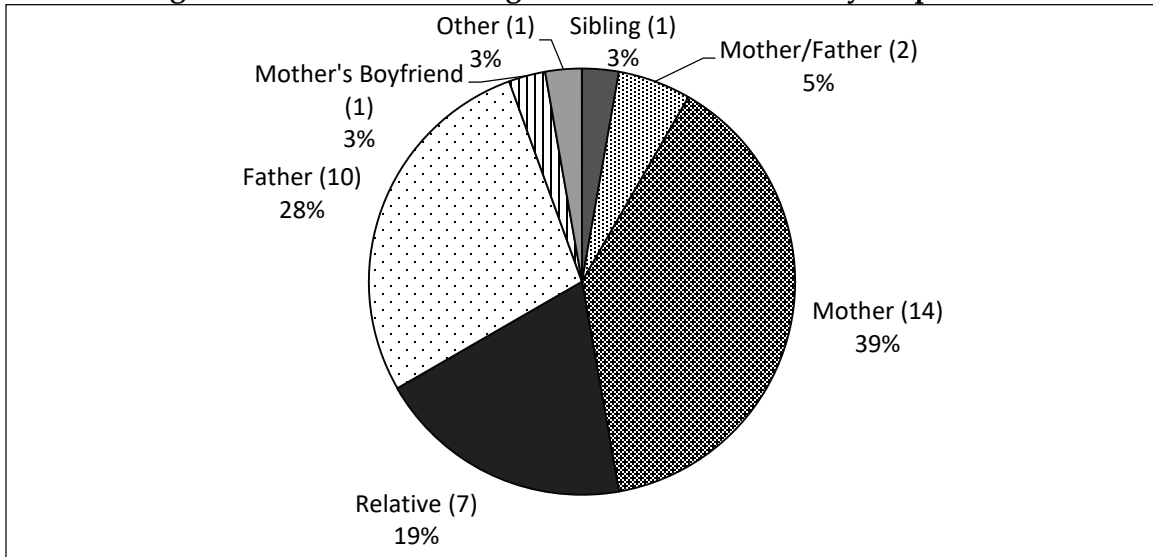


Number of victims: 43 children

Age range of victims: Newborn to 17-year-old youth. 26 children were age five and younger

Finding: Usually involved young children with primary perpetrator as mother (46.5%), father (44%), or boyfriend (19%).

Figure 16. FY2018 Drowning (Accidental) Fatalities by Perpetrator

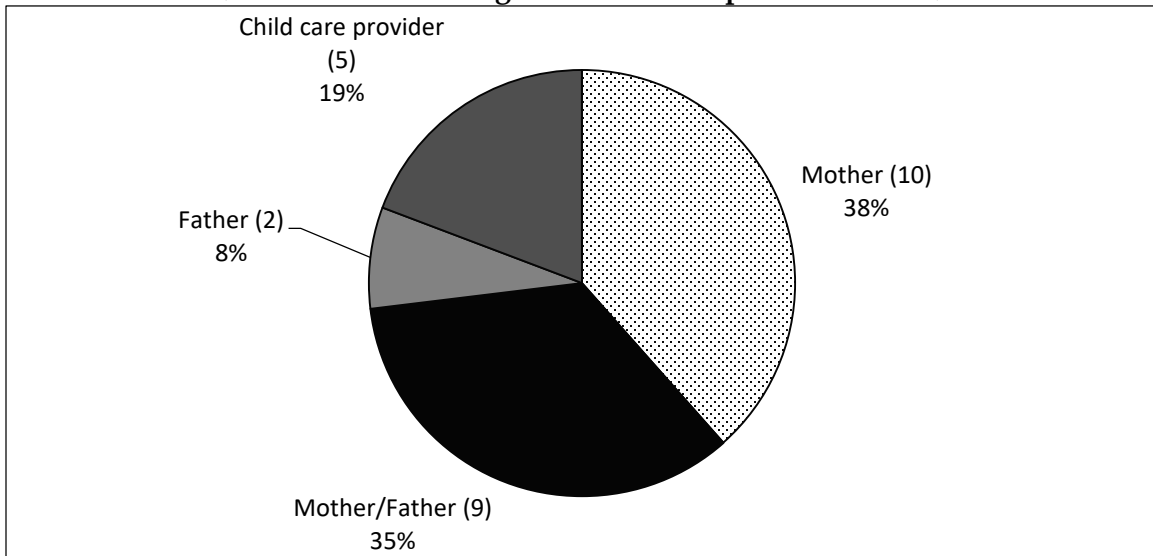


Number of victims: 36 children

Age range of victims: 2 month old to 8 years old. Thirty three children were 5 and younger (92%).

Finding: Usually involve young children with mother as primary perpetrator (44%)

Figure 17. FY2018 Unsafe Sleep Fatalities by Perpetrator (includes bed-sharing and unsafe sleep environments)

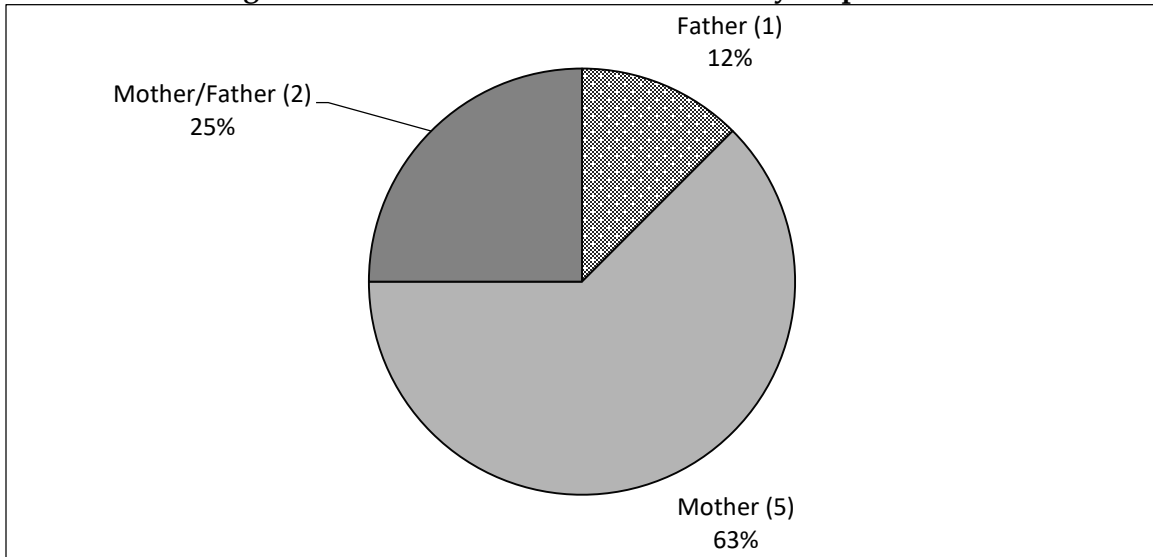


Number of victims: 26 children

Age range of victims: Newborn old to 6 months old

Finding: Involved infants with primary perpetrator generally the mother, father, or both mother and father.

Figure 18. FY2018 Fire Related Fatalities by Perpetrator

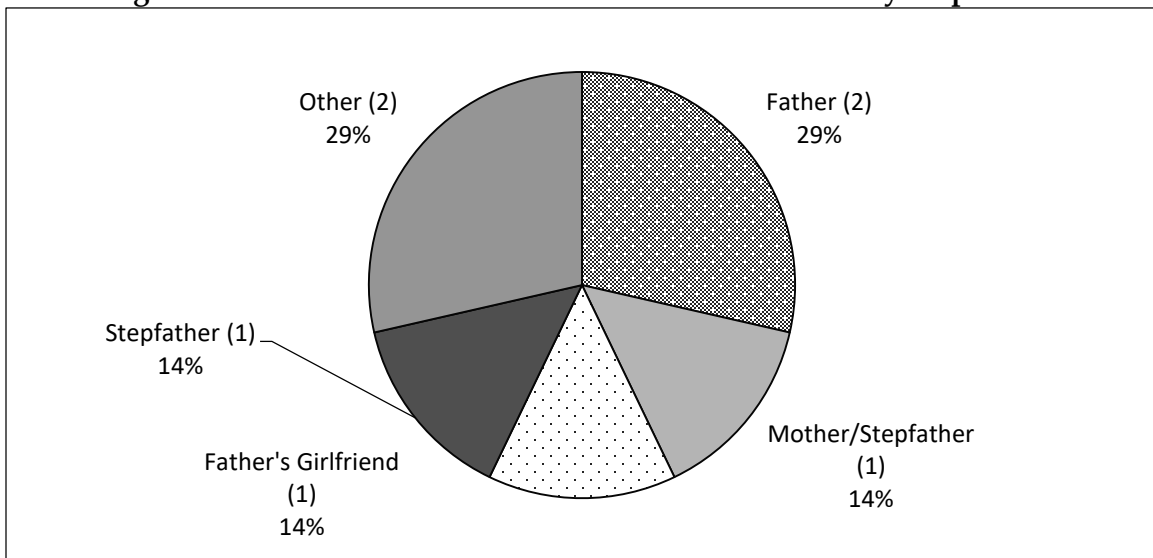


Number of victims: 8 children

Age range of victims: 8 months old to 12 years old

Finding: Usually happens while in care of the mother (63%), father (16%), or with both parents (25%).

Figure 19. FY2018 Firearm - Accidental Related Fatalities by Perpetrator

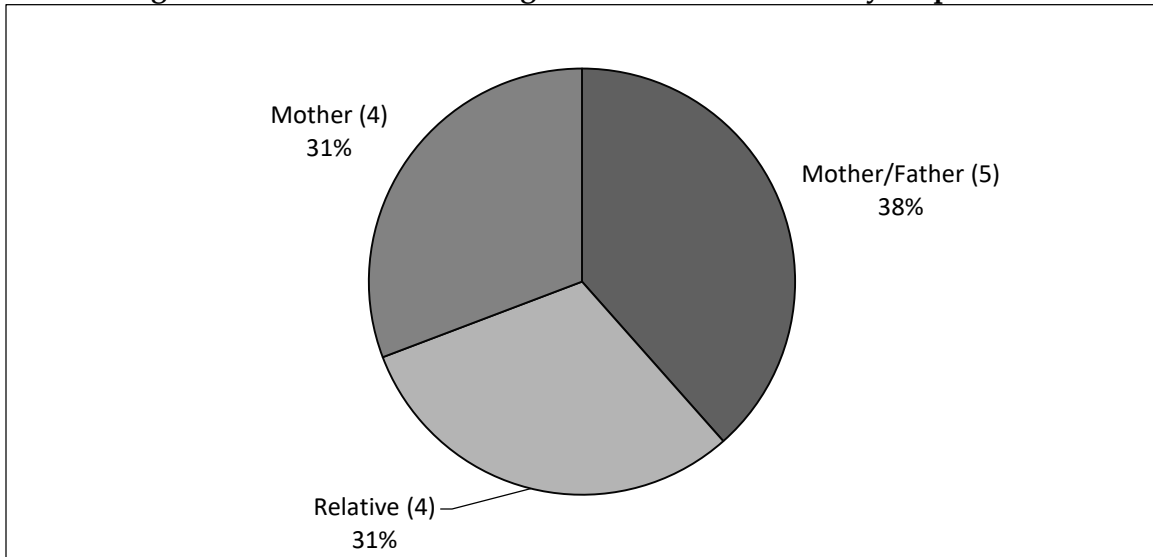


Number of victims: 7 children

Age range of victims: 2 years old to 15 years old

Finding: Usually happens while in care of the father (29%) or with an unrelated individual (71%).

Figure 20. FY2018 Medical Neglect - Related Fatalities by Perpetrator

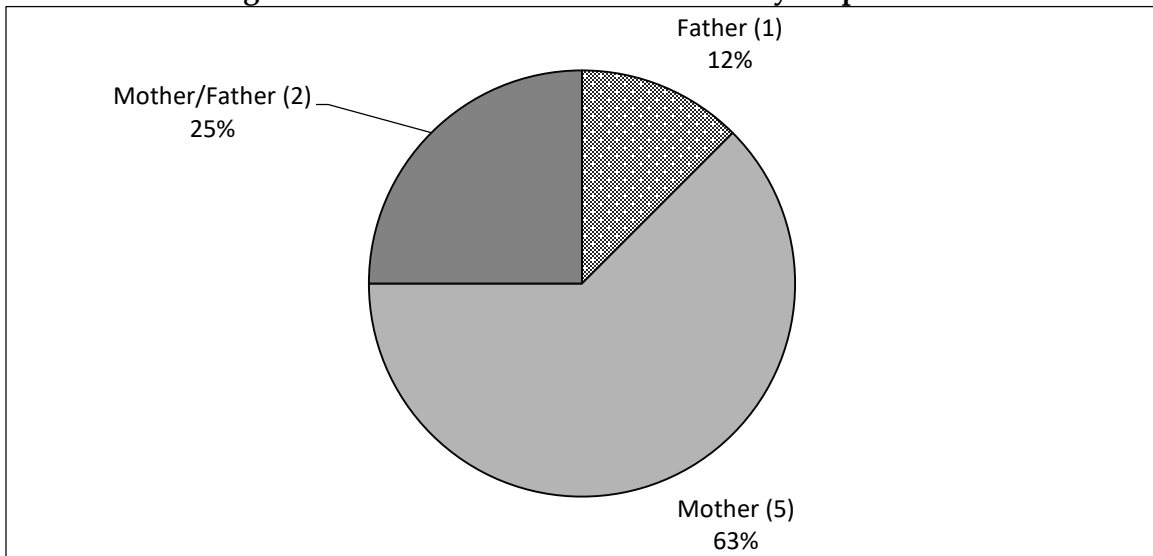


Number of victims: 13 children

Age range of victims: Newborn to 17 years old

Finding: Usually happens while in care of the mother (69%), father (31%), or relative (31%).

Figure 21. FY2018 Fire Related Fatalities by Perpetrator



Number of victims: 8 children

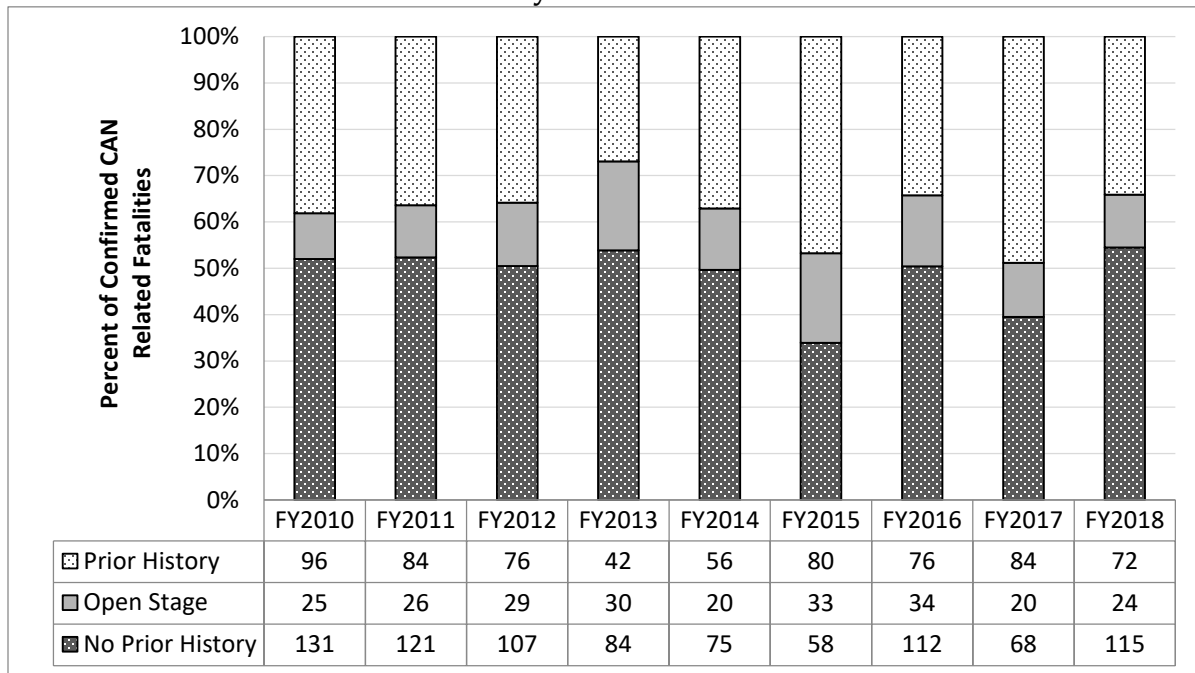
Age range of victims: 5 months old to 12 years old

Finding: Usually happens while in care of the mother (88%) or father (37%).

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 and or Child Protective Investigations (CPI). DFPS defines prior agency history broadly, if the deceased child or a designated perpetrator in the fatality had either been in a CPI investigation or received CPS services at any time before the child's death, meaning that under this definition, it counts as prior history even if the last contact 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 11 percent of the child abuse and neglect fatalities, CPS was involved with the family or the child at the time of the death. In 45.5 percent of confirmed child fatalities, CPS had been involved with the child or the perpetrator in the past.

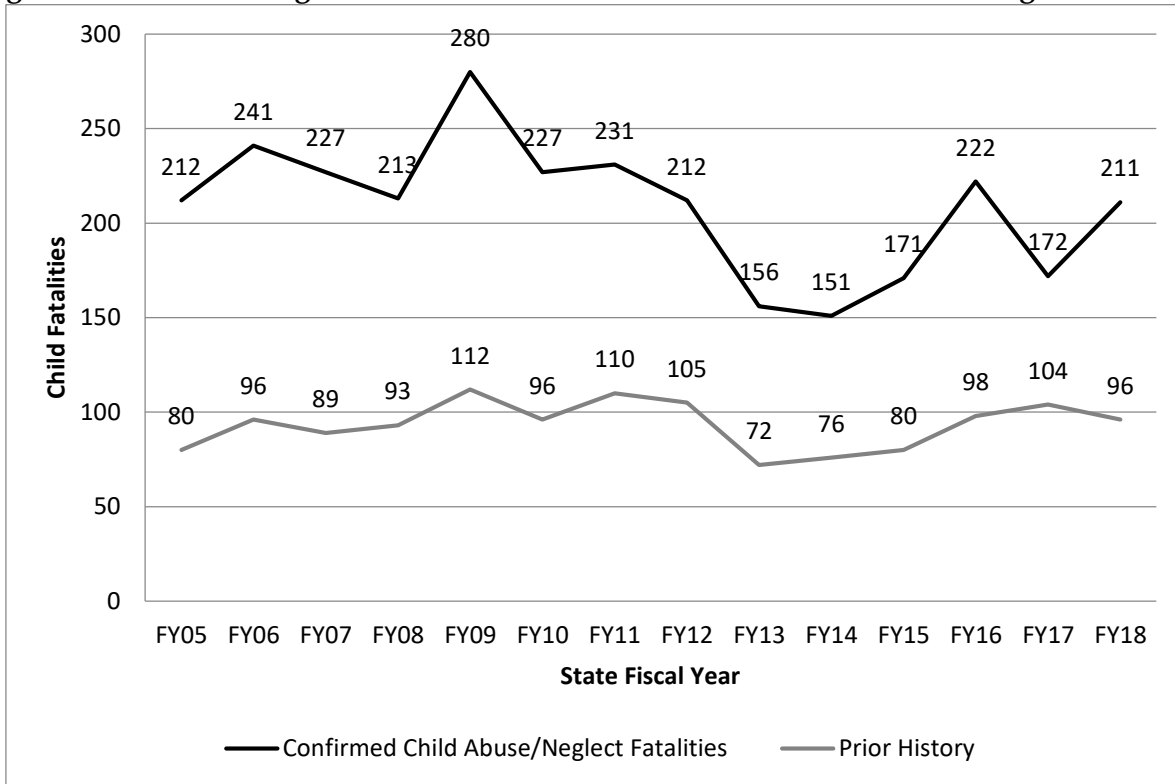
Figure 22. CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Fiscal Year



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 FY2018 often consisted of neglectful supervision/unintentional acts (12 fatalities) and physical abuse fatalities such as blunt force trauma or intentional homicide (10 fatalities).

Figure 23. DFPS Investigated Child Fatalities and Confirmed Child Abuse/Neglect Fatalities



Source: DFPS Data Warehouse Report FT_06

For FY2018, based on Figures 22-24, the following themes are noted:

- 24 children's families were involved with CPS at the time of death.
 - 10 of the children were in an active investigation when a new incident of abuse or neglect occurred leading to the fatality; one child was in an active alternative response stage when a new incident of abuse or neglect occurred leading to the fatality;
 - Eight of the children were in an active Family Based Safety Services stage when a new incident of abuse or neglect occurred leading to the fatality
 - Five of the children or their family was involved in an active conservatorship stage at the time of the fatality
 - **There were no fatalities of children in foster care during FY2018.**
 - Two children had a sibling in foster care and a new incident of fatal neglectful supervision occurred with one of the children who remained in the care of the parents
 - One child was in a kinship placement when a new incident occurred at this placement that lead to the fatality; one child was in a kinship placement but the fatality was related to the ongoing medical neglect by the parents and not the kinship caregiver
 - One child was in a monitored return home with their parent and a new incident occurred once returned home that lead to the fatality

- For families with prior history, the majority had only one worker assigned during the family's last involvement with DFPS (85 percent) and caseloads were often at 20 cases or fewer per staff member assigned.
 - Thirteen families had two workers assigned and two families had three workers assigned.
 - Starting caseloads: 40 with 10 or fewer cases; 40 with 11-20 cases; 10 with more than 20 cases; 16 were unknown due to the age of the history or the staff member in transition between units.
 - Ending caseloads: 28 with 10 or fewer cases; 46 with 11-20 cases; 16 with more than 20 cases; 16 were unknown due to the age of the history or the staff member in transition between units.
- In the 96 child fatalities with prior history:
 - 43 families had prior involvement with Family Based Safety Services (FBSS).
 - 36 involved the deceased child and a prior safety plan that required the parents or their significant other was to have supervised contact with the children. 78 percent of safety plans were documented as being followed during the family's involvement with DFPS.
 - On average, families were seen monthly, with their involvement in FBSS ranging from 3 months to one year. In general, these cases had few attempted initial visits as the policy and practice is to work collaboratively with Investigations and the family to engage in FBSS services at case transfer.
 - Services offered in the previous or open stage include:
 - Counseling for family, individual, or group: 37 cases
 - Crisis intervention counseling: 2 cases
 - Daycare or respite care: 4 cases
 - Domestic violence shelter or counseling: 11 cases
 - Drug testing or treatment: 37 cases
 - Family support services: 2 cases
 - Infant or early childhood screening or development services: 6 cases
 - Mental health (psychological testing, mental health assessment or treatment, referral to local mental health authority): 23 cases
 - Parenting skills / evidence-based parent education: 36 cases
 - Other (support groups, referrals, community based services): 20 cases
 - 67 percent of families that had been involved with FBSS were reportedly fully compliant or partially compliant with their service plan.

**Figure 24. FY2018 Department of Family and Protective Services (DFPS)
Data on Child Abuse and Neglect Related Fatalities Statewide**

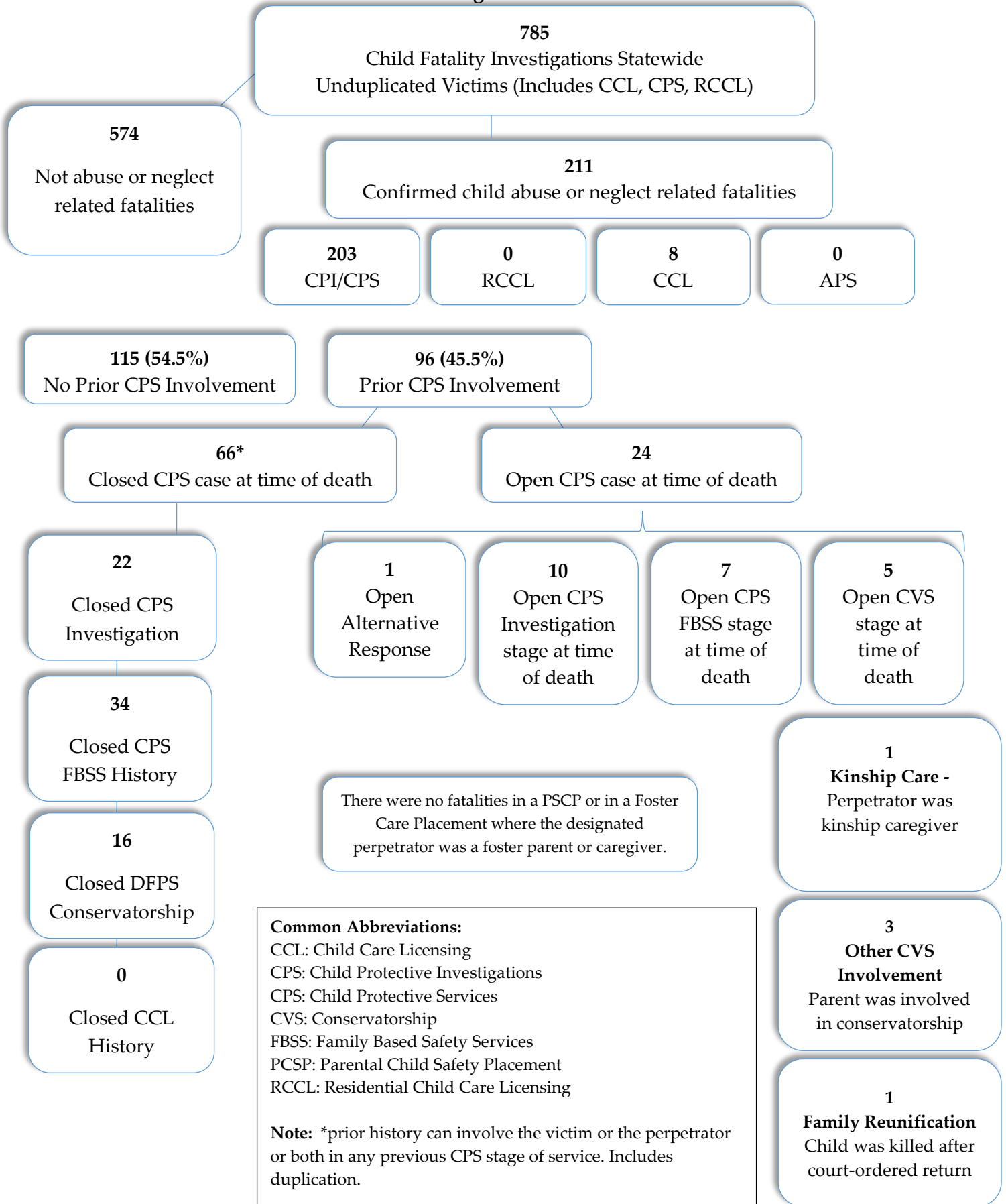
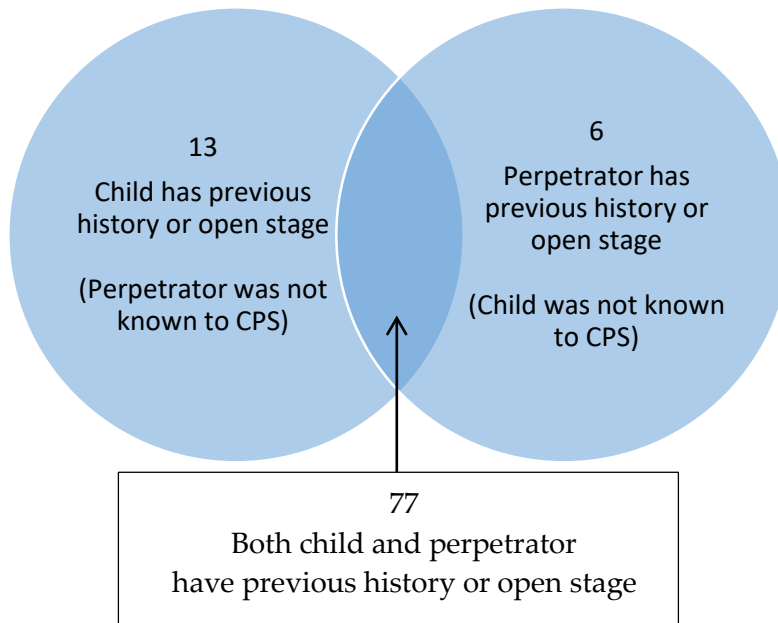
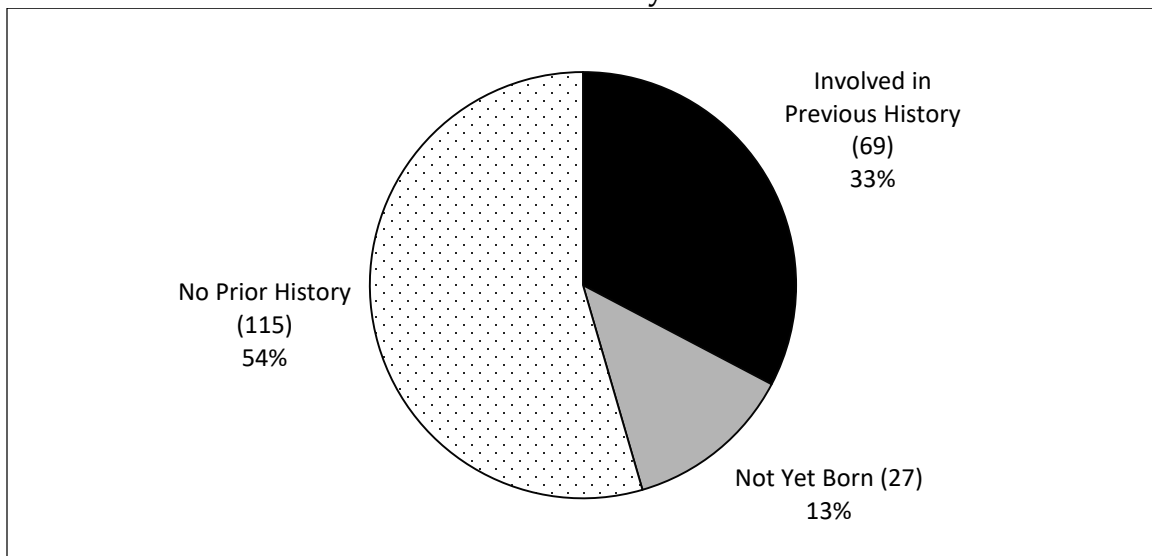


Figure 25. FY2018 Prior History by Child/Perpetrator with Previous Involvement



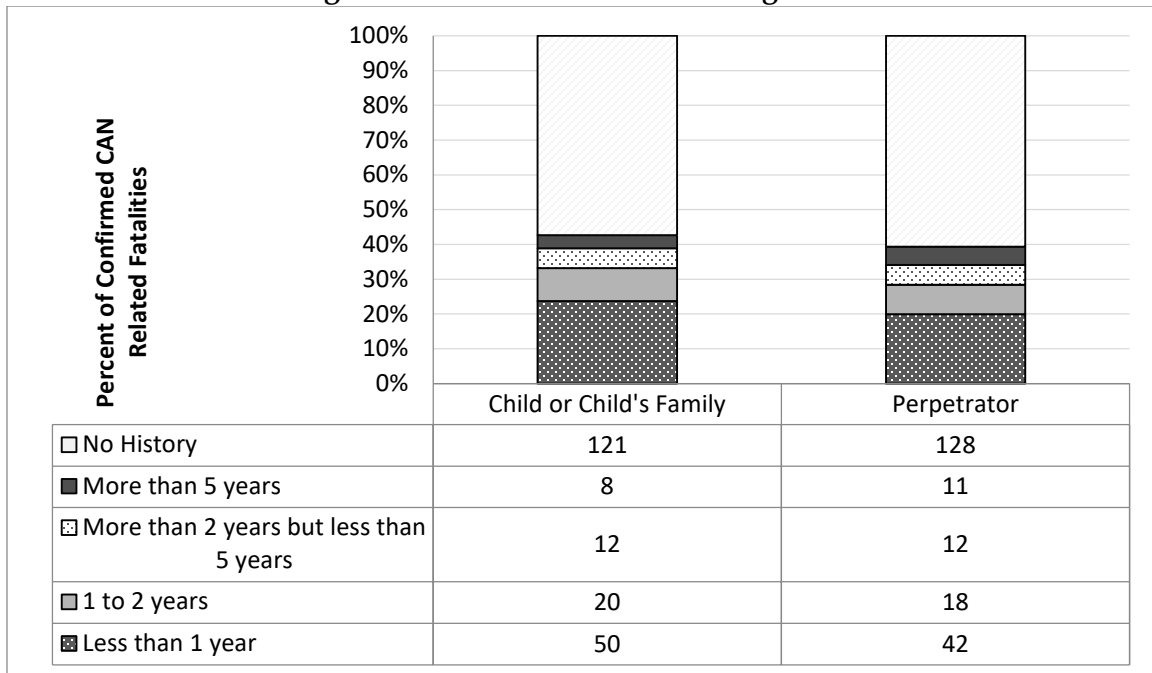
Source: DFPS individual case reviews – includes history that may be purged from IMPACT but referenced in case narrative.

Figure 26. FY2018 Prior History Where Deceased Child was Present in Previous Involvement with Family



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

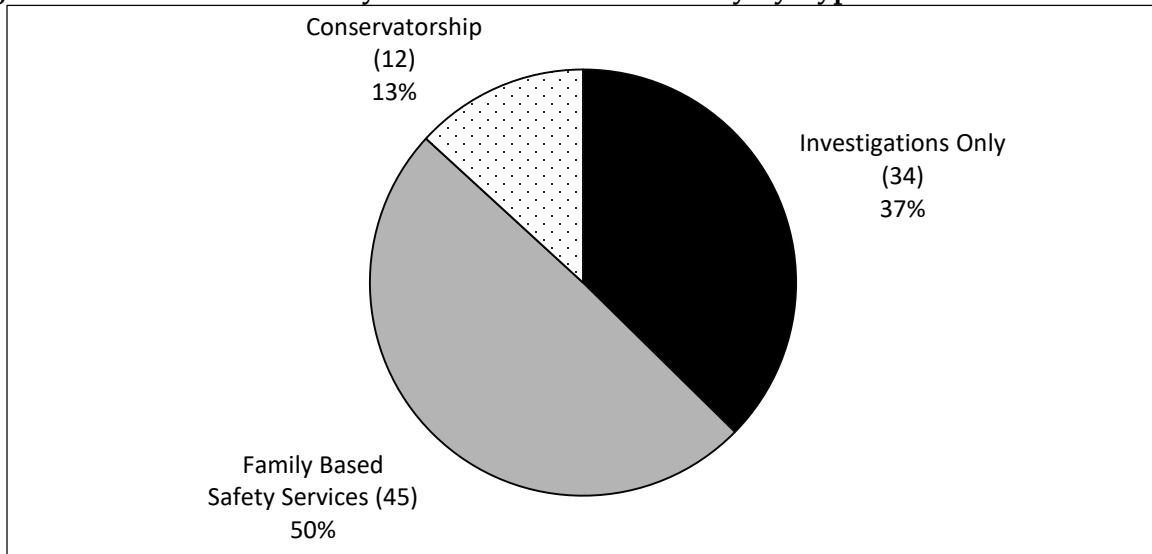
Figure 27. FY2018 CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Length of Time since Last Active Stage Closed



Source: DFPS individual case reviews

Note: The figure above regard history for the child or the child's family in accordance with Texas Family Code Sec. 264.5032. Report on Child Fatality and Near Fatality Data

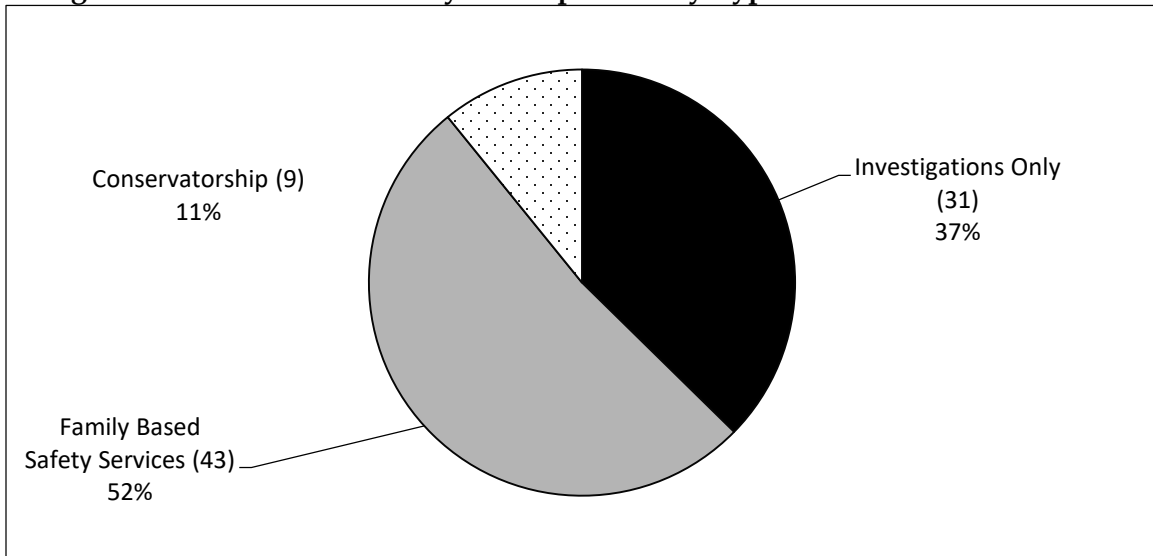
Figure 28. FY2018 Prior History for Child or Child's Family by Type of Previous Involvement



Source: DFPS individual case reviews

Note: The figure above regards history for the child or the child's family in accordance with Texas Family Code Sec. 264.5032. Report on Child Fatality and Near Fatality Data

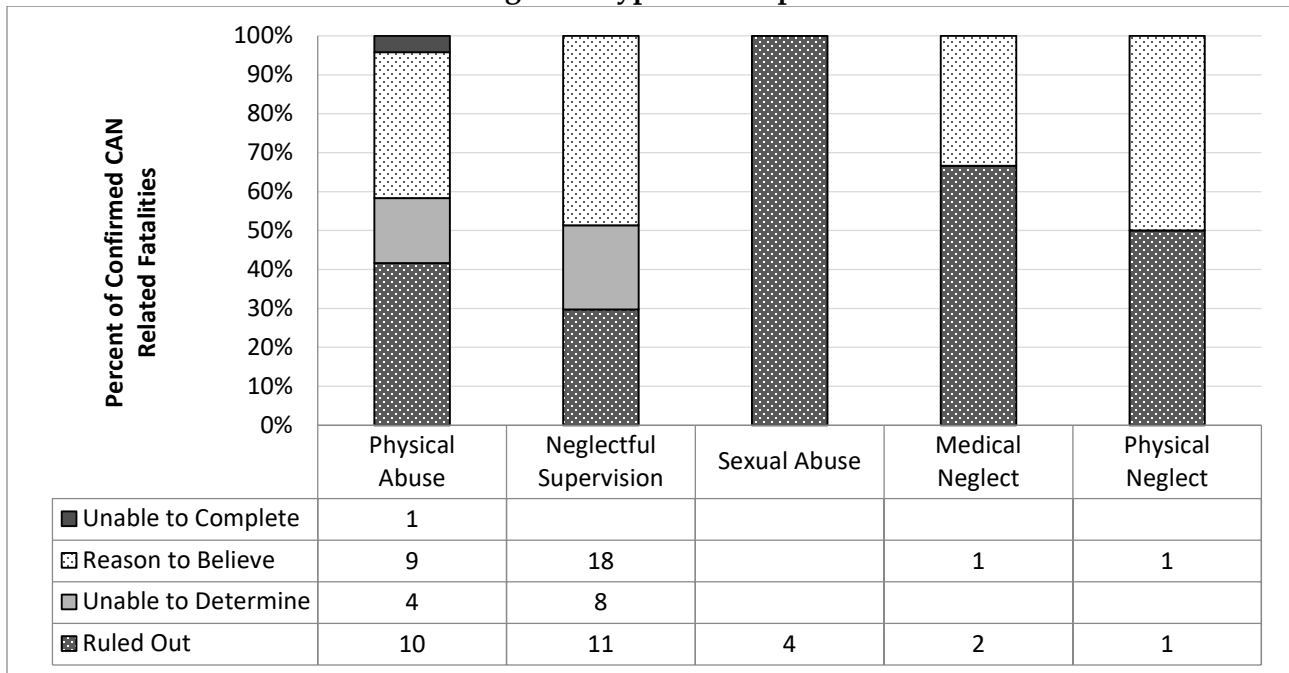
Figure 29. FY2018 Prior History for Perpetrator by Type of Previous Involvement



Source: DFPS individual case reviews

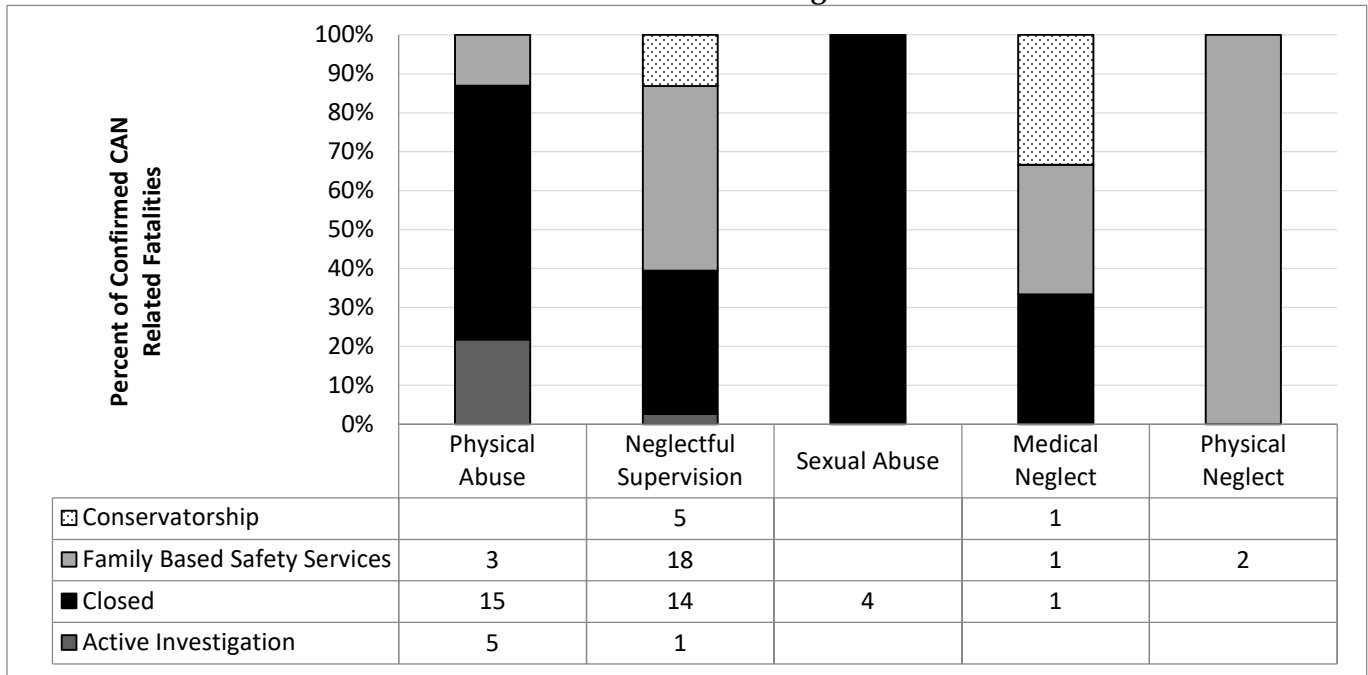
Note: The figure above regards history for the child or the child’s family in accordance with Texas Family Code Sec. 264.5032. Report on Child Fatality and Near Fatality Data

Figure 30. FY2018 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or Child’s Family in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



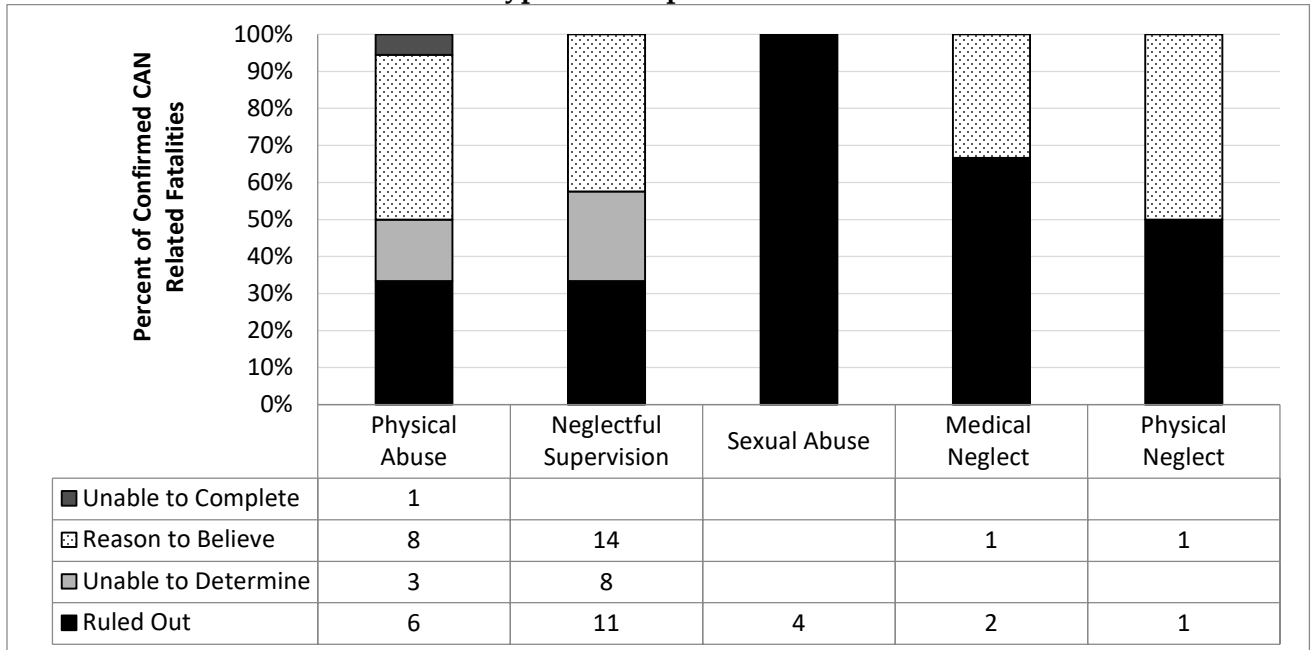
Source: DFPS individual case reviews

Figure 31. FY2018 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or the Child’s Family in the Two Years Prior to Fatality, by Outcome of Prior Investigation



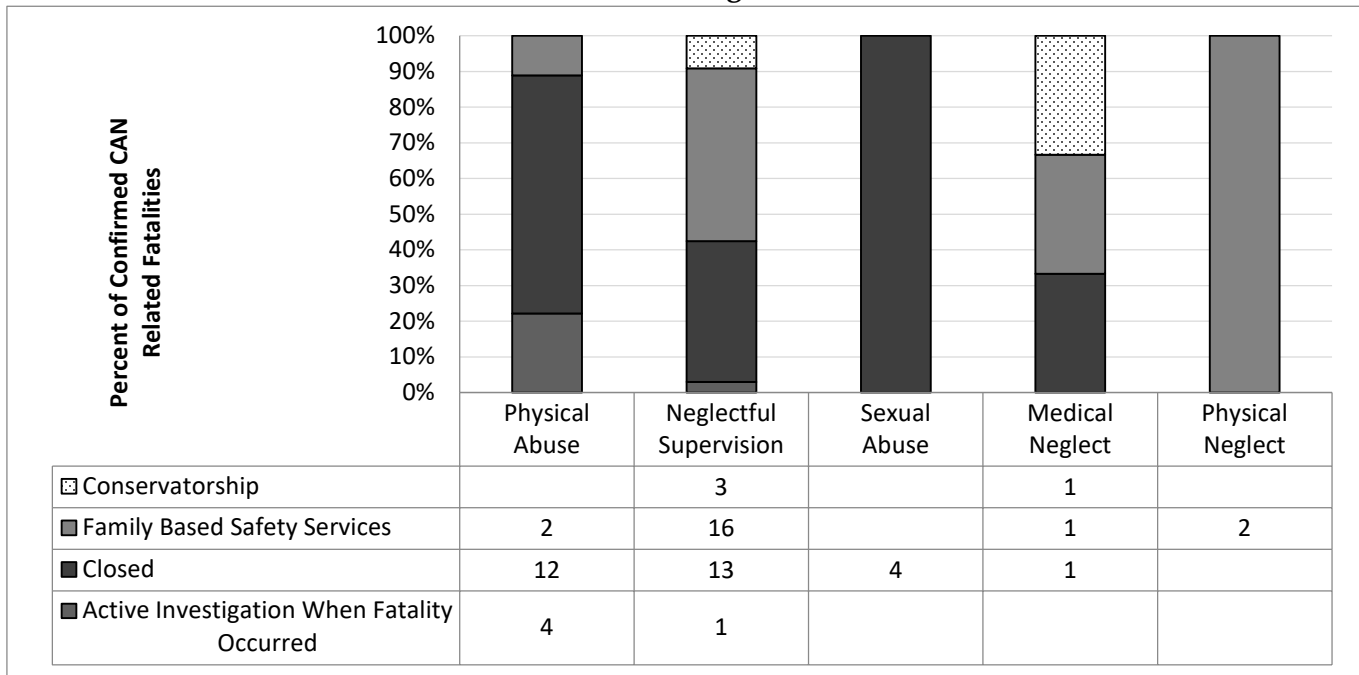
Source: DFPS individual case reviews

Figure 32. FY2018 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



Source: DFPS individual case reviews

Figure 33. FY2018 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



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 FY2018, this pattern is also repeated in the subset of confirmed fatalities where the child or perpetrator had history with DFPS in the previous two years..

- When the perpetrator or the child was previously known to DFPS, the child fatality is often related to physical abuse, neglect, drowning, or unsafe sleep.
- When the child was previously known to DFPS because of prior physical abuse allegations, 60 percent were involved in a new incident of physical abuse which caused the fatality. In comparison, when the prior allegation was neglectful supervision, 45 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 allegations, 66 percent were involved in a new incident of physical abuse which caused the fatality. In comparison, when the prior allegation was neglectful supervision, 46 percent were involved in a new incident of physical abuse which caused the fatality.

Table 8. FY2018 Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or Child’s Family in the Two Years Prior to Fatality, by Prior Allegation Type and Cause of Fatality

	Drowning Related	Unsafe Sleep Related	Vehicle Related	Physical Abuse	Other	Total
Prior Physical Abuse Allegation	5	2	1	17	3	28
Prior Neglectful Supervision Allegation	5	7	1	17	8	38
Prior Sexual Abuse Allegation	1	2	1			4
Prior Medical Neglect Allegation				2	3	5
Prior Physical Neglect Allegation			1		1	2
Prior Alternative Response						0
Total with History	11	11	4	36	15	77
<i>No Prior History or History Greater than Two Years</i>	25	15	7	56	31	134
<i>Overall Total</i>	36	26	11	92	46	211

Source: DFPS individual case reviews

Table 9. FY2018 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	1	14	2	21
Prior Neglectful Supervision Allegation	4	7	1	16	7	35
Prior Sexual Abuse Allegation	1	2	1	1		5
Prior Medical Neglect Allegation				1	2	3
Prior Physical Neglect Allegation			1	1	1	3
Prior Alternative Response						0
Total with History	8	10	4	33	12	67
<i>No Prior History or History Greater than Two Years</i>	28	16	7	59	34	144
<i>Overall Total</i>	36	26	11	92	46	211

Source: DFPS individual case reviews

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

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. Aggregate information to analyze child fatalities in which abuse or neglect occurred but did not cause the fatality can be used to develop specific prevention and intervention services.

Further analysis and individual case readings in these types of investigations are a useful tool to inform strategies to prevent child fatalities. These cases continue to have similar demographics in FY2018 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 persistent difference is that victims in this category are often three months of age or younger.

General Findings

- In FY2018, there were 122 child fatalities where the death was not related to abuse or neglect, but the investigation found abuse or neglect had occurred in the home.
- 79 child fatalities where the death was not related to abuse or neglect had some form of prior history (65 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.

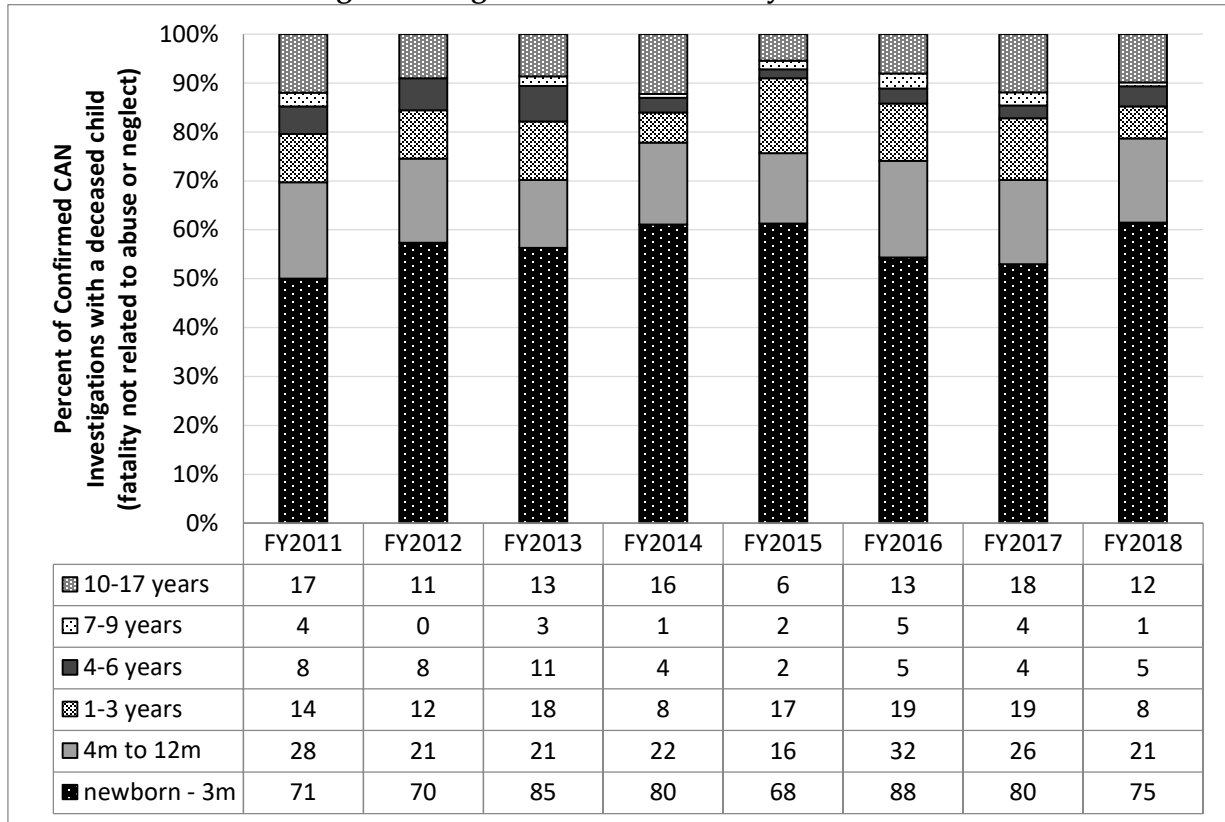
Victim Children

- 13 of the 122 children were previous alleged victims but allegations were not confirmed in prior cases.
- 16 of the 122 children were previously confirmed victims in prior cases.
- 11 of the 122 children were involved in Family Based Safety Services previously and three had been involved in DFPS conservatorship.

Perpetrators

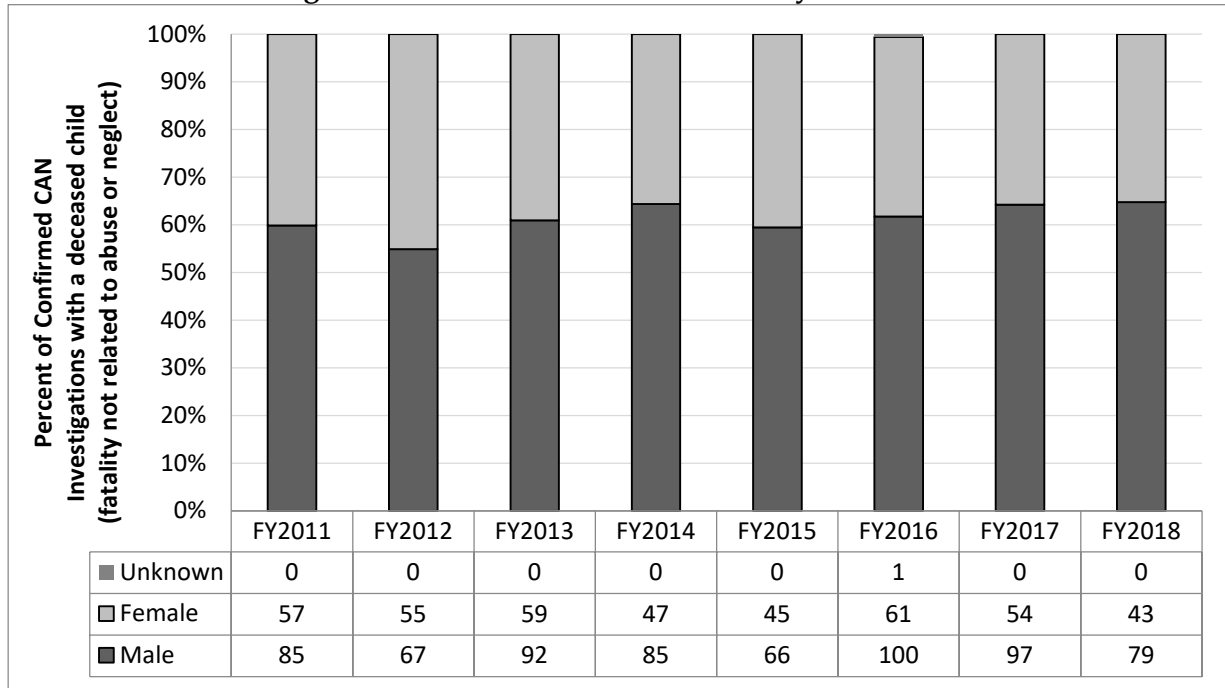
- 26 of the confirmed perpetrators were previously alleged perpetrators but allegations were not confirmed in prior cases.
- 41 of the confirmed perpetrators were previously confirmed perpetrators in prior cases.
 - The cause of death in these 41 confirmed cases were: natural, health-related, undetermined, vehicle accident, accidental drowning.

Figure 34. Age of Child at Death by Fiscal Year



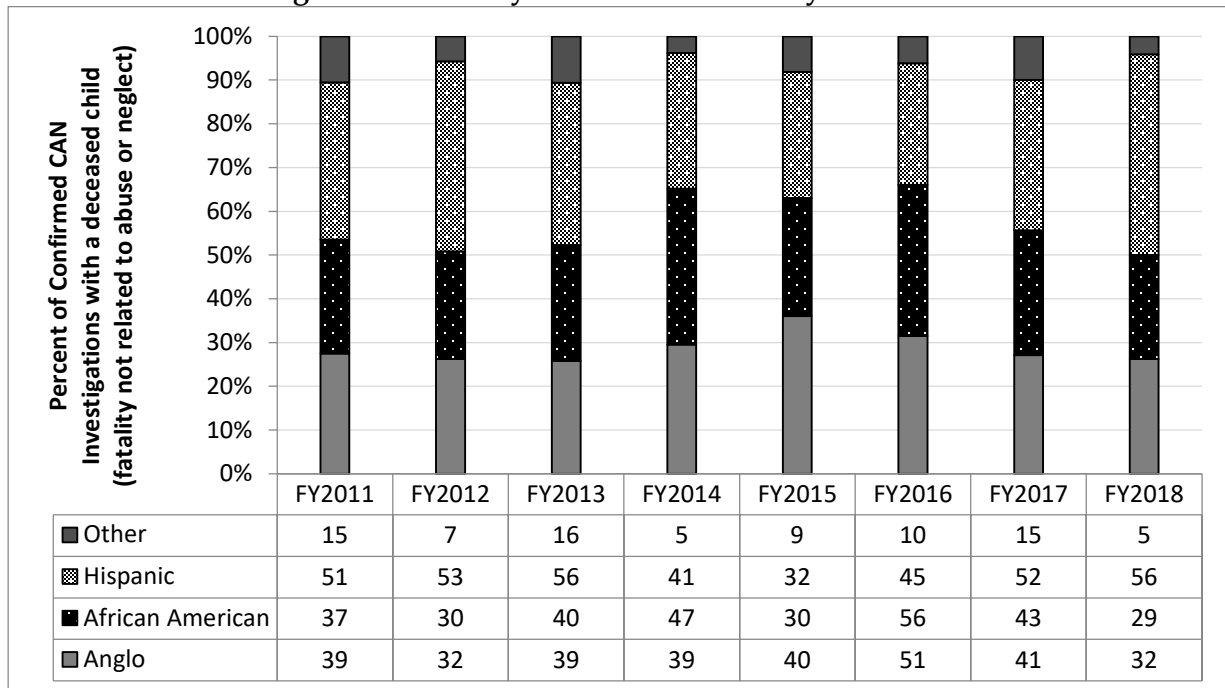
Source: DFPS Data Warehouse Report ft_12

Figure 35. Gender of Deceased Child by Fiscal Year



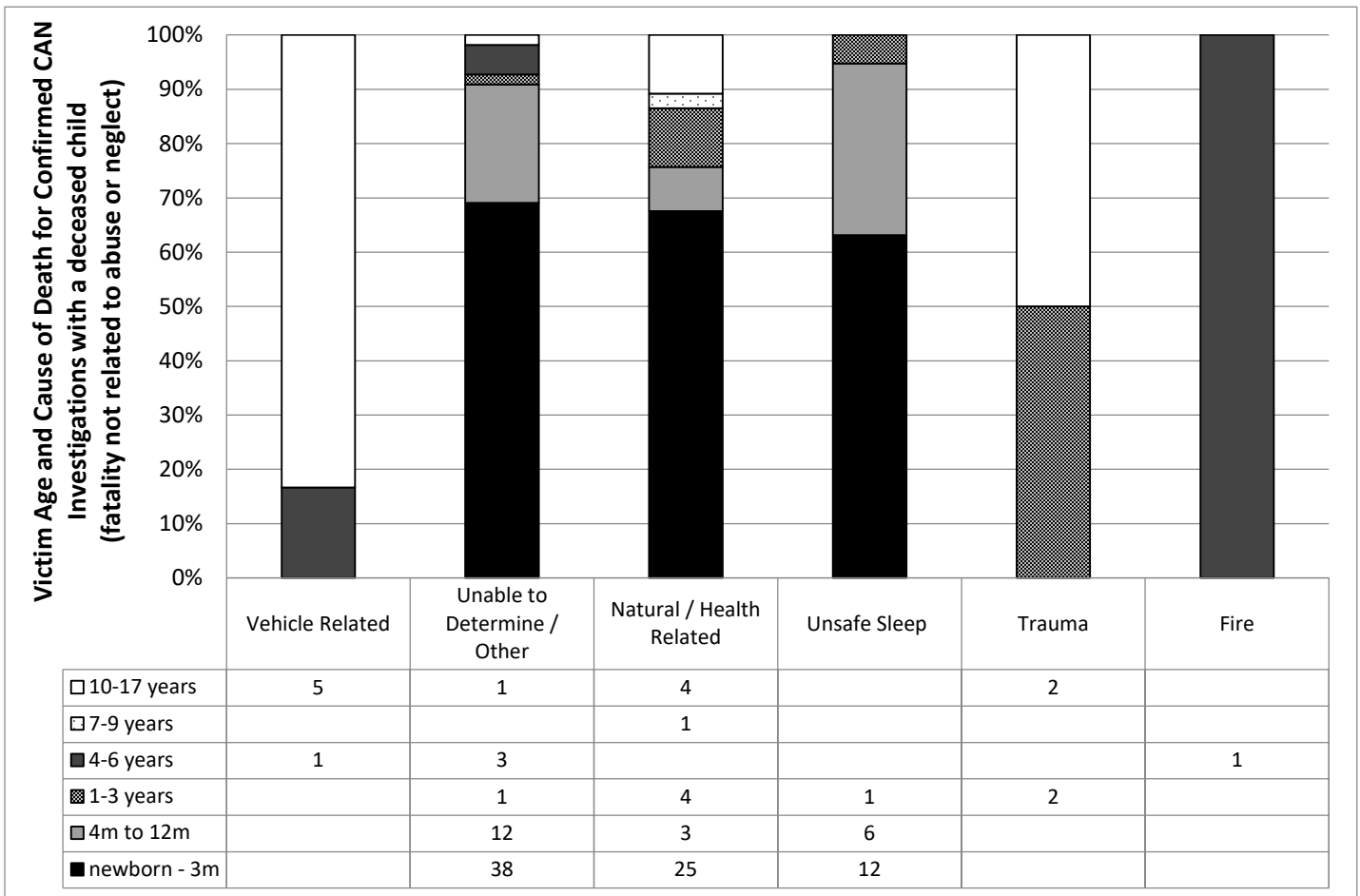
Source: DFPS Data Warehouse Report ft_12

Figure 36. Ethnicity of Deceased Child by Fiscal Year



Source: DFPS Data Warehouse Report ft_12

Figure 37. FY2018 - 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



Source: DFPS Data Warehouse Report ft_12

Child Fatalities in Texas within the National Context

Varying definitions of abuse and neglect among states: The Children's Bureau of the U.S. Department of Health and Human Services publishes [Child Maltreatment](#)⁶, an annual report comprising data from the National Child Abuse and Neglect Data System (NCANDS).⁷ 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.⁸

Texas's definition of abuse and neglect is broad. Texas has broad abuse and neglect definitions and mandatory reporting so that any child fatality alleged to involve abuse or neglect is investigated. If the death is a confirmed child abuse or neglect related fatality it is reported to NCANDS. Texas is able to do this by:

- 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;⁹
- investigating any report of child abuse or neglect allegedly committed by a person responsible for a child's care, custody, or welfare;¹⁰
- including in the definition of child abuse and neglect the use of a controlled substance¹¹ and defining medical neglect as the failure to *seek, obtain, or follow through* with medical care for the child;¹² 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 capita compared to a national average of 2.36 confirmed child abuse and neglect related fatalities per capita. It is important to note that for federal reporting, not all states report data and child fatalities during the federal fiscal year. Also, there are not common reporting and definition requirements when calculating child fatalities; it has been estimated that as many as 50 percent to 60 percent of child deaths resulting from abuse or neglect are not recorded.¹³ Some states do not even report at all; for example, in the annual federal *Child Maltreatment 2017* 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 time periods.

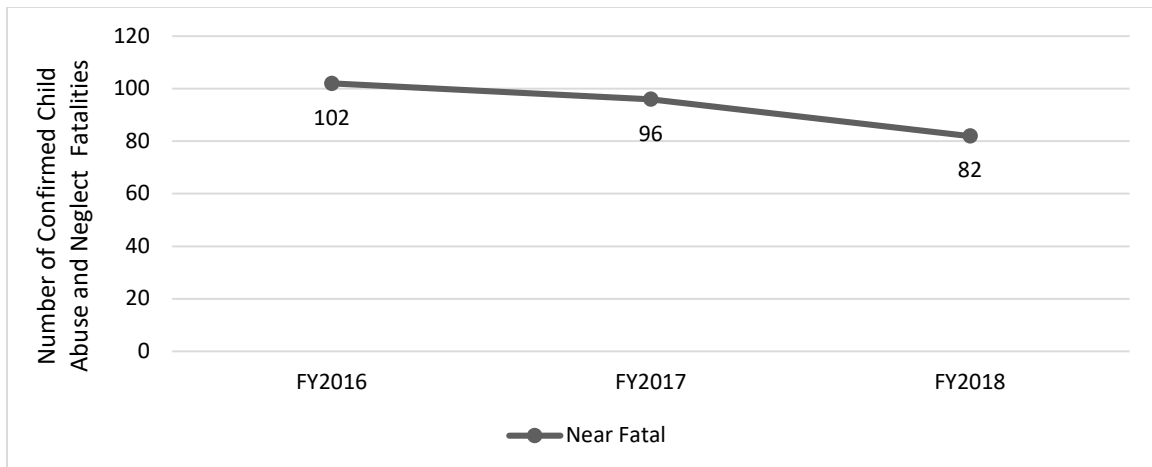
Near Fatalities

In the 85th Texas Legislature, House Bill 1549 included collecting additional details on near fatalities in addition to confirmed child maltreatment fatalities.

In FY2018, Texas had 82 confirmed abuse and neglect-related near fatalities, a decrease of 14.6 percent compared to FY2017. The largest decrease was seen in non-fatal drownings which dropped 33.3 percent compared to FY2017. This may be in part due to increased public awareness campaigns and services through both DFPS Prevention and Early Intervention and non-profit organizations within the community. Additionally, close collaboration between the Forensic Assessment Center Network (FACN), child abuse pediatricians, and DFPS has aided in more accurately identifying consistent definitions and determinations when a child was in critical or serious condition due to abuse or neglect.

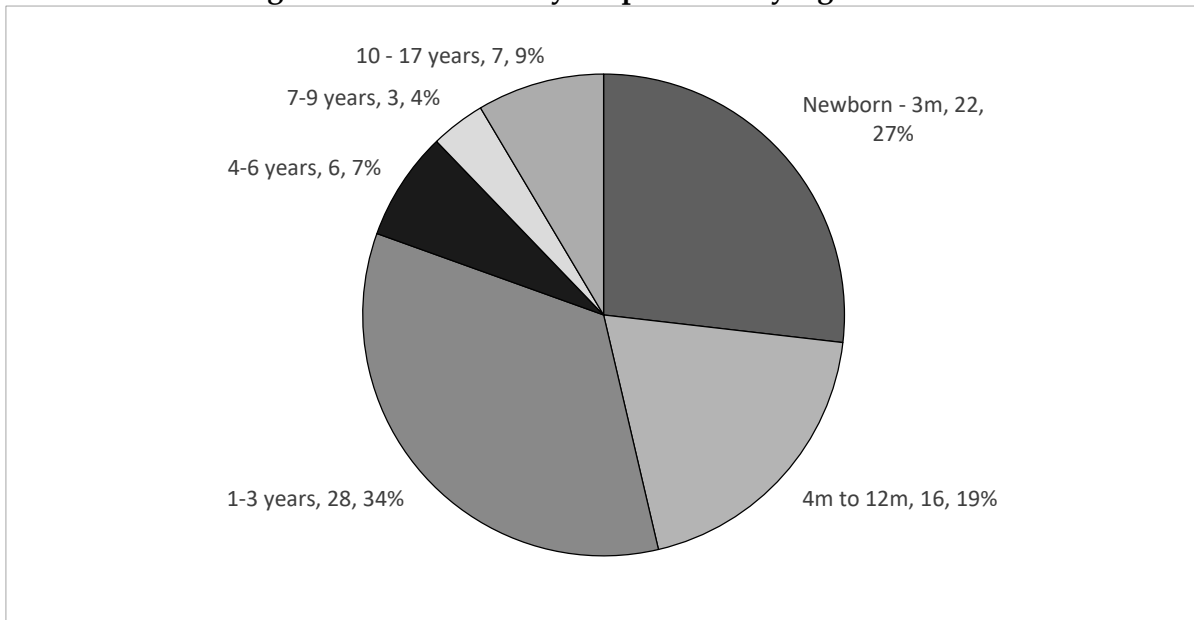
Boys comprise 51 percent of children whose maltreatment is determined to be near fatal. Eighty percent of children with a near fatal determination were age 3 or under. The highest number of abuse and neglect-related near fatalities were seen in Region 6 (Greater Houston) with 22 near fatalities. Region 8 (San Antonio) had 16 near fatalities, followed by Region 7 (Austin) with 11 near fatalities. The most common cause of abuse and neglect-related near fatalities involved physical abuse to include blunt force, inflicted trauma and Abusive Head Injury also known as Shaken Baby Syndrome.

Figure 38. Abuse/Neglect Related Near Fatalities by Fiscal Year



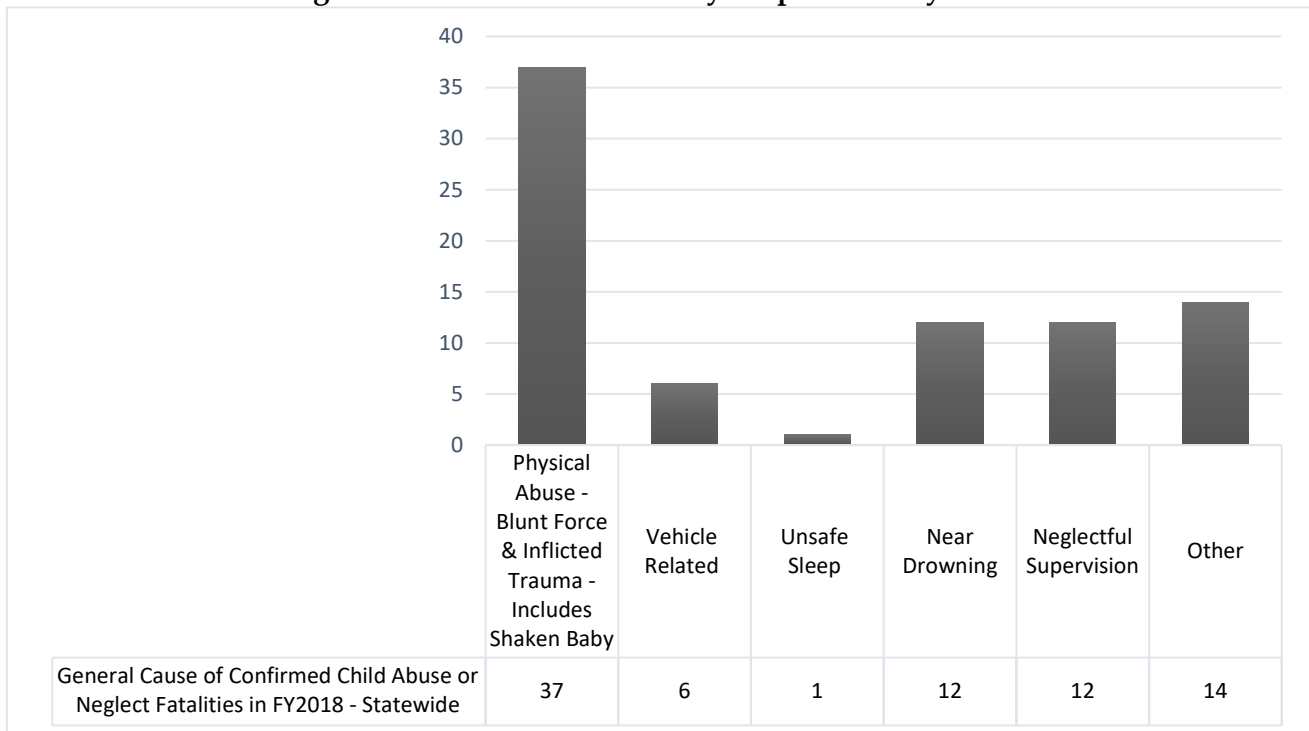
Source: DFPS individual case reviews

Figure 349. Near Fatality Dispositions by Age of Child



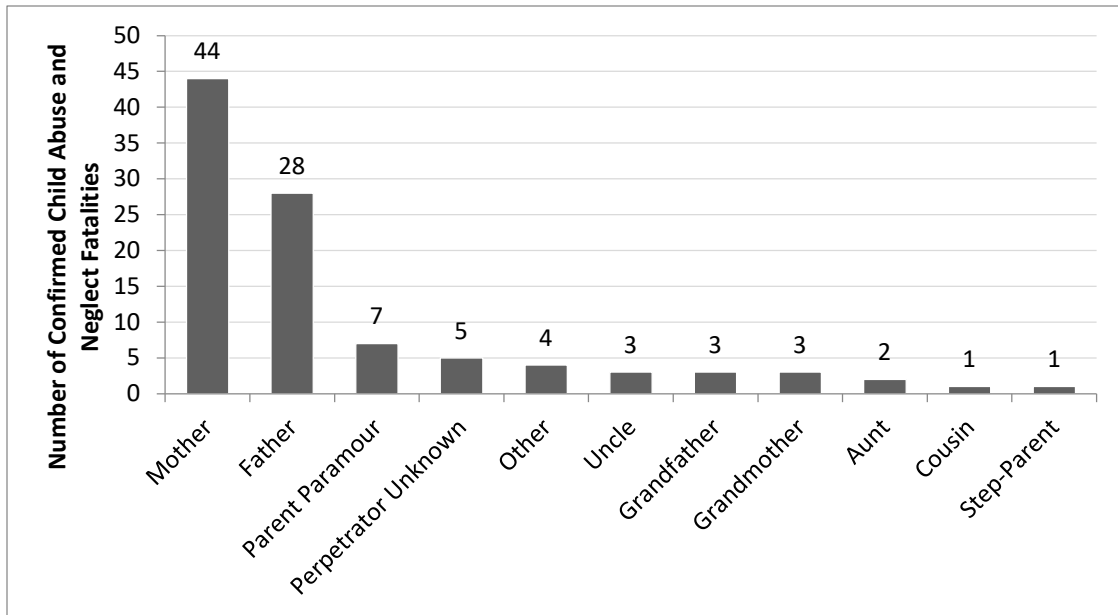
Source: DFPS individual case reviews and Data Warehouse nf_01

Figure 40. FY2018 – Near Fatality Dispositions by Cause



Source: DFPS individual case reviews

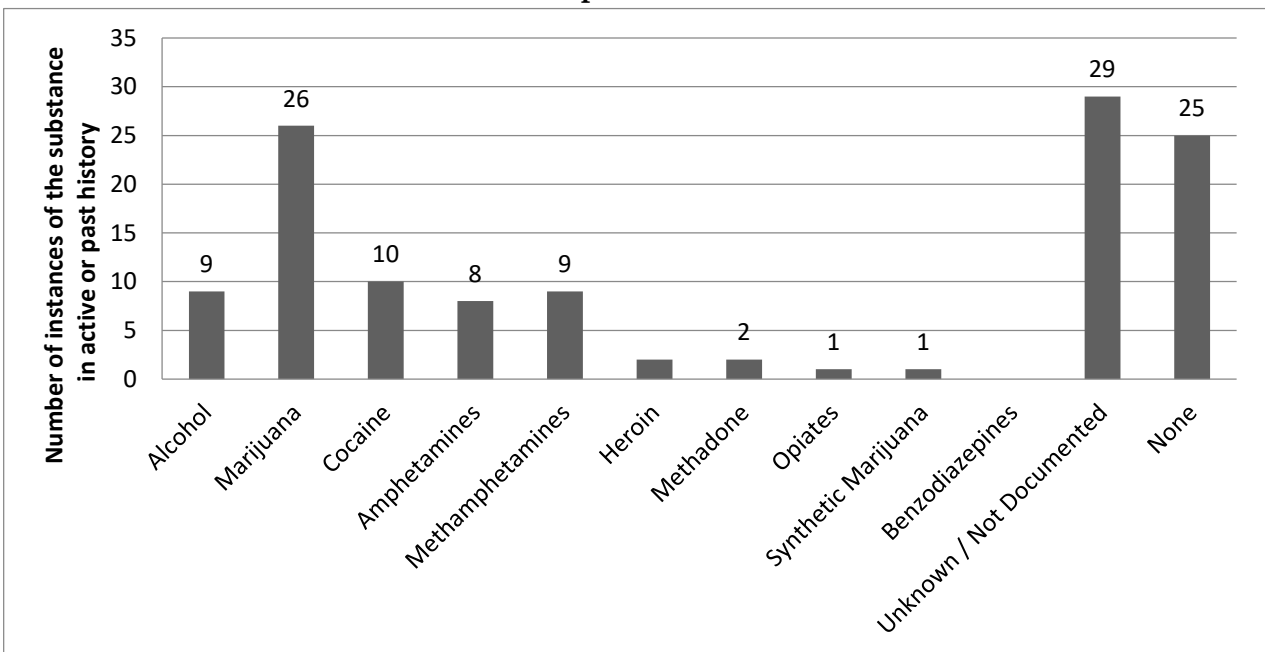
Figure 41. FY2018 Relationship of Primary Perpetrator to Victim



Source: DFPS individual case reviews

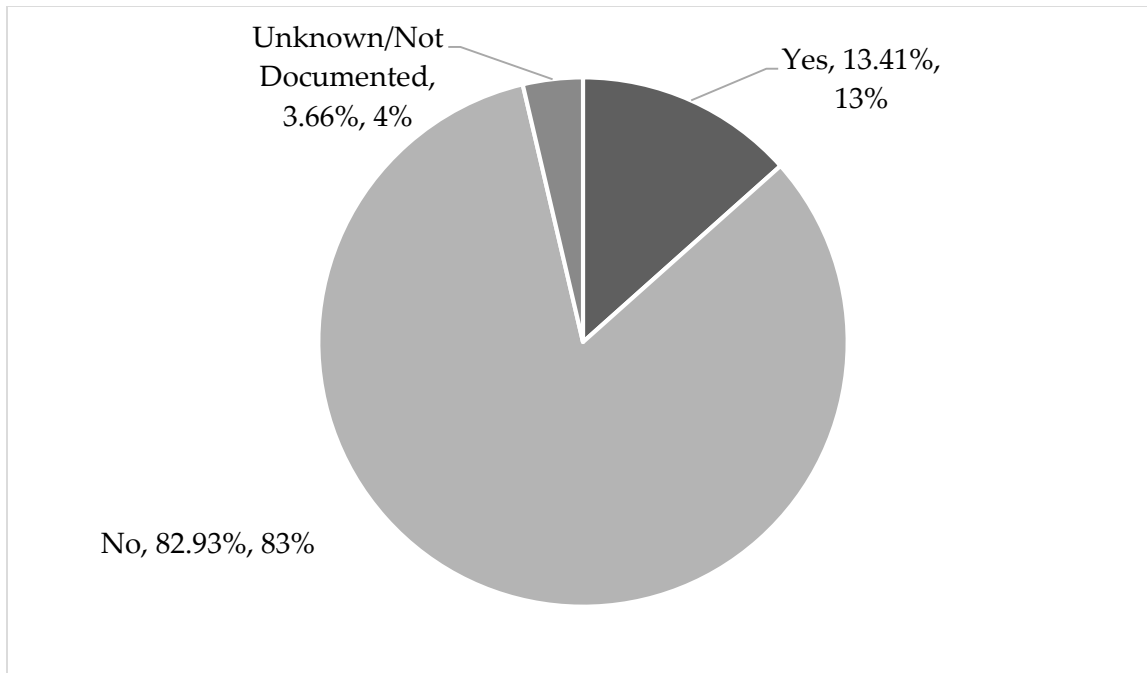
Note: Number of victims: 82; however, in many cases more than one functional perpetrator was identified.

Figure 42. Confirmed Child Abuse or Neglect Near Fatality by Substance Abuse by Perpetrator



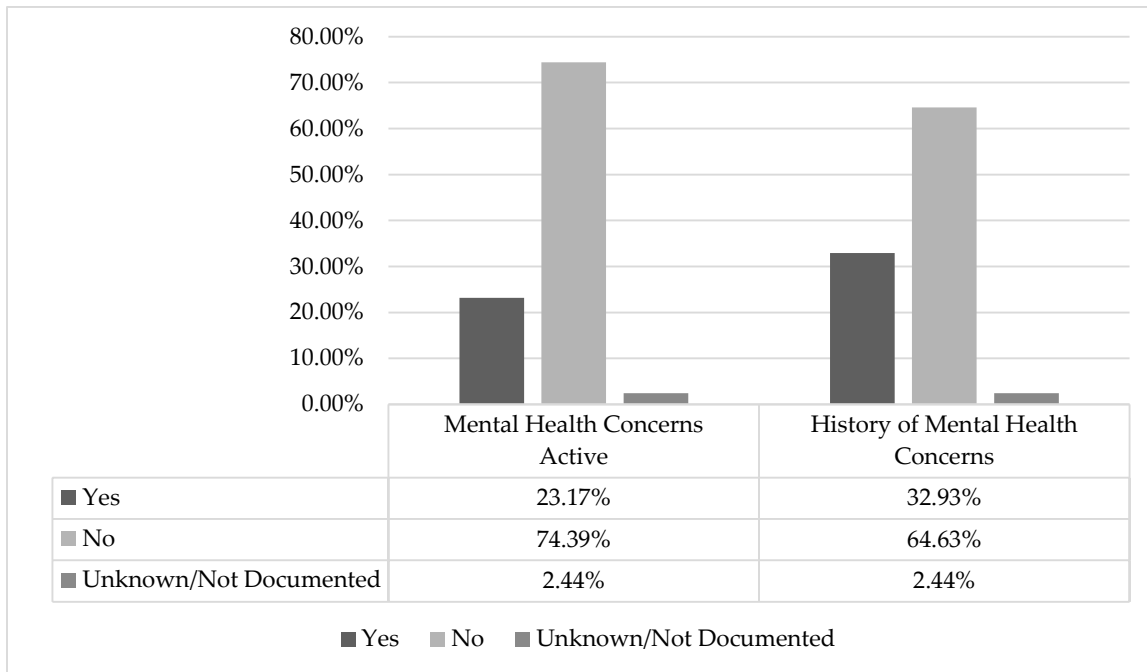
Source: DFPS individual case reviews

Figure 43. FY2018 Active Domestic Violence Concerns for Caregiver and/or Perpetrator



Source: DFPS individual case reviews

Figure 44. FY2018 Mental Health for Caregivers and/or Perpetrator



Source: DFPS individual case reviews

In 46 near fatalities, the family had prior history with the department.

- In two cases, the boyfriend of the mother had been involved with another family and was the perpetrator of fatal physical abuse.
- 27 families had prior investigations that were closed without ongoing DFPS involvement.
- 19 families had prior FBSS involvement and 18 of the 19 families had a safety plan at some point during the FBSS stage: 79 percent of families complied with their safety plan during services.
 - o On average, families were seen monthly, with their involvement in FBSS ranging from three months to one year. In general, these cases had few attempted initial visits as the practice is to work collaboratively with Investigations and the family to engage in FBSS services at case transfer.
 - Services offered in the previous or open stage include:
 - Counseling for family, individual, or group: 10 cases
 - Daycare or respite care: one case
 - Domestic violence shelter or counseling: three cases
 - Drug testing or treatment: 17 cases
 - Family support services: two cases
 - Infant or early childhood screening or development services: four cases
 - Mental health (psychological testing, mental health assessment or treatment, referral to local mental health authority): 24 cases
 - Parenting skills / evidence-based parent education: 18 cases
 - Other (support groups, referrals, community based services): four cases
 - 90 percent of families that had been involved with FBSS were reportedly fully compliant or partially compliant with their service plan.
- In 21 of the 46 cases with prior history, initial contacts were made timely in 60 percent of the qualifying investigations.

Prevention Programs

The 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 to prevent juvenile delinquency and child maltreatment. Prevention services are provided through contracts with non-profit organizations and local governments throughout Texas.

PEI programs reached more than 67,000 families in FY2018, and 99 percent of children and youth remained safe from maltreatment while receiving PEI services. As impressively, more than 95 percent of youth engaged in services avoided any involvement 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 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. .
- **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.. Targeted services are designed to improve pregnancy outcomes by helping women engage in good preventive health practices, including getting prenatal care improving their diet, and reducing their use of cigarettes, alcohol, and illegal substances..
- **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 designed to prevent maltreatment, especially abusive head trauma, in the first year after birth. More than 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. Program funding from TFTS was merged into other PEI programming in FY2019.

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 FY2018 and FY 2019 include:
 - Fatherhood Effects;
 - Basic parent education;
 - Respite care;
 - Home visiting, Education, and Leadership (HEAL); Program funding from HEAL was merged into other PEI programming in FY2019.
 - Public awareness campaigns such as Safe Sleep and other special initiatives.
- **Community Based Family Services (CBFS)** serves families who have been investigated by CPI but with low priority or unsubstantiated allegations. Program funding from CBFS was merged into other PEI programming in FY2019.
- **Helping through Intervention and Prevention (HIP)** provides identified 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 designed 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 particular 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 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.¹⁴
- [Room to Breathe](#) on safe sleep practices for infants.¹⁵
- [Watch Kids Around Water](#) about drowning prevention.¹⁶

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. With the 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
- Assessing root causes of child fatalities to develop guidance for 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 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 FY2018, the Office of Child Safety held the annual Safety Summit to support Child Protective Investigation's use of high risk case staffing between Child Safety Specialists, Investigators, and regional field management. 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 concepts.

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.

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 continuing the use of predictive analytics to improve outcomes. The DFPS Office of Data and Systems Improvement uses analytics to better target case review resources and leadership focus on high risk populations in all stages of service and to evaluate whether new program initiatives are having their intended impact on improving outcomes. Examples of this work includes utilizing predictive analytics to focus case reviews on families at a statistically higher risk of having a serious incident during an open Family Based Safety Services case and evaluate the impact of Alternative Response on recidivism.

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.¹⁷ 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](#)¹⁸

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

The 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 US Centers for Disease Control and Prevention at:
<http://www.cdc.gov/violenceprevention/childmaltreatment/riskprotectivefactors.html>

⁶ *Child Maltreatment 2011*, <http://www.acf.hhs.gov/sites/default/files/cb/cm11.pdf>.

⁷ 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>.

⁸ 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>

⁹ Tex. Fam. Code §261.102 Matters to be Reported, Section 261.101 Persons Required to Report; Time to Report.

¹⁰ Tex. Fam. Code §261.301 Investigation of Report.

¹¹ 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.

¹² Tex. Fam. Code §261.001 Definitions

¹³ 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](http://www.odontologiapediatrica.com/img/Child_Abuse_and_Neglect_Fatalities._Statistics_and_Interventions_(en_ingl%C3%A9s)..pdf).

¹⁴ DFPS Public Website, <http://www.helpandhope.org/index.html>

¹⁵ DFPS Public Website, http://www.dfps.state.tx.us/Room_to_Breathe/default.asp

¹⁶ DFPS Public Website, http://www.dfps.state.tx.us/Watch_Kids_Around_Water/default.asp

¹⁷ DSHS State Child Fatality Review Team Members,
<https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589985017>

¹⁸ Texas Child Fatality Review Biennial Report 2014-2015,
https://www.dshs.texas.gov/mch/pdf/Texas-SCFRT-Biennial-Report_2014-2015.pdf