

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

A. Identifying Information:

Child: Luz Valdez
DOB: 09/04/2007
DOD: 12/30/2007 (age 3 months)

Parents:
Mother: Mary Elizabeth Maes/Campos (age 21)
Father: Isidoro Valdez (age24) (Person allegedly responsible for the fatality)

B. Involved Counties:

Denver County Department of Human Services (DDHS)
Arapahoe County Department of Human Services (ACDHS)

C. Introductory Statement:

The Colorado Department of Human Services Child Fatality Review Team conducted the review of the circumstances surrounding the death of Luz Valdez. 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 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:

On 12/28/07, Denver County DHS received a referral from a mandated reporter regarding possible child abuse. The parents, Mary Campos and Isidoro Valdez, brought three-month-old Luz Valdez to the hospital Emergency Room. Doctors found major internal head bleeding which was believed to be the result of abuse. Luz was stabilized and transferred to Children's Hospital where she died 2 days later on 12/30/2007. Isidoro Valdez admitted to shaking the child and was arrested.

Prior to the referrals in 2007 and the birth of Luz there was one referral in the spring of 2004 on the Maes/Campos family. This is not relevant to the decedent and therefore confidential.

Two referrals in the first seven months of 2007 reported concerns about the potential of neglect and/or abuse. These were prior to Luz's birth. These two referrals were not assigned for assessment. There were two referrals in November of 2007 prior to Luz's death that were assigned for assessment; none were founded for abuse or neglect.

Denver County DHS Findings related to the fatality: Fatal abuse is founded with the father being responsible for the abuse.

E. Chronology:

Referral - 01/15/2007:

Denver County DHS received a referral from a mandated reporter stating that Mary Campos/Valdez was six weeks pregnant with her fourth child and due 09/09/2007; allegedly she did not have physical custody of her other three children because of a history of methamphetamine and alcohol use. Another concern was that the father of her two daughters was killed in a gang related incident on 08/25/2005. Mary was living with her previous foster parent but the reporter didn't know the name of the foster parent. The Screener did not get information on the other children's placement. Denver County DHS did not assign the referral for investigation.

Referral - 07/10/2007:

Denver County DHS received a referral from a mandated reporter stating that she was concerned about the way Mary Campos/Valdez spoke to her children. Mary had her son in the emergency room to have sutures removed and was overheard threatening her children if they did not listen to her and behave. The reporting party (RP) offered to have Mary talk with a social worker and Mary declined. The RP was not sure if Mary has other children in the home. Denver County DHS did not assign the referral for investigation.

Referral - 11/02/2007:

Denver County DHS received a referral from a mandated reporter regarding a civil dispute between Mary Campos/Valdez and the paternal grandparents of her preschool age child. The child had been residing with the paternal grandparents. The mother, who had legal custody, took the child back into her home. The officer expressed concerns regarding Mary's ability to care for the child.

Denver County DHS assigned a caseworker and a Spanish-speaking caseworker that interviewed the child. The child denied being abused by anyone, felt safe and had no concerns for himself or his baby sister (Luz). The caseworker made an inconclusive finding for neglect or injurious environment and noted that the family was high risk. The caseworker noted that the strong support Mary Campo/Valdez received from her former foster mother decreased the risk to the children. A referral to the community Family to Family Program was submitted.

Referral - 11/26/2007:

A second referral was received by Denver County DHS while the previous assessment was still open. The mandated reporter stated that Mary Campos/Valdez brought her 4-year-old child into a medical clinic. During the exam Mary asked the doctor if he would examine her baby, Luz Valdez, because Luz had been dropped three times by the baby's father, Isidoro Valdez. Mary stated that Isidoro tends to place the baby in precarious positions, like on the edge of the couch. The reporting party examined Luz and reported that she had no injuries. The referral was assigned to the caseworker that still had the 11/02/07 assessment open.

The caseworker met with the family at their home on 12/04/2007. The caseworker talked with Mary about the concerns regarding Luz's safety and felt that Mary was a caring mother as she had reached out to the doctor and "the concerns (about Luz) had come from her". After talking with the family, the caseworker believed that rather than dropping the baby, Isidoro had placed the baby in precarious positions and she fell. The caseworker was made aware of physical changes made to the environment in order to promote the child's safety. The caseworker assessed the family as high risk, but believed that the former foster mother was a huge support for the family, therefore decreasing the risk to the children.

Referral - 12/28/07:

A referral was received from a mandated reporter indicating that the three month old, Luz Valdez was at the emergency room suffering from major head trauma, most likely resulting from physical abuse. She was stabilized and transferred to Children's Hospital where she died on 12/30/07. When interviewed, the father admitted to shaking the child. He was arrested.

The assessment/investigation revealed that the child had been seen two (2) times by medical personnel prior to being admitted to the hospital on 12/28/07. On 12/25, she was diagnosed with an ear infection and prescribed medication. She was seen again by medical personnel on 12/27/2007 as her parents wanted to make sure she was doing better.

F. Policy Findings:

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

1. Finding:

DDHS did not do a thorough record review of the county department files on the 7/10/2007 referral and did not obtain additional information before deciding what action to take on the referral. Further review would have revealed an open case on a Mary Campos, and the status of that case needed to be determined. This required assignment. This is in violation of Volume 7, Section 7.202.4, ,D, (1,2,3), (12 CCR 2509-3) which states:

D. The county department shall conduct an initial assessment. The initial assessment shall decide the appropriateness of further investigation. It shall include, but not be limited to, the following activities:

1. Checking the State Department's automated system.
2. Reviewing county department files.
3. Obtaining information from collateral sources, such as schools, medical personnel, law enforcement agencies, or other care providers.

County Response:

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

There were no reported allegations of abuse or neglect as defined in statute. The record indicates that DDHS did conduct a thorough assessment. However, DDHS has admitted (in Finding #3 below) that it did not document its review efforts by entering them into Trails.

Action Required:

DDHS will develop and implement internal protocols that direct staff on how to obtain information from collateral resources, county files and the State's automated system to determine the appropriateness of further investigation. This process will also include responding to the reporting party when the referral will not be accepted for assessment.

2. Finding:

The 7/10/2007 referral warranted assignment, due to the new child maltreatment allegations and the 1/15/2007 allegations, as well as possible case status as an open case. As part of the 1/15/2007 referral, the reporting party and Trails, specifically the Prior Referral Search Results, showed the case open in another county. This is in violation of Volume 7, Section 7.202.4, F, which states:
F. The county department shall assign a referral for assessment and investigation if it:

1. Contains specific allegations of known or suspected abuse or neglect as defined in statutes and regulations. A "known" incident of abuse or neglect would involve those reports in which a child has been observed being subjected to circumstances or conditions that would reasonably result in abuse or neglect. "Suspected" abuse or neglect would involve those reports that are made based on patterns of behavior, conditions, statements or injuries that would lead to a reasonable belief that abuse or neglect has occurred or that there is a serious threat of harm to the child.

County Response:

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

The record reflects that there was no pattern of behavior that would indicate suspected abuse or neglect. The record reflects that this mother made responsible decisions concerning her children. In years prior, she had chosen appropriate caretakers for all of her children. Only those three children were in existence at the time of the referral mentioned in this finding.

Action Required:

DDHS will submit and implement a plan as to how they will train and supervise staff to consider both known and suspected child abuse or neglect, as defined by statute, when deciding to assign a referral for further investigation.

3. Finding:

DDHS did not document in Trails their decision not to assign the 7/10/2007 referral. This is in violation of Volume 7, Section 7.202.4, G (12 CCR 2509-3) which states:

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.

County Response:

DDHS accepts this finding of a rule violation. The decision was not documented in Trails as stated above.

DDHS has implemented practice to include documentation in Trails as required by this finding, and is in process of developing written policy.

Action Required:

DDHS 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.

4. Finding:

DDHS did not respond to the assigned referrals in a timely manner. Documentation did not adequately indicate efforts made to contact the family and determine the safety of the child. Contact and interviews with the alleged victims were not timely on the 11/26/2007 referral. Contact was made on 12/04/2007.

DDHS staff failed to adhere to assigned response times. This is in violation of Volume 7, Section 7.202.4, I, (1,2,3), (12 CCR 2509-3):

I. The county department shall assign priority in response time using the following time frames:

1. Immediate and/or same day response when the report indicates that there may be present danger. If the report is received after regular business hours, the time frame is immediate and/or up to eight hours.
2. End of the third calendar day following receipt of the report when the report indicates there may be impending danger.
3. Within five (5) working days from the date of the report when the report indicates maltreatment or risk of maltreatment and indicates an absence of present or impending danger.

County Response:

DDHS accepts this finding of a rule violation.

This referral was assigned a 5-day response time, which requires a response within five working days. The DDHS worker responded on the sixth working day following the referral.

Action Required:

DDHS will develop and implement protocols to ensure a timely response to any report of a known or suspected incident of child abuse or neglect, as defined in rule.

5. Finding:

Isidoro Valdez was not interviewed regarding the 11/02/2007 referral or the 11/26/2007 referral. In both referrals he was an individual who played a role in being responsible for the care of the children and was alleged to be responsible for dropping the infant on three separate occasions.

DDHS staff were in violation of Volume 7, Section 7.202.52 D, (12 CCR 2509-3), which states, "The person alleged as responsible for the abuse or neglect shall be advised of the report and given an opportunity to respond."

County Response:

DDHS divides this Finding into two parts and responds as follows:

a. As to failure to interview Mr. Valdez:

DDHS accepts this finding of a rule violation.

DDHS has previously taken action to remedy this violation. On February 12, 2008, DDHS clarified the risk and safety assessment protocol by instituting a new policy, "Assessment Worksheet for Social Case Worker and Assessment Closing Checklist for Supervisory Staff" (Appendix A). The policy reviews practice and ensures that all appropriate case steps have been taken before the assessment is closed. This includes ensuring that:

- All Adults in Household Interviewed: ALL caretakers, ALL other adults living in the home, and intra-familial alleged perpetrators shall be

interviewed. Furthermore the interviews shall be made independently of others subject to being interviewed.

b. As to advising Mr. Valdez and giving him an opportunity to respond:

DDHS disagrees with the finding concerning the requirement that Mr. Valdez “be advised of the report and given an opportunity to respond.” The facts of this case do not support a finding of a rule violation.

Normal business practice at DDHS is to present parents with a Parent Information Sheet describing their rights including their opportunity to respond when they first meet with the parents. There is no documentation in the record to indicate that normal business practice was not followed. In fact, the record documents that on 11/2/2007, the caseworker presented the information sheet to the parents and pointed out that it was written in both English and Spanish. The rule does not require more.

Action Required:

Staff providing child protection services will be trained in conducting investigations, specifically in requirements to interview caretakers and family members in the household, and all alleged perpetrators.

6. Finding:

DDHS did not conduct a sufficient assessment of safety as part of the 11/26/07 child neglect investigation to determine whether the infant was in danger from conditions or family actions. Given the prior 2007 allegations of child abuse or neglect, and other family known risk factors a more comprehensive assessment was indicated.

This was in violation of Volume 7.202.52 G, H and I (12 CCR 2509-3), which states, “the investigation shall include a safety assessment that identifies the conditions or family actions that may endanger child safety.”

County Response:

DDHS accepts this finding of a rule violation. However, please note mitigating factors explained below.

In October 2007, DDHS voluntarily requested a third party review of its policies, protocols, and practices related to investigating and intervening in possible incidents of child abuse and neglect. One purpose of the third party review was to evaluate whether existing procedures provided sufficient guidance for staff to successfully assess risk and safety to inform appropriate intervention with families.

The third party review team issued its findings in a report that was released March 7, 2008. The review team found widespread problems with the application of the safety tool required by State rules. The report stated, "It is clear that risk and safety assessment continues to be an on-going problem, both within Denver County and in the State."

Based upon the team's findings, Denver immediately put into place a formal work plan, which includes but is not limited to:

- 1) a re-training of risk and safety training for all intake staff by April 14, 2008 and all other case carrying staff by August 31, 2008.
- 2) a clarification of the use of the risk and safety assessment protocol at assessment closure.

Action Required:

DDHS staff providing child protection services will be trained in conducting investigations and specifically, in completing 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 and will be trained in completing the Colorado Risk Assessment and required documentation.

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.