Children's Administration

Executive Child Fatality Review

Izayah Denison

October 2, 2008
Child's Date of Birth

December 28, 2008
Child's Date of Death

May 12, 2009
Executive Review Date

Committee Members:
*Tami Mistretta, Intake Supervisor, Division of Children and Family Services (DCFS), Region 6
*Dorene Perez, Intake Supervisor, DCFS, Region 2
*Marilee Roberts, Practice Consultant, Children's Administration
*Marilyn Walli, Public Health Nurse and Program Supervisor, Spokane Regional Health District

Observer:
* Mary Meinig, Director, Office of the Family and Children's Ombudsman

Facilitator:
*Nicole LaBelle, Regional Programs Administrator, DCFS, Region 1

Table of Contents

Executive Summary

On December 26, 2008, Children's Administration (CA) Central Intake (CI) received a report of serious injury to 2 ½-month old Izayah Denison (I.D.). The referent, hospital emergency room staff member, reported the infant was brought to the Sacred Heart emergency room in Spokane, WA by Emergency Medical Technicians (EMT). At the time of admission (10:01pm) I.D. was non-responsive and could not breathe on his own. Referent reported it appeared he had suffered a brain injury; however no trauma to the head was visible at time of admission. The referent also reported bruising to the infant's buttocks of an unknown origin. I.D. was diagnosed with anoxic brain injury[1] and placed on life supports.

CA was notified by an emergency room nurse I.D.'s mother (age 22) had arrived at Sacred Heart emergency room alone earlier in the evening (7:25pm) for issues related to post-partum depression and self-disclosed suicidal ideation. She was notified I.D. had been admitted to the hospital and of his fragile condition. Law enforcement was notified and dispatched to the hospital. Child Protective Services (CPS) also dispatched an after hours worker to the hospital to collaborate with law enforcement. Inquiries with family members were made by CPS regarding the whereabouts of I.D.'s 3-year old sibling, D.O. CPS and law enforcement were able to determine D.O. was in his paternal grandmother's care in Tacoma, WA and had been since prior to the Christmas holiday.

The investigating police officer interviewed, Andrew Whitmire[2] (age 22) at the hospital the night of December 26, 2008. Mr. Whitmire stated he was caring for I.D. when his mother left the family home to go to the hospital. According to the investigating officer Mr. Whitmire admitted he shook I.D. and spanked him leaving several bruises. When unable to arouse I.D., he called 911 who dispatched the paramedics. Following his statement Mr. Whitmire was arrested for 1st Degree Assault of a Child while at the hospital.

On December 27, 2008, the attending physician notified family members I.D.'s prognosis was poor and on the following day he died as a result of his injuries. Given Mr. Whitmire's statement to law enforcement on December 26, 2008 charges were amended to 2nd Degree Murder and he is currently incarcerated in the Spokane County jail.

Following the death, Spokane County Medical Examiner's office conducted an autopsy and determined I.D.'s cause of death: *"blunt force head injury; manner: homicide."*

Prior to the December 2008 report referencing I.D.'s injuries and subsequent death CA had received one other referral on this family; a November 2008 referral screened as Information Only. A mandated reporter, a Public Health Nurse (PHN), providing services in the home contacted CA with concerns regarding a high volume of people coming and going from the family home and allegations I.D.'s mother was smoking marijuana with a 16-year old neighbor. The PHN also reported the children looked good and the parents were engaged in nursing services. This

[1] Anoxic brain injury results from a total lack of oxygen to the brain. Reference: http://www.brainandspinalcord.org/traumatic-brain-injury-types/anoxic-brain-injury/index.html

[2] The full name of Andrew Whitmire is being used in this report as he has been charged in connection to the incident and his name is a part of the public record.

referral screened as information only as allegations did not meet the Washington Administrative Code[3] definition of child abuse or neglect.

In May 2009, CA convened an Executive Child Fatality Review[4] committee to review the case practice and decisions regarding 2 ½-month-old infant, I.D. and his family. The fatality review members included CA staff and one community member all of whom had no involvement in the case. Committee members were directed to review case documents consisting of one CPS referral from November 2008, Service Episode Record (SER) information regarding the fatality investigation and autopsy information. At the time of review a verbal summary of records from the Spokane Public Health District and law enforcement regarding this family was provided to committee members.

The review committee addressed issues related to intake practice and procedures and referral screening decisions. Following a review of the documents and case history the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

The review committee reviewed the family's CPS history along with information provided by the Spokane Public Health District which began providing services to the family in April 2008.

The First Steps[5] (FS) program was initiated by a referral from the family's social worker at the Department of Social and Health Services, Community Services Office. Case record information from the First Steps services provider documents home visits to the family for 8 months. Provider notes detail information provided to I.D.'s mother during visits included information to ensure a healthy pregnancy and delivery. In addition, services were provided to support and assist the family in other activities such as caring and feeding of the newborn, safe sleep environments, and shaken baby syndrome. Varied topics focused on providing the family with the necessary supports that would assist them in making positive parenting and health care decisions.

In August 2008, the provider notes Mr. Whitmire moved in with the family. Though not the father of I.D., he did engage in and participate in educational services provider by the FS worker. Notes reflect he was present during discussions regarding *Safe Sleep, Shaken Baby Syndrome and Who is Watching Your Baby.*

---

[3] Washington Administrative Code 388-15-009.

[4] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may 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 take personnel action or recommend such action against DSHS employees or other individuals.

[5] The First Steps program is a Medicaid program administered jointly by the DSHS Medicaid Assistance Administration and the Maternal Infant Health program at the Washington State Department of Health (DOH).

In early October 2008, I.D. was born. FS record reflects the delivery was uncomplicated and following release from the hospital the family continued to engage in FS services. During a home visit in October, FS provider again discussed safe sleeping as the family did not have a crib for I.D. and they were sleeping together on a mattress on the floor. FS provider did order a crib from the Lend a Crib program for the family. The provider also verified during the October 2008 visit the family was actively engaged and participating in the Women, Infants, and Children (WIC) program.

It was in November 2008, CA received the first of only two referrals regarding this family. The first referral received states the following: *"The referent stated she is involved with the family and the parents are engaged. The referent stated the children look good and the home is in good condition except for the fact numerous people live there or come and go. The referent stated both children are sleeping in the same bed as the parents. A neighbor reported to the referent that [mother] is smoking pot with a 16-year old...he has an open CPS case and is on probation. The referent stated there are a lot of people in the home and they all discipline the 3-year old."* This referral was screened as information only.

The next referral received by CA regarding this family is the December 2008 notification of I.D.'s injuries and subsequent death. On the night of I.D.'s injury, (December 26, 2008), his mother had left him in the care of Mr. Whitmire to go to the emergency room to obtain medical care. The investigation determined I.D.'s mother was being admitted into the hospital at the time of I.D.'s arrival at the same hospital emergency room.

Statements made by Mr. Whitmire during the course of the investigation into what caused I.D.'s death resulted in the arrest and charging (Murder in the 2nd degree) of Andrew Whitmire. Findings made in the CPS investigation were as follows; founded findings for physical abuse against Mr. Whitmire and unfounded findings of neglect and negligent treatment of I.D. by his mother.

The review team discussed at length the screening decision regarding the November 2008 intake. The screening decision was based on the following factors: no specific allegations of child abuse and/or neglect were identified, the family had no previous CPS history, the family was engaged in services to support caring for their infant, and both children in the home appeared healthy and doing well. The review committee agreed based on the information provided at the time of intake the screening decision, *information only*, was appropriate.

The review committee did discuss intakes received from mandated reporters in general warrant close scrutiny. They noted the November 2008 intake screening decision was reviewed and approved by an Intake supervisor. In reviewing FS notes not all the information in the notes were captured in the intake received by CA. It was suggested when intakes are received from mandated reporters that may not support assignment for investigation, it is prudent to ask the mandated reporter what intervention if any they are expecting or if they have additional information related to safety or risk. Documentation of this additional information should then be recorded in the intake along with discussion regarding expectations of CA's intervention.

Referencing I.D.'s 3-year old sibling: D.O. remained in the care of his paternal grandmother for a period of time following I.D.'s death at the request of CA. Preliminary background checks

(criminal history and child abuse and neglect history) were completed on the paternal grandmother with no concerns noted. D.O. was not placed in protective custody by law enforcement and remained in the care of his paternal grandmother. He is now in the care of his biological father and a parenting plan is in place supporting visits and contact with his mother.

Findings and Recommendations

The committee made the following findings and recommendations based on review of the case record, department policy and procedures, Revised Code of Washington (RCW), and Washington Administrative Code (WAC).

Findings

- Review of the First Steps provider notes appears some information may not have been captured in the November 2008 intake. Whether this is a result of CA not recording information received or the referent not including the information in their initial report is unknown.

Recommendations

- Re-contacting referents making reports of child abuse/neglect, particularly mandated reporters, to assist in screening decisions is recommended. Asking if they have additional information regarding safety or risk factors and what expectations regarding CA intervention they have may can be used in making screening decisions. Record additional information, if any, under the *Additional Risk Factors* tab on the intake report.

- At the recommendation of the Office of Family and Children's Ombudsman, CA should consider contacting law enforcement when information in an intake alludes to possible criminal activity at a residence (e.g. smoking marijuana with a 16-year old). Currently CA is required to notify law enforcement regarding referrals if its investigation reveals that a crime against a child has been committed (RCW 74.13.031(3)) or if a child is alleged to have died or had physical injury inflicted as a result of alleged child abuse or neglect or has been subject to alleged sexual abuse (RCW 26.44.030(4)). While such contact may provide additional insights into possible risk factors if law enforcement is aware of any previous criminal activity or intervention associated with the family, CA should weigh this against the possibility that such reports may deter people from voluntarily seeking or participating in services through DSHS or other agencies.