RCW 74.13.500

Children's Administration

Executive Child Fatality Review

L.F.

December 09, 2011
Date of Child's Death

April 19, 2012
Child Fatality Review Date

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Table of Contents

Executive Summary	3
Case Overview	4-5
Committee Discussion	5-6
Findings and Recommendations	6-8

Executive Summary

On April 19, 2012, Children's Administration (CA) convened a Child Fatality Review[1] (CFR) committee to examine the practice and service delivery in the case involving 8-month-old L.F. and her family. The incident initiating this review occurred on the evening of December 7, 2011 when L.F. was admitted to the hospital for severe injuries from which she later died. The injuries were the result of non-accidental trauma while in the care of her father, Ivryee Flowers.[2] Nine days earlier CPS had received notification that L.F. had suffered a minimally displaced left parietal temporal skull fracture (no intracranial bleeding) that appeared to be from accidental trauma. That report was accepted for CPS investigation, and the case was open at the time of L.F.'s second hospitalization and subsequent death on December 9, 2011.

The CFR committee included CA staff and community members selected from diverse disciplines with relevant expertise, including representatives from the fields of medicine, public health, law enforcement, parenting instruction, 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 mother and child, un-redacted CA case-related documents, as well as medical and law enforcement records obtained shortly after the fatality incident.

Available to committee members at the review were (1) additional case related documents (e.g., technical-based medical records such as lab tests; recent amended court filings by the county prosecutor), (2) several CA policy and practice guides relating to CPS investigations and assessment of risk and safety, (3) a copy of the *Child Sexual and Physical Abuse Investigation Protocols for Pierce County (2010)*, and (4) copies of relevant laws relating to CPS duties, authority to place children, and legal definitions involving child maltreatment. During the course of the review the CPS investigator and supervisor involved with the case were made available for interview by the CFR committee members.

Following review of the case file documents, interview of the CPS social worker and his supervisor, and discussion regarding social work activities and decisions, the

[1] 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.

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

review committee made findings and recommendations which are detailed at the end of this report.

Case Overview

Children's Administration first became aware of L.F. and her parents on November 28, 2011 when Central Intake was notified by Mary Bridge Children's Hospital of an 8-month-old infant with a minimally displaced left parietal temporal skull fracture (no intracranial bleeding). The father's story was that on Saturday, November 26, he had been feeding L.F. when she burped and threw up. When he was wiping her face, which she didn't like, L.F. reportedly had thrown her head back and hit it on a table. He reportedly looked at the child's head, did not see any injury, and did not mention the incident to anyone. L.F. then spent the night with her maternal grandmother. When L.F. returned home Sunday evening, November 27, the mother noticed a bumpy/boggy area on the child's head. The mother and the child's paternal grandmother took the child to the Emergency Department (ED) at Tacoma General/Mary Bridge Hospital. The ED physician notified the family of his concerns regarding the explanation provided for the injury and the need to admit the child for further examination. Both CPS and local law enforcement were notified.

The intake report was assigned for CPS investigation (emergent 24 hour response) and in collaboration with law enforcement subject interviews were conducted with the parents and the maternal grandmother who had cared for the child during the weekend. An incident re-creation was conducted by law enforcement and CPS at the family apartment. Consultation was sought with a state Child Protection Medical Consultant[3] who, upon review of records and the reported circumstances, presented an overall assessment of "probable accidental trauma." A staffing was held at the Child Advocacy Center[4] of Pierce County on December 2, 2011, the same day the infant was seen for follow-up examination by her primary care physician.

Four days later the child was medically examined again when she was brought to the emergency room in the late evening of December 6, 2011. The mother reported that her daughter was being "really fussy." Medical records obtained by CPS show that the attending ED physician was aware of the recent hospital admission for a skull fracture when he conducted the ED exam. X-rays showed that L.F. was very

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[3] The tasks of the statewide Child Protection Medical Consultants (CPMC) network include providing telephonic consultations, case staffing/case review, training, court testimony, and written consults to CA staff, law enforcement officials, prosecuting attorneys, and physicians regarding child maltreatment cases.

[4] The CAC of Pierce County is a member of the Washington State Chapter of the National Children's Alliance (NCA) which is the accrediting organization. The NCA has established standards for CACs that include (1) child-focused, child-friendly facilities for children and their non-offending family members, (2) multidisciplinary team case staffing participation by law enforcement, prosecution, medical experts, social work, and advocacy, (3) medical evaluation onsite or through referral, (4) therapy onsite or through referral, (5) onsite forensic interviews, (6) and case tracking. [Sources: Children's Advocacy Centers of Washington www.wsacac.org and CAC of Pierce County website at www.multicare.org/marybridge/childrens-advocacy-center]

constipated, had no noticeable fractures or other trauma. The infant was discharged home with her parents around 3:00 a.m. on December 7, 2011.

On December 7, at approximately 8:00 p.m., a 911 call was made regarding an unresponsive child. First responders arrived at the home and performed CPR and immediately transported the child to the hospital. Upon hospital arrival, at approximately 8:30 p.m., L.F. was assessed as being cold, cyanotic, without respiratory effort or pulse, and only occasional electrical activity. A CT scan showed bi-lateral bleeding in the brain; no other injuries or bruising were noted.

The hospital notified CA Central Intake of the non-accidental trauma and the likelihood that the child would not survive. The intake was assigned for CPS investigation of physical abuse (emergent 24 hour response). Ivryee Flowers confessed to police that he had physically abused his infant daughter causing the severe injuries. He also admitted that he had shaken L.F. on other occasions, but denied he had done so at the time of L.F.'s skull fracture in late November. Ivryee Flowers was booked for Assault of a Child in the First Degree. When his daughter was pronounced dead on December 9, 2011, the charges were amended to Murder in the Second Degree and a trial is set for September 2012. The CPS case was closed in late February 2012 and founded for physical abuse of a child.

Committee Discussion

Committee members reviewed and discussed the documented social work activities completed by CPS from intake to case closure. As a means to provide structure and context to reviewing social work practice, the committee members were provided overview information on the Structured Decision Making (SDM)[5] risk assessment tool, the Child Safety Framework,[6] and expected practice regarding CPS investigations and timelines for completion of work.[7] In this way, committee members were better able to evaluate the reasonableness of actions taken and decision made by the CPS social worker and supervisor. In addition to reviewing social work practice, discussions occurred around policy issues. These largely focused on two areas, the use of the SDM as an assessment tool and the criteria used by CA in determining a child to be "medically fragile." Finally, the committee also discussed

[5] The Structured Decision Making® (SDM) risk assessment is an evidence-based actuarial tool from the Children's Research Center (CRC) that was implemented by Washington State Children's Administration in October 2007. It is one source of information for CPS workers and supervisors to consider when making the decision to provide ongoing services to families.

[6] In partnership with the National Resource Center-CPS (NRC-CPS), Washington State Children's Administration implemented the Child Safety Framework in November 2011. The safety framework is built on key principles of gathering, assessing, analyzing, and planning for a child's safety through (1) collecting information about the family to assess child safety, (2) identifying and understanding present and impending danger threats, (3) evaluating parent/caregiver protective capacities, (4) determining if a child is safe or unsafe, and (5) taking necessary action to protect an unsafe child. http://www.dshs.wa.gov/ca/general/index.asp

[7] See CA Practices and Procedure: Child Protective Services. http://www.dshs.wa.gov/ca/pubs/manuals.asp

system issues relating to criminal and domestic violence background checks, and the process of collaboration between CPS and law enforcement.

Findings

Based on the information available to the CPS social worker during the short time period between the initial investigation and the fatality incident, the actions taken and decisions made by the social worker appear reasonable. The committee finds no alternative actions that reasonably could have been taken by the CPS social worker that would have likely changed the outcome of the case. However, in examining the broader aspects of the case work, the committee finds several opportunities where practice could have been improved.

- The committee recognizes the extra efforts taken by both CPS and the investigating detective to conjointly investigate the circumstances of the first injury to L.F. given the medical consultant's initial opinion that the injury was the result of "probable" accidental trauma. While the injury may have plausibly been accidental, the social worker made no additional inquiry as to the degree of probability or actual likelihood that the event was inadvertent rather than intentional.
- The CPS social worker appears to have sought and been provided generalized criminal background information as to the parents, but did not seek more detailed records accessible through the local law enforcement agency. This could have included seeking information as to the criminal backgrounds of the other adults living in the home and information as to any law enforcement responses to the home (non-arrest incidents). Similarly, the social worker could have been more curious about the domestic violence situations self-reported by the parents and appears to have relied on the parents' accounts rather than pursue other sources of information. A more full disclosure of the criminal and domestic violence histories (including juvenile records) may have been beneficial to the multidisciplinary staffing at the Child Advocacy Center.
- The social worker's SDM scoring does not appear accurate and may have underestimated risk. It does not reflect the number of adults actually living in the home, or their history of CPS involvement. Furthermore, the social worker did not identify L.F. as having developmental delays or any disability. When interviewed, the social worker indicated that the basis for his determination was that the infant had been described by medical professionals as "developing normally." While L.F. may have been progressing normally in consideration of her gestational age at delivery, the social worker did not appear to consider the significant developmental issues at hand and the fact that the infant was receiving SSI benefits and was receiving physical therapy. When interviewed, the CPS social worker stated that the SDM scoring had been intended only as an initial inputting of assessment information, with a plan to update the SDM as more information emerged during the investigation. However, no attempt was made to update or otherwise correct the SDM prior to completing and closing the assessment.

- L.F. was a "micro preemie"[8] and spent her first few months of life in a Neonatal Intensive Care Unit. At the time CPS became involved L.F. was eight-months-old, no longer requiring intensive medical care, and did not meet the current CA criteria for being identified as medically fragile.[9] However, several committee members expressed concern that the definition of medically fragile as currently used by CA (including within the SDM tool) may be too narrow in not considering the medical vulnerability common to preterm infants even if not evaluated as having pervasive medically intensive needs.

Recommendations:

- While admittedly having only brief introduction to the SDM risk assessment tool used by CPS, the committee concludes that the SDM appears to have limited usefulness and CA should consider eliminating the tool.
- CA should engage the state Child Protection Medical Consultant (CPMC) group in a discussion about improving communication with department social workers when consulting on child injury cases. Specifically, this would be to look at going beyond determinations of "possible" or "plausible" for causes of injuries, and offering more detailed estimated probability that would include a statement as to "how likely" an injury was accidental or non-accidental. This would increase the ability of social workers to understand and assess the safety needs of the child as well as support investigative findings that are based on a "more likely than not" standard of proof.[10]
- Although it is recognized that the criteria for medically fragile status as used by CA is consistent with that of the Washington State Developmental Disabilities Council Policy 109 (1990),[11] it is suggested that CA consider

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[8] The term **"micro preemie"** is used in the medical field to refer to the smallest and youngest preterm babies born before 26 weeks gestation or weighing less than 1 pound, 12 ounces (800 grams). **"Extreme prematurity" (or extreme preterm)** refers to babies who are born before 28 completed weeks gestational age or have a birth weight of less than 1000 grams (about 2 lbs 3 oz). **Moderate prematurity (or very preterm)** refers to babies who are born
28 to 32 completed weeks of gestational age with a birth weight range between 1000 and 1500 grams (about 2 lbs 3 oz and 3 lbs 5 oz). **Mild prematurity (or preterm)** refers to babies who are born between 33 and 37 completed weeks gestational age and/or have a birth weight between 1500 and 2500 grams (about 3 lbs 5 oz to 5 lbs 8 oz).

[9] A child is considered "medically fragile" when meeting the following criteria: (1) Child has medical conditions that require the availability of 24-hour skilled care from a health care professional or specially trained family or foster family member; (2) These conditions may be present all the time or frequently occurring; (3) If the technology, support, and services provided to a medically fragile child are interrupted or denied, the child may, without immediate health care intervention, experience death.

[10] CPS findings in Washington State follow a preponderance of evidence standard rather than "clear and convincing evidence" or "reasonable doubt" standards of proof. In this way "Founded means the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur." [See: RCW 26.44.020(9)]

[11] WSDDCP: Medically fragile individuals are those who have medically intensive needs. Their chronic health-related dependence, continually or with unpredictable periodicity, necessitates a 24-hour a day skilled health care provider or specially trained family or foster family member, as well as the ready availability of skilled health care supervision. Further, if the technology, support and services being received by the individual are interrupted or denied, he or she may, without immediate health care

expanding the criteria to include medically vulnerable preterm infants who have substantial needs although not medically intensive needs.

- CA should consider offering training to social workers on preterm ("preemie") babies. Given the increased number of preterm deliveries nationally and the increasing research regarding short and long term health and disability risks,[12] awareness of the subject may be beneficial to those providing public child welfare services. It is suggested that such training could be offered in a web based format that could be blended with other related training (e.g., infant safe sleep).
- CA should consider reaching out collaboratively with state law enforcement to support the introduction of new legislation that would require law enforcement officers to promptly notify Child Protective Services whenever a child is present or in close proximity to a situation involving domestic violence of a parent or caretaker, regardless of any observable harm to the child. Such notification could then be retained by CA in the statewide child welfare information system, FamLink. This would be similar to the efforts made in 2010 in enacting RCW 46.61.507 which requires law enforcement to notify CPS of DUI situations whereby a child is present and the operator of the vehicle is a parent, custodian, or caretaker.
- CA should continue with statewide presentations of Lessons Learned from Child Fatalities that would be available annually by a variety of venues and formats (in person training, web-based training, web casts). It is suggested that future presentations consider including the following lessons: (1) Social workers should try to verify information provided by parents such as relating to their domestic violence and criminal history. This might include a request with law enforcement contacts to search data bases available to their agency that may have information beyond arrest, charges, or conviction data. (2) While consultation with medical professionals is often critical to gathering information for investigation and assessment, medical opinion should not be the only source of information when assessing risk or safety, or making a finding decision. (3) In cases where the medical opinion may be that an injury is "plausibly accidental," social workers should ask for a more specific estimate of probability (e.g., "how likely" is it that the injury was accidental or non-accidental?).

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intervention, experience irreversible damage or death. Medically fragile also includes individuals who are at risk for medical vulnerability. These individual's chronic health-related dependence does not require 24-hour supervision by a skilled health care provider, but they do experience unpredictable life threatening incidence. Without appropriate monitoring and the availability of licensed, certified or registered providers, their condition could deteriorate and the intensity of their medical needs increase.

[12]The rate of premature births has increased by 36 percent since the early 1980s and currently in the U.S. about 12.8 percent of babies (more than half a million a year) are born prematurely. Sources: World Health Organization and March of Dimes [www.marchofdimes.com].