A Review of Child Protective Services Investigations Regarding Colton Turner

By

The Department of Family and Protective Services

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Executive Summary

Over the course of two years, Child Protective Services (CPS) received six reports and conducted four investigations into allegations that Colton Turner, born September 21, 2011, had been abused or neglected. In all of those investigations, there were failures to follow policy as well as mistakes in judgment by caseworkers and/or supervisory personnel. As a result, CPS failed to protect Colton Turner. This report describes the major issues found during the review of Colton's death and actions CPS is taking to remedy both immediate and systemic problems.

For several years, Travis County CPS has struggled to keep enough investigation caseworkers on the job and performing quality and timely casework. These retention issues impact the workers' ability to complete investigations in a timely and thorough manner.

Currently, more than 450 investigations in Travis County have been open for more than 60 days, at which time a case would be considered delinquent. These delinquent cases represent more than 30 percent of all CPS investigations in the county. In Region 7, which includes Travis County, 22 percent of all CPS investigations are open more than 60 days.

It is important in child abuse/neglect investigations to see children and families as soon as possible after allegations are reported. In addition, CPS must maintain regular contact with the children and families until it can be determined that children are safe and the risk to children living in the household has been reduced or eliminated. Delinquent investigations can put children at risk because the conditions in the household may be unsettled and unknown to CPS if children are not seen following allegations of abuse or neglect. To address delinquent investigations, CPS deployed three Master Investigators[1] and a Master Investigator supervisor to Travis County on August 4.

However, even with the challenges in Travis County CPS, the failures in the Colton Turner investigations are unacceptable. As a result of this case, CPS has taken immediate action to strengthen Travis County abuse/neglect investigations and thereby increase the protection to children who may be in danger from abuse or neglect. In response to this review, CPS made immediate personnel changes, is bringing in additional experienced personnel to scrutinize hundreds of cases in Travis County, and will be putting additional quality controls in place.

[1] Master Investigators are highly trained and assist programs across the state with a high number of delinquent investigations and/or a high number of caseworker vacancies.

Summary of CPS History on Colton Turner

Investigation #1 − July 27, 2012 - September 11, 2012
Investigation #2 − March 23, 2013 - June 13, 2013
Investigation #3 − June 27, 2013 - March 3, 2014
Investigation #4 − May 21, 2014 (investigation is ongoing)

On July 27, 2012, CPS received a report alleging that Colton was being abused and neglected by an individual, who was described to CPS as the boyfriend of Colton's mother. The report said Colton had been seen with scrapes and bruises and that there was drug use in the home.

The day the report was made, July 27, a CPS investigator made an unannounced visit to the home and interviewed the mother and the boyfriend. The investigation caseworker saw nine-month-old Colton and he appeared healthy and in good condition. The investigation caseworker did not observe any bruises or scrapes on Colton. The mother and boyfriend tested negative on an oral swab drug test. The investigation caseworker found the home to be in good condition. The allegation of abuse/neglect was ruled out and CPS closed the investigation on September 11, 2012.

Policy violations:

- This report was classified as a Priority 1, the highest priority, with an allegation of Risk of Physical Abuse. CPS policy requires that CPS staff arrange a joint investigation with law enforcement when the case is classified as Priority 1 with an allegation of Physical Abuse. CPS did not arrange a joint investigation with law enforcement.
- Case narratives stated that the case worker took a photograph of Colton, but a review of records does not confirm this information. A photograph is important to the case so that the physical appearance of the child is documented.
- CPS staff did not contact a potential collateral source for more information about the boyfriend.

Areas of Concern:

- The reporter alleged that the family was living in a home that had been condemned but no photographs of the home were taken to document and verify the validity of the allegations or to illustrate the condition of the home.

On March 23, 2013, CPS received a report that alleged abuse and neglect of Colton, including risk of sexual abuse, and chronic drug use by his mother. An investigation caseworker saw Colton in his home on March 26, 2013, and April 30, 2013. The investigation caseworker observed no injuries or signs of neglect at either visit.

A CPS investigator interviewed Colton's mother on March 26 and she denied the drug usage but did agree to submit to a urinalysis which showed positive for marijuana. When confronted on April 17, she admitted to occasional marijuana usage. Other drug tests later administered were negative. Colton's mother agreed in a safety plan on April 30, 2013 to stop using drugs and to keep Colton away from a drug use environment.

The investigation caseworker classified the neglectful supervision allegation as "unable to determine" since there was no indication that the mother's drug use had impacted her care of Colton and ruled out the other allegations. Colton's mother tested negative on an instant drug swab on June 11, 2013. The case was closed on June 13, 2013.

Policy violations:

- The investigation was not completed within 60 days.
- The investigation caseworker did not address the alleged risk of sexual abuse of Colton.

Areas of concern:

- The living conditions for the family were not appropriately investigated. Due to concerns about Colton's safety and care, CPS management directed the caseworker to meet with the family and discuss the living conditions and direct them to move out of the current residence. There is no documentation that staff ensured the change in residence had occurred.
- Identified risk factors to Colton justified referral by CPS investigation staff to Family Based Safety Services. This did not occur.

On June 17, 2013, several days after the prior investigation was closed, CPS received a report that alleged the physical abuse and neglect of Colton, and that he suffered from severe diaper rash. The report also stated there was continued drug use in the home and the risk of sexual abuse by a relative.

An investigation caseworker saw Colton on June 19, 2013 and observed no visible injuries. Multiple drug tests administered to Colton's mother during the course of the investigation were negative.

Colton was not seen by CPS from June 19 to December 18, 2013. The first and second investigation caseworkers assigned to investigate this report both left the agency. A CPS Special Investigator[2] was assigned on August 27, 2013, with directions to increase efforts to locate the family. Multiple attempts to locate Colton were made during this time period. The Special Investigator saw Colton in his home on December 18, 2013. However, the Special Investigator did not document Colton's condition, and although written documentation indicates a photograph was taken, there is no photo of Colton in the case file. During this visit, drug tests administered to the boyfriend and mother were negative.

The final time CPS saw Colton was on March 3, 2014, by the special investigator.

The case was closed on March 3, 2014 with all allegations ruled out.

Policy violations:

- Colton was not seen by CPS for extended periods of time because of case reassignment and difficulty locating the family. CPS did not exhaust every resource to locate Colton.
- The report was inappropriately downgraded to a less urgent classification (Priority 2). Given the CPS history and very young age of the child, it should have been classified as Priority 1.
- Investigation caseworkers did not address all of the abuse/neglect allegations.
- The Special Investigator did not document Colton's health or condition during the face-to-face visit.
- There were no photos of Colton in the case file.
- The investigation was not completed within 60 days, although the Special Investigator made multiple attempts to find the mother and child between August 27 and December 18.

[2] CPS Special Investigators are skilled investigators, typically with former law enforcement experience, who are assigned to complex CPS investigations and those with intense law enforcement involvement.

Areas of concern:

- Given the circumstances and the allegations, there should have been a home visit before closing the case as stable housing had been an issue for this mother and child.
- The assigned worker did not follow up on the concern about the alleged sexual abuse victimization.
- CPS staff did not contact a potential collateral source for pertinent information about the mother, including possible locating information.
- As the family could not be located, a Special Investigator was assigned to the case; however, the Special Investigator also could not locate the family. The Special Investigator should have immediately notified the supervisor of this issue so that additional resources could have been explored to locate the family.

About two months later, on **May 21, 2014,** CPS received a report that Colton had bruises and slap marks, and alleged continued drug use by Colton's mother and her boyfriend. The reporter indicated there were photos of Colton's injuries. The investigation caseworker initiated the investigation on May 23 by talking to two individuals who knew the family, including the reporter. The investigation caseworker never requested the photos. On June 14, 2014, CPS received an anonymous report that Colton had visible injuries and that he looked ill in photographs posted on the mother's Facebook page. The report also alleged that Colton's mother was still using drugs. The assigned investigation worker was on vacation at this time and no other investigation caseworker was assigned to look for Colton.

From May 21 until August 28, 2014, no significant effort was made to locate the family despite CPS having multiple sources of information that could have been pursued. The investigation caseworker never saw Colton Turner during this period.

On August 28, 2014, CPS received another report and it was assigned to a new investigator who immediately began looking for Colton and his mother. The new investigator worked closely with law enforcement and ultimately learned of Colton's death on September 12, 2014.

When DFPS learned of Colton's death, an internal review found multiple CPS policy violations and serious concerns about the open investigation. Despite reports for two months that Colton was physically abused, including physical evidence in the form of photos on the mother's Facebook page, CPS made no attempts to locate Colton until it received another report on August 28, 2014.

Policy violations:

- No investigation worker saw Colton and the caseworker did not receive supervisory approval for extending the investigation in order to find the family.
- The investigation caseworker and supervisor did not exhaust all available resources to locate the family.
- The investigation was not completed timely and lacked attention to child safety factors.

Areas of concern:

- The June report was inappropriately assessed and no investigation worker was assigned to find Colton with the additional information provided
- There was no urgency demonstrated by the worker, supervisor and program director about whether Colton was safe.

As a result of this review, DFPS has taken or will take these actions:

- DFPS has terminated three employees: the investigation caseworker, supervisor and the program director who had responsibility for the May 21, 2014, investigation.
- To ensure the safety of children who are possible victims in pending Travis County investigations, CPS has assigned additional Master Investigators. By October 6, there will be 10 Master Investigators and three Master Investigator Supervisors assigned specifically to Travis County.
- Special investigators from other parts of the state will be temporarily reassigned to Travis County to assist investigative caseworkers with delinquent and difficult investigations.
- A program director from another region is assigned to support staff in the investigation units formerly overseen by the program director who was terminated.
- By October 15, 2014, CPS investigation caseworkers will be instructed to record differently the date and time of all face-to-face contact with alleged victims. This change will allow CPS to better track face-to-face visits with children in investigations.
- CPS began a targeted case review process on September 29 in Travis County using specialized reviewers from outside the region. A team of case readers from the Child Safety Specialists and CPS Quality Assurance teams will review the open investigations, prioritizing cases with children 5 or younger with previous CPS reports and when no actual initial contact is recorded. The case reviewer will identify and refer any cases needing immediate action. As that concludes, reviewers also will examine recently closed cases using the same tool. Plans to expand beyond Travis County will be formulated based on the issues that arise from the case review.

- Pursuant to some allegations of unfair and ineffective management practices in the Central Texas region of the agency, CPS has requested a Management initiated investigation (MII) by the HHSC Office of Civil Rights (OCR).
- DFPS Internal Audit is conducting a review of the use of Child Safety Specialists and Special Investigators. The audit will look specifically at the role of these specialist positions and how CPS can more effectively use them.
- CPS will implement a research-based tool to guide and support child-safety decisions. CPS will require investigators to conduct and document a safety assessment within 24-hours after first contact with victim(s). Early adopters in each region will begin using the tool in January 2015, and all CPS Investigators will begin using the tool by April 2015.
- CPS is reviewing policy regarding how new reports are handled in open investigations and will issue new directives if needed.
- CPS is reviewing policy regarding when home visits are required in investigations and will issue new directives if needed.
- IMPACT, the CPS database for cases, is being upgraded and CPS will seek improvements in how historical data on closed investigations is stored for ease of review.