

**Rafael Gomez  
Fatality Review**

Report of the Fatality Review Committee  
May 28, 2004

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## **Executive Summary**

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In December 2003, the Children's Administration (CA) convened a multi-disciplinary fatality committee to review the case, practice and events that occurred prior to the death of two-year old Rafael Gomez in September 2003.

While it is natural and understandable to want to assign blame and responsibility for Rafael's death, it is the duty of the fatality committee to review information, ask critical questions and to arrive at recommendations that provide direction, strengthen and, if needed, correct systems that have child safety and welfare as their mission.

This review focuses on the Gomez case and findings are specific to this case. In its efforts to gather information for this task, the Committee reviewed documents from the case record, the Kids Come First (KCF) Practice Guide to Risk Assessment, Department of Social and Health Services (DSHS) policies and procedures, the December 17, 2003 Office of the Family and Children's Ombudsman (OFCO) report and chronology of the Gomez case, the Zy'Nyia Nobles Fatality Review Report, the Lauria Grace Fatality Review report, and various articles and reference materials. The Committee interviewed 16 people who were directly involved in the Gomez case. These individuals included the CA social workers who had been assigned to the case over the course of two years, CA supervisors and the area administrator, service providers for the family, the foster parents, the assistant attorney general (AAG) who represented the department in the dependency action, the guardian ad litem (GAL), a superior court judge, and members of the Child Protection Team (CPT) that heard Rafael's case.

The case of Rafael Gomez is notable for its involvement of service providers and professionals, the frequency of CPT staffings, the amount of documentation on the case and the number of reports from professionals who worked on the case. CA supervisors and social workers demonstrated an impressive awareness of the importance of culture and efforts were consistently made to ensure that the family worked with providers who were culturally competent. Social workers and service providers who worked with the family were bilingual and documents provided to the family were written in Spanish.

In addition to the amount of documentation found in this case, it is also significant that the requirements for staffings, home visits, health and safety checks, and supervisory reviews were met. A great deal of work was completed on this case; it is the quality of the work that is in question. At issue for the department is the utilization of any analysis of practice that is primarily based on quantitative analysis. The department must be able to assess the quality of work beyond audits or reviews that only measure meeting timelines or the fulfillment of required activities. This case exemplifies that quantity of work does not always equal quality of work or the safety, protection and well-being of children.

Often cited as a challenge of casework and a barrier to quality practice is the influence of workload. Workload was not an issue in this case. The CA social workers who worked on this case had between 10 – 15 cases. Additionally, the Moses Lake office was going through the

process of becoming accredited while this case was open. This process places additional emphasis on workload and sets the standard for child protective services (CPS) investigation caseload at 15 families and for child welfare services (CWS) caseload at 18 children.<sup>1[1]</sup>

Another issue cited in these types of cases is the number of caseworkers that can be assigned to a case over its lifetime. This was not an issue for this case. There were two child welfare services (CWS) social workers assigned to this case and there was one child protective services (CPS) social worker assigned to investigate the referrals during Rafael's life.

A possibly confounding aspect of this case is that Rafael appeared to be the only child who was physically abused. Maribel Gomez is the mother of [REDACTED], [REDACTED], [REDACTED], Rafael and [REDACTED]. Jose Arechiga is the father of Rafael and [REDACTED] who was born almost one year after Rafael's birth. Jose is step-father to the three older children. The four other children in the family were never known by the department to have been abused during the two years of Rafael's life. It appears for this reason, the case focused almost solely on Rafael. However, this review finds that the pattern, type and number of injuries to Rafael, the parents' use of drugs and their erratic participation in chemical dependency treatment presented a risk to the other children which was either over-looked or never adequately assessed. There was also enough information known about Rafael to rule out accidental or self-inflicted injuries and the reports, evaluations and recommendations from professionals should have caused significant concern about Rafael's safety while in the care and supervision of his parents.

It should be noted that the Committee does not view this case as unusually complicated or difficult. The Committee also believes that there were adequate systems checks and balances in place, and that policies for practice required by the department are sufficient. The department failed to enforce and ensure that policies were followed, that social workers were trained on best practice which was then properly resourced and applied and that child safety was the priority.

It is also important to note that the community stakeholders on the Gomez case who assisted in providing the checks and balances articulated in law, agreed-upon in contracts and supplied by community services did not place the safety of Rafael above the interests of reunification. It is acknowledged by this Committee that these checks and balances are critical in the delivery of public child welfare services. The review of this case indicates that these checks and balances are as vulnerable to bias, flawed decision-making, and mistakes as department social workers and that community stakeholders, courts and service providers must share responsibility not only for the successes in child welfare but also for the tragedies.

This case remains open to CA and on January 8, 2004, a review of medical records revealed that [REDACTED] was treated for a broken leg on December 26, 1999. [REDACTED] was 12 months old at the time and saw three doctors. Two of them, including the physician who evaluated the x-ray, expressed concerns about possible child abuse because the break was atypical. A thorough

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<sup>1[1]</sup> Council on Accreditation Standards 7<sup>th</sup> Edition 1.1, child protective services (Section S10.7.06) and child welfare services (Section S21.11).

review of CA records completed by CA staff indicates that no report of this injury was ever made by any of the physicians as required by the mandatory reporting statute<sup>2[2]</sup>.

The Committee identified the following as issues of concern in this case.

### **Child Safety v. Family Reunification**

The KCF initiative, introduced in the fall of 2000, had four primary goals which included that child safety was the highest priority for child welfare social workers and that “while family preservation is very important to the well-being of the child, the preeminent goal of public child welfare in Washington State is to protect the safety of endangered children”<sup>3[3]</sup>.

The single minded emphasis on reunification in the Gomez case eliminated the possibility for consideration of an alternative or concurrent permanent plan for Rafael. The goal of reunification in this case continually placed him in danger of abuse and injury.

### **Similarities in the cases of Rafael Gomez, Zy’Nyia Nobles and Lauria Grace**

The factors that appeared to most significantly contribute to the tragic death of Rafael were also seen by the fatality teams that reviewed the death of Lauria Grace in 1995<sup>4[4]</sup> and Zy’Nyia Nobles in 2000<sup>5[5]</sup>.

It is startling to conclude that many of the issues raised in the Grace and Nobles’ fatality reviews are more similar than different to Rafael’s case. This report will address those similarities. This report will also examine the trenchant nature of the thematic issues and make recommendations on what is needed to compel and assist systems to make changes.

### **Influence and impact of chemical dependency issues and mental health**

Professionals who provided case management and services to the family, including CA social workers and contracted service providers, did not demonstrate an understanding of the behavioral and characterological indicators of addiction, treatment and recovery.

Chemical dependency and addiction are prevalent in child welfare cases and the case of Rafael Gomez is no exception. His parents’ use of substances was a significant focus of the case and yet their failure to participate in and follow their course of recommended treatment was not recognized by their caseworker or by the decision makers on this case. Verbal and written reports and evaluations from chemical dependency providers clearly stated that the parents were having difficulty complying with their recommended treatment plans. These reports, however, were

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<sup>2[2]</sup> RCW 26.44.030 requires suspicion or belief of child abuse or neglect be reported to either CPS or law enforcement by mandatory reporters.

<sup>3[3]</sup> Kid’s Come First press release, August 2000.

<sup>4[4]</sup> Lauria Grace died in February 1995 while her case was open to CA. A fatality team was convened to review and present a report on her death to CA.

<sup>5[5]</sup> Zy’Nyia Nobles died in May 2000 while her case was open to CA. A fatality team was convened to review and present a report on her death to CA.

subject to the interpretation of the CWS social worker who concluded that the parents were succeeding in treatment.

CA social workers are expected to understand the basic dynamics of chemical dependency and mental illness as risk factors for child abuse and neglect. They do not have the expertise to recognize or negotiate the complicated dynamics of chemical dependency and addiction nor is it reasonable to expect that they have this expertise. Certified chemical dependency professionals (CDPs) work daily with CA social workers and are available throughout the state.

Social workers also do not have the expertise to diagnose mental illnesses. They use contracted or independent professionals to evaluate mental health issues and then consider following-up on the recommendations of these experts, incorporating the information into the service plan. This report will examine ways to increase and improve collaboration with these professionals in order to achieve better and safer outcomes for children and their families.

### **Communication**

During the Gomez case, a great deal of information was generated and gathered. Many individuals from an array of institutions and agencies had contact and interacted with the Gomez family; these individuals included professionals and para-professionals, service providers, and CA social workers. Evaluations, assessments, medical evaluations, and reports are found throughout the record. Information about Rafael's health and well-being, his injuries, his development and the parents' progress with the caseplan was not accurately shared among the professionals and decision makers in this case. Information that was shared was not done so openly or objectively and it does not appear that the service providers, particularly physicians, were aware of evaluations and information others had that might have altered their assessment, opinions or recommendations.

While the Gomez case was open to CWS, CPS investigations were conducted and information about these investigations does not appear to have been incorporated into the decisions made by CWS. Although concerning, this phenomenon is not uncommon when social workers define their responsibilities and actions by program.

In the Gomez case, the CPS social worker and CWS social worker strictly defined themselves by program, with the CPS social worker as the investigator and assessor of safety and risk and the CWS social worker focusing only on the service plan and reunification of the family. This strict role definition was reinforced by the supervisors on this case who adhered to the view that the programs and responsibilities were separate rather than seeing the need to openly share information, collaborate and coordinate their activities, sharing the responsibility for the safety of and risk to all the Gomez children.

There is no CA policy requiring collaboration when a child has an open case in CWS and a report of abuse or neglect is made regarding the child. While shared decision-making, supervisory conferences and other staffing procedures are in place with CA, this case exemplifies the importance of a coordinated effort between CPS and CWS when families have cases open to both programs.

## **Bias, Intuitive Judgment and Critical Thinking**

As the findings in this report demonstrate, there was ample information available to raise serious questions about the safety of Rafael in his parents' home, the parents' compliance with the court-ordered services and the plan of reunification.

The Committee's observation is that bias in favor of the parents, which is addressed throughout this report, contributed significantly to the manner in which this case was managed and in the way that information was interpreted, viewed and presented to others. Any information that may have reflected negatively on the parents or would have challenged the permanent plan of reunification was dismissed, re-characterized, or ignored. Those who expressed concerns about Rafael's safety, including foster parents and physicians, were discounted or ignored. The CWS social worker would or could not view the parents objectively and he consistently believed their explanations and versions of events over anyone else's.

While it is clear that the social worker's bias was powerful, why were so many others in the case similarly inclined to support the plan of reunification despite serious concerns about the source and severity of Rafael's injuries? One could argue that there was a failure to share information. That may be true, however, why did others making decisions in this case fail to ask probative questions that challenged, confronted and further-developed information that seemed necessary to decision-making on this case?

It is evident in the review of case notes, letters written on behalf of the parents, reports and evaluations and in interviews conducted by the Committee that there was a failure on the part of the department social workers and supervisors, the GAL, the court, the AAG and service providers for the family to think critically about the very concerning elements and facts of this case. It is also evident that the CWS social worker and several of the service providers assigned to Rafael's case during the last 12 months filtered information, persistently favored the parents, viewed Rafael as the problem and acted as advocates for the parents in every way possible including supporting Rafael's return to their care. Almost all of those interviewed by the Committee identified reunification as their mandate.

This report will examine the systems in place that influence decision-making in child welfare cases and will offer recommendations that may have greater effect in controlling for the powerful influence of bias.

## **Case Overview**

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The case of Rafael Gomez begins in August 2000 approximately one year prior to his birth. On 8/16/00, Rafael's mother was involved in a car accident. The three oldest children were in the car with their mother. The mother was determined by law enforcement to be intoxicated at the scene and was charged with driving under the influence (DUI). A referral was made to CPS and the three children were placed into protective custody. The mother denied the incident to CPS social workers investigating the case.

After a CPT staffing, the children were returned to her care with the agreement that she would participate in treatment. The mother was referred to a local chemical dependency treatment provider for an evaluation. She was found to be dependent on alcohol and an abuser of cocaine. Intensive inpatient (IIP) treatment was recommended. The case was closed in early October 2000. The mother did not follow-through with any of the treatment recommendations<sup>6[6]</sup>.

In July 2001, a CPS referral was received from a hospital social worker reporting the mother to be positive for cocaine in the third trimester of her pregnancy. The mother admitted to using cocaine although denied regular use. She reported that she had been receiving regular prenatal care at a local health clinic. Medical records from the clinic showed no evidence of any prenatal care. The mother was admitted to the hospital over concerns for her pregnancy and was discharged the next day. The mother agreed to participate in follow-up prenatal care, however, failed to do so between July and the date of Rafael's birth.

On 8/7/01, Rafael Arechiga Gomez was born at home in a car. The mother and Rafael were transported to the hospital by ambulance. Jose Arechiga was now living with the family.

Rafael was a full term delivery, weighing 7 pounds, 2 ounces and measuring 20 inches in length. He tested positive for cocaine and methamphetamines at birth. He was in the hospital for three days. His newborn screening tests were normal. Rafael had mild jaundice for a few days after birth but did not require treatment. He was noted to have Mongolian spots on his back and buttocks.

Upon discharge from the hospital, Rafael was placed in foster care with the G foster parents who cared for him for the first ten months of his life, excepting a brief period when a relative placement was attempted. This was the first drug-exposed newborn that the G foster parents had cared for and it was an adjustment for them.

Rafael received extensive medical care throughout his life and, while in the care of his foster parents, he received regular well-child care. Medical reports from this period indicate that Rafael exhibited symptoms that were likely related to his prenatal drug-exposure. He was sensitive to stimuli and often was fussy. At six weeks of age he was noted to be colicky. These symptoms abated and Rafael's health stabilized. His development was noted to be normal by his medical care providers.

On 8/7/01, a 30-day shelter care hearing was held. The permanent plan for Rafael was reunification with his parents who agreed to complete services including chemical dependency evaluations and treatment, psychological evaluations, and supervised visits with Rafael. A GAL was assigned to the case.

Supervised visits began with Rafael in October. These visits occurred up to three times per week and lasted two hours. The mother and father would usually both attend and they were often

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<sup>6[6]</sup> The information in this report on chemical dependency evaluations and treatment compliance was taken from the case record. The treatment provider declined to be interviewed citing 42 CFR regulating federal confidentiality law.

accompanied by one or more of their other children. A home support specialist (HSS)<sup>7[7]</sup> was assigned to the family to assist with supervised visits which began in October. She continued to work with the family throughout this case.

The HSS's impression of the family is generally positive. The mother is observed to be an excellent homemaker, her cooking and emphasis on having a clean and tidy home are noted. The mother stays at home and the father is employed at a local dairy. While the HSS finds occasion to offer guidance to the father about his physical play with Rafael, she generally is impressed by the parents and observes both parents and the siblings to be affectionate with Rafael and happy to see him at visits.

The parents began urinalysis (UA) testing in August 2001 and, between August and December, both parents tested positive for cocaine and/or amphetamines frequently on a weekly basis. Both parents were referred to separate, local chemical dependency providers to begin their evaluations. A Parent Child Assistance Program (PCAP) worker was assigned to work with the mother and visit her regularly. This assignment was scheduled to last over the next three years.

The mother's treatment recommendation was again for IIP treatment lasting three to six months. A 30 day bi-cultural program was available for Spanish-speaking adults which the mother began on 10/01/01. On 10/5/01, the mother left treatment.

The father was referred for his chemical dependency evaluation in November. There is no indication that the father followed through with the evaluation.

In October, Rafael's aunt and uncle began the process to become licensed caregivers for Rafael. On 12/03/01, Rafael was moved to his relatives' home. They were well-prepared for his arrival. Soon after the move, Rafael's aunt expressed an unwillingness to continue to care for him due to his crying throughout the night. Rafael returned to the G foster parents on 12/12/01.

In mid-December the mother admitted to relapsing and requested a return to IIP. The mother was re-admitted to Sea Mar in January of 2002 and was reported as successfully completing treatment on 2/13/02 with a referral and recommendation for intensive outpatient treatment. Between March and October 2002 there were documented negative UAs but no indication that the mother had begun the recommended treatment.

In January of 2002, the father was referred for another evaluation at PARC. His UAs for January and February were negative. On 2/14/02, the evaluation found the father to be an abuser of alcohol and cocaine. His treatment recommendation included completion of an outpatient treatment program for one year and random UAs throughout that period. The father began treatment in May and negative UAs were documented from April through November on a weekly basis.

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<sup>7[7]</sup> Home support specialists are employed by CA and are referred by social workers to assist families with accessing services, organizing and maintaining the safety of a home, parenting, budgeting, transportation, visitation, transportation, etc.

In April 2002, the case was staffed with the CPT. The department recommended that Rafael's visits with his parents be unsupervised and that a request be made to court to begin overnight visits sooner than the next court date in July so that Rafael could be reunified with his family in July. The CPT agreed with the recommendations. Rafael began visiting with his parents and siblings in their home. The foster parent reported to the social worker that Rafael was demonstrating increased anxiety when he returned from the visits.

In May 2002, the court order was modified to allow for overnight visits and Rafael began visiting with his family overnight and for weekends. During this period, the case notes reflect a change in the relationship between the foster parents and the social worker. The notes reflect that the social worker is keeping the foster parents advised of the case plan and progress. The foster parents appear to be withdrawing contact from the social worker and this appears to be the beginning of an increasingly tense relationship between the foster parents and the department.

On 5/24/02, Rafael had his first overnight visit with his parents. The mother began to express concerns about the care that Rafael was receiving from his foster parents. On 5/31/02, a referral was made for FPS services. The social worker, after consult with her supervisor, the GAL supervisor, and the AAG, decided to return Rafael home. The social worker notified the foster parents that Rafael would be returning home in five days. On 6/4/02, Rafael went to his parents' home for an overnight visit and did not return to the foster home. Rafael was not ordered reunified by the court; a consult with the supervisor, AAG and GAL, resulted in an "extended visit" so that Rafael could remain home.

On 6/10/02, FPS began with the family. By the month's end, reports from the FPS provider stated that the family was functioning well, the parents had "superb" parenting skills and that they were working well with the provider.

On 7/31/02, two referrals were received by CPS. Both were determined to be information only, so no investigation was required. The first referral reported that the mother had been drinking alcohol. The second referral reported that the mother had been observed to slap Rafael in the mouth and cheek. Both reports were made by a roommate who had reportedly lived with the family for two months.

On 9/1/02, the case was transferred to CWS social worker T.

On 9/14/02, [REDACTED] was born.

On 9/21/02, CPS received a referral from a local hospital alleging physical abuse and neglect of Rafael who was found to have a right tibial fracture and bruises to the right, lower abdomen and to the left side of his body. Rafael's leg was put into a cast and he was placed in the G foster home. His three older siblings were placed with the S foster parents after the parents signed a voluntary placement agreement. [REDACTED], who was in the hospital being treated for [REDACTED], was returned to his parents care on 9/25/02.

According to the CPS investigation, Rafael was at home playing on a toy truck and broke his leg. His uncle, living in the home at the time, was supervising him while the parents were reportedly

at the hospital with [REDACTED]. The explanation of the injury appeared plausible and a review of the fracture was requested. A consulting physician in Spokane reviewed Rafael's case who concluded that the fracture was probably accidental or a "toddler fracture". As Rafael was known to have Mongolian spots, he assumed that the alleged bruises were probably Mongolian spots. There were no pictures of the alleged bruises for review.

A CPT was held on 9/26/02 with the department recommendation that the children be returned to their parents. The CPT agreed with the recommendation and the children were returned to the care of their parents. The CPS allegations were unfounded.

On 10/07/02, a CPS referral was received alleging neglect of Rafael who was reported to have a bump and bruise on his forehead. The PCAP worker making the report also alleged that Rafael was losing weight because the mother would only allow him a certain amount of food. On 10/17/02, the CPS social worker visited the mother and Rafael. The mother denied that Rafael had been injured and said that he did hit his head on the crib bars. She also said that she was monitoring his intake per the doctor's information that drug-affected children were prone to gorge but was not limiting his food. The social worker did not note any injuries on Rafael and found the mother's explanations plausible.

In October of 2002, a non-compliance letter from the treatment provider stated that the mother would be discharged if no individual appointment was completed. This pattern was repeated on a monthly basis with the mother failing to comply with her treatment expectations. The mother would then attend a group or two and be back in compliance for a short period.

In the same month, the mother began a pattern of reporting minor injuries to the CWS social worker with various explanations for the injuries which included accidents and self-injury. The mother also provided various and conflicting explanations for the source of Rafael's injuries to medical providers.

On 12/07/02, a CPS referral was received from a local hospital reporting physical abuse and neglect. Rafael's mother took him to the hospital for left leg pain stating he had slipped on a wet floor. Rafael was transferred to another hospital and was noted to have several injuries including a left femur fracture, an older skull fracture, healing burns to his left hand, a pinch-like bruise to his right ear, a scab on the back of his head and possible burns to his tongue. The physician felt that Rafael's multiple injuries were not compatible with the history given by his mother and were most consistent with child abuse. Rafael was admitted to the hospital for treatment, both his legs were placed in casts and upon discharge he returned to the G foster home. Several physicians saw Rafael during this hospitalization and expressed concerns to the department that the injuries were concerning for child abuse. The other children were not placed out of the home during this incident. Supervised visits began with Rafael within a week of his return to the G foster parents.

Soon after this injury, the parents reported additional disturbing behaviors from Rafael. This began a pattern of reports that led some to believe that Rafael had neurological or other problems related to his prenatal drug-exposure.

The mother and father, continuing with the pattern of near-termination from their chemical dependency treatment, were referred for psychosocial evaluations which were completed in January 2003. The mother was found to have mental health issues which were cause for concern. There was a recommendation that she receive treatment and the FPS provider was identified as the person who would follow-up with these issues. The psychosocial evaluator was asked to provide addendum recommendations about reunifying Rafael with his parents and the evaluator did so, recommending that Rafael return to his parents care. Also in January is a neurological evaluation of Rafael which showed normal results.

In February, a CPT staffing was held with the department recommending that Rafael be returned home. There was a disagreement on the CPT recommendation for return and a request that the medical records be reviewed by a medical expert. A follow-up CPT was recommended after the results were received.

A consultation with a physician was scheduled and the medical records were reviewed. The physician reported the discovery of a second skull fracture and, while he could not conclude definitively that the injuries were the result of physical abuse, stated that the parent's explanations for the injuries were questionable and that the injuries were highly concerning. This report is interpreted by Rafael's caseworkers to mean that there was no medical evidence for physical abuse. The CPS allegations were inconclusive for physical abuse and founded for neglect.

The court hearing in mid-March resulted in the first time that the court had heard evidence on the record. The foster parents sent a letter and pictures to the court expressing their serious concerns about the plan to return Rafael to his parents. The social worker and the GAL both recommended the return home. The court, understanding that a CPT was scheduled to hear the reunification issue, deferred the decision to return to the CPT.

Rafael returned home for an "extended visit" on 3/21/03. He did not return to foster care.

On 3/25/03, the CPT, missing two of the three members who disagreed on the reunification plan, heard from the social worker about the results of the medical consult. Rafael and his parents were present for the CPT. The CPT agreed that Rafael should be reunified with his parents.

Over the next six months, the parents continued their chemical dependency treatment with minimal compliance. The mother reported to the CWS social worker that she was stressed by Rafael's care due to his "neurological" problems and persisted in her characterization that injuries observed in March, May, July and August were accidents or self-inflicted. Rafael was reported to be sleeping for many hours at a time, and many home visits from the HSS found him asleep during the day. FPS continued during this period with regular reports about the parents' positive parenting skills, strong family bond and nurturing care of their children.

In August, the mother began to express a desire to end her chemical dependency treatment and stated she had almost completed the treatment. The social worker encouraged her to get a letter confirming that she would be completing the treatment and made plans to dismiss the dependency. The chemical dependency provider reported that the mother would not complete her

treatment by the end of August. The FPS provider ended his services with the family. His report was positive.

In early September, the mother requested assistance from the social worker on a matter facing her in criminal court and the social worker provided her with a letter supporting her success in treatment and her progress in overcoming many of her past problems.

On September 9, the social worker received a phone call from the mother telling him that she had been feeding Rafael who had passed out and fallen. The social worker told her to take the child to the hospital. The mother and Rafael arrived at the hospital and Rafael was not breathing. Rafael was airlifted to a Spokane hospital and died that same day.

## **Analysis of Issues**

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### **Child Safety v. Family Reunification**

Child safety is stated as the highest priority of public child welfare in Washington State. Balancing the child's needs for safety and permanence with the goal of keeping a child with their family can be a challenge for child welfare social workers. There is widespread agreement among child welfare professionals, the courts, community stakeholders and child and family advocates that children should be with their families. When children cannot be safely cared for by their parents, social workers and courts face the difficult decision of where the child can best be safely parented.

In this case, safety was not prioritized. The preeminent fact of this case is that Rafael sustained repeated serious injuries only under the care and supervision of his parents. The explanations for these injuries, as provided by the parents, were numerous and at times conflicting. The court and CA social workers and supervisors involved in this case wanted proof that Rafael's parents caused his injuries. An unnecessarily narrow standard was used as a basis for their decision-making. There is frequent mention in case notes and in staffing information that there was no "evidence" that the injuries were a result of child abuse. The fact that physicians had expressed concerns about the nature of the injuries appeared to be of little consequence in the assessment of safety. The department social worker and other decision-makers did not appear to adequately consider the known circumstances of where and when Rafael was injured and, until they had conclusive proof of who had harmed him, were willing to risk his safety by returning him repeatedly to the home of his parents.

It should be emphasized that when the parents agreed to a dependency of Rafael, they agreed to the facts that they had abused or neglected Rafael and that they were not capable of adequately caring for him. While these facts were agreed to when Rafael was an infant, the fact that he sustained ongoing and serious injuries each time he returned to their care should have continued to raise questions about the parent's ability to safely care for and supervise him.

It is not the role of social workers in Washington State public child welfare to prove, beyond a reasonable doubt, that abuse or neglect occurred. While proof beyond a reasonable doubt is the criminal standard, child welfare cases are managed in the civil arena where guilt or proof of abuse is not a requirement for intervention. Based on interviews and review of written documents, it is evident that a higher than necessary standard of proof was used by the department and the court in this case. The Committee finds it difficult to understand the emphasis on proof when the risks to Rafael were so numerous.

The legislature recognizes and supports a risk assessment practice in child welfare and allows for risk-based intervention with children in dependency actions.<sup>8[8]</sup>

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<sup>8[8]</sup> RCW 26.44.030 (13) "The department shall use a risk assessment process when investigating alleged child abuse and neglect referrals. The department shall present the risk factors at all hearings in which the placement of a dependent child is an issue."

Risk assessment, as practiced in child welfare, is the use and application of factors that have been identified through research as most predictive of future abuse and neglect. The risk factors in the Gomez case included a history of serious injuries to a vulnerable child, chemical dependency and mental illness. Additional risk factors included dangerous acts, poor social support, bonding to Rafael, recognition of problem, and level of cooperation.

The department social worker and the courts appeared to have ignored the many and serious risk factors to Rafael.

Reunification was the goal and focus of this case. Permanent plans are entered in juvenile court proceedings for children under the supervision of the court, with a primary and secondary plan. In Rafael's case the plan of reunification was entered as the primary plan with no secondary plan identified. The plan of reunification for Rafael never varied from the time that it was entered in September 2001. Interviews with the department social workers and supervisors indicate that there was never any consideration of a secondary or concurrent plan.

It is acknowledged that a dependency action on one child in a family of five children is unusual. It is also unusual for the siblings of a seriously injured child to be perceived as safe and well-cared for. The mother artfully perpetuated the notion that Rafael's behaviors were the problem, ergo Rafael was the problem. The record indicates that Rafael's oldest sibling also saw Rafael as a problem, making statements that the home and family life had been better when Rafael was not there. The social worker endorsed this notion. Believing that Rafael's injuries were accidental and believing the parents had exceptional parenting skills as evidenced by the care of their other children made it easier for all involved to continue with a reunification plan.

This type of superficial thinking resulted in the lack of careful and critical examination of the issues that were placing Rafael at risk. It appears that the parents, particularly the mother, may have been scapegoating Rafael and that he alone was the target of abuse. There is no indication that this possibility was ever considered.

Many systems were included in making decisions on behalf of Rafael. These systems most prominently included the judicial system and the GAL. As recognized earlier in this report, the Grant County Court and the AAG not only supported reunification but regard it as the mandate in child dependency cases. It is incumbent upon those in the judicial system to understand that the safety of children may at times conflict with reunification and, when this happens, the safest option is for the child to be in another permanent home.

The KCF initiative was introduced by the department after the death of Zy'Nyia Nobles in an effort to respond to issues that were identified by the Nobles Fatality Team. Based on information learned by this Committee and after a review of the similarities in the Gomez and Nobles cases, it does not appear that the concepts and changes introduced by the KCF initiative were followed in this case.

The KCF initiative caused an examination of and a major change in practice with the introduction of tools designed to assist social workers in decision-making on child safety, risk assessment, reunification and transitioning children home. These tools include:

- Intake Risk Assessment
- Safety Assessment
- Safety Plan
- Investigative Risk Assessment
- Reassessment of Risk
- Reunification Assessment
- Transition Plan

The safety assessment and plan and the investigative risk assessment help workers identify specific safety threats and risk factors that should then inform safety and service planning.

The safety assessment asks eight questions targeting threats to children. There are two questions that apply to Rafael's case: one about the escalating pattern of neglect/incidents/injuries involving any child in the family and another about the caregiver's judgment, impulse control, reality contact and/or ability to parent. Both of these are relevant to Rafael's case and should have highlighted the danger to he and his siblings. The investigative risk assessment lists risk factors, categorizing these factors into risk domains. There are several areas that rate as high risk in this case across several of these domains. The CPS social worker completed the safety and risk assessments in this case.

The ongoing risk assessment helps social workers identify how plans are affecting risk levels. The reunification assessment assists social workers in decision-making about returning children home and is designed to be used in decision-making forums such as CPTs. If the decision is made to return the child, the transition plan assists in identifying and establishing a safety plan for their return. The plan also addresses continuity for children with the goal of ensuring a smooth transition with as few disruptions as possible.

The CWS social worker did not use any of the KCF tools in his work. An analysis of reunification did not occur apparently because reunification was a foregone conclusion. There is no evidence that a transition plan was developed other than an extension of visits prior to return. Rafael's transitions home were abrupt with little planning for safety and continuity of care.

The department should expect that social workers are following policies and using the tools that are designed to assist in assessing safety and risk and evaluating caseplans.

### **Similarities in the Cases of Rafael Gomez, Zy'Nyia Nobles, and Lauria Grace**

#### 1. Age of children and placement history.

In all three cases, the child who was later killed had been placed at birth by CPS. In all three cases, the child essentially spent all of their infancy and toddler years (two - three years) in foster care before being returned to the care of their parent(s). There was ample evidence that all three children had been thriving in care and had become attached to their foster parents. There is every reason to believe that, in each case, the child had minimal attachment with their parent(s) at the time of reunification, as an inevitable consequence of their placement history and thus needed an intensive transition and re-bonding process.

Although visits between the children and their parent(s) did occur prior to the child's return home, there is strong evidence to believe that the lack of attachment between each child and their parent(s) was never confronted therapeutically or supportively by the agency. It is expected that each of these children was attached to their foster parent. It seems highly likely that each of these biological parents struggled post-reunification with a grieving, unresponsive or defiant pre-school child, whose understandable attachment to their foster parents posed painful quandaries for the parents.

The Committee sees a pattern in the agency's lack of recognition of the child development dynamics involved in attachment and loss, and lack of intensive services to help these parents build a bond with their child after years of foster care placement.

## 2. Injuries after reunification.

All three of these young children were known to have suffered injuries in the care of their parents after being returned home, prior to the fatality. In the Nobles case there was documentation of a scalded foot and concerns by professionals about harsh discipline. In the Grace case, there were several incidents of head injuries and reports of the mother striking the child aggressively. In the Gomez case, Rafael suffered broken bones twice, skull fractures, burns and several lacerations during periods of reunification.

With the exception of physicians on the Gomez case, professionals in the three cases appeared to miss the indicators of physical abuse, even in its most extreme form. The social workers did not connect the dots, failing to think critically about the nature of the injuries. Supervisors also did not appear to recognize the indicators of physical abuse in these cases. These children did not sustain injuries in any care other than that of their parents and there is no evidence in any of the reviews that this was regarded as a significant issue.

Because of early recognition and intervention in child abuse and the changing pattern of child care, the term "battered child syndrome" has undergone an evolution. "Battered child syndrome" was originally described as altered parent and child behavior, malnutrition, and multiple types and ages of inflicted injury. There is increased recognition of child abuse from laypeople to professionals and more children are seen by a variety of people including child care providers and alternative caregivers. As a result of these changes, children are less likely to suffer the full array of abusive injuries originally described and are more likely to suffer a "single or brief series of severe assaults." (Helfer, Kempe, Krugman)

All three of the children suffered exactly this type of abuse and given their age, vulnerability and the history of their caregivers; the professionals should have recognized the risks for and signs of physical abuse.

The Committee sees a pattern in the lack of appropriate alarm shown by the agency to these events, especially given the parents' long term troubled histories, the vulnerable age of the children, and their recent return home.

### 3. Chemical Dependency/Mental Health Concerns Unmet.

As in the Gomez case, both of the prior fatality teams emphasized that the agency dismissed signals that the parents needed far more rigorous treatment for drug/alcohol addiction and/or mental health treatment. Partial compliance with court-ordered services was interpreted as adequate by the social worker, without the expertise of a specialist. The concept of truly random UAs was misunderstood in all three cases. Parents were easily able to evade detection and manipulate their social workers when they clearly were in denial of any need for treatment. There was a lack of understanding of the difference between signs of actual recovery and just “going through the motions”. In all three cases, the parents actually received little treatment, but were described as fully complying. In all three cases, the behavior of the parents included lies, blaming others, triangulation of professionals, as well as anger and intimidation of others; all classic addiction indicators.

*“The issue of Rochelle Grace’s chemical addiction was not accurately assessed or addressed before or during Lauria’s return to her mother. Lack of understanding of the behaviors and possible consequences of her drug use appears to have been a major contributing factor in the circumstances leading to Lauria’s death. The court ordered plan to send Lauria to Childhaven and to obtain random urinalysis tests (UAs) from Rochelle Grace did not appear to be strongly supported by the caseworker. The UAs obtained were not random. Possible drug abuse was minimized by the caseworker in spite of Rochelle Grace’s history of cocaine addiction and allegations from community members of ongoing drug use.” (Lauria Grace Fatality Review, August 12, 1995).*

*“Ms. Sconiers’ chemical dependency issues were never adequately addressed...The social workers involved in the case never enforced the recommendation that Ms. Sconiers follow through with chemical dependency treatment. Furthermore, it appears that Ms. Sconiers was given the message that marginal compliance with the TASC urinalyses (UA) was sufficient for reunification with her children.” (Zy’Nyia Nobles Fatality Review, November 20, 2000).*

In two of the three cases (Gomez and Nobles) mental health problems of the mother were not adequately treated.

The Committee sees a pattern in the failure of staff to understand the dynamics of addiction and a failure to utilize appropriate consultants to help with planning in these cases. Similarly, assessment and treatment of mental health concerns was not properly completed.

### 4. Inability to Use New Information

In all three cases, a striking uniformity is found in the workers’ insistence on a point of view not shared by others, namely that all signs indicated it was safe and timely for the child to return home. Reports from community members, other professionals and foster parents, alarmed about events or injuries they had witnessed, were rejected as unreliable or biased. In none of these cases is there evidence that disturbing reports were taken seriously, staffed conscientiously, or even investigated. There was no evidence of anyone actively taking the role of “devil’s advocate” in questioning the worker’s return home plan. While CPT and supervisory review did

occur, the worker's view was presented, without primary source material to document his/her description of the case status and parents progress in services. Much of this review seemed to be cursory, with no mandate for rigorous debate expected.

The Committee sees a pattern of inadequate critical thinking on the part of the workers involved in these three fatalities and lack of agency structure and processes to support effective review of worker decision-making in such cases.

## 5. Relationship and Communication with Foster Parents

In two of the three cases, the children were bonded and attached to their foster parents as a result of being placed at birth. Equally, the foster parents were bonded and attached to the children. It is understandable and expected that foster parents would develop affection, care and attachment to the children in their care particularly when children are placed as infants and remain until they are toddlers. The developmental gains during this period include language development, movement, emotional expression and bonding with caregivers.

The foster parents were characterized by the department as overly-attached to the children. This was viewed as somewhat problematic and when foster parents expressed emotion, anger or concern on behalf of the children, the department responded by accelerating the transition of the children home.

Foster parents expressed that they did not receive adequate communication on the case. They expressed feeling taken advantage of and that their attachment to the child was discounted.

In these two cases, the Committee sees a pattern of failure to appropriately include foster parents in caseplanning, a pattern of discounting legitimate interest and concerns as expressed by foster parents and a pattern of failing to recognize that attachment between foster parents and the children they care for should be expected and regarded as a strength rather than characterized as an intrusion.

## **Influence and impact of chemical dependency and mental health issues**

The findings in this report demonstrate the failure of the department to accurately assess the progress of Rafael's parents in their chemical dependency treatment. The CWS social worker and others did not recognize the behaviors, personality traits and lengths that the parents, particularly the mother, went to in order to obfuscate the facts and avoid her participation in treatment.

It appears that this mother was highly capable of getting her needs met. She was able to engage others to assist her in activities that she was capable of doing on her own. Examples of these interactions include having the social worker and GAL advocate for her in criminal court and having the HSS her in completing application for SSI for Rafael although there was no indication that he was eligible for SSI, having the father's physician offer a medical opinion about Rafael without an examination. Many of these "helpers" moved beyond the boundaries of their role to

assist the mother and her interactions suggest a manipulative quality that “helpers” did not appear to recognize.

While clean UAs might have been a positive indicator of progress, missed UAs, evading treatment, missing appointments and frequent near-termination from treatment should have been regarded as highly concerning. The social worker acted as the mother’s advocate and in doing so, allowed her to escape accountability for treatment compliance and recovery, accepting her excuses and explanations. Recovery requires diligent compliance with treatment expectations and the mother did not demonstrate recovery. Reports of her sobriety and drug-free lifestyle were the opinion of the social worker rather than an evaluation provided by her chemical dependency provider.

The Committee saw little attention given to the mother’s mental health issues and believes that the “treatment” she received was delivered by professionals unqualified to deliver the level of treatment that she needed.

The mental health evaluation of the mother indicated problems that should have raised concerns about her ability to safely parent her children. The evaluator noted her moderate to severe levels of anger, poor impulse control and mood swings that could lead to “dramatic and unexpected behavioral outbursts”. The FPS provider who worked for the mental health evaluator was asked to provide this therapy to the mother. The FPS provider focused on family functioning and parenting. The mother needed individual therapy and possibly further evaluation to assess the source and degree of her anger, mood swings and behavioral outbursts.

The record indicates that the mother expressed having problems with Rafael and his behaviors. She was reportedly stressed by the level of care that she reported he needed. There was some indication that she might be depressed. Her relationship with Rafael was also different than the relationships with her other children due to his placement at infancy. Given the assessment of her mental health, it is concerning that little consideration was given to how her problems might be manifested in caring for a little boy that she described as having problems.

Finally, assessing and treating addiction and accessing mental health treatment pose individual challenges. When clients have mental health issues and chemical dependency use or addiction issues, consideration must be given to a dual diagnosis treatment modality. This type of treatment is not well-resourced and can be a challenge to access. However, the Committee believes that this type of service, which incorporates attention to mental health while assessing the client’s use of substances as a possible mechanism to cope with mental health problems is critically important to successful treatment.

## **Communication**

Communication in child welfare cases happens at a variety of levels and in a variety of ways. Social workers provide verbal and written reports for staffings, court, service providers and others. They take case notes and gather written materials, which include evaluations and reports from service providers including physicians, educators, chemical dependency providers, mental

health providers, and others. The Committee believes objective communication sharing, vital to informed decision-making, was one of the weakest aspects of this case.

As noted prior, a great deal of information was generated and gathered in the course of the Gomez case. Most of this information was held by the social worker and was interpreted by him as to content. While the reason for this interpretation appears to be his clear bias in favor of the parents, the department must attend to the issue of information sharing. When social workers can pick and choose the information to share, objective analysis of information and decision-making is threatened.

In the Gomez case, the CPT heavily relied on information from the social worker. The social worker provided summaries, rather than objectively sharing reports, documents and the opinions of experts, particularly physicians, with the CPT. When asked why he did not share with the CPT that the court had deferred to their decision to return and that Rafael had already returned home on an “extended visit”, the social worker stated that he would not normally share that type of information. It is unclear why court orders and Rafael’s current location was not shared with the CPT. It also appears that the CPT did not have a full understanding of concerns as expressed by physicians.

Foster parents should be invited to CPTs so that they can present and answer questions that the CPT might have about the child. The foster parents were not invited routinely to the CPTs. They were asked to attend the final CPT and refused largely due to the fact that Rafael had gone home and they felt that their opinions and thoughts about the case had been so routinely discounted that they would not be listened to at that point.

Law enforcement and CPS did not appear to work collaboratively or communicate effectively on this case. The CPS referrals on the injuries to Rafael resulted in reports to law enforcement for investigation. The December 2002 referral of multiple injuries to Rafael resulted in a law enforcement investigation that was ongoing through Rafael’s return home. Different local law enforcement jurisdictions were involved in the Gomez case highlighting the need for ongoing, clear communication. There is no information in the case record that indicates the status of the investigations or that CPS and law enforcement communicated on these investigations. Early coordination and collaboration between law enforcement and CPS is a critical component to the successful investigation of allegations of child abuse that result in serious injuries and risk to children.

The internal sharing of information was inadequate on this case. The case was open in both CPS and CWS. The case record indicates that the CPS worker did attempt to share information with the CWS social worker; however, there is no indication that the CWS social worker gave consideration to or incorporated any of the information into the caseplan. When cases are carried across programs and information is not shared, the safety of children may be compromised and plans are not reassessed.

The Committee believes that there is insufficient practice protocol in place to ensure that information is shared with and between decision-makers in an open and objective way. This limits and compromises the ability of others to make informed decisions. There is great value in

the department practice of utilizing experts for services, evaluation and consultation. However, if social workers are not trained in how to utilize and share this information, the practice is undermined.

### **Bias, Intuitive Judgment and Critical Thinking**

As is seen throughout this report, the team found pervasive individual and system bias contributing powerfully to the death of Rafael Gomez. The literature on bias in child welfare work, particularly the work of Eileen Munro (1996 and 2001), was consulted, as it was in the Zy’Nyia Nobles Fatality Review in 2000. A number of factors Munro describes are found in the Gomez case. Munro describes the strengths and weaknesses of the intuitive versus the analytical style of reasoning, representing a continuum of reasoning with both styles having value.

In this case, it is clear that the CWS worker relied on his intuition to the exclusion of empirical or objective analysis. A more analytical process would have sought out evidence and opinion from outside sources, and considered their factual content objectively. If concerns or quandaries were raised, follow-up inquiries would have been pursued, and then discussion with supervisor/CPS/CWS/area administrator, etc. Evidence or information that didn’t “fit” would be especially valued, as a safeguard against bias. For example, why were these parents repeatedly threatened with expulsion from chemical dependency treatment for poor attendance, while claiming to be in full recovery? Why were Rafael’s reputed self-harming behaviors not seen outside of the Gomez home? Why would people well-known to the family report this seemingly loving mother’s hostility toward Rafael? Why did so many doctors put in writing their doubts about the accidental nature of his many injuries?

Individual open mindedness and a strong organizational culture of critical thinking would have brought many critical facts into the open and into the decision-making process. A supervisory role of devil’s advocate would have repeatedly questioned the bases for the worker’s conclusions and required more complete documentation and explanation from outside experts. A CPT review process that required evidence of the worker’s assertions throughout the case would have given rise to more debate and testing of the hypothesis that this was properly a reunification case. Regular comparing of notes and observations between CPS and CWS workers and supervisors would have revealed a disparity in point of view mandating serious reflection and a higher level of administrative review.

Munro emphasizes that a willingness to change one’s mind in the face of new evidence is a strength. In child protection work social workers need to view their opinions as tentative and open to revision. In the death of Rafael Gomez, the CWS worker proved unable to take that stance and the surrounding systems did not effect the necessary mid-course corrections.

## **Findings and Recommendations**

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The Committee makes the following findings and recommendations based on interviews, review of case records and department policy and protocol, RCW and WAC, contracts, and certification documents. Not all the findings necessitated recommendations, however, the Committee believes that the findings were important to note because of their significance in the case; the findings on “Family Dynamics and Functioning” are illustrative of this point.

### **Fatality Review Process**

#### **Recommendations:**

1. This report should be made available in English and Spanish and be disseminated to department employees and stakeholders connected to this case. The report should be made easily accessible to any others who are interested in this case.
2. The Committee requests that the department provide a response to the Committee on plans to follow or not follow recommendations.

### **Case Management and Practice**

#### **Findings:**

- While workload was not a factor, what may have impacted this case is the manner in which the cases were assigned. The CPS social worker was the only bilingual (English and Spanish) worker in the unit so received all referrals on families that spoke Spanish. The CWS social worker was assigned his entire caseload at one time. His ability to learn his cases and manage his caseload was not given proper consideration by his supervisor.
- All social workers and the HSS assigned to the Gomez case were language certified by the department, fluent in both Spanish and English.
- The department ensured that service providers working with the family were bilingual and demonstrated an awareness of and sensitivity to cultural issues in this case.
- Lack of training and experience by the CWS social worker was a factor in the mishandling of this case. Although not new to the agency, the CWS social worker assigned to the case in the last 12 months had no prior CWS experience. He received no specific training for his new role.

- Rafael had an open CWS case with one social worker and CPS investigations were conducted by another social worker. This resulted in a perceived division of duties with the assessment of safety and risk being the exclusive responsibility of the CPS social worker and the CWS social worker as responsible only for service provision and reunification of the family. There was insufficient coordination and communication between the two programs. There was no evidence of debate, problem solving or joint analysis of the case by the two units.
- This case was not viewed as a high profile case and was not brought to the attention of the area administrator for review other than to consult on an issue relating to involvement of the foster parents. The September 2002 and December 2002 CPS referrals reporting serious injuries to Rafael were not flagged as serious injury and therefore did not come to the attention of the proper chain of command which would have included the area administrator.
- There was an improper emphasis on evidence or proof of abuse in the form of conclusive reports or eyewitness accounts as to the source of Rafael's injuries. Because of this, safety and risk to Rafael and the other children was not properly assessed.
- Rafael spent the first ten months of his life in a Caucasian foster home, growing and developing in a culture different than that of his family of origin. During this time, he developed a bond with the foster parents. While in foster care, Rafael had regular and frequent visitation with his parents. When Rafael was first returned home, he was ten months old, at a time in his development when his stranger anxiety would be high. Rafael's first language would have been English, as spoken in his foster home. While his parents were not strangers, his foster home was the environment known to him and it should be expected that a return home would require great emotional and psychological adjustment.

A transition plan, required by CA, was not developed and implemented. Rafael was returned home abruptly given the amount of time he spent in care and he was not transitioned home in a manner that would have allowed for emotional, psychological and cognitive (including language) adjustment. Also given no consideration was the cultural adjustment that Rafael would have needed to make. The food, routines, social and family environments in his foster home and in his family home were different. It appears that social workers assumed that because Rafael was Hispanic, he would require no adjustment when he returned to his family's home. Each subsequent time that Rafael was returned home, the return was abrupt, with no adequate transition. These abrupt transitions likely exacerbated the stressors of adjustment for Rafael, for his parents and his siblings.

- The KCF tools designed to assess safety and risk throughout the life of a case were not utilized effectively as decision-making tools that would inform practice and service planning for the family. At some points in the case, these required tools were not used at all.

## **Recommendations:**

1. The department needs to reexamine the application of the KCF concepts and the use of KCF tools by CA social workers. The tools may be in need of revision or strengthening in order to be effective. Ongoing training on the concepts of safety as the priority, safety and risk assessment should be required for any worker and supervisor handling cases, particularly when children are being reunified with their families. Additional training is needed for social workers on the issue of the competing interests of safety and family preservation.
2. Consequences should apply when social workers and supervisors fail to follow policy and protocols in practice manuals, policy, RCW and WAC.
3. The department should develop and administer supervisory training on bias and critical thinking. This training should include stressing the importance and value of a “devil’s advocate” or dissenting opinion and how to accept challenges to pre-conceived or developed beliefs.
4. Supervisors should ensure that social workers receive basic academy training prior to carrying cases or when changing positions into programs that they have not worked in prior.
5. The department should implement a protocol for staffing cases when a family has a case open in two or more CA programs.
6. The department should ensure that a report to law enforcement or the prosecutor’s office is made when they learn that a mandatory reporter has failed to report child abuse or neglect.
7. The department should ensure that social workers are trained to flag serious injury, near fatality, high profile referrals so that the appropriate chain of command is alerted.
8. Transition plans should include activities and services that assist children in moving from one cultural experience to another. These activities and services should address daily routines, food and diet, language, etc.  
  
Plans should also include how attachment will be transitioned. Children, particularly those placed at birth, need time to attach to their new caregivers (even when those caregivers are their own parents) and time to separate from their last caregiver. Attachment to biological parents upon reunification should not be assumed. Biological parents as well as foster parents should receive support and assistance as they negotiate the transition.
9. Child care should be put in place when preschool children are reunifying with their families. This provides the child with additional care from a caregiver who can independently monitor the child’s safety and development.

## Child Protective Services

### Findings:

- There were eight CPS reports of child abuse and neglect, from August 2000 through September 2003. The first report was made a year before Rafael was born, six of the reports were made during the two years of his life and the eighth report was made as a result of his death.
- Two referrals were received by the department as Information Only. While they contained concerning information from a person who had direct knowledge of the mother's relationship with Rafael, it appears that the concerns were discounted because the person no longer had a friendship with the mother.
- A letter of complaint was received by the CPS supervisor on 12/13/02 from one of Rafael's treating physicians about the multiple injuries that Rafael sustained on 12/7/02. The physician questioned the decision to return him home after the tibial fracture in September 2002. Attached to the complaint was the discharge summary of December 2002 that expresses a "serious concern of child abuse and leaves no doubt" in the physician's mind that Rafael was physically abused. There is no indication that these documents were provided to the CPT, that the supervisor staffed them with the proper chain of command, with the CWS social worker or CWS supervisor.
- A criminal history check was conducted on the mother in August 2001. The results reflect criminal activity between August 2000 through July 2001 including theft, driving while intoxicated, open container and obstruction charges. There were no additional criminal checks after August 2001. A criminal history request was submitted on the father in May 2002; the results were never received.
- The CPS social worker completed the KCF safety assessment, safety planning and risk assessment tools as required by policy. The assessments do not appear to reflect known information on the case.
- There are documented observations of bruises and injuries to Rafael in the record. There were also two occasions when Rafael's siblings were observed home alone. On one occasion, a provider to the family found [REDACTED] home alone and on another, [REDACTED] was found home alone. None of these incidents resulted in CPS reports.
- The CPS investigations on this family were consistently brief, limited in scope and the findings did not match the information known at the time. The CPS social worker relied primarily on the parents as the source for information and did little collateral checking during the course of the investigations.
- There was little coordination between CPS and law enforcement on any of the CPS reports including investigations of the physical injuries sustained by Rafael while in the care of his parents. It is unclear in the record how law enforcement investigations of

Rafael's injuries were resolved and that the information was incorporated in any way into the case.

- The CPS case was regularly reviewed by the CPS supervisor.

### **Recommendations:**

1. CPS should be required to coordinate investigations with law enforcement at the earliest point possible on serious physical abuse cases. The Committee recommends that the department develop a protocol for serious physical abuse cases similar to the county protocols that define and describe coordination of investigations on sexual abuse cases. "Serious physical abuse cases" are defined by the Committee as those children who come to the attention of medical providers because of their injuries.
2. Medical records of all children in a family, whether they are the identified victim or sibling(s) should be obtained at the earliest point possible in the case.
3. Risk tags on CPS referrals accepted for investigation on any case already open to the department should be assessed at a higher risk.

### **Child Welfare Services**

#### **Findings:**

- The CWS social workers did not use any of the required KCF safety and risk assessment tools in their decision-making and planning on the case.
- The permanent plan for Rafael, entered at the 30 day agreed order of dependency, was reunification. This plan never varied. Professionals interviewed for this report stated that no other permanent or concurrent plan was considered despite the serious nature of Rafael's injuries sustained in the care of his parents and the parents' difficulty in completing recommended chemical dependency treatment.
- The CWS social worker acted as the mother's advocate and ally. The social worker relied on the mother as his primary source of information and did little or no collateral checking to verify information he heard from her. The social worker idealized the parents, particularly the mother, and his objectivity on the case was compromised by this perspective.
- The CWS social worker did not adequately incorporate or value input from the chemical dependency treatment providers thereby allowing the mother to triangulate, manipulate and misrepresent the facts of her treatment progress and plan.
- A documented pattern of parental resistance to chemical dependency treatment was consistently misinterpreted by the CWS social worker. In reports to the CPT, the juvenile court, the district court, medical providers, the psychosocial evaluator and others, the

social worker portrayed the parents as in compliance with treatment and as having not used illegal substances for 1 ½ years basing this portrayal on the parents' self-report and clean UAs for a period of time. The social worker missed the significance of their continued denial of addiction, poor record of treatment participation and the lack of known indicators of recovery.

- During the last year of Rafael's life, the social worker ignored or minimized documented opinions of experts that should have been cause for concern and initiate reconsideration of the service plan and reunification goal in shared decision-making settings. For example:
  1. A neurological evaluation that showed Rafael to have a normal nervous system and normal response to pain which contradicted his mother's insistence that neurological problems, self-injurious behaviors and a failure to feel pain were the cause of his frequent bruises, contusions and broken bones.
  2. A psychosocial evaluation assessing the mother as angry, impulsive, irritable, hostile, having mood swings and unexpected behavioral outbursts.
  3. Reports from three medical experts that Rafael's injuries were very concerning, not plausibly explained by the parents, and of a suspiciously repetitive nature.
- During the course of his life, Rafael saw a total of 11 physicians and 2 physician assistants. The record reflects that the parents may have sought out different medical providers for Rafael in an effort to deceive providers about his injuries and conditions. Reports from medical providers, who interacted with the mother, indicate that they believed she made efforts to minimize or mislead them about Rafael. Case notes also indicate that the mother gave false information to medical providers about her own and Rafael's medical histories.
- The provider for the psychosocial evaluations of the parents did not receive adequate, objective information and history on this case from the CWS social worker.
- The CWS case was regularly reviewed by the CWS supervisor.

### **Recommendations:**

1. The department must ensure that CWS social workers understand that assessing safety and risk is part of their job and that they do not focus solely on permanency and reunification. The department must examine the content of training delivered specifically to CWS social workers and ensure that there is proper emphasis on safety and risk assessment.
2. Children who are dependent should have one primary medical provider and this medical provider should be consistent throughout transitions home or in the event of a return to placement. If this is not a viable plan due to distance and location, the department should

ensure that medical records follow children as they change providers for continuity of care and that one medical consultant reviews all medical records.

## **Chemical dependency**

### **Findings:**

- In October 2000, the mother was determined to be alcohol dependent and an abuser of cocaine by her chemical dependency treatment provider and a treatment plan was recommended. In February 2002, the father was determined to be an abuser of both alcohol and cocaine by his chemical dependency treatment provider and a treatment plan was recommended.
- The mother established a pattern early on of minimal and/or failure to participate in treatment which resulted in continual near- termination from treatment. The father was more successful in his treatment program; however, also had instances of near-termination from treatment for failure to comply with program expectations.
- The mother and fathers' alcohol use was never adequately addressed. The focus of their chemical dependency treatment was cocaine and amphetamine abuse. There was evidence in the record that the father was drinking after Rafael had returned home.
- The social workers assigned to the case ignored and/or minimized mother's drug-related criminal offenses and did not adequately consider the risk this posed to the children.
- The chemical dependency providers did not provide full disclosure of treatment to CA despite having signed releases of confidentiality from the parents. However, the information that was available in the record does allow for the findings noted above.

### **Recommendations:**

1. Social workers need training to learn and understand how to best hold substance using clients accountable to their treatment program. The department should develop joint treatment plans with chemical dependency providers which would assist CA social workers in assessing their clients' sobriety v. their recovery.

The department should explore establishing or strengthening partnerships with chemical dependency providers or perhaps the Division of Alcohol and Chemical dependency (DASA) in order to increase the availability of expertise and the accessibility of chemical dependency professionals (CDPs) to department social workers. This partnership could include the outstationing of CDPs in CA offices. If this is a challenge due to funding, the department should bring this issue before the legislature.

2. The department should report chemical dependency treatment providers who do not provide reports per the WAC to the proper monitoring and certification authorities.

## **Family Dynamics and Functioning**

### **Findings:**

- Rafael's behavior deteriorated in his parents' care. Behaviors that were not observed by other caregivers, e.g.) foster parents and daycare providers, were reported only by his parents. Visitors to the home observed behaviors that would be expected from a child Rafael's age and behaviors that were more unusual and possibly symptomatic of childhood depression and/or inflicted head injury. These symptoms included excessive sleeping, as much as 16 hours per day at age two years.
- The mother consistently characterized Rafael as having neurological problems and described behaviors not seen in the foster home, two prior daycare settings, or by professionals visiting the home. These behaviors included eating feces, head banging, gorging, obsessive picking and biting. The mother expressed frustration in her ability to manage and handle these reported behaviors.
- This family's ability to interact with others, seek out resources, and maintain a clean and tidy home appeared to sharply contrast with other families that the professionals considered to be drug-involved. This contrast influenced providers and the department to view the parents in a positive light and supported a superficial assessment of the family.
- The mother had a domineering role in the family, was the primary contact and source of information with providers. The father's role in the family appeared to be secondary.

## **Service Providers**

### **Findings:**

- The Committee found that although both parents underwent a psychosocial evaluation, no specific assessment was made of the parents' potential for violence by the evaluator nor was there a request by the CWS social worker that violence potential be addressed. It was noted that the department does not have a defined violence risk assessment protocol, although there are protocols for psychological, psychosocial, and sexual deviancy evaluations.
- Psychosocial evaluations are currently defined in contract language exactly the same as psychological evaluations, however, provider qualifications are different. The providers of psychological evaluations are required to be certified by the State, providers of psychosocial evaluations are not.
- The psychosocial evaluator did not take into consideration the findings from his own evaluation of the mother which reported her to be impulsive, having mood swings and anger problems; all serious mental health issues that could place the children at risk. The mother also expressed feeling stressed about parenting Rafael and there is no indication that any attention was given to this matter.

Instead of referring the mother for treatment that would address these problems, the psychosocial evaluator referred a family preservation services (FPS) provider, who worked at the same agency. This referral is inappropriate and the service delivered by FPS was inadequate for the severity of mother's problems as identified by the evaluator.

- The FPS provider demonstrated a bias in favor of the parents and did not move beyond a superficial level of service with the family.
- The psychosocial evaluator was asked to provide recommendations regarding reunification of Rafael with his parents and did so without reviewing records or asking for additional information. Instead, he recommended that Rafael go home due to concerns about reactive attachment disorder. It is unclear from a review of the provider's credentials if the evaluator is qualified to make this recommendation and how he arrived at the conclusion.

### **Recommendations:**

1. Referrals to service providers from department social workers should always include information of greatest concern and include source documents for provider review. Protocols should be developed for social workers that reflect which source documents should be provided for the service being requested.<sup>9[9]</sup>
2. When a review or consult is requested from an outside provider, one consistent source should be used to review all information. This consultation should then be available by speaker phone in the event the information is needed for CPT and/or other staffings.
3. The department should clarify the distinction between psychosocial and psychological evaluations and ensure that social workers and supervisors understand the difference between the two so that they may make better informed choices about the evaluation they recommend.
4. The department needs to contract with qualified providers for specific violence risk assessment (VRA) in cases where child injury is an element of the case. Content of VRAs should be contractually defined with specific tests or instruments identified. This should be updated or reviewed annually. The department will need to establish specific provider credentials for contractors providing VRAs.
5. The department should eliminate the option for contractor self-referral.
6. Annual training of service providers on safety and risk assessment should be required and written into contracts with service providers.

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<sup>9[9]</sup> Dependency and Termination Equal Justice Committee report, page 10

## **Child Protection Team**

### **Findings:**

- The Moses Lake office has four CPTs with one specializing in cultural issues called the Cultural Awareness Review Team (CART). The CART CPT was used to staff the Gomez case. The Gomez case was staffed by the CPT on five separate occasions.
- The CPT staffings in Moses Lake last one hour and three to four cases are staffed per hour. With this structure, the staffings are limited in scope and CPT members do not have adequate time to review case information, hear case presentation and to develop recommendations for the cases they hear.
- CPTs are staffed by volunteers whose participation is variable. While members of the teams in Moses Lake are committed to the process and regular attendance is encouraged, the members who attended the meetings are not always the same. This makes it difficult for members to have a full grasp of the family history, including progress or lack of progress in chemical dependency treatment and information about medical examinations or evaluations that would support or oppose a decision to return Rafael to his parents' home.
- Case notes and interviews reflect that department professionals staffing the case with the CPT emphasized that reunification of Rafael with his family was the primary reason for the staffing.
- The CPT that heard the plan of reunification in February 2003 did not agree with the plan and recommended that an expert review the medical records prior to reunification. A follow-up CPT was scheduled to re-staff the case after the review of the medical records was completed.
- The follow-up CPT in March 2003, after the expert review of the medical records, did not include two of the CPT members who disagreed with the reunification plan from the February 2003 staffing. The CPT was not aware that Rafael had already gone home nor that the court had deferred to their decision on the reunification. The CPT was not made aware that there was an open law enforcement investigation of the injuries Rafael sustained in December 2002. It is also not clear that the information from the expert medical review was accurately and objectively shared with the CPT.

### **Recommendations:**

1. The Committee is troubled by the serious flaws in the CPT system in Moses Lake and recommends a statewide review of the CPT process by a multi-disciplinary team including internal and external stakeholders. The team should review the following items which this Committee believes directly impact the overall functioning and efficacy of the CPT.

- Multi-disciplinary membership, including participation of CDPs
- Case presentation and sharing of source documents with CPTs
- Case staffing and continuity of teams and members for subsequent staffings
- Variability of participation by CPT members
- Appointment of designated “devil’s advocate”
- Invitation and inclusion of service providers, foster parents and GALs
- Time allocation and format of case staffings
- Clarification of CPT member role
- Resolution of dissent and disagreement by CPT members on recommendations

The following recommendations highlight issues relating to the items listed above.

2. Social workers should provide copies of CPS referrals, evaluations and any pertinent information related to the case on hand. CPTs should be fully informed of all circumstances, services and treatment provided, with progress reports from the providers, recommendations and evaluations from department contracted and non-contracted providers. Such information should be provided to the CPT members in advance of the CPT meetings so members can have the time to absorb and digest the information on which they would base their recommendations.
3. CA employees should not be members of the CPT.
4. The department should ensure that foster parents are invited to participate when CPTs staff cases on the children living in their homes. Foster parents should receive proper notice of the CPT staffing time and place so that they can adjust their schedules as needed in order to attend.
5. The department should ensure that when a child has a GAL that the GAL receives proper notice and are invited to CPTs.

## **Judicial System**

### **Findings:**

- The parents agreed to a (b) and (c) dependency<sup>10[10]</sup> of Rafael at the 30 day shelter care hearing on 09/11/01. By doing so, they agreed that they had abused or neglected Rafael and that they were not capable of adequately caring for him.
- The case had regular court reviews as required and, with the exception of the final permanency planning hearing, each resulted in an agreed order without an in-court

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<sup>10[10]</sup> “. . . any child who . . . (b) Is abused or neglected as defined in chapter [26.44](#) RCW by a person legally responsible for the care of the child; or (c) Has no parent, guardian, or custodian capable of adequately caring for the child, such that the child is in circumstances which constitute a danger of substantial damage to the child's psychological or physical development.”

hearing, evidence was never presented, and no judicial officer ever heard argument about Rafael's safety, parental progress, or reunification planning.

- In February 2003, the court, hearing no objection other than those offered by the foster parents via letter and photographs, deferred to the CPT the decision to reunify Rafael with his parents. The judge stated that the CPT were the experts and better equipped to make the reunification decision. According to all those interviewed, this is the only time such a decision has been deferred to the CPT by the court.
- The judge stated that reunification is the goal of dependency cases, as mandated per the statute and, unless there is evidence or proof of abuse, children are returned to their homes.
- The GAL, as an employee of Grant County Superior Court, states that she is supervised by the superior court judges and that they will not consult on dependency cases due to conditions on ex parte communication. The GAL does not have adequate support or supervision.
- The GAL's workload is not manageable. The GAL has a caseload of 50 and also supervises seven CASA volunteers who carry 15 – 20 cases between them.
- The GAL agreed with the department's recommendations for reunification. Although she expressed concern about the repeated injuries, she did not object to the final return home and said she agrees with the department "95% of the time" on her cases. She states that the goal of the court is family reunification, even when the parties disagree, and that the GAL recommendations have little impact on the court.
- The three superior court judges in Grant County are on a four-month rotation for juvenile court. This eliminates the opportunity for continuity of judicial oversight, limits judicial memory and familiarity with the case and the progress of the service plan. The agreed orders on this case were signed sequentially by the three rotating judges.
- It is customary for dependency cases in Grant County to be discussed at a "round-table discussion" or a pre-trial conference before hearings. The AAG states that the premise of the dependency statute is family reunification and this settlement process moves that plan along most efficiently.

### **Recommendations:**

While it is recognized by the Committee that the department cannot change the judicial system, the Committee recommends that the department support the following recommendations.

1. Court Appointed Special Advocates (CASA)/GAL caseloads need to meet the standards set by the National CASA Association<sup>11[11]</sup> and CASA/GALs need proper administrative supervision and support as recommended by the National CASA Association.
2. Judges should receive training on child welfare issues and dependency practice from the Office of the Administrator of the Courts (OAC).<sup>12[12]</sup>
3. Judicial rotations should be extended to allow for the continuity of judicial oversight on dependency cases.<sup>13[13]</sup>
4. Judges should be alert to a pattern of non-contested agreed orders and consider the value of having an in-court hearing so that evidence, recommendations, agreed-upon services and the status of the case can be reviewed on the record.

## **Foster Parents**

### **Findings:**

- The foster parents provided consistently safe and nurturing care for Rafael despite receiving no specialized training on caring for drug-affected infants.
- Rafael had healthy and normal development while in the care of his foster parents.
- The foster parents did not have confidence that their concerns about Rafael's safety and well-being were taken into consideration by the CWS social worker.
- The relationship between the foster parents and the CWS social workers was not collaborative and became increasingly complicated by feelings of mistrust. Despite these tensions, the department had confidence in their abilities to care for Rafael and he was placed with them each time he came back into care.
- It is not clear that the foster parents understood their role and ability to participate in the court reviews. The foster parents indicated that they received one of three ISSPs. The case notes reflect that ISSPs were sent with court date and time attached.
- The foster parents' many concerns about the biological parents and their fears about the parents' chemical dependency issues were interpreted by the department as culturally-based discrimination.
- Interviews reflect that the foster parent made statements that the department regarded as culturally derogatory. These statements caused the department to view the foster parents as adversarial.

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<sup>11[11]</sup> National CASA Association standards specify that CASA staff can supervise up to 30 CASA volunteers who will carry a maximum of two children or sibling groups at one time.

<sup>12[12]</sup> Fostering the Future report, page 47

<sup>13[13]</sup> DTEJC report, page 28

- The foster parent liaison was not adequately utilized to facilitate and assist in communicating with the foster parents.
- The foster parents developed a caring and loving bond with Rafael. They were not given adequate time and preparation for Rafael's moves back to his parents' home nor were they included in the transition planning. Their normal and appropriate care and concern for Rafael was misread as over-attachment.

**Recommendations:**

1. The department should vigorously pursue recruitment and retention of Hispanic foster parents in the Grant County area.
2. The department should ensure that foster parents are invited, with proper notice, to dependency hearings and that they understand their right to provide information to the court.
3. Foster parents should receive proper training before being asked to care for special needs or drug-affected children.
4. The department should ensure that foster parent liaisons are visible and a known resource for the foster parents.

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