TEXAS
Department of Family
and Protective Services

# 2021-2022 Citizen Review Team Report

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April 2023

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# Background

Pursuant to the Child Abuse Prevention and Treatment Act section 106, each State to which a grant is made shall establish not less than 3 Citizen Review Panels (Teams). A State may designate for the purposes of this subsection one or more existing entities established under State or Federal law, such as child fatality panels or foster care review panels, if such entities have the capacity to satisfy the requirements of paragraph (4) and the State ensures that such entities will satisfy such requirements. These requirements include, that each panel shall, by examining the policies, procedures, and practices of State and where appropriate, specific cases, evaluate the extent to which State and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with the State plan.

The Texas Family Code (TFC §261.312) requires the Department of Family and Protective Services (DFPS) to create Citizen Review Teams; and authorizes DFPS to create one or more review teams for each region to evaluate staff casework and decision-making related to child protective investigations. Six of DFPS' regions are designated as meeting the requirements of the Child Abuse Prevention and Treatment Act Appendix I, and include Regions 1, 3E, 3W, 6 (6A and 6B), 7, and 11. These regions represent a mixture of urban and rural communities and reflect a broad range of issues encountered by DFPS statewide. This report consists of information concerning the issues addressed by the Citizen Review Teams, including the teams in the six Child Abuse Prevention and Treatment Act regions.

The Child Abuse Prevention and Treatment Act also states that each panel shall prepare and make available to the State and the public, on an annual basis, a report containing a summary of the activities of the panel and recommendations to improve the child protection services system at the State and local levels. Not later than 6 months after the date on which a report is submitted by the panel to the State, the appropriate State agency shall submit a written response to State and local child protection systems and the citizen review panel that describes whether or how the State will incorporate the recommendations of such panel (where appropriate) to make measurable progress in improving the State and local child protection system.

### Structure

As required, all Citizen Review Team members, including those of the Child Abuse Prevention and Treatment Act Citizen Review Teams, are volunteers who represent a broad spectrum of their communities. The members are nominated locally and approved by the DFPS Commissioner. DFPS staff assist the Citizen Review Team with coordination, team development, training, and statewide distribution of team reviews and recommendations. DFPS staff facilitate the meetings and the exchange of case-specific information, ensuring that confidentiality is maintained.

## Reporting Process

To coincide with the federal fiscal year reporting period, this report covers the period from October 2021 through September 2022 (FFY 2022). Information presented consists of data gathered by all Citizen Review Teams, including the Child Abuse Prevention and Treatment Act Citizens Review Teams. In FFY 2022, the teams reviewed child fatalities that met criteria for a Regional Child Death Review Committee.

Criteria for a Regional Child Death Review Committees includes child fatality cases in which:

- The child's death has been determined by Child Protective Investigations (CPI) to be the result of abuse or neglect; for example, there is a disposition of Reason to Believe for an allegation with a severity of fatal (RTB – Fatal), regardless of whether the medical examiner or other external parties reach the same conclusion; and
    - the deceased child or the designated perpetrator of the RTB – fatal had an open CPI or Child Protective Services (CPS) case at the time of the child's death or
    - the Designated Perpetrator of the RTB - Fatal has been an alleged or designated perpetrator in a prior CPI case within the last 3 years; or
    - the deceased child has been an alleged or designated victim in a CPI case within the last 3 years; or
    - the deceased child was a principal in a Family Based Safety Services and/or Conservatorship stage of service within the last 3 years.

If there was not a child fatality case meeting criterion to review in the quarter, another case was selected. These meetings included reviews of prior investigations within the last three years; previous Family Based Safety Services, Conservatorship, Kinship, and/or Adoption within the last three years if applicable; various types of abuse and neglect allegations in cases; and appropriateness of service delivery. Reports of the meetings were documented on the DFPS Notification of Child Fatality – Part C Form.

## Agency Response

The Citizen Review Teams often present recommendations for local Child Protective Investigations and Child Protective Services direct delivery staff about actions they would like to see taken on a particular case. These case-specific recommendations are communicated during the Citizen Review Team meetings to the Child Protective Investigations and/or Child Protective Services representatives who are present, and recorded on the standardized reporting form. Required actions relating to case-specific recommendations are handled at the regional level.

The Citizen Review Teams also present recommendations with a statewide scope. These recommendations are presented to the Child Safety Review Committee throughout the year and to

DFPS leadership for consideration of policy development, training, and coordination with external entities.

All Citizen Review Team recommendations are placed on the DFPS public website after approval of the annual report. As required by CAPTA, DFPS will provide a written response to each recommendation within 6 months, and the updated annual report publicized. The DFPS public website contains a Citizen Review Team specific mailbox that the public can use to comment on the recommendations.

The annual Citizen Review Team Report can be found at:
https://www.dfps.state.tx.us/Investigations/CRT/default.asp.

**Team Activities**

The Child Safety Specialists within the Office of Accountability act as the Citizen Review Team coordinator within their assigned Region of responsibility. The Citizen Review Team coordinators meet regularly with State Office program staff to discuss better ways to engage the community in the review process.

In an effort to gain essential feedback from the public, the Citizens Review Team coordinators and the Child Protective Investigations and Child Protective Services Regional Leadership continue to work with their communities to engage and encourage volunteers to become involved in these Teams.

**Analysis**

During FFY 2022, the Citizen Review Teams reviewed 92 child fatality or serious injury cases. At the time of the fatality of these cases, 13 had an open Investigation, one had an open Family-Based Safety Services case, four had an open Conservatorship case, and one case was open in Conservatorship and Investigations. No recommendations were given in 34 of these reviews. Recommendations that were given or concerns noted as part of the other reviews were in the following areas: Safety and Risk, Policy and Practice, Training Needs, and Coordination with External Entities.

If the recommendation or concern was case specific, it was referred to regional management. Those that were noted to have a statewide scope are listed below.

DFPS values collaboration with our partners in the child welfare system in Texas. Building community relationships and partnerships is an integral part of DFPS work and is critical to providing clients with needed support. Overall, teams felt DFPS was doing well and acknowledged the Department's ongoing efforts in staff development and casework improvement.

# Chapter 1 - Safety and Risk

### Recommendation 1

The Department should consider more stringent safety plans when someone is monitoring the children in person 24/7. In addition, field staff should provide more clear direction to the family when it comes to what supervision entails when documenting the safety plan. Further there should be training on safety planning as it relates to how to appoint a family monitor and how to monitor if a Supervision Plan is being followed appropriately.

### Recommendation 2

Staff need to thoroughly assess individuals used for Supervision/Placement based on the current situation versus assuming a person is appropriate because they were used in the past. Staff should also assess individuals on an ongoing basis to ensure they continue to be an appropriate monitor/supervisor.

Case specific: CPI approved an individual based on their role as a supervisor of parent-child contact in a prior case; however, sufficient checks/assessments were not completed in the new Investigation and after the case was transferred, on-going stages did not complete their own assessments.

### Recommendation 3

The Department should put something in place for multi-level checks and balances that goes above the worker and supervisor level to ensure safety and timely review of case actions. It was recommended that the Department's case management system IMPACT (Information Management Protecting Adults and Children), add an alert for the next level of management (Program Director) to notify them that the required review is outstanding.

Case specific: The 15-day review that is required by policy was not completed, and there currently is not a Data Warehouse report or IMPACT alert provided to management that notifies them that this task has not been completed by the Supervisor.

### Recommendation 4

Forensic interviews through the Child Advocacy Center should be requested and attempted when there are surviving siblings as they might yield more information. In addition, it connects families to services at a different level than the Department can provide.

Case specific: Surviving siblings were under 4-year-old, and documentation reflected they had limited verbal skills. The team indicated that even with limited vocabulary, a forensic interview may have been able to provide additional information regarding the abuse that occurred.

# Chapter 2 - Policy and Practice

### Recommendation 1

When a child has a medical related diagnosis, the worker must contact medical professionals and obtain the official diagnosis, treatment plan, and compliance information. If referrals are made, the worker should follow up with service provider/agency prior to closure of the stage of service, as this would help mitigate risk factors. In addition, there should be something in place where additional efforts must be made to identify/confirm a family support for these families prior to case closure.

Further, it was recommended that DFPS expand the Primary Medical Needs (PMN) staffing required for children in Conservatorship to include PMN children involved in Investigations or Family-Based Safety Services as way to ensure all supports and medical care is being followed.

### Recommendation 2

Child death cases should be automatically referred for a Multiple Disciplinary Team (MDT) staffing.

### Recommendation 3

Criminal history checks should be among the first things to occur when initiating an investigation to ensure staff is aware and able to discuss criminal history in the initial assessment of the family.

### Recommendation 4

CPI should assign cases where there is extensive history to staff that have more experience in recognizing trends/patterns or who have developed skills to ensure higher risk cases get the level of attention needed.

### Recommendation 5

The Department should look at drug testing all individuals who are utilized to care for the children as a safety plan supervisor or those whom the family has chosen as a Parental Child Safety Placement. It was suggested a small pilot study could be done to see how often the potential supervisor is no longer approved.

Case specific: The caregivers selected were also using illegal substances; however, all their background checks and references cleared them per policy.

**Recommendation 6**

Hair strand drug testing should occur on cases where there are ongoing allegations of drug usage in the home to ensure child safety.

**Recommendation 7**

The Department should do more to notify and evaluate the absent parent to prevent removal.

**Recommendation 8**

If the Court has ruled and dismissed the Department from a legal case, there should be a policy exception to making on-going contact with the family while the Investigation is still open. As well, the Department should explain to the Court and all legal parties that even though the legal case is dismissed the Department still has an open investigation and will be continuing to make contact monthly with the family until case closure. This provides the Court an opportunity to determine if they no longer wish for the Department to contact the family any further.

**Recommendation 9**

CPI should consider a more standard practice of having all children under the age of 4 seen by a doctor at the beginning of the case, specifically if the allegations are medical neglect or physical abuse when bruising is observed

**Recommendation 10**

Staff should refer to bruising/injuries as physical abuse (versus excessive discipline) so as not to downplay the abuse that has occurred; promote the use of referrals to the Forensic Assessment Center Network; and ensure that medical examinations are completed on young children as not all injuries will be visible when they are internal.

**Recommendation 11**

When vulnerable children are identified as having been present during an incident of domestic violence, they should be referred to the Child Abuse Resource and Education (CARE) Team for evaluation to ensure no injuries.

**Recommendation 12**

Children who have witnessed any form of domestic violence in the home should be referred to counseling/therapy.

**Recommendation 13**

The attorney representing the Department must present all information gathered by the Department to the court/Judge. This should include juvenile criminal records.

Ultimately, the case must be resolved within a year (with the possibility of a six-month extension) of when DFPS received temporary custody of the child/children. At trial, the Department has the burden of proof to offer evidence to the court supporting the relief it seeks.

Regarding juvenile records, these are not records kept by DFPS and would have to be obtained from the Texas Juvenile Justice Department. To the extent that the Department has these records, the Department is unauthorized by law to release the records absent a court order, as there are state and federal laws prohibiting the release of these records. See TAC 700.204(b); Government Code section 411.114; Government Code section 411.1141.

**Recommendation 14**

It should be required that all affidavits filed with the court are uploaded to One Case for further review by others as needed.

**Recommendation 15**

The Department needs to have at minimum, the preliminary autopsy findings before a Reason to Believe – Fatal disposition is determined, and the Reason for Death is chosen as Abuse/Neglect related.

**Recommendation 16**

Staff need to verify a person's identity by requesting proof of identity.

**Recommendation 17**

All families should be provided with local resources that could assist and help them in the future upon closure of an investigation.

# Chapter 3 - Training Needs

**Recommendation 1**

The Department should provide its staff with ongoing and more consistent statewide training regarding family dynamics in households where domestic violence is occurring. There should be an annual number of required training hours for all levels of staff. Different levels of training are needed for newer versus more tenured staff in order to build upon prior knowledge and understanding. This would enhance staffs' ability to gather information needed to ensure child

safety in a home where violence is taking place in addition to learning how to better engage the non-offending parent.

**Recommendation 2**

Training regarding bottle propping and how to speak to families regarding the dangers of bottle propping, much like staff speak of the dangers of co-sleeping, should be provided to all staff. Additionally, more in-depth conversations should be completed with families about co-sleeping, to include questions such as why they choose to co-sleep as opposed to reading off the handout that is required per policy.

**Recommendation 3**

Staff should be educated regarding when siblings of an injured child need skeletal exams; knowing what to ask for when scheduling forensic exams (to include providing medical information from the pediatrician); and knowing the difference between the various Child Abuse Resource and Education (CARE) teams.

**Recommendation 4**

Ensure children are being forensically interviewed when criteria are met or when staff feel that it would be beneficial to do so. Perhaps a case study could be utilized as a training tool to show staff where alternative case decisions could have been made or to point out red flags/signs they should look for.

**Recommendation 5**

Several teams identified the need for staff to be aware of resources within the community that can provide additional support to families who have children with special needs (autism, medically fragile, Intellectual or Developmental Disability, significant mental health, etc.) outside of the Department's involvement. This would include services such as respite, education, and coordination of care services. This is especially needed in rural areas.

**Recommendation 6**

More collaboration and joint trainings with community agencies/resources that could assist with legal/custody issues.

**Recommendation 7**

There needs to be more community resources that offer parent/child conflict type assistance that focuses on older children.

Case specific: Suicide by teenager placed with relative. There may have been more that the Department could have done during a conservatorship case such as notifying the courts how detrimental the situation was and/or could get worse without the children attending counseling. The providers could have spoken to the courts on how serious the situation was and emphasize the need to place the children back in care. The Department's method of measuring risk in the home needs to be looked at since it was based on the grandmother's household (that didn't have much history) therefore rated moderate. With the current rating, the grandmother's case didn't require services. There may need to be some training with the courts to discuss these types of cases that involve teenagers participating in risk taking behaviors and how dangerous that can be. The Department's staff may need this same training, so they are better prepared in presenting their cases to the courts. We need to change how teenagers with mental health issues are perceived.

**Recommendation 8**

Provide further training regarding:

- Domestic Violence
- How to address gun safety and knowledge of local resources for free/low-cost gun safety courses
- Signs of mental health
- The root causes of behavior and impact of early trauma
- How to communicate more effectively with service providers
- How to thoroughly assess for substance abuse (What does addiction look like?)
- Drug testing tools and what we are trying to test for
- Working with teens and pre-teens – useful interventions
- "How to be an FBI Detective" – for CPI staff
- Importance of case merging

# Chapter 4 - Coordination with External Entities

**Recommendation 1**

Sufficient resources should be made available to assist the non-offending/protective parent, who wants to seek legal custody, but cannot afford it or does not have the knowledge to go through the civil legal system themselves. This could include legislation that would protect a parent financially or setting up specialized court dockets for these parents as the Department cannot legally intervene, but legal orders are needed to ensure child safety and permanency. Expand upon legal programs and pilot projects across the state that do assist families in these situations, to include expansion of legal financial resources.

**Recommendation 2**

Collaborate with local Law Enforcement to provide training/resources to staff about the drugs they are seeing in the community.

**Recommendation 3**

Educate/train hotel personnel on what to look for/refer to SWI, specifically for those children not of school age or not attending school.

**Recommendation 4**

The Department should provide education to local law enforcement (for example, cadet training or police academies, etc.) regarding when to make a referral as well as the Department policies, joint investigations, forensic assessment center network, forensic interviews, multiple disciplinary team meetings, etc.

**Recommendation 5**

Report lawyers and individuals who do not report suspected abuse/neglect to the appropriate entity (Law Enforcement or District Attorney's Office) for criminal prosecution. Report attorneys to the State Bar of Texas.

**Recommendation 6**

In general, there should be Memorandum of Understandings between the Department and state parole/probation officials. There should be a statewide contact person or access to a database in which CPI/CPS would be able to obtain information regarding a person's probation/parole status.

**Recommendation 7**

The team discussed the barriers in policies and practice with regards to different county judicial system requirements, for example the Court requiring the family's initial plan to be Family Reunification despite the Department's recommendations or case circumstances.

Case specific: The team felt that this policy was not protective of the children and asked questions about who would be held accountable if the family was reunified and another child died.

**Recommendation 8**

When legal denies and then a fatality or serious incident occurs, the Department should notify the attorneys of the outcome and discuss the case to find out what (if anything) we could have done to obtain legal intervention. Additionally, the Courts should be notified about cases where

the Department did not agree with reunification/dismissal, but the Court did and then a fatality or serious incident occurred after case closure.

**Recommendation 9**

The team would like to see a type of database for children at high risk of death from caregivers who meet certain criteria, such as previous child fatalities, serious injuries, or sexual abuse. This would be similar to how the Bureau of Vital Statistics deals with parents who have Reason to Believe – Fatal designation or rights terminated.

**Recommendation 10**

Preventative services should be put into place for victim children in order to break the cycle of abuse in the family.

**Recommendation 11**

Develop mentorship programs to help families navigate CPI/CPS, such as expanding the Parent Collaboration Groups that are in Conservatorship to include Investigations and Family-Based Safety Services.