

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

**A. Identifying Information:**

Child: Alize J. Vick  
DOB: 5/28/2005  
DOD: 10/10/2007 (age 2)

Parents:  
Mother: Ashley Lindenberger (age 20)  
Father: Christopher Vick (age 22)

Caretaker of Children at time of Alize Vick death:  
Jules Cuneo (age 34) CPA foster mother

Alleged Person Responsible for Abuse/Neglect (if different than parents):  
Jules Cuneo

**B. Involved Agencies:**

El Paso County Department of Human Services (EPCDHS)  
Kids Crossing Child Placement Agency (CPA)

**C. Introductory Statement:**

The Colorado Department of Human Services Child Fatality Review Team conducted the review of the circumstances surrounding the death of Alize Vick. The team members include county and state staff, as well as legal, clinical and medical consultants. The purpose of the review is to examine existing practices and policies and how they currently affect the child welfare system in order to explore ways to improve it. These findings should not be construed to link the counties' actions to the actions allegedly perpetrated on this child by her caretaker.

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:**

Alize Vick died on October 10, 2007 while in foster placement with Jules Cuneo.

On 10/9/2007, the El Paso County Department of Human Services received a call from Kids Crossing CPA, the agency that licensed and supervised the Cuneo foster home, indicating that they had received a call from foster parent Jules Cuneo concerning an injury to Alize Vick. 911 was called and the child was airlifted to Memorial Hospital. After examination, the physician reported to law enforcement

that he did not believe that the minor fall described by Ms. Cuneo could have caused the injury to the brain that the victim had sustained. Alize died as the result of the head injury.

Law Enforcement interviewed Jules Cuneo regarding the incident. Ms. Cuneo explained that she had gotten angry with the child because the child would not talk to her. She indicated that she had thrown the child down where she struck the table a second time; hard enough that she landed on the opposite side of the table on the floor.

Ms. Cuneo was charged with murder in the first degree and child abuse.

El Paso DHS Findings related to the fatality: The EPCDHS assessment was founded for fatal physical abuse of Alize Vick by Jules Cuneo.

#### **E. Chronology**

The child was in foster care and died as the result of abuse by her foster mother. The child's family history prior to her placement in foster care is confidential. The decedent, Alize Vick was taken into protective custody pursuant to court order in a dependency and neglect matter in the Fourth Judicial District Juvenile Court. She was placed in the Cuneo CPA Foster Home on 3/6/2007. The following reports were received during this period of time related to her placement.

##### Referral - 4/23/07:

A mandated reporter from the child placement agency (CPA) supervising the foster home and overseeing the casework of the Vick family, made a referral to the department stating that Alize had marks after she fell while taking a bath. As a result of the incident, which happened on 4/22/07, the child had bruises and a small scratch. Ms Cuneo made a phone call to the child's doctor to determine what she should do. The CPA was made aware of this information. The referral was not assigned for investigation.

##### Referral - 5/8/07:

An anonymous informant made a referral on Alize in the Jules Cuneo foster home, alleging verbal abuse. Further alleged was that Jules is "unrelenting and abusive to the two year old – way beyond the child's comprehension". Jules is manic in her interactions with the child. The reporting party described Ms. Cuneo as a heavy woman and that she physically sits on the child. The Department investigated within the assigned five working day response time, interviewing the foster mother, foster children and biological children. The children were seen outside the presence of the person alleged to have committed the abuse. The intake caseworker found no evidence of abuse or neglect. The allegations were unfounded.

##### Referral - 10/9/07 and 10/10/07:

A mandated reporter called the department indicating that Alize was hospitalized due to serious head injury and was not likely to survive the night. The treating

physician believed the injuries resulted from abuse. Alize died 10/10/07. The assessment was founded for the fatal physical abuse of Alize Vick. Ms. Cuneo was arrested and charged with first-degree murder and child abuse.

## **F. Policy Findings:**

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

### **1. Finding:**

There is no documentation in the assessment that the tape or letter sent by an anonymous party was used by the 5/08/07 investigating caseworker to make a determination regarding the safety of Alize in the Cuneo foster home. However, according to the EPCDHS supervisor and manager, the assigned caseworker told them after the child's death that she read the letter and listened to parts of the tape prior to her investigation of the Cuneo home. This same caseworker was subsequently reassigned within the county department.

It is the goal of child protection to protect children whose physical, mental or emotional well-being is threatened by the actions or omissions of parents, legal guardians or custodians, or persons responsible for providing out-of-home care, including a foster parent, an employee of a residential child care facility, and a provider of family child care or center-based child care. Action to protect the children was indicated and the lack of action was in violation of Volume 7, Section 7.202.5 (12 CCR 2509-3), Investigation Procedures, which states, "The purposes of the intake investigation are to:

- A. Assess and ensure safety;
- B. Assess risk, needs, and strengths of children and families;
- C. Oversee development and coordination of the initial Family Services Plan; and,
- D. Obtain appropriate resources for children and their families."

### **County Response:**

The intake caseworker assessed the safety of Alize Vick at the time of the May 8 referral. Requirements regarding the Family Services Plan, "strengths of children and families," and determination of appropriate resources for children and families quoted from Volume 7 above should in this case all be viewed in the context of the existence of the ongoing dependency and neglect action. There is no mention of the letter or tapes in this caseworker's assessment, and EPCDHS questioned her about her review of this evidence. She indicated she had received and reviewed this evidence. Like the initial referral, these items were delivered to the offices of the EPCDHS anonymously. It is believed the anonymous delivery occurred some time after the May 8 referral. The intake caseworker conducted visits to the foster home as part of her assessment and communicated with the CPA's foster home supervisor as part of her assessment. The 5/08/07 intake caseworker offered the letter and tapes to her colleague, the intake facility abuse investigator, who was assigned to investigate the October 9-

10, 2007 referrals. The 5/08/07 intake caseworker reported to the EPCDHS Office of Child Protective Services Administrator that she did in fact read the letter and listened to the micro cassette tapes at the time of their receipt into EPCDHS. She further reported that she did in fact take further action after reading the letter and listening to the tapes by conducting two home visits – including the home supervisor from the Child Placement Agency in the first home visit – interviewing the foster mother and the children, and reviewing the records of the department in an attempt to determine whether any other matters had been brought to the agency’s attention. The 5/08/07 intake caseworker based on all these factors ultimately determined the matter was unfounded. As noted, a dependency and neglect action had already been filed.

Action Required: EPCDHS will establish a protocol for supervisory review and approval of all investigation decisions with a related documentation process that justifies subsequent actions and assures that the agency provides services to children observed to be in danger.

2. Finding:

EPCDHS violated CRS 19-3-308 (2), which states: The investigation, to the extent that it is reasonably possible, shall include: (f) All other data deemed pertinent and Volume 7, Section 7.202.52 I, (12 CCR 2509-3) and Volume 7, Section 7.202.54 H, 5:

7.202.52 I: All of the information resulting from the investigation shall be documented in the case file as a summary of investigation findings, along with any specific evidence gathered, such as photographs or videotapes.

7.202.54 H, 5: Include in the initial assessment as much of the following information as possible from the reporting party and records.

5. Any other information which might be helpful in establishing the cause of the injury, abuse and/or neglect

County Response:

This allegation is incorrect, and EPCDHS refutes this finding. Please see the County Response to Finding 1 above. The caseworker stated she did review all the evidence and conducted home visits in response to the referral. It appears the additional evidence (letter and tapes), delivered anonymously, did not come to or through our Child Abuse Reporting Hotline to be recorded as additional information or connected to the original referral and were not delivered for some time after May 8.

Action Required: EPCDHS will review, and rewrite its internal policies and bring them into compliance with State law and regulations concerning what constitutes an adequate investigation. Specifically, the county will train caseworkers on how to include the use of collateral information when conducting investigations, ensure that documentation is complete, accurate and in compliance with state standards. Caseworkers will be trained in how to do adequate documentation.

3. Finding:

Regarding the referral dated 10/9/07 and closed 1/7/08, EPCDHS was in violation of Volume 7, Section 7.202.56, (12 CCR 2509-3), Conclusion of Investigation, which states: An investigation shall be completed within 30 calendar days of the date the investigation/assessment was assigned, unless there are circumstances, which have prevented this from occurring. Such circumstances shall be documented in the case record. An extension was not found in Trails.

County Response:

Respectfully, this finding is unrelated to the child fatality. Although the fact of the timeliness of data entry is not challenged, EPCDHS did respond to the substance of the referral in an immediate and appropriate manner upon notice of Alize's injury. Investigation of this incident by law enforcement continued for some time, and at all times, EPCDHS cooperated with the ongoing investigation.

Action Required: EPCDHS will review its procedures on case closure in order to assure compliance with this regulation.

4. Finding:

An investigation was completed on 6/1/07 but was not entered into Trails until 10/11/07, the day after Alize died. EPCDHS was in violation of the Institutional Abuse and Neglect Investigation requirements under Volume 7 Section 7.202.54 (k) (1-4), (12 CCR 2509-3) which requires the submission of a written report by the investigating county within 60 calendar days after the initial receipt of the report of child abuse or neglect, and (h) summary of findings/conclusions and the information on which they are based.

The 3-month delay in entering the report into Trails circumvented reviews by that of the CDHS Institutional Abuse Review Team and the CDHS 24hr Monitoring Team. These teams provide a "check and balance" review process for children alleged to be abused or neglected that are in out-of-home placement.

County Response:

The assessment was performed, and it was completed on 6/1/07, within 30 days after the initial report of child abuse or neglect. Although the fact of the timeliness of data entry is not challenged, EPCDHS did respond to the substance of the referral in a reasonable and appropriate manner.

Action Required: EPCDHS will review its policies and procedures to ensure that all employees are aware of, and complying with, this requirement.

5. Finding:

Regarding the referral dated 5/8/07, an allegation of institutional abuse was given a 5-day response time in violation of Volume 7, Section 7.202.54 (12 CCR 2509-

3) which states: (f) institutional abuse or neglect investigations shall be initiated within 24 hours to determine the child(ren)'s safety. Children must be seen with in 24 hours.

It was reported to the Fatality Review Team during the face-to-face interviews that EPCDHS routinely assigns response times to allegations of institutional abuse based on the allegations versus assigning 24-hour response times to all allegations of institutional abuse.

County Response:

EPCDHS did respond to the substance of the referral in a reasonable and appropriate manner. EPCDHS received just under 10,400 referrals in 2007, the second highest number in the state. The allocation of child welfare funds and resources has not increased proportionally to help us manage the incredible volume of referrals and subsequent assessments. The county department's decision on how quickly to initiate an investigation is based on specific reported information that is credible and that indicates that a child is in present or impending danger, as Volume VII dictates. EPCDHS did so in this case. The county department is unable to comply with a requirement to assign a 24-hour response time to all allegations of institutional abuse since that response time was eliminated from Volume VII effective 2/1/07 (7.202.4.I.), and the field for the 24-hour response time was removed from Trails in March of 2007.

Action Required: EPCDHS will revise its current policies, procedures and practice to accommodate the requirement that that institutional abuse or neglect investigations shall be initiated within 24 hours of receipt of a report in order to determine the safety of the child(ren). All supervisors and caseworkers will be trained as to this requirement.

**H. 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.