COLORADO
Department of Human Services
Administrative Review Division

The case-specific executive summary report for case ID: 24-004 is in reference to a fatal and egregious incident of child maltreatment reviewed by the Child Fatality Review Team (CFRT) on May 6, 2024. It is not in the best interest of the child or the child's family to release the full CFRT report.

Colorado Revised Statutes 26-1-139(5)(i)(I) and (IV) state, "The case-specific executive summary or other release of disclosure of information pursuant to this section shall not include: (I) Any information that would reveal the identity of the child who is the subject of the executive summary, any member of the child's family, any member of the child's household who is a child, or any caregiver of the child;" and "(IV) Any information which, if disclosed, would not be in the best interests of the child who is the subject of the report, any member of the child's family, any member of the child's household who is a child, or any caregiver of the child, as determined by the state department in consultation with the county that reported the incident of fatality, near fatality, or egregious abuse or neglect and the district attorney of the county in which the incident occurred, and after balancing the interests of the child, family, household member, or caregiver in avoiding the stigma that might result from disclosure against the interest of the public in obtaining the information."

The CFRT and the Colorado Department of Human Services (CDHS) are releasing the team's findings with regard to identified systemic strengths; identified systemic gaps; recommendations for changes in the systems, practices, policy, rules, or statute; policy findings; and recommendations to address the policy findings. Pursuant to the statutes cited above, no additional information will be released on this case.

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

Public Notification Case ID: 24-004

Investigating County Name: Douglas

County(ies) with Previous Involvement: Douglas

Incident Level: Fatal

Incident Date: 1/11/2024

~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

Age: 7 years old **Gender:** Male
Race or ethnicity: White
Child's residence: In-home

B. Caregivers

Mother
Age: 43 years old **Race or ethnicity:** Unknown

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

IV. COUNTY INTERNAL REVIEW

County: Douglas County **Date:** 2/9/2024

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: May 6, 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. Douglas County's Internal Review Report Dated: 2/9/2024
5. Autopsy
6. Police Records

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

- The family's financial hardships
- The father removed the mother from back accounts and was operating them without the mother
- The father was abusing his pain medication
- Sometimes the victim of domestic violence does not realize they are being victimized due to power and control dynamics
- The child was non-verbal
- The family was facing eviction
- Day trading can lead to financial loss
- The child had many delays and needs which could have contributed to the overall stress in the home
- The family had providers in the home often, which can be stressful for families
- A firearm in the home
- The father back injury caused a shift from him being a financial contributor to being a person with a disability
- The father grew up in a home with alcohol abuse

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 identified a strength in service delivery involving the service providers reaching out to DCDHS to ask about training or warning signs that could have been seen over time, but were potentially missed.
2. The team identified a strength in service delivery to the sibling, as they were provided consistent mental health services with providers the sibling knew well.
3. The team identified that is was a strength that the children had been connected with appropriate services for their individual needs.
4. The team identified a strength regarding the prior assessments, as they were thorough and allowed the caseworker to understand the dynamics in the home despite their being no surviving adults to speak to.

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:

The team did not identify any gaps at this review.

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 team did not identify any recommendations at this review.