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

Public Notification Case ID: 23-066

Investigating County Name: Adams

County(ies) with Previous Involvement: Adams and Broomfield

Incident Level: Fatal

Incident Date: June 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: 2 days old **Gender:** Female

Race or ethnicity: White

Child's residence: In-home

B. Caregivers

Mother

Age: 33 years old **Race or ethnicity**: American Indian or Alaska Native

Father

Age: 43 years old **Race or ethnicity**: White

C. Description of the child's family (non-identifying information): The infant, who was initially considered to be a Safe Haven Baby, was born into a family with four siblings, who were 9 years old, 3 years old, 2 years old, and 11 months old. There were several people living together in the mother's home, including the mother, a maternal relative who recently required full-time caregiving, two elderly maternal relatives, the four siblings, and a family member who assisted the mother in caring for everyone else in the home. The father did not live in the home, but he did visit on a regular basis.

The mother reported meeting the father when she was 22 years old and having history of methamphetamine use prior to their relationship. The mother also reported a trauma history during her adolescence, resulting in Post-Traumatic Stress Disorder (PTSD). She denied a history of homelessness or criminal charges.

The father primarily resided with paternal family members. The father did not engage much during the family's prior child welfare case, and little social history information was gathered about him.

The father reportedly engaged in substance use and used power and control dynamics in his relationship with the mother. The father's criminal history included drug charges, weapons, and theft.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 6/26/2023 **Date closed:** 10/6/2023
County: Adams **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the near fatal child maltreatment incident (non-identifying information): On June 26, 2023, Adams County Human Services Department (ACHSD) received a report of concern regarding a newborn infant. The reporting party (RP) reported that the infant was "relinquished at a fire station," and taken to a local hospital for medical care before being transferred to Children's Hospital Colorado (CHC), as she needed to be admitted into the Neonatal Intensive Care Unit (NICU). The infant was diagnosed with "[m]alnourishment, apnea requiring intubation, tachy-cardia [*sic*] (cardiovascular system)[,] and decreased levels o[f] responsiveness." Further testing showed the infant had a "[s]ubarachnoid [h]emorrhage and [c]erebral [e]dema." Any additional tests would require medical consent from a caregiver; therefore, ACHSD was contacted to see if they could obtain custody of the infant in order to consent to further testing and treatment.

A caseworker responded to CHC and learned that the infant was likely older than her estimated age; however, CHC had used her relinquishment date as her date of birth. It was believed she was born at 37 weeks gestation, and scans "showed several brain bleeds." Further tests were being done to determine if the infant had Meningitis or any illicit substances in her system.

On June 28, 2023, a court hearing was held in which ACHSD was granted temporary legal custody of the infant and the ability to make medical decisions on the infant's behalf; however, the Judge did not believe the court had the authority to make end-of-life decisions for the infant, which were needed. Two of the infant's doctors from CHC participated in the court hearing and reported that the infant no longer had any brain functioning and could "not [breathe] on her own."

On June 30, 2023, a second court hearing was held, during which the courts determined that it was in the infant's best interests to withdraw life saving measures at that time.

Later that day, another caseworker and a supervisor met with the infant and her medical team as they disconnected her from life support. The infant's medical team took turns holding the infant until she passed away. The supervisor and the other caseworker discussed next steps with the medical team with regards to the infant's autopsy and funeral planning. "[The supervisor] thanked the medical [team] for all that they ha[d] done for [the infant], and [for giving] her support and attention [when] no one else [was] able to be there for her."

On July 26, 2023, law enforcement advised the caseworker that the infant's biological family had been identified, including the mother, the father, and four siblings. Law enforcement believed that the infant had been born in the middle of June 2023, at home, but that the mother had not received any prenatal care or care for the infant after her delivery. The mother had been interviewed by law enforcement and reported that after a few days, the infant appeared ill, so a family member drove the mother to a nearby fire station, where the mother handed off the infant and advised that the infant was in need of medical care. The mother also reported later needing to be hospitalized herself and was diagnosed with sepsis. Law enforcement reported that the infant had tested "positive for methamphetamine and amphetamines;" however, the mother denied knowing how the infant could have been exposed to any substances. Law enforcement planned to charge the mother for the infant's death.

On July 31, 2023, the caseworker and the other caseworker met with the mother, unannounced, at the family's home. The mother reported that she lived in the home with the maternal relative, two additional elderly maternal relatives, all of whom relied on her to care for them, along with the four siblings, and the family member who assisted the mother in caring for the siblings and the three maternal relatives. The father did not live in the home, but frequently visited the home. The mother admitted to relapsing on methamphetamine and relying on the maternal relatives and the family member to be the sober caregivers in the home while she was under the influence, but denied ever actively using methamphetamine while in the home. The two caseworkers offered to provide the mother with several resources, therapeutic services, and in-home supports for the family.

On August 2, 2023, the caseworker exchanged text messages with the father to schedule a time to meet and discuss the assessment.

The two caseworkers returned to the family home to meet with the siblings. The mother reported that she had not yet shared the news with the oldest sibling that the infant had passed away. The caseworkers observed the home to be very cluttered, with narrow walkways, and noticed that there were infant supplies in the home, such as "a couple [of] infant car seats and baby blankets." The caseworkers were able to observe and interact with all of the siblings. The caseworkers also spoke with the mother and learned that she had told the father about the infant's death. The mother reported that the father could be verbally aggressive, but that she did not worry about him becoming physically aggressive with her or the siblings.

On August 3, 2023, the caseworker communicated with the father again via text messages. The father asked the caseworker to explain in the text message why an assessment was open. He stated he responded to the ACHSD office for the agreed upon meeting, but noticed several law enforcement jurisdictions present, and learned that the caseworker had canceled the meeting. The caseworker responded that law enforcement was usually present at the office and that the meeting had been cancelled because the father had never confirmed his plan to participate. The caseworker provided a brief synopsis of the concerns for the assessment and the hope to engage the father in the assessment.

On August 7, 2023, the caseworker communicated with the father again via text message. The father became more agitated and upset in his text exchange with the caseworker, denying that he had anything to do with the infant's relinquishment at the fire station or need for medical attention. The father wanted to know where the infant's body was at that time. The caseworker advised that the infant's body was in the coroner's care, and that the father would still be expected to participate in the court-involved case that would be opened following the assessment.

On August 24, 2023, a forensic interview was scheduled for the two older siblings; however, the family member, who agreed to drive them to the interviews, did not arrive at the interview with the two older siblings at the agreed upon time.

The family member later called the caseworker to report being lost and unable to find the location where the forensic interviews were to take place.

On September 7, 2023, the caseworker called and spoke with the family member to advise that the forensic interviews for the two older siblings had been court ordered and rescheduled for September 14, 2023. The family member agreed to bring the two older siblings to the interviews on the new date and time.

On September 14, 2023, the oldest sibling was forensically interviewed.

The second oldest sibling was too young to be forensically interviewed.

Law enforcement then interviewed the family member, who reported being able to tell the mother was pregnant with the infant, despite the mother never acknowledging the pregnancy. The family member encouraged the mother to seek prenatal care, but the mother refused. The family member also could tell when it appeared that the mother was closer to delivering the infant; however, the mother continued to refuse to seek medical care for herself or the infant. The family member reported that after the infant was born, the infant initially appeared healthy. However, after a few days, the infant's health appeared to decline and "[the family member] could hear [the infant] gargling in her throat and then [the family member] became concerned about [the infant's] breathing." The family member reported driving the mother to the fire station when the mother agreed to seek medical treatment for the infant; however, the family member denied realizing that the mother would return without the infant. The family member reported questioning "[the mother] daily about finding [the infant] and [the mother's] answers to [the family member's] questions became more and more vague so [the family member] just stopped asking [the mother] about [the infant]." The family member reported eventually realizing that the infant must have passed away. The family member also reported knowing that the mother had relapsed on substances, but denied seeing the mother actively use or be under the influence of substances while at the home. "[The family member] believe[d] [the mother] was overwhelmed and did not know what to do with another [infant]," in addition to caring for the four siblings and the three maternal relatives who relied on the mother's caretaking.

The assessment was closed on October 6, 2023. A court-involved case was opened to provide services to the family. In the assessment closure summary, it was documented that the infant was likely closer to one week old by the time the mother left the infant at the fire department. It was believed that had the mother sought medical care earlier for the infant, the infant might have been diagnosed with Meningitis, which could have led to possible earlier medical interventions for her.

Findings: The allegations of minor, intrafamilial neglect – environment injurious were substantiated.

The allegation minor, intrafamilial abuse – physical was inconclusive.

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

The allegation of fatal, intrafamilial neglect – failure to protect was substantiated.

Supplemental Information:

The coroner determined that the infant's cause of death was "[s]epsis complicating bacterial meningoencephalitis," while the manner of death was "[n]atural."

Per the law enforcement records, the infant was exposed prenatally to methamphetamine; however, that exposure was not enough to contribute to the infant's death. Additionally, the infant's medical team from CHC reported that the infant likely contracted bacterial Meningitis after her birth, but it was unknown if more timely medical intervention would have prevented her death or not. Law enforcement issued a warrant for the mother's arrest for child abuse.

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with Adams and Broomfield County Departments of Human Services, consisting of one referral, one assessment, and one case.

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.

11/6/2019-7/23/2021	ACHSD opened a court-involved case with the family. The case was closed with the indicated reason of, "Court Action."
3/12/2021-5/12/2021	ACHSD completed an assessment regarding concerns that the mother struggled with substance abuse and was in a recovery treatment facility during the beginning of her pregnancy. The allegations of minor, intrafamilial neglect – environment injurious were substantiated.
10/7/2021	Broomfield Health and Human Services (BHHS) received a report of concern. The referral was determined not to meet criteria for assessment with the indicated reason of, "Refer to: Other Department of Social/Human Services, other Agency, or Individual." It was documented in the RED Team framework that a referral would be made to the prevention unit to ensure the mother had the resources and supports she needed.
~6/2023	The infant was born.
6/26/2023	ACHSD received the report of concern regarding the infant being in critical condition after being relinquished at the fire station.
6/30/2023	The infant passed away.

IV. COUNTY INTERNAL REVIEW

County: Adams **Date:** October 13, 2023

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. Adams County's Internal Review Report Dated: October 13, 2023
5. Medical Records
6. Autopsy Report
7. Law Enforcement Records

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

- Domestic violence, with the father as the perpetrator exerting power and control over the mother without living in the home
- Substance use
- Some of the children had developmental delays
- Lack of medical treatment for the children
- Lack of prenatal care, which might have been related more to the fear of the child welfare system or concern for financial constraints than a cultural reason
- Lack of post-natal care for the infant
- The mother was 10 years younger than the father, and they began their relationship when the mother was fairly young
- The father's DV assessment rated him at the highest level of threat
- Cultural dynamics between the parents: the father disregarded the mother's Native American heritage, as well as the Indian Child Welfare Act (ICWA) needs in the case.
- The mother's trauma history and diagnosis of PTSD
- The mother was vulnerable when she met the father
- The oldest sibling was parentified
- The mother was pregnant and gave birth to four children in four years
- The mother's postpartum depression
- The family's extensive child welfare history
- The mother was responsible for caring for her own children as well as the maternal relatives who lived in the home
- The father's lack of engagement in the previous case made it difficult to create or ensure safety for the mother and children due to the domestic violence dynamics

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 multiple services and supports offered to the family throughout their prior child welfare involvement, including domestic violence referrals and developmental evaluations for the siblings.

2. The CFRT identified a strength in the great collaboration between law enforcement and CHC in meeting the infant's needs after she was relinquished at the fire station.

3. Additionally, the CFRT identified a strength in the love and attention CHC staff provided to the infant while she was in their care, and especially for the attentiveness and empathy shown by the CHC staff, as well as the ACHSD staff, who were present during the infant's final moments.

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 systemic gap related to the lack of information about and the visibility of the Safe Haven Laws, how they work, and how families can utilize them, if needed.

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 fatality.