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

Public Notification Case ID: 22-032

Investigating County Name: Denver

County(ies) with Previous Involvement: Jefferson

Incident Level: Fatal

Incident Date: April 17, 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)(2019).

I. IDENTIFYING INFORMATION

A. Child victim

Age: 3 years old **Gender:** Male

Race or ethnicity: Hispanic

Child's residence: In-home

B. Caregivers

Mother

Age: 39 years old **Race or ethnicity**: Hispanic

Father

Age: 34 years old **Race or ethnicity**: Hispanic

C. Description of the child's family (non-identifying information): The child, who was 3 years old, primarily lived with the parents and the younger half-sibling, who was 9 years old. The mother had two other children, the 19-year-old adult half-sibling and the 16-year-old older half-sibling, both of whom lived with a maternal relative. The mother reported being a young, teen mother when she had the adult half-sibling, and being pregnant with the younger half-sibling when her relationship with the half-siblings' father ended. The adult half-sibling and the older half-sibling maintained their relationship with the half-siblings' father, even moving in with him for a while before moving in with the maternal relative.

The mother reported that she met the father while she was pregnant with the younger half-sibling and began a relationship with him. The father then raised the younger half-sibling as his own. The parents ended their relationship about one week prior to the child's death, but continued to spend time together to keep up appearances for the father's family members. The mother reported being able to stay home with the child and younger half-sibling during her relationship with the father, but was not sure how to manage financially without his support. The mother denied any criminal history or substance use, other than marijuana.

The father was reported to be gang affiliated and dangerous. There was reported domestic violence in the parents' relationship, with the father as the perpetrator. He maintained power and control over both the mother and the younger half-sibling, which was reported by several extended family members. The father's criminal history included domestic violence, assault, menacing, and trespassing charges. Due to the father's prior felony charges, he was not supposed to own or possess weapons.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 4/18/2022 **Date closed:** 8/10/2022
County: Denver **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On April 18, 2022, Denver Department of Human Services (DDHS) received a report of concern regarding a three-year-old who had been "shot in the head" the previous day. Rather than calling for emergency medical services, the father drove the child to the emergency room on April 17, 2022, and stated "[the child] was outside playing and was shot in the face in a drive by shooting." The reporting party (RP) reported that the parents were too upset to provide any additional information about the child, his injuries, or the family. Law enforcement had been notified and responded to the hospital. It was noted in the child's medical chart that the parents believed law enforcement was "rude to them." After his interaction with law enforcement, the father was described as "'irritable and agitated.'" The child's condition was critical and it was unknown if he would survive.

On April 19, 2022, a caseworker spoke with law enforcement to gather additional information. A family member reported that the family was celebrating Easter together outside, but they were concerned about their safety as a relative had recently been shot. The father had placed his gun on the front seat of his car, which was parked near the family's gathering. "The [child] at some point climbed into the car and found the gun where he accidentally shot himself." Per law enforcement, most of the family members present for the gathering were not willing to be interviewed, while others reported the child was the victim of a drive by shooting. However, law enforcement did not have any other information from outside witnesses to support that explanation. Due to the father's extensive criminal history, he was not supposed to have any guns in his possession. It was speculated that someone removed the gun from the scene, as it had not been recovered by law enforcement. Law enforcement anticipated charging the father for the child's death.

The parents and other family members were at the hospital with the child, who no longer had any brain function. The caseworker met with the parents and observed the child. Due to the ongoing criminal investigation, the caseworker did not interview the parents about the incident. The caseworker offered supports and resources for the family, addressed the importance of gun safety, and requested to meet with the half-siblings at a later time.

On April 20, 2022, the child passed away.

On April 22, 2022, the caseworker scheduled to meet with the half-siblings later that day; however, when the caseworker arrived to the home prior to the scheduled visit, no one was there.

The caseworker spoke with the half-siblings' father on the phone.

The caseworker returned to the home and met with several extended maternal family members who had gathered together to mourn the child's death. The caseworker met alone with the older half-sibling. In speaking with other extended maternal family members, the caseworker learned that they were fearful for the younger half-sibling's safety in the parents' care due to the father's abusive and coercive behaviors toward the mother and the younger half-sibling.

On April 26, 2022, the half-sibling' father reported filing for custody of the half-siblings through the courts.

The caseworker then watched the previously recorded law enforcement interviews with the younger half-sibling.

The caseworker then watched the previously recorded law enforcement interview with the adult half-sibling.

On April 28, 2022, the mother was arrested and the half-siblings' father arranged for maternal family members to pick up and care for the younger half-sibling.

Another caseworker observed the mother's interview with law enforcement after her arrest. The mother reported learning that the child's injuries were self-inflicted after hearing it reported on the news. She reported that she and the father had recently separated, so were together at the Easter family gathering for appearance purposes, but she was not mentally present and had wandered off to the side of the yard just prior to hearing the gun shot. She reported turning around and seeing the father hold the child before the father told her they needed to drive to the hospital. The mother grabbed the child and got into the passenger seat. The mother denied that she owned her gun anymore, stating that she had previously pawned it, but could not recall when or where that took place. The mother denied knowing there was a gun at the Easter family gathering or in the family's car.

Following the interview, law enforcement discussed the possibilities for how the child gained access to the gun in the car. Following the incident, neither the gun nor the bullet casing had been located. Law enforcement speculated that the father's family members, who were present at the Easter family gathering, might have been hiding them.

On May 4, 2022, law enforcement advised that the father had been found and arrested, while the mother had recently bonded out of jail. Law enforcement was going to look into the possibility of issuing a protection order, protecting the mother and the half-siblings from the father.

The caseworker learned that the maternal relative assisted in posting the mother's bond. The child's funeral had been scheduled for the following week.

On May 9, 2022, the caseworker spoke with the mother on the phone. The caseworker advised the mother that she, too, could file custody paperwork with the courts to establish a legal custody arrangement. The father, who was present with the mother and had been listening in on the conversation, got on the phone and became very belligerent with the caseworker, cussing, calling the caseworker racist, and talking over the caseworker.

On May 10, 2022, the caseworker met with the younger half-sibling, the older half-sibling, and the half-siblings' father.

On May 12, 2022, "[law enforcement] report[ed] that the charges against [the] parents ha[d] been dropped and there [was] no protection order in place."

On May 16, 2022, the caseworker called the mother in an attempt to schedule a visit to the parents' home. The mother declined to schedule an appointment with the caseworker and reported that the parents would contact their lawyers and the caseworker's supervisor about allowing the younger half-sibling to reside with the half-siblings' father.

On June 8, 2022, the caseworker advised the half-siblings' father that the mother had filed custody paperwork with the courts.

Through the months of May, June, and July 2022, the caseworker made multiple attempts to meet with the parents and schedule a visit with them at their home.

On July 19, 2022, the parents agreed for the caseworker to meet with them in their home the next day.

On July 20, 2022, the caseworker met with the parents individually at their home. The mother denied that there were any weapons in the home at that time, while the father denied that there had ever been any weapons in their home. The caseworker offered the parents resources; however, both of them declined them.

On July 26, 2022, the caseworker testified in the domestic relations court hearing. Custody of the younger half-sibling was vested with the father, with the mother having weekly supervised visits.

On July 27, 2022, the caseworker coordinated with the mother, the half-siblings' father, and the maternal relative to schedule weekly visits for the mother and the younger half-sibling, to be supervised by the maternal relative.

A Facilitated Family Meeting was held on August 3, 2022.

The assessment was closed on August 10, 2022, and a non-court-involved case was opened to provide services and supports to the family.

Findings: The allegations of fatal, intrafamilial neglect – lack of supervision/supervision inconsistent with child's need were substantiated.

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

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

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

Supplemental Information:

Per the law enforcement records, the charges against the parents were dropped out of concern for not being able to secure a conviction in their criminal cases.

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with Jefferson County Department of Human Services consisting of two referrals within the last three years.

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.

~5/2019	The mother, while out shopping with the younger half-sibling, purchased the gun from a pawn shop.

3/3/2020 Jefferson County Division of Children, Youth, Families and Adult Protection (JCDCYFAP) received a report of concern. The referral was determined not to meet criteria for assessment with the indicated reason of, "No information available from reporter of abuse and neglect as defined in law."

3/4/2020 JCDCYFAP received another report of concern. The referral was determined not to meet criteria for assessment with the indicated reason of, "No information available from reporter of abuse and neglect as defined in law."

~4/10/2022 The parents separated, with the mother, the younger half-sibling, and the child moving out of the family home and staying with the maternal relative.

4/16/2022 The child and the younger half-sibling spent the night at the family's home with the father.

4/17/2022 The mother, the father, the younger half-sibling, and the child went to an Easter gathering with the father's family. The child sustained a self-inflicted gunshot wound to the head while playing with a gun in the family's car.

4/20/2022 The child died from his injuries.

IV. COUNTY INTERNAL REVIEW

County: Denver and Jefferson **Date:** July 12, 2022

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: May 1, 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. Denver and Jefferson Counties' Internal Review Report Dated: July 12, 2022
5. Law Enforcement Records
6. Autopsy Report

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

- The parents gang involvement
- There was easy access to multiple weapons in the home
- History of domestic violence, with the mother as the victim in her past and current relationships
- Power and control dynamics perpetrated by the father towards the mother and the children
- The father's previous criminal charges for domestic violence
- The mother limited the half-sibling's father's parenting time/access with the half-sibling
- The father did not call 911 for help, instead driving the child to the hospital himself
- The parents did not have a good relationship with law enforcement
- Distrust of institutions
- Conflict between the maternal and paternal families

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 decision to immediately place the younger half-sibling with the half-siblings' father, rather than subjecting the younger half-sibling to another type of out-of-home care before being placed with the half-siblings' father.

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:

The CFRT did not identify any systemic gaps or deficiencies in service delivery.

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 counties 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 CFRT did not make any formal recommendations during the review of this fatality.