Child Fatality Prevention System: 2025 Annual Legislative Report

Child Fatality Prevention Act §25-20.5-401 C.R.S.

July 1, 2025:

Submitted to: Governor Polis and Members of the Colorado General Assembly

Contents

Acknowledgments

This report is dedicated to and honors the lives of those children whose preventable deaths had a profound impact on their families and communities. We extend our deepest gratitude to members and partners of the Child Fatality Prevention System for their vital contributions in the form of participating in death reviews, data analysis, and developing future prevention recommendations, as it contributes to the program's overarching mission of preventing child deaths in Colorado.

Executive Summary

The Child Fatality Prevention System is housed within the Colorado Department of Public Health and Environment, as stipulated in the 2013 Child Fatality Prevention Act §§25-20.5-401 — 25-20.5-409 C.R.S.). Promoting the safety and well-being of Colorado's children is a community responsibility. This also requires multidisciplinary and multi-agency child death reviews to take place in the locality where the child died, with a child identified as someone under 18 years old.

Child death reviews consider those deaths that occurred because of abuse and neglect, fire, gun violence, motor vehicle incidents, suicide, sudden unexpected infant death, undetermined causes, and water-related deaths. Review teams are composed of local multidisciplinary and multi-agency professionals and are led by local public health agencies. The purpose of the death review is to gather and analyze the facts surrounding how the child died through a public health lens, to arrive at robust prevention recommendations that address the systemic issues that led to the child's death.

As stipulated in the Child Fatality Prevention Act, this report provides a comprehensive overview of child death data (2019 – 2023) and identifies child death prevention recommendations for 2025. These recommendations include online safety, improving outcomes for new parents and caregivers, improving access to behavioral health, affordable childcare, safely co-existing with firearms, and water safety, as well as progress updates on previous years' recommendations.

This report serves as a mechanism to understand the incidence and causes of child deaths, highlighting any service gaps or deficiencies that may exist, while making prevention recommendations to encourage public action to support the safe and healthy development of Colorado's children and to prevent future child deaths.

The recommendations contained within this report are a product of the Child Fatality Prevention System members and partners, and should not be construed as recommendations or specific opinions of the Colorado Department of Public Health and Environment.

Each year in the annual legislative report, the Child Fatality Prevention System makes policy recommendations based on research and highlights areas that may be of particular interest to General Assembly members.

Approach

The Child Fatality Prevention Act identifies the protection of the health and welfare of Colorado children as a serious public health concern and a shared community responsibility. The same also recognizes how professionals from diverse disciplines hold expertise that can lead to a greater understanding of, and in turn, develop prevention recommendations to counter the systemic root causes of preventable child deaths in Colorado.

Building upon the framework established in prior reports, local multidisciplinary and multi-agency review teams assess each preventable death that occurred within their county. The outcomes are deidentified and inputted into a secure national database. The data is reviewed to ensure quality, which is essential for conducting reliable data analysis to inform the current year's prevention priorities.

The information gathered as part of child death reviews includes the manner and cause of death as listed on the death certificate, caregiver information, the child's demographic information, any physical and behavioral health factors, possible life stressors adversely impacting the child and/or family, and the review team's prevention recommendations.

To develop the 2025 prevention recommendations, coordinators from each local review team and members of the State Review Team were invited to a data presentation wherein preliminary data covering 2019-23 was shared. This approach enhanced the team's ability to identify emerging trends, understand the efficacy of past interventions, and hone in on persistent areas of vulnerability. This process ensured evidence-based decision-making and fostered a unified understanding of the landscape of preventable child deaths in Colorado. This shared knowledge strengthened collaborative efforts, enabling the development of focused, impactful recommendations for legislative consideration.

The 2025 prevention recommendations prioritization meeting involved a comprehensive review of the 2023 death review findings. The group identified the following key themes:

1. Data Sharing & Surveillance - Effective prevention requires timely, accurate data and strong interagency communication.

2. Equity & Community Engagement — To ensure prevention efforts are inclusive and culturally responsive, addressing disparities in access, awareness, and resources, especially for marginalized and high-risk populations.

3. Mental Health & Wellbeing — Mental health factors are core drivers behind youth risk behaviors, suicides, substance use, and violence. Supporting early interventions is essential to long-term prevention.

4. Policy & Legislative Action — Prevention through laws, regulations, and funding mandates ensures strategies move beyond recommendations into enforceable actions and systemic change.

5. Safety & Injury Prevention — Practical, on-the-ground interventions, helping to prevent injuries and deaths before they occur. It ties together education, environment, and behavior change.

Once themes were identified, similarly worded and intended recommendations were grouped under each theme into a table, which were then consolidated and reworded into an overarching recommendation.

Once this process had been completed, the coordinator from each child death review team and members of the State Review Team were invited to a virtual meeting wherein teams assigned to each theme refined the overarching recommendations, guided by Specific, Measurable, Achievable, Relevant, Timely, Inclusive, and Equitable (SMARTIE) principles. More than 60 people participated.

External to the virtual meeting, the prevention recommendations underwent additional refinement before being presented to the original invitees to vote on their preferred recommendations under each theme. Fifty-six responses were recorded, and from this process, the 2025 prevention recommendations were decided.

Findings

Each year, Colorado Department of Public Health and Environment staff review state child death data. The data include information from reviews of deaths in Colorado due to motor vehicle crashes, sudden unexpected infant death (SUID)/sleep-related infant death, suicide, child maltreatment (abuse and neglect), unintentional injuries (e.g., poisoning, drowning, fires, falls), homicide, and undetermined causes. The data was analyzed, along with the specific local findings for each case. Data in this report come from reviews of deaths among those younger than 18 years of age occurring in Colorado between 2019 and 2023, including non-Colorado residents. The overall rate of deaths reviewed by the Child Fatality Prevention System for the period was 18.6 per 100,000 Colorado residents (n = 1169). This rate combines all causes of death reviewed by Child Fatality Prevention System state staff and interpreted as the overall rate of death among Colorado residents younger than age 18 due to injury, violence, and undetermined causes. The overall rate fluctuated year to year and ranged from a low of 17.4 per 100,000 population in 2019 (n = 219) to a high of 20.0 per 100,000 population in 2022 (n = 251). Overall, the rate stayed relatively stable across the period and none of the year-to-year changes were statistically significant.

The 2019-2023 leading causes of death were suicide, motor vehicle and other transportation, firearm, sudden unexpected infant death (SUID), child maltreatment, unintentional poisoning/overdose[1], homicide, and unintentional drowning (Figure 1). **Some of these deaths may be counted in multiple categories**. For example, of the

deaths included in the firearm deaths (n = 252) category, 113 are also categorized as suicide, 102 as homicide, 33 as child maltreatment, and 8 as unintentional firearm-related injuries. Between 2022 and 2023, motor vehicle and other transportation deaths increased, while suicide and sudden unexpected infant deaths remained relatively stable, and other leading causes of death decreased. The Child Fatality Prevention System will monitor these trends in the coming years.

Across several of the leading causes of death, the Child Fatality Prevention System observed disparities for non-Hispanic American Indian or Alaska Native, non-Hispanic Asian, non-Hispanic Black, Non-Hispanic Native Hawaiian/Pacific Islander, non-Hispanic multiracial, and Hispanic infants, children, and youth, as well as for young people residing in rural and frontier counties in Colorado. These disparities might be mitigated through addressing existing policies and systems that are associated with inequities in the number of child deaths.[2] Appendix A: Detailed Overview of Child Fatality Prevention System Disparities offers detailed information regarding observed disparities in the data based on racial, ethnic, and geographic differences.

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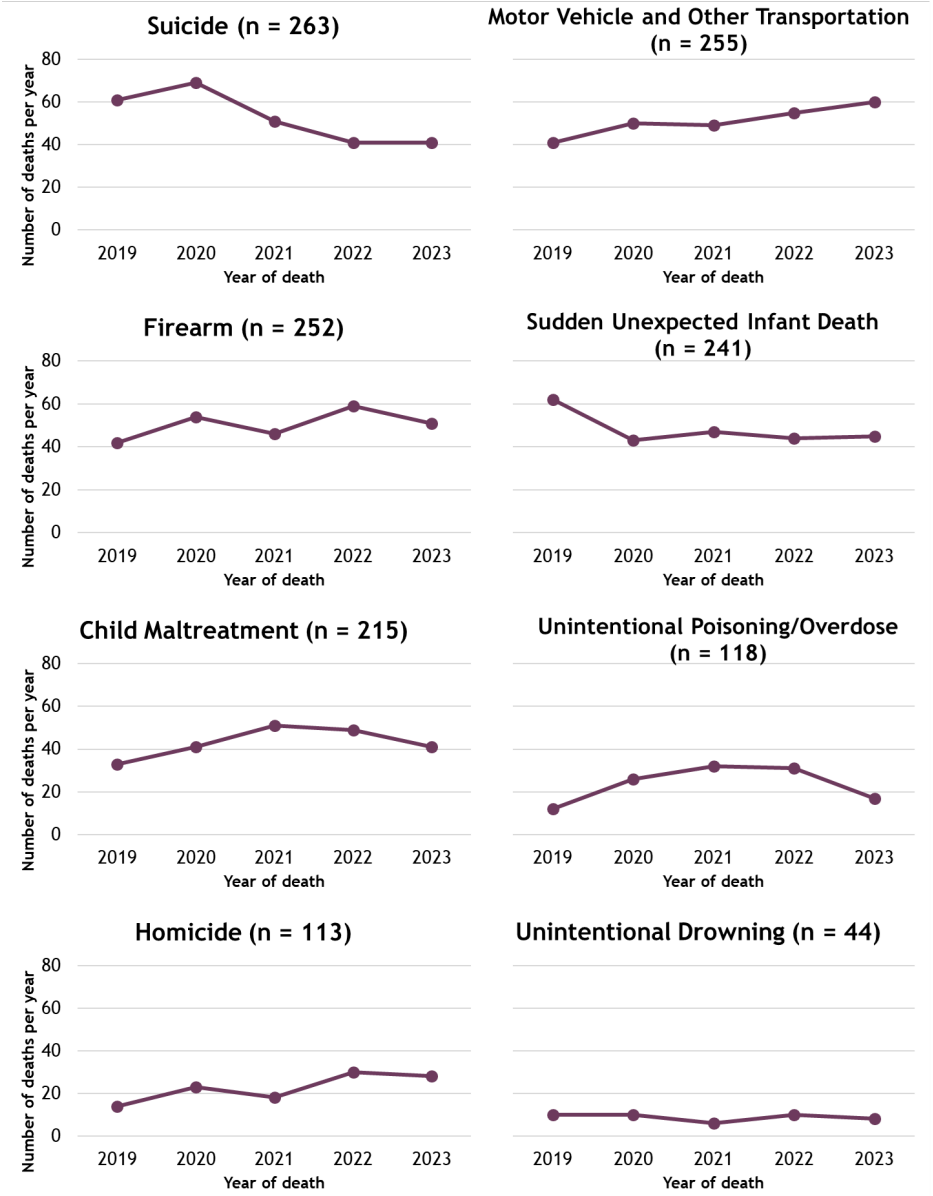
[1] Overdose deaths include those of accidental and undetermined manners of death, as determined by the coroner. These can include deaths due to overdose by prescription, illicit, or over-the-counter drugs, or may also result from poisoning with other substances, such as household cleaners, carbon monoxide, plants, or pesticides. It does not include intentional deaths (i.e., deaths that are the result of homicide or suicide), although making those determinations in some deaths can be difficult.

[2] Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the U.S.A.: evidence and interventions. The Lancet, 389(10077), 1453-1463.

Figure 1
Leading causes of death occurring among those under age 18 in Colorado and reviewed by the Child Fatality Prevention System by year, 2019-2023 (n=1231)

Note: Some of these deaths may be counted in multiple categories. The categories are not mutually exclusive.



To access this data in spreadsheet form, visit https://docs.google.com/spreadsheets/d/18Q46gAip3Uz6ZLRbePSd62ZNrLIyUEhL/edit?usp=sharing&ouid=112737414647626263303&rtpof=true&sd=true

Recommendations

Annually, the Child Fatality Prevention System leverages a five-year data analysis along with team insights, and identifies and prioritizes prevention recommendations. This process, informed by rigorous quality assurance and thematic analysis as previously outlined, ensures that each recommendation is evidence-based, and focused on reducing preventable child deaths.

The following 2025 child death prevention recommendations are based on the collective expertise of the Child Fatality Prevention System members and partners, independent from the Colorado Department of Public Health and Environment, and do not reflect the official position of any individual Child Fatality Prevention System member organization.

Enhance online safety for children through comprehensive education and prevention strategies relying on existing toolkits and other resources that are focused on responsible social media use. Provide focused education and support for children, youth, and caregivers using varied communication methods to maximize reach.

- Connected to the following categories of death: Firearm, Motor Vehicle and Other Transportation, Unintentional Poisoning/Overdose, and Suicide.

Improve outcomes for childbearing parents/caregivers and enhance family well-being by ensuring equitable access to evidence-based services. Provide new parent/caregiver resource kits that deliver essential and culturally relevant resources, support, and education.

- Connected to the following categories of death: Child Maltreatment and Sudden Unexpected Infant Death.

Improve behavioral health for children, youth, and families. Expand access to telehealth services, educate caregivers on social-emotional wellness, and educate parents and caregivers on how they can support young people's behavioral health.

- Connected to the following categories of death: Child Maltreatment, Firearm, Homicide, Motor Vehicle and Other Transportation, Sudden Unexpected Infant Death, Suicide, Unintentional Drowning, and Unintentional Poisoning/Overdose.

Support policies that ensure access to quality, affordable childcare. Increase access to childcare and provide direct financial assistance to families, ensuring safe, supervised care that enhances healthy development and reduces risks to safety.

- Connected to the following categories of death: Child Maltreatment, Sudden Unexpected Infant Death, and Unintentional Poisoning/Overdose.

Support evidence-based firearm safety practices to safely coexist with guns by reducing access to firearms through safe storage and increasing access to affordable gun safety resources. This includes education on safe storage options, integrating mental health awareness into firearm training, and strengthening legal frameworks focused on firearm safety.

- Connected to the following categories of death: Child Maltreatment, Firearm, Homicide, and Suicide.

Improve water safety knowledge and skills for children, youth, and their caregivers statewide by expanding affordable, safe swim programs in schools and recreational facilities. Implement a statewide public awareness campaign and establish a centralized water safety resource hub.

- Connected to the following categories of death: Unintentional Drowning.

As required by section §25-20.5-407 (1)(i) of the Child Fatality Prevention Act, in collaboration with the Department of Human Services Child Fatality Review Team, this year's 2025 joint recommendation is:

> **Improve outcomes for childbearing parents/caregivers and enhance family well-being**. Ensure equitable access to evidence-based services and provide new parent resource kits that deliver essential and culturally relevant resources, support, and education.

System Strengths and Weaknesses

As required by section §25-20.5-407 (1)(g) of the Child Fatality Prevention Act, this section details a list of system strengths and weaknesses identified through the review process and recommendations for preventive actions to promote the safety and well-being of children. Appendix B provides an update of 2024's prevention recommendations for improving child safety and well-being. Some past recommendations have been updated to remain relevant.

- **Enhanced information sharing:** Policy and statutory changes should address existing barriers to interagency information sharing among providers serving children and their families. Facilitating seamless and confidential data exchange will enhance collaborative efforts, improve coordination of intervention strategies, and ultimately contribute to the safety and well-being of children and a reduction in preventable child deaths.

- **Improving the information gathered during death scene investigations:** The consistent use of standardized death scene investigation forms is critical for enhanced understanding of the risk factors and circumstances surrounding child deaths and to inform prevention recommendations and actions better. Law enforcement agencies and coroner offices should be encouraged and incentivized to utilize the Sudden Unexpected Infant Death Investigation Reporting Form (SUIDIRF), the Colorado Suicide Investigation Form, and the Water-Related Death Scene Investigation Protocol, during relevant investigations.

- Utilizing **an equity lens to enhance data quality:** Bolstering data quality and prevention recommendations requires local teams to consider equitable access to health care, behavioral health, and other community-based services, as well as addressing the challenges faced by low-income households, food insecurity, disability inclusion, accounting for geographic disparities, and other factors that may contribute to disparate health outcomes. To this end, 2024-2025 initiatives include equity-focused training on data entry best practices and the creation of a Family Interview Specialist to include the lived experiences of the child and family.

Conclusion

The Child Fatality Prevention Act recognizes child safety as a shared community responsibility. This report offers key recommendations to reduce child fatalities in Colorado by leveraging the collective expertise of the Child Fatality Prevention System members and partners. These prevention recommendations focus on the following critical areas: online safety, equitable family well-being services, behavioral health, affordable childcare, firearm safety, and water safety.

Advancing these critical recommendations requires strengthened interagency data sharing, enhanced death scene investigation information, and the consistent application of an equity lens to address compounding adverse factors like service access, poverty, and discrimination. It is now incumbent upon community partners to take these prevention recommendations and translate them into meaningful actions that promote child safety across Colorado.

Appendices

Appendix A: Detailed Overview of Child Fatality Prevention System (CFPS) Disparities

The impact of policies and systems on child deaths

Generations of social, economic, and environmental inequities contribute to the deaths of infants, children, and youth. People exposed to these factors experience additional harm, resulting in higher rates of death. When interpreting the data, it is critical not to lose sight of these systemic, avoidable, and unjust factors. Researchers work towards understanding how geography, race, ethnicity, sexual orientation, and gender identity correlate with health. Data systems like CFPS must identify and understand the lifelong inequities that persist across groups to eliminate them. When limitations in the data system exist due to how data are collected, or because data are not collected, CFPS strives to provide additional context and research about how inequities impact child deaths. By changing policies and systems that create and perpetuate inequities, CFPS can reduce the number of child deaths that occur in Colorado. Examples of these inequities include, but are not limited to:

Race and Ethnicity

- Racism, discrimination, and historical trauma.[3,4]
- Limited access to high-quality education,[5] employment opportunities,[6] healthy foods,[7] culturally traditional foods,[8] and health care.[9]

- Chronic stress.[10]

These factors result in lasting health impacts for people of color that include infant mortality,[11] high rates of homicide and gun violence,[12] and increased motor vehicle deaths.[13]

Rural and Frontier Geography

- Limited access to Level 1 trauma centers and mental and behavioral health services.[14]
- Increased stigma associated with mental illness and seeking help.[15]
- Longer response times by emergency medical services.[16]

These and other factors contribute to higher death rates in rural areas, including suicide[17] and passenger vehicle deaths.[18]

Sexual Orientation and Gender Identity

- Discrimination, stigma, and bias.[19]
- Rejection from family, friends, and community.[20]
- Non-inclusive school curricula and inadequate anti-harassment policies.[21]
- Insufficient access to LGBTQ+-informed health care.[22]

The chronic social stress that LGBTQ+ children and youth experience influence health across the lifespan, including higher rates of suicide[23] and substance use.[24] Given the stigma and sensitive nature of sexual orientation and gender identity among youth, CFPS often has missing or incomplete data on these elements of a young person's identity. For further information about disparities impacting LGBTQ+ youth, please refer to the Healthy Kids Colorado Survey.

Racial and Ethnic Disparities**

Racial and ethnic disparities from 2020 to 2023 are compared to the overall state rate for the respective cause of death and are presented below.

Table 1: Infant, Children, and Youth Deaths in Colorado by Race and Ethnicity (2020-2023)

Population	Suicide (per 100,000 population)	Homicide (per 100,000 population)	Firearm (per 100,000 population)	Child Maltreatment (per 100,000 population)	Motor Vehicle Crash (per 100,000 population)	Sudden Unexpected Infant Death (per 100,000 live births)	Drowning (per 100,000 population)	Unintentional Poisoning/ Overdose (per 100,000 population)
Non-Hispanic Black	7.3 (n=12)	10.2 (n=23)	13.8 (n=31)	12.0 (n=27)	3.6 (n=8)	186.5 (n=22)	2.2 (n=5)	7.1 (n=16)

Population	Suicide (per 100,000 population)	Homicide (per 100,000 population)	Firearm (per 100,000 population)	Child Maltreatment (per 100,000 population)	Motor Vehicle Crash (per 100,000 population)	Sudden Unexpected Infant Death (per 100,000 live births)	Drowning (per 100,000 population)	Unintentional Poisoning/ Overdose (per 100,000 population)
Non-Hispanic Asian	8.1 (n=10)	*	4.6 (n=8)	1.72 (n=3)	*	*	*	*
Non-Hispanic Native Hawaiian/ Pacific Islander	42.6 (n=3)	*	*	*	*	*	*	*
Non-Hispanic American Indian/Alaska Native	*	*	*	*	*	242.3 (n=3)	*	*
Non-Hispanic Multiracial	2.9 (n=5)	1.2 (n=3)	2.5 (n=6)	2.9 (n=7)	*	164.7 (n=11)	*	1.2 (n=3)

Population	Suicide (per 100,000 population)	Homicide (per 100,000 population)	Firearm (per 100,000 population)	Child Maltreatment (per 100,000 population)	Motor Vehicle Crash (per 100,000 population)	Sudden Unexpected Infant Death (per 100,000 live births)	Drowning (per 100,000 population)	Unintentional Poisoning/ Overdose (per 100,000 population)
Non-Hispanic White	5.0 (n=105)	0.3 (n=8)	2.5 (n=67)	2.3 (n=64)	2.3 (n=63)	51.2 (n=71)	0.4 (n=12)	1.2 (n=34)
Hispanic	5.2 (n=62)	3.7 (n=60)	5.7 (n=93)	3.9 (n=63)	3.6 (n=58)	91.9 (n=58)	0.7 (n=12)	2.8 (n=46)
Overall State Population	5.3 (n=199)	1.9 (n=98)	4.1 (n=208)	3.4 (n=171)	2.7 (n=137)	70.1 (n=174)	0.6 (n=32)	2 (n=103)

*Data suppressed due to fewer than 3 deaths

Non-Hispanic Black infants, children, and youth were

- 1.4 times more likely to die by suicide [7.3 deaths per 100,000 population (n=12) vs. 5.3 deaths per 100,000 population (n=199)]
- 5.3 times more likely to die by homicide [10.2 deaths per 100,000 population (n=23) vs. 1.9 deaths per 100,000 population (n=98)]

- 3.3 times more likely to die by firearm [13.8 deaths per 100,000 population (n=31) vs. 4.1 deaths per 100,000 population (n=208)]
- 3.5 times more likely to die by child maltreatment [12.0 deaths per 100,000 population (n=27) vs. 3.4 deaths per 100,000 population (n=171)]
- 1.3 times more likely to die by motor vehicle crashes [3.6 deaths per 100,000 population (n=8) vs 2.7 deaths per 100,000 population (n=137)]
- 2.7 times more likely to die by sudden unexpected infant death [186.5 deaths per 100,000 live births (n=22) vs. 70.1 deaths per 100,000 live births (n=174)]
- 3.5 times more likely to die by drowning [2.2 deaths per 100,000 population (n=5) vs. 0.6 deaths per 100,000 population (n=32)]
- 3.5 times more likely to die by unintentional poisoning/overdose [7.1 deaths per 100,000 population (n=16) vs. 2.0 deaths per 100,000 population (n=103)]

Non-Hispanic Asian infants, children, and youth were

- 1.5 times more likely to die by suicide [8.1 deaths per 100,000 population (n=10) vs. 5.3 deaths per 100,000 population (n=199)]
- 1.1 times more likely to die by firearm [4.6 deaths per 100,000 population (n=8) vs. 4.1 deaths per 100,000 population (n=208)]

Non-Hispanic Native Hawaiian/Pacific Islander infants, children, and youth were

- 8.1 times more likely to die by suicide [42.6 deaths per 100,000 population (n=3) vs. 5.3 deaths per 100,000 population (n=199)]

Non-Hispanic American Indian/Alaska Native infants, children, and youth were

- 3.5 times more likely to die by sudden unexpected infant death [242.3 deaths per 100,000 live births (n=3) vs. 70.1 deaths per 100,000 live births (n=174)]

Non-Hispanic multiracial infants, children, and youth were

- 2.4 times more likely to die by sudden unexpected infant death [164.7 deaths per 100,000 live births (n=11) vs. 70.1 deaths per 100,000 live births (n=174)]

Hispanic infants, children, and youth were

- 1.9 times more likely to die by homicide [3.7 deaths per 100,000 population (n=60) vs. 1.9 deaths per 100,000 population (n=98)]
- 1.4 times more likely to die by firearm [5.7 deaths per 100,000 population (n=93) vs. 4.1 deaths per 100,000 population (n=208)]
- 1.1 times more likely to die by child maltreatment [3.9 deaths per 100,000 population (n=63) vs 3.4 deaths per 100,000 population (n=171)]

- 1.3 times more likely to die by motor vehicle crashes [3.6 deaths per 100,000 population (n=58) vs. 2.7 deaths per 100,000 population (n=137)]
- 1.3 times more likely to die by sudden unexpected infant death [91.9 deaths per 100,000 live births (n=58) vs. 70.1 deaths per 100,000 live births (n=174)]
- 1.2 times more likely to die by drowning [0.7 deaths per 100,000 population (n=12) vs. 0.6 deaths per 100,000 population (n=32)]
- 1.4 times more likely to die by unintentional poisoning/overdose [2.8 deaths per 100,000 population (n=46) vs. 2.0 deaths per 100,000 population (n=103)]

CFPS continues to observe disparities for non-Hispanic American Indian or Alaska Native (AI/AN) infants, children, and youth. Due to the changes in the race and ethnicity categories that were made to align with the 2020 Census, CFPS was only able to calculate race and ethnicity rates for 2020-2023. This, in combination with:

- the national trend of underreporting, misreporting, or misclassification of American Indian or Alaska Native identity on death certificates,[25, 26, 27] and
- overall lower population numbers,[28, 29]

resulted in several deaths among non-Hispanic American Indian or Alaska Native infants, children, and youth for 2020-2023, which is subject to data suppression guidelines. When the number of deaths in a category is relatively small, rate calculations are not as reliable and hinder our ability to detect disparities quantitatively. As a result, the Child Fatality

Prevention System is only able to report sudden unexpected infant death disparities for the “non-Hispanic American Indian/Alaska Native, alone” population at this time.

The Child Fatality Prevention System would also like to acknowledge that the way the program has historically reported race and ethnicity data can be limiting. Although the program is still constrained by the way race and ethnicity are collected on death certificates, CFPS plans to change how race and ethnicity data is analyzed and reported. In future reports, CFPS aims to report and analyze race and ethnicity in a way that reflects the fact that individuals may identify with more than one race and ethnicity. Thus, CFPS will expand the definition to include AI/AN, alone or in combination with other races/ethnicities. For AI/AN populations in particular, CFPS will share data based on both definitions (AI/AN, alone and AI/AN, alone or in combination with other races/ethnicities) side-by-side.[30]

***Note: Racial and ethnic disparities should be interpreted with caution. Due to changes in the race and ethnicity categories that were made to align with the 2020 Census, CFPS was only able to calculate race and ethnicity rates for 2020-2023. Also, the 2025 legislative report compares rates for each racial/ethnic group to the overall rate for the respective cause of death. This differs from the methodology used in previous CFPS Legislative Reports.*

Geographic Disparities***

Table 2: Infant, Children, and Youth Deaths in Colorado by Geography (2019-2023)

Population	Suicide (per 100,000 population)	Firearm Suicide (per 100,000 population)	Homicide (per 100,000 population)	Firearm (per 100,000 population)	Child Maltreatment (per 100,000 population)	Motor Vehicle Crash (per 100,000 population)	Sudden Unexpected Infant Death (per 100,000 live births)	Drowning (per 100,000 population)	Unintentional Poisoning/ Overdose (per 100,000 population)
Frontier	5.0 (n=5)	3.0 (n=3)	*	3.1 (n=4)	*	6.9 (n=9)	137.2 (n=8)	*	*
Rural	5.2 (n=23)	2.3 (n=10)	*	2.6 (n=15)	3.7 (n=22)	5.4 (n=32)	80.5 (n=22)	1.9 (n=11)	1.2 (n=7)
Urban	5.6 (n=232)	2.4 (n=100)	2.0 (n=109)	4.1 (n=229)	3.1 (n=175)	2.1 (n=119)	73.0 (n=203)	0.5 (n=30)	1.9 (n=105)

*Data suppressed due to fewer than 3 deaths

From 2019 to 2023, infants, children, and youth residing in **frontier** counties in Colorado were **3.2 times** more likely to die in motor vehicle crashes [6.9 deaths per 100,000 population (n=9) vs. 2.1 deaths per 100,000 population (n=119)]**, **1.9 times** more likely to die by sudden unexpected infant death [137.2 deaths per 100,000 live births (n=8) vs. 73.0

deaths per 100,000 live births (n=203)], and **1.3 times** more likely to die by firearm suicide [3.0 deaths per 100,000 population (n=3) vs. 2.4 deaths per 100,000 population (n=100)] when compared with infants, children, and youth residing in urban counties.

From 2019 to 2023, infants, children, and youth residing in **rural** counties in Colorado were **3.5** times more likely to die by drowning [1.9 deaths per 100,000 population (n=11) vs. 0.5 deaths per 100,000 population (n=30)]**, **2.6 times** more likely to die in motor vehicle crashes[5.4 deaths per 100,000 population (n=32) vs 2.1 deaths per 100,000 population (n=119)]**, **1.2 times** more likely to die by child maltreatment [3.7 deaths per 100,000 population (n=22) vs. 3.1 deaths per 100,000 population (n=175), and **1.1 times** more likely to die by sudden unexpected infant death [80.5 deaths per 100,000 live births (n=22) vs. 73.0 deaths per 100,000 live births (n=203)] when compared with infants, children, and youth residing in urban counties.

****Urban counties include Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, El Paso, Gilpin, Jefferson, Larimer, Mesa, Park, Pueblo, Teller, and Weld counties. Rural counties include Alamosa, Archuleta, Chaffee, Conejos, Crowley, Delta, Eagle, Fremont, Garfield, Grand, Lake, La Plata, Logan, Montezuma, Montrose, Morgan, Otero, Ouray, Phillips, Pitkin, Prowers, Rio Grande, Routt, and Summit counties. Frontier counties include Baca, Bent, Cheyenne, Costilla, Custer, Dolores, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, Las Animas, Lincoln, Mineral, Moffat, Rio Blanco, Saguache, San Juan, San Miguel, Sedgwick, Washington, and Yuma counties. These categories are based on county designations from the Colorado Rural Health Center.*

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Appendices

Appendix B: Analysis of 2024's Prevention Recommendations for Improving Child Safety and Well-Being.

2024 Report Recommendation	Progress Towards Recommendation
Overdose Prevention: Provide information to parents and communities in their preferred language about the risks associated with substance use and overdose and evidence-informed strategies to reduce these risks, including how to access and use naloxone and fentanyl test strips; how to respond to a suspected drug overdose, including information on Colorado's Good Samaritan Law; how to safely store and dispose of both prescription and illicit drugs; how to avoid accidental ingestion of drugs by young children; and how to have conversations with children about overdose and poisoning	No bills directly related to this recommendation were passed in the 2025 Legislative Session. The Overdose Prevention Unit, housed in CDPHE, continues to provide technical support to organizations statewide, supporting local communities to address drug use through public health and harm reduction strategies, as an alternative to the criminal justice system (Harm Reduction Grant). The Overdose Prevention Unit continues to provide additional funding for distribution to a broad list of eligible organizations (appropriated through the HB22-1326 Fentanyl Accountability and Prevention Act). The unit offers Colorado Coroner and Medical Examiner offices reimbursement for toxicology testing in suspected opioid overdose deaths. The CDC's Overdose Data to Action-States Program continues to provide funds to enhance evidence-based opioid overdose prevention programming and evidence-informed interventions that have an immediate impact on

2024 Report Recommendation	Progress Towards Recommendation
prevention in age-appropriate ways.	reducing overdose morbidity and mortality, with a focus on opioids, stimulants, and polysubstance use. Grant recipients are expected to implement required interventions that facilitate access to harm reduction services and linkage to and retention in care. This work began in 2019 and was expanded in 2023.
Suicide Prevention: Provide resources and education to parents and caregivers in their preferred language about how to prevent child and youth suicide, including family- and health-related factors that protect against suicide risk; resources around safe technology use and considerations around restricting technology access for young people; and ways to support and affirm LGBTQ+ children and youth.	SB25-236 consolidates Colorado's crisis response services by merging the existing Colorado Crisis Line with the national 988 Crisis Hotline. This bill directed that callers to the Colorado Crisis Line be routed to the 988 Crisis Hotline. It also updated the requirement for student identification cards in Colorado schools to include the 988 number instead of the state-specific crisis line number. The legislature passed SB24-189, Gender-Related Bias-Motivated Crimes, which explicitly included gender identity and gender expression as protected classes under Colorado's bias-motivated crimes and harassment laws. This means that individuals who are targeted or harassed based on their gender identity or expression will have the same protections as those targeted based on race, religion, or other protected characteristics. The Suicide Prevention Commission approved the Colorado Suicide Prevention Commission's Youth-Specific Initiatives Workgroup's recommendation of increasing the availability of peer support as a protective factor in addressing suicidal despair, stress management, safety and well-being of Colorado youth, particularly among underrepresented communities such as LGBTQIA+

2024 Report Recommendation	Progress Towards Recommendation
	youth and BIPOC youth. Peer support can be informal, semi-formal, such as structured conversations with a mentor and mentee, or formal, such as nationally utilized school-based programs like Sources of Strength. The Office of Suicide Prevention in CDPHE, the Behavioral Health Administration, the Colorado Department of Education, and Colorado school districts are releasing a suicide prevention policy and guide. This resource will support the implementation of best practices in suicide prevention, intervention, and post-intervention within schools. The Office of Suicide Prevention continues to fund evidence-based upstream suicide prevention programs for youth in Colorado schools through Sources of Strength, covering implementation and licensing costs for middle and high schools, as well as Train-the-Trainer and Elementary Coaches training.
Behavioral Health: Increase access to culturally responsive behavioral health resources for children, youth, and families by: increasing and diversifying the behavioral health workforce; incentivizing care in rural areas; improving affordability of care; decreasing stigma related to seeking help; improving access to respite care; educating caregivers on social-	The legislature passed SB25-178 Colorado K-5 Social and Emotional Health Pilot Program, which supports schools in increasing the ratio of school mental health professionals to students. The program was created through House Bill 19-1017 and provides funding to seven public school districts. The bill's provisions for new rules and criteria will apply to the current pilot schools. The legislature passed HB24-1038 High-Acuity Crisis for Children and Youth, which focuses on addressing the shortage of treatment beds and enhancing services for children and youth with complex behavioral health needs. The bill establishes a system of care, expands treatment foster care, and

2024 Report Recommendation	Progress Towards Recommendation
emotional wellness and ways that caregivers can support young people's behavioral health; increasing telehealth services, especially in rural areas and for behavioral health care; strengthening youth connections to trusted adults; and increasing youth access to community-based supports and programs outside of school.	increases funding for residential treatment programs. It also includes provisions for standardized assessment tools, intensive care coordination, and expanded supportive services. The legislature passed HB24-1406, which addressed the School-Based Mental Health Support Program, housed within the Behavioral Health Administration. The program focuses on providing training, resources, and support to school educators to deliver evidence-based mental health services to students. The program prioritizes supporting rural schools and those with limited access to mental health care.
Gun Violence Prevention and Firearm Safety: Support evidence-based firearm safety practices by reducing access to firearms through safe storage and increasing access to affordable gun safety resources.	The legislature passed SB25-003 Semiautomatic Firearms and Rapid-Fire Devices, which primarily restricts the sale and purchase of certain semiautomatic firearms with detachable magazines, and bans the sale of rapid-fire conversion devices. The bill requires individuals seeking to purchase these restricted firearms to complete a safety course and obtain a permit through their local sheriff's office.
Child Maltreatment Prevention: Integrate primary care with wraparound services to support family resilience and promote positive childhood development, including	No bills directly related to this recommendation were passed in the 2025 Legislative Session. The legislature passed HB24-1046 Child Welfare System Tools, which enhances the state's child welfare system by improving tools and procedures

2024 Report Recommendation	Progress Towards Recommendation
connection to culturally responsive behavioral health care for parents and caregivers; community-based services through parent navigators, community health workers/promotoras and doulas; proven, community-based home visitation programs for all families; and quality, affordable, and stable child care, especially for infants and young children.	for reporting and investigating child abuse and neglect. The bill establishes a bill of rights for foster youth, mandates reports of suspected abuse or neglect, and requires the state department to review and improve screening processes used by county departments and hotline operators. Family Connects is an evidence-based model that connects parents of newborns to community resources through postpartum nurse home visits. Beginning in FY 2024-25, state funds became available to support Family Connects, which is being offered through a partnership with Illuminate Colorado. Services are available to families giving birth in participating hospitals in Boulder, Denver, Eagle, Jefferson, and Mesa counties. Advocacy groups have been successful in advancing new home visiting models in Colorado, including Child First and Family Connections. Child First is a national, evidence-based, two-generation, trauma-informed model that works with young children and their caregivers to build strong, nurturing relationships that heal and protect them from the devastating impact of trauma and chronic stress. Child First is available in 24 counties across the state. Specific locations can be found at: https://iik.org/programs/child-first/
Infant Safe Sleep Environments: Offer evidence-informed and culturally and linguistically appropriate education on promoting safe sleep environments	No bills directly related to this recommendation were passed in the 2025 Legislative Session. The Colorado Infant Safe Sleep Partnership worked to engage hospitals and

2024 Report Recommendation	Progress Towards Recommendation
— including harm reduction approaches — to parents and multigenerational caregivers, and expand safe sleep education, modeling, and discharge safety screening at birthing hospitals.	health care settings to provide them with model safe sleep policies and provide training opportunities to improve skills and knowledge. Examples of work include the development of a "Safe Sleep, Every Sleep" infographic for providers, which was created using Child Fatality Prevention System data showing that more infants died from sudden unexpected infant death than children and youth died in motor vehicle crashes during 2011-2015. The partnership is also developing a conversation guide to help providers, including health care providers, have more meaningful and nuanced conversations with families about their barriers to safe sleep and ways to minimize risks. The Child Fatality Prevention System also partners with hospital quality improvement initiatives like Children's Hospital Colorado's Data-Driven Engagement of Family to Improve the NICU Experience (DEFINE) Project to engage families with NICU lived experience to provide feedback on hospital safe sleep work, participate in education efforts, etc. In Fiscal Year 2024-25, this partnership resulted in compensating a family with lived experience to participate in four NICU-specific safe sleep videos publicly available in English and Spanish. The videos profile those with lived experience as they navigate the progression of sleep practice milestones for their infants. These videos are now publicly available on the Children's Hospital Colorado NICU YouTube channel. DEFINE hospitals continued to develop implementation strategies to integrate these safe sleep videos into clinical care in the NICU.
Motor Vehicle Safety: Partner with	The legislature passed HB24-1055 Child Passenger Safety and Education,

2024 Report Recommendation	Progress Towards Recommendation
new parents, youth, and families to promote safe driving practices through child passenger safety programs, including car seat distribution programs; young driver safety programs; and education on graduated drivers license laws.	which requires the division of highway safety to use existing national Highway Traffic Safety Administration occupant protection grant funds to implement a program for public information and education concerning updates to child restraint system requirements, the use of child restraint systems, and Colorado law regarding child restraint system. The legislature also passed HB24-1021 Motor Vehicle Minor Driver Education Standards, mandating a 30-hour driving education course for individuals under 18 seeking an instruction permit (with some exceptions). It specifies supervision requirements for permit holders, allows for temporary licences, and prohibits commercial driving instructors with specific criminal convictions from teaching minors or at-risk-adults, requiring fingerprint-based background checks. SB24-065 Mobile Electronic Devices and Motor Vehicle Driving was passed, limiting the use of mobile phone devices while driving, with a tiered citation system if an officer observes the use of a mobile device causing careless or imprudent driving.
Drowning Prevention: Improve knowledge of and skills for parents and caregivers, children, and youth to follow water safety practices through expanded availability and affordability of safe swim	No bills directly related to this recommendation were passed in the 2025 Legislative Session. Colorado is participating in a national project with the National Center for Fatality Review and Prevention and the CDC to build capacity in the existing review process to collect standardized information about pediatric drowning

2024 Report Recommendation	Progress Towards Recommendation
programming.	and water-related deaths.
Housing: Expand access to quality, affordable, and stable housing.	The legislature passed SB25-006 Investment Authority of State Treasurer for Affordable Housing, which authorizes the State Treasurer to invest up to $50 million in bonds issued by quasi-governmental entities for the creation or financing of new affordable, income-restricted for-sale housing. This investment can include below-market interest rates and allows the treasurer to reinvest money from the redemption of these investments. The housing must remain affordable long-term and be accessible to borrowers earning no more than 140% of the statewide median income. The legislature also passed HB25-1240 Protections for Tenants with Housing Subsidies, which strengthens tenant protections, particularly for those using housing subsidies, and increases landlord accountability. It mandates landlords to comply with specific federal eviction notice requirements, cooperate with subsidy applications, and accept all subsidy programs, including Section 8. The bill also removes exemptions for small landlords, making all rental property owners subject to the rules. Other bills passed by the legislature during the 2025 session include the following. HB25-1093 Limitations on Local Anti-Growth Land Use Policies, expanding the definition of "anti-growth laws" to include any law that reduces permitted residential density or uses in census-designated urban areas without

2024 Report Recommendation	Progress Towards Recommendation
	compensating increases elsewhere. It also clarifies when local governments must offer property owners a fee in lieu of land dedication and allows municipalities to seek a judicial determination on the legality of citizen-initiated land use ordinances before an election. HB 25-1090 Protections Against Deceptive Pricing Practices, which protects consumers from deceptive pricing practices and hidden fees, particularly in the rental market. The bill requires businesses to clearly disclose the total price, including all mandatory fees, and prohibits landlords from charging certain fees or increasing them beyond a set limit. HB25-1019 Third-Party Administration of Division of Housing Programs, which focuses on allowing the Division of Housing to contract with third-party organizations to administer its programs for homeless individuals, hoping to streamline program administration and potentially increase efficiency in providing services to those experiencing homelessness. The program shall provide rental assistance, housing vouchers, and eviction defense assistance, including legal, financial, and case management, to persons experiencing homelessness or at risk of experiencing homelessness. SB24-174 Sustainable Affordable Housing Assistance, which provides planning grants for local governments to complete Housing Needs Assessments and Housing Action Plans, and requires them to encourage the development of housing types, and increase housing affordability at different income levels.

2024 Report Recommendation	Progress Towards Recommendation
Broadband Internet: Expand access to broadband internet to improve access to educational, social, and health care opportunities, such as telehealth.	No bills directly related to this recommendation were passed in the 2025 Legislative Session. In June 2022, Governor Polis signed Executive Order 2022 023, accelerating broadband deployment in Colorado by setting a goal of connecting 99% of Colorado households to high-speed broadband by 2027.
Interagency Information Sharing: Address barriers to interagency information sharing among providers who support young people and their families.	No bills directly related to this recommendation were passed in the 2025 Legislative Session.