RCW 74.13.640(d)

Washington State Department of Social & Health Services

CA Children's Administration

Children's Administration

Executive Child Fatality Review

J.T.

April 1994
Date of Child's Birth

March 17, 2012
Date of Child's Death

August 7, 2012
Child Fatality Review Date

Committee Members:
Carol Almero, MA, LMHC, CSOTP, Director of Residential Treatment Services, Friends of Youth
Debra Boiano, MSW, Regional Licensor, Children's Administration
Hoppy Hopkins, Chemical Dependency Professional
James Kairoff, Family Reconciliation Services (FRS) & Child and Family Welfare Services (CFWS) Adolescent Supervisor, Children's Administration
Mary Meinig, MSW, Director, Office of Family and Children's Ombudsman
Kris Sanborn, LICSW, Clinical Supervisor II, YMCA—Family Services and Mental Health

Observers/Facilitator's Aides:
Paul Smith, Critical Incident Program Manager, Children's Administration
Rhonda Haun, Critical Incident Case Review Specialist, Children's Administrator

Facilitator:
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Executive Summary

On August 7, 2012, Children's Administration (CA) convened a Child Fatality Review[1] (CFR) committee to examine the practice and service delivery in the case involving 17-year-old J.T. and her family. The incident initiating this review occurred on March 17, 2012 when J.T. was found unconscious and suffering from stab wounds. J.T. was visiting a friend at an apartment in Tukwila when she was attacked by a 17-year-old male acquaintance who was staying at the same apartment. He told police that after J.T. fell asleep he "felt an urge to hurt someone." He was later charged with second degree murder.

J.T. was a dependent youth residing in the Virginia Miller House (VMH) Group Home. She had permission from her assigned social worker and VMH staff to leave VMH and go to her uncle's home for an overnight visit with her father. J.T. and her father had a disagreement about her original intent to visit his home; he felt she was intending to visit friends instead and he told her to return to VMH. J.T. did not return to VMH and met up with friends later that night.

J.T. was transported to Harborview Medical Center where she was pronounced dead a short time later. The Medical Examiner reported the stabbing as a homicide and the injuries were the result of non-accidental trauma.

The CFR committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from the fields of mental health, chemical dependency, staffed residential facilities, foster care licensing, and social work. Committee members had no previous involvement with the case. Prior to the review each committee member received a chronology of known information regarding the father and child, un-redacted CA case-related documents and some relevant service provider reports.

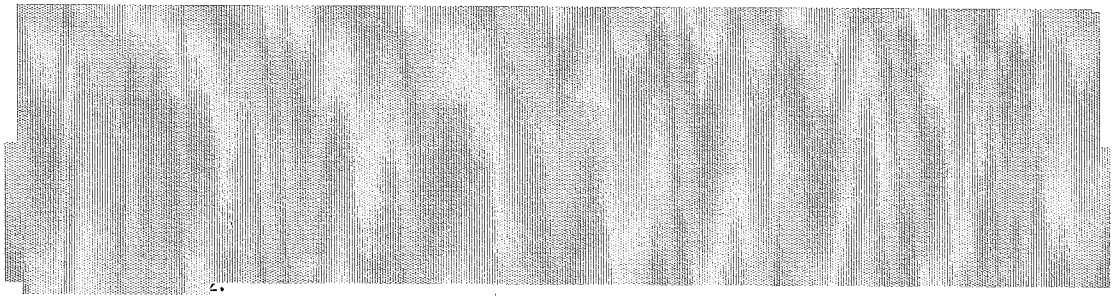
Available to committee members at the review were (1) additional case related documents (e.g., records, court records and case file), (2) copies of relevant laws relating to CPS duties, legal definitions involving child maltreatment, and licensing

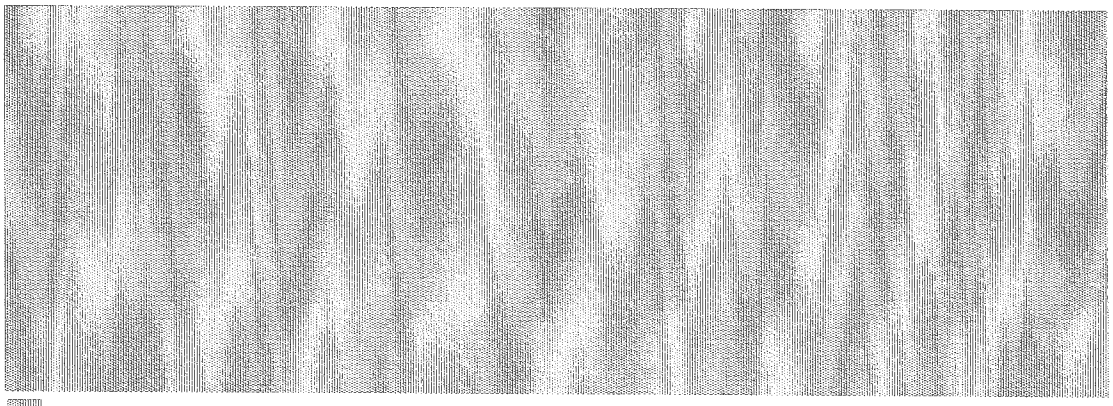
[1] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review Committee's review is generally limited to documents in the possession of or obtained by DSHS or 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.

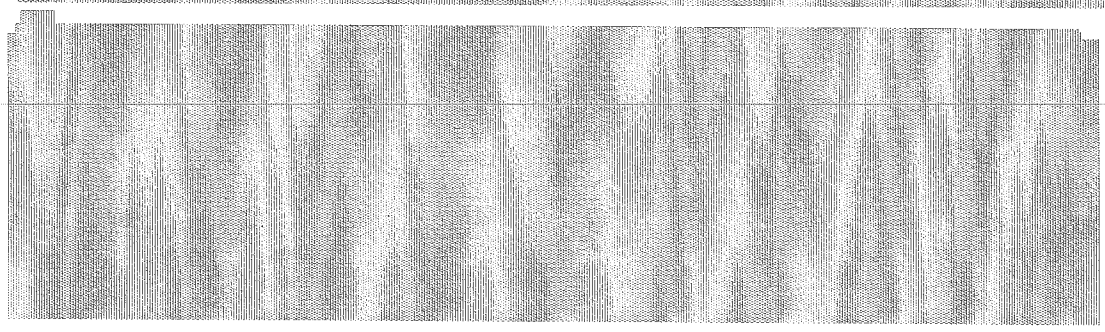
requirements for staff residential facilities. During the course of the review the DLR Licensor was made available for interview by the CFR committee members.[2]

Following review of the case file documents, interview of the Department of Licensed Resources (DLR) licensor and discussion regarding social work activities and decisions, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview





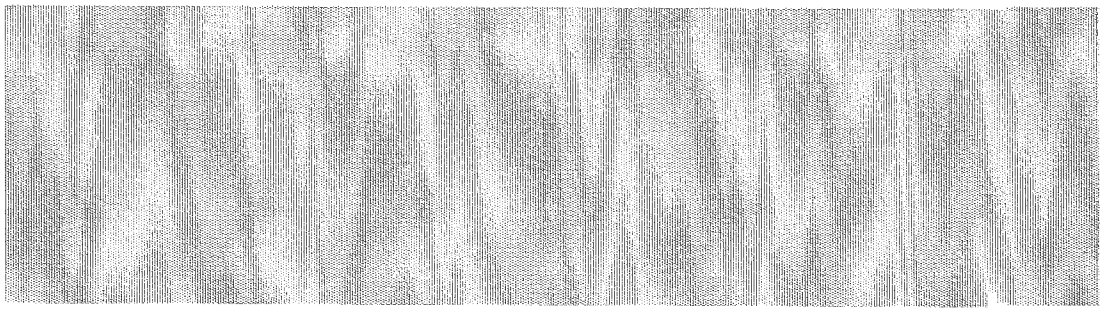


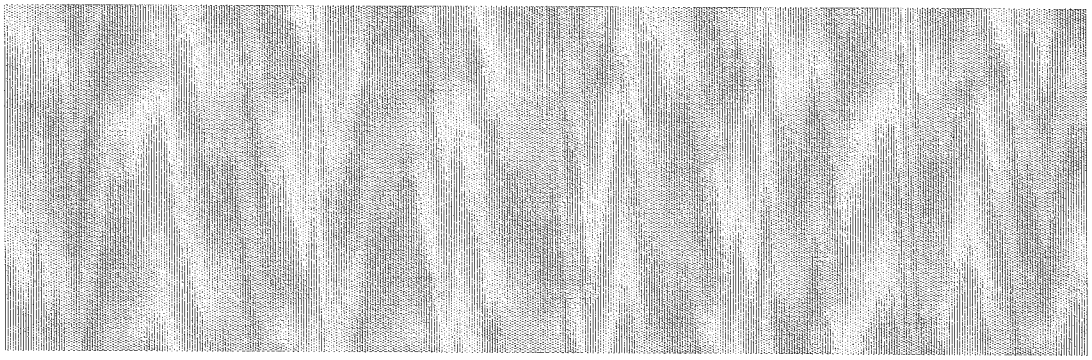
[2] The committee requested to interview J.T.'s last assigned social worker. The former worker no longer works for CA but initially agreed to come to the fatality review to be interviewed. However, a scheduling conflict on the day of the review precluded him from attending.

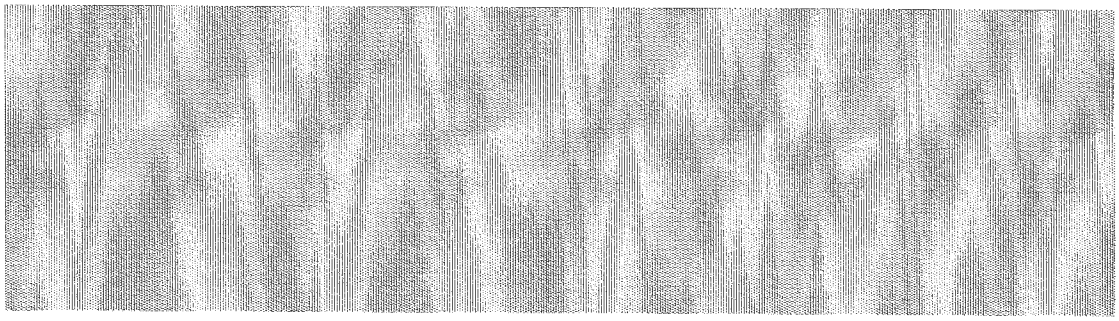
[3] When an allegation is "Unfounded, " it means that CPS investigated the allegation and, based on the information available, determined that it was more likely than not that the alleged abuse or neglect did not occur, or that there was insufficient evidence to determine whether the abuse did or did not occur.

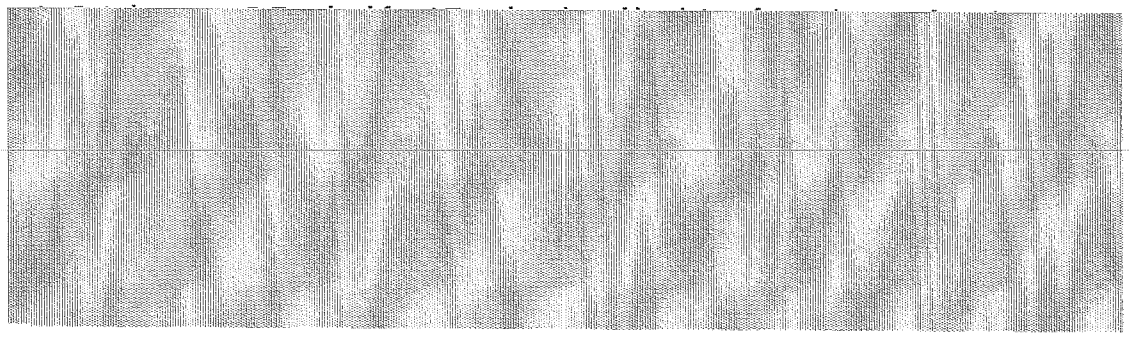
RCW 70.02.020

RCW 13.50.100









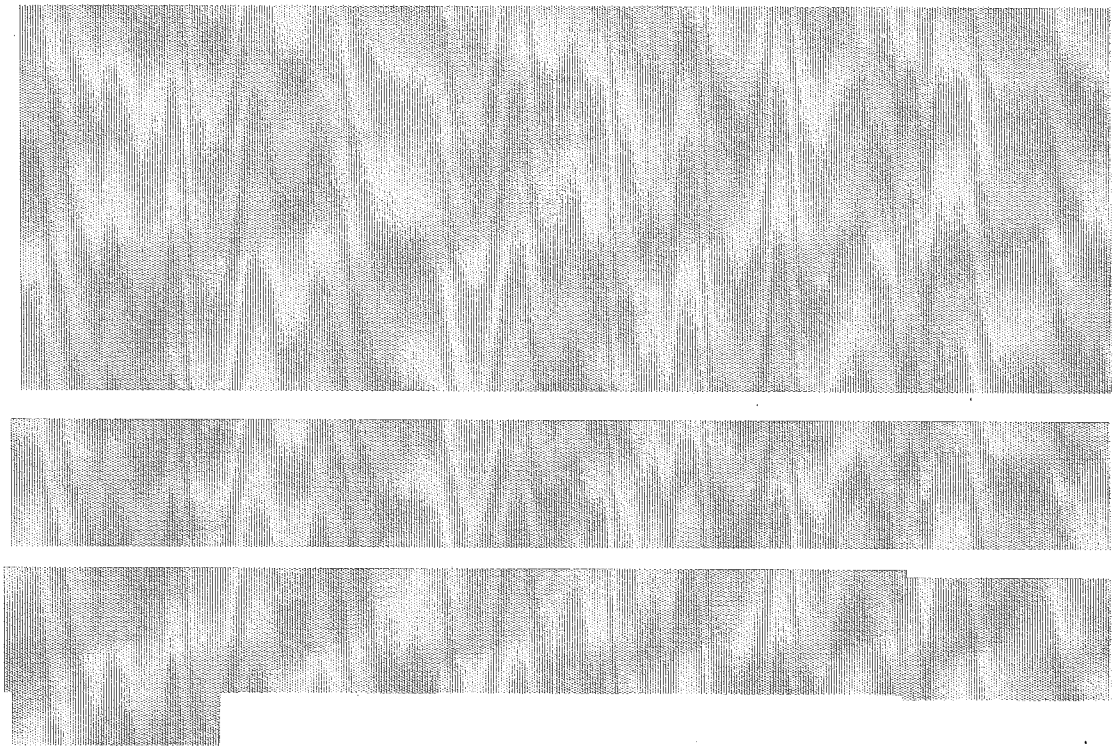
[4] When an investigation is "Founded," it means that CPS investigated the allegation and, based on the information available, has determined that it was more likely than not that the abuse and/or neglect occurred.

[5] Virginia Miller House (VMH) is an "Interim Care Program." Virginia Miller House accepts female youth between 12 to 18 years old. The youth usually have behaviors that make it difficult to maintain a less restrictive placement. The program is staffed 24 hours a day, seven days a week. There is one or more staff for every three youth during the day.

[6] BRS Wraparound is a Children's Administration contracted service. The contractor supports families (including relative placements) in the stabilization of children in their current placements. The contractor provides the family with consultation, case aides, 24 hour on-call staff, and assistance with parenting techniques for behaviorally challenged youth.

RCW 70.02.020

RCW 13.50.100



On March 17, 2012, J.T. was granted a weekend pass by VMH staff. J.T. had been granted permission to ride the bus alone as part of her independent living skills. The assigned social worker confirmed that J.T. was authorized to visit her dad on the weekend and was approved for overnights at the uncle's home. J.T. was expected to go to her uncle's home where she would spend the weekend. J.T. did not go to her uncle's home as agreed upon. Instead, J.T. met up with two high school friends and went to their house. Another peer from the alternative high school came to the friends' home and he reportedly stabbed J.T. around 2:40 a.m.

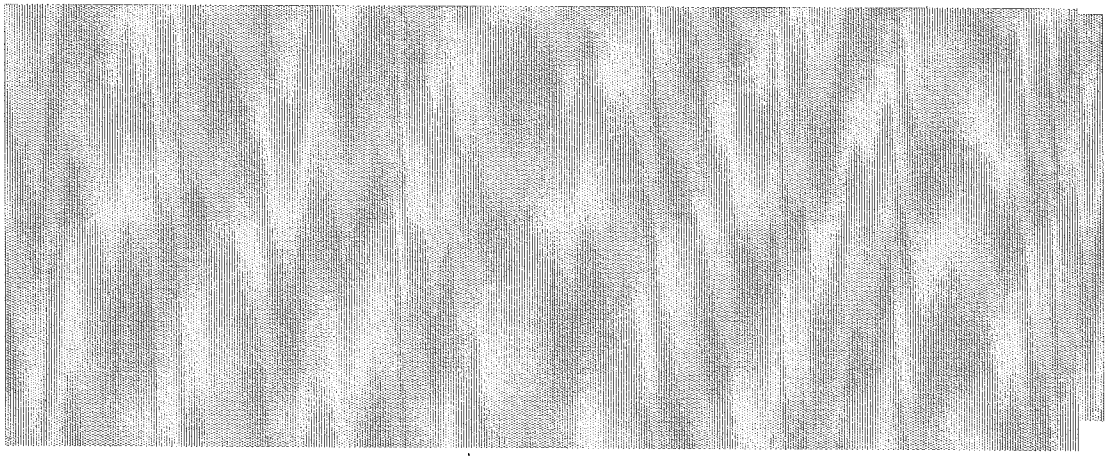
Committee Discussion

Committee members reviewed and discussed the documented social work activities completed by Children's Administration from intake to case closure. As a means to provide structure and context to reviewing social work practice, the committee was provided a case summary and had access to J.T's case file. In addition, the committee was provided information on policy and procedure as it relates to placement in state licensed staffed residential facilities such as VMH. In this way, committee members were better able to evaluate the reasonableness of actions taken and decisions made by Children's Administration social workers. In addition to social work practice, discussions occurred around policy issues. The discussions largely focused on the

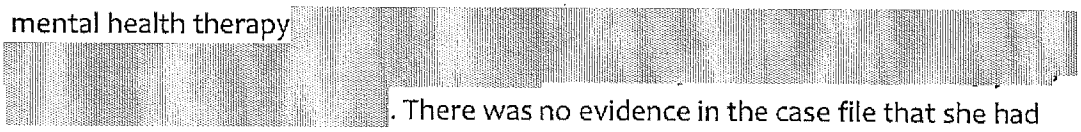
[7] CA Policy 4301: Shared Planning Meetings bring individuals together to help make decisions for children about safety, permanency and well-being.

following areas: the age of the child and how that impacted case decisions, the licensing and monitoring of the staffed residential facility, the Becca Law,[8] and services offered to J.T. during her out-of-home placements.

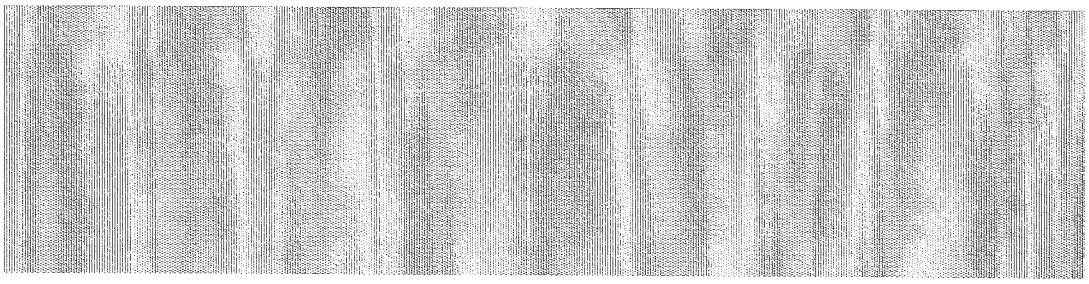
The committee noted that J.T. was 17 years old at the time of her death and 15 years old at the time she came into care. The committee recognized that older children present unique challenges to social workers and care providers. The committee acknowledged that J.T. needed to have some personal investment in her case plan if it was going to succeed while noting how challenging it can be to motivate any teen child. J.T.'s case plan was noted to have appropriately included Independent Living Skills (ILS).



J.T.'s chemical dependency services and mental health treatment were discussed by the committee. The committee was concerned that J.T. should have been offered mental health therapy

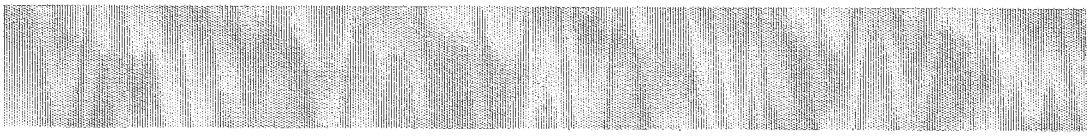


. There was no evidence in the case file that she had received or was offered mental health treatment prior to her initial placement.



[8] The Becca Law (RCW28A.225.010) was enacted by Washington State Legislature to: protect children who are endangering themselves; keep families together through assessment and treatment services; provide tools for schools, parents and Juvenile Court to keep children in school; and to hold children and parents accountable to the order of the Court.

[9] Career Link is a high school completion program for students ages 16-21 who no longer attend traditional high school. Students are offered the opportunity to work on academic skills, personal development, and earn progress towards a high school diploma



However, very few records were received and the committee was concerned about the lack of provider reports in the case file. The committee expressed concern that the social worker may not have been aware of all the documents that he should have been receiving from the providers. The committee found insufficient documentation regarding J.T.'s treatment, placement and education.

The committee discussed J.T.'s placement history and found that J.T.'s care in her uncle's home was appropriate. The committee also determined that the use of BRS Wraparound Services was beneficial to J.T.'s stability in this placement. The BRS Wraparound provider was noted to have done an excellent job of providing reports to the social worker and delivering services to J.T. and her relatives.

J.T. was placed at VMH during the majority of her time in out-of-home placement. A review of the case file provided the committee with limited information regarding J.T's level of care while at VMH. The committee noted that the VMH director did not respond to requests to be interviewed by the committee and this resulted in a limited understanding of the safety measures in place at that facility. The committee noted that available documentation showed a positive relationship between J.T. and some VMH staff. The committee discussed the number of CPS licensing reports and compliance agreements regarding VMH. Some of the intakes resulted in compliance agreements. The committee was informed by the DLR Licensor that the compliance agreements were designed to help VMH meet standards consistently. There was significant discussion around the use of compliance agreements and how many compliance agreements are needed to remedy concerns about a provider. Committee members believed VMH may have benefitted from COA[10] accreditation. The committee members believed Children's Administration would benefit from contracting with COA accredited placement providers whenever reasonably possible.

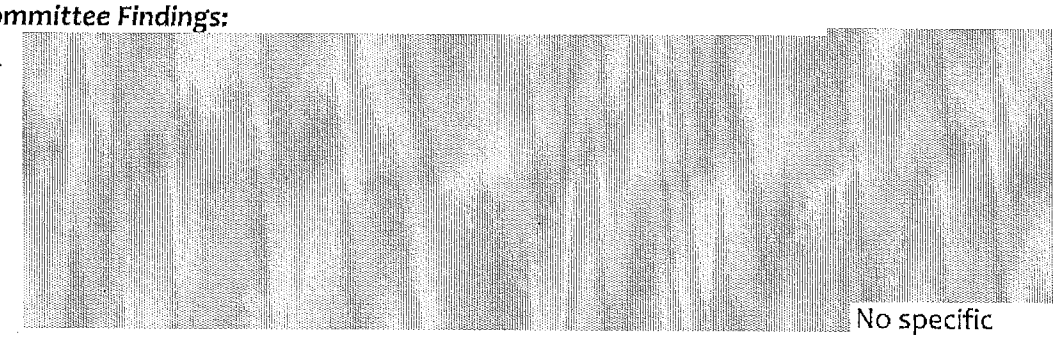
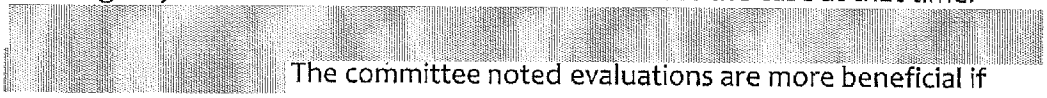
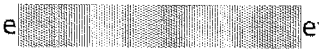
The committee noted that J.T. had a cell phone and usually checked in with VMH staff; however, she did not check in the night of her fatality. J.T. had multiple contacts with her father the night of her death. J.T.'s father told investigators that he

[10] The Council on Accreditation (COA) partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards.

had directed J.T. to return to VMH due to her unwillingness to come directly to the uncle's house. The father did not inform VMH that J.T. should be returning to VMH.

The committee discussed the report by a VMH staff that a high needs and medically fragile youth was placed at VMH shortly before the fatality. VMH staff reported this youth required extensive staff time and that their focus was on serving this youth. In doing so, they forgot to check in with J.T. to confirm that she arrived at her uncle's home for her scheduled visit. The committee noted this was J.T.'s first overnight visit and the first visit where J.T. was not picked up and transported by her uncle. The visit was in compliance with the court order and authorized by the social worker, but no specific plan (regarding times when J.T. would depart and/or arrive) was in place according to the uncle.

Committee Findings:

1.  No specific plan to address academic concerns was located in the case file.
2. Voluntary mental health services should have been offered to J.T. immediately following the referra  T. The committee stated that a Multi-Disciplinary Team staffing may have been beneficial in the assessment of the case at that time.
3.  The committee noted evaluations are more beneficial if the evaluator has all reasonably available information prior to the date of the evaluation. Collateral information was critical for J.T.  The information available to the committee from the case file failed to show where J.T.'s  history was provided to the  evaluators.
4. The assigned social worker encouraged continued contact between J.T. and her uncle following her placement disruption from the uncle's home. The practice of continuing family support despite placement disruption was viewed as good practice by the committee. The committee noted that J.T. further benefited from only having one CFWS social worker.

5. There was insufficient communication between the social worker, VMH staff, the father and the uncle on the night of the fatality. The committee members also acknowledged that there was no possible way of predicting the set of circumstances that eventually led up to J.T.'s death.

Committee Recommendations:

1. Providing all collateral information to evaluators is a critical part of any referral process related to mental health and/or chemical dependency evaluations. Mental health and chemical dependency trainings should include a focus on the need for detailed collateral information.
2. Service providers who are contracted with CA to provide services to CA clients should be contractually obligated to participate with reviews and turn over any relevant documents when requested.