Children's Administration

Executive Child Fatality Review

Summer Phelps Case

December 2, 2008

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Executive Summary

On March 11, 2007, Children's Administration Central Intake (CI) received a referral reporting possible physical abuse of four-year-old Summer Phelps (S.P.) The referent, a Spokane police officer, told CI the father, Jonathan Lytle[1] brought the child to Deaconess Hospital emergency room unconscious and covered in bruises. Upon arrival it was reported S.P. had no vital signs and was pronounced dead shortly after admission. The attending physician reported S.P.'s injuries were inconsistent with the story provided by the father and abuse was suspected.

Additional concerns were raised when it was reported another child was in the family's home. Law enforcement initiated a child welfare check and found Mr. Lytle's wife, Adriana Lytle, at home with their 8-month old son (J.L.). Ms. Lytle is the step-mother to S.P. Law enforcement requested a response from a Child Protective Services (CPS) social worker as they were placing the infant in protective custody. On this same day, Jonathan and Adriana Lytle were arrested and later charged with first degree murder.

The Spokane County Medical Examiner's Office conducted an autopsy of S.P. and determined that the child's "cause of death was drowning; manner of which was homicide." Jonathan Lytle was subsequently convicted of homicide by abuse with aggravated circumstances. Adriana Lytle pled guilty to homicide by abuse.

Prior to the March 2007 referral regarding S.P.'s death, CPS had received eight referrals regarding S.P. or her parents. Seven of those referrals were regarding S.P. when she lived with her biological mother and were screened as "information only" referrals. One referral in June 2006 was regarding Mr. and Ms. Lytle and their unborn child (J.L.) and was assigned for a CPS investigation.

The June 2006 referral that was assigned for investigation alleged negligent treatment and pre-natal exposure to illicit substances of an unborn child. This referral was made by a Spokane Health Department Medicaid funded First Steps Maternity Support Services (MSS) program nurse. This referral identified Ms. Lytle as the subject and did not reference S.P. as she was not yet living in her father's home.

Subsequent to the birth of J.L., in July 2006, Family Home Care (Spokane agency) First Steps Maternity Support Services (MSS) were re-offered and accepted by the family. CPS subsequently closed its case in October 2006 based on reports provided by the Family Home Care MSS provider given there were no new allegations of child abuse or neglect. The family continued to participate in First Steps MSS and then Infant Case Management (ICM) services on a voluntary basis until the report of S.P.'s death in March 2007. It was the MSS service provider in the home who learned S.P. had come to live with her father and step-mother in September 2006.

[1] Both S.P.'s father and stepmother were charged with and subsequently convicted of homicide by abuse in connection with the child's death and their names are a matter of public record. RCW 74.13.500(1).

The ninth CPS referral in March 2007 was regarding the death of S.P. There was not an open CPS case at the time of S.P.'s death.

In December 2008, Children's Administration convened an Executive Child Fatality Review committee to review the practice and decisions regarding the case of four-year-old Summer Phelps (S.P.) and her family.[2]

The fatality review committee members included CA staff and community members who had no involvement in the case. Committee members received case documents including: a summary of CPS referrals regarding S.P. and her family, Service Episode Record (SER) documents of the June 2006 investigation, and First Steps MSS/ICM notes from First Steps State Team, Department of Social and Health Services (DSHS) and Department of Health (DOH). During the course of the review the committee members had the opportunity to meet and interview two of the professionals who provided services in the Lytle home prior to S.P.'s death. They were the First Steps MSS behavioral health specialist and ICM case manager (who was a nurse).

The review committee addressed issues related to intake practice and procedures, referral screening decisions, safety and risk assessment, and information sharing between partner agencies and service providers. Following a review of the documents, case history, and interviews with providers, the review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

The review committee reviewed all nine Child Protective Services (CPS) referrals referencing this family and the screening decisions made on those referrals. At no point during this period does it appear that S.P.'s mother and father resided together. The first seven referrals alleged child abuse or neglect of S.P. while she was in her mother's care and custody and three of those referrals were made by S.P.'s father, who was subsequently convicted of her death. The following is a description of each referral and action taken by CA.

[2] 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.

Referral 1:

RCW 74.13.500

Referral 2:

RCW 74.13.500

Referral 3:

On December 26, 2003, CPS received a report from S.P.'s mother alleging that Mr. Lytle was molesting S.P. S.P.'s mother said S.P. suffers from diarrhea before visiting with her father and upon her return does not want to be touched, or have her diaper changed or cleaned. S.P.'s mother reported her diaper rash worsens after seeing her father which is every Saturday. S.P.'s mother could not give any other specifics as to why she suspected S.P. was being molested, and the child was too young to make any disclosures. This referral was screened as information only.

Referral 4:

On September 1, 2004, S.P's mother again contacted CPS stating she found what she thought was a pubic hair in S.P.'s genital area. In addition, she said when changing her diaper the previous evening S.P. pointed to her genital area and said 'daddy.' At the time of the report S.P.'s mother was advised to take S.P. to the local sexual assault center or to her regular physician. This referral was screened as information only.

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[3] CA's Practice and Procedures Guide Section 2220 (B) (1-4) Sufficiency Screen outlines the four questions answered by Intake to determine need for referral assignment. The four questions are: 1. Is there sufficient information to locate the child; and 2. Is the alleged perpetrator a parent/caretaker of the child or someone acting in *Loco Parentis*; and 3. Is there a specific allegation of child abuse and/or neglect meeting the Washington Administrative Code (388-15-009) definition; or 4. Do risk factors exist which place the child in danger of imminent harm?

Referral 5:

On April 21, 2005, CPS received a report from a local transitional living program regarding S.P.'s mother and concerns they had regarding decisions she was making on behalf of S.P. The referrer reported S.P.'s mother told them she had reported in December 2003 fears that S.P.'s father was molesting her. In September 2004, the referrer spoke with S.P.'s mother again who said she was concerned S.P. was being molested. The referrer stated S.P's mother was now back in their program and had told them she was considering letting S.P. live with her father. The referrer asked S.P.'s mother why she would consider this given her earlier reported concerns. S.P.'s mother responded by saying S.P. likes her father's new girlfriend and would be better off living with her. When questioned further about her reported suspicions she said S.P's father is afraid and S.P. would not be alone with him. At the time of this referral, it was reported that S.P. was living with her father. This referral was screened as information only.

Referral 6:

On June 1, 2005, Mr. Lytle contacted CPS and reported that his daughter S.P. had been abandoned by her mother and had been living with him for the past six weeks. Mr. Lytle was told that since he is the child's father she is not considered abandoned. Mr. Lytle stated S.P.'s mother continues to receive benefits on behalf of S.P. CPS recommended Mr. Lytle contact the local Community Services Office regarding benefit information, and he could contact the Family Court to pursue custody of S.P. This referral was screened as information only.

Referral 7:

On January 24, 2006, a child care provider reported to CPS possible neglect of S.P., *age three and half years,* while in her mother's care. The referrer reported S.P. comes to school with no coat or socks. On this particular day she came to school with no underwear under her sweatpants. The referrer said S.P. walks around with her hands in her pants saying 'owie owie' and says this while using the toilet. On the day of this referral while assisting S.P. with toileting the referrer noted her genitals were red and she had a strong odor similar to being unwashed or possibly an infection. On this same day CPS called the referrer back and suggested they encourage S.P.'s mother get her a medical exam to rule out pin worms or an infection and speak with her about appropriate hygiene. The referrer agreed to do so on the date the referral was received. This referral was screened as information only.

Referral 8:

RCW 74.13.500