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

Public Notification Case ID: 22-042

Investigating County Name: Denver

County(ies) with Previous Involvement: Denver

Incident Level: Fatal and Egregious

Incident Date: 6/2/2022

~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. The older child victim

Age: 10 years old **Gender:** Female
Race or ethnicity: Black or African American
Child's residence: In-home

The younger child victim

Age: 8 years old **Gender:** Male
Race or ethnicity: Black or African American
Child's residence: In-home

B. Caregivers

Mother
Age: 30 years old **Race or ethnicity**: Black or African American

Father of the older chld

Age: 42 years old **Race or ethnicity**: Unknown

Father of the younger Child

Age: 44 years old **Race or ethnicity**: Black or African American

C. Description of the child's family (non-identifying information): The children lived with the maternal great aunt (henceforth the custodial aunt), who had custody of them. The children were involved in two prior child welfare cases with concerns regarding domestic violence between the

mother and the father of the younger child, the mother's mental health, and the mother's alcohol abuse, and were ultimately placed into kinship care when the parents were unable to complete their treatment plans. The older child was initially placed with her biological father, but when he became incarcerated she joined her brother in his kinship placement with the custodial aunt. The older child was placed with kin following the death of the younger child. The mother was experiencing homelessness at the time of the incident.

IV. COUNTY INTERNAL REVIEW

County: Denver **Date:** 8/15/2022

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: January 8, 2024

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 County's Internal Review Report Dated: 8/15/2022
5. Law enforcement report
6. Autopsy report

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

- The custodial aunt isolated the children and kept them from seeing family members who wanted to be involved in their lives.
- The custodial aunt did not have the skills to appropriately deal with the younger child's behavior problems.
- Inappropriate discipline techniques.
- The custodial aunt was parenting non biological children on her own, without help
- Pandemic isolation.
- The children had prior trauma history from things that occurred prior to them coming into the care of the custodial aunt.
- There was domestic violence between the mother and the father of the youngest child, with the youngest child's father as the perpetrator of the violence.
- There was a disconnect between the aunt's comfort level with beating the younger child so severely for mundane issues under the guise of loving the child and wanting to do right by him.
- The custodial aunt's misguided belief that she was one of the most capable people to parent the children in contrast to other family members, despite excessive physical punishment occurring in the home.
- The custodial aunt forced the older child to watch the abuse that killed the younger child. In addition, the children were forced to go on the shopping trip where the custodial aunt bought the items used to kill the child.

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 and egregious 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 team determined that it was a county specific strength that after the incident, the older child was connected to therapy.
2. The team determined a county specific strength in that the custodial aunt was a certified kinship provider, and had training for her caregiver role prior to and during placement.

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 and egregious 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 determined a systemic gap in that the children's schools did not report their numerous absences either to child welfare or as truancy. The children had 50 or more absences from school that school year.
2. The team determined that it was a systemic gap that the school did not reach out to emergency contacts when they were unable to make contact with the custodial aunt to discuss the children's absences.

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 team did not make any formal recommendations during this review.