TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

COMMISSIONER
H. L. Whitman, Jr.

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

On July 6, 2015, during an open Child Protective Services (CPS) investigation, Jakayden Peoples, died as a result of blunt force trauma. CPS was involved with the family due to concerns for abuse and neglect received on May 19, 2015.

The Office of Child Safety completed a review of all CPS involvement concerning Jakayden'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 Jakayden Peoples' family and the death of Jakayden that merit further examination.

Family Composition

Region 7 - Bell County

Name or Relationship to Jakayden Peoples	Age at time of incident
Jakayden Peoples	1 year 9 months
Mother	19 years
Mother's Paramour	21 years

Summary of CPS History on Jakayden Peoples / Family of Jakayden Peoples

- On May 19, 2015, CPS received a report alleging neglectful supervision of Jakayden by his mother's paramour. The allegations were being investigated when a subsequent report was received.
    - On July 6, 2015, CPS received a report involving the death of Jakayden. The reports were merged and the investigation is ongoing.

Detailed Account of CPS History on Family of Jakayden Peoples

On **May 19, 2015**, CPS received a report alleging neglectful supervision of Jakayden by his mother's paramour. Jakayden was taken to the emergency room due to an injury. Jakayden reportedly had been injured twice while in the care of Jakayden's mother's paramour. During the investigation, on May 19, 2015, the assigned caseworker observed Jakayden for signs of maltreatment. He was observed to have a ½ inch diameter bump on his forehead; however, no other injuries were visible on his face, stomach or back. Jakayden was reported to be non-verbal and when asked how he sustained the bump on his head, he pointed to a chair. Jakayden's mother reported that he had fallen off a chair while she was at work and her paramour was caring for Jakayden. His mother reported that about three weeks prior, Jakayden

had an open cut to his lip due to a fall while in the care of her paramour. She went on to explain the cut had become infected so she had taken Jakayden to his primary care physician at that time. A safety plan was implemented stating that Jakayden would not be left alone in the care of the mother's paramour. Jakayden's mother further agreed to go to the Texas Workforce Commission (TWC) the following day to apply for child care. She enrolled Jakayden in daycare and he was attending regularly. The mother's paramour was interviewed on June 16, 2015, and he stated that Jakayden had sustained the bump to his forehead after falling from a chair while sitting at the dining table.

During the open investigation, on July 6, 2015, Jakayden Peoples died while in the care of his mother's paramour as a result of blunt force trauma. The investigation is ongoing at this time.

OCS Assessment:

- Jakayden's mother's paramour was interviewed a month after the allegations were received.
- The allegations involving the bump to Jakayden's forehead were addressed with the mother's paramour; however, there was no discussion regarding the incident in which Jakayden reportedly cut his lip after a fall also while in the care of the paramour.
- Although the caseworker spoke with Jakayden's mother via telephone on June 17, 2015, and reiterated the agreement detailed in the safety plan, there was no face to face follow up with the family to renew the safety plan. The safety plan implemented on May 19, 2015, expired on June 20, 2015.
- The primary care physician and the emergency room were not contacted in regards to the injuries in which Jakayden required medical care. However, the discharge paperwork from the ER was viewed by the caseworker.
- Aside from the initial contact, the majority of the contacts including the safety assessment were not documented until after the child fatality report was received in July 2015. CPS handbook policy 2271 Time Frames for Completing a Safety Assessment or Reassessment, states in part*, "*The safety assessment must be documented within 24 hours of the priority response time".
- The caseworker documented that a referral to CPS Family Based Safety Services (FBSS) program was sent on June 15, 2015; however, there is no additional documentation regarding the outcome of that staffing. During a staffing regarding the child fatality, it was explained that additional investigative tasks were needed prior to determining whether the FBSS program was appropriate for the family.
- The last contact with Jakayden's family prior to his death was on June 17, 2015 via telephone; however, the last face to face contact was on May 19, 2015.

Overall Case Review Findings and Recommendations

CPS was in the process of investigating allegations of abuse and neglect involving Jakayden stemming from a report received on May 19, 2015. Jakayden's family has no CPS history as perpetrators prior to the report received in May 2015.

On May 20, 2015, after meeting with Jakayden and his mother in their home, a safety plan was implemented stating that Jakayden would not be left alone in the care of his mother's paramour. On June 15, 2015, the case was staffed with a CPS supervisor, who advised a follow up home visit be conducted and a referral made to CPS Family Based Safety Services program. There was one attempt to visit the home on June 16, 2015, which was unsuccessful. It appears there

was insufficient information gathered during the investigation at the time the referral was made to Family Based Safety Services on June 16, 2015, to determine whether the family required ongoing services. Although the caseworker reminded the family via telephone the safety plan would still need to be adhered to, attempts to update the safety plan in person were not made. The original safety plan expired two weeks before the report involving Jakayden's death was received.

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 the following areas for further analysis:

- Ensure all allegations are thoroughly addressed with the alleged perpetrator.
- CPS should consider supervisor directives include deadlines to ensure staff comply within reasonable time frames.
- Review purpose and importance of professional collateral contacts, such as medical staff, in assessing ongoing child safety.