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

Public Notification Case ID: 23-053

Investigating County Name: Adams

County(ies) with Previous Involvement: Adams

Incident Level: Fatal

Incident Date: 5/22/2023

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

B. Caregivers

Mother
Age: 30 years old **Race or ethnicity**: White

Father
Age: 33 years old **Race or ethnicity**: Unknown

C. Description of the child's family (non-identifying information): At the time of the incident, the child resided with the mother, the three older maternal half-siblings' father, and all four of the maternal half-siblings (ages 11, 9, 6, and 3 years). The mother and the three older maternal half-siblings' father were in the process of a separation prior to the incident and had a pattern of separation and reconciliation. The child's father was not involved. The youngest maternal half-sibling's father's contact with the youngest maternal half-sibling was unclear. The three older maternal half-siblings' father had another child (age 10), but it was unclear what his contact was with said child.

The mother was reported to have been employed, while the three older maternal half-siblings' father was a stay at home father and was the primary caregiver for the children. The mother had identified the three older maternal half-siblings' father's family as a support to her and the family, even in times when the mother and the three older maternal half-siblings' father were separated.

The mother was reported to have been engaged in therapeutic services for two years and had a history of anxiety and postpartum depression. The three older maternal half-siblings' father was

reported to have Bipolar Disorder and Post Traumatic Stress Disorder (PTSD). The three older maternal half-siblings' father was reported to have been unmedicated for an undisclosed period of time, but was medicated following the incident. "[The three older maternal half-siblings' father] [was] an honorable discharge veteran [and was] on disability."

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 5/22/2023 **Date closed:** 8/15/2023
County: Adams **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On May 22, 2023, Adams County Human Services Department (ACHSD) received a report of concern regarding the death of the child. The reporting party (RP) reported that the child had drowned in the family's "above ground pool," which was three-feet tall and required a ladder to gain access into the pool. The three older maternal half-siblings' father was supervising the children when "[he] went inside for three minutes." The RP reported that the three older maternal half-siblings' father had changed his story regarding how long he was gone from outside, so the actual timing was unknown. The mother and the three older maternal half-siblings' father were married, but had separated for a while. During their separation, the mother became pregnant with the child. There were no obvious injuries to the child, who was taken by ambulance to a local hospital where she was pronounced deceased.

On May 24, 2023, the caseworker went to the family home and met with the three older maternal half-siblings' father. There were several relatives at the home and the mother and the maternal half-siblings were reported to be at another relative's home. The three older maternal half-siblings' father reported that he planned to cooperate with the investigation, but did obtain legal counsel. The three older maternal half-siblings' father reported that he was preparing the home for the mother and the three older maternal half-siblings to return and planned to drain the pool that day, as he received permission from law enforcement to do so. The caseworker informed the three older maternal half-siblings' father that they did not plan to re-interview the maternal half-siblings regarding the incident, as they had been forensically interviewed the previous day.

The caseworker went to the relative's home and met with the mother, the maternal half-siblings, and the relative. The mother was not at the home when the caseworker arrived, but arrived while the caseworker spoke with the relative. The relative reported no concerns regarding the three older maternal half-siblings' father's care of the children, but did express concerns for the conditions of the home. The relative reported that the three older maternal half-siblings' father had several home renovation projects that were left unfinished and described the children's room to have exposed insulation. The mother reported she had been in contact with her therapist and the victim advocate. The mother reported that the three older maternal half-siblings' father struggled with completing one project before starting another and the family would not return to the home until the renovations were completed. The three older maternal half-siblings' father was reported to feel guilty, as he was watching the children when the child drowned. The mother reported the day of the incident the family was working on cleaning up the home.

On May 26, 2023, the caseworker requested the maternal half-siblings' forensic interviews from law enforcement.

On June 7, 2023, the caseworker met with the mother and the maternal half-siblings and provided the family with "grief [and] housing resources." The mother informed the caseworker the family was making progress on the home renovations and she expected the family to return to the family home in "the next few months."

On June 30, 2023, the caseworker observed the recorded forensic interviews of the maternal half-siblings.

On July 11, 2023, the caseworker reviewed law enforcement records. The three older maternal half-siblings' father was reported to have not provided a formal statement to law enforcement, but stated he had taken his eyes of "[the child] for no more than five minutes." It was documented that the child was in the pool for five minutes. The mother was documented to have been in the home when "[the three older maternal half-siblings' father] brought… [the child's] lifeless body" into the home.

On August 11, 2023, the caseworker contacted the mother and the three older maternal half-siblings' father and informed them that the assessment would close as founded.

On August 15, 2023, ACHSD closed the assessment. The assessment closure summary noted that the mother and the three older maternal half-siblings' father "share[d] responsibility for the children when they [were] both in the home. While [the three older maternal half-siblings' father] was… outside with the children in the pool, [the mother] was home and aware [the three older maternal half-siblings' father] and the other children had come inside. As [the mother] and [the three older maternal half-siblings' father] were inside and both failed to notice [the child] was missing, they [were] equally responsible for the lack of supervision that resulted in her drowning."

This assessment was closed on August 15, 2023.

Findings: The allegations of fatal, intrafamilial neglect – lack of supervision/supervision inconsistent with child's need were substantiated.

The allegations of medium – intrafamilial neglect – environment injurious were substantiated.

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with Adams County Department of Human Services consisting of four referrals and one assessment.

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.

4/14/2021	ACHSD received a report of concern that the mother treated two of the maternal half-siblings differently than the other maternal half-siblings, and had "slapped [the second youngest maternal half-sibling] in the face." The referral was determined not to meet criteria for assessment with the indicated reason of, "No information from reporter of abuse and neglect as defined in law."

9/9/2021-11/8/2021	ACHSD completed an assessment regarding concerns that the mother had been yelling at and hitting the maternal half-siblings. The mother had also recently gotten upset with the oldest maternal half-sibling for not following directions and "picked up [the oldest maternal half-sibling] and threw [the oldest maternal half-sibling] to the ground," leaving bruises and fingernail marks on the oldest maternal half-sibling's arms. The second oldest maternal half-sibling was reportedly struggling in school, and all of the maternal half-siblings reported being yelled at and hit by the mother. The mother was pregnant with the child at that time, but the father was not involved with the family. The mother and the three oldest maternal half-siblings' father reconciled during the assessment, and the mother moved back into the family's home. The mother denied physically disciplining the maternal half-siblings, though did acknowledge that she yelled at them too much. The maternal half-siblings denied being physically disciplined. The allegations of minor, intrafamilial abuse – physical were unsubstantiated. The allegations of minor, intrafamilial abuse – emotional were unsubstantiated.
9/10/2021	ACHSD received a report of concern that was duplicative of the allegations in the assessment dated September 9, 2021. The referral was determined not to meet criteria for assessment with the indicated reason of, "Duplicate referral."
3/2022	The child was born.
3/24/2022	ACHSD received a report of concern regarding "[the father threaten[ing] to kill [the mother], [the child,] and the other children in the family," after the three older maternal half-siblings' father told the father's spouse that the father had fathered the child with the mother. The father was a law enforcement officer who was suspended after his threats were reported to law enforcement, and he therefore had to relinquish his weapon. The RP believed that the children were safe in the three older half-siblings' father's care, and that the mother was doing the best she could in the situation. The mother had also reported having thoughts of harming the child, as the child reminded the mother of the father. When she had those thoughts, the mother would walk away from the child. The mother also had a history of depression and self-harming behaviors. 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." It was documented in the RED Team framework that the matter was being handled criminally and that no abuse or neglect had occurred at that time.
9/15/2022	ACHSD received a report of concern regarding allegations of physical abuse by the mother towards the maternal half-siblings that had occurred in the past. The RP reported that once the three older maternal half-siblings' father learned of the abuse, he put a stop to it. The mother had also moved back into the family's home, due to not being able to afford housing on her own. 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."

IV. COUNTY INTERNAL REVIEW

County: Adams **Date:** 8/14/2023

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: October 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. Adams County's Internal Review Report Dated: 8/14/2024
5. Law enforcement records
6. Autopsy

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

- Complex family dynamic which included the three older maternal half-siblings' father caring for two children that were not his own
- A history of multiple separations and reconciliations between the parents
- The three older maternal half-siblings' father was a veteran and had been diagnosed with bipolar disorder and post-traumatic stress disorder (PTSD)
- Multiple children in the home
- Vulnerable child due to age
- The pool in the backyard did not have prevention devices to prevent the children from entering the pool
- The family had a complicated relationship with law enforcement due to the mother's employment interacting often with law enforcement

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 the family being connected with grief services during the assessment.

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 identified a systemic gap regarding the father being placed on leave from law enforcement, following his threats towards the mother and the child. The team discussed that, though the father was placed on leave, it was unclear if any further actions were taken.
2. The team identified a potential gap regarding law enforcement's response to the incident. It was unclear if the mother's employment impacted the law enforcement response to the incident. ACHSD believed the response from law enforcement was outside their typical response for such an incident. ACHSD was requested to respond immediately to the home, despite the maternal half-siblings being at another home following the incident.

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.