TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

COMMISSIONER
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A Review of Department of Family and Protective Services Involvement
Child Fatality and Near Fatality

On April 3, 2015, during an open Child Protective Services (CPS) investigation, Da'Mon Samuel died from an unknown cause. Da'Mon was born on October 22, 2014. He was residing with his mother, father, twin sibling, and older sibling in a hotel room. CPS has a history of involvement with Da'Mon's mother and father.

The Office of Child Safety (OCS) completed a review of all current and past CPS investigations concerning Da'Mon's family. This report presents the Office of Child Safety's findings, summary of CPS investigations, assessment of strengths in casework practice, and areas for improvement. This report describes the timeline and actions taken by CPS as well as issues found during the review of CPS' involvement with Da'Mon Samuel's family and the death of Da'Mon that merit further examination.

Family Composition

Region 3 - Dallas County

Name or Relationship to Da'Mon	Age at time of incident
Da'Mon Samuel	5 months
Mother	25
Father	24
Sibling – twin to Da'Mon	5 months
Sibling	1 year

Summary of CPS History on Family of Da'Mon Samuel

- On January 30, 2015, CPS received a report regarding the alleged medical neglect of Da'Mon's twin sibling by their mother. The report is currently under investigation.
- On March 15, 2015, CPS received a second report regarding the alleged neglectful supervision of Da'Mon and his twin sibling by their father. The report was merged into the previous investigation and investigated with the prior report.
- On April 3, 2015, CPS received a report regarding the death of Da'Mon while under the care of his father. The investigation has been completed.

Detailed Account of CPS History on Family of Da'Mon Samuel

On **January 30, 2015**, a report was received regarding Da'Mon's mother for the alleged medical neglect of Da'Mon's twin sibling. Allegation included concern that the twin babies were born

premature on October 22, 2014, at 27 weeks and 6 days. While hospitalized, Da'Mon's twin sibling was being screened for retinopathy of prematurity and medical professionals said that the child would need to be seen after discharge occurred on December 18, 2014. Da'Mon's twin sibling had yet to be seen for follow up by any doctors.

CPS staff met with the family about the report at their residence, a hotel room. All three of the children were observed free of marks or bruises. The father stated that the twins slept on one bed while the oldest child slept in a pack and play. Safe sleeping practices were discussed with the father. Four days later, Da'Mon's mother reported that the twins slept in bassinets while the oldest child slept in a pack and play. Da'Mon's mother admitted to staff that there had been a previous domestic violence incident between her and the father. CPS staff discussed the incident with both parents, who seemed to minimize the concerns. The parents signed a safety plan agreeing to set up the needed medical appointment for Da'Mon's sibling. CPS staff later assisted the family by scheduling the appointment for the family.

OCS Assessment:

- Contact with the children was made within required time frames. CPS Policy 2241 Interviews With Children states Priority 1 reports must have all alleged victims interviewed, or attempted to be interviewed: immediately, if circumstances indicate possible substantial bodily harm or death; or within 24 hours of the intake date and time, for all other cases.
- A photograph obtained on January 30, 2015 appears to show Da'Mon's twin sibling in an unsafe sleeping position on the child's stomach, placed on a pillow laid on a bed, with blankets around the child.
- The mother and father reported different sleeping practices in the residence. The parents later stated that after CPS staff provided safe sleeping information to the father, they adjusted their sleeping practices. It is not documented whether or not CPS staff observed the bassinets and pack and play in the home.
- CPS staff did not request medical documentation.
- During the investigation, Da'Mon's mother reported that a primary care physician appointment was rescheduled. CPS staff did not follow up on this appointment.
- CPS staff was aware that the father previously resided outside of Texas but did not request criminal or CPS history from the other state.
- CPS staff was aware that the family had maternal relatives living at the same hotel, but did not speak with the them..
- The maternal grandmother reported to staff that she had concerns the father would smoke outside of the hotel room home and walk away from the door when doing so. He would also walk to the sidewalk in front of the room. Staff did not address the concerns about the children being unsupervised during this time with the father or mother.

On **March 15, 2015**, a report was received regarding Da'Mon's father for the alleged neglectful supervision of Da'Mon and his twin sibling. The report included concerns that Da'Mon's father left Da'Mon and his twin sibling home alone while he went to the mother's work and physically assaulted her. The report states the mother did not want to press charges.

During a visit from CPS staff on March 16, 2015, Da'Mon's mother confirmed the events of the report. She explained that the father physically assaulted her while leaving the children home alone. She also stated that earlier in the day, law enforcement arrived in the hotel as the mother and father were discussing resources. The father was found hiding in the bathtub and arrested. Da'Mon's mother stated that she did not want to press charges against the father

because she wanted to work on being a family. Da'Mon's mother signed a safety plan which stated that the father would not reside in the home and he would only have supervised contact with the children. At the time of the visit, the maternal grandmother arrived and agreed to contact CPS should the father return. She also signed the Safety Plan. Documentation indicates that the case would be referred to Family Based Safety Services (FBSS). A staff meeting was held on April 2, 2014 regarding the case transfer. It was determined at the staff meeting that CPS investigative staff would file an order to participate for the parents to work services and that the safety plan would be updated to state that the father will have no unsupervised contact with the children and that the mother cannot supervise.

OCS Assessment:

- CPS staff was aware that this was the second domestic violence incident between the parents and that the father had been arrested, but did not make contact with him. Staff also failed to notify the father that a safety plan was signed by the mother which restricted his contact with the children.
- Although the mother admitted that the father left the children alone while assaulting her and she did not want the father arrested, CPS allowed the children to remain in the home with the mother regardless of her inability to protect her children.
- The implemented safety plan did not detail who was approved to supervise the father's contact with the children. The safety plan form used was a Spanish form. The family does not speak Spanish.
- Staff did not discuss with the mother her plans for child care after the father was arrested. The father was the primary caretaker most days.
- Although there is indication that the case was referred to ongoing services, there is no documentation that CPS staff discussed ongoing services with either parent.
- The children were observed four times during the investigation; however staff documented a description of the children only once.
- It was reported that on March 30, 2015, the FBSS worker contacted the CPS Investigative worker to report that the father, mother, and children were all present in the home. The investigator explained that a third party should be supervising the father at all times around the children, but CPS had not specified who was approved to supervise the contact. No follow up was made to address the issue.

On **April 3, 2015**, a report was received that Da'Mon was deceased. The report stated that on that day, the father was at the family hotel room home with the children while the mother was at work. The maternal grandmother stopped by the home during the day. Around 6:45pm the mother returned from work and the father walked out of the room holding Da'Mon. It was reported that Da'Mon had been deceased for several hours.

Da'Mon's two surviving siblings were placed in Temporary Managing Conservatorship of CPS. Both children were taken for a medical evaluation. Da'Mon's twin sibling was admitted into the hospital after a skeletal survey and computed tomography (CT scan) indicated results of non-accidental trauma. The medical examiner's office also expressed concerns relating to non-accidental trauma found during Da'Mon's autopsy. The investigation found the death of Da'mon was caused by neglectful supervision and concerns of physical abuse and his twin brother's injuries were consistent with a near fatality from physical abuse.

Overall Case Review Findings and Recommendations

Da'Mon was born premature and remained in the hospital for almost two months following his birth. Approximately six weeks after discharge, CPS received the first report regarding the

family. After another report was received, CPS identified that the family was in need of additional assistance when Da'Mon died.

During the review of a child fatality, certain areas of improvement may be identified including individual training needs, statewide trainings, policy revisions, updates to best practice guidance, and/or revisions to state statutes.

The Office of Child Safety recommends evaluating the following:

- Require CPS staff to obtain medical records when investigating allegations of medical neglect.
- Provide refresher information to CPS staff on how to effectively utilize regional Nurse Consultants, Forensic Assessment Center Network, or other medical resources when investigating medical neglect cases.
- DFPS is currently involved in a task force on domestic violence. Recommend that CPS state office and regional DFPS Family Violence liaisons review the report that will be provided by the task force to develop protocol implementable by CPS staff when a parent confirms current or past domestic abuse. The protocol and engagement strategies should be developed and shared in conjunction with local community resources per region. The protocol should include resources for the family as well as information regarding the effects domestic violence has on children.