



TEXAS
Department of Family
and Protective Services

Fiscal Year 2025
Child Maltreatment Fatalities
and Near Fatalities Annual Report

February 28, 2026

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Executive Summary

Protecting children and helping them reach their greatest potential begins at home for the over 7 million children of Texas. Family members, neighbors, schools, and communities all serve as a safety net. When safety concerns arise, allegations of abuse, neglect or exploitation are investigated by the Texas Department of Family and Protective Services to ensure the safety of Texas children. To address child maltreatment before it starts and protect children from future harm, DFPS works in partnership with communities to provide a continuum of prevention and intervention programs. These partnerships with families, communities, service providers, law enforcement, and the medical community allow DFPS to utilize a public health framework to address fatal and near fatal child maltreatment. Specifically, through analyzing and addressing trends in child abuse and neglect fatalities, and strengthening community partnerships, DFPS continually seeks to improve policy and practices for investigations, interventions, and services provided to children, youth, and families to address child safety and well-being through prevention efforts *before* families are in crisis.

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

We have seen communities take on these issues directly--from water safety outreach, to working to ensure all birthing hospitals in a community are safe sleep certified, and even partnering with parent education resources to connect parents with the support they need on an individual level. For children to remain safe, and thrive, it takes community collaboration to build support networks and resources, while normalizing a parent's ability to seek help and engage families before tragedy strikes.

In nearly every child maltreatment fatality, someone or some system could have intervened and prevented the child's death. By utilizing a proactive, public health approach, DFPS continues to work with communities to improve messaging and education around child safety by increasing the awareness of the community, service providers, and local leaders about the scope and problems associated with child maltreatment. Some of these efforts include consistent messaging about water safety, safe sleep practices, and caregiver selection. DFPS policies

surrounding discussing safe sleep practices, supporting family preservation efforts, and connecting families to services have been strengthened to support building a stronger safety net for families that come to the attention of the agency.

In accordance with Texas Family Code, Section 261.204, and Section 264.5032, DFPS presents the FY25 Annual Child Fatality Report which includes aggregated data compiled from each child fatality investigation for which the department made a finding regarding abuse or neglect, including cases in which the department determined the fatality was not the result of abuse or neglect. Additionally, investigations resulting in a finding of abuse or neglect related to a near fatal incident are included in this report.

Tasked with systematically investigating and addressing child maltreatment fatalities, DFPS is aware of the risk factors that lead to child fatalities— young, vulnerable children often left with caregivers or in dangerous situations. The co-occurrence of substance abuse, domestic violence, and mental health concerns with child maltreatment is prevalent. It requires intensive coordination and collaboration between DFPS, other state agencies, and community providers so that families can be supported. With the efforts of other state agencies to address child fatalities and child maltreatment, this report can inform the development of prevention and early intervention programs and intervention strategies if abuse and neglect is suspected, as well as to support child safety in regulated childcare settings.

Since FY 2022, changes in legislation, policy and practice have been made that affect how DFPS conducts fatality investigations. Those practices are intended to reduce the impact of trauma on families when there is no allegation of abuse or neglect. Additionally, changes in the definition of neglect may affect the determination of whether neglect occurred, but the definition change did not affect the determination of whether abuse occurred. These practice changes occurred between FY 2022 and FY 2024, since then DFPS practices on fatality investigations have stayed consistent.

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. Based on administrative data and individual case reviews for confirmed child abuse and neglect related fatalities during FY 2025, the following trends and areas for review have been identified:

General Findings

- In FY 2025, 124 children died due to abuse and neglect in Texas (Table 1). Of those deaths:
 - 69 children, accounting for 55.6 percent, died as a result of neglect. The change in the definition of neglect and corresponding policy and practice changes

impacted the number of fatalities DFPS determined occurred as a result of neglect beginning in fiscal year 2022.

- 55 children, accounting for 44.4 percent, died as a result of abuse. This determination was not impacted by the revised definition of neglect.
- In 50 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had prior history with CPS (Figure 21, 22).
- In FY 2025, Texas had 64 confirmed abuse and neglect-related near fatalities (Figure 37).

Victims

- In FY 2025, children 3 years of age and younger made-up 73.4 percent of confirmed child abuse and neglect fatalities. Male children represented a majority of confirmed child abuse and neglect-related fatalities (Figure 9, 10).
- During FY 2025, Hispanic children accounted for the largest percentage of children who died from abuse or neglect at 36.3 percent. The per capita rate for African American children who die from maltreatment continues to be higher than any other ethnicity in Texas. That is also true across the United States (Table 3).
- 65.3 percent of children who died from abuse or neglect in FY 2025 were too young for school and not enrolled in a registered or licensed day care. Four children were being cared for by a day care operation that was not registered or licensed through HHSC (Page 25).

Perpetrators

- Physical abuse fatalities most commonly involved blunt force trauma or intentional trauma inflicted by a father or mother (Figures 13-15).
- In all confirmed cases of abuse and neglect, parents continue to be the most common perpetrators (Figure 12).
- When the perpetrator or the child was previously known to DFPS in the two years prior to fatality, the child fatality is often related to physical abuse or neglectful supervision. (Table 9, 10).
- 87 of the 124 child fatalities, or 70.2 percent, caused by abuse or neglect involved a parent or caregiver actively using a substance and/or who was under the influence of at least one substance that affected their ability to care for the child (Figure 11).

Background: Changes to Practice and Legislation and Definitions

Evolving Child Protection Landscape

Consistent with national research on child protection and childhood trauma¹, the State of Texas recognizes that separating a child from his or her parent is a traumatic experience that can adversely affect wellbeing. While separation of a parent from a child is sometimes necessary, Texas policy and practice have shifted in recent years to recognize that children should remain in the home with their parent or parents whenever they can be safe in that environment. As a result, and consistent with nation-wide trends², the number of children in substitute care in Texas has decreased from 26,164 on August 31, 2021, to 16,208 on August 31, 2025³.

Legislative Changes

In acknowledgment of the significant impact that findings of abuse or neglect can have on families, the State of Texas revised its policies and practices. Findings in child fatality investigations are determined according to the definitions of abuse and neglect outlined in Texas Family Code, Section 261.001(4). Notably, in FY 2022, the definition of Neglect was updated to state that it encompasses "...an act or failure to act by a person responsible for a child's care, custody, or welfare that demonstrates blatant disregard for the consequences of such actions, resulting in harm to the child or creating an immediate danger to the child's physical health or safety...". This revision led to a decline in the number of child fatalities classified as neglect since FY 2021, a trend that has continued through FY 2025. Importantly, this change did not affect the determination of abuse in physical abuse cases.

Practice Changes

Before September 2022, when the Statewide Intake (SWI) received a report regarding a child fatality under DFPS jurisdiction, it was automatically assigned as a full investigation. This approach involved DFPS in families' lives even when there was no evidence suggesting that abuse or neglect contributed to the child's death, often retraumatizing families already coping with such a loss. Consequently, starting in September 2022, intakes related to child fatalities without explicit concerns for abuse or neglect are now processed as a Case Related Special Request instead of a full investigation. This allows for initial confirmation regarding any concerns from the reporter or first responders. If any concerns are identified, the investigation then proceeds as a full investigation. This procedural adjustment, along with the legislative updates to the definition of neglect, has contributed to a reduction in the number of fatality investigations conducted by DFPS, ensuring that only relevant allegations are assigned for full investigation.

DFPS Special Investigators continue to take on the primary responsibility for all child fatality investigations and case-related special requests. These investigators, who possess prior law enforcement experience, enhance collaboration between DFPS and law enforcement, ensuring a thorough and consistent response to affected families.

Additionally, to maintain alignment with the changes to Texas Family Code, Section 261.001, DFPS implemented a process beginning in FY 2024 to review certain investigations that concluded with a “reason to believe for neglect” disposition and a fatal severity code. This includes cases such as drownings and unsafe sleep-related fatalities.

No further changes have been made for FY 2025 with regard to practice surrounding fatality investigations however all prior changes remain in effect.

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

Child Fatality Investigations

DFPS is required under the Texas Family Code to investigate child fatalities or near fatalities where allegations are made of abuse or neglect. Investigations are carried out to determine if abuse and/or neglect occurred and, if applicable, whether the fatality was caused by abuse or neglect.⁴

DFPS investigates child abuse or neglect fatalities based on where the child was living at the time of death and when there is an allegation of abuse or neglect either at the time of the death or if the death is suspected to be caused by abuse or neglect. This includes investigations in the following types of settings:

- Daycares (child care settings);
- Residential child care settings, including children in DFPS conservatorship in foster care placements; and
- Family settings, including deaths of children living with their families, or deaths where the child is in DFPS conservatorship and in non-foster care kinship placements

Investigations are conducted on fatalities that occur while a child is in DFPS conservatorship, whether the fatality is from natural causes, from injuries sustained before coming into foster care, or when the fatality involves allegations of abuse or neglect while the child was in DFPS conservatorship. If the investigation determines that the death is related to abuse or neglect that occurred prior to entering conservatorship or while in conservatorship, it is counted as a confirmed child abuse or neglect fatality.

In child abuse investigations, allegations of abuse or neglect must be substantiated by a preponderance of the evidence. This standard is met when the available evidence demonstrates that it is more likely than not that the alleged abuse or neglect occurred.

Investigation Dispositions for Child Fatalities

Texas Family Code, Section 261.203, states that "if, after a child abuse or neglect investigation is completed, the department determines a child's death was caused by abuse or neglect, the department shall promptly release" specific information related to the disposition of the investigation. To track and report on these fatalities, DFPS utilizes the following 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 investigation.

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

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

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

Near Fatality Investigations

As set out in Texas Family Code, DFPS is required to investigate child abuse and neglect allegations. In some instances, the level of abuse or neglect caused the child to be in serious or critical condition. Texas Family Code §264.5031 defines a near fatality as a situation where a physician has certified that a child is in critical or serious condition. Texas Family Code §264.5032 states the information required to be made public when a CPI investigator determines that the child's condition in a near fatal situation was caused by the abuse or neglect of the child or that abuse or neglect contributed to the child's condition.

As there is no universal definition of "serious" or "critical" condition, DFPS worked with child abuse pediatricians from around the state to help provide common, clarifying guidance for both

staff and medical professionals to utilize. A near fatality consists of an act of abuse or neglect to a child who, without imminent medical intervention, would likely have died as a result of the maltreatment. “Imminent medical intervention” must be performed by a licensed medical professional and requires some form of:

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

In most circumstances, the child is admitted to an intensive care unit, including neonatal intensive care units, pediatric intensive care units, or trauma units.

Investigation Dispositions for Near Fatalities

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

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

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

Child Fatality Review Teams

Community based child fatality review teams systematically review circumstances surrounding child deaths in the state, including maltreatment related deaths, to identify preventable causes and guide community and policy interventions. For their review process, deaths are categorized into one of three categories.

- **Intentional deaths** are defined as those where the perpetrator intended to cause harm or death to the child and most often results in 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.
- **Maltreatment related child deaths** are those in which a child's death was confirmed to be the result of abuse or neglect.

DFPS works in collaboration with other partners such as medical examiners, law enforcement, and DFPS Special Investigators to ensure thorough child fatality investigations. Additional training has been provided to CPI staff on various topics ongoing to support more thorough investigations including training on: contacting reporters, utilizing collateral contacts, family engagement, building a support network, and assessing safety throughout the investigation.

Findings: Investigating Child Abuse and Neglect Related Fatalities

Table 1 provides data regarding overall trends in child abuse and neglect in Texas. While the child population of Texas has continued to increase, the number of intakes assigned for investigation declined from FY 2022 through FY 2025, with FY 2022 having the highest number of intakes in the past 10 years.

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

	FY2021	FY2022	FY2023	FY2024	FY2025
Child Population of Texas	7,594,941	7,675,490	7,757,746	7,843,350	7,927,718
Number of child abuse and neglect Intakes to the Texas Statewide Intake Hotline	293,898	317,928	317,977	293,950	289,854
Number of Intakes Assigned for Investigation or Alternative Response by CPI	253,054	273,415*	264,464*	232,176*	227,199*
Number of Investigated Child Fatalities	964	997*	690*	587*	581*
Number of fatalities where abuse was confirmed	71	76	70	38	55
Number of fatalities where neglect was confirmed	128	106*	94*	61*	69*
Number of fatalities where abuse/neglect was confirmed	199	182*	164*	99*	124*
Percentage of fatalities where abuse/neglect was confirmed	20.6%	18.2%*	23.7%*	16.9%*	21.3%*
Child Maltreatment Fatality Rate per 100,000 Children	2.62	2.37	2.11	1.32	1.56
National Maltreatment Rate for Equivalent Federal Fiscal Year⁵	2.63	2.73	2.73	**	***

Source: Data from US Census Bureau; Texas State Data Center; DFPS Data Books FY2010-FY 2024; DFPS Data Warehouse Report FT_06; U.S. Department of Health and Human Services. Population Data Source: Population Estimates and Projections Program, Texas State Data Center, Office of the State Demographer and the Institute for Demographic and Socioeconomic Research, University of Texas at San Antonio. Current Population Estimates and Projections Data as of December 2025

*This data was impacted by the change in the definition of Neglect in Texas Family Code 261.001. The definitional change did not impact investigations or dispositions related to physical abuse.

** Child Maltreatment 2024 is scheduled to be released after the publishing of this report. National rates were not available at the time this report was published.

*** Child Maltreatment 2025 is scheduled to be released after the publishing of this report.

The distribution of case dispositions for child fatality investigations conducted over the last 10 years are presented in Table 2 - Percentage of Child Fatality Investigations by Disposition. The percentage of confirmed child abuse and neglect-related fatalities have varied between 16.85 percent and 30.44 percent in the past ten years. In FY2025, 21.34 percent of all fatalities investigated were confirmed to be caused by abuse or neglect.

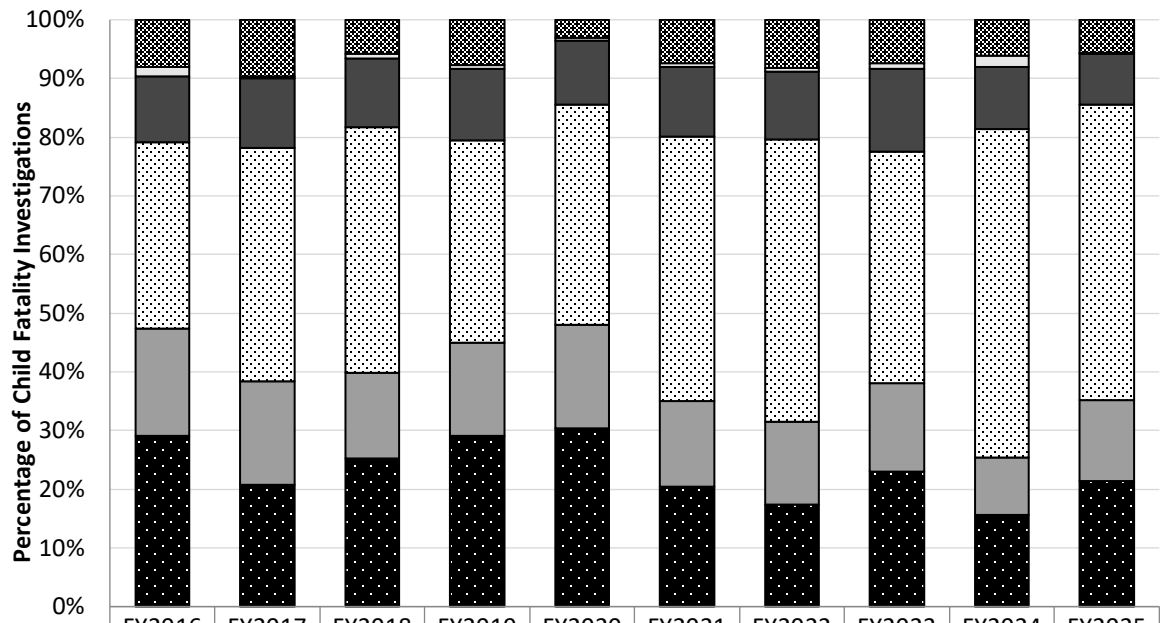
Table 2. Percentage of Child Fatality Investigations by Disposition

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)
FY2015	739	23.27%	15.01%	39.44%	12.48%	0.66%	9.69%
FY2016	796	28.94%	18.25%	31.55%	11.21%	1.83%	8.21%
FY2017	807	21.31%	17.65%	39.66%	11.97%	0.24%	9.67%
FY2018	785	25.18%	14.56%	41.89%	11.69%	0.72%	5.58%
FY2019	772	30.44%	16.58%	33.82%	11.92%	0.73%	7.54%
FY2020	826	30.39%	17.55%	37.53%	11.02%	0.48%	3.03%
FY2021	964	20.64%	14.73%	45.44%	11.93%	0.62%	7.47%
FY2022	997	17.37%	14.12%	48.09%	11.55%	0.67%	8.21%
FY2023	690	23.77%	15.65%	40.87%	14.49%	1.01%	7.68%
FY2024	587	16.85%	10.39%	51.95%	11.75%	2.04%	7.15%
FY2025	581	21.34%	13.76%	50.43%	8.6%	0.17%	5.67%

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

Source: DFPS Data Warehouse Report FT_01, FT_02, FT_06

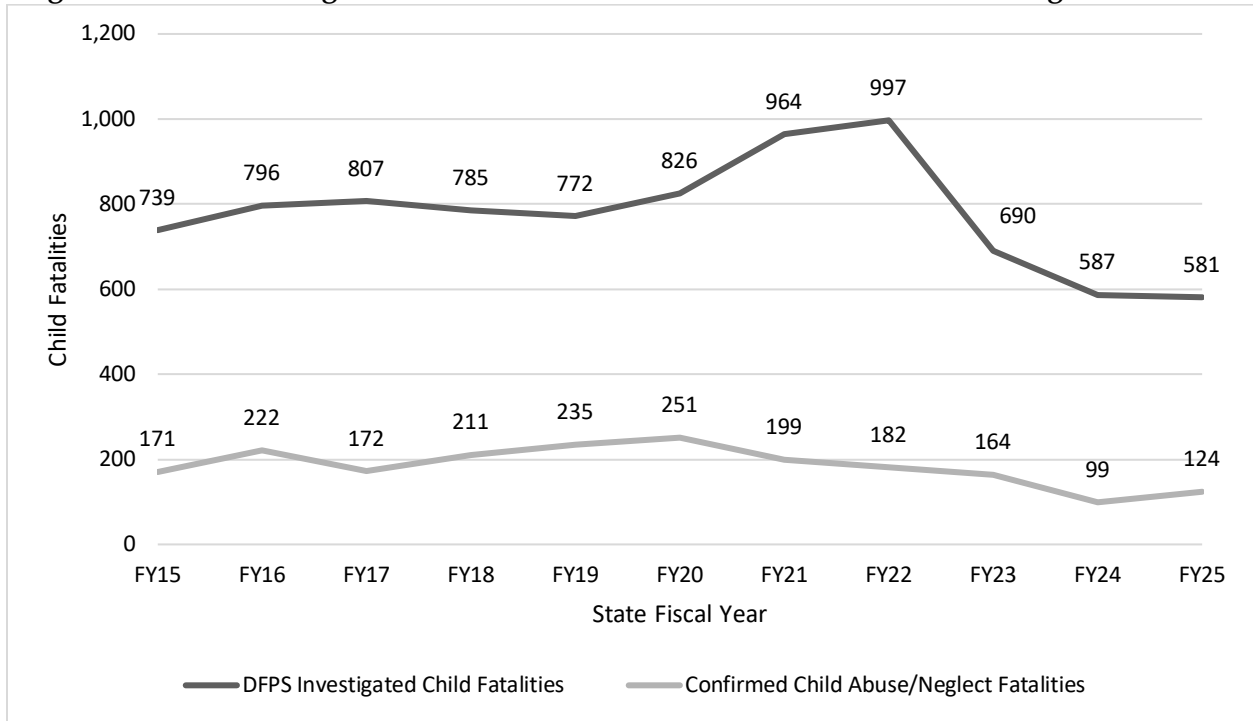
Figure 1. Count of Completed Child Fatality Investigations by Disposition per Fiscal Year



	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025
Administrative Closure	62	80	49	62	25	72	86	53	39	33
Unable to Complete	12	2	6	6	4	6	7	7	12	1
Unable to Determine	86	99	98	98	91	115	121	100	67	50
Ruled Out	242	328	351	278	310	438	504	282	353	293
Reason to Believe - Not Fatal*	140	146	122	128	145	142	148	108	61	80
Reason to Believe - Fatal*	222	172	211	235	251	199	182	164	99	124

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

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



Source: DFPS Data Warehouse Report FT_06

In FY 2025, DFPS investigated 581 possible child abuse and neglect-related fatalities. That number was at its highest in the last ten years in FY 2022 at 997 investigated child fatalities. (Figure 2).

FY 2025 Confirmed Child Abuse and Neglect-Related Fatalities

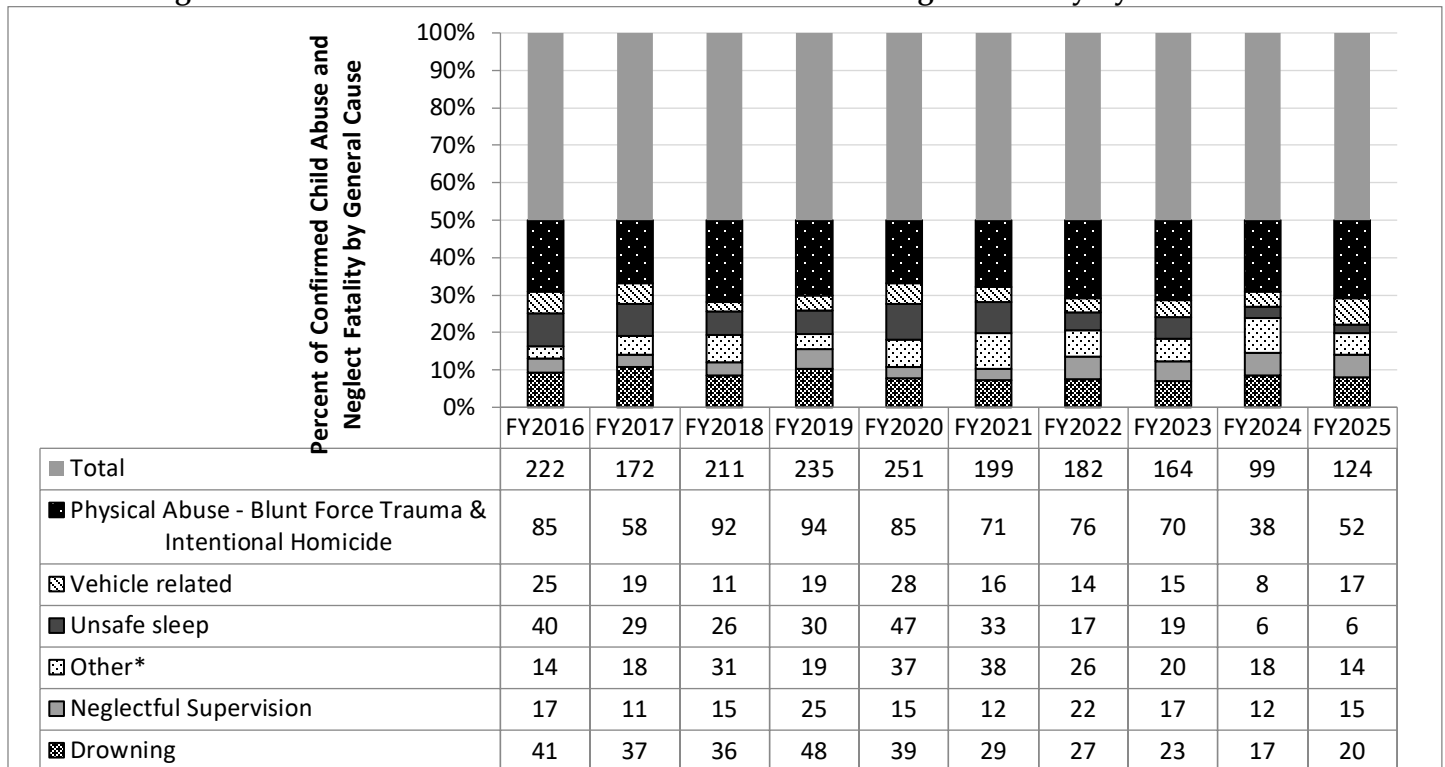
General Findings

- In FY 2025, 124 children died due to abuse and neglect in Texas (Table 1). Of those deaths:
 - 69 children, accounting for 55.6 percent, died as a result of neglect. The change in the definition of neglect and corresponding policy and practice changes impacted the number of fatalities DFPS determined occurred as a result of neglect beginning in fiscal year 2022.
 - 55 children, accounting for 44.4 percent, died as a result of abuse. This determination was not impacted by the revised definition of neglect.
- In 50 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had prior history with CPS (Figure 21, 22).
- In FY 2025, Texas had 64 confirmed abuse and neglect-related near fatalities (Figure 37).

General Cause/Manner of Child Abuse or Neglect Fatality

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

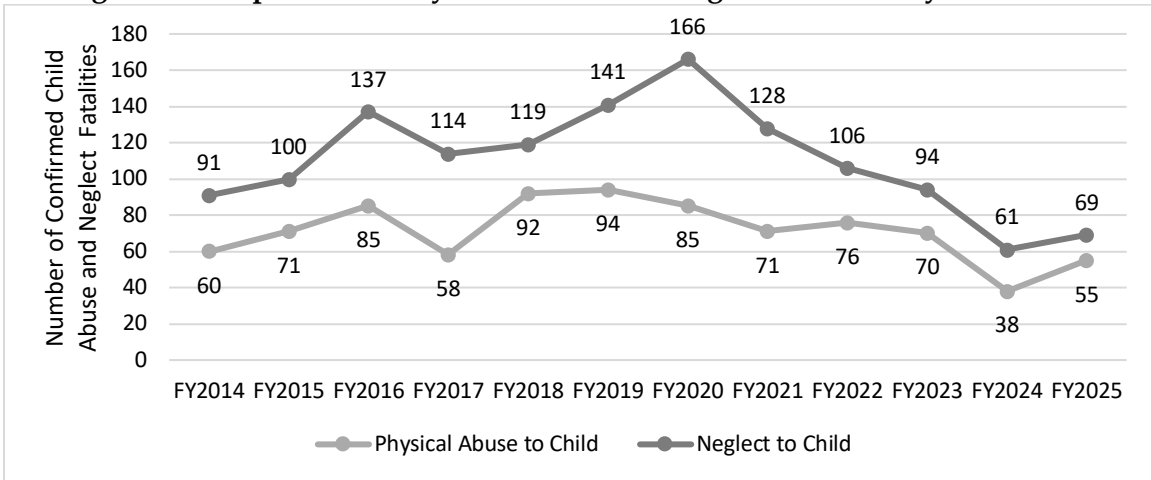
Figure 3. General Cause of Confirmed Child Abuse or Neglect Fatality by Fiscal Year



*Other category includes medical neglect, physical neglect, and suicide.

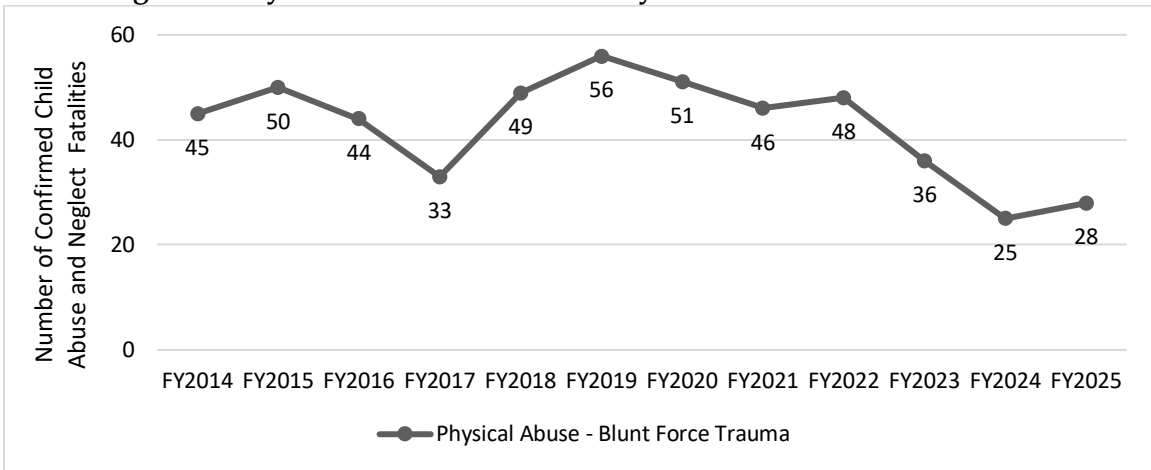
Source: DFPS individual case reviews

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



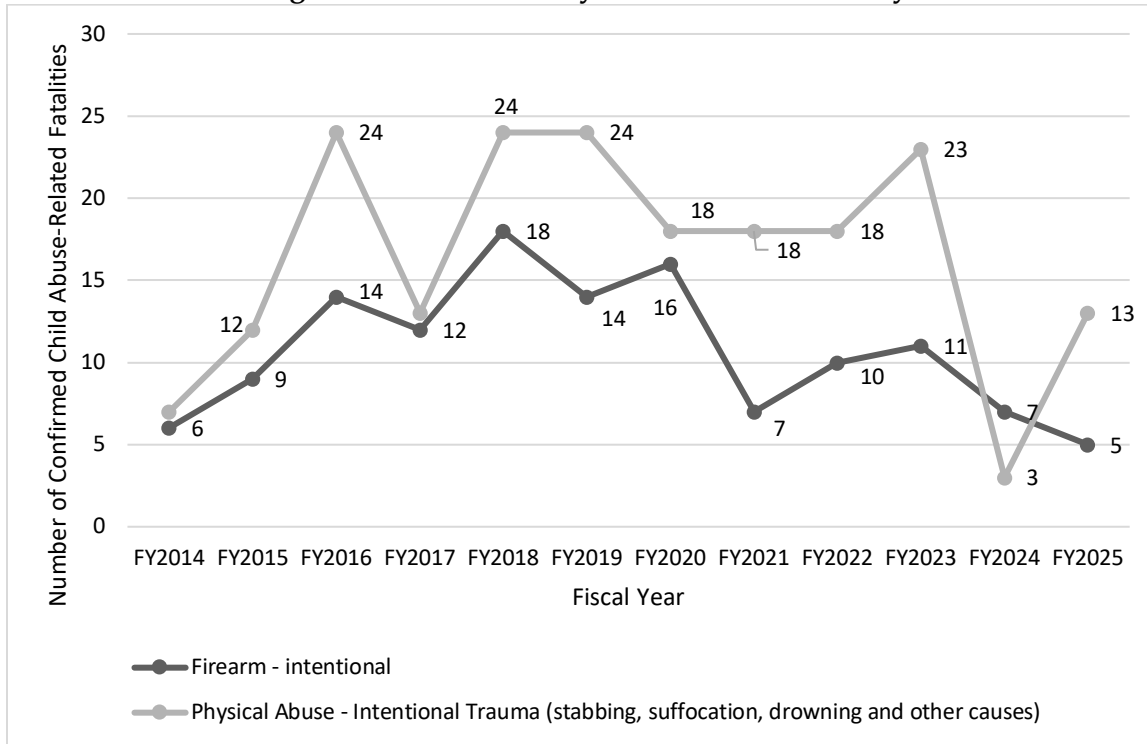
Source: DFPS individual case reviews

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



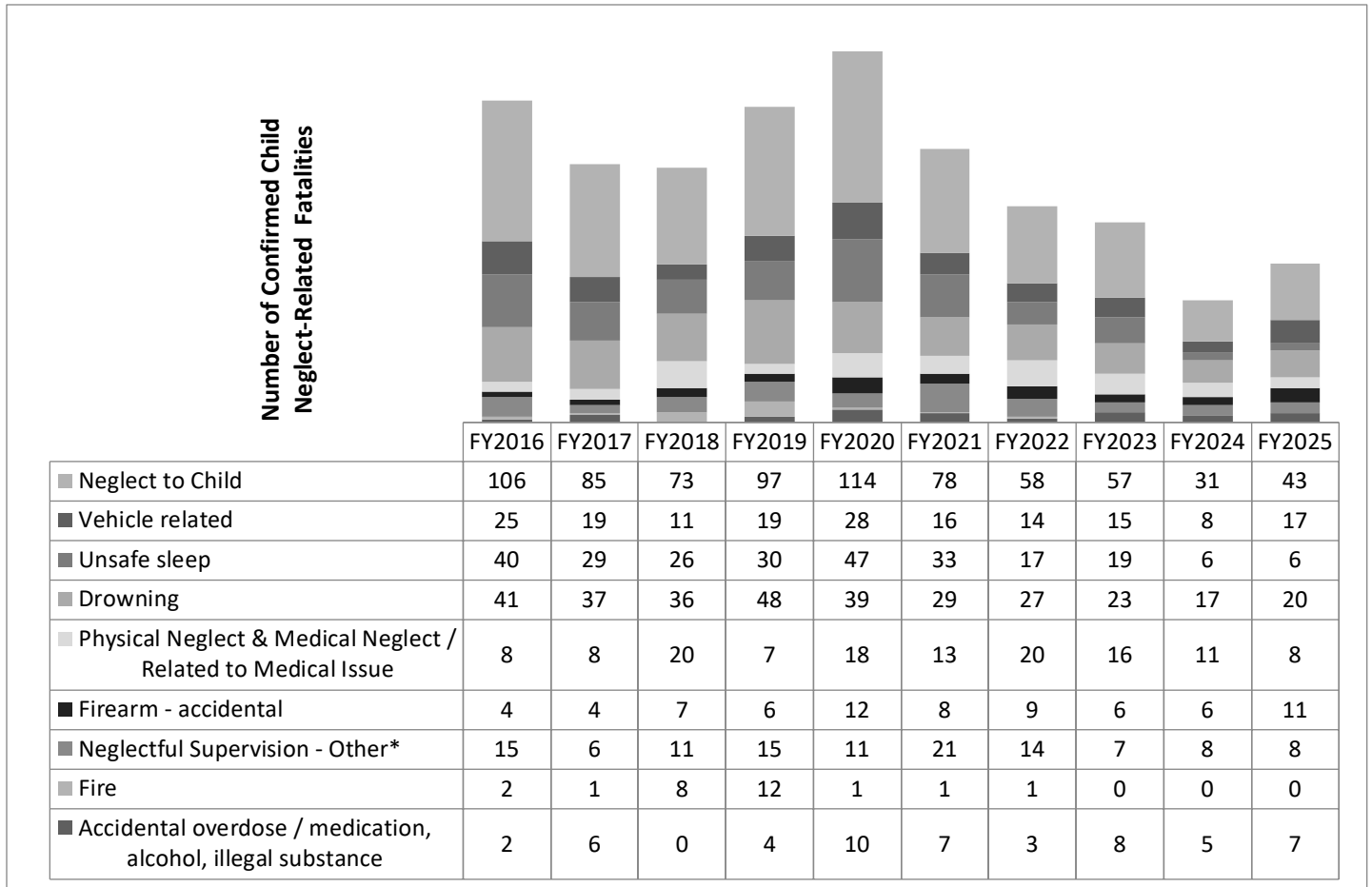
Source: DFPS individual case reviews

Figure 6. Intentional Physical Abuse to Child by Cause



Source: DFPS individual case reviews

Figure 7. Neglect-Related Child Fatality by Cause



* Neglectful Supervision - Other includes choking, and suicide,
 Source: DFPS individual case reviews

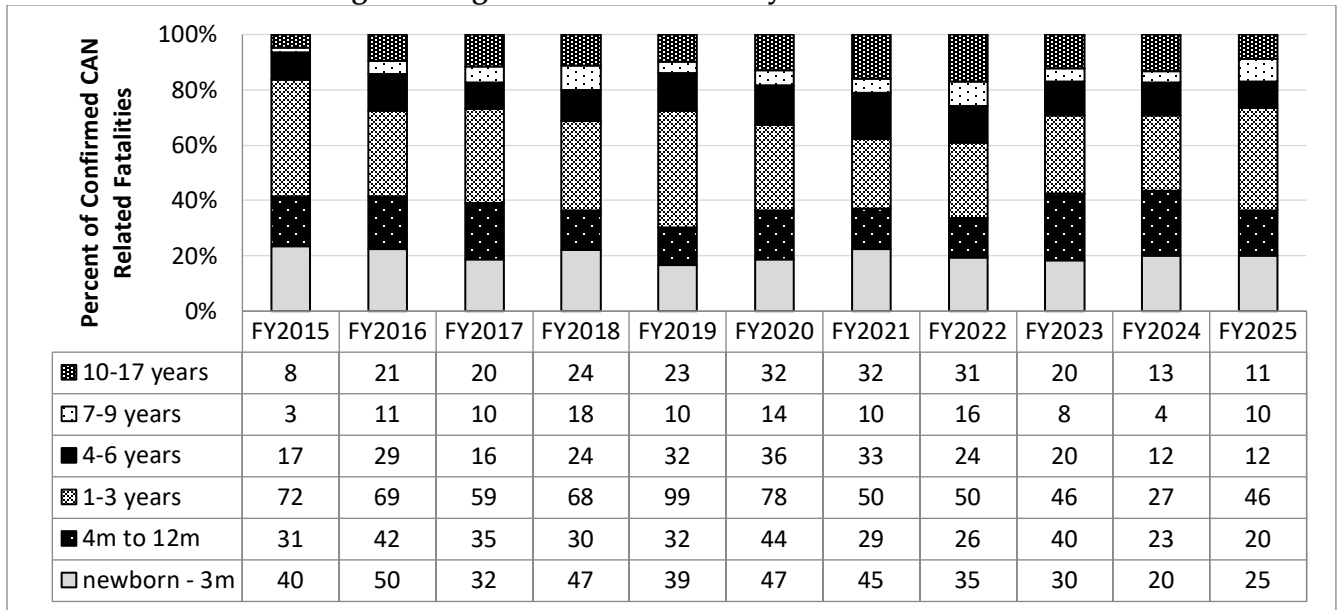
Victim Demographic Characteristics - Age, Gender, Ethnicity

Victims

- In FY 2025, children 3 years of age and younger made-up 73.4 percent of confirmed child abuse and neglect fatalities. Male children represented a majority of confirmed child abuse and neglect-related fatalities (Figure 9, 10).
- During FY 2025, Hispanic children accounted for the largest percentage of children who died from abuse or neglect. The per capita rate for African American children who die from maltreatment continues to be higher than any other ethnicity in Texas. That is also true across the United States (Table 3).

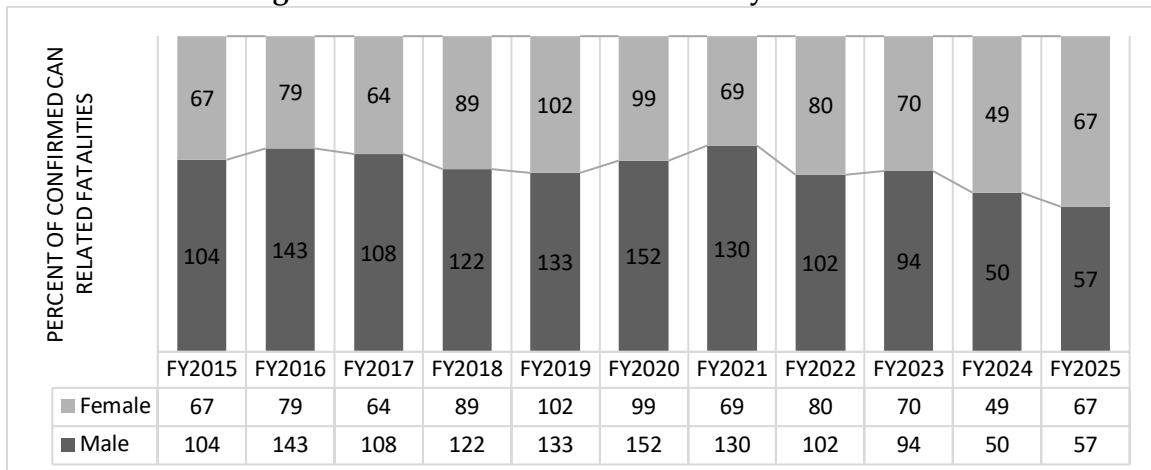
- 65.3 percent of children who died from abuse or neglect in FY 2025 were not old enough to attend school and were not enrolled in day care. Four children were being cared for by a day care that was not registered or licensed through HHSC (Page 25).

Figure 8. Age of Child at Death by Fiscal Year



Source: DFPS Data Warehouse Report FT_06

Figure 9. 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 FY 2025, children of Hispanic heritage represented the largest number of child abuse and neglect fatalities. As in previous years, the child per capita rate of fatal abuse/neglect for African American children is disproportionately higher in FY25 as compared to the overall Texas child population (Table 3).

Table 3. FY2025 Per Capita Rate (per 100,000 Children) by Ethnicity - Confirmed Child Abuse Neglect Fatalities

Ethnicity Represented	African American	Anglo	Hispanic	Other / Non-Hispanic	Total
Child Population	951,012	2,342,894	3,927,101	706,711	7,927,718
Number of Fatalities	41	28	45	10	124
Per Capita Rate of Fatality	4.31	1.19	1.14	1.41	1.56

Sources: Texas State Data Center; DFPS Data Book FY2025; DFPS Data Warehouse Report FT_06

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

Risk factors for child maltreatment are defined as early signs associated with child maltreatment.⁶ While they may not be direct causes, these factors frequently appear in situations where children are alleged or confirmed victims of maltreatment. The data in this report reflects those established patterns. Children age three and younger, those with a prior history of maltreatment, and those living in homes affected by substance abuse, mental health challenges, or domestic violence are at elevated risk. Children with special needs or significant medical concerns may also face increased vulnerability.

Protective factors also can affect child safety. Protective factors, such as parent support systems and parenting skills, help safeguard a family from risk factors associated with child maltreatment.

Special Needs & Medical Concerns as Risk Factor

In FY 2025, 21.7 percent of child maltreatment fatalities involved a child with special medical needs or medical concerns.

**Table 4. FY2025 Confirmed Child Abuse Neglect Fatalities
where Child had Special Medical Needs***

*Child may have more than one special medical need and appear more than once

Identified Special Need	FY2025 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality
None/Unknown	97 Fatalities
Asthma	2 Fatalities <ul style="list-style-type: none"> • Neglectful Supervision (2)
ADD/ADHD	2 Fatalities <ul style="list-style-type: none"> • Neglectful Supervision (2)
Autism	6 Fatalities <ul style="list-style-type: none"> • Neglectful Supervision (5) • Physical Abuse (1)
Bipolar	1 Fatality <ul style="list-style-type: none"> • Physical Abuse (1)
Cerebral Palsy	1 Fatality <ul style="list-style-type: none"> • Neglectful Supervision (1)
Developmental Disability/Diabetes	2 Fatalities <ul style="list-style-type: none"> • Physical Abuse (1) • Neglectful Supervision (1)
Down Syndrome	1 Fatality <ul style="list-style-type: none"> • MDNG/PHNG (1)
Extreme Prematurity (Born before 28 weeks of gestation)	6 Fatalities <ul style="list-style-type: none"> • Physical Abuse (4) • Neglectful Supervision (2)
Feeding Tube	2 Fatality <ul style="list-style-type: none"> • Neglectful Supervision (1) • Medical/Physical Neglect (1)
Hearing Impaired	2 Fatalities <ul style="list-style-type: none"> • Physical Abuse (2)
Infant Drug Addiction/Prenatal Drug Exposed	5 Fatalities <ul style="list-style-type: none"> • Physical Abuse (3) • Neglectful Supervision (2)
Intellectual Disability	1 Fatality <ul style="list-style-type: none"> • Physical Abuse (1)
Mobility Impaired	1 Fatality <ul style="list-style-type: none"> • Physical Abuse (1)
Mood Disorder	2 Fatalities <ul style="list-style-type: none"> • Neglectful Supervision (2)

Identified Special Need	FY2025 Number of Confirmed Abuse or Neglect Fatalities and Cause of Fatality
Oppositional Defiant Disorder	1 Fatality <ul style="list-style-type: none"> • Neglectful Supervision (1)
Physical Disability	1 Fatality <ul style="list-style-type: none"> • Physical Neglect (1)
Post-traumatic Stress Syndrome	1 Fatality <ul style="list-style-type: none"> • Neglectful Supervision (1)
Reactive Attachment Disorder	1 Fatality <ul style="list-style-type: none"> • Neglectful Supervision (1)
Speech Disabled	5 Fatalities <ul style="list-style-type: none"> • Neglectful Supervision (3) • Physical Abuse (2)
Spinal Bifida	1 Fatality <ul style="list-style-type: none"> • Neglectful Supervision (1)
Other—Hirschsprung’s Disease, Hydrocephalus, Epilepsy, Heart Murmur, other medical concerns	7 Fatalities <ul style="list-style-type: none"> • Physical Abuse (2) • Neglectful Supervision (3) • Medical/Physical Neglect (2)

Substance Use and Substance Abuse Disorder by Caregiver as Risk Factor

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

For FY2025, 87 of the 124 child fatalities, or 70.2 percent, caused by abuse or neglect involved a parent or caregiver actively using a substance and/or who was under the influence of at least one substance that affected their ability to care for the child. In the tables and chart below, the substance abuse is described by type and if it was identified as a factor in the case.

Figure 10. FY 2025 Confirmed Child Abuse or Neglect Fatality by Substance Abuse by Perpetrator or Parent

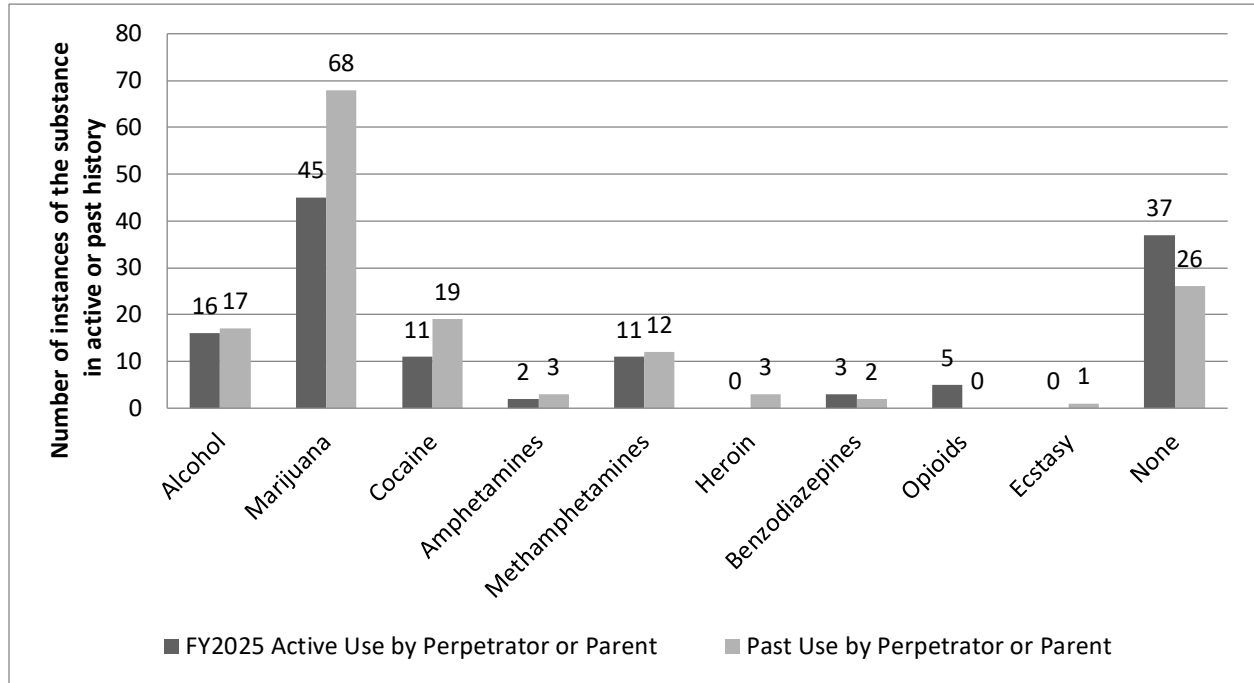


Table 5. FY 2025 Confirmed Child Abuse or Neglect Fatality by Co-Occurring Substance Abuse by Perpetrator

Co-Occurring Substances	Active	Past History
Alcohol and Marijuana	9	11
Cocaine and Marijuana	6	16
Cocaine and Alcohol	6	6
Methamphetamines and Marijuana	6	7
More than two substances	5	7

Mental Health Concerns as Risk Factor

During the review of confirmed child fatalities due to abuse and neglect, cases were reviewed for a documented history of mental health concerns and if there were concerns for mental health at the time of the child fatality. In FY 2025, 41 percent of child fatalities involved a parent or caregiver who self-reported experiencing active mental health concerns.

Table 6. FY 2025 Mental Health Concerns both Active and in Past History for Perpetrator of Confirmed Child Abuse Neglect Fatalities

Mental Health Concern	Active	Past History
Total Number of Parents/Caregivers with Mental Health Concern*	51	62
• Bipolar Disorder	13	19
• Depression	21	33
• Anxiety	14	22
• Postpartum Depression	7	7
• Post-Traumatic Stress Disorder	7	10
• Schizophrenia	4	4
• Substance abuse disorder	5	6
• ADD/ADHD	13	17
• Other**	4	13
• Unknown Diagnosis – Reported by Individual	6	3
No	34	38
Unknown (not identified in case read)	39	24

* Parents and caregivers may have more than one mental health concern and appear more than once.

**Others include mood disorder, suicidal ideation, behavior disorder, oppositional defiance disorder, and personality disorder.

Domestic Violence Concerns as Risk Factor

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

In FY 2025, DFPS continued several partnerships in the community with local domestic violence intervention providers to provide direct services and outreach, including in the San Antonio, Dallas, Houston, Waco, and McAllen areas.

During the review of confirmed child fatalities due to abuse and neglect, cases were reviewed for a documented history of domestic violence concerns and active concerns for domestic violence in the home at the time of the child fatality. As with other risk factors, there is concern that individuals are underreporting active domestic violence either to the department, law enforcement, or to community providers.

In FY 2025, there was active domestic violence occurring in the home environment for 41 families with confirmed child abuse or neglect fatalities. A history of domestic violence was identified in 60 case reviews. For the 28 child fatalities where the family had a history of

domestic violence and reported active concerns for domestic violence, 78.5 percent of those fatalities were due to physical abuse.

Table 7. FY 2025 Domestic Violence Concerns both Active and in Past History for Perpetrator Confirmed Child Abuse Neglect Fatalities

Domestic Violence Concern	Active	Past History	Both Active and Past History
Total Number of Parents/Caregivers Reporting Domestic Violence	41	60	28
No	53	38	30
Unknown (not identified in case read)	30	26	18

Source: DFPS individual case reviews

School and Day Care Enrollment as Protective Factor

With 73.3 percent of child fatalities involving children age three and younger, protective, and attentive parents and caregivers are critical to maintaining child safety. When a parent works, care for the child must be found; sometimes that care is a family member or friend, or commonly a day care provider. Finding reliable and safe care is critical, especially when the primary parent/caregiver to the child is out of the home. Schools and day cares also provide another adult outside the family the opportunity to be around the child regularly and be on the lookout for signs of abuse or neglect. 80 percent of children who died due to abuse or neglect were not involved with either a registered or licensed day care or a school system.

FY 2025 Confirmed Child Abuse and Neglect Fatalities:

- In 82 (66.1 percent) of the 124 child fatalities due to abuse or neglect, the child was not enrolled either in a day care or in school.
- In 21 (16.9 percent) of the 124 child fatalities due to abuse or neglect, the child was enrolled in day care or school.
- In nine (7.3 percent) of the 124 child fatalities due to abuse or neglect, the status of the child being in school, or daycare was unknown.
- In seven (5.6 percent) of the 124 child fatalities due to abuse or neglect, the children were home schooled.
- In four (3.2 percent) of the 124 child fatalities due to abuse or neglect, the child was being cared for by a caregiver that should have been registered or licensed through HHSC but was not.

- One (.8 percent) of the fatalities occurred when school was out of session for the summer or winter break.

Table 8. FY 2025 Child Abuse and Neglect Related Fatalities - By County

County	Region	Child Abuse/Neglect Related Fatalities	Children in DFPS Conservatorship at Time of Fatality*
Angelina	05	2	
Atascosa	08	1	
Bell	07	3	
Bexar	08	12	1
Bowie	04	2	
Cameron	11	2	
Collin	03	2	
Colorado	06	1	
Dallas	03	10	1
Delta	04	1	
Denton	03	2	
Ector	09	3	
Fannin	03	1	
Galveston	06	2	
Grayson	03	1	
Gregg	04	1	
Harris	06	19	
Henderson	04	1	
Hidalgo	11	7	
Hood	03	1	
Hunt	03	3	1
Kaufman	03	2	
Lamar	04	1	
Limestone	07	1	
Lubbock	01	2	
McLennan	07	1	
Medina	08	1	
Montgomery	06	3	
Nueces	11	1	
Presidio	10	1	

FY 2025 Child Fatality and Near Fatality Annual Report

County	Region	Child Abuse/Neglect Related Fatalities	Children in DFPS Conservatorship at Time of Fatality*
Randall	01	1	
Rockwall	03	3	
Sabine	05	1	
Scurry	02	2	
Smith	04	4	
Tarrant	03	15	1
Travis	07	5	
Victoria	08	1	
Waller	06	1	
Wharton	06	1	
Total		124	4

* Of the four fatalities that occurred while the child was in DFPS Conservatorship, two were a result of fatal injuries caused prior to the child entering foster care and both were caused by the child’s parent or caregiver.

<i>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 Investigations – Field Division (116), Child Day Care Investigations (7), Residential Child Care Investigations (1), and Adult Foster Care (0)</i>

FY 2025 Confirmed Child Abuse and Neglect Related Fatalities - Case Review Data

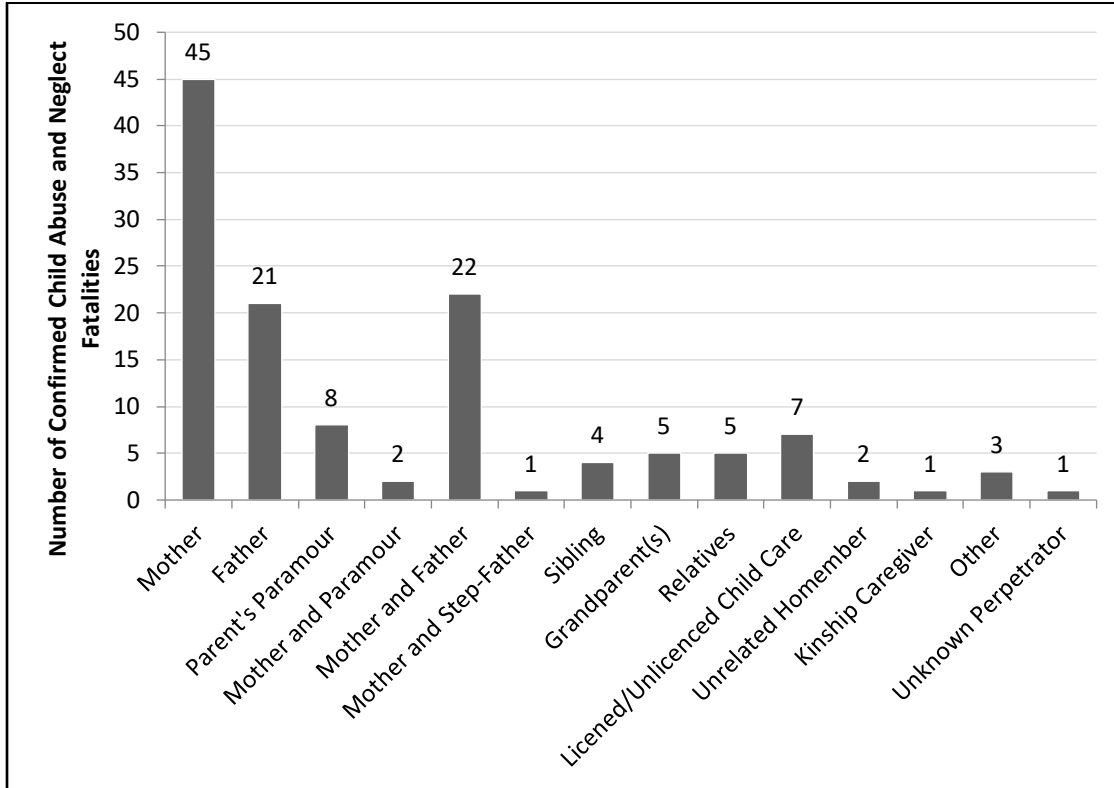
Independent case reviews were conducted for all eligible cases to identify relevant information regarding confirmed perpetrators in abuse- and neglect-related fatalities. The following summarizes the key findings..

FY 2025 Perpetrator Demographic and Characteristics - Relationship and History

Perpetrators

- In confirmed cases of abuse and neglect, parents continue to be the most common perpetrators (Figure 12).
- Fatalities resulting from physical abuse most commonly involved blunt force trauma or intentional trauma inflicted by a father or mother (Figures 13-15).
- In 50 percent of the confirmed child abuse and neglect-related fatalities, the child or the perpetrator had prior history with CPS (Figure 21, 22).
- When the perpetrator or the child had history with DFPS in the two years prior to fatality, the child fatality is often related to physical abuse or neglectful supervision. (Table 9, 10).

Figure 11. FY2025 Relationship of Primary Perpetrator to Victim



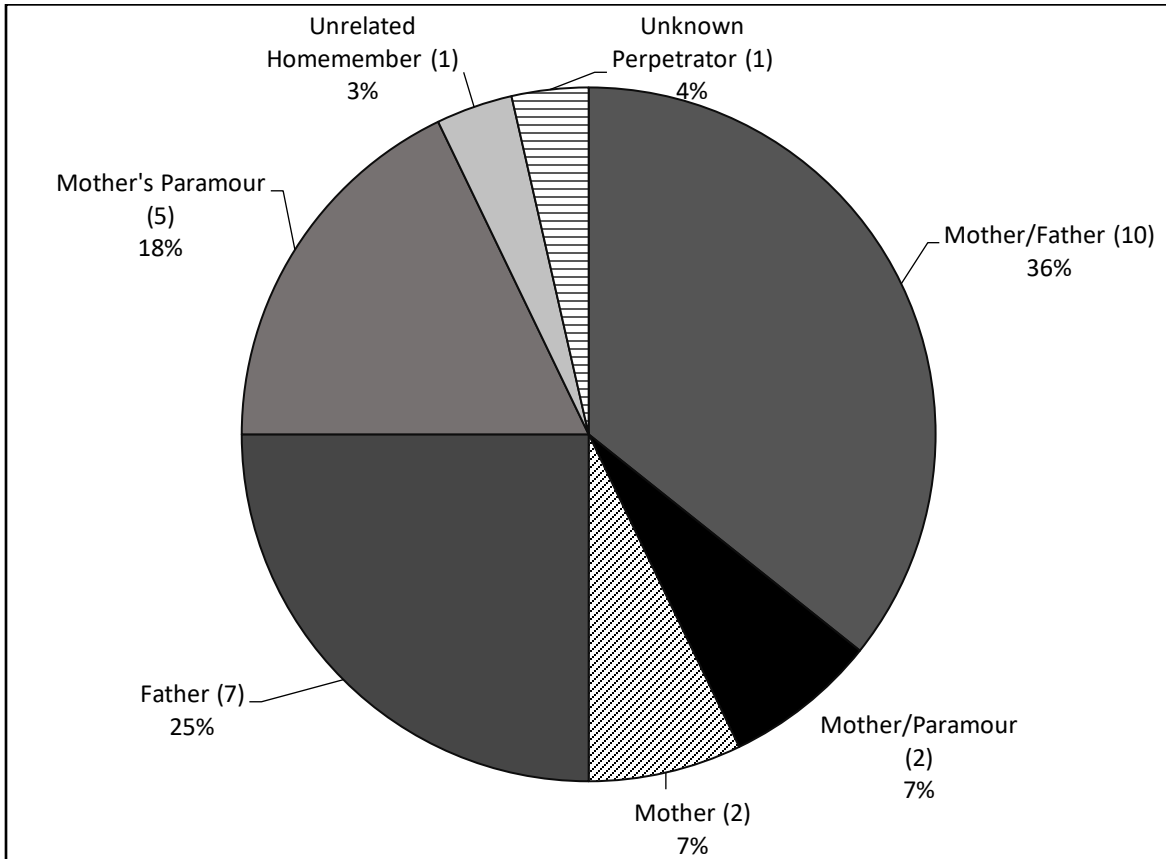
Source: DFPS individual case reviews.

*In some cases, there were multiple primary perpetrators per fatality victim.

FY 2025 Primary Perpetrator, Child Age and Cause of Death

Only those where the cause/manner of death was identified in six or more abuse or neglect related fatalities are detailed below. All data in this section is based on case reviews.

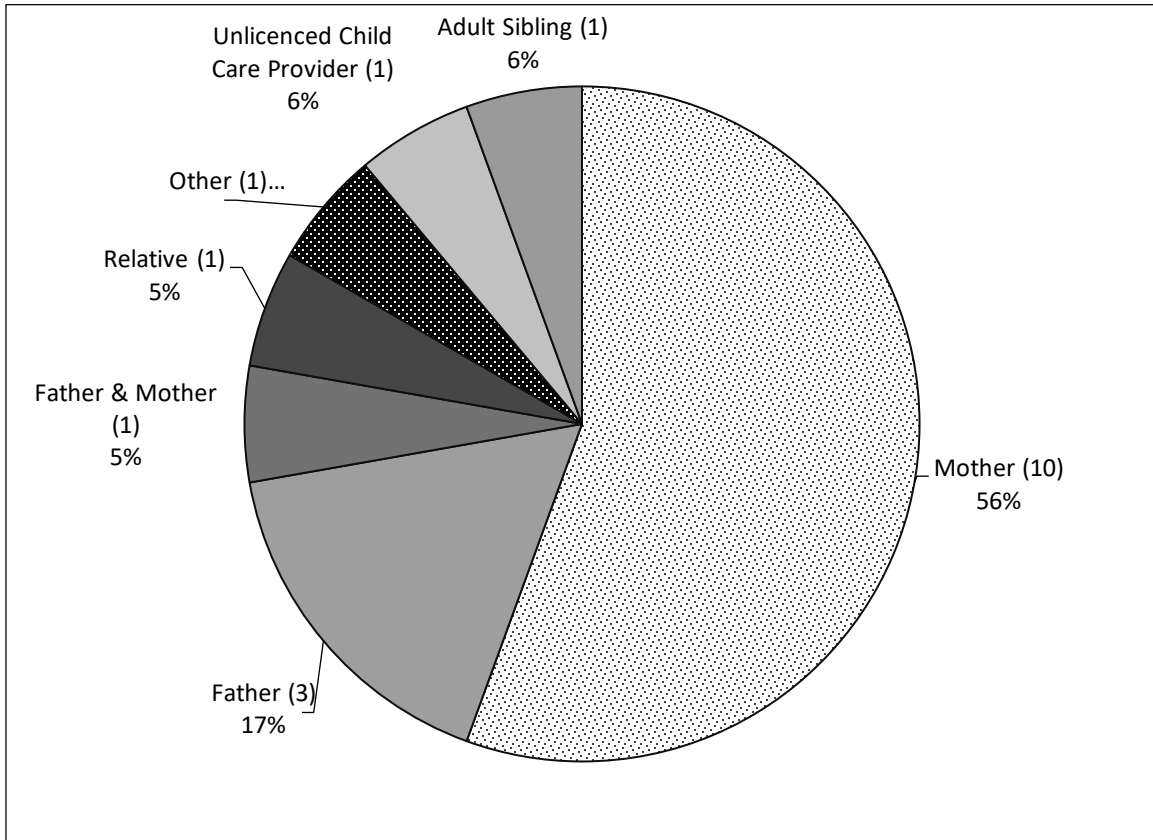
Figure 12. FY 2025 Blunt Force Trauma Fatalities by Perpetrator



Number of victims: 28 children

Age range of victims: Newborn to 6-year-old youth. 19 children were younger than one year old; 92.8% were aged three or younger

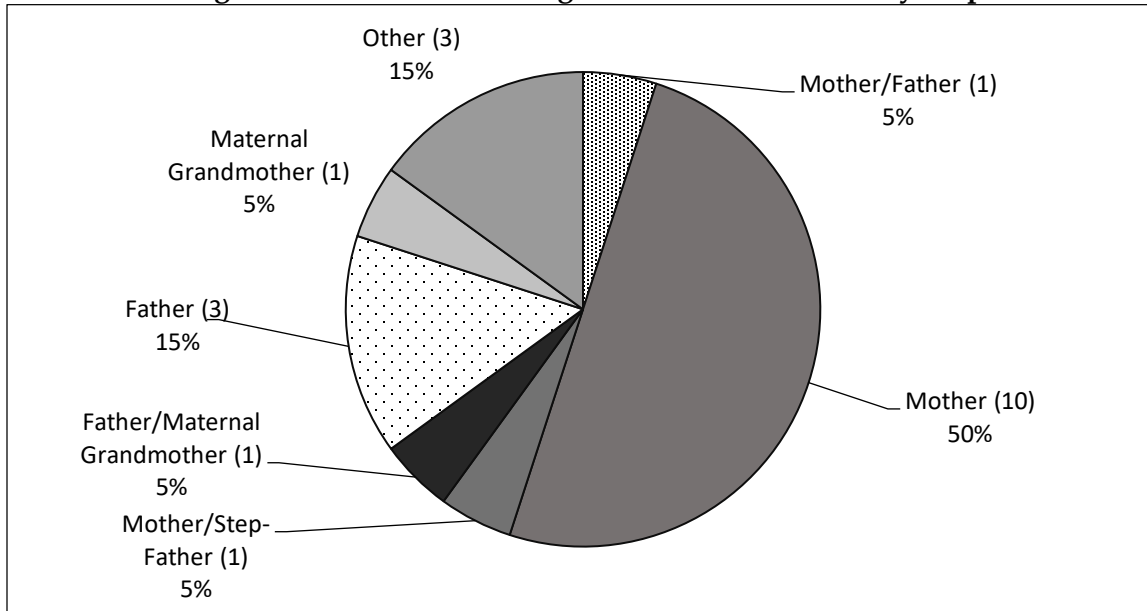
Figure 13. FY 2025 Intentional Physical Abuse Fatalities by Perpetrator



Number of victims: 18 children

Age range of victims: Newborn to 17-year-old youth. 55.5 percent were children aged three years and younger

Figure 14. FY 2025 Drowning (Accidental) Fatalities by Perpetrator

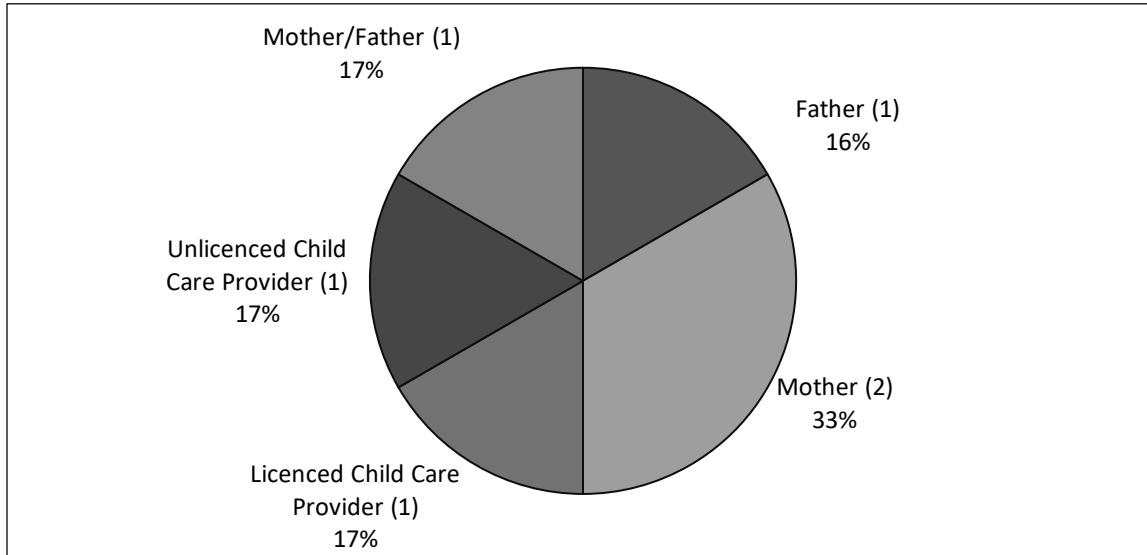


Number of victims: 20 children

Age range of victims: Newborn to 17-year-old child. 16 children were three years old and younger (80%).

Many fatalities related to drownings do not result in a finding of abuse or neglect, however; when a caregiver demonstrates blatant disregard to the circumstances involving in the drowning, which results in a fatality, then the fatality is determined to be caused by neglect.

**Figure 15. FY 2025 Unsafe Sleep Fatalities by Perpetrator
(Includes bed-sharing and unsafe sleep environments)**

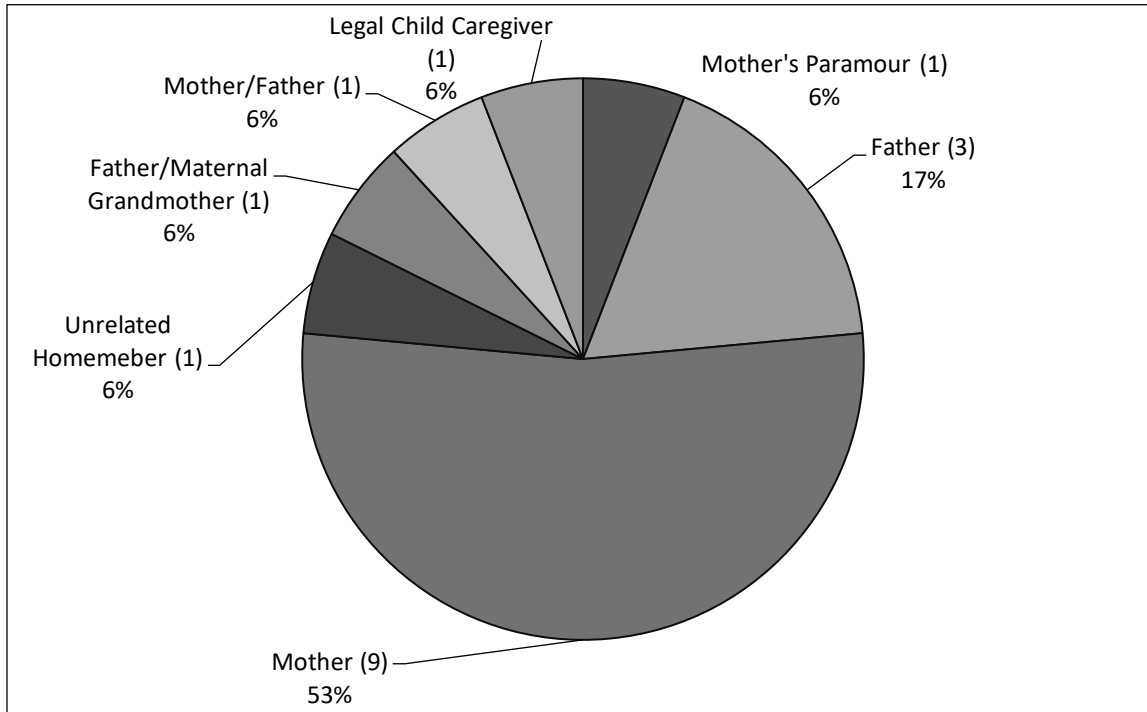


Number of victims: Six children

Age range of victims: Newborn to 12 months

*Many fatalities related to unsafe sleep do not result in a reason-to-believe finding, and therefore are not a result of abuse or neglect. However; when a caregiver demonstrates blatant disregard as to the situation that results in a fatality, the fatality is determined to be caused by neglect.

Figure 16. FY 2025 Vehicle Related Fatalities by Perpetrator



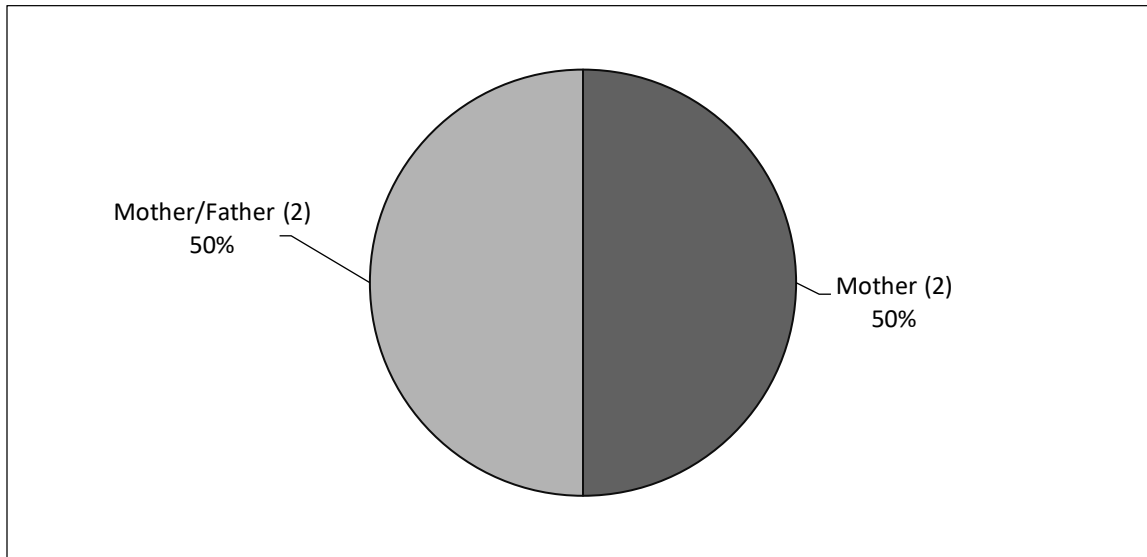
Number of victims: 17 children

Age range of victims: Newborn to 17 years old

Note: 7 children died after being left in a vehicle.

This figure includes any vehicular related event where a caregiver demonstrated blatant disregard or an additional element indicating abuse at the time of the incident.

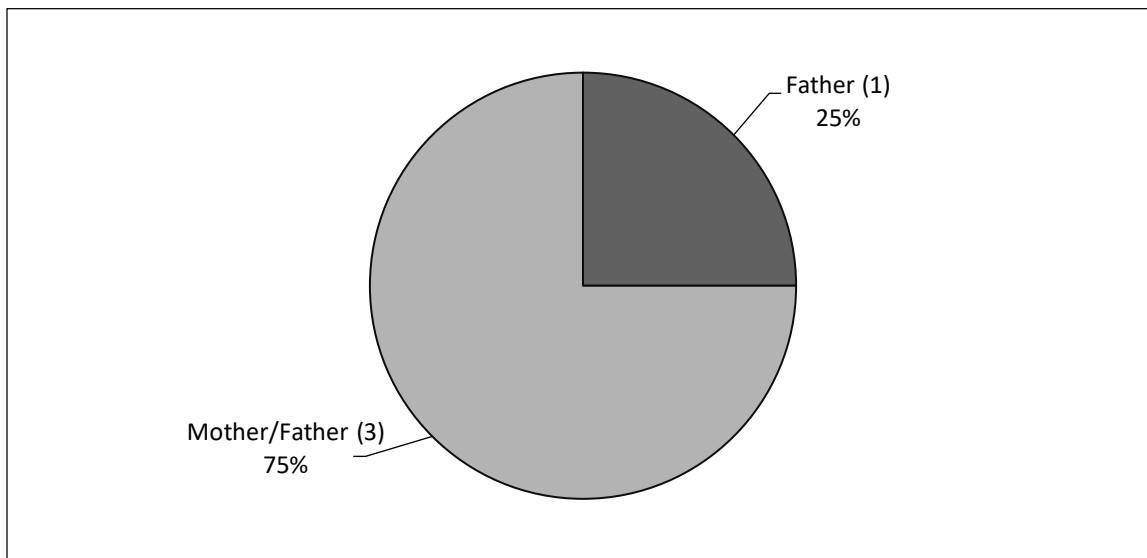
Figure 17. FY 2025 Medical Neglect Related Fatalities by Perpetrator



Number of victims: Four children

Age range of victims: Newborn to 17 years old

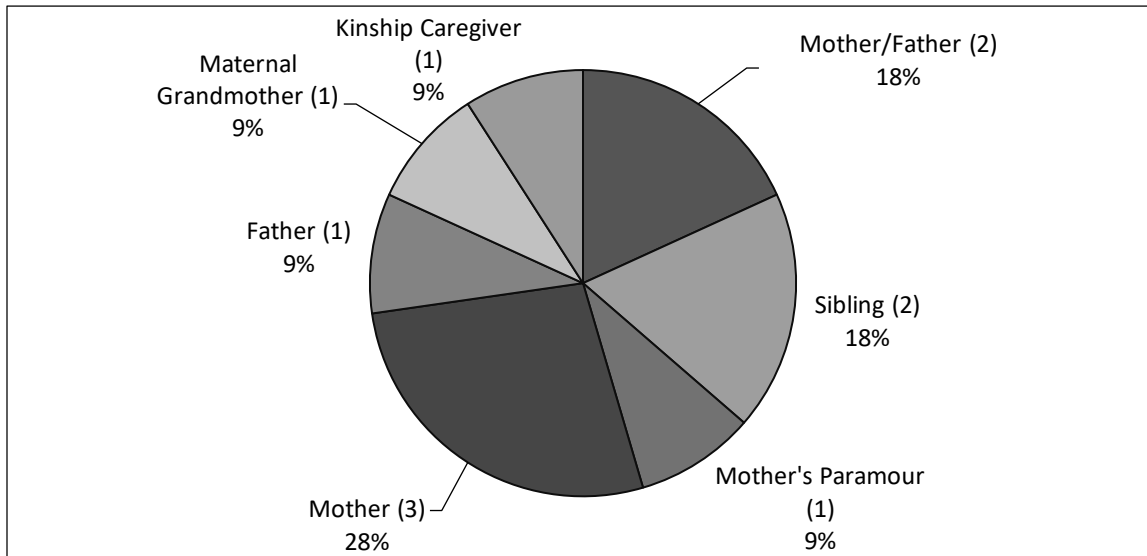
Figure 18. FY 2025 Physical Neglect Related Fatalities by Perpetrator



Number of victims: Four children

Age range of victims: Newborn to three years old

Figure 19. FY 2025 Firearm - Accident-Related Fatalities by Perpetrator



Number of victims: 11 children

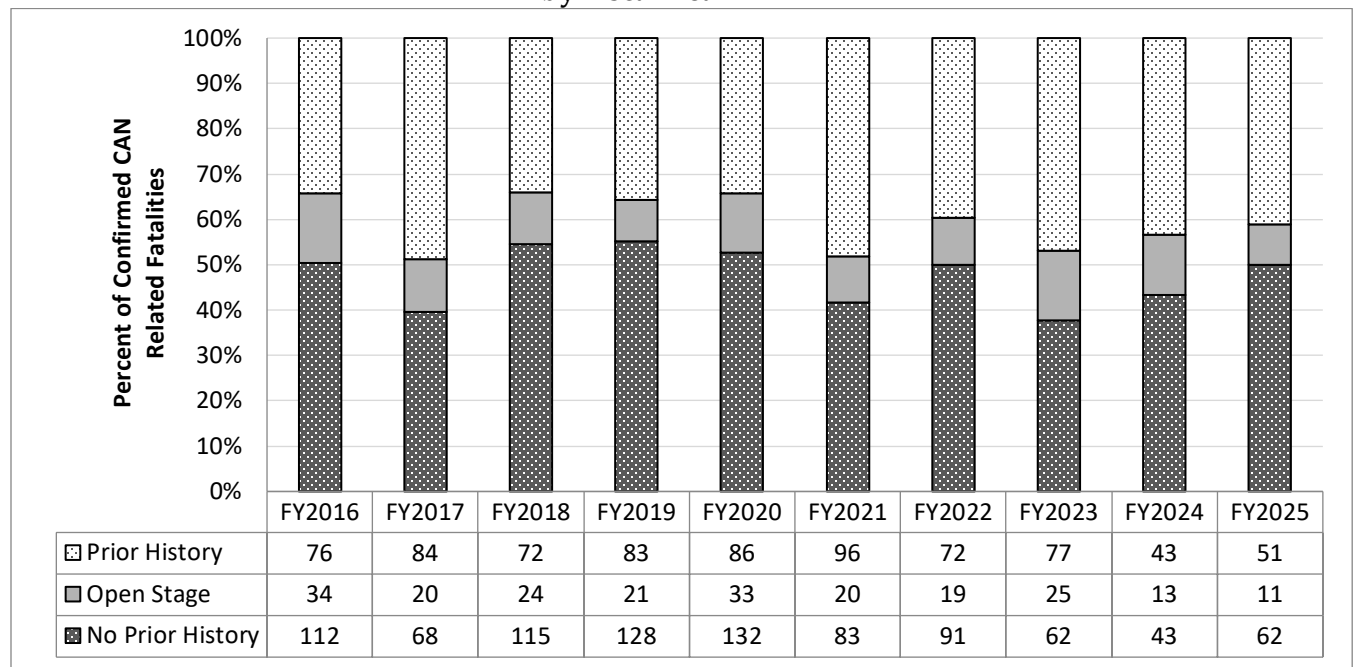
Age range of victims: Four months old to 17 years old

Note: 6 (55 percent) occurred while in care of the mother, father, or both parents.

Prior CPS History in Child Abuse and Neglect-Related Fatalities

To better understand fatalities, it is important to identify if families had prior involvement with DFPS. DFPS defines prior CPS history broadly – if the deceased child or a designated perpetrator in the fatality was involved in a CPI investigation or received CPS services before the child's death. CPS history is identified even if contact with CPS was years before the death or was unrelated to the circumstances of the fatality. In 8.7 percent of the child abuse and neglect fatalities, CPI or CPS was involved with the family or the child at the time of the death. In 41.1 percent of confirmed child fatalities, CPI or CPS had been involved with the child or the perpetrator in the past.

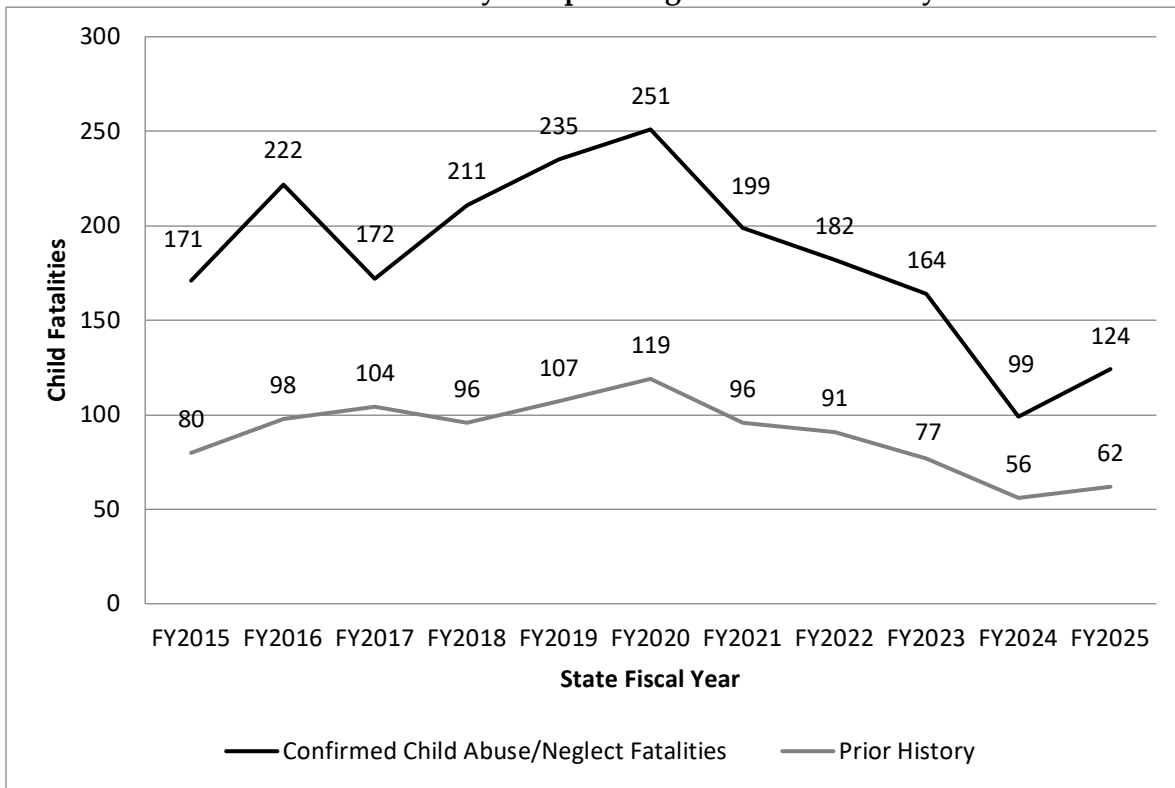
Figure 20. CPI/CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Fiscal Year



Source: DFPS Data Warehouse Report FT_06

A child fatality may occur in an open case such as Investigations, Family Based Safety Services, or Conservatorship. Child abuse and neglect-related fatalities where the child died while CPS was involved with the family in FY 2025 often consisted of physical abuse (7 fatalities) and neglectful supervision (4 fatalities).

Figure 21. DFPS Investigated Child Fatalities and Confirmed Child Abuse/Neglect Fatalities with Prior History or Open Stage at time of Fatality



Source: DFPS Data Warehouse Report FT_06

For FY 2025, based on Figures 22-24, the following themes are noted:

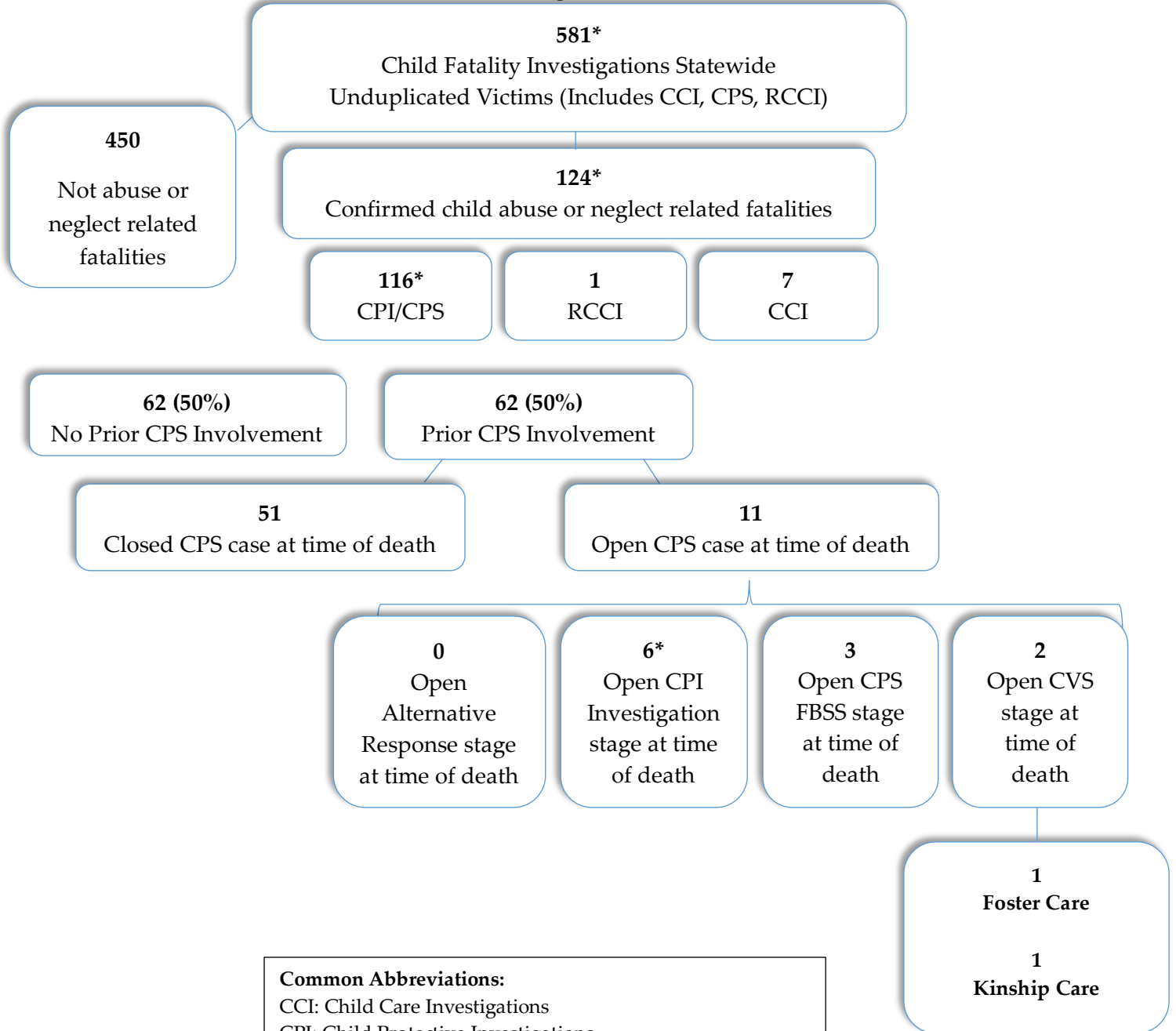
- In 11 child fatalities, the child or the child’s family was involved with CPI or CPS at the time of death, and a new incident of abuse or neglect occurred.
 - Six of the children were in an active investigation and a new incident of abuse or neglect occurred leading to the fatality.
 - Initial contacts were completed in all six of the open investigations.
 - In all six of the investigations there was only one caseworker assigned.
 - There were no parental child safety plans in place in the investigations.
 - Caseloads for the staff at the time the case was opened: Two had 10 or fewer cases; Four had 11-20 cases.
 - Three of the children were in an active Family Based Safety Services (FBSS) stage and a new incident of abuse or neglect occurred leading to the fatality.
 - Initial contacts in open FBSS were completed timely and the children were being seen timely according to policy for all three children.
 - All three FBSS cases had only one worker assigned.
 - Safety plans were in place in three of the open FBSS cases.

- Caseloads for the staff at the time of the fatality: All three caseloads were between 11-20 cases.
 - Services referred in FBSS cases included:
 - Counseling for family, individual, or group: 1 case
 - Substance abuse testing: 1 case
 - Substance abuse treatment: 2 cases
 - Mental health services: 2 cases treatment.
 - Parenting classes: 2 cases
 - At the time of the fatalities, one family was fully compliant with services, and two families were not compliant.
- Two children were in an active Conservatorship (CVS) stage when a new incident of abuse or neglect resulted in a fatality.
 - One of the children was in a licensed residential placement and one child was in a kinship placement.
 - Initial contact in both open CVS stages was completed timely according to policy.
 - In one of the fatalities, there was only one worker assigned. The other open CVS stage had three caseworkers assigned.
 - Caseloads for the staff at the time of the fatality: Both open stages were assigned to a caseworker with a workload between one and 10 cases.
- In 62 child fatalities, the child, their family or the perpetrator had prior history with DFPS:
 - 67.7 percent had only one caseworker assigned during the family's last involvement with DFPS
 - Caseloads were often at 10 cases or fewer per staff member assigned.
 - Caseloads for staff at the time the case was opened: 42 had 10 or fewer cases; 13 had 11-20 cases; two had more than 20 cases; five were unavailable in accordance with retention and purge schedules consistent with the relevant stage of service.
 - Caseloads for staff at the time the case closed: 39 had 10 or fewer cases; 13 had 11-20 cases; two had more than 20 cases; eight were unavailable in accordance with retention and purge schedules consistent with the relevant stage of service.
 - 21 families had prior involvement with Family Based Safety Services (FBSS) after an investigation concluded.
 - 16 families had a safety plan that required the parents, significant other or the designated perpetrator to have supervised contact with the children.

68.7 percent of safety plans were documented as being fully or partially followed during the family's involvement with DFPS.

- Four families did not have a safety plan implemented, and one family refused to sign a safety plan.
- On average, families were seen monthly, with their involvement in FBSS ranging from three months to one year. In general, initial visits were completed timely as the policy and practice is to work collaboratively with Child Protective Investigations and the family to engage in FBSS services at case transfer. On average, families had 14 or more visits with the FBSS caseworker.
- Services referred in the prior or open stage include:
 - Anger management: 1 case
 - Counseling for family, individual, or group: 14 cases
 - Daycare or respite care: 2 cases
 - Domestic violence shelter or counseling: 3 cases
 - Drug testing or treatment: 13 cases
 - Family support services (Food stamps, TANF, etc.): 1 case
 - Food, clothing, or personal items: 1 case
 - Homemaker assistance: 1 case
 - Infant or early childhood screening or development services: 4 cases
 - Mental health (psychological testing, mental health assessment or treatment, referral to local mental health authority): 6 cases
 - Parenting collaboration group (CPS Local Parent Support Group): 2 cases
 - Parenting skills / evidence-based parent education: 17 cases
 - Transportation: 1 case
- 81 percent of families that were involved with FBSS were reportedly fully compliant or partially compliant with their service plan.

**Figure 22. FY 2025 Department of Family and Protective Services (DFPS)
Data on Child Abuse and Neglect Related Fatalities Statewide**



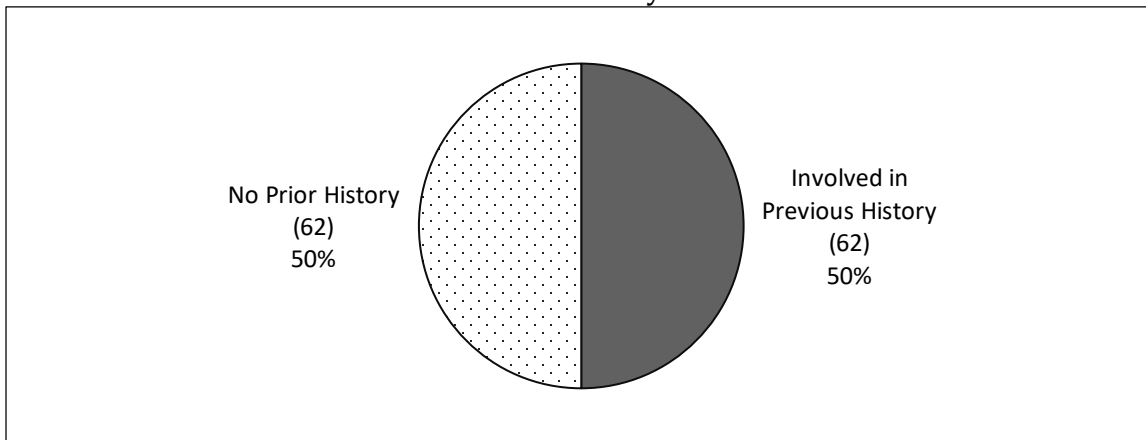
Common Abbreviations:
 CCI: Child Care Investigations
 CPI: Child Protective Investigations
 CPS: Child Protective Services
 CVS: Conservatorship
 FBSS: Family Based Safety Services
 PCSP: Parental Child Safety Placement
 RCCI: Residential Child Care Investigations (Day Cares)
Note: prior history can involve the victim or the perpetrator or both in any previous CPS stage of service. Includes duplication.
 *One child is RTB/FT on two INV stages (CPI & CCI)

Figure 23. FY 2025 Prior History by Child/Perpetrator with Previous Involvement

Type of Previous History	Total Count
Child has previous history or open stage (Perpetrator was not known to CPS)	12
Perpetrator has previous history or open stage (Child was not known to CPS)	33
Both child and perpetrator have previous history or open stage	17
Total with previous history or open stage	62

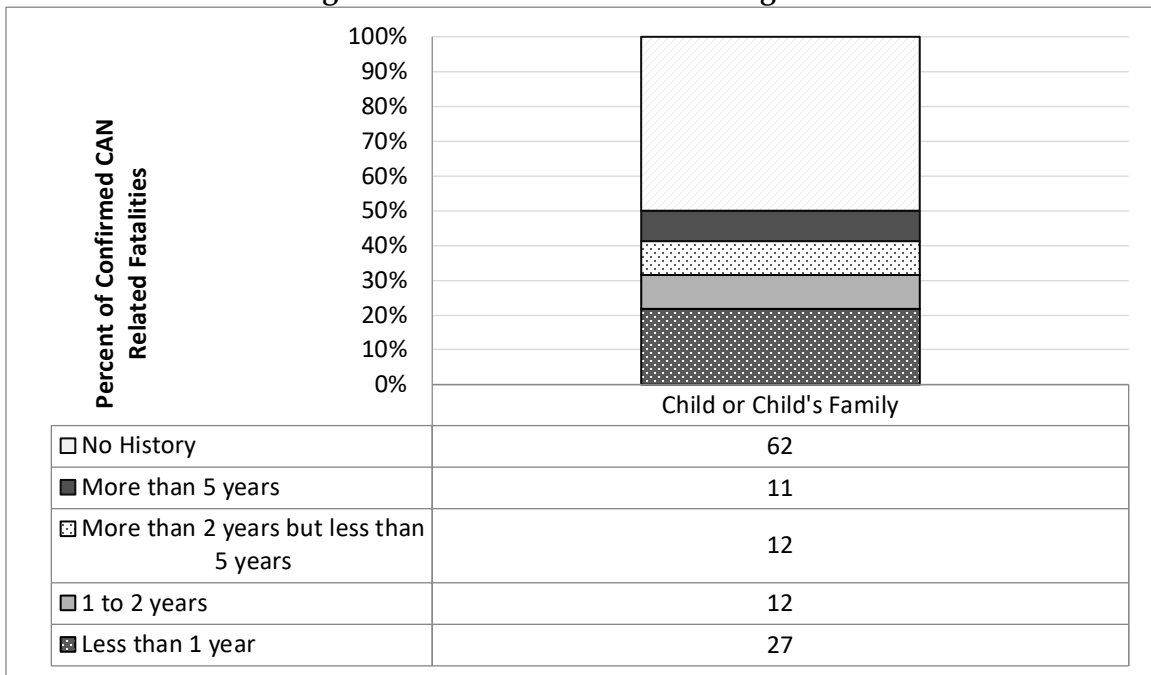
Source: DFPS individual case reviews

Figure 24. FY 2025 Prior History Where Deceased Child was Present in Previous Involvement with Family



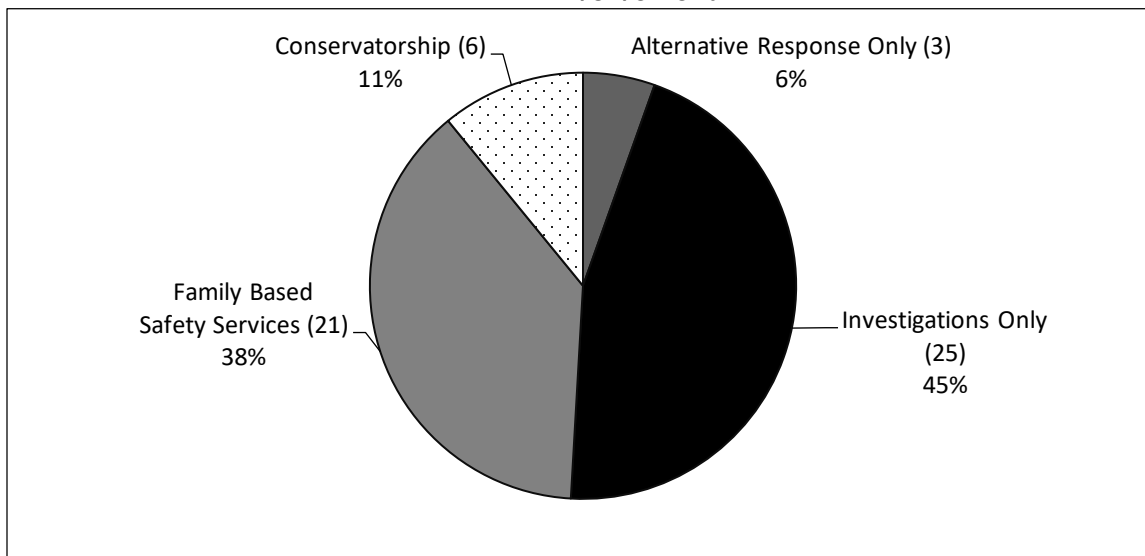
Source: DFPS individual case reviews – includes history that may be purged from IMPACT but referenced in case narrative.

Figure 25. FY 2025 CPS History for Confirmed Child Abuse and Neglect Related Fatalities by Length of Time since Last Active Stage Closed



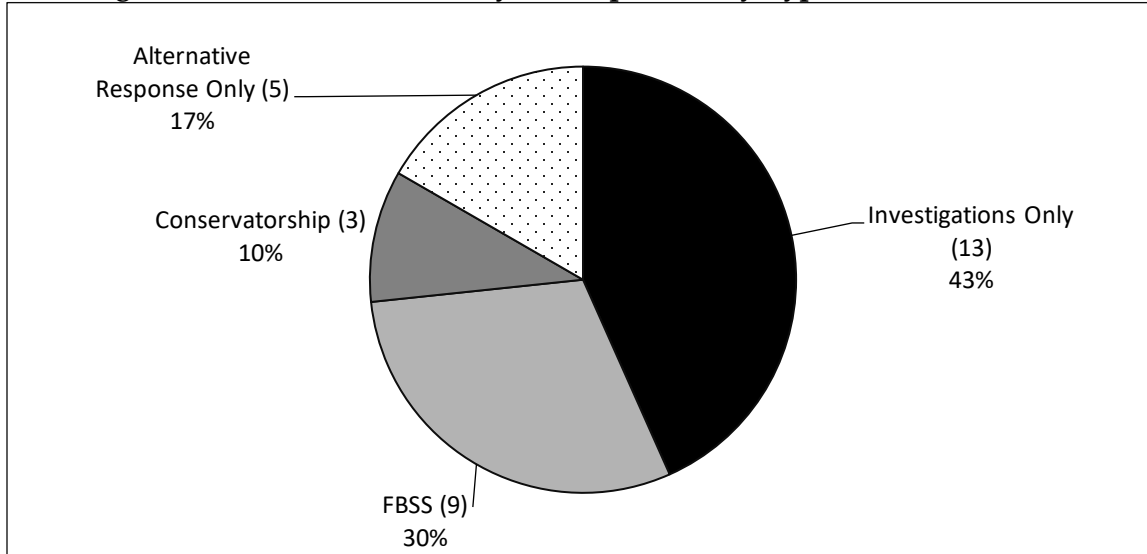
Source: DFPS individual case reviews

Figure 26. FY 2025 Prior History for Child or Child's Family by Type of Previous Involvement



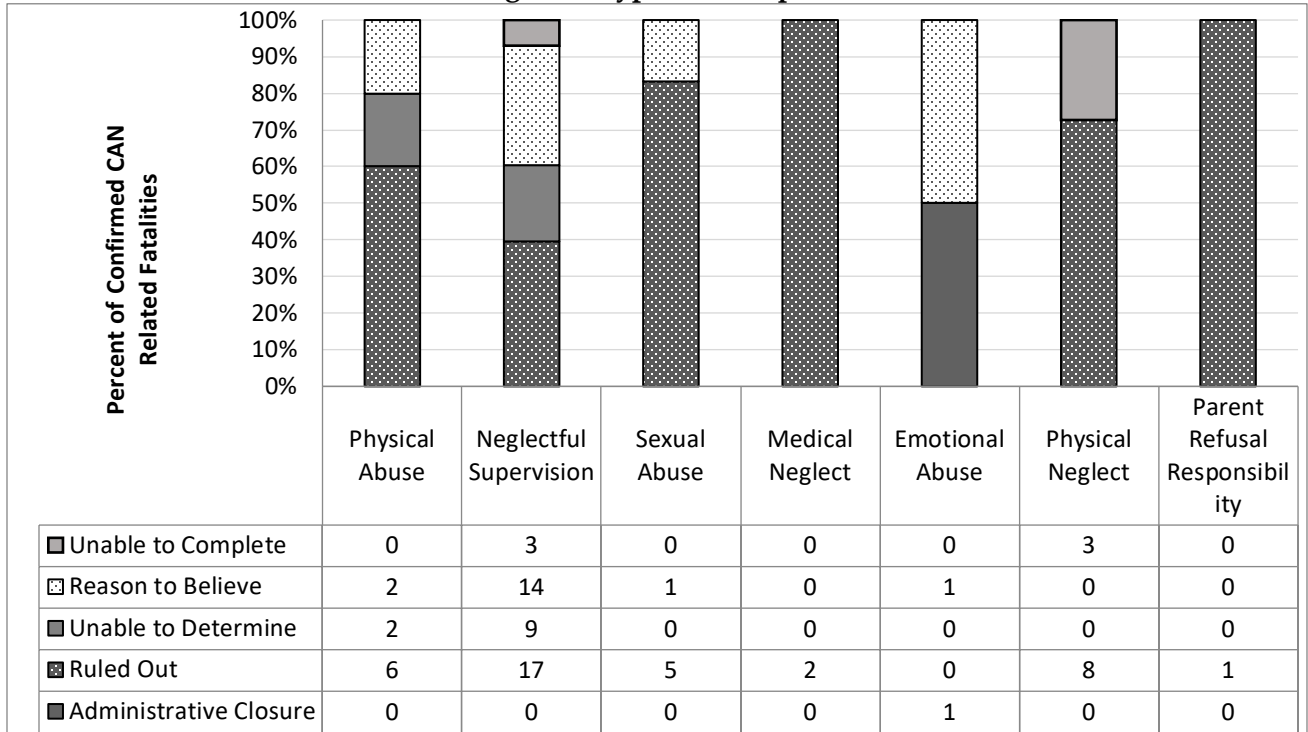
Source: DFPS individual case reviews; history may include more than one stage of service.

Figure 27. FY 2025 Prior History for Perpetrator by Type of Previous Involvement



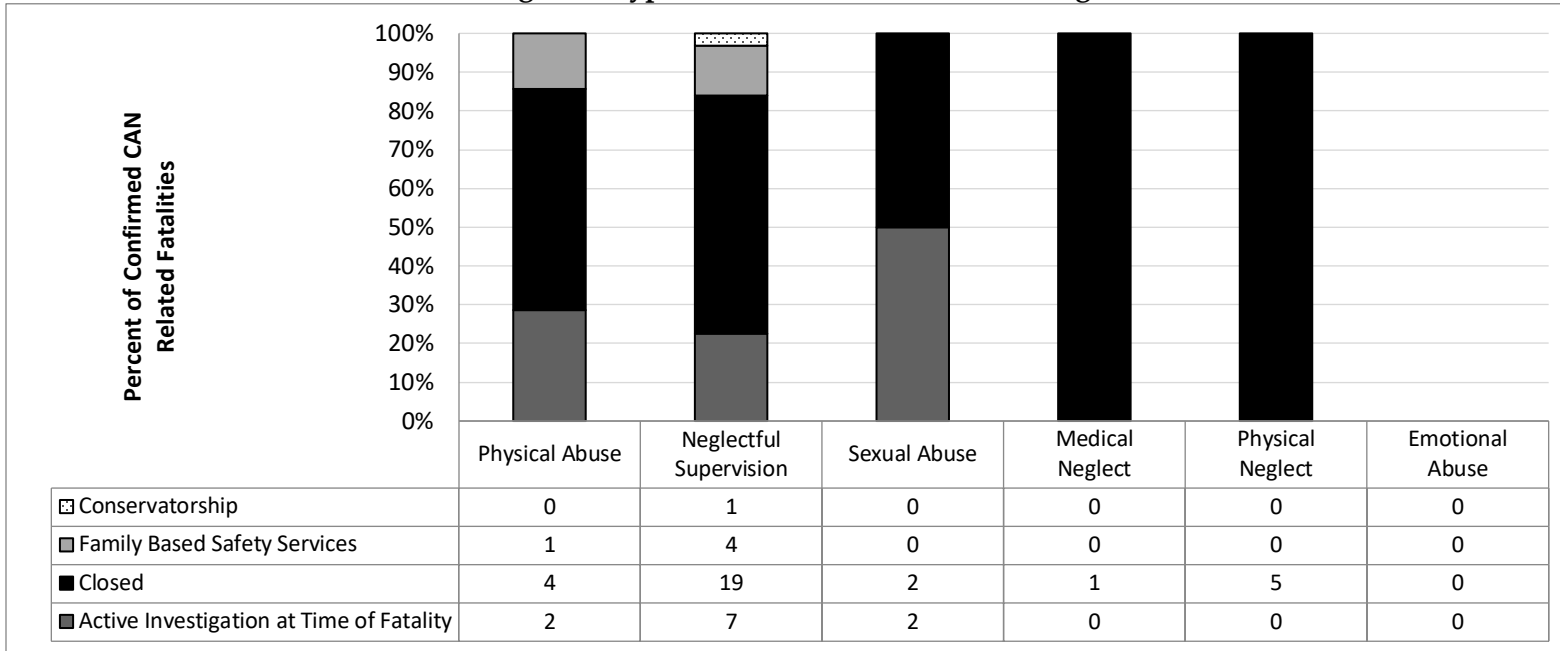
Source: DFPS individual case reviews; history may include more than one stage of service

Figure 28. FY 2025 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or Child’s Family in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



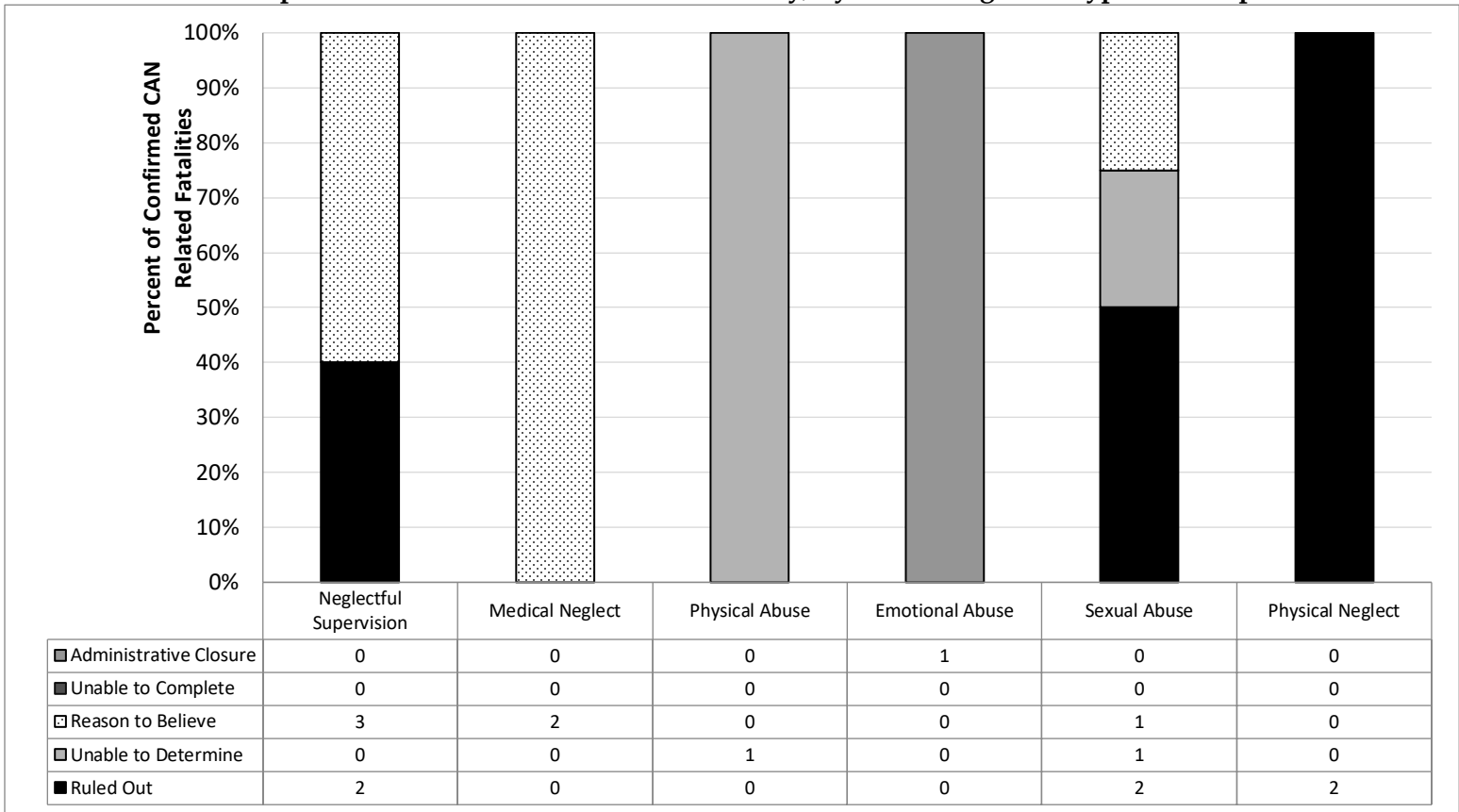
Source: DFPS individual case reviews; an investigation may have more than one allegation type and disposition.

Figure 29. FY 2025 CPS History for Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or the Child’s Family in the Two Years Prior to Fatality, by Prior Allegation Type and Outcome of Prior Investigation



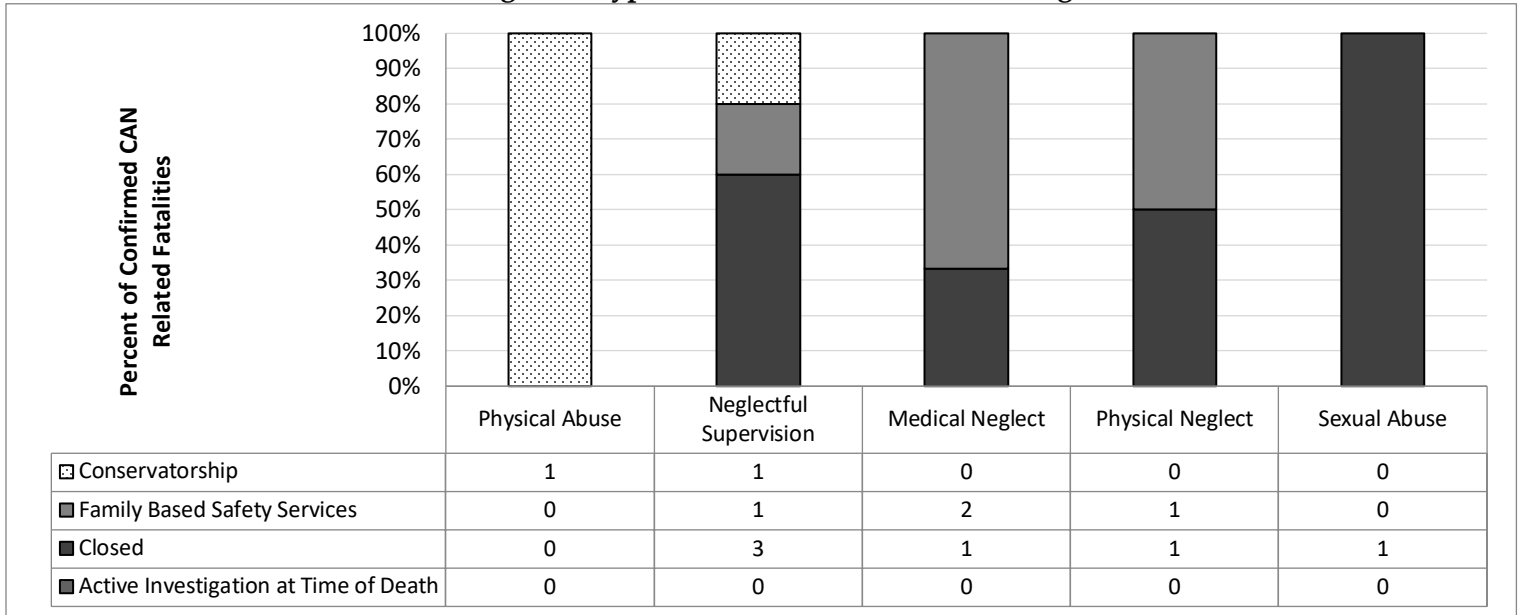
Source: DFPS individual case reviews; an investigation may have more than one allegation type and disposition.

Figure 30. FY 2025 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; an investigation may have more than one allegation type and disposition.

Figure 31. FY 2025 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 Outcome of Prior Investigation



Source: DFPS individual case reviews

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

Table 9. FY 2025 Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Child or Child’s Family in the Two Years Prior to Fatality, by Prior Allegation Type and Cause of Fatality

	Drowning Related	Unsafe Sleep Related	Vehicle Related	Physical Abuse	Neglectful Supervision/ Other	Total
Prior Physical Abuse Allegation	3	0	6	5	2	16
Prior Neglectful Supervision Allegation	12	1	19	18	16	66
Prior Sexual Abuse Allegation	0	0	1	2	3	6
Prior Medical Neglect Allegation	1	0	0	1	1	3
Prior Physical Neglect Allegation	3	0	11	3	1	18
Total Child Fatalities with History with Child or Child’s Family	19	1	37	29	23	109

Source: DFPS individual case reviews; an investigation may have more than 1 allegation type

Table 10. FY 2025 Confirmed Child Abuse and Neglect Related Fatalities – CPS Involvement with the Perpetrator in the Two Years Prior to Fatality, by Prior Allegation Type and Cause of Fatality

	Drowning Related	Unsafe Sleep Related	Vehicle Related	Physical Abuse	Neglectful Supervision/ Other	Total
Prior Physical Abuse Allegation	0	0	0	1	0	1
Prior Neglectful Supervision Allegation	0	1	1	1	2	5
Prior Sexual Abuse Allegation	0	0	0	2	0	2
Prior Medical Neglect Allegation	0	0	1	2	0	3
Prior Physical Neglect Allegation	0	0	1	2	0	3
Total with History	0	1	3	8	2	14

Source: DFPS individual case reviews; an investigation may have more than 1 allegation type

Child Fatality Case Summary

As part of this annual report and ongoing program review, the Office of Child Safety conducts in-depth reviews for child fatalities occurring when the child is involved with DFPS in an open stage (Investigations, Family Based Safety Services, or Conservatorship) and death is confirmed to be caused by abuse or neglect.

In FY2025, there were 11 confirmed child fatalities due to abuse or neglect that occurred during an active stage of service with DFPS. For each of those children, a short description of the involvement is included below.

- Devada, a 16-year-old female, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on November 18, 2024, alleging that an adult family member was using drugs and having a sexual relationship with Devada; they were said to be living together. During the investigation, Devada died on November 21, 2024; she became unresponsive while traveling with her mother. Devada died of a drug overdose.
- Jayden, a 2-month-old male, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on June 19, 2025, due to concerns for neglectful supervision of Jayden and his siblings. During the investigation, Jayden died on June 28, 2025. Jayden was found unresponsive after being left in a vehicle.
- Luke, a 7-year-old male, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on October 27, 2024, due to concerns of sexual abuse of Luke and his sibling. During the investigation, Luke died on January 9, 2025, while in the care of his adult brother. Luke died of asphyxiation by strangulation.
- Patience, a 17-year-old female, was involved in an open Child Protective Investigations (CPI) at the time of the fatality. The investigation was initiated on November 15, 2024; alleging sexual abuse of Patience when she was a younger child by her mother. During the investigation, after her psychological hospital admission and release, Patience went to reside with her father where she died on January 10, 2025. Patience died as a result of acute alcohol poisoning.

- Roman, a 1-year-old male, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on July 09, 2025, alleging neglectful supervision of Roman's infant sibling due to an amputation of two fingers by the family cat. During the investigation, Roman died on August 16, 2025. Roman was found unresponsive in a backyard pool while in the care of his mother. Roman died as a result of the drowning.
- Zachariah, a 1-month-old male, was involved in an open Child Protective Investigations (CPI) case at the time of the fatality. The investigation was initiated on June 05, 2025, alleging Zachariah and his mother tested positive for amphetamines at birth and cocaine. During the investigation, Zachariah died on July 27, 2025. Zachariah was found unresponsive in his home and passed away due to methamphetamine toxicity.
- Julius, a 3-month-old male, was involved in an open CPS family-based safety services (FBSS) case at the time of the fatality. The FBSS stage was open on August 14, 2024 due to concerns of neglectful supervision of Julius and his siblings due to ongoing domestic violence in the home. During the FBSS case, Julius died on October 25, 2024. Julius died as a result of physical abuse due to blunt force injuries. Julius' death was ruled as a homicide.
- Miguel, a 1-month-old male, was involved in an open CPS family-based safety services (FBSS) case at the time of the fatality. The FBSS stage was open on May 9, 2025, due to concerns of physical abuse and neglectful supervision of Miguel and his siblings. During the FBSS case, Miguel died on June 20, 2025. Miguel died as a result of physical abuse.
- Zayn, a 2-month-old male, was involved in an open CPS family-based safety services (FBSS) case at the time of the fatality. The FBSS stage was open on August 4, 2024, due to concerns of physical abuse of Zayn. During the FBSS case, Zayn died on September 11, 2024. Zayn died as a result of physical abuse and criminal charges resulted from this incident.
- Owen, a 11-year-old male, was involved in an open CPS conservatorship (CVS) case at the time of the fatality. Owen entered foster care on May 11, 2023. On November 13, 2024, Owen was placed in a residential treatment facility after being discharged from his previous placement. Owen died as a result of neglectful supervision and criminal charges resulted from this incident.

- Paul, a 2-year-old male, was involved in an open CPS conservatorship (CVS) case with an accompanying kinship stage at the time of the fatality. Paul entered foster care on April 6, 2024, and was placed with a relative. A kinship stage was opened on October 17, 2024. Paul died on December 25, 2024. The fatality investigation was initiated on December 17, 2024, after Paul had been found unresponsive with trauma due to a gunshot wound. Criminal charges resulted from this incident.

Child Fatalities Not Caused by Abuse and Neglect

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

Further analysis and individual case readings in these types of investigations are a useful tool to inform strategies to prevent child fatalities and ensure consistency in investigations in which a child fatality has occurred. These cases continue to have similar demographics in FY 2025 as confirmed child fatalities caused by abuse and neglect in previous years: the victim is often three months of age or younger, and there is a component of neglectful supervision. Many situations involve premature delivery of a newborn child (unrelated to suspected abuse or neglect) alongside other concerns in the home that rise to the level of confirmed maltreatment.

Many incidents involving a child's death are tragic accidents. While some child fatality investigations reveal that abuse or neglect contributed to the fatality, the majority indicate that these deaths were not caused by such factors. In FY 2025, of the 581 child fatalities investigated by DFPS, 21.34 percent were determined to be the result of abuse or neglect. Additionally, in 13.76 percent of cases, although abuse or neglect was identified, it did not cause the child's death. These findings are detailed below:

General Findings

- In FY 2025, there were 80 child fatalities where the death was not related to abuse or neglect, but the investigation found abuse or neglect had occurred in the home.
- 55 child fatalities where the death was not related to abuse or neglect had some form of prior history, with 64 percent of those cases occurring in the past two years.
- Most child fatalities that were not found to be abuse or neglect related were due to health-related issues (20%) followed by deaths determined by the medical examiner as unable to determine at (13%).
 - The cause of death in 43 of the confirmed cases were: health-related, accidental suffocation, accidental drowning, vehicle-related, and sudden unexplained infant death.
 - Four children died due to an injury or trauma where a caregiver was not at fault.

- The other investigations involved a fatality where the cause of death was undetermined.

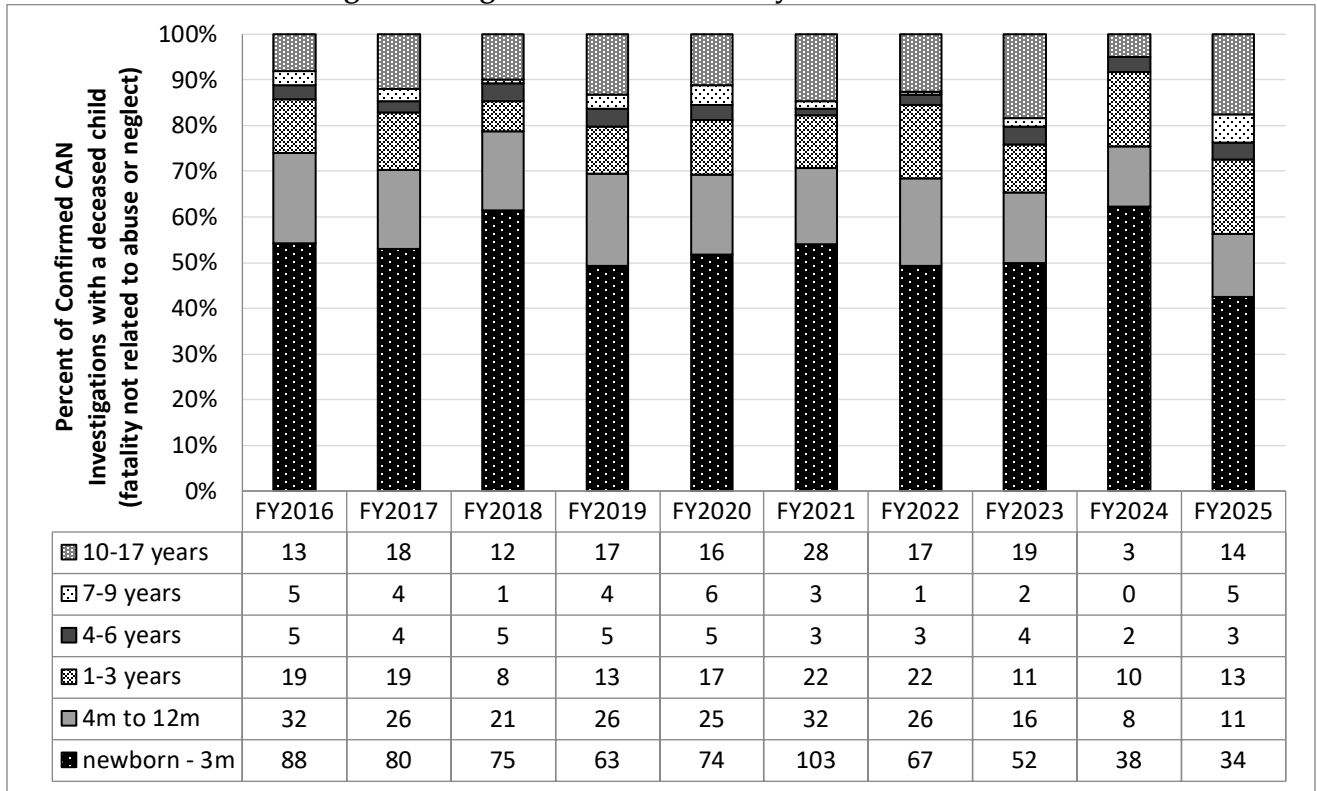
Victim Children

- 13 of the 80 children were prior alleged victims but allegations were not confirmed in the prior cases.
- 12 of the 80 children were confirmed victims in prior cases.
- 13 of the 80 children were involved in Family Based Safety Services previously and four had been involved in DFPS conservatorship.

Perpetrators

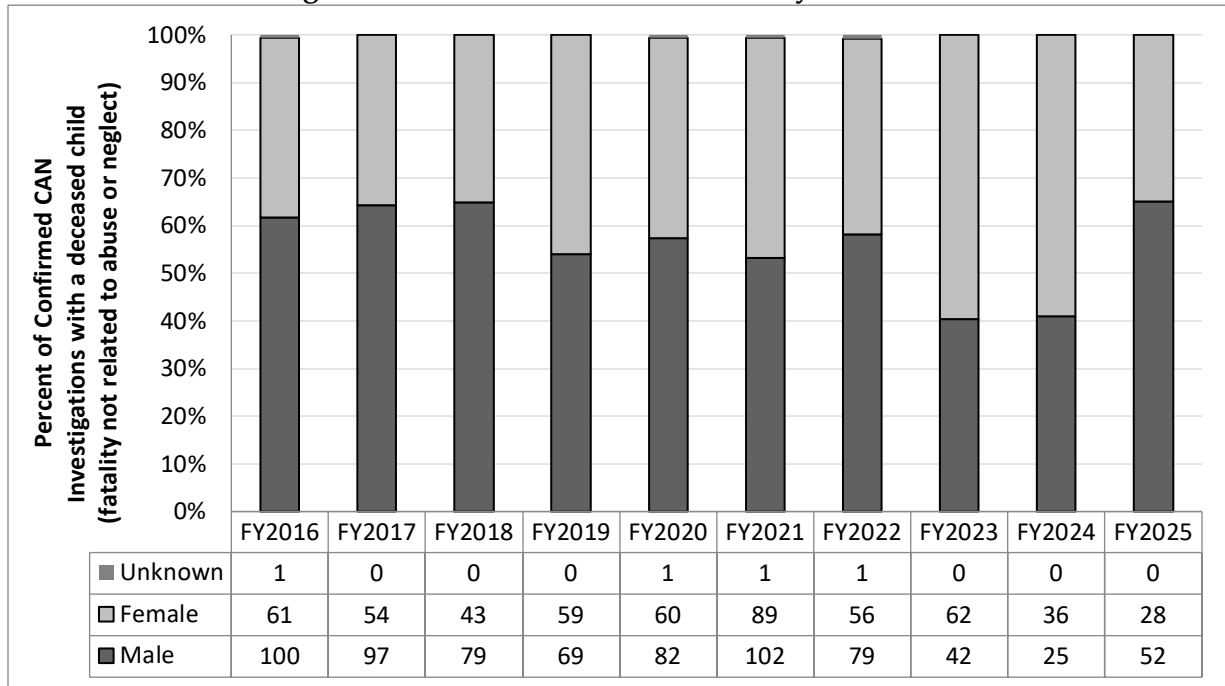
- 14 of the confirmed perpetrators were previously alleged perpetrators but allegations were not confirmed in prior cases.
- 28 of the confirmed perpetrators were previously confirmed perpetrators in prior cases.

Figure 32. Age of Child at Death by Fiscal Year



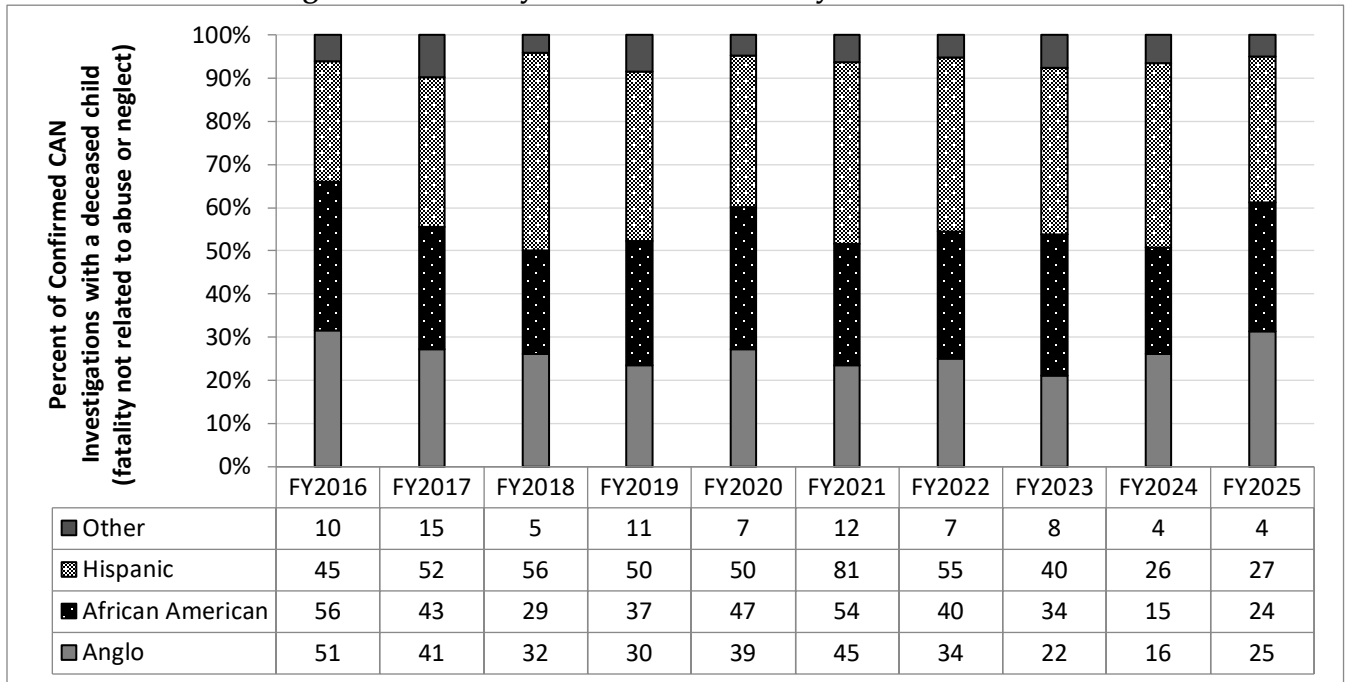
Source: DFPS Data Warehouse Report ft_12

Figure 33. Gender of Deceased Child by Fiscal Year



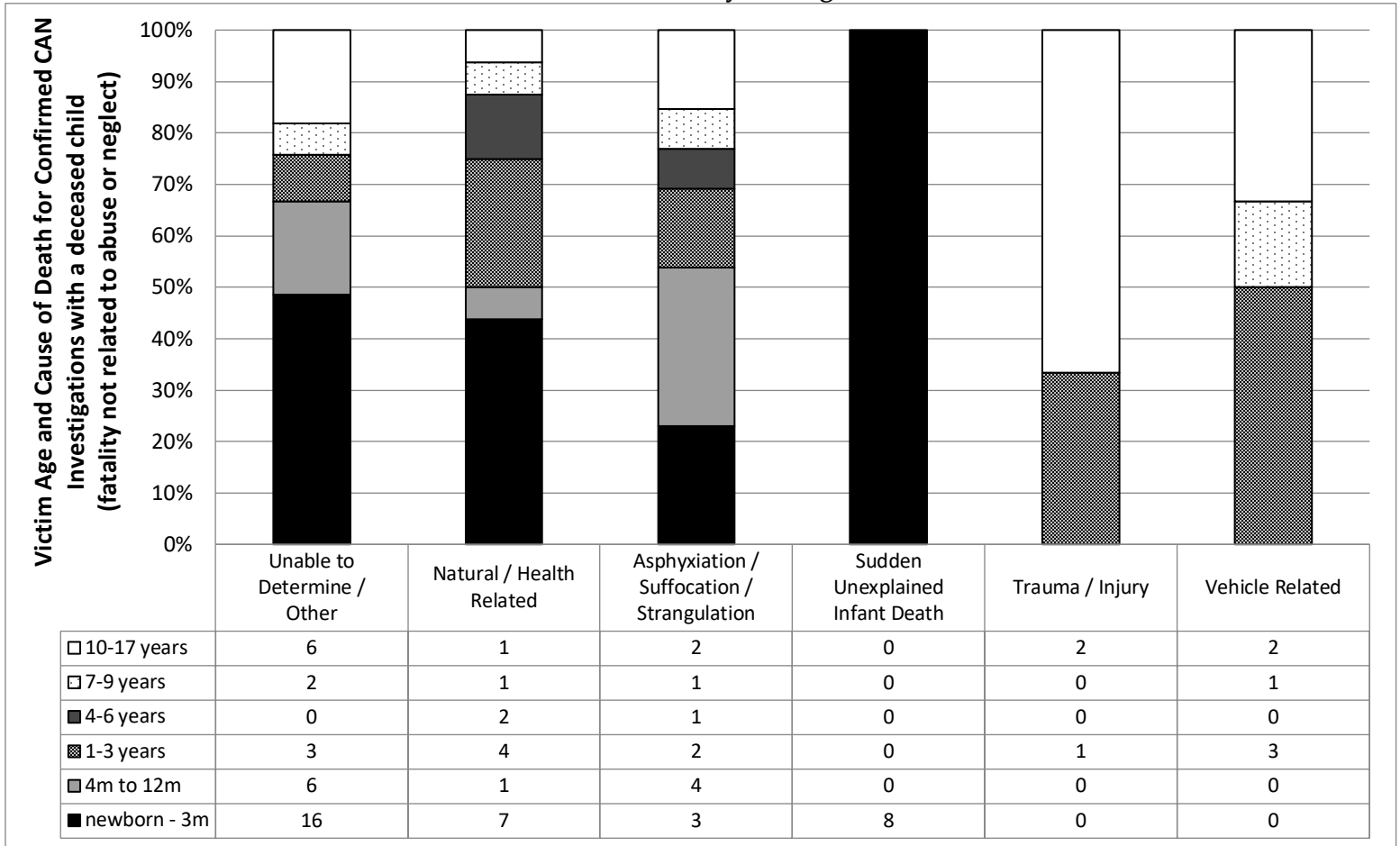
Source: DFPS Data Warehouse Report ft_12

Figure 34. Ethnicity of Deceased Child by Fiscal Year



Source: DFPS Data Warehouse Report ft_12

Figure 35. FY 2025 - Investigated Child Fatalities that were not Abuse and Neglect Related Fatality but Maltreatment Confirmed in Investigation (RTB with Severity Type Other than Fatal) -- Cause of Fatality and Age of Child



Source: DFPS Data Warehouse Report ft_12

Child Fatalities in Texas within the National Context

Varying definitions of abuse and neglect among states: The Children's Bureau of the U.S. Department of Health and Human Services publishes *Child Maltreatment*⁷, an annual report comprising data from the National Child Abuse and Neglect Data System (NCANDS). While this data allows for some comparison between the states that report, there are several areas where states differ in reporting such as inconsistent definitions of abuse/neglect, variation in the definition of previous history, and states limiting reportable child fatalities to only those children already known to or actively involved in the child welfare system.⁸

Texas' approach: Texas addresses these issues by having 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;⁹
- investigating reports of child abuse or neglect allegedly committed by a person responsible for a child's care, custody, or welfare;¹⁰
- including the use of a controlled substance in the definition of child abuse and neglect¹¹ and defining medical neglect as the failure to *seek, obtain, or follow through* with medical care for the child;¹² and
- defining prior history very broadly.

Defining prior history: While other states limit prior history to those cases with previous investigations, direct service delivery, or conservatorship of the child within a certain time, Texas does not limit either the time or type of involvement when reporting history. Texas defines prior history as, at the time of the child fatality, either the deceased child or a designated perpetrator in the fatality had been in an investigation or received CPS services before the child's death. According to this definition, it counts as prior CPS history even if the last contact with CPS was several years before the death, the perpetrator was involved with a different family, the deceased child was not yet born, or if the history was completely unrelated to the circumstances of the fatality.

Per capita rate: Given the broad definitions in Texas, the Texas per capita rate for child abuse and neglect fatalities (rate per 100,000 children in the child population), has been higher than the national average. For federal fiscal year 2023 (the most recent year reported for all states), the Texas rate was 2.0 confirmed child abuse and neglect related fatalities per 100,000 compared to a national average of 2.73 confirmed child abuse and neglect related fatalities per 100,000. It is important to note that for federal reporting, not all states report data and child fatalities are

reported during the federal fiscal year in which the death was determined to have been caused by maltreatment which is not necessarily the year in which the child died.

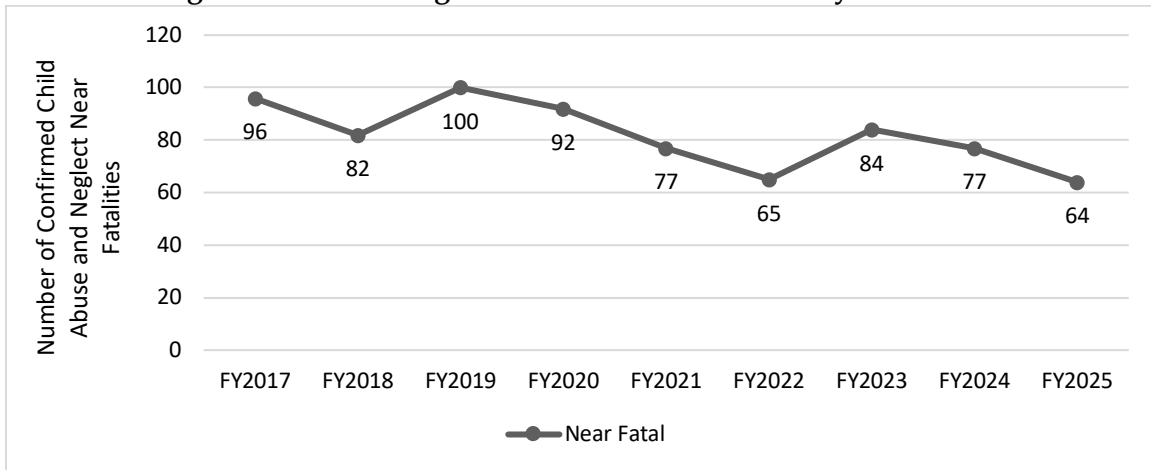
Near Fatalities

In FY 2025, Texas had 64 confirmed abuse and neglect-related near fatalities. The most common cause of abuse and neglect-related near fatalities involved physical abuse to include blunt force, inflicted trauma and abusive head injury, which accounted for 42.1 percent of the near fatalities in FY2025.

During FY 2025, children aged three and younger accounted for 75 percent of the confirmed child abuse and neglect-related near fatalities. Hispanic children comprised the largest percentage of children who experienced a near fatal incident due to abuse or neglect at 54 percent. Male children made up 53.1 percent of all confirmed near fatalities.

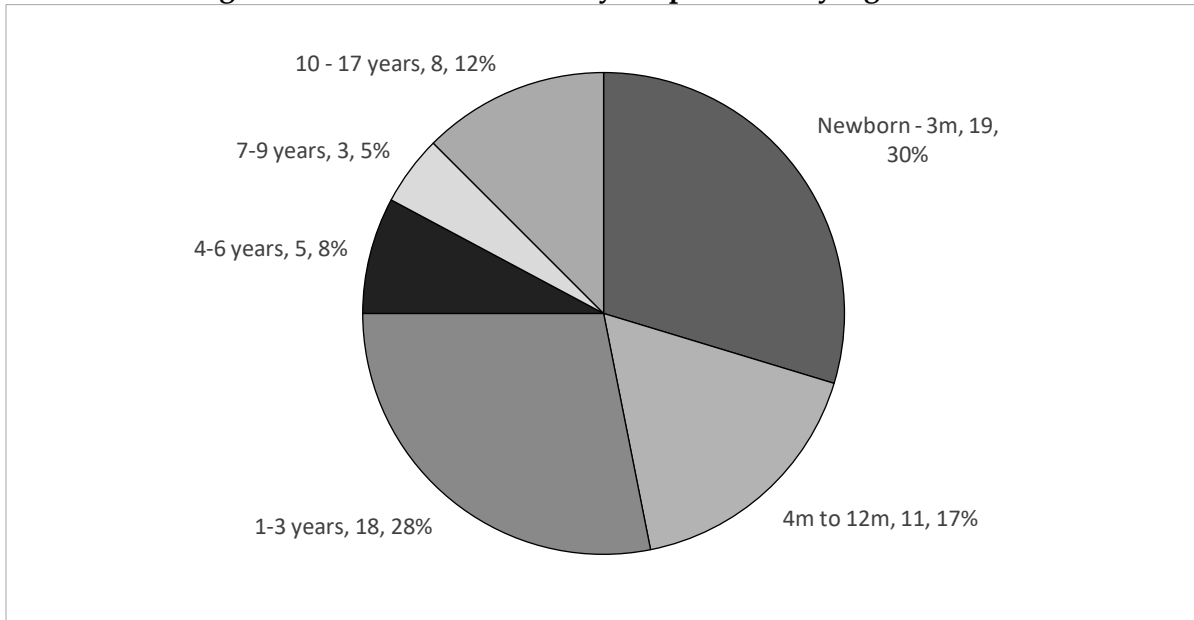
The highest number of abuse and neglect-related near fatalities were seen in Region 3 with 15 near fatalities. Regions 8 and 11 had 10 confirmed near fatalities each.

Figure 36. Abuse/Neglect Related Near Fatalities by Fiscal Year



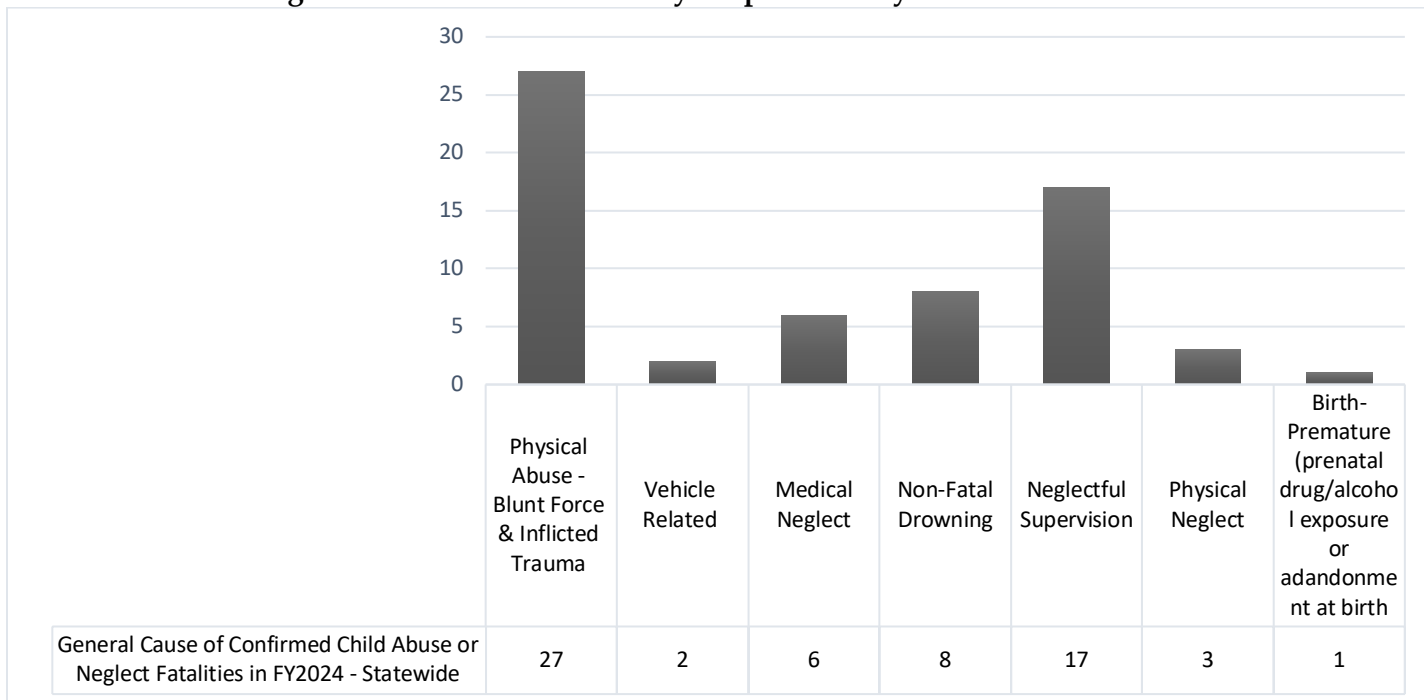
Source: DFPS individual case reviews

Figure 37. FY 2025 Near Fatality Dispositions by Age of Child



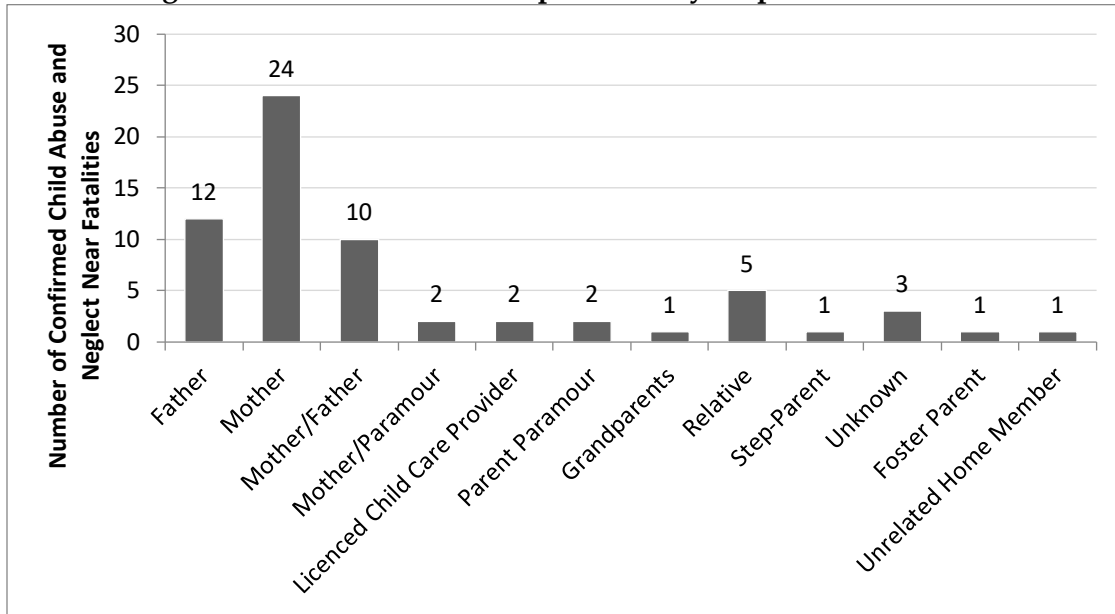
Source: DFPS individual case reviews and Data Warehouse nf_01

Figure 38. FY2025 –Near Fatality Dispositions by Cause



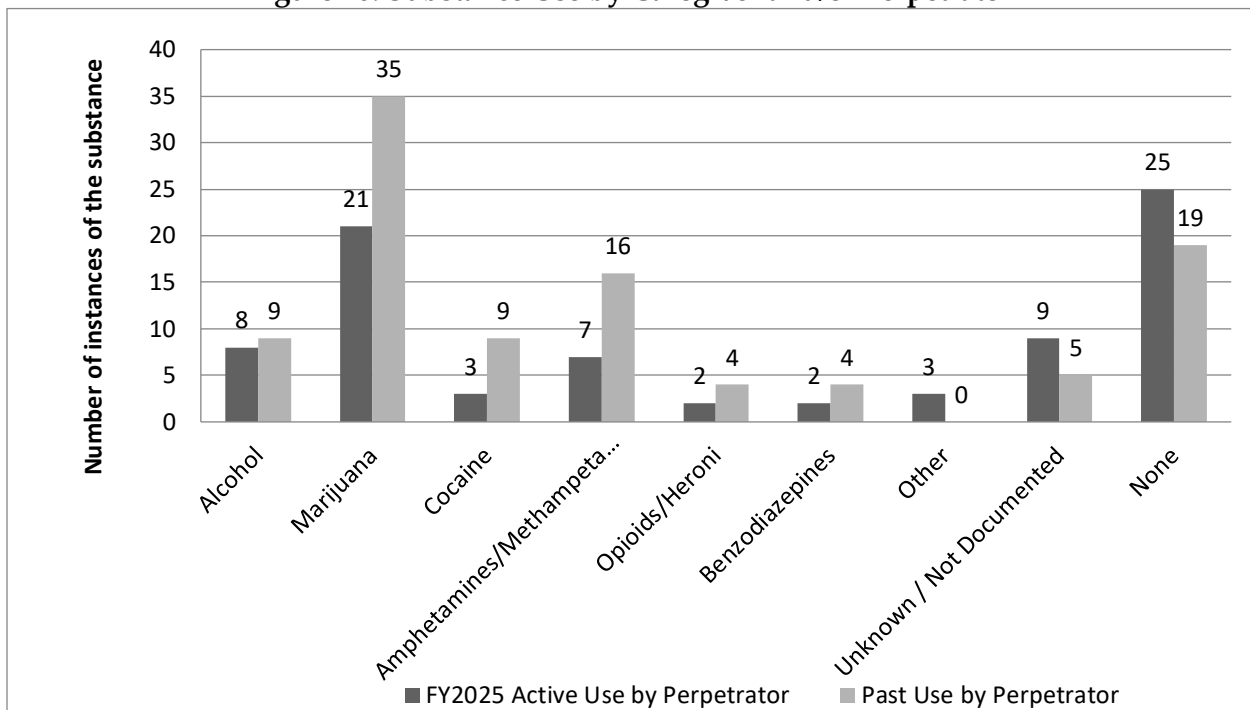
Source: DFPS individual case reviews

Figure 39. FY 2025 Relationship of Primary Perpetrator to Victim



Source: DFPS individual case reviews

Figure 40. Substance Use by Caregiver and/or Perpetrator



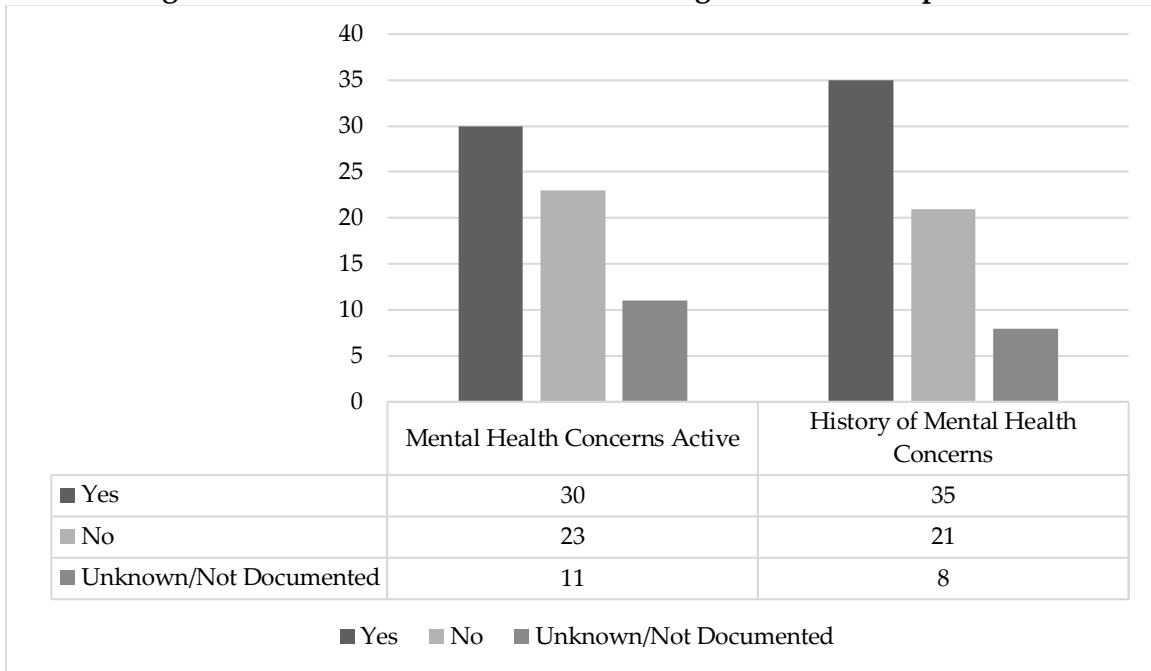
Source: DFPS individual case reviews Note: Some individuals had multiple substances recorded in both active and history.
 *Others include Barbiturates and Fentanyl

Table 11. FY 2025 Active Domestic Violence Concerns for Caregiver and/or Perpetrator

Domestic Violence Concern	Active	Past History	Both Active and Past History
Total Number of Parents/Caregivers Reporting Domestic Violence	26	37	22
No	28	36	-
Unknown (not identified in case read)	10	4	-

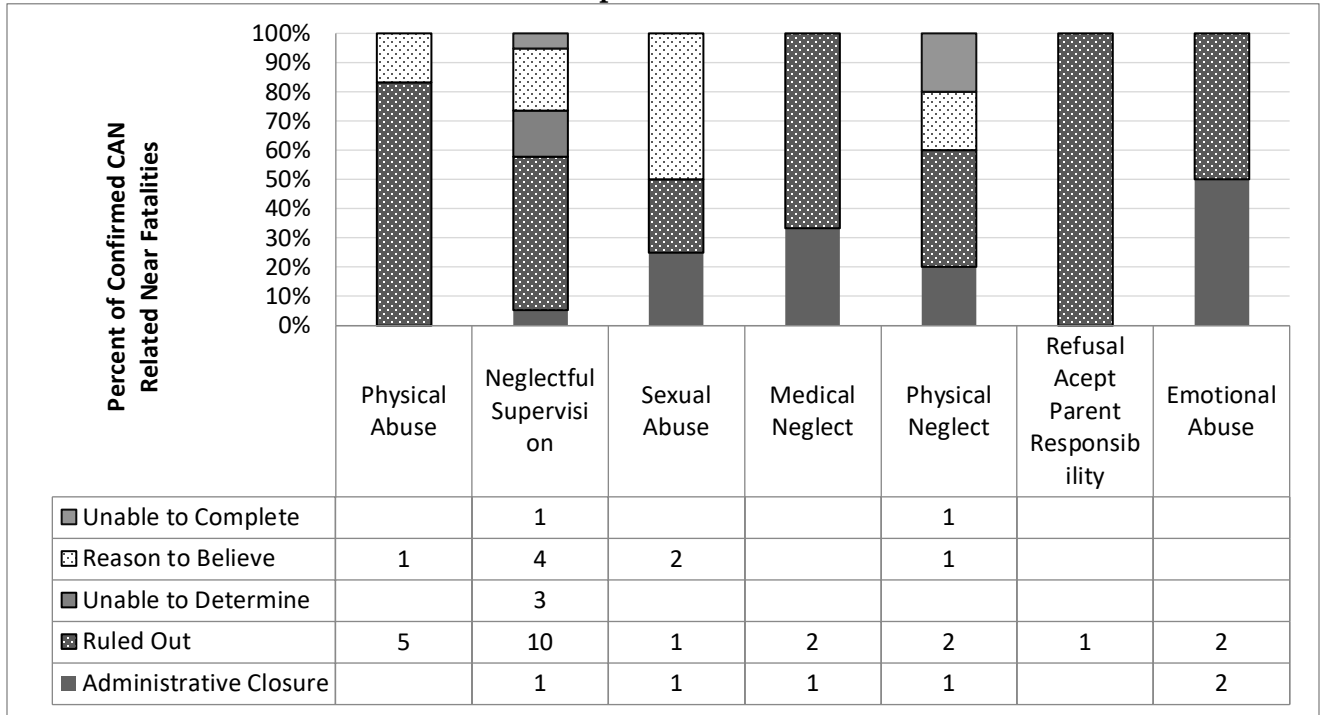
Source: DFPS individual case reviews

Figure 41. FY 2025 Mental Health for Caregivers and/or Perpetrator



Source: DFPS individual case reviews

Figure 42. FY 2025 CPS History for Confirmed Near Fatalities – CPS Involvement with the Child or Child’s Family in the Two Years Prior to Fatality, by Prior Allegation Type and Disposition



Source: DFPS individual case reviews

- In 38 near fatalities, the family had prior history with the department accounting for 59.4 percent of all near fatalities caused by abuse or neglect.
 - 17 families had prior investigations that were closed without ongoing DFPS involvement, accounting for 44.7 percent.
 - Eight families, accounting for 21.1 percent, had an open stage of service: four open investigations, three had open FBSS stages, and one in DFPS Conservatorship. 100 percent of initial contacts were completed timely. Seven of the open cases had one worker assigned per stage, and one of the open FBSS stages had been assigned to two different case workers.
 - 13 families, or 34.2 percent, had prior FBSS involvement. Nine of the families had a safety plan in place during the involvement. One-hundred percent of families reportedly complied or partially complied with their safety plan during services.
 - On average, families were seen monthly, with their involvement in FBSS ranging from three months to one-year. In general, initial visits were made timely as the policy and practice is to work collaboratively with Investigations and the family to engage in FBSS services at case transfer.

- Services referred in the previous or open stage include:
 - Counseling for family, individual, or group: 6 cases
 - Drug testing or treatment: 9 cases
 - Family support services (food stamps, TANF, etc.): 3 cases
 - Housing (rent, section 8, etc.): 1 case
 - Infant or early childhood screening or development: 1 case
 - Mental health (psychological testing, mental health assessment or treatment, referral to local mental health authority): 4 cases
 - Parenting skills / evidence-based parent education: 6 cases
 - Physical health (medical and dental, i.e. Medicaid, TX Health Steps, CHIPS, TX Healthy Kids Corporation, local health resources, etc.): 2 cases
 - Support groups (Such as Parents Anonymous, AA, ALANON, etc.): 1 case

- In eight of the 64 near fatalities, the family had prior involvement through DFPS Conservatorship accounting for 12.5 percent. In 17 of the 38 cases with prior history, initial contacts were made timely in 76.1 percent of the qualifying investigations.

Statewide Internal and External Child Fatality Review

DFPS works collaboratively with communities and state agencies to reduce child abuse and neglect overall, with a focus on addressing child abuse and neglect-related fatalities. Over time, several national and state initiatives have been launched to address child fatalities, and a number of these efforts remain active today.

Child Safety Review Committee - DFPS Review Team with External Stakeholders

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

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

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

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

DSHS publishes an annual report from the SCFRT. The most recent report is the State Child Fatality Review Team Committee Biennial Report – April 2024.¹⁴

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

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

- Providing assistance, direction, and coordination to investigations of child deaths;
- Promoting cooperation, communication, and coordination among agencies involved in responding to child fatalities;

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

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

Endnotes

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

² See US Centers for Disease Control and Prevention at:
<https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html>

³ *Child Maltreatment 2024*, <https://acf.gov/sites/default/files/documents/cb/cm2024.pdf>

⁴ 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>

⁵ Tex. Fam. Code §261.102 Matters to be Reported, Section 261.101 Persons Required to Report; Time to Report.

⁶Tex. Fam. Code §261.301 Investigation of Report.

⁷ 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.

⁸Tex. Fam. Code §261.001 Definitions

⁹ DSHS State Child Fatality Review Team Members,
https://www.dshs.state.tx.us/mch/child_fatality_review.shtm?terms=SCFRT

¹⁰Texas Child Fatality Data and Recommendations – April 2022,
https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/State_Child_Fatality_Review_Team_Committee_Biennial_Report_for_2022.pdf

Appendix A: Texas Family Code, Section 261.204

Introduction: This section outlines the requirement of the Department of Family and Protective Services to publish an annual report by March 1 of each year related to child fatality investigations confirmed to be caused by abuse or neglect.

Citation: Texas Family Code, Section 261.204 states:

ANNUAL CHILD FATALITY REPORT.

(a) Not later than March 1 of each year, the department shall publish an aggregated report using information compiled from each child fatality investigation for which the department made a finding regarding abuse or neglect, including cases in which the department determined the fatality was not the result of abuse or neglect. The report must protect the identity of individuals involved and contain the following information:

- (1) the age and sex of the child and the county in which the fatality occurred;
- (2) whether the state was the managing conservator of the child or whether the child resided with the child's parent, managing conservator, guardian, or other person entitled to the possession of the child at the time of the fatality;
- (3) the relationship to the child of the individual alleged to have abused or neglected the child, if any;
- (4) the number of any department abuse or neglect investigations involving the child or the individual alleged to have abused or neglected the child during the two years preceding the date of the fatality and the results of the investigations;
- (5) whether the department offered family-based safety services or conservatorship services to the child or family;
- (6) the types of abuse and neglect alleged in the reported investigations, if any; and
- (7) any trends identified in the investigations contained in the report.

(b) The report published under Subsection (a) must:

- (1) accurately represent all abuse-related and neglect-related child fatalities in this state, including child fatalities investigated under Subchapter E, Chapter 264, and other child fatalities investigated by the department; and
- (2) aggregate the fatalities by investigative findings and case disposition, including the following dispositions:
 - (A) abuse and neglect ruled out;
 - (B) unable to determine cause of death;
 - (C) reason to believe abuse or neglect occurred;
 - (D) reason to believe abuse or neglect contributed to child's death;
 - (E) unable to complete review; and

(F) administrative closure.

(c) The department may release additional information in the annual report if the release of the information is not prohibited by state or federal law.

(d) The department shall post the annual report on the department's Internet website and otherwise make the report available to the public.

(e) The executive commissioner of the Health and Human Services Commission may adopt rules to implement this section.

(f) At least once every 10 years, the department shall use the information reported under this section to provide guidance for possible department policy changes.

Appendix B: Texas Family Code, Section 264.5302

Introduction: This section outlines the requirement of the Department of Family and Protective Services to publish additional data related to child fatality investigations including information related to near fatality investigations which must also be published in an annual report by March 1 of each year. This information may be combined with the requirement for .

Citation: Texas Family Code, Section 264.5302 states:

REPORT ON CHILD FATALITY AND NEAR FATALITY DATA.

- (a) The department shall produce an aggregated report relating to child fatality and near fatality cases resulting from child abuse or neglect containing the following information:
- (1) any prior contact the department had with the child's family and the manner in which the case was disposed, including cases in which the department made the following dispositions:
 - (A) priority none or administrative closure;
 - (B) call screened out;
 - (C) alternative or differential response provided;
 - (D) unable to complete the investigation;
 - (E) unable to determine whether abuse or neglect occurred;
 - (F) reason to believe abuse or neglect occurred; or
 - (G) child removed and placed into substitute care;
 - (2) for any case investigated by the department involving the child or the child's family:
 - (A) the number of caseworkers assigned to the case before the fatality or near fatality occurred; and
 - (B) the caseworker's caseload at the time the case was opened and at the time the case was closed;
 - (3) for any case in which the department investigation concluded that there was reason to believe that abuse or neglect occurred, and the family was referred to family-based safety services:
 - (A) the safety plan provided to the family;
 - (B) the services offered to the family; and
 - (C) the level of compliance with the safety plan or completion of the services by the family;
 - (4) the number of contacts the department made with children and families in family-based safety services cases; and
 - (5) the initial and attempted contacts the department made with child abuse and neglect victims.

(b) In preparing the part of the report required by Subsection (a)(1), the department shall include information contained in department records retained in accordance with the department's records retention schedule.

(c) The report produced under this section must protect the identity of individuals involved in a case that is included in the report.

(d) The department may combine the report required under this section with the annual child fatality report required to be produced under Section 261.204.