A FATALITY REVIEW: RAFAEL GOMEZ

Two-year-old Rafael Gomez died on September 10, 2003, six months after the DSHS Division of Children and Family Services (DCFS) returned him to the care of his biological parents. An autopsy determined that Rafael died of "blunt-force trauma" to his head.

DCFS was involved in Rafael's life since his birth. The agency filed a dependency petition in court and placed Rafael in foster care a few days after he was reportedly born with drugs in his system. At 10 months of age, he was returned to his parents, while they participated in services. While in his parents' care, Rafael suffered serious physical injuries including broken bones, skull fractures and burns. Following these injuries, Rafael was again placed in foster care. In March 2003, at the recommendation of DCFS, the court ordered that Rafael again be returned to his parents' care. Rafael and his family remained under DCFS supervision until his death.

The Ombudsman asked the review team to focus on several key issues:

- **Performance Issues**
  - ✓ Screening and Investigation
  - ✓ Risk Assessment
  - ✓ Child Protection Team
  - ✓ Support Services
  - ✓ Non-Compliance
- **System Issues**
  - ✓ CPT Staffings
  - ✓ In-home Service Providers

The Ombudsman reviewed DCFS case records to learn more about the history of the agency's involvement with Rafael's family, including the circumstances that led to his placement in foster care, the services offered and provided to the family, and the agency's March 2003 recommendation to the court that Rafael again be returned to his parents' custody. The Ombudsman also wanted to examine the issues and concerns that arose on both occasions after the child was returned home, together with DCFS' response.

Rafael's death was also reviewed by a Community Fatality Review Team convened by DCFS. The Team included community professionals and legislators. At the Team's first meeting on December 17, 2003, the Ombudsman presented its completed investigation summary and identified several issues and areas of concern.

The Ombudsman found that caseworker bias was a key contributing factor to the agency's erroneous decision to advocate for Rafael's return home. The case record reflects that the DCFS worker assigned to this case believed that the parental deficiencies of Rafael's parents were limited to substance abuse, and that once this issue was addressed, the parents were capable of providing Rafael with safe and appropriate care. The worker appeared reluctant to reassess his belief despite the frequency and severity of the child's injuries while in his parents' care, abuse concerns raised by medical professionals and Rafael's foster parent, and the mother's complaints regarding the child's behavior. Instead, these incidents and concerns were minimized or discounted. The worker's failure to objectively test or reassess his perceptions about Rafael's parents and their potential for physical abuse led him to unreasonably advocate for the child's return home.

Caseworker bias was also a prominent factor in the death of three-year-old Zy'Nyia Nobles in 2000. Zy'Nyia was killed by her mother several months after DCFS returned her to her mother's care. In that case, the CWS worker appeared to act as the mother's advocate and pushed for Zy'Nyia's return home despite the mother's violent history, documented concerns about her mental health and parenting capacity, and her failure to complete or make progress in court-ordered services.[1]

Despite previous efforts by the DSHS Children's Administration to address this issue, biased decision-making by caseworkers persists and continues to place children at risk of serious harm.

Considering the Issues

The Ombudsman asked the Community Fatality Team to consider the following issues in a review of Rafael's death.

Performance Issues

- **Screening and Investigation**—Shortly after Rafael was returned the first time to his parents' care, DCFS Child Protective Services (CPS) received several reports clearly indicating that he was at risk of physical abuse. In fact, the child suffered several severe injuries while living with his parents. Case records indicate that many of these reports either were not investigated or determined to be inconclusive or invalid by CPS workers. Moreover, on one occasion, a DCFS Child Welfare Services (CWS) worker documented a service provider's concern about the suspicious nature of one of Rafael's injuries, but did not forward the concern to CPS for screening and investigation.
- **Risk Assessment**—The severity and chronicity of Rafael's injuries alone suggested the strong possibility of physical abuse. However, the CWS worker did not assess his parents' risk for physical abuse – even though assessment tools specifically designed to identify this risk were available. The worker did obtain a "psycho-social" evaluation of both parents. However, this assessment was inadequate as assessment tools designed to measure the risk for physical abuse were not. Moreover, the worker failed to provide sufficient background information on the parents to the psycho-social evaluator.
- **Child Protection Team**—The DCFS worker failed to provide complete information to the Child Protection Team (CPT) as it was deciding whether to support the worker's plan to return Rafael home.[2] Specifically, the Ombudsman questioned whether the CPT was provided with all medical reports and findings regarding the child's injuries, as well as reports of maltreatment after the child was returned home. Additionally, the Ombudsman raised concerns that information to the CPT accentuated the parents' progress and minimized any deficiencies.[3]

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[1] Ombudsman July 2000 Review of Zy'Nyia Nobles Fatality (edited to protect confidentiality): www.governor.wa.gov/ofco.

[2] RCW 74.14B.030 requires that DSHS "establish and maintain one or more multidisciplinary teams in each state region of the division of children and family services. The team shall consist of at least four persons, selected by the department, from professions which provide services to abused and neglected children and/or the parents of such children. The teams shall be available for consultation on all cases where a risk exists of serious harm to the child and where there is dispute over whether out-of-home placement is appropriate."

[3] Issues and recommendations regarding the use of Child Protection Teams are discussed in greater detail in the section titled "Exploring the Purpose and Value of Child Protection Teams" of this report.

- **Support Services**—The CWS worker did not ensure that critical in-home support services, such as of a public health nurse, were provided to Rafael's family upon his return home. Also, the worker did not ensure that Rafael was provided with therapeutic day-care services to help address his reported behavioral problems and further assess his treatment needs.
- **Non-Compliance**—Case records showed that Rafael's mother did not fully comply with substance abuse treatment services. Moreover, on more than one occasion she insisted on changing treatment providers whom she perceived as being critical of her progress. There is no evidence that this caused the DCFS worker to reassess his support for returning Rafael to parent's care.

System Issues

- **CPT Staffings**—The Ombudsman asked the Review Team to consider how the structure and operation of CPTs could be improved to enable them more effectively to fulfill their role. Specifically, the Ombudsman identified CPT membership, the decision making process, and the timing of CPT meetings as issues of concern.
- **In-home Service Providers**—The Team was asked to consider whether Family Preservation Service (FPS) and Home Support Service (HSS) providers were sufficiently able to address the issues identified in the psycho-social evaluation of Rafael's parents and whether FPS or HSS providers were adequately trained to identify and assess child safety issues and/or parents' potential for physical abuse.

The Community Fatality Review Team released its report on May 28, 2004. The report addressed many of the issues identified in the Ombudsman's review.[4]

[4] Rafael Gomez Fatality Review - Report of the Fatality Review Committee, May 28, 2004, http://www1.dshs.wa.gov/ca/pdf/Gomez.pdf