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

Public Notification Case ID: 23-052

Investigating County Name: Fremont

County(ies) with Previous Involvement: Fremont

Incident Level: Fatal

Incident Date: 5/21/2023

~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: 10 months old **Gender:** Male
Race or ethnicity: White
Child's residence: In-home

B. Caregivers

Mother
Age: 20 years old **Race or ethnicity**: White

Father
Age: 20 years old **Race or ethnicity**: White

C. Description of the child's family (non-identifying information): At the time of the incident, the infant was residing with the mother and the mother's boyfriend in a hotel where the mother was also working. The sibling, who was 4 years old, was in the home often, but was reported to have lived with the maternal relative on and off since birth. The maternal relative was caring for the sibling at the time of the incident, because the mother's boyfriend had a difficult time coping with the sibling's behavior. The family believed that the sibling had Autism; however, the sibling had not been assessed for or diagnosed with Autism. The father was not residing in the home, as he had moved out when the parents separated "earlier in the year."

The mother's boyfriend had child welfare history as a youth, during which he was placed outside the home in a residential facility on two occasions, both in Colorado and in another state. The mother's boyfriend's criminal history included assault, a related protection order, and sexual offenses.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 5/21/2023 **Date closed:** 8/10/2023
County: Fremont **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On May 21, 2023, Fremont County Department of Human Services (FCDHS) received a report of concern regarding the infant. The reporting party (RP) reported that emergency medical services (EMS) responded to the home and found the infant unresponsive, not breathing, and without a pulse. EMS performed cardiopulmonary resuscitation (CPR) and was able to regain the infant's pulse. At the local hospital, the infant was found to have "a chronic brain bleed, hematomas, and fresh brain bleeds." The family reported that the infant had been unwell for several days prior to the event. It was believed that the infant's injuries would not be survivable. It was reported that the mother's boyfriend "was very agitated" and made statements about getting arrested.

The following day, an FCDHS administrator spoke to law enforcement and learned that the sibling had been residing for an unknown period of time with the maternal relative, as "[the mother's boyfriend] could not handle the [sibling's] behaviors as [the sibling] [wa]s autistic." The infant, who was on life support, "[was] technically brain dead" and was likely to pass away that day. The mother's boyfriend "admitted to shaking the [infant], and" that he had told the mother that the family's dog had bitten the infant, when she noticed the bite mark on the infant. Later the mother's boyfriend admitted he had bitten the child himself. There was evidence that this was the second brain injury the infant sustained, as some of the observed brain bleeding was not new.

A brain death test showed that the infant had no brain activity. Another test would be performed the following morning if the infant survived until then. "[The mother] [was] waiting for [the father] to arrive to sign a [d]o [n]ot [r]ecusitate [o]rder." The physician, who was an expert in medical child abuse/neglect, explained that it was likely the infant suffered more than one abusive event, and "recommend[ed] that [the sibling] be given a full medical evaluation" to rule out any injuries.

Two supervisors responded to CHC and observed the infant, who was on life support. The supervisors observed that he "appeared almost lifeless" and had visible significant bruising and swelling to his skull and face. The supervisors made arrangements to visit with the sibling, and stated that they would be following up with the family again soon. The supervisors also told the mother that FCDHS would help connect the sibling to available relevant services during the assessment.

Law enforcement transported the father to the hospital to see the infant.

The infant passed away in the early morning hours of May 23, 2023.

A safety plan was documented in Trails, which entailed that "[the sibling] [would] be cared for by a sober caregiver… [and] the residence should be free from any safety hazards, domestic violence, and illicit substances." The sibling would be cared for by the maternal relative until such time that all concerns had been mitigated. The family agreed to the plan.

A supervisor visited the maternal relative and the sibling at the maternal relative's home. The sibling had been in the care of the maternal relative "off and on since [the sibling] was born." There were times when the mother, the father, the maternal relative and the children all lived together. After a fire in the mother's trailer in the spring of 2023, the sibling began living "primarily with [the maternal relative.]" The maternal relative did not know the mother's boyfriend well, but had cautioned the mother after a third party accused the mother's boyfriend of harming a puppy. The mother stated that the incident with the puppy was "blown out of proportion and she didn't have any concerns." The mother's boyfriend was watching the infant "[four] days a week" while the mother worked.

The day before the incident the mother told the maternal relative the infant was ill, so the maternal relative stopped by to see him. The maternal relative suggested the infant see a doctor.

The mother stated that the infant appeared to get better for periods of time and then appeared sick again. The maternal relative believed "[the infant] looked sleepy" that day and reminded the mother to ensure he did not get dehydrated and to take him to the doctor if he was not feeling better by the following day. The following morning, the mother called the maternal relative when the infant stopped breathing. The maternal relative believed that the mother moved in with the mother's boyfriend too soon after beginning her relationship with him and had concerns about him being left home alone with the sibling, so took the sibling to stay with her. The maternal relative agreed to undergo a urinalysis (UA) to prove her sobriety.

The supervisor then visited with the mother and the father in the mother's hotel room. Both appeared to be under the influence of substances. They admitted to using cannabis and taking a shot of alcohol that day. The supervisor documented that the room was unclean, had a bad odor, and was in disarray. Both parents agreed to undergo UA's as well.

On May 24, 2024, the supervisor stopped by the maternal relatives' home, unannounced, to check to see that the safety plan was being followed, but no one was home.

The mother, the father, and the maternal relative's UA results were positive for cannabinoids. FCDHS planned to file for protective supervision of the sibling to ensure the sibling's continued safety.

On May 25, 2024, the supervisor informed the parents that FCDHS was filing a petition for protective supervision of the sibling.

The supervisor attended the CHC Child Protection Team (CPT) meeting about the infant's case. On the day of the incident, the infant was unwell, but "alert and awake." The mother gave him an electrolyte drink before leaving the infant with the mother's boyfriend so she could begin working. The mother worked at the hotel where the family was residing. The mother's boyfriend called the mother 30 minutes after she left the room to alert her that "something was wrong." A neighbor performed cardiopulmonary resuscitation (CPR) until help arrived and took the infant to the local hospital, where he was diagnosed with "[bilateral] subdural hemorrhage[ing],…. poor neurological [functioning] and fixed/dilated eyes." The infant was transported to CHC where "a human bite" mark was documented on the infant's arm. The mother's boyfriend tried to explain that the mark was from the family's dog, "but later admitted he had bitten [the infant]." There was also a new bruise on the infant's forehead and knee that had not been there that morning when the mother left for work. The infant also had retinal hemorrhaging in both eyes. The mother's boyfriend admitted to "treat[ing] [the infant] like the dog and showed how he would throw the dog on the bed and he would do the same to [the infant]." The mother's boyfriend was jailed and charged with homicide. There were concerns that what the mother construed as illness was the infant suffering from a prior head injury, as there was evidence of an earlier brain bleed. The team believed the infant likely suffered two incidents of abuse and that the infant would have become "symptomatic immediately" following the second event.

The other supervisor spoke to the father, who was extremely upset at the upcoming court action. The other supervisor explained that the sibling was not going to be removed, but FCDHS needed to ensure the sibling was cared for by sober, safe caregivers.

The parents did not attend a scheduled interview with FCDHS and law enforcement.

The maternal relative relayed to the supervisor that the sibling had been forensically interviewed, but was unable to communicate and the interview was ended.

At the hearing, FCDHS was granted legal custody of the sibling, who would be placed with the maternal relative.

On May 26, 2023, the mother missed another scheduled interview between FCDHS and law enforcement. The mother had been advised by counsel not to undergo an interview.

On May 30, 2023, the sibling was examined by the sibling's primary physician, who referred the sibling for Autism Services and prescribed a skeletal examination to rule out any injuries. The sibling's physician stated that the sibling had not been formally diagnosed with autism and the physician was concerned that the maternal relative did not appear to want services in place for the sibling. The physician stated that the sibling's behaviors could be attributed to autism, but could also be developmental delays or a trauma response. The family appeared to be reticent to accept services of any kind. They were offered grief intervention and counseling after the house fire and denied needing either. The physician noted that the sibling had not been seen by a doctor since June 5, 2021.

On June 7, 2023, the supervisor documented information about the sibling's progress in developmental testing and next steps.

On June 9, 2023, the supervisor learned that law enforcement interviewed the mother without contacting FCDHS.

On June 29, 2023, the supervisor met with the sibling and the maternal relative in their home to discuss case progress and what needs FCDHS could help the family meet for the sibling and maternal relative.

On July 6, 2023, the supervisor learned that the sibling's skeletal exam did not raise any concerns.

This assessment was closed on August 10, 2023

Findings: The allegations of fatal, intrafamilial neglect – environment injurious were substantiated against the mother and the father as to the infant.

The allegations of fatal, intrafamilial abuse – physical were substantiated against the mother's boyfriend as to the infant.

The allegations of medium, intrafamilial neglect – environment injurious were substantiated against the mother and the father as to the infant.

Supplemental Information: (additional information gathered from the supplemental documents)
When interviewed by law enforcement, the mother's boyfriend stated that the mother left the hotel room to begin her shift. The infant was sitting in a "bouncer… [until] it was time to give him medicine again. [The mother's boyfriend] state[d] that [the infant] was not crying and acting normal. [The mother's boyfriend]… [gave] [the infant] a syringe (5 ml) of the [electrolyte drink] and [the infant] [spit] it out. [The mother's boyfriend]… then pick[ed] up [the infant] and [put] him on the bed to change his diaper. While [the mother's boyfriend was] reaching for a baby wipe… [the infant] arch[ed] his back and [became] stiff and [began] gurgling. [The mother's boyfriend] then pick[ed] up [the infant], [shook] him and [patted] [his] back while also bouncing. [He] then" decided to take the infant to the mother as "he [was not] acting right." On the way "back to the room… [the infant] [went] limp and stop[ed] breathing. [The mother's boyfriend] stat[ed] that it [was] all of a sudden that [it] all happen[ed] 'almost as if' he 'did it.'"

The mother's boyfriend's behavior was described to be "defensive, self-soothing, nervous, and anxious" while at the hospital, while the mother presented "as normal, appropriate crying, cooperative with [medical professionals]." The mother's boyfriend declined to say good bye to the infant as he was prepped for flight for life.

Regarding the bite mark on the infant, the mother's boyfriend indicated that he did bite the infant, but had done so playfully and that the infant had not cried afterward. He also admitted to horse play in which he tossed the infant in the air.

Another person staying in the hotel reported hearing the mother's boyfriend yell to the mother that "[the infant" was not breathing." Then the other person "observed [the mother's boyfriend] shake [the infant] really hard [three] times and then begin to hit him on his back" shortly before assisting the mother's boyfriend in administering CPR to the infant.

The mother's boyfriend was arrested and charged with felony child abuse, murder in the first degree, and cruelty to animals.

The mother was charged with felony child abuse, misdemeanor child abuse, and cruelty to animals.

Referral

Date received: 5/21/2023
County: Fremont **Date not accepted for assessment:** 5/22/2023
Reason for not accepting referral for assessment: "Duplicate referral"

Referral narrative summary and additional information contained in referral (non-identifying information): On May 21, 2023, FCDHS received a report of concern regarding the infant. The RP reported that the infant had been transferred from a local hospital to Children's Hospital Colorado in Colorado Springs (CHC), after suffering an anoxic brain injury, which was likely to be life ending. The RP also noted that they observed the infant had a healing bite mark and bruising. The mother's boyfriend had admitted to shaking and biting the infant. The referral was determined not to meet criteria for assessment with the indicated reason of, "Duplicate referral."

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with Fremont County Department of Human Services consisting of 2 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.

6/14/2022	FCDHS received a report of concern regarding the maternal relative yelling at the sibling. The maternal relative was watching the sibling because the mother was on bedrest while pregnant with the infant. When law enforcement responded to a complaint about the yelling, the maternal relative was speaking with slurred speech, after having taken her prescription medication. The maternal relative called another maternal relative to come and pick up the sibling to care for her. No one was charged with a crime. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law.
7/8/2022	The infant was born

7/28/2022 FCDHS received a report of concern regarding the infant testing positive for cannabinoids in his umbilical cord blood. No other concerns for the infant were noted. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."

2/2023 The family's house fire occurred

~3/2023 The parents split up.

The mother and the mother's boyfriend began their relationship and moved in to the mother's hotel room together.

The maternal relative brought the sibling to live with her, believing "that [the mother's boyfriend] [could not] handle [the sibling's] behavior."

5/21/2023 The incident occurred.

5/23/2023 The infant passed away.

IV. COUNTY INTERNAL REVIEW

County: Fremont **Date:** 8/1/2023

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: March 4, 2024

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. Fremont County's Internal Review Report Dated: 8/1/2033
5. Medical Records/CPT summary
6. Law enforcement reports

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

- Age of the children made them vulnerable
- Sibling was diagnosed with autism
- The sibling did not have regular medical care/medical care on the typical schedule we would expect
- The maternal relative did not seek medical care for the sibling while the sibling was in her care either
- The mother's history in the Division of Youth Services
- Newness of the mother's relationship
- There were concerns about the mother's boyfriend's violent behavior, especially toward a puppy right before the incident
- Substance use/abuse
- Two children born drug exposed
- Young parents

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 determined a family specific strength in that the sibling had no injuries, upon examination after 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 all the charges against the perpetrators were dropped due to the DA not accepting the case. Although charges were initially brought and some minor charges remain, no one will face prosecution for the child's death.

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 team did not make any recommendations stemming from the review of this incident.