Zy'Nyia Nobles

Fatality Review

Report Of The

Fatality Review Committee

November 20, 2000

Committee Members:

Shirley Caldwell, Co-Chair
Dr. Willa Fisher, Co-Chair
Carol Dearinger
Kikora Dorsey
Mary Gipson
Mike Harum
Ruth Kagi
Doug Klinman
Venita Lang
Kathleen Martin
Alice Shumate
Val Stevens
Bob Stutz

Table of Contents

Executive Summary ..... Page 1

Findings and Recommendations ..... Page 1-9

Overview ..... Page 9-14

Judgment and Decision Making ..... Page 14-21

Policy and Procedures ..... Page 21-28

Legal Issues ..... Page 28-32

References ..... Page 33

Attachments:

Chronology ..... Page 34-46

Executive Summary

This report summarizes the findings of the Fatality Review Committee that was convened to look at the circumstances leading up to Zy'Nyia Noble's death on May 27, 2000. During its four month review, the Committee looked at documentation in the file, DSHS policies and procedures, the July 13, 2000 Ombudsman's report to The Fatality Team, and interviewed 18 individuals including DSHS social workers and supervisors, community based providers, Guardians Ad Litem[1] (GAL's), representatives from the Attorney General's office, a foster parent and community members. There were other community members contacted who declined to be interviewed with regards to Zy'Nyia's case, including a foster parent and a court commissioner.

The purpose of our review was to try to determine where the checks and balances of our system failed and how practice and policies should be changed to better protect children in the future. During her brief life Zy'Nyia had five social workers and five placements including the return home to her mother. Termination of Parental Rights trials were set and continued at least five times in Pierce County Court and the case was heard before numerous commissioners and judges. This resulted in a lack of continuity that affected decisions made by the court, Department and service providers. Because the child welfare system inherently requires many subjective judgments and decisions, case continuity is critical for effective case management. The committee concluded that this issue of assuring continuity of child welfare cases is critical in improving our system to protect and care for children.

Findings:

1. After Zy'Nyia was initially placed in protective custody at the hospital, she was returned to her mother's care with a voluntary service agreement with the

[1] A guardian ad litem is an individual appointed by the court to advocate in the child's best interest. The Juvenile Court GAL for Zy'Nyia Nobles was a paid employee of Pierce County. Pierce County also has a Volunteer GAL/CASA program. Out of 39 counties in Washington, 30 have volunteer programs. The guardian ad litem is a full party to the case and, as such, is entitled to notice of all proceedings and is a necessary signatory to orders.

Department. A risk level assigned to this case was lowered although the investigation did not appear to objectively support a significant reduction of risk.

2. Ms. Sconiers' children remained in dependency status and in out of home care far too long. Too many continuances of the termination trials occurred in this case. Several requests for continuances were made because the Department and the Attorney General's office did not believe they would prevail at trial. In other instances courtrooms were not available.

3. Ms. Sconiers' chemical dependency issues were never adequately addressed. The primary reason that the children were removed from Ms. Sconiers was her use and distribution of illegal drugs. Although it was recommended numerous times that the mother attend drug and alcohol treatment there is no documentation and no information obtained in the interviews that Ms. Sconiers ever completed any chemical dependency treatment. The social workers involved in the case never enforced the recommendation that Ms. Sconiers follow through with chemical dependency treatment. Furthermore, it appears that Ms. Sconiers was given the message that marginal compliance with the TASC urinalyses (UA) was sufficient for reunification with her children.

4. Similarly, Ms. Sconiers' mental health issues were not adequately assessed.

5. At various points in the case, groups of staff and outside experts were called together for CPT reviews or prognostic staffings. However, these separate reviews of the case by differing groups of people did not, and probably could not, provide for consistent case management utilizing the knowledge and perspective of both social workers and community providers familiar with the family and Zy'Nyia's foster parents.

6. Social workers in this case were often put into roles that too easily became contradictory: having to ensure the safety of children while working towards reunifying the family; or taking parents to court and moving cases towards termination while trying to earn parents' trust and engage them in services. These

contradictory roles can create ambiguity, mistrust and confusion for all involved in a case.

7. Once the determination was made by the social worker that the children should go home to their mother it seems that the social worker formed an opinion from which she judged further information regarding the mother's compliance or lack of compliance with court ordered services. The conclusion that the children should be returned to their mother seemed to impact the interpretation of all further information regarding the mother's progress in court ordered services. Consequently, information about the mothers' progress (or lack of progress) was presented by the social worker in reports to the court and other professionals in a manner to support the belief that the children should be returned to their mother, as opposed to presenting the information in a more objective manner.

8. It appears that at least two mandated reporters failed to properly report one incident of potential abuse or neglect as mandated by RCW 26.44.030. (When Zy'Nyia scalded her foot in 4-00). This failure to report, or failure to cause a report, may have prevented an opportunity for CPS to intervene on behalf of the children. Because the injury was not reported, there was no chance to obtain collateral or medical information that might have been useful in providing the social worker with an objective assessment of Ms. Sconiers' parenting ability or at a minimum assessed her ability to appropriately supervise her children.

9. In this case the second GAL's reports appeared to mirror and rely primarily on information provided by the CWS worker. This may have been due to the fact the GAL had approximately 140 cases at the time that he had this case. The Guardian Ad Litem (GAL) involved in a given case must be an independent party, collecting his own information regarding the progress being made in the case.

10. The Department's transition plan was developed without adequately considering input from service providers, the mother's history, the amount of time the children were in placement, the behavioral problems of the children, the level of

attachment and bonding the children had with their mother, or the mother's ability to parent the children when under stress.

11. Individual CWS social workers assigned to the Nobles case carried from 24 to 36 cases, and were responsible for a wide variety of clerical and paralegal tasks. The average caseload for individual workers in Region 5 has dropped over the past three years from 34 to 29. Caseloads far exceed the national standards established by the Council on Accreditation for Children and Family Services of 20 cases per social worker.

12. Compliance with court ordered services, which often was marginal in this case, was accepted as progress when it seemed that little in the way of behavioral changes in the key risk areas actually occurred over the course of the dependency.

13. This mother was able to manipulate the system through self-reporting.

14. Verbal communication and written documentation was not consistently shared between social workers, service providers and GAL's to assure proper case management.

15. For extended periods of time during this case, no social worker was available due to staff vacancies or because the social worker was working other cases. For example, during the month prior to Zy'Nyia's death the social worker assigned to this case was required to be in court on another termination trial. There was inadequate case coverage during these periods.

Recommendations

Judgment and Decision Making

In order to help prevent errors in future judgments and decision making, the review team recommends that:

1. A team of DSHS staff and other involved professionals (herein referred to as the case management team) should be developed around a case within the first 60

days that the children are in placement. As much as possible this team should manage the case throughout the time that the children are in care.

2. Cases in which a Dependency is established, or 90 days after the pick-up order is issued, which ever comes first, should be viewed by the Department as high risk cases with regards to returning the child home. The team managing the case should be required to document why the risk is no longer viewed as high prior to the children being returned.
3. If individuals such as mental health counselors, drug and alcohol counselors, domestic violence treatment professionals and others involved with the family cannot be present at Child Protection Team meetings (CPT's) or Prognostic staffings, their written reports should be submitted at the meetings or staffings. The CPT or Prognostic team should not rely on the social worker's summary of these reports.
4. Supervisors must take an active role in questioning the conclusions that social workers make about a given family, and in reviewing and challenging the social worker's case plan.
5. Social worker caseloads must be significantly reduced. The current average caseload of 29 far exceeds the national standards, and severely limits social workers' ability to thoughtfully manage each family's case. The state should move towards the Council on Accreditation practice standard of 20 cases per caseworker.
6. We strongly recommend that DCFS hire sufficient clerical and paralegal staff to allow social workers to focus on case management and family contact.
7. To maintain case continuity, a social worker or case aide with working knowledge (verbal communication and sharing written communication) of that case must be assigned to cover the case when the lead worked is not available.
8. Guardians Ad Litem or Volunteer Court Special Advocates (CASAs) must be assigned to dependent children and must have adequate time to monitor their caseload. Pierce County currently has both paid Juvenile Court GALs and a volunteer GAL/CASA Program. Best practice indicates that Pierce County

should aggressively seek to expand its volunteer program, perhaps using the current paid Juvenile Court GALs as supervisors for volunteers. This would lead to significant reduction in caseload ratios. The National CASA Association recommends three cases per volunteer and 30 volunteers per supervisor in order to properly represent children.

9. Procedures must be implemented to insure that information flows more freely between treatment providers and the Department social workers and is distributed in a more timely manner.
10. A Continuous Quality Insurance[2] team (CQI) should be initiated to strengthen objective decision making by social workers and supervisors with regards to case management.
11. Psychological assessments should be utilized more frequently in dependency cases in which mental health issues are indicated.
12. Parenting assessments should be utilized in dependency cases in which children have been separated from their parents for extended periods in order to objectively assess the bonding and attachment between the child(ren) and their parents or caregivers.
13. Family Group Conferences should occur frequently in dependency cases to assure family and community members share responsibility for the care and protection of dependent children.
14. The legislature, the Governor and the judiciary need to review the recommendations contained in this report and seek ways to sufficiently fund or support their implementation. Furthermore, the state should continue to pursue grants and other funding options to increase resources for dependent children.

[2] A CQI is a team composed of trained, individuals who work on specific projects or improve work processes, systems, policies, procedures, structures, behaviors, attitudes, work habits.

Policy and Procedure issues:

RECOMMENDATIONS REGARDING CHILD PROTECTIVE TEAMS:

Child Protective Teams (CPT's) should be mandatory in all dependency cases established due to abuse and or neglect. This CPT should occur 30 to 60 days prior to court hearings where the recommended plan is return home.

1. CPTs should always have the ability to make recommendations regarding placement of children, as well as service recommendations.
2. If the service providers involved with the family are not able to present their reports regarding the family directly to the CPT, their reports should be made available to the team as opposed to the interpretation of these reports by the presenting social worker.

RECOMMENDATIONS REGARDING IMPLEMENTATION OF THE CASE MANAGEMENT TEAM:

1. The case management team should be developed around the child within 60 days of out of home placement. As much as possible, this team should manage the case throughout the time that the children are in care.
2. The Department should reassess the need for Prognostic Staffings in light of the above recommendation.

RECOMMENDATIONS REGARDING SUMMARY ASSESSMENTS[3]:

1. In addition to the already established times when a Summary Assessment is required, it should also be performed when the risk in a case changes substantially.
2. The Department should set up a tracking system to audit a percentage of the cases in each office on an ongoing basis to monitor any trends in compliance or non-compliance with mandated requirements.

[3] The summary assessment is a tool utilized by social workers to help gather and interpret information needed to predict the likelihood that a child will be abused or neglected in the future. It is composed of a risk matrix which both identifies and organizes information needed to predict abuse and neglect, and a narrative section were the interaction of the family strengths, risk factors, and the family's history can be addressed.

3. The Department should investigate the use of the Summary Assessments and assess why they are not being utilized.

RECOMMENDATIONS REGARDING THE TRANSITION PLAN:

1. When developing the transition plan, the case management team put in place to monitor the progress of the family should involve the family and friends who will be involved in insuring the well being of the child(ren). A contract should be made with all the parties involved to insure accountability with regards to the implementation of the plan. The developers of the plan should take into consideration:
    a. The length of time that the child(ren) has been out of the home and the age of the child(ren).
    b. The parents' history, the child's history, and the level of attachment and bonding between the parent(s) and child(ren).
    c. The level of participation in services of the parents during the time the children were out of their care and how these services have impacted the risk factors with regards to their ability to care for their child(ren).
    d. The quality and extent of services that will be in place during the transition period both prior to the child(ren) being returned home and after the children are reunified with their parents.
2. The providers responsible for monitoring the placement of the children must immediately alert social workers when the parent is not following through with court ordered services, or when they are not present for scheduled visits. Contracts for service providers should include specific requirements for reporting non-compliance.

RECOMMENDATIONS REGARDING MANDATORY REPORTING:

The Department should develop a uniform core curriculum for all mandated reporters.

Legal Issues:

RECOMMENDATIONS REGARDING CONCURRENT PLANNING:

1. The Department must create a concurrent planning model that gives clear guidance to social workers on how to proceed in dependency cases in which concurrent planning is an appropriate option.

Other legal recommendations:

2. The Washington State legislature should enact a law requiring a hearing before the court twelve months after the Dependency Petition is filed to determine if DSHS has made reasonable efforts to reunify the family.
3. Juvenile Dependency cases should be assigned to one specific judicial officer at the time of filing. The same judicial officer assigned at the time of filing should hear all proceedings in the case, to the extent possible. When this is not possible, subsequent judicial officers should consider all prior judicial rulings.
4. The Department should develop a way to monitor and verify progress in court ordered services as well as compliance with court ordered services.
5. Continuances must be kept to a minimum; a limit should be set at 2 continuances that the Assistant Attorneys General can request for the termination trial.
6. Courtrooms must be made available to hear termination trials.
7. There should be consistency and continuity in the Individual Service and Safety Plans[4] (ISSPs) which the Department submits to the court. Services should not be deleted from an ISSP without a reason given as to why the service is no longer needed.

Overview

Perhaps a fatality review of this sort can best be described as an intense case analysis. In an after the fact manner the team looks over case records that outline the history of the case and interviews various individuals with regards to what happened as the case

[4] An ISSP is a document written by the assigned social worker on the status of the child and family to both update the prior to court reviews every 6 months, and to document satisfaction of Federal Funding requirements.

progressed. With hindsight the committee looks for trends and patterns that may have led to the tragic death of a child. The Committee must then generalize from the aspects and patterns in the case that stand out and make recommendations to the Department that make changes to benefit the children and families the Department serves. A natural result of this process is that there is a focus on what might have gone wrong. In so doing, much of the good work of individuals involved in the case is overlooked, while the possible errors made are highlighted. However, it is important to note up front that the individuals we interviewed are dedicated to the welfare of children and families. These social workers, supervisors and support staff must advocate for the best interest of children in an arena that is overwhelmed with ambiguity and uncertainty. Furthermore, they must do so with limited resources and enormous caseloads and responsibilities. Our hope as a committee is to make recommendations for changes that enable the Department and community to better serve children and families. The committee believes that one way to do this is to support, train and give resources to the staff that work with families on a daily basis, and improve systems that insure accountability.

Zy'Nyia Nobles was born on November 16, 1996 and at birth she tested positive for marijuana. On November 17, 1996, her mother learned that a hospital hold had been placed on her infant and tried to flee the hospital with Zy'Nyia in her arms. This action created an extremely high risk situation for Zy'Nyia and resulted in Ms. Sconiers' arrest by the Tacoma Police Department. After an initial investigation, the Child Protective Services (CPS) social worker returned Zy'Nyia to her mother's care because he believed that the risk was not great enough to warrant continued out of home placement. For the next two months the social worker made many visits to the mother's house and reported that Zy'Nyia's care was adequate. The mother made it clear during this time that she would not follow through with any of the services initially agreed upon.

When Zy'Nyia was two months old she was placed in foster care again. At that time her mother, Ms. Sconiers, was arrested for dealing illegal drugs and was sent to prison. Zy'Nyia would spend the next 36 months in foster care. She spent much of the time with a family friend who was a licensed foster parent, but was removed from this placement on two occasions due to the instability of the foster home. The only time that she seems

to have truly been in a stable, potential long-term placement is in the six months prior to being returned to her mother's care. During much of the time that Zy'Nyia was in care she had one to one and a half hour supervised visits a week with her mother. However, in the course of interviews, it was disclosed that Zy'Nyia had some unauthorized visits with her mother. The attachment and bonding between Zy'Nyia and her mother at the time she was returned home could best be described as minimal.

Prior to her arrest on January 1,1997, Ms. Sconiers had no CPS history as a mother, but was no stranger to the system. As a child she had been placed into protective custody on two occasions, and in 1988 was placed under the supervision of the state. In 1989, due to crimes she committed as a juvenile, she was sentenced to between three and three and a half years in juvenile rehabilitation. In 1992 she was released from detention and had her first child [redacted]. Between 1992 and 1996 the mother reports that she made a living by selling illegal drugs. During this time period she was arrested a number of times before being incarcerated in January of 1997. In November of 1996, at Zy'Nyia's birth, Ms. Sconiers tested positive for marijuana and cocaine and Zy'Nyia tested positive for marijuana. Upon learning that her child might be placed in protective custody, Ms. Sconiers picked up her newborn and tried to flee the hospital. She assaulted a security guard and was eventually arrested. The police report indicates that the security guard feared for the well being of Zy'Nyia as the mother was trying to flee. Zy'Nyia, who was only a day old at that time, was described as having her head bounce back and forth and at some points it appeared that Zy'Nyia would fall out of Ms. Sconiers hands.

After an initial investigation, the CPS social worker determined that the risk to the children in the family was only moderate and Zy'Nyia was returned to Ms. Sconiers two days after this incident at the hospital. A condition of return was that Ms. Sconiers sign a Voluntary Service Contract with the Department. This agreement stated that she would participate in UAs for 1 month and meet with a Public Health Nurse. If any UAs were positive, she would go to into substance abuse treatment. Voluntary services contracts are not legally binding. Over the course of the next two months, prior to being arrested, Ms. Sconiers had made it clear to the social worker that she was not going to follow through with the agreed upon services.

While incarcerated between January of 1997 and May of 1998, Ms.Sconiers was offered the opportunity to participate in drug and alcohol treatment but she was terminated from the program due to an unknown major infraction. (The nature of the infraction is unknown because DSHS is unable to obtain the documentation from the Department of Corrections under federal confidentiality statutes). Ms. Sconiers completed some parenting classes while incarcerated. Once Ms. Sconiers left her work release program in May of 1998, and over the course of the next 20 months, she can best be described as being in sporadic or marginal compliance with court ordered services. She completed of the UAs, went to some of the parenting classes, participated in approximately five months of mental health treatment, but never fully engaged in services. Several professionals in the case reported that Ms. Sconiers repeatedly stated she did not need services and did not want to comply.

While DSHS was involved with the family, the case transferred from a CPS worker to a Child Welfare Services (CWS) worker, to a CWS worker in a different unit, to the CWS supervisor, to another CWS worker in that unit, and then to a CWS worker in yet another unit. At times it seemed that the case was being well covered and case managed but there were also periods when it appears that no one covered the case and little was done to monitor progress. Also, this case was transferred from one GAL to another. The GAL who had the case for the longest period of time relied heavily on the social worker for information and could not be described as being an independent advocate for the child. The GAL had a caseload of about 140 children at the time. There was no consistency with regards to the judges or court commissioners who heard the case.

In August of 1997 the Department social worker filed a termination petition on the children, but continuance after continuance prevented the termination trial from occurring. One continuance was due to questions regarding whether the Department social workers had made diligent efforts to offer visitation to the mother while she was in prison. At least one continuance was due to a lack of an available courtroom. Several continuances were related to the mother's partial compliance in services with the social worker and the GAL asking to give her more time. During this phase of the case the permanent plan was concurrent for either return home or termination of parental rights.

In August of 1999 the permanent plan was changed to return home. A new social worker was assigned the case in May of 1999, and the mother seemed to be moving in a positive direction. She agreed to engage in mental health counseling and started attending another parenting class. She attended her TASC[5] appointments and her visits with the children. However, after the plan was changed to return home, little attention seemed to be given to the red flags that indicated that she was again falling out of compliance with court ordered services. By the time the children were returned to Ms. Sconiers, she was out of compliance with the services that had initially been put in place to assess her progress and support her ability to be a primary caretaker, although she agreed to work with a Family Preservation Service (FPS) worker.

Just prior to the children being returned home, Family Preservation Services (FPS) were put in place. After a short time and a few meetings with the first FPS worker, Ms. Sconiers refused to cooperate with that worker. A new worker was assigned who was supposed to meet with the family one or two times a week. Between the return of the children in early February and Zy'Nyia's death on May 27, 2000, the FPS worker had met with the family approximately six times. The last visit occurred at the end of April. The visits missed from the end of April through the month of May were missed due to the mother's lack of cooperation. During the last six weeks there was a breakdown in communications between the FPS worker and the social worker, and no discussion regarding the seriousness of the missed visits seems to have occurred. Also, the social worker assigned to the case was in court for much of the month of May, and no system was in place to have coverage for the social worker during this time. The mother was asked to do one UA during this time, which she followed through with 15 days after it was requested.[6] [redacted] No other services were in place during the time between February of 2000 and June of 2000, and no explanation of this gap has been offered.

'1960 absence per RCW 74.04.060 - not re: Zy'Nyia & RCW 74.13.500 - re: siblings

[5] TASC stands for The Alternatives to Street Crimes. TASC is a monitoring and case management program for adults with chemical dependency issues. In this case they required the mother to do two UA's and two clinical contacts a month. The TASC case manager was clear in pointing out that TASC is not a drug and alcohol treatment program.

As noted earlier, a fatality review of this type may be described as a case analysis. The recommendations the committee makes are based on a review of the case records, numerous interviews and a review of DSHS's Policies and Procedures as they apply to this case. Although this type of study runs the risk of being case specific, the committee members believe that the issues that arose in this case are not unique to this case, but share similarities to many of the other cases in which the Department is involved. Many people interviewed during this review cited the issues raised as reoccurring problems with DSHS and the court system. Many of those interviewed remarked that this was not a stand out case or viewed as a high-risk case. Most of the committee members have experience with at-risk families involved with the Department, with the legal issues confronting social workers, and with social service agencies and policies and procedures. Finally, many of the issues and concerns noted in this case are similar to the issues raised in past fatality reviews, such as the Lauria Grace fatality review which was done in 1995.

Judgment and Decision Making

There is a large amount of research regarding how humans function as decision-makers. Munroe (1996 & 1999) summarizes this research and writes on how it applies to the reasoning of child protective social workers. In general, Munroe notes that there are two forms of reasoning, analytical and intuitive. Analytical reasoning is a step-by-step, conscious, logically defensible process. Intuitive reasoning is described as a cognitive process that somehow produces an answer, solution or idea without the use of a conscious, logical, defensible, step-by-step process. Munroe notes that for various reasons social workers tend to rely on intuitive reasoning. When intuitive reasoning is used it may lead to biased decision making. When using intuitive reasoning the decision maker relies on a number of cognitive rules to simplify the decision making task. The cognitive rules that individuals use often reduce complicated judgments into simpler ones by reducing the amount of information that the decision maker utilizes. This may include interpreting new information based on preexisting beliefs, and paying more attention to

information that confirms one's beliefs. Consequently, individuals may be slow to revise their judgments despite the presentation of evidence that challenges their beliefs.

Munroe, who reviewed 45 child abuse inquiry reports published in Britain between 1973 and 1994, found that professionals based risk assessment on a narrow range of evidence. Munroe (1999) notes that the judgments were biased towards the information readily available to the social worker, overlooking significant data known to other professionals, and that "a major problem was that professionals were slow to revise their judgments despite mounting body of evidence against them." (745). Munroe goes on to point out that, ideally, professional judgments should be treated by both the judgment maker and by those to which they are presenting as hypotheses requiring further testing.

There were many instances in this case where it seemed that social worker bias may have impacted the decision making process of the social worker assigned to the case. An example of this can be seen near the time that Zy'Nyia was being returned to her mother. In the months just prior to the children being returned to Ms. Sconiers she was discharged from TASC in a neutral status even though she had not followed through with the drug/alcohol treatment recommendations, she was no longer taking her medication, and was not in counseling. Despite her lack of compliance, the plan remained to return the children home as soon as the mother had housing. It also appears that the mother's lack of follow through with court ordered services at this time was not accurately reported in court reports and at staffings.

Attempts to increase social worker objectivity have been addressed in the past by the Department. In 1995 the Department came out with the Shared Decision-Making Appendix to the policy manual. The authors of the policy note, "Shared decision making means systematically employing teams for key decision making. Team decision making will provide opportunities for critical thinking and creative problem solving; sharing responsibility for decisions; share liability; and provide opportunities for ensuring quality assurance." The authors of the manual go on to write that they believe "that most of the long term benefits to the children and families will come from implementing prognostic staffing teams". This committee agrees with much that was written in the Shared

Decision Making policy manual, and many of the recommendations regarding how to improve judgment and decision making can be viewed as building on the ideas already outlined in this manual.

In order to help prevent errors made with regards to judgments and decision making in a case the review team recommends that:

1. *A team of DSHS staff and other involved professionals should be developed around a case within the first 60 days the children are in placement. As much as possible this team should be responsible for managing the case throughout the time that the children are in care.* This team could be a reformulation of the Departments current use of prognostic staffings. However, these staffings should make greater use of professionals and other community members who are involved in the case. Currently these staffing are often composed primarily of Department personnel. By including professionals in the community who are involved in the case such as drug and alcohol counselors, GAL's, mental health counselors and other service providers, the committee members believe that decisions would more likely be based on all available information. No one individual would be responsible for screening what is and is not vital for the team to take into consideration. An effort should be made to maintain continuity of the members of the team, so that the same individuals are monitoring the progress of the case throughout the time that the family is involved with the Department. The Department may want to examine the manner in which this case management team and the CPT's should interact.
2. *Cases in which a Dependency is established or 90 days after the pick-up order is issued, which ever comes first, should be viewed by the Department as high risk cases with regards to returning the child home. The team managing the case should be required to document why the risk is no longer viewed as high prior to the children being returned.*
3. *If individuals such as mental health counselors, drug and alcohol counselors, domestic violence treatment professionals and others involved with the family are*

management must insure that each GAL or CASA is in compliance with statutory training requirements. The GAL who had this case for the majority of the time reported that he typically had about 144 cases at the time. The Pierce County Juvenile Court GAL program has seven GALs on staff to serve all the Dependency cases in the county and each GAL has approximately 140 cases. This caseload clearly does not allow enough time for the assigned GAL to adequately investigate cases and simultaneously attend to other case obligations. Because GALs are parties to the cases, they must report to the court on the progress of cases, attend hearings or trials and, whenever possible, attend any CPT or Prognostic staffings. Counties with volunteer programs already in place must maximize their GAL capabilities through increased recruitment and community support for the programs. Professional staff, such as the current Pierce County Juvenile Court GALs, can provide a base of supervisors for the volunteer force. This staff would then be available to provide volunteers with the appropriate training and case management skills necessary to effectively advocate for children. Judges and county officials must make acceptance, development and recognition of their volunteer programs a priority.

The recent Ombudsman report on Guardians Ad Litem notes that "[r]esearch clearly indicates that in cases where children are not represented by a GAL, the cases take longer to resolve, and the children themselves are likely to spend significantly more time in substitute care, compared to cases in which children are represented by a GAL." In this case it seemed that even though a GAL was appointed to the case there was little evidence that the GAL adequately obtained first hand information about the situation and the needs of the children. Rather, it appeared that the reports simply reiterated what the Department social worker was presenting. The review team believes that having a GAL assigned to a case who does not have time to be an objective advocate for the child(ren) creates a situation in which a false sense of security is established. It creates the illusion that an independent objective voice is speaking out for the well being of the children.

not able to be at CPT or Prognostic staffings, they should have their written reports submitted directly to the team as opposed to a social worker's summary of these reports.

4. *Supervisors must take an active role in questioning the conclusions that social workers have made about a given family, and must take an active role in reviewing/challenging the social worker's case plan.*
5. *Social worker caseloads must be significantly reduced. The current average caseload of 29 far exceeds the national standards, and severely limits social workers' ability to thoughtfully manage each family's case. The state should move towards the Council on Accreditation practice standard of 20 cases per caseworker.* It was clear during the interviews with department personnel that social workers frequently "run" from one emergent situation to another and have minimal time to reflect on the decisions that they make regarding their case load. In order to make good judgments and decisions, social workers must be given more time to work with and think about each of the families on their caseload. The more time pressured the social workers are, the less they are going to be able or willing to incorporate new information in regards to their case plans, especially if this information runs counter to their existing beliefs about the situation.
6. *We strongly recommend that DCSF hire sufficient clerical and paralegal staff to allow social workers to focus on case management and family contact.* This includes clerical staff to assist in report writing, documentation, filing, scheduling, and so on. Also, social workers should have direct access to paralegals to assist with such tasks as writing Dependency petitions, preparing records for discovery and disclosure, doing diligent searches for absent parents and so on.
7. *To maintain case continuity, a social worker or case aide with working knowledge (verbal communication and sharing written communication) of that case must be assigned to cover the case when the lead worked is not available.*
8. *Guardians Ad Litem must be assigned to dependent children and must have adequate time to monitor their caseload. Counties should maximize volunteer GAL/CASA availability and manpower in order to reduce caseloads. Program*

The assigned GAL reported that he believes that reunification is always his initial goal in his cases. The committee questions this philosophy from the individual involved in the case whose statutory obligation is to independently advocate for the child's best interests.

9. *Procedures must be implemented to ensure that information flows more freely between treatment providers and the Department social worker, and this information should be distributed in a more timely manner.* At times the flow of information between service providers was too slow to ensure the best chance for child safety. Effective decision-making is much more difficult when all some important information is lacking, or is not received in a timely manner.
10. *A Continuous Quality Insurance Team (*CQI) *should be initiated to strengthen objective decision making by social workers and supervisors with regards to case management.* This CQI should address issues such as how the supervisory role can encourage critical thinking and consideration of alternative points of view. Objectivity in group thinking should be addressed as well because groups of people are prone to many of the same judgment errors as individuals. The CQI should look at ways to assign an individual to question the groups' discussion and call attention to other issues that may not have been raised.
11. *Psychological assessments should be utilized more frequently in dependency cases in which mental health issues are indicated.* At various times throughout the case there was indication that Ms. Sconiers, primarily from her own self reporting, may have had mental health problems that could impact her ability to parent her children. For example, in 1999 Ms. Sconiers reported to her TASC case manager that she was experiencing mood swings and viewed herself as bi-polar. In May of 1999, Ms. Sconiers had started taking medication, apparently for her bi-polar disorder, but she stopped taking the medication in July of 1999. During the TASC case manager's interview with the committee she reported that she had spoken to the counselor that Ms. Sconiers was seeing and both agreed that the mother's marijuana use was a form of self-medication.

A psychological evaluation would have given the social worker and service providers valuable information regarding the mother's ability to care for her children. This would also have indicated which services would be of value to help stabilize the mother's mental health issues. A psychological evaluator would not be required to maintain a working relationship with the mother but would have been in a good position to objectively review the records and offer an independent assessment of the mother's mental health condition and her willingness to follow through with any needed services. This information would likely have aided in making the decision of whether the children should have been returned to the mother's care.

12. *Parenting assessments should be utilized in dependency cases in which children have been separated from their parents for extended periods to provide objective assessments of the bonding and attachment between the child(ren) and their parents/caregivers.* During the three years the children were in out-of-home care, they had approximately 43 supervised visits with their mother. Zy'Nyia had spent nearly her whole life in foster homes, and there is some indication that the other child, prior to being made a dependent of the state, was primarily cared for by a family friend. The minimal level of contact between Ms. Sconiers and her children calls into question the quality of attachment and bonding between Ms. Sconiers and her children. The concern about Ms. Sconiers' ability to care for her children is heightened if one considers her apparent mental health problems, her ongoing drug use, her criminal history (which includes various assaults), and her children's ([redacted]) behavior problems. A parenting assessment evaluator could objectively assess these factors and would not have been responsible for maintaining a working relationship with the mother. An evaluator could have provided an objective report on the mother's ability and desire to be a parent and assess her ability to meet the childrens' needs after reviewing the records, talking to the service providers, meeting with Ms. Sconiers, and viewing her interactions with her children. This information would

have been helpful in determining if it was safe for the children to return to the mother.

13. *Family Group Conferences should occur in dependency cases to assure family and community members share responsibility for the care and protection of dependent children.* The committee makes this recommendation because in reviewing the case records, it seems that many of the extended family and friends of the family who had ongoing contact with the family became more alienated from the Department as the case progressed. Also, because of problems that either the Department social workers or the mother had with various family members, the mother was encouraged to distance herself from them. It is significant that one family friend reported that after the dependency was dismissed, family friends had agreed to care for the children. This indicates a lack of trust in the Department, and their desire to have the Department social worker out of the family so that they could deal with the situation on their own terms. The family group conference model creates an atmosphere of more shared responsibility between the Department and a family's natural supports and can be an important step in building trust between the concerned parties.
14. *The legislature, the Governor and the judicial branch need to review the recommendations included in this report and seek ways to sufficiently fund or support their implementations. Furthermore, the state should continue to pursue grants and other funding options to increase resources for dependent children.*

Policy and Procedures

Child Protective Teams (CPTs)

The policy regarding Child Protective Teams and returning children home, according to Children's Administration Policy 97-02, is that a CPT must be done "in all cases prior to return home or dismissal of dependency, when the child is age six or younger and any risk assessment has resulted in a risk level of moderately high or high risk." In addition, Policy Memorandum #96-01, issued to Region 5 supervisors on

January 1, 1996, states that a CPT must also be done when the above is true and in dependency cases – 30 days prior to court hearing where the recommended plan is return home.

How Child Protective Teams were utilized in this case:

The case was initially staffed at a CPT on December 12, 1996, prior to Zy'Nyia's removal from the home. The social worker assigned to the case at that time completed an initial summary assessment and assessed the overall risk as moderate prior to the CPT. This was the only summary assessment ever done in the case. The CPT recommended that the mother complete a drug and alcohol evaluation and follow treatment recommendations, that the mother attempt drug treatment and that the mother participate in the birth to three program. The mother refused to participate in any of the recommended services. Based on the mother's refusal to participate in services, the CPS social worker's supervisor advised the social worker to file a dependency petition. The petition was filed on January 21, 1997. The Department social worker recommended that both a B and C dependency petition be established. (A "B" dependency alleges that the child is abused or neglected as defined in Chapter 26.44 RCW, and a "C" dependency alleges that the child has no parent, guardian, or other custodian capable of adequately caring for the child such that the child is in circumstances which constitute a danger of substantial damage to the child's psychological of physical development.).

The case was again staffed with the CPT on January 27, 2000 but for a Service Consult Only, implying that the topic of placement of the children was not to be addressed at the CPT. According to policy, this case did not need to be staffed prior to the return home of the children because a risk assessment had never been done to reflect more than moderate risk in the family, even though the children were made dependent based on the allegation of abuse and neglect. There is an apparent loophole in the CPT staffing process that allows cases to be staffed for service recommendations only. By policy, recommendations by CPTs are advisory to DCFS staff, except when deciding to place a child or return home. Using CPT staffings only to provide a service consult circumvents one of the primary purposes of the Child Protective Teams.

RECOMMENDATIONS REGARDING CHILD PROTECTIVE TEAMS:

1. *Child Protective Teams (CPTs) should be mandatory in all dependency cases established due to abuse and or neglect. This CPT should occur 30 to 60 days prior to court hearings where the recommended plan is return home. CPTs should always have the ability to make recommendations regarding placement of children, as well as service recommendations.*
2. *If the services providers involved with the family are not able to present their reports regarding the family directly their reports should be made available to the team, as opposed to the interpretation of these reports by the presenting social worker.*

Prognostic/Permanency Planning Staffings:

According to Policy Memorandum: #97-03, issued on 4-2-1997, the Practice and Procedures Manual states "all children in placement beyond 60 days will be staffed by an internal team." The memorandum goes on to state that the staffing will occur at 3 months, 9 months, 17 months, 22 months and every 3 months thereafter until permanency has been achieved. If the established DSHS/DCFS case position needs revision, it will be necessary to re-staff the case to establish a new or modified DSHS/DCSF case position.

How Prognostic/Permanency Planning Staffings were utilized in this case:

The records indicate that a prognostic staffing was held on April 22, 1997 (at 3 months), in October 20, 1997 (at 9 months), a staffing might have (records are not clear) occurred on January 14, 1998 (at 12 months), and on July 14, 1998 (at 18 months.) The July 14, 1998 prognostic staffing was the last staffing of the case. The recommendations of July 14, 1998 staffing were that the department social worker should continue the dependency and seek termination of the parent's parental rights.

According to policy, a prognostic staffing should have occurred around December of 1998 and every three months thereafter until the children were returned home in February of 2000. Therefore, the last five prognostic staffing did not occur. According to the Policy Memorandum, if the DCFS case plan needs revision, the case shall be

re-staffed. In this case the plan changed from termination to return home without any prognostic staffing after the plan changed.

RECOMMENDATION REGARDING IMPLEMENTATION OF THE CASE MANAGEMENT TEAM:

1. *The case management team should be developed around the child within 60 days of out of home placement. As much as possible, this team should manage the case throughout the time that the children are in care. (See 1st recommendation made under Judgment and Decision making section for a more complete description)*
2. *The Department should reassess the need for Prognostic Staffings in light of the above recommendation.*

Summary Assessment Reviews:

The policy regarding summary assessments is that the social worker completes Summary Assessment Reviews at the following intervals:

1. Every 90 days for non-court cases served with voluntary service contract.
2. At case transfer between CPS and CWS.
3. Prior to the return home of a child placed in care due to child abuse/neglect.
4. Prior to re-placement in care of a child who had been returned home.
5. At case closure.

The Policy and Procedure manual requires that the social worker utilize a Summary Assessment Review to evaluate how the risk to the child has changed from the previously completed Summary Assessment. This tool is a key element to determine if providing services has accomplished goals set in the permanency plan for the child. Also, the summary assessment can be used by a social worker recently assigned to the case to obtain an understanding of the key risk factors in the case, as well as to learn some of the family's history with the department.

How Summary Assessment Review was utilized in this case:

Only one Summary Assessment was done in the 42 months that the case was open prior to the fatality. A Summary Assessment was done about one month after the initial CPS referral and at that time the overall risk level was seen as moderate (The narrative section was apparently updated at around the time that the children were removed from the home). According to policy, it is arguable that another Summary Assessment should have been done at the transfer between CPS and CWS, and clearly a Summary Assessment should have done prior to the children being returned home. In this case, the Summary Assessment was not used as a tool to help assess the areas of risk in the case, nor was it utilized to determine the effectiveness of the services in impacting the key risk factors.

1. *In addition to the already established times when a Summary Assessment is to be done, it should also be done when the risk in the case substantially changes.*
2. *The Department should set up a tracking system to audit a percentage of the cases in each office on an ongoing basis to monitor any trends with regards to mandated requirements that are and are not being met.*
3. *The Department should assess the reason for the lack of utilization of the Summary Assessment tool.* In this case the Summary Assessment was apparently not relied on as a tool to assess risk, help in the determination of needed services, and track how the implemented services have impacted the family with regards to the key risk factors.

Transition plan:

The review team is unaware of any current policy and procedure regarding transition of children who are being returned to their parents care.

How a transition plan was utilized in this case:

Zy'Nyia and [redacted] had been out of their mother's care for 36 months prior to being returned to her. For approximately the 18 months immediately prior to the childrens' return home, the mother did have weekly supervised visits. The mother had a

long history of instability and had only partially complied with services. Ms. Sconiers had not parented either child in three years and information the Review Team was given indicates that the mother was not the primary caretaker for [redacted] prior to Zy'Nyia's birth. Ms. Sconiers had never been a full time parent to both children. [redacted] Zy'Nyia's last foster parent reported that she attempted to care for both children but was unable because [redacted]

RCW 74.04.060 not re: Zy'Nyia

In November of 1999, Gateways, the agency that was supervising Zy'Nyia's foster home and supervising the visits between the mother and her children, wrote a transition plan developed between that agency, the GAL and the foster parent and submitted it to the social worker. This proposed transition plan would have started by extending supervised visits and moved to unsupervised visits and finally to overnight visits prior to returning the children home. However, the Department social worker reported that she did not accept this plan and did not believe it was appropriate for the Gateways agency to establish a plan. The GAL did not object to the social worker implementing a different transition plan rather than following the Gateways' plan.

In this case, the social worker's transition plan was to return the children to the mother as soon as she obtained housing. [redacted] was returned to his mother one week and Zy'Nyia was returned to her the following week. A Family Preservation Worker was assigned to meet with the family on a weekly basis. A more extensive transition plan, which would have moved the children back home more slowly, monitored the parent-child interactions as they children spent more time with their mother, and occurred while the mother and children were engaged in other services would have been more appropriate.

RECOMMENDATIONS REGARDING TRANSITION PLANS:

1. *When creating a transition plan, the case management team put in place to monitor the progress of the family should involve the family and friends who will be involved in insuring the well being of the child(ren). A contract should be*

made with all the parties involved to insure accountability with regards to the implementation of the plan. The developers of the plan should take into consideration:

a. *The length of time that the child(ren) has been out of the home and the age of the child(ren).*
b. *The parent's history, the child's history, and the level of attachment and bonding between the parent(s) and child(ren).*
c. *The level of participation in services of the parents during the time the children were out of their care and how these services have impacted the risk factors with regards to their ability to care for their child(rens).*
d. *The quality and extent of services that will be in place during the transition period both prior to the child(ren) being returned home and after the children are reunified with their parents.*

2. *The providers responsible for monitoring the placement of the children must immediately alert social workers when the parent is not following through with court ordered services, or when they are not present for scheduled visits. Contracts for service providers should include specific requirements for reporting non-compliance.*

Mandatory reporting requirements:

What occurred in this case with regards to the reporting of abuse and neglect:

At various points in the case there are indications that incidents of abuse or neglect occurred to [redacted] and Zy'Nyia by their mother. However, official Child Protective Service reports were never made regarding these incidents. For example, after the children were returned home, there was an incident in which Zy'Nyia reportedly scalded her foot and was taken to the hospital. Apparently, a family friend who had previously cared for the children, told another family friend, who then called the assigned CWS social worker. Shortly after this phone call, the CWS social worker met with the family. Ms. Sconiers told the social worker that [redacted] had run a bath for Zy'Nyia and that the bath water was too hot, resulting in Zy'Nyia burning her foot. A Family Preservation Services worker also talked to the mother about this incident while on a

home visit but never pursued the incident further. The children were never questioned about what had occurred and a CPS referral was never made. Also, there are indications that in the latter part of May, Zy'Nyia's previous foster parent and another mandated reporter both knew of Zy'Nyia having a black eye and had suspected Ms. Sconiers, but did not report it to Child Protective Services.

RECOMMENDATION REGARDING REPORTING CHILD ABUSE AND NEGLECT:

The review committee understands that the issues surrounding mandatory reporting are complicated, and how to encourage family members and family friends to report concerns is even more troublesome. (RCW 26.44.030 outlines who shall and who may report incidents of child abuse and/or neglect) However, the Committee does make the following recommendations to encourage the reporting of concerns of abuse and neglect.

DSHS should develop a core curriculum for all mandated reporters. Additionally, DCFS/CA must insure that Child Welfare workers are adhering to the standards of "causing a referral to be made" especially if they encounter situations and/or are given information relevant to an open CWS case.

Legal Issues

In many respects the review team had the same questions and drew the same conclusions as in the 1995 Lauria Grace fatality review. First and foremost the team questions why Zy'Nyia was ever returned home.

Zy'Nyia was placed in foster care when her mother was arrested on an outstanding warrant on a charge of possession with the intent to sell. This was not Ms. Sconiers first criminal offense. As a juvenile, she was booked in 1988 for possession of stolen property and forgery, in 1989 with criminal assault, and in 1989 first degree assault (2 counts), robbery 1st degree (2 counts). As a result of these crimes she spent the next three to three and one-half years in a juvenile rehabilitation center. As an adult, in 1992 she was booked for assault 2, police obstruction, and a parole violation; in 1993 possession of stolen property 2 and criminal assault; in 1995 driving with out a license on two occasions and police obstruction; and in 1996 possession of illegal substance with

intent to sell. Ms. Sconiers also reports that she made a living between 1992 and 1996 by selling drugs. Ms. Sconiers was arrested in January of 1997 and remained incarcerated until May of 1998. In sum, between the age of 15 and 25 Ms. Sconiers had spent between five and one-half and six years in prison and reported that she supported herself by selling illegal drugs when she was not incarcerated.

After Ms. Sconiers' children were removed from her care and she was incarcerated, she partially complied with services. She attended some parenting classes but was terminated from and alcohol treatment while incarcerated for an unknown "major infraction". Within a month after being released from her work release program (in May of 1995) Ms. Sconiers did some binge drinking and Marijuana use. She was evaluated in July of 1998 as chemically dependent, and treatment was recommended. Although Ms. Sconiers had numerous opportunities to access treatment, she refused.

Over the next year and a half, prior to her children being returned home, she was at best marginally compliant with her UA's. Of the 54 scheduled UA's 20 were negative, 4 were positive, 4 samples were unacceptable because they tested as diluted, 2 were excused misses and 4 were no-shows. In all, over the year and a half Ms. Sconiers successfully met the requirement of less than 60% of her UA's. During this time Ms. Sconiers went to two parenting classes but did not successfully complete either. Also, she was enrolled in mental health services for about 5 months, but stopped meeting with a counselor and stopped taking her medication prior to the children being returned.

The Department filed a termination petition on the children in August of 1997. After that time, there were numerous continuances. Initially there was concern that the Department did not make a diligent effort to offer Ms. Sconiers services. In reviewing the records early in the case there was one six-month time period and, later in the case, one three-month time period where very little casework accomplished. As the case went on, the continuances started mounting. Sometimes the continuances were due to the mother showing some motivation to engage in services and on at least on one occasion because there was no courtroom available to proceed with the termination trial. The Department's recommendations regarding the legal side of the case reflected the mother's progress at that time. If she was not in compliance a termination trial was set. If, while

waiting for the hearing to proceed, she started to make progress, the termination trial was continued. The children were finally returned to their mother 36 months after they were initially removed with no termination trial ever having occurred.[6]

In November 1997 Congress passed the Adoption and Safe Families Act (AFSA). As Linda Katz (1998) points out, Congress passed this act "in response to a growing frustration with the length of time children reside in foster care and concern about decisions being made to return children to dangerous home settings."(2). Of particular interest to this committee is the section of ASFA that addresses concurrent planning. Concurrent planning is in place of sequential planning. With sequential planning parents are given time to rectify the issues which led to their children being removed from their care if the parents fail to address the issues, the department social worker then looks for other long term options for the children. A "concurrent plan" establishes two tracks; either return home to the parents if the parents successfully comply with reasonable services and do not pose a risk to the child or in the alternative, placement of the child with a family who is willing to adopt the child or become the child's legal guardian. With concurrent planning a contingency plan of who will care for the child(ren) if they are unable to return to their parents is worked on simultaneously, as is the plan to return the children back to their parents. Concurrent planning is particularly appropriate with very young children, and children whose parents are unlikely to in a timely manner rectify the problems that initially led to the dependency.

RECOMMENDATIONS REGARDING CONCURRENT PLANNING:

---

[6] Attorneys from the Attorney General's office reported in interviews that the procedure at the time the trial was originally scheduled, was that if a courtroom was unavailable by 2:00 pm on the date scheduled, the trial would be continued until another trial date was available, (which could be several months later), and attorneys were free to leave. This policy placed dependency matters on the same trial call calendar as all other civil cases, which only are assigned courtrooms after all criminal matters have been assigned a courtroom.

Superior Court personnel were interviewed and reported that current policy is that Dependency Trials are on the same readiness calendar as criminal cases, giving dependency cases a higher priority over other civil matters. This docket procedure provides that if a courtroom is not available on the trial date, all parties must appear the next day to wait for a courtroom assignment unless the parties agree to continue the matter. The Fatality Review Team was unable to ascertain when the current policy took effect.

1. *The Department must create a concurrent planning model that gives clear guidance to social workers in how to proceed in dependency cases in which concurrent planning is an appropriate option. The Department must also allocate the resources so these clear guidelines can be followed.*

Linda Katz (1999) outlines a concurrent planning model. The committee believes that this model gives a good outline of how a Concurrent Planning Model may be set up.

> "**a.** ***Differential Diagnoses.*** Within the first 90 days of placement the agency completes a standardized assessment of the family's likelihood of being reunited within the next two months, based on the families history, relationships with the child, and demonstrated progress to date. Families with poor prognosis are given a concurrent plan
> **b.** ***Full Disclosure.*** All families are given information about the detrimental effects of out-of-home care on children, the urgency of reunification, and the agency's concurrent plan to safeguard the child from drifting in care. The family's options are thoroughly and repeatedly reviewed with them, including the use of extended family resources and the option of voluntary relinquishment for adoption.
> **c.** ***Timelines.*** The entire case plan is structured by the legal requirements for timely permanency. These timelines are explained to families as part of "full disclosure".
> ***d. Visiting.*** Vigorous efforts are made to institute frequent parental visiting, even with ambivalent or unresponsive parents. The agency's zeal in promoting visiting will result in either faster reunification or early decision making in favor of an alternative permanent plan.
> **e.** ***Plan A/Plan B.*** In every poor prognosis case, children are placed with a family willing and able to work cooperatively with the biological parents but also prepared to become the children's permanent family if needed. This could be a relative or a foster family. Such a placement is acknowledged openly to the parents and supported by the agency and the court.
> **f.** ***Written Agreement.*** Parents are helped by workers to reduce the overall case plan into small steps, written down with or by them, on a weekly or monthly basis. This facilitates observable compliance and improvements, and provides documentation for the court of unsatisfactory progress if it should be needed.
> **g.** ***Behavior (Not Promises).*** The agency and the court proceed based only on the progress (or lack of progress) documented by observations, service provider reports, and expert testimony.
> **h.** ***Forensic Social Work.*** The agency provides its staff with ongoing legal training, consultation, and support, so that its social workers produce legally sound case plans, concise court reports, and competent testimony.

i. ***Success Redefined.*** The agency and the court define their primary goal as timely permanency, with family reunification as the first, but not only, option".

OTHER LEGAL RECOMMENDATIONS:

2. *That the Washington State legislature should enact a law enabling the court to determine after 12 months if DSHS has made reasonable efforts to reunify the family.* The state would be required to show "clear, cogent and convincing evidence" that it has offered appropriate services to the parent(s). Once a determination has been made that services have been offered and not accepted or adequately engaged in, the Department would be relieved of further obligation to provide services.
3. *To achieve the most informed and consistent judicial decisions, and to reduce the time to resolution, juvenile dependency cases should be assigned to a judicial officer at the time of filing. The judicial officer assigned at the time of filling should hear all proceedings in the case, to the extent possible. When this is not possible, prior judicial rulings should be considered in subsequent judgments.*
4. *The Department should develop a way to monitor and verify progress in court ordered services as well as compliance with court ordered services.* Many times in this case, especially with regards to drug and alcohol issues, the mother apparently went through the motions without ever making progress in addressing these issues.
5. *Continuances must be kept to a minimum; a limit should be set at 2 continuances that the Assistant Attorneys Generals can request for the termination hearing.*
6. *Courtrooms must be available to hear termination trials.*
7. *There should be consistency and continuity in the ISSP's that the Department submits to the court.* The progress with regards to previously ordered services should be updated in each new ISSP. If old service recommendations are dropped, a justification for this must be made. Likewise if new services are being recommended, the reason for requiring of the participation in the services must be outlined.

References

Katz, L. (1999). Concurrent planning: Benefits and pitfalls. *Child Welfare.* LXXVII, (1), 71-87. (Linda Katz became the Program Manager for the King County Juvenile Court CASA Program on August 21, 2000.)

Munro, E. (1996). Avoidable and unavoidable Mistakes in child protection work. *British Journal of Social work,* 26, 792-808.

Munro, E. (1999).Common errors of reasoning in child protection work. *Child Abuse & Neglect,* 23(8), 745-758.

Weinberg, A., & Katz, L. (1998). Law and social work in partnership for permanency: The Adoption and Safe Families Act and the role of concurrent planning. *Children's Legal Rights Journal.* 18(4), 2-23.

Chronology Of Key Events

11-17-96	CPS report from the hospital stating that at the birth of Zy'Nyia the mother tested positive for cocaine and marijuana. When Ms. Sconiers was informed she tried to flee with the child, and assaulted a security guard while holding Zy'Nyia. Ms. Sconiers was arrested and Zy'Nyia was placed into protective custody.
11-19-96	CPS social worker placed the child back with her mother.
12-5-96	Ms. Sconiers had a urinalysis test done and tested positive for cocaine and marijuana.
12-16-96	Ms. Sconiers had a urinalysis test done and tested positive for cocaine and marijuana.
12-23-96	Summary assessment done in which the CPS worker notes that the mother was abused as a child and was placed into protective custody on 1985 and in 1988, at which time she became a dependent of the state. Notes that mother denies having a drug and alcohol problem even though she has had three positive urinalyses since the birth of the child. Summary assessment rates the family at moderate risk, noting that Ms. Sconiers seems to be a good mother and the home was clean.
12-24-96	CPT occurred. Recommended mother to have a chemical dependency evaluation and follow all recommendations; mother to attend drug treatment; mother to participate in a birth to three program.
1-3-97	Mother refused to participate in drug/alcohol evaluation.
1-16-97	Ms. Sconiers residence was raided by law enforcement and mother was arrested on outstanding warrants.

1-21-97	Dependency petition was filed on both children.
2-14-97	Initial agency ISSP. Notes that mother is expected to be incarcerated for 2 years. The social workers recommendation for the permanent plan is for the children to return home.
2-18-97	Initial GAL report. The GAL reports that Ms. Sconiers was recently charged with unlawful possession with Intent to Deliver Controlled Substance (cocaine). She was sentenced to 30 months at Purdy correctional facility. Also GAL notes that the care provider at the current placement of the children reports that she has been the primary care provider of [redacted] since he was born and would like to be a permanent resource for both children. GAL notes that both fathers involved in this matter are currently incarcerated.
3-12-97	Dependency established as to the mother for both children.
3-21-97	Case transferred from CPS worker to first CWS worker.
4-22-97	90 day prognostic staffing occurred.
5-23-97	Agency ISSP submitted by the social worker. The CWS worker recommends that the permanent plan remain return home.
5-30-97	GAL report. GAL notes that she had contact with the foster mother and the jail staff. She notes that she attempted but was unable to contact the CWS worker assigned to the case. The GAL notes in the report that Ms. Sconiers was enrolled in drug/alcohol treatment services, however she was discharged from the program due to a serious infraction that was not disclosed. The GAL recommends that DCFS pursue permanency planning for the children, and that the permanent plan be termination/adoption.
6-3-97	Dependency review hearing. Mother found not in compliance. Department ordered to file a termination petition within 60 days.
8-2-97	Termination referral done for Zy'Nyia.

9-10-97 Ms. Sconiers attended 10 hours out of 10 available hours of parenting class while incarcerated.

9-16-97 Drug and alcohol evaluation done on Ms. Sconiers. Ms. Sconiers was assessed as middle stage chemically dependent (cannabis dependency) and was recommended to complete 12 weeks of intensive outpatient treatment, 24 weeks of aftercare services, moral recognition therapy and one NA/AA meeting per week.

10-1-97 Fact-finding hearing-probably continued to 10-15-97.

10-6-97 Case transferred to the 2nd CWS social worker.

10-15-97 Docket call for termination. Continued to docket call 3-9-98 and trial for 3-11-98

10-20-97 Prognostic staffing. Plan to continue the dependency. The record did not reflect documentation of reasonable efforts sufficient to proceed with termination of parental rights. Set to be restaffed on 1-12-98.

10-30-97 Ms. Sconiers attended 9 hours of 9 hours available in a parenting class on parenting from a distance and attended 9 hours out of 9 available on parent-child interactions. Both were attended while Ms. Sconiers was incarcerated.

11-12-97 Agency ISP submitted. Recommendation is for dual tracking, termination and adoption. GAL report submitted by the first GAL recommends the permanent plan of termination/adoption. At the review hearing on this day the court modified the proposed permanent plan to termination of parental rights/adoption. Notes that the mother has partially complied with services.

2-2-98 Agency ISSP submitted. Department social worker recommendation for the permanent plan is dual track, return home and adoption.

2-10-98	Mother in compliance; mother has made progress. Father of Zy'Nyia partial compliance; father has not made progress. Court accepts department recommendation of dual tracking, return home and adoption.
3-9-98	Docket call for termination as to the mother. Motion and order of continuance.
6-4-98	Letter sent to Ms. Sconiers by the Department social worker informing her that she has been referred to TASC for a drug and alcohol evaluation, and to Bates Technical College for parenting classes.
7-12-98	Docket call for termination of parental rights. Social worker SER indicates that through an in court request made by the social worker this hearing was set over to 11-16-98.
7-14-98	17 month prognostic staffing. The DCFS legal recommendation from the panel was termination, and foster parent adoption.
7-20-98	Ms. Sconiers participated in a TASC evaluation. The evaluator noted that the mother had reported that she had drunk whiskey with co-workers on 5-30-98, and had smoked pot on a three-day binge from 7-15-98 to 7-17-98. (the mother had left the work release program on 5-28-1998). The evaluator initially recommended that the mother have UA's done but did not recommend treatment. In 8-1998 the evaluator modified her recommendations to include intensive outpatient treatment due to the mother testing positive to THC on 8-6-1998. The TASC evaluator informed the review team that two times in 8-98 an intake meeting for treatment was arranged for Ms. Sconiers, however she never followed through with the scheduled intake meetings.
7-21-98	Affidavit of social worker to support motion to change the placement of the children.
7-21-99	Meeting between social worker, foster parents of Zy'Nyia, and the coordinator for the private agency foster care program. Notes that the

permanent plan is to return Zy'Nyia to her mother. Also notes that if Ms. Sconiers continues to progress the foster parent and Ms. Sconiers can work together as a type of co-parenting plan in order to transition Zy'Nyia back to her mother's care.

8-5-98 TASC report on July participation. Mother had 2 urinalysis both were negative. Ms. Sconiers noted as being in partial compliance.

8-11-98 Agency ISSP submitted. Department social worker recommends dual track, return home and termination.

8-12-98 Report from the 2nd GAL done. Recommends termination/adoption. GAL reports contact with the social worker, foster mother, and children.

8-17-98 Review hearing. Mother not in compliance; mother has not made progress. Father for Zy'Nyia not in compliance; father has not made progress. Permanency planning finding: dual track-termination/adoption and reunification. Review hearing set for 2-9-99.

9-10-98 TASC report on August. Ms. Sconiers had 2 negative UA's 1 positive for THC and 1 no show. Ms. Sconiers was noted as being in violation of the program and intensive outpatient treatment was strongly recommended.

10-12-98 TASC report on September. Ms. Sconiers had 3 negative UA's. Noted as being in partial compliance. Intensive outpatient treatment recommended.

11-9-98 TASC report on October. Ms. Sconiers had 3 negative UA's and 1 unacceptable. Noted as being in partial compliance. Intensive outpatient treatment is recommended.

12-11-98 Letter from parent educator noting that Ms. Sconiers attended 7 out of 10 parenting classes offered by Bates Technical College. Notes that this did not meet the minimum hours required for a certificate. Notes that Ms. Sconiers was cooperative and participated in class discussion while at the classes.

[redacted]

RCW 74.04.0060 not re: Zy'Nyia

11-16-98 Affidavit from social worker requesting continuance of termination trial for three months. Notes that since the last review hearing the mother has started to comply with some of the court ordered services.

11-16-98 On or about this date 2nd CWS social worker left the position and the CWS supervisor covered the case.

11-16-99 Docket call for termination of parental rights. It seems that this matter was continued to 12-14-98 and an early review was set for 12-8-98.

12-8-98 Early review hearing. Records indicate the CWS supervisor appeared and requested that the termination hearing proceed. Court commissioner agrees and set hearing date for the following week.

12-8-98 On or about this date CWS supervisor transferred the case to 3rd CWS social worker.

12-14-98 TASC report for month of November. Ms. Sconiers took 2 UA's this month, both were negative. Ms. Sconiers noted as being in partial compliance. Notes that intensive outpatient treatment is recommended and that she has rescheduled her intake meeting for treatment twice and was a no show on 12-2-98.

1-8-99 TASC report on December. Ms. Sconiers did not show for either of her UA's that month. Notes that Ms. Sconiers reported that her attorney told her that she did not have to do treatment, as it was not a part of the court order. Women's recovery treatment was recommended.

2-4-99 TASC report for 1-1-99. Mother had one negative UA and one positive UA-marijuana. Ms. Sconiers is noted as being in violation of program requirements. Notes that Ms. Sconiers is not amenable to chemical

dependency treatment at this time. With any further positive urinalysis results treatment will be required.

2-9-99 Review hearing set for 2-9-99 continued to 3-8-99.

3-3-99 Agency ISSP submitted. File copy not signed or dated. The permanent plan is dual track, return home/adoption. The social worker writes that the mother was again given the opportunity to participate in services. However, the mother "has consistently shown the department and the court that she in incapable of full compliance with services that would reduce risk to the children..."

3-5-99 TASC report for month of February. Ms. Sconiers had one negative UA and one positive UA-marijuana. Both Drug and Alcohol treatment and mental health counseling are recommended. Notes that Ms. Sconiers is reporting that she is having mood swings and reports that she believes she is bi-polar. Ms. Sconiers noted as being in violation of program requirements.

3-8-99 Agreed review hearing. Mother not in compliance: mother has not made progress. Father not in compliance; father has not made progress. No permanent plan is defined in the court order. Permanency planning hearing is set for 8-30-99.

3-26-99 Affidavit, motion and agreed order of continuance of 3-10-99 termination trial. No courtroom was available for the trial. Next available date for the parties established as; docket call 5-17-99 and trial 5-19-99.

3-29-99 Case transferred to 4th CWS social worker.

4-7-99 TASC report for the month of March. Ms. Sconiers had two UA's both negative. Ms. Sconiers had her intake meeting for mental health on 3-31-00. Drug and alcohol treatment is recommended. Mother noted as being in satisfactory compliance.

5-4-99 TASC report on April. Ms. Sconiers had one negative and one unacceptable UA. Notes that mother is attending mental health counseling and that Drug/Alcohol treatment is recommended. Ms. Sconiers is noted as being in Partial compliance.

5-7-99 Affidavit of social worker requesting a continuance of the termination trial for 90 days. The social worker notes that the mother is now involved in court ordered mental health counseling and has been prescribed psychotropic medication for her bipolar disorder. The social worker notes that there has not been enough time to monitor the mother while she is taking the medication and to see if she will comply with mental health services. Social worker also notes that the mother is consistently going to her TASC appointments and is in compliance with her probation. In addition, the social worker notes that since she had just recently been assigned the case that she had not yet had enough time to work with the Ms. Sconiers in order to assist her in complying with court ordered services.

6-14-99 TASC report for the month of May. Ms. Sconiers had 1 negative UA, and did not show for her other UA. She is attending mental health counseling. Drug/Alcohol treatment is recommended. Ms. Sconiers is noted as being in partial compliance.

7-8-99 TASC report for month of June. Ms. Sconiers had 2 negative UA's, and she was attending her mental health counseling. Drug/Alcohol treatment was recommended. Ms. Sconiers compliance was noted as being Satisfactory

8-6-99 TASC report for month of July. Ms. Sconiers had 2 negative UA's, and she was attending mental health counseling. Drug/Alcohol treatment was recommended. Ms. Sconiers is noted as being in satisfactory compliance.

8-11-99 Agency ISSP submitted by social worker. The social worker writes that the mother is attending counseling at Greater Lakes Mental Health, and

that she has been meeting her TASC requirements. The social worker notes that the mother did have one positive urinalysis in February for marijuana, but that she has been clean since. Also notes that Ms. Sconiers was referred to a parenting class at Catholic Community Services, that she has been attending regularly and only has three classes remaining. The recommendation is that the children remain dependent, that Ms. Sconiers continue complying with services, and that Ms. Sconiers needs to obtain clean, sober, stable housing immediately so these children can be returned home. The primary plan in the ISSP is noted as return home and the alternative plan is adoption.

8-24-99 GAL report. Notes that the GAL had contact with the social worker, mother, foster mother and children. GAL recommends that the court adopt all of the social workers recommendations.

8-30-99 Review hearing. Mother in compliance; mother has made progress. Father not in compliance; father has not made progress. Permanency plan: dual track planning-termination of parental rights and reunification. Court ordered services are consistent with the agency ISSP and include continue with TASC services and follow through with all services recommended by provider, mother to submit to random urinalysis testing, mother to refrain from using any drugs or alcohol and to refrain from any association with other drug/alcohol sellers or users, and mother to obtain clean, stable, safe housing...and the children can be transitioned and returned home by agreed order. One recommendation that was in the ISSP but not the court order was that Ms. Sconiers was to continue with mental health counseling and medication, if deemed necessary by the counselor. (It is unknown why this recommendation was not included in the court order).

9-10-99 TASC report for the month of August. Ms. Sconiers had one negative and one unacceptable UA. Notes that she is attending mental health counseling. Drug/Alcohol treatment is recommended. Ms. Sconiers is noted as being in partial compliance.

9-15-99 Affidavit of the social worker requesting a continuance of the termination trial

9-15-99 Letter from the counselor at Greater Lakes Mental Health to the social worker stating that Ms. Sconiers has kept all of her appointments and has participated adequately in both individual therapy and group therapy.

9-20-99 Letter from the social worker to the counselor at Greater Lakes Mental Health requesting that the mother be scheduled for another appointment.

10-8-99 TASC report for month of September. Mother apparently did not participate in TASC for the month of September. Reports that she resumed UA testing in September.

11-3-99 Gateways For Youth and Families treatment team meeting notes. Private agency providing the foster home for Zy'Nyia. Present at the meeting was the Licenser/director, the foster mother, the foster care support person and the GAL. With regards to a transition plan the recommendation is that once Ms. Sconiers is stabilized she will work into extended visits, and then unsupervised visits to overnight visits.

11-8-99 TASC discharge summary. Ms. Sconiers' UAs for October were one unacceptable (appeared dilute) and one positive-marijuana. The mother was discharged from TASC in a Neutral Discharge, the reason being that she was transferred to another program. The report indicates Ms. Sconiers reported for 28 of 34 UA's/breath test between 7-20-98 and 10-29-99. Two absences were excused and 4 no shows. Four of the UA's were positive for marijuana and 4 samples were unacceptable (appeared dilute). The report indicates that the mother did make some progress in the course of her time in the program. It is noted that the mother was prescribed medication for mental health problems but has not been taking the medication. The recommendation is that Ms. Sconiers be referred to MICA (mentally ill chemically addicted) treatment at Greater Lakes Mental Health, have ongoing mental health counseling and be consistent

with prescribed medication. The evaluator notes that if the Ms. Sconiers follows these recommendations her prognosis is positive.

12-15-99 Referral made to Advantages Plus Counseling for an FPS provider.

1-12-2000 Affidavit of social worker requesting placement of the children be amended to allow the children to be returned home.

1-27-2000 Case staffed with CPT for services only. Notes to the CPT team indicate that she had two relapses of THC in a year but completed the drug and alcohol program. Also notes that the mother completed parenting classes and mental health counseling. Social worker reports that upon the return home a counselor will work with [redacted] and Ms. Sconiers and that FPS is already in place. Social work notes that risk is low at this point.

2-2-2000 [redacted] was returned home to his mother.

2-3-2000 Motion hearing to amend placement and continue termination. Placement amended to in-home dependency and termination trial continued to 5-22-00.

2-9-2000 Zy'Nyia returned home to her mother.

2-9-2000 Agency ISSP submi"ed by the social worker. The social worker notes that Ms. Sconiers has completed her probation. She has completed her TASC requirements, and the closing summary recommended that if Ms. Sconiers relapses she should be referred to the MICA program. The Social worker also notes that services such as FPS, family's counseling with Greater Lakes, and a home support specialist have been assigned.

2-11-2000 Notes indicate that the social worker did a 90 day Health and Safety check.

2-15-2000 Notes from FPS worker indicate that he spoke with mother about concerns with regards to mother having someone watch children who has not had a criminal background check done. The FPS worker later reported that it

was a cousin of Ms. Sconiers that was involved in a shooting in Tacoma in which someone was killed.

2-22-2000 Review hearing. Mother in compliance; mother has made progress. Permanent plan modified to an in-home dependency, placement in mother's home. Next review scheduled for 8-8-00.

3-1-2000 Monthly Status report from FPS worker indicates that he made a referral to Greater Lakes Mental Health for the family. Also reports that he gave Ms. Sconiers referral so that she could have a UA done on 3-1-2000.

3-8-2000 FPS workers notes indicate that Ms. Sconiers was very upset with him on this day, [redacted] Notes that Ms. Sconiers did not want to speak with him regarding noncompliance with treatment.

RCW 74.04.050 not to Zy'Nyia

3-15-2000 Mother went in and did urinalysis test on this day. (One she was referred to on 3-1-2000), Result was negative. Also on this day notes indicate that social worker spoke with mother and agreed to look into having the FPS worker changed. Also talked to mother about getting counselor to work with her and [redacted] back on the case.

4-4-2000 2nd FPS worker scheduled to meet with Ms. Sconiers today. Ms. Sconiers not home for appointment. Notes concern that mom is not in compliance and feels she does not want services.

4-10-2000 FPS worker's first meeting with the family.

4-11-2000 90-day health and safety contact by the social worker. Home visit was made with a counselor who was supposed to start working with the mother and [redacted] Reports that Zy'Nyia is doing well. Notes that mother reported that [redacted] ran a bath for Zy'Nyia and the water was too hot and she burned her foot. Mother reported that she took Zy'Nyia to the hospital and she is doing fine.

4-17-2000 FPS worker met with mother. Notes that Ms. Sconiers needs some help with discipline. Reports that she has some concerns regarding Ms. Sconiers form of discipline.

RCW 74.04.0060 not rel: Zy'Nyia

4-25-2000 FPS worker's 3rd visit with the family. [redacted] Concerns noted are that Ms. Sconiers is currently unemployed and has $100.00; unsure how she is going to pay May's rent. Mother has exhibited very little interaction with the children while she has been at the home, and the mother has a very intimidating voice.

5-1-2000 FPS worker status report sent to case worker for the month of April. Reports that mother is trying to implement more appropriate methods of handling the children's behaviors. Notes that mother continues a way of verbalizing that intimidates children and creates an adversarial forum.

5-1-2000 Mother not there for scheduled meeting with FPS worker.

5-4-2000 Service Episode Report indicating that the FPS worker spoke with the social worker and reported that the mother is doing well.

5-8-2000 FPS visit attempted, mother not home for scheduled visit.

5-16-2000 FPS visit attempted, mother not home for scheduled visit.

5-17-2000 FPS worker spoke with the social worker. Told her about the missed appointment again. FPS worker informed social worker about money running out for FPS services and that she feels the family would benefit from continued services.

5-22-2000 FPS visit attempted, mother not home for scheduled visit, the next appointment is set for 5-30-99.

5-27-2000 CPS report received indicating that Zy'Nyia Nobles had died. Referent reports that Zy'Nyia was in cardiac arrest when the medics arrived. Referent reported that Zy'Nyia had huge significant size bruises all over her body. Child's sibling was placed in protective custody.