# TEXAS DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

**COMMISSIONER**
John J. Specia, Jr.

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

Over the course of six years, Child Protective Services (CPS) received fifteen reports and conducted nine investigations into allegations that Ryan Welch or his siblings had been abused or neglected. The majority of those investigations remained incident driven and either failed to delve into underlying issues in the home, or failed to provide recommended services to the family. While CPS was in the process of seeking legal intervention to address both immediate and ongoing concerns, Ryan died from a gunshot wound. This report describes the major issues found during the review of Ryan's death and actions that CPS is taking to address those issues.

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.

Several of the historic issues noted in investigations involving Ryan's family are contributing to revisions of CPS practice and policy as part of CPS Transformation. For example:

- A program specialist has been hired to provide additional support to field domestic violence concerns. Other efforts currently underway will address domestic violence in investigations and service delivery including enhancements to training, guidance on dispositions and utilization of services to address family dynamics, intimate partner violence, and impact of trauma on the family.
- Risk assessments and structured decision-making tools are being implemented. The safety assessment tool will assist a caseworker during the first contact with a child and family, a critical opportunity to assess safety. The new risk assessment tool will be more objective and based on actuarial principles that have been scientifically accepted and adapted for Texas.
- The case transfer process between Investigations and FBSS staff is being simplified and expedited. That fluid transition begins once an investigator identifies that a family can benefit from ongoing services.
- The Child Safety Review Committee, a standing workgroup of external and internal stakeholders to CPS, has identified the need for ongoing training and resources to staff surrounding firearm safety guidelines and working with families to address child safety when firearms are in the home or may be accessible to children.
- An audit of the Child Safety Specialists is currently underway to strengthen these subject matter experts' roles in addressing child safety. Child Safety Specialists are legislatively mandated positions designed to assist regional staff in assessing and addressing risk and safety for children. The Child Safety Specialist provides feedback on case related

issues involving policies and practice standards to enhance service delivery, especially on high-risk cases when families have had multiple referrals to DFPS and also must approve certain investigations prior to closure. This includes approving investigations involving child fatalities or when an investigation has a disposition of reason to believe, unable to determine, or unable to locate and involves a child under the age of four where no services will be provided to the family at case closure.

**Summary of CPS History on Ryan Welch / Family of Ryan Welch**

- Intake #1: December 2, 2009 - February 1, 2010 / Completed Investigation
  - Intake #2: December 19, 2009 - December 22, 2009 (addressed in Intake #1)
  - Intake #3: December 30, 2009 - December 31, 2009 (addressed in Intake #1)
- Intake #4: March 1, 2011 - May 19, 2011 / Completed Investigation
- Intake #5: June 14, 2011 - July 16, 2011 / Completed Investigation
- Intake #6: September 12, 2011 - December 19, 2011 / Completed Investigation
- Intake #7: April 15, 2013 - May 10, 2013 / Completed Investigation
- Intake #8: July 13, 2013 - August 5, 2013 / Completed Investigation
- Intake #9: August 27, 2013 - November 20, 2013 / Completed Investigation
- Intake #10: May 19, 2014 - June 19, 2014 / Completed Investigation
  - Intake #11: May 20, 2014 - May 21, 2014 (addressed in Intake #10)
- Intake #12: October 25, 2014 (currently open) / Open Investigation
  - Intake #13: Nov. 8, 2014 - Nov. 10, 2014 (addressed in Intake #12)
  - Intake #14: Nov. 20, 2014 - Nov. 21, 2014 (addressed in Intake #12)
  - Intake #15: Nov. 20, 2014 - Nov. 20, 2014 (addressed in Intake #12)

On **December 2, 2009**, Ryan's parents were investigated for neglectful supervision, physical abuse and physical neglect of Ryan's oldest brother. Allegations included a lack of food in the home, no utilities, and ongoing domestic violence. There were concerns that the child was malnourished and below size for his age. Allegations also included that the parents were leaving the child with a relative whose disabilities prevented him from caring for the child. Two additional intakes were received during the investigation alleging that there were no heat/utilities in the home and that the home had significant health and safety hazards such as roaches, rodents and cat excrement throughout the home.

The investigator followed up with law enforcement. There were no records of domestic violence calls involving either parent or child. These allegations were ruled out because the home had working utilities and parents denied domestic violence. The investigation closed in February 2010.

**OCS Assessment:**

- While the investigation was initiated within 72 hours as a Priority II investigation, attempted and actual contact with the family was not made within required time frames. CPS Policy 2348. Follow-Up When Contact Is Not Made Within Priority Time Frames requires that an action plan must be developed and include attempts to contact the child no less than once every 72 hours until the case is formally staffed for closure as *Unable to Locate.* The mother was contacted by phone 19 days after the intake and the child was not seen face-to-face until January 17, 2010, 46 days after the intake.
- The investigator received information about the child's primary care physician and immunization status, but there was no documented follow-up with this provider. Concerns about the child's weight were not addressed in the investigation.

- The physical neglect allegations were ruled out although the concerns were not addressed in the investigation.

On **March 1, 2011**, Ryan's parents were investigated for physical abuse of the children based on concerns surrounding domestic violence between the parents while the children were present. There were additional concerns regarding the children's access to drugs when at their father's home. Both parents admitted to having arguments with the children present but denied physical aggression. The children had no visible injuries during the investigation. The home condition was clean and orderly. The investigator made contacts with professional collaterals to check on any concerns with the parents or children; no concerns were noted with the care of the children, no concerns of substance abuse, and reports that both parents were appropriate with the children. The allegations were ruled out and the investigation closed in May 2011.

**OCS Assessment:**

- The investigation was not initiated timely and actual contact with the family was not until May 2011. CPS Policy 2253. Time Frames for Initiating Priority I and Priority II Investigations requires a Priority II investigation to be initiated with 72 hours.
- The safety assessment was not completed until May 2011.CPS Policy 2311.2. Time Frames Related to the Initial Safety Assessment requires that the safety assessment be completed within the first seven days after the investigation is initiated.
- While the father had completed anger management classes just prior to the investigation, the reported altercation occurred after completing this service. This repeat incident after services had been completed suggests that additional interventions or services were necessary to address the domestic violence occurring in the home.
- An incident of domestic violence had been reported but then downplayed by the family. The difference in the explanations between the original domestic violence incident and then the follow-up discussion show a minimization of the concerns and safety threats present in the home.
- The concerns of substance abuse were not fully explored, as there was no drug test completed.

On **June 14, 2011**, a new intake was received alleging neglectful supervision as Ryan's sibling was able to get out of the home early in the morning and get into the front seat of a car without an adult present. Additionally, there were allegations of physical abuse regarding the domestic violence previously investigated. The allegations of neglectful supervision and physical abuse were ruled out as the child was able to get out of the home but the parent followed outside after him. The parents safety proofed the home so that the child could not get outside again on his own. The investigator contacted professional collaterals to confirm the welfare of the children and check on any concerns regarding the family. Parents completed drug tests and were negative. The investigation was ruled out and closed in July 2011.

**OCS Assessment:**

- The allegations surrounding domestic violence were not explored with the mother.

On **September 12, 2011**, an investigation was launched after allegations of medical neglect, neglectful supervision and physical abuse were received. Allegations included that the mother hit Ryan's sibling daily and grabbed the child by the hair; there were concerns that Ryan was supposed to wear a special cast for his clubfoot but that the parents did not make him wear the

cast; and it was alleged that the parents leave the children with a family member who suffers from medical conditions that render him unable to care for the children. During the investigation, it was noted that home environment appeared somewhat unstable as the parents continually separated and reunited, moving frequently between homes of their own and that of their relatives. The investigator noted that while the parents denied any domestic violence, others have reported witnessing the altercations and case history suggests that there is domestic violence occurring. During the investigation, the worker contacted professionals to discuss concerns regarding the family. There were no concerns regarding the health of Ryan and domestic violence concerns had been addressed through anger management for the father. The investigation was ruled out and closed in December 2011.

**OCS Assessment:**

- The investigation was not initiated within 72 hours as required in a Priority II investigation and actual contact with the family was not until 36 days after the intake. CPS Policy 2253. Time Frames for Initiating Priority I and Priority II Investigations requires a Priority II investigation to be initiated with 72 hours. CPS Policy 2348. Follow-Up When Contact Is Not Made Within Priority Time Frames requires that an action plan must be developed and include attempts to contact the child no less than once every 72 hours until the case is formally staffed for closure as Unable to Locate.
- The safety assessment was not completed until December 2011. CPS Policy 2311.2. Time Frames Related to the Initial Safety Assessment requires that the safety assessment be completed within the first seven days after the investigation is initiated.
- Allegations of physical abuse were never fully assessed. While the children did not have outward signs of injury, the parents never directly discuss the physical abuse allegations.
- The investigator did identify that counseling may be of help to the family and provided them with a resource for counseling. However, there was no follow-up to verify that the family was in counseling.
- While the Child Safety Specialist completed a Multiple Referral report and provided specific guidance to staff such as referring the family to Family Based Safety Services (FBSS), completing a more thorough interview with the father, having the parents complete psychological evaluations, and providing parenting and counseling services to the family, the investigator did not refer the family to FBSS.

On **April 15, 2013**, an investigation was launched due to allegations of physical abuse as Ryan had scratches all over his face that did not have an explanation. Ryan was developmentally delayed and had a speech delay/autism spectrum disorder. The parents stated that the scratches came from Ryan and another child fighting over a toy at school the previous day. The scratches were photographed and appeared superficial/not in need of medical treatment. The investigator followed up with professionals to inquire about the children's medical care and to discuss any concerns. None were noted. All children were seen and there were no signs of abuse or neglect. The allegations were found unable to determine for an unknown perpetrator as the scratches appeared to be superficial and it was unknown as to when or where the scratches were received. The investigation was closed in May 2013.

**OCS Assessment:**

- During a routine discussion with the parents about home safety, there was a conversation regarding firearms. The investigator did not fully assess the safety and storage of the firearms away from the children.

On **July 13, 2013**, Ryan and his family were residing with extended family members. Concerns about the home condition included roach infestation and animal feces in the home as four pets were kept inside. There were concerns that a sibling had cradle cap and marks from scratching her head. Two investigations were launched -- one with Adult Protective Services and one with Child Protective Services. During the Adult Protective Services investigation, there was evidence of roaches throughout the home, animal feces in several rooms, and food for the various pets throughout the home. The CPS investigator completed a parental child safety plan with the family so that the children would be out of the home until the home was cleaned and the dogs were placed in a secure area away from the children. In this case, it is noted that there are concerns that the father has guns in the home and concerns about domestic violence in general, although the parents deny this. The parents had cleaned the home, mopped and steamed floors, had the pets removed from the home and provided a receipt for an exterminator who completed a follow-up treatment a week later. During a subsequent visit, the animals were not in the home and the home condition had improved. The CPS investigation was ruled out allegations of physical neglect and closed in August 2013 as the home condition had been addressed and no other concerns for abuse or neglect were noted.

**OCS Assessment:**

- There are concerns about firearms in the home but the investigator does not fully assess the safety and storing of the firearms away from the children.
- The investigator made contact with the family and observed the home in unsanitary condition. Based on the condition of the home, the investigator should have contacted the supervisor at the time of the visit to discuss further case directive. A Parental Child Safety Placement was not sought until the following day, after concerns were shared with the supervisor. In CPS Policy 2433. Making the Parental Child Safety Placement, a caseworker must have supervisor approval for the Parental Child Safety Placement.
- There were no services offered to the family during this investigation although. Services may have been helpful, such as a psycho-social evaluation, counseling, homemaker/parenting services, domestic violence screening and service referrals, and ongoing Family Based Safety Services.

On **August 27, 2013**, a new intake was received for physical neglect and medical neglect, alleging that the home conditions had deteriorated again and that the children all had poor personal hygiene. Ryan was alleged to have a gash on his head that was alleged to be infected. There was also concern that the youngest child had whooping cough. During the investigation, the home was noted to be clean and free of hazards. Ryan did have a cut on his head from being hit by a toy thrown by another child. The parent was treating the injury but the child picked at the scab. The investigator contacted professional collaterals to ensure that the children's medical and educational needs were being addressed. The mother had a sibling tested for learning disabilities and ADHD during the investigation. The case was staffed with the county attorney's office as the parents refused to cooperate with the investigation and refused drug testing. The allegations were ruled out and the investigation closed in November 2013.

**OCS Assessment:**

- While the investigation was initiated within 24 hours in a Priority I investigation, attempted and actual contact with the family was not made within required time frames. CPS Policy 2348. Follow-Up When Contact Is Not Made Within Priority Time Frames requires that if caseworkers are unable to make actual contact within 24 hours of a

Priority I report, they must attempt to make contact every calendar day until contact is made with each alleged victim; a protective parent; a principal; or a collateral with new and relevant information. The mother and children were on September 10, 2013, 14 days after the intake.

- While the Child Safety Specialist completed a Multiple Referral report and provided specific guidance to staff such as completing unannounced visits, assessing firearm safety in the home, assessing the medical care for the children and referring the family for FBSS service, these referrals were not completed and the family did not receive FBSS services.
- The investigator staffed the case with Legal as soon as the family became uncooperative to assess the ability to have legal intervention to drug test the parents or cooperate with the ongoing investigation; however, legal intervention was denied by the county attorney's office.

On **May 19, 2014**, there were concerns of physical abuse reported as Ryan had a number of scratches and bruises all over his body including to his arms, knees, and scratches to his nose/head. It was reported that he was constantly dirty, wore soiled clothing and had body odor. It was alleged that these conditions had persisted since August 2013. Additionally, the child's backpack smelled of marijuana previously. The investigator originally needed law enforcement assistance to see the children as the mother refused any contact. Ryan continued to wear a brace to address his clubfoot. The injury to Ryan's head was allegedly from playing with toys with one of the other children and did not appear to need medical attention. The investigator followed up with law enforcement that had no reports to the home. In addition, contacts were made with medical professionals who had no concerns and had recently seen the children. The investigation was ruled out for physical abuse and closed in June 2014.

**OCS Assessment:**

- The investigator did not initiate the investigation until May 26, 2014, seven days after the intake was received. The investigation was not initiated within 72 hours as required in a Priority II investigation and actual contact with the family was not until 36 days after the intake. CPS Policy 2253. Time Frames for Initiating Priority I and Priority II Investigations requires a Priority II investigation to be initiated with 72 hours. CPS Policy 2348. Follow-Up When Contact Is Not Made Within Priority Time Frames requires that an action plan must be developed and include attempts to contact the child no less than once every 72 hours until the case is formally staffed for closure as Unable to Locate.
- Conflicting information from law enforcement on the scene was given: the officer knew the family from patrolling the area but also stated that there were no callouts to the family home.
- The school was not contacted to assess the ongoing needs of the children or any concerns that the school may have had.

On **October 25, 2014**, an intake was received stating that the family was again living in poor conditions with animals/animal feces throughout the home. In a bedroom of a family member, there was trash surrounding the bed with roaches and flies on the walls. The mother and children reside at the home of a relative while the father lives at another location. When the investigator went to the home to interview the family, the mother would not allow the worker into the home and law enforcement assistance was requested. The father and officer arrived at the home and assisted the worker in seeing the children outside. While Ryan had scratches on his face, they did not appear to need medical attention. The parents explained that the scratches

were from playing outside. The parents were fighting for custody of the children and the mother had pulled Ryan from school so that the father would not be able to take him from school. The mother stated that the police had been out to the home previously but would not discuss why. The mother refused the investigator's request to enter the home and would only allow her to do so the following day. When the investigator arrived at the home the following day, the mother again refused entry to the home and refused to speak to the caseworker.

On November 4, 2014, an affidavit was filed with the court to aid in the investigation and seek a motion to participate in services. The hearing was scheduled by the court for November 18, 2014 to which the parents and their attorney did not attend. The hearing was rescheduled for December 2, 2014.

Additional intakes were received on November 8, 2014 alleging unsanitary living conditions, and two intakes on November 20, 2014 alleging that Ryan had several scratches and peck marks to his face and neck. The investigator returned to the home on November 21, 2014 to meet with the mother and see Ryan to assess the latest allegations. Again, the mother would not allow the investigator into the home but did allow Ryan to go outside. The mother stated that the new scratches were from a sibling. The father filed a family violence report on or around November 22, 2014, due to the mother hitting him while he was trying to pick up a child for visitation. The mother alleges that she is the one who was hit.

On November 25, 2014, Ryan died from a gunshot wound. The mother had left the children unsupervised for three hours that morning while she was outside. The home conditions were deplorable with a foul stench, animal feces/urine throughout the home, and covered with flies and roaches. Several safety hazards were noted including broken glass, trash, cockroach nests, no functioning plumbing in two used restrooms, and open access to a firearm, an air rifle, and a machete. During the investigation into Ryan's death, domestic violence was confirmed between the parents and had been occurring since at least 2010.

On December 2, 2014, the court hearing was held and the surviving siblings were brought into the conservatorship of DFPS. At the time of the fatality, the home condition was deplorable with a foul stench, animal feces/urine throughout the home, and covered with flies and roaches. The surviving siblings were brought into the conservatorship of the Department of Family and Protective Services.

**OCS Assessment:**

- Because not all parents had been served the required notice through the court system prior to the hearing, the hearing was reset.