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 March 8, 2015, during an open Child Protective Services (CPS) Family Based Safety Services case, Audrey Torres died in an auto accident, allegedly caused by her father while he was intoxicated. Prior to Audrey's birth, CPS completed two investigations involving an older sibling. Since Audrey's birth on October 23, 2011, CPS conducted two investigations into allegations that Audrey Torres had been abused or neglected.

The Office of Child Safety (OCS) completed a review of all current and past CPS investigations concerning Audrey'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 Audrey Torres family and the tragic death of Audrey that merit further examination.

Family Composition

Region 1 - Hall County

Name or Relationship to Audrey	Age at time of incident
Audrey Torres	3
Sibling	7
Father	24
Mother	25

Summary of CPS History on Audrey Torres / Family of Audrey Torres

- On August 3, 2009, CPS received a report of neglectful supervision and physical abuse of an older sibling. It was found unable to determine and closed November 18, 2009.
- On December 2, 2009, CPS received a second report of neglectful supervision. The investigation was closed on February 8, 2010 as unable to complete.
- On May 3, 2010, CPS received a third report alleging neglectful supervision. The investigation was ruled out and closed June 4, 2010.
- On October 30, 2014, CPS received a fourth report of neglectful supervision including allegations of active drug use with the children present. The investigation was found reason to believe for neglectful supervision and ongoing services were provided through Family Based Safety Services.

- On December 8, 2014, Family Based Safety Services began working with both parents to address concerns surrounding ongoing domestic violence in the home and substance abuse by both parents.

Detailed Account of CPS History on Family of Audrey Torres

On **August 3, 2009,** Audrey's mother and father were investigated for allegations of neglectful supervision and physical abuse of Audrey's older sibling due to domestic violence and ongoing methamphetamine and marijuana use while the child was present. There were additional allegations that the child must beg for food. Drug tests completed during the investigation were positive for marijuana. The child was placed out of the home with a paternal relative while the parents completed a drug assessment. That assessment recommended no ongoing drug treatment or counseling for the parents. The parents were drug tested again and were negative.

The allegation of neglectful supervision of Audrey's older sibling was found unable to determine as it was unclear how the mother's drug use affected her ability to provide care for the child. The allegation of physical abuse was ruled out as the child had no injuries and domestic violence was denied.

OCS Assessment:

- Staff identified that substance abuse may be a safety concern and referred Audrey's mother to complete drug assessment.
- A courtesy worker was assigned when the child was placed in a Parental Child Safety Placement with a relative in another area of the region.
- Staffings between the caseworker and the supervisor/program director were documented with clear guidance.
- The parents were interviewed together although part of the allegations involved domestic violence. The allegations of domestic violence were not explored with the parent.
- The reporter on the case was not contacted and the only collateral contact is with a worker at the apartment complex.

On **December 2, 2009,** concerns of ongoing marijuana use in the home were investigated. When the worker went to the home, the parents allowed the investigator to view the home and observe the child. The family then asked the worker to leave the home and refused to cooperate with CPS. The investigator staffed the case with the supervisor and was given guidance to attempt to re-engage the family before seeking legal intervention to order the family to participate in the investigation. The investigator attempted to contact the family, including by mail, but the family did not contact the investigator. Legal intervention was denied as there was not enough information in the intake to warrant orders for the family to cooperate in the investigation or participate in ongoing services.

The allegations of neglectful supervision of Audrey's older sibling were given a disposition of unable to complete as the family refused to cooperate in the investigation and legal intervention was denied.

OCS Assessment:

- The child was seen within 24 hours of receiving the report.
- Staffings between the caseworker and the supervisor/program director were documented with clear guidance.
- The investigator attempted to locate the reporter to gather more information.

- No collateral contacts were made to gather more information regarding the child's safety.

On **May 3, 2010,** CPS received a report that the father had to be rushed to the hospital due to an alcohol overdose. It was alleged that Audrey's older sibling was present in the home at the time of the medical emergency. During the investigation, it was found that the child had spent the night with another caregiver as the parents had been out to celebrate at a family event. The father was taken to the hospital but the mother had been sober. The allegations were ruled out as the child had been in the care of someone else at the time of the medical emergency.

OCS Assessment:

- The child was seen within 72 hours of receiving the report.
- The investigator made contact with several neighbors to assess the family's daily functioning and overall child safety.
- The father was not interviewed.
- The case was assigned to a Child Safety Specialist (CSS) for a full review but was closed prior to the CSS completing the review.

On **October 30, 2014,** CPS received a report that there has been domestic violence in the home between the parents while both Audrey and her older sibling are present. There were allegations that the father had child pornography on his cell phone and that there is methamphetamine use by the parents. Both parents were given hair follicle drug screens which both came back positive for methamphetamine, marijuana, and cocaine (father's test only). The children were placed in a safety plan with a maternal relative, stating that the mother could continue to reside with her children but must be supervised at all times. There was no evidence of child pornography and no charges were brought. The allegations of neglectful supervision were found reason to believe as there was drug use by both parents while caring for the children. The investigation was closed and Family Based Safety Services were opened on December 8, 2014.

OCS Assessment:

- The investigator completed a detailed interview with the older sibling and father.
- There appeared to be good communication between the investigator and law enforcement.
- The investigator followed up on allegations of drug use by other family members.
- The investigator attempted to initiate the investigation and meeting with the family within 24 hours of the intake.
- The children were placed in a safety plan on November 3, 2014, but the home was not seen until November 11, 2014. The home environment must be assessed prior to or at time of placing the children in a safety plan.
- An unrelated home-member/paramour to the caregiver had recent criminal history that was not fully assessed.

On December 8, 2014, Family Based Safety Services began working with both parents to address concerns surrounding ongoing domestic violence in the home and substance abuse by both parents. At the start of the FBSS case, the father had filed for divorce. The mother started engaging in services to address her mental health as well as ongoing counseling for both the mother and the older sibling. The children were in a safety plan until the beginning of March 2015. On March 1, 2015, the maternal relative hit the mother and was arrested. The mother moved the children to the home of another person previously approved by CPS to help provide

care of the children. Additionally, another relative was assessed as a possible place for the children to stay if needed.

Early in the morning of March 8, 2015, Audrey and her father died in a fatal car accident; her older sibling was life-flighted to the hospital. The mother and father had spent the previous night and early morning drinking alcohol. The mother had a panic attack and went to the local emergency room. The father went to the home of the approved caregiver for the children and removed them from that person's care. While leaving from that home, the father was in a car accident. While Audrey was in a car seat, it was not secured in the vehicle. She died at the scene. Her older sibling was ejected from the vehicle and severely injured with extensive head trauma. The investigation into the child fatality remains open.

OCS Assessment:

- There are detailed case consultations between the caseworker and the supervisor.
- The caseworker was able to engage quickly the mother in counseling services and had ongoing contact with the service provider to assess progress made in the sessions.
- The older sibling was engaged in counseling services to directly address the child's specific needs.
- The father was not engaged in services until the end of February 2015. The family service plan did not include tasks assigned to the father.
- The safety plan between the family, CPS, and the caregiver was clearly explained and reviewed with the family.
- No services appeared to directly address the drug use of the parents.

Overall Case Review Findings and Recommendations

Child Protective Services (CPS) conducted four investigations into allegations that Audrey Torres or her older sibling had been abused or neglected. In the first investigation, staff assessed risk concerns surrounding substance abuse but did not assess the allegations of domestic violence between the parents. Use of collateral contacts to fully assess child safety was limited. In the second investigation, staff was able to complete a cursory interview with the mother and assess the home environment. The parents refused any ongoing contact with the department and staff did assess the need for legal intervention. In the third investigation, staff did utilize collateral contacts to provide more information to support the case disposition. In the most recent investigation prior to the child fatality, the investigator completed thorough interviews with the family and identified the need for services to address child safety.

In the last investigation and subsequent FBSS stage of service, it was difficult to fully engage the father, as he was located in a county farther away from where the mother resided. A secondary (or courtesy) worker was needed to make contact and engage the father. This process took multiple months to complete. Services focused on the mother's mental health needs but did not address substance abuse by either parent.

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.

CPS is currently implementing a new practice model and assessment tools. These changes will help support staff assess child safety throughout the department's involvement with the family. It is designed to help staff determine child safety and needed protective measures to keep the

child safe. Included in this process is the addition of practice guidelines to provide ongoing training for all staff, including training surrounding notification and involvement of parents, caregivers, and support networks. Additionally, CPS is implementing new safety assessment and an actuarial-based risk assessment. Both assessments require a caseworker to assess the entire household and all primary and secondary caregivers in making safety and risk determinations. These additions to CPS' daily practice and protocol structure will help support better outcomes for families by strengthening the overall safety assessment in the home and further connecting the entire family with needed interventions.

In addition to the work that CPS is already undertaking, the Office of Child Safety recommends CPS exploring a more efficient way to request, assign and track cases that need secondary workers to engage parents or children residing in other locations across Texas. Strengthening this process will ensure that families are provided timely information, safety is continually assessed, and that there are no gaps in services or safety interventions.