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

On September 20, 2015, during an open Child Protective Services (CPS), Family Based Safety Services case. Lily Register died after she was reportedly found hanging from a Digital Versatile Disk (DVD) player cord. CPS was involved with the family due to concerns for abuse and neglect which were initially received on December 14, 2014. The allegations were investigated and the case was transferred on May 7, 2015, to CPS' Family Based Safety Services program where it remained open at the time of Lily's death.

The Office of Child Safety completed a review of all current and past CPS involvement concerning Lily's family. 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 necessitate further examination.

Family Composition

Region 2 - Hardeman County

Name or Relationship to Lily Register	Age at time of incident
Lily Register	1 year 6 months
Mother	23 years
Father	28 years
Sibling	3 years

Summary of CPS History on Lily Register / Family of Lily Register

- On December 4, 2014, CPS received a report alleging neglectful supervision and physical neglect of Lily and her sibling by their parents, and medical neglect of Lily's sibling by both parents. On February 13, 2015, during the open investigation, CPS received a subsequent report alleging abuse and neglect of Lily and her sibling. The reports were merged and the allegations were investigated.
    - The investigation was closed on May 7, 2015, and the case was transferred to CPS' Family Based Safety Services program.
    - On July 13, 2015, during the open Family Based Safety Services case, CPS received a report alleging physical abuse of Lily by her parents and physical neglect of Lily and her sibling by their parents. The allegations were investigated and the investigation was closed on September 19, 2015. The Family Based Safety Services case remained opened.
    - On September 20, 2015, during the open Family Based Safety Services case, CPS received a report involving the death of Lily Register. The allegations in the investigation were found reason to believe for neglectful supervision of

both children, reason to believe for medical neglect of the siblint, and unable to determine for physical abuse of Lily by her parents.
    - On September 23, 2015, Lily's sibling was placed in the Temporary Managing Conservatorship (TMC) of the department.

Detailed Account of CPS History on Family of Lily Register

On **December 4, 2014**, CPS received a report alleging neglectful supervision and physical neglect of Lily and her sibling by their parents, and medical neglect of Lily's sibling by both parents. There were concerns that the children were being left home alone. Additionally, there were concerns of domestic violence between the parents and substance abuse by the father.

On **February 13, 2015**, during the open investigation, CPS received a subsequent report alleging abuse and neglect of Lily and her sibling. Here were new concerns about the sibling being fed appropriately and that the children in general were not having their needs met when with their parents. The reports were merged and the allegations were investigated. During the investigation, it was discovered that Lily's sibling had cerebral palsy and Lily's parents failed meet the medical needs of this child including missing several appointments and failing to engage in needed services. The children's basic needs and hygiene were of concern. Lily's mother was aware of father's alcohol and marijuana use yet allowed him to care for the children while under the influence of these substances. Lily's parents also acknowledged ongoing domestic violence in the presence of the children. The allegations of medical neglect, neglectful supervision, and physical neglect of the children by their parents were found reason to believe. The investigation was closed on May 7, 2015, and the case was transferred to CPS' Family Based Safety Services program to provide ongoing services to the family.

OCS Assessment:

- Initial contact was made fourteen days after the intake was received. There was a delay beyond the required time frame to follow up after the initial attempt to contact the family was unsuccessful. There is no documented staffing with the CPS supervisor or a follow up plan as required by CPS policy 2241 *Interviews With Children.*
- There were no investigation activities from the initial visit with the family in December 2014 until February 2015, when the subsequent report was received.
- An attempt to contact the family was made on February 14, 2015, after receiving the subsequent report but was unsuccessful. Contact with the family was made on March 11, 2015; however, there is no documented staffing with the CPS supervisor or follow up plan as required by CPS policy CPS policy 2241 *Interviews With Children.*
- Although a subsequent report with new information was received, a reassessment of the Structure Decision Making (SDM) Safety Assessment was not completed as required in CPS policy 2271 *Time Frames for Completing a Safety Assessment or Reassessment.*
- The allegations against Lily's father with regard to leaving the children alone were not address with either parent.
- A Family Team Meeting (FTM) was held.
- The documented safety plan does not address immediate safety concerns or provide for a safety monitor to help ensure the children's immediate safety needs.

On **May 7, 2015**, the case was transferred to CPS' Family Based Safety Services program, where ongoing services to mitigate risk of abuse and neglect due to domestic violence and drug

use would be provided. Lily was referred to Early Childhood Intervention (ECI) by her pediatrician and CPS referred Lily's family for counseling for both parents, and random drug screens.

OCS Assessment:

- Although domestic violence and anger management were identified as a concern, there does not appear to be any services provided to target these specific areas of concerns outside of traditional counseling. Utilizing a batters intervention program to address these concerns is clinically appropriate.
- There is no indication that Lily was ever evaluated by ECI staff.
- During a home visit on July 13, 2015, the FBSS caseworker observed bruises on Lily; however, photos of the injuries were not taken until approximately fourteen days later when the newly assigned CPS investigator visited the family.
- Lily's mother was administered an oral drug screen on July 13, 2015. The documentation states, "it appeared to be positive for amphetamines." However, there was no clarification as to what was meant by "appeared" or follow up with the family by the FBSS caseworker.
- During August and September 2015, the FBSS caseworker did not have any contact with Lily's family; rather a contact from the CPS investigator was copied onto the FBSS stage of service for these two months.
- Lily's father was not engaged with services and there was no mention that he was visited at any time during the Family Based Safety Services case.
- Community providers and professional collaterals were not contacted.

On **July 13, 2015**, during the open Family Based Safety Services case, CPS received a report alleging abuse and neglect of Lily and her sibling. The report alleged physical abuse of Lily due to the multiple bruising noted on her face, arms, and foot. Additional allegations included physical neglect of Lily and her sibling. During the investigation, both children were observed and a drug screen was administered to Lily's mother which returned with negative results. The caseworker documented Lily had "bruising on various areas of her body that were seen in several stages of healing." The allegations of physical abuse were given a disposition of unable to determine as the caseworker was uncertain if the injuries were a result of abuse. The allegations of physical neglect were ruled out and the investigation was closed on September 19, 2015. However, the case remained open with Family Based Safety Services for continued services and ongoing monitoring.

OCS Assessment:

- The initial contact with the family was made on July 24, 2015, eleven days after the intake was received. Two prior attempts to contact the family were made; however, they were unsuccessful. An immediate staffing with the supervisor was not conducted nor was a follow up plan implemented as required in CPS policy 2241 *Interviews with Children.*
- It appears contact was made by a secondary caseworker who assisted the primary caseworker. The caseworker took photos of Lily at the time of his visit; however, there is no description in the narrative of the investigation report regarding the bruises observed on Lily. *Note:* The photo was taken eleven days after the Family Based Safety Services caseworker first observed the injuries.

- The documentation with regard to the bruises on Lily's person was inconsistent throughout the investigation report. The Safety Assessment stated, "the child did have a bruise but it appeared to be consistent with the mother's story." The Allegation Detail section of the investigation report stated, Lily had "bruising to various areas of the body."
- During the Family Based Safety Services case, an oral drug screen on July 13, 2015, returned what "appeared" to be a positive result for amphetamines. However, this was not addressed with Lily's mother until two months later on September 14, 2015, during a follow up visit with regard to the open investigation. A new drug screen was then administered which returned with negative results.
- The Safety Assessment was not completed or documented within the time frames required in CPS policy 2271 *Time Frames for Completing a Safety Assessment or Reassessment.*
- There was no significant contact with the family or investigative activities between the initial visit in July 2015, and the follow up visit on September14, 2015.
- The Forensic Assessment Center Network (FACN) or a child abuse pediatrician was not consulted with regard to the injuries observed on Lily.
- Lily's father was not interviewed or drug tested during the investigation despite the directives of the CPS Supervisor during the initial case staffing held on July 13, 2015.
- The narrative states that the investigator referred the family to a local service provider; however, it was not clear why the family was referred to this community provider given the case remained open with Family Based Safety Services. There is no indication this information regarding the referral was shared with the assigned Family Based Safety Services caseworker.

Prior to case closure, on **September 20, 2015**, Lily register died after she was reportedly found hanging from a Digital Versatile Disk (DVD) cord. On September 23, 2015, Lily's sibling was placed in the Temporary Managing Conservatorship (TMC) of CPS.

Overall Case Review Findings and Recommendations

Child Protective Services (CPS) was in the process of providing services to Lily's family as part of CPS' Family Based Safety Services. Although several risk factors were identified during the initial investigation in December 2014, and during ongoing assessments, it does not appear that the family was engaging in sufficient services to address the specific concerns involving domestic violence and drug use. The three investigation reports received in December 2014, February 2015, and July 2015 exhibit similar patterns of ineffective investigation practices. Each investigation showed the initial contact with the family was not timely, delay in completing safety assessments, a significant gap of time between investigative activities after initial contact with the family, and allegations that were not thoroughly addressed with the parents.

During the Family Based Safety Service case, monthly visits with Lily's family were not conducted timely and there were no documented efforts made to engage Lily's father with services. Concerns arose regarding physical abuse of Lily as she was observed to have several bruises. Although an investigation was launched regarding these bruises, a safety plan was not immediately put in place although the bruising was present and a drug test was positive for amphetamines. Photos of the injuries were not taken until fourteen days after the injuries were first observed and CPS staff did consult with medical staff or with the Forensic Assessment Center Network (FACN) to determine if the explanation provided by the mother was consistent with the injuries incurred. Additionally, once the investigation was initiated during the Family Based Safety Services case, there was no further contacts by the Family

Based Safety Services caseworker, with Lily's family from the end of July 2015 through September 2015. Family Based Safety Services staff must continue to engage the family during an open investigation unless there is a compelling legal interest to the investigation to only have the investigator maintaining contact.

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. New tools for assessing safety at the start of an investigation as well as throughout the involvement with the family are now statewide.

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 following areas of policy and best case practice were reviewed with staff assigned to the previous investigations and Family Based Safety Services case. The topics were included in ongoing training with investigations staff and Family Based Safety Services.

- All victim children be seen within the required time frames.
- A staffing with the CPS supervisor should be held to develop a follow up plan if contact cannot be made or the family is unable to be contact within timeframes specified by CPS policy.
- All allegations must be thoroughly addressed, especially when multiple referrals are received and merged into one investigation.
- Contacting professional collateral contacts and service providers is key to assessing ongoing child safety.
- Staff should photograph injuries as soon as they are observed.
- CPS staff should utilize regional Nurse Consultants, Forensic Assessment Center Network, or other medical resources available when injuries on young children are noted, in particular on vital parts of the body.
- Ensure drug tests are administered timely and child safety is assessed accordingly and at the time of a positive drug test result being known to the department.
- If a concern regarding child safety is known to a staff member, immediate safety measures should be put in place and, if needed, a new intake and investigation should be launched. Staff cannot defer this responsibility until a new investigation is started.