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**Texas Department of Family and Protective Services  
A Better Understanding of Child Abuse and Neglect Fatalities**

**FY2010 through FY2013 Analysis**

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A report from the Department of Family and Protective Services

March 2015

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## Executive Summary

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Nearly one in 10 children in the United States lives in Texas. Of those children, about one third are under the age of six, which according to state and national data is the most vulnerable population for abuse and neglect. DFPS, in partnership with law enforcement, the medical community, service providers and the community, is committed to the continuing decline of child abuse and neglect fatalities.

To dedicate thoughtful and innovative analysis to these tragedies, Commissioner John Specia formed the Office of Child Safety in September of 2014. The Office of Child Safety will independently analyze both individual child abuse and neglect fatalities, near fatalities and serious injuries as well as patterns and the systemic issues involved. This very important work will involve 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 this 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, in March 2015 the Department of Family and Protective Services (DFPS) and the Department of State Health Services (DSHS) released the joint report "Strategic Plan to Reduce Child Abuse and Neglect Fatalities." 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" provides 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.

As its first major publication and demonstration of the transparency and trend analysis to come, the DFPS Office of Child Safety is releasing this companion report, "A Better Understanding of Child Abuse and Neglect Fatalities," to explore how Texas reports fatalities and to offer context and show trend analysis for the information reported. DFPS, through the Office of Child Safety, is using this data to evaluate, review, and strengthen policy and practices across the agency. Together with the "Strategic Plan," the information from these reports 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 healthy families.

This report is divided into four major sections:

- Definitions: Child Abuse and Neglect Fatalities Investigation Dispositions
- Findings: Data Analysis for FY2010 through FY2013

- 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 from FY2010 through FY2013, the following trends and areas for review have been identified:

### **General Findings**

- There were 156 confirmed child abuse and neglect fatalities in FY 2013 – a 26 percent decrease from the 212 confirmed fatalities in FY 2012. (Table 2)
- Confirmed physical abuse/intentional trauma fatalities have decreased by 35 percent since FY2010. (Figure 3)
- Confirmed neglect related fatalities have decreased by 31 percent since FY2010. (Table 2)
  - In fatalities involving neglect, the most common causes of death were drowning, unsafe sleep, and car and firearm accidents. (Figure 7, 8)
- Children who die due to abuse and neglect are more likely to have suffered from physical abuse compared to all investigations where abuse or neglect has been confirmed.
- Child abuse and neglect-related fatalities in foster care (those where the caregiver is implicated in the death) are less likely to involve physical abuse and more likely to involve some form of neglectful supervision. (Figure 13, 16)

### **Victims**

- In FY2013, 81 percent of children in abuse and neglect fatalities were 3 years old or younger and 58 percent were male. (Figure 9, 10)
- The largest percentage of children who die from abuse or neglect are Hispanic, who also represent the greatest percentage of overall child abuse and neglect victims. (Table 3)

### **Perpetrators**

- Physical abuse in fatalities most commonly involved blunt force trauma inflicted by a father or boyfriend. (Figure 12)
- Parents are the most common perpetrators in fatal child abuse and neglect investigations. (Figure 11)
- In the majority of child abuse and neglect-related fatalities, the child or the perpetrator had no prior history with CPS. (Figure 18)
  - In cases where CPS was involved with the family at the time of the death, most fatalities were caused by unintentional acts involving inadequate supervision.
  - In the remaining cases where CPS was involved with the child or perpetrator in the past, most fatalities were the result of intentional acts such as physical abuse.

## **Definitions: Child Abuse and Neglect Fatalities Investigation Dispositions**

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The Department of Family and Protective Services 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.<sup>1</sup>

DFPS investigates child abuse or neglect fatalities based on where the child was living at the time of death. Adult Protective Services investigates deaths of children placed in Adult Protective Services 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 sought to be proved are more likely than not. Sometimes this is referred to as the "51 percent" standard, a more stringent standard than "reasonable doubt" but less stringent of a standard as 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 that exist on 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 Reason to Believe, 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 the evidence that the worker gathered through the required and supplemental actions he or she took 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 in DFPS' jurisdiction to investigate.

## 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 increased. 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
<b>Child Population of Texas</b>	6,865,824 <sup>ii</sup>	6,952,177 <sup>iii</sup>	6,996,352	7,121,499
<b>Number of child abuse/neglect reports that were reported to DFPS</b>	231,532	222,541	206,200	194,801
<b>Number of Investigated Child Fatalities</b>	1024	973	882	804
<b>Number of fatalities where abuse/neglect was confirmed</b>	227	231	212	156
<b>Child Fatality Rate per 100,000 Children</b>	3.31	3.32	3.03	2.19
<b>National Rate for Equivalent Federal Fiscal Year<sup>iv</sup></b>	2.10	2.10	2.20	2.04

Source: Data from US Census Bureau; Texas State Data Center; DFPS Data Books FY2010-FY 2013; DFPS Data Warehouse Report FT\_06; U.S. Department of Health and Human Services.

The distribution of case disposition codes for investigations conducted in FY2010 through FY2013 are presented in Table 2 - Percentage of Child Fatality Investigations by Disposition. The total number of child fatalities investigated between FY2010 and FY2013 has decreased by more than 20 percent. The decrease in the number of confirmed child abuse and neglect fatalities in Texas is mirrored in the national data with a national decline of 12.7 percent in confirmed child abuse and neglect fatalities between FFY2009 and FFY2013.<sup>v</sup>

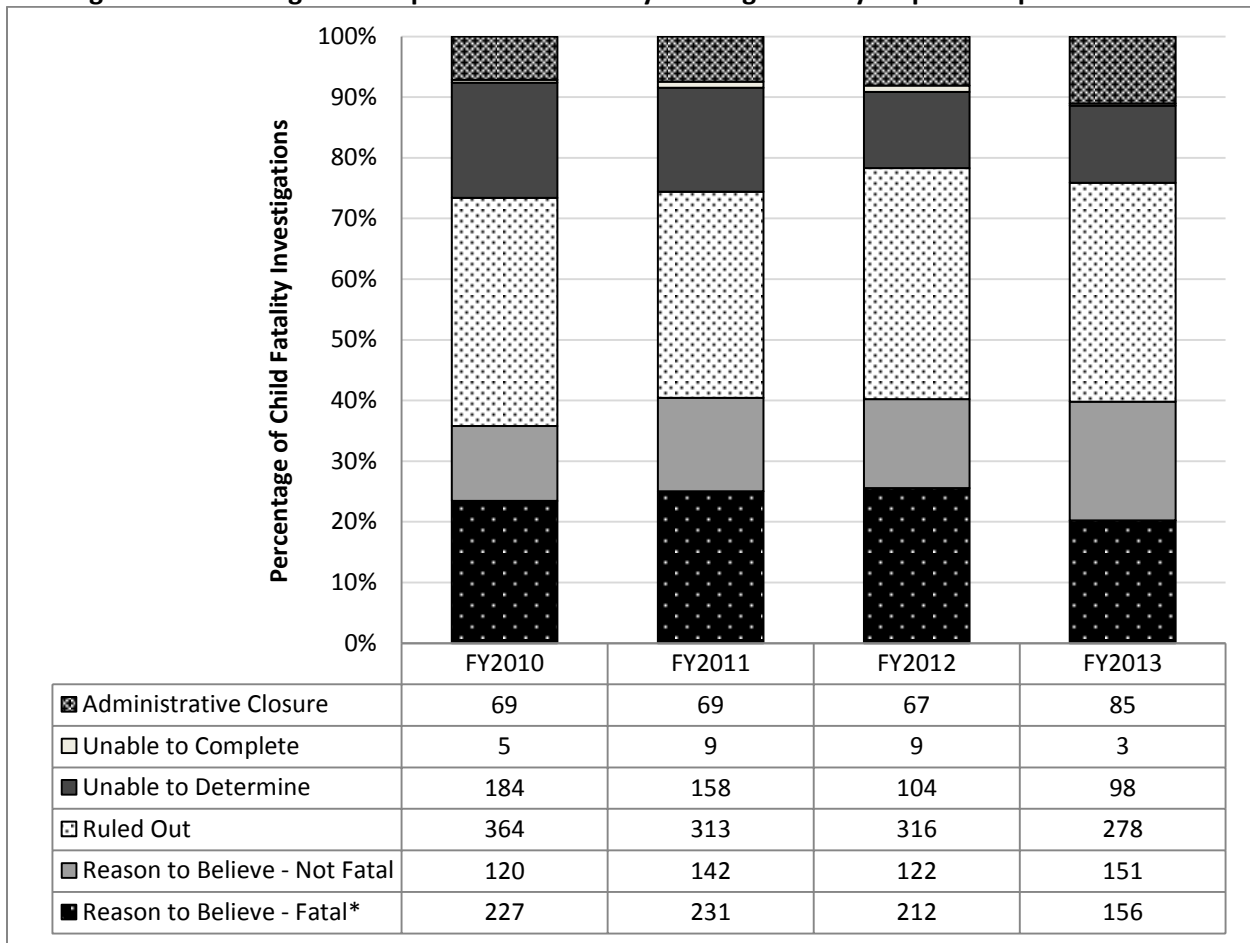
**Table 2. Percentage of Child Fatality Investigations by Disposition**

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%

\*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  
 Source: DFPS DRIT Request

In the past four fiscal years, there has been an increase in the percent of administrative closures which 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). Additionally, there has been a 26 percent increase in the number of investigations where there is a reason to believe finding for abuse or neglect to a child in the investigation but that the child fatality was not caused by abuse or neglect. This increase corresponds with providing enhanced disposition guidelines to field staff investigating child fatalities where the role of abuse or neglect causing 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.

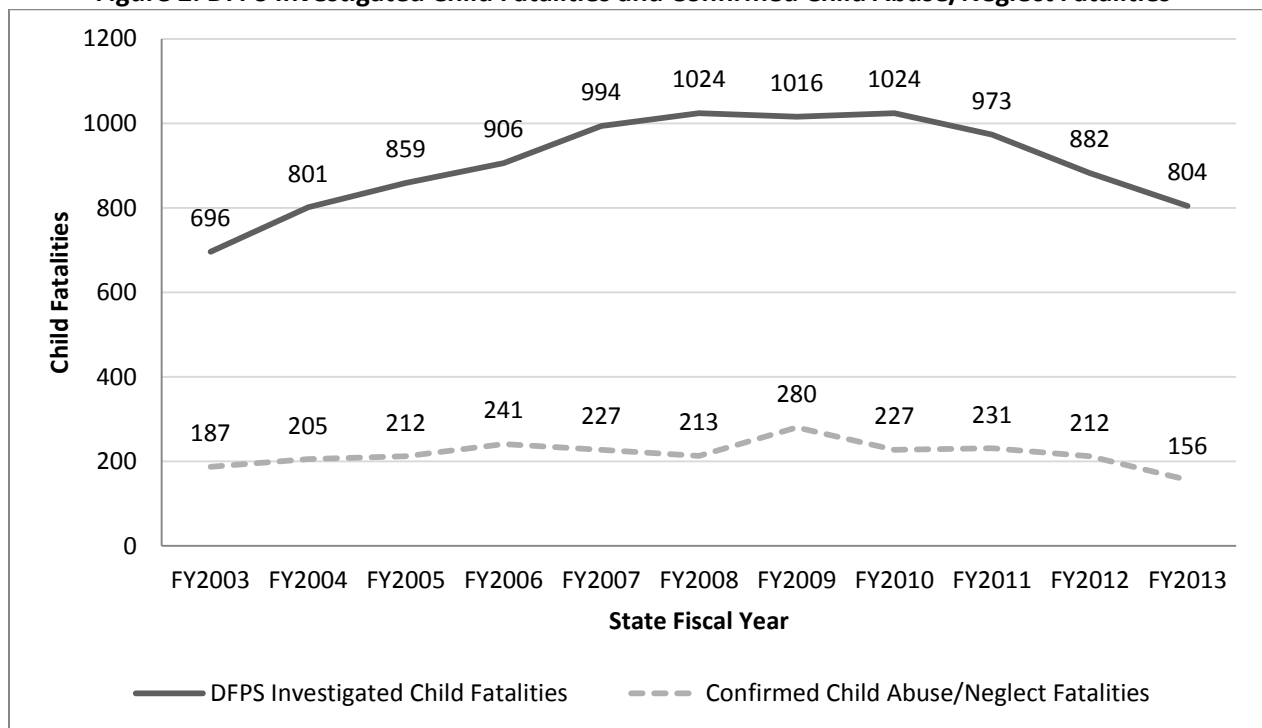
Despite a growing child population in Texas, the number of confirmed child abuse and neglect related fatalities has dropped by more than 30 percent in the last four years. There are a number of reasons that have likely contributed to the decline, including:

- 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<sup>vi</sup> and the State Child Fatality Review Team<sup>vii</sup>



- As the economy stabilizes in communities, there may be less financial stress on families<sup>viii</sup>
- Access to community services
- Increased medical community knowledge about child abuse and neglect as well as specialized treatment centers including Medical Child Abuse Resources and Education System (MEDCARES)<sup>ix</sup> and the Forensic Assessment Center Network (FACN)<sup>x</sup>
- Access to community health care, mental health services, substance abuse services
- Community programs and media campaigns such as Water Safety Month and child safety programs (like car seat use, safety around water, safe sleep)<sup>xi</sup>
- DFPS' focus on enhanced child safety practices

**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 907 investigated child fatalities per fiscal year. In FY2013, DFPS investigated 804 reports regarding possible child abuse and neglect related fatalities. Compared to FY2008 and FY2010 when DFPS had record highs of 1024 investigations, this is a decrease of over 20 percent of alleged child abuse and neglect fatalities reported and investigated. (Figure 2)

Part of the decline in child abuse and neglect fatalities in FY2013 is also related to more consistent disposition of fatalities. In FY2012, guidelines were provided to staff to help ensure consistent dispositions on child fatalities that involved cosleeping, drownings, firearm accidents, suicides and children left in cars. CPS in FY2013 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 in all stages of service to strengthen information gathering, engaging the family and their support systems, as well as utilizing information from professionals who have contact with the family to complete thorough

investigations and service delivery practices. This has helped in determining and supporting consistent dispositions in child fatality investigations.

Additionally, CPS has worked to ensure that the intakes sent on to field staff for full investigation meet DFPS jurisdiction to investigate. Before FY2013, an intake that involved a child fatality but did not have clear abuse or neglect allegations would be sent to the field as a Priority 1 investigation. This likely increased the number of child fatalities that would be 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 investigations directly. 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 for follow-up before progressing to a full investigation.

The decline in FY2013 may also reflect some 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.<sup>xii</sup>

## ***FY2010 - FY2013 Confirmed Child Abuse and Neglect Related Fatalities***

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During the 81<sup>st</sup> Texas Legislature, passed legislation (SB1050) 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."<sup>xiii</sup> The following data are collected from IMPACT data 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 156 confirmed child abuse and neglect fatalities in FY 2013 – a 31 percent decrease from the 227 confirmed fatalities in FY2010. (Table 2)
- Confirmed physical abuse/intentional trauma fatalities have decreased by 35 percent since FY2010. (Figure 3)
- Confirmed neglect related fatalities have decreased by 31 percent since FY2010. (Table 2)
  - In fatalities involving neglect, the most common causes of death were drowning, unsafe sleep, and car and firearm accidents. (Figure 7, 8)
- Children who die from abuse and neglect are more likely to have suffered from physical abuse compared to all investigations where abuse or neglect has been confirmed.
- Child abuse and neglect-related fatalities in foster care (those where the caregiver is implicated in the death) are less likely to involve physical abuse and more likely to involve some form of neglectful supervision. (Figure 13, 16)

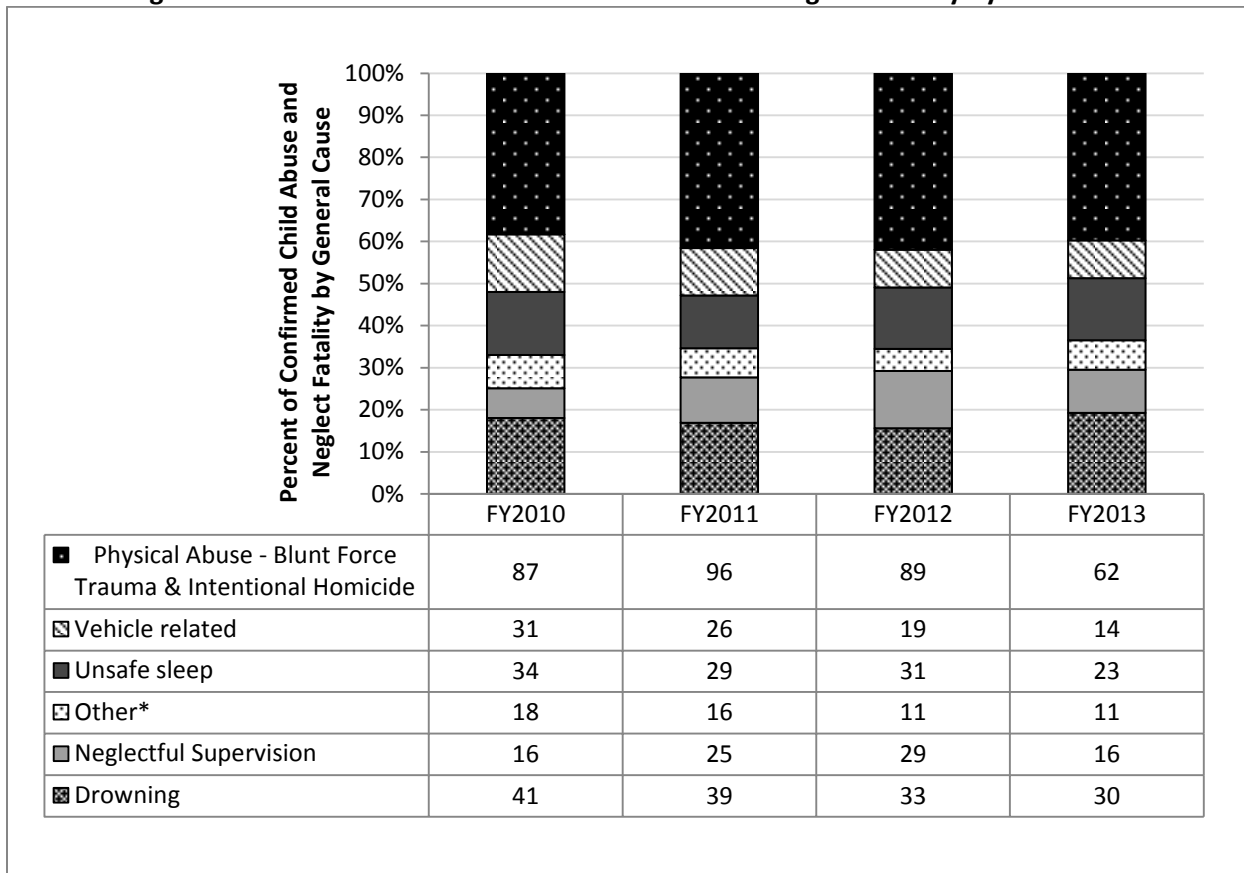
### ***General Cause/Manner of Child Abuse or Neglect Fatality***

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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 child abuse. Unintentional deaths are those where the level of inattention and or impairment by the child's caregiver was so high that it was considered neglect.

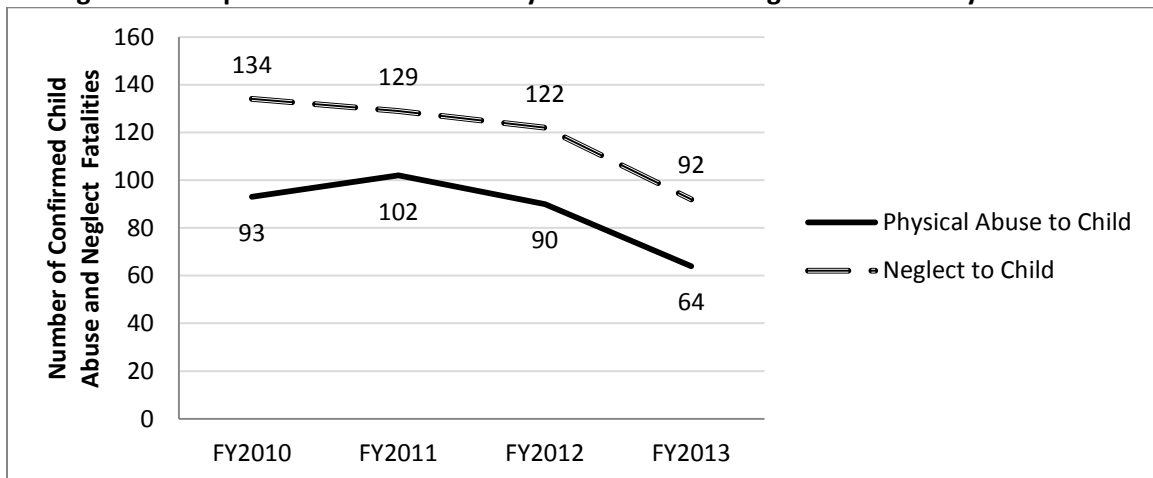
**Figure 3. General Cause of Confirmed Child Abuse or Neglect Fatality by Fiscal Year**



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

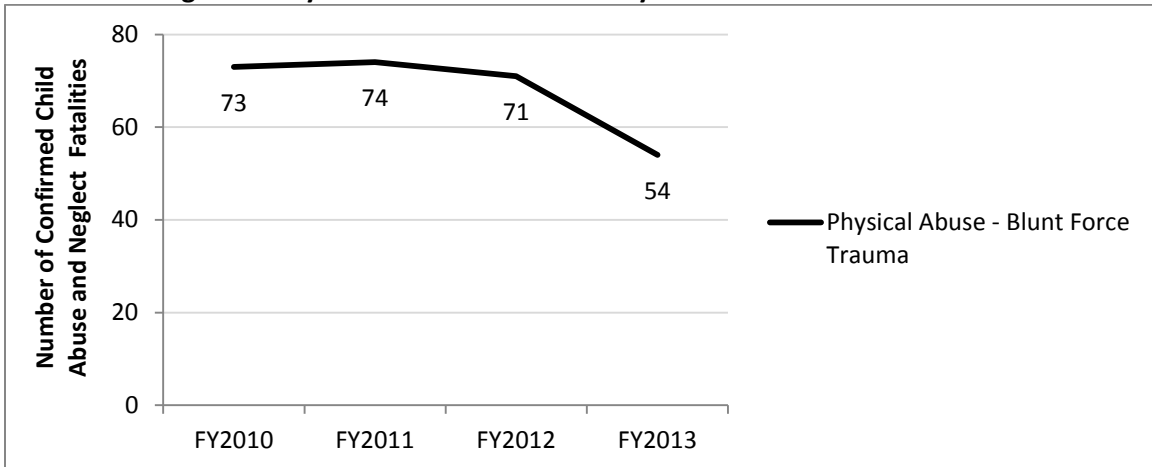
Source: DFPS individual case reviews

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



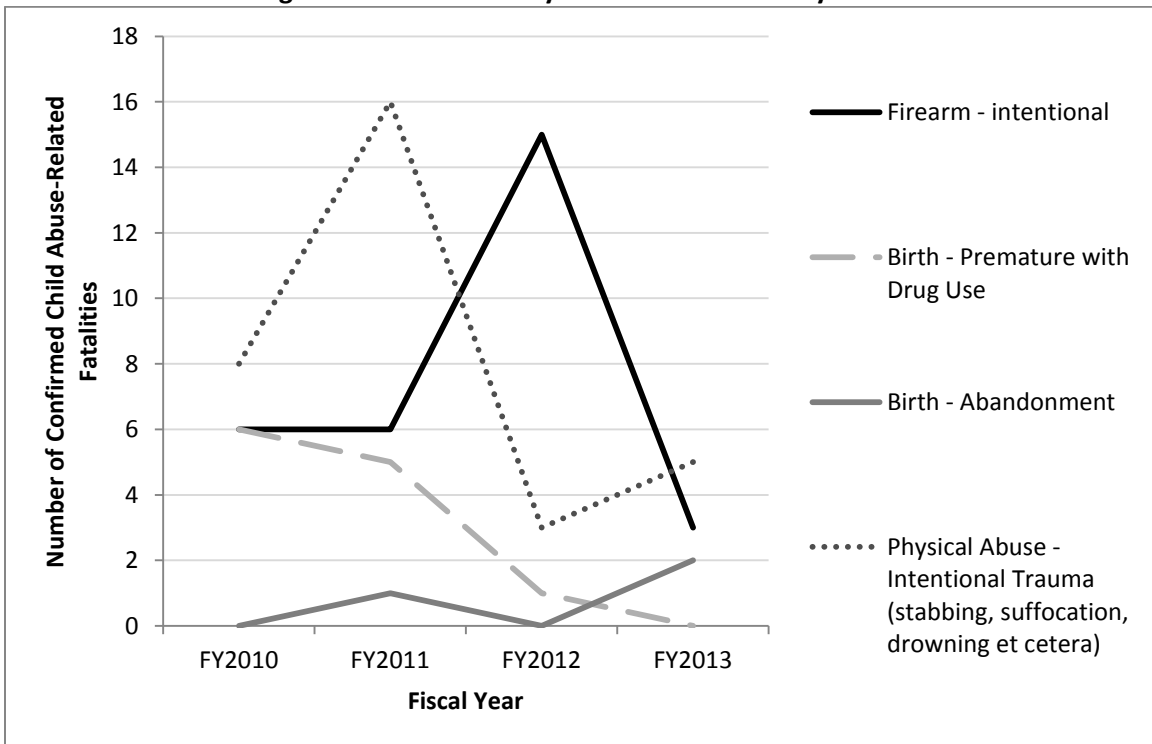
Source: DFPS individual case reviews

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



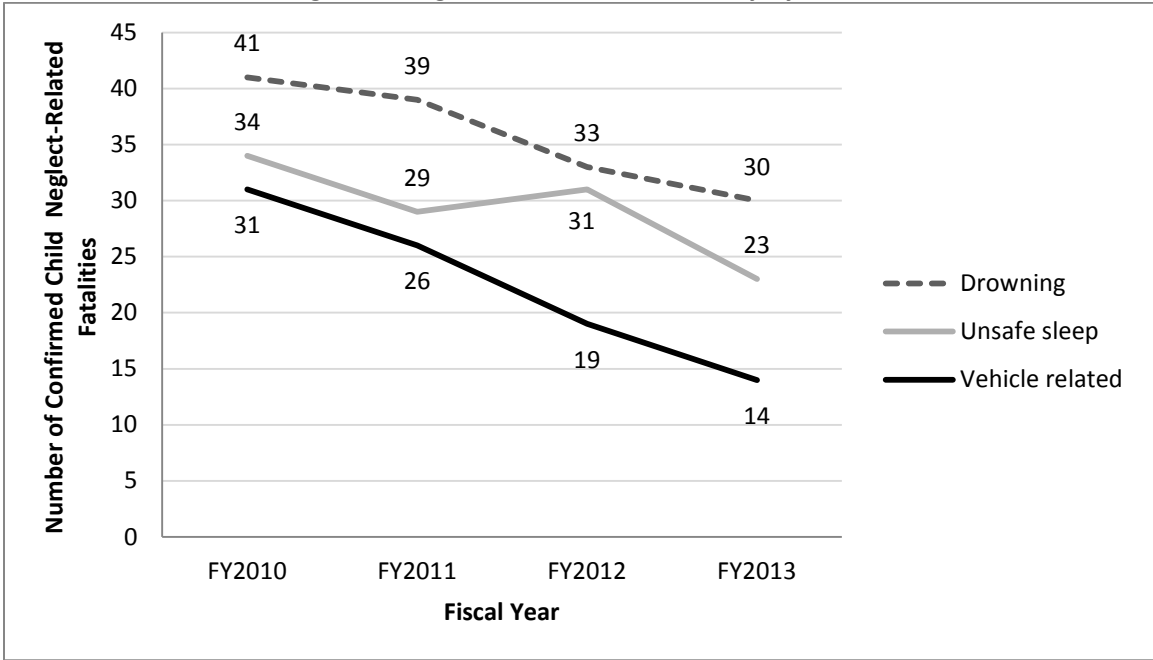
Source: DFPS individual case reviews

**Figure 6. Intentional Physical Abuse to Child by Cause**



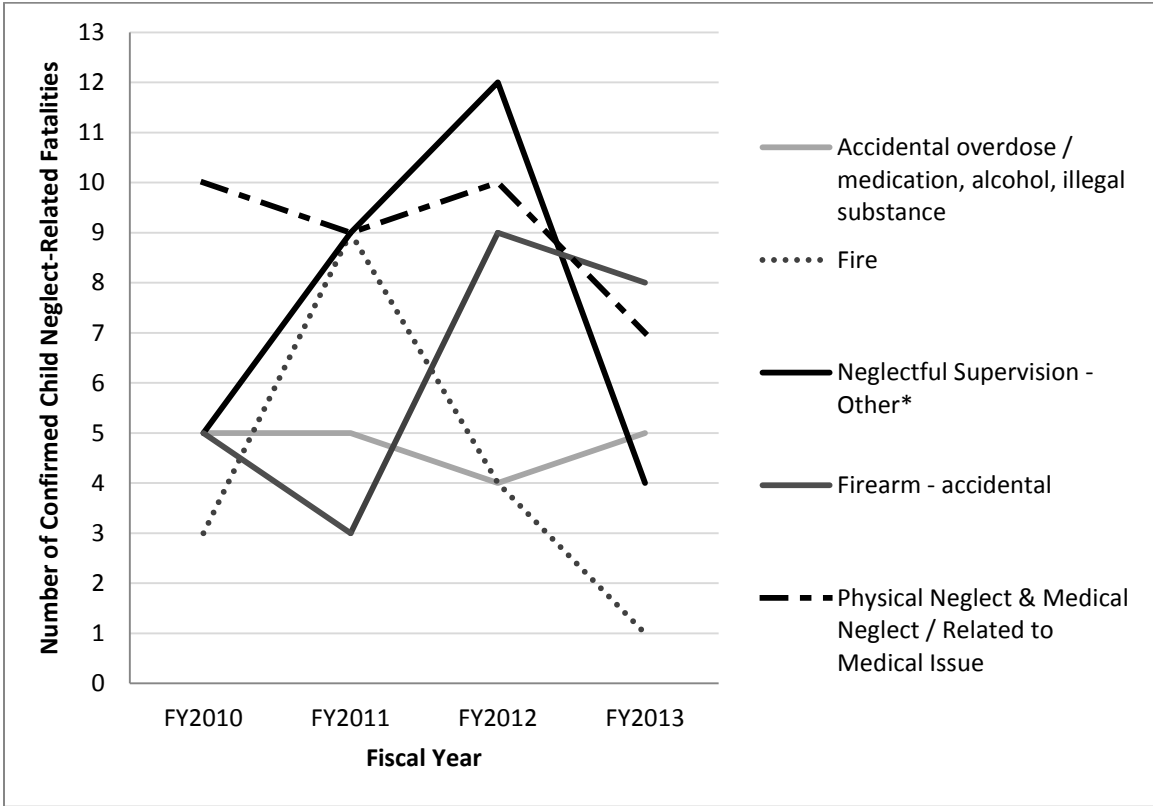
Source: DFPS individual case reviews

**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 dog attack, object falling on child, suicide

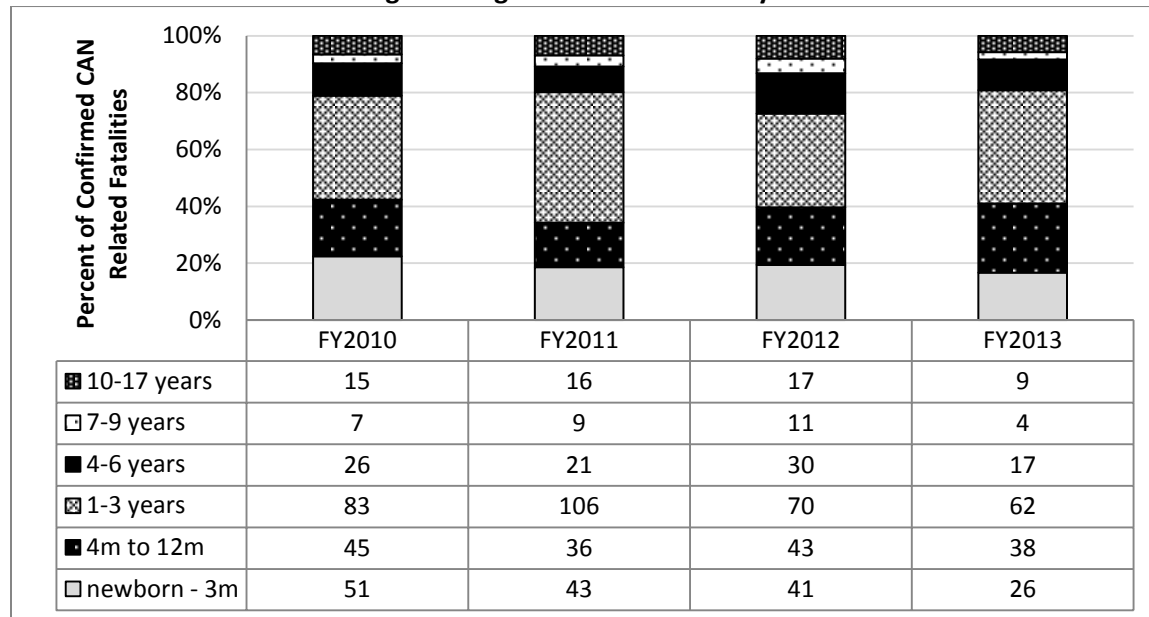
Source: DFPS individual case reviews

*Victim Demographic Characteristics - Age, Gender, Ethnicity*

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

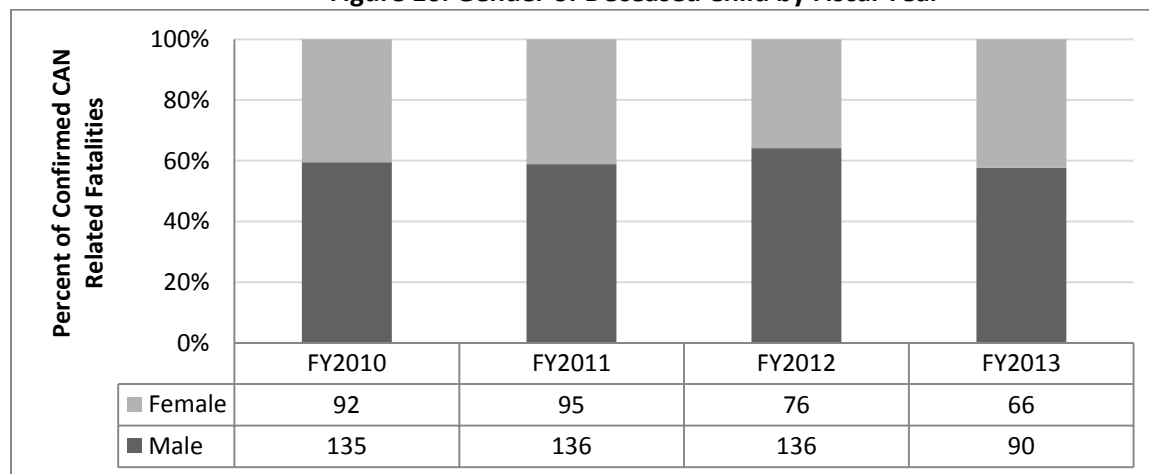
- Based on the confirmed child abuse and neglect related fatalities, children 3 years of age and younger made up 80 percent of all confirmed child abuse and neglect fatalities. Male children made up more than half of all confirmed child abuse and neglect related fatalities.
- In FY2013, 81 percent of children in abuse and neglect fatalities were 3 years old or younger and 58 percent were male.
- The largest percentage of children who die from abuse or neglect are Hispanic, who also represent the greatest percentage of overall child abuse and neglect victims.

**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 these fatalities in context of the child per capita rate for Texas. While children of Hispanic heritage represent the largest percentage of child abuse and neglect fatalities, the child per capita rate of fatal abuse/neglect for African American children is disproportionately higher compared to their overall representation in the Texas child population (Table 3). Texas Health and Human Services is actively working with state and federal agencies, universities, private groups, communities, foundations, and offices of minority health to decrease or eliminate health and health access disparities among racial, multicultural, disadvantaged, ethnic, and regional populations.<sup>xiv</sup>

**Table 3. Per Capita Rate (per 100,000 Children) by Ethnicity  
for Confirmed Child Abuse or Neglect Fatalities  
FY2010**

<b>Ethnicity Represented</b>	<b>African American</b>	<b>Anglo</b>	<b>Hispanic</b>	<b>Other / Non Hispanic</b>	<b>Total</b>
<b>Total Child Population</b>	810,543	2,322,661	3,317,777	414,843	6,865,824
<b>Number of Fatalities</b>	46	78	85	18	227
<b>Per Capita Rate of Fatality</b>	5.68	3.36	2.56	4.34	3.31

**FY2011**

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

**FY2012**

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

**FY2013**

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

Sources: Texas State Data Center; DFPS Data Warehouse Report FT\_06



## *Perpetrator Demographic and Characteristics - Relationship and History*

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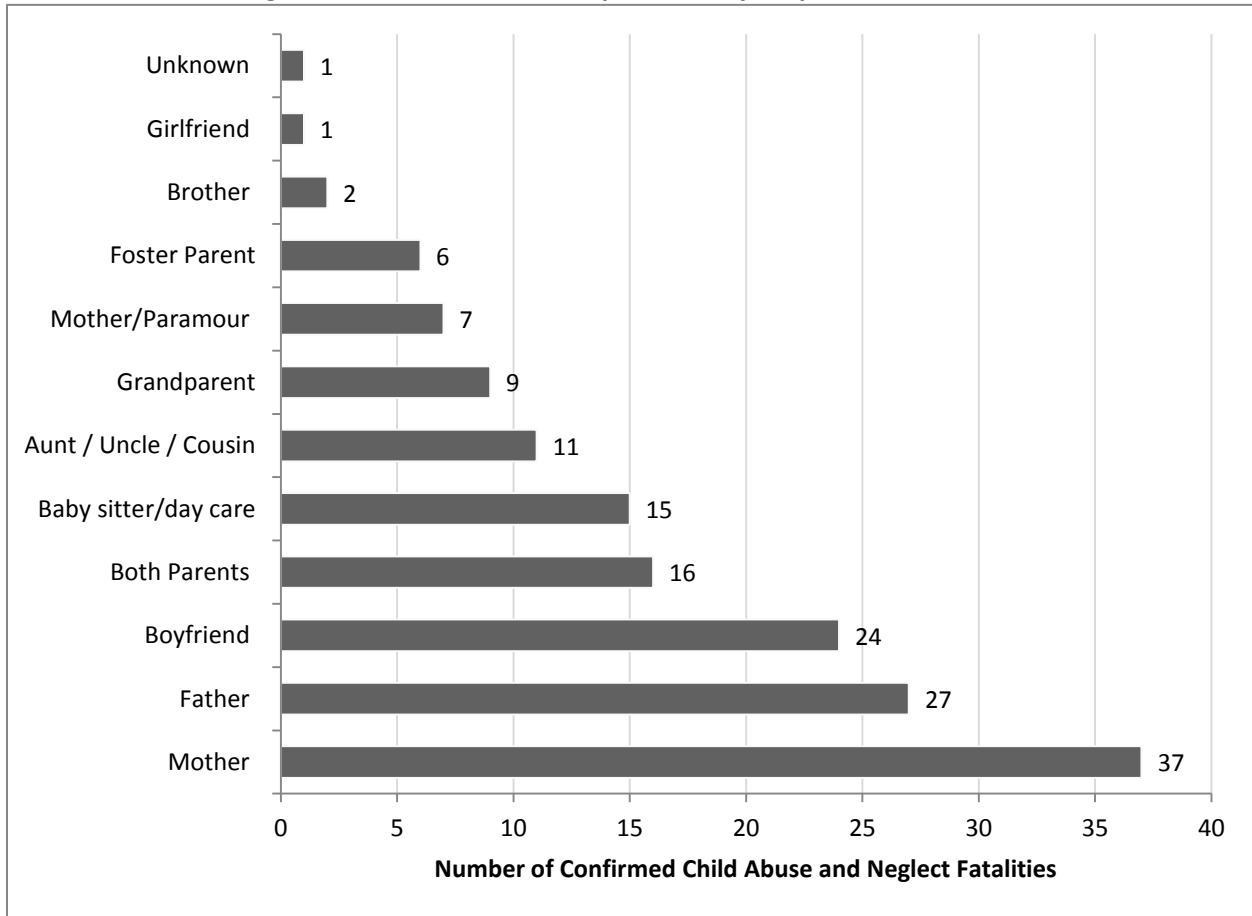
To analyze the perpetrator demographics, FY2013 cases were utilized for an in-depth review. Based on the confirmed child abuse and neglect fatalities that occurred during FY2013, several key demographic areas allow for specialized targeting of prevention and intervention in child abuse and neglect cases. Data from these fatalities infer that these parents would benefit from support, education and other targeted campaigns. Communities could use this data to target their messaging and provision of available resources to families and caregivers.

For purposes of 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 knowingly allowed the primary perpetrator to harm the child may have also been designated as perpetrators. For example, in a case where a paramour beat the child and the mother was neglectful in allowing the paramour access, the paramour would be identified as the primary perpetrator. As with the majority of all child abuse and neglect, cases with a fatality most commonly had a parent as the primary perpetrator. A paramour, however, was the primary perpetrator in 20 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 the majority of child abuse and neglect-related fatalities, the child or the perpetrator had no prior history with CPS.
  - In cases where CPS was involved with the family at the time of the death, most fatalities were caused by unintentional acts involving inadequate supervision.
  - In the remaining cases where CPS was involved with the child or perpetrator in the past, most fatalities were the result of intentional acts such as physical abuse.

**Figure 11. FY2013 Relationship of Primary Perpetrator to Victim**

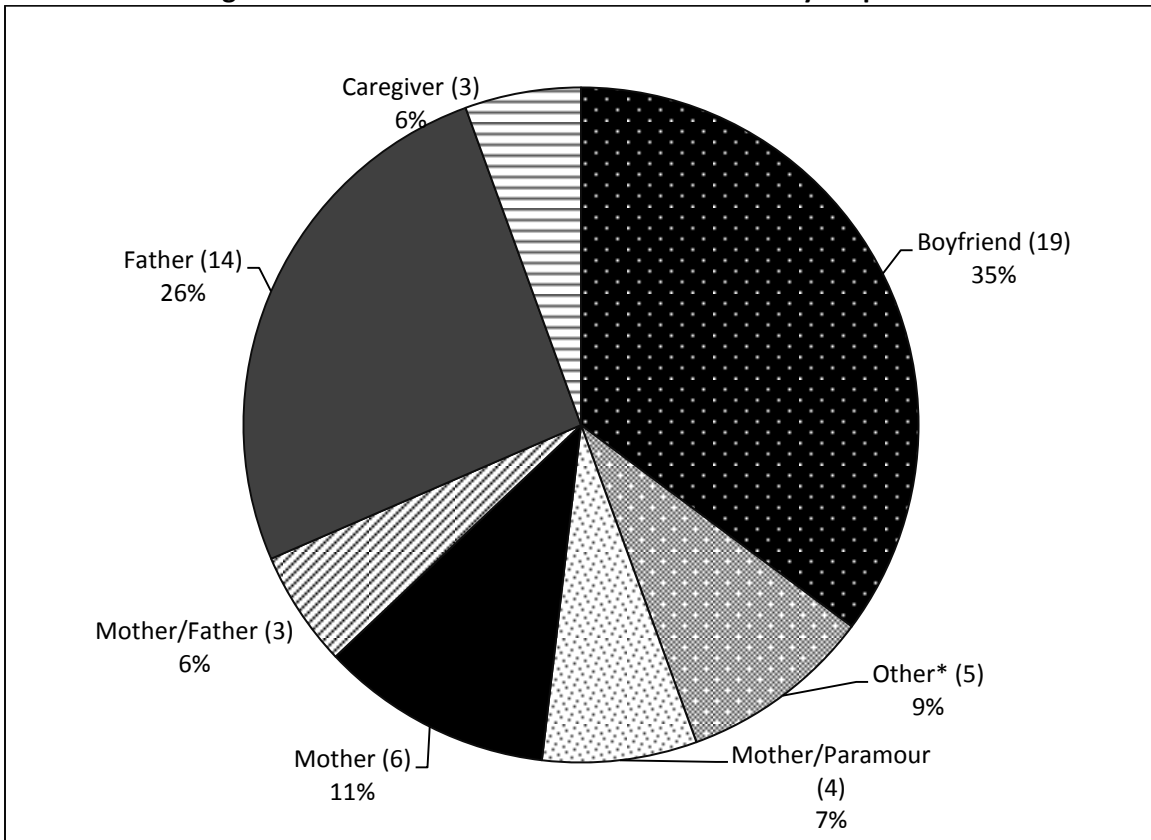


Source: DFPS individual case reviews

*FY2013 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 for causes of death involving six children or more. Other categories (such as accidental overdose, dog related, fire, intentional fatality at birth, suicide and intentional acts such as suffocation, shooting, drowning, strangulation and stabbing), each involved less than six children. All data in this section is based on the DFPS individual case reviews completed for FY2013 confirmed child abuse and neglect related child fatalities.

**Figure 12. FY2013 Blunt Force Trauma Fatalities by Perpetrator**



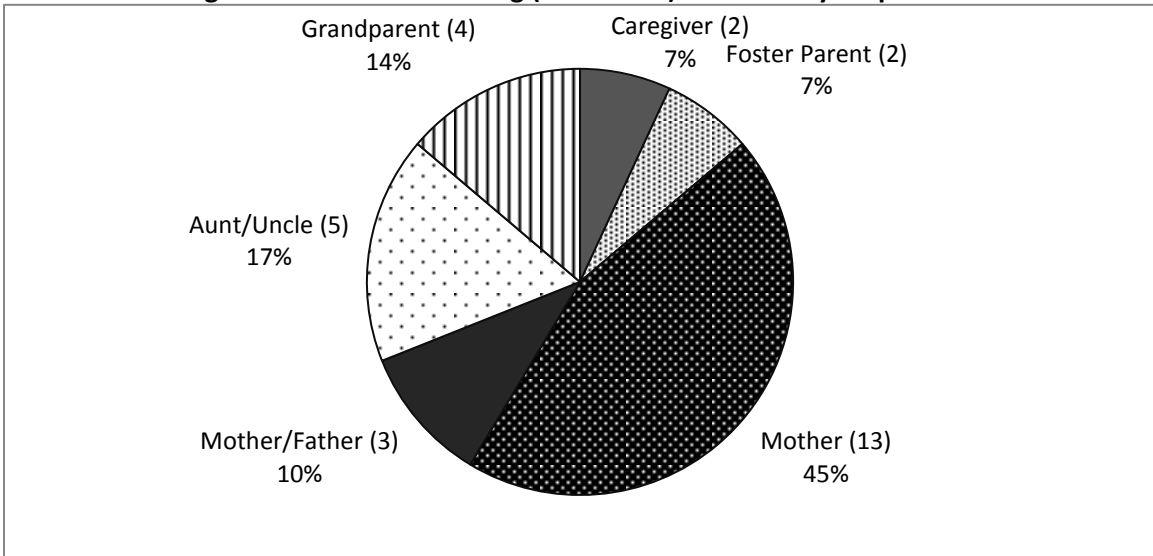
\*Other includes: Girlfriend (1), Uncle, (1), Babysitter (1), Foster Parent (1), Unknown (1)

Number of victims: 54 children

Age range of victims: Newborn to 6-year-old child. 25 children were younger than one year old.

Finding: Usually involve young children being physical abused by father (30 percent) or a boyfriend (42 percent)

**Figure 13. FY2013 Drowning (Accidental) Fatalities by Perpetrator**

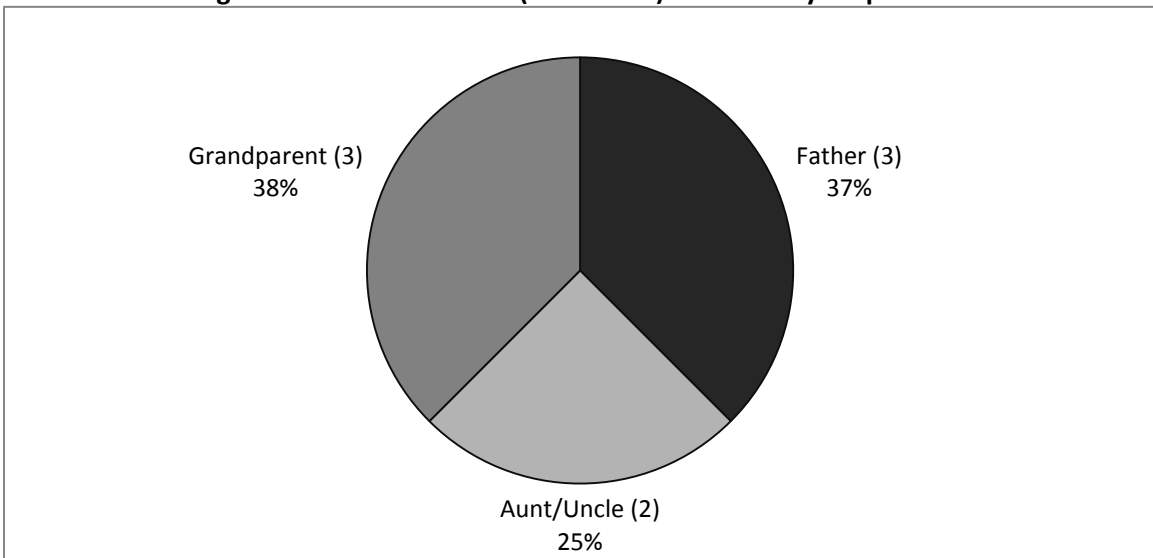


*Number of victims:* 29 children

*Age range of victims:* 9 months to 6 years old

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

**Figure 14. FY2013 Firearm (Accidental) Fatalities by Perpetrator**

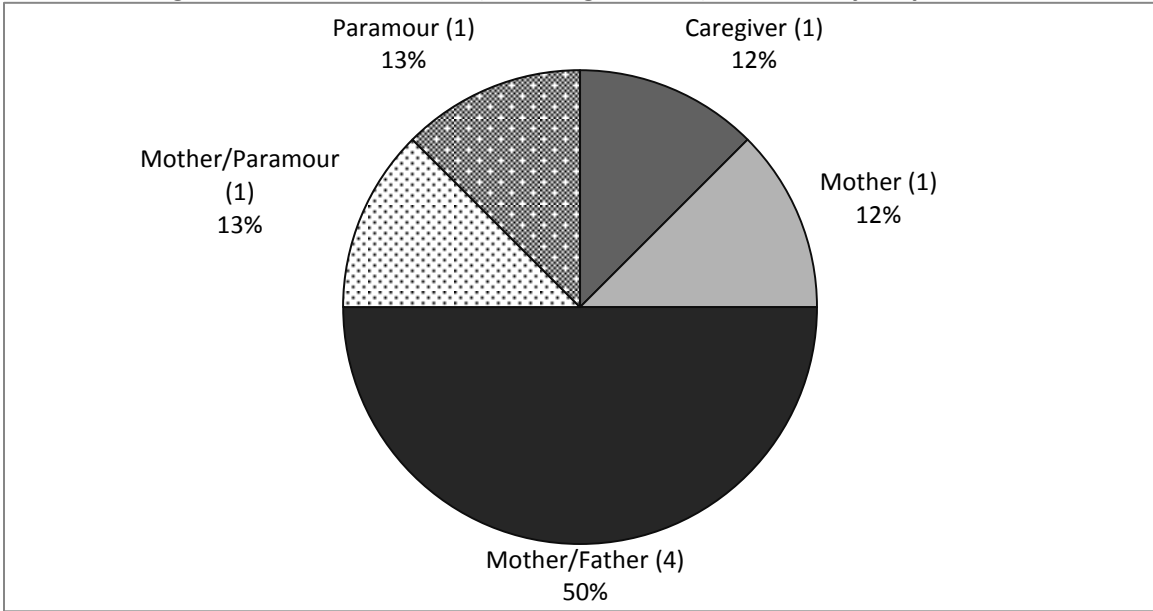


*Number of victims:* 8 children

*Age range of victims:* 2 years old to 13 years old

*Finding:* Usually happens while in care of someone other than mother

**Figure 15. FY2013 Medical (including seizures) Fatalities by Perpetrator**

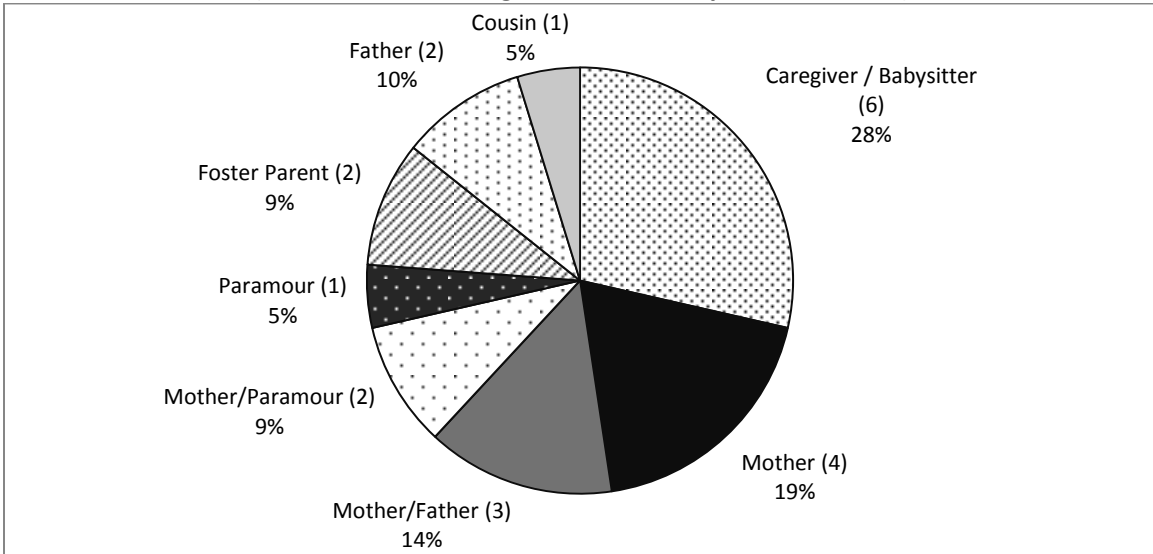


*Number of victims:* 8 children

*Age range of victims:* 3 months to 15 years old

*Finding:* Usually happens while in care of the mother (75 percent)

**Figure 16. FY2013 Unsafe Sleep Fatalities by Perpetrator (includes bed-sharing and unsafe sleep environments)**

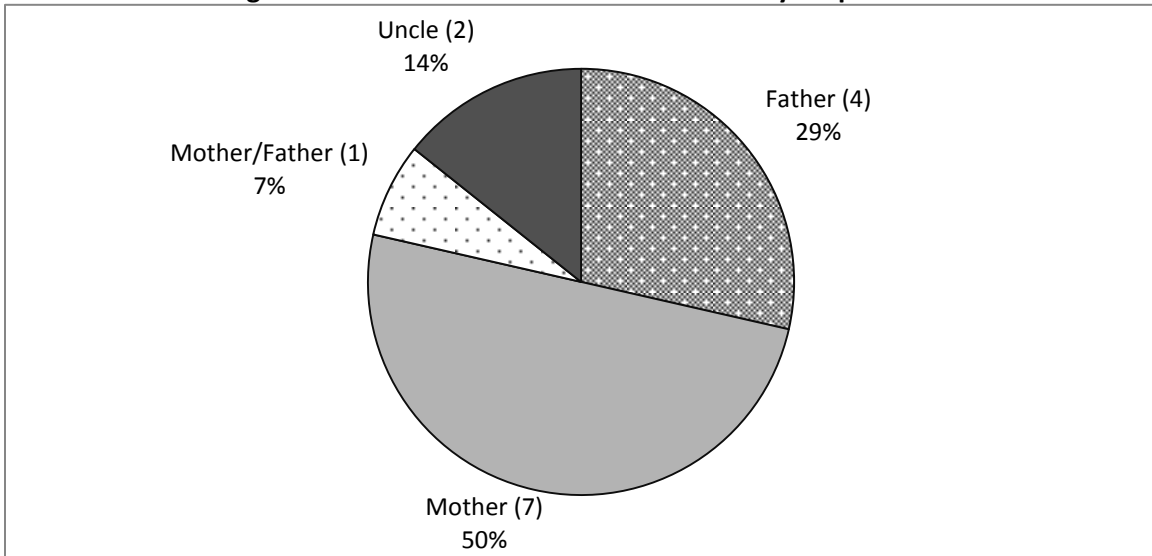


*Number of victims:* 21 children

*Age range of victims:* newborn to 1.5 years old

*Finding:* Generally involve infants but no patterns on primary perpetrator although likely involve the mother either by herself or with either the child's father or her paramour.

**Figure 17. FY2013 Vehicle Related Fatalities by Perpetrator**



*Number of victims:* 14 children

*Age range of victims:* 5 months to 13 years old

*Finding:* Usually happens while in care of the mother (57 percent)

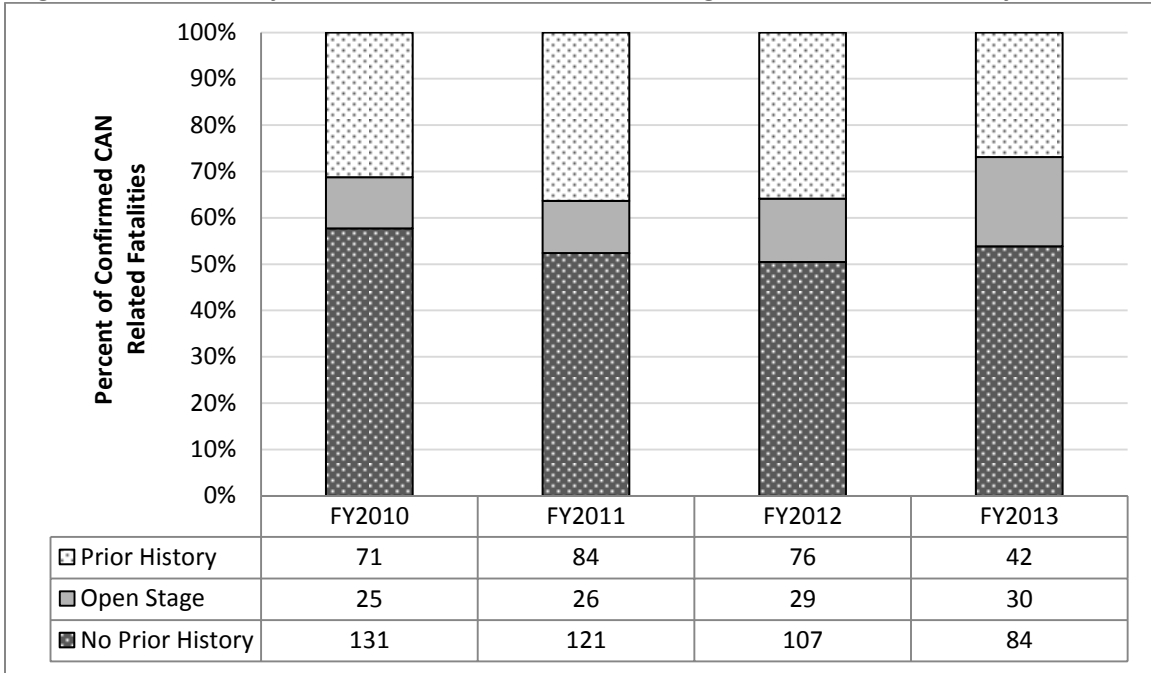
### *Prior CPS History in Child Abuse and Neglect-Related Fatalities*

To better understand fatalities, it is important to identify cases with, and without, prior CPS history and the nature of the prior history. 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 ago or was unrelated to the circumstances of the fatality. Even under this broad definition, the majority of 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 the remaining 31 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 consisted of unintentional acts such as accidental drowning and unsafe sleep. It can be difficult to predict or foresee when or if these types of circumstances will occur. Preventing child fatalities centers primarily with educating caregivers about things such as proper supervision around water and safe sleep.

In contrast, over a third of child abuse and neglect-related fatalities where the child died and CPS had investigated or provided services to the child or perpetrator in the past involved intentional acts, such as blunt force trauma. A more detailed analysis is needed to explore whether physical abuse was involved in the prior CPS cases as well.

**Figure 18. CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Fiscal Year**

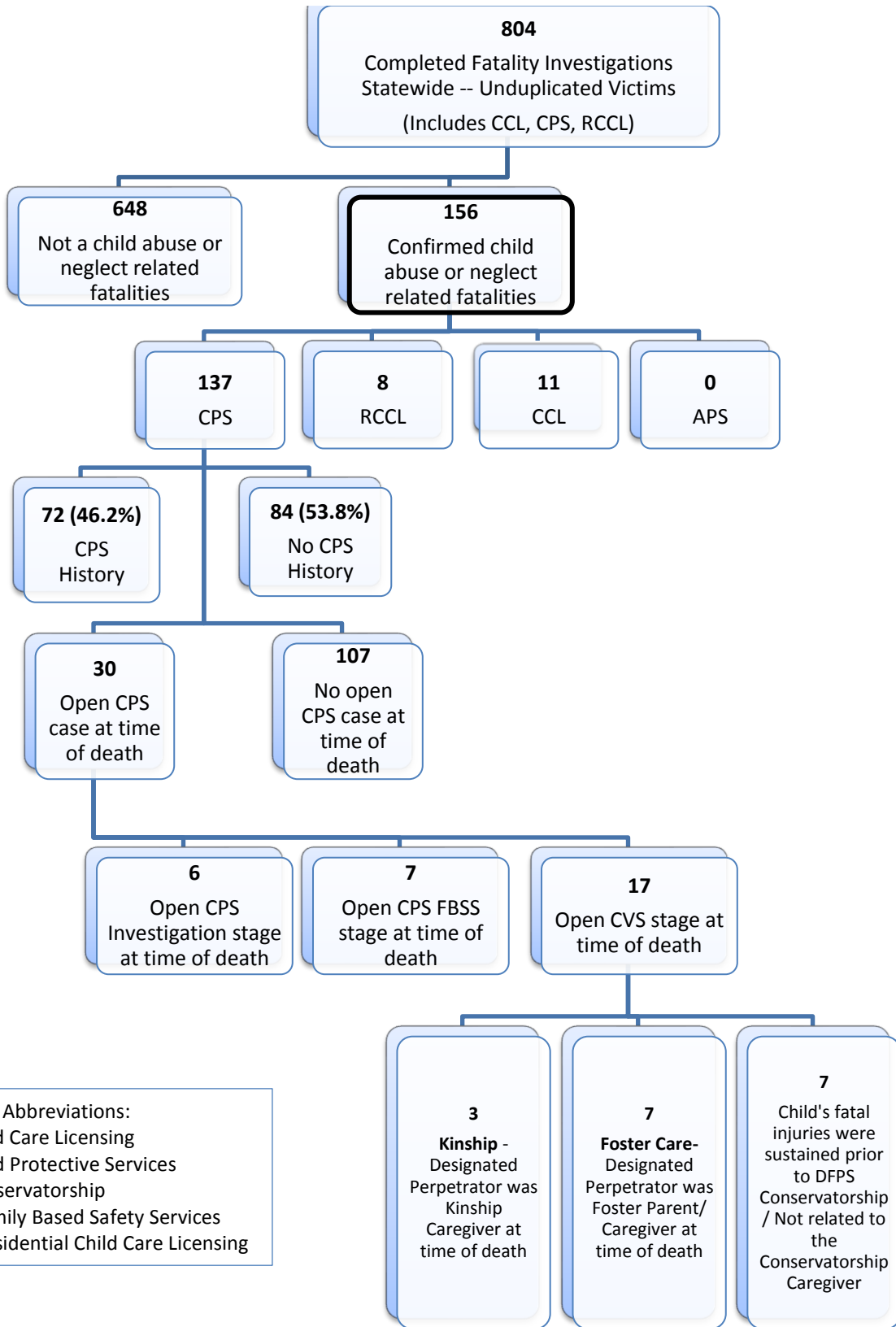


Source: DFPS Data Warehouse Report FT\_06

Additionally, a child fatality may occur in an open stage of service such as Investigations, Family Based Safety Services, or Conservatorship. The majority of fatalities that occur in the Conservatorship stage of service are not found to abuse or neglect related but often due to terminal medical conditions that existed prior to DFPS intervention. Figure 19 uses FY2013 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. Comparing Figure 18 and Figure 19, the data show that there were 30 confirmed child abuse or neglect related fatalities with an open stage at the time of the fatality. Based on Figure 19, the following conclusions are noted:

- 30 children were involved with Child Protective Services at the time of their death.
  - 6 of the children were in an active investigation stage 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 stage and a new incident of abuse or neglect occurred leading to the fatality data
  - 17 of the children were in an active conservatorship stage at the time of the fatality
    - 3 of the children were being cared for in a kinship placement at the time and a new incident of abuse or neglect occurred leading to the fatality
    - 7 of the children were being cared for in a foster care placement and a new incident of abuse or neglect occurred leading to the fatality data
    - 7 of the children were brought into DFPS conservatorship having already suffered the fatal injuries and subsequently died while in care

**Figure 19. FY2013 Department of Family and Protective Services (DFPS)  
Data on Child Abuse and Neglect Related Fatalities Statewide**



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

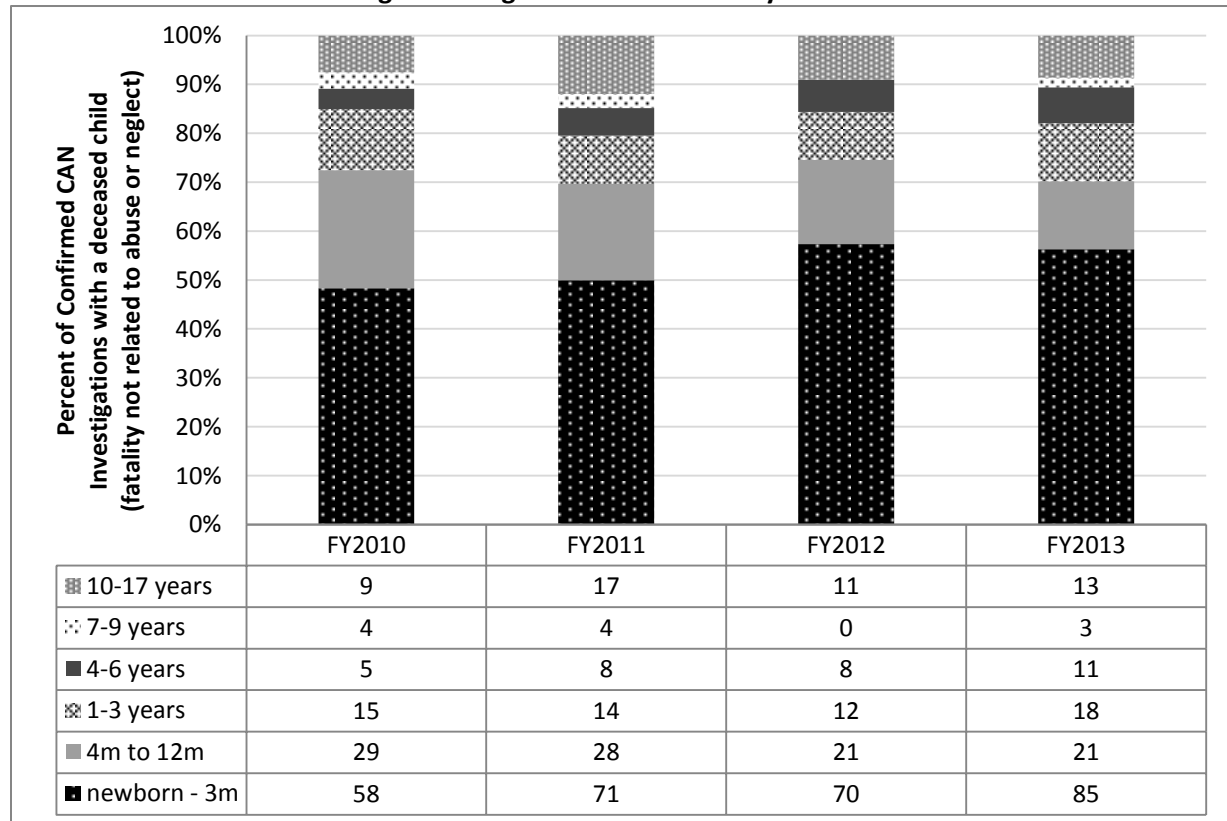


*Child Fatalities Not Caused by Abuse and Neglect but Abuse or Neglect was Found In General*

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. Texas Family Code otherwise 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. However, analyzing child fatalities where there is a confirmation of abuse or neglect in the home even though it did not cause the fatality can help target specific prevention and intervention services both in the community and in those contracted by DFPS. It is important to remember that dispositions in child fatality investigations are reviewed by several levels of management in the region and rely heavily on input from medical personnel and law enforcement.

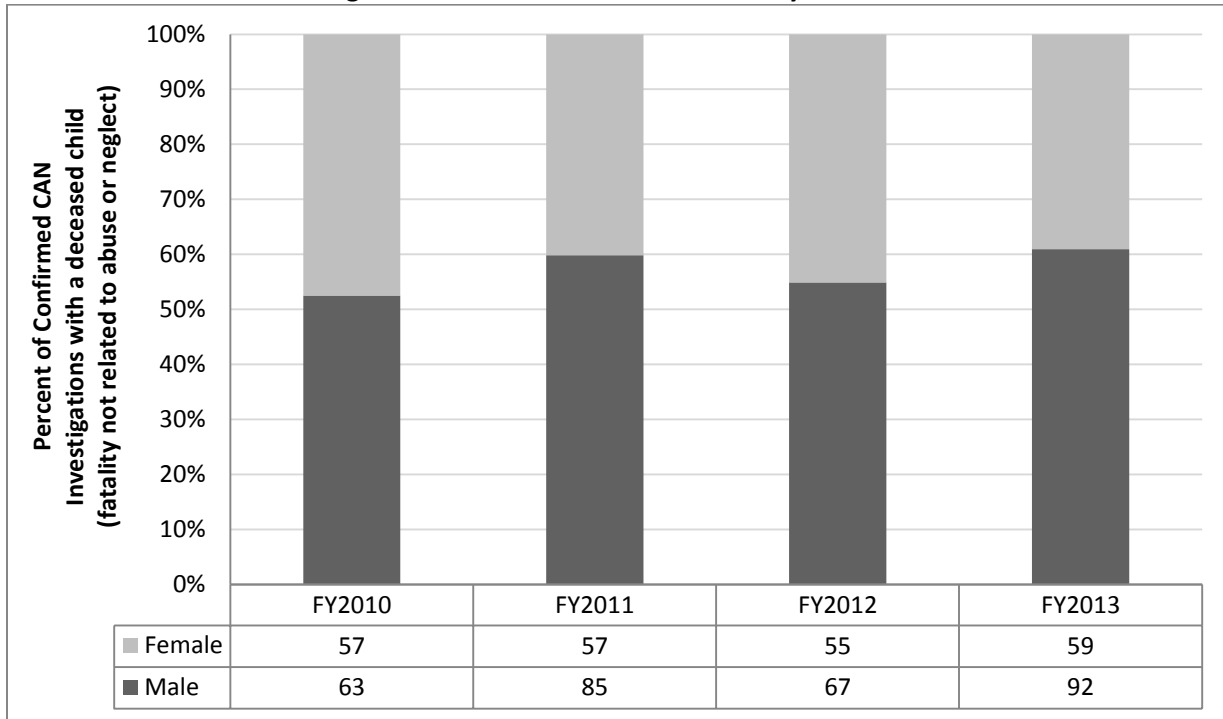
Further analysis and individual case readings in these types of investigations is needed to help inform strategies to prevent child fatalities in general and ensure consistency in decision making surrounding investigations where a child fatality has occurred. The Office of Child Safety will complete a review of cases where a child fatality occurred but was found to be caused by something other than abuse or neglect. This in-depth analysis is needed as these cases have similar demographics as confirmed child fatalities caused by abuse and neglect: the victim is often under one year old, Hispanic and male. One noted difference is that victims in this category are often three months of age or younger at the time of their death.

**Figure 20. Age of Child at Death by Fiscal Year**



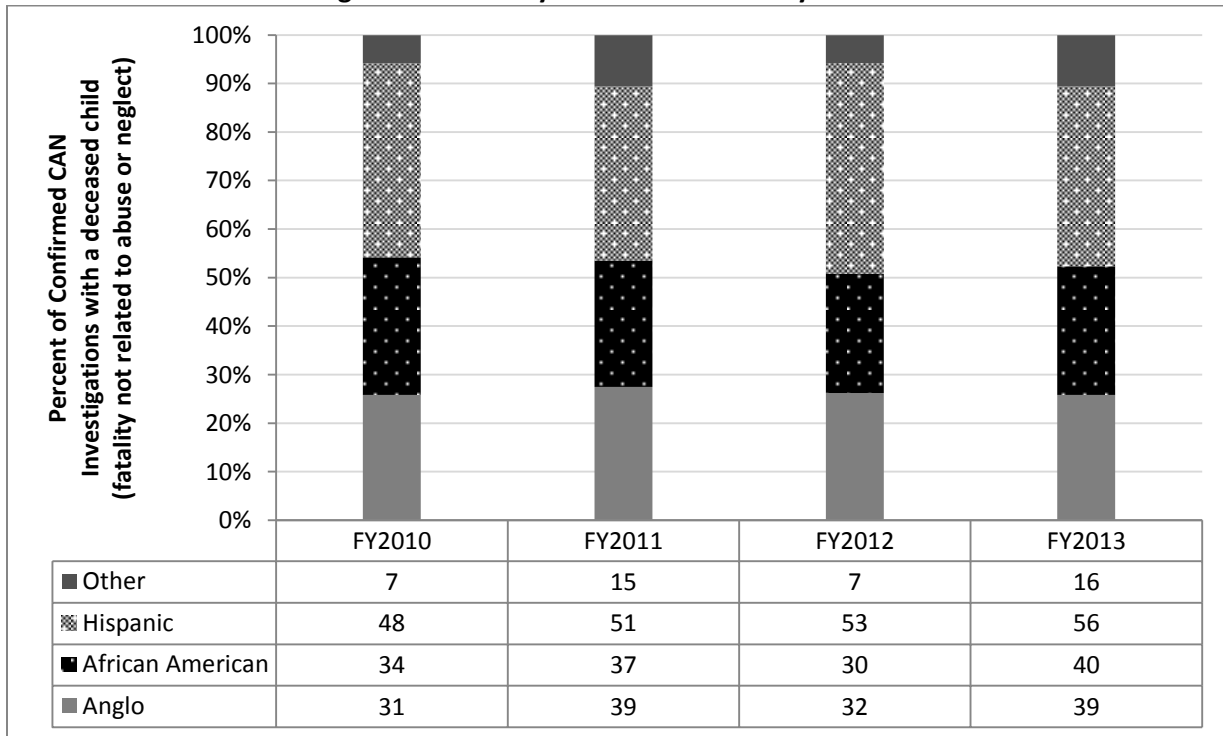
Source: DFPS DRIT Request

**Figure 21. Gender of Deceased Child by Fiscal Year**



Source: DFPS DRIT Request

**Figure 22. Ethnicity of Deceased Child by Fiscal Year**



Source: DFPS DRIT Request

## Child Fatalities in Texas within the National Context

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**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*<sup>xv</sup>, an annual report comprising data from the National Child Abuse and Neglect Data System (NCANDS).<sup>xvi</sup> 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.<sup>xvii</sup>

**Texas's definition of abuse and neglect is broad:** Texas addresses these issues by having very broad abuse and neglect definitions and reporting structure 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;<sup>xviii</sup>
- investigating any report of child abuse or neglect allegedly committed by a person responsible for a child's care, custody, or welfare;<sup>xix</sup>
- including in the definition of child abuse and neglect the use of a controlled substance<sup>xx</sup> and defining medical neglect as the failure to *seek, obtain, or follow through* with medical care for the child;<sup>xxi</sup> and
- defining prior history very broadly.

**Defining prior history:** While other states limit prior history to those cases that had previous investigations, direct service delivery, or conservatorship of the child within a certain timeframe, Texas does not limit either the timeframe 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. Under this definition, it counts as prior CPS history even if the last contact with CPS was several years ago, the perpetrator was involved with a different family, the deceased child was not yet born, or if the history was 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 2012 (the most recent year reported for all states), the Texas rate was 3.03 confirmed child abuse and neglect related fatalities per 100,000 compared to a national average of 2.2 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.<sup>xxii</sup> Some states do not even report at all; in the annual federal *Child Maltreatment 2012* report, Idaho, Maine and Massachusetts did not report on child fatalities.

**Delay in national reporting:** National data comparisons for FY2013 will not be available until late December 2014 or early 2015. It is important to note that the number of confirmed child abuse and neglect related fatalities continued to decline in FY2013; it is likely that when the federal level data for FY2013 is released that Texas will be close to or below the national rate.

## Initiatives & Program Improvement

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### Internal Initiatives and Program Improvement

**DFPS Transformation** is a rigorous self-improvement process that Child Protective Services (CPS) began in 2014 to transform itself into a better place to work and the most effective program possible. It is a bottom-up effort built on the knowledge and insights of front-line staff and led by both regional and state office staff. 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. Additionally, several national and state efforts are currently underway 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 provisions. 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.

The Office of Child Safety will conduct a review of child fatality investigations where the death was not found to be from abuse or neglect but that there was abuse or neglect found in general. Within the constraints of Texas Family Code 261.201 confidentiality, the Office of Child Safety will produce a report.

### ***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.<sup>xxiii</sup>
- Room to Breathe on safe sleep practices for infants.<sup>xxiv</sup>
- Watch Kids Around Water about drowning prevention.<sup>xxv</sup>
- Look Before You Lock on preventing deaths in hot cars.<sup>xxvi</sup>

### ***Prevention and Early Intervention - Project HOPES***

DFPS is increasing services through Prevention and Early Intervention. Project HOPES will establish flexible, community-based child abuse and neglect prevention programs in select 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 caused fatalities. Communities can propose evidence-based programming that meets the needs of their population. DFPS worked 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.

### ***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 initially.

### ***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.<sup>xxvii</sup> 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 a single Texas team covers is 26.

DSHS publishes an annual report from the SCFRT. The most recent report is: [FY2013 Annual Report](#)<sup>xxviii</sup>

#### ***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 collaboration between DFPS and DSHS has the specific aim of taking the results of an in-depth analysis of the risks that exist within families and communities that have experienced an abuse or neglect fatality and use those results to guide a strategic plan that coordinates support services between DSHS and DFPS. The ultimate goal of this plan is to reduce abuse and neglect fatalities by strategically providing timely, coordinated, and evidence-based services to families and communities in need.

### ***Protect Our Kids Commission***

During the 83<sup>rd</sup> Texas Legislature, SB66 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 will identify necessary resources and develop recommendations to reduce child abuse and neglect fatalities that can be implemented at the local and state level. DFPS serves as one of the 15 members on the Commission. As an active member, DFPS is helping form and strategize recommendations for future implementation including:

- identification of best practices and evidence-based strategies to reduce child fatalities from abuse and neglect.
- development of recommendations for a comprehensive strategy to bring together local agencies, private sector, non-profits, and government programs to reduce child fatalities from abuse and neglect.
- development of guidelines for information that should be tracked to improve interventions to prevent child fatalities from abuse and neglect.

### ***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

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<sup>i</sup> 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.

<sup>ii</sup> 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>

<sup>iii</sup> 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>

<sup>iv</sup> 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>

<sup>v</sup> 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>

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

<sup>vii</sup> See State Child Fatality Review Team. Available at

[http://www.dshs.state.tx.us/mch/child\\_fatality\\_review.shtm](http://www.dshs.state.tx.us/mch/child_fatality_review.shtm)

<sup>viii</sup> Wood, J.N., S.P. Medina, C. Feudtner, X. Luan, R. Localio, E.S. Fieldston, and D.M. Rubin. 2012. Local macroeconomic trends and hospital admissions for child abuse, 2000-2009. *Pediatrics*.

Available at: <http://pediatrics.aappublications.org/content/130/2/e358.full.pdf>

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

<sup>x</sup> See Forensic Assessment Center Network. Available at: <http://facntx.org/Public/About.aspx>

<sup>xi</sup> See DFPS Child Safety Resource Page. Available at:

[http://www.dfps.state.tx.us/Child\\_Protection/Child\\_Safety/default.asp](http://www.dfps.state.tx.us/Child_Protection/Child_Safety/default.asp)

<sup>xii</sup> 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>.

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

<sup>xiv</sup> See HHSC Center for the Elimination for Disproportionality and Disparities.

Available at: [http://www.hhsc.state.tx.us/hhsc\\_projects/cedd/about/index.shtml](http://www.hhsc.state.tx.us/hhsc_projects/cedd/about/index.shtml)

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

<sup>xvi</sup> 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>.

<sup>xvii</sup> 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>

<sup>xviii</sup> Tex. Fam. Code §261.102 Matters to be Reported, Section 261.101 Persons Required to Report; Time to Report.

<sup>xix</sup> Tex. Fam. Code §261.301 Investigation of Report.

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<sup>xx</sup> 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.

<sup>xxi</sup> Tex. Fam. Code §261.001 Definitions

<sup>xxii</sup> 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). (Accessed on February 3, 2014).

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

<sup>xxiv</sup> DFPS Public Website, [http://www.dfps.state.tx.us/Room\\_to\\_Breathe/default.asp](http://www.dfps.state.tx.us/Room_to_Breathe/default.asp)

<sup>xxv</sup> DFPS Public Website, [http://www.dfps.state.tx.us/Watch Kids Around Water/default.asp](http://www.dfps.state.tx.us/Watch_Kids_Around_Water/default.asp)

<sup>xxvi</sup> DFPS Public Website,

[http://www.dfps.state.tx.us/Prevention\\_and\\_Early\\_Intervention/Vehicle\\_Safety/default.asp](http://www.dfps.state.tx.us/Prevention_and_Early_Intervention/Vehicle_Safety/default.asp)

<sup>xxvii</sup> DSHS State Child Fatality Review Team Members,

<https://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589985017>

<sup>xxviii</sup> Texas Child Fatality Review Annual Report 2013,

<http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589987385>