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In Memory of Baby Trinity Jabore:
Ensuring Better Outcomes for D.C.'s Children and Families

July 21, 2017

On June 26, 2017, Jay Crowder and Trishelle Jabore pled guilty to voluntary manslaughter and first degree child cruelty in the starvation death of their 7-week-old daughter Trinity.[1] According to the Proffers of Facts submitted at the plea hearing, little baby Trinity died on Christmas Day 2016 as a result of malnutrition, hyponatremia (abnormally low levels of sodium in the blood), and trunk trauma.[2] As discussed in this paper, D.C. child protection officials had opportunities both before and during little baby Trinity's short life to take action that could have resulted in a different outcome for Trinity and her family. But each time, those opportunities were squandered.

Trinity's brief life was filled with constant horror and pain. When she was born on November 6, 2016 at United Medical Center in Southeast D.C., she tested positive for THC, the main chemical in marijuana. While still in the hospital, medical staff counseled the parents because they were not feeding Trinity enough formula, and also instructed the parents not to feed her cow's milk until she was one-year-old.[3] Social worker reports obtained by the Washington Post indicate both parents had limited cognitive abilities.[4]

As set forth in the Proffers of Facts,[5] upon discharge, Trinity's parents were provided 11 bottles of pre-mixed infant formula. They were advised to take Trinity to a pediatrician within the next few days so she could have a well infant check-up and where they could

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[1] Mr. Crawford and Ms. Jabore also pled guilty to welfare fraud – unlawful food stamp usage, and Mr. Crowder pled guilty to a charge of attempted distribution of a controlled substance (synthetic cannabinoid or K2). Sentencing is scheduled for Sept. 8, 2017. The Court will need to approve Mr. Crawford's agreed-upon sentence of 10 to 12 years in prison, and could impose a term of 6 to 15 years for Ms. Jabore under its voluntary sentencing guidelines. In return for the pleas, the government agreed not to prosecute First Degree Murder - Felony Murder with Aggravating Circumstances. *See* Plea Agreement and Waiver of Trial (June 26, 2017), *District of Columbia vs. Crowder, Jay Allen*, Case Nos. 2017 CF1 007735 and 2016 CF1 013845; Plea Agreement and Waiver of Trial (June 26, 2017), *District of Columbia vs. Jabore, Trishelle*, Case No. 2017 CF1 007736. *See also* Press Release, Department of Justice, U.S. Attorney's Office District of Columbia, *Parents Plead Guilty to Voluntary Manslaughter And Other Charges in Starvation Death of Infant Daughter* (June 26, 2017), available at https://www.justice.gov/usao-dc/pr/parents-plead-guilty-voluntary-manslaughter-and-other-charges-starvation-death-infant.

[2] Proffer of Facts (June 26, 2017), *District of Columbia vs. Crowder, Jay Allen*, Case No. 2017 CF1 007735 and 2016 CF1 013845; Proffer of Facts (June 26, 2017), *District of Columbia vs. Jabore, Trishelle*, Case No. 2017 CF1 007736.

[3] *Id.*

[4] Keith L. Alexander and Paul Duggan, *Agency Got Complaints About Couple Charged in Death of Malnourished Newborn.* The Washington Post, May 15, 2017, available at https://www.washingtonpost.com/local/traffican D.C.ommuting/D.C.-social-workers-had-received-parenting-complaints-about-couple-charged-with-first-degree-murder-in-the-death-of-their-malnourished-newborn-police-said/2017/05/14/178768ee-371c-11e7-b412-62beef8121f7_story.html?utm_term=.e655db7e41b7.

[5] Proffers of Facts (June 26, 2017), *supra* note 2.

enroll to receive WIC benefits to buy more formula for Trinity. However, her parents still did not feed her properly at home and never took her to the pediatrician as the hospital had advised. After Trinity's death, investigators found plenty of food in the home but no baby formula. Trinity's parents admitted that they did not feed her enough and that when they ran out of formula, they fed her evaporated or powdered cow's milk heavily diluted with water and sometimes added infant cereal. Testing of a bottle found in the home revealed it contained mostly water and had no nutritional value.[6] The Medical Examiner found baby Trinity had lost 10 ounces since her birth with little to no fat on her body, had a bruised sacrum, had scarring to her labia and genitalia from severe diaper rash, and had blood in her diaper. She also had suffered 13 rib fractures as well as a fractured collarbone. These fractures were determined to be consistent with constriction of the chest or blunt force trauma.[7]

According to the Affidavits in Support of Arrest Warrants,[8] investigators found the home dirty and cluttered with drug-related paraphernalia visible in the living areas. Ms. Jabore admitted that she and Mr. Crowder smoked marijuana on most days. Witnesses also reported use of synthetic marijuana.[9] Ms. Jabore told investigators that she was unable to care for baby Trinity properly because she had severe back pain from the birth and could not get out of bed. She further said that she was afraid to ask Mr. Crowder for help because of domestic violence in the home. Witnesses reported that Ms. Jabore may have suffered from post-partum depression, presenting as hopeless, stressed, and losing her hair. Mr. Crawford reported he was diagnosed with bipolar disorder, schizophrenia, and deep depression. In sum, baby Trinity's parents presented with serious mental health issues, limited cognitive abilities, domestic violence, and drug dependency.

Prior to Trinity's death, Ms. Jabore and Mr. Crowder had been brought to the attention of the Child and Family Services Agency (CFSA), the agency charged with protecting the District's children, for alleged neglect of Trinity's siblings. According to the Washington Post, CFSA received at least four calls about the family between May 2014 and early December 2016.[10] In fact, the Post reported that when Trinity died, CFSA was investigating allegations that Ms. Jabore had punched Trinity's older brother but, over the course of three weeks, CFSA never made contact with the parents or visited the home.

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[6] The government presented the opinion of Jessica McGee, a nutritionist from Children's National Medical Center that "all infants 0-6 months should receive breastmilk or infant formula as their sole source of nutrition . . . . that water "can cause the infant's sodium levels to drop leading to water intoxication. . . and [a]n infant's gastrointestinal system cannot handle solids or cow's milk." *See* Proffers of Facts, *supra* note 2.

[7] *Id.*

[8] *See* Affidavits in Support of Arrest Warrants (May 3, 2017), *District of Columbia vs. Crowder, Jay Allen*, Case No. 2017 CF1 007735 and *District of Columbia vs. Jabore, Trishelle*, Case No. 2017 CF1 007736.

[9] Synthetic marijuana or cannabinoid is not marijuana (although often confused as such); rather, it is a substance containing man-made mind-altering chemicals. Synthetic marijuana is an illegal controlled substance, can have unpredictable effects on the user including psychosis, and can even be life-threatening. The combination of chemicals used is constantly changing to avoid detection by authorities. For more information, *see* National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, *Drug Facts: What are Synthetic Cannabinoids?* (Nov. 2015), available at https://www.drugabuse.gov/publications/drugfacts/synthetic-cannabinoids.

[10] *See* Keith L. Alexander and Paul Duggan, *supra* note 4.

This story is appalling. But unfortunately, it is not all that unusual for abused and neglected children in the District. And it will happen again if something is not done. D.C.'s child abuse and neglect laws and CFSA failed baby Trinity in the gravest way. They also failed her parents who are now in prison, and her siblings who are now in foster care or being cared for by relatives.

To understand how this could happen, in Section I, we examine CFSA's implementation of D.C.'s child abuse and neglect laws, from the beginning when an allegation of child abuse or neglect is called into the hotline continuing through the various decision-points during CFSA's handling of a case. Section II addresses specific issues raised under federal and D.C. law and policy when an infant tests positive for drugs or an allegation of child abuse or neglect involves parental substance use. In Section III, we describe the missed opportunities for CFSA to intervene with baby Trinity's family. In Section IV, we propose a thorough review of D.C. child abuse and neglect law and policy to help produce better outcomes for D.C. children and families.

I. Background on CFSA's Hotline, Investigation, and Case Management Practices

As reported, CFSA had multiple interactions with baby Trinity's parents and siblings prior to her death. Those interactions should have raised "red flags" and, if pursued vigorously, might have been the difference between life and death for Trinity. Due to privacy laws,[11] we cannot know all the details of how CFSA handled the various allegations against Ms. Jabore and Mr. Crowder. However, the public record suggests several points at which CFSA's process may have broken down, including certain policies and practices that have previously raised concern among D.C. child welfare experts. This section provides an overview of how CFSA responds to reports of alleged child abuse or neglect and certain decision-points that have raised concerns in the past. Specific issues related to parental substance use are discussed in Section II.

A. The Intake Process and the Decision Whether to Investigate

When a call alleging abuse or neglect comes in to the CFSA hotline and is entered into the hotline database, a decision is made whether to "screen out" the report because the allegation does not meet D.C.'s statutory definitions of abuse or neglect, or to "screen in" (accept) the report. For reports that are accepted, CFSA may initiate an investigation into the allegation of abuse or neglect (as described in Section B, below) or, when there are no immediate safety concerns, may respond to the allegation through the Family Assessment pathway.[12] When the Family Assessment pathway is utilized, CFSA is required to see the alleged victim child and other children in the household within five days of receipt of the report to assess whether the family has any service needs.[13] When needs are identified, CFSA must assist the family in accessing services; however, the family's acceptance of services is completely voluntary.

[11] D.C. law restricts access to child protection information in the possession of CFSA to the immediate family; police officers, attorneys, and CFSA and court personnel as part of their official duties related to an abuse or neglect cases; and certain other narrowly-defined categories of individuals. *See* D.C. Code § 4-1302.03.
[12] *See Id.* § 4-1301.04(a)(2).
[13] *Id.* § 4-1301.04(a)(5).

According to CFSA, in fiscal year 2016, 16,671 calls to the hotline were entered into CFSA's hotline database. Of these calls, 22% (3,712 calls) were accepted for investigation. Another 20% (3,300 calls) involved allegations that were accepted for Family Assessment. Approximately half of the calls entered into the hotline database were "screened out" for no further action.[14]

Concerns have been raised about the quality of CFSA's decision-making at the intake stage. In March 2016, the Federal Court Monitor[15] conducted a review of a statistically significant sample of reports entered into the hotline database. The Federal Court Monitor's analysis showed that reviewers disagreed with CFSA's screening decisions (either the decision to screen out the report or the pathway decision if the report was screened in) for 23% of the reports.[16] With respect to just the universe of reports that were screened out, reviewers disagreed with that decision 27% of the time. Further, in only 57% of the reviewed cases did the hotline worker gather all of required information with respect to the reporter, child victim, other children, parent or caregiver, and alleged maltreater. The written memorialization of hotline calls was inaccurate in 30% of reviewed cases.

B. Quality of Investigations and the Decision-Making About Abuse or Neglect

If CFSA accepts an allegation for investigation, there are statutory timeframes for initiation and completion of the investigation.[17] In addition, the investigative social worker is required to take the following steps to ensure the quality of the investigation: (1) research the family's involvement with CFSA and review criminal records; (2) contact the alleged maltreater, any other caregiver, the reporting source, and the victim child and all other children in the household (outside the presence of the caretakers); (3) conduct inquiries of third parties, such as the Metropolitan Police Department, school and medical personnel, and other family members.[18] With respect to contacting the victim child, other children in the home, and family members, CFSA policy requires the social worker, among other things, to "make a minimum of three unannounced home visits at different times within a 48-hour time frame

[14] Child and Family Services Agency, *Responses Performance Oversight Hearing FY 2016 and FY 2017 (First Quarter) Pre-Hearing Questions Submitted to the Council of the District of Columbia, Committee on Human Services* (Feb. 21, 2017), available at http://dccouncil.us/files/user_uploads/budget_responses/CFSA_FY16-17_Pre-HearingPerformanceOversightHearing_Responses.pdf.

[15] In 1994, to resolve a class action lawsuit against the District on behalf of children in foster care or known to the child welfare because of reported abuse or neglect, a federal judge issued an order setting forth certain performance requirements for the District to meet and appointing the Center for the Study of Social Policy as Monitor to assess the District's compliance with those requirements. *See LaShawn A. v. Kelly*, 1994 U.S. Dist. LEXIS 20872 (D.D.C. 1994). More than 20 years later, D.C.'s child welfare system remains under court supervision.

[16] The Child and Family Services Agency and the Center for the Study of Social Policy, *An Assessment of the District of Columbia's Child and Family Services Agency Child Abuse and Neglect Hotline and Intake Practices and Decision Making* (Sept. 6, 2016), available at http://www.cssp.org/publications/child-welfare/district-of-columbia-lashawn-a-v-fenty/document/An-Assessment-of-the-District-of-Columbia-Child-and-Family-Services-Agency-Child-Abuse-and-Neglect-Hotline-and-Intake-Practices-and-Decision-Making.pdf.

[17] D.C. Code §§ 4-1301.04(b) and 4-1301.06(a).

[18] *Id.* § 4-1301.04(c)*;* The Child and Family Services Agency, *Procedural Operations Manual, Investigations* (December 2013), available at https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/Investigations-POM_0.pdf; CFSA Administrative Issuance, *Policy: Investigations* (latest rev. Jan. 16, 2015), available at https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/Program%20-%20Investigations_2015_Final.pdf.

with at least one visit between the hours of 8pm - 8am."[19] The most recent Progress Report issued by the Federal Court Monitor determined that 23% of the 132 investigations reviewed were not of acceptable quality, specifically identifying the insufficient collection of information from core, collateral, and non-victim children in the household.[20]

At the conclusion of the investigation, CFSA must decide whether to "substantiate" the allegation of abuse or neglect, *i.e.*, make a finding that abuse or neglect occurred.[21] Of the cases screened-in for investigation, approximately 25% were substantiated in FY 2016.[22] D.C. law provides that the decision to substantiate rests on whether there is "credible evidence" of abuse or neglect and defines "credible evidence" as "any evidence that a child is an abused or neglected child, including ***the statement of any person worthy of belief***."[23] *(emphasis added)*. Anecdotal evidence raises serious questions about how CFSA applies this credibility test. Specifically, in the experience of D.C. child welfare experts, the alleged maltreater may be believed more often than a child and, if a child does not corroborate a reporter's allegation or if the child recants, CFSA typically will not substantiate. This is the case even though the majority of hotline reports nationwide are made by healthcare, law enforcement, and education professionals.[24] In addition, children will often be untruthful to protect their parents at all costs. Indeed, a recent study of recantations of truthful allegations made by six to nine-year-olds established that 23% of children recant, and this number increases to 46% when a parent merely suggests that the child should recant.[25] Accordingly, CFSA should give more weight to the credibility of the reporter and victim child. CFSA also may want to consider supplementing its child interviews with a modified trauma assessment, similar to the one used by CFSA for foster children, to provide more reliable information about whether this child has been abused and/or is at significant risk of future abuse.

C. Case Pathways

If the allegation is substantiated, CFSA has only two options under applicable law. First, it must undertake all "reasonable efforts" . . . "to prevent or eliminate the need for removing the child."[26] If the child cannot be "adequately protected" in the home, then the agency is required to remove the child to foster care.[27]

The specific ways CFSA will allow children to remain in their homes are as follows: (1) counsel the parent(s) to ameliorate the safety concerns without any further CFSA involvement; (2) refer the family for voluntary services with a local D.C. agency or

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[19] *Id.*
[20] Center for the Study of Social Policy, *LaShawn A. v. Bowser Progress Report for the Period July – December 2016* (May 18, 2017), available at https://www.cssp.org/publications/child-welfare/district-of-columbia-lashawn-a-v-fenty/document/LaShawn-A-v-Bowser-Progress-Report-for-the-Period-July-Dec-2016.pdf.
[21] D.C. Code §§ 4-1301.04(c)(3)G) and 4-1301.06(b).
[22] CFSA, *Responses Performance Oversight Hearing FY 2016 and FY 2017 (First Quarter)*, *supra* note 14.
[23] D.C. Code § 4-1301.02(5) and (19A).
[24] U.S. Department of Health & Human Services, Children's Bureau, *Child Maltreatment 2015*, available at https://www.acf.hhs.gov/sites/default/files/cb/cm2015.pdf#page=20.
[25] Lindsay C. Malloy and Allison P. Mugno, *Children's Recantation of Adult Wrongdoing: An Experimental Investigation,* Journal of Experimental Child Psychology, vol. 145, May 2016, pp. 11-21, available at http://www.sciencedirect.com/science/article/pii/S0022096515003045.
[26] D.C. Code § 4-1301.09a.
[27] *Id.* § 4-1303.04(c).

Collaborative;[28] (3) open a voluntary in-home case with a CFSA caseworker assigned to visit the family regularly and ensure the family is connected to services in the community; (4) arrange for the children to live with kin for a period of time (often known as "informal kinship care") with no further agency involvement,[29] or (5) rarely, file a "community case" in court that requires the family to participate in services and meet certain thresholds to avoid removal of the children.[30]

Child welfare experts have questioned the effectiveness of these approaches. With the exception of community cases, when CFSA utilizes the above options, it typically provides support by "connecting" the family to voluntarily services. Evidence suggests that voluntary services generally are not effective because there is no guarantee that the family will follow-up with the referral and/or that appropriate services are even available.[31] In this regard, it should be noted that the most recent Progress Report of the Federal Court Monitor found that only 38% of in-home cases reviewed were rated as acceptable quality with respect to both the services provided and safe case closure.[32] Moreover, CFSA's data indicates a high rate of repeated abuse or neglect of children among in-home and Family Assessment cases.[33] If the above options are not viable to keep children safe in the home, then CFSA ***must*** remove the child to foster care, which can be with relatives pursuant to a fast track temporary licensing process.[34]

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[28] There are five Collaboratives in the District, each located within the neighborhoods it serves. The Collaboratives provide some services directly, but mostly refer clients to other community-based service providers. *See* https://cssd.dc.gov/page/healthy-families-collaboratives.

[29] CFSA maintains this is a voluntary arrangement initiated by the parent to ensure safety of the child and avoid removal; anecdotal evidence suggests the arrangement often is neither parent initiated nor voluntary and, therefore, should be considered a constructive removal of the child without the any supports and services. *See* Tiffany Allen and Karen Malm, *A Qualitative Research Study of Kinship Diversion Practices*, Child Trends (July 2016), available at http://www.childtrends.org/publications/a-qualitative-research-study-of-kinship-diversion-practices-2-2/; The Annie E. Casey Foundation, *The Kinship Diversion Debate* (Jan. 2013), available at http://www.aecf.org/m/pdf/KinshipDiversionDebate.pdf.

[30] In 2016, CFSA issued a revised policy on community papering. *See* Child and Family Services Agency, *Administrative Issuance CFSA-16-7 Community Papering*, (December 2016), available at https://cfsa.D.C..gov/sites/default/files/D.C./sites/cfsa/publication/attachments/AI_Community_Papering_2016_DEC_FINAL.pdf.

[31] *See* Professor Elizabeth Bartholet, *Creating a Child-Friendly Child Welfare System: Effective Early Intervention to Prevent Maltreatment and Protect Victimized Children,* 60 Buffalo Law Review 1321 (2012), available at http://www.buffalolawreview.org/past_issues/60_5/Bartholet.pdf.

[32] Center for the Study of Social Policy, *LaShawn A. v. Bowser Progress Report for the Period July – December 2016* (May 18, 2017), *supra* note 20. A recent Children's Bureau review found CFSA was ***not*** in substantial conformity with all seven child and family outcomes reviewed, and performed particularly poorly for children in the home, *i.e.,* not removed to foster care. United States Department of Health and Human Services, Children's Bureau, *Child and Family Services Reviews District of Columbia Final Report 2016*, available at https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/page_content/attachments/DC%20CFSA%20Statewide%20Assessment%20FINAL.pdf.

[33] Child and Family Services Agency, *District Of Columbia Statewide Assessment March 2016*, available at https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/page_content/attachments/DC%20CFSA%20Statewide%20Assessment%20FINAL.pdf.

[34] D.C. Mun. Reg. tit. 29, § 6207; Child and Family Services Agency, *Policy: Temporary Licensing of Foster Homes for Kin* (Sept. 2011), available at https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/Program%20-%20Temporary%20Licensing%20of%20Foster%20Homes%20for%20Kin%20%28final%29%28H%29_2.pdf.

II. Federal and D.C. Abuse and Neglect Law and Policy Related to Substance Use

A. Healthcare Providers' Obligation to Report Drug Affected Newborns

The landmark Child Abuse Prevention and Treatment Act (CAPTA) was enacted in 1974 to address child abuse and neglect for the first time as a nationwide priority.[35] To receive federal funding under CAPTA, states and D.C. must have certain child abuse and neglect provisions in their laws and policies. In 2003, CAPTA was amended to require states and D.C. to have provisions to address the needs of "infants born and identified as being affected by ***illegal*** substance abuse or withdrawal symptoms resulting from prenatal drug exposure."[36] (*emphasis added*). Specifically, healthcare providers must make referrals to child protective services of such affected infants, and a plan of safe care must be developed for the infant.[37]

In accordance with CAPTA, D.C. law requires healthcare providers to notify CFSA or the Metropolitan Police Department when abuse or neglect of a child is suspected.[38] D.C. law also defines the term "neglected child" to include an infant who "is born addicted or dependent on a ***controlled substance*** or has a significant presence of a ***controlled substance*** in his or her system at birth."[39] (*emphasis added*).

The partial legalization of marijuana in the District, however, has created the potential for confusion regarding the scope of healthcare providers' reporting obligations when a newborn tests positive for marijuana. Marijuana is categorized as a controlled substance by both D.C. and federal law.[40] However, effective February 26, 2015, the D.C. Controlled Substances Act was amended to provide that it shall be lawful and a not a criminal offense under D.C. law for an adult 21 years or older to purchase, possess, or use up to two ounces of marijuana.[41] The amendments to the D.C. Controlled Substances Act further provide that the term "controlled substance" in the D.C. Code does not include marijuana in the personal possession of an adult 21 years or older that weighs two ounces or less.[42] This limited exclusion of certain marijuana from the definition of the term "controlled substance," on its face, applies to the entire D.C. Code, including the provision defining "neglected child" noted above. As a result, healthcare providers may be uncertain whether they have an obligation under D.C. law to make a report of a marijuana-exposed newborn because they may be more focused on whether a mother had legally used marijuana during the pregnancy. In addition,

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[35] Child Abuse Prevention and Treatment Act, Public Law 93-247 (1974).
[36] Keeping Children and Families Safe Act of 2003, Public Law 108-36, codified at 42. U.S.C. § 5106a(b)(2)(B)(ii). The law does not define, and leaves to the states to define, the terms "affected" and "substance abuse."
[37] *Id.* § 5106a(b)(2)(B)(ii) and (iii).
[38] D.C. Code § 4-1321.02.
[39] *Id.* § 16-2301(9)(A)(viii).
[40] *Id.* § 48.902.01 et seq.; 21 U.S.C. § 812; U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division, *Controlled Substances Schedules*, available at https://www.deadiversion.usdoj.gov/schedules/index.html#list. (Controlled substances include both illegal drugs and legally prescribed drugs that have a potential for abuse). Efforts to legalize marijuana at the federal level have been unsuccessful to date.
[41] D.C. Code § 48-904.01(a)(1)(A).
[42] *Id.* § 48-904.01(a)(1A)(A)(i). A person may possess more than two ounces of medical marijuana pursuant to a legal prescription. *Id.* § 48-904.01(d)(1).

there appears to be a general misperception in the community that marijuana is no longer a "controlled substance" in D.C under any circumstances.

The need to rectify this ambiguity is underscored by new federal requirements adopted in response to the national prescription drug opioid epidemic.[43] On July 22, 2016, President Obama signed into law the Comprehensive Addiction and Recovery Act of 2016 (CARA).[44] As relevant here, CARA expanded health care provider reporting under CAPTA by removing the qualifying term "illegal" in the provisions requiring reporting of infants born affected by substance abuse.[45] The U.S. Department of Health and Human Services, the agency responsible for implementing CARA, explained in recent guidance that CARA is intended to "address the needs of infants born affected by both legal (*e.g.*, prescribed drugs) and illegal substance abuse."[46] Further, CARA provides that a plan of safe care must not only address the health and substance use disorder treatment needs of the infant, but also the affected family or caregiver.[47] Since CARA was effective upon enactment, states and D.C. were required to take immediate steps to comply.

While D.C.'s law technically complies with CARA to the extent it requires healthcare providers to report newborns exposed to prescription drugs that are included in the definition of "controlled substance," *e.g.*, prescription opioids, it contains needless uncertainty with respect to marijuana-exposed newborns. D.C. should take immediate steps to clarify that, notwithstanding the partial legalization of marijuana for adults, the definition of "neglected child" includes newborns exposed to marijuana. Correspondingly, D.C. should conduct educational efforts to ensure that healthcare providers understand their duties to make reports when a newborn has been exposed to marijuana or to opioids or other highly addictive drugs for which the mother has a valid prescription, as that may also cause confusion for healthcare providers. This reporting is an essential component of the District's child welfare system because, once a hospital makes such a report, a plan of safe care must be implemented for the baby, her mother, and/or family.

We are not contending that marijuana use during pregnancy, in and of itself, constitutes child neglect. However, the reporting of an exposed newborn is required by federal law, and studies show that marijuana is not a safe drug to use during pregnancy because of potential negative outcomes. These outcomes include abnormal infant neurobehavior, as well as inattention and impulsive behavior and deficits in problem solving skills, learning, and memory in older children.[48] Further, like alcohol, the concern with parental marijuana use is not whether the substance is legal or illegal, but whether its use increases the likelihood of

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[43] The Centers for Disease Control reports that nearly half of all U.S. opioid overdose deaths involve prescription opioids. *See* https://www.cdc.gov/drugoverdose/index.html. Further, in 2015, two million Americans had a substance use disorder involving prescription pain relievers. *See* https://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf.

[44] Comprehensive Addiction and Recovery Act of 2016, Public Law 114-198.

[45] 42 U.S.C. § 5106a(b)(2)(B)(ii).

[46] U.S. Department of Health & Human Services, Children's Bureau, *Program Instruction* (Jan. 17, 2017), available at https://www.acf.hhs.gov/sites/default/files/cb/pi1702.pdf.

[47] 42 U.S.C. § 5106a(b)(2)(B)(iii).

[48] Marylou Behnke, MD, Vincent C. Smith, MD, *Technical Report: Prenatal Substance Abuse: Short- and Long-Term Effects on the Exposed Fetus*, Pediatrics, Vol. 131, No. 3 (March 2013), available at http://pediatrics.aappublications.org/content/131/3/e1009.

abuse or neglect of a fragile newborn.[49] Indeed, marijuana use during pregnancy could be a symptom of other issues in the home that should be assessed by CFSA before the infant is discharged.[50]

B. CFSA Practices and Policies Regarding Substance-Exposed Newborns

CFSA acknowledges that babies born exposed to drugs "are some of the most at-risk children who come into contact with the child welfare system . . . . due to the baby's inherent vulnerability combined with the obvious impairments of the caregiver who is struggling with substance abuse."[51] However, CFSA's practices for handling allegations of neglect involving substance-exposed newborns have been uneven. It is our understanding from CFSA officials that CFSA did not routinely investigate reports of marijuana-exposed newborns. Some reports were screened out if the reporter presented an assessment of the mother's parenting ability that suggested the infant was not at risk. Other reports may have been sent to the Family Assessment pathway.[52] However, in June 2017, CFSA issued a new policy to conduct an investigation of every report of a marijuana-exposed newborn. As of this writing, this policy has not been made available publicly.

When CFSA investigates a report of a substance-exposed newborn, social workers have substantial discretion, including with respect to what safeguards need to be in place before a mother can take the child home from the hospital. Indeed, for infants with a positive toxicology screen, the CFSA investigative procedures manual states that "we do not hold a policy of immediate removal of these children nor do we immediately open cases."[53] As a CFSA spokesperson explained to the Washington Post, "although hospitals are required by law to notify Child and Family Services when babies are born 'tox-positive,' officials typically do not remove such infants from their mothers' care unless additional aggravating circumstances warrant such action."[54] Rather, the investigative social worker must conduct "a thorough investigation and determine whether there is ***evidence that the substance use impacts the mother's parenting***."[55] (*emphasis added*). This is a standard that is construed narrowly by CFSA, as discussed in Section C below. The CFSA procedures manual states

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[49] At least one recent study found an increased risk of physical abuse of children whose parents use marijuana. *See* Bridget Freisthler, Paul J. Gruenewald, and Jennifer Price Wolf, *Examining the Relationship between Marijuana Use, Medical Marijuana Dispensaries, and Abusive and Neglectful Parenting*, Child Abuse and Neglect, Vol. 48 pp. 170-178 (October 2015), available at http://luskin.ucla.edu/sites/default/files/Freisthleretal_2015_MJUseMMDAbuseandNeglect.pdf.

[50] It is well documented that parental substance abuse is a risk factor for child maltreatment. National data establishes that slightly more than one-third of adults with substance use disorders have a co-occurring mental illness (including post-traumatic stress disorder), social isolation, poverty, unstable housing, and domestic violence. *See* U.S. Department of Health and Human Services, Children's Bureau, Child Welfare Information Gateway, *Parental Substance Use And The Child Welfare System* (2014), available at https://www.childwelfare.gov/pubPDFs/parentalsubabuse.pdf.

[51] CFSA, *Procedural Operations Manual, Investigations* (December 2013), *supra* note 18.

[52] CFSA officials recently represented that an internal review found that 7 of 14 children who died between December and May were in the Family Assessment pathway. This review is not publicly available. Accordingly, we do not know whether Trinity was one of these 7 children.

[53] CFSA, *Procedural Operations Manual, Investigations* (December 2013), *supra* note 18.

[54] *See* Keith L. Alexander and Paul Duggan, *supra* note 4.

[55] Child and Family Services Agency, *Procedural Operations Manual, Investigations* (December 2013), *supra* note 18.

that social workers should discuss with the mother her drug use and history, review records regarding same, speak with the father and other family members who can provide support, make a referral to the infant-to-three early intervention program, and assess the safety of the home to "ensure that the mother has a crib or safe sleeping arrangement for the baby. . . . that the mother has supplies and a plan to have resources to feed, clothe, and shelter the baby."[56]

C. CFSA Practices Concerning Substantiation of Neglect Allegations Involving Parental Substance Use

While federal law does not specifically address substance use in the context of children who are not newborns, D.C. law provides that neglect is found when a child's "parent, guardian, or custodian is unable to discharge his or her responsibilities to and for the child because of incarceration, hospitalization, or other physical or mental incapacity."[57] The term "mental incapacity" has been interpreted to include parental drug or alcohol use.[58] However, a finding of neglect under this section also requires a causal nexus between a parent's drug/alcohol use and the neglected condition of the child.[59] Under a separate statutory provision, a child is neglected when he or she is "regularly exposed to illegal drug-related activity in the home."[60]

With respect to the first type of neglect, CFSA pronouncements along with informal discussions with CFSA officials reveal that CFSA feels hamstrung by the language of the statute and court interpretations and will only substantiate in extreme cases -- when the parent is incapacitated at the time the investigative social worker visits the home, *i.e.*, arrested, unconscious, hospitalized, or otherwise physically unable or unavailable to care for the child.[61] This approach fails to take into account the well established risk factors for abuse and neglect associated with parental substance use and, accordingly, seems to undermine a thorough investigation into the child's and family's overall well-being, including looking outside the home and talking with education and health professionals involved with the family to identify any concerns. Further, a parent's use of certain drugs of abuse alone (*e.g.* PCP, synthetic marijuana, cocaine, heroin, and oxycodone)[62] should presumably engender a hightened level of scrutiny because of their well known dangerous effects on the user, including unpredictable, violent and aggressive behavior, psychosis, and/or hallucinations.[63]

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[56] *Id.*
[57] D.C. Code § 16-2301(9)(A)(iii).
[58] See, e.g., *In re* B.L., 824 A.2d 954 (D.C. 2003); *In re* Am. V., 833 A.2d 493 (D.C. 2003).
[59] *Id.*
[60] D.C. Code § 16-2301(9)(A)(x); D.C. Code § 16-2301(37) defines "drug-related activity" as "the use, sale, distribution, or manufacture of a drug or drug paraphernalia without a legally valid license or medical prescription."
[61] *See* Raymond Davidson (CFSA Acting Director), *Testimony on CFSA Fiscal Year 2015-16 before the CFSA Performance Oversight Hearing, the Council of the District of Columbia, Committee on Human Services* (March 3, 2016).
[62] Eleanor Erin Artigiani, M.A., and Eric D. Wish, Ph.D, *Patterns and Trends of Drug Abuse in the Baltimore/Maryland/Washington, DC, Metropolitan Area—Epidemiology and Trends: 2002–2013*, available at https://www.drugabuse.gov/sites/default/files/baltimoremddc2014a.pdf.
[63] *See* National Institute on Drug Abuse, *Commonly Abused Drug Charts*, available at https://www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts.

Indeed, the most recent D.C. Medical Examiner's Annual Report found that two-thirds of the homicide deaths in D.C. in 2015 had positive toxicology results for these drugs.[64]

With respect to the second type of neglect, in the experience of D.C. child welfare experts, CFSA will only substantiate for drug-related activity in the home when there is evidence of drug manufacturing or distribution, usually in connection with a police drug raid. CFSA does not typically substantiate neglect if the caretaker is using drugs in the home, even though the law includes such use within the definition of "drug-related activity." This practice completely ignores the issue of how a parent using drugs in the home in front of his or her children increases children's risk of abuse and neglect, and also does not address the very real concern about children's access to and potential ingestion of such drugs.

III. How D.C. Law and Policy Failed Baby Trinity

When looking at the tragedy of baby Trinity, it becomes apparent that there were touch points in her short life when she could have been protected from harm. But, because of D.C. law and CFSA policy, practices, and interpretations of D.C. law, she was not.

A. Trinity's Parents Came to CFSA's Attention As Far Back as 2014

The first opportunity to protect baby Trinity from harm came even before she was born. According to CFSA social worker records reviewed by the Washington Post,[65] two calls were made to the CFSA hotline about neglect of other children in the family before Trinity's birth. One report was made in May 2014 by a physician who saw Trinity's then three-year-old brother and declared that the child had the worst case of diaper rash that the doctor had ever seen. Subsequently, in October 2015, someone called CFSA to report that Ms. Jabore was neglecting her first daughter and that both Ms. Jabore and the newborn child had a positive toxicology screen for THC. The Post could not determine the outcome of these reports.

As discussed in Section I, CFSA has significant discretion regarding which cases should be investigated and it is possible CFSA determined that one or both of these allegations did not warrant an investigation. To the extent CFSA did investigate the allegation that Trinity's sister was born "tox-positive," the CFSA policies and anecdotal evidence described in Section II suggest that the agency likely would not have substantiated neglect or taken any action if a visit to the home revealed no imminent danger in plain sight and that the children's basic needs were being met.

If CFSA had substantiated and opened an in-home or community case at the time of these reports about Trinity's siblings, a caseworker would have been assigned to identify appropriate services for this family's multiple and varied needs and to assist the family in obtaining those services. Perhaps under those circumstances, when Trinity was born, her parents would have been better prepared to care for her.

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[64] D.C. Office of the Chief Medical Examiner, *2015 Annual Report* (Feb 21, 2017), available at https://ocme.D.C..gov/sites/default/files/D.C./sites/ocme/2015%20OCME%20Annual%20Report%20FINAL%2002%2021%2017.pdf. Alcohol and marijuana were also found in the majority of the toxicology reports.

[65] *See* Keith L. Alexander and Paul Duggan, *supra* note 4.

B. CFSA Should Have Implemented a Plan of Safe Care for Trinity

The next time baby Trinity could have been protected was at her birth, when both she and her mother tested positive for marijuana and when her parents were not feeding her enough while still in the hospital.[66] Social worker reports described by the Washington Post also indicated that the parents had serious cognitive and mental health issues.[67] However, explaining Trinity's discharge two days after her birth, a United Medical Center spokesperson told the Washington Post that she "underwent a 'comprehensive' physical examination and was found to be healthy enough to go home with her mother. 'Everything was determined to be good, . . . other than the marijuana.'"[68] It is unclear whether the hospital made a report to CFSA regarding the marijuana found in Trinity's system or any concerns the hospital had about her parents' ability to care for her, or whether a plan of safe care was implemented.

A CFSA spokesperson confirmed to the Washington Post that there was no open case regarding baby Trinity at the time of her death.[69] Assuming the hospital made a report, this means that either CFSA did not conduct an investigation (because the allegation was screened out or sent to the Family Assessment pathway), or it did conduct an investigation but closed it with no further action or by referring the family to voluntary services with no oversight by the agency. If CFSA *did* investigate, how thorough was any such investigation? As discussed in Section II, because Trinity was a substance-exposed newborn, CFSA procedures would have required a social worker to review medical records, speak with Trinity's parents about drug use, and assess the safety of the home. A visit to Trinity's home should have identified major "red flags" – when baby Trinity died only seven weeks later, her parents were not using a crib and did not have appropriate supplies for feeding her. Additionally, there was evidence that both of Trinity's parents had mental health issues and cognitive deficits, and there was drug use in the home. It is worth reiterating that, under current CFSA practices described in Section II, this evidence of drug use in the home, in and of itself, likely would not have been sufficient for CFSA to substantiate neglect.

If CFSA had opened an in-home or community case and stayed involved with Trinity's family, the outcome could have been very different. CFSA could have worked with Trinity's parents to ensure a safe and healthy living environment with supports to help the parents care for their child in light of their physical, mental health, and cognitive deficits. For instance, a nurse could have assisted with caring for Trinity, a home health aide could have helped Trinity's mother (who said she could not get out of bed due to back pain after childbirth), and/or a delivery service could have provided food, including baby formula, to the home. The family might have benefited from mental health, substance abuse, and/or domestic violence counseling. In sum, if the hospital had reported to CFSA and CFSA had thoroughly investigated and followed up, perhaps baby Trinity would not have suffered, her parents would not be in prison for her death, and her siblings would not be in foster care or living with relatives.

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[66] Proffers of Facts (June 26, 2017), *supra* note 2.
[67] *See* Keith L. Alexander and Paul Duggan, *supra* note 4.
[68] *Id.*
[69] *Id.*

C. CFSA's Investigation into Allegations Involving Trinity's Brother Should Have Raised Red Flags about the Family

The final time baby Trinity could have been protected from harm was three weeks before her death when, according to the Washington Post, [70] a teacher at her five-year-old brother's school called CFSA. Specifically, the teacher reported that the child had come to school with a black eye and said his mother hit him because he was not listening. According to the Post account, the CFSA social worker spoke with Trinity's brother at school and determined that "he had not been beaten or badly hurt, and there was not a huge red flag." The worker also stated that CFSA had unsuccessfully attempted to contact the parents.

This history raises serious questions about quality of CFSA's investigation. First, consistent with anecdotal evidence of CFSA practices, the social worker accepted an apparent recantation by Trinity's brother, a five-year old, without also speaking with family members and collateral contacts to determine the veracity. Second, it is not clear that the social worker complied with the requirement to consult with medical personnel. The Arrest Warrant Affidavits indicated that Trinity's brother, as well as the one-year-old girl in the home, had not been to a pediatrician in over a year. If the worker obtained this information during the investigation, it should have raised a red flag about Mr. Crowder and Ms. Jabore's parenting abilities. Finally, and most significantly, how could a three-week period go by without CFSA making contact with this family? Did the social worker conduct the required three unannounced home visits at Mr. Crowder's and Ms. Jabore's residence within the 48-hour time frame? Did the worker knock on neighbors' doors or try to talk with relatives? Did he or she ask the teacher how Trinity's brother was getting to and from school and, if he was being accompanied by his parents, try to speak with the parents then? If the child was walking to and from school alone, could the worker have accompanied the child home after school? There does not appear to be a reasonable explanation for why the family could not be reached for such a long time, and this likely made all the difference between life and death for baby Trinity. If this social worker had entered baby Trinity's home at any point in the three weeks before her death, that worker presumably would have observed the perilous state of her health. Perhaps, baby Trinity would have received medical care and she would be alive today.

IV. Lessons Learned and Considerations for the Future

What can we learn from what happened to baby Trinity? Can her death be a beacon of light for other abused and neglected children in the District? We set forth below some thoughts to consider for remedying these very complex but important issues. Hopefully, this paper will start a serious dialogue to ensure better outcomes for these children and their families.

(1) *Clarify healthcare providers' reporting obligations with respect to substance-exposed newborns.* The partial legalization of marijuana in the District has created the potential for confusion with respect to the child neglect reporting requirements for healthcare providers when a baby is born exposed to marijuana. To rectify this

[70] *Id.*

problem and conform with the federal requirements, D.C. should expeditiously clarify the requirement that health care providers must report newborns exposed to both illegal and legal controlled substances (including those taken with a valid prescription) and educate healthcare providers about their duties to do so.

(2) *Strengthen CFSA procedures regarding release of substance-exposed newborns from the hospital.* Further, serious discussion is needed in the child welfare community to delineate under what circumstances a mother should be permitted to take home a newborn affected by substance use. CFSA should provide investigative social workers with additional guidance regarding best practices for determining whether the mother can parent her newborn in light of any substance use, cognitive, and/or mental health issues, the baby's unique or special needs, and what family supports are available and present in the home. In particular, when should the social worker open an in-home or community case? When should the mother be required to enter into a drug treatment and/or mental health program and/or comply with other specified criteria before the bringing the child home?

(3) *Review definition of neglected child in the context of parental substance use.* A thorough review should be undertaken of the D.C. law that defines a neglected child as one whose parent is under a mental disability, which can include drug use. As the law is currently written and interpreted, CFSA feels handcuffed when faced with making such a determination because of the requirement that the mental incapacity must impact parenting. Therefore, CFSA only makes such a finding in the most extreme cases where the investigative social worker observes such incapacity at the time of the visit. This approach seems to result in social workers not investigating or ignoring other indicators of abuse or neglect of the child. What are best practices in this area? Should a finding of abuse or neglect based on substance use always require a showing that it impacts parenting, or should use of certain substances be considered so dangerous that there is a rebuttable presumption that it does impact parenting? How should substance use in the home be viewed as compared to use only outside the home? Further, under what circumstances should CFSA open an in-home or community case, require the parent to enter a drug treatment and/or mental health program, and/or comply with other specified criteria to ensure the safety of the child in the home?

(4) *Revise investigative policy and practices.* Finally, we submit that CFSA should consider revisions to its investigative policy and practices to ensure the safety of children, specifically by:

   a. giving substantial weight to a healthcare or other professional's report of abuse or neglect and his or her opinion as to the level of risk to the child;
   b. conforming to best practices for handling child recantations; and
   c. including a trauma assessment and predictive analytics in determining whether there has been abuse or neglect and the risk of future abuse or neglect for a particular child.

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Marla Spindel is the co-founder and Executive Director of DC KinCare Alliance. Prior to starting DC Kincare Alliance, Ms. Spindel co-founded the DC Volunteer Lawyers Project ("DCVLP"), whose mission is to create, support, and utilize a network of volunteer lawyers to provide high-quality, *pro bono* legal services to domestic violence victims and at-risk children in Washington, D.C. While at DCVLP, Ms. Spindel managed its Child Advocacy Program for nine years and then acted as Special Counsel, primarily focusing on national and DC child welfare policy. She currently serves on DCVLP's Advisory Board. Ms. Spindel's advocacy work at DCVLP led her to establish the DC Kincare Alliance to support kin who care for children. Ms. Spindel served on the D.C. Superior Court's Domestic Relations Branch Subcommittee, and was instrumental in advocating for and assisting the Court with drafting the *Practice Standards for Guardians Ad Litem in Custody and Related Consolidated Cases* and the *DC Superior Court's Handbook for Self-Represented Litigants*. She has practiced family law in D.C. for over a decade and is a certified mediator. Ms. Spindel was previously a member of the Court's Counsel for Child Abuse and Neglect Attorney Panel. She earned a J.D., with honors, from George Washington University Law School and a B.A. in Government from Cornell University.

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