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 January 31, 2016, during an open Child Protective Services (CPS) investigation and Family Based Safety Services (FBSS) case, Jerrell Jones died due to complications from asthma while visiting his father's residence.

The Office of Child Safety completed a review of all current and past CPS involvement concerning Jerrell Jones. 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 Jerrell Jones	Age at time of incident
Jerrell Jones	11 years old
Mother	29 years old
Mother's paramour	29 years old
Father	30 years old

Summary of CPS History on Family of Jerrell Jones

- On April 1, 2005, CPS received a report alleging medical neglect of Jerrell by his mother and his grandmother. This investigation was closed reason to believe with factors controlled.
- On December 9, 2009, CPS received a report alleging physical neglect of Jerrell Jones by his mother. The investigation was closed ruled out and purged from the system.
- On August 18, 2011, CPS received a report alleging neglectful supervision of Jerrell by his mother. This investigation was closed ruled out and abbreviated.
- On April 25, 2012, CPS received a report alleging medical neglect of Jerrell by his mother. The investigation was closed ruled out.
- On July 5, 2013, CPS received a report alleging medical neglect of Jerrell by his mother. The investigation was abbreviated and closed ruled out.
- On May 29, 2014, CPS received a report alleging neglectful supervision. The investigation was closed ruled out with factors controlled.
- On September 12, 2015, CPS received a report alleging medical neglect of Jerrell by his mother. This investigation was found reason to believe and the case was transferred to FBSS on November 10, 2015.
- On January 29, 2016, during an open FBSS case, CPS received a report alleging neglectful supervision of Jerrell by his mother.

- On January 31, 2016, Jerrell Jones died due to complications of asthma.

Detailed Account of CPS History on Family of Jerrell Jones

On **April 1, 2005**, the agency received a report alleging medical neglect of Jerrell by his mother and his grandmother. The report indicated that Jerrell was born premature with lung and breathing problems and he had a breathing machine in the home to assist with his problems. The report alleged the mother and grandmother presented Jerrell to a medical clinic on March 24, 2005, because the grandmother was concerned about his breathing. The mother had failed to bring Jerrell to his scheduled appointments in January and February 2005. The report alleged that the mother was arrested in the clinic because she stole money and billfolds during Jerrell's appointment in December 2005. During the investigation, the mother admitted she did not take Jerrell to his scheduled medical appointments out of fear she would get in trouble. The mother was able to show the caseworker she had all of Jerrell's necessary medication and supplies. The mother admitted to marijuana use but denied use of any other drugs. The mother signed a safety plan agreeing not to use marijuana, follow up with any criminal proceedings relating to her arrest and to make all follow-up medical appointments for Jerrell. The mother was referred to a new doctor for Jerrell because she was no longer allowed to return to his original clinic. The caseworker followed up with the new doctor's office and they confirmed Jerrell had been brought in for his appointment. The case was closed reason to believe for medical neglect of Jerrell Jones by his mother and his grandmother due to him missing medical appointments. The family was referred to outside resources.

OCS Assessment:

- Per CPS handbook policy at the time of the investigation, the case was not initiated timely.
- There were not sufficient safety measures taken after the mother disclosed to drug use.
- The grandmother was never interviewed, although she was listed as a designated perpetrator.

On **December 9, 2009**, the agency received a report alleging physical neglect of Jerrell Jones by his mother. The report alleges EMS had seen the child four times within one month due to breathing issues. The report alleged that the mother was not giving Jerrell his breathing treatments appropriately. An investigation revealed Jerrell had been seen by medical professionals, was prescribed proper medication and all of his medical needs were being met. The investigation was closed ruled out and purged from the system; therefore, OCS could not conduct a thorough review of the case or produce an assessment.

On **August 18, 2011**, the agency received a report alleging neglectful supervision of Jerrell by his mother. The report alleged that Jerrell was found wondering in his apartment complex and when Jerrell returned home, his mother was asleep and was not aware of him being outside. Jerrell was interviewed by a caseworker at school and did not make any outcry of abuse or neglect and was not found to have any marks or bruises. Jerrell's mother was interviewed and denied the allegations. The mother reported Jerrell and his friend went to a neighbor's home for candy, when he was found by law enforcement. This investigation was closed ruled out for neglectful supervision and abbreviated on January 6, 2012.

OCS Assessment:

- Per CPS handbook policy at the time of the investigation, the case was not initiated timely.
- There was no attempt to gather more information pertaining to Jerrell being outside of the apartment, in order to clarify the allegations. There was no request for law enforcement records and there was no collateral contacts pertaining to the incident involving Jerrell being found by law enforcement.

On **April 25, 2012**, CPS received a report alleging medical neglect of Jerrell by his mother. The report indicated that Jerrell had serious bronchitis and asthma and required life sustaining medications and breathing treatments. The report alleged that the mother was not consistently giving Jerrell his medications and breathing treatments which resulted in a hospitalization and his lungs almost collapsing. The report alleged that the mother was using drugs while supervising Jerrell. The caseworker conducted timely contact with the family and interviewed Jerrell in the home. Jerrell disclosed to domestic violence between his mother, maternal aunt and grandmother, who all resided in the home. Jerrell also disclosed to a relative and his mother smoking marijuana. Jerrell reported getting his medications and breathing treatments when needed. The mother was interviewed and admitted to daily use of marijuana. The mother also admitted to dating men who used drugs and were violent towards her. The mother was given an oral swab drug test and she tested negative, although the mother admitted to smoking marijuana on the same day the caseworker conducted the interview. A safety plan was implemented with the mother stating the maternal great grandfather would supervise the contact between the mother and Jerrell, for that day only, due to the mother admitting to marijuana use earlier in the day. The safety plan also stated the mother would not allow Jerrell to have contact with the grandmother or maternal aunt. The caseworker spoke with the mother about the seriousness of Jerrell's asthma and how he cannot be around anyone who smokes. The caseworker also counseled the mother on the importance of her quitting marijuana use. The mother participated in additional oral swab drug tests in May and June, 2012, and was negative both times. Jerrell's primary doctor was contacted and denied having any concerns of abuse or neglect. The case was closed ruled out for medical neglect and neglectful supervision on June 29, 2012, due to the mother testing negative on three oral swab tests and participating in a treatment program.

OCS Assessment:

- The case was initiated timely according to policy guidelines.
- According to CPS handbook policy 2230, the reporter should be contacted. There were no attempts to contact the reporter.
- The mother was given an oral swab drug test which was negative, after the mother admitted to marijuana use. The investigator did not follow-up with drug urinalyses.
- The mother reported the maternal aunt using drugs and the agency was aware that the aunt had children. There was no report filed to investigate the safety of the sister's children.
- All household members were not interviewed
- Evidence gathered during the investigation included the child admitting to witnessing domestic violence and being aware of drug use by the mother and other household members. The mother also admitted to the maternal grandmother smoking marijuana in the presence of the child and she failed to remove him from the situation. These findings supported ongoing interventions to address child safety were not reflected in the case disposition.

On **July 5, 2013**, CPS received a report alleging medical neglect of Jerrell by his mother. The report indicated that Jerrell frequently resided with his maternal grandmother and grandfather

because his mother was not functioning as the primary caregiver. The report alleged that Jerrell had rrespiratory syncytial virus (RSV) and severe asthma. The report alleged that Jerrell's mother was not taking him to the doctor and she was using drugs. The case was initiated by interviewing the mother. The mother denied medical neglect of her son but did admit to marijuana use every couple of days and reports Jerrell is with the maternal aunt or maternal grandmother when she is smoking. It should be noted that the maternal aunt and maternal grandmother were not allowed any contact with Jerrell in the previous case due to drug use. The mother was not confronted with this information. Jerrell was interviewed and admitted to observing his mother smoke marijuana outside. Jerrell reported when he gets sick, he is taken to the doctor by his mother, grandmother or grandfather. The caseworker observed all of Jerrell's medication. The caseworker contacted Jerrell's pulmonologist who advised Jerrell had been discharged from their practice because the mother requested a new pulmonologist and they had no record of his records being sent to a new pulmonologist. The mother was contacted and agreed she would be seeking a new pulmonologist when Jerrell needed medication refills. The mother was mailed an education pamphlet on "quitting marijuana" and the case was abbreviated and closed ruled out for medical neglect and neglectful supervision.

OCS Assessment:

- The case was initiated timely.
- According to CPS handbook policy at the time of this investigation, this case did not meet the qualifications for an abbreviated investigation. There were multiple risk factors and concerns identified throughout the investigation. The mother admitted to marijuana use and failed to seek a pulmonologist for Jerrell. Jerrell admitted to seeing his mother smoke marijuana and the mother had a history of drug use in previous investigations.
- Per CPS handbook policy 2291, abbreviated investigations must be closed within 30 days of the intake. This case was not closed timely.
- Evidenced gathered during the investigation included Jerrell's disclosure of witnessing drug use, the mother admitting to drug use, a documented history of drug use and instability by the parent and a documented history of severe medical concerns regarding Jerrell, all supported a need for ongoing CPS intervention.

On **May 29, 2014**, CPS received a report alleging neglectful supervision of Jerrell by his mother. The report alleged that the mother used marijuana and would leave Jerrell home alone while she travels out of town. A collateral contact was conducted with a representative from the housing authority who denied having any concerns of abuse or neglect for Jerrell and denied ever getting complaints of Jerrell being unsupervised. The caseworker initiated the case by attempting a home visit and leaving a business card on the mother's door. The mother contacted the caseworker by telephone and agreed to meet with the caseworker at the caseworker's office. The mother was interviewed at the CPS office and denied leaving her son unsupervised. The mother reported Jerrell spent time at Boys and Girls club and with a relative while the mother worked. The mother was not questioned about her drug use. A collateral was contacted and reported Jerrell was attending summer classes and he has a history of behavior problems in school but that they did not report any concerns of abuse or neglect in the home. Jerrell was interviewed on July 25, 2014. Jerrell denied any abuse or neglect and was able to verbalize who cares for him when his mother is not home. The investigation was closed ruled out for neglectful supervision on July 25, 2014.

OCS Assessment:

- Per CPS handbook policy at the time of the investigation, contact with the victim child was not made timely. Although the case was initiated timely within the 72 hour timeframe,

there were no attempts to interview the child prior to July 25, 2014, which is nearly two months past the required policy timeframe.
- All of the allegations were not addressed in the investigation. There were no questions asked regarding the mother's drug use nor was she sent for a drug test.

On **September 12, 2015**, CPS received a report alleging medical neglect and neglectful supervision of Jerrell by his mother. The report alleged that the mother was told Jerrell needed a pulmonologist and his lungs were not developing due to lack of appropriate medical care. The report also alleged that the mother and father were using drugs and the mother was leaving Jerrell home alone while she leaves town. An additional referral was received on **September 12, 2015** alleging medical neglect and neglectful supervision of Jerrell by his mother. This referral indicated that Jerrell was getting asthma attacks daily and had to be taken to the hospital when visiting family members the previous month. The referral alleged that the mother was a chronic cocaine user and travels out of town, leaving Jerrell home alone, for a week at a time to visit with her boyfriend who is a gang member. Jerrell was interviewed at school and denied any abuse or neglect. Jerrell reported he will visit his dad and other family on weekends when he travels to Dallas with his mother. Jerrell denied anyone using drugs and reported taking his asthma medication.

When the caseworker made initial contact with the mother, at the residence, the mother informed the caseworker she was getting ready to "smoke a blunt" right before the caseworker arrived to the home. The mother admitted to daily marijuana use and also admitted to the use of Xanax. The mother reported she becomes violent when she is sober and stressed out. The mother reported Jerrell's father is addicted to Phencyclidine (PCP) and she does not allow Jerrell around him. The mother advised she was evicted from her previous apartment after the United States Marshalls kicked in her apartment door to locate her boyfriend, who was wanted for an aggravated robbery criminal offense. The mother admitted to still being involved with that boyfriend who had previously been in prison for 10 years. At the time of the interview with the mother, the mother's boyfriend was sitting in his vehicle with the windows rolled up and the car off. There was no attempt to interview or make contact with the boyfriend. The mother submitted to a drug urinalyses and tested positive for marijuana. The child's primary care doctor was contacted and the office denied having any concerns of abuse or neglect. The primary care doctor advised Jerrell was referred to a pulmonologist in April, 2015; however, they were not aware if the mother ever followed-up with the pulmonologist. The caseworker contacted the mother and the mother admitted she had not taken Jerrell to the pulmonologist because she did not have a vehicle to use during the week, although the mother was borrowing her friend's vehicle to travel out of town on the weekends.

During the course of the investigation, a jail log was reviewed by a caseworker who found the mother had been arrested. The police report was requested and advised the mother and her boyfriend had been pulled over for speeding on October 12, 2015. When the officer approached the vehicle, he could smell marijuana. The mother, her boyfriend and Jerrell were in the vehicle. Two bags of marijuana were found and both adults were placed under arrested. In addition to the marijuana charge, the mother was also charged with tampering and fabricating evidence, possession of a controlled substance and bringing prohibited items into a correctional institution. The mother was confronted with the new arrest on October 26, 2015, and the mother admitted the marijuana was hers. A safety plan was put into place stating the mother would not use marijuana when Jerrell was present and she agreed to participate in Family Based Safety Services (FBSS).This investigation was found reason to believe for neglectful supervision and ruled out for medical neglect. The investigation was closed and transferred to FBSS on November 10, 2015.

OCS Assessment:

- The second referral was sent to the investigation field as a priority one, giving the caseworker 24 hours to make contact with Jerrell. A supervisor downgraded the referral to a priority two, delaying the initial response time. The referral clearly met the guidelines to be initiated as a priority one.
- The mother reported she did not allow Jerrell to see his father because of PCP use but Jerrell reported seeing his father every weekend. The mother was not confronted with this information.
- Prior to the mother's arrest, a serious case staffing was conducted between the caseworker, a child safety specialist and a program director. The caseworker was advised to contact the mother's friend, who keeps Jerrell while mother is out of town, to confirm appropriate supervision and then contact a pulmonologist to confirm Jerrell is seen. Once those items were completed, the case would be closed without further CPS intervention or services. Based on the history of the mother's drug use, her failure to ensure Jerrell was seen by a pulmonologist initially and the child's serious medical problems, further intervention was needed regardless.
- The caseworker found out about the mother's arrest on October 12, 2015, but there was no staffing with a supervisor until October 20, 2015.
- According to CPS handbook policy 3200, a safety plan was not implemented to ensure child safety. According to CPS handbook policy 3210, a Parental Child Safety Placement should have been implemented. The mother admitted to drug use, was arrested for possessing drugs and was in the presence of the child, confirmation was given that the mother did not follow up with a pulmonologist to address Jerrell's medical issues and the mother has a long history of drug use with the agency. There was no consideration given for an out of home placement.
- There was no contact with a pulmonologist to ensure Jerrell was seen for his asthma.
- There was no attempt to interview the mother's boyfriend, who was also arrested for possession of drugs and was in the presence of the child at the time of the arrest.

On **November 10, 2015,** the case was transferred to Family Based Safety Services. According to the family plan of service, Jerrell's mother was required to complete counseling to address drug use, family issues and emotional behaviors, participate in random drug testing and continue to get pulmonology care for Jerrell. The mother agreed to participate in the recommended services. The caseworker conducted a home visit in November and December, 2015; however was not able to make contact with the family in January 2016. There are several documented attempts to visit the family at the home but there were not any attempts to visit Jerrell at his school. During the monthly visit in December 2015, the mother admitted to continued marijuana use but denied use in the presence of the child. The caseworker requested the mother participate in a drug test. The mother never submitted to a drug test nor did she initiate any of her recommended services.

OCS Assessment:

- A thorough family assessment was conducted in a timely manner.
- The caseworker initiated the case within policy timeframes.
- There were no attempts to contact the father of Jerrell.
- The mother admitted to continued marijuana use and no safety plan was put into place.
- The caseworker did not make reasonable efforts to locate the family after her home visit attempts. The caseworker did not attempt to see Jerrell at school. The documentation reflects the family resided in an apartment complex, there were no attempts to speak

with property management to determine if the family still lived there. There were also no telephone attempts to coordinate a home visit or address the mother's failure to submit to her drug test.

On **January 29, 2016**, during an open FBSS case, CPS received a report alleging neglectful supervision of Jerrell by his mother. The reporter stated that Jerrell was living with his mother and her boyfriend. The report alleged that the family just moved and was residing in a hotel but now is living "here and there" and was just "put-out" of the home they were in that night. The report indicates Jerrell had chronic asthma and needed a breathing treatment every 3-4 hours and required the use of 5-6 medications; additionally, the breathing machine requires electricity. The reporter did not know if Jerrell was getting all his necessary medication but did state Jerrell needed to see a pulmonologist. The reporter indicated Jerrell's asthma is severe and he had "flat-lined" three months prior from asthma. The report also alleged that the mother and her boyfriend were using cocaine. This investigation was not initiated prior to the child fatality.

An additional referral was received on **February 2, 2016**, indicating Jerrell Jones died on **January 31, 2016**, due to complications from asthma. Jerrell died while visiting his father's residence. An investigation has determined the father and his girlfriend left Jerrell home with a young babysitter who was caring for Jerrell, along with seven other children. When Jerrell started to have breathing issues, the babysitter attempted to call the father multiple times without success. The babysitter also called Jerrell's mother to notify her of Jerrell's state of distress and requested her to bring Jerrell's breathing machine over. When Jerrell collapsed to the floor, the babysitter dialed 911. Emergency personnel services were unable to revive Jerrell. The investigation found that both the mother and father were liable for Jerrell’s medical and physical wellbeing and did not make his medication available to him. Both were found reason to believe of medical neglect and the father a perpetrator of neglectful supervision.

OCS Assessment:

- According to SWI handbook policy 4250, an allegation of medical neglect would have been an appropriate allegation based on the reporter alleging Jerrell needed to see a pulmonologist due to his severe asthma. The reporter advised Jerrell had "flat-lined" three months prior because of an asthma attack. The reporter also advised Jerrell needs breathing treatments every three to four hours and he takes five to six medications. The reporter did not know if Jerrell had all his medications. The breathing machine requires electricity for use but the reporter indicated the mother was not living in a stable residence so there would be justifiable concern that Jerrell may not have electricity for his breathing machine.
- According to SWI handbook policy 4310 and CPS handbook policy 2143.11, consideration should have been given to assign a priority one to the referral. The reporter indicated the child had a history of near death experiences due to asthma, the child needed a breathing machine and there was concern about his access to electricity, the child needed multiple medications and there was concern if he had all the medications and the child needs a pulmonologist; the CPS history reflected the mother was not following up with a pulmonologist.
- According to CPS handbook policy 2241, all alleged victims must be seen within the established guidelines depending on the intake priority. The child was not seen timely according to policy.

The Overall Case Review Findings and Recommendations

Since Jerrell's birth, he has been involved in seven investigations and one Family Based Safety Services (FBSS) case. In every investigation, there were concerns regarding Jerrell's severe

asthma. The mother had a history of drug use and had minimal positive family support. The mother moved often and consistently traveled between Dallas, Texas and Brownsville, Texas leaving Jerrell with friends or his father.

After reviewing the case history involving Jerrell's family, there were several trends and patterns that stood out when referencing common casework practices. Over the course of seven investigations, the majority of the cases were not initiated timely. There appeared to be a minimization of the mother's marijuana use and how the marijuana use negatively affected the mother's ability to provide appropriate care for her child. In nearly every investigation, the mother admitted to regular marijuana use but there was no enforcement of services through the agency. Additionally, staff relied heavily on a mother's negative drug result from an oral swab drug test even when mother was admitting to regular marijuana use. The mother was consistently given oral swab drug tests instead of a more reliable method of urinalysis. There were multiple investigations involving allegations of medical neglect of Jerrell's asthma; however, there was no follow-up with a pulmonologist to ensure Jerrell was receiving proper treatment.

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. Examples of this include staff asking parents or caregivers during their visits to discuss specific things they are learning as a result of any services they are receiving, changes they are or will be making as a result of learning these new skills, and how have they plan ensure the safety and well-being of their children in the future.

The Office of Child Safety recommends the following:

- The OCS has noticed a growing pattern of investigations relying solely on oral swab drug tests to determine dispositions relating to substance abuse. The reliability of oral swab drug tests are low and cannot be used in court because they are not as accurate as other drug testing options. When determining child safety, the agency should be utilizing the same theory and not rely solely on oral drug tests. Oral drug tests should only be used in emergency situations wherein a drug testing facility is not available at the time of contact; however, an oral drug test should always be followed-up with a urine or hair follicle test to determine accuracy.
- Training Needs: Educate CPS staff on how to effectively utilize regional nurse consultants, Forensic Assessment Center Network, or other medical resources when investigating Medical Neglect.
- Review purpose and importance of professional collateral contacts, such as medical staff, in assessing ongoing child safety.
- CPS program should evaluate the pattern of minimizing marijuana use to establish a clear and concise protocol to deal with cases of this nature. There is a trend of child deaths in homes where marijuana is used regularly.
- When the same victim child has been involved in multiple CPS investigations, staff should work with their management team and subject matter experts to determine what

services and interventions can be provided to address child safety and if legal intervention may be needed.