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 July 25, 2016, during an open Child Protective Services (CPS) investigation, 3 month old Legend Dary died as a result of injuries caused by physical abuse. The child presented at the hospital on July 23, 2016, unresponsive, with injuries (skull fractures and a severe brain injury) of unknown cause. The criminal investigation remains pending at this time.

The Office of Child Safety completed a review of all current and past CPS involvement concerning Legend Dary. 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 Legend Dary	Age at time of incident
Legend Dary	3 months old
Mother	21 years old
Sibling	2 years old
Unrelated home member/baby-sitter	50 years old

Summary of CPS History on Family of Legend Dary

- On November 4, 2014, CPS received a report of neglectful supervision of Legend's sibling by their mother. The case was investigated and the allegations were ruled out and the case was closed.
- On July 17, 2016, CPS received a report of physical abuse of Legend's sibling and neglectful supervision of both children by their mother. The report was assigned for investigation and remained open at the time of the child's death.
- On July 23, 2016, during an open investigation, CPS received a report regarding Legend's admission to the hospital with a "grim" prognosis due to multiple injuries associated with abusive head trauma.
- On July 23, 2016, a second report was received with the same allegations from the July 17 and 23 earlier reports.
- On July 24, 2016, Legend's sibling was removed and placed in foster care.
- On July 25, 2016, Legend was pronounced deceased as a result of his injuries.

Detailed Account of CPS History on Legend Dary

On **November 4, 2014**, CPS received a priority one referral which indicated that a relative was the usual caregiver for Legend's older sibling, who was approximately 4 months old at the time.

The relative was no longer residing in the home and the child was in the care of the mother. The mother was reported to be diagnosed with Bipolar Disorder and not compliant with her medications or treatment. The mother was also alleged to leave the child unattended on the couch and became angry and throw things and yell and had yelled at the infant “Shut the f*** up!” It was alleged that the child would be found in a soaking wet diaper with “feces hanging out.” The report also stated that the mother was selling prescription drugs. There was concern that the mother was having issues with attachment to the child and that she had made comments of wishing she had “given the child away” and made comments during the pregnancy that she wanted to have an abortion.

The worker attempted contact with the reporter without success and attempted a home visit on November 4, 2014. The worker made contact with the mother by telephone and an appointment was made for the following afternoon. The worker interviewed the mother on November 5, 2014. The mother reported a great deal of conflict between the grandmother and herself and reported that her mother was diagnosed with bipolar disorder and would throw and break things in the home. The mother reported that she was raised at times by her own grandmother and that she and her mother had a strained relationship. The mother reported she had previously been in counseling for 3 years and taken medication for bipolar disorder but that she is “fine now.” She was given an oral swab drug test but the result was invalid. The mother denied the allegations as reported.

The worker requested law enforcement reports for the mother and found only two, one in which she was arrested for shoplifting and the other in which she called the police after a friend became angry with her and slapped her two times in the face. The worker spoke with the child’s pediatrician on December 30, 2014 and they reported they had seen the child 3 times with no concerns noted but that the mother had recently called and indicated the child fell off of the bed. The worker then spoke with a relative, who lived out of state, and denied she had concerns for the child’s well-being and reported receiving photos of the child frequently.

OCS Assessment:

- The case was not initiated timely in accordance with CPS handbook policy 2243.1. The worker attempted contact at the residence on November 4, 2016 but did not make contact with the family. Contact was not made until the afternoon of November 5, 2016.
- There is no documentation of contact with the child in this case. While the narrative states the worker met with the mother and child at the residence, there is no narrative contact relating to the observation and assessment of the child. No photographs were taken or could be located in external documentation of the case. CPS handbook policy 2244.4 requires that the alleged victim be photographed. CPS handbook policy 2244.3 outlines the requirements for visual examination of children for signs of physical abuse or physical neglect.
- The worker contacted law enforcement and the child’s pediatrician as professional collaterals.
- The documentation in the narrative was minimal and did not include specific plans for the safety of the infant.
- The mother admitted that she was previously diagnosed with bipolar disorder and prescribed medication which she was no longer taking. The worker did not request previous mental health records or ask the mother to complete a mental health assessment.

- The worker drug tested the mother but the test returned as “invalid.” No further testing was completed and the allegation of substance abuse was not resolved although the allegation was given a ruled out disposition and the case was closed.
- The worker only made one attempt to speak with the reporter by phone and then did not follow up again. The worker did not have contact with the maternal grandmother or anyone with whom the mother and child had frequent contact and could speak to family functioning and her ability to parent.

On **July 17, 2016**, CPS received a report alleging the neglectful supervision of Legend and his sibling by their mother and physical abuse of Legend’s sibling by the mother. The intake was received as a priority one referral but was downgraded to a priority two due to “additional calls made.” The report stated that the mother was diagnosed with Bipolar Disorder and did not take her medication and was “very violent” and this included family members. The report stated that the mother had “very aggressive behavior” and that she struck the 2 year old child “every day.” The report indicated that there were numerous police reports as the mother had been engaging in violent altercations with numerous neighbors and that the 2 year old child was present during these and was knocked down during one of them. The mother was reported to pull pepper spray on a neighbor and then run inside the home when it overwhelmed her and she closed the door, leaving the 2 year old outside the home. The report stated that the mother had been unable to buy a legal handgun because of her numerous arrests so one was purchased off the street and she had pulled it out, including in front of the 2 year old, and there is a video proving this occurred. The mother was reported to have no interaction with Legend and did not care for or feed him, leaving this to the grandmother. It was reported that Legend’s sibling would “flinch” when touched and it was believed because of her being struck and so she had started to do the same to her infant brother, Legend.

Due to the case being downgraded, it no longer required joint investigation with law enforcement and thus law enforcement was not engaged at the initial contact. The worker observed both Legend and his sibling on July 18, 2016 and noted that there were no obvious indications of abuse or neglect present. The worker obtained consent to enter the home from the mother. The mother admitted that she had recently engaged in an altercation with a neighbor but denied being “on the run” from her probation officer. She denied all of the allegations and stated that the only “hitting” that she does is slapping the 2 year old on the hands. Safe sleeping was discussed with the mother and she showed the worker where the children were sleeping. The mother completed an oral swab drug test which returned an invalid result. The mother denied in this interview that she was diagnosed with bipolar disorder and stated that she took medication when she was in high school but stopped when she was 18 years old.

The worker spoke with a relative, who had other children in foster care and not in her custody after an arrest. She stated that she believed the mother was experiencing post-partum depression and that she spanked the two year old “a little too hard” and that she was concerned her daughter would “end up on the news” if she left the children alone in her care.

The worker staffed the case with the supervisor and was instructed to put a safety plan in place that the mother would receive a mental health evaluation, not use physical discipline with the children, and not argue or fight with the grandmother in front of the children. However, the mother had already left the residence so a safety plan was not completed at that time.

On July 18, 2016, the mother sent a text message to the worker stating that she expected her probation officer to put her in jail the following day and asked that the caseworker come and

pick up her children. The worker replied that she would not be able to do this without a reason and she would staff with her supervisor and asked the mother to meet her at the residence the following morning, to which the mother agreed.

On July 19, 2016, the worker met with the mother again at the home. She was advised that the worker had contacted her probation officer and she did not have a warrant for her arrest but she needed to comply with all terms in the future. She was asked to sign the safety plan the supervisor had requested with the added task of completing a urine drug screen. The mother told the worker that she “did not want” her son, Legend. She stated that she wanted to place the child for adoption when he was born but her mother had told her she would care for him. She repeated that she did not want him and wanted to find him a better home. The worker stopped the conversation with the mother to staff the case with the supervisor. The supervisor advised the worker that CPS did not “have anything to do with that” and that there were “places like Buckner” where the mother could take her child to place him for adoption. The mother told the worker that she did not wish to place her daughter for adoption but she did wish to place Legend and that his father was not involved with him and she wanted to give him a better home. The worker told the mother the information for the services and resources would be sent to her and sent her a text message with the information for drug testing later in the day. The worker submitted a referral to Family Based Safety Services (FBSS). The worker also spoke with law enforcement who advised they had received a report about the mother kicking the 2 year old child and they responded but the mother denied this action and the child had no obvious signs of injury at that time.

On July 20, 2016, the worker received additional text messages from the mother asking for the information where she could place her child and that she needed to do this “ASAP” as her mother had left the home and was not returning. The worker told her to stay by her phone and she would obtain the information. The worker then staffed the case with the supervisor and advised that the worker needed the information to provide the mother for placement of her child as the mother was adamant that she did not want to care for Legend. The supervisor instructed the worker to provide the number to the mother and not communicate about it further as this was not the role of CPS to “do the work for her.” The worker provided the mother with the information and reminded her about taking the drug test before the end of the day. The mother sent a text message telling the worker they could come and get the children because she was not doing anything else that “they” say. She told the worker twice they could come and get the children and she would not be doing any of the tasks requested. The worker informed the mother the best solution would be for her to place the children with a family member. The worker spoke with two personal collaterals the mother had provided and both stated that they did not have concerns for the safety or well-being of her children. The children’s pediatrician was contacted and the worker was advised Legend had missed both is one and two month check-up but the doctor did not have concerns when seeing the child at 20 days of age.

On July 21, 2016, the worker received additional text messages from the mother asking if the worker was coming to pick up the children. The mother stated that she was moving and the worker could come get the children. The worker told the mother there was not a reason to come get the children but to please advise the agency of her new location. The mother replied that she was not communicating with the worker after her move and that she did not want “either one of (her) kids” and if “you all want them to come and get them.” The mother followed up with asking if there was someplace that the children could be dropped off as in the next two days, they would have to sleep in a car with the mother who was being evicted from her apartment. The worker staffed the case with the supervisor and informed the supervisor of the text

messages received from the mother and that the worker had not engaged the mother, per the supervisor's instructions.

OCS Assessment:

- The case was initiated timely, as required by CPS Handbook policy 2243.1.
- The case was downgraded from a priority one referral to a priority two due to "additional calls made" given as the supporting rationale; however, no calls were documented in the narrative. The information contained in the narrative, along with the age of the children in the report, was not appropriate for downgrade.
- The mother repeatedly told the CPS caseworker in a series of text messages that she did not wish to be the caregiver for her children any longer and wanted the agency to take custody of the children. The worker repeatedly shared this information with the supervisor and asked for resources to assist the mother with placement of the children and also staffed the case for removal of the children due to the worker's concern for the safety. The worker was repeatedly instructed not to engage with the mother and to give her the phone number for a resource and allow her to handle the required tasks from there. The case was staffed with the supervisor repeatedly and with a program director on June 19, 2016. The program director advised that the safety plan in place was correct and that there was not sufficient information for a removal of the child at that time.

On **July 23, 2016**, during an open investigation, CPS received a report regarding Legend being in the hospital with critical injuries believed to be the result of physical abuse. The child was intubated and non-responsive with two skull fractures and severe brain injury. The child's prognosis was reported to be "grim". The mother and baby-sitter were both interviewed and gave conflicting timelines. Legend's older sibling was removed and placed in foster care after the report was received. Later on **July 23, 2016**, a second report was received alleging the neglectful supervision and physical abuse of both children by their mother. The report alleged the mother was seen kicking the older child in the back and stomach the previous weekend. Law enforcement was contacted but did not see any injuries. The report alleged that the mother neglected Legend and would not provide care for him for hours at a time and had said she did not want him but had not made arrangements to place him for adoption. The report alleged that the mother snorted cocaine and smokes marijuana "every day" and that Legend had been transported by EMS earlier in the day and was hospitalized in ICU.

On **July 25, 2016**, Legend was declared deceased. A perpetrator of the injuries was not able to be identified. There were multiple caregivers of the child. There was a companion investigation completed on the baby-sitter which resulted in a ruled out disposition.

Overall Case Review Findings and Recommendations

The agency was involved with the family for two investigations, one of which remained open at the time of Legend's death. The allegations in each of the two referrals were similar and involved the mother being a young parent to very young and vulnerable children, to be diagnosed with bipolar disorder and not medication compliant, to be volatile and engaging in violence, to not provide appropriate care for the children, and allegations of drug use. There was an inappropriate assessment of the circumstances in each instance of involvement with the family. The mother was not asked to do a mental health evaluation in the first investigation nor were her mental health records requested. The mother tested "invalid" on both drug tests she was given. In the closed investigation, no follow up was done on this and the case was closed with a ruled out disposition despite the allegation not being adequately or appropriately addressed. In the open investigation, the mother repeatedly told the worker in person and over text message that she did not wish to care for her children, and specifically stated she did not

wish to parent Legend on multiple occasions. The worker appropriately staffed this information with the supervisor and program director and brought the concerns to their attention for further action. The chain of command denied further action and admonished the worker for allowing the mother to manipulate the worker into doing the necessary tasks for her instead of giving the mother the information and telling her to handle the follow-up and not engaging in a “back and forth” with her. The worker expressed great concern for the circumstances of the case and the mother’s repeated statements that she did not want her children.

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 Office of Child Safety recommends the following:

- Ensure staff are receiving adequate and appropriate training and guidance to make appropriate assessments of cases that should be responded to as a priority one referral instead of a priority two. Ensure staff have thorough understanding of the information necessary to support the downgrade of an intake report while ensuring it is appropriate for child safety.
- Ensure staff are receiving adequate and appropriate training and guidance regarding the safety threat to children when a caregiver experiences a lack of attachment or bonding with a child, particularly young, non-verbal children. Ensure training addresses how to elicit information from parents and caregivers to appropriately assess this, how to identify “red flag” concerns, and what observations of parents and children should be clearly documented in the narrative.
- Ensure staff are aware of the need to follow up with drug testing when an “invalid” result is received and the allegations, dynamics in the case, or previous CPS or criminal history present cause for concerns for substance abuse.