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 June 12, 2016, during an open Child Protective Services (CPS) investigation, 3 month old Leanna Fuentes was found deceased while co-sleeping with her mother, who tested positive for cocaine and admitted to using Xanax, alcohol, and smoking marijuana.

The Office of Child Safety completed a review of all current and past CPS involvement concerning Leanna Fuentes. 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 6- Harris County

Name or Relationship to Leanna Fuentes	Age at time of incident
Leanna Fuentes	3 months old
Mother	27 years old
Sibling	3 years old
Sibling	1 year old
Unrelated home member	61 years old

Summary of CPS History on Family of Leanna Fuentes

- On July 23, 2012, CPS received two reports alleging the neglectful supervision of a newborn by their mother. The investigation was ruled reason to believe (allegation confirmed) and was referred to Family Based Safety Services (FBSS).
- On August 16, 2012, CPS initiated an FBSS case for the mother and her newborn. Services were provided and the case was closed on March 11, 2013.
- On February 29, 2016, CPS received a report alleging the neglectful supervision of Leanna Fuentes and her sibling by their mother.
- On June 12, 2016, during an open investigation, CPS received a report of Leanna's death. At the time of the response to the fatality, it was learned there was also a one year old child in the home. Both of Leanna's siblings were removed and placed in foster care.

Detailed Account of CPS History on Leanna Fuentes

On **July 23, 2012**, CPS received two reports alleging the neglectful supervision of a newborn by the mother. The report indicated that the mother had been admitted to the hospital approximately one month prior to delivery and had tested positive for cocaine, marijuana, and benzodiazepines on a urine drug screen. The mother was then discharged. The mother

returned on July 23, 2012, and delivered her newborn, and again tested positive for benzodiazepines.

The caseworker received initial staffing instructions from the supervisor prior to initiating the investigation. The supervisor advised the worker to obtain a Parental Child Safety Placement (PCSP) and put a safety plan in place if the mother did not have valid prescriptions to explain the positive drug test. The worker made contact with the infant and the mother at the hospital, within policy timeframes. The mother reported that she did not have a prescription for Xanax but that she had been using it for approximately 4 years. She admitted to smoking marijuana in June and stated she "could not remember" when she last used cocaine. She reported that she planned to "give" her newborn to her mother and that while she wanted to raise the child, the infant was "better off" in her mother's care. There are no details of any safety arrangements made at the time of initial contact; however, the maternal grandmother participated in an interview and indicated she was willing to provide care for the newborn.

The investigation was ruled reason to believe and was referred to Family Based Safety Services (FBSS). The narrative indicated that the mother was in a treatment program at the conclusion of the investigation. It was not clear where the infant was living.

OCS Assessment:

- The case was initiated timely in accordance with CPS Handbook policy 2243.1.
- It is not clear why a PCSP was not put into place or the mother's access to her child limited due to her positive drug screens both while pregnant and at delivery.
- The documentation in the narrative was minimal and did not include specific plans for the safety of the infant.
- It appears from future documentation the child was placed in a PCSP at one point and then possibly entered the drug treatment facility with the mother. However, none of these details appear in the narrative documentation and it appears to have been completed in some type of shortened format.

On **August 16, 2012**, CPS initiated an FBSS case for the mother and her newborn. The FBSS worker completed the FBSS assessment on August 16, 2012. The recommended services were substance abuse treatment, parenting classes, and individual counseling to address domestic violence in a prior relationship. On September 12, 2012, the worker met with the mother and her substance abuse counselor who indicated that she was participating well in treatment. The mother had completed approximately 45 days of intensive in-patient treatment at that time and was soon to transition to supportive out-patient. The mother said she had completed an assessment with the local mental health authority and was told she did not qualify for services. The mother said she understood that she would have to remain supervised with her child until further notice. The infant was seen in the facility's child care center with no concerns noted. The mother also self-reported that the infant had a screening with Early Childhood Intervention (ECI) and they had advised her the child would be reassessed at 6 months and one year of age.

On October 4, 2012, the worker met with the mother, her infant, and the substance abuse counselor. The mother was completing 6 hours a week of substance abuse counseling at this point. The mother had begun a medication to assist her with anxiety. The worker included detailed documentation about the infant's appearance, development, condition, and the mother's interaction with the child. On October 12, 2012, the worker met with the mother, grandmother, and the grandmother's boyfriend at their residence and completed an assessment of the home environment and had already completed background checks and collateral

reference checks. A new safety plan was completed. These actions were discussed with the mother's substance abuse counselor, the supervisor, and Program Director for the case and received approval. On October 24, 2012, the mother submitted a negative drug test. On October 30, 2012, the mother contacted the worker and was crying. She indicated that her mother was trying to take her son before finally admitting that she had been in contact with one of her old boyfriends (who was a known drug user and dealer) but denied she had been using drugs.

On November 1, 2012, the mother called the worker again and stated she wanted to leave the home. The worker spoke with the grandmother who reported that she had an argument with the mother. The mother did not return to the residence until 4:30 AM and the grandmother was concerned that the mother was using drugs again. The grandmother also stated that the mother was engaging with her "old dealer." The worker called the mother and left a message with an unknown male that the mother needed to take a drug test by the following day. A short time later, the worker received a call back from the same number indicating that the male was concerned for the mother as she had an argument with the grandmother, was very upset, and he had witnessed the mother taking a large number of pills. The worker met with the mother and grandmother in the home on November 2, 2012 and they agreed to continue to work things out. The mother completed the requested urinalysis (UA) and it was returned as negative.

The worker met with the mother on December 19, 2012, and she admitted she had not attended her required classes in almost a week and did not have a valid reason for not doing so. The worker explained that the mother was jeopardizing her sobriety and custody of her son by not participating in the agreed upon services. The worker included detailed documentation of the observation and interaction of the infant and information provided by the family about the child's medical appointments. The mother completed a UA that was negative..

The worker met with the mother, grandmother, and infant at the CPS office on January 11, 2013. The mother expressed she had re-engaged in her services at the treatment facility and that she had completed her psycho-social assessment prior to the meeting with CPS and understood she would need to follow the recommendations. The worker observed the infant and mother's interaction and included detailed information about this and the child's appearance. The worker made contact with the service provider at the facility who indicated mother participated well in November, only attended two sessions in December, and was now reportedly re-engaging. The worker spoke with the provider who administered the psycho-social assessment who recommended that the mother continue with the treatment plan and engaging in parenting, counseling, and random UA screenings.

The worker met with the mother, grandmother, and child at the residence on February 14, 2013. There were no concerns noted. The worker received information from the service provider engaging the mother for treatment on February 19, 2013, and was informed that the mother had re-engaged with services and her attendance had improved, attending 7 sessions in January. The mother completed a UA which was returned as negative.

The case was closed with "risk reduced" on March 11, 2013.

OCS Assessment:

- The case was initiated timely, as required by CPS Handbook policy 2530, Contacting Principals that Receive FBSS.

- The worker had monthly contact with the mother and child and entered detailed narrative discussions about the mother's participation in services, the child's development and condition, and observations of the mother's interaction and bonding with the child.
- The worker obtained background checks on all necessary persons and completed a home visit and new safety plan prior to approving the mother's move to a new location.
- When the worker received new information, the mother was requested to take a drug test.
- The worker maintained contact with service providers although details obtained about progress from those providers was minimal.
- It is not clear that the mother completed any of the recommended services but was still engaged in them at the conclusion of the case.

On **February 29, 2016**, CPS received a report alleging the neglectful supervision of Leanna Fuentes and her sibling, by their mother. The report indicated that the mother was living in a motel and had tried to sell her 1 week old child (believed to be Leanna) to her next door neighbor. The 3 year old sibling had been observed unattended in the parking lot of the motel. The door to the motel room was left open and the mother was reportedly found "passed out" in the bed, asleep, with the 1 week old child with "blankets all over her face" and the child was believed to be at risk of suffocating. There were concerns that the mother may have been using drugs and potentially prostituting herself. The case was received as a priority one referral but was downgraded with the reason noted "additional phone calls made" after the reporter was contacted and advised they did not have first-hand knowledge of the information in the report. The worker reportedly attempted contact at the motel on March 3, 2016. The worker was informed that a woman matching the description of the mother had vacated the hotel on March 1, 2016. On May 18, 2016, the supervisor entered a staffing labeled "action plan" in the narrative and indicated that the mother had CPS history and the worker should contact relatives and others from that history in an attempt to locate her and the worker should re-staff the case if those attempts were not successful. A home visit was attempted on May 24, 2016, at an address located in a database, and the person who answered the door stated that they did not know the mother. On June 6, 2016, the supervisor documented a staffing which indicated that attempts to locate relatives had not been successful, although additional attempts had not been documented, and that the worker should update the contacts and prepare the case for referral to a special investigator. At the time of the fatality, this had still not occurred. No additional contacts were documented in the case and after the fatality the staff indicated that there were no additional attempts or efforts made on the investigation.

OCS Assessment:

- The case was not initiated timely, as required by CPS Handbook policy 2243.1.
- The case was downgraded from a priority one referral, which required contact within 24 hour hours, to a priority two referral, which expanded the contact window to 72 hours. The information contained in the narrative, along with the age of the children in the report, was not appropriate for downgrade. The lack of response to the case within 24 hours meant that the mother had vacated the location prior to initial contact being made.
- When the fatality investigation was initiated, the mother reported that the hotel staff had informed her the worker had come there looking for her and the worker left a card there for her but she never heard back from the worker.
- After the attempted contact on March 3, 2016, no contacts occurred on the case until May 24, 2016, which was over two months after the initial attempt. No explanation was provided for the delay in contact.

- The unable to complete case protocol was not followed and a special investigator was not requested although the family had not been located over three months into the investigation.

On **June 12, 2016**, during an open investigation, CPS received a report regarding Leanna's death. The mother was co-sleeping with Leanna and when she woke up, she discovered the child unresponsive. The mother reported that she had laid down on a couch with the child in her arms. At the time of CPS response to the home, the mother was asked to undergo drug testing. The mother tested positive for cocaine and admitted to using alcohol, marijuana, and Xanax, for which she did not have a prescription. Leanna's siblings were removed from their mother's custody and the court ordered them to be placed with maternal relatives.

Overall Case Review Findings and Recommendations
The agency was involved with Leanna's mother for two investigations and one FBSS case. The mother has a long history of abusing Xanax and other drugs. She engaged in services through her FBSS case but the case was closed prior to her completing those services, although she remained engaged at the time of case closure. The FBSS worker drug tested the mother multiple times throughout that case and the mother returned negative tests. The mother did have a support network in place at the time of case closure.

There was an open investigation at the time of Leanna's death and contact had never been made with her or her family. The report was downgraded from a priority one to a priority two although the allegations and age of the children supported a priority one response time. The delay in time to initiate the contact led to the family reportedly no longer being present when the worker attempted to initiate the case three days later. Once the investigator could not locate the family, efforts to locate should have been made and documented, such as: contacts made with relatives whose information was available through prior case history, internet searches, follow-up with the reporter, and the assistance of a special investigator should have been requested.

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 supervisors are receiving adequate and appropriate training and support to monitor the workloads of their workers to ensure they are in compliance with timeframes for documentation, contacts with children and families, and ensuring appropriate safety measures are in place for children where it is necessary.
- Ensure staff are aware of requirements for assigning a special investigator to a case when unable to locate a family and the urgency required of completing the Unable to Locate checklist and of the resources available to assist with locating children and families.
- Ensure staff are aware of CPS policy requiring children who are not able to be located being placed on the Child Safety Check Alert List in a timely manner.