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

Public Notification Case ID: 22-115

Investigating County Name: Larimer

County(ies) with Previous Involvement: Larimer

Incident Level: Fatal

Incident Date: December 3, 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

The Older Child

Age: 8 years old **Gender:** Female

Race or ethnicity: White

Child's residence: In-home

The Younger Child

Age: 6 years old **Gender:** Female

Race or ethnicity: White

Child's residence: In-home

B. Caregivers

Mother

Age: 38 years old **Race or ethnicity**: Unknown

Father

Age: 36 years old **Race or ethnicity**: White

C. Description of the child's family (non-identifying information): The children, who were 8 years old and 6 years old, were in the care of their father at the time of the fatal incident. The parents, who had a contentious relationship following their divorce, were going through their domestic relations court case to modify their custody arrangement. It was reported that the mother was likely to be granted full custody of the children, in order for her to move out-of-state with them, while "the father's… parenting time [would be] during the summer[s] and on holidays."

The father was reported to have depression, Attention Deficit Hyper Activity Disorder (ADHD), and a history of suicidal ideation. The father was actively seeking mental health therapy, which was reportedly going well and that he had gained useful coping strategies to help him manage his

mental health struggles. The mother reported that the father had been abusive towards her during their relationship, which led to their divorce. The father kept multiple weapons in his home and was reported by collaterals to be very responsible with them. There were contradictory reports regarding the father's employment, as some collaterals believed he was gainfully employed at the time of the incident, while others reported that the father had recently lost his job.

A neighbor reported seeing the children at the door to accept a pizza delivery, the night before the incident, and that "they all looked happy."

There was very little information documented about the mother. It was reported that she was considering moving out-of-state with the children to be closer to her own family. Neither parent had any concerning criminal histories or reported child welfare involvement as children.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 12/5/2022 **Date closed:** July 26, 2023
County: Larimer **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On December 5, 2022, Larimer County Department of Human Services (LCDHS) generated a report of concern regarding the deaths of two children. The reporting party (RP) reported that law enforcement received a call from the father on the morning of December 3, 2022, "stat[ing] 'you will find three deceased people in the house.'" Upon law enforcement's arrival to the home, they found the father and the two children deceased. "[The father] had shot and killed both [children] in the household overnight and" killed himself after calling law enforcement. The father had written a letter, advising of his desire to kill himself and the need to kill the children in order to save them from "dealing with [the father's] suicide." The parents had shared custody of the children, and the mother was receiving grief and loss services.

LCDHS initially determined the referral did not meet criteria for assessment due to the lack of any ongoing safety concerns for the deceased children, since the father was also deceased.

On May 31, 2023, LCDHS assigned the referral for assessment.

On July 6, 2023, a supervisor documented a summary of the information gathered by law enforcement during their investigation. The remaining information in the assessment came from that summary.

The father murdered the children in their beds, both of whom "died [from]… gun shot [*sic*] wounds." The father was then found in his own room, deceased from "a gunshot wound [to] the head…. with 3 guns positioned around him." The father had left notes, and "[m]arijuana gummies were found in the trash."

Law enforcement notified the mother of the deaths, who reported having ended her relationship with the father due to his abusive behaviors towards her and the children. The mother reported several instances of domestic violence perpetrated by the father, and reported that he often expressed suicidal thoughts while around the children. The mother stated she had last spoken to the children on December 2, 2022, at which time the children reported that they had missed school that day due to not feeling well. The younger child reported feeling dizzy and sleepy; however, "the phone call ended abruptly once [the mother] started to ask more questions about the illness." The mother believed the father might have given the children marijuana gummies on December 1, 2022, as "a test run."

Law enforcement also notified the father's girlfriend of the incident. The father's girlfriend was in

the process of moving into the home with the father, but he had asked her not to be at the house the previous evening in order for him to have some "alone time with his [children]." The father's girlfriend was aware of the father's mental health issues and reported that there were guns kept in the home. Per the father's girlfriend, the parents were fighting over custody of the children, and the father was likely going to lose custody of them.

Law enforcement spoke with several collaterals to gather additional information about the father's home with the children.

Through the parents' domestic relations case, a Parental Responsibility Evaluator (PRE) had worked with the family and had made a recommendation for the mother to be allowed to move out-of-state with the children, allowing the father visitation during the summer and school breaks.

On July 26, 2023, the assessment was closed.

Findings: The allegations of fatal, intrafamilial abuse – physical were substantiated.

Referral
Date received: 12/5/2022
County: Larimer **Date not accepted for assessment:** 12/5/2022
Reason for not accepting referral for assessment: "No current A/N allegation"

Referral narrative summary and additional information contained in referral (non-identifying information): On December 5, 2022, LCDHS received a report of concern regarding the family. The information in the referral was the exact same information as the referral that was generated later and assigned for assessment. This referral was determined not to meet criteria for assessment with the indicated reason of, "No current A/N allegation."

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with Larimer County Department of Human Services consisting of two referrals.

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.

1/16/2020	LCDHS received a report of concern that the father advised the mother that the older child had fallen down the stairs at his house while playing; however, the younger child later told the mother that the older child had gotten hurt while trying to jump on the father. The older child was medically assessed and had no injuries; however, the RP reported being concerned about the discrepancies in the two different explanations and the older child's behaviors, such as shutting down and curling into a fetal position, when asked to explain what happened. 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." The family was referred to prevention services.

4/8/2020 LCDHS received a report of concern regarding the younger child's vagina being red after parenting time with the father. The RP reported that the mother had also reported a history of domestic violence in her relationship with the father. "[Additionally,] [the father] ha[d] been violent enough that he ha[d] put holes in the walls at the[ir] home." The mother also shared that the father had expressed suicidal ideation while in front of the children. The RP reported being concerned for the children's wellbeing while in the father's care. 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." It was documented in the RED Team framework that while there were concerns of possible sexual abuse, the younger child was receiving therapy and might make a disclosure in therapy soon.

12/3/2022 The father shot and killed both children before killing himself.

IV. COUNTY INTERNAL REVIEW

County: Larimer **Date:** August 23, 2023

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. Larimer County's Internal Review Report Dated: August 23, 2023
5. Law Enforcement Records
6. Autopsy Reports

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

- The parents' high conflict divorce
- The father's history of depression
- The father's history of suicidal ideation
- The father's access to weapons while in treatment
- History of domestic violence/power and coercive control in the parents' relationship, perpetrated by the father
- The father believed he was going to lose access to his children through the custody case
- The potential sex abuse the children allegedly experienced
- The disclosures the children did make did not line up with their injuries
- There was a pattern of the children not wanting to disclose what happened while in the father's care
- The mother previously obtained a protection order against the father, for physical and sexual coercion
- The father's high-risk behaviors to track and find the mother at a shelter
- The father's possession of weapons, despite previously asking a friend to keep them

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 systemic strengths during the review of this 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 lack of appropriate domestic violence resources for offenders when there are no criminal charges related to their history of violence or coercion. The team noted that it is difficult for people who commit domestic violence to find resources and therapists who are well-versed in the nuances of domestic violence entitlement, coercion, and manipulation.

2. The CFRT identified a systemic gap regarding the difficulties counties and families face when working concurrently with both domestic relations court cases and dependency and neglect court cases, especially when they are high risk or high conflict cases.

3. The CFRT identified another systemic gap regarding Volume 7 Rules and Regulations not reflecting trauma informed practice, especially as it relates to fatal incidents when there are no surviving siblings and no surviving person responsible for the abuse/neglect.

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:

1. The CFRT made a formal recommendation to review empirically supported domestic violence risk and lethality assessment tools to determine if they can be more widely available and utilized for all domestic violence incidents across the state, regardless of criminal charges or financial ability to access resources.

2. The CFRT made a formal recommendation to review how different court systems working concurrently with a family can intersect and collaborate together to systematically collect and share information and make recommendations for the involved families.

3. The CFRT made a formal recommendation regarding a need for a rule change in Volume 7 to be able to enter a founded finding in referral stage, based on the law enforcement records or coroner reports. The current process of having to complete an assessment, when there are fatalities with no surviving siblings and no surviving person responsible for the abuse/neglect, is not trauma informed for the family or the child welfare staff who have to complete the assessments.