

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

Public Notification Case ID: 24-007

Investigating County Name: First County>Second County

County(ies) with Previous Involvement: Second County

Incident Level: Fatal

Incident Date: January 2024

-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: 7 years old

Gender: Female

Race or ethnicity: White

Child's residence: In-home

The Younger Child

Age: 3 years old

Gender: Female

Race or ethnicity: White

Child's residence: In-home

B. Caregivers

Mother

Age: 39 years old

Race or ethnicity: White

Father

Age: 45 years old

Race or ethnicity: White

C. Description of the child's family (non-identifying information): The children, who were seven and three years old, were the parents' only children together.

The mother was the primary caregiver for the children. The mother reported that the father was abusive and controlling of her during their relationship. The mother shared that she and the father had known each other most of their lives and that she was aware of his abusive and controlling behaviors in his previous relationships. Once the mother and the father began their romantic relationship, she reported that the father's abuse worsened. The mother attempted to leave the

father by moving out-of-state; however, he followed her to the new state. They eventually returned to Colorado, and the mother was able to end her relationship with the father. She believed that he recently sought custody of the children, not out of a desire to parent them, but rather as retaliation against the mother and a means to stay connected to her. The mother reported that she had recently remarried, which seemed to have upset the father. The mother had a history of cannabis use, but she did not have any other known substance use concerns or criminal history.

The father lived in First County and had weekend parenting time with the children, which had recently been ordered through the parents' Domestic Relations case. The father had a prior stalking charge, with the mother as the victim, which had been dismissed. The father did not have any other pertinent criminal history. There were no known concerns for substance use by the father, and no alcohol or illicit substances were found in his home after the incident. It was reported that the father was employed, but had been distracted at work lately due to the ongoing custody issues between the parents. The father was the perpetrator of domestic violence in his previous relationships, as reported by the mother and one of the father's ex-wives.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 1/2024 **Date closed:** 4/2024
County: First County>Second County **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): In January 2024, First County Department of Human Services (FCDHS) received and transferred to Second County Human Services (SCHS) a report of concern regarding the deaths of two children and their father. The reporting party (RP) reported that law enforcement was investigating a murder/suicide involving the two children and their father, which occurred during a visit with the father that weekend. The mother had been notified and was traveling to First County. The RP reported that the parents were involved in "a contentious divorce and [the mother] had not supported [the children] having parenting time with [the father]." The RP believed that there might have been recent changes ordered through the parents' Domestic Relations case.

The administrator learned that the children died from gunshot wounds.

The administrator spoke with the mother and offered her services and supports.

The administrator spoke with law enforcement in First County. A law enforcement officer from another jurisdiction, who lived closer to the father's home, was able to respond to the father's home and confirmed the deaths.

The administrator went to the mother's home for a scheduled visit; however, the mother was not there at that time. The mother had traveled to First County in order to gather the children's belongings.

The administrator called and left the mother a message to follow up on any possible supports SCDHS could provide her.

The assessment was closed in April 2024. It was documented in the assessment closure summary that the father's motive for killing the children and himself was unknown.

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

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with Second County Human Services consisting of one 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.

- 10/10/2023 SCHS received a report of concern that the mother had been driving the children while the mother was under the influence of cannabis. The mother was also not allowing the father to have contact with or see the children. 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."
- ~11/27/2023 The father was granted parenting time with the children through the parents' Domestic Relations court case.
- 12/15/2023 The mother remarried.
- ~1/2024 The parents met outside of a police station in another county to exchange the children for the father's third parenting time weekend.
- ~1/2024 The father shot and killed the children prior to killing himself.

IV. COUNTY INTERNAL REVIEW

County: Second County Date: March 4, 2024

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: July 1, 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. Second County County's Internal Review Report Dated: March 4, 2024
5. Autopsy Reports
6. Law Enforcement Records

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

- Domestic violence and coercive control, perpetrated by the father towards the mother
- The father had access to a firearm
- The mother remarried just prior to the father's first in-person, unsupervised, visit with the children, which the father saw as evidence that the mother had moved on from him
- The father's escalated behavior at the custody exchange prior to the incident
- The father's prior stalking charges (related to stalking the mother)

- The father lived in an isolated community and it was unknown if he knew how to access the resources in the community
- The father's family also blamed the mother for the father's actions

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 related to the mother seeking grief supports for herself and her family.

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 case-specific gap related to the lack of reports made to the county department of human services regarding the signs or concerns of the father's coercive control over the mother that happened during their domestic relations case.
2. The CFRT identified a systemic gap regarding domestic violence related criminal charges being dismissed in court and perpetrators of domestic violence not being held accountable for their violent and controlling behaviors. The team discussed the difficulties victims face in pursuing charges against their perpetrators, when they often get dismissed, which exacerbates the power and control dynamics in the relationship and makes it harder for victims to pursue charges again in the future.

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 CFRT made a formal recommendation for domestic relations court cases to look at the totality of a family's history, including child welfare allegations, criminal charges that are either dropped or dismissed, and criminal convictions before making custody decisions, in order to better understand the relationship dynamics and the impact those decisions will have on the children and caregivers.
2. The CFRT made a formal recommendation to explore existing domestic violence task groups that are looking at the broader, more systemic recommendations related to data collection, moving from risk to safety concerns, and the thresholds for lethality assessments. The aggregated data collected can help to discern historical and systemic domestic violence related trends in domestic relations, criminal, and child welfare cases.