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

Public Notification Case ID: 24-033

Investigating County Name: Mesa

County(ies) with Previous Involvement: Mesa

Incident Level: Fatal

Incident Date: 3/17/2024

~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: 1 month old **Gender:** Male
Race or ethnicity: Hispanic
Child's residence: In-home

B. Caregivers

Mother
Age: 20 years old **Race or ethnicity**: Unknown

Father

Age: 19 years old **Race or ethnicity**: Hispanic

C. Description of the child's family (non-identifying information): The infant lived with the parents in the home of the maternal relatives. The parents reported having been in a relationship for the better part of the prior five years, with one short break. The father was employed full-time, while the mother stayed home to care for the infant. The family moved from one city in Colorado to Mesa County to be closer to the maternal relatives during the mother's pregnancy with the infant. The mother was exclusively breastfeeding the infant. The mother and father regularly used cannabis and cannabis products. The mother noted that her "psychiatrist, [her obstetrician], and the [infant's] pediatrician all knew that she used [cannabis]." The mother used several different providers for her obstetric care. One provider was from before the family moved and they used whichever provider was available at the clinic, which was the practice at that clinic. The mother was diagnosed with depression and was taking prescribed antidepressant medications. During a recent prior pregnancy, which ended in miscarriage, the mother and her psychiatrist made a plan for reducing her medication. The mother loosely followed that plan during her pregnancy with the infant, finding that lessening her dosage of her antidepressants left her feeling depressed, so she

usually took the normal dose. The mother denied that her obstetric providers recommended that she lower her mental health medication dosages during pregnancy.

The family was enrolled in a local home nursing program. As a part of that program, the parents were educated about safe sleep practices for infants. The parents were able to discuss infant safe sleep practices with law enforcement, and had a crib available in the home that was not being used yet. The father had child welfare history as a child, during which he was removed from the care of his mother.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 3/19/2024 **Date closed:** 5/16/2024
County: Mesa **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On March, 19, 2024, Mesa County Department of Human Services (MCDHS) received a report of concern regarding the infant's death. The reporting party (RP) reported that initially the infant's death was not suspicious for abuse or neglect and appeared to be due to adults co-sleeping with the infant. Later, the mother admitted to using cannabis products and prescribed mental health medications while breast feeding. The infant's autopsy showed no injuries, but there were "suspicions that [the infant] was accidentally asphyxiated due to positioning and [the] parents not waking up due to possible drug use."

On March 19, 2024, a supervisor reached out to law enforcement to inquire about the infant's autopsy, stating that MCDHS would not do an assessment unless there were concerns related to abuse or neglect. Law enforcement relayed there was an investigation underway due to "the mixture of medications & [cannabis]" the mother admitted to using, which was a concern. The infant's autopsy did not reveal any injuries. A toxicology report was pending. It was believed that the infant died from positional asphyxiation "and [the] parents not waking up due to possible drug use." The supervisor told law enforcement that the situation met criteria for assessment.

On March 20, 2024, the caseworker reached out to a service provider to see whether they were working with the family.

On March 21, 2024, the caseworker reviewed the law enforcement report about the incident. The father told law enforcement the day prior to the infant's death was uneventful. The mother breastfed the infant and placed him in the middle of the adult/king sized bed between the parents to sleep. The infant routinely shared the adult bed with the parents. The father indicated that he believed the mattress was too soft, which caused the infant to sink into the mattress and suffocate. The infant was not covered by a blanket. The infant awoke two times during the night and the mother breastfed him. The father awoke around 6:00 a.m. and noticed the infant's face was blue and there was blood on his face. The father woke the mother and the maternal relative. The maternal relative performed cardiopulmonary resuscitation (CPR) while the father called 911. The maternal relative rode in the ambulance with the infant, while the parents followed in their car. The father noted that the mother was difficult to awaken when she was asleep, due to medication she was prescribed. The father indicated that he was usually the one to wake up during the night to feed and care for the infant. The mother's physician was aware that she used cannabis to manage pain. The father shared that he used cannabis edibles occasionally, but typically only on weekends. He had not eaten an edible prior to the infant's death.

Law enforcement planned to test the mother's stored breast milk as well as the parent's blood and urine to assess for substance abuse.

When interviewed by law enforcement, the mother noted that while she slowed her cannabis use while pregnant, she had resumed her pre-pregnancy use levels. The day prior to the infant's death, the mother smoked cannabis three times. The mother also shared that she was on several psychotropic medications, which caused her to sleep very deeply. While the parents stated that the infant had been found on his back, lividity on the infant's body matched a pattern that would be expected if the infant had been nursing. The parents had a bassinet, but did not use it.

On March 22, 2024, the caseworker spoke to a medical collateral who relayed that infant safe sleep guidelines were discussed with the mother several times during her prenatal care. The parents had ordered a firmer mattress, to try to make co-sleeping safer, but the new mattress had not yet arrived.

On March 27, 2024, the caseworker documented watching a recorded law enforcement interview with the mother. While much of the information was duplicative of information already gathered, the mother noted that she usually breastfed the infant prior to bedtime, in the adult bed "putting him next to her right side" or "holding him in both arms on her chest… [or] sometimes he would be across her [with] [the infant] being on the left breast and be diagonal across [the mother's body]. She said that she would also lay with him on her breast and motioned to be laying on her right side with him on her right breast, along the right side of her body." The mother indicated that if she breastfed at night, she would typically be groggy due to her medication. The mother set alarms during the day to remember to pump, but did not set alarms at nighttime. The infant slept in a zipped swaddle, and the parents were not touching him, but were in the bed.

The assessment was closed on May 16, 2024.

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

Referral
Date received: 3/17/2024
County: Mesa **Date not accepted for assessment:** 3/20/2024
Reason for not accepting referral for assessment: "No information available from reporter of abuse and neglect as defined in law"

Referral narrative summary and additional information contained in referral (non-identifying information): On March 17, 2024, MCDHS received a report of concern regarding the infant's death. The RP reported that the infant had passed away while co-sleeping with the parents. There were no other concerns documented. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."

Supplemental Information: (additional information gathered from the supplemental documents)
The infant's autopsy report noted that "[the] [a]utopsy revealed no injuries that contributed to [the] death. There was also no significant natural disease [observed]… The cause of death [was] asphyxia (lack of the ability to adequately breathe) due to an unsafe sleep environment which included co-sleeping with two adults. The manner of death [was] accident." The infant's toxicology testing revealed "relatively low concentrations of fluoxetine (25.7 ng/ml) and norfluoxetine (278 ng/ml) [antidepressants] along with the presence of caffeine. The [infant's] urine was negative for drugs of abuse."

The law enforcement report noted that the parents had been provided safe sleep education "at least three times by there [*sic*] pediatrician" and thus both parents were charged with "Child Abuse- Negligently Cause Death and Criminally Negligent Homicide."

The parents were both sentenced to two years of Diversion.

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with Mesa County Department of Human Services consisting of one referral.

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.

12/26/2023	MCDHS received a report of concern regarding the mother using cannabis during her pregnancy. The mother had not yet given birth. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."
3/17/2024	MCDHS received a report of concern regarding the infant's death. Please see above for more information. This referral was not accepted for assessment with the indicated reason of "No information available from reporter of abuse and neglect as defined in law."
3/19/2024	MCDHS received information that the infant's death was suspicious for child maltreatment.

IV. COUNTY INTERNAL REVIEW

County: Mesa County **Date:** 5/31/2024

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: 2/3/2025

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: May 31, 2024
5. The infant's autopsy report
6. Law enforcement records

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

- The mother's substance abuse
- The mother's mental health
- The mother's mental health provider was not local so it was hard for the mother to access care
- Vulnerable child due to age
- The decision to co-sleep
- The mother used her medication at night, although it made her difficult to rouse
- The father's child welfare history and removal from his own home as a child

- The mother became unemployed during her pregnancy and did not return to work postpartum

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 systemic strength that someone from the nurse family partnership program had visited with the family and explained safe sleeping arrangements for newborns prior to the incident. The family appeared to be receptive to the advice given, as evidenced by the family buying a new mattress, which the parents believed would be safer to use while co-sleeping.

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 a gap related to the review of this 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 make any formal recommendations during the review of this incident.