TEXAS
Department of Family
and Protective Services

2024-2025 Citizen Review Team Report

February 2025

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Background

Pursuant to the Child Abuse Prevention and Treatment Act (CAPTA) section 106, each State to which a grant is made shall establish not less than three Citizen Review Panels (Teams). A State may designate for the purposes of this subsection one or more existing entities established under State or Federal law, such as child fatality panels or foster care review panels, if such entities have the capacity to satisfy these requirements and the State ensures that such entities will satisfy such requirements. These requirements include that each panel shall, by examining the policies, procedures, and practices of the State and where appropriate, specific cases, evaluate the extent to which State and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with the State plan.

CAPTA also states that each panel shall prepare and make available to the State and the public, on an annual basis, a report containing a summary of the activities of the panel and recommendations to improve the child protection services system at the State and local levels. Not later than six months after the date on which a report is submitted by the panel to the State, the appropriate State agency shall submit a written response to State and local child protection systems and the citizen review panel that describes whether or how the State will incorporate the recommendations of such panel (where appropriate) to make measurable progress in improving the State and local child protection system.

Additionally, the Texas Family Code (TFC §261.312) requires the Department of Family and Protective Services (DFPS) to create Citizen Review Teams; and authorizes DFPS to create one or more review teams for each region to evaluate employee casework and decision-making related to child protective investigations.

Structure

Pursuant to the CAPTA requirements, five of DFPS' regions are designated as meeting the requirements of CAPTA Appendix I, resulting in six teams that include Regions 1, 3E, 3W, 6 (6A and m), 7, and 11. These regions represent a mixture of urban and rural communities and reflect a broad range of issues encountered by DFPS statewide. All Citizen Review Team members, including those of the CAPTA Citizen Review Teams, are volunteers who represent a broad spectrum of their communities. The members are nominated locally and approved by the DFPS Commissioner. DFPS employees assist the Citizen Review Team with coordination, team development, training, and statewide distribution of team reviews and recommendations. DFPS representatives facilitate the meetings and the exchange of case-specific information, ensuring that confidentiality is maintained.

Reporting Process

To coincide with the federal fiscal year (FFY) reporting period, this report covers the period from October 2024 through September 2025 (FFY 2025). The information presented consists of data gathered by all Citizen Review Teams, including CAPTA Citizens Review Teams.

In FFY 2025, the teams reviewed child fatalities that met criteria for a Regional Child Death Review Committee. These meetings included reviews of prior investigations within the last three years; previous Family-Based Safety Services, Conservatorship, Kinship, and/or Adoption cases within the last three years if applicable; various types of abuse and neglect allegations in cases; and appropriateness of service delivery.

Criteria for a Regional Child Death Review Committee includes child fatality cases in which:

- The child's death has been determined by Child Protective Investigations to be the result of abuse or neglect; for example, there is a disposition of Reason to Believe for an allegation with a severity of fatal (RTB – Fatal), regardless of whether the medical examiner or other external parties reach the same conclusion; and
    - the deceased child or the designated perpetrator of the RTB – Fatal had an open Child Protective Investigations or Child Protective Services case at the time of the child's death or
    - the Designated Perpetrator of the RTB - Fatal has been an alleged or designated perpetrator in a prior Child Protective Investigations case within the last three years; or
    - the deceased child has been an alleged or designated victim in a Child Protective Investigations case within the last three years; or
    - the deceased child was a principal in a Family-Based Safety Services and/or Conservatorship stage of service within the last three years.

If there was not a child fatality case meeting criterion to review in the quarter, another case was selected, or a meeting was held to discuss the Title IV-B State Plan.

Agency Response

The Citizen Review Teams often present recommendations for local Child Protective Investigations and Child Protective Services direct delivery employees about actions they would like to see taken on a particular case. These case-specific recommendations are communicated during the Citizen Review Team meetings to the Child Protective Investigations and/or Child Protective Services representatives who are in attendance. Required actions relating to case-specific recommendations are handled at the regional level.

All Citizen Review Team recommendations with statewide implications and the DFPS written response to each recommendation are placed on the DFPS public website after approval of the annual report.

The annual Citizen Review Team Report can be found at:

https://www.dfps.texas.gov/Investigations/CRT/default.asp

Team Activities

The Child Safety Specialists within the Office of Child Safety act as the Citizen Review Team coordinators within their assigned region of responsibility. The Citizen Review Team coordinators meet regularly with the Director and Lead Child Fatality Specialist within the Office of Child Safety to discuss better ways to engage the community in the review process.

DFPS values collaboration with our partners in the child welfare system in Texas. Building community relationships and partnerships is an integral part of DFPS work and is critical to providing clients with needed support. To gain essential feedback from the public, the Citizens Review Team coordinators, Child Protective Investigations regional leadership, and Child Protective Services regional leadership continue to work with their communities to engage and encourage volunteers to become involved in these teams.

Along with discussion of Child Protective Investigations, Child Protective Services, and Community Based Care cases, each Citizen Review Team reviewed and discussed the CAPTA State Plan at least once during regularly scheduled meetings.

Analysis

During FFY 2025, the Citizen Review Teams reviewed 46 cases of which 37 were child fatality cases. Of the fatality cases reviewed, nine had an open case at the time of the fatality; two had an open investigation, four had an open family-based safety services case, one had an open investigation and family-based safety services case, one had an open conservatorship case with community-based care, and one had an open conservatorship case with the department. Additionally, when there was not a qualifying case, alternate cases were reviewed to ensure a quarterly meeting was held. Eight meetings were held that focused solely on the Title IV-B State Plan and how the department meets CAPTA requirements.

Recommendations with statewide implication were given in 16 reviews, resulting in 16 different recommendations. Although none of the 16 recommendations were exactly the same, there were recurring themes, such as procedures in cases involving substance abuse, child fatalities, and vulnerable children.

If there was a recommendation or concern that was case specific or at the regional level, it was referred to regional management. If recommendations were already a part of existing policy and

procedures or training, team members were informed of these, and the recommendation or concern was seen as an area needing improvement. There were also several recommendations that would require legislative changes or new legislation. In those situations, the team members were encouraged to reach out to their representatives to address their concerns.

Recommendations Implemented

The following recommendations were determined to require actions be taken or further discussions held to determine how to incorporate them into existing policy, practice, or training.

Recommendation 1

When an individual's prior history (criminal and DFPS) poses a danger to the children that individual has access to, the agency should be able to provide this information to the parent/caregiver of those children. Currently, DFPS cannot disclose that confidential information.

Response 1

Criminal history information may only be released under very limited circumstances. One of these is to an adult residing with an alleged victim and alleged perpetrator when the release is necessary to ensure safety. For cases where the alleged perpetrator is not living with the child, the release would require a statutory change to Texas Government Code §411.114(a)(7)(C) to encompass individuals who are not living with the child.

DFPS, in collaboration with Legal and Background Check divisions, will be developing training to provide clearer guidance to staff on when criminal history information may be released and how it should be properly documented in the case record.

See 1840 Disclosure and Release of Criminal History Records Information (CHRI)

Recommendation 2

Create a video training in English and Spanish for parents/caregivers that addresses all home safety concerns (safe sleep, water safety, gun safety, etc.) in the video. The training link or QR code can be shared easily out in the field when verbally reviewing the information or providing tip-sheets may not be enough or the parent/caregivers preferred learning medium. The team acknowledged that the Prevention and Early Intervention webpage has lots of resources, however they do not address all home safety topics CPI/CPS address and are individual videos.

Response 2

Expanding access to essential home safety information through easily shareable resources would benefit families and caregivers. Collaborating with the Training Division to assess the feasibility of creating comprehensive video training and associated handouts in both English and Spanish is a practical approach to meeting caregivers' diverse learning needs. A consolidated video addressing key home safety topics—such as safe sleep, water safety, gun safety, and other critical

areas—could be an effective resource to share with families in the field via QR codes, links, or other accessible formats.

CPI and CPS will collaborate with Leadership and Development to explore the feasibility of this proposal and outline the necessary next steps to bring it to fruition. A joint meeting to discuss and plan this initiative took place in January 2026.

Recommendation 3

Statewide Intake (SWI) and Child Protective Investigations (CPI) should review how Case Related Special Requests (CRSR) that pertain to child fatalities are handled to ensure there are clear policies/procedures/guidelines. Specifically, more guidelines regarding what should be sent to CPI as a CRSR versus an Intake as well as when CPI can close the CRSR without calling it in to SWI, including timeframes for decision making and when one can be closed without an Investigation, similar to Administrative Closure policy.

Response 3

SWI and CPI have reviewed how these reports are handled and determined that there is no need to make adjustments at this time. SWI already has clear policy and guidance for assessing and processing reports involving child fatalities and each of these assessments are staffed with a SWI Supervisor. Policy includes a guide to help intake specialists make assessments quickly and determine the most appropriate report type: intake vs Information and Referrals (I&R) vs CRSR. Additionally, CPI has a CRSR Child Fatality Protocol in place that clearly outlines how these are to be handled and when a new referral is to be made to SWI.

see SWI Handbook 4630 Child Death
see Child Death Assessment Table

Recommendation 4

It was recommended that Statewide Intake (SWI) review their policy and/or guidelines regarding when to take reports that involve domestic violence incidents in the home that may not occur when the child/ren are present but are frequently occurring.

Response 4

In September of 2025, SWI updated policy and guidelines related to reports involving family violence to ensure guidance for staff emphasizes the importance and consideration of all relevant factors and notes the criterion of a child's proximity to the violence is important information but not paramount.

see SWI Handbook NSUP as a Result of Exposure to Family Violence

Recommendation 5

The service authorization process (2054) for drug testing should be reviewed to determine if it is possible to enter multiple types of drug testing requests on one form. For example, instead of three

2054s being sent to the provider for alcohol testing, hair strand testing, and UA testing, one form could be sent requesting all three tests, streamlining the process and eliminating errors.

Response 5

The service authorization process (2054) for drug testing was reviewed and it was determined that it is not possible at this time to enter multiple types of drug testing requests on one form. While there may be potential benefits combining multiple drug tests into a single 2054, the current process for drug testing is set up to ensure proper approvals are obtained for different levels of drug testing to avoid errors leading to unnecessary costs or time delays that in turn can delay safe decision making for families. A change of this nature is also dependent, in part, on the contractors necessary to facilitate the testing for clients.

see DFPS Substance Use Resource Guide
see CPS Handbook Section 1930 Drug Testing

Recommendation 6

Secondary approval by the Child Safety Specialist should be required on cases involving medically fragile children, regardless of age, as they are an extremely vulnerable population.

Response 6

Policy was updated in August 2025 regarding investigations involving a child with multiple, serious, or chronic health conditions; to include mandatory staffings in which the Child Safety Specialist participates. This process facilitates the ability for multiple subject matter experts, including the Child Safety Specialists, to review and provide input and recommendations in case decisions and direction.

See 2233 Complex Medical Investigations

Recommendation 7

Child Safety Specialist should be required to conduct reviews of cases before Family-Based Safety Services (FBSS) closes cases if the family is declining services or if FBSS determines the case does not warrant services.

Response 7

Although Child Safety Specialists are not required to review these cases, Child Safety Specialists are available to review an FBSS case and consult with FBSS personnel as requested by FBSS managers. Staff will be reminded that Child Safety Specialists are available for case staffings as requested by their management. The agency will complete an analysis to assess the feasibility of this as a requirement.

Recommendation 8

Information regarding the importance of not providing adult medication to children and to follow all dosage recommendations should be added to the 'Keeping Children Safe Wherever You Go' handout.

Response 8

The agency has a handout that addresses medications with families. This resource directs parents to follow the dosing evidence that is provided from the prescribing physician or the label. Further medical direction is deferred to the family's physician or another medical professional. DFPS will continue to explore this topic with field staff during advisory council meetings to assess how often this is seen in the field and if a change in the handout is needed.

Recommendations not Implemented

There were numerous recommendations made that the department did not take action on. After a thorough review of existing policy, practice, and training was completed, it was determined that no changes or actions were needed. The following recommendations fell into this category.

Recommendation 1

The criteria for Administrative Closures should be reassessed, as a Program Administrator may need to serve as the final approver in specific situations, such as cases involving prior abuse or neglect validations and/or removals, recently closed investigations, and cases involving children under five.

Response 1

This recommendation is not being implemented at this time as there is an existing policy that requires both supervisors and program directors to review and approve cases to be administratively closed.

See 2310 Criteria for Administrative Closure of an Investigation

Recommendation 2

CPS and SSCC policy should be updated to require a law enforcement involvement/call out report be requested when completing a home study. Additionally, involvement/call out reports should be completed periodically to ensure no new concerns regarding the home have occurred.

Response 2

This recommendation will not be incorporated at this time. When staff are evaluating the totality of the circumstances, this should include a comprehensive and ongoing evaluation of the home environment. If there were law enforcement involvement/call out reports available for a caregiver's home, the assessment of the home would address any concerns identified in the report as well. Due to requirements by the FBI for the release of criminal history record information,

DFPS is limited to what information related to criminal history can be included in records, however DFPS is in the process of revising the Kinship Caregiver Home Assessment which includes considerations of whether additional information is needed from the potential caregiver to assess safety.

Additionally, law enforcement involvement/call out reports could take an extended period to receive, if received at all, as they come directly from individual law enforcement agencies instead of a database. Delaying the approval of a home assessment to wait for this information would cause delays in placement and permanency for youth. Law enforcement call outs/involvement reports are a part of the verification process for foster homes under Texas Human Resources Code and Texas Administrative Code for Minimum Standards for Child-Placing Agencies.

See §§42.0449 Required Actions After Notice of Family Violence Call
See 42.0561 Information Relating to Family Violence Reports
See TAC Foster Home Screenings

Recommendation 3

CPI should be observing and documenting all medications in the home on fatality cases when it is not clear what the cause/manner of death is.

Response 3

Although policy does not specify documenting medications (prescribed or non-prescribed), thorough investigations and information gathering is required to assist in determining the cause of death. Investigators are already conducting home assessments and collaborating with law enforcement to ensure relevant information is being gathered from the family and the scene.

Recommendation 4

CPI should be drug testing caregivers on all fatality cases with infants where cause of death was unknown (i.e. Sudden Unexpected Infant Death or co-sleeping), even if there is no current suspicion or history that would normally warrant a drug test.

Response 4

Under current policy, substance use testing is initiated only when credible evidence indicates it may have been a contributing factor during the investigation. Substance use is not present in all child fatalities.

See 1900 Substance Use

Recommendation 5

Staffing with Program Directors should be required when Safety Plans are implemented with children that meet a specific age criteria (0-1yo).

Response 5

This recommendation will not be incorporated into policy at this time. There is existing policy in place and trainings that reinforce best practices in assessing safety monitors and safety plans, with a focus on cases involving domestic violence and vulnerable age groups.

See 3210 Safety Plan

Recommendations not within DFPS authority

The following two recommendations were not within the statutory authority of DFPS and would require statutory changes:

1. Current statute and/or the existing Memorandum of Understanding (MOU) should be expanded to cover automatic referrals from the Department of State Health Services (DSHS) when there is a new birth match to a parent who was found Reason to Believe – Near Fatal in a Child Protective Investigation.

2. Current statute and/or the existing MOU should be expanded to remove the current time limit of automatic referrals from the Department of State Health Services (DSHS) when there is a new birth match to a parent who was found Reason to Believe – Fatal in a Child Protective Investigation.