Policy 1.31 – Responding to the Death of a JR Youth
Summary

- Establishes reporting and review requirements for the death of a youth in Juvenile Rehabilitation

Background:

The policy was reviewed for a sunset review, and a request was made for an Appointing Authority's checklist to support timely reporting and incident review. No major changes were made to the substance of the policy.

Policy Summary

The policy addresses reporting and review processes in the event that a JR youth dies while in residence or while on parole.

Changes from Former Practice

- The policy clarifies protocols for reporting and reviewing this major incident.

Training Required: No

Policy Effective Date: July 23, 2018

Please note that the effective date is not two weeks out as usual practice, because the new checklist does not change any of the protocols that are already in effect.

POLICY 1.31 RESPONDING TO THE DEATH OF A JR YOUTH

Policy Committee Chair
Lori Kesl
Regional Administrator, Regions 1 & 2
Juvenile Rehabilitation

Approved

_____
Rebecca Kelly, Acting Assistant Secretary
Juvenile Rehabilitation
7/23/2018

Authorizing Sources
RCW 13.40
RCW 26.44
RCW 68.50
RCW 70.124
RCW 74.34
DCYF AP 3.01
DCYF AP 7.02

Information Contact
Andrea Ruiz
Policy, Planning & Lean Administrator
Juvenile Rehabilitation

Effective Date ***(Technical Edit 12/13/19)***[1]
7/23/2018

Sunset Review Date
7/23/2022

I. PURPOSE AND SCOPE

This policy establishes reporting and review requirements for the death of a youth under the jurisdiction of Juvenile Rehabilitation.

All staff, contractors, volunteers, and interns working in or for Juvenile Rehabilitation (JR) are responsible for reviewing and complying with JR policies.

II. POLICY

1. **In the event of a death, JR will report to JR and DCYF administration in accordance with JR Policy 1.30, *Reporting Serious and Emergent Incidents*. Refer to the Appointing Authority Checklist (DCYF Form 20-326).**

YOUTH IN RESIDENCE

2. **The first responder to the scene must secure the area to preserve evidence.**
3. **Notification procedures must begin immediately.**

3.1. The Superintendent, Regional Administrator or designee must immediately report the death of a youth in residence to:

3.1.1. Local Law Enforcement

[1] 12/13/19 Technical Edit: Updated DSHS references and forms to DCYF.

3.1.2. Child Protective Services (in accordance with Policy 5.91, *Reporting Abuse and Neglect of JR Youth*)

3.2. The Superintendent, Regional Administrator or designee must report the death of a resident to the appropriate Division Director within two hours of knowledge of the event if the resident's death appears to be unexpected.

3.2.1. The verbal report must be followed up with a written Administrative Report of Incident (ARI) as soon as possible. The report must be completed no later than 24 hours after the verbal report was provided (in accordance with Policy 1.30, *Reporting Serious and Emergent Incidents*).

3.3. If the Director is unavailable, the Superintendent or Regional Administrator acts as the Director's designee and reports per Section 4.

3.4. The Superintendent, Regional Administrator or designee makes other reports as needed to comply with state or federal requirements, as well as DCYF and JR policy.

4. The Superintendent, Regional Administrator or designee will:[2]

4.1. Contact the youth's custodial parent or guardian by phone within two hours of knowledge of the incident.

4.1.1. If attempts to contact the custodial parent or guardian are unsuccessful, law enforcement must be contacted for assistance in reaching the parent.

4.1.2. If law enforcement is unsuccessful in reaching the custodial parent or guardian, notification will be sent via certified mail the next business day.

4.1.3. Collateral contacts may be used to reach the custodial parent or guardian, if available.

4.2. Confer with the JR Crisis Response Team within two hours of the incident.

4.3. Ensure that the youth's case file (including the medical file), related documentation and personal property are gathered and secured as soon as possible.

5. During an investigation, JR staff are expected to cooperate with requests made by law enforcement, the Coroner, and tribal authorities consistent with agreement.

YOUTH ON PAROLE

6. In the event of death of a JR youth on parole supervision, the Regional Administrator or designee will initiate an Administrative Report of Incidents (ARI) in ACT.

6.1. All procedures for timely reporting will be followed.

6.2. The ARI will summarize both the facts of the event and the JR response.

6.3. Notifications to the Division Director and Assistant Secretary will be made within two hours of JR learning of the death.

[2] 12/13/19 Technical Edit: Removed sub-statement referencing foreign national policy (superseded by Interim Directive).

REQUIRED REVIEWS

7. **Resident deaths will be investigated by an internal administrative review.**

   7.1. The Division Director will initiate and direct a thorough internal review into the circumstances of the death within one working day of notification of the death.

      7.1.1. The review will be completed by a JR staff outside of the chain of command of the unit in which the death occurred, and must be completed per DCYF Administrative Policy or direction.

      7.1.2. The review report must be submitted to the Division Director within 30 days.

8. **Any death of a youth in residence will have a medical evaluation completed.**

   8.1. The Division Director or designee initiates a medical evaluation, under the supervision of the local appointing authority, of the circumstances surrounding ANY death of a youth in residence, within one working day of notification of the death.

      8.1.1. The medical review must be completed by a licensed physician, other than the youth's attending physician.

      8.1.2. The medical review must state whether the death was or was not expected.

      8.1.3. The medical report must be submitted to the Division Director within 30 days. The report must be included in an addendum to the Administrative Report of Incident.

9. **Unexpected deaths of youth in residence will have an administrative review completed by an independent review team.**

   9.1. The Assistant Secretary initiates an independent review for the apparent UNEXPECTED death of youth in JR within one working day of notification of the death.

   9.2. The final report will be submitted to the Assistant Secretary within 90 days.

   9.3. The Assistant Secretary will appoint the members of the review team and the chair.

      9.3.1. The independent review team will consist of at least three members from relevant professions such as mental health, education, or social services or topical experts relevant to issues present.

      9.3.2. Independent Review Team members who are not employed by JR must sign a confidentiality statement (DCYF Form 03-374b) before reviewing JR records or documents.

      9.3.3. The qualification of the contractor, scope of work and the nature and contents of the report will be in accordance with the statement of work and as negotiated by the Division Director or as in a contract with DCYF.

   9.4. The Division Director may assign a staff liaison to the independent review team who may:

      9.4.1. Facilitate the initial orientation meeting of the team,

      9.4.2. Coordinate clerical support, and

      9.4.3. Schedule staff interviews; site visits; access to documents, records and other materials; or assistance as requested by the review team chair.

10. The Superintendent, Regional Administrator or designee initiates corrective action, when warranted, and ensures that corrective action includes:

10.1. Identifying immediate corrective measures necessary to prevent a reoccurrence of identified circumstances that may have contributed to the death; and

10.2. Evaluating recommendations documented in the investigation reports and implementing remedial measures, as indicated.

III. DEFINITIONS

Unexpected death: A death not resulting from a diagnosed terminal illness or other debilitating or deteriorating illness or conditions where death is anticipated.

Expected death: A death that is a direct result of a known medical condition or illness.

Independent Review Team: Qualified individuals or agency, outside and independent of Department of Social Health Services, contracted to conduct an independent review of the causes and circumstances surrounding the death of a youth in JR residential care.

Collateral Contacts: People who act as a source of information about a youth or family's situation and who may support information provided by a youth or be able to locate them in an emergency.

JR Crisis Response Team: A team of JR staff trained to assist employees who have experienced a traumatic event at work. The staff are on call and have agreed to respond to provide care for the traumatized employees within 24-72 hours after the incident. The Superintendent, Regional Administrator or Director may activate the team response.

IV. REFERENCES

NCCHC Y-A-12

NCCHC Y-A-10

V. RELATED JR POLICIES

Policy 1.30 – Reporting Serious and Emergent Incidents

Policy 5.91– Reporting Abuse and Neglect of JR Youth

VI. FORMS AND DOCUMENTS

Document Title	Available In ACT	Form Link
Appointing Authority Checklist		DCYF Form 20-326
Agreement on Non-Disclosure of Confidential Information – Non-Employee		DCYF Form 03-374b