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

Public Notification Case ID: 24-088

Investigating County Name: Arapahoe

County(ies) with Previous Involvement: Arapahoe, Denver, Douglas

Incident Level: Fatal

Incident Date: 8/13/2024

~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: 3 months old **Gender:** Male
Race or ethnicity: Black or African American and White
Child's residence: In-home

B. Caregivers

Mother
Age: 23 years old **Race or ethnicity**: Hispanic

Father
Age: 25 years old **Race or ethnicity**: Black or African American

Description of the child's family (non-identifying information): At the time of incident, the parents were residing in separate households and had an informal split custody arrangement for the infant and the sibling, who was 17 months old. The mother was the primary caregiver for the infant, as she was reportedly breastfeeding, and had been in a substance abuse treatment program for a period of time prior to the incident. While there, the infant was able to remain in her care. After being discharged from the treatment program, the mother and the infant were residing with a friend of the mother. The mother had a history of trauma which included being involved in the child welfare system as a child and being adopted. The mother identified her adoptive parents as being supportive. The mother also had a history of alcohol abuse and reported she started drinking alcohol at 12 years old. The mother struggled to maintain stable housing and employment. The father was reportedly employed and had a lot of support from his family. The sibling was reported to be on track with their growth and development. The infant was exposed to alcohol while in utero.

II. SUMMARY OF THE FATAL CHILD MALTREATMENT INCIDENT

A. Assessment **Date received:** 8/13/2024 **Date closed:** 10/31/2024
County: Arapahoe **Overall Finding:** Substantiated

Description of the incident, including the suspected cause of the fatal child maltreatment incident (non-identifying information): On August 13, 2024, Arapahoe County Department of Human Services (ACDHS) received a report of concern regarding the infant. The reporting party (RP) reported that dispatch received two calls regarding the incident; "one [stated] [that] [the infant] may have been strangled and the other said that [a] parent fell asleep on the infant." When emergency medical services responded to the home, the infant was reportedly "limp, pulseless, not breathing…, [and the mother] was attempting [cardiopulmonary resuscitation] CPR." The home was reported to be clean and well-kept and there were no signs of trauma to the infant. The infant was pronounced deceased due to cardiac arrest, but it was not clear what happened.

The hotline caseworker contacted law enforcement to gather additional information. The parents were reported to have split custody of the children, and the sibling was in the care of the father at the time of incident. The maternal relative informed law enforcement of prior reported concerns regarding the mother sleeping with the children while intoxicated.

On August 14, 2024, the caseworker met with the father and the sibling at the father's residence. It was learned that the split custody arrangement was agreed upon by the parents without court involvement. The father reported the mother had been at an inpatient treatment program for alcohol abuse and had the infant with her while she attended the program. The mother was discharged from the program not long before the incident. The father assumed the mother's participation in the treatment program and her ability to take the infant with her meant the mother was making progress and maintaining sobriety. Due to the incident, the father reported he would not allow the mother to have unsupervised contact with the sibling. The father had a lot of family support, some of whom were present at that time.

The caseworker attempted to meet with the mother at her residence but was unsuccessful.

The caseworker followed up with law enforcement who reported they did not have any concerns with the father and his care of the sibling. There was a question around whether the mother was successfully discharged from the rehabilitation program due to the mother admittedly consuming alcohol on the day of the incident.

On August 15, 2024, the caseworker attempted to reach the mother by phone, but was unsuccessful and left a message requesting the mother contact the caseworker.

On August 18, 2024, the caseworker received notification that the mother was at a behavioral health facility and would likely be discharged by August 20, 2024.

On August 20, 2024, the caseworker met with the mother at a local hospital. The mother reported the maternal relatives were concerned that the mother was suicidal as she was consuming alcohol daily and was then admitted to the hospital. The mother denied the need to return to a treatment center and expressed needing to move forward and not "dwell on the past." The mother was informed that her contact with the sibling would be supervised.

On August 21, 2024, the mother was discharged from the hospital and was admitted to a sober living program.

On August 27, 2024, the caseworker contacted the father who reported no concerns, and that the sibling was doing well in his care.

On September 5, 2024, the caseworker was informed that law enforcement continued to investigate the incident and were awaiting additional information before concluding their investigation.

The caseworker checked in with the mother who reported she was engaged in treatment services and maintaining sobriety. The mother also reported having weekly contact with the sibling, which was supervised by the father.

On September 26, 2024, the caseworker followed up with the father who was working on obtaining full custody of the sibling.

The mother also provided an update to the caseworker and reported she was seeking employment and remained engaged in treatment services.

On September 30, 2024, the caseworker completed a home visit with the father and the sibling. The father reported that the mother's contact with the sibling remained supervised and that the father continued to work on obtaining full custody.

The caseworker received notification from law enforcement on October 1, 2024, indicating that law enforcement had filed charges against the mother and sent the information to the district attorney's office.

On October 17, 2024, the caseworker followed up with law enforcement for a status update and it was reported that there was no update from the district attorney's office.

On October 23, 2024, the caseworker had contact with the mother who reported she located employment and was continuing to engage in treatment services. The mother was informed that her contact with the sibling would continue to be supervised.

On October 24, 2024, the caseworker spoke with the father and advised him that ACDHS would be closing their assessment.

This assessment was closed on October 31, 2024

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

Referral
Date received: 8/14/2024
County: Arapahoe **Date not accepted for assessment:** 8/14/2024
Reason for not accepting referral for assessment: "Current allegations have previously been assessed."

Referral narrative summary and additional information contained in referral (non-identifying information): On August 14, 2024, ACDHS received a second report of concern regarding the incident. The information in the referral narrative was duplicative to that in the incident assessment. The referral was not accepted for assessment with the indicated reason of "Current allegations have previously been assessed."

Supplemental Information: (additional information gathered from the supplemental documents)
On August 13, 2024, law enforcement interviewed the mother who reported she consumed alcohol a couple of hours prior to the incident and law enforcement could smell an odor of alcohol on the mother's breath. The mother provided conflicting statements regarding how much alcohol was

consumed prior to the incident, varying from two to five shots of alcohol. Additionally, the mother reported taking prescribed medications, but was not sure if they had any adverse side effects when combined with alcohol.

Law enforcement interviewed the mother's roommate who reported the mother and infant had resided with a friend of the mother for a short period of time prior to the incident. The roommate reported that when they arrived at the residence on the day of the incident the mother was observed sleeping with the infant on a bed and the infant was face down and between the mother's body and arm. The roommate picked the infant up and the infant was unresponsive. The roommate then woke up the mother and notified emergency medical services.

The autopsy report was completed September 10, 2024, and it was reported that "[the infant]… died of asphyxia due to external obstruction of the airways by co-sleeping parent. … An unsafe sleeping environment (adult bed with bedding, pillow, and co-sleeping parent) and low body weight and height for infant age were significant conditions."

On October 1, 2024, an arrest warrant was signed, and the mother was listed as the defendant.

Information obtained through Colorado Courts Data Access reflected that the mother was charged with "Child Abuse – knowing/reckless Cause Death." The case was pending.

B. FAMILY CASE HISTORY

Within the last three years, the family had prior involvement with Arapahoe, Denver, and Douglas County Departments of Human Services consisting of two 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.

3/9/2023	Denver Department of Human Services (Denver DHS) received a report of concern regarding the mother testing positive for cannabis at the time of the sibling's birth. The mother admitted to daily cannabis use while pregnant with the sibling and expressed intent on continuing use while breastfeeding. The local hospital provided education resources to the mother regarding risks related to using cannabis while breastfeeding. 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."
4/2/2024- 6/11/2024	Douglas County Department of Human Services (Douglas County DHS) received a report of concern, which was transferred to ACDHS regarding allegations that the mother was intoxicated while caring for the sibling. The RP reported that the condition of the home was hazardous with small items on the floor that the sibling could choke on. The sibling was observed with their diaper halfway on and had not been fed the entire day. A relative intervened and cared for the sibling until the father arrived to take the sibling back to his residence. The mother entered a treatment program, and the infant was

born in May 2024. The father shared custody of the children with the mother. In addition to the father, the maternal relatives and the treatment service provider for the mother were supports for the family. The assessment was closed with the treatment services and family support in place. The allegation of minor, intrafamilial neglect - lack of supervision/supervision inconsistent with the child's need was substantiated against the mother as to the sibling.

4/7/2024 Douglas County DHS received a report of concern regarding the mother being admitted to a local hospital after being involved in a high-speed motor vehicle accident, in which she was a passenger. The mother was intoxicated and pregnant. The mother was admitted to the local hospital for fetal monitoring. The sibling was not in the vehicle. 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."

~5/2024 The infant was born

8/13/2024 The infant died.

IV. COUNTY INTERNAL REVIEW

County: Arapahoe, Denver, and Douglas **Date:** October 29, 2024

V. CDHS CHILD FATALITY REVIEW TEAM

A. Review Date: May 5, 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: 10/29/2024
5. Autopsy Report
6. Law Enforcement Records

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

- The mother had issues with substance misuse
- The mother had few supports due to ongoing misuse of substances
- The mother started using substances as a young teenager
- The mother had a history of abuse/neglect as a child
- The infant was vulnerable due to age
- Young mother
- The mother lacked accountability/understanding regarding how her substance misuse impacted her ability to care for her children
- Lack of safe sleep due to the mother co-sleeping with the infant
- The mother lacked stable housing

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 case specific strength related to the caseworker and law enforcement's collaboration.

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 potential gap related to the father not receiving information regarding the mother's inpatient treatment progress due to privacy policies. This led to the father being unaware of the mother's treatment as it related to her ability to provide care for the children and any future planning related to the safety of the children.

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 team did not identify any recommendations related to the review of this incident.