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

Public Notification Case ID: 23-028

Investigating County Name: Adams

County(ies) with Previous Involvement: Weld

Incident Level: Fatal

Incident Date: 3/16/2023

~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)(2016).

I. IDENTIFYING INFORMATION

A. Child victim

Age: 14 years old **Gender:** Female
Race or ethnicity: Hispanic
Child's residence: In-home

B. Caregivers

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

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

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

At the time of the incident, the youth resided in the home with the maternal grandparents. The youth moved in the maternal grandparents' home in January 2022. Prior to moving in with the maternal grandparents, the youth resided with the parents, the half-sibling (age 17), and the sibling (age 11).

The youth, who was born positive for tetrahydrocannabinol (THC) and alcohol, struggled at the parents' home and was reported to have often been in conflict with the parents. The family was reported to have completed multiple rounds of family therapy, and the youth had been engaged in individual therapy. The family had prior child welfare contact, mostly regarding concerns for the youth and her treatment in the home. The youth was reported to have had a suicide attempt several months prior to her death. A psychological evaluation was recommended to the family when the youth was discharged from the hospital, but an intake was not scheduled until the day of her suicide. The family had recently experienced the loss of several family members and it was unclear if they had sought support for their grief.

The father and the maternal grandmother did not have criminal history, while the mother only had a traffic violation. In 2007, the mother petitioned the court for a protection order against the half-sibling's father, which was later dismissed.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 3/20/2023 **Date closed:** 7/14/2023
County: Adams **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the near fatal child maltreatment incident (non-identifying information): On March 20, 2023, Adams County Human Services Department (ACHSD) received a report of concern regarding the youth's death. The reporting party (RP) reported that they were reporting for another individual and did not have all the information. The youth was reported to have had her phone confiscated at school on March 16, 2023. The youth became upset and left school. The family was notified of the youth's absence, and the maternal grandmother went to the home to check on the youth. The maternal grandmother "found [the youth] unresponsive with empty prescription bottles and alcohol bottles around her." The youth was then transported to a local hospital, but the family made the decision to withdraw care when her condition failed to improve, and the child died on March 18, 2023. The RP reported that a suicide note was found, where the youth mentioned wanting to join a deceased relative and dog.

On March 21, 2023, the caseworker left a voicemail for the maternal grandmother to contact them.

On March 22, 2023, the caseworker emailed the coroner's office and requested a copy of the autopsy report once it was completed. The coroner's office responded on March 24, 2023, and informed the caseworker that a toxicology report was pending and requested they speak in a few weeks to discuss "the final cause of death."

Between March 30, 2023 and April 11, 2023, the caseworker attempted to get in touch with the family's neighbor, finally speaking with them on April 11, 2023. The neighbor reported knowing the children in the family for four years, but reported that they "ha[d] never physically met [the parents]." The neighbor reported that they believed the mother was on disability and did not work outside of the home. The neighbor reported their child played with the sibling, but the sibling had never mentioned the youth. The neighbor reported they spoke to the youth through a fence "when [the youth] was locked in the backyard." The neighbor reported that this was a punishment for the youth and that it lasted "12 [to] 14 hours[,]" but she was able to go inside to use the restroom. The youth had reported to the neighbor that the half-sibling washed walls for punishment, while the sibling was never punished. The neighbor reported that this had been reported to law enforcement and child welfare in the past. Law enforcement was reported to have believed the youth was exaggerating what occurred. The youth had disclosed to the neighbor that the father had pushed her down the stairs causing her to hit her head. The youth felt that the parents were "'get[ting] rid of her'" by sending her to the maternal grandmother's home. The neighbor reported the youth had previously run from the home upon the parents punishing her by taking all the clothes from her room. The neighbor also had a copy of a story the youth wrote for a class about a mother and daughter who fought.

On April 19, 2023, the caseworker spoke with the maternal grandmother. The maternal grandmother expressed confusion regarding ACHSD being involved. The maternal grandmother explained "that the family ha[d] lost [three] [people] in the [l]ast 6 months" and she did not understand why she was not contacted when the cousin passed away. The caseworker explained the concerns surrounding the care of the youth and that "[the cousin] was medically fragile, which [was] a different scenario." The caseworker scheduled a home visit with the maternal grandmother for April 26, 2023.

On April 26, 2023, "[two caseworkers] met with [the maternal grandmother] at her home." The maternal grandmother reported that the family had been struggling since the loss of the youth and described them to be "in 'survival mode.'" The maternal grandmother described the youth to be "a 'typical' 14 year-old, [who] was sassy, rebellious and struggled with behaviors." The youth was reported to have moved into the maternal grandmother's home in January 2022, as "[the youth] had 'gotten out of hand' and [the youth] and [the mother] were butting heads daily." The youth had recently spoken to the mother about her feelings regarding the mother not visiting the youth while she was hospitalized in December 2022. The youth was reported to be in therapy and that the family had previously engaged in family therapy. The youth was reported to have lost electronics, as she had shown on several occasions that she did not make safe decisions while using the internet. The maternal grandmother expressed that the youth's social life was important to her and she struggled with not being able to be on social media. The maternal grandmother explained that the youth would speak to people on the internet, which made the parents worry for her safety. The maternal grandmother was aware of prior child welfare contact with the parents in regards to the youth. The maternal grandmother reported that the youth was not locked out of the home for punishment, but was asked to complete outdoor chores as punishment.

On the day of the youth's death, the maternal grandmother reported that it was a typical day and the two were "having a fun morning" before each left the home for the day. The maternal grandmother reported that when she was done with work she contacted a mental health provider to get the youth set up for an intake, which was "scheduled for March [29, 2023]." The maternal grandmother then went into the home and noticed that it was locked, which was not uncommon, but the youth did not come and greet the maternal grandmother, which was out of the norm. The maternal grandmother walked towards the youth's room and found "5-6 post[ed] notes on her door and [that] was [the youth's] suicide note." The grandmother entered the youth's room and found her "laying on the bed, curled up facing the wall." The youth did not respond to the maternal grandmother or attempts to wake her. The maternal grandmother reported she then noticed "the pills on the bed." The maternal grandmother then called emergency medical services (EMS) and began preforming cardiopulmonary resuscitation (CPR). The youth was taken to the local hospital and later transferred to another local hospital. The youth had consumed the recently deceased cousin's pills. The maternal grandmother reported that she never had concerns regarding the youth harming herself and did not "hide sharps or med[icine]." The maternal grandmother reported that the youth had just returned to school following a three day suspension for fighting, being disrespectful to teachers, and vaping. The maternal grandmother reported that she did not know what happened at school the day of her death other than she was found to have a phone that belonged to a classmate. The youth then left school grounds for the day, but the maternal grandmother was not notified by the school.

On May 3, 2023, the caseworker left a voicemail for the mother to contact the caseworker.

On May 15, 2023, the caseworker was informed by the coroner that the toxicology results had come back, but that they had not yet evaluated them.

On May 19, 2023, the second caseworker completed an unannounced visit to the parents' home. The parents were not home, so the second caseworker left a letter asking the parents to contact them.

On June 15, 2023, the second caseworker uploaded documents from the youth's medical records and the law enforcement investigations. The youth was noted to have been seen at the emergency room in December 2022, for a psychological evaluation. The assessment closing summary noted that the youth was seen in the emergency room following a suicide attempt when she consumed a bottle of vodka. The discharge paperwork indicated that the youth was to follow up with her primary care physician and utilize the resources provided by the mental health team. The police report was noted to have stated that the prescription bottles found with the youth were prescribed to the cousin, who had recently passed.

The second caseworker contacted the coroner's office inquiring about the toxicology report and was informed on July 3, 2023, that an autopsy was not performed. "The manner of death [was] [s]uicide [with] [t]he cause of death [being] [c]ombined [d]rug (clobazam, lacosamide, and phenobarbital) toxicity."

On July 14, 2023, the assessment was re-opened and closed for the addition of clarifying information. The assessment's closing summary noted that the youth was "recommended… [to] receive a psychological evaluation and follow-up care" after her previous suicide attempt, but did not receive any therapy or mental health treatment following her discharge from the hospital.

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

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

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with Weld County Department of Human Services, consisting of 10 of referrals, 4 assessments, and 2 prevention cases.

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.

1/24/2021-
3/10/2021 Weld County Department of Human Services (WCDHS) completed an assessment with the family regarding concerns that the youth was left outside of the home and was not observed entering the home to eat or use the restroom. During the assessment, it was determined that the youth and the half-sibling were sent outside to do chores for significant behaviors. The parents and the half-sibling reported that the children were provided food and access to the restroom and were not locked out of the home. The mother did not allow the sibling to be interviewed during the assessment and would only allow the caseworker to observe the sibling. The youth denied having access to food and water, but the parents reported she refused meals and water. The allegations of minor, intrafamilial neglect - environment injurious were unfounded.

7/25/2021 WCDHS received a report of concern regarding the youth being outside in the heat all day and was not allowed to return to the home until dinner time. The RP reported providing the youth with food, while others provided her with sunscreen. The youth was reported to have been pulling weeds since the morning. The referral was not accepted for assessment for the indicated reason of "No information available from reporter of abuse and neglect as defined in law.

WCDHS received 3 additional reports of concern for identical concerns, each of which were not accepted for assessment for the indicated reason of "Duplicate referral."

7/27/2021	WCDHS received another report of concern regarding the youth being outside all day in the heat, and had been seen outside "in the winter as well." The referral was determined not to meet criteria for assessment with indicated reason of, "No information available from reporter of abuse and neglect as defined in law."
7/29/2021- 9/8/2021	The family was referred to WCDHS prevention, but did not respond to any attempts of contact from the prevention caseworker. The prevention case was closed with the indicated reason of, "Cannot Locate."
9/29/2021- 10/28/2021	WCDHS completed an assessment with the family regarding concerns the mother had scratched the youth while taking a toothbrush from her in an argument. The RP reported concerns that the other children in the home did not receive the same consequences. During the assessment, the youth disclosed instances when she sustained minor injuries from the parents being physical towards her. Following the initial contact with the caseworker, the youth ran away to a friend's home. The family did not allow the caseworker into the home and reported that the youth lost access to electronics after it was discovered that she had gone onto a sex site. At the time of the assessment, the youth was engaged in individual therapy. The youth later recanted her statements to the caseworker and reported they were exaggerations of what occurred. The allegation of minor, intrafamilial abuse – physical was inconclusive.
10/4/2021- 10/28/2021	WCDHS completed an assessment with the family regarding concerns of physical abuse to the youth by the father. During the assessment, the father denied the allegations, and later the youth recanted, stating she had exaggerated the concerns. The allegation of minor, intrafamilial abuse – physical was inconclusive.
10/9/2021	WCDHS received a report of concern regarding the family. The RP reported the youth had been locked out of the home "for 12 to 14 hours" and expressed concern that the youth was "using drugs and/or alcohol." The referral was not accepted for assessment for the identified reason of "No information available from reporter of abuse and neglect as defined by law."
10/11/2021	WCDHS received a report of concern for substance use in the home. The youth was reported to be isolated and to not feel safe at home. The youth recently ran from the home twice, including once when law enforcement was called. Upon the youth's return from the run, the parents removed all of the youth's clothing from her room and only left her with a mattress and blanket. The referral was not accepted for assessment for the identified reason of "Other." It was noted that there were similar concerns reported in previous referrals, two of which were open for assessment at the time of this referral.
11/4/2021	WCDHS received a report of concern regarding the youth wearing shoes with holes and being forced to do chores for punishment "all hours of the night." The referral was initially assigned for assessment, but later screened out. It was noted "the [youth] [was] manipulating…[upon speaking to the family, they] ha[d] a lot of services including therapy and [the youth] [was] in school. The family [did] not feel they need[ed] any assistance from [WCDHS] at [that] time." The referral was not accepted for assessment for the identified reason of, "Other."
11/9/2021	WCDHS received a report of concern regarding the youth not having a coat or backpack. The mother was reported to have taken the youth's backpack due to

concerns she was stealing. The referral was not accepted for assessment for the identified reason of, "Other."

11/12/2021-
11/30/2021 WCDHS completed an assessment with the family regarding concerns the mother hit the youth and that the youth did not have anything in her room other than a mattress. The parents met with the caseworker, but did not allow them into the home. The mother denied hitting the youth. The family reported that prior to the referral being made, the family had begun family therapy. The youth reported feeling safe in the home and that her consequences were due to her behavior. The youth did report being hit by the mother during a heated argument, but denied any injuries. The allegation of minor, intrafamilial abuse – physical were unfounded.

12/2/2021 WCDHS received a report of concern regarding the youth. The RP reported the mother and the youth were arguing, when an unidentified male came and yelled at the youth. The unidentified male "[told] [the youth] that she needed to listen to [the mother], that she was facing 2 years in jail, and that this was her final warning." The RP also mentioned prior referrals of concern made regarding the youth being locked out of the home, not being provided with food, and not having adequate clothing. The referral was not accepted for assessment for the identified reason of, "No information available from reporter of abuse and neglect as defined in law."

12/9/2021-
1/5/2022 The family was referred to WCDHS for prevention services, but did not respond to attempts of contact from the prevention caseworker. The prevention case was closed with the indicated reason of, "Cannot Locate."

12/12/2022 The youth was found awake in the school bathroom "with several empty bottles of [v]odka." Once at the hospital, the youth was placed on a mental health hold. The youth was discharged from the hospital with a recommendation to follow up with her primary care physician and there was a reported discussion of the youth's need for a psychological evaluation.

~1/2023 The youth moved into the maternal grandmother's home.

~3/13/2023 The youth was suspended from school for fighting, vaping, and being disrespectful to faculty.

3/15/2023 The youth and the maternal grandmother attended a school re-entry meeting.

3/16/2023 The youth was taken to the hospital after she ingested several pills.

3/18/2023 The youth was taken off life support and passed away.

IV. COUNTY INTERNAL REVIEW

County: Weld **Date:** 3/16/2023

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: September 11, 2023 and January 8, 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. Weld County's Internal Review Report Dated: 3/16/2023
5. Medical Records
6. Police report

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

- Family conflict – the mother and the youth had a strained relationship
- The youth's mental health needs
- It was unknown if the adults really understood the youth's mental health needs
- The accumulation of the family's trauma history, included multiple recent losses
- Pattern of neglect and emotional abuse through the lens of conflict
- Not having insight into how the parents' behaviors impacted the youth and worsened the youth's mental health
- Lack of proper medication storage or disposal
- The delay in seeking follow-up mental health care/treatment
- The cousin's recent death
- The adults in the household were struggling, which made it difficult to be present for the youth and the youth's needs
- The youth was getting in trouble at school, it was unknown if mental health services were provided through the school
- The youth had a positive rapport with the school in Weld County, it was unknown how the move to Adams County impacted the youth

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 in the services and supports put in place for the family during their prior involvement with WCDHS.

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 gap related to the lack of reports made regarding the youth's safety and wellbeing, especially after her intoxication at school or after the referrals were made through the Safe-to-Tell program. Had reports been made on the youth's behalf, additional services and supports could have been offered to the family.

2. The CFRT identified a gap related to the youth's discharge from the hospital, following her possible mental health hold, and the lack of information known about the level of supervision or supports the youth needed following her hospitalization. The hospital records, which were not initially provided to the county, did not characterize the youth's high level of intoxication as a suicide attempt; therefore, it was difficult to know what information the maternal grandmother was provided regarding the youth's mental health needs and how the maternal grandmother could help keep the youth safe.

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:
The CFRT did not make any formal recommendations during the review of this incident.