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

Public Notification Case ID: 23-077

Investigating County Name: Boulder

County(ies) with Previous Involvement: Boulder

Incident Level: Fatal

Incident Date: 7/26/2023

~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: 15 years old **Gender:** Female
Race or ethnicity: White
Child's residence: In-home

B. Caregivers

Mother
Age: Deceased **Race or ethnicity**: Unknown

Father
Age: Deceased **Race or ethnicity**: Unknown

C. Description of the child's family (non-identifying information):

At the time of the incident, the youth resided with the stepmother and seven other adults, which included the stepmother's adult male child. The parents were deceased and there was no legal guardian for the youth. The stepmother reported she had begun the process to become the youth's legal guardian prior to the youth's death. The father was reported to have been the adoptive father of the youth and sibling. The sibling (age 16) was reported to have been adopted by the father and the sibling's adoptive mother. The sibling resided in another state with the sibling's adoptive mother. The stepmother reported meeting the family when she answered the father's ad to help home school the children.

The stepmother reported having medical issues such as "[f]ibromyalgia, Marfan Syndrome, lime [*sic*] disease, congestive heart failure and chronic fatigue." The stepmother reported her medical issues required her to take "oxycodone, fentanyl patches, laudanum, and morphine for pain." The stepmother reported she had also recently started cannabidiol (CBD) and marijuana to alleviate pain.

The stepmother reported that the youth received medical care for stomach issues and had seen a rheumatologist. The youth's significant other reported that the youth often had headaches and stomachaches, which went unaddressed. Prior to the youth's death she reported ulcers and was taking omeprazole and other nausea medication. The youth also had a nebulizer for her asthma. The stepmother's adult child was reported to have taken the youth in for medical treatment, as the stepmother refused. The youth was reported to have used a vape pen, blue pills and powder (later identified as oxycodone), which the stepmother provided. The youth would snort the oxycodone, as the stepmother had instructed her to take it that way. The youth was reported to have had suicidal ideation.

The father was reported to have been a former law enforcement officer, who was injured on the job. Prior to his death, the father had been associated with stolen vehicles, some that may have been used in a homicide. The father also struggled with substance use.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 7/26/2023 **Date closed:** 10/29/2023
County: Boulder **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On July 26, 2023, Boulder County Housing and Human Services (BCHHS) received a report of concern regarding the youth. The reporting party (RP) reported the youth was deceased. The RP was uncertain who the next of kin for the youth was, as both parents were deceased. Law enforcement had responded to the home, which was known to law enforcement for suspected drug use. The stepmother was reported to have disclosed that she did not have legal custody of the youth, but that the father had been previously told by the child welfare department that the youth could reside with her. The hotline screener then spoke with another RP, who reported law enforcement would be requesting a search warrant for the home. It appeared that the youth had disclosed to an unidentified individual that she was experiencing substance withdrawal. At the time of the 911 call, there were eight other individuals in the home, including the stepmother. The other RP reported that fentanyl use was suspected.

On July 27, 2023, the caseworker observed video footage of law enforcement's interview with the stepmother. The stepmother reported the youth had not eaten much, but she believed this was normal due to the heat. The stepmother reported that she had been sick and had not cooked much during that time. The youth was described to have appeared pale and to have lost approximately 20 pounds in the prior several weeks. The day of the incident, the youth informed the stepmother that she was not feeling well and needed to throw up. Prior to the youth throwing up the stepmother noticed the youth hide "something under her seat." The youth and the stepmother argued, as the stepmother believed the youth had stolen money from her. During the argument the stepmother pushed and grabbed the youth. The youth, who had asthma, requested her nebulizer, but the stepmother refused her. The stepmother reported she heard shallow breathing and did not believe the youth needed the nebulizer and believed she was just experiencing anxiety. On the way to the house the youth soiled herself, which was not typical. Upon arriving to the home the youth showered. The stepmother reported drinking beer and taking a shooter, but was not certain if the youth took anything. The youth's nebulizer was located at the stepmother's adult child's home and the stepmother sent someone to get the nebulizer when the youth was still having trouble breathing. The nebulizer appeared to help the youth's breathing, "but she was still making a noise while breathing." The youth then went to bed and the stepmother later woke the youth up and she ate some watermelon. The youth was described to have been drowsy and mumbling when the stepmother woke her. The stepmother reported the youth had a history of being dishonest about being sick, so she was not alarmed by the behavior. The stepmother initially denied substance use in the home, but then discussed roommates not sleeping, "us[ing] blues[,]" finding foils, methamphetamine use, and discussed several opioids she had received for pain management. The

stepmother denied any knowledge of the youth using substances, but when the stepmother was confronted on evidence of substance use in the home and fentanyl testing strips being found in the home, the stepmother reported she suspected the youth to be using substances. The stepmother reported she used the fentanyl test strips to test the youth. Law enforcement informed the stepmother that this was not how the strips are used and that she was being dishonest in her statements to law enforcement. The stepmother reported that the torches found at her home were for candles and CBD, again law enforcement confronted the stepmother about her being dishonest. Law enforcement explained that the youth was found to have fentanyl in her system and that despite telling the stepmother she was struggling to breathe several times, the stepmother failed to get the youth medical care. The stepmother then asked for an attorney to represent her, but would then engage in conversation with law enforcement. The stepmother reported that a friend did take the youth to the hospital, but on the way there the youth stated she did not want to go. The youth then slept in the car prior to being carried into the house. The stepmother reported when she and the roommates woke the youth up, she began to throw up and then was no longer breathing.

The caseworker then observed the video footage of the law enforcement interview with the youth's significant other. The youth's home was described to be messy and full of trash, though the youth kept her room clean. The stepmother was reported to invite many people to the home, which would result in the youth not having enough food. The youth was reported to have often complained of headaches and stomachaches, but the stepmother did not believe her and refused to take her to get medical care. The stepmother's home was reported to have been full of marijuana and often smelled like marijuana. The youth's significant other witnessed the stepmother snorting a blue powder, which she stated was medication. The stepmother was reported to have told the youth to take the powder if she was in pain. The youth's significant other witnessed the youth take the blue powder and blue pills, which were identified to be oxycodone. The youth was reported not to have taken the oxycodone often. The stepmother was reported to have recently removed the youth's door, as she believed the youth stole eight thousand dollars. The stepmother's home was reported to always have money, but it was unknown where the money came from. The youth's significant other believed the stepmother treated the youth poorly and was using her for her money. The youth was often forced to give up any money she had and the youth's significant other's family provided the youth with lunch money. The youth was reported to have been observed to have marks from altercations with the stepmother.

The caseworker spoke with law enforcement, who reported that there were eight adults residing in the home, but the youth was the only child. The youth was reported to have some old injuries, which were believed to be caused by self-harm. Law enforcement planned to review the interviews from the previous night and had plans for additional interviews the following week.

On August 8, 2023, the caseworker attempted to contact law enforcement to follow up on any planned interviews.

On September 7, 2023, the caseworker and law enforcement went to the stepmother's home and spoke with the stepmother. At the visit, the home was condemned due to high levels of methamphetamine. The stepmother expressed she was upset with law enforcement, as they had released the youth's body to a relative that was uninvolved. The stepmother reported she took the youth to seek medical care many times, and had recently taken her to a local hospital due to the youth reporting she was in pain. The stepmother reported the local hospital reported the youth was fine and stated that she may have been faking her pain. The stepmother again reported she believed the youth was okay the day she passed, as she ate and did not throw up. The stepmother reported the youth later woke up, vomited black, and then stopped breathing. The stepmother reported she asked the youth to go to the hospital, but the youth stated she did not want to. The stepmother reported that it was believed the youth had a hemorrhage, as she was found in a pool of blood. The mother was reported to have died from hemochromatosis, which the stepmother reported the youth had been scheduled to be evaluated for. The stepmother reported the youth

had stolen money from her, but denied the youth stealing drugs. The stepmother stated the garage roommate was using substances, but she did not have him leave the home as he helped in the home. The stepmother reported she was aware of how to use Narcan and had used it on several people in the past. Law enforcement found Narcan in the trash when they searched the home, but the stepmother denied using the Narcan on anyone recently. The stepmother reported the home always had Narcan.

On October 2, 2023, the caseworker met with law enforcement to "[discuss the] case and presentation to the [district attorney) DA." Law enforcement discussed the time line of events prior to the youth's death. "[The youth's] cause of death was a combination of Fentanyl overdose and pancreatitis." The youth's medical records indicated the youth did not get regular medical care. Law enforcement reported that another individual died at the stepmother's home of an overdose and sepsis in July 2023. It was unclear if the Narcan found in the home was used on the youth.

On October 27, 2023, the caseworker attempted to contact the stepmother to inform her of the findings of the assessment, but her phone was disconnected.

On October 29, 2023, the assessment was closed.

Findings: The allegation of fatal, intrafamilial neglect – medical neglect was substantiated.

The allegation of fatal, intrafamilial neglect – environment injurious was substantiated.

Referral ID: 3434161
Date received: 7/27/2023
County: Boulder **Date not accepted for assessment:** 7/27/2023
Reason for not accepting referral for assessment: "Duplicate referral"

Referral narrative summary and additional information contained in referral (non-identifying information): On July 27, 2023, BCHHS received a report of concern regarding the youth's death. The RP reported that the youth had passed away. One of the causes of her death was reported to be "hemorrhaging in her stomach," though the death was still under investigation. The RP reported "[they] kn[ew] someone could get constipated from using opiates and [the] RP kn[ew] [the youth] ha[d] been using fentanyl." Two days prior to the youth's death, the RP reported knowing the youth was experiencing substance withdrawal. Due to conflict between the RP and the stepmother, the RP no longer had regular contact with the youth. The RP reported that they had been told the youth had been beaten by the stepmother due to the youth stealing fentanyl pills from the stepmother. The stepmother was described to be "an active user for the past four years." The stepmother was reported to have regularly used substances in front of her own, now adult, children, and the youth. The RP believed the stepmother's roommate had also provided the youth with fentanyl pills. The referral was not accepted for assessment with the indicated reason of, "No information available from reporter of abuse and neglect as defined in law." BCHHS shared the additional information with law enforcement.

Supplemental Information: (additional information gathered from the supplemental documents)
Per law enforcement records, the youth was reported to have exhibited signs of illness for several days prior to her death.

B. FAMILY CASE HISTORY
Within the last three years, the family had prior involvement with Boulder County Department of Human Services, consisting of eight referrals and two assessments.

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.

7/31/2020	BCHHS received a report of concern about the father. The RP expressed concerns the father was using substances, but was unsure if he was currently using substances. The father was reported to have had a "pill problem and [to have] almost overdosed a few times." The referral was not accepted for assessment for the identified reason of 'No current A/N allegation."
11/1/2020-2/3/2021	BCHHS received a report of concern regarding the father using substances in the home. During the assessment the youth and the sibling denied the father used substances, the father did not complete a requested urine analysis (UA), and the family moved from their home. The caseworker was unable to locate the family after they moved. The allegations of minor, intrafamilial neglect – environment injurious was unsubstantiated.
~2020	The sibling moved out of state.
11/7/2020	BCHHS received a report of concern that the father was selling drugs and using substances. The youth was reported to have recently found methamphetamine in the home. The sibling was reported to be using fentanyl. The father was reported to have used fentanyl the day of the referral. The referral was not accepted for assessment for the identified reason of "Duplicate referral."
11/11/2020	BCHHS received a report of concern regarding the father. The RP expressed concerns the father was using substances and was engaged in violence. Foils were reported to have been found in home and various people frequently visited the home. The RP reported the sibling had disclosed lying to child welfare, as the stepmother had told them to. The referral was not accepted for assessment for the identified reason of, "Duplicate referral.
8/24/2021-10/02/2021	BCHHS completed an assessment regarding the family. The youth resided with the stepmother at the time of the assessment. The youth was reported to have disclosed an incident where she believed someone laced her drink, as "[she] passed out and woke up with them shooting up drugs in her arm." The youth had also disclosed prior sexual assault by friends of the father. During the assessment the youth reported she had lied about the sexual assault and had been in therapy for a year. The youth's accounts of events were inconsistent with law enforcement. The youth expressed she wanted to reside with the stepmother and did not report any concerns for the stepmother's home. The stepmother reported the father had provided her with guardianship papers

and she planned to adopt the youth. The allegations of minor, intrafamilial neglect were unsubstantiated.

8/26/2021 BCHHS received a report of concern regarding the stepmother's home. The youth was reported to be the stepmother's "foster child" and was residing with the stepmother, the stepmother's partner, and the stepmother's adult male child, as the father struggled with substance abuse. The stepmother was reported to have been a friend of the father. The stepmother and the stepmother's boyfriend were reported to abuse substances and the RP was able to provide descriptions of behaviors that indicated the stepmother and the stepmother's partner were under the influence. The youth and the stepmother's adult male child were reported to have been in the home when this occurred. The RP reported they witnessed the stepmother taking a pill, though they were unsure if this was a prescribed medication. The referral was not accepted for assessment for the identified reason of 'No current A/N allegation."

BCHHS created a separate referral with identical information, as the stepmother's adult male child, was a minor at the time. The referral was not accepted for assessment for the identified reason of, "No current A/N allegation."

11/14/2022 The father passed away.

~11/2022 The youth made internet searches seeking information "if a youth could live alone."

12/18/2022 BCHHS received a report of concern regarding the youth. The RP reported law enforcement investigated allegations regarding the youth being sexually assaulted by a male at the home. The stepmother was reported to be in shock regarding the allegations and the youth denied the allegations. The youth reported that there was a miscommunication in a text message, but she had not been sexually assaulted. The referral was not accepted for assessment for the identified reason of, "No current A/N allegations."

1/2023 The youth stopped attending school.

3/17/2023 BCHHS received a report of concern regarding the youth not attending school. The RP was informed by a classmate that the stepmother was not allowing the youth to attend school. The referral was not accepted for assessment for the identified reason of "No current A/N allegation."

4/7/2023 BCHHS received a report of concern that "the youth had not been to school all semester." The youth was reported to reside with the stepmother, as both parents were deceased. The stepmother was reported to have planned to unenroll the youth and the stepmother's adult male child, but failed to show at the school. The referral was not accepted for assessment for the identified reason of "No current A/N allegation."

7/2023 An unrelated adult overdosed and died at the stepmother's home.

7/26/2023 The youth passed away.

IV. COUNTY INTERNAL REVIEW

County: Boulder **Date:** 7/26/2023

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: August 5, 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. County's Internal Review Report Dated: 7/26/2023
5. Law enforcement report

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

- Both parents were deceased
- The sibling resided out-of-state
- Substance use by the parents and the stepmother
- Substance use by the youth
- The youths method of substance use
- The stepmother was providing the youth with substances
- The stepmother's denial of medical care for the youth
- Lack of a legal caregiver as the youth and the stepmother had an informal living arrangement
- The impact of substances on decision making
- Fentanyl and opioid use in the home
- The youth's medical and mental health needs
- The recent overdose death of an unrelated adult in the home

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 that the collaboration between BCHHS and law enforcement allowed for a conclusion to the case and lead to the stepmother's criminal charges. The team identified this as an incident specific strength.

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 recommendation at this review.