

**Children's Administration**  
**Executive Child Fatality Review**

**Orlando Potts**

**November 23, 2006**

*Child's Date of Birth*

**July 28, 2009**

*Child's Date of Death*

**December 2, 2009**

*Date of Fatality Review*

**Committee Members**

- \*Roland Bautista, Sgt., Pierce County Sheriff's Department
- \*Lori Van Slyke, MSW, Crisis Social Worker Mary Bridge Children's Hospital
- \*Ann Eft, Director, Pierce County Commission Against Domestic Violence
- \*Linda Miner, Family Support Partnership Program Coordinator, Tacoma-Pierce County Health Department
- \*Lawrence Cross Sr., SGM Retired, MSW, U.S. Army Warrior Program Soldier and Family Advocate (Armed Forces Services Corporation)

**Medical Consultant to the Committee**

- \*Michelle Terry, M.D.

**Observers**

- \*Mary Meinig, MSW, Director of the Office of the Family and Children's Ombudsman
- \*Tonya Fox, MSW Practicum Student, Children and Family Services Region 5

**Facilitator**

- \*Bob Palmer, Regional Child Fatality Program Consultant, Children's Administration

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## Executive Summary

On December 2, 2009, Children's Administration (CA) convened an Executive Child Fatality Review<sup>1</sup> committee to examine practice and service delivery in the Kitsap County fatality case involving two year old Orlando Potts. CA received a low risk intake on June 24, 2009. This intake was screened for Alternate Intervention by a contracted provider for Early Family Support Services (EFSS) and was still active at the time of Orlando's death.

Committee membership consisted of a diverse group of individuals from outside Kitsap County, representing the fields of law enforcement (LE), domestic violence (DV), military advocacy, medical social work, and community family services. Four of the five members had no prior knowledge of the case, and none had any direct involvement with case.

The incident initiating this review occurred on July 27, 2009, when a hospital social worker from Harrison Medical Center (Kitsap County) notified Child Protective Services (CPS) of the impending death of a young child from suspicious injuries. The child was subsequently transported to Mary Bridge Children's Hospital (MBCH) in Pierce County where brain death was assessed. Medical intervention was discontinued and Orlando Potts died within minutes of life support removal on the evening of July 28, 2009. Cause of death was determined to be from blunt force trauma, and manner of death declared a homicide. Jimmie Joseph Wright III<sup>2</sup>, the cohabitating fiancé of the deceased child's mother, was the only adult caretaker present in the residence at the time of the incident. Mr. Wright has been charged with second-degree murder.

Prior to the fatality the Potts family involvement with CA consisted of a low risk case<sup>3</sup> assigned in June 2009 for Alternate Intervention by a contracted provider for Early Family Support Services (EFSS)<sup>4</sup>. The identified clients were the mother (S.P.), her son

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<sup>1</sup> 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.

<sup>2</sup> The full name of Jimmie Joseph Wright III is being used in this report as he has been charged in connection with the death of Orlando Potts and his name is part of the public record.

<sup>3</sup> "Low to Moderately Low Risk Cases means cases where the primary concerns are issues of neglectful social, environmental, parenting practices that have not yet resulted in serious injury, developmental delays or other significant problems for the at-risk child" [DSHS Central Contracted Services 2045XS Early Family Support Services – Client Service Contract 6-1-09].

<sup>4</sup> EFSS was previously known as Alternative Response Services (ARS). The EFSS contractor provides direct services to families and/or links families to community resources to accomplish the following goals

Orlando Potts, and a younger sibling (T.P.). The EFSS case was still active at the time of the fatality and more detail can be found in the Case Overview section of this report. There had also been recent CA involvement with Jimmie Joseph Wright III, his estranged wife T.H.W., and their three children (J.A.W., J.J.W., and J.L.W.). None of the Wright family history involved allegations of physical abuse (see Case Overview).

Prior to assemblage, committee members were provided a summary of the EFSS intervention provided to the Potts family, two newspaper reports regarding the fatality incident, and detailed chronologies for both the Potts and the Wright families. A large portion of the information contained in the two family chronologies was obtained post-fatality from a variety of sources outside DSHS/CA (e.g., Naval Hospital, Naval Housing, local law enforcement).

Available to committee members at the time of the Executive Child Fatality Review were un-redacted copies of the CPS files for the Potts and Wright cases. A listing of the specific set of documents can be found in the Addendum section of this report. Additionally, a considerable array of reference materials were made available to committee members, including DSHS and CA publications regarding policy and practice, several Washington State laws relating to child abuse and authorized response by CPS, published articles on domestic violence (in general and with regard to spousal abuse in the military), articles on non-accidental head trauma, and internet source materials regarding the Navy Family Advocacy Program, the Institute of Family Development (IFD), and the National Safe Kids Organization. A listing of the reference materials can be found in the Addendum section of this report.

Personnel from IFD, the contracted EFSS provider, were available for interview but the panel declined as the documentation appeared sufficient. Additionally, CA social workers involved with the Potts and the Wright cases were available for interview but were not called to appear.

Following review of the CA case file documents, the additional information regarding the Potts and the Wright families from non-CA sources, and discussion of CA policy, practice, and procedures, the review committee made one recommendation which is presented at the end of this report.

## **Case Overview**

**RCW 74.13.500**

### **Wright Family:**

Prior to her marriage to Jimmie Joseph Wright III, [REDACTED]

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for families: (1) reduce risk of abuse or neglect of children in the home; (2) enhance parenting skills, family and personal self-sufficiency, and family functioning; (3) reduce stress on the family; (4) reduce the likelihood of additional referrals to CPS; and (5) enhance the health status of families and linkages to health services [DSHS Central Contracted Services 2045XS Early Family Support Services – Client Service Contract 6-1-09].

[REDACTED]

Mr. Wright was deployed by the U.S. Navy a large portion of that time. Mr. Wright and his wife [REDACTED] subsequently had three children (November 2004, January 2006, and April 2007), all born in the state of Washington.

RCW 74.13.500

[REDACTED] there were no further concerns reported to CPS until December 2008 when CA intake was notified by Bremerton Police of a domestic dispute call that resulted in both parents being arrested for violations of mutual No Contact Orders (NCO).

In February 2009 Bremerton Police responded to a complaint by Mr. Wright that his estranged wife had again violated the NCO, [REDACTED]

RCW 74.13.500

The three Wright children remained in the care of their father.

[REDACTED]

[REDACTED]

The Wright family case was in process of case closure at the time of the fatality to Orlando Potts while in the care of Jimmie Joseph Wright III. Following that fatality, the three Wright children who had been in the care of their father were placed into protective custody and dependency actions initiated.

[REDACTED]

RCW 74.13.500

**Potts Family:**

On June 24, 2009, the Bremerton Naval Hospital made a referral to CPS regarding possible parental delay in seeking medical intervention for a laceration on the leg of two year old Orlando Potts. While the wound was not significant in terms of required medical intervention or threat to the child's health, the possibility that lack of supervision by his mother had resulted in the injury was noted at CPS intake. The report was taken for Alternate Intervention (low risk) and sent to the Early Family Support Services (EFSS) contracted provider for Kitsap County. The identified clients were S.P. and her two children.

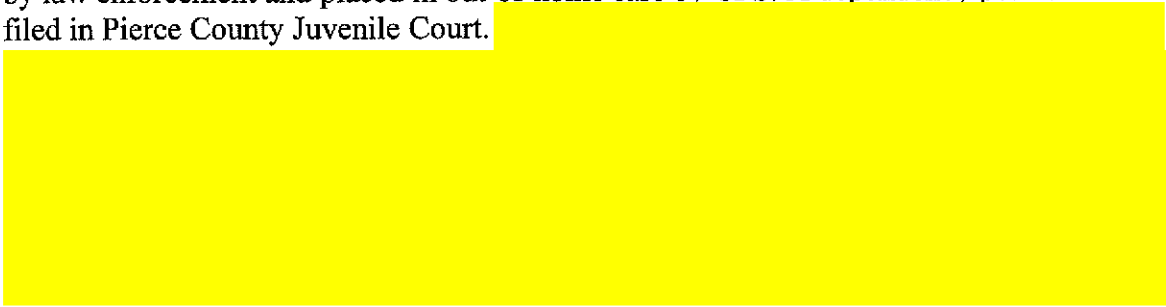
Attempted contact by the EFSS provider was made within three days of the intake, but unbeknownst to the interventionist the client had moved. Persistent efforts to contact the family were successful, resulting in a home visit being conducted on July 14, 2009.

Three days after the EFSS home visit, Orlando was seen at Harrison Medical Center following a reported fall from playground equipment. No referral to CPS was made. Medical records obtained (and reviewed by CA Regional Medical Consultant) show there were no injuries upon medical examination and no report was made to CPS. When interviewed following the later fatality incident, S.P. revealed that her son had actually fallen out a window during nap time (observed by a neighbor) and she had lied about the fall due to fear that the incident would jeopardize her custody situation with her estranged husband.

A second home visit by the EFSS therapist was conducted on July 21, 2009. Present were S.P. and her two children. The fiancé (Jimmie Wright) was present at the home but he did not participate in the session. Mr. Wright's three biological children were also present at the home that day. S.P. expressed concern about how her estranged husband might react to her seeking custody and a NCO, although she did not indicate fear of physical violence. The EFSS therapist and the mother discussed safety issues and available community resources. The EFSS provider was not informed as to Orlando having been seen at the ER following a fall. A third home visit was scheduled for July 28, 2009.

On July 27, 2009, CPS received a report from Harrison Medical Center of the impending death of a young child from suspicious injuries. The attending ER physician and other medical professionals involved concluded that the injuries were not consistent with the explanation of the child having fallen backwards on a coffee table or some other object. Jimmie Joseph Wright III, the cohabitating fiancé of the deceased child's mother, was the only adult caretaker present in the residence at the time of the incident. The child was subsequently transported to Mary Bridge Children's Hospital (MBCH) where brain death was determined. Medical intervention was discontinued and Orlando Potts died within minutes of life support removal on the evening of July 28, 2009. Cause of death was determined to be from blunt force trauma, and manner of death declared a homicide. Mr. Wright is currently charged with second-degree murder and remains incarcerated pending trial. Although the criminal case has not been concluded, the CPS investigation resulted in a finding of founded for child maltreatment by Mr. Wright.

Immediately following his brother's death, sibling T.P. was taken into protective custody by law enforcement and placed in out-of-home care by CPS. A dependency petition was filed in Pierce County Juvenile Court.



**Findings and Recommendations**

The committee made the following finding and recommendation based on review of CA case records including contracted provider documents, department policy and protocol, and records obtained from sources outside CA.

***Finding***

Overall the EFSS provider for the Potts family appeared to have met service requirements as described in the current DSHS Central Contracted Services EFSS County Program Agreement and EFSS Client Service Contract. However, a review of the EFSS documentation, including therapist notes, suggested that some aspects of the discussion and intervention around domestic violence issues involving the mother and her estranged husband (who was not involved with the fatality incident), could have been improved.

***Recommendation***

The current DSHS Central Contracted Services EFSS County Program Agreement and EFSS Client Service Contract require CA to provide mandatory EFSS training for all direct EFSS service staff. It is recommended that the contract be amended to specifically require domestic violence training for all EFSS direct service staff, through CA if available, or as acquired by the provider agency from community sources.

# Addendum

## *Case file documents available at review*

### **Potts Family**

EFSS documentation from contracted provider [Institute for Family Development]  
Post-fatality CPS records (from the July 2009 fatality incident through October post-fatality activities)

Results of various assessments (provided by CA post-fatality)

- Regarding the biological father: DV assessment, Parenting Assessment, Family Assessment/Homebuilders Intervention
- Regarding the biological mother: 2 Psychological evaluations

Law enforcement documents

- Initial police report regarding the fatality incident [additional documentation from law enforcement was not available due to on-going criminal prosecution]

Medical records – Orlando Potts [pre-reviewed by the committee medical consultant]

- Two pre-fatality Emergency Room visits
- Critical care records following the fatality incident

Medical records – Miscellaneous

- Pre-fatality and post-fatality medical records regarding sibling T.P.
- Pre-fatality medical notes (Navy) regarding mother S.P. (2008 pregnancy)

Navy documents (pre-fatality records)

- DV/Family Advocacy
- Naval Housing
- Psychiatric services summary for S.P.
- Naval Hospital records (S.P. 2008 – family advocacy)

### **Wright Family**

**RCW 74.13.500**

CPS records 2008-2009 (Jimmie Joseph Wright III and spouse T. [redacted])

Law enforcement documents [pre-fatality] involving responses to violations of NCO between Jimmie Joseph Wright and his estranged wife [redacted]

## *Reference Materials Available at Review*

### **Washington State/DSHS/CA Publications**

- Children's Administration Practice Guide to Intake and Investigative Assessment (Draft 4; 2009)
- CA Practice & Procedures Guide Section 2332: Alternate Intervention
- CA Structured Decision Making Procedures Manual® (2007)
- CA Policy Summary - Co-occurring Domestic Violence and Child Maltreatment (July 2009)
- CA Key Points from the Domestic Violence (DV) Practice Guide (April 2009)



- Protecting the Abused & Neglected Child: A Guide for Mandated Reporters In Recognizing & Reporting Child Abuse & Neglect (DSHS 22-163 Rev /09)
- WAC 388-15-009: What is child abuse or neglect?
- WAC 388-15-020: How does CPS respond to reports of alleged child abuse or neglect?
- WAC 388-15-005: What definitions apply to these rules?
- Comparison of Court Orders for Washington State (prepared by the Washington State Coalition Against Domestic Violence)
- Memorandum of Understanding (MOU) between Navy Region Northwest and Washington State Department of Social and Health Services regarding child abuse and neglect involving military personnel (August 2009)
- DSHS Central Contracted Services 2046CS Early Family Support Services (EFSS County Program Agreement 6-2-09)
- DSHS Central Contracted Services 2045XS Early Family Support Services (EFSS Client Service Contract 6-1-09)

#### **Articles:**

- Synopsis of Army family study of the rate of spousal abuse to child abuse and neglect (article originally published November 2000 issue of Child Abuse and Neglect).
- *Should childhood exposure of adult domestic violence be defined as child maltreatment under the law?* Jeffrey L. Edleson (2004).
- *The Battered Mother in the Child Protective Services Caseload: Developing an Appropriate Response.* Evan Stark (2001) - Originally developed for class action lawsuit Nicholson v. Williams et al.
- Synopsis of facts emerging from the National Survey of Children's Exposure to Violence (2008; published 2009 NatSCEV).
- *Tin Ear Syndrome: Rotational Acceleration in Pediatric Head Injuries* (Hanigan, Peterson & Njus, Pediatrics Vol. 80 No. 5 November 1987)

#### **Miscellaneous:**

- 2001 Memo from Deputy Secretary of Defense Paul Wolfowitz regarding Domestic Violence in the Department of Defense.
- List of common acronyms used by Children's Administration

#### **Internet Materials:**

- [usmilitary.about.com](http://usmilitary.about.com)
  - Navy Family Support
  - Military Domestic Problems – Part IV Family Violence
- [Fapmip.defense.gov](http://Fapmip.defense.gov)
  - Department of Defense Family Advocacy Program
- The Navy Fleet and Family Support Center [www.nffsp.org](http://www.nffsp.org)
  - Family Advocacy Program
- Institute for Family Development web site – program materials [www.institutefamily.org](http://www.institutefamily.org)

- Abusive Head Trauma (Reviewed by Elaine Cabinum-Foeller, MD for Kids Health Organization [www.kidshealth.org](http://www.kidshealth.org))
- National SAFE KIDS Campaign – statistics/incident rates regarding childhood injuries from falls (including window falls). [www.usa.safekids.org](http://www.usa.safekids.org)