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

Public Notification Case ID: 22-004

Investigating County Name: El Paso

County(ies) with Previous Involvement: El Paso

Incident Level: Fatal

Incident Date: 1/13/2022

~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: 5 years old **Gender:** Female
Race or ethnicity: Hispanic
Child's residence: In-home

B. Caregivers

Mother
Age: 27 years old **Race or ethnicity**: Hispanic

Father

Age: 45 years old **Race or ethnicity**: Unknown

C. Description of the child's family (non-identifying information):
At the time of the incident, the child resided with the mother, the stepfather, and maternal half-sibling (age 13 months). The father was reported to reside out-of-state, where the family had relocated from in the summer of 2021. The stepfather and the mother began their relationship in December 2018 and were the biological parents of the maternal half-sibling.

The mother was a victim of the domestic violence, which was perpetrated by the stepfather. At the time of the incident, there was a protection order in place that did not allow the stepfather to have contact with the mother, but they were residing together. The mother reported that the father had previously strangled her.

The stepfather reported that he had a child (age 9 or 10), but he had not had contact with said child for approximately three years.

The stepfather was not employed at the time of the incident, while the mother was employed in car sales. The mother was reported to work from home, while the stepfather cared for the children. The stepfather denied any current alcohol use, as he received a Driving Under the Influence (DUI) in August 2021. The stepfather reported he was working toward getting himself sober, so he could work and had reduced his marijuana use to once or twice a month.

In the family's home state, the child had previously been removed from the mother and the father's care due to substances being found in the home. The mother reported that the father had hidden drugs in the family's home without her knowledge, which were later found by law enforcement. The child was reported to have recently struggled with wetting and defecating herself, which the mother and the stepfather struggled to handle.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 1/13/2022 **Date closed:** 3/12/2022
County: El Paso **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On January 13, 2022, El Paso County Department of Human Services (EPCDHS) received a report of concern regarding the child. The reporting party (RP) reported that the stepfather made "a 911 call" earlier in the day, as "[the child] was found unresponsive and making gurgling noises." The child was reported to have been transported to a hospital in Colorado Springs, after emergency medical services (EMS) "worked on [the child] for [approximately] 1 hour." The child was observed to "ha[ve] multiple bruises on her body" and was not expected to survive.

The caseworker responded to the hospital in Colorado Springs and was met by law enforcement. The caseworker observed the half-sibling and noted the half-sibling did not have "any observable marks or bruising." The caseworker was informed the mother and the stepfather used exercise for punishment and reported the child's injuries were self-inflicted. The child was reported to have bruising on her back, ribs, forehead, and "the back of her head." The child was noted to have had a shaved head. The parents reported they shaved the child's head, as she pulled her hair out while self-harming. The parents provided explanations for the child's bruises, stating that the child punched herself in the ribs and "slam[med] her … head on tables." Law enforcement expressed concerns that the parents' explanation did not match the injuries. The caseworker later observed the child and noted the bruising on the child's body.

Law enforcement reported a protection order was issued on October 5, 2021, between the stepfather and the mother, which restricted the stepfather from contacting the mother. Law enforcement planned to "[arrest] [the stepfather] for breaching the protection order." Law enforcement reported the mother expressed concerns that if the child had passed away, the protection order protecting the mother from the father would be lifted and she feared he would be released from "jail and kill her."

The caseworker and law enforcement interviewed the mother. The mother provided the family's history from their previous state and reported that the father was currently incarcerated on drug related charges. The mother reported that when the family disciplined the child, they would use exercise or "pow-pows" which "were light spankings on [the child's bottom] with an open hand" or a white belt. The mother described behavioral struggles with the child, which included the child lying, stealing the maternal half-sibling's food, and injuring herself. The mother reported that the child would pull her hair out, which resulted in the mother shaving the child's head. The mother reported that once she shaved the child's head she noticed bruising "on her forehead and the back of her head." The mother reported that recently the child had banged her head on table in

frustration. The mother reported she questioned the child regarding the bruises and she reported that it was from "trip[ping] or fall[ing] down." The mother reported that she did not reach out to medical professionals regarding the child's behaviors or bruising as the family did not have insurance or a car for transportation. The mother provided a timeline of events. The previous day the child had complained of a stomachache and she heard the child fall in the mother's bedroom, where the child was with the stepfather. When the mother entered the bedroom, the stepfather explained that the child's blanket needed to be washed as there was fecal matter on it. The child had begun to fold her blanket, when she fainted. The child then continued to complain about not feeling well and "was unable to keep food or liquids down." The family moved their mattresses to the living room, so they could all remain together for the night. Later in the evening the child stated she felt better, so the mother made her some food, which the child was unable to keep down. The child then defecated herself again and the mother washed her and cuddled her back to sleep. By the morning the child was able to keep some food and liquids down, but later fainted and wet herself. The mother was cleaning the child in the bathroom when she "went limp and tiled [*sic*] to the side and her eyes were open[,] but she was unconscious, her teeth were grinding, and she was clenching her fists." The child then stopped breathing, so the stepfather contacted emergency medical services (EMS) and began chest compressions. The mother reported that once she arrived that the hospital, she was informed that the child had died and been revived several times, and the mother needed to make a decision as to whether medical staff should continue life-saving measures, as this had caused irreversible issues for the child. The mother reported that "she decided to have them stop the life saving measure and to spend [the child's] final moments in bed with her." The mother reported that aside from her and the stepfather, the stepfather's relative had watched the child recently. The mother requested that law enforcement notify her when the father was notified, as she feared for her life once the father was released from prison. The mother denied causing any of the child's injuries or knowing who caused them.

The caseworker and law enforcement interviewed the stepfather. The stepfather initially denied using physical discipline, but reported that the mother was brought up with physical discipline. The stepfather later went on to describe what the family called "[p]ow [p]ow[,] [which] mean[t] a strike of the belt" to the child between one to 3 times. The stepfather reported that this most recently occurred a few days prior. The stepfather reported an example of an incident when this discipline would be used, was the child soiling herself or soiling her hands. The stepfather provided examples of incidents of when the child was disciplined. The child was reported to "have poop all over her butt." The mother then informed the child she would be unable to sleep in a bed and would need to sleep on the floor. The child was reported to have struggled with using the bathroom and "would [at times] poop in her hand[s] and wipe it all around the home." The stepfather described the mother being upset and yelling at the child in frustration that she would have an accident next to the toilet and the child received one "'pow pow'" from the mother. The stepfather described the family using exercise as a form of discipline for the child, which included the child completing "a cycle of workout." The workout cycle was described as "10 [j]umping [j]acks [,] 10 second [l]eg [l]ifts[,] [a] [b]reak[,] 5-10 push ups[,] [h]igh plank for as long as she can, 5-10 seconds[,]" and it is repeated "2-3 times[,]" and ends with "[the child] run[ning] up and down the hallway." The stepfather then reported that he had last slapped the child on her bottom, two days prior to her hospitalization. The day prior to the child's death the family discovered feces in her room and began to remove all the items from her room. While the stepfather and the mother were doing this, the stepfather noticed that the child began to eat the feces. As punishment for eating the feces, the child was required to complete a cycle of exercises. The stepfather ensured that the child had had breakfast, and then checked on the child as he heard her making noises that led him to believe she was injuring herself. The child fell down in the laundry room, and when the stepfather checked on her, "she was very slow and her eyes were rolling back." When she went to another room she appeared to be drowsy. The mother was reported to have believed the child was exaggerating. The child then defecated herself, but the stepfather believed that this occurred due to the child not feeling well as she had informed them she had a stomachache. Though the stepfather reported he wanted to contact EMS, the family did not, as they believed that her condition could have been due to not eating or drinking enough that

day. The child was reported to have woken the stepfather up hourly for stomach issues the night prior to the incident, but the mother still did not believe the child was unwell. The stepfather reported he spent the night helping the child in the bathroom and by the morning, she was still nauseous, but appeared better. The child was provided water at her request, but while "drinking [she] lost control and passed out." The mother then took the child to the tub and noticed the child began to wet herself and grind her teeth. The stepfather reported that he believed the protection order between he and the mother had been modified and he returned to the family's home in November 2021. As the protection order had not been modified, the stepfather was arrested following the interview. The caseworker discussed kin placement options for the children with the stepfather prior to his arrest.

The caseworker spoke with the mother following her interview with law enforcement. The caseworker discussed kin placement options with the mother. The mother and the stepfather both identified kin as the most appropriate option for the child. EPCDHS was granted custody of the half-sibling, and the half-sibling was placed with kin.

On January 14, 2022, the caseworker was provided an update by law enforcement. Law enforcement reported that during their interview with the mother, the stepfather was reported to have strangled the mother previously. The mother was also reported to have disclosed that the child began harming herself approximately two weeks prior and described the child hitting her head on a "'marble looking table.'" Law enforcement spoke to neighbors, who had reported the child described the stepfather as mean and neighbors heard him yelling at the child in the past. The evening prior to the incident, yelling was heard from the home, though it was unclear what the yelling was regarding. On the day of the incident, neighbors reported that they "heard the shower going off a lot" which they found to be odd. The child's autopsy results were pending, but the child was found to have "11 different small bruises in the abdomen area[,] a[brasions on the head, [a] long linear abrasion on the back of the head[,] [and] [multiple organ[s] [were] not in good shape[.] [The] pancreas [was] cut in [two] [,] [which was] only possible [with] extreme force [such as] a punch, [*sic*] or stomp." The child was also found to have an "[e]xtreme amount of" abdominal bleeding and a lacerated liver.

On February 3, 2022, the caseworker received legal documents from law enforcement regarding the mother and the father.

On March 10, 2022 and March 11, 2022, the caseworker attempted to contact the father via telephone.

On March 11, 2022, the caseworker was informed by law enforcement that they were able to contact the father and that law enforcement was "working with [the father] for [the child's] funeral arrangements. Though the father had not returned the caseworker's attempts for contact, law enforcement reported that he remained in contact with them "throughout the investigation."

The caseworker informed the mother and the stepfather that the assessment would be closing with substantiated findings.

The Colorado Safety Assessment noted that the child's hair had been shaved by the parents, which they explained to be due to the child pulling her hair out.

On March 12, 2022, the assessment was closed with the family participating in a court involved permanency case.

Findings: The allegations of fatal intrafamilial abuse –physical were substantiated.

The allegations of fatal intrafamilial neglect – medical neglect were substantiated.

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

Referral ID: 3255876
Date received: 1/13/2022
County: El Paso **Date not accepted for assessment:** 1/14/2022
Reason for not accepting referral for assessment: Duplicate referral

Referral narrative summary and additional information contained in referral (non-identifying information): On January 13, 2022, EPCDHS received a report of concern regarding the child. The RP reported EMS responded to the home and found the child naked, while the mother performed cardiopulmonary resuscitation (CPR). The mother and the stepfather were reported to have followed the ambulance to the hospital. The RP described the mother to have "freaked out" when law enforcement arrived at the hospital. The child was reported to have several bruises on her body and to have a shaved head. The RP reported the family reported "the child ha[d] mental issues and would pull out her hair and this would cause bruises, so they shaved her." The child was reported to have been pronounced dead at the hospital.

Supplemental Information:

Per Colorado Courts, the stepfather and the mother were charged with "[m]urder 1 – [v]ictim, [u]nder 12/ pos[ition] [o]f [t]rust[,] [and two counts of] [c]hild [a]buse – knowing/reckless [c]ause [of] [d]eath."

The child's autopsy report revealed the following blunt force trauma injuries, " [e]xtensive contusions, face, scalp, trunk and extremities[,] [a]brasions, face, ears, abdomen, back, and hips[,] [s]ubcutaneous hemorrhages, neck, shoulders, and back[,] [n]early confluent subscalp hemorrhage/contusion[,] [t]hin, lightly clotted subdural hemorrhage…[c]erebral edema and acute neuronal necrosis[,] [t]ymic subscapular hemorrhage[,] [s]trap muscle hemorrhages[,] [l]ung contusions[,] [d]iaphragm hemorrhages[,] [g]reater and lesser omentum hemorrhages[,] [l]iver lacerations and subcapsular hemorrhages[,] [p]ancreatic transection[,] [r]enal hilar hemorrhages[,] [r]enal pallor[,] [p]eriadrenal soft tissue hemorrhages[,] [h]emorrhages of small and large bowel and mesentery[,] [h]emoperitoneum with scant clotiting, [and] [f]ractures of… left" ribs six to ten. The child's death was determined to be the "result of multiple blunt force injuries" which were consistent with the injuries being caused by other individuals.

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with El Paso Department of Human Services, consisting of one referral.

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.

11/2020	The maternal half-sibling was born.
6/30/2021	The stepfather was charged with DUI.
~7/2021	The family moved to Colorado from out-of-state.
10/1/2021	EPCDHS received a report of concern regarding the family. The RP reported "[the stepfather] shoved [the m]other" and was arrested. The children were reported to have been in another room and there were not reported safety concerns for the children. The referral was not accepted for assessment for the identified reason of, "No information available from reporter of abuse and neglect as defined in law."
10/5/2021	A protection order was put in place for the recent domestic violence incident perpetrated by the stepfather against the mother. The protection order did not allow the stepfather to have contact with the mother.
~11/2021	The stepfather returned to the family home.
1/12/2022	The child began to exhibit symptoms that she was not feeling well.
1/13/2022	The child became unresponsive and died at the hospital.

IV. COUNTY INTERNAL REVIEW

County: El Paso **Date:** 3/22/2022

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: January 9, 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. County's Internal Review Report Dated: 3/22/2022
5. Autopsy Report
6. Police Report

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

- The mother was a victim of domestic violence, which had been perpetrated by the father and the stepfather
- The relational power dynamics in the home between the mother and the stepfather
- The stepfather was violating an active protection order
- The family may have lacked the skills to deal with the child's challenging behaviors
- Poverty
- The family did not have health insurance
- The family lacked a vehicle
- The stepfather used marijuana
- The stepfather had a prior DUI
- The child was reported to be longing for her father and was described to have self-harming behaviors

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:

The team did not identify any strengths at this review.

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 team identified a systemic gap in information sharing in child welfare between states. When the county lacks information about the family's prior child welfare history in another state, it can be difficult to make decisions regarding safety and risk for 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:

The team did not identify any recommendations at this review.