
**Texas Department of Family and Protective Services
Child Abuse and Neglect Fatalities
Annual Report**

Fiscal Year 2014 and Fiscal Year 2015 Analysis

A report from the Department of Family and Protective Services

April 2016

Table of Contents

Executive Summary.....	4
Definitions: Child Abuse and Neglect Fatalities Investigation Dispositions.....	6
Findings: Investigating Child Abuse and Neglect (CAN) Related Fatalities	8
FY2014 and FY2015 Confirmed Child Abuse and Neglect-Related Fatalities.....	13
General Cause/Manner of Child Abuse or Neglect Fatality	13
Victim Demographic Characteristics - Age, Gender, Ethnicity	17
Risk Factors and Protective Factors Involved in Confirmed Child Abuse or Neglect Fatalities.....	19
FY2014 Child Abuse and Neglect Related Fatalities- By County	25
FY2015 Child Abuse and Neglect Related Fatalities - By County	27
FY2014 and FY2015 Confirmed Child Abuse and Neglect Related Fatalities - Case Review Data	29
FY2014 Perpetrator Demographic and Characteristics - Relationship and History	29
FY2014 Primary Perpetrator, Child Age and Cause of Death Together	30
FY2015 Perpetrator Demographic and Characteristics - Relationship and History	34
FY2015 Primary Perpetrator, Child Age and Cause of Death Together	35
Prior CPS History in Child Abuse and Neglect-Related Fatalities.....	40
FY2014 Prior CPS History in Child Abuse and Neglect-Related Fatalities	43
FY2015 Prior CPS History in Child Abuse and Neglect-Related Fatalities	50
Child Fatalities Not Caused by Abuse and Neglect but Abuse or Neglect Confirmed Overall.....	57
Office of Child Safety - Individual Child Fatality, Near Fatality and Serious Event Reviews	61
Child Fatalities in Texas within the National Context	82
Initiatives & Program Improvement	83
Endnotes	88

Executive Summary

Nearly one in ten children in the United States live in Texas. Of those children, about one third are under the age of six. According to state and national data that age range is the most vulnerable population for abuse and neglect. The Department of Family and Protective Services (DFPS), in partnership with law enforcement, the medical community, service providers and the rest of the state, remains committed to lowering the rate of child abuse and neglect fatalities.

To dedicate thoughtful and innovative analysis to these tragedies, DFPS Commissioner John Specia formed the Office of Child Safety in September 2014. The Office of Child Safety independently analyzes individual child abuse and neglect fatalities, near fatalities and serious injuries as well as the risk factors and systemic issues involved. This involves reviewing state and national trends regarding child fatalities, near fatalities, and serious injuries in DFPS cases and in the general population as well as strategies that can be deployed by DFPS programs and by other state agencies and local communities. With the overarching goal of supporting implementation of prevention and intervention strategies to address and reduce fatal and serious child maltreatment, the Office of Child Safety is specifically tasked with:

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

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

The Office of Child Safety is releasing this annual report to support work both internally and externally that address child maltreatment and risk factors associated with child maltreatment. DFPS, through the Office of Child Safety, is using this data to evaluate, review, and strengthen policy and practices across the agency. Together with efforts across state agencies to address child fatalities, the information within this report can be utilized in the development of prevention and early intervention programs, intervention strategies where abuse and neglect is suspected, and community initiatives to support child safety and positive outcomes for families.

This report is divided into four major sections:

- Definitions: Child Abuse and Neglect Fatalities Investigation Dispositions
- Findings: Data Analysis for Confirmed Child Abuse and Neglect Fatalities in FY2014
- Child Fatalities in Texas within the National Context
- Initiatives & Program Improvement

Based on administrative data and individual case reviews for confirmed child abuse and neglect-related fatalities during FY2014 and FY2015, the following trends and areas for review have been identified:

General Findings

- There were 151 confirmed child abuse and neglect-related fatalities in FY2014 and 171 confirmed child abuse and neglect fatalities in FY2015. The increase in FY2015 is localized to Region 3 (neglectful supervision-related fatalities) and Region 6/Region 11 (physical abuse homicides). (Figure 2)
- Confirmed physical abuse/intentional trauma fatalities have decreased by 26 percent since the five-year high in FY2011. (Figure 3)
- Confirmed neglect-related fatalities have decreased by 22.5 percent since FY2011. (Table 2)
 - In fatalities involving neglect, the most common causes of death were drowning, unsafe sleep, and vehicle related deaths. (Figure 7, 8)

Victims

- Based on the confirmed child abuse and neglect-related fatalities over the past five fiscal years, children 3 years of age and younger made up almost 80 percent of all confirmed child abuse and neglect fatalities. Male children made up more than half of all confirmed child abuse and neglect-related fatalities. (Figure 9, 10)
- During FY2014, the largest percentage of children who died from abuse or neglect were Anglo, and in FY2015, Hispanic children represent the greatest number of children who died from abuse or neglect. (Table 3)
- Almost 60 percent of children who died from abuse or neglect were too young for school and were not enrolled in daycare. (Page 24)

Perpetrators

- Physical abuse related fatalities most commonly involved blunt force trauma inflicted by a father or boyfriend. (Figure 15, 21)
- Parents were the most common perpetrators in fatal child abuse and neglect investigations. (Figure 14, 20)
- In confirmed child abuse and neglect-related fatalities, about half of the children or the perpetrator involved in the fatality had no prior history with CPS. (Figure 29)
- Risk factors such as substance abuse, mental health concerns, and domestic violence were factors in confirmed child abuse and neglect fatalities:
 - In FY2014, 48 percent of fatalities caused by abuse or neglect included a parent or caregiver actively using a substance and/or under the influence of one or more substances that impacted his or her ability to care for the child. In FY2015, that number had decreased to 38 percent. (Figure 11, Table 5)
 - Between 13 and 18 percent of child abuse and neglect fatalities involved a parent or caregiver with reported or confirmed mental health concerns. (Table 6)
 - Domestic violence was identified in almost half of the child fatalities confirmed to be from abuse or neglect. (Figure 12, 13)

Definitions: Child Abuse and Neglect Fatalities Investigation Dispositions

The Department of Family and Protective Services (DFPS) is required under the Texas Family Code to investigate child fatalities where there are allegations of abuse or neglect in order 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 placed in APS regulated placements. Child Care Licensing (CCL) and Residential Child Care Licensing (RCCL) investigate deaths of children in daycare settings and regulated care placement, including children in DFPS conservatorship in foster care placements. Child Protective Services (CPS) investigates deaths of children living with their families or who are in DFPS conservatorship and in non-foster care kinship placements. Both CPS and RCCL may investigate cases jointly, such as when a child dies in foster care from injuries sustained before coming into foster care or when a potentially abusive foster parent has his or her own biological children. If either division determines that the death is related to abuse or neglect, it is counted as a confirmed child abuse or neglect-related fatality.

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

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

Investigation Dispositions

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

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

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

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

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

Unable to Determine (UTD) - Staff conclude that:

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

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

Findings: Investigating Child Abuse and Neglect (CAN) Related Fatalities

Table 1 provides data regarding overall trends in child abuse and neglect in Texas. While reports in general have decreased, confirmed investigations have also decreased. In terms of child fatalities, the number of reports involving a child fatality also has declined. The percent of confirmed child abuse and neglect-related fatalities have varied between 19 percent and 24 percent in the past four years.

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

	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
Child Population of Texas	6,865,824 ⁱⁱ	6,952,177 ⁱⁱⁱ	6,996,352	7,121,499	7,266,760	7,311,923
Number of Intakes Assigned for Investigation or Alternative Response by CPS	231,532	222,541	206,200	194,803	215,512	232,159
Number of Investigated Child Fatalities	1024	973	882	804	797	739
Number of fatalities where abuse/neglect was confirmed	227	231	212	156	151	171
Child Fatality Rate per 100,000 Children	3.31	3.32	3.03	2.19	2.1	2.3
National Rate for Equivalent Federal Fiscal Year^{iv}	2.10	2.10	2.20	2.04	2.13	***

Source: Data from US Census Bureau; Texas State Data Center; DFPS Data Books FY2010-FY 2015; DFPS Data Warehouse Report FT_06; U.S. Department of Health and Human Services.

*** Child Maltreatment 2015 is scheduled to be released in January/February 2017.

The distribution of case disposition codes for investigations conducted in FY2010 through FY2015 are presented in Table 2 - Percentage of Child Fatality Investigations by Disposition. The total number of child fatalities investigated between FY2010 and FY2015 has decreased by more than 27 percent. The decrease in the number of confirmed child abuse and neglect fatalities in Texas is also reflected in national data with a national decline of 12.7 percent in confirmed child abuse and neglect fatalities between FFY2009 and FFY2013.^v In FFY2014, an increase in child fatalities reported nationally occurred as well, a trend also seen in Texas data between FY2014 and FY2015.

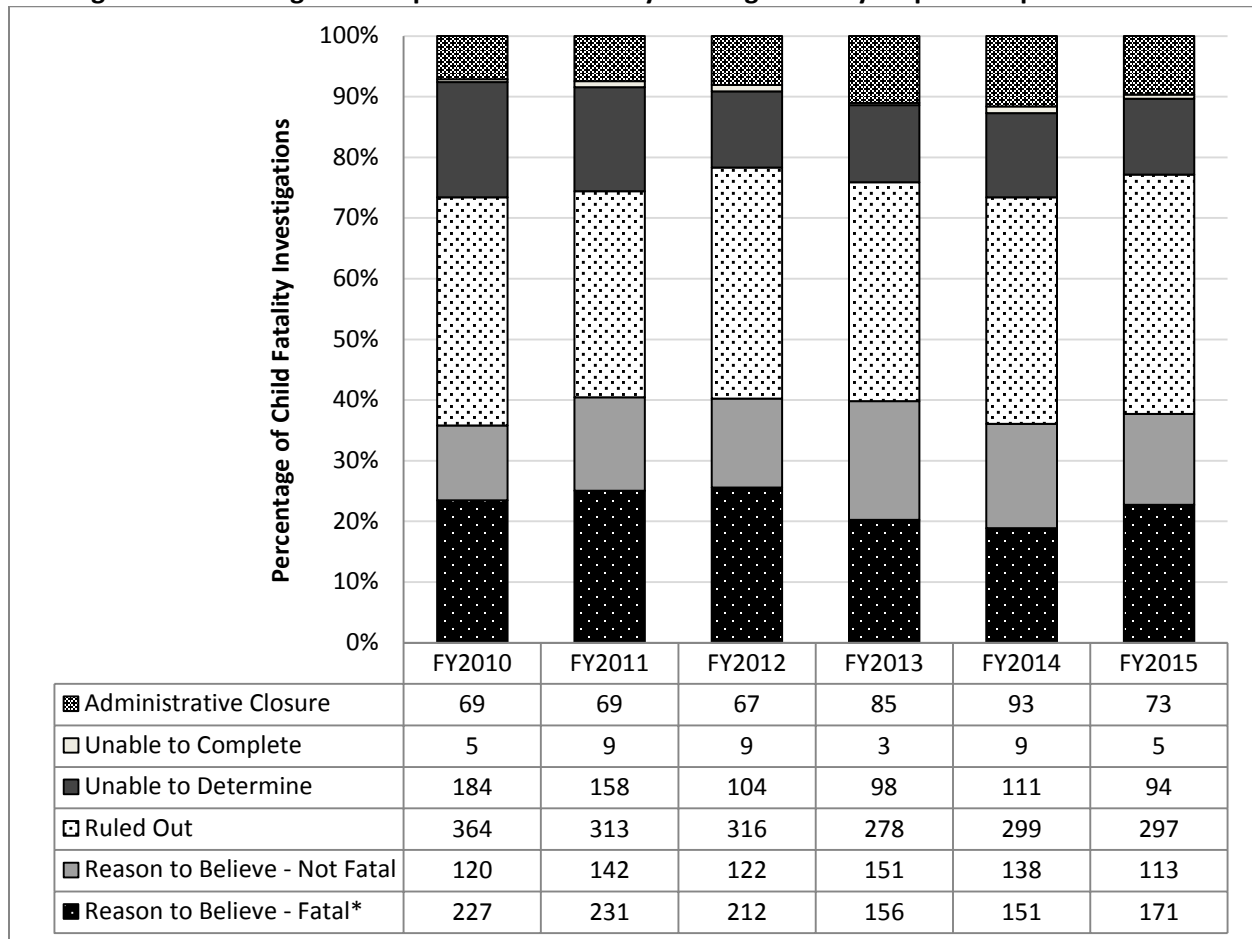
Table 2. Percentage of Child Fatality Investigations by Disposition

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%

*Count by child. All other dispositions are count by investigation. Count by investigation includes duplicated children and may include confirmation of abuse and neglect of a child that is not the deceased child. Multiple DFPS divisions such as Child Protective Services (CPS) or Residential Child Care Licensing (RCCL) may investigate a child fatality. Additionally, a child may die in a home where there are multiple families being investigated due to the child fatality.

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

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



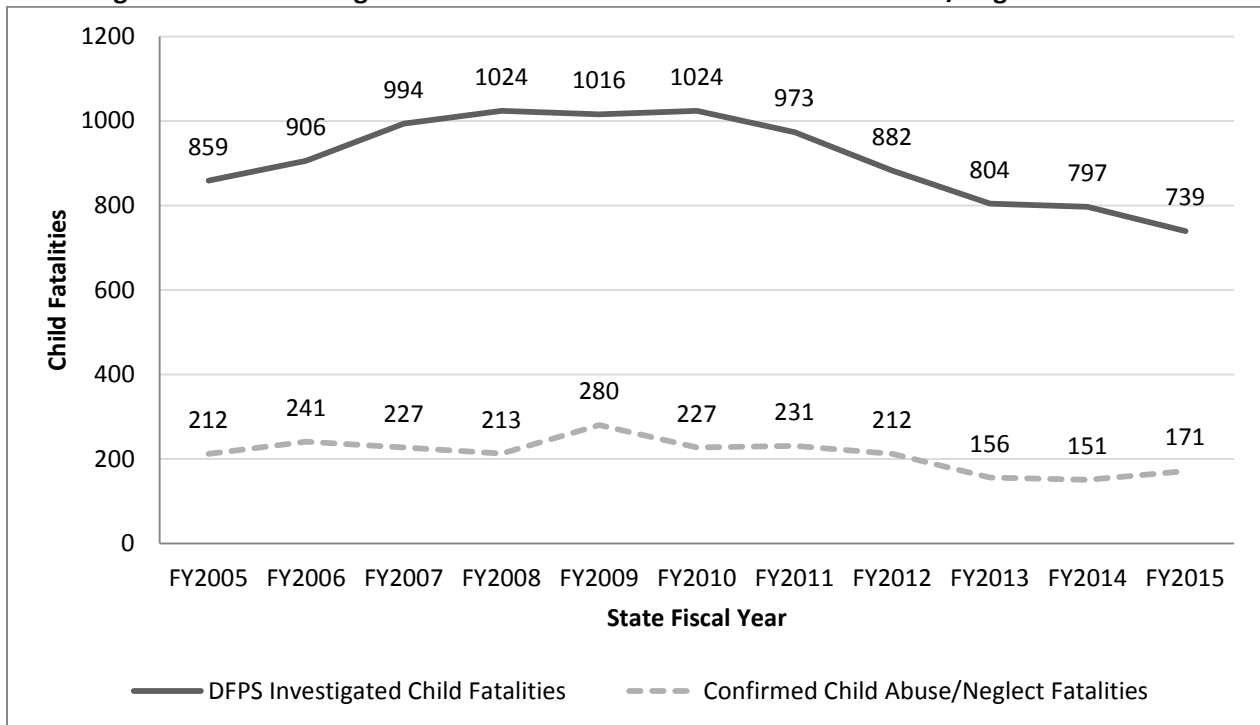
* Count by Child, all other categories are count by investigation. Source: DFPS DRIT Request

In the past five fiscal years, there has been an increase in administrative closures that coincides with strengthening the review process at intake and utilizing screeners to review all child fatality intakes so that investigations are only initiated when allegations clearly meet statutory authority for DFPS to investigate (Figure 1). Also, there has been a 20 percent decrease in the number of investigations with a reason to believe finding for abuse or neglect but the fatality was not caused by abuse or neglect. This decrease is linked to more thorough investigations where information from law enforcement, scene investigation information, and the medical examiner help support either reason to believe-fatal findings or ruled out abuse and neglect as the cause of the fatality.

Despite a growing child population in Texas, the number of confirmed child abuse and neglect-related fatalities has dropped by more than 25 percent in the last five years. A number of reasons have likely contributed to the decline, including:

- Reduction in number of reports overall about alleged child abuse and neglect fatalities
- Communities have increased prevention and early intervention efforts, including campaigns by the Blue Ribbon Task Force^{vi}, the State Child Fatality Review Team^{vii}, and local Child Fatality Review Teams
- Access to community services and expansion of DFPS prevention services in high-risk areas
- Increased medical community knowledge about child abuse and neglect and specialized treatment centers including the Medical Child Abuse Resources and Education System (MEDCARES)^{viii} and the Forensic Assessment Center Network (FACN).^{ix} These medical professionals and hospital systems are also supporting prevention, training, and service programs to target issues specific to their communities.
- Access to community health care, mental health services, and substance abuse services
- Community programs and media campaigns such as Water Safety Month and child safety programs (like car seat use, safety around water, and safe sleep)^x
- DFPS focus on enhanced child safety practices and consistency in dispositions: Enhanced disposition guidelines are used by CPS field staff investigating child fatalities. This supports statewide consistency where the role of abuse or neglect in the fatality may be medically undetermined or the level of abuse or neglect rising to fatal may be subjective, such as cosleeping, drowning, suicide, or firearm-related fatalities
- DFPS is also working closely with partners to address child safety with a proactive, public health approach. Ongoing work through the DFPS/DSHS Strategic Plan to Reduce Child Abuse and Neglect Fatalities specifically targets safe sleep, vehicle safety, and the impact of domestic violence on child safety, which are significant areas found in child fatality reviews.^{xi}

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



Source: DFPS Data Warehouse Report FT_06

In the last decade, DFPS averaged approximately 916 child fatality investigations per fiscal year. In FY2014, DFPS investigated 797 reports regarding possible child abuse and neglect-related fatalities. That number continues to decrease, with 739 child fatalities reported for investigation in FY2015. Compared to FY2008 and FY2010 when DFPS had record highs of 1024 investigations, this is a decrease of more than 27 percent. (Figure 2)

In FY2015, the number of child fatalities did increase compared to the previous fiscal year, but remains lower than other years. The increase in confirmed child abuse and neglect fatalities is localized to three regions:

- Region 3 (Dallas-Fort Worth area) had a 54 percent increase in confirmed abuse and neglect fatalities compared to FY2014 and the most confirmed fatalities since FY2009. Compared to previous years, deaths increased involving substance abuse and neglectful supervision linked to unsafe sleep and drownings.
- Region 6 (Houston-Galveston metropolitan area) saw a 25 percent increase compared to FY2014. There were 25 confirmed child abuse deaths related to physical abuse. Two sibling groups—ten children--were murdered by a parent during FY2015.
- Region 11 (Corpus Christi/Rio Grande Valley) had more than double the number of child abuse fatalities than in FY2014, with eight physical abuse-related fatalities in FY2015.

Part of the overall decline in child abuse and neglect fatalities is related to more consistent disposition of fatalities. In FY2012, guidelines were provided to CPS staff to help ensure consistent dispositions on child fatalities that involved cosleeping, drownings, firearm accidents, suicides and children left in cars. In FY2013, CPS created the Statewide Child Fatality Disposition Review Team, comprised of regional and

state office staff, to ensure consistency in child fatality investigations with a disposition of Reason to Believe-fatal for abuse or neglect. CPS also trained staff and management to strengthen information gathering, engage the family and support systems, and utilize information from professionals who have contact with the family. This has helped to determine and support consistent dispositions. In FY2015, the Statewide Child Fatality Disposition Review Team reviewed a random sample of all child fatality investigations from FY2013 to look at overall consistency in dispositions in those investigations. This allows the department to continue working with staff to support consistent dispositions statewide across all investigations, not just those involving child fatalities.

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

The overall decline in child fatality investigations may also reflect random fluctuation. The number of child abuse and neglect fatalities spiked in FY2009 despite a slight decline in the number of reported deaths. After an exhaustive review of the fatalities through an independent analysis conducted by the Texas Health and Human Services Commission, the spike was attributed to a random increase in Harris County. No single factor was responsible for this increase. The following year, child abuse and neglect fatalities returned to previous lower levels, including Harris County. (Figure 2) This same trend is true at the national reporting level with a spike in confirmed child abuse and neglect fatalities in FFY2009 and a return to lower levels in the following year.^{xii}

FY2014 and FY2015 Confirmed Child Abuse and Neglect-Related Fatalities

During the 81st Legislative Session, the Texas Legislature passed Senate Bill 1050 codifying Child Abuse Prevention and Treatment Act (CAPTA) reporting requirements and directing DFPS to provide specific information regarding all child fatalities alleged to be from abuse or neglect as well as detailed information if the DFPS "determines a child's death was caused by abuse or neglect."^{xiii} During the 84th Texas Legislature, Senate Bill 949 was passed to support additional reporting elements for child fatality investigations. The following data are collected from IMPACT and individual case reads where the child's death was caused by abuse or neglect which is distinguished with the disposition of reason to believe - fatal.

General Findings

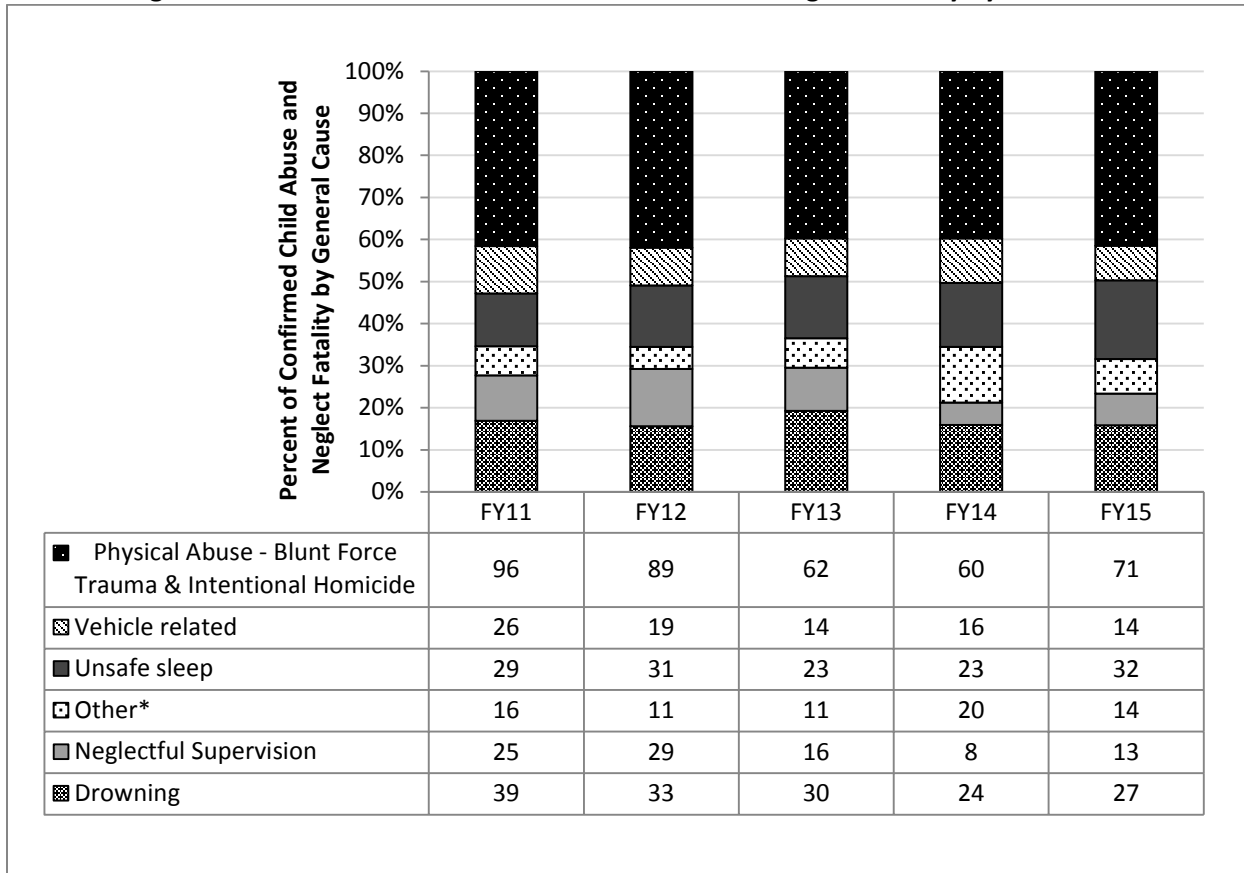
- There were 151 confirmed child abuse and neglect fatalities in FY2014. In FY2015, there were 171 confirmed child abuse and neglect fatalities – a 36 percent decrease from the 231 confirmed fatalities in FY2011. (Table 2)
- Confirmed physical abuse/intentional trauma fatalities have decreased by 26 percent since the five-year high in FY2011. (Figure 3, 4)
- Confirmed neglect related fatalities have decreased by 22.5 percent since FY2011. (Figure 4)
 - In fatalities involving neglect, the most common causes of death were drowning, unsafe sleep, and vehicle related deaths. (Figure 7, 8)

General Cause/Manner of Child Abuse or Neglect Fatality

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

In this section, intentional deaths are defined as those where the perpetrator intended to cause harm or death to the child and are most often to be a confirmed allegation of physical abuse. Unintentional deaths are those in which the level of inattention and/or impairment by the child's caregiver was enough to be considered neglect.

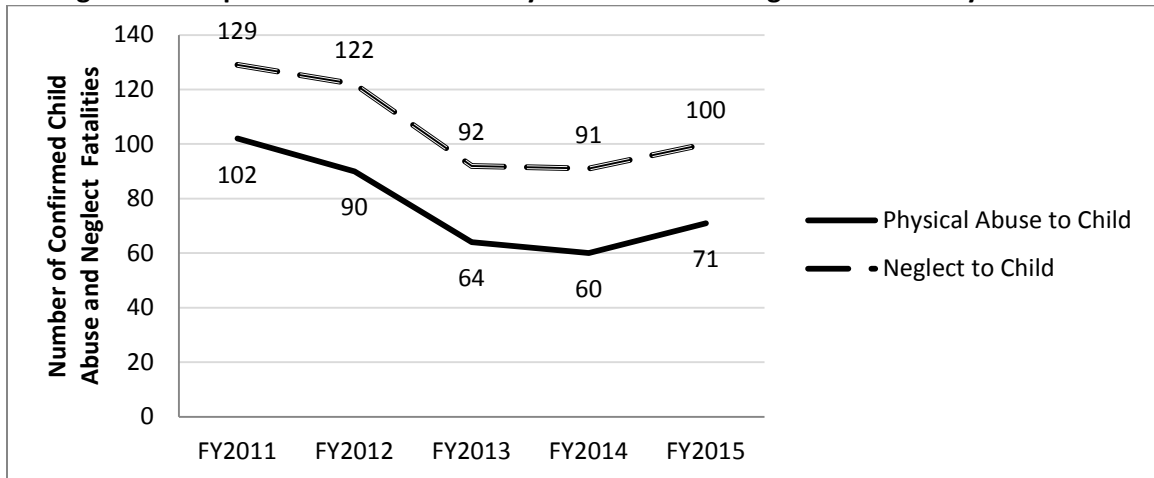
Figure 3. General Cause of Confirmed Child Abuse or Neglect Fatality by Fiscal Year



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

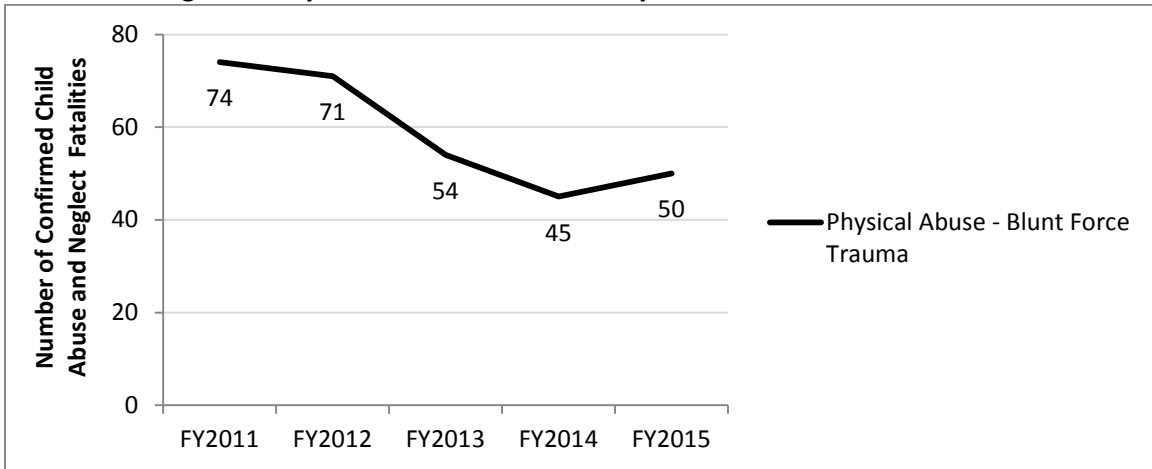
Source: DFPS individual case reviews

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



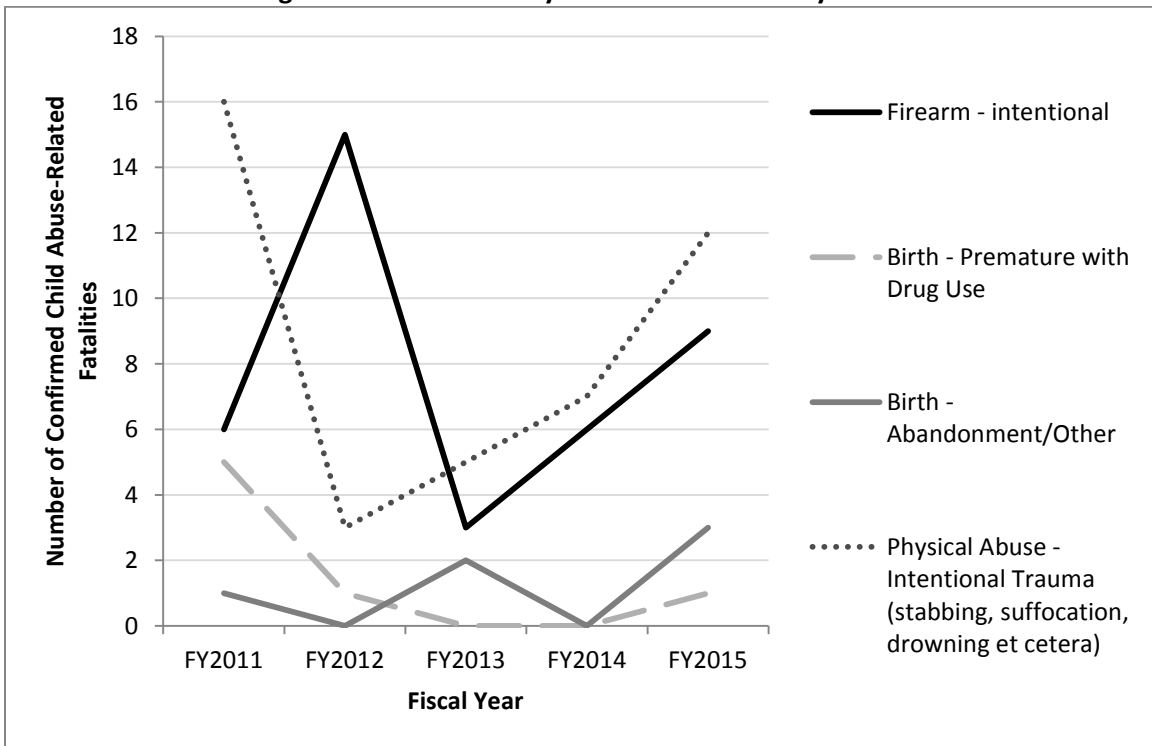
Source: DFPS individual case reviews

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



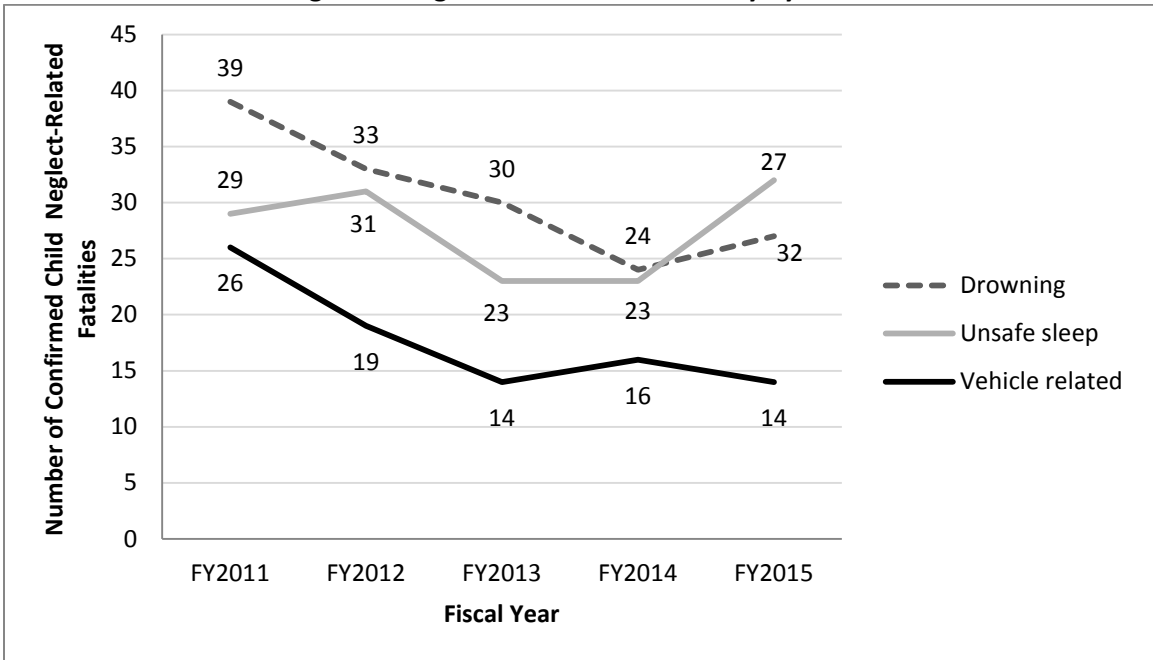
Source: DFPS individual case reviews

Figure 6. Intentional Physical Abuse to Child by Cause



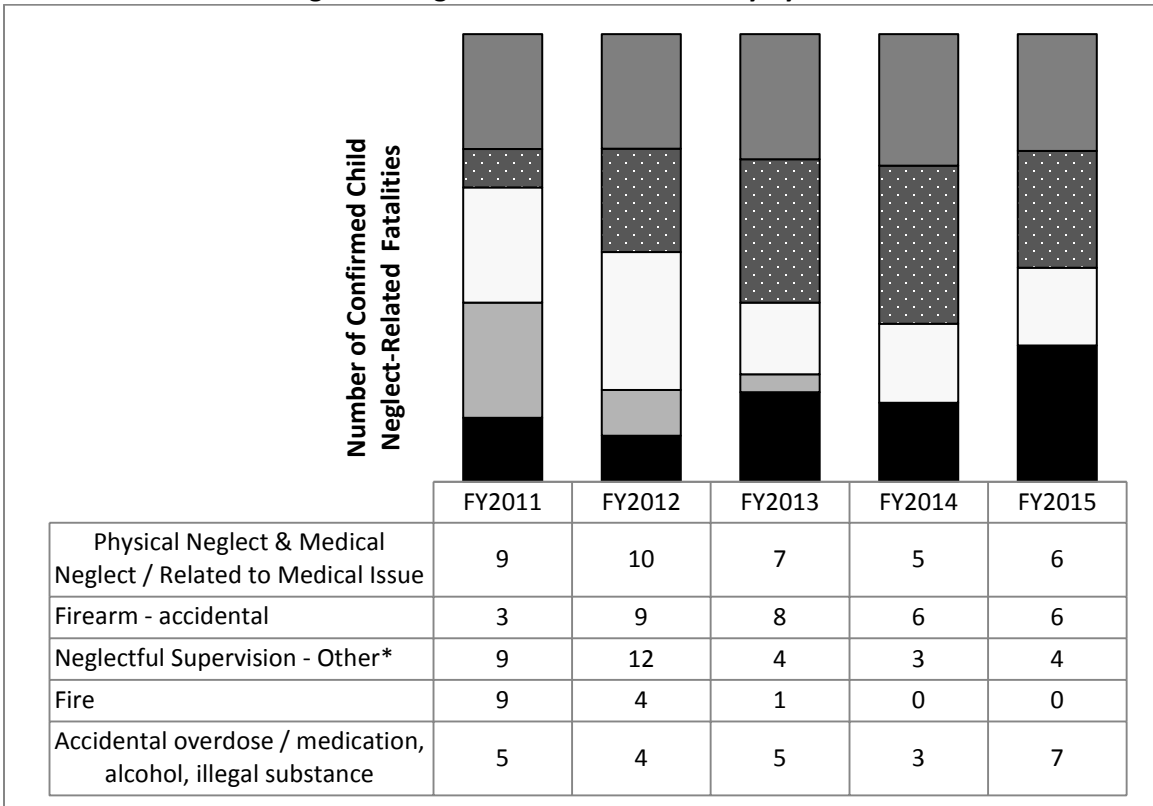
Source: DFPS individual case reviews

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

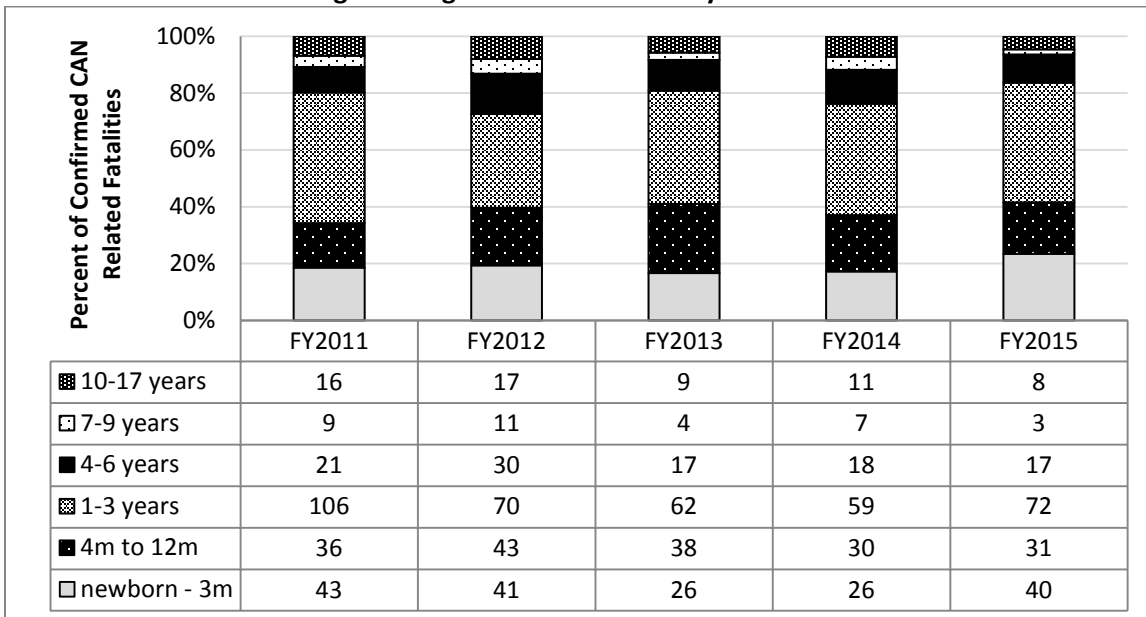
Source: DFPS individual case reviews

Victim Demographic Characteristics - Age, Gender, Ethnicity

Victims of Confirmed Child Abuse and Neglect (CAN) Related Fatalities

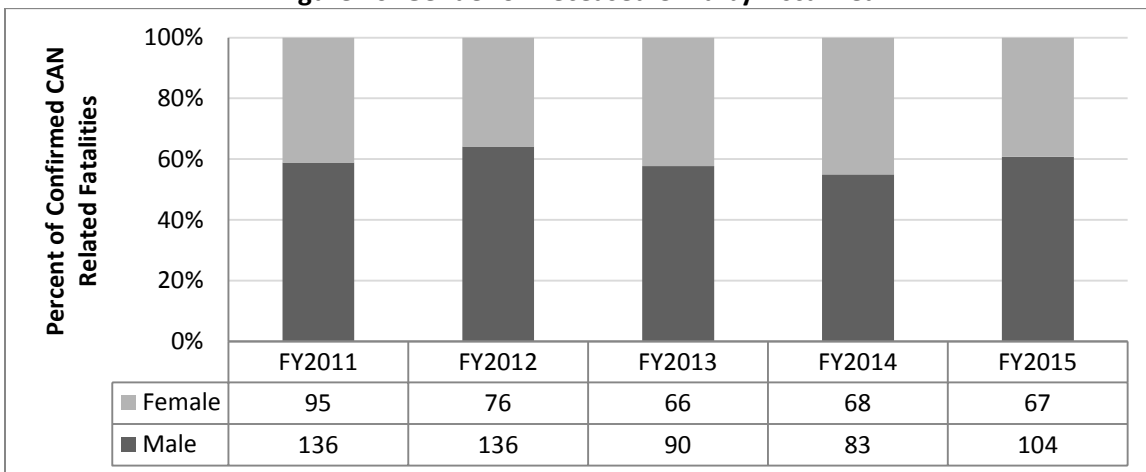
- Based on the confirmed child abuse and neglect related fatalities over the past five fiscal years, children 3 years of age and younger were almost 80 percent of all confirmed child abuse and neglect fatalities. Male children were more than half of all confirmed child abuse and neglect-related fatalities.
- In FY2014, 76 percent of children in abuse and neglect fatalities were 3 years old or younger and 55 percent were male. In FY2015, 84 percent of children in abuse and neglect fatalities were 3 years old or younger and 61 percent were male.

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 context of the child per capita rate for Texas. In FY2014, children of Anglo heritage represent the largest number of child abuse and neglect fatalities. However, in FY2015, children of Hispanic heritage returned to representing the largest number of child abuse and neglect fatalities. Moreover, the child per capita rate of fatal abuse/neglect for African-American children remains disproportionately higher compared to overall representation in the Texas child population (Table 3). The Texas Health and Human Services Commission is actively working with state and federal agencies, universities, private groups, communities, and stakeholders to address health and health access disparities among racial, multicultural, ethnic, and regional populations.^{xiv}

**Table 3. Per Capita Rate (per 100,000 Children) by Ethnicity - Confirmed Child Abuse Neglect Fatalities
FY2011**

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

FY2012

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

FY2013

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

FY2014

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

FY2015

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

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

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

The United States Center for Disease Control and Prevention defines risk factors for child maltreatment as characteristics associated with child maltreatment.^{xv} 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. Three other major risk factors are special needs of the child, substance abuse, and mental health concerns.

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

Special Needs & Medical Concerns as Risk Factor

In FY2014, 18 children who died from abuse or neglect had special needs or medical concerns. . While the majority of child fatalities do not involve a child with special needs, 12 percent involved a child with some level of special needs or medical concerns. Almost a fourth of the children with special needs whose death was confirmed to be from abuse or neglect were caused by physical abuse. This emphasizes that parents and caregivers of children with special needs must have a strong support systems.

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

Identified Special Need	FY2014 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality	FY2015 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality
Cerebral Palsy/Seizures	3 fatalities <ul style="list-style-type: none"> • Medical neglect • Physical neglect • Neglectful supervision - drowning 	2 fatalities <ul style="list-style-type: none"> • Physical abuse • Neglectful supervision - drowning
Developmental delay	2 fatalities <ul style="list-style-type: none"> • Physical abuse (2) 	3 fatalities <ul style="list-style-type: none"> • Physical abuse (2)
Medically fragile	4 fatalities <ul style="list-style-type: none"> • Physical neglect • Neglectful supervision - car accident • Physical abuse • Neglectful supervision - drowning 	6 fatalities <ul style="list-style-type: none"> • Unsafe sleep • Physical neglect • Medical neglect (2) • Neglectful supervision (2)

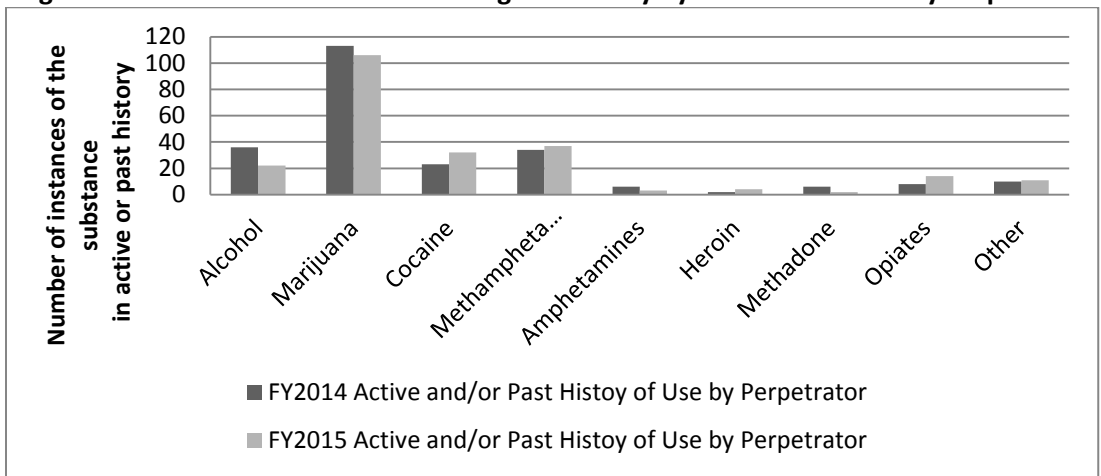
Recently ill	4 fatalities <ul style="list-style-type: none"> Neglectful supervision - cosleeping Physical abuse Neglectful supervision – hot vehicle Neglectful supervision – overdose of medication 	1 fatality <ul style="list-style-type: none"> Neglectful supervision – cosleeping/unsafe sleep
Other--asthma, autism, depression, drug addiction, sleep apnea	5 fatalities <ul style="list-style-type: none"> Neglectful supervision - drowning Neglectful supervision - suicide Neglectful supervision – cosleeping/unsafe sleep Medical neglect (no asthma medication) Neglectful supervision - drug overdose 	7 fatalities <ul style="list-style-type: none"> Neglectful supervision – cosleeping/unsafe sleep Neglectful supervision – vehicle Physical abuse (3) Physical abuse / medical neglect – birth related

Substance Abuse by Caregiver as Risk Factor

During the review of confirmed child fatalities due to abuse and neglect, cases were reviewed for a documented history of substance abuse (including inappropriate use of prescribed medications) and for active concerns for substance abuse at the time of the child fatality.

For FY2014, 73 of the 151 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 FY2015, 66 of the 171 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. In more than half of the confirmed child abuse and neglect fatalities where there was substance abuse, the perpetrator used more than one substance.

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



**Table 5. Confirmed Child Abuse or Neglect Fatality by Substance Abuse by Perpetrator
FY2014**

<i>Substance Abuse Concern</i>	<i>Active</i>	<i>Past History</i>	<i>Substance Abuse Concern</i>	<i>Active</i>	<i>Past History</i>
Alcohol	22	14	Heroin	-	2
Marijuana	38	75	Methadone	4	2
Cocaine	10	13	Opiates	4	4
Methamphetamines	17	17	Other:	11	5

Other: amphetamines (5 active, 1 past), Phencyclidine – PCP (1 active), Synthetic Marijuana (3 active, 2 past), Ecstasy (1 active, 1 past), Xanax (1 active), Medication abuse (1 past)

FY2015

<i>Substance Abuse Concern</i>	<i>Active</i>	<i>Past History</i>	<i>Substance Abuse Concern</i>	<i>Active</i>	<i>Past History</i>
Alcohol	11	11	Heroin	2	2
Marijuana	46	61	Methadone	2	-
Cocaine	13	19	Opiates	6	8
Methamphetamines	16	21	Other:	8	4

Other: amphetamines (3 active), Phencyclidine – PCP (1 active, 2 past), Ecstasy (1 active, 1 past), Xanax (1 past), Medication abuse (3 active)

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 FY2014, almost 13 percent of child fatalities involved a parent/caregiver who reported a history of mental health concerns. Nine of the 19 parents/caregivers reported a mental health concern but could not specify the concern. For FY2015, almost 18 percent of child fatalities involved a parent/caregiver who reported a history of mental health concerns. Six of the 30 parents/caregivers reported having a mental health concern but could not specify the concern.

**Table 6. Mental Health Concerns both Active and in Past History for Perpetrator
Confirmed Child Abuse Neglect Fatalities
FY2014**

Mental Health Concern	Active	Past History
Bipolar Disorder	-	2
Depression	5	4
Anxiety	-	1
Multiple Concerns/Co-occurring disorders	1	3
Postpartum Depression	-	1
Post-Traumatic Stress Disorder	2	1
Schizophrenia	1	-
Unknown – Reported by Individual	9	7*

* The seven or the nine perpetrators who reported an active mental health concern also reported a concern previously.

FY2015

Mental Health Concern	Active	Past History
Bipolar Disorder	8	9
Depression	3	3
Anxiety	3	2
Multiple Concerns/Co-occurring disorders	6	5
Postpartum Depression	1	1
Post-Traumatic Stress Disorder	3	3
Schizophrenia	1	-
Unknown – Reported by Individual	5	6

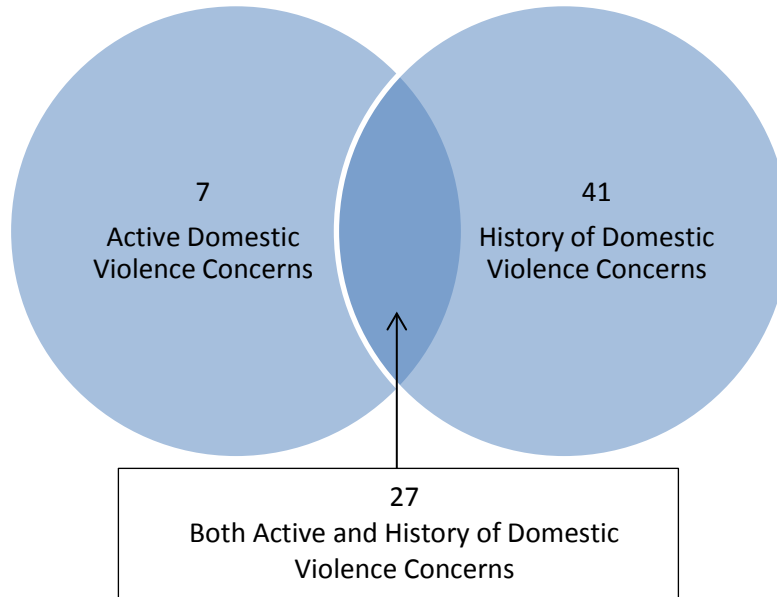
Domestic Violence Concerns as Risk Factor

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

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

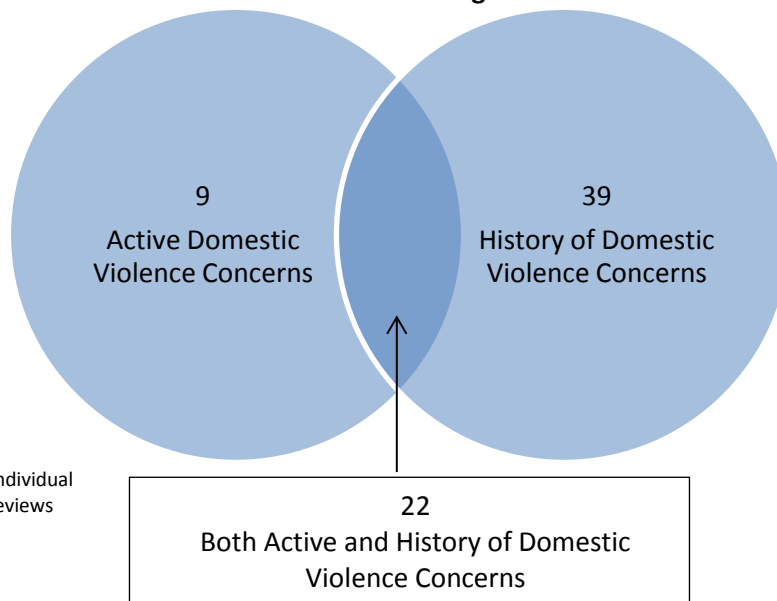
During the review of confirmed child fatalities due to abuse and neglect, cases were reviewed for a documented history of domestic violence concerns and active concerns for domestic violence in the home at the time of the child fatality. In FY2014, almost half of all confirmed child abuse and neglect fatalities involved either active domestic violence concerns or previous domestic violence.

Figure 12. FY2014 Domestic Violence Concerns both Active and in Past History for Perpetrator Confirmed Child Abuse Neglect Fatalities



Source: DFPS individual case reviews

Figure 13. FY2015 Domestic Violence Concerns both Active and in Past History for Perpetrator Confirmed Child Abuse Neglect Fatalities



Source: DFPS individual case reviews

School and Daycare Enrollment as Protective Factor

With almost 80 percent of child fatalities involving children age three and younger, protective and attentive parents and caregivers are critical to protect children. When a parent works, care for the child must be found; sometimes that care is a family member or friend, or commonly a daycare 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 daycare also provide another adult outside the family the opportunity to be around the child regularly and be on the lookout for abuse or neglect. Almost 60 percent of children who died due to abuse or neglect were not involved with either a daycare or a school system that could have provided additional eyes and ears.

FY2014 Confirmed Child Abuse and Neglect Fatalities:

- In 85 of the 151 child fatalities due to abuse or neglect, the child was not enrolled either in a daycare or in school.
- In 35 of the 151 child fatalities due to abuse or neglect, the child was enrolled in daycare or school. Two of the fatalities occurred when school was out of session for the summer break.
- In 31 of the 151 child fatalities due to abuse or neglect, there is limited information about the child's daycare or school.

FY2015 Confirmed Child Abuse and Neglect Fatalities:

- In 106 of the 171 child fatalities due to abuse or neglect, the child was not enrolled either in a daycare or in school.
- In 21 of the 171 child fatalities due to abuse or neglect, the child was enrolled in daycare or school. Nine of the fatalities occurred when school was out of session for the summer break.
- In 4 of the 171 child fatalities due to abuse or neglect, the child was being cared for by a caregiver that should have been registered or licensed through DFPS but was not. (Illegal operation)
- In 30 of the 171 child fatalities due to abuse or neglect, there is limited information about the child's daycare or school.

FY2014 Child Abuse and Neglect Related Fatalities- By County

The charts below are from the DFPS Data Book and available online.

Table 7. FY2014 Child Abuse and Neglect Related Fatalities- By County

Child Abuse/Neglect Related Fatalities Fiscal Year 2014			
County	Region	Child Abuse/Neglect Related Fatalities	Child Abuse/Neglect Related Fatalities in Foster Care at Time*
Angelina	005	1	0
Aransas	011	1	0
Atascosa	008	1	0
Bastrop	007	1	0
Bell	007	1	0
Bexar	008	12	1
Bowie	004	1	0
Brazoria	006	1	0
Callahan	002	1	0
Camp	004	1	0
Chambers	006	1	0
Cherokee	004	1	0
Collin	003	4	1
Dallas	003	14	1
Denton	003	3	0
Dimmit	008	1	0
Ector	009	2	0
Ellis	003	1	1
El Paso	010	4	0
Galveston	006	3	0
Garza	001	1	0
Grayson	003	1	0
Hamilton	007	1	0
Hardin	005	1	0
Harris	006	21	0
Harrison	004	1	0
Hays	007	1	0
Henderson	004	2	0
Jasper	005	1	0
Jefferson	005	4	0
Johnson	003	1	0
Kendall	008	1	0

County	Region	Child Abuse/Neglect Related Fatalities	Child Abuse/Neglect Related Fatalities in Foster Care at Time*
Lamar	004	1	0
Lampasas	007	1	0
Limestone	007	1	0
McLennan	007	3	0
Montgomery	006	1	0
Nacogdoches	005	2	0
Navarro	003	1	0
Nolan	002	1	0
Nueces	011	2	0
Orange	005	2	0
Panola	004	1	0
Parker	003	1	0
Shelby	005	1	0
Smith	004	3	0
Tarrant	003	11	0
Taylor	002	1	0
Terry	001	1	0
Tom Green	009	1	0
Travis	007	9	0
Victoria	008	2	0
Webb	011	2	0
Wichita	002	2	0
Wilbarger	002	2	0
Williamson	007	4	3
Wood	004	2	0
Yoakum	001	1	0
Young	002	1	0
State Total		151	7
<i>Fatality Counts were frozen on 01/21/15. Does not include corrections or updates, if any, that may subsequently be made to DFPS data.</i>			
<i>Includes child fatalities investigated and confirmed by Child Protective Services (143), Adult Protective Services (0), Child Day Care Licensing (4), and Residential Child Care Licensing (4).</i>			
<i>Note: Child fatalities in foster care may be the result of injuries inflicted prior to the child's entry into foster care and are not necessarily a reflection on the current caretaker.</i>			

FY2015 Child Abuse and Neglect Related Fatalities - By County

Table 8. FY2014 Child Abuse and Neglect Related Fatalities - By County

Child Abuse/Neglect Related Fatalities Fiscal Year 2015			
County	Region	Child Abuse/Neglect Related Fatalities	Child Abuse/Neglect Related Fatalities in Foster Care at Time*
Andrews	009	1	0
Angelina	005	2	0
Atascosa	008	1	0
Bee	001	1	0
Bell	007	4	0
Bexar	008	4	1
Brazoria	006	3	1
Brazos	007	2	0
Calhoun	008	3	0
Cameron	001	3	0
Chambers	006	1	0
Collin	003	1	0
Cooke	003	1	0
Dallas	003	24	0
Denton	003	2	0
Eastland	002	1	0
Ector	009	2	0
Ellis	003	1	0
El Paso	010	4	0
Fort Bend	006	3	0
Freestone	007	1	0
Galveston	006	2	0
Garza	001	1	0
Grayson	003	1	0
Gregg	004	3	0
Hall	001	1	0
Hardin	005	1	0
Harris	006	25	0
Henderson	004	1	0
Hidalgo	001	8	2
Hood	003	2	0
Hunt	003	2	0
Hutchinson	001	1	0
Jefferson	005	2	0

Child Abuse/Neglect Related Fatalities Fiscal Year 2015			
County	Region	Child Abuse/Neglect Related Fatalities	Child Abuse/Neglect Related Fatalities in Foster Care at Time*
Johnson	003	2	0
Kaufman	003	2	0
Lamar	004	1	0
Leon	007	1	0
Lubbock	001	2	0
McLennan	007	1	0
Milam	007	1	0
Montague	002	1	0
Nueces	001	1	1
Parker	003	1	0
Potter	001	1	0
Randall	001	1	0
Real	008	1	0
Reeves	009	1	0
Rockwall	003	2	0
Sabine	005	1	0
Shelby	005	1	0
Smith	004	1	0
Tarrant	003	16	0
Taylor	002	2	0
Tom Green	009	1	0
Travis	007	2	0
Uvalde	008	1	0
Webb	011	4	0
Wichita	002	1	0
Wilbarger	002	1	0
Williamson	007	4	0
Wood	004	2	0
State Total		171	5

Fatality Counts were frozen on 02/01/16. Does not include corrections or updates, if any, that may subsequently be made to DFPS data.

"Includes child fatalities investigated and confirmed by Child Protective Services (158), Adult Protective Services (0), Child Day Care Licensing (13), and Residential Child Care Licensing (0).

Note: Child fatalities in foster care may be the result of injuries inflicted prior to the child's entry into foster care and are not necessarily a reflection on the current caretaker.

FY2014 and FY2015 Confirmed Child Abuse and Neglect Related Fatalities - Case Review Data

Based on the confirmed child abuse and neglect fatalities that occurred during FY2014 and FY2015, several key demographic areas allow for specialized targeting of prevention and intervention in child abuse and neglect cases. Data from these fatalities tells us that these parents would benefit from support, education and targeted campaigns. Communities can use this data to strategically message and target available resources for families and caregivers.

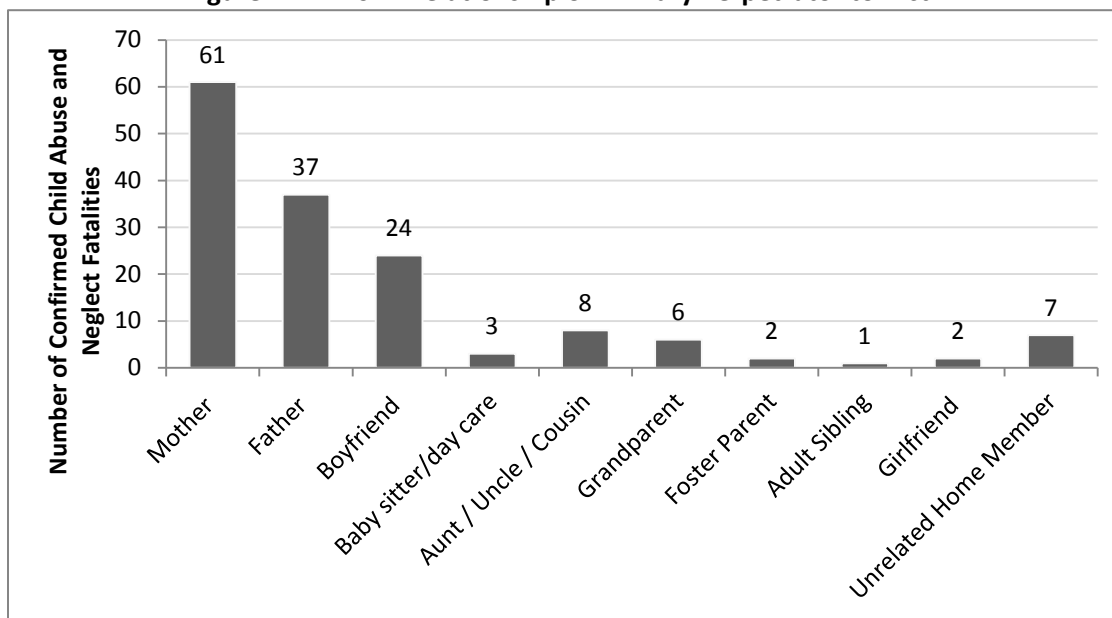
For this analysis, DFPS identified the individual who harmed or was responsible for the child at the time of the fatality, based on a review of the individual cases. In the actual investigation, others in the home at the time of the injury or those who allowed the primary perpetrator to harm the child may also have been designated as perpetrators. For example, in a case where a boyfriend physically abused the child and the mother was neglectful in allowing the boyfriend access, the boyfriend would be identified as the primary perpetrator. In most fatality cases, the parent is the primary perpetrator - but a boyfriend (or rarely, girlfriend), was the perpetrator in 18 percent of the fatalities.

Perpetrators

- Physical abuse in fatalities most commonly involved blunt force trauma inflicted by a father or boyfriend.
- In all confirmed cases of abuse and neglect, parents are the most common perpetrators.
- In just under half of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had no prior history with CPS.

FY2014 Perpetrator Demographic and Characteristics - Relationship and History

Figure 14. FY2014 Relationship of Primary Perpetrator to Victim

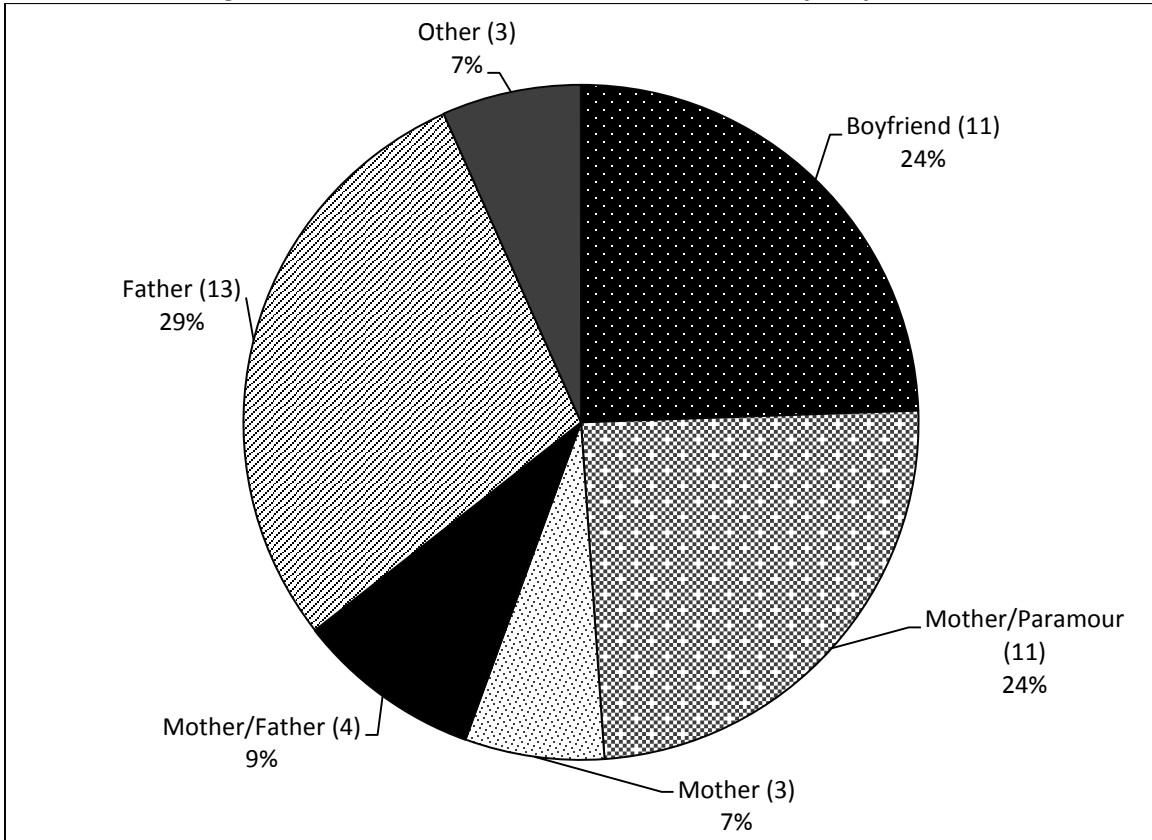


Source: DFPS individual case reviews

FY2014 Primary Perpetrator, Child Age and Cause of Death Together

This analysis looks for patterns in the child's age and the type of primary perpetrator in categories for causes of death involving six children or more. Other categories (such as suicide, house fire, neglectful supervision), each involved fewer than six children. All data in this section is based on case reviews.

Figure 15. FY2014 Blunt Force Trauma Fatalities by Perpetrator



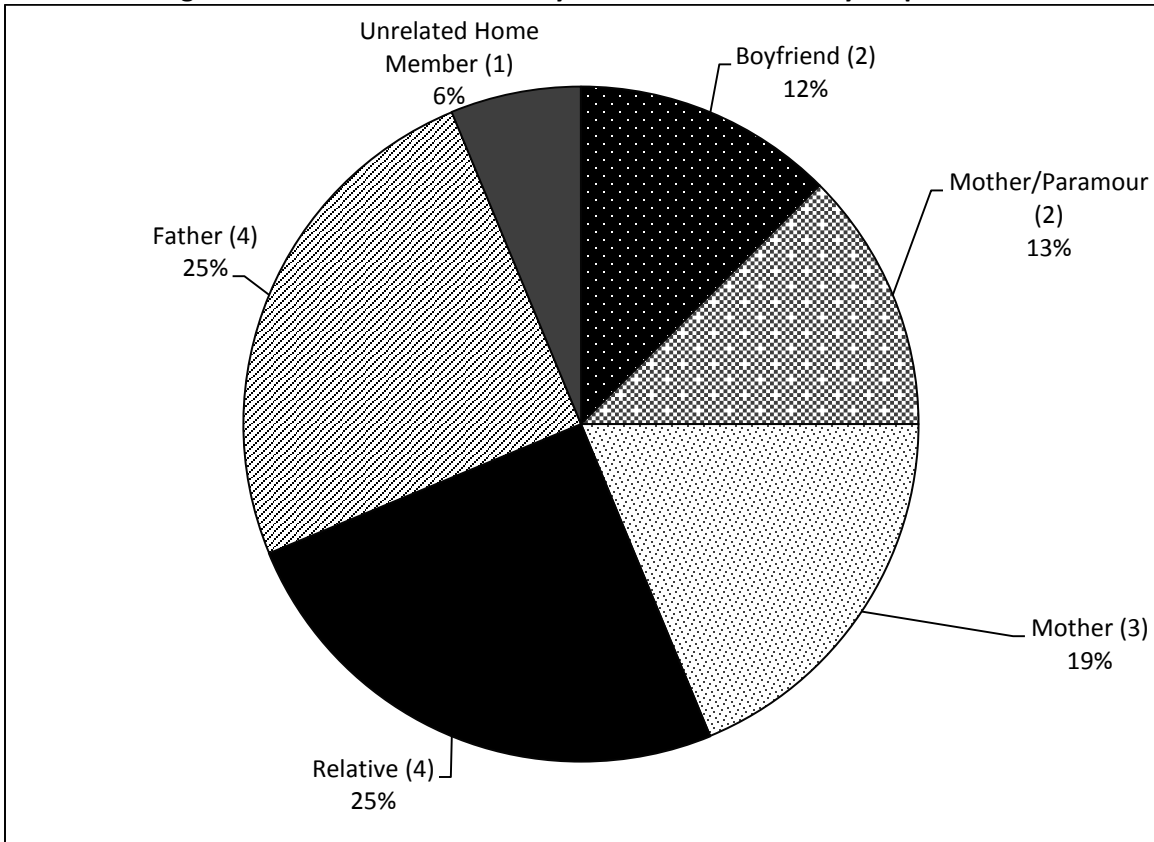
*Other includes: Relative (1), Foster Parent (1), Unrelated Home Member (1)

Number of victims: 45 children

Age range of victims: Two months to six-year-old child. 22 children were younger than one year old; 91% were age two or younger

Finding: Usually involve young children being physically abused by the father (37%) or a boyfriend (48%)

Figure 16. FY2014 Intentional Physical Abuse Fatalities by Perpetrator

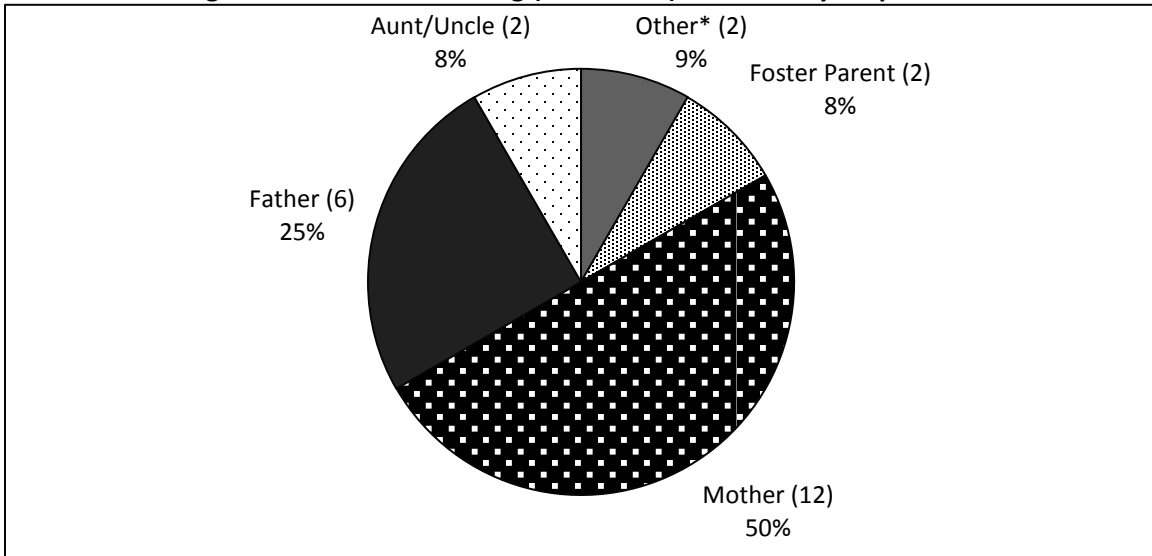


Number of victims: 16 children

Age range of victims: Newborn to 13-year-old child. 12 children were age five and younger

Finding: Usually involve young children being killed by male: father (25%) or a boyfriend (12%) or uncle (25%)

Figure 17. FY2014 Drowning (Accidental) Fatalities by Perpetrator

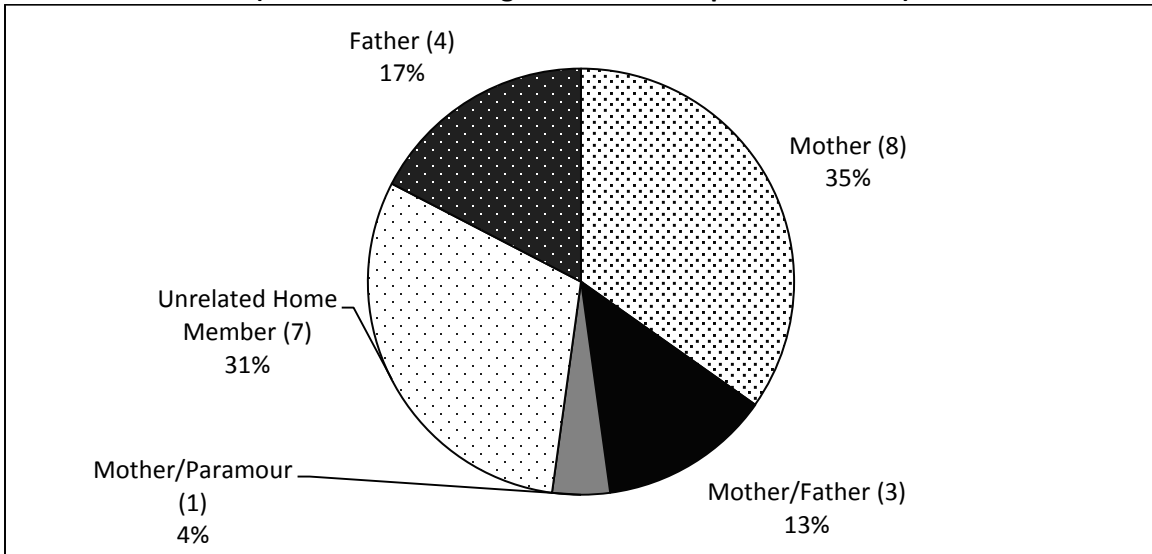


Number of victims: 24 children

Age range of victims: 6 months old to 10 years old

Finding: Usually involve young children with mother as primary perpetrator (55%)

Figure 18. FY2014 Unsafe Sleep Fatalities by Perpetrator (includes bed-sharing and unsafe sleep environments)

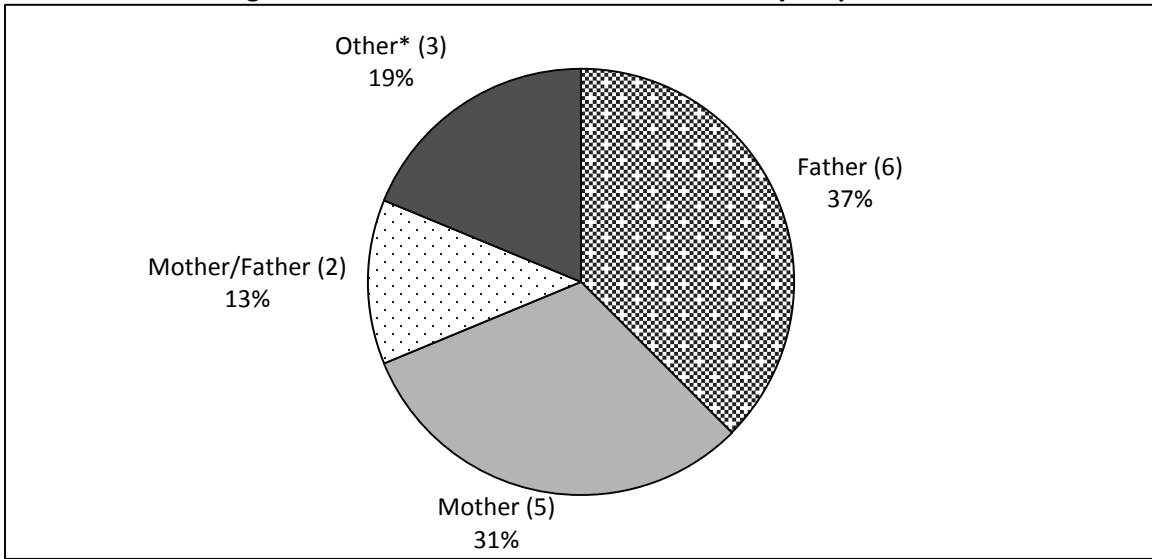


Number of victims: 23 children

Age range of victims: one month old to 1.5 years old

Finding: Generally involve infants but no patterns on primary perpetrator but likely involve the mother either by herself or with either the child's father or boyfriend. In a third of cases, an unrelated home member was involved in the care/supervision of the child while the child was sleeping. The majority of unsafe sleep deaths occurred in a bed with an adult (74%). Deaths while on a couch or chair made up 26% of fatalities.

Figure 19. FY2014 Vehicle Related Fatalities by Perpetrator



*Other** includes unrelated home member (2) and relative (1)

Number of victims: 16 children

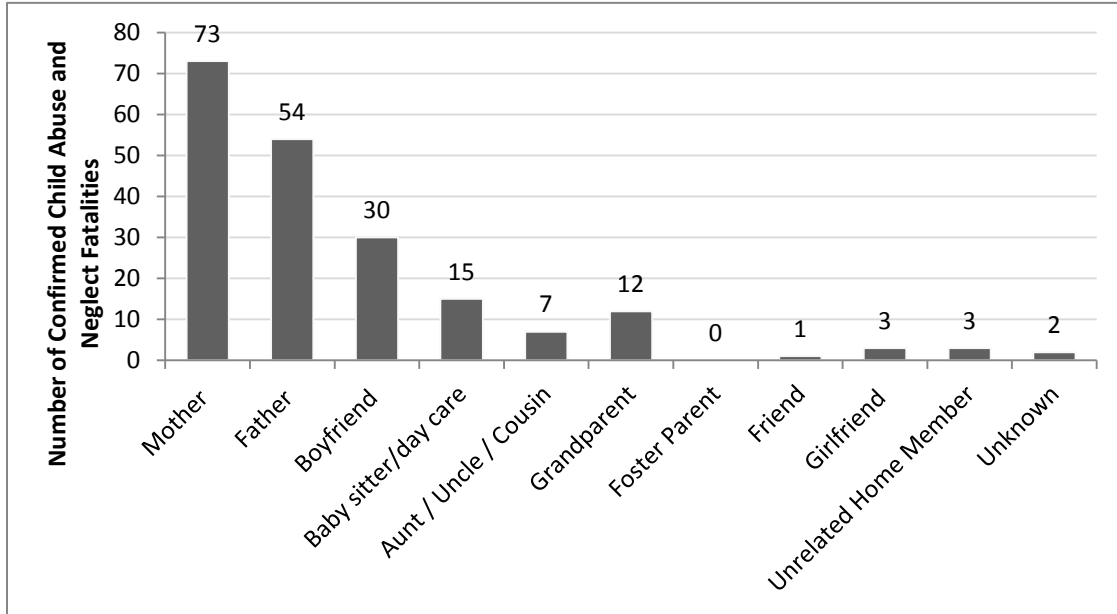
Age range of victims: 3 months old to 12 years old

Finding: Usually happens while in care of the father (37%) compared to in FY2013 when over 50% occurred while in the care of the mother. Almost 80% of children were 5 years old or younger.

FY2015 Perpetrator Demographic and Characteristics - Relationship and History

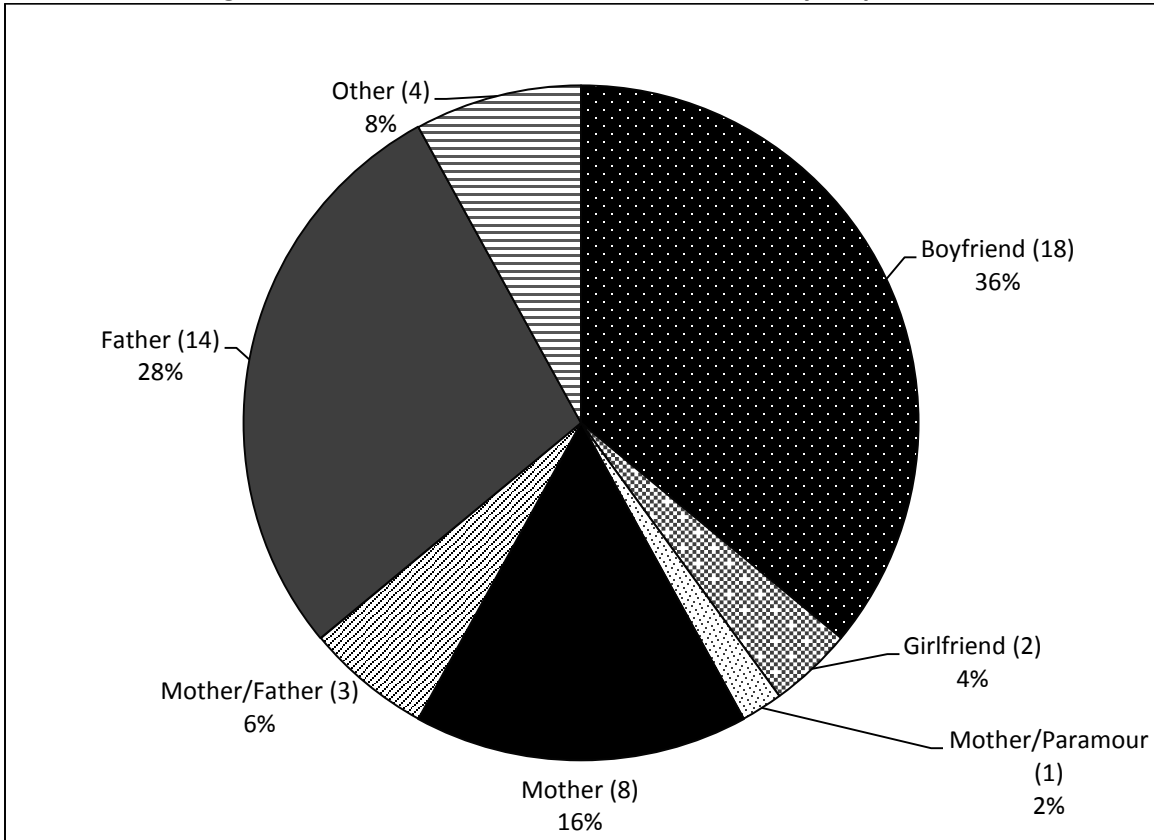
This analysis looks for patterns in the child's age and the type of primary perpetrator in categories for causes of death involving six children or more. Other categories (such as suicide, house fire, neglectful supervision), each involved fewer than six children. All data in this section is based on the DFPS individual case reviews completed for FY2015 confirmed child abuse and neglect related child fatalities.

Figure 20. FY2015 Relationship of Primary Perpetrator to Victim



Source: DFPS individual case reviews

Figure 21. FY2015 Blunt Force Trauma Fatalities by Perpetrator



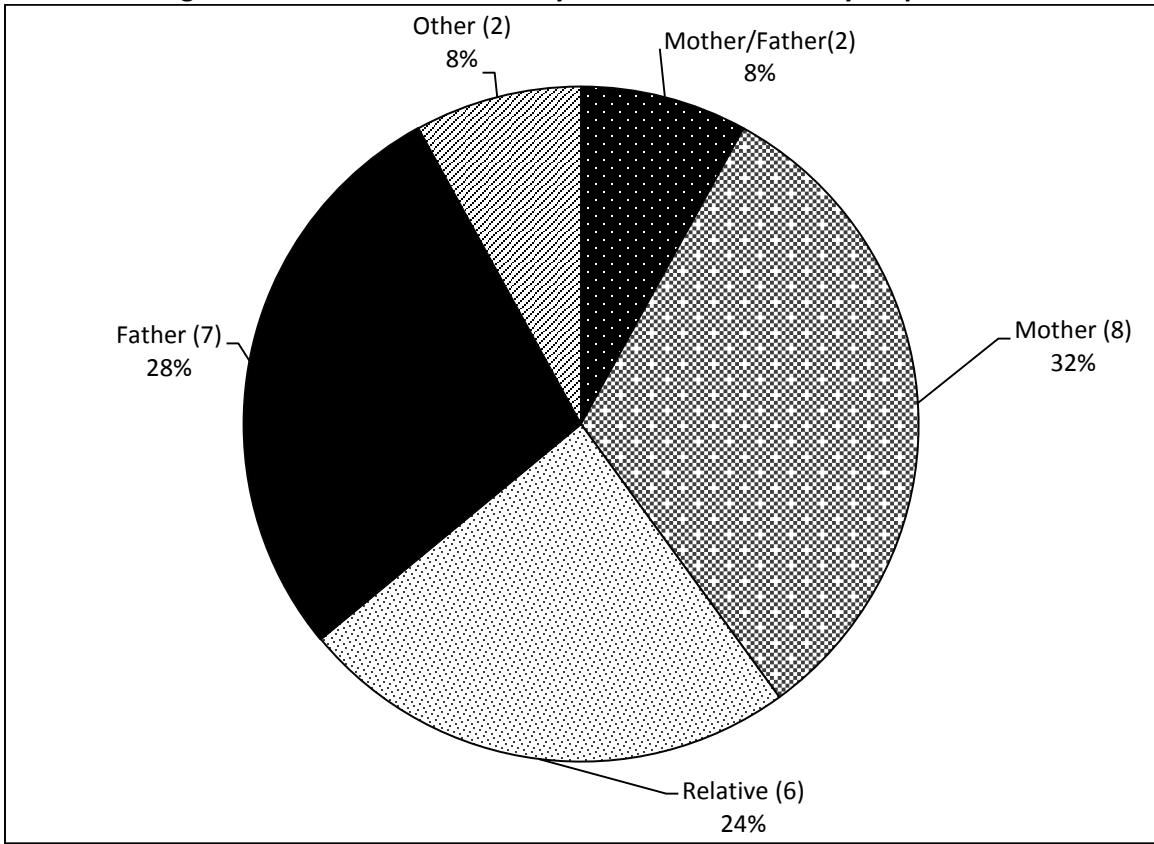
*Other includes: Unknown (2), Babysitter/Day Care (2)

Number of victims: 50 children

Age range of victims: One month to five-year-old child. 20 children were younger than one year old; 82% were age two or younger

Finding: Usually involve young children being physically abused by the father (34%) or a boyfriend (38%)

Figure 22. FY2015 Intentional Physical Abuse Fatalities by Perpetrator



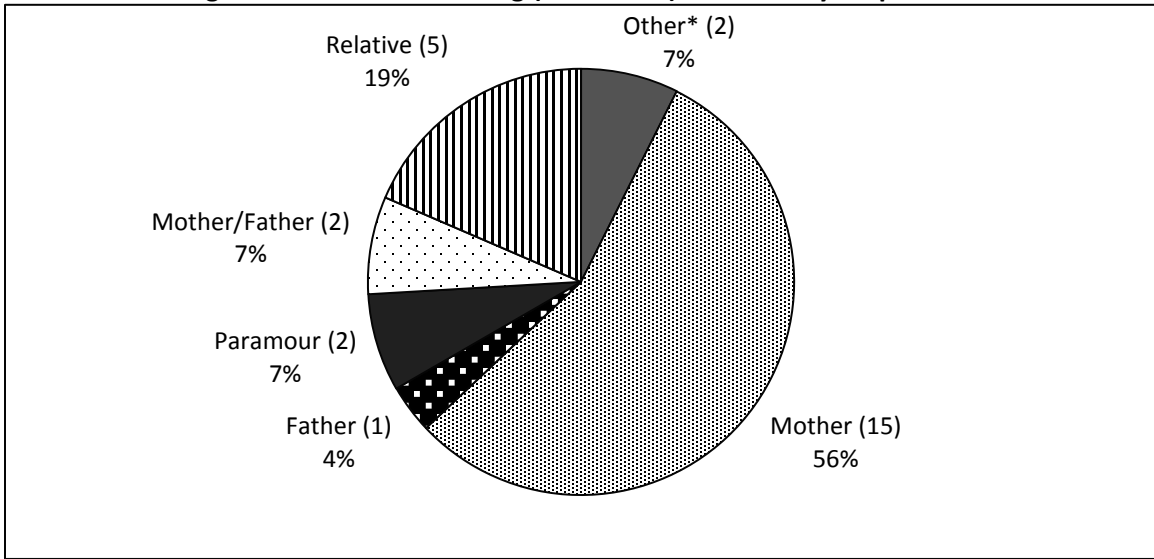
*Other includes: a relative's paramour (1), unrelated home member (1)

Number of victims: 25 children

Age range of victims: Newborn to 16-year-old child. 16 children were age five and younger

Finding: Usually involve young children being killed by known family member: mother (40%), father (36%), or a relative (24%). Three sibling groups died due to intentional acts on the part of a parent or relative in FY2015.

Figure 23. FY2015 Drowning (Accidental) Fatalities by Perpetrator

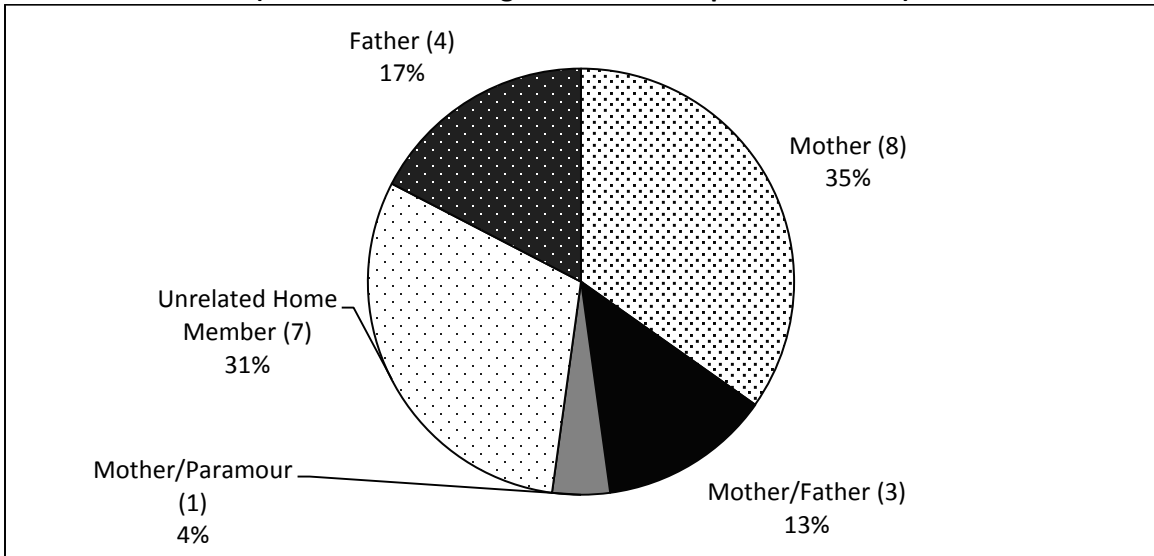


Number of victims: 27 children

Age range of victims: 8 months old to 11 years old

Finding: Usually involve young children with mother as primary perpetrator (63%)

Figure 24. FY2015 Unsafe Sleep Fatalities by Perpetrator (includes bed-sharing and unsafe sleep environments)

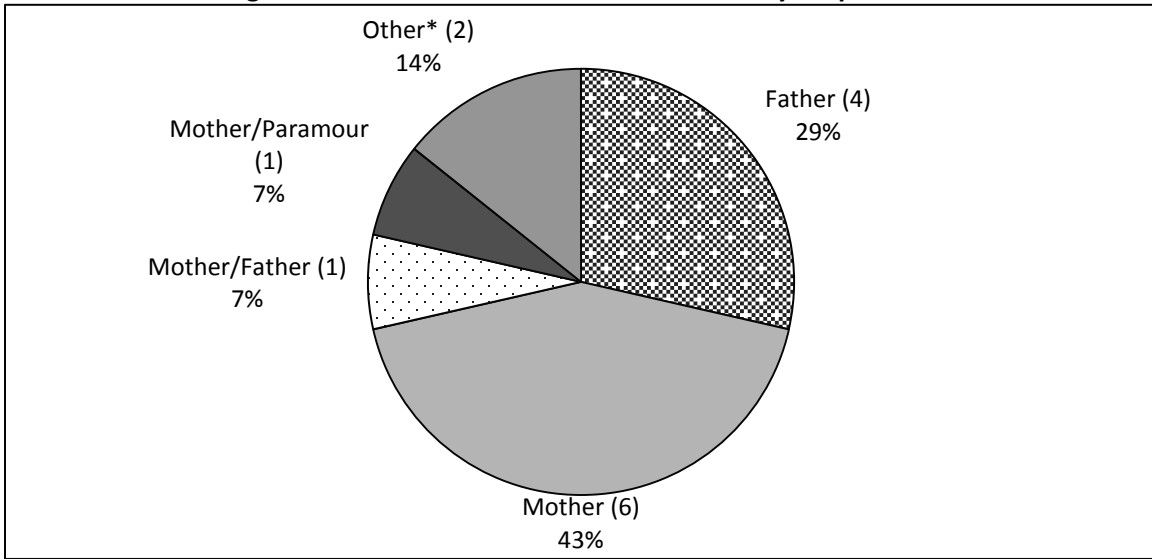


Number of victims: 32 children

Age range of victims: less than one month old to 1 years old

Finding: Generally involve infants but no patterns on primary perpetrator but likely involve the mother either by herself or with either the child's father or her boyfriend. In almost a third of cases, an unrelated home member was involved in the care/supervision of the child while the child was sleeping.

Figure 25. FY2015 Vehicle Related Fatalities by Perpetrator



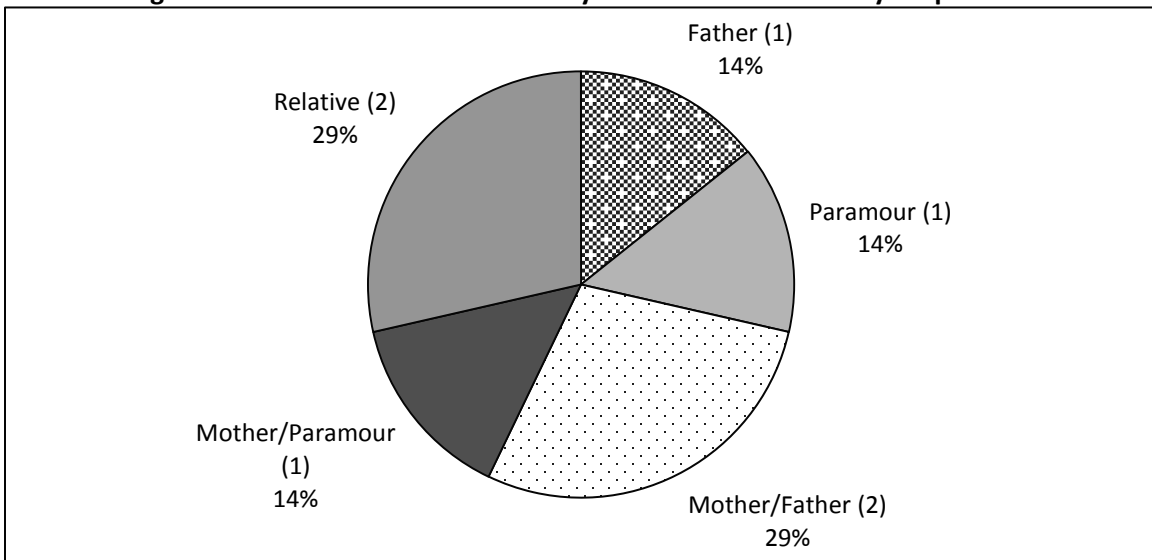
*Other** includes unrelated home member (1) and relative (1)

Number of victims: 14 children

Age range of victims: 1 month old to 5 years old

Finding: Usually happens while in care of the mother (57%) or father (36%). All of children were 5 years old or younger.

Figure 26. FY2015 Fatalities Caused by Accidental Overdose by Perpetrator

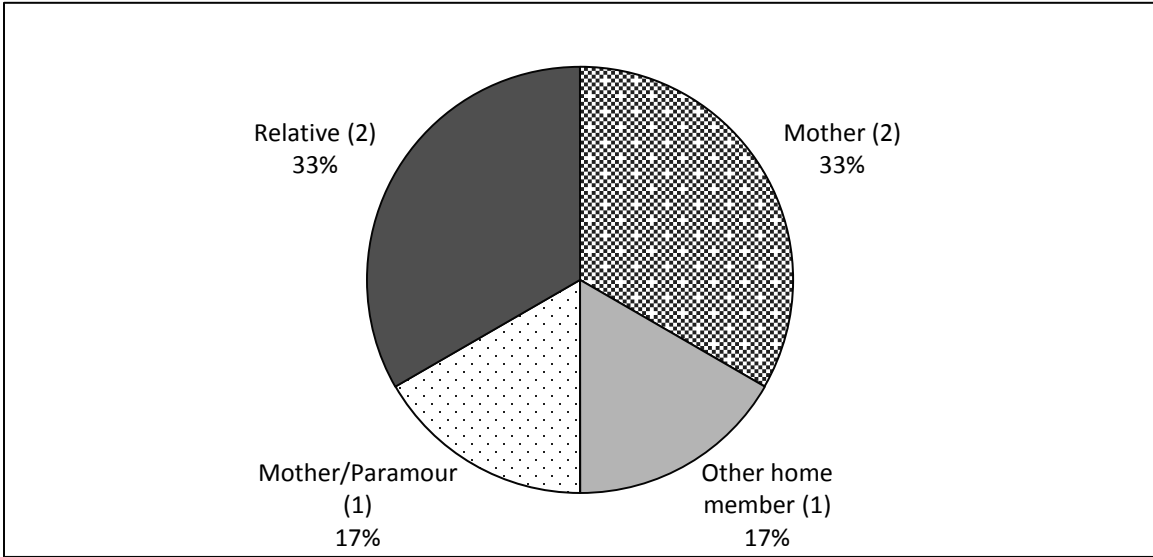


Number of victims: 7 children

Age range of victims: 2 months old to 3.5 years old

Finding: Usually happens while in care of the mother (43%) or father (43%). All of children were 5 years old or younger.

Figure 27. FY2015 Fatalities Caused by Accidental Firearm by Perpetrator

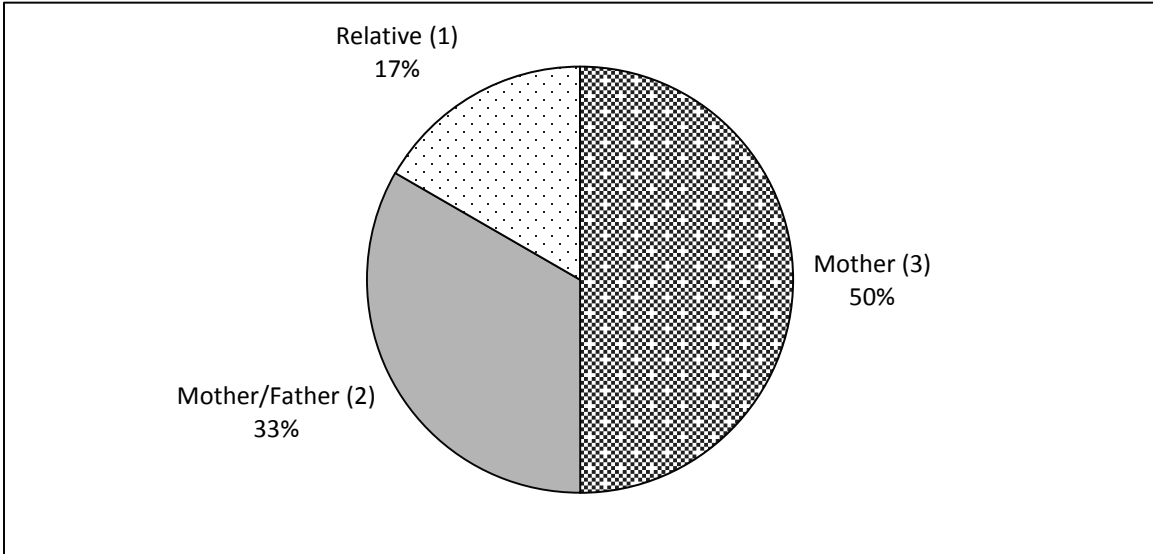


Number of victims: 6 children

Age range of victims: 2 years old to 4.5 years old

Finding: Usually happens while in care of the mother (50%) or a relative/other home member (50%). All of children were 5 years old or younger.

Figure 28. FY2015 Physical Neglect/Medical Neglect Fatalities by Perpetrator



Number of victims: 6 children

Age range of victims: 1 month old to 2 years old

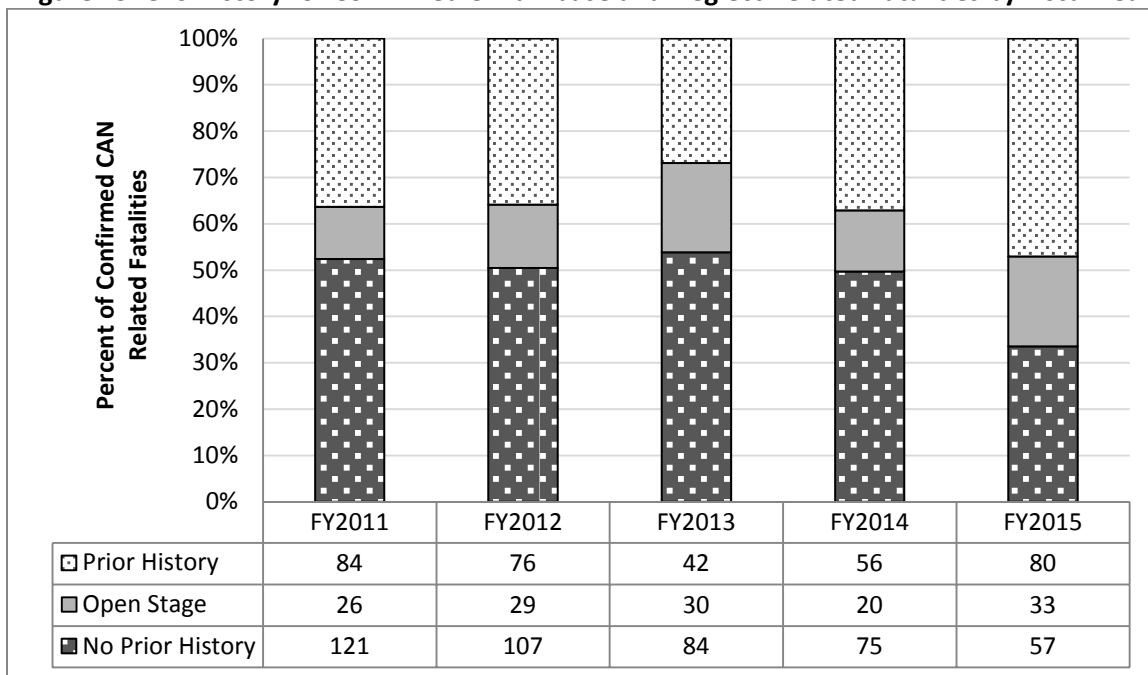
Finding: Usually happens while in care of the mother. All of children were 5 years old or younger.

Prior CPS History in Child Abuse and Neglect-Related Fatalities

To better understand fatalities, it is important to identify if families had prior involvement with CPS. DFPS defines prior CPS history broadly – if the deceased child or a designated perpetrator in the fatality had been in a CPS investigation or received CPS services before the child's death. Under this definition, it counts as prior CPS history even if the last contact with CPS was several years before the death or was unrelated to the circumstances of the fatality. Even under this broad definition, most child abuse and neglect fatalities had no prior CPS history. In about 15 percent of the child abuse and neglect fatalities, CPS was involved with the family or the child at the time of the death. In almost 30 percent, CPS had been involved with the child or the perpetrator in the past.

Child abuse and neglect-related fatalities where the child died while CPS was involved with the family usually consists of unintentional acts such as accidental drowning and unsafe sleep. It can be difficult to predict if these types of circumstances will occur. Preventing child fatalities primarily depends upon educating caregivers about "situational awareness," for example proper supervision around water and safe sleep. In contrast, more than a third of child abuse and neglect-related fatalities with prior CPS involvement involved intentional acts, such as blunt force trauma.

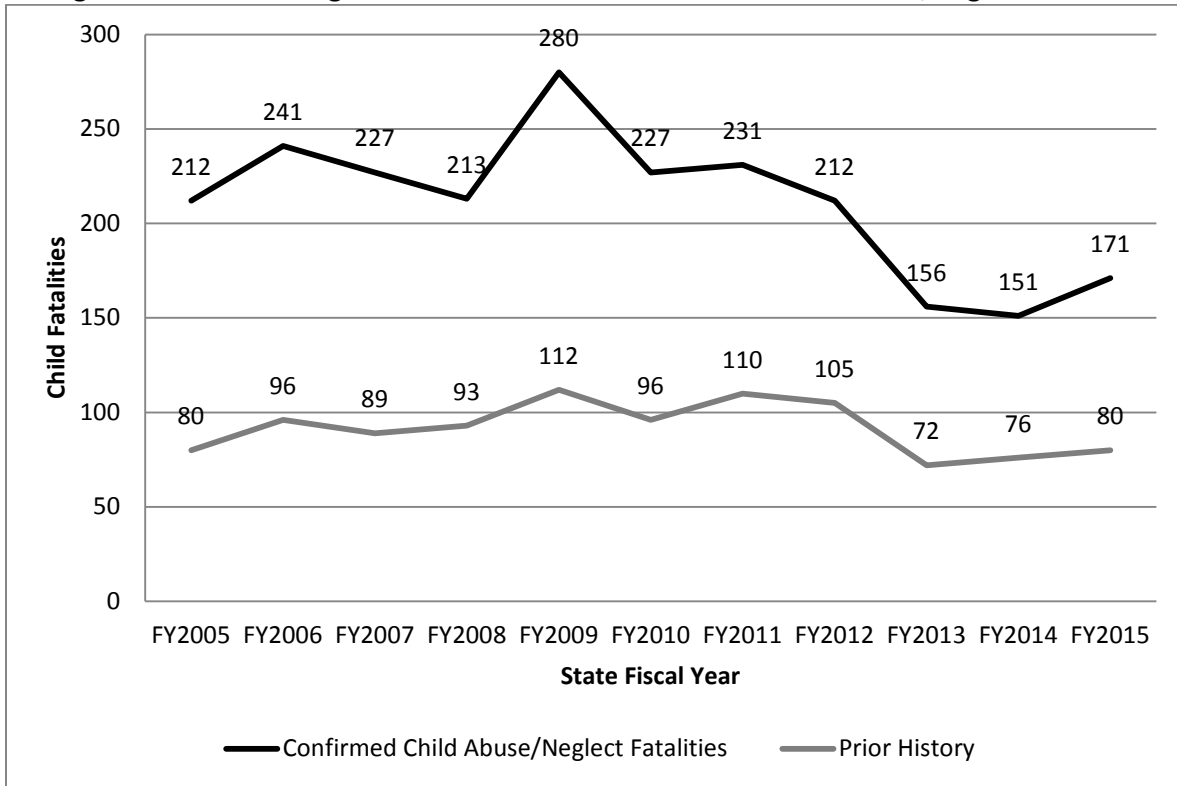
Figure 29. CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Fiscal Year



Source: DFPS Data Warehouse Report FT_06

Also, a child fatality may occur in an open case such as Investigations, Family Based Safety Services, or Conservatorship. Most fatalities that occur in the CPS custody are not abuse or neglect-related but from terminal medical conditions that existed prior to DFPS intervention. Figure 30 uses FY2014 and FY2015 child abuse and neglect fatality investigation data to breakdown the overall number of child fatalities investigated and those where the abuse or neglect caused the child fatality. In FY2014, there were 20 confirmed child abuse or neglect-related fatalities with an open case at the time. In FY2015, there were 19 confirmed child abuse or neglect-related fatalities with an open case at the time.

Figure 30. DFPS Investigated Child Fatalities and Confirmed Child Abuse/Neglect Fatalities



Source: DFPS Data Warehouse Report FT_06

For FY2014, based on Figure 19, the following conclusions are noted:

- 20 children were involved with CPS at the time of death.
 - 9 of the children were in an active investigation and a new incident of abuse or neglect occurred leading to the fatality
 - 8 of the children were in an active Family Based Safety Services stage and a new incident of abuse or neglect occurred leading to the fatality
 - 7 of the children were in an active conservatorship stage at the time of the fatality
 - 3 of the children were in foster care and a new incident of abuse or neglect occurred leading to the fatality
 - 4 of the children were removed into CPS custody after suffering fatal injuries while in the care of their parents and died while in care

For FY2015, based on Figure 19, the following conclusions are noted:

- 19 children were involved with CPS at the time of their death.
 - 10 of the children were in an active investigation and a new incident of abuse or neglect occurred leading to the fatality
 - 7 of the children were in an active Family Based Safety Services case and a new incident of abuse or neglect occurred leading to the fatality
 - 2 of the children were in an active conservatorship stage at the time of the fatality
 - 2 of the children had been ordered home by a court and were involved in a Family Reunification stage when a new incident of abuse or neglect occurred leading to the fatality

- 4 of the children were removed into CPS custody after already suffered the fatal injuries and died while in care
- There were no fatalities in foster care or kinship care in FY2015. Six investigations remained open at time of publishing and are not included in the data below.

FY2014 Prior CPS History in Child Abuse and Neglect-Related Fatalities

Figure 31. FY2014 Department of Family and Protective Services (DFPS) Data on Child Abuse and Neglect Related Fatalities Statewide

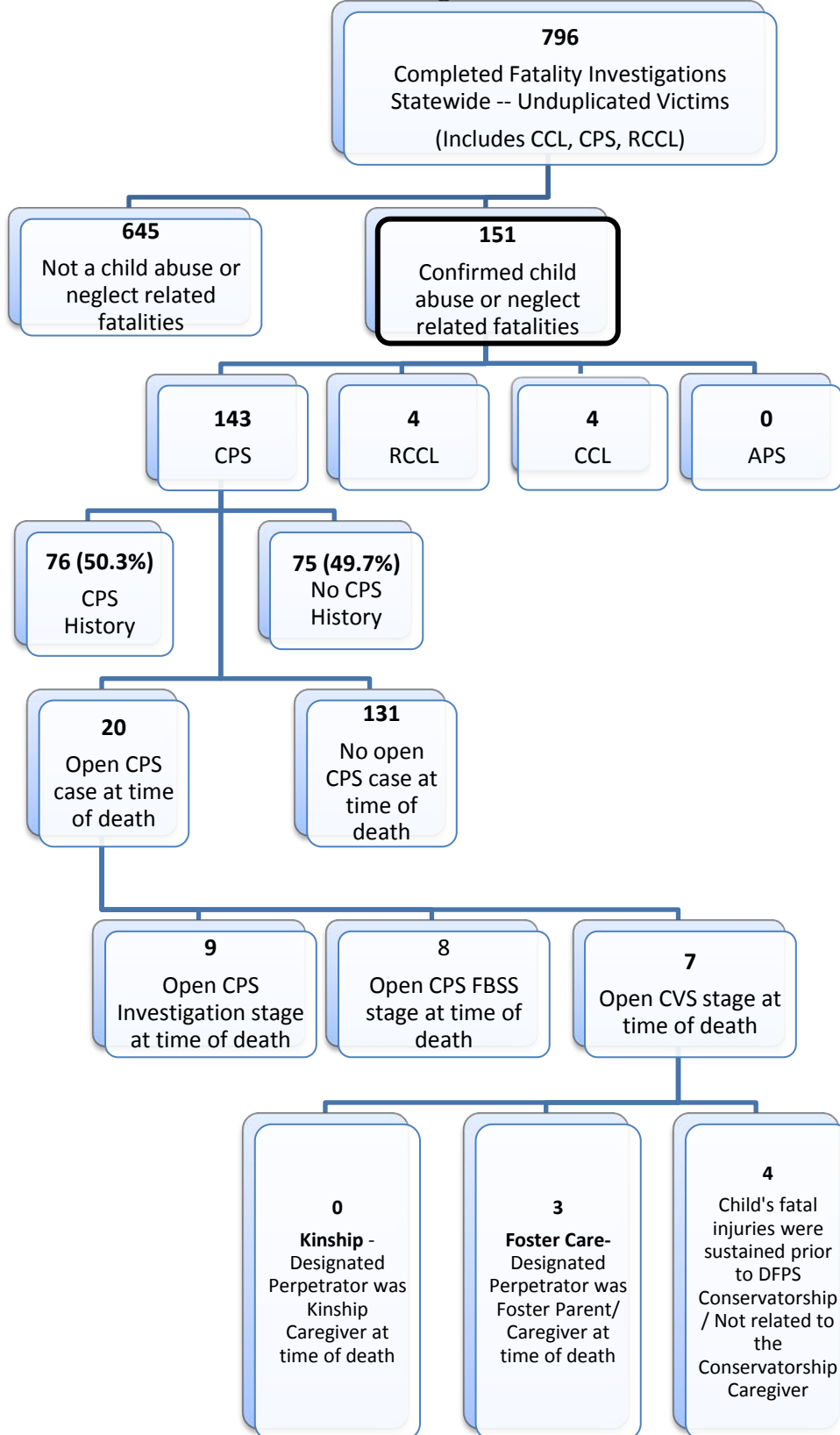
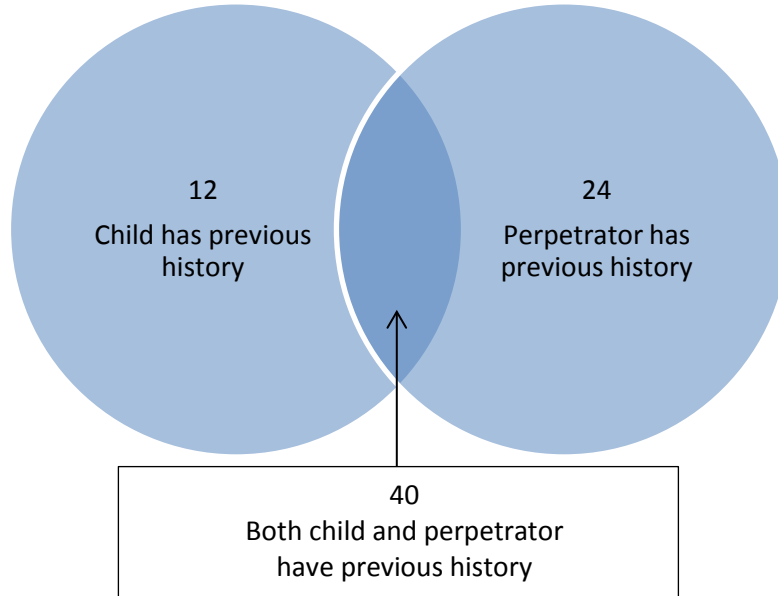
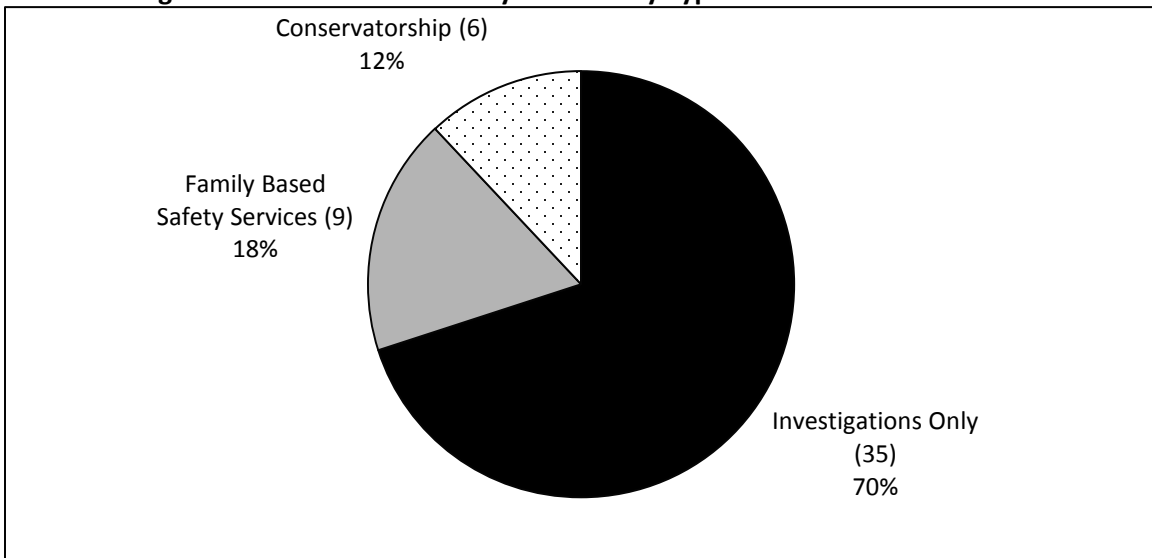


Figure 32. FY2014 Prior History by Child/Perpetrator with of Previous Involvement



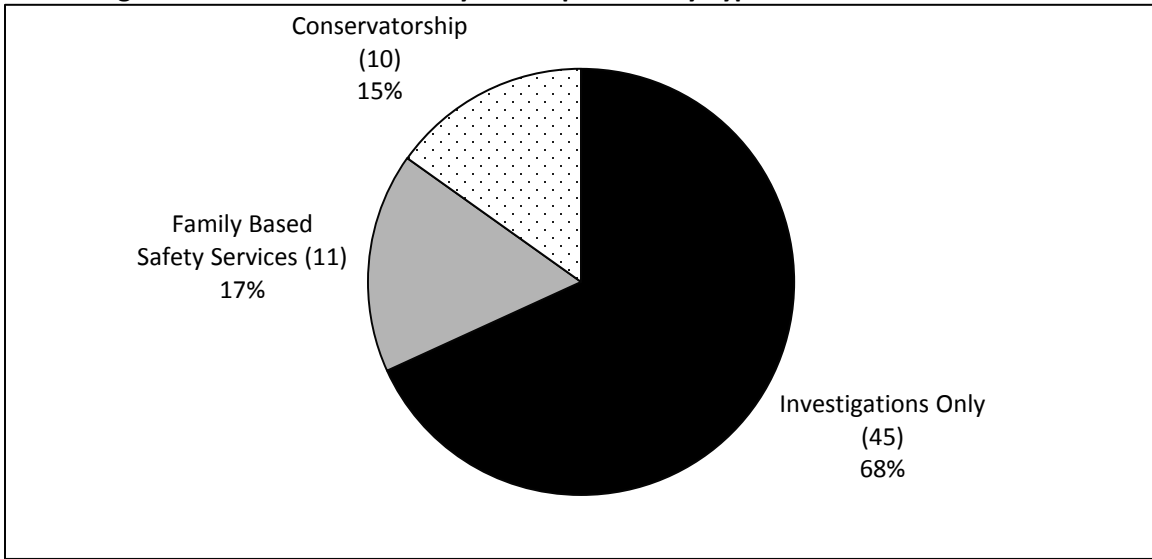
Source: DFPS individual case reviews – includes history that may be purged from IMPACT but was referenced in case narrative.

Figure 33. FY2014 Prior History for Child by Type of Previous Involvement



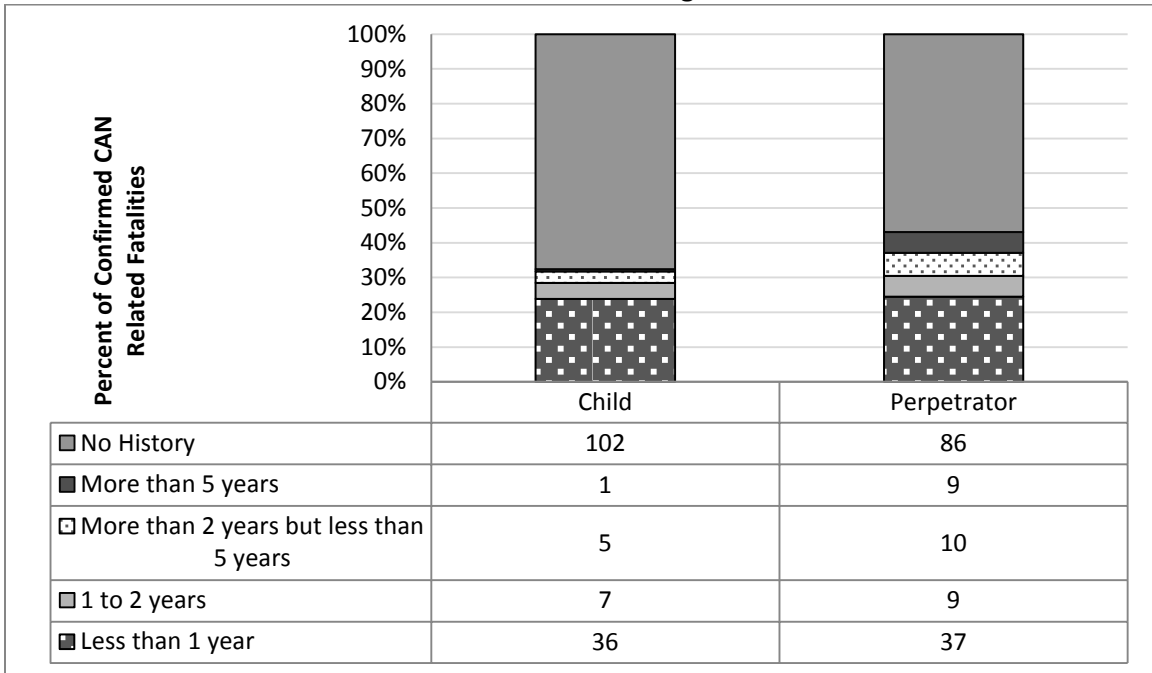
Source: DFPS individual case reviews

Figure 34. FY2014 Prior History for Perpetrator by Type of Previous Involvement



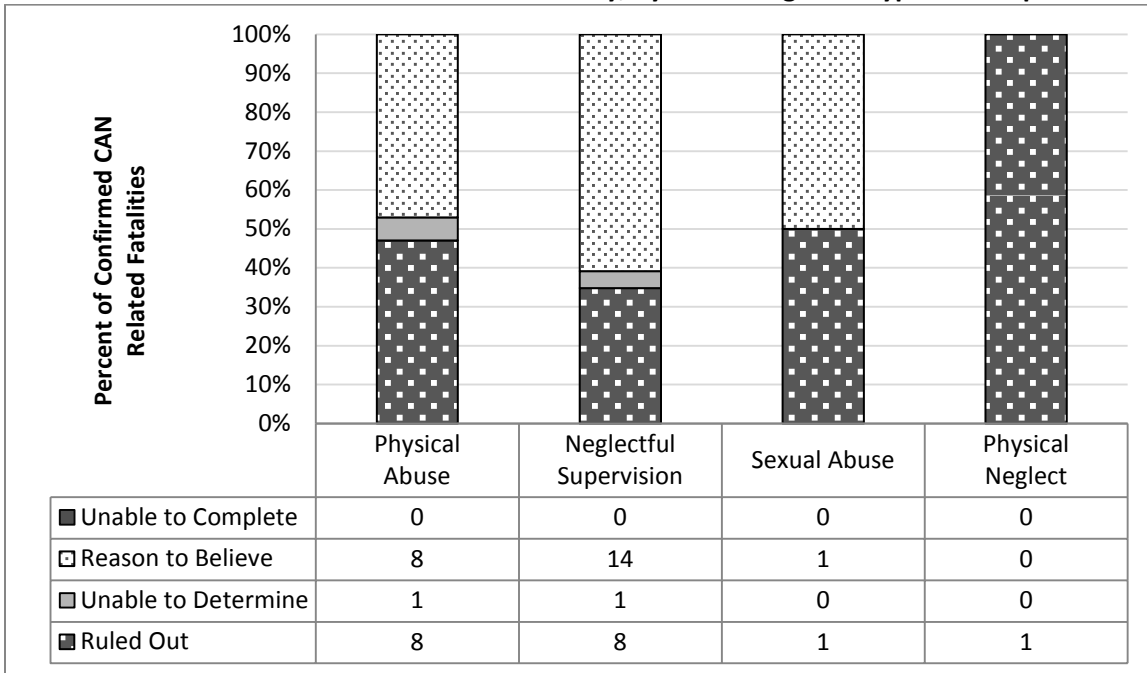
Source: DFPS individual case reviews

Figure 35. FY2014 CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Length of Time since Last Active Stage Closed



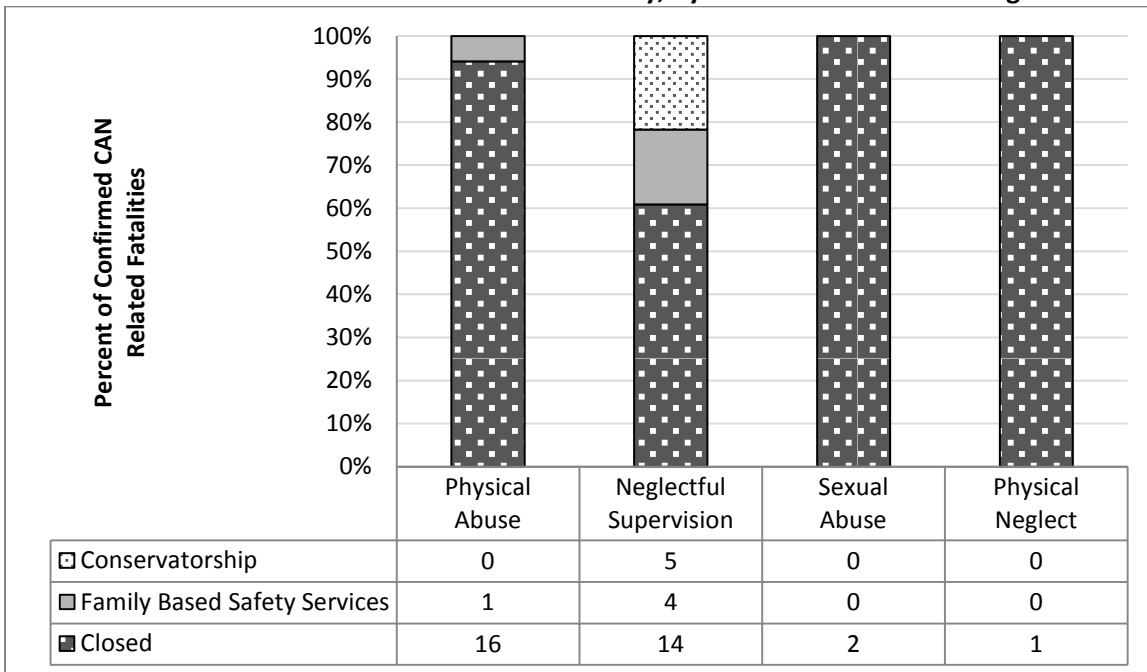
Source: DFPS individual case reviews

Figure 36. CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



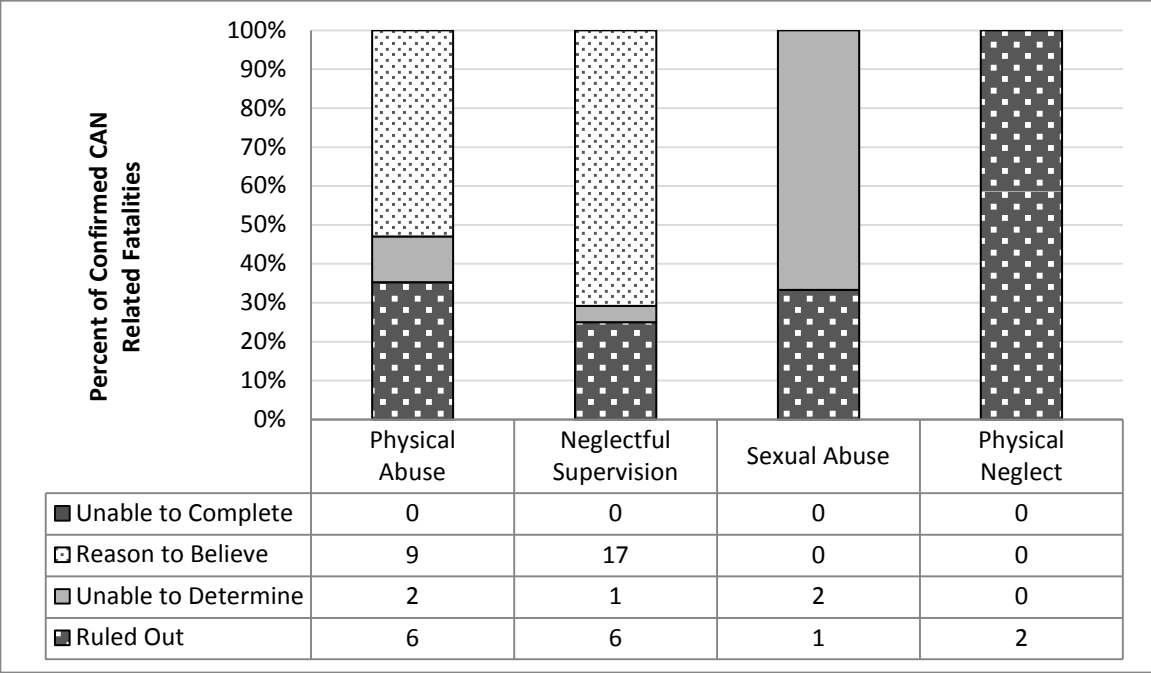
Source: DFPS individual case reviews

Figure 37. CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child in the Two Years Prior to Fatality, by Outcome of Prior Investigation



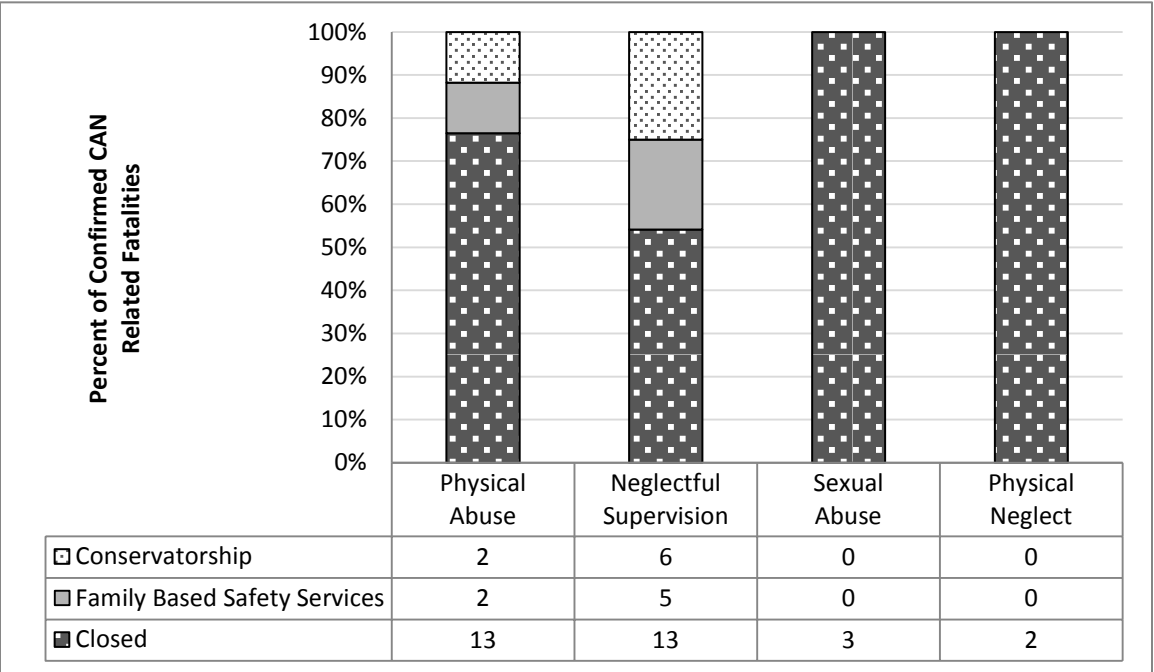
Source: DFPS individual case reviews

Figure 38. 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 39. 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 60 percent of all confirmed child abuse and neglect fatalities in FY2014, this pattern is also repeated in the subset of confirmed fatalities where the child or perpetrator had previous history with DFPS.

- When the child or perpetrator was previously known to DFPS due to concerns for neglect, the child fatality is most likely to involve a new incident of neglect.
- When the child or perpetrator was previously known to DFPS due to concerns for physical abuse, about half of the confirmed child fatalities are likely to involve a new incident of physical abuse. For FY2014, 16 of the 17 children who had previous history in the two years prior to their death had allegations of physical abuse but did not receive services. Ongoing work will look at medical evaluations during physical abuse investigations, child safety at case closure, and if services were recommended to address physical abuse concerns.

Table 9. FY2014 Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child in the Two Years Prior to Fatality, by Prior Allegation Type and Cause of Fatality

	Drowning Related	Unsafe Sleep Related	Vehicle Related	Physical Abuse	Other	Total
Prior Physical Abuse Allegation	-	3	1	8	5	17
Prior Neglectful Supervision Allegation	4	3	4	7	5	23
Prior Sexual Abuse Allegation	-	-	-	1	1	2
Prior Physical Neglect Allegation	-		-	-	1	1
Total	4	6	5	16	12	43

Source: DFPS individual case reviews

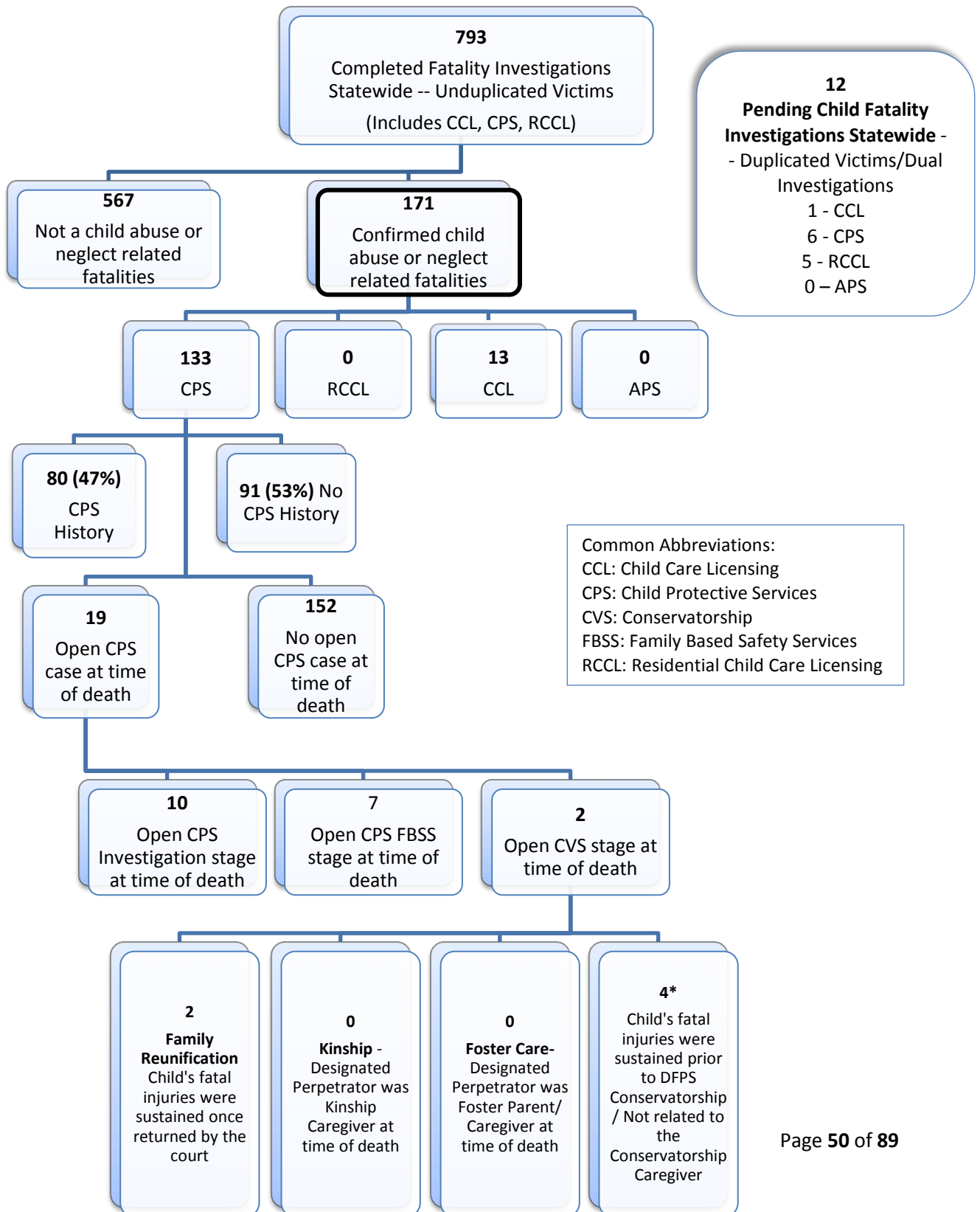
Table 10. FY2014 Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Perpetrator in the Two Years Prior to Fatality, by Prior Allegation Type and Cause of Fatality

	Drowning Related	Unsafe Sleep Related	Vehicle Related	Physical Abuse	Other	Total
Prior Physical Abuse Allegation	1	3	-	9	4	17
Prior Neglectful Supervision Allegation	4	6	3	5	6	24
Prior Sexual Abuse Allegation	-	-	2	1	-	3
Prior Physical Neglect Allegation	-	1	-	-	1	2
Total	5	10	6	14	11	46

Source: DFPS individual case reviews

FY2015 Prior CPS History in Child Abuse and Neglect-Related Fatalities

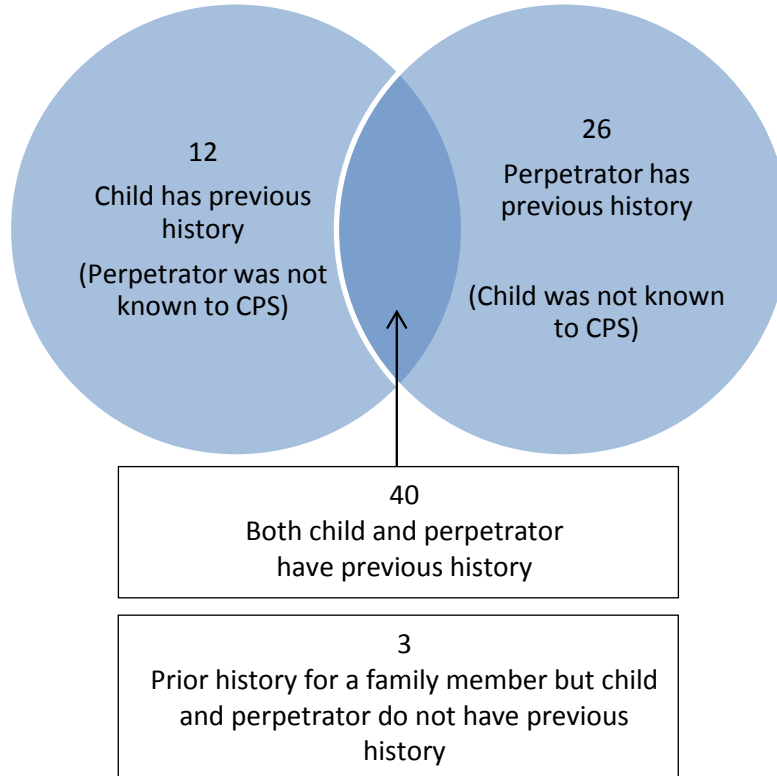
Figure 40. FY2015 Department of Family and Protective Services (DFPS) Data on Child Abuse and Neglect Related Fatalities Statewide



12
Pending Child Fatality Investigations Statewide -
 - Duplicated Victims/Dual Investigations
 1 - CCL
 6 - CPS
 5 - RCCL
 0 - APS

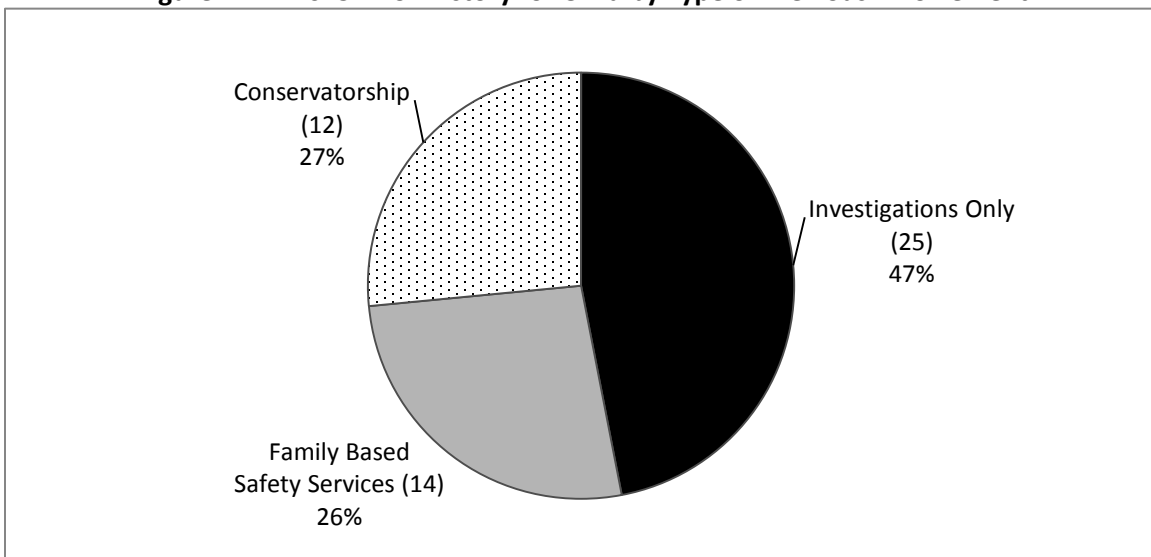
Common Abbreviations:
 CCL: Child Care Licensing
 CPS: Child Protective Services
 CVS: Conservatorship
 FBSS: Family Based Safety Services
 RCCL: Residential Child Care Licensing

Figure 41. FY2015 Prior History by Child/Perpetrator with of Previous Involvement



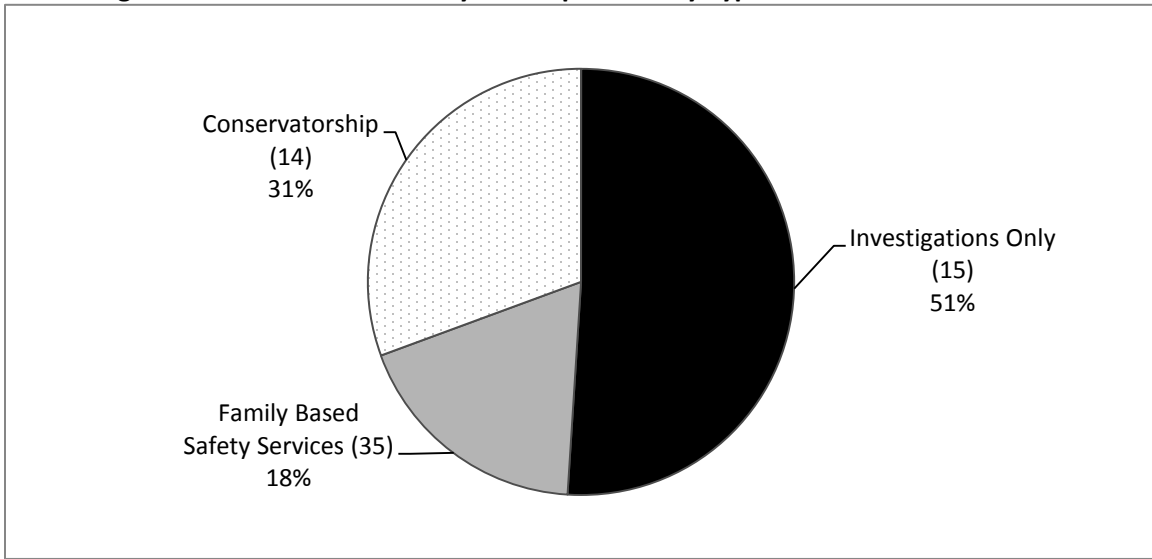
Source: DFPS individual case reviews – includes history that may be purged from IMPACT but was referenced in case narrative.

Figure 42. FY2015 Prior History for Child by Type of Previous Involvement



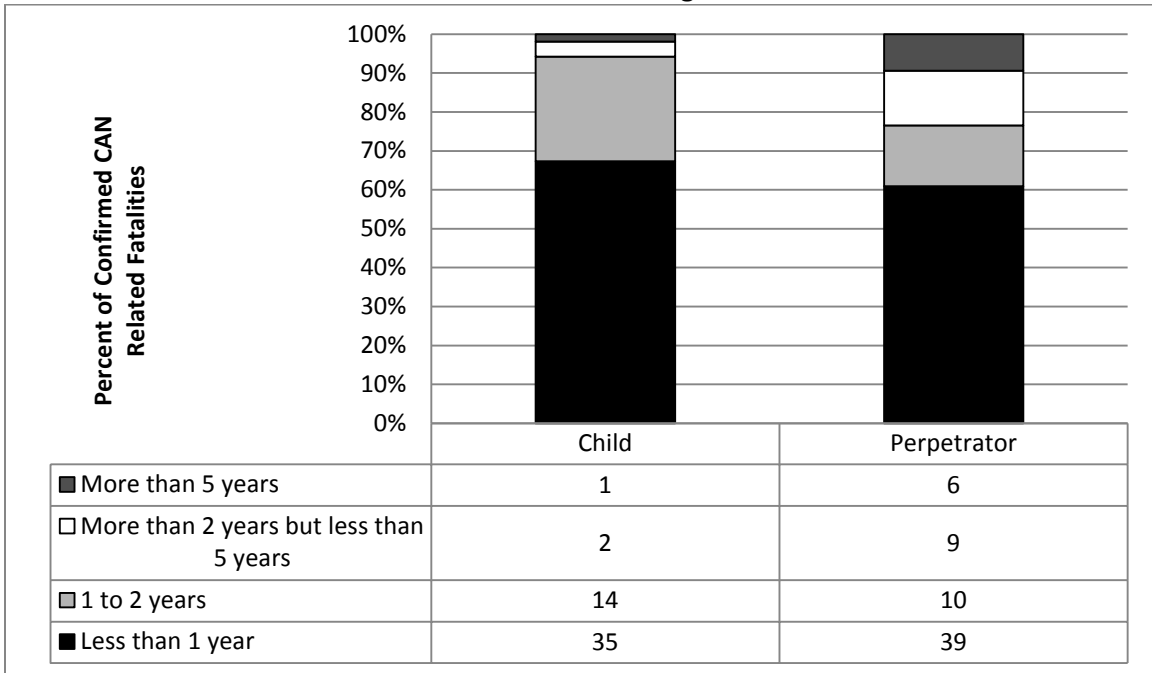
Source: DFPS individual case reviews

Figure 43. FY2015 Prior History for Perpetrator by Type of Previous Involvement



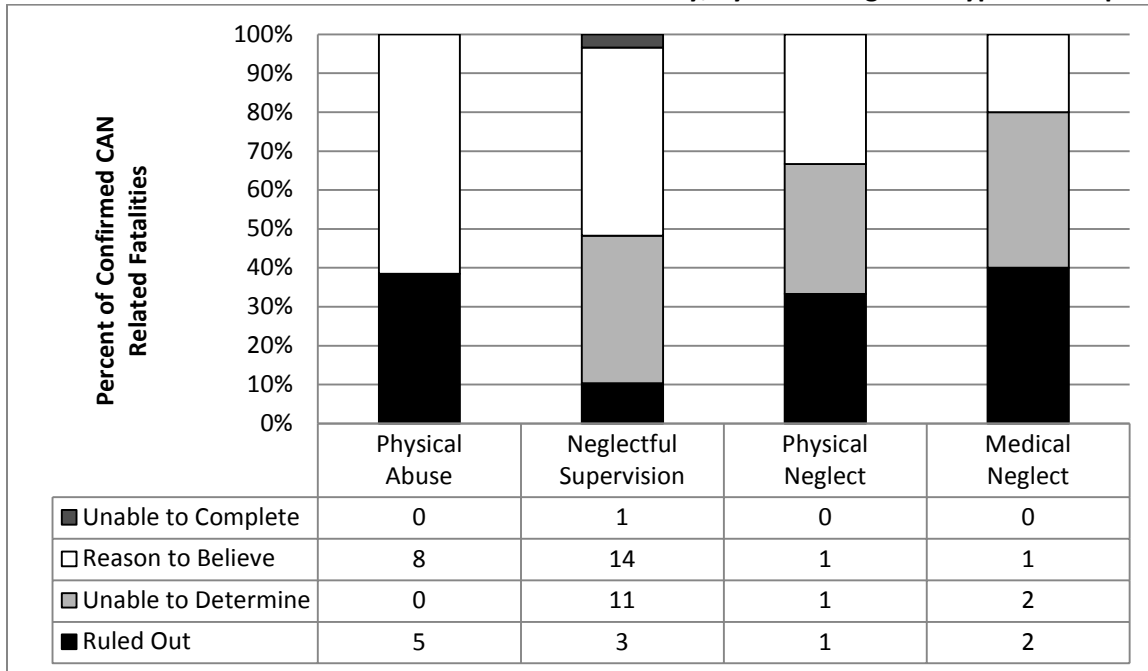
Source: DFPS individual case reviews

Figure 44. FY2015 CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Length of Time since Last Active Stage Closed



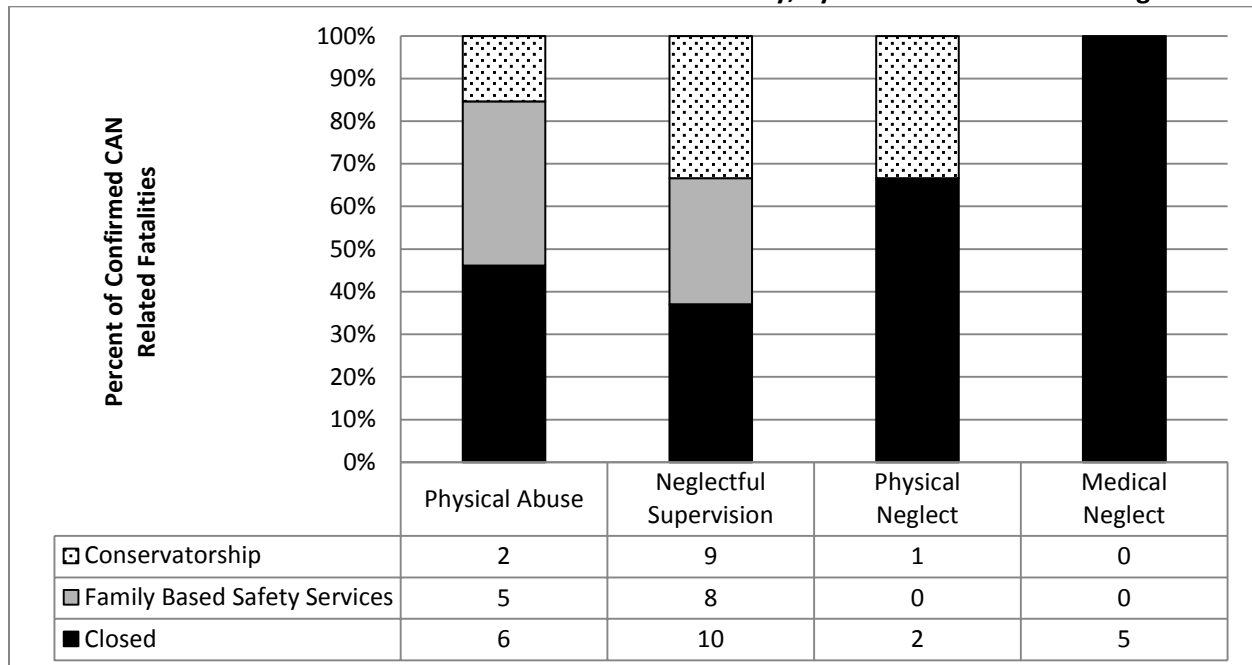
Source: DFPS individual case reviews

Figure 45. FY2015 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



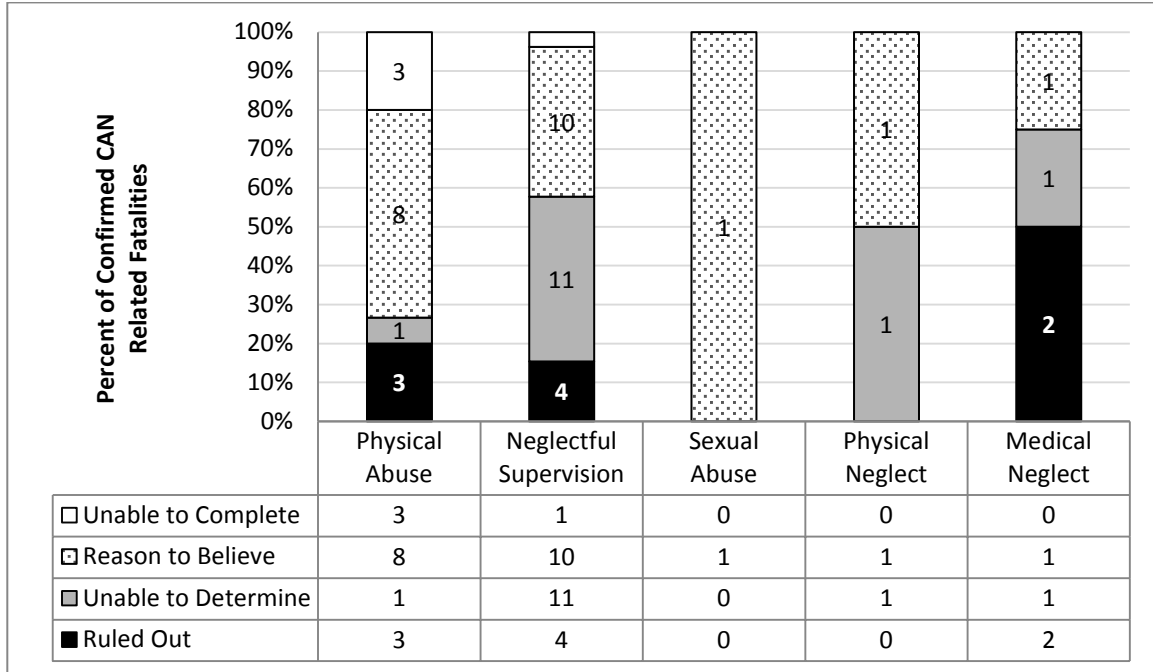
Source: DFPS individual case reviews

Figure 46. FY2015 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child in the Two Years Prior to Fatality, by Outcome of Prior Investigation



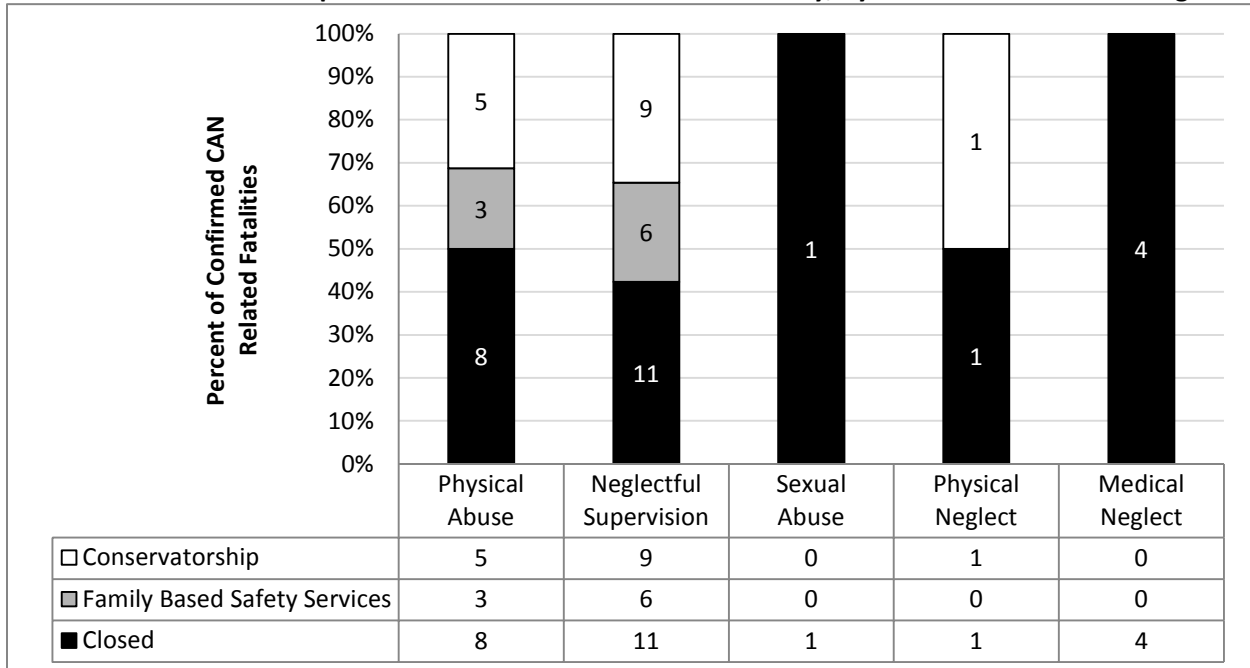
Source: DFPS individual case reviews

Figure 47. FY2015 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 48. FY2015 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 the 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 60 percent of all confirmed child abuse and neglect fatalities in FY2015, this pattern is also repeated in the subset of confirmed fatalities where the child or perpetrator had previous history with DFPS.

- When the child or perpetrator was previously known to DFPS due to concerns for neglect, the child fatality is most likely to involve a new incident of neglect.
- When the child or perpetrator was previously known to DFPS due to concerns for physical abuse, about half of the confirmed child fatalities are likely to involve a new incident of physical abuse. For FY2015, 6 of the 13 children who had previous history in the two years prior to their death had allegations of physical abuse but did not receive services. Ongoing work will look at medical evaluations during physical abuse investigations, child safety at case closure, and if services were recommended to address physical abuse concerns.

Table 11. FY2015 Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child in the Two Years Prior to Fatality, by Prior Allegation Type and Cause of Fatality

	Drowning Related	Unsafe Sleep Related	Vehicle Related	Physical Abuse	Other	Total
Prior Physical Abuse Allegation	2	2	2	6	1	13
Prior Neglectful Supervision Allegation	3	4	1	11	9	28
Prior Physical Neglect Allegation	-	-	-	1	2	3
Prior Medical Neglect	1	-	-	4	-	5
Total	6	6	3	22	12	49

Source: DFPS individual case reviews

Table 12. FY2015 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	4	4	1	6		15
Prior Neglectful Supervision Allegation	1	4	2	12	7	26
Prior Sexual Abuse Allegation				1		1
Prior Physical Neglect Allegation					2	2
Prior Medical Neglect Allegation	1			1	2	4
Total	6	8	3	20	11	48

Source: DFPS individual case reviews

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

The Federal Child Abuse Prevention and Treatment Act (CAPTA) and Texas Family Code (Tex. Fam. Code §261.203 and Tex. Fam. Code §261.004) require that specific information about fatalities *caused by or the result of* abuse or neglect be reported. The Texas Family Code considers all other information to be confidential. (Tex. Fam. Code §261.201) As a result, we cannot currently report case specific details on child fatalities where abuse or neglect was not the cause of the fatality, but can report aggregate information. Analyzing child fatalities in which abuse or neglect occurred but did not cause the fatality can help target specific prevention and intervention services both in the community and by DFPS contractors. It is important to remember that dispositions in child fatality investigations are reviewed by several levels of management and rely heavily on medical personnel and law enforcement.

Further analysis and individual case readings in these types of investigations is a useful tool to inform strategies to prevent child fatalities and ensure consistency in investigations in which a child fatality has occurred. These cases have similar demographics as confirmed child fatalities caused by abuse and neglect: the victim is often under a year old, male, and often there is a component of neglectful supervision. One difference is that victims in this category are often three months of age or younger at the time of their death.

General Findings

- In FY2015, there were 111 child fatalities where the death was not related to abuse or neglect, but the investigation found abuse or neglect had occurred in the home.
- Most child fatalities that are found to be not related to abuse or neglect are due to medical issues or accidents unrelated to abuse or neglect (such as car accident, fire in the home, undetermined cause while sleeping). When abuse or neglect is confirmed, it is often because a newborn has died from a medical condition or undetermined causes but there were concerns for substance abuse or issues in the home for either that child or a surviving sibling.
- Fatality investigation often show coordination with law enforcement, medical examiner's office, and the use of forensic interviews to determine the role that abuse or neglect played in the death

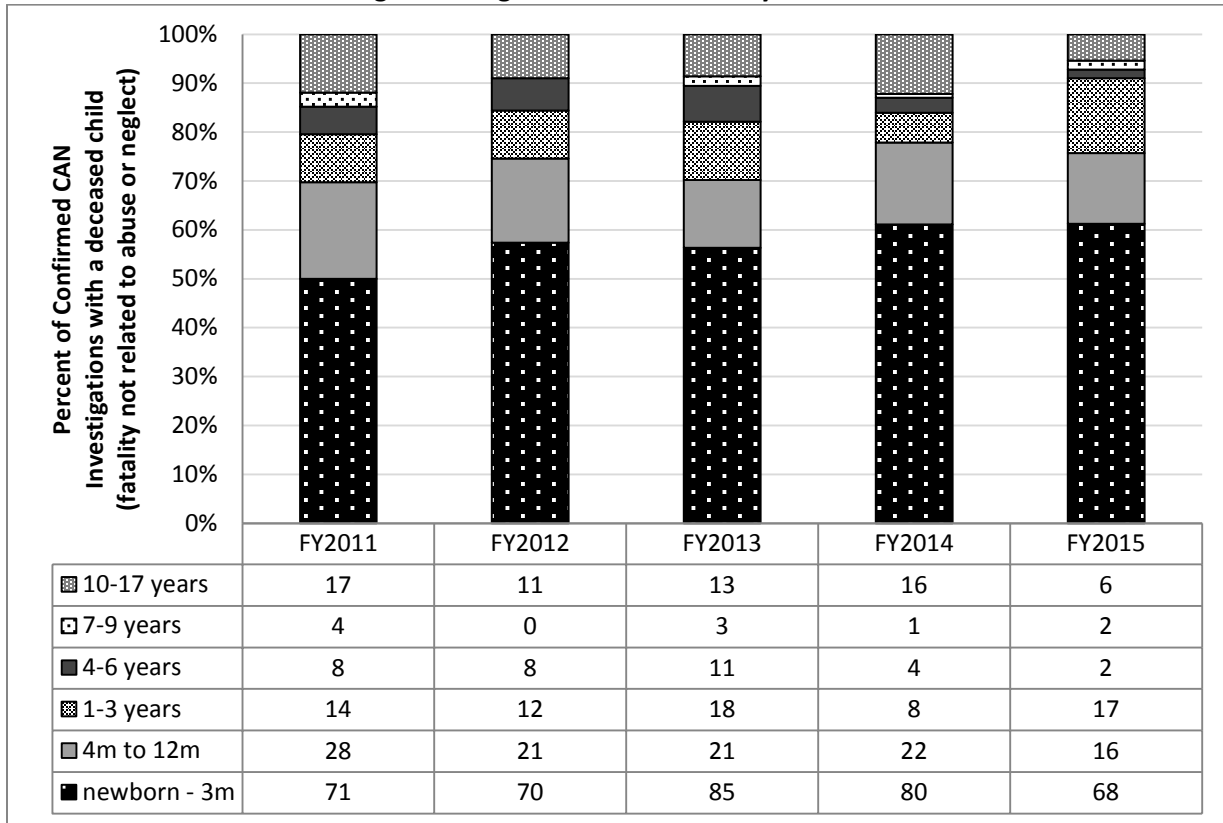
Victim Children

- 9 of the 111 children were previous alleged victims but allegations were not confirmed in prior cases.
- 8 of the 111 children were previously confirmed victims in prior cases.
- 10 of the 111 children were involved in Family Based Safety Services previously and 3 had been involved in DFPS conservatorship.

Perpetrators

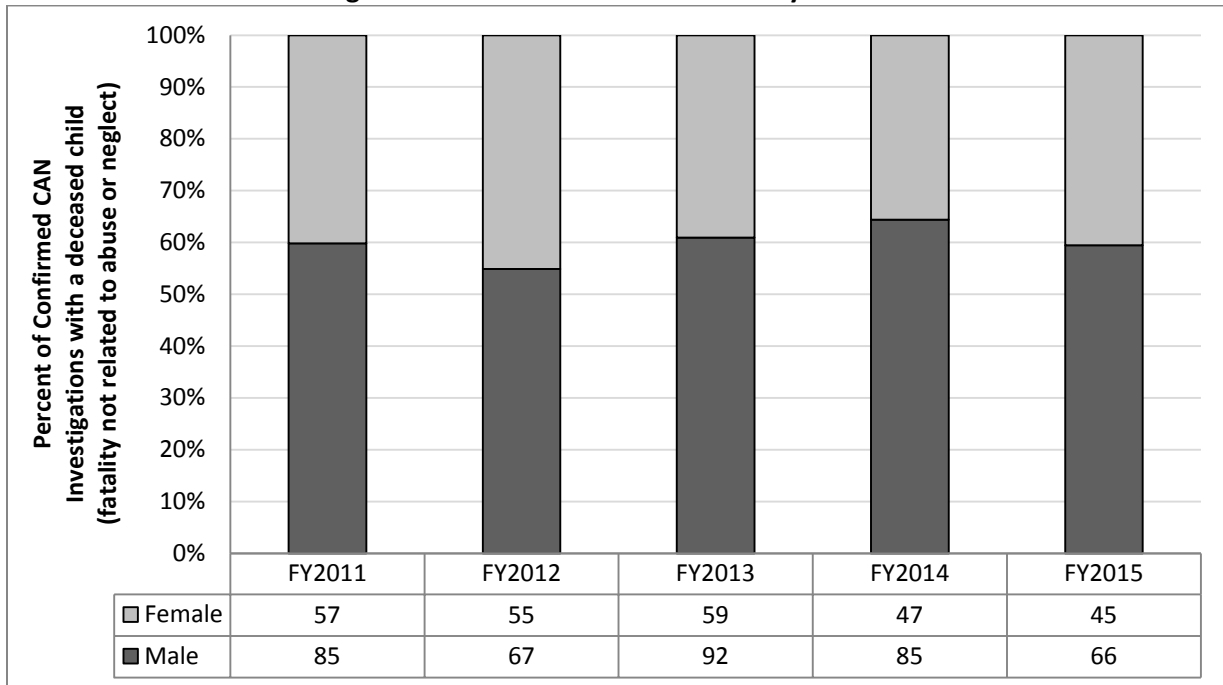
- 22 of the confirmed perpetrators were previously alleged perpetrators but allegations were not confirmed in prior cases.
- 33 of the confirmed perpetrators were previously confirmed perpetrators in prior cases.
 - The cause of death in 31 of the confirmed cases were: natural, health-related, or undetermined; 1 teen suicide; 1 vehicle accident

Figure 49. Age of Child at Death by Fiscal Year



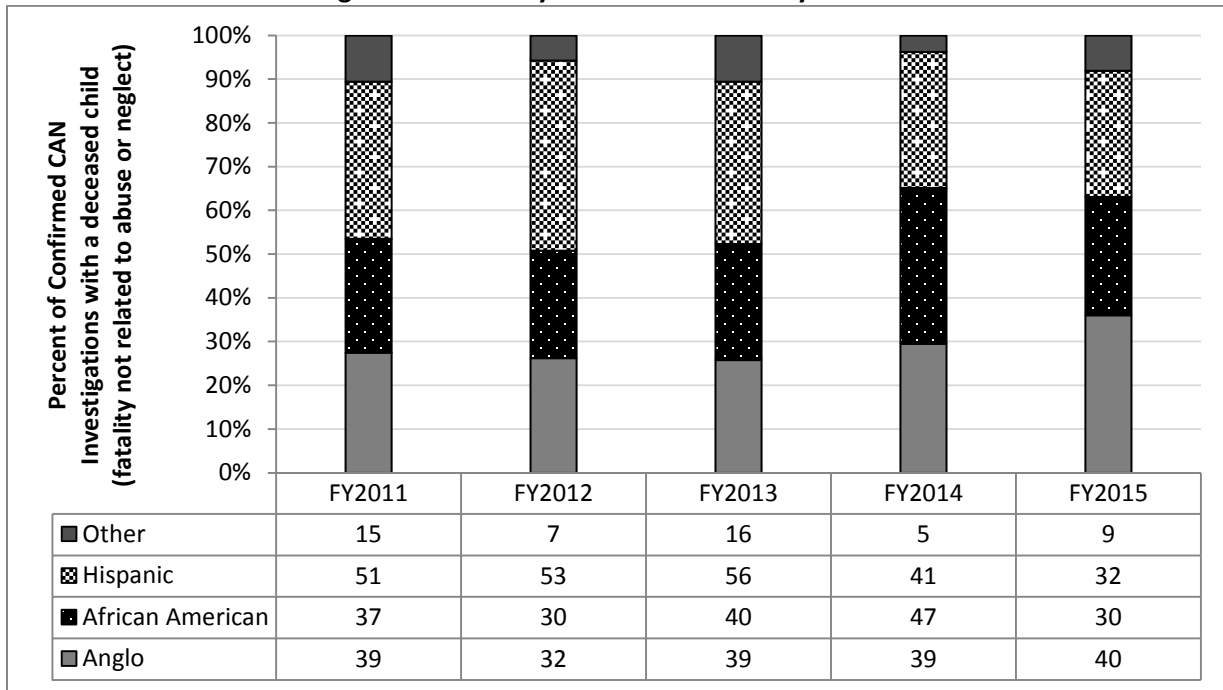
Source: DFPS DRIT Request

Figure 50. Gender of Deceased Child by Fiscal Year



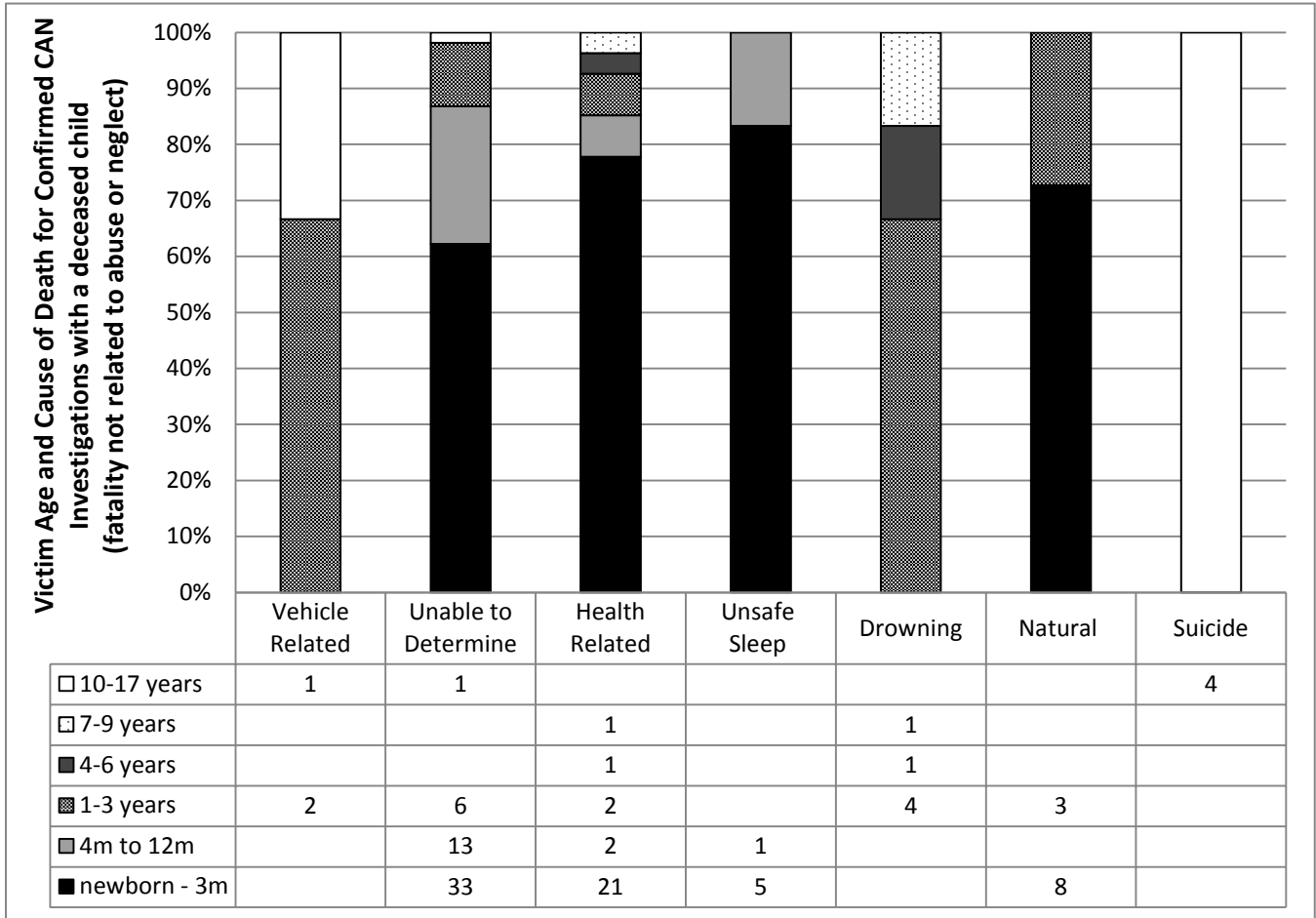
Source: DFPS DRIT Request

Figure 51. Ethnicity of Deceased Child by Fiscal Year



Source: DFPS DRIT Request

**Figure 52. FY2015 - 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**



Office of Child Safety - Individual Child Fatality, Near Fatality and Serious Event Reviews

During FY2015, the Office of Child Safety completed 66 child-specific reviews of child fatalities, near fatalities, and serious incidents. Each review provides overall findings, summary of DFPS involvement and actions taken, assessment of strengths in casework practice, and areas for improvement that warrant further examination. As part of each review, certain areas of improvement may be identified including individual training needs, statewide trainings, policy revisions, updates to best practice guidance, and/or revisions to state statutes.

Transformation

Prior to the Office of Child Safety starting detailed case analysis, DFPS began a far-reaching self-improvement process within Child Protective Services (CPS) to transform itself into a better place to work and the most effective program possible. Transformation has several components including: recruiting and training, mentoring caseworkers, empowering staff to make sound decisions, and eliminating bureaucratic clutter so that staff spend the majority of their time focused on children and families. In the end, CPS will have a deeper pool of highly-valued, highly-trained caseworkers who devote the most time possible to their top priority — meeting the needs of families, youth and children.

As part of Transformation, CPS is currently implementing a new practice model and assessment tools. These changes will help support staff assess child safety throughout the department's involvement with the family. It is designed to help staff determine child safety and needed protective measures to keep the child safe. Included in this process is the addition of practice guidelines to provide ongoing training for all staff, including training surrounding notification and involvement of parents, caregivers, and support networks. Additionally, CPS is implementing new safety assessment and an actuarial-based risk assessment. Both assessments require a caseworker to assess the entire household and all primary and secondary caregivers in making safety and risk determinations. These additions to CPS' daily practice and protocol structure will help support better outcomes for families by strengthening the overall safety assessment in the home and further connecting the entire family with needed interventions. During the design and delivery of these trainings, it is important to include the recommended training themes identified below. Several of the recommendations below are already in progress as part of Transformation and OCS' inclusion of these areas highlights the need to address these specific areas.

Below are all of the recommendations from OCS reports completed in FY2015 by topic and region is noted. Often, each topic area may have many recommendations or findings. These issues are addressed collectively by program as there may be more efficient ways to address findings as a group or they may already be part of greater system improvements, such as work being done through Transformation or ongoing training for staff.

Assessing the Family & Home Members

- Background checks and IMPACT history reviews are critical to informing solid casework decisions. Conducting timely background checks and IMPACT history searches also help staff detect when there may be others in the home that either have current CPS involvement or concerns that impact child safety in the home. (R11)
- CPS should consider developing guidance for all stages of service to determine if families involved with CPS have additional home members (adults or children) residing in the home. The guidance may need to include a series of questions to ask children and parents, as well as what to look for when completing home visits. (R7)
- Encourage staff to obtain a basic understanding of the family's daily routine from the family, home members, and collateral contacts. This will enable staff to better understand who parents are utilizing as caretakers to their children and discuss concerns with the parents as appropriate. (R3)
- CPS history involving the family and any related history should be reviewed in order to conduct a thorough assessment of the family. When a family has extensive history with CPS but does not generate a Multiple Referral (M-Ref) which requires a full review by a CPS Child Safety Specialist, consider having a CPS Risk Manager review the history and provide recommendations. (R11)
- Staff should observe parents demonstrating and discuss what they have learned from services and document the parent's demonstrations of new parenting skills, prior to closing any case. (R3)

Program Response: CPS is currently implementing a full practice model with specific practice guides for staff on how to best engage and assess children, youth, parents and caregivers. Part of this work includes updated tools to help staff assess safety both immediately and in the foreseeable future. The practice model and practice guides will have a focus on obtaining more information about the household make-up and in-depth information about the family functioning.

Case Transfer

- During a case transfer, reinforce the importance of ongoing communication between the differing programs and the need for the receiving caseworker to review all prior CPS history as an added measure in ensuring sound decisions are made during case planning. Consider having caseworkers or supervisors from other program areas present at program meetings to give a realistic overview of their program and how best to work together during case transfer. (R3)
- Although the case transfer process between Investigations and Family Based Safety Services staff is being simplified and expedited, there are no identified timeframes relating to the transfer. Regional management teams should establish a culture in their units that supports timeliness of case transfer from one stage of service to the next so that families are able to receive services quickly and at the time of crisis. (R3)

Program Response: Through the Investigations/Family Based Safety Services Transformation Workgroup, CPS has been working on the above recommendations related to the case transfer process. We are in the process of rolling out the initiative statewide.

In the new model, Investigations and Family Based Safety Services staff work in tandem to ensure that families receive services at the time of crisis. The training provided includes an emphasis on creating a positive working relationship between the stages of service and collaboration for the best interest of the family. During the training process, there is built in 30, 60, and 90 day debriefings. The focus of the debriefings is to re-emphasize the need for timely transfer when the family is still in crisis and to resolve any barriers or issues that impede the transfer process.

Collateral Contacts

In several reviews, OCS found that contacting collaterals would have provided additional information for staff to utilize to address child safety. OCS and CPS are working together to find ways to address this gap in practice. Policy and best case practice already address the importance of using collateral contacts in all stages of service.

- Review purpose and importance of professional collateral contacts and service providers in assessing ongoing child safety. (R11)
- When parents or children are engaged in services—including those provided outside of CPS direction--staff should contact the individual who is providing a service and/or treatment to the parents or child to obtain relevant and detailed information about the progress made in the service. (R3)
- Use of collateral contacts in investigation and FBSS cases help staff to assess a parent's ability to address child safety and determine if there are other issues not readily apparent to staff from interviews with the family. This includes staff communicating with service providers about the parent's drug use, both currently and historically, as well as any relapse into drug use. (R5)
- CPS policy regarding collateral contacts exists. Recommendation to review purpose and importance of professional collateral contacts and service providers in assessing ongoing child safety. (R7)
- Review purpose and importance of professional collateral contacts and service providers in assessing ongoing child safety. (R3)
- Review the importance of maintaining at a minimum telephone contact with the providers throughout the life of the case. It is important to inquire of issues being addressed, progress made, and any concerns that may have arisen during treatment, as opposed to relying primarily on certificates of completion and progress notes. (R3)
- Local staff: Staff should understand the purpose and importance of professional collateral contacts and service providers in assessing ongoing child safety. (R8)
- CPS policy regarding collateral contacts exists. Recommendation to review purpose and importance of professional collateral contacts and service providers in assessing ongoing child safety. (R6)
- Review purpose and importance of professional collateral contacts, such as medical staff, in assessing ongoing child safety. (R7)
- Training needs: CPS staff should contact services providers involved with the family and documenting these contacts. Staff should explore with providers the services that are being provided, the progress made in the services, and how the parent's knowledge and protective factors, and child safety have been addressed/increased through the use of the service. (R7)
- A review on how to utilize information from professional collaterals such as medical staff in determining dispositions. (R2)
- Review purpose and importance of contact with service providers in assessing ongoing child safety. (R6)

- CPS policy regarding collateral contacts exists and ongoing work is being done to help field staff utilize collateral contacts. Reviewing the purpose and importance of professional and personal collateral contacts as well as service providers with staff. This includes talking to apartment management or neighbors to further explore who all is present in the home and having significant contact with the children. (R6)
- When collaterals or reporters have additional information, such as photographs or information gathered from social media, staff should review the information or collect copies for the investigation. Photographs of alleged physical abuse injuries should be reviewed by the Forensic Assessment Center Network to help determine cause or seriousness of the injuries. Additionally, this information should be provided to law enforcement to help inform the criminal investigation. (R3)
- Review purpose and importance of professional collateral contacts, such as medical staff, in assessing ongoing child safety. (R5)
- Review CPS policy regarding collateral contacts. Recommendation to review purpose and importance of professional and personal collateral contacts in assessing ongoing child safety. (R5)
- CPS policy regarding collateral contacts exists. Program should evaluate how to best help staff understand the importance and utilization of professional collateral contacts and service providers in assessing ongoing child safety. (R9)
- Training Needs: Remind staff of the importance of contacting the individual who is providing a service and/or treatment to the parents or caregiver to obtain relevant and detailed information about the progress made in the service. (R6)
- Review CPS policy regarding collateral contacts. Recommendation to review purpose and importance of professional and personal collateral contacts in assessing ongoing child safety. (R3)
- When parents or children are engaged in services—including those provided outside of CPS direction--staff should contact the individual who is providing a service and/or treatment to the parents or child to obtain relevant and detailed information about the progress made in the service. (R3)

Program Response:

CPS is currently addressing the above recommendations through several avenues. A workgroup is developing strategies to improve collateral contacts in all stages of service. This workgroup will evaluate previous strategies and develop new strategies to improve collateral contacts moving forward

CPS is working on a safety networking practice guide. The practice guide will include information to include:

- general information on the role of services providers,
- reinforce the use of professional collaterals, and
- direct staff on how to obtain and utilize feedback from providers

CPS is also working with the Forensic Assessment Center Network (FACN) to develop a resource guide that will provide better guidance to staff on when they should utilize the FACN. The guide will also outline what type of cases FACN can assist on. The guide will include information about what should be provided to FACN when a referral is made, which will include photos obtained as a part of the investigation.

Community-based Services

- Although it is appropriate to refer families to community agencies for services, when the basis of closing the case is because the family will engage with services within the community, therefore, risk is reduced; staff should consider contacting the provider to ensure the families are engaged. It is also recommended to inform the provider when appropriate that the CPS case is being closed because the family is engaged with services through the provider and should additional concerns arise, the provider should contact the Department of Family and Protective Services abuse hotline. (R8)

Program Response: Contact with service providers is a topic of discussion in the collateral workgroup. A workgroup is developing strategies to improve collateral contacts in all stages of service.

Conservatorship / Ongoing Services to Children, Youth, and Families

- Require CPS staff to make monthly contact with community professionals (such as ECI) involved with children in conservatorship. The requirement should include contacting professionals by telephone or face-to-face as well as obtaining records. (R3)
- An initial medical exam is required of every child placed in Conservatorship within the first 45 days that the child is placed in care. Information from the medical exam should be required to be entered into IMPACT. (R3)
- Require CPS staff to make a referral to Early Childhood Intervention within seven (7) days of a caregiver's notification that a child in conservatorship may be delayed. (R3)
- Circumstances surrounding changes in placement should be clearly documented as well as whether CPS and/or the court approved the placement. If CPS does not approve a placement but the court is requiring the placement, then staff should document why the placement will move forward and document any efforts made by CPS to address the concerns with the placement. Any changes in circumstances in which a placement that was not initially approved may now be approved should also be noted. (R3)
- Require CPS staff to contact medical professionals on a quarterly basis when a child in DFPS conservatorship has a diagnosed condition or for whom there is elevated concern. The requirement should include contacting medical professionals by telephone or face-to-face to inquire on the medical professional's observation of the child. Staff should also be required to obtain and review medical records of the child. Regional Nurse Consultants should be utilized by staff to assist in the review of medical records. (R3)
- Developing an online tracking process within IMPACT when a change in a child's Level of Care has been requested from Youth for Tomorrow. (R3)

Program Response:

The level of care recommendation will be addressed through IMPACT Modernization. The current process requires the child's STAR health provider or caregiver to make a referral to ECI for any children suspected of having a delay. During the Healthy Steps screening, a comprehensive developmental assessment is performed. If there are any concerns, the STAR health provider makes the referral to ECI. However, if there is a suspicion of a developmental delay and services are needed prior to the medical appointment/screening, then the caregiver or caseworker is to refer the child to ECI within 2 days of staffing with the supervisor.

Requiring monthly contact with community professionals is necessary in all cases. Contacts should be quarterly based upon the needs of the child and specifics of the case. These contacts can be not required to be face-to-face and should be the most effective way of communication.

The collateral workgroup will also evaluate professional contacts in CVS and FBSS cases and how to improve outcomes in those stages of service.

Daycare Requests

- Approving all daycare requests from Parental Child Safety Placements when funding is available and the use of general protective daycare will address the safety of the child as well as provide stability in the placement. Currently, general protective daycare funds may be used when staff assess that the use of daycare will address child safety and prevent the removal of the child from the placement. When daycare funds have been authorized during a stage of service, up to six months of ongoing daycare can be provided through the local Texas Workforce Commission office upon case closure. (R3)

Program Response: CPS re-messaged this topic in the PCSP resource guide. Daycare services are also a prompt on the PCSP tool.

Decision Making Support

- Ensure case history is reviewed at the onset of the investigation in order to thoroughly address child safety. Additional, ensure a copy out of state case history when extensive, is received and included in the case file. (R3)
- Staff should utilize subject matter experts to help support critical case decision-making points. Child Safety Specialist and Risk Managers in the regions, and statewide specialists such as the mental health and substance abuse program specialists can provide additional guidance or support with service providers, such as when a substance abuse screening recommends no ongoing service although the parent has had a substance abuse issue for more than twenty years. (R5)
- When the same victim child has been in multiple CPS investigations, staff should work with their management team and subject matter experts like child safety specialists or risk managers to determine what services and interventions can be provided to address child safety and if legal intervention may be needed. (R9)
- Staff should consider consulting with the CPS Risk Manager for case reviews and recommendations when the family has extensive or complex history and criteria is not met for a full review by a CPS child safety specialist. (R6)

Program Response: Regional and State Office Subject Matter Experts (SMEs) information was released in December Meeting in a Box. Each Region will have a listing of essential SMEs and brief summary of how they can assist in specific topics.

Documentation

- Best Practice: Documentation must reflect all activities, conversations, and case decision-making guidance. This includes documenting the outcome of all court hearings or other legal proceeding.

Clearly and concisely documenting all critical junctures in the case help staff and management ensure case directives are followed to support the need for ongoing intervention, services, and ways that child safety is addressed in the immediate and foreseeable future. (R11)

Program Response: A critical review of this case was completed and concerns were noted, to include the concern listed above. On August 27th CVS PA from Region 11 held a meeting with all the CVS Programs Directors to discuss the importance of documentation that includes details that would allow anyone reading the case to be fully aware of what happened in the case. Critical case reviews from child deaths were reviewed during this meeting as well as notes and recommendations from our Regional Child Death Review Committee. A discussion took place regarding the various places things can be documented in CVS stages of service and PDs were reminded that Monthly evaluations should "tell the story as to how we got where we are." PDs discussed how each of the CCM reports shows a pattern of CVS staff not entering documentation regarding critical decision making points in the monthly assessment. Since court reports and court orders are not in the IMPACT data base monthly narratives/evaluations must include information that is included in court reports and court orders. CVS Program Directors were then to go back and discuss this with unit supervisors by the end of the following month. Supervisors were told that narratives that did not include all relevant information were not to be approved.

Domestic Violence

- In several reviews completed by OCS, domestic violence was an ongoing concern prior to the child's death. Domestic violence is often a precursor to child maltreatment and is often an indicator to larger issues in the home. DFPS and CPS are working closely with staff, providers, and stakeholders to recognize and address domestic violence with the families that come to the attention of CPS. Part of this work includes:
 - the hiring of a subject matter expert within CPS;
 - development of training for all staff including newly hired staff and those that are tenured;
 - guidance on how to investigate, disposition allegations, and provide services to families where domestic violence or intimate partner violence is a concern;
 - strengthening the connections between local providers and CPS staff so that consultations between the provider and staff allow for a more accurate assessment of the level of danger and needed interventions to address safety in the home;
 - working closely with the Texas Counsel on Family Violence, CPS is addressing barriers to providing families with batterer intervention services and accessing services in communities across Texas; and
 - through the new safety decision making process and practice model, staff are being trained on how to assess, provide services and work with families to ensure that case closure is based on behavioral change and establish safety plans with the family that are long-term and address day-to-day danger that might jeopardize child safety.
- DFPS is currently involved in a task force on domestic violence. Recommend that CPS state office and regional DFPS Family Violence liaisons review the report that will be provided by the task force to develop protocol implementable by CPS staff when a parent confirms current or past domestic abuse. The protocol and engagement strategies should be developed and shared in conjunction

with local community resources per region. The protocol should include resources for the family as well as information regarding the effects domestic violence has on children. (R3)

Program Response: CPS's Division of Practice Excellence (DPE), in partnership with the Texas Council on Family Violence (TCFV), worked with the Center for Learning and Organizational Excellence (CLOE) to expand and revise the training provided on domestic violence for new workers and it is now being implemented across the state. It will significantly increase the knowledge of new workers and improve their skills in intervening when an offender is harming a child(ren) and an adult caretaker. We will also be able to draw from that effort to devise in-service training for tenured staff.

CPS has worked closely with the Texas Council on Family Violence over the last couple of years to devise the "Disposition Guidelines for Domestic Violence Resource Guide". This guide defines domestic violence and describes the distinctions to be made when determining the appropriate disposition for child abuse cases -when working with families in which domestic violence has also been committed. Two Train-the-Trainers conferences have been held for leadership who will deliver training to staff with the support of a curriculum CLOE is developing with DPE and others in CPS. This guide will be published in Meeting-in-a-Box and delivered to staff through training, which will also include general discussions and best practice in working domestic violence cases.

Additionally, CPS is developing a practice guide regarding domestic violence to accompany the new Texas Child Protective Services Model which will include strategies for assessing domestic violence, providing support to victims, increasing accountability for offenders and urging them to avail themselves of specialized services. We will be rolling out additional training to staff to support the practice guide in 2016 under the grant from the Office of the Governor (OOG). Lastly, in our partnership with Texas Council on Family Violence under the OOG grant, we will also be working at the state/local level with local Domestic Violence provider agencies to establish better relationships and develop/implement interagency cross-training.

Face-to-Face Contacts

- Varying CPS policies require staff to make contact with family per timeframes, based on the situation. Recommendation that staff be reminded child safety is tied directly to policies requiring timely face-to-face contact with families and that the timeframes should be met. (R9)
- Utilizing an alert system or report to notify CPS Supervision staff when a required monthly contact has not been completed by staff. (R3)
- Varying CPS policies require staff to make contact with family per timeframes, based on the situation. Recommendation that staff be reminded child safety is tied directly to timely face-to-face contact with families and that the timeframes set forth in policy should be met. (R6)
- CPS policy exists regarding contact with parents of victim children. CPS staff should be reminded that all parents of children involved with CPS, including fathers, should be contacted within 24 hours of their child being observed or interviewed. If contact is not made, efforts to contact the parent must continue. CPS should seek engagement of both parents while the family is involved in services. (R6)

- During an investigation children must be seen timely and in other stages of service must be seen monthly in accordance with CPS policy. (R3)
- Varying CPS policies require staff to make contact with family per timeframes, based on the situation. Recommendation that staff be reminded child safety is tied directly to policies requiring timely face-to-face contact with families and continuous, ongoing assessments are critical to addressing child safety. Data warehouse reports support staff and management in tracking timely contacts with children and families. (R6)
- Training needs: On February 15, 2015, an updated policy regarding home visits was put into effect. A review of the policy is recommended. CPS Policy 2250 Home Visits states the caseworker must conduct a home visit and take photographs of the condition of the home if there is a principal child in the home who is 5 years old or younger, the allegations involve the condition of the home, or other circumstances in the case make a home visit necessary to ensure child safety. (R6)
- Varying CPS policies require staff to make contact with family per timeframes, based on the situation. Recommendation that staff be reminded child safety is tied directly to policies requiring timely face-to-face contact with families and that the timeframes should be met. (R9)
- Families and children must be visited monthly during a Family Based Safety Services case, even during an open investigation. Consider making attempts to visit earlier in the month to allow for additional attempts later in the month if needed, and attempt visits at different times of the day. If children are school aged, ensure they are seen at school if contact at home is not possible. (R11)

Program Response:

Historically CPS has documented investigation contacts in a manner that would not allow us to determine through a data pull if children in open investigations had been seen. Through the November 2014 Meeting in a Box staff were instructed to begin documenting every contact with children in IMPACT in a separate contact detail window beginning in December 2014. This change allowed contacts with to be captured in a data warehouse report that is updated daily. The report allows staff to know on a daily basis which children have been seen in an open investigation. For FBSS and CVS, we currently have monthly data warehouse reports that indicate whether or not the children in the case were not seen for the previous month. In addition, through IMPACT Modernization, many data elements will be captured for both workers and supervisors to use in tracking and monitoring case status. This will include a "real time" indicator of when required contact has not been made for all stages of service.

CPS recently streamlined Investigation and Family Based Safety Services policy. It was determined that regional program directors would be responsible for training their staff on the policy changes. In order to facilitate this, an overview of the policy changes was presented to Investigation and Family Based Safety Services Program Directors through a series of webinars. Then, in January 2015, information about the streamlined policy, including training materials was issued through a Meeting in a Box. The new policy went into effect on February 15, 2015. The bullets identified above as training needs would have been covered in a review of the streamlined policy.

Investigations staff have recently completed Structured Decision Making training on the updated Safety Assessment and Family Assessment. Both tools will be used to assist caseworkers in assessing the entire household, as well as primary and secondary caregivers

when making safety and risk assessment decisions. CPS is preparing to train CVS and FBSS on the assessment tool.

Family Based Safety Services / Ongoing Services to Families

- Local staff: Family Based Safety Services (FBSS) and/or community resources should be offered to both parents as an option when risk is identified. (R8)
- CPS Policy does not designate time limitations regarding Family Based Safety Services cases. Consider strengthening guidance for staff on how to proceed on FBSS cases in which families are not actively participating but child safety still needs to be addressed. Time frames may be beneficial in instances where families are not engaging and participating in services so that staff may discuss the case with the legal department for court intervention. (R3)
- When parents and/or caregivers admit to drug use or yield positive drug test results but the parents/caregiver deny using in the presence of the children, explore this further with other family members, personal/professional collaterals, and the children if age appropriate. Ask specific questions to target neglect issues such as inquiring about the children's schedules/routines, appearance, attendance at school, etcetera. If the case is not referred to Family Based Safety Services in these situations, provide the family with community resources. (R11)

Program Response: The timeframes were eliminated from policy as a result of streamlining. The focus is to allow staff to make decisions based on the needs of the family rather than having to follow agency created timeframes that may not be reflective of the family's needs, thus establishing services in a faster timeframe. There is a new FBSS transfer process that provides guidance for FBSS and Investigation staff on when a case should be referred and transferred.

Family Reunification

- Current policy and protocol address several key factors in supporting child safety when a child is in DFPS conservatorship and reunification is the planned permanency goal. This includes contacting service providers to assess the parent's progress in services as well as assessing the parent's demonstration of skills learned during services both prior to and during the return home. (R8)
- Program should explore if concerns noted are an isolated event or if staff would benefit from additional guidance when family reunification is occurring. Issues of particular note are:
 - All children are to be visited after returning home.
 - Staff need to contact service providers regarding the parent's progress and assess for safety both prior to and during reunification.
 - Evaluate the services initially recommended to the court prior to returning children home and the parent's demonstration of the learned skills prior to reunification. A Permanency Conference or Family Group Conference can assist staff in this in order to determine if the parents can articulate the skills learned from the service, if the service is still needed, or if there are other issues that must be addressed prior to reunification. (R8)

Program Response: These recommendations are already CPS requirements. These items will be addressed specifically in the region.

Investigation Process

- CPS policy exists regarding contact with parents of victim children. CPS staff should be reminded that all parents of children involved with CPS, including fathers, should be contacted within 24 hours of their child being observed or interviewed. If contact is not made, efforts to contact the parent must continue. CPS should seek engagement of both parents while the family is involved in services. (R9)
- Ensure all allegations are thoroughly addressed in particular when multiple referrals are received and merged. (R6)
- Staff should be familiarized on policy regarding how to handle new intakes during open investigations and open FBSS stages including working collaboratively between the stages of service to address child safety concerns and ensure that child safety plans are implemented at the time the issue of concern arises. (R5)
- Transfer protocol between after-hours/night investigation units and traditional investigative unit needs to be reviewed there is no lapse in time when the workers make contact. (R6)
- Staff need to ensure that there is timely response by the day field staff in situations where night staff initiated the case. The caseworker who receives a case already initiated by another worker must not assume all the casework is complete. The new caseworker and supervisor should check the persons list and safety plan to ensure all safety measures have been exhausted and follow up immediately on any outstanding tasks. (R3)
- Training needs: CPS staff be reminded that parents of children involved with CPS should be contacted within 24 hours of their child being observed or interviewed. Parents should also be interviewed face-to-face. (R1)
- Training needs: CPS staff be reminded that as part of the investigation, they are to assess risk factors, to include mental health of the parents and caregivers. (R1)
- Local staff: a review of policy that requires all victim children be seen within proper time frames (R6)
- Local staff: a review of policy that requires CPS staff to utilize Special Investigators when families are unable to locate or have moved. (R6)
- Training needs: CPS staff should be reminded that all parents of children involved with CPS, including fathers, should be contacted within 24 hours of their child being observed or interviewed. If contact is not made, efforts to contact the parent must continue. CPS should seek engagement of both parents while the family is involved in services. (R3)
- In an effort to ensure continuity for the family and efficiency in case resolution, CPS should consider developing a process for communication between units when transferring investigations between a night unit and a traditional investigation unit to ensure immediate follow-up on transferred investigations. (R3)
- A review of policy that requires CPS staff to utilize Special Investigators when families are unable to be located or have moved. (R2)
- Training needs: A review of the policy that requires investigations to be completed within a specified time frame. (R7)
- Ensure all allegations are thoroughly addressed as well as any inconsistencies that arise during the course of the investigation. (R2)
- Ensure all allegations are thoroughly addressed with the alleged perpetrator. (R7)
- Training needs: Staff must interview each child listed as a victim in the allegation list. (R3)
- Training needs: Ensure all allegations are thoroughly addressed, in particular when multiple referrals are received and merged. (R6)

- Training needs: A home visit should always be made in a timely manner to evaluate the home environment and appropriately identify health and safety hazards, as well implementing a safety plan to address hazards identified. (R6)
- Ensure all allegations are thoroughly addressed in particular when multiple referrals are received and merged. (R3)
- When a family cannot be located, ensure all required tasks are completed to include utilizing a CPS Special Investigator or the FINDRS unit for further assistance. (R11)

Program Response:

As notated above, CPS recently streamlined Investigation and Family Based Safety Services policy. It was determined that regional program directors would be responsible for training their staff on the policy changes. In order to facilitate this, an overview of the policy changes was presented to Investigation and Family Based Safety Services Program Directors through a series of webinars. Then, in January 2015, information about the streamlined policy, including training materials were issued through a Meeting in a Box. The new policy went into effect on February 15, 2015. The bullets identified above as training needs would have been covered in a review of the streamlined policy.

In March 2015, DFPS developed the handout "Keeping Children Safe Wherever You Go!" which addresses gun safety. This handout is to be provided to all families in an investigation and used as a prompt for the investigator to address each safety concern with the family.

Additionally, DFPS is developing a video that will be made available to staff via the intranet. This video will provide staff with tips on how to address gun safety with families.

CPS developed a guide for staff that provides an overview of all Subject Matter Experts, including Risk Managers. The guide clarifies the role of each Subject Matter Expert and how staff can best utilize these subject matter experts as resources. This guide was released in the December Meeting in a Box.

The recommendation on communication between the night and day units have been shared with Region 3 management and they are working on developing this protocol. This recommendation will be shared with the other regions to ensure they have a similar plan in place to ensure efficiency in transferring cases between units.

CPS has implemented the new CSCAL policy that requires timely SI assistance when a family cannot be located.

Juvenile Justice

- When a child is involved with the juvenile justice system, staff should work with the assigned case manager with juvenile justice to ensure that services are addressing specific concerns that CPS has noted. Family Group Conferencing should be considered when families are engaged in services through both departments and staff from juvenile justice should be invited to participate in the meeting as well. This recommendation can also be applied broadly, so that when a family is involved with

multiple systems, a family group conference can be utilized to help develop an overarching plan to address the needs of the family by each department. (R1)

Program Response:

CPS is in the process of streamlining policy, to include policy related to Family Group Decision Making Meetings. When the Family Group Decision Making policy is updated, juvenile justice and other systems that children may be involved with will be added as suggested participants in meetings as appropriate.

Law Enforcement

- Law enforcement should be contacted for Priority 1 (P1) investigations when sexual abuse (SXAB) or physical abuse (PHAB) is alleged. (R8)
- Ongoing contact with law enforcement throughout the life of the case should be made to determine the outcome of a criminal investigation related to the child abuse or neglect under investigation by CPS. (R3)
- Law enforcement should be contacted for Priority 1 (P1) investigations when sexual abuse (SXAB) or physical abuse (PHAB) is alleged. (R3)

Program Response:

CPS will update and re-release the joint investigations resource guide that was sent out to workers several years ago as a reminder of these policies.

Legal Intervention / Legal Staffing

- Staff should assess the safety of all children involved in the investigation or residing in the home. When seeking conservatorship in a case, the staffing with the legal department should include discussing the safety of all children in the home, including the need to bring all children into conservatorship, if needed. (R9)
- In those cases where legal intervention is denied by the local District Attorney's office, the caseworker and supervisor should staff with their Program Director and/or Program Administrator on plans to address ongoing child safety. If after staffing, there is consensus that the case needs to be reviewed by legal for possible legal intervention or request for court ordered services, then they should staff with a Regional Attorney. (R4)
- CPS to consider consulting with legal department prior to referring a family to ongoing services via voluntary Family Based Safety Service when the identified family or parent has been unwilling or unsuccessful at engaging in voluntary services with the Department in the past. Court ordered services, either offered through Family Based Safety Services or through Conservatorship should be considered. (R6)
- CPS should consider requiring staff to complete recommendations from legal discussions within 48 hours. (R6)
- CPS should consider consulting the department's legal counsel in cases involving a parental child safety placement that will remain in place at case closure. (R3)

Program Response: CPS will work with legal to develop a tip sheet related to legal staffings that can be sent out in an upcoming Meeting in a Box.

Medical Concerns

- Any time a child is hospitalized or seeks medical attention during an open CPS case, staff should contact the medical professional to obtain information surrounding the circumstances, concerns, and recommended treatment. (R3)
- Educate/provide refresher information to CPS staff on how to effectively utilize regional Nurse Consultants, Forensic Assessment Center Network, or other medical resources when investigating Medical Neglect cases. (R3)
- In situations where a child is diagnosed failure to thrive, staff should work closely with the pediatrician and DFPS subject matter experts to have timely weight checks and medical monitoring appointments both while the child is in DFPS conservatorship as well as once the child is returned home. (R5)
- CPS staff should utilize regional nurse consultants, Forensic Assessment Center Network, or other medical resources when investigating Medical Neglect, Physical Neglect and Physical Abuse cases. (R5)

Program Response:

CPS will address the appropriate use of contact with medical professionals in the Safety Network Practice Guide.

CPS is reviewing the roles of all subject matter experts, including Nurse Consultants, and is developing a guide for staff regarding their roles and when to utilize them. This was released in December Meeting in a Box.

CPS HB 11260 states DFPS staff document in the IMPACT case management system, on the *Medical/Dental Detail* page, the Texas Health Steps medical and dental checkups and follow-up treatments obtained for all children in DFPS conservatorship. The worker must ensure that the medical and dental information on a child in DFPS conservatorship is current in IMPACT. The worker also documents any known allergies. The caseworker has 7 days from the date they are informed of the appointment to enter the information into the IMPACT system. This policy will be reiterated during CVS Program Administrator meetings and staff will be reminded of the policy requirements.

A workgroup is developing strategies to improve collateral contacts in all stages of service. This workgroup will evaluate previous strategies and develop new strategies to improve collateral contacts moving forward

Mental Health

- Utilize the CPS subject matter specialist for mental health services to discuss any questions or concerns related to a caregiver's mental health needs. This may include helping caseworkers understand how to best work with a caregiver who has mental health needs, provide the

caseworker with assistance in seeking out community resources, and providing guidance on questions to ask of mental health providers to better assess the progress being made by the caregiver. (R3)

- Utilize the CPS's subject matter specialist for mental health services to discuss any questions or concerns related to a caregiver or a child's mental health needs and assistance in seeking out community resources. (R1)
- Utilize the CPS's subject matter specialist for mental health services to discuss any questions or concerns related to a child's mental health needs, how to best work with the caregiver or children who have mental health needs, and assistance in seeking out community resources. Additionally, the CPS subject matter expert for substance abuse should be utilized when issues involve substance abuse by a parent or child. (R3)
- Utilize the CPS subject matter specialist for mental health services to discuss any questions or concerns related to a caregiver's mental health needs. (R6)
- CPS Best Practice Issue: Medical and mental health records should be requested any time there is a concern with the mental health of a parent or child. (R3)
- CPS currently has a subject matter specialist for mental health services to assist staff statewide on addressing mental health needs for children and families. This specialist can be utilized by field staff to assist staff in understanding how to best work with a caregiver who has mental health needs, provide assistance in seeking out community resources, and providing guidance on questions to ask of mental health providers to better assess the progress being made by the caregiver. (R3)
- Utilize CPS's subject matter specialist for mental health services to assist in seeking community-level suicide prevention programs and/or support groups targeted at youth and their parents, as a resource for the family. (R3)
- Utilize the CPS's subject matter specialist for mental health services to discuss any questions or concerns related to a caregiver or a child's mental health needs. This may include helping caseworkers understand how to best work with caregiver or children who have mental health needs, provide the caseworker with assistance in seeking out community resources, and providing guidance on questions to ask of mental health providers to better assess the progress being made by the caregivers or child. (R6)

Program Response:

CPS is working to develop a protocol for suicide prevention that will incorporate best practices and services related to trauma informed care, crisis management and STAR Health services to work with this issue. The kinship program will also develop a protocol for suicide prevention and implement it through training kinship staff, information sent to providers via the kinship newsletter, and the information will be posted on the kinship website. Kinship will work with placement/FAD to develop a protocol that is consistent with contracted placements.

CPS developed a guide for staff that provides an overview of all Subject Matter Experts. The guide clarifies the role of each Subject Matter Expert and how staff can best utilize these staff as resources. This guide was released in a Meeting in a Box.

CPS will also release a practice guide that will provide guidance on obtaining medical and mental health records when there are existing concerns with a family member.

Ongoing Training / Practice Across Stages of Service

- Review with staff the importance of addressing any new and relevant concerns related to a child's well-being that arise during the case. Additionally, document the concern and how it was addressed and/or resolved. (R3)

Program Response: These recommendations are already CPS requirements. These items will be addressed specifically in the region.

Placements – Assessments and Ongoing Contact

- The home environment including kinship placements should be assessed on a regular basis and observations documented. (R8)
- Assessment of a child's placement and their physical or mental health needs is ongoing, including when the child is visiting family or friends for an extended amount of time, such as over weeks or months. (R3)

Program Response: These recommendations are already CPS requirements. These items will be addressed specifically in the region.

Parental Child Safety Placements & Safety Plans

- Training needs: Overview of parental child safety placements to include when a removal into DFPS conservatorship is more appropriate than a parental child safety placement. Additionally, guidance should be given to staff on completing thorough assessments of the caregiver(s) and the home environment. (R6)
- Recommendation that staff discuss all details when requiring that parents be supervised around their children. This should include discussing plans for when the person supervising is unavailable, working, or has an emergency. Staff should also discuss plans for overnight supervision and where the child will sleep. (R7)
- Work with staff on understanding the importance of speaking to potential caregivers regarding their ability to care for the children and abide by the safety plan in addition to running criminal background checks prior to the potential caregiver being made a monitor. (R3)
- In cases where children remain in parental child safety placements at the conclusion of the case and CPS will not be intervening legally, information should be provided to the caregiver(s) on how to proceed with obtaining legal custody of the child. (R3)
- Overview of parental child safety placements to include guidance given to staff on completing thorough assessments of the caregiver(s) and the home environment. (R2)
- If a safety plan or a parental child safety placement is required as a result of a new investigation during an open stage of service, such as in an open family based safety services case, the assigned caseworkers should work together to ensure that the plan is understood by all involved and child safety is maintained by both the investigation staff and the staff working with the family in the open stage of service. (R6)
- Identifying the name and contact information of any individual who has previously cared for the child or are caring for siblings to the child while discussing the Parental Child Safety Placement with parents. Staff should explore with the parent if that person could be a current placement option for the child and contact that person, as appropriate, to inquire about placement options. (R3)
- Requiring legal staffing when cases close when a child cannot safely return home and a Parental Child Safety Placement is in place. Current CPS Policy 2437.32. Child Cannot Safely Return to Parent

does not mandate consultation with the appropriate legal department prior to closure of cases in which a child will remain in a Parental Child Safety Placement at case closure, as the child cannot safely return to the parent who made the PCSP. It is recommended that CPS explore requiring a legal staffing be held prior to case closure in these instances. (R3)

Program Response:

The caregiver is provided with the "Voluntary Caregiver Manual" at the time the placement is made. This manual provides information about resources to help with legal issues. CPS has a resource manual regarding PCSPs. On page 14 of that manual, staff are instructed on the steps that need to be taken prior to closing a case with the child still in the PCSP. Staff are directed to staff the case with their chain of command as well as to staff the case with legal.

CPS developed a PCSP Caregiver and Assessment Tool that will be used statewide to assist with the assessment of PCSP caregivers and their home environment. This tool rolled out statewide October 2015. The training included information about when a removal into DFPS conservatorship is more appropriate than a Parental Child Safety Placement.

CPS is currently reviewing policies and procedures related to closure of cases with Parental Child Safety Placements still intact. Included in this review is what resources the department will provide to the family prior to and after case closure, to include information related to obtaining legal custody of the children.

CPS is developing a pilot with the Office of the Attorney General regarding how they can provide legal assistance to family members and fictive kin who are caring for children placed in their home during a CPS case. The pilot will focus on obtaining legal resolution for children who remain in PCSPs when the case is closed.

One of the critical conversations that the caseworker must have with the PCSP caregiver before deciding to close the case is whether or not the caregiver is willing or able to seek legal custody. During those discussions, the caregiver will be notified about resources that can assist them in seeking custody.

Region 3 is also piloting a PCSP program which includes PCSPs workers who maintain contact with families and QA staff specifically for PCSP cases.

Photographs

- Photos to be taken and uploaded onto CPS' database system, IMPACT, of all children in CPS custody. (R11)
- Local staff: Photographs of children should be taken unless extenuating circumstances apply. (R8)

Program Response: Policy does not currently require caseworkers to upload a digital photograph to IMPACT. As conservatorship moves forward with streamlining policy, requirements will be changed to include uploading child photographs into IMPACT.

Physical Abuse Investigations

- Photographs of alleged physical abuse injuries and medical records should be reviewed by the Forensic Assessment Center Network or a child abuse pediatrician to help determine cause or seriousness of the injuries. Additionally, this information should be provided to law enforcement to help inform the criminal investigation. (R2)
- In investigations where there is confirmed physical abuse but the perpetrator is unknown, staff should have guidance on how to disposition these allegations and how to work with a family to address child safety when the perpetrator is unknown or likely a household member/unable to determine. (R7)
- When a child is seen with an injury to a vital body area, the caseworker should utilize child abuse pediatricians or the Forensic Assessment Center Network (FACN) to review the injury and ensure that the parent's statement is consistent with the injury and that no further medical treatment or follow-up is needed. (R3)

Program Response: Discussions have begun on how to more effectively use medical collaterals in physical abuse cases with non-verbal children. CPS will continue to meet about this topic to discuss improve efforts from state office. This topic will also be addressed in the collateral workgroup.

Pregnant Mothers

- Explore creating a protocol when there is suspicion that a mother is pregnant, has continued unaddressed concerns that are a danger to a child (such as continued drug addiction that impacts the ability to meet a child's needs) and is at the end of legal involvement with CPS where parental rights will soon being terminated or voluntary relinquishment is being sought. (R6)

Program Response: There is currently a policy that requires a staffing when CPS becomes aware of a mother's pregnancy with an open CVS case. Project HIP also identifies parents whose rights have been terminated through birth match records.

Safety in the Home Practices

- DFPS is currently involved in a Safe Sleep workgroup to address the concern of child fatalities due to unsafe sleeping arrangements. The progress from the workgroup should be shared across DFPS and implementation tracked to completion. (R3)
- Require staff to provide safe sleep information to all parents involved with DFPS whose children are one year of age or younger. (R3)
- If firearms are kept in the home, staff should discuss with the family their plans to secure the firearms at all times and to prevent the child from accessing the firearm. (R6)
- Require staff to provide safe sleeping information to all families with children under the age of two. (R9)

Program Response: In March 2015, DFPS developed the handout "Keeping Children Safe Wherever You Go!" which addresses safe sleep. This handout is to be provided to all families in

an investigation and used as a prompt for the investigator to address each safety concern with the family.

Progress from the Safe Sleep workgroup (part of the DFPS/DSHS Strategic Plan) will be shared with CPS staff upon receipt of the information.

Secondary Workers

- Evaluate the practice and oversight of assigning courtesy workers to assist when the primary worker is unable to complete tasks. (R9)
- Recommends CPS explore a more efficient way to request, assign and track cases that need secondary workers to engage parents or children residing in other locations across Texas. Strengthening this process will ensure that families are provided timely information, safety is continually assessed, and that there are no gaps in services or safety interventions. (R1)

Program Response:

The CPS Reunification and Permanency Transformation Workgroup developed a Universal Referral Form to be used when requesting I See You and Courtesy Supervision services, which are performed by secondary workers. Information about the new form was released in the November 2014 Meeting in a Box and went into effect December 1, 2014. Along with the form, instructions were provided to set up a mailbox to receive the form and the requirement that the primary caseworker be notified of the assigned secondary worker within two days.

Services for Youth

- Developing a response protocol for all placements to address suicide prevention and mental health needs when a child expresses suicidal ideations. (R3)
- OCS and Child Protective Services PAL Program collaborate on providing material to help support the mental health needs of youth in care. (R3)

Program Response: CPS is working to develop a protocol for suicide prevention that will incorporate best practices and services related to trauma informed care, crisis management and STAR Health services to work with this issue. The kinship program will also develop a protocol for suicide prevention and implement it through training kinship staff, information sent to providers via the kinship newsletter, and the information will be posted on the kinship website. Kinship will work with placement/FAD to develop a protocol that is consistent with contracted placements.

Substance Abuse

- When the allegations involve drug use, a drug test should be administered as soon as possible. (R7)
- There has been an issue with drug treatment providers and facilities not releasing information to CPS during an open CPS investigation. While the CPS state office substance abuse program specialist can assist field staff, local/regional CPS offices should continue to developing working relationships between CPS and drug treatment facilities in the area in order to assist caseworker's in obtaining

information regarding our clients so we are able to best suit our client's needs and ensure child safety. (R6)

- When allegations involve drug use of parents, caretakers, or other household members, appropriate drug tests should be administered timely. (R6)
- CPS should consider creating guidance regarding drug testing when there are concerns of past drug use. (R7)
- Staff to utilize DFPS State Office Substance Abuse Specialist as appropriate. (R9)
- When the allegations involve drug use, a drug test should be administered at the onset of the investigation or as soon as the allegations arise. (R9)
- With prescription drug abuse as a leading cause of unintentional death in America, it is prudent for staff to understand how to assess and provide services for families dealing with prescription drug abuse. Training for staff should include identifying and assessing child safety when there is active prescription drug abuse. (R3)
- Develop guidance for staff to specifically address investigations regarding marijuana use by caretakers, to include dispositioning allegations. (R9)
- Require staff to contact the physician(s) prescribing controlled substances to parents when there is concern of current or past addiction. (R3)

Program Response:

The Drug Testing Basics CBT, released in the Meeting in a Box in May 2015, reminds caseworkers of the need to drug test a parent when there is an allegation of drug or alcohol abuse that creates a threat to child safety. It also addresses other scenarios when drug testing should be considered and staffed for appropriateness:

- Criminal history indicates prior drug related involvement
- Previous CPS history indicates prior concerns of drug or alcohol use
- Unexplained changes in parents behavior
- Credible reports by collaterals on a case
- Court Order

CPS developed a guide for staff that will provide an overview of all Subject Matter Experts, with the state office substance abuse specialist included. The guide will clarify the role of each Subject Matter Expert and how staff can best utilize these staff as resources. This guide was released in the December Meeting in a Box.

With regards to the release of information by drug treatment providers, Strict HIPPA and 42 CFR laws prohibit the disclosure of confidential treatment information. Caseworkers have to obtain the necessary consents from the parents to communicate with the treatment providers - the consents are revocable and parents *may* rescind their consent once in treatment which would then limit any further communication between the provider and CPS on progress or treatment status.

The substance abuse resource guide will provide guidance to staff about addressing substance abuse and dispositioning allegations. The guide will also include language the will remind staff about contacting physicians when prescription drugs play a role in the case.

Supervisor Directives / Staffings

- Local staff: Supervisors should follow up to ensure tasks assigned during case staffing are completed or document the reason(s) why the task was no longer necessary. (R8)
- CPS should consider supervisor directives include deadlines to ensure staff comply within reasonable time frames. (R6)
- CPS should consider supervisor directives include deadlines to ensure staff comply within reasonable time frames. (R3)
- Child Safety Specialists and Program Directors should review cases before closure if a Multiple Referral Review was completed to ensure the recommendations were followed, even if the case is being closed with a ruled out finding. (R11)
- When supervisor/program director directives are given to staff to include deadlines, follow up should be made within a reasonable time after the deadline by the supervisor/program director to ensure staff complied with the directives. If the directive has changed based on additional information, staff should document the change in directive. (R8)
- CPS should consider supervisor directives include deadlines to ensure staff comply within reasonable time frames. (R7)

Program Response:

The CPS Continuous Learning Transformation Workgroup will be reviewing and updating the training currently provided to supervisors. This work is scheduled to begin in January 2016. The above recommendations will be provided to the workgroup to ensure inclusion in the new training model.

CPS is in the process of piloting changes to the review process that will require that the CSS review cases identified as high-risk cases both at the beginning and the end of the investigation.

DFPS/External Stakeholder Collaboration

- Collaboration between CPS Substance Abuse Specialist, DFPS Prevention and Early Intervention, DSHS Narcotic Treatment Section of the Patient Quality Care Unit, and Narcotic Treatment Centers to develop a collaborative, preventative-focused and family-centered home visiting program for pregnant women who are enrolled in a Narcotic Treatment Center. (R3)
- Office of Child Safety and CPS to work collaboratively in identifying the underlying reasons for the lack of timely communication with families during investigative cases. (R3)

Program Response:

DFPS has collaborated with DSHS to develop a service array webinar discussing all of the services offered by DSHS Substance Abuse Services including Outpatient treatment, Intensive Outpatient treatment, Inpatient treatment, Women and Children programs, and PPI and PADRE programs (PPI is a prevention and early intervention program for women and mothers, PADRE is a prevention and early intervention program specifically for men). DFPS will further explore collaboration with prevention services and home visiting programs to meet the needs of families.

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*^{xvi}, an annual report comprising data from the National Child Abuse and Neglect Data System (NCANDS).^{xvii} 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.^{xviii}

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

- requiring any person who believes that a child has been or may be abused or neglected or has died of abuse or neglect to report his or her concerns, with a heightened reporting requirement for professionals;^{xix}
- investigating any report of child abuse or neglect allegedly committed by a person responsible for a child's care, custody, or welfare;^{xx}
- including in the definition of child abuse and neglect the use of a controlled substance^{xxi} and defining medical neglect as the failure to *seek, obtain, or follow through* with medical care for the child;^{xxii} 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 2014 (the most recent year reported for all states), the Texas rate was 2.13 confirmed child abuse and neglect related fatalities per 100,000 compared to a national average of 2.04 confirmed child abuse and neglect related fatalities per 100,000. The higher rate is likely due in part to under-reporting in other states. For example, studies in Nevada and Colorado have estimated that as many as 50 percent to 60 percent of child deaths resulting from abuse or neglect are not recorded as such.^{xxiii} Some states do not even report at all; for example, in the annual federal *Child Maltreatment 2013* report, Maine and Massachusetts did not report on child fatalities.

Delay in national reporting: National data comparisons for FY2015 will not be available until early 2017. It is important to note that the number of confirmed child abuse and neglect related fatalities continued to decline in FY2014 but then rose in FY2015; it is likely that when the federal level data for FY2015 is released that Texas will be near or below the national rate.

Initiatives & Program Improvement

Internal Initiatives and Program Improvement

DFPS Transformation is a rigorous self-improvement process that Child Protective Services (CPS) began in 2014 to dramatically improve into a better place to work and the most effective program possible. It is built on the knowledge and insights of front-line staff and led by both regional and state office management. Transformation will improve child safety, build community collaboration, create a stable workforce, and build leadership.

As part of DFPS Transformation, DFPS has undertaken 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.

Streamlining Policy - CPS has begun streamlining and updating 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 being fully revised. The safety assessment tool will assist a caseworker during the first contact with a child and family, a critical opportunity to assess safety. The new risk assessment tool will be more objective and based on actuarial principles that have been scientifically accepted and adapted for Texas.

Utilizing Predictive Analytics - CPS is expanding the use of predictive analytics to address emerging problems, coordinate and improve fragmented quality assurance processes, and establish clear accountability for overseeing change in state office and in the regions. Currently, CPS is utilizing predictive analytics to improve child safety in Family Based Safety Services cases by piloting real time case reviews in high-risk cases. This pilot is set to expand statewide for Family Based Safety Services cases and then be replicated for Investigations.

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.

Prevention and Early Intervention - Office of Child Safety - In FY2015, DFPS established the Office of Child Safety to address child fatalities and serious injuries through thorough case review, data analysis, practice recommendations and collaboration with local agencies, private sector, non-profits, and government programs to reduce child abuse and neglect fatalities. The goals of the new Office of Child Safety are to:

- Produce consistent, transparent, and timely review of child fatalities and serious injuries by independent experts outside any specific program.
- Find root causes of child fatalities to provide guidance on the most effective prevention changes as well as improvements in child welfare practices;

- Operate with the understanding that many systems impact outcomes for children and that prevention and intervention efforts will involve many sectors and non-traditional partners;
- Work closely with the Department of State Health Services (DSHS) and others to share data and information; and
- Develop strategic recommendations to bring together local agencies, private sector, non-profits, and government programs to reduce child abuse and neglect fatalities.

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.^{xxiv}
- Room to Breathe on safe sleep practices for infants.^{xxv}
- Watch Kids Around Water about drowning prevention.^{xxvi}
- Look Before You Lock on preventing deaths in hot cars.^{xxvii}

Prevention and Early Intervention - Project HOPES

DFPS is increasing services through Prevention and Early Intervention. Project HOPES is establishing flexible, community-based child abuse and neglect prevention programs in specific communities targeting families of children ages 0-5 who are at high-risk for abuse and neglect and even more at-risk for abuse/neglect fatalities. Communities can propose evidence-based programming that meets the needs of their population. DFPS works with external stakeholders to identify communities with high child abuse and neglect risk factors such as family violence, substance abuse, teen pregnancy, child fatalities, and child poverty. After identifying the high-need communities, those with an existing community services infrastructure that DFPS could leverage were chosen as the target for Phase I. The eight counties selected are Potter, Webb, Gregg, Ector, Cameron, Hidalgo, Travis, and El Paso Counties. Phase II involves the counties of Dallas, Wichita, Taylor, Lubbock, Harris, McLennan, Nueces, and Jefferson. A third phase will start in 2016 to expand Project HOPES into more counties across Texas.

Prevention and Early Intervention - Military Families Prevention (MFP) Project

The Military Families Prevention (MFP) Project is a program to support and provide coordinated prevention efforts for military families in Texas. The goal of the MFP Project is to establish flexible, community-based child abuse and neglect prevention programs in specific military communities targeting families of children ages 0-17 who are at-risk for abuse and neglect. Due to multiple combat deployments and frequent moves, military families, especially young enlisted families, face different challenges that may require assistance such as home visitation services, parent education services and other prevention activities.

Prevention and Early Intervention - Safe Babies Funding

The 84th Texas Legislature appropriated funding for DFPS Prevention and Early Intervention to address abusive head trauma and child maltreatment concerns for newborns and infants. The Safe Babies initiative is designed to provide training and services to prevent abusive head trauma and other child abuse and neglect related fatalities. This initiative will engage families through hospital-based and prenatal provider parent education.

Prevention and Early Intervention - Fatherhood programs

DFPS Prevention and Early Intervention division is supporting work around engaging fathers and father figures in the lives of children. These programs are designed to develop and deliver evidence-based or promising practice prevention programs that target fathers or father figures. The goal of these programs are to increase protective factors in families who are considered at-risk for child abuse and neglect.

Prevention and Early Intervention - Project HIP

Project HIP is a new effort that provides both CPS interventions and voluntary prevention services to families to increase protective factors and prevent child abuse. The program provides an extensive family assessment, home visiting programs that include parent education and basic needs support to targeted families. Eligible families are those who have previously had their parental rights terminated due to child abuse and neglect in year 2008 or later who currently have a newborn child, families who have previously had a child die with the cause identified as child abuse or neglect in year 2008 or later who have a newborn child, or current foster youth who are pregnant or who have given birth in the last four months. CPS investigates the majority of new births in the first two categories

Child Safety Review Committee

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.

Statewide/External Initiatives and Program Improvement

DSHS State Child Fatality Review Team Committee (SCFRT)

The State Committee is a multidisciplinary group comprised of members throughout Texas.^{xxviii} 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.

Local Child Fatality Review Teams (CFRT)

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.

DSHS publishes an annual report from the SCFRT. The most recent report is: [FY2013 Annual Report](#)^{xxix}

DFPS/DSHS Strategic Plan to Reduce Child Abuse and Neglect Fatalities

In April 2014, DFPS and DSHS combined efforts to address proactively child fatalities through the Strategic Plan to Reduce Child Abuse and Neglect Fatalities. 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. With the robust data systems available to DSHS, a broader picture of influencing factors and possible intervention points can be determined for all child fatalities, including those caused by abuse and neglect.

The goal of the collaboration between DFPS and DSHS is to use in-depth analysis to guide strategic planning that coordinates support services between DSHS and DFPS.

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>

Statewide Child Fatality Disposition Review Team

The Statewide Child Fatality Disposition Review Team, comprised of regional and state office staff, currently is reviewing a sample of child fatality investigations with a variety of dispositions. This review is

conducted to ensure statewide consistency in decision making with dispositions and severity types applied during a child fatality investigation.

National Initiatives and Program Improvement

Casey Family Programs - Child Safety Forums

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

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

Federal Commission for the Elimination of Child Abuse and Neglect Fatalities

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

Endnotes

ⁱ 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.

ⁱⁱ FY2010 Population data from U.S. Census Bureau, Census 2010 Census Summary File 1. Available at: <http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>

ⁱⁱⁱ FY2011 and FY2012 data from Texas State Data Center, Texas Population Estimates; FY2013 data from Texas State Data Center, Texas Population Estimates. Available at: <http://txsdc.utsa.edu/data/TPEPP/Index.aspx>

^{iv} 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>

^v 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*, <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>

^{vi} See Statewide Blue Ribbon Task Force. Available at: <http://www.blueribbontaskforce.com/index.html>

^{vii} See State Child Fatality Review Team. Available at http://www.dshs.state.tx.us/mch/child_fatality_review.shtm

^{viii} See Medical Child Abuse Resources and Education System (MEDCARES). Available at <https://www.dshs.state.tx.us/mch/medcares.shtm/>

^{ix} See Forensic Assessment Center Network. Available at: <http://facntx.org/Public/About.aspx>

^x See DFPS Child Safety Resource Page. Available at: http://www.dfps.state.tx.us/Child_Protection/Child_Safety/default.asp

^{xi} *Strategic Plan to Reduce Child Abuse and Neglect Fatalities*, available at: http://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2015/2015-03-16_DFPS_DSHS_Strategic_Plan.pdf

^{xii} 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>.

^{xiii} See SB1050 enrolled bill at: <http://www.legis.state.tx.us/tlodocs/81R/billtext/html/SB01050F.htm>

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

^{xv} See US Centers for Disease Control and Prevention at:
<http://www.cdc.gov/violenceprevention/childmaltreatment/riskprotectivefactors.html>

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

^{xvii} 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>.

^{xviii} 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>

^{xix} Tex. Fam. Code §261.102 Matters to be Reported, Section 261.101 Persons Required to Report; Time to Report.

^{xx} Tex. Fam. Code §261.301 Investigation of Report.

^{xxi} 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.

^{xxii} Tex. Fam. Code §261.001 Definitions

^{xxiii} 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).

^{xxiv} DFPS Public Website, <http://www.helpandhope.org/index.html>

^{xxv} DFPS Public Website, http://www.dfps.state.tx.us/Room_to_Breathe/default.asp

^{xxvi} DFPS Public Website, http://www.dfps.state.tx.us/Watch_Kids_Around_Water/default.asp

^{xxvii} DFPS Public Website,
http://www.dfps.state.tx.us/Prevention_and_Early_Intervention/Vehicle_Safety/default.asp

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

^{xxix} Texas Child Fatality Review Annual Report 2013,
<http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589987385>