

Colorado Department of Human Services
Child Fatality Review
4/15/2008

A. Identifying Information:

Child: Kayla Dutcher
DOB: 1/19/2002
DOD: 10/7/2007 (age 5)

Parents and persons allegedly responsible for the fatality:
Mother: Amy Dutcher (age 26)
Father: James Dutcher (age 35)

B. Involved County:

El Paso County Department of Human Services (EPCDHS)

C. Introductory Statement:

The Colorado Department of Human Services Child Fatality Review Team conducted the review of the circumstances surrounding the death of Kayla T. Dutcher. The purpose of the review is to examine existing practices and policies and how they currently affect the county child welfare programs. These findings should not be construed to link the county's actions to the actions allegedly perpetrated on this child by her parent(s).

Statutory authority for this review is in Title 26-1-111, Colorado Revised Statutes. The Department of Human Services supervisory authority is outlined in the areas of child welfare and other programs as specified. It is in the capacity of supervision of the county's administration of child welfare programs that the state has the legal responsibility to require the corrective actions and to conduct follow-up reviews.

D. Case Summary:

Five year-old Kayla Dutcher was legally blind. She died on 10/7/07, from what the coroner described as an overdose of Tramadol, a class IV narcotic and prescription painkiller. There were inconsistent statements from the parents about how the narcotic got into Kayla's system. The Sheriff's Department search, pictures of the residence (34' RV-class A motor home) and subsequent interviews contra indicated that the parents were cautious about the storage of their medication. No criminal charges were filed.

El Paso DHS Findings related to the fatality: Fatal neglect was confirmed on Kayla Dutcher for founded neglect - injurious environment with the parents listed as being responsible.

E. Chronology:

Prior to the 9/2007 referral there were 5 referrals beginning in the fall of 2002 that did not involve the decedent. The prior history is not relevant to the death and therefore confidential.

Referral - 9/19/07:

The department received a referral at 6:45 p.m. stating that there was no gas in the Dutcher home to cook food, or hot water. A floor heater was used for heat and the children were not in school. This referral was not entered into Trails. The hard copy of the referral indicates it was not assigned for assessment, but was referred internally to Team SUCCESS, which provides in-home services so children can remain safely at home while families work toward financial independence and safe and stable family situations. Some families receiving TANF (Temporary Assistance for Needy Families) face barriers to independence and need more casework or intervention to reach their self-sufficiency goals.

Team SUCCESS offered the family voluntary services to help them. Mr. Dutcher called the department on 10/2/07 declining services. Mr. Dutcher stated that there was food in the house and the children were in school. Team SUCCESS provided no further follow-up.

Referral - 10/12/2007:

The department received a report of Kayla Dutcher's death, which occurred, on 10/7/08. Five days later on 10/17/08 the toxicology screen came back indicating that Kayla died of an overdose of Tramadol. The assessment was founded for neglect-injurious environment-fatal.

F. Policy Findings:

Findings described below outline violations of state policy. Corrective actions are required by EPCDHS in response to each finding.

1. Finding:

A referral was received on 9/19/07 and was not entered into Trails until February 6, 2008 and did not obtain information from collateral sources, such as the schools. This is in violation of Volume 7, Section 7.202.4 D, (3)(12 CCR 2509-3), which states that:

D. The county department shall enter all referrals into Trails as outlined in Volume 7, Sections 7.200.6 (12 CCR 2509-3) and 7.200.61 (12 CCR 2509-3), and conduct an initial assessment.

3. Obtaining information from collateral sources, such as schools, medical personnel, law enforcement agencies, or other care providers.

Action Required: El Paso will review and rewrite its internal policies to assure that all appropriate referrals are entered into the Trails system. All intake staff caseworkers and supervisors will receive additional training to assure

compliance. The County will develop a method for effectively monitoring this requirement through some type of internal audit/review procedure.

County Response:

Although the fact of the timeliness of the data entry is not challenged, EPCDHS did respond to the substance of the referral in a reasonable and appropriate manner. EPCDHS refutes the finding that we did not obtain information from collateral sources. EPCDHS did check Trails, including a specific search for prior confirmed abuse or neglect findings, CBMS, and our internal CATS data system. According to the Colorado Department of Human Services' Administrative Review Division's Results from the Screen Out Review in September of 2007, Trails records searches and other database searches were considered by the counties and by the Administrative Review Division to be collateral sources (or else they would not have counted these data bases as collaterals in the responses).

EPCDHS prioritizes going out to respond to reports over data entry when necessary. This does not mean that we do not understand the importance of entering accurate data into the system. EPCDHS has added temporary staff to help manage the volume of required data entry.

CDHS Response:

While Trails and other databases were available as response options, they are not considered collateral contacts. Examples of collateral contacts include: law enforcement, schools, doctors, etc.

2. Finding:

The EPCDHS did not document in Trails why the referral was not accepted for assessment and used internal codes as justification for not assigning referrals. These codes are not universally known, the reason for not accepting a referral for investigation would only be known to El Paso County personnel, not to all Trails users. The county is in violation of Section 7.202.4 G (12 CCR 2509-3), which states that:

- G. The county department shall ensure that referrals that do not need to be assigned for assessment and investigation are documented in TRAILS with the reasons why further investigation was not needed. In those reports in which a full investigation is not going to be conducted the supervisor shall approve that decision.

Action Required: El Paso County will review and revise its internal procedures and policies to assure compliance with these regulations. All child protection supervisors will receive additional training, and supervisors will develop a plan for monitoring adherence to this regulation.

County Response:

EPCDHS' child welfare supervisors meet every workday in Triage, review all referrals that come into the county department, and approve all decisions in which a full investigation is not going to be conducted, with the exception of referrals that are assigned for immediate response, which are processed immediately. This supervisory review is documented on the paper referral, then data entered. The 9/19/07 referral was reviewed in Triage, and the same was documented by a supervisor on the hard copy of the referral.

G. Follow-up Actions Required:

This statement provides notice that a corrective action plan is required on all findings with required action and that a corrective action plan is due to the State forty-five (45) days after receipt of this report, and that upon receipt and review of the plan the State will approve or request further county action.