TEXAS
Department of Family
and Protective Services

# 2022-2023 Citizen Review Team Report

---

March 2024

# Table of Contents

# 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 the requirements of paragraph (4) 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 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.

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 staff casework and decision-making related to child protective investigations. Six of DFPS' regions are designated as meeting the requirements of CAPTA Appendix I, and include Regions 1, 3E, 3W, 6 (6A and 6B), 7, and 11. These regions represent a mixture of urban and rural communities and reflect a broad range of issues encountered by DFPS statewide. This report consists of information concerning the issues addressed by the Citizen Review Teams, including the teams in the six CAPTA regions.

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.

### Structure

As required, 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 staff assist the Citizen Review Team with coordination, team development, training, and statewide distribution of team reviews and recommendations. DFPS staff 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 2022 through September 2023 (FFY 2023). Information presented consists of data gathered by all Citizen Review Teams, including CAPTA Citizens Review Teams. In FFY 2023, 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 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 Committees 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. Reports of the meetings were documented on the DFPS Notification of Child Fatality – Part C Form.

## Agency Response

The Citizen Review Teams often present recommendations for local Child Protective Investigations and Child Protective Services direct delivery staff 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 and recorded on the standardized reporting form. Required actions relating to case-specific recommendations are handled at the regional level.

All Citizen Review Team recommendations with statewide implications are placed on the DFPS public website after approval of the annual report. As required by CAPTA, DFPS will provide a written response to each recommendation within six months, and the updated annual report publicized.

The annual Citizen Review Team Report can be found at:
https://www.dfps.state.tx.us/Investigations/CRT/default.asp.

**Team Activities**

The Child Safety Specialists within the Office of Child Risk and 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 Risk and 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. In an effort 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 and Child Protective Services cases, each Citizen Review Team reviewed and discussed the CAPTA State Plan during regularly scheduled meetings. There were also four meetings held that specifically focused on reviewing the CAPTA State Plan.

**Analysis**

During FFY 2023, the Citizen Review Teams reviewed 79 child fatality or serious injury cases. At the time of the fatality, of these cases 19 had an open investigation, and one had an open conservatorship case. No recommendations were given in 25 of these reviews.

Recommendations that were given or concerns noted were in the following areas: Safety and Risk, Policy and Practice, Training Needs, and Coordination with External Entities, as well as some miscellaneous topics.

If the recommendation or concern 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 seen as areas needing improvement. There were also several recommendations that required legislative changes or new legislation. In those

situations, the team members were encouraged to reach out to their representatives to address their concerns. Recommendations that were noted to have a statewide scope are listed below.

# Chapter 1 - Safety and Risk

### Recommendation 1

Several teams recommended more training around how to talk with safety monitors, non-offending parents, collaterals, and service providers to better assess child safety. The training would help staff identify relevant collaterals and interview them in a systematic, purposeful manner to help staff make informed safety decisions. This would include information in the following areas:

- Contacting medical collaterals early in the investigation if injuries were reported but not seen by the department.
- What to ask medical providers for children with medical or mental health diagnosis.
- What to ask service providers to ensure progress in services, to include the need to review the actual therapy notes.
- How to communicate the department's concerns/worries for the parent's behaviors to safety monitors or relatives given Permanent Managing Conservatorship (PMC), how they can recognize unsafe behaviors, and what their responsibilities are long-term steps they need to take.
- If the non-offending parent lives outside the household of concern, what questions should be asked regarding the child's care.
- Improved assessments of alternate caregivers/extended support/safety monitors that will be helping care for children.

### Recommendation 2

When there is an open case and there is a pending legal situation occurring as it relates to custody of a child, and the department has concerns with one or both parents; a legal staffing should be held to determine what intervention or recourse could occur to ensure child safety.

### Recommendation 3

Several teams made recommendations regarding gun safety and how staff should discuss how to safeguard the children in the home from any guns in the household. Specifically, the department should provide gun locks and/or a locked gun box to families who own firearms, as well as refer the adults in the home to a gun safety course.

# Chapter 2 - Policy and Practice

### Recommendation 1

Several teams recommended more oversight on cases involving a child with a Primary Medical Need. This could include required follow-up contacts with the child and family after initial visit, along with mandatory medical collaterals and referrals to services in the community.

### Recommendation 2

Staff should be required to confirm medical needs are being met in every case on every child, regardless of the allegations.

### Recommendation 3

The department should develop a special classification for cases involving non-verbal children to help prioritize the need for the case to be more closely monitored, outside of current requirements.

### Recommendation 4

Specific criteria should be outlined in policy to indicate when a closing family team meeting should be offered to a family, especially when high risk factors are identified.

### Recommendation 5

Template style documentation should not be allowed in the documentation narrative and interview templates should only be used as a guide. More than one team indicated the use of templates made the interview more of a check-list, shutting off the caseworkers critical thinking skills and their ability to ask the needed follow up questions.

### Recommendation 6

Case Closure or Case Resolution staffings should not be used in certain circumstances which may include (but not limited to): Children with special needs (medical, intellectual, or developmental), non-verbal children, or high risk.

### Recommendation 7

Several teams recommended a mandatory referral be made when there is a special needs child (medical, intellectual, or developmental) in the home. This could include referrals to:

- Family-Based Safety Services to ensure the family is connected to services and training.
- The case management program through Department of State Health Services.
- A home visiting program to help the family navigate the medical community and services. These programs typically have a nurse work with the family by teaching, demonstrating, monitoring, and assessing the needs of the family.

**Recommendation 8**

The department should establish a process to ensure young children are completing medical evaluations when they exhibit delays that may impede their ability to make disclosures.

**Recommendation 9**

The department should develop formal protocols for staff to engage Children's Advocacy Center staff and law enforcement to help them determine when forensic interviews are warranted for sexual abuse and physical abuse cases.

**Recommendation 10**

Priority 1 intakes that involve a non-verbal child should never be downgraded and should require a staffing with a program director.

**Recommendation 11**

Law enforcement and/or emergency medical services calls to the home should be summarized and documented in every case. This will help ensure there is a clear picture of the number of times first responders have been to the home, and the outcome of each call, as these may not have resulted in a referral to the department. This is critical information, specifically in cases where domestic violence is or has been a concern.

**Recommendation 12**

A Texas Integrated Eligibility Redesign Project (TIERS) search should be done on every case.

In the case reviewed, a TIERS search could have linked the sibling to this family. His interview and information about his brother and the lack of supervision could have been beneficial in assessing safety of the deceased child, prior to the fatal event occurring.

**Recommendation 13**

A legal staffing should be mandatory every time a family becomes uncooperative and there are allegations of substance abuse and a child is under the age of five.

**Recommendation 14**

Policy should be updated to ensure there is clear communication between the department, Mexico's Desarrollo Integral de la Familia (DIF), and the department's DIF liaison to obtain information from contacts made by DIF during an open investigation.

In the case reviewed, a DIF referral was sent in an attempt to contact the family caregivers and infant in Mexico, but the department did not follow up to determine the outcome of DIF's actions.

**Recommendation 15**

Policy should be updated to require follow up contacts with relatives that were given Permanent Managing Conservatorship of children to ensure the child remains safe and under their care after the department is dismissed.

**Recommendation 16**

There were numerous recommendations related to the need for the department to provide staff with updated direction and policy guidelines with regard to substance use/abuse concerns and drug testing. This would include:

- Criteria on which type of drug test is appropriate for the caregiver based on the circumstances and concerns reported.
- When to complete the initial testing and follow-up testing.
- Having the Substance Abuse specialists train staff on how different illicit drugs impact a parent/caregiver's functioning and ability to care for children
- Determining child safety if parent/caregiver declines to submit to drug testing.
- Standardized disposition guidelines for parent/caregiver that is unwilling to drug test.

**Recommendation 17**

The department should request patient records and notes from service providers to search for patterns in treatment, see what clients are telling service providers, and see if any progress is being made. If after review of notes no progress is being made, treatment efficacy needs to be considered. Request to have a statutory change with regard to communicating with professionals about cases. Staff should be able to speak openly and have free conversations without having to worry about violating confidentiality. This should extend to all providers to include private providers. The department should have access regionally to a "subject matter expert" or psychiatrist/psychologist who staff can utilize to help evaluate mental health treatment plans for effectiveness. If treatment is not efficient or working, this subject matter expert could assist in helping to identify a more helpful treatment plan which would help to facilitate true change within the individual and family.

**Recommendation 18**

The department should have a formal process in place when cases are transferred from one county or region to another to ensure a staffing and/or certain communication occurs.

# Chapter 3 - Coordination with External Entities

**Recommendation 1**

The department should establish clearer guidelines when working fatality cases with law enforcement as it relates to contacting the family, as there should not be a delay in interviews being conducted and overall safety being assessed.

In the case reviewed, the department was asked by law enforcement not to interview the home members, which delayed the department obtaining information about the surviving siblings and potential relatives for placement. The team understood that interviewing the family about the allegations could interfere with the criminal investigation, however interviewing for social history should still be allowed.

**Recommendation 2**

There should be procedures or a system in place to alert or notify the department when a parent has had previous removals or is missing and has a new child.

In the case reviewed, the mother was pregnant and did not have any of her children in her care, however the timeframe for notification as a Vital Statistics case had passed. There is local protocol in place (for one county in this team's area) where a pregnant individual can be placed on the "watch list" with the local hospitals, however, the team recommended something similar be done across the state, so the department is alerted when a new child is born into a family with concerning history or is at high risk of abuse and neglect. This would also include improved communication with hospitals and medical staff to make a report when a high-risk for abuse/neglect mother gives birth.

**Recommendation 3**

There were numerous recommendations made regarding providing training to external partners. The trainings would discuss when and how to report to the department, joint investigation procedures when a serious injury or death occurs, general investigation procedures and timeframes, what services and supports are provided by both agencies, and overall goal to improve relationships and collaborative training. The external partners mentioned included:

- Medical personnel in hospitals and clinics
- Home Health agencies
- Law Enforcement agencies
- Domestic Violence partners
- District and County Attorney offices

# Chapter 4 - Training Needs

**Recommendation 1**

Training should be developed to emphasize writing skills, and how the investigation narrative should read to ensure that complete sentences are being used and to help cut down on the excessive grammatical errors.

**Recommendation 2**

There were numerous recommendations regarding the need for critical thinking training. This would include:

- Training regarding the importance of gathering and documenting detailed information versus generic information.
- Training for management level staff regarding how to mirror the information that staff provides to them during staffing's to promote critical thinking.
- Training on how to ask follow-up questions.

**Recommendation 3**

Staff need more training on the topics to discuss with families with young children. This should include, but not limited to:

- Hygiene
- Daily routines such as how often diapers are changed, what does bath-time look like, how often is the child fed (include what is a typical meal), is bedtime consistent, etc.
- How to educate parents on the basics as staff should not assume a parent knows what or how to care for an infant.

**Recommendation 4**

There were several recommendations regarding the need for more training on how to research, read, and use information learned from DFPS history to help make informed decisions in the family's current case.

**Recommendation 5**

Training regarding Post-Partum Depression to include how to recognize symptoms which may affect safety, interventions, and how to safety plan with family members.

**Recommendation 6**

Specialized training on interviewing collaterals as staff need to learn how to identify relevant collaterals and interview them in a systematic, purposeful manner to help staff make informed safety decisions.

**Recommendation 7**

Staff should receive training on how to gather sufficient information which includes any medication taken by the child and/or caregiver and be able to assess how it may impact their functioning.

**Recommendation 8**

Investigation workers and supervisors should be adequately trained on the steps to take when they are investigating serious abuse cases including learning when young children need to undergo additional evaluations or full skeletal exams when there is history of abuse.

### Recommendation 9

The department needs to provide training to ongoing services staff (i.e. Family-Based Safety Services and Conservatorship) on how to enter legal actions in the documentation and to clearly document the actions of the final court orders (i.e. who has legal custody, what type of custody the legal guardian has, were the rights of the parent's terminated, what type of contact was ordered between the child(ren) and parent, and etc.).

## Chapter 5 – Miscellaneous

### Recommendation 1

Look into the hiring criteria for caseworkers, as it relates to the prerequisites and qualifications. Specifically, working to recruit social workers for Child Protective Investigations.

### Recommendation 2

Track data regarding family members not reporting concerns or not following safety plans that result in bad outcomes (Perhaps add to 2701 form or Utilize local CFRT to collect data that can be used).

### Recommendation 3

More positive stories in the news and on social media about the department. This could educate the community on the services and supports the department can offer and clarify any misconceptions. Specifically, there is a need to reach the current generation, who depend on alternative social media outlets for information, via those outlets.