Colorado Department of Human Services
Child Fatality Review Team
Case-Specific Executive Review Report
NON-CONFIDENTIAL

Public Notification Case ID: 22-001

Investigating County Name: Adams

County(ies) with Previous Involvement: Adams

Incident Level: Fatal

Incident Date: 2022

~PUBLIC DISCLOSURE NOTICE~

This report outlining the non-confidential findings or information regarding a child fatality, near fatality, or egregious incident which occurred as the result of child abuse or neglect within a family who was involved with a County Department of Human/Social Services within three years prior to the incident is subject to public disclosure in accordance with C.R.S. § 26-1-139 and Federal requirements under the Child Abuse Prevention and Treatment Act: CAPTA 42 U.S.C. § 5106a (b)(2)(B)(x)(2016).

I. IDENTIFYING INFORMATION

A. Child victim

Age: 22 months old **Gender:** Female

Race or ethnicity: Hispanic

Child's residence: In-home

B. Caregivers

Mother

Age: 30 years old **Race or ethnicity**: Hispanic

Father

Age: 31 years old **Race or ethnicity**: White

C. Description of the child's family (non-identifying information): The child, who was 22 months old, lived at home with the mother, the father, and the half-sibling, who was 10 years old. The child was born with a cleft palate, which required surgery to correct.

The mother reported being the primary caretaker for the child and the half-sibling. She stated that she had previously worked in medical coding and housekeeping, but was no longer able to work after her pregnancy with the child. The mother's criminal history included charges of driving while under the influence and other traffic offenses. She denied a history of domestic violence, mental health issues, or homelessness. She stated that while she did not have child welfare involvement as a child, she and the half-sibling's father were involved with child welfare when the half-sibling was younger. It was during that case that the mother met the father and the two of them began their relationship. The mother was reported to have times of sobriety in her life, but that she also struggled with chronic substance use. At the time of the child's death, the mother's drug of choice was crack cocaine.

The father reported working as a handyman previously. The father's criminal history included charges of possession and distribution of dangerous drugs, assault, theft, false reporting, impersonation, forgery of government documents, and driving under the influence. The father denied having any mental health issues. The father denied having any previous child welfare involvement. The father also was reported to do well when he was sober, but often reverted back to substance use, including using crack cocaine and Fentanyl, while also using Methadone. The father also sold Fentanyl to help fund his cocaine use.

The half-sibling's father reported a history of criminal behavior and substance use with the mother during their relationship. In 2017, the half-sibling's father stopped using substances and strived to live a better life. The half-sibling's father reported current marijuana use, to manage residual pain, but stated he had otherwise been sober for several years.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 2022 **Date closed:** 2022
County: Adams **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): In 2022, Adams County Human Services Department (ACHSD) received a report of concern regarding the death of the child. The reporting party (RP) reported that the child, who had been in her room from 9:00 a.m. to 2:00 p.m. was "cold to the touch" when the parents checked on her at 2:00 p.m. The parents called the paramedics and started administering cardiopulmonary resuscitation (CPR). When the paramedics arrived, they reported that the child showed signs of rigor mortis and had "dried blood… on the left side of her nose and mouth area." The child would remain in the family's home until the coroner assumed custody of her body. The child's room appeared cluttered, with "a lot of stuffed animals in [her] crib," and "a roll of tin foil in her room." Law enforcement reported that the father initially provided a false name to them. Law enforcement was able to determine the father's correct name and found criminal histories for both parents, as well as warrants for the father. The father requested an attorney be present during his interview with law enforcement, so the father's interview was stopped at that time. However, later, the father reported knowing that the child had fallen. The mother showed law enforcement video footage taken by the video camera in the child's bedroom; however, she "tr[ied] to skip past some timeframes." The half-sibling was reported to be in the care of the maternal relatives, but was later determined to be in the care of the half-sibling's father.

The caseworker called law enforcement to gather additional information. Law enforcement reported that the preliminary toxicology reports for the child were "positive for Buprenorphine, which [was] the main ingredient in Suboxone and a few other med[ication]s for opiate withdrawal." The father reported taking Methadone and smoking Fentanyl in the child's presence, which was captured on video. The mother also reported treating the child's gums with an oral gel, and law enforcement speculated that the mother might have had some substance residue on her fingers. The parents had security cameras set up within their home, including one in the child's room. The mother provided the video footage from the cameras, which contradicted the mother's statement about putting the child in her crib around 9:00 a.m., as there was no movement in the child's room at that time. When confronted about her timeline, "[the mother] broke down and admitted that after putting [the child] down [around 2:00 a.m.] [the mother] didn't check on her again for 12-14 hours." Law enforcement reported that the child likely died in the early morning hours, based on the sounds they could hear from the video footage, and that the parents likely did not hear the child's cries at that time due to being under the influence of substances.

The caseworker then spoke with the half-sibling's father by phone.

The caseworker then spoke with the maternal relatives by phone who provided some social history information about the family.

The half-sibling's father called the caseworker again with some additional information regarding his concerns for the mother and the father's substance use. The caseworker encouraged the half-sibling's father to file for full custody of the half-sibling through the courts.

The caseworker spoke with the coroner, by phone, who reported that they did have photos of a white powdery substance that was found in the parents' bedroom, but the type of substance was unknown at that time.

Law enforcement provided an update on their investigation. When law enforcement responded to the home to conduct their search, the parents were at home with a known "'drug [associate]'" and took an additional 20-30 minutes to do things in the house before allowing law enforcement to execute the search warrant. Upon entering the home, law enforcement observed "tons of paraphernalia and signs of recent drug use." The parents were reported to use "crack rock," and had been selling Fentanyl to pay for their cocaine. "[Law enforcement]… found a mixing station in the bathroom where [the parents] [would] melt the cocaine into crack rock to smoke it." The caseworker was advised to be very cautious if meeting with the parents at their house, as there were known drug transactions happening. Law enforcement also shared that the preliminary autopsy results showed signs that the child's death would have been painful, causing her to cry out.

The caseworker brought a second caseworker to complete an unannounced visit to the parents' home, but no one was there.

The caseworker met with the half-sibling, the half-sibling's father, and the half-sibling's paternal relative.

The mother responded to the caseworker's email, stating that she was in the process of hiring an attorney and she would wait until obtaining legal counsel before speaking with the caseworker.

The caseworker emailed the mother to advise her of the court orders.

Law enforcement provided information regarding charges that were filed against the father in July 2020, after the parents were stopped by another law enforcement jurisdiction, with the child in the car, and they were found to have several narcotics and paraphernalia in the car. The father took responsibility for everything and had charges, including child abuse charges, pending from that situation.

An initial Family Team Meeting (FTM) was held virtually, to transition the family from the assessment caseworker to their ongoing caseworker who would manage their court-involved case. During the meeting, "[the father] immediately became escalated and would not stop yelling about all the lies that ha[d] been told about him and his family." The mother disconnected their call and they did not participate in the rest of the meeting.

The mother emailed the caseworker to set up a supervised visit with the half-sibling. The mother apologized for their behavior during the FTM meeting.

Law enforcement provided an update from the child's autopsy and toxicology reports. "[The child's] hair follicle was positive for [tetrahydrocannabinol] THC, cocaine, and meth[amphetamine] plus the metabolites for all three. [Law enforcement] explained that the metabolites could get into her system through [the parents'] sweat, oils, and/or through her own body. [The child's] blood tox[icology] was positive for meth[amphetamine] and a very high level of fentanyl. The fentanyl level was 30 nanograms/mL…. Fentanyl toxicity [was] the cause of death and the manner of death

[was] accidental." Law enforcement also had confirmation that the parents were using and dealing drugs in the home.

The caseworker emailed the mother asking for the father's contact information, in an attempt to speak with the father. The caseworker also offered to meet with the mother, if the mother was willing. The mother responded and provided the father's cell phone number.

The caseworker called the father, but was unable to leave him a message.

The assessment was closed in 2022. A court-involved case was opened to provide services to the family.

Findings: The allegations of fatal, intrafamilial neglect – environment injurious were substantiated.

The allegations of minor, intrafamilial neglect – environment injurious were substantiated.

Referral
Date received: 2022
County: Adams **Date not accepted for assessment:** 2022
Reason for not accepting referral for assessment: "Duplicate referral."

Referral narrative summary and additional information contained in referral (non-identifying information): In 2022, ACHSD received another report of concern regarding the child's death. The RP provided similar information regarding the timeline of the child's death, with the additional information that father checked on the child around noon, when the child was heard crying. The father reported that the child was asleep. The RP also reported that "[m]arijuana, unknown pills[,] and unknown powder [were] found in [the parents'] room." The parents had not been arrested and a cause of death was still unknown at that time. The referral was determined not to meet criteria for assessment with the indicated reason of, "Duplicate referral."

Supplemental Information:

Per the law enforcement report, the parents were arrested and were both charged with "Child abuse Resulting in Death… and… Distribution of a Controlled Substance."

Per the child's autopsy report, the child was also diagnosed with pneumonia, which was a contributing factor in her death. In the final autopsy report, the manner of the child's death had been changed to undetermined, rather than accidental, following the receipt of additional toxicology results.

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with Adams County Human Services Department consisting of two assessments.

III. TIMELINE SUMMARY

The following timeline was created using supporting documents and information gathered during the review of this incident. Supporting documentation may include but not be limited to: law enforcement report(s), autopsy or coroner report(s), medical records, Trails records, etc. The timeline is intended to organize information and illustrate relevant events, patterns, relationships, behaviors, risk, and protective factors associated with these incidents of fatal, near fatal, and/or egregious child maltreatment. Please note, there may be information contained within the timeline that was not available or known to the county department(s), or other professionals, during their involvement with the child and/or family.

2020	The child was born.
4/2/2020-5/1/2020	ACHSD conducted an assessment regarding concerns for the child. At six weeks of age, the child had started losing weight following her discharge from Children's Hospital Colorado (CHC), after spending two weeks there following her birth. The child had a cleft lip and palate and had difficulties eating. During a medical appointment to check the child's weight, the parents were asked to take the child to CHC for further evaluation. However, they did not take the child to CHC. The RP reported it was not an immediate emergency, but could prove to be a major concern for the child if she did not receive proper medical attention. During the assessment, ACHSD learned that the family had taken the child to a different doctor instead of CHC. The allegations of minor, intrafamilial neglect – medical neglect were unsubstantiated.
7/26/2020	The parents were pulled over by law enforcement and were found to have several narcotics and paraphernalia in the car with them, along with the child. The father took responsibility for everything and faced criminal charges, including child abuse charges, stemming from that situation.
3/21/2021	The child had surgery at CHC to correct her cleft palate.
4/15/2021	The child was seen for a follow-up appointment after her surgery.
6/7/2021-7/20/2021	ACHSD conducted an assessment regarding concerns that the child was not seen for an additional follow-up medical appointment after her surgery at CHC in March 2021. The child also had not been seen by her primary pediatrician since December 2020, and had missed appointments with that doctor as well. Due to the cleft palate, the child had difficulties eating and it was unknown if those difficulties continued after her surgery. The parents reported having scheduling issues, as the child's well-child check with her pediatrician had been scheduled for the same day as her surgery. The parents rescheduled all of the appointments and reported that the child was recovering well from her surgery. The allegations of minor, intrafamilial neglect – medical neglect were unsubstantiated.
2022	The child died from Fentanyl toxicity.

IV. COUNTY INTERNAL REVIEW

County: Adams **Date:** 2022

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: February 6, 2023

Documents Reviewed

1. Trails referrals, assessments, and case records
2. Colorado Children's Code - Title 19 of the Colorado Revised Statutes
3. Volume 7 State Child Welfare Rules and Regulations
4. Adams County's Internal Review Report Dated: 2022
5. Autopsy Report
6. Law Enforcement Records

B. Identified Risk and Contributing factors that may have led to the incident:

- Both parents had a significant substance abuse history
- The father had a DUI charge in 2020, with the child in the car at that time
- Vulnerable Child – due to age and medical needs
- The child had been left alone/unsupervised for a long period of time
- The parents used video cameras to monitor the child
- Drug sales in the home
- Criminal activity in the home
- History of extended family members also using substances
- Unsafe sleeping environment
- Unmet medical needs for the child
- The child had pneumonia at the time of her death
- The child was exposed to multiple substances prior to her death
- The parents had difficulties maintaining employment, due to Covid-19
- Financial struggles
- Unstable parenting relationship for the half-sibling's father, which kept him from reporting his concerns for the children in the mother's care
- The mother's mental health struggles
- Contentious relationship between the parents and CHC due to the child's medical needs from birth

C. Summary of identified systemic strengths in the delivery of services and supports to child/ren and/or family (non-identifying information).

The CDHS Child Fatality Review Team (CFRT) reviewed the fatal child maltreatment incident and the previous involvement and identified strengths in the delivery of services and supports to the children and family. These strengths are:

1. The CFRT identified a strength in the county's internal review documentation regarding their observations of the children and the parents throughout the prior history.

D. Summary of identified systemic gaps and deficiencies in the delivery of services and supports to child/ren and/or family and recommendations for changes in systems, policy, rule, or statute (non-identifying information).

The CDHS CFRT reviewed the fatal child maltreatment incident and the previous involvement and identified systemic gaps and/or deficiencies in the delivery of services and supports to the children and family. These gaps and/or deficiencies are:

1. The CFRT identified a gap in the prior assessments regarding the lack of engagement by the county with the half-sibling's father. Had he been contacted by the county directly, he might have been more comfortable sharing his concerns for the safety and well-being of the children in the mother's care.

2. The CFRT identified a gap in the lack of a report made to the department of human services at the time of the father's DUI and child abuse charges from 2020, when the child was in the car with him.

3. The CFRT identified a gap in the service delivery to the child and family due to the lack of referrals or education for the parents about early childhood education resources or in-home nursing programs that could have offered assistance and support to the family.

E. Review of Compliance (references to Rule Manual Volume 7, Child Welfare Services, of the Colorado Code of Regulations [12 Colo. Code Regs. §2509] are referred to by rule number): Compliance with statutes, regulations, and relevant policies and procedures is considered through the internal review by county departments of human/social services who had prior involvement in the previous three years, a qualitative case review conducted by the Administrative Review Division (ARD), and a review and discussion by the CFRT. The findings were provided to the county in order to assist them in identifying areas needing improvement. There were no direct correlations between the compliance findings and the fatal incident.

F. Recommendations from the review of the incident:

1. The CFRT made a formal recommendation to ensure that the Memorandums of Understanding (MOUs) between county departments and law enforcement highlight the laws and requirements around making a report of concern to child welfare whenever there is a crime of child abuse.