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

Public Notification Case ID: 22-092

Investigating County Name: Adams

County(ies) with Previous Involvement: Adams

Incident Level: Fatal

Incident Date: November 10, 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: 4 years old **Gender:** Female
Race or ethnicity: Unknown
Child's residence: In-home

B. Caregivers

Mother
Age: 45 years old **Race or ethnicity**: Unknown

Father
Age: 34 years old **Race or ethnicity**: White

C. Description of the child's family (non-identifying information): The child, who was four years old, lived in the home with the mother and the five-year-old half-sibling. Due to financial stress, the family recently moved in with a maternal relative, who assisted the mother in caring for the child. The child required around-the-clock care and attention. The child was fed through a gastrostomy tube (g-tube), was non-verbal, and non-ambulatory. The child had several medical and developmental services in place.

The mother reported being in a relationship with the father for five or six years, but stated they were never legally married. They ended their relationship in September 2021. The father was minimally involved in the child's life. The half-sibling's father was not involved at all in the half-sibling's life. The mother reported having two adult children. There was very little information documented about the father, the half-sibling's father, or the two adult children.

The mother was employed as a Certified Nursing Assistant (CNA) to provide care for the child on a daily basis. The mother reported a prior history of methamphetamine use, but had not used it in 13

years. The mother also reported a prior history of alcohol use, but had reportedly been sober for one month. The mother's criminal history included charges in 2002 for "[c]onspiracy to [m]anufacture," for which she served one year in jail.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 11/11/2022 **Date closed:** 3/9/2023
County: Adams **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On November 11, 2022, Adams County Human Services Department (ACHSD) received a report of concern regarding the death of a four-year-old child. The reporting party (RP) reported that the child, who had suffered from multiple health issues since her birth, died on November 10, 2022, due to sepsis. The mother transported the child to a branch of Children's Hospital Colorado (CHC) on November 10, 2022, where the child passed. The RP reported being concerned about the children and having made several reports to child welfare in the past, but was unsure if any of the reports had been assessed. The RP stated that had the RP's concerns previously been taken seriously, the child might not have died. The RP was concerned for the safety and well-being of the half-sibling, who was still in the mother's care. The RP reported that the mother was an alcoholic, who sought medical treatment multiple times a week, due to her alcohol abuse. Additionally, the child was born drug-exposed, which caused all of her health issues, including needing a feeding-tube, being an invalid, and not being able to talk or see. The RP reported that the child's father was involved in the child's life; however, while he was caring for the child and the half-sibling in the past, "[the half-sibling] ended up having a broken femur." The mother had planned on home-schooling the half-sibling, reportedly due to being too intoxicated to "take [the half-sibling] to school;". The RP requested for ACHSD to remove the half-sibling from the mother's care.

The caseworker spoke with a social worker at CHC, in an effort to get updated contact information for the mother. The CHC social worker believed the mother had been staying in motels, but would see what additional information could be passed along to the caseworker.

The caseworker met with the mother, the half-sibling, and maternal relative at the maternal relative's home. The mother provided information about the child's medical diagnosis, and the child's needs for multiple medical and developmental services. The mother was employed as a CNA to meet the child's daily needs. The mother reported that she had been too sick recently to take the child to her medical appointments, and then the child started feeling ill as well. The child had had "a fever for two days and it finally broke" on November 10, 2022. When the mother checked on the child, who had been sleeping on the floor due to the family just recently moving into the maternal relative's home, "[the mother] saw that [the child] was breathing heavily…. [h]er eyes 'got dark' and started rolling back in her head. [The mother] immediately put [the child] in the car and brought her to [CHC]." As the doctors at CHC were attempting to revive the child, "they told [the mother] that [the child's] [g]-tube was leaking blood into her stomach and she had hypothermia." The mother reported that the child's g-tube site had been bleeding consistently for the previous two weeks. The mother stated she notified the child's doctor, who recommended a cream for the mother to put on the g-tube site. However, the mother could not locate the name of the cream or the tube of cream itself to show to the caseworker. The mother denied following up with the doctors when the child's g-tube site continued bleeding, despite the use of the cream. The mother provided social history information about herself and the family for the remainder of her interview with the caseworker.

The caseworker then met with the maternal family member, who reiterated that the mother and the children had just moved in with the maternal relative two weeks earlier. The maternal relative reported a history of substance use for the mother, but that the maternal relative told the mother

she could not drink alcohol while in the maternal relative's home. Therefore, the maternal relative had not seen the mother consume alcohol in the past week. The maternal relative reported noticing that the child had been losing weight since moving into the maternal relative's home, but that the mother had advised that the child's weight often fluctuated. The maternal relative denied having any safety concerns for the half-sibling while in the mother's care and reported that should the mother start drinking again while caring for the half-sibling, "[the maternal relative] would stay home from work" in order to care for the half-sibling at that time.

The caseworker then met with the half-sibling.

On November 15, 2022, the caseworker spoke with the coroner by phone. The coroner reported that "[the child's pediatrician] said [the child's death] was expected and [the child's pediatrician] would sign off on it being ruled a natural death." Since the coroner was not aware of any other concerns for medical neglect at that time, the child's death was determined to be from natural causes related to her medical condition; therefore, an autopsy would not be completed.

On November 21, 2022, the caseworker spoke with the CHC social worker again by phone. The CHC social worker reported that the child's medical providers were concerned about the child's weight being too low, as she was about half the weight she should have been for her age and medical condition, and that the lower weight would prevent the child from being able "to fight off [an] infection." The CHC social worker had also heard from the child's in-home service providers regarding their own concerns for the child. The CHC social worker had encouraged them to file reports with ACHSD; however, they later stated "'they didn't know how to make a report.'"

The caseworker spoke with the mother by phone on December 7, 2022. The mother reported having 40 days of sobriety and that she had been looking for a new job and was open to accessing therapeutic services for herself and the half-sibling. They were continuing to live with the maternal relative for the time being.

On December 9, 2022, the caseworker spoke by phone with one of the child's CHC medical providers, who reported having concerns for the child's malnutrition, but was not sure if it rose to a level of being called medical neglect. The CHC medical provider reported having also spoken with one of the child's in-home providers who reported having a prior concern for the child's care at home, but who did not make a report to ACHSD due to the length of time since that in-home provider's last appointment with the child. The CHC medical provider reported feeling "devastated and wishe[d] [the CHC medical provider] had done something [for the child] sooner."

On February 22, 2023, the caseworker pasted into Trails a copy of a law enforcement report dated February 17, 2023, when the mother, the half-sibling, and an adult male had law enforcement contact. It appeared that the mother and the half-sibling were living out of their car, and the adult male was found to have cocaine and paraphernalia on his person upon his arrest for an outstanding warrant. The mother denied that she and the half-sibling were living in their car.

The caseworker then met with the half-sibling at school.

The caseworker then called and spoke with the mother by phone. The mother reported that the adult male was someone she had dated briefly before the child's death and who had recently reached out to her for help and support. The mother stated she was giving him a ride on February 17, 2023, and that all of the personal items in the car were his, not hers. The caseworker advised the mother that he was found to have drugs and paraphernalia on him at the time of his arrest. The mother thanked the caseworker for the information, reported that she had continued to maintain her sobriety, and was invested in continuing her treatment services and supports.

On February 23, 2023, the caseworker attempted to contact the father via phone and email.

The caseworker also called the half-sibling's father and advised him of the report of concern for the half-sibling.

On February 27, 2023, the caseworker pasted the child's CHC medical records into Trails.

The assessment was closed on March 9, 2023. In the assessment closure summary, it was documented that, "Upon careful review of [the child's] medical records, conversations with providers, interviews with family members, and family circumstances, ACHSD… determined that [the mother's] failure to seek care for [the child] despite all of her medical needs negatively impacted [the child's] health and more likely than not contributed to her death."

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

The allegation of fatal, intrafamilial neglect – deprivation of necessities was substantiated.

The allegation of minor, intrafamilial neglect – environment injurious was substantiated.

Referral
Date received: 11/11/2022
County: Adams **Date not accepted for assessment:** 11/13/2022
Reason for not accepting referral for assessment: "Duplicate referral"

Referral narrative summary and additional information contained in referral (non-identifying information): On November 11, 2022, ACHSD received a second report of concern regarding the child's death. The RP reported that the mother had been neglectful to the child by not cleaning the child's feeding tube, which caused the child to become septic. The half-sibling was placed into the care of one of the mother's adult children the previous evening, while the child was taken to the hospital. The half-sibling reported feeling ill due to being fed baby food by the mother. The half-sibling also reported "that [the mother's other adult child] was allegedly leaving drugs laying [*sic*] around the home[,] and that… 'they put rags in [the half-sibling's] mouth, so people did not hear [the half-sibling] crying when they spank[ed] [the half-sibling].'" The RP shared that the mother had a history of methamphetamine and alcohol use, was homeless, and reportedly had a seizure the previous night as well. The referral was determined not to meet criteria for assessment with the indicated reason of, "Duplicate referral."

Supplemental Information:

On January 4, 2023, law enforcement closed their investigation after receiving confirmation from the coroner "that the [child] died of natural causes due to severe protein calorie malnutrition, due to sepsis, [and] due to cardiac arrest."

Open Involvement (open at the time of the fatal child maltreatment incident)**:**

Assessment **Date received:** 10/28/2022 **Date closed:** 3/9/2023
County: Adams **FAR:** No **Overall Finding:** Substantiated

Referral narrative, assessment summary, status of investigation (non-identifying information)**:** On October 28, 2022, ACHSD received a report of concern regarding the child's medical needs being neglected. The RP reported that the child's nutritional needs were not being met and that the child was underweight. The child had medical issues, making proper "nutrition… very important to adequately… [gain] weight." Over the years, the child's weight had maintained around 16.75 pounds, when her weight needed "to be in the high 20's-30 pounds." The RP reported that the

child was supposed to be seen by several specialty clinics at CHC, in additional to the nutrition clinic, "but [was] also missing other specialty appointments such as ortho[pedics], gastro[intestinal], rehab[ilitation], and metabolic appointments." The child was last "seen at [CHC]… on 5/18/22," and no one from CHC had been able to reach the mother since that date. The RP reported CHC had been unable to speak with any extended family members regarding the missed appointments and concerns for the child due to the Health Insurance Portability and Accountability Act (HIPAA) regulations.

The caseworker made two unsuccessful attempts to see the family, on November 4, 2022 and November 9, 2022.

The remaining information documented in the assessment from November 2022, through March 2023, was identical to the fatality assessment dated November 11, 2022, with the exception of the law enforcement contact with the family, or the subsequent contacts with the mother and the half-sibling about that contact, being entered into the assessment.

The assessment was closed on March 9, 2023.

Findings: The allegation of medium, intrafamilial neglect – medical neglect was substantiated.

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with Adams County Human Services Department consisting of one open assessment and one prior referral.

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.

8/13/2020	ACHSD received a report of concern regarding a fire that started outside of the apartment complex where the mother, the father, and the children were living. The parents had been seen discarding their cigarettes out their apartment window, near where a fire started. The RP reported there were concerns for the condition of the family's home; however, "the children seemed healthy." The family might stay with the maternal relative, who lived in the apartment across the hall, while their apartment was being repaired. 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."
~9/2021	The parents ended their relationship.
11/16/2021	The child had cataract surgery.
12/21/2021	The child was seen by the nutrition department at CHC due to concerns for poor weight gain. Palliative care and a six-month follow-up care were recommended.
~5/2022	The child's last known medical appointment.

10/28/2022 ACHSD received the report of concern regarding possible medical neglect for the child due to the lack of follow up care for the child and the medical professionals' inability to reach the mother to schedule additional appointments. Please see the Open Assessment for additional information.

~11/2022 The mother and the child were both ill. The mother reported being too ill herself to take the child to any medical appointments. The mother noticed consistent bleeding around the child's g-tube.

11/10/2022 The child had difficulty breathing and the mother took her to the north branch of CHC, where the child was diagnosed with sepsis. Resuscitation efforts were unsuccessful and the child passed away.

IV. COUNTY INTERNAL REVIEW

County: Adams **Date:** February 10, 2023

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. Adams County's Internal Review Report Dated: February 10, 2023
5. Law Enforcement Records
6. Medical Records

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

- The child's high medical needs, which lead to a decline in the child's health
- The mother did not follow through with medical or palliative care for the child
- The mother's alcohol use
- History of housing instability
- Financial struggles
- Reports of concern for the child were not made, mainly due to her poor prognosis, but the potential reporting parties later expressed regret over not reporting their concerns sooner
- The father was not involved
- The mother was a single caregiver

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:

The CFRT did not identify any strengths during the review of this fatal incident.

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 the standard of best practice when families cannot be located within their assigned response time, and the reasonable efforts to observe or interview the child to be made based on the reported allegations and/or the severity of concerns to the child should the child not be located, rather than just making those efforts one or two days a week.

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:

The CFRT did not make any formal recommendations during the review of this fatal incident.