Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

D.L.

April 2014
Date of Child's Birth

September 27, 2015
Date of Fatality

December 10, 2015
Child Fatality Review Date

Committee Members
Cristina Limpens, MSW, Senior Ombuds, Office of the Family and Children's Ombuds
Yolanda Duralde, MD, Medical director of the Child Abuse Intervention Department at Mary Bridge Children's Hospital/MultiCare and the Pierce County CAC
Jenna Kiser, Intake and Safety Program Manager, Children's Administration
Jessica Sullivan, Sergeant, King County Sheriff's Office
Meagan Cordova, MSW, Social and Health Program Consultant/Quality Practice Specialist Region 2 North, Children's Administration
Kristy Suydam, MSW, Child Protective Services Supervisor, Children's Administration

Observer
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Table of Contents

Executive Summary

On December 10, 2015, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to 17-month-old D.L. and his family.[2] The child will be referenced by his initials, D.L., in this report.

At the time of his death, D.L. lived with his father, his father's girlfriend Alicia Goemaat and Ms. Goemaat's son.[3] D.L.'s mother did not live with or have contact with him at the time of his death. On September 27, 2015, CA received a call from the King County Medical Examiner's Office stating D.L. was pronounced dead at his father's residence. The Medical Examiner's Office reported that D.L.'s death was unattended as he had been placed down for a nap and was later found unresponsive. The intake indicates that several bumps and bruises were found on D.L.'s body. The father stated that D.L. sustained these injuries while roughhousing with his sibling (Alicia Goemaat's son, not biologically related). At the conclusion of the autopsy, it was found that D.L. died of blunt force trauma consistent with non-accidental trauma. Additionally, Alicia Goemaat made admissions to law enforcement regarding her assault of D.L.

The review Committee included members selected from diverse disciplines within the community with relevant expertise, including the Office of the Family and Children's Ombuds, a Child Protective Services supervisor with CA, a sergeant with the King County Sheriff's Office, a contracted medical consultant with CA who specializes in child abuse, an intake and safety program manager with CA and a quality practice specialist with CA. Also present was an observer from CA. Neither CA staff nor any other Committee members had previous involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and un-redacted CA case documents

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[1] Given its limited purpose, a Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CFR 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 only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. 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 or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's near fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] D.L.'s family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system.[Source: RCW 74.13.500(1)(a)]

[3] Alicia Goemaat is named in this report due to her current criminal charges of Second Degree Murder.

(e.g., intakes, investigative assessments, and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included relevant state laws and CA policies.

The Committee interviewed the assigned CPS worker and her supervisor as well as the CPS worker who investigated the fatality. Both CPS workers' supervisor had taken positions outside of CA.

Family Case Summary

On January 27, 2015, CA received a call regarding D.L.'s mother. The intake alleges the mother appeared to be RCW 70.02.020 when she arrived at the hospital for RCW 70.02.020 . The caller was concerned due to the fact that the mother was reportedly caring for six-month-old D.L. This intake was screened out as there was no indication the mother was providing care for that child and she was not the custodial parent.

The second intake was received on September 21, 2015. A person called on behalf of Dr. Kenneth Feldman, a contracted medical consultant with CA who works at Seattle Children's Hospital. Dr. Feldman expressed concern for D.L. based on photographs taken the previous day that showed bruises and abrasions not consistent with common toddler injuries. Dr. Feldman expressed concern for the child's safety in the home. Dr. Feldman had not personally observed the child; rather, the photographs were taken while the child had been in the hospital the previous day. D.L. had been seen at the hospital due to an RCW 70.02.020 abuse to another child living in the home. The alleged offender of the RCW 70.02.020 assault was another adult living in the home. This intake was assigned for a 24-hour CPS investigation.

On September 21, 2015, the assigned CPS worker contacted the Children's Protection Program at Children's Hospital and requested a copy of the Suspected Child Abuse and Neglect (SCAN) consultation and the four photographs that were taken of D.L. She learned that a detective with Seattle Police Department had been assigned. The worker attempted contact at the family residence but was unable to enter the building.

The next day, the CPS worker contacted SPD and was advised to wait until the end of the week before making contact with the family. The CPS worker stated that she was told the detectives were all busy working to support security while the President of China was in Seattle. The CPS worker stated she made a second attempt to contact the family after having been advised to wait for the detective to contact her. The CPS worker stated she knew she had to meet the face-to-face

timeframes per policy. This second attempt at the family home was not documented.

On September 27, 2015, D.L.'s body was found unresponsive at the father's home. The medical examiner reported he was declared dead at the scene and had visible bruises and bumps on his body. Alicia Goemaat had been providing care for him that day. The King County Medical Examiner's Office determined the resulting injuries led to his death.

Committee Discussion

For purposes of this review, the Committee focused on case activity prior to the fatality. The CPS investigation regarding the fatality was briefly discussed.

The majority of the Committee's discussion centered on the lack of urgency related to D.L.'s injuries as observed by medical personnel on September 20, 2015. While the Committee is charged with assessing the actions or inactions of CA, there was also a discussion surrounding the actions and inactions of medical personnel and law enforcement. The intake call and statements contained in the intake report indicate that Dr. Feldman expressed concern and urgency regarding the injuries. The Committee felt it would have been appropriate for the attending physicians to have called law enforcement when they observed the injuries. This led to a conversation regarding a concern for lack of child abuse training for physicians.

The second area where urgency was not overtly expressed was during the interview with the assigned social worker and supervisor. The Committee noted that the assigned CPS investigator and supervisor stated they were not concerned about the child's safety because the child had been released by the hospital. However, the Committee believed the fact that Dr. Feldman was calling with concern based on his review of the pictures as well as the age of the child and D.L.'s lack of verbal skills to describe how he was injured all indicated a higher risk necessitating more urgency in CA's actions.

During her interview, the CPS investigator stated she called SPD and spoke with the administrative assistant for the lieutenant in charge of assigning cases to detectives. That person is the one who indicated to the CPS worker that she should wait to contact the family. The Committee noted that the CPS worker could have taken the next step to ask to speak with the lieutenant directly or to call and ask for a patrol officer to accompany her to the home.

Findings

The Committee did not find any critical errors that directly resulted in the fatality. However, the Committee identified areas where practice could improve.

The Committee noted a lack of critical thinking by the worker. Taking into consideration the case was open for six days before D.L. was killed, there were actions that could have been taken in order to allow for a more thorough assessment of D.L.'s safety. While trying to work within the agreed boundaries and in collaboration with law enforcement, there are times when CA must see a child before the assigned detective is available. This case highlighted that need. The Committee believes CA staff should have realized the urgent need to assess the safety of a 17-month-old child with what appeared to be non-accidental injuries and staffed the case with their area administrator to discuss the next steps.

The Committee also noted that Dr. Feldman was not contacted by CA staff. They understood that Dr. Feldman did not directly call CA; rather, someone called on his behalf. The question that could have been asked to help provide more urgency could have been, "What type of follow up does Dr. Feldman hope will occur?" The answer to this question may have provided the CPS worker a timeframe and structure necessary for law enforcement intervention and intervention by CA.

Recommendations

When an intake is assigned that includes alleged injuries to a child under three years of age and that requires an extension or exception to meeting the face-to-face timeframe, the case should be staffed with the area administrator prior to granting the extension. This staffing should be documented in a case note.

The Committee believes that a MedCon[4] should reach out to Seattle Children's Hospital to conduct child abuse identification and subsequent mandatory reporter training.

CA should provide a training to educate its staff on MedCon which should include when, why and how to use them. This training should also include skills training on how to converse with and professionally question a professional within the medical community regarding his or her assessment of a child or situation. An integral piece of the training should also include the dynamics of child abuse. This training should be offered every two years for all staff regardless of how long they have been employed by CA.

CA should develop ongoing supervisor training to discuss the dynamics of child abuse, working with community partners and critical thinking. This training

[4] Medical Consultation Network

should include all supervisors regardless of how long they have been employed by CA.