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

Public Notification Case ID: 22-072

Investigating County Name: Larimer

County(ies) with Previous Involvement: Larimer and Weld

Incident Level: Fatal

Incident Date: September 9, 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: 3 months old **Gender:** Male

Race or ethnicity: White

Child's residence: In-home

B. Caregivers

Mother

Age: 29 years old **Race or ethnicity**: White

Father

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

C. Description of the child's family (non-identifying information): The infant lived at home with the mother, the father, and the two-year-old sibling.

Both parents had child welfare history as children. The mother was placed into out-of-home care as a youth, while the father was adopted through the child welfare system. The mother's criminal history included theft and motor vehicle related charges, while the father's criminal history included drugs, motor vehicle theft, and weapons charges.

The parents had two older children, both of whom were removed from their care. One was adopted by a family friend and the other was placed into the permanent custody of a family member. There were also concerns of substance use and domestic violence between the parents during their prior child welfare case.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 9/9/2022 **Date closed:** 10/4/2022
County: Larimer **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On September 9, 2022, Larimer County Department of Human Services (LCDHS) received a report of concern regarding the death of a three-month-old infant. The reporting party (RP) reported that the infant was found unresponsive in the morning, "around 9am -9:30am…. [The mother] called 911 at 9:42am…. [and] [the infant] was pronounced deceased at 10:15am." The mother had breastfed the infant around 4:00 a.m., before falling back asleep. "[The infant] was purplish and not breathing" when the mother woke again later that morning.

A caseworker responded to the family home and observed the parents' interviews with law enforcement. The father reported having gotten into an argument with the mother the previous day, which resulted in him leaving the home and staying with a friend. The father admitted to methamphetamine use while at the friend's house. The mother reported being frustrated with the infant's crying in the middle of the night, but that she fed him and they both fell back asleep. When the sibling woke the mother the next morning, the mother realized that the infant was still in the mother's bed and that he had died. The mother admitted to marijuana use before going to bed the previous night, and "using methamphetamine while she was twenty weeks pregnant with [the infant]." The mother submitted a urinalysis (UA) that "was positive for [tetrahydrocannabinol] THC." A relative agreed to care for the sibling on a short-term basis.

On September 12, 2022, the relative supervised a visit for the mother and the sibling at a local park.
The caseworker spoke with a local hospital, where the infant was born, and confirmed that the infant "was only positive for THC" at the time of his birth. The infant's last medical appointment was on July 19, 2022.

The infant's preliminary autopsy results showed signs of petechial and aspirated blood, which the coroner reported "[was] consistent with [the mother's] explanation," of the infant's death and was indicative of "the [infant]… not getting oxygen…. [T]here were no other injuries observed on [the infant]."

The caseworker spoke with the parents, individually, by phone. The father was upset and verbally aggressive during the phone call, "demanding to know when he could see [the sibling]." The father was advised of his need to complete a UA and to contact the relative to schedule a supervised visit with the sibling. The caseworker asked the father for additional placement options for the sibling. During the mother's call a few hours later, the mother was also advised of the need to find another placement option for the sibling, as well as what an ongoing case and treatment plan would entail in order for the mother to reunify with the sibling.

On September 13, 2022, the caseworker spoke with the parents on the phone, who were together at that time. The caseworker advised them of the date and time for their upcoming court hearing, which they stated was the same date and time as the viewing for the infant. The caseworker offered to reschedule the court hearing in order for the parents to tend to the funeral arrangements for the infant.

On September 16, 2022, the caseworker supervised a visit between the parents and the sibling.

The Dependency and Neglect (D&N) hearing was held.

On September 19, 2022, the caseworker consulted with a medical provider regarding the concerns in the case.

On September 20, 2022, the caseworker learned that the mother's UA was almost dilute, which impacted the validity of the test. The mother was also asked to submit a hair follicle test.

On September 23, 2022, the caseworker supervised another visit between the parents and the sibling. Following the visit, the parents agreed to submit their respective sobriety monitoring tests.

The parents and the sibling had another supervised visit on September 30, 2022.

The caseworker called the parents and spoke to them about their respective hair follicle test results. The father agreed to participate in services and reported that he was moving to a new town. The mother became defensive about her test results.

On October 4, 2022, the assessment was closed and a court-involved case was opened to provide placement for the sibling and services for the family. In the assessment closure summary, it was documented that the mother's hair follicle test was positive for methamphetamine only, despite the mother previously admitting to daily marijuana use and denying recent methamphetamine use. The father's hair follicle test was positive for amphetamine, methamphetamine, and THC.

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

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

Supplemental Information: (additional information gathered from the supplemental documents)
The completed autopsy report documented that the infant's cause of death was "sudden death in infancy. The death occurred in the setting of an unsafe sleeping environment, specifically co-sleeping in an adult bed. By convention, [those] deaths [have been] certified with cause and manner of death listed as undetermined."

Law enforcement closed their investigation and determined that no charges would be filed related to the infant's death.

B. FAMILY CASE HISTORY
Within the last three years, the family had prior involvement with Larimer and Weld County Departments of Human Services consisting of four referrals and one FAR assessment-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.

1/3/2020	LCDHS received a report of concern regarding the mother seeking counseling services to help her abstain from methamphetamine use, as she had used sporadically during her pregnancy, and was due to deliver the sibling later that month. Both parents reported history of methamphetamine use, but had recently become sober. There were no children in the parents' care at that time. 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."

1/22/2020
-7/14/2020 LCHDS conducted an assessment after the mother delivered the sibling. There are no findings in a FAR.

1/27/2020 LCDHS received a report of concern regarding the parents' lengthy substance use history, homelessness, domestic violence, and pattern of losing custody of their children due to their substance use. The referral was determined not to meet criteria for assessment with the indicated reason of, "Refer to: Other Department of Social/Human Services, other Agency, or Individual."

1/27/2020 Weld County Department of Human Services (WCDHS) received a report of concern regarding historical concerns for the parents' substance use, history of DHS involvement, and the removal of the parents' other children. The RP reported that one of the parents' other children was almost smothered once and that another child had to be hospitalized for three days after not being fed properly. The referral was transferred to LCDHS and was determined not to meet criteria for assessment with the indicated reason of, "Refer to: Other Department of Social/Human Services, other Agency, or Individual."

5/19/2022 WCDHS received a report of concern regarding the mother testing positive for marijuana at the time of the infant's birth. The infant's toxicology screen was pending, and there were no reported concerns for the infant or the parents' care of the infant. On 5/26/2022, 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." Per RED Team, a new referral would be generated if the infant's toxicology report was positive for anything other than marijuana. On 5/31/2022, WCDHS was notified that the infant's toxicology screen was positive for THC.

9/9/2022 The infant died.

IV. COUNTY INTERNAL REVIEW

County: Larimer **Date:** November 9, 2022

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: July 10, 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. Larimer County's Internal Review Report Dated: November 9, 2022
5. Autopsy Report
6. Law Enforcement Records

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

- Domestic violence in the family, with the father as the controller/perpetrator
- The mother's substance use
- The father's substance use
- Substance use during pregnancy
- Extensive child welfare history, including losing custody of two other children
- The mother's child welfare history as a child, she was raised in the system
- Financial instability
- Housing instability
- Unsafe sleep environment
- The parents had a disagreement the night of the incident
- The mother was frazzled when the infant would not stop crying on the night of the incident
- The mother's supports struggled to hold her accountable when the father was present
- The sibling tested positive for substances at birth

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 mother's previous participation in services, which enabled her to achieve and maintain periods of sobriety. The mother was also able to access resources for the children, such as food and formula, in order to meet their basic needs.

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 regarding the length of time a county department of human services can leave a case or assessment open in order to support a caregiver's sobriety. There is a lack of more long-term community resources available to assist caregivers in maintaining their sobriety after an assessment or case closes.

2. The CFRT identified another systemic gap related to the complex dynamics created by domestic violence when trying to provide services and supports to an intact couple, as most domestic violence resources need the caregivers to complete their services separate from each other; however, most caregivers tend to remain in their relationships.

3. The CFRT identified a case-specific gap related to the father's lack of participation in services during the family's prior child welfare involvement. He was reported to be uncooperative with the requested services or in working towards his own sobriety.

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:
There were no formal recommendations made during the review of this fatality.