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

Public Notification Case ID: 22-103

Investigating County Name: Douglas

County(ies) with Previous Involvement: Arapahoe

Incident Level: Fatal

Incident Date: 11/22/2022

~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)(2019).

I. IDENTIFYING INFORMATION

A. Child victim

Age: 22 months old **Gender:** Male
Race or ethnicity:
Child's residence: In-home

B. Caregivers

Mother

Age: 27 years old **Race or ethnicity**: Unknown

Father

Age: 22 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, the mother's boyfriend and the half-sibling, who was 7 years old. The child also spent weekends in the care of the father and paternal relatives during the father's parenting time. An official custody agreement had not yet been determined. The child was diagnosed with DiGeorge syndrome, and was gastric-tube (g-tube) dependent for most of his nutrition in the past, but had passed a swallow study prior to his death, and was able to ingest food normally. The child's medications were still administered using the g-tube.

The mother had a history of alcohol abuse, with periods of sobriety and relapse. The mother also occasionally used cocaine and cannabis. She did not report any ongoing physical or mental health problems. The father did not report any substance use/abuse, or any ongoing physical or mental health problems. The mother's boyfriend had a history of cocaine use/abuse and used cannabis. None of the adults had significant criminal history.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 11/22/20222 **Date closed:** 1/18/2023
County: Douglas **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On November 22, 2022, Douglas County Department of Human Services (DCDHS) received a report of concern regarding the child's death. The reporting party (RP) reported that the child had passed away, and that there were no immediate concerns that the child's death was abuse or neglect related, as the child had DiGeorge syndrome and there were no obvious signs of trauma on the child's body. Interviews with the parents had not yet taken place. The father picked the child up from the mother's home, and noticed that he seemed "limp and lifeless[,]" but the mother believed the child was just sleeping. When the father arrived at his home, he realized the child was not breathing, and called for emergency medical services (EMS). It was noted that the parents shared custody of the child, and that both parents were extremely emotional over the child's death. The mother had a history of substance abuse, which included a period of sobriety and a relapse approximately nine months prior to the incident, when the mother resumed drinking alcohol.

The caseworker and law enforcement met with the mother and maternal relatives. The mother stated that the child had eaten a meal and then fell asleep on her lap. He slept for over three hours. The father picked the child up around 10:00 pm. The mother stated that she contacted the father several times to see whether the child awoke in the car, but he did not answer. The next contact she had with the father was after EMS was already at his home working on the child. The father immediately began accusing the mother of harming the child.

On November 28, 2022, the caseworker discussed the coroner's initial findings with law enforcement. The coroner believed the death was likely from natural causes related to DiGeorge Syndrome. Results from some testing, including toxicology testing, were pending.

On December 2, 2022, the caseworker contacted the mother to set up a time to meet with the half-sibling. The caseworker met with the half-sibling in the presence of the mother on December 6, 2022.

On December 8, 2022, the caseworker spoke to the father on the phone about the child. The father dropped the child off to the mother on the morning of November 21, 2022 and he was happy and healthy. After work, the father returned to the mother's home to pick the child up. The father believed it was odd that the mother wanted him to go into the apartment and get the child, as she usually did not ask him to do that. The mother placed the child into his car seat and handed him off to the father. When the father looked at the child, "something did not look right." When he arrived at his destination the child still did not appear as normal, and the paternal relative could not wake him up.

The caseworker spoke to the father of the half-sibling, who did not have concerns for the care of the half-sibling with the mother.

The caseworker reached out to numerous collaterals to gather information regarding the child and was awaiting return calls from several collaterals as of December 14, 2022.

On December 16, 2022, the caseworker learned that the child's toxicology testing revealed that he had been positive for fentanyl at the time of the child's death. A search warrant was served on the mother's home, where fentanyl was found.

The caseworker corresponded with the father of the half-sibling, who was able to care for the half-sibling full time as long as was necessary. The father of the half-sibling agreed that the half-sibling was not to have contact with the mother or the maternal relatives until further notice.

The caseworker spoke to the mother about the concerns regarding the child's fentanyl toxicity. The mother stated that there were some pills in the home that "were [a] house[ ]warming gift" for the mother's boyfriend. They were kept on a high shelf in the bathroom. The pills were loose and not in a bottle. The mother's boyfriend admitted to having cocaine and two blue pills in the home. The pills were a gift from a friend. The mother's boyfriend's drug of choice was not fentanyl and he stated that he was unsure why he accepted the pills as a gift. He stated that he did not use the pills. Prior to the child's death, the mother had been prescribed three OxyContin pills after a miscarriage, and took all three pills. Both the mother and the mother's boyfriend used cocaine after learning of the miscarriage.

The caseworker spoke to a maternal relative who was offering to be a placement option for the half-sibling.

The caseworker spoke to the mother about the mother's boyfriend accepting pills from a friend in the past. The mother's boyfriend was not concerned about taking additional pills from that friend, as the pill he took in the past was fine.

On December 19, 2022, the caseworker spoke to the mother about the placement hearing that would take place that day.

The following day the caseworker sent the mother information about her required drug testing/urinalysis (UA).

The caseworker spoke to the maternal relative about the need for supervision between the half-sibling and the mother by the maternal relative, during the mother's scheduled parenting time.

On December 21, 2022, the caseworker spoke to the child's primary care provider, who did not have concerns for the child the last time he was seen in that office. There were no concerns that the child would pass away from his medical condition and they never noticed any suspicious behavior from any of the adults in his life.

On December 27, 2022, the caseworker spoke to the mother about the assessment and a recap of assessment related information.

On January 11, 2022, the caseworker made phone calls to the involved adults to apprise them of the findings of the assessment.

This assessment closed on January 18, 2023.

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

Supplemental Information: (additional information gathered from the supplemental documents)
In the final law enforcement report regarding the incident, it was documented that the mother denied the father ever mentioned that the child appeared unwell or unresponsive when he picked him up on the night of the incident. Law enforcement did not observe obvious signs of illegal drug use in the home. Although the home was not officially searched, no illegal substances or paraphernalia were observed at that time of the incident. The child tested positive for fentanyl, which was not used to treat the child when he became unresponsive. The mother's boyfriend

admitted that he was given two blue pills from a friend several days prior to the incident, but stated that he had not taken the pills. Two blue pills were found loose in a bathroom cabinet at the mother's home, when law enforcement served a search warrant at that home a few weeks after the incident. The two blue pills were "consistent with counterfeit prescription medication that contains [f]entanyl." The mother's boyfriend denied intentionally using fentanyl, and stated that he believed the two blue pills had been those used for erectile dysfunction. The mother and the mother's boyfriend both denied using fentanyl recreationally. The mother told law enforcement that she and the mother's boyfriend had an agreement that "if drugs were going to be used, they were not to be done in the apartment." The mother denied knowing fentanyl was in the home. The two blue pills found in the mother's home tested positive for fentanyl. One of the two blue pills was slightly dissolved. Law enforcement asked if there was a time when one of the two blue pills had been in the child's mouth. The mother denied any knowledge of the child getting ahold of any pills. The friend who gave the two blue pills to the mother's boyfriend told the mother that he had told the mother's boyfriend the two blue pills were fentanyl. The mother was unsure if that was true. Forensic testing showed that deoxyribonucleic acid (DNA) from the child was found on the two blue pills found in the mother's apartment. A review of the mother's phone history revealed that she routinely connected various individuals with the friend who provided the mother's boyfriend the two blue pills, for the purposes of facilitating drug deals between those parties. Various substances were involved, including benzodiazepines, Adderall and other substances. There was also evidence that the mother and mother's boyfriend were buying drugs to use themselves and that they may have also sold substances to friends themselves occasionally.

After the mother and the mother's boyfriend's relationship ended, the mother told law enforcement that during the break up the mother's boyfriend indicated that he had killed the child/had something to do with his death, on several occasions. Reportedly the mother's boyfriend also made similar statements to his own mother. There was no evidence that corroborated the mother's statements about what the mother's boyfriend may have said. Furthermore the mother stated that the mother's boyfriend admitted that he put the two blue pills in the cabinet after the child died, as he found them while cleaning the house after the child's death.

There was a separate investigation regarding the friend selling substances. During that investigation, law enforcement spoke to the friend about the child's death. The friend stated that the mother's boyfriend had asked him for fentanyl and confirmed that it was for personal use, and that he "[did not] want [the mother] to know about it." The friend specifically told the mother's boyfriend to be careful with the pills, as they were dangerous — warning him not to take more than one at a time. The friend provided the mother's boyfriend with two fentanyl pills in the plastic wrapper from a cigarette pack.

B. FAMILY CASE HISTORY

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

~1/2021	The child was born at 29.5 weeks gestation.
~2/2022	The parents ended their relationship and were sharing custody of the child.
5/2022	The mother and the mother's boyfriend began their relationship.
6/6/2022	Arapahoe County Department of Human Services (ACDHS) completed an assessment in regard to the condition of the mother's home, which was alleged to be in disarray with clutter, animal waste and alcohol containers throughout the house. The caseworker noted that aside from a pet urine odor in the mother's home it was clean and well organized. A Family Assessment Response (FAR) assessment has no findings.
6/24/2022	ACDHS opened a prevention case to pay for services provided during the FAR assessment. This case was closed on June 24, 2022 once those services were in place.
~6/2022	The mother's boyfriend moved in with the mother, the child and the half-sibling.
11/22/2022	The father dropped the child off to the mother in the morning, and planned to return to pick him up later that evening. When the child was dropped off, he was described as happy and behaving normally. Around 9:30 p.m. the maternal relative saw the child on a video call, and described that he was acting normally and playing. The mother and the child lay together in the mother's bed, awaiting the father's arrival. The child fell asleep. Law enforcement found a video on the mother's phone taken on the night of the incident at 9:50 p.m., in which the child was observed lying on the mother's bed, blinking and watching television. Around 10:45 p.m. the father retrieved the child from the mother's home. He stated that the mother told him the child was asleep, but he believed something might be wrong. When he arrived home the child was unresponsive, and emergency medical services responded but were unable to revive the child, who passed away.

IV. COUNTY INTERNAL REVIEW

County: Douglas and Arapahoe combined internal review **Date:** 5/4/2021

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: December 4, 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. Douglas and Arapahoe Counties Combined Internal Review Report Dated: May 4, 2023
5. Autopsy Report
6. Law enforcement report

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

- The child was vulnerable due to age and illness
- Prior concerns for substance abuse by the mother
- Access to fentanyl
- Multiple substances in the home
- Substances not stored in a safe manner
- Non-relative caregiver in the home
- The mother's boyfriend was new to the family environment
- The communication/relationship between the parents was poor
- Criminal activity/drug distribution on the part of the mother and the mother's boyfriend
- There was no immediate medical care sought for 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 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 noted a county specific strength in Arapahoe County connecting the family for services and support prior to the 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 team determined a systemic gap in that there was an early assumption that the child's death was due to a medical condition and that until toxicology testing was completed there was little to no assessment of the safety of the sibling, who still lived in the home.
2. The team determined a systemic gap in that there was a delay in connecting the family with a speech therapist prior to the incident. Had there been another professional involved it is possible that concerns about substance use in the home would have been uncovered sooner.

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:

1. The team did not identify any recommendations regarding this incident.