

Colorado Department of Human Services  
Child Fatality Review  
4/15/08

**A. Identifying Information:**

Child: Neveah Gallegos  
DOB: 8/1/2004  
DOD: 9/24/2007 (age 3)

Parents:  
Mother: Miriam Gallegos (age 20)  
Father: Unknown

Other involved parties/member of household:  
Grandmother: Janet Gallegos (age 51)

Other involved parties:  
Angel Ray Montoya (age 22)  
Relationship: Boyfriend to Miriam Gallegos

**B. Involved County:**

Denver Department of Human Services (DDHS)

**C. Introductory Statement:**

The Colorado Department of Human Services Child Fatality Review Team conducted the review of the circumstances surrounding the death of Neveah Gallegos through interviews and a review of the documentation. 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 caregiver(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:**

Neveah Gallegos, age 3 years, was pronounced dead on 9/24/07 following the discovery of her body in the Dry Gulch area in Denver, Colorado. Neveah's mother, Miriam Gallegos, reported to the Denver Police Department (DPD) on 9/21/07 that Neveah had been kidnapped and an Amber Alert was issued. After a subsequent interview with Miriam Gallegos, the Amber Alert was cancelled and the DPD requested the public's assistance in finding Neveah's body.

Neveah's body was discovered on 9/24/07 and an autopsy was conducted. The results of the autopsy indicated the cause of death was undetermined. DPD has treated the death as a homicide. The autopsy stated, "There is evidence of trauma of varying ages, including a blunt impact to the abdomen, which are likely from non-accidental (abusive) trauma. However, there is no evidence of hemoperitoneum or peritonitis related to this abdominal injury. An asphyxial mechanism in the death (suffocation or strangulation) has not been ruled out. Additional information through continuing investigation may yield a more definitive cause of death. The manner of death is undetermined."

Miriam Gallegos and Angel Ray Montoya were arrested, but not formally charged, and subsequently released from police custody. Mr. Angel Montoya was arrested on a later date for failure to register as a sex offender. The homicide investigation is ongoing at this time.

DDHS had a prior open voluntary case regarding Neveah Gallegos that closed on 1/2/07. This case focused on improving Miriam Gallegos' parenting skills. DDHS also had involvement regarding Miriam Gallegos as a juvenile.

Angel Montoya's previous DDHS history was a finding for physical abuse of his previous girlfriend's five-year-old disabled child, which, it was reported, resulted in a criminal conviction of assault with a deadly weapon and a permanent restraining order preventing all contact with the victim. Angel Montoya also had involvement with DDHS as a juvenile.

**E. Chronology:**

Referral - 7/15/06:

A mandated reporting party reported that the maternal grandmother and mother of two-year old Neveah, had brought the child to the hospital due to vaginal bleeding. The physician examined the child and diagnosed a small hymeneal tear. The emergency response caseworker immediately responded to the hospital. The mother reported that she had left Neveah Gallegos alone with her boyfriend, "Ray," on July 14, 2006. He reportedly had given Neveah a bath. The mother said that Ray's mother and sister were also present that day. The initial medical report indicated that Neveah had suffered a penetration injury but it was inconclusive as to what had penetrated the child. A Denver Police Detective also responded to the hospital.

The officer placed a police hold on Neveah Gallegos for placement with the DDHS and agreed to placement of the child with the maternal grandmother. The officer, in conjunction with the caseworker, ordered that the mother have no unsupervised visits and not reside in the same house with the grandmother and have no contact with Angel Ray Montoya. The officer and caseworker ordered that the mother, grandmother and child appear at the Family Crisis Center (FCC) on 7/17/06. The documentation stated that the grandmother appeared appropriate.

The officer and the caseworker checked the DPD's data system and determined that Angel Ray Montoya was a registered sex offender. The officer made contact with

Mr. Montoya but he refused to participate in an interview. DPD reported that due to the lack of evidence, there was insufficient probable cause to arrest the alleged perpetrator.

The case was transferred to an intake caseworker on 7/16/06. The intake caseworker completed the safety and risk assessments on 7/17/06. The safety assessment noted no safety concerns.

7/18/06:

The grandmother brought Neveah to the FCC for a culpa scope examination. Dr. Kathryn Wells, Medical Director at the FCC, was consulted regarding the medical findings and after reviewing the results, determined that the injury was to the urethra opening and not the hymen. Dr. Wells stated that although the findings did not rule out sexual abuse, it was much less indicative of sexual abuse than a hymeneal tear, as the injury could have occurred during diapering.

Miriam Gallegos attended the Team Decision Making (TDM) meeting that was held on 7/27/07. A case was opened for services. The TDM resulted in a documented agreement that custody of Neveah was returned to Miriam Gallegos and Miriam could return to her mother's home. A safety plan was developed that required Miriam to report to DDHS any contact with Angel Ray Montoya. DDHS agreed to provide in-home services for three months, and Family-to-Family resources would be made available to assist Miriam Gallegos with parenting skills and a GED program. The agreement indicated that Miriam Gallegos would take full responsibility for parenting Neveah with day care assistance from the grandmother and the aunt.

8/02/2006:

The intake caseworker conducted a home visit with Miriam, her mother, her aunt and Miriam's daughter Neveah. The intake caseworker completed a social history interview and observed the home. The intake caseworker informed Ms. Gallegos that the case was being transferred to an ongoing worker. The caseworker noted no safety concerns in her documentation of the home visit. The intake caseworker noted in the social history that Janet Gallegos, Neveah's grandmother, wanted her daughter to take on the full role of parenting Neveah.

8/03/2006:

The caseworker and supervisor concluded that the allegation of sexual abuse was unfounded based upon the inconclusive medical findings, lack of verbal history by Neveah, and the inability to interview Angel Montoya. The department reported that Angel Montoya's whereabouts were unknown.

10/03/2006:

The therapist assigned to work with the family from a contract service provider conducted safety, risk and NCFAS assessments on the family using the Colorado Assessment Continuum. The safety assessment documented safety concerns, and a safety plan indicated that "suspected perpetrator must not have access to the child."

11/13/06:

The therapist called the caseworker and stated she did not have any safety concerns and would like to talk about closing the case. A home visit was conducted on 11/17/06 and the caseworker noted no safety concerns. The caseworker documented that contact had been made with the Denver Indian Family Resource Center and the West Side Family to Family program. The caseworker concluded with the statement "Miriam still has not stated that Neveah was sexually abused by her boyfriend. But she does understand the safety concerns." The closing NCFAS was completed on 11/21/06.

11/17/2006:

A treatment-staffing meeting was held with the caseworker, the therapist, the therapist's supervisor, and Miriam Gallegos. Ms. Gallegos reported that things were going well and the team agreed to close the therapeutic service and to close the DDHS case in one month. Ms. Gallegos again denied having any contact with Angel Montoya.

11/21/2006:

The therapist completed The Colorado Safety Assessment/Plan. The therapist noted that Miriam Gallegos continued to minimize the extent of the injury and deny that Angel Montoya caused injury. Miriam Gallegos stated that the suspected perpetrator no longer has contact with the child; therefore current conditions or family actions addressed all identified safety concerns. The Colorado Risk Reassessment was completed with risk level rated at low.

1/02/2007:

Case closed as Miriam Gallegos had complied with her treatment plan, completed the in-home treatment with the community based service provider, continued to do well in the home with her mother, had a job and was connected to community resources. Closing statement indicated there were no child protection concerns at that time.

Referral - 9/24/2007:

A referral was received reporting that Neveah Gallegos' body was found and she was declared deceased by the Medical Examiner. DDHS was notified. The next day the preliminary autopsy was completed on Neveah Gallegos. The coroner reported that the "death is due to undetermined causes."

## **F. Policy Findings:**

Findings described below outline violations of State policy that occurred while DDHS provided assessment and treatment services to the Gallegos family a year prior to the child's death. Corrective actions are required by DDHS in response to each finding.

### **1. Finding:**

DDHS did not document safety concerns in the 7/17/06 safety assessment. Although DDHS took action to address the safety concerns, the safety concerns were present, and were the basis for DDHS intervention and services.

This was in violation of Volume 7, Section 7.202.52 G and H (note: these are pre-2/1/07 citations.) (12 CCR 2509-3):

Section G: "The investigation shall include a safety assessment that identifies the conditions or family actions that may endanger child safety."

1. If one or more safety concerns are identified, current conditions or family actions that intended to assure safety shall be documented."

County Response:

DDHS disagrees with the findings as stated. The facts in the record do not support a finding of a rule violation.

The safety assessment was completed on 7/17/06. At that time, the child was living with her grandmother. The child was not allowed to have contact with Mr. Montoya and was not allowed to have unsupervised visits with her mother. Under these circumstances there were no safety concerns that should have been documented.

Action Required: Staff providing child protection services will be trained in conducting investigations and specifically, in developing safety assessments that identify the conditions or family actions that may endanger child safety. They will also be trained in developing safety plans when safety concerns are noted.

2. Finding:

Components of the Family Services Plan were not completed in a timely manner.

7.301.21 (12 CCR 2509-4) Family Services Plan Timing Requirements

The Family Service Plan document must be completed:

- A. Within sixty (60) calendar days of opening an assessment in the automated case management system for children in their own homes...

County Response:

DDHS accepts this finding of a rule violation.

The case documentation indicates that the Savio Direct Link Family Service Plan (FSP) for 9/15/06 was completed on the 62<sup>nd</sup> day.

Action Required: Denver County will review and rewrite its internal policies and procedures to assure compliance with this portion of the regulations. All child protection caseworkers and supervisors will be trained as to these requirements, and supervisors will develop a plan to effectively monitor.

**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.