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

Public Notification Case ID: 22-048

Investigating County Name: Weld

County(ies) with Previous Involvement: Weld

Incident Level: Fatal

Incident Date: 6/20/2022

~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: 10 years old **Gender:** Male **Race or ethnicity:** White
Child's residence: In-home

B. Caregivers

Mother
Age: 40 years old **Race or ethnicity**: Unknown

Father
Age: 37 years old **Race or ethnicity**: Unknown

C. Description of the child's family (non-identifying information): At the time of the incident, the child lived with the mother and the sibling and visited with the father. The parents separated during the assessment dated December 20, 2021. Both parents experienced alcoholism and drank to excess. Both parents sought treatment for their drinking, but it continued to be a problem for them. Neither parent had significant criminal history as an adult. The parents had a tumultuous relationship and fought with one another when they were drinking. The child and the sibling were present for the fighting/domestic violence. It was unclear who the aggressor of the domestic violence was, as alcohol also played a significant role in the fighting. The mother used methamphetamine at times, but her substance of choice was alcohol.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:**6/20/2022 **Date closed:** 7/29/2022
County: Weld **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the near fatal child maltreatment incident (non-identifying information): On June 20, 2022 Weld County Department of Human Services (WCDHS) received a report of concern about the child's death in a motor vehicle accident. It was reported that few details were known at the time the referral was made; however, the father, who was driving the car, was "'very intoxicated'" at the time of the accident. The sibling, who was also in the car during the accident, did not have life threatening injuries, but did have unspecified injuries. The referral stated "that [the parents] took a shot together before [the father] took the children in the car."

The caseworker learned that the father's blood alcohol level .255 mlg which was "critically high."

The caseworker and another caseworker visited the mother, the adult sibling, and the adult sibling's partner at home. The mother was distraught over the loss of the child. The caseworker discussed the need for a safety plan for the sibling, with the mother. The safety plan was necessary due to the mother's excessive drinking. It was noted that the mother was intoxicated during the home visit, as well as at the time of the incident, allowing the child and the sibling to go into the car with the father, who was also intoxicated. The safety plan entailed that the sibling would be supervised by other adult family members if the mother was intoxicated. If the mother was intoxicated, the other family members would bring the sibling to the sibling's appointments.

The caseworker spoke to the sibling, who "had a broken nose, stitches on their lip, a broken tail bone and lots of bruises, but were doing okay for the most part." The sibling was made aware of an upcoming forensic interview and was then allowed to go and be with their friends.

Law enforcement explained to the caseworker that during the accident, the car rolled a total of three times. The child was ejected from the car's sunroof on the second roll, and crushed by the car. Law enforcement believed the child's seatbelt may have broken his neck, due to bruising observed in that area. The father was ejected during the third roll of the car.

The father was unable to immediately be interviewed by the caseworker or law enforcement, due to his condition.

On July 6, 2022, law enforcement informed the caseworker that the father was conscious, but reporting that he had no recollection of the accident.

On July 13, 2022, the caseworker met with the mother at the WCDHS office. The mother indicated that while she was grieving terribly, she was making plans for her future. The mother stated that she had stopped drinking, as "she… associated drinking with [the child's] death." The mother was made aware of the findings of the assessment.

On July 15, 2022, the caseworker met with the father, who was still hospitalized. The father admitted to taking a shot of alcohol with the mother prior to leaving her home with the children. The caseworker explained that WCDHS had obtained custody of the sibling, and that the sibling was placed with kin. The father was made aware of the findings of the assessment.

The assessment was closed on July 29, 2022.

Findings: The allegations of medium, intrafamilial neglect - environment injurious were substantiated.

The allegation of severe, intrafamilial neglect - environment injurious was substantiated.

The allegation of fatal, intrafamilial neglect - environment injurious was substantiated.

Supplemental Information: (additional information gathered from the supplemental documents)
The father was initially charged with Child Abuse-knowing/reckless Cause Death, Vehicular Homicide - DUI, Vehicular Assault DUI, Driving under the Influence, Reckless Endangerment and Reckless Driving. The father pled guilty to Child Abuse-knowing/reckless Cause SBI and Vehicular Homicide - DUI.

Per the autopsy report, "the cause of death [was] multiple blunt force injuries which were sustained during a single motor vehicle rollover-type crash with subsequent ejection. The manner of death [was] accident."

B. FAMILY CASE HISTORY

Within the last three years, the family had current and prior involvement with Weld County Department of Human Services, consisting of one current case, three prior prevention cases, eight prior referrals, and two prior 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.

8/31/2020	WCDHS received a report of concern regarding the child and the sibling's behaviors and demeanors while at school. The child and the sibling were often late to school and exhibited "separation anxiety and anger" when they were dropped off at school. In addition, the parents yelled at the children, which caused the child and the sibling to believe they might be struck. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."
9/3/2020-10/7/2020	WCDHS briefly opened a prevention case to offer services to the family. The family declined needing additional services, as they were already enrolled in services and believed they had all the support they needed. The prevention case was closed with the indicated reason of, "Services to Be Given by Other."
10/19/2020	WCDHS received a report regarding concerns that the home was in disarray, and that the parents appeared to lack the skills necessary to care for children. There were no specific examples noted to describe the concerns. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."
10/22/2020-11/10/2020	WCDHS briefly opened a prevention case to offer services to the family. The family declined needing additional services, as they were already enrolled in a program and believed they had all the support they needed. The prevention case was closed with the indicated reason of, "Services not Needed."

2/19/2021-
4/19/2021 WCDHS performed an assessment regarding allegations of educational neglect and maltreatment of the child and the sibling related to being exposed to the behavior the father exhibited while he was drinking. The allegation of minor, intrafamilial neglect – environment injurious was unsubstantiated.

3/18/2021-
1/13/2022 WCDHS opened a prevention case to offer voluntary services to the family. "[The] [p]arents completed several therapy sessions each and then stopped. [The mother] requested [to] keep the case open for support. Child welfare referrals received in Dec[ember] 2021 and Jan[uary] 2022. [The case was closed] as child welfare … [opened a traditional] case." The prevention case was closed with the indicated reason of, "Opening Child Welfare Case."

10/8/2021 WCDHS received a report of concern regarding the sibling worrying that the child might be left home alone while the father worked. In addition, the father was not accepting of the sibling's gender identity. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."

10/9/2021 WCDHS received a report of concern regarding the sibling worrying about the fact that the parents allowed the child to stay home alone occasionally, and that sometimes the child then went to visit neighbors. The sibling believed the child needed more supervision. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."

12/20/2021-
1/24/2022 WCDHS performed an assessment regarding concerns about the father's excessive drinking and the father threatening to stab himself in the presence of the sibling. The allegation of minor, intrafamilial abuse – emotional was substantiated. The allegations of minor, intrafamilial neglect – environment injurious were unsubstantiated.

12/20/2021-
Pending WCDHS opened a non-court involved case to provide support and services to the family around the parents' drinking and domestic violence in their relationship. The case became court involved after the child's death. The sibling was placed in kinship care and later into foster care before returning to the care of the mother February 2023.

1/13/2022 WCDHS received a report of concern regarding the parents consuming alcohol/being suspected alcoholics and using marijuana. There were concerns that the father blew marijuana smoke in the sibling's face once, at an unknown time. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."

4/8/2022 WCDHS received a report of concern regarding the sibling, who was residing with kin. The sibling was worried they would be disciplined by having their phone taken away, which greatly upset the sibling. In addition, the kin were using physical discipline with the sibling. No injuries to the sibling were reported. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."

5/7/2022 WCDHS received a report of concern regarding the sibling. The RP reported that the sibling was taken to a local crisis center for the sibling's behavior that day during an altercation with family members. The RP indicated that it appeared that the mother

intentionally riled the sibling up so that crisis services were needed, in an attempt to get the sibling admitted into residential treatment. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."

5/7/2022 WCDHS received a second report of concern regarding the sibling, who was brought to a local crisis center that day. Initially, the mother could not be contacted to pick the sibling up when the sibling was ready to go home. Instead, staff brought the sibling home. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."

6/20/2023 The child passed away due to a car accident which occurred due to the father driving while intoxicated.

IV. COUNTY INTERNAL REVIEW

County: Weld **Date:** 8/31/2022

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: August 7, 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. Weld County's Internal Review Report Dated: August 31, 2022
5. Law Enforcement Report
6. Autopsy Report

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

- While the mother had periods of sobriety, both parents had significant substance abuse history/alcohol addiction.
- Because of the parents' historical alcohol problem, the mother may not have been able to discern how inebriated the father was when he left with the children on the day of the incident.
- The parents had a volatile relationship
- There was documented domestic violence between the parents, with the father as the perpetrator of the violence.
- The parents functioned much better when separated than as a unit.
- The parents were very private about the concerns in the home in terms of engaging extended family. Extended family may not have been aware of the issues in the family so they could not adequately contribute to safety.
- There were three Adverse Childhood Experiences (ACEs) at play in this family. Mental Health Struggles, Domestic Violence, and Substance Abuse. The family was high risk from a trauma informed/developmental lens.
- Juxtaposition of alcohol use and domestic violence
- The sibling was questioning their gender identity

- It appears that although the father was driving the vehicle, he asked sibling to hold the wheel during the drive so he could drink alcohol.
- It is unclear whether appropriate car safety laws, such as proper seat belt usage, were followed during the drive.
- The onus was on the children to decide whether it was safe to drive with the father as he began drinking in the car.
- Regarding the open treatment plan for voluntary case involving the sibling, the mother was engaged in the case but the father was not.

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 team identified a county specific strength in that there was a prevention case to provide substance abuse intervention for the family.
2. The team identified familial strengths in that the family was working to address the sibling's struggles, and that the mother was familiar with local crisis management programs and utilized them when needed.

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 that referrals regarding the parents' alcohol abuse were screened out, but there was no documentation which showed that the parent's drinking did not negatively affect the child and the sibling.

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 fatal incident.

F. Recommendations from the review of the incident:

1. The team did not make a formal recommendation regarding the review of this incident.