TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

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

On July 29, 2015, Hannah Davis passed away due to inflicted, abuse-related injuries. Hannah, who was born on August 4, 2014, had been residing with her mother, her mother's boyfriend, and two of his children. Hannah's half siblings would also visit and stay overnight in the home. CPS has a history of involvement with Hannah's family, as well as the mother's boyfriend's family.

The Office of Child Safety (OCS) completed a review of all current and past CPS investigations concerning both families. 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 Hannah Davis's family and the death of Hannah that merit further examination.

Family Composition

Region 7 - Bell County

Name or Relationship to Hannah	Age at time of incident
Hannah Davis	11 months
Half-sibling	8
Half-sibling	6
Half-sibling	11
Mother	27
Mother's boyfriend	27
Boyfriend's child	2
Boyfriend's child	5

Summary of CPS History on Family of Hannah Davis

- On September 8, 2009, CPS received a report regarding Hannah's family. The allegations were of neglectful supervision. The investigation was closed on November 13, 2009.
- On March 28, 2010, CPS received a report regarding Hannah's family. The allegations were of physical neglect. The investigation was closed on June 5, 2010.
- On June 19, 2010, CPS received a report regarding Hannah's family. The allegations were of neglectful supervision.
    - On September 15, 2010, CPS received Temporary Managing Conservatorship (TMC) of the children.

    - On September 24, 2010, the family agreed to work Family Based Safety Services (FBSS) and the case was referred for services.
    - On September 30, 2010, the legal case for TMC was non-suited.
    - On October 15, 2010, the investigation was closed.
    - On March 24, 2011, the Family Based Safety Services case was closed.
- On August 4, 2014, Hannah was born.
- On February 23, 2015, CPS received a report regarding Hannah's half-siblings. The investigation was closed on April 22, 2015.

Summary of CPS History on Family of Hannah's mother's boyfriend

- On December 1, 2013, CPS received a report regarding the family. The allegations were of neglectful supervision.
    - On January 23, 2014, the investigation was closed and case referred to Family Based Safety Services.
- On April 22, 2014, CPS received a report regarding the family. The allegations were of neglectful supervision and physical abuse.
    - On May 5, 2014, CPS received TMC of the children.
    - On May 15, 2014, FBSS was closed.
    - On June 4, 2014, the investigation was closed.
    - On November 6, 2014, the children were returned to their father.
    - On April 2, 2015, CPS was dismissed from the legal case.
    - On May 8, 2015, the CPS case was closed.
- On June 16, 2015, CPS received a report regarding the family. The allegations were of physical neglect. The investigation was closed on July 9, 2015.

Detailed Account of CPS History on Family of Hannah Davis

On **September 8, 2009**, CPS received a report regarding Hannah's family. Allegations included concerns of neglectful supervision (Hannah was not yet born). Concerns stated there was drug use by the parents and that a year prior, one child had been climbing on a dresser and a television fell on the child.

The allegations were determined to be ruled out. Staff contacted law enforcement regarding the family and no concerns were reported.

OCS Assessment:

- The investigation has been purged from the CPS database and further information could not be obtained regarding details of the case.

On **March 28, 2010**, CPS received a report regarding Hannah's family. Allegations included concerns of physical neglect (Hannah was not yet born). Concerns were regarding an infection a child had.

The allegations were determined to be ruled out, as staff were able to observe prescribed ointment and healing stages of the infection. Notes indicate that the parents were appointed temporary joint managing conservatorship of the children with father as the primary conservator. The mother was to have standard visitation with the children under supervision until she was able to produce a clean drug test.

OCS Assessment:

- The investigation has been purged from the CPS database and further information could not be obtained regarding details of the case.

On **June 19, 2010**, CPS received a report regarding Hannah's family. Allegations included concerns of neglectful supervision to Hannah's three older half siblings by Hannah's mother and father of the children (Hannah was not yet born). The report stated that a five year old child was found wandering in the woods dehydrated and sweating. The child had been in the woods with an uncle and ran away. Law enforcement returned the child home, however, the mother was not home because she was in the woods searching for the child. There was concern that the mother had not contacted law enforcement regarding child missing child.

The allegations were determined to be reason to believe for the neglectful supervision of the two older children by their mother and father; the allegations for the neglectful supervision of the youngest child by the child's parents were found unable to determine; and neglectful supervision of the oldest child by the child's uncle was ruled out. It was determined that the child did get accidentally lost during a walk with the uncle in the woods, then returned by law enforcement. Initially, it was reported that the mother resided in a separate residence from the children and their father. The father stated the children would only visit with their mother when she tested negative on drug tests. During the investigation, the mother admitted to current use of methamphetamines. For his part, father denied any recent drug use but tested positive for marijuana. The older two children were seen unattended outside of the home several times by staff while making unannounced visits. The parents originally agreed that the mother would not have unsupervised contact with the children due to her admission of methamphetamine use, however, concerns arose during the investigation that she may have moved back into the home and was having intermittent contact with the children, possibly without supervision, while continuing illegal substance abuse. The family eventually became uncooperative with CPS and the removal of the children into DFPS' Temporary Managing Conservatorship (TMC) was granted on September 15, 2010.

Once TMC was obtained, the parents refused to inform staff of the children's location. Two days later, the parents allowed staff to retrieve the children for foster home placement. A week later hair follicle drug tests returned negative for both parents. The parents informed staff that they were willing to participate in Family Based Safety Services (FBSS) and allow staff to have contact with the children when asked. On September 30, 2015, the court approved court ordered services and dismissed DFPS' TMC of the children.

The parents minimally engaged in services during the FBSS case. They completed psychological evaluations and home based parenting education, and remained drug free. They also initially attended Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) meetings. Although the parents did not complete all services recommended, they were provided with community resources related to childcare, substance abuse, and parenting education should they be needed in the future. The court ordered services were dismissed and the FBSS case was closed on **March 24, 2011**.

OCS Assessment:

- The plan to control for safety of the children during the investigation did not include measures to address the mother's active substances abuse and inability to safely care for the children as the mother continued to have access to the children while using illegal substances.

- Lack of timely follow-up by staff to monitor that safety measures were being adequately maintained.
- Staff intended to refer the case to FBSS, however, allowed a month to lapse without contacting the family. Upon contact with the family after a month, they were no longer willing to cooperate.
- The FBSS case was staffed for three visits a month with the family. Staff did not visit with the family three times monthly, but did maintain contact with the family.
- Interviews and observations of the children during visits were not extensive.
- The mother did not receive impactful treatment to address her substance abuse issues as she needed more intensive services such as outpatient or inpatient drug treatment to address her specific issues.
- Staff did not communicate with service providers regarding the progress of the parents or the ability of the parents to be protective.

On **August 4, 2014**, Hannah was born.

On **February 23, 2015**, CPS received a report regarding the family. Allegations included concerns of neglectful supervision and physical abuse. The report stated that a father of some of the children in the home hit the children with a belt while asleep, waking them up. It was believed he was under the influence of drugs at the time. The mother's whereabouts were unknown, but was also reported to use "hard drugs" with the father daily. The children were also reported to be seen outside without supervision.

The allegation of physical abuse was determined to be ruled out. The allegations of neglectful supervision were closed administratively. Staff interviewed Hannah's three older half siblings and no concerns were noted. Staff contacted their father via telephone to schedule an appointment and for a drug test. The case was then discussed with investigation supervision staff and closed.

OCS Assessment:

- The case was very minimally worked, as staff initially made contact with an aunt and uncle on February 25, 2015, then allowed the case to lapse for over a month before making contact with the children.
- Staff did not initiate the case timely. The children were not interviewed until over a month after the report was received.
- Staff initially met with an aunt and uncle of the children regarding the investigation. The aunt stated the investigation did not make sense as her children were not the ages of the reported children and she could not be the person mentioned in the report. Staff did not make contact with the aunt and uncle's children or update the person list to reflect the relationship of the aunt and uncle to the children interviewed.
- Staff spoke with the children's father, who stated he would only agree to a hair follicle test and would contact staff at a later date to schedule an appointment in person. Staff did not follow up with the father, but instead closed the case without meeting with him in person for an interview.
- Staff did not attempt to meet with the children's biological mother, who was reportedly living in the home according to the uncle who was interviewed.
- No drug tests were administered.
- A home visit did not occur, as the uncle was interviewed outside of the home.
- It is uncertain who was residing in the home, as staff did not fully explore this. Background checks were not completed during the investigation.

Detailed Account of CPS History on Family of Hannah's mother's boyfriend

On **December 11, 2013**, CPS received a report regarding the mother's boyfriend's children. In the home were the boyfriend, his two children (aged one and three at the time of the report), and the mother of the children. Allegations included concerns of neglectful supervision of the children by their mother. The concerns stated that the mother appeared to have untreated mental health concerns that placed the children at risk while under her care.

The allegations were determined to be reason to believe for neglectful supervision of the children by their mother. The mother admitted to use of marijuana to calm herself while caring for the children. The mother admitted she needed medical attention for her mental health concerns and was unable to care for the children due to her mental state. The children were placed in a Parental Child Safety Placement (PCSP) with their paternal grandmother, as their father was unable to leave work and assume responsibility. The father later tested positive for marijuana. The investigation was completed and the case transferred to Family Based Safety Services (FBSS) on **January 23, 2014**.

During the FBSS case, the father appeared to engage in counseling services while the mother was to work services for her mental health concerns. The children were initially placed with their paternal grandmother and then returned to their father once he tested negative on drug tests. The mother did not maintain contact with CPS during the FBSS case.

The father was in the process of seeking legal primary custody of the children until a new CPS report regarding the family was received. On **April 22, 2014**, CPS received a report regarding the children. Allegations included concerns of neglectful supervision and physical abuse to both children by the father, a paternal aunt to the children, and the aunt's boyfriend. The report stated that both children (aged one and four at the time of the report) resided with their father. The youngest child was found to have multiple injuries, including a broken right humerus bone, swelling to the right arm, a ruptured ear drum, a bruised black eye, and bruises on the child's back. The child was in the care of the aunt and her boyfriend at the time the child was taken to the hospital with the injuries.

The allegations of neglectful supervision were determined to be reason to believe. The allegations for physical abuse were listed as unable to determine. The child was found to have a recent fracture to the right arm and a previous fracture to the left arm. The injuries were determined to be non-accidental trauma by medical professionals. It was unclear when the injuries occurred, as the child had been in the care of multiple individuals prior to enduring the injuries and the exact date of when the injuries were sustained could not be determined. Additionally, the aunt's boyfriend admitted to recent methamphetamine use. The children were again placed in a PCSP with the paternal grandparents, then later moved to a PCSP with a family friend because the paternal grandmother did not believe the injuries were inflicted and did not appear protective.

On **May 5, 2014**, DFPS was granted temporary managing conservatorship (TMC) of the children. The children remained with the above-referenced family friend for almost two months in a kinship placement, and then were placed back in the home of the paternal grandparents. The father completed services including random negative drug tests, continuing employment, maintaining a safe and appropriate home, completing a psychological, successfully completing counseling, and participating in visits with his children regularly. The mother also engaged in services, but was not consistently participating in parenting classes, counseling, and drug

testing as requested. On **November 6, 2014**, the children were returned to their father for ongoing monitoring. The father and mother engaged in counseling sessions in order to better co-parent their children. On **April 2, 2014**, CPS involvement was dismissed by the court and joint managing conservatorship was given to the parents. The father was allowed to establish residence and supervise visits between the children and the mother. He was to increase and allow unsupervised contact with the mother as he felt comfortable.

OCS Assessment:

- Staff did not interview the paternal grandparents or visit the home prior to approving the PCSP.
- Staff did not interview the father in person or complete a full interview to include a social history assessment during the investigation.
- Staff did not attempt to locate the mother of the children during the new investigation.
- Case was not transferred to FBSS until three weeks after case was identified to need ongoing services.
- Staff did not communicate with service providers regarding the progress of the parents during the FBSS case. Minimal documentation with service providers was documented by staff throughout the case.
- Staff again did not interview the paternal grandparents or visit the home prior to approving the second PCSP.
- Staff did not appear to have conversations with parents or children regarding additional individuals who may be residing in the home.
- The physical abuse allegations were found unable to determine. The physical injuries had been determined to be non-accidental. While the perpetrator was unable to determine, the injuries met the definition of being abuse-related. A finding of reason to believe for physical abuse was supported and the perpetrator should be listed as unknown.

On **June 16, 2015**, CPS received a new report regarding the family. Allegations included concerns of physical neglect to the father's two children. The report stated there was no electricity in the home and there was concern for the children's health due to extreme temperatures. The report also stated there is a history of drug use in the home.

The allegations were determined to be ruled out. Staff met with the father and both children. Staff visited the home and observed running water, working electricity, working air conditioner, and food. The children were seen and interviewed and no outcries were made.

OCS Assessment:

- Staff did not attempt to contact the children's biological mother.
- The children's interviews were not extensive.
- There were no drug tests administered by CPS although there were allegations of drug use.
- The risk assessment was not completed.

On **July 29, 2015**, CPS received multiple reports regarding Hannah's death. Allegations were of neglectful supervision, physical abuse, and sexual abuse. Reports stated that Hannah passed away due to physical abuse while she was under the care of her mother's boyfriend. The allegation of physical abuse of Hannah by her mother's boyfriend was found reason to believe due to Hannah's death being caused by blunt force trauma while she was in the care of the boyfriend.

Overall Case Review Findings and Recommendations

Child Protective Services first became involved with Hannah's mother in 2009. At the time there were concerns of drug use. The children were temporarily placed into foster care until the parents agreed to work services. It appears that because the mother was unable to maintain consistent sobriety, the children's primary residence was with their father who would allow contact with their mother as he deemed appropriate. In 2015, the father of the children started to allow their mother to have contact with the children. The mother was now residing with a new boyfriend and his two children.

Child Protective Services had previously been involved with the boyfriend's family in 2013. At the time there were concerns of mental health by the children's mother. While services were being worked, one of the children was found with inflicted injuries. The two children were placed into the temporary custody of CPS. The father completed services and the children were returned to him in April 2015.

Both Hannah's half-siblings and the children of their mother's boyfriend were involved in CPS investigations as recent as April 2015 and three weeks prior to Hannah's death. Neither case appears to have been extensively worked. There is no mention of Hannah in either case. There is also concern that CPS was involved with the boyfriend/perpetrator of Hannah's death during the last few months of his CPS involvement with his own children; it appears this was unknown to staff working with Hannah's mother.

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.

As part of standard protocol after a child fatality, CPS reviews past investigations involving the family and the work of staff involved in those cases. Reviews and individual follow-up with staff of the investigations from 2015 have been completed at the local level at this time.

- CPS should consider developing guidance for all stages of service to determine if families involved with CPS have additional home members (adults or children) residing in the home. The guidance may need to include a series of questions to ask children and parents, as well as what to look for when completing home visits.
- CPS should consider creating guidance regarding drug testing when there are concerns of past drug use.
- In investigations where there is confirmed physical abuse but the perpetrator is unknown, staff should have guidance on how to disposition these allegations and how to work with a family to address child safety when the perpetrator is unknown or likely a household member/unable to determine.