TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

COMMISSIONER
John J. Specia, Jr.

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

On June 24, 2015 during an open Child Protective Services (CPS) investigation, August Smith drowned. Her two siblings, Anthony Smith and Trishawn Smith, also drowned. CPS was involved with the family at the time of the deaths due to concerns relating to sexual abuse of a younger sibling.

The Office of Child Safety completed a review of all current and past CPS involvement concerning August Smith, Anthony Smith and Trishawn Smith. This report presents the Office of Child Safety's findings, summary of CPS involvement and actions taken, assessment of strengths in casework practice, and areas for improvement that merit further examination.

Family Composition

Region 3- Dallas County

Name or Relationship to August, Trishawn, and Anthony Smith	Age at time of incident
August Smith	10 years
Trishawn Smith	9 years
Anthony Smith	11 years
Mother	30 years
Mother's paramour	40 years
Sibling	13 years
Sibling	6 years
Sibling	3years

Summary of CPS History on Family of August Smith, Trishawn Smith and Anthony Smith

- On September 16, 2014, CPS received a report alleging abuse and neglect of August, Trishawn, Anthony and their three siblings by their mother. This report was closed at intake and not investigated.
- On June 18, 2015, CPS received a report alleging sexual abuse of a sibling. The report is being investigated.
- On June 24, 2015, CPS received a report of the death of August Smith while under her mother's supervision. Two other children also drowned at the same time but were not pronounced deceased until June 25, 2015..

Detailed Account of CPS History on Family of August Smith, Trishawn Smith and Anthony Smith

On **September 16, 2014,** CPS received a report alleging abuse and neglect of August, Trishawn, Anthony and their three siblings, by their mother. This report was closed at intake and not investigated. The allegations indicated the mother was at a domestic abuse shelter with her children and concerns were expressed about the children not being enrolled or attending school. The intake alleged that the children did not speak and were not allowed to speak without the presence of the mother. The intake alleged domestic violence between the mother and one of the fathers as the reason the family was at the shelter. There was also a concern expressed about the mother leaving the domestic abuse shelter prior to shelter staff being able to assist the mother in enrolling the children in school. The whereabouts of the mother and children were not known at the time of the intake.

OCS Assessment:

- According to CPS Handbook policy 2150, DFPS is authorized to determine, after contacting a professional or other credible source, whether a child's safety can be assured without further investigation. There were not sufficient questions asked of the reporter to determine if the children's safety could be assured. At the time of the intake, the family's whereabouts was unknown; the family could have returned to the home where the domestic violence was occurring. There were no questions asked regarding the alleged perpetrator of the domestic violence and how much access he had to the children. There were no questions asked regarding the background history the mother provided to get into the shelter. There were no questions asked about why the shelter staff felt the children did not talk, the mother's parenting abilities or her protective capacities.
- According to DFPS policy 2156.1, a supervisor must obtain approval from a program director to approve an intake for closure. There is no documentation reflecting a staffing with a program director was conducted.

On **June 18, 2015**, CPS received a report alleging sexual abuse of one sibling by another sibling. The report alleged that the mother found two of her children in the bathroom with no clothes on. After finding the two children, the mother spanked the alleged perpetrator and he/she subsequently ran away from the home. After the alleged perpetrator was found by law enforcement, the mother disclosed her observations which prompted a criminal investigation. The alleged victim was forensically interviewed and provided information that validated sexual abuse. There was information obtained during the investigation that suggested the mother and the other children knew of the sexual abuse occurring in the home. The mother continued to leave the children home alone with the child/alleged perpetrator of the sexual abuse. A safety plan was implemented stating five of the children would remain in the care of the mother's paramour while the mother took the alleged perpetrator back to her Dallas apartment. The mother reported her neighbor in Dallas, who runs a daycare, would assist her in watching the child if she needed to go back to Irving if her paramour had to work. The safety plan also stated the child would not have access to his/her siblings, that the mother would allow the siblings to participate in forensic interviews and the parents would not discuss the details of the allegations with the children. Three siblings were forensically interviewed on June 22, 2015. One of the siblings disclosed that the child attempted to coerce him/her into allowing them to touch him/her inappropriately by bribing with food and toys. All the siblings disclosed to having knowledge of the sexual abuse by the child and the child watching pornography in the home.

OCS Assessment:

- The case was initiated timely, by night response, and the CPS history was summarized/reviewed by staff.
- The safety plan did not address all aspects of child safety. The mother was in a domestic violence shelter within 8 months of the current investigation and the mother reported being involved with her paramour for the past 5-6 years. There was no questioning about his involvement in the past domestic violence to determine he was a safe and appropriate caregiver.
- A Parental Child Safety Placement was not implemented although the current safety plan required for the children to reside outside of the mother's residence and could not return to the mother's residence safely with the child/alleged perpetrator still in the home.
- The neighbor who was supposed to be assisting the mother in caring for the alleged perpetrator in Dallas was not interviewed nor was a background check completed to ensure she would be an appropriate caregiver. The caseworker was made aware the neighbor had a daycare in her home; however, there were no stipulations or concerns addressed about the child/alleged perpetrator being around the daycare children.
- CPS caseworker worked well with law enforcement. A joint investigation was conducted according to policy.
- Per CPS policy 2250 regarding home visits, since there was a child under the age of 5yrs old living in the home, photographs of both residences should have been taken.
- The case was transferred to "day staff" on June 19th, 2015 and that caseworker attended the forensic interviews on June 22, 2015. There was no follow-up by the new caseworker after the forensic interviews to conduct a plan for child safety and future direction of the case. The detective on the case advised the caseworker that the alleged perpetrator was staying at a neighbor's house while the mother was at the forensic interviews; however, the caseworker failed to follow up and obtain appropriate collateral information on the neighbor.

During the open sexual abuse investigation, a CPS report was received on **June 24, 2015,** regarding the drowning of August Smith. Two of the siblings, Trishawn Smith and Anthony Smith, passed away on June 25, 2015, due to the same incident. The report alleged that the mother was in the pool with five of her children; the mother and her two younger children were by the steps in the shallow end of the pool while the three older children were playing near the deep end of the pool. The mother reported being distracted by her 3-year-old child and while attending to that child for a minute, the pool area became quiet and she noticed her three older children were missing. The mother reported the pool water was murky and you could not see the bottom of the pool. It was reported that neither the mother, nor any of her children, could swim. The investigation found that there were concerns for a lack of appropriate supervision when the children drowned.

Overall Case Review Findings and Recommendations

Child Protective Services (CPS) became involved with the family six days prior to the first child's death. During the investigation, a safety plan was implemented, a medical exam was completed and forensic interviews were conducted within the first six days of the investigation. While the family was at the apartment pool, August, Trishawn, and Anthony Smith drowned.

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.

Child Protective Services is currently implementing a full practice model with specific practice guides on how to best engage and assess parents and caregivers. Part of this work includes having parents identify and discuss specific changes and actions needed to address child safety and the parent's ability to meet the needs of the child. This includes staff asking parents how they will ensure the safety and well-being of their children in the future.

The Office of Child Safety is currently working with the Department of State Health Services and the State Child Fatality Review Team to partner with communities to provide water safety information and safety outreach.

The Office of Child Safety recommends evaluating the following:

- Work with staff on understanding the importance of speaking to potential caregivers regarding their ability to care for the children and abide by the safety plan in addition to running criminal background checks prior to the potential caregiver being made a monitor.
- Staff need to ensure that there is timely response by the day field staff in situations where night staff initiated the case. The caseworker who receives a case already initiated by another worker must not assume all the casework is complete. The new caseworker and supervisor should check the persons list and safety plan to ensure all safety measures have been exhausted and follow up immediately on any outstanding tasks.