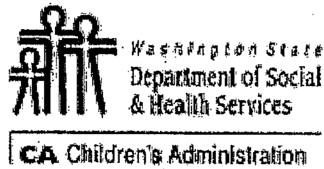

Children's Administration
Child Fatality Review

J.G.

June 2012
Date of Child's Birth

May 21, 2013
Date of Child's Death

September 18, 2013
Child Fatality Review Date

Committee Members
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RCW 74.13.640

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Executive Summary

On September 18, 2013, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to review the department's practice and service delivery to an eleven-month-old female child and her family. The child will be referenced by her initials, J.G., in this report. At the time of her death, J.G. shared a home with her father, mother, and her father's wife. Three siblings also resided in the household including one full-sibling, one half-sibling, and one stepsister. The incident initiating this review occurred on May 21, 2013 when J.G. died from drowning in a bucket of water.

The review is conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with the case.

Prior to the review, each committee member received a case chronology, a summary of CA involvement with the family and non-redacted CA case documents (e.g., intakes, safety assessments, investigative assessments, provider records, law enforcement records, and Child Protective Services investigative reports).

Supplemental sources of information and resource materials were available to the committee at the time of the review. These included copies of state laws and CA policies relevant to the review and the complete case file.

The Committee interviewed two CA social workers and a CA supervisor previously assigned to the case.

Following a review of the case file documents, interview of the CA social workers and supervisor, and discussion regarding department activities and decisions, the Committee made findings and recommendations, which are detailed at the end of this report.

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[1] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. It does not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

A child fatality or near-fatality review completed pursuant to RCW 74.13.640 is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to RCW 74.13.640(4).

Case Overview

J.G. and her mother first came to CA's attention following her birth. On June , 2012, CA received an intake from a local hospital alleging the mother lacked a support system Upon discharge, the hospital offered and the mother accepted public health nursing services. The June 24, 2012 intake was screened out by CA due to the lack of an allegation of abuse or neglect.[2] The mother had no other CA history prior to the fatal incident.

[2] CA intake staff must screen in intake reports meeting the following criteria: 1) a child (birth to 5 years old), reported by a licensed physician or medical professional on "the physician's behalf," or 2) a non-mobile infant (birth to 12 months) with bruises, regardless of the explanation for how the bruises occurred. CA must accept an intake where a child is alleged to have been abused or neglect by the child's parent, guardian, or custodian, the subject is a licensed foster parent, group care provider, or a volunteer or employee of a child care agency, or a person alleged to have committed child abuse or neglect (CA/N) in an institutional setting. CA staff must not treat allegations of CA/N in licensed or certified facilities as third party abuse or neglect. CA will generally screen out intakes: 1) Abuse of dependent adults or persons 18 years of age or older. Such services are provided by the Adult Protective Services (APS) section; 2) Third-party abuse committed by persons other than those responsible for the child's welfare; 3) Child abuse and neglect (CA/N) that is reported after the victim has reached age 18, except that alleged to have occurred in a licensed facility; 4) Child custody determinations in conflictual family proceedings or marital dissolution, where there are no allegations of CA/N; 5) Cases in which no abuse or neglect is alleged to have occurred; and 6) alleged violations of the school system's Statutory Code, Administrative Code, statements regarding discipline policies.

[3] CA will generally screen out intakes where the CA/N is committed by a person other than those responsible for the child's welfare.

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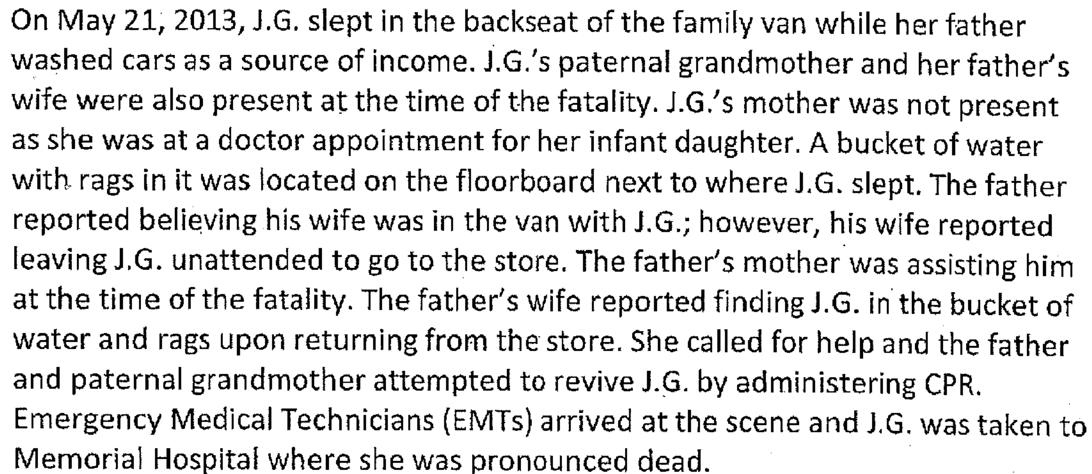

On May 21, 2013, J.G. slept in the backseat of the family van while her father washed cars as a source of income. J.G.'s paternal grandmother and her father's wife were also present at the time of the fatality. J.G.'s mother was not present as she was at a doctor appointment for her infant daughter. A bucket of water with rags in it was located on the floorboard next to where J.G. slept. The father reported believing his wife was in the van with J.G.; however, his wife reported leaving J.G. unattended to go to the store. The father's mother was assisting him at the time of the fatality. The father's wife reported finding J.G. in the bucket of water and rags upon returning from the store. She called for help and the father and paternal grandmother attempted to revive J.G. by administering CPR. Emergency Medical Technicians (EMTs) arrived at the scene and J.G. was taken to Memorial Hospital where she was pronounced dead.

Local police interviewed the father, paternal grandmother and his wife.

The paternal grandmother told law enforcement that she believed the fatal incident was her fault as she should have been with J.G. as the father's wife is unable to provide care. An autopsy was completed on May 21, 2013 and J.G.'s death was ruled as a fresh water drowning with no other signs of trauma. The family is considered to be a Limited English Proficient (LEP) family. [4]

Discussion

The primary areas of Committee discussion centered on the April 2010 and March 2013 investigations. The Committee focused specifically on the investigative methods used by the social workers, caseload size, communication between law enforcement and CA, the challenges of meeting the needs of a LEP family and office morale. The Committee discussed the low office morale and

[4] Limited English Proficiency - This means persons whose primary language is not English and they have not developed fluency in the English language. A person with LEP may have difficulty speaking or reading English. CA staff utilizes an interpreter service when working with LEP clientele. An LEP person will also receive documents from CA in his or her primary language so that person can understand important documents related to health and human services.

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believe the causes may be attributed to ineffective communication and leadership within the Yakima Children's Administration office. The findings and recommendations at the end of this report summarize the Committee discussion regarding the aforementioned areas.

The Committee discussed the challenges faced by the social workers when attempting to contact the family. The Committee noted both investigative social workers utilized similar but ineffective techniques in their attempts to contact the family. Both social workers made multiple attempts to visit the family home. Both social workers attempted to contact the family via mail correspondence in their native language. The Committee acknowledged the efforts of the social workers to contact the family but believed the social workers may have been more effective if they had utilized the *Reasonable Efforts to Locate Children and Parents Guideline.* The Committee suggested social workers facing similar circumstances attempt to time the unannounced home visits to coincide with the school-aged child getting on or off the school bus. The Committee noted extended family and prior referrers may also have had suggestions regarding how to contact the family. The Committee also suggested social workers contact school personnel as they usually have an effective method of communicating with parents.

The Committee discussed the benefits of quality clinical supervision. The Committee noted both investigations afforded multiple missed opportunities for increased supervision and critical thinking surrounding the investigative processes. The April 2010 investigations were closed as 'unable to complete.' The Committee believed quality clinical supervision may have provided the social worker with additional techniques for engaging the family. The March 2013 investigation required a face-to-face contact with the children within 72 hours. The social worker was granted two extensions by a supervisor that delayed the investigation for approximately two weeks. The extensions were granted based upon the Yakima County Child Abuse Protocol[5]. However, the Committee

[5] Yakima County Child Abuse Protocol--Law enforcement agencies should assume primary responsibility for conducting the investigation in the following cases: 1. Sexual assault or sexual abuse of children by persons other than household members. (third party reports) 2. Minor to moderate physical abuse allegedly perpetrated by persons other than a household member. Minor to moderate physical abuse includes cases where injuries do not require immediate medical attention. 3. Abuse or neglect by persons other than a household member (third party reports), except for those types of cases subject to joint investigation (schools, institutions, licensed group care facilities, child care settings, foster care providers). 4. Lack of proper supervision of children, or children being left alone, whether in a residence, vehicle or other unattended. CPS should assume the primary responsibility for handling cases where criminal law violations are less obvious or not present. The purpose of a joint investigation involving both CPS and law enforcement is to avoid multiple interviews while providing the best protections for the child(ren) and the most thorough investigation. Conducting a joint investigation requires a high level of coordination and

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believed the extensions were not warranted as the child had no physical injury and it was unlikely law enforcement would take part in the investigation due to the nature of the allegation. The Committee reviewed the collaborative efforts between CA and local law enforcement and believed increased communication regarding the assignment of cases following an intake would be beneficial.

Findings

1) The Committee believed the CPS investigations lacked elements needed to ensure a thorough assessment of child safety. The elements identified by the Committee as lacking include:
   a) Failure to follow the *Reasonable Efforts to Locate Children and Parents Guideline*
   b) Insufficient collateral contacts
   c) Timeliness of investigations

   The Committee identified the following factors that may have contributed to the investigative issues identified above: high caseloads, staff turnover, low office morale, and limited training and information around LEP resources.
2) The Committee noted the April 2010 investigating social worker received 19 new investigative assignments during April 2010. The Committee believes the investigating social worker received too many case assignments during April 2010.
3) The CPS investigators informed the Committee that they received inadequate training and information regarding the use of telephone interpreters.[6]
   Action Taken: The Yakima office has since provided social workers with the necessary information to utilize telephone interpreters.
4) The Committee believes the Yakima office would benefit from the streamlining and coordinating of activities between CA and law enforcement.

Recommendations

1) The Committee recommends CA facilitate a joint meeting between the Yakima CA office and law enforcement to review how investigative efforts are coordinated as specified in the Yakima County Child Abuse Protocol.
2) The Committee recommends LEP cases be weighed in a manner that sufficiently reflects the additional workload involved. The Committee also

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flexibility. When law enforcement or CPS receives a case requiring joint investigation, the receiving agency should contact the other agency. Both CPS and the law enforcement agency should assign personnel to conduct the investigation.

[6] CTS Language Link provides multilingual interpretation and translation communication including interpreter services that can be accessed through the phone. The Yakima County Profile reports 65,673 individuals residing in Yakima County who speak Spanish at home. the county population is approximately 231,800. For more information: http://www.yakimacounty.us/oem/hmp/yakimacountyprofile.pdf

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recommends CA focus on recruiting and retaining qualified Spanish speaking staff in offices with a high Spanish speaking population.

Nondiscrimination Policy

The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran's status or the presence of any physical, sensory or mental disability.

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