

Colorado Department of Human Services
Child Fatality Review
4/15/08

A. Identifying Information:

Child: Jesse Weaver
DOB: 08/28/1995
DOD: 07/08/2007 (age 11)

Biological parents:
Mother: Traci Weaver (age 34)
Father: Wade Weaver (age 37)

B. Involved County:

Lincoln County Department of Social Services (Lincoln County DSS)

C. Introductory Statement:

The Colorado Department of Human Services Child Fatality Review Team conducted the review of the circumstances surrounding the death of Jesse Weaver through interviews and a review of the documentation. The purpose of the review is to examine existing practices and policies and how they currently affect the county child welfare programs. These findings should not be construed to link the county's actions to the actions allegedly perpetrated on this child by his parents.

Statutory authority for this review is in Title 26-1-111, Colorado Revised Statutes. The Department of Human Services supervisory authority is outlined in the areas of child welfare and other programs as specified. It is in the capacity of supervision of the county's administration of child welfare programs that the state has the legal responsibility to require the corrective actions and to conduct follow-up reviews.

Due to the complexity of this review, as well as the persistent issue of payment responsibility for out-of-home placement for children diagnosed as mentally ill, the Colorado Department of Human Services, Division of Mental Health, was asked to participate in the extended fatality review, which involved interviewing collateral parties involved with the child and family.

D. Case Summary:

Jesse Weaver died on 07/08/2007. The cause of death given was Seroquel toxicity due to an overdose. Elbert County Department of Social Services was requested by Lincoln County DSS to initiate a fatality investigation. This was requested to assure compliance with state policy, which requires that the caseworker and supervisor assigned to the fatality investigation not be previously involved with the family. Elbert County Department of Social Services concluded that the parents were responsible for emotional abuse, medical neglect and failure to protect Jesse. The emotional abuse finding was based on the agency's conclusion that the parents

understood the impact of their domestic violence on Jesse's mental health. The department concluded, "Jesse was not capable of functioning under chaotic and explosive conditions." The medical neglect finding was based on the agency's conclusion that the parents withheld medication necessary to keep Jesse safe.

Prior to the fatality, Jesse and his family had been known to the Lincoln County Department of Social Services since 1999. Safety issues existed throughout the family's involvement with Lincoln County DSS.

Lincoln County DSS received 15 or more referrals during the history of this case alleging neglect, domestic violence, substance abuse, and physical abuse. All the referrals were found by Lincoln County DSS to be unsubstantiated or inconclusive; however, because these issues were of concern to the department, the case remained open and services were provided.

A lack of consistent and timely information sharing (both verbal and written) between the community mental health center and the county department of social services contributed to inadequate responses to the family's needs.

E. Chronology:

In 2007, Jesse was living at home and was on medications for ADHD and Disruptive Behavior Disorder, under the supervision of a psychiatrist at Centennial Mental Health Center (CCMHC). The family was working with the caseworker from Lincoln County DSS on a behavior modification program. The following chronology summarizes specific activities preceding Jesse's death:

05/18/2007:

Jesse's psychiatrist met with Jesse and made adjustments to his medication regimen and diagnosis. The Seroquil prescription was increased to 800 mg and the Wellbutrin and Depakote were refilled. Jesse's diagnosis was modified to Disruptive Behavior Disorder and Mood Disorder. Jesse's mother reported to Lincoln County DSS that the psychiatrist recommended hospitalization for Jesse, as he felt that Jesse needed more structure.

06/07/2007:

A staffing was held at CCMHC regarding the possibility of out-of-home placement or hospitalization. Lincoln County DSS requested that CCMHC take financial responsibility for the placement since it was determined that Jesse was mentally ill. Jesse's mother asked about taking Jesse off his medications and CCMHC advised her that a discontinuation of medications was best done in a hospital setting, where it could be done slowly. The outcome of the staffing was that the Continuity of Care director from CCMHC would review additional information from the Home-Based Services caseworker and make a decision about placement.

06/10/2007:

Jesse's mother reported that Jesse became very angry the previous night and talked about wanting to kill her and himself. She called the Lincoln County DSS

caseworker, who encouraged her to call CCMHC. Jesse's mother reached the weekend emergency call person for CCMHC who advised that since Jesse was now calm, nothing further would occur that day, and that Jesse should speak with his therapist during the week.

06/16/2007:

Lincoln County DSS received a report from the mother that Jesse had another "outburst," hitting her with a broom handle and telling her that he wanted to kill her. Jesse's mother was advised to call CCMHC, which she did.

06/21/2007:

Jesse's mother failed to get Jesse to his therapy appointment.

06/22/2007:

Jesse's mother told the Lincoln County Home-Based Services caseworker that she had taken Jesse off all his medications as of 6/15/07. The caseworker told her to call Jesse's psychiatrist immediately. Jesse's mother said that she left a message at CCMHC. Lincoln County DSS did not view the mother's actions as medical neglect, so no investigation to determine the safety of the child was initiated.

07/03/2007:

Traci Weaver reported to CCMHC that she took Jesse off his medications. CCMHC tried to contact her. CCMHC left a message for Jesse's mother advising that they needed to complete a safety plan for Jesse and that if an emergency occurred he needed to be hospitalized at Colorado Mental Health Institute at Ft. Logan.

07/05/2007:

Traci Weaver, Jesse's mother, reported to the CCMHC therapist that she took Jesse off all medications, except Wellbutrin, approximately 2½ weeks earlier. The therapist documented informing her of the risks involved in taking a child off medication and scheduled another appointment with Jesse on 07/19/2007.

07/08/2007:

At approximately 9:00 A.M., Wade Weaver, Jesse's father, found Jesse in bed having seizures. Jesse was transported to the hospital, where he was pronounced dead. His father reported that an empty bottle of Seroquel was found by Jesse's bed. Jesse's medications were easily accessible to him.

07/11/2007:

Lincoln County DSS referred the case to Elbert County Department of Social Services to investigate allegations of fatal neglect.

09/04/2007:

The certificate of death was filed, listing the cause of death as Seroquel toxicity from "ingested pills."

F. Policy Findings:

Findings described below outline violations of state policy. Corrective actions are required by Lincoln County DSS in response to each finding.

1. Finding:

A provision in statute intended to help resolve disagreement about which agency was most responsible for Jesse, the county department or CCMHC was not used when there were new referrals on Jesse containing allegations of child abuse or neglect. Lincoln County DSS was in violation of CRS 19-3-308 (1.5)(b), which states, "if during the investigative process, the county department determines that the family's issues may be attributable to the child's mental health status...the department shall contact the mental health agency. The department will do this within 10 days of the commencement of the investigation."

County Response:

The County concurs with the State findings.

Action Required: Protocols will be developed with CCMHC and Lincoln County DSS to be utilized in referring clients to the mental health center and for collaboration between the two agencies.

2. Finding:

Lincoln County DSS routinely did not respond to and assess new referrals of alleged child abuse/neglect received while services were being provided, as required in Volume 7, Section 7.202.4 D, E, F (12 CCR 2509-3).

D. The county department shall review all reports and conduct an initial assessment. The initial assessment shall include:

- 1) Checking the State Department's automated system
- 2) Reviewing county departments' files
- 3) Obtaining information from collateral sources such as schools, medical personnel, law enforcement.

E. The county department shall gather and document the following information:

- 1) Decision as to investigation response and caseworker's signature.
- 2) Supervisory approval of the decision and signature."

F. The county department shall accept a report for investigation if it:

- 1) Contains specific allegations of known or suspected abuse or neglect as defined in statutes and regulations".

County Response:

The County concurs with the State findings.

Action Required: All agency caseworkers and supervisors will be trained in their responsibility to review all child abuse/neglect referrals and conduct an initial assessment to determine the need for an investigation.

3. Finding:

Lincoln County DSS routinely did not enter information in Trails on new referrals of alleged child abuse/neglect as required in Volume 7, Section 7.200.61 (12 CCR 2509-3), which states, "All reports that meet the definition of a referral shall be entered into the State automated system (Trails). Any time a case is opened, it shall come through the referral or assessment process in Trails".

County Response:

The County concurs with the State findings.

Action Required: Lincoln County DSS will develop and implement protocols to ensure that all reports that meet the definition of a referral shall be entered into Trails.

4. Finding:

Lincoln County DSS did not document in Trails required supervisory review of caseworker reports and case decisions of casework staff as required in Volume 7, Sections 7.202.4 E, G; 7.202.52; 7.202.53 (12 CCR 2509-3); and 7.301.22 (12 CCR 2509-4).

County Response:

The County concurs with the State findings.

Action Required: Supervisory staff will be instructed to identify all areas in which Volume 7 requires review of caseworkers' material. Supervisory staff will enter this information into Trails in a timely manner. The Director will monitor the supervisory oversight on a monthly basis to assure compliance. This information will be reviewed with the supervisor at a regularly scheduled monthly meeting. At this meeting, the Director will review the minutes from the Child Protection Team.

G. Follow-up Actions Required:

This statement provides notice that a corrective action plan is required on all findings with required action and that a corrective action plan is due to the State forty-five (45) days after receipt of this report, and that upon receipt and review of the plan the State will approve or request further county action.

H. Division of Mental Health: Review Findings

As a result of the interviews and case documentation the Division of Mental Health (DMH) found the following policy violation:

1. Finding:

The executive director of CCMHC was in violation of QI.4 as a result of the following actions:

- a. The critical incident was not reported, by telephone, to the Division of Mental Health.

- b. A written critical incident report was not sent to the Division of Mental Health within 24 hours of the incident.
- c. Follow-up reports were only sent after a request was made by DMH.

Section QI.4 states that, "Critical incidents that are issues of public concern or public safety must be reported by telephone as soon as possible to the director of MHS/DMH by the executive director of the organization.

- a. A written critical incident report must be sent to DMH within 24 hours of the incident excluding Saturdays, Sundays and holidays:
- b. Follow-up reports and other pertinent information also shall be sent to DMH."

Action Required: A plan will be submitted to the Division of Mental Health for how critical incidents will be reported via telephone to the director of the Division of Mental Health and how written critical incident reports will be sent within 24 hours of the incident excluding Saturdays, Sundays and holidays. The plan will state that reports or other pertinent information will be sent to the Division of Mental Health as a follow-up to the critical incident report.