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

Public Notification Case ID: 22-049

Investigating County Name: El Paso

County(ies) with Previous Involvement: El Paso

Incident Level: Fatal

Incident Date: June 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: 1 month old **Gender:** Male

Race or ethnicity: Black or African American

Child's residence: In-home

B. Caregivers

Mother

Age: 39 years old **Race or ethnicity**: Black or African American

Father

Age: 39 years old **Race or ethnicity**: Black or African American

C. Description of the child's family (non-identifying information): At the time of the incident, the one-month-old infant lived with the mother and the 23-month-old sibling, while the father was incarcerated. An older maternal half-sibling, who was 14 years old, had previously been living with family out-of-state, but began living with the mother again after the infant's death.

Both parents had a history of methamphetamine use and struggled at times to maintain their sobriety while caring for the children. Due to their methamphetamine use, the sibling was placed into out-of-home care in 2021 for several months prior to returning to the mother's care.

The parents also had a history of domestic violence in their relationship, primarily perpetrated by the father towards the mother. Following a domestic violence incident in April 2022, the mother made plans to separate from the father in order to keep herself and the children safe.

The mother reported being involved with the child welfare system as a child, including out-of-home placement for the mother and some of her siblings. While the mother did not have any formal mental health diagnoses, there was speculation that she might suffer from Bipolar Disorder and/or

Schizophrenia. The mother's criminal history included charges of theft and motor vehicle violations.

The father was incarcerated at the time of the infant's death on charges related to domestic violence after assaulting the mother and the sibling. The father's criminal history also included charges of robbery, burglary, kidnapping, and assault. The father was reportedly diagnosed with Bipolar Disorder and Schizophrenia. The father reported blacking out while under the influence of methamphetamine and could not recall the things he said or did while under the influence of substances. The father denied any child welfare history as a child, and reported being interested in services and supports following his release from jail.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment Date received: 6/20/2022 **Date closed:** 8/12/2022
County: El Paso **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On June 20, 2022, El Paso County Department of Human Services (EPCDHS) received a report of concern regarding the infant. The reporting party (RP) reported "[the] [i]nfant was brought in to [*sic*] [a local hospital], unresponsive and in critical condition… [it was unclear] if the infant [was] going to survive." The infant was transferred to Children's Hospital Colorado (CHC) in Colorado Springs. Law enforcement was involved and had "initially [been] told [the mother] was co[-]sleeping, but [law enforcement] later found drug paraphernalia in the home." The mother was reported to have a history of substance use, and admitted to using methamphetamine a few days prior. The mother was reported to have initially contacted emergency medical services (EMS), as "[the infant] ha[d] blood [coming] out of his mouth." The infant was without a pulse when EMS responded, but EMS was able to resuscitate the infant prior to transporting him to the local hospital. The RP expressed concerns that the infant was exposed to narcotics as the mother was reported to be breastfeeding the infant while using substances. The sibling's whereabouts were unknown to the RP, but they reported that the sibling was not in the home at the time of the incident. The mother's home was reported to have substances that "were not secured," and RP believed "[the sibling] would have [had] access to [the] narcotics."

The caseworker met with law enforcement at the mother's home. The caseworker was informed that the maternal relative resided in the home with the mother and the children. The mother was reported to have fallen asleep in the bed after playing with the children. When the mother awoke, she found the infant unresponsive, called EMS, and performed cardiopulmonary resuscitation (CPR). The infant was reported to have been between the mother and the sibling on the bed when the mother found the infant. The mother was reported to have not known what happened, but she speculated that the sibling may have kicked the infant. Law enforcement believed that co-sleeping was the cause of the infant's condition, but the mother had also recently used methamphetamine. The mother was reported to have stated the drug paraphernalia belonged to the maternal relative, who used heroin, but law enforcement found foils in the mother's room.

The caseworker spoke with the CHC social worker. The CHC social worker reported the infant did not have any reflexes and would most likely be brain dead or pass away. The infant was reported to be on a ventilator and was unable to breathe on his own. The CHC social worker reported that no substances were found in the infant's toxicology at the local hospital, but toxicology was pending from CHC of Colorado Springs.

The caseworker met with the mother and the infant, who had been admitted into the Pediatric Intensive Care Unit (PICU). The mother reported early in the morning she woke up twice to feed the infant, but at the third feeding she noticed the infant had "blood on his face and he was

unresponsive." The mother reported she immediately contacted EMS and performed CPR while on the phone with EMS. The maternal relative stayed at the home the evening prior, but was outside at the time of the incident. The father was in the local jail and there was a protection order in place due to a prior domestic violence incident in March 2022. The mother reported that she co-slept with the infant, but in the evenings she would place him in the bassinet. On the day of the incident, the mother fell asleep after breastfeeding the infant, but prior to placing the infant in the bassinet. The mother questioned if the prior domestic violence incidents the father perpetrated against her may have caused this to happen to the infant. The mother described a time when the father attempted to suffocate her, and another time when the father kicked her in the stomach while she was pregnant. The mother denied that the foils located in her room where hers, and reported she found them when she cleaned out the maternal relative's car. The mother reported she had not thrown away the items she found in the vehicle, but she did inform the maternal relative that they could not remain in the home if they were using substances. The father was also reported to have used methamphetamine prior to going to jail. The mother admitted to using marijuana the prior evening and reported prior methamphetamine use. The mother reported she attended "individual therapy and [was] about to graduate relapse prevention phase II." The mother reported that she believed that a urinalysis (UA) would be positive for marijuana and possibly amphetamines as "her kidneys [were not] good and things stay[ed] in her system longer."

The caseworker spoke with the paternal relative, who had previously provided care for the sibling. The paternal relative expressed concerns regarding the maternal relative residing in the home due to their substance use and that it jeopardized the mother's sobriety. The paternal relative reported that the mother slept often and she believed "[the mother] [did not] know how to be a [mother]." The caseworker developed a safety plan with the paternal relative, where the sibling would remain with the paternal relative and the mother would have supervised visits with the children. The caseworker made attempts to notify the mother of the safety plan. The caseworker later met the sibling at another relative's home.

The caseworker was informed by law enforcement that they did not plan to "[press] charges at [that] time."

The caseworker spoke with the mother's sobriety sponsor. The mother's sobriety sponsor reported that they had known the mother for seven years and had seen the mother the prior weekend, at which time she was sober and attentive to the children.

The caseworker was able to confirm with the mother via text message that she was aware of the current safety plan and she reported she was searching for "people to sit with her at the hospital."

On June 21, 2022, the caseworker received an update on the infant's condition from the CHC social worker. The CHC social worker reported the infant's condition had worsened. The mother was reported to have reached out to her church for support, and the family members met and reported they did not want the infant to suffer. "[The infant] [did not] have any injuries," but was "positive for [the] adno virus [*sic*]."

The caseworker then completed a video call with the father while he was in jail. The father denied having any concerns for the children in the mother's care and believed that she had been sober prior to his incarceration.

On June 22, 2022, the infant passed away. His official cause of death was determined to be cardiac arrest.

The mother's UA results, on June 29, 2022, "[were] positive for [tetrahydrocannabinol] THC only." The mother agreed to submit another UA.

The mother's second UA results were returned on July 5, 2022, and were also only positive for THC. The caseworker also learned that the infant's toxicology results, taken at CHC, were negative for all tested substances. However, the toxicology screen through his autopsy would be more comprehensive.

The caseworker spoke with the mother by phone, who admitted to methamphetamine use the day prior to the infant's death, but reported that she fed the infant formula after her use.

On July 11, 2022, the caseworker and the mother spoke by phone regarding the mother's progress in treatment and compliance with the safety plan. The mother reported that she asked the maternal relative to leave the home, in order to not compromise her sobriety.

On July 13, 2022, the caseworker met with the older maternal half-sibling, who had been residing with the mother since the infant's death. The older maternal half-sibling reported feeling safe in the mother's care and denied any concerns for fighting or substance use by the mother.

The mother submitted another UA, which only tested positive for THC, and completed a hair follicle test.

On July 19, 2022, the mother's hair follicle results were "negative for all substances."

The assessment was closed on August 12, 2022.

Findings: The allegation of fatal, intrafamilial neglect – environment injurious was substantiated.

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

Referral ID: 3307404
Date received: 6/20/2022
County: El Paso **Date not accepted for assessment:** 6/21/2022
Reason for not accepting referral for assessment: "Duplicate referral"

Referral narrative summary and additional information contained in referral (non-identifying information): On June 20, 2022, EPCDHS received a report of concern regarding the infant. The RP, a nurse, reported almost identical information as that in the incident assessment. The mother reported she fell asleep while breastfeeding the infant and awoke to the infant unresponsive and with "blood coming from his nose." The mother was reported to have been exhausted due to the sibling and infant being on different sleep cycles. The referral was not accepted for assessment for the identified reason of, "Duplicate referral."

Supplemental Information:

Per the infant's autopsy report, "[the infant]… died as a result of asphyxia occurring in an unsafe sleep environment. This [death] was incurred by co-sleeping in an adult bed. An adenovirus infection contributed to his death." The manner of death was determined to be an accident. The infant's postmortem toxicology report showed the infant was negative for all illicit substances. The only positive toxicology was for benzodiazepine, which medical records showed was used in treating the child prior to his passing.

Based on the autopsy findings, the law enforcement investigation was moved into inactive status. No charges were filed.

B. FAMILY CASE HISTORY

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

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.

~6/2020	The sibling was born.
9/1/2020	EPCDHS received a report of concern regarding the father entering the mother's home, despite a protection order in place, to pack up some of his belongings. The father attempted to take the sibling with him when he left; however, the mother threatened to call law enforcement if he did so. The father returned the sibling to the mother prior to leaving the home. 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."
4/23/2021-6/22/2021	EPCDHS completed an assessment regarding concerns that the sibling ingested methamphetamine. The mother admitted to "recently drop[ping] 12 pills" and was unable to find two of them. The mother believed the sibling might have ingested the remaining two pills. The mother reported her last use was 90 days earlier; however, the mother's hair follicle test results were "[p]ositive for THC/[m]ethamphetamine." The father was reportedly receiving in-patient substance abuse treatment at that time. The allegation of minor, intrafamilial neglect – environment injurious was substantiated.
4/23/2021-2/23/2022	EPCDHS opened a court-involved case following the sibling's methamphetamine ingestion. The sibling was placed into out-of-home care with the paternal unt while the parents worked on completing their treatment plan objectives. The sibling was reunified with the mother in November 2021. The parents successfully completed their treatment plans and reported being committed to their sobriety and stability. The case was closed with the indicated reason of, "Services Successful."
~11/2021	The sibling was returned to the mother's care and custody.
4/11/2022-6/9/2022	EPCDHS completed an assessment regarding concerns for physical domestic violence perpetrated by the father on the mother while she was holding the sibling and pregnant with the infant, including the father's attempt to suffocate her. Law enforcement responded to the home and the father was reported to be under the influence of methamphetamine at that time. The father was later arrested and incarcerated, and a permanent restraining order was issued protecting the mother and the sibling from the father. The allegation of minor, intrafamilial neglect – environment injurious was substantiated. The allegation of minor, intrafamilial abuse – physical was substantiated.

~5/2022 The infant was born.

6/16/2022 The mother's reported last methamphetamine use. The mother reported using methamphetamine that day with the maternal relative, and later asked them to move out of her home since she struggled to maintain her sobriety in their presence.

6/20/2022 The infant was taken to a local hospital in critical condition after co-sleeping with the mother while she was possibly under the influence of methamphetamine.

6/22/2022 The infant passed away.

IV. COUNTY INTERNAL REVIEW

County: El Paso **Date:** August 15, 2022

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: June 5, 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. EL Paso County's Internal Review Report Dated: August 15, 2022
5. Law Enforcement Records
6. Medical Records
7. Autopsy Report

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

- The mother's history of methamphetamine use
- The father's history of methamphetamine use
- The mother was the victim of domestic violence, perpetrated by the father
- The mother was then parenting alone after the father's incarceration
- The mother's trauma history related to the domestic violence in her relationship with the father
- Young, vulnerable children
- The mother's child welfare history as a child, possibly experiencing out-of-home placement
- The father's mental health history, which was possibly untreated

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 service delivery to the family during their prior case, which enabled for the mother to continue to engage in services even after the case closed. Additionally, there was a permanent restraining order issued against the father after the most recent domestic violence incident perpetrated by the father towards the mother.

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 systemic gap related to observed inconsistencies across the state with regard to the child welfare and law enforcement involvement, policies, and practices when a child dies in an unsafe sleeping environment, and how those inconsistencies impact findings or charges for parents.

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:

There were no formal recommendations made through the review of this fatal incident.