

Office of Colorado's
CHILD PROTECTION
OMBUDSMAN

2013-2014 Annual Report



September 1, 2014

OFFICE OF COLORADO'S CHILD PROTECTION OMBUDSMAN

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I am pleased to present the FY2013-2014 Annual Report detailing the work of the Office of Colorado's Child Protection Ombudsman. The report contains information regarding our outreach efforts, goals, accomplishments, statistical highlights of the program, special project conclusions and our recommendations to improve the child protection system presented to the State and County Human Services Departments.



AN ELECTRONIC VERSION OF THIS REPORT IS AVAILABLE AT
WWW.PROTECTCOLORADOCHILDREN.ORG

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Executive Summary

I am pleased to present the 2013-2014 Annual Report detailing the work of the Office of Colorado's Child Protection Ombudsman from July 1, 2013, to June 30, 2014. The Ombudsman Office had another productive and successful year. The Ombudsman workload continues to climb each year. Last year, the Office had 317 contacts. This year the numbers rose to 405 contacts, of which 186 were reviews and one was an investigation. Even with the increase in contacts, the Office was able to reduce response time to less than two business days and resolve the backlog from the previous year's reviews and investigations. Two investigation reports were released and another one is pending.

The Ombudsman Office introduced two new initiatives to improve our service to the child protection system. "Working Together for Colorado's Children" is a newsletter written to inform all stakeholders and citizens of what we are doing, hearing and seeing. It is issued quarterly and can be found on our website. The other concept was a new classification of case reviews. We have added "Review with Recommendations" to our disposition categories. A Review with Recommendations is simply a review of a complaint in which we make recommendations to an agency (usually a county human services department) to assist them in improving their future response. The recommendations are sent to the agency and they respond with a plan of action to improve their practice.

The Office of Colorado's Child Protection Ombudsman participated in a statutorily required performance and fiscal audit this year. The auditor's report was released in July 2014, and made five recommendations which will be addressed over the next several months.

The Ombudsman also sought and received a \$136,000 budget increase for FY 2014-2015 as a result of a request to the Joint Budget Committee and an annual increase presented by Colorado Department of Human Services.

This year, Senate Bill 14-201 was introduced by Senator Newell and Representative Singer, receiving a wide range of support from public and private stakeholders, as well as a significant number of state legislators. The bill was signed by Governor Hickenlooper and reestablishes a child protection ombudsman advisory work group to develop a plan for accountable autonomy for the Office of Colorado's Child Protection Ombudsman.

I am most proud of the collaborative efforts developed with the following: Director Reggie Bicha; the Office of Children, Youth and Families; the Child Fatality Review Team; the county commissioners; county human services departments; the general assembly; the Ombudsman Advisory Council; Kendall Marlowe; the National Association of Counsel for Children; and the private stakeholders, advocates and citizens who have welcomed us into their work lives. We are at the table providing recommendations, solving problems, and supporting efforts to improve child protection in Colorado. This is why this office was created, and we appreciate the respect and encouragement this office has received. We are truly thankful to be serving on behalf of the children and families of Colorado.

Working Together for Colorado's Children,



Dennis G. Goodwin, Child Protection Ombudsman

I. Year 3 Accomplishments

During FY 2013-2014, the Office of Colorado's Child Protection Ombudsman (Ombudsman Office) has been busy achieving and maintaining our goal of exemplary customer service, as well as continuing ongoing efforts to promote our office and build relationships with the community, county departments, the legislature and all other stakeholders in the child protection community. It was a primary goal of the Ombudsman Office to change the culture and perception of the office in an effort to be more effective when working with all constituents and stakeholders surrounding issues facing Colorado children and families. The Ombudsman Office has built lasting relationships with county departments and various community stakeholders, demonstrating that this goal has been achieved. Further, the Ombudsman Office far exceeded the initial call volume outlined at its onset and has found success in maintaining excellent customer service through servicing constituents, educating the community and being a resource for questions and concerns related to child protection issues.

II. Legislative Efforts 2013-2014

The Ombudsman Office actively supported two bills during the 2013 Colorado General Assembly's legislative session. The Ombudsman Office further advocated on behalf of necessary funding for HB 13-1271 which the Ombudsman Office supported and the legislature passed during the 2012 session. Each of the bills supported this session is directly related to issues that have been identified while working with constituents who reached out to the office.

SB 14-177 and SB 14-178

Defining a "Drug Endangered Child" With Respect to Child Abuse and Neglect.

Primary sponsors for this bill were Senators Newell and Kerr and Representative Young.

Support for this bill in FY 2012-2013 was based on issues identified in the Year 1 Annual Report, Identifying Substance Abuse and Implication for Parenting. The bill was unsuccessful in Year 2 and again this year. The Ombudsman Office continues to see substance abuse as a significant role in child protection cases and has received numerous contacts from county officials asking for assistance and guidance in how to intervene in substance-using families, as well as clearer guidelines for when it is appropriate to intervene. The Ombudsman Office believes that the spirit of this bill is crucial to preventing child abuse and neglect, and we will continue to support the work of the legislature in attempting to clarify this area for the child protection stakeholders, as well as the community.

SB 14-201

Concerning Reestablishing a Child Protection Ombudsman Advisory Work Group to Develop a Plan for Accountable Autonomy for the Child Protection Ombudsman Program

Sponsors for this bill included Senators Newell; Aguilar; Carroll; Guzman; Kefalas; Lambert; Lundberg; Nicholson; Steadman; Todd; Crowder; Heath; Herpin; Hill; Jones; Kerr; Rivera; Schwartz; Tochtrop; and Zenzinger. Representatives who sponsored the bill were Singer; May; Melton; Beck; Exum; Fields; Ginal; Kraft-Tharp; Labuda; Lee; McCann; Rosenthal; Ryden; Schafter; Tyler; Williams; and Young.

The Ombudsman Office supports this bill as it addresses the ongoing concerns of conflict of interest, both real and perceived, by constituents and stakeholders. The Ombudsman Office believes this bill will look at how this office can be most effective in improving the outcomes for children and families. The bill will task a workgroup with assisting the general assembly and the governor in reviewing the current structure of the ombudsman program and develop a plan for the autonomy and accountability of the program. The workgroup was appointed and named in July 2014 and will begin meeting in August 2014, concluding with a report to the governor in December 2014. The Ombudsman Office welcomes the feedback as it continues to move forward and grow into a strong voice in the child protection community.



III. Other Year 3 Initiatives/Special Projects

The Ombudsman Office was involved in the following special projects during FY 2013-2014:

- As a continuation of Years 1 and 2, the Ombudsman Office facilitated meetings between adoption stakeholders and Colorado Department of Human Services (CDHS) staff regarding 2011-2012 Annual Report issues and ongoing concerns.
- The Ombudsman Office concluded the process of assessing local and state level grievance processes.

Overview of the Ombudsman Office: Year 3

The Ombudsman Office was created to be **an independent, trusted intermediary between the public and child protection** in Colorado. The ombudsman's purpose is to help identify and provide feedback regarding concerns, and to look into individual complaints to ensure no children fall through the cracks.

The Ombudsman Office reviews and investigates complaints, tracks themes and trends, and makes system improvement recommendations to CDHS, the governor, and the state legislature through supporting active legislation, providing testimony to legislative committees and through an annual report.

The critical issues surrounding child welfare, such as child safety and well-being, evoke strong emotions among families, communities, and professional stakeholders. The Ombudsman Office works closely with county and state child welfare stakeholders, foster care providers, adoption authorities, child advocates, juvenile justice officers, policy makers, members of the faith community, and others to further the collective mission of ensuring that every child has the opportunity to grow and develop safely, with the promise of a healthy future.

Legislative History and Authority

The Ombudsman Office opened in May 2011, and is managed and hosted by the National Association of Counsel for Children (NACC), the Colorado-based non-profit organization selected as the vendor for the contract with CDHS. The Ombudsman Office was established through the passage of Senate Bill 10-171 in 2010. The bill passed by a unanimous vote of both the Colorado House of Representatives and the Senate. The bill was brought to the governor and legislature by the Child Welfare Action Committee as a top priority among twenty-nine recommendations offered to improve the child protection system.

Pursuant to C.R.S. Sections 19-3.3-101 through 109, the Ombudsman Office has the power and duty to facilitate a process of independent, impartial review of family and community concerns to request independent, accurate information, and conduct case reviews to help resolve child protection and overall systemic issues. Anyone may file a confidential complaint or concern with the Ombudsman Office. The Ombudsman Office



“THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN HAS THE POWER AND DUTY TO FACILITATE A PROCESS OF INDEPENDENT, IMPARTIAL REVIEW OF FAMILY AND COMMUNITY CONCERNS; REQUEST, INDEPENDENT, ACCURATE INFORMATION AND TO CONDUCT CASE REVIEWS TO HELP RESOLVE CHILD PROTECTION ISSUES AND OVERALL SYSTEMIC ISSUES.”

SENATE BILL 10-171

must report annually to the governor, the legislature, and the executive director of CDHS regarding systemic issues, data trends, and recommendations for improvements. The Ombudsman Office also serves as a resource and “systems navigator” to stakeholders and the general public by assisting with individual cases while also providing ongoing public education and resources to promote the best interest of children and families.

CDHS is required to manage and monitor the Ombudsman Office contract and its associated performance and program responsibilities, administering the contract independent of the divisions of the department that are responsible for child welfare, youth corrections, or child care. CDHS is responsible for developing policies and procedures and, as necessary, facilitate the operation of the Ombudsman Office and training to the Ombudsman Office staff to ensure compliance with Colorado and federal laws and regulations. The CDHS and the Ombudsman office have reserved twenty thousand dollars in each of the last three years to accommodate any legal expenses incurred.

Performance Audit

The state auditor conducted a performance and fiscal audit of the Colorado Child Protection Ombudsman Program operating under a contract managed by CDHS. The audit and subsequent report investigated all three years of the program’s existence. The reported findings, conclusions and recommendations can be found at www.state.co.us/auditor.

The ombudsman staff, the National Association of Counsel for Children and CDHS fully cooperated with the audit and respect the findings and recommendations. The audit was particularly valuable to the Ombudsman Office because it gave the newly appointed ombudsman both an in-depth look and an outside perspective on areas that may need improvement. The audit highlighted several areas for improvement listed in last year’s annual report under Moving Forward (pp. 46-47) including: initial response time; timely completion of reviews and investigations; effective and efficient completion of reviews and investigations; communication of outcomes; accurate data tracking; and public awareness. Although, improvements in these areas were made over this last fiscal year, we can and will do better. The auditor’s recommendations for the ombudsman to address are:

The State auditor shall conduct or cause to be conducted a performance and fiscal audit of the program at the beginning of the third year of operation of the program.

Section 19-3.3-103, C.R.S.

- Maintain comprehensive documentation, establish a supervisory review system, maintain a complete database, and ensure that reviews are assigned within established timelines.
- Ensure that complaint finding and recommendations are communicated to the appropriate parties involved, and included in case files and in published reports. Also, finalize reviews and investigations in a timely manner.
- Ensure that statutory requirements and contract deliverables are met.
- Ensure that the handling of confidential information is in compliance with state and federal standards. Ensure that background checks are maintained for employees. Data security agreements should be in place with all sub-contractors.

The ombudsman program has been working, and will continue to work on these recommendations to improve the efficiency of our day-to-day operations.

Accomplishments and Goals

Year 3 Accomplishments

Prior to Year 3, the Ombudsman Office outlined many goals and objectives for this fiscal year. The Ombudsman Office views Year 3 as a success in the areas as outlined below:

- Improved communication and collaboration with CDHS and the county human services departments (Year 3 goal).
- In collaboration with the Office of Children, Youth and Families, agreed on the recommendations and implementation plans made by the Ombudsman Office as a result of investigations during 2011-2013 (Year 3 goal).
- Worked with CDHS, legislators and advocates to pass SB 14-201 calling for a work group to develop a plan for the autonomy and accountability of the Office of Colorado's Child Protection Ombudsman.
- Resolved the delay issue in receiving reports from law enforcement agencies through education, a new report request letter, and an ombudsman fact sheet.
- Completed all investigations initiated prior to July 2013. One investigation initiated after July is pending.
- Reduced completion time of reviews to an average of less than fourteen working days.
- Resolved the issue of budgetary needs due to increased workload and responsibilities through seeking and receiving a budget increase granted by the joint budget committee (Year 3 goal).
- Created a new disposition for reviews entitled "Review with Recommendations."
- Completion times for all contacts has significantly improved.

- Provided recommendations to the county departments to improve their practice. These recommendations are then tracked by the Ombudsman Office for implementation and progress (Year 3 goal).
- Created a new investigative report format that is more clear and concise that includes an agency response section.
- Participated in the statutorily required performance audit.
- Created a newsletter entitled “Working Together for Colorado’s Children” to inform stakeholders of the current work of the Ombudsman Office.
- The ombudsman staff handled a 28 percent increase in contacts over last year.
- Decreased initial response time to complainants to less than two days. Most complainants are acknowledged within twenty-four hours (Year 3 goal).
- Made improvements in data collection accuracy through consistency and training.
- All case files from 2011 to January 2013 are now stored electronically.
- Improvements have been made to case file documentation in response to the auditor’s recommendations.
- The grievance process across the state has been reviewed, evaluated and found to be sufficient.
- The Ombudsman Office facilitated meetings with CDHS and the Coalition of Adoptive Families to review subsidy issues.
- The Associate Ombudsman has been appointed to the Colorado Department of Public Health and the Environment Child Fatality Prevention state team.
- Increased public awareness and presence at child welfare events, trainings and conferences.
- Provided additional opportunities for professional development and training. Currently, all ombudsman staff have obtained ombudsman certification status from the United States Ombudsman Association (USOA). The ombudsman and associate ombudsman are members of USOA.
- Solidified the ombudsman role on the Child Fatality Review Team through active participation and a commitment to sharing information in cases which are reviewed by both entities.

Future Goals:

The Ombudsman Office recognizes that there is always a need for improvement of services and service delivery to the constituents that the Ombudsman Office serves. With this in mind, the Ombudsman Office outlined the following goals for FY 2014-2015:

- Support the efforts of the SB14-201 Work Group by providing information about the Office of the Child Protection Ombudsman as requested by the group.
- Partner with CDHS to complete the performance audit recommendations.

- Purchase a new database, or improve the capabilities of the existing database, to improve overall case management and data collection (audit recommendation).
- Improve the database and case file accuracy through supervisor review of every case (audit recommendation).
- Improve the accuracy of the information entered into the database by directing the intake and administrative coordinator to confirm all entries and closures in the system after supervisor approval (audit recommendation).
- Ensure that every review with recommendation is communicated in writing to the director of the entity reviewed and that the case file contains a copy of the documentation (audit recommendation).
- Dedicate a portion of the dollars approved by the joint budget committee to increase outreach and education to citizens who may not know about the role and efforts of the Ombudsman Office (audit recommendation).
- Continue to positively collaborate with CDHS and the sixty-four county human services agencies as demonstrated in FY 2013-2014.
- Increase statewide outreach to county human services agencies and stakeholders via the Ombudsman Office newsletter, speaking engagements and introductory visits to the region or agency.
- Continue to provide training and professional development to increase the knowledge and expertise of the ombudsman staff. This includes attending relevant conferences and specialized education provided by CDHS as well as the New Child Welfare Training Academy.
- Explore how the Ombudsman Office may provide information to the juveniles committed to the Department of Youth Corrections regarding the role and responsibilities of the Ombudsman Office.
- Partner with CDHS and county human services departments regarding implementing the Ombudsman Office's recommendations provided during the course of reviews and investigations.
- Establish a "Frequently Asked Questions" section on the Ombudsman Office website.

Budget

The Ombudsman Office is funded by state general fund dollars as determined by the enabling legislation in 2010. The allocation is based on the state's fiscal year, which begins July 1 of every year. Therefore, FY 13-14 would have funded any operations between July 1, 2013, and June 30, 2014. The general fund allocation is explained in Table 1.

**Table 1. Estimated Contract Costs Under SB 10-171
(all numbers are rounded)***

	FY 11-12	FY 12-13	FY 13-14
Contract Services	\$343,000	\$343,000	\$343,000
Operating Expenses/Legal Services	27,000	27,000	27,000
Total	\$370,000	\$370,000	\$370,000

*Table from the fiscal note for SB 10-171.

The Ombudsman sought and received an additional \$136,000 budget increase for FY 2014-2015 as a result of a request to the joint budget committee and an annual increase presented by CDHS. The increase will be used to fund the increase in call volume which more than doubled since the initial year. It will further fund staff resources and retention, IT and office equipment needs, and the desire to increase outreach and public education. The Ombudsman Office has not received any additional funds since its inception. This budget increase will go a long way to improve the Ombudsman Office response to citizens, stakeholders and agencies.



Advisory Council

The Child Protection Ombudsman Advisory Council (Council) serves as an advisory body to the Ombudsman Office, ensuring timely responsiveness to its statutory mandates. The Council also keeps the Ombudsman Office informed of any public policy regarding child welfare concerns that may arise. The Council operates with a goal to improve the child protection system and the services provided to children and families. In addition, it assists the Ombudsman Office with community outreach and educating the public about the Ombudsman Office. The Council consists of individuals who are passionate about ensuring that the Colorado child welfare system operates in the best interest of children and who are committed to the improvement of the system.

The Council members and their affiliation are listed in Table 2.

**TABLE 2. OFFICE OF COLORADO'S CHILD PROTECTION OMBUDSMAN
ADVISORY COUNCIL 2013-2014**

First Name	Last Name	Representing	City	Stakeholder Category
Sister Michael Delores	Allegrì	President, Colorado Foster Parent Association/Mt. St. Vincent Home/Current Foster Parent	Denver	Foster Care & Provider
Terraine	Bailey	Guardian Ad Litem, Bailey Law Firm/Board of Directors of Office of the Child's Representative	Denver	Guardian Ad Litem
Jim	Barclay	President & CEO, Lutheran Family Services Rocky Mountains	Denver & Colorado Springs	Child Placement Agencies (CPA)/Foster Care
Debi	Brilla	Foster Parent	Greeley	Foster Parent
Sabrina	Byrnes	Office of Colorado's Child Protection Ombudsman	Aurora	Associate Ombudsman
Deborah	Cave	President, Colorado Coalition of Adoptive Families/Adoptive Parent	Louisville	Adoption
Brian	Cotter	Denver Police Department/Foster Parent	Denver	Law Enforcement
Dennis	Goodwin	Office of Colorado's Child Protection Ombudsman	Aurora	Ombudsman
Elisa	Hicks	Rite of Passage & Ridge View Youth Services Center	Denver	Division of Youth Corrections/ Provider
Kim	Johnson	Social Worker, Denver Indian Family Resource Center	Denver	Indian Child Welfare
Martha	Johnson	Deputy Director, La Plata County Department of Human Services	Durango	County Department of Human Services
Lisa	Kreutzer-Lay	Office of Colorado's Child Protection Ombudsman	Aurora	Quality Assurance & Research Specialist
Julie	Krow	Office Director, Colorado Department of Human Services	Denver	State Department of Human Services
Kendall	Marlowe	National Association of Counsel for Children	Aurora	Director
Lori	Moriarity	Board of Directors and Co-Founder, National & Colorado Alliance for Drug Endangered Children	Arvada	Substance Abuse and Law Enforcement
Karen	Nielsen	Office of Colorado's Child Protection Ombudsman	Aurora	Intake & Administrative Coordinator
Janet	Rowland	Former County Commissioner, Center for Local Government, Colorado Mesa University	Grand Junction	County Commissioner

Grace	Sage	Denver Indian Family Resource Center	Denver	Supervisor
Shari	Shink	Founder/President, Rocky Mountain Children's Law Center	Denver	Legal Advocate
Kathryn	Wells	Physician, Denver Health and Denver Department of Human Services	Denver	Medical Professional
Julie	Westendorff	La Plata County	Durango	County Commissioner
Tom	Westfall	Parent Educator/Trainer/Former County Department of Human Services Director	Sterling	Consultant

Outreach Efforts

The Ombudsman Office outreach efforts are designed to not only educate the public generally about this office and its ability and responsibility to improve the child protection system, but also to educate the community on its role in prevention and identification of child abuse and neglect in an effort to strengthen families and keep children safe.



“The Ombudsman will educate the public about child maltreatment and the role of the community in strengthening families and keeping children safe.”

Senate Bill 10-171



As such, efforts have included speaking engagement to citizens, stakeholders and professionals within the child protection area. Ombudsman Office staff have also participated in a variety of community events and educational forums on an ongoing basis to stay current on child protection trends. The chart below details the Ombudsman Office’s outreach efforts for FY 2013-2014.

TABLE 3. FY 2013-2014 OUTREACH/PRESENTATIONS

Date	Topic	Audience	Location	Representative	No. of Attendees
07/31/2013	Commendation	Police Chief	Lakewood, CO	Dennis Goodwin	2
08/09/2013	Rules and Regulations	Advisory Council/CDHS	Aurora, CO	Dennis Goodwin	8-10
08/21/2013	CDHS Town Hall and Strategic Planning	Child Welfare Constituents	Golden, CO	Dennis Goodwin	75
08/22/2013	Ombudsman Introduction	Human Services Supervisors	Golden, CO	Dennis Goodwin	8
09/12/2013	Annual Report	Child Welfare Executive Leadership Council	Denver, CO	Dennis Goodwin	15
09/17/2013	Systems Collaboration	ISPCAN International Conference	Dublin, Ireland	Sabrina Byrnes	150
09/25/2013	Ombudsman Introduction	Director and Administrator	Castle Rock, CO	Dennis Goodwin	2

09/30/2013	Ombudsman Introduction	District Attorneys	Golden, CO	Dennis Goodwin	30-40
10/08/2013	Ombudsman Introduction	Human Services Stakeholders	Denver, CO	Karen Nielsen Lisa Kreutzer-Lay	250
10/09/2013	Ombudsman Introduction	Administrators	Denver, CO	Dennis Goodwin	4
10/09/2013	Ombudsman Introduction and Update	Public Awareness Subcommittee	Denver, CO	Dennis Goodwin	6
10/22/2013	Creation and Function of the Ombudsman Office	Denver University GSSW Policy Class	Denver, CO	Dennis Goodwin	23
11/05/2013	Ombudsman Introduction and Update	Legislative Council	Denver, CO	Dennis Goodwin Sabrina Byrnes Karen Nielsen Lisa Kreutzer-Lay	30
12/04/2013	CCI Winter Conference	County Commissioners and Directors	Colorado Springs, CO	Dennis Goodwin	100
12/20/2013	KYGO Christmas Crusade for Children	Nominated Families	Lakewood, CO	Dennis Goodwin Karen Nielsen	75
04/03/2014	Kempe National Forum Dinner	Leaders of the Former US Advisory Board and Colorado Leaders	Aurora, CO	Dennis Goodwin	50
04/09/2014	Senate Bill 14-177	State Senators, Representatives and Community Members	Denver, CO	Sabrina Byrnes	40-60
04/26/2014	Kempe Foundation Gala	Community members, Kempe staff and donors	Denver, CO	Dennis Goodwin Sabrina Byrnes	400
06/04/2014	Ombudsman Introduction and Update	Children's Bureau-Administration for Children and Families	Aurora, CO	Dennis Goodwin Sabrina Byrnes Karen Nielsen Lisa Kreutzer-Lay	6
06/05/2014	Ombudsman Introduction and Update	Community members and stakeholders	Westminster, CO	Sabrina Byrnes	50

Online Presence

The website for the Ombudsman Office can be found at www.protectcoloradochildren.org. The site provides pertinent information, articles, investigative reports and recommendations, as well as the quarterly Ombudsman newsletter. The Ombudsman Office will be adding a frequently asked questions section to the website in FY 2013-2014.

The Ombudsman Office also maintains profiles on the social networking sites Facebook (OmbudsmanCO) and Twitter (@OmbudsmanCO). The Facebook page has grown from 262“likes” in Year 2 to 380“likes” in Year 3. The Twitter feed has grown from 99 followers in FY 2012-2013 to 118 in FY 2013-2014. The Ombudsman Office maintains the pages with up-to-date information pertaining to the Ombudsman Office and other related topics impacting child protection.



Overview of Contacts to the Ombudsman Office

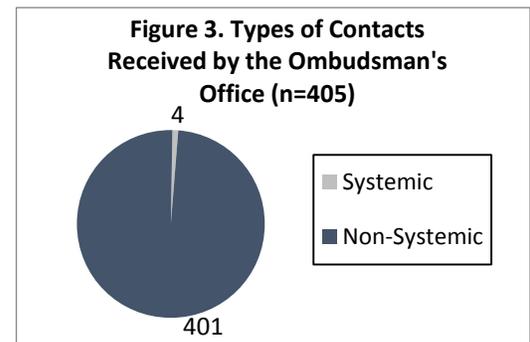
Inquiries, Reviews, and Investigations

From July 1, 2013, to June 30, 2014, the Office received 405 total contacts (Appendix B). This is in comparison to FY 2011-2012 when the Office received 156 total contacts, and FY 2012-2013 receiving 317 total contacts, a total increase from FY 2011/2012 to FY 2013/2014 of 160 percent.

Figure 2. Systemic and Non-Systemic Contacts for FY 2011/12-FY 2013/14				
	Year 1	Year 2	Year 3	Percentage Change 2012- 2014
Systemic	21	20	4	-80%
Non-Systemic	135	297	401	197%
Total	156	317	405	160%

For FY 2013-2014, the contact breakdown can be seen in Figure 3.

- Four hundred one contacts (99 percent) were non-systemic;
- Four contacts (1 percent) involved systemic issues.
- The following pages provide details on the non-systemic contacts to the Ombudsman Office during FY 2013-2014.



The data includes:

- The race or ethnicity of the child on the case;
- The familial circumstances of the child on the case;
- Contacts received and resolved by month;
- The nature of the contacts to the Ombudsman Office;
- Timeliness of case resolution;
- The Ombudsman Office's response to contacts; and
- The disposition or results of the contacts.

It also includes information on how citizens contacting the Ombudsman Office:

- Heard about the Ombudsman Office;
- Related to the child welfare case they are looking for help with; and
- Tried contacting other complaint or help mechanisms before calling the ombudsman.

Table 4. Relationship of Referring Party to the Family or Child on the Case: in Non-Systemic Cases

Advocate	2.0%
Attorney General's Office	<0.5%
Attorney	<0.5%
CASA	1.0%
Child	<0.5%
Child's Grandparent	18.0%
Child's Parent	36.0%
Child's Other Relative	12.0%
Community Professional	7.0%
DHS Employee	1.0%
Doctor/Medical Personnel	1.0%
Friend/Neighbor	3.0%
Foster/Adoptive Parent	4.0%
Judge/Commissioner	<0.5%
Law Enforcement	1.0%
Licensed Day/Group Care Provider	<0.5%
Legislator	1.0%
No Relationship Specified	1.0%
Not Applicable	4.0%
Unknown	10.0%
Number	(401)

Information about Referring Parties

When a citizen contacts the Ombudsman Office to inquire or complain, some basic information about the referring individual is collected. Table 4 shows how the party contacting the Ombudsman Office is related to the child on the child welfare case. Most of the parties contacting the Ombudsman Office are a relative to a child in the child welfare system. Thirty six percent of the parties are the biological parent, 18 percent are the grandparents, and 12 percent are another type of biological relative. A few are foster/adoptive parents (4 percent), community professionals (7 percent), and 8 percent were mandatory reporters.

There are a wide variety of ways that the contacting parties heard about the Ombudsman Office. About 16 percent of contacting parties heard about the office by being a previous

Table 5. How the Referring Party Heard about the Ombudsman Office: in Non-Systemic Cases

Advocate	2.0%
Attorney	1.0%
Attorney General's Office	<0.5%
CASA	<0.5%
Community Agency	5.0%
Conference, Training, or Workshop	<0.5%
County DSS	4.0%
Court Clerk or Other Staff Member	<0.5%
Educator	<0.5%
Facebook, Twitter, Internet or OCCPO Website	36.0%
Friend or family member	4.0%
Foster Parent	1.0%
GAL	1.0%
Governor's Office	<0.5%
Judge/Commissioner	<0.5%
Judicial	<0.5%
Legislator's Office	<0.5%
Media	5.0%
Medical Personnel	<0.5%
Other Child Welfare Agency	<0.5%
Previous Contact with Ombudsman Office	16.0%
State DSS	9.0%
Unknown	13.0%
Number	(401)

contact to the office and 5 percent through the media. Four percent heard about CDHS; 5 percent heard about the Ombudsman Office from a community agency; 4 percent heard about the Ombudsman Office from a friend or family member. The Ombudsman Office's website, Facebook page, and/or Twitter feed displayed an increase of 30 percent from last fiscal year. (Table 5).

The Ombudsman Office accepts contacts from individuals through a variety of methods. Referring parties can call the Office using a local number or a toll-free number, complete and submit a complaint form on the ombudsman website, email an office staff member (email addresses are available on the website), download a complaint form and fax

it to the office, and/or use regular mail.

As displayed in Figure 4, most of the parties contacted the Ombudsman Office over the phone (70 percent). Nine percent of the referring parties emailed their complaints to the office and 1 percent mailed in their complaints, while 19 percent filed an online complaint. Online contacts show an increase of 17 percent from the last fiscal year.

Child Specific Information

The Ombudsman Office also collects limited information on children about whom the referring party is calling.

There were a total of four hundred fifty children in the 401 contacts received by the Ombudsman Office in FY 2013-2014. This is an average of 1.12 children per Ombudsman Office case. Of these four hundred fifty children, 57 percent are White, Non-Hispanic, 14 percent are Multi-Racial, 13 percent are Hispanic, 5 percent are African American, and 3 percent are Native American. (Table 6)

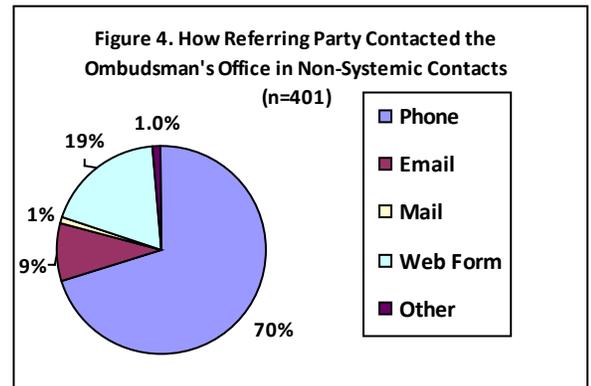


Table 6. Child Specific Information: on Non-Systemic Cases

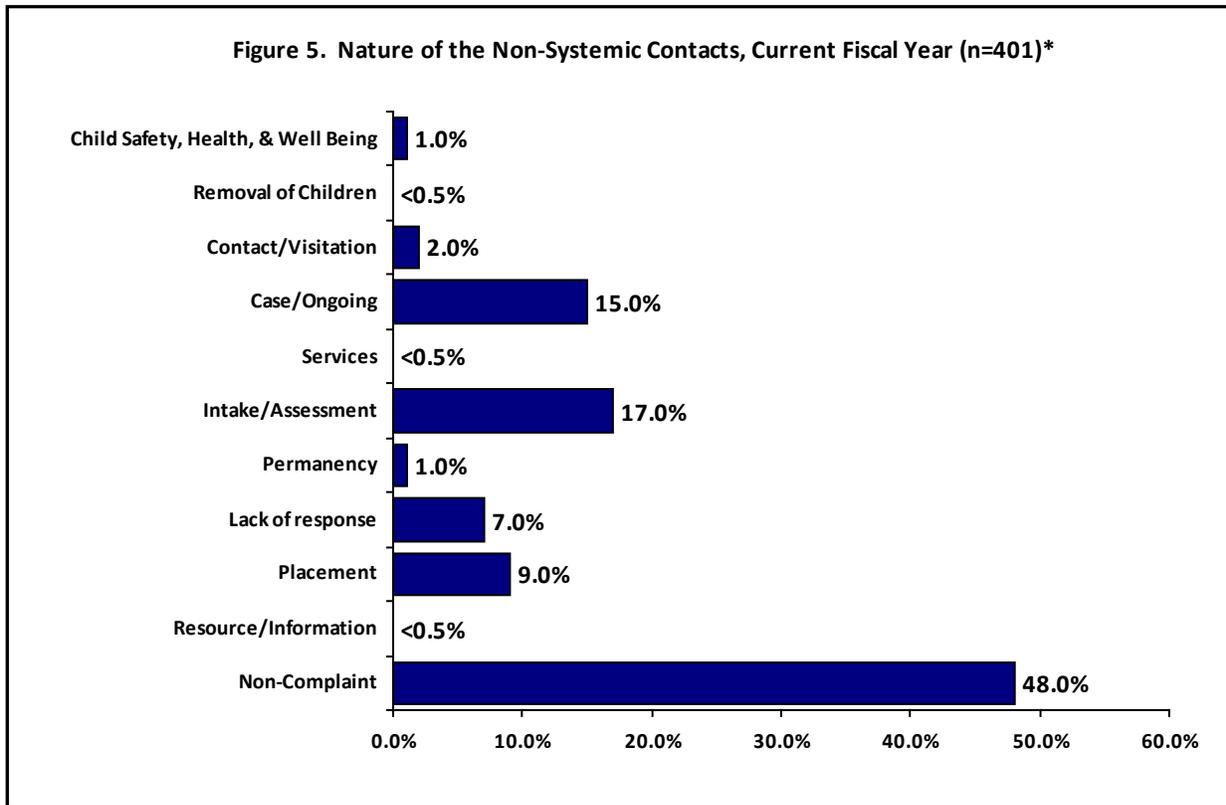
Total number of non-systemic cases	401
Total number of children covered by the non-systemic cases	450
Average number of children per OCCPO case	1.12
Race/Ethnicity of Children Involved in OCCPO Cases	
African American	5.0%
Asian	<0.5%
Hispanic	13.0%
Multi-Racial	14.0%
Native American	3.0%
Refused/Unknown	7.0%
White, Non-Hispanic	57.0%
Number	(450)

Nature of Contact

The Ombudsman Office asks parties to detail their complaint which helps the Ombudsman Office focus its actions on the referring party's concerns.

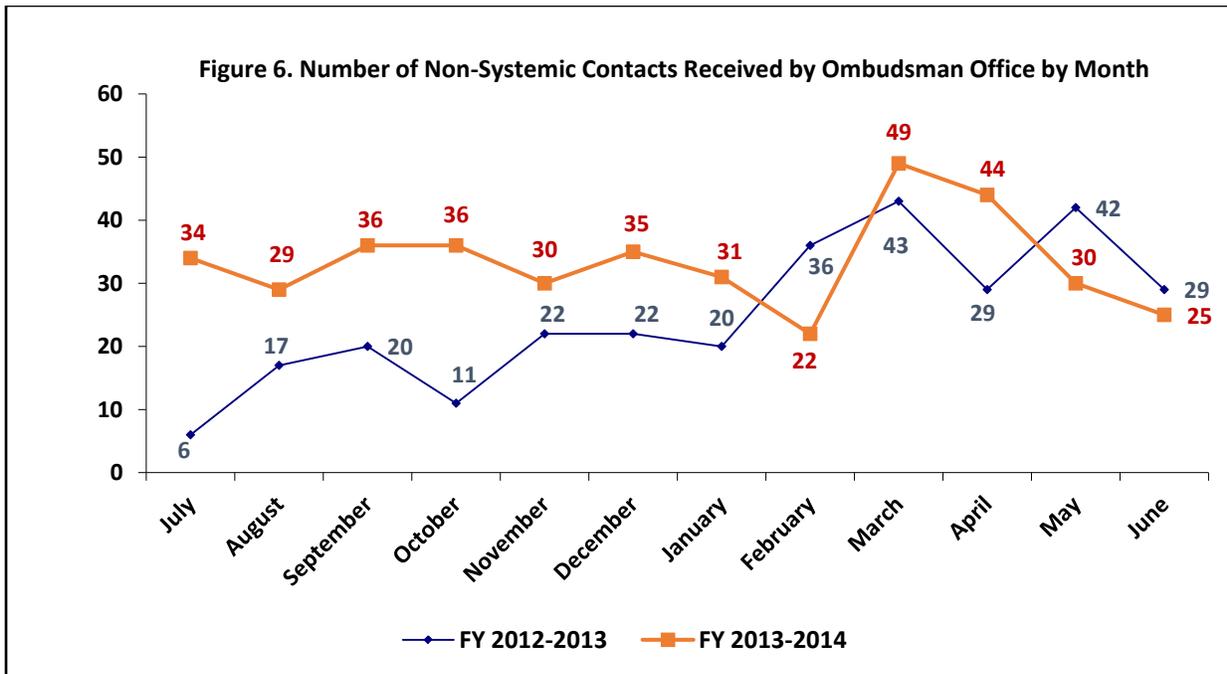
As shown in Figure 5, the most commonly cited nature of contact made to the Ombudsman Office was intake/assessment at 17 percent. Case or ongoing case work (*i.e.*, a concern with case management, decisions, services, being offered to a party during their child protection case) was second highest with 15 percent of referring parties citing this as the nature of their contact; 9 percent cited placement issues (*i.e.*, Interstate Compact on the Placement of Children, kinship placement, non-kinship placement, etc.) and 7 percent cited lack of response.

Less than 2 percent of the contacts were in regard to contact or visitation, permanency, child health, safety, well-being, the removal of children, or services.



Contacts to the Ombudsman Office by Month

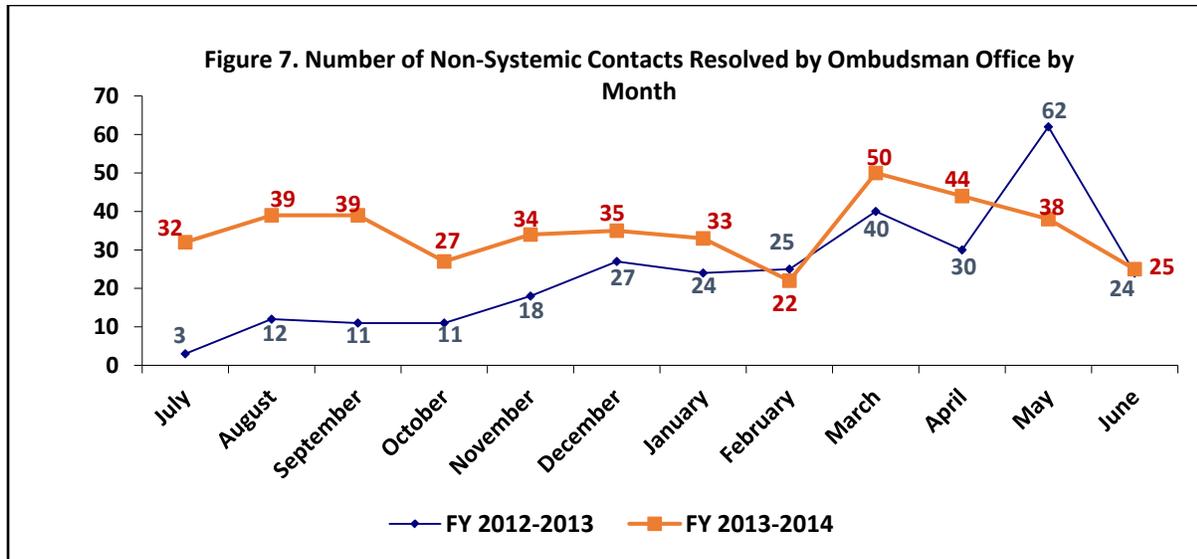
Figure 6 shows the number of contacts coming into the Ombudsman Office by month during the current fiscal year (FY 2013-2014), and the previous fiscal year (FY 2012-2013). The Ombudsman Office received a total of 401 non-systemic contacts this year. During the second year of operation, the Ombudsman Office received 297 non-systemic contacts. As shown in the figure, the number of contacts started high at the beginning of the fiscal year, with thirty-four coming in during July 2013. The number of contacts decreased to twenty-nine in August 2013, and again increased to thirty-six in September and October of that year. In November, the number fell to thirty. There were thirty-five contacts during December, and thirty-one in January 2014. Beginning in February 2014, the contacts decreased to twenty-two, and in March, increased to an all-time high of forty-nine contacts. The numbers decreased to forty-four in April and thirty contacts in May. In June 2014, the contacts also decreased to twenty-five. The most contacts came into the Ombudsman Office during March and April 2014, when ninety-three contacts were received. During FY 2012-2013, the highest number of contacts in any one month came in March 2013, when the Ombudsman Office received forty-three contacts. The Ombudsman Office in FY 2013-2014 received an average of thirty-three contacts per month.



Contacts Resolved by Month

During FY 2013-2014, the Ombudsman Office resolved 418 non-systemic contacts. Of these, 401 of the contacts were made during FY 2013-2014, and seventeen were made during the previous fiscal year. The open cases that have not been resolved will continue to be worked during FY 2014-2015.

Figure 7 shows the number of contacts that the Ombudsman Office resolved by month during the current and previous fiscal year. The Office resolved thirty-two contacts in July 2013. The number of contacts resolved then increased to thirty-nine resolved contacts per month in August and September 2013. The Ombudsman Office's number of resolved contacts decreased to twenty-seven cases in October 2013, and then averaged thirty-three between November 2013 and January 2014. The number of resolved contacts decreased to twenty-two in February 2014 and increased to fifty in March 2014. The Ombudsman Office resolved forty-four contacts in April 2014, thirty-eight in May 2014, and twenty-five in June 2014 to close out the fiscal year. In March and April 2014, the Ombudsman Office resolved the most contacts, closing a combined ninety-four contacts. In FY 2012-2013, the Ombudsman Office resolved 287 contacts, an average of twenty-four contacts per month. The Ombudsman Office, in FY 2013-2014, resolved an average thirty-five contacts per month.



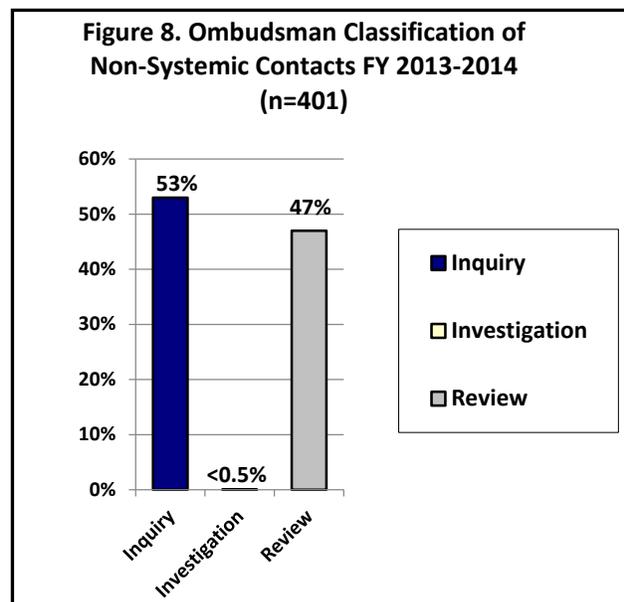
Classification of Contacts

A contact to the Ombudsman’s Office can be classified in one of three ways: inquiry, review, and investigation. As shown in Figure 8, 53 percent of the contacts (214) during FY 2013-2014 were classified as inquiries (i.e., a question or a request for information; assistance; resource referral; declined to investigate; closed per complainant; or closed lack of information), or other information that is relevant for tracking but is not considered a review. Forty-seven percent (186) of the contacts to the Office during the FY 2013-2014 were classified as reviews. During a review, the Ombudsman Office conducts an initial search of TRAILS and the Colorado court database, and gathers any other information necessary to determine whether the complaint warrants further review and/or an investigation by the Ombudsman Office.

Investigations generally include a review of records and actions or inactions, and may also include assessing additional facts, interviewing caseworkers, supervisors and other department staff, law enforcement, or any other party that may provide insight into the complaint being investigated. The Ombudsman Office initiated one investigation in FY 2013-2014.

Contact Outcomes

Of the 397 resolved contacts that came into the Ombudsman Office during the current fiscal year, 38 percent were resolved with



the Ombudsman Office affirming the child protection agency and/or caseworker actions (Table 7). In 6 percent of the contacts, the Ombudsman Office offered recommendations to improve practice and service delivery. Eleven percent of the contacts were closed due to a lack of information and 37 percent were closed with a resource referral. In 3 percent of the resolved contacts, the office found that the agency or caseworker was not in compliance with policy (Volume VII).

Table 7. Ombudsman Office Contact Dispositions of Resolved Contacts, FY 2013-2014 (n=397)

Affirmed Agency or Caseworker Actions	38.0%
Affirmed Agency or Caseworker Actions, with Recommendations	3.0%
Agency/Caseworker Non-Compliance with Policy or Law	3.0%
Case Closed per Complainant	2.0%
Case Closed, Lack of Information	11.0%
Case Still Open, No Disposition	1.0%
Declined to Investigate	2.0%
Deviation from Best Practice Standards	<0.5%
Duplicate Referral	4.0%
Resource Referral	37.0%
Number	(397)

FY 2012-2013 Investigation Resolution

During FY 2013-2014, the Ombudsman Office concluded all outstanding investigations from the previous fiscal years. These included investigations in Montezuma and Adams Counties. The Ombudsman Office initiated a third investigation in Montezuma County during the first fiscal year. However, after further review of the case details, the Ombudsman Office reversed that decision and proceeded with a review with recommendations. The delay in resolution to outstanding investigations was primarily based on the following:

- Restrictions on Release.** Oftentimes cases that the Ombudsman Office has under review and/or investigation are also involved in criminal or civil proceedings that disallow the release of information prior to the resolution of those matters. In the instance of one of these investigations, a gag order was issued in the criminal case, prohibiting the Ombudsman Office from releasing any information in the investigation until receiving release from the district attorney in the charging matter. Once the order was lifted, the Ombudsman Office compiled the information necessary for a complete investigation, inserted it into the complaint, and issued findings to the county, CDHS, and the public.

In these two investigations, the Ombudsman Office found instances of practice concerns, along with policy violations. It is important to note that the Ombudsman Office also found areas of strength in each investigation, and that information, along with the findings and recommendations were forwarded to the counties for response prior to releasing the reports to CDHS, or posting the reports on the ombudsman website. The complete public release of these reports outlining concerns and strengths identified by the Ombudsman Office can be found at www.protectcoloradochildren.org under the "Reports" tab. The executive summaries of these investigations can be found in Appendix C.

FY 2012-2013 CDHS Investigation Recommendation Resolution and Implementation

The Ombudsman Office, CDHS, and the Office of Children, Youth and Families have been reviewing the recommendations made by the Ombudsman Office to CDHS during Years 1 and 2. The recommendations were generated through the investigations conducted during the first three years of the Ombudsman Office's operations. This year, one of the goals was to come to a consensus on exactly what those recommendations require, and collaborate with CDHS regarding a plan of action to implement those recommendations. The recommendations and actions are designed to improve policy and practice, and ultimately improve the safety, health and well-being of children in Colorado. A complete list of the recommendations, as well as implementation strategies can be found in Appendix D.

The Ombudsman Office would like to recognize and thank the Office of Children, Youth and Families and the Division of Child Welfare for their continuing efforts in implementing these recommendations to improve child safety and protection across Colorado.

FY 2013-2014 Investigations

The Office of Child Protection Ombudsman shall be "a key advisor concerning issues related to child safety and protection in Colorado by virtue of his or her responsibility and authority to make advisory recommendations to the State Department, County Departments, County Commissioners, the Governor, and the general assembly based upon the Ombudsman's experience and expertise."

(C.R.S. 19-3.3-102)

The Ombudsman Office opened one investigation in FY 2013-2014 in which the Office investigated a county's response to allegations of an egregious incident of child abuse and neglect. The Ombudsman Office has been unable to release the findings of this investigation publicly due to the ongoing criminal proceedings. However, the Ombudsman Office has been working diligently with the county department over this

past year to implement recommendations for improvement of practice within the department and community. The response from the county department has been refreshing and the

Ombudsman Office believes the impact of the Ombudsman Office investigation, and the response by the county department is improving service delivery for children and families in that community.

Review with Recommendations

The disposition of review with Recommendations was established this year to give recommendations to the county human services departments for providing better services to children and families while promoting excellence in the casework. The counties have embraced this concept and have been overwhelmingly responsive to the recommendations as demonstrated by the chart below. (Table 8)

County Recommendation Summary

In the above investigations and reviews with recommendations, the Ombudsman Office offered a comprehensive list of recommendations to both the county departments, as well as CDHS. In making recommendations, the Ombudsman Office seeks to offer solutions to issues on a multi-level basis, including recommendations for specific caseworkers and/or supervisors, recommendations for agency improvement around specific practice-related issues, and specific improvements in overall child protection policy. The Ombudsman Office is working with county departments and CDHS to improve overall child protection policy and practice to ensure the safety and well-being of Colorado's children.

During the course of FY 2013-2014, the Ombudsman Office has offered fifty-eight recommendations to local county departments. Although the data is raw, the Ombudsman Office pinpointed several notable trends during the review. Two consistent recommendations made during this fiscal year focused on improving documentation (24 percent) and training regarding safety and risk assessments (26 percent). In nearly every instance to date, the county departments have acknowledged receipt of the recommendations and implemented departmental changes and/or trainings to improve service delivery, as well as overall practice and performance. The Ombudsman Office will continue to monitor and track recommendations made to the county departments for ongoing trends, and will make appropriate recommendations to CDHS in an effort to continue to improve service delivery to children and families in Colorado. A comprehensive list of the Ombudsman Office's recommendations can be found below.

TABLE 8. FY 2013-2014 RECOMMENDATIONS BY COUNTY

County	Recommendation Date	Recommendation Type	Acknowledged Receipt	Completed
Adams	08/26/2013	<ul style="list-style-type: none"> • Accurate and Complete Documentation 	Yes	Yes
	05/13/2014	<ul style="list-style-type: none"> • Accurate and Complete Documentation • Systems Collaboration • Safety Assessment Training 	Yes	Yes
Arapahoe	04/15/2014	<ul style="list-style-type: none"> • Accurate and Complete Documentation 	Yes	Yes
Costilla	08/16/2013	<ul style="list-style-type: none"> • Job Specific Staff Training • Department develop an internal audit system to identify overall performance/practice issues • Accurate and Complete Documentation • Systems Communication • Systems Collaboration • Review/Revise Memorandum of Understanding with Law Enforcement 	Yes	Yes
Delta	03/25/2014	<ul style="list-style-type: none"> • Safety Assessment/Plan Training 	Yes	Yes
Denver	05/16/2014	<ul style="list-style-type: none"> • Ongoing Red Team training • Accurate and Complete Documentation • Safety Assessment Training • Risk Assessment Training 	Yes	Yes

Douglas	07/02/2013	<ul style="list-style-type: none"> • Safety Assessment Training 	Yes	Yes
	01/03/2014	<ul style="list-style-type: none"> • Volume VII Training on Inputting Referrals • Documentation Training • Safety Assessment Training • Risk Assessment Training 	Yes	Yes
	02/10/2014	<ul style="list-style-type: none"> • Intake Extension Requirement Training • Safety Assessment Training • Risk Assessment Training • Supervisor Training on Assessment Closure Requirements 	Yes	Yes
El Paso	11/19/2013	<ul style="list-style-type: none"> • Documentation Training • Safety Assessment Training 	Yes	Yes
Fremont	11/20/2013	<ul style="list-style-type: none"> • Documentation Training 	Yes	Yes
Jackson	03/26/2014	<ul style="list-style-type: none"> • Training on Volume VII Requirements for Face to Face Contacts • Documentation Training 	Yes	Yes
Jefferson	11/08/2013	<ul style="list-style-type: none"> • Documentation Training • Diligent Search Training 	Yes	Yes
	11/11/2013	<ul style="list-style-type: none"> • Training on Timely Completion of Assessments and Extensions • Safety Assessment/Plan Training 	Yes	Yes
	12/03/2013	<ul style="list-style-type: none"> • Documentation Training 	Yes	Yes
	04/04/2014	<ul style="list-style-type: none"> • Case Transfer Training • Red Team Training • Documentation Training • Safety Assessment Training • Child Development Training • Collaboration • Training around Policy Concerning Lack of Compliance in Voluntary Cases 	Yes	Yes
Logan	11/18/2013	<ul style="list-style-type: none"> • Documentation Training 	Yes	Yes

Mesa	09/16/2013	<ul style="list-style-type: none"> • Safety Assessment Training 	Yes	Yes
Montezuma	05/13/2014	<ul style="list-style-type: none"> • Training and Technical Assistance Concerning Child Fatality Investigations • Volume VII Training Concerning Investigation of Reports of Abuse/Neglect • Training and Technical Assistance Concerning Internal Review Procedures 	Yes	In Progress
	05/13/2014	<ul style="list-style-type: none"> • Collaboration with Neighboring County Departments 	Yes	Awaiting Response
Montrose	08/19/2013	<ul style="list-style-type: none"> • Safety Assessment/Plan Training • Review Removal Policy 	Yes	Yes
	02/04/2014	<ul style="list-style-type: none"> • Volume VII Training Regarding Abuse Definitions • Documentation Training 	Yes	Yes
Pueblo	03/11/2014	<ul style="list-style-type: none"> • Review/Revise Memorandum of Understanding with Law Enforcement • Safety Assessment/Plan Training • Abuse Recognition Training • Volume VII Training Regarding Findings Policy 	Yes	Yes
Weld	01/15/2014	<ul style="list-style-type: none"> • Training on Internal Policy Changes • Supervisory Training around Volume VII Intake/Assessment Requirements 	Yes	Yes

Data Highlights for FY 2013-2014

The following are key findings of a statistical analysis of information recorded by the Ombudsman Office staff on all contacts to the Ombudsman Office during Fiscal Year 2013-2014:

- The Ombudsman Office received 405 contacts, 401 non-systemic contacts and four systemic contacts.
- Most contacting parties were biological parents (36 percent), grandparents (18 percent), or other relatives (12 percent).
- Most contacting parties learned about the Ombudsman Office by having previously contacted the Ombudsman Office (16 percent) or through the Ombudsman Office's website, Facebook page, or Twitter feed (36 percent), representing a 30 percent increase from FY 2012-2013.
- A significant amount of contacts (53 percent) were classified by the Ombudsman Office as an inquiry, (47 percent) were classified as reviews, and less than (<0.5 percent) classified as investigations.
- Eighty-seven percent of all reviews were resolved with an affirmation of agency and/or caseworker policy. In 12 percent of the reviews, the Ombudsman Office offered recommendations regarding practice improvements.
- The Ombudsman Office found, in 6 percent of the reviews completed, instances in which the reviewed agency or caseworker was not in compliance with law or policy.
- The Ombudsman Office, in FY 2013-2014, received an average of thirty-three contacts per month.
- The Ombudsman Office, in FY 2013-2014, resolved an average of thirty-five contacts per month, which included contacts carried over from previous months.
- The Ombudsman Office closed two investigations that were initiated during previous fiscal years.
- The Ombudsman Office initiated one investigation during FY 2013-2014.

Issues Tracked by the Ombudsman Office in Year 3

The Ombudsman Office has been fully operational for three years as of the writing of this report. Although the Ombudsman Office has been gathering large amounts of data throughout these three years, the data pool continues to not be large enough for adequately tracking and identifying significant trends or issues. The Ombudsman Office, in conjunction with CDHS, began operation of the Ombudsman Office with the shared knowledge that it may require multiple years of consistent data collection before trends or themes with some measure of reliability would emerge. This being said, the data collected since the inception of the Ombudsman Office continues to identify areas of potential themes or issues.

Status of 2013-2014 Action Steps:

Risk and Safety Assessments:

Year 3 Action Step: The Ombudsman Office will continue to monitor existing and new tools for effectiveness and appropriate use, and will remain in communication with CDHS regarding any issues identified during and after roll out of the new safety and risk assessment tools.

Conclusion: The Ombudsman Office has maintained close communication with CDHS concerning the development and implementation of the new safety assessment tool. CDHS has confirmed the new tool will roll out in the fall 2014. Training on the new tool will be required for all county and state department staff. These trainings will be offered statewide in regional training locations established by CDHS. CDHS is working on a revision to the risk assessment tool, and will be offering similar training once the tool is complete and has been validated. The Ombudsman Office will attend these trainings to ensure that reviews are in line with current practice and rule. The Ombudsman Office continues to provide CDHS with feedback on issues arising from the accurate completion of safety and risk assessment tools. CDHS has been responsive and continues to monitor the county departments through the administrative review division and offers on-site technical support and training for county departments when warranted.

Intake Inconsistencies or Issues:

Year 3 Action Step: The Ombudsman Office will continue to track and monitor intake issues and inconsistencies for trends.

Conclusion: The Ombudsman Office continued to receive a high number of calls concerning the actions or inactions taken at the time of intake/assessment. The Ombudsman Office worked closely with county departments when inconsistencies or concerns arose with regard to the intake process, and provided recommendations for

additional training and technical assistance when appropriate. The Ombudsman Office has kept CDHS apprised of concerns regarding intake issues observed through the course of reviews, and when necessary, CDHS has provided county departments with training and technical assistance. With the development of the regional training sites by CDHS and the overhaul of the Child Welfare Training Academy, the Ombudsman Office foresees improvement in this area as the training delivery becomes more readily available and consistent.

Mandatory Reporting of Child Abuse:

Year 3 Action Step: The Ombudsman Office continues to strongly support broad and accessible discipline-specific training for all mandatory reporters.

Conclusion: During Year 1, the Ombudsman Office surveyed county human services directors about mandatory reporter issues, and more than 80 percent of the respondents believed that school personnel, medial responders, clergy, and first responders needed more or better training about mandatory reporting. During FY 2013-2014, CDHS responded to this recommendation and developed an online mandatory reporter training accessible through the CDHS website. Trainees are tested at the conclusion of the training and are able to print off a certificate of completion once the test has been successfully completed. Further, CDHS is able to track data related to who is accessing and completing the training that will provide additional guidance for developing future outreach campaigns.

Substance Abuse and Implications for Parenting:

Year 3 Action Step: The Ombudsman Office strongly supports improved training for child welfare professionals regarding risks of substance abuse and implications for children and families.

Conclusion: The Ombudsman Office has made many recommendations to county departments, as well as CDHS, related to training of substance abuse impacts. CDHS has included improved substance abuse training in the New Worker Child Welfare Training Academy, and has contracted with Colorado Alliance for Drug Endangered Children to provide a series of advanced training concerning the impact of substance use on children and families. Further, the Ombudsman Office, at the request of county department staff, has supported the development of a legislative definition for a drug endangered child to assist county departments and other child protection stakeholders in identifying children who are being impacted by substance use in their families, offering a more consistent approach when identifying and intervening with substance-using families.

Systems Navigation Issues:

Year 3 Action Step: The Ombudsman Office continues to support more and/or better training for child welfare professionals and other stakeholders around educating clients about system navigation, decision making, and expectations.

Conclusion: During FY 2013-2014, CDHS rolled out a public-facing website offering assistance and guidance to the community and stakeholders in an effort to provide all individuals with information on available resources.

Concerns and/or Fear of Retribution:

Year 3 Action Step: The Ombudsman Office will monitor, and also suggests that CDHS do it as well, reports made to the office by complainants of threats of retribution by either a county or a specific worker for trends. The Ombudsman Office supports legislative or policy changes addressing threats of retribution issues from within the system to decrease and mitigate inequities across counties, while promoting the best interest of children and families.

Conclusion: During FY 2013-2014, the Ombudsman Office has not identified any trend or pattern of this behavior within county or state departments. Although the issue has occasionally appeared in a complaint, the Ombudsman Office has not received clear evidence that retribution following the filing of a complaint with any of the grievance processes has occurred. The Ombudsman Office recognizes that this is a concern of constituents and stakeholders, and will address concerns with CDHS or the appropriate county department, should the situation arise.

Training Issues:

Year 3 Action Step: The Ombudsman Office will continue to track and monitor complaints and concerns regarding training issues.

Conclusion: During FY 2013-2014, CDHS has continued its work developing the New Worker Child Welfare Training Academy, including developing the regional training sites. CDHS has also begun to develop and roll out improved advanced worker training across Colorado and is exploring improvements to the training offered to supervisors.

Adoption Subsidies:

Year 3 Action Step: The Ombudsman Office will continue to lead and facilitate communications between adoption stakeholders and CDHS regarding adoption subsidies, post-adoptive services, and other issues brought forth in these dialogues. The

Ombudsman Office will continue to track and monitor complaints, trends, and legislative/policy progress on these issues.

Conclusion: Throughout the past three years, the Ombudsman Office has assisted in the establishment and ongoing dialogue between adoption stakeholders and CDHS. The Ombudsman Office's assistance has been valuable in opening the lines of communication between the parties by providing an environment for meaningful discussion to occur. The Ombudsman Office understands that the need for dialogue between the stakeholders and CDHS will need to continue in an effort to educate current and potential adoptive families on the laws and guidelines surrounding adoption subsidies. However, the Ombudsman Office believes the relationship between the parties is strong enough that future facilitation is not needed.

Child Fatality Review Team/Ombudsman Office's Role:

Year 3 Action Step: The Ombudsman Office continues to see value in being part of the review team and will continue to participate in, and monitor, these processes.

Conclusion: The Ombudsman actively participates in the child fatality review team monthly meetings. The Ombudsman Office has worked diligently throughout Year 3 with the administrative review division at CDHS to implement recommendations made by the Ombudsman Office in Year 2 in an effort to improve the process of reviewing fatalities, near fatalities or egregious incidents of abuse and/or neglect.

Child Protection Team Issues:

Year 3 Action Step: The Ombudsman Office will continue to monitor the issues surrounding the development and use of child protection teams. Further, the Ombudsman Office is willing to continue serving on the ad hoc work group to help improve child protection teams statewide.

Conclusion: The Ombudsman Office has continued to monitor the need for increased utilization and consistency across county departments. The Ombudsman Office will continue working with stakeholders around these issues and will bring any necessary concerns to the attention of CDHS.

Grievance Processes:

Year 3 Action Step: The Ombudsman Office will continue to explore ways to improve and streamline grievance processes across child welfare systems.

Conclusion: Over the past three years, the Ombudsman Office has remained Colorado's only independent entity to review such complaints. Therefore, the Ombudsman Office finds, through the Year 3 review and from work completed in Years 1 and 2 of this

program, that the grievance processes presently in place, along with the Ombudsman Office process, are sufficient and meeting the needs of the citizens of Colorado. The Ombudsman Office further finds that the creation of the Ombudsman Office provides a statewide grievance process that is transparent, accountable and accessible by children and families within the child protection system, as charged by the child welfare action committee.

Issues Identified in FY 2012-13:

- Lack of After-Hours Response to Law Enforcement
- Ombudsman Oversight

Summary of FY 2012-2013 Concerns and Status at End of FY 2013-2014:

Lack of After-Hours Response to Law Enforcement: In Year 2, the Ombudsman Office received complaints from three separate law enforcement jurisdictions regarding lack of, or inadequate responses from county human services departments after-hours and/or during weekends. Specifically, law enforcement officials complained that county human services workers either failed to respond, or responded inappropriately to requests for response to an arrest scene with children present. During conversations and training sessions with local law enforcement during Year 2, law enforcement personnel stated that on numerous occasions, county human services workers claimed they were understaffed and unable to respond directly to the scene, leaving law enforcement to find care for the child or children involved until the human services workers were able to respond. Out of these conversations, four formal complaints were filed and reviewed by the Ombudsman Office.

Outcome: The Ombudsman Office brought case specific information to the attention of CDHS with regards to this issue. CDHS conducted an internal review into the concerns brought forth by the Ombudsman Office and found that policy was followed in the specific instances under review. During the discussions with CDHS, it became apparent that many county departments either did not have current memoranda of understanding (MOU) with their local law enforcement agencies, or they simply were unaware of what the policy was. CDHS worked with county departments to update all memoranda of understanding between county departments and local law enforcement, and has provided access to this information to the Ombudsman Office. These updated MOUs will result in more appropriate and consistent response by all parties in instances of shared responses and/or investigations of child abuse and/or neglect.

Ombudsman Oversight: The Ombudsman Office has served via contract at the pleasure of CDHS since it opened in 2011. During this time, the Ombudsman Office has maintained compliance with the law and the contract with CDHS, including monthly reporting and meeting with CDHS leadership. While the Ombudsman Office understands and appreciates the value of collaboration and partnership with CDHS, the Ombudsman Office asserts that it is unable to

function truly independently while being managed by the entity it was intended to monitor and investigate.

Outcome: During FY 2013-2014, the Ombudsman Office, together with members of the legislature, CDHS and other community stakeholders, began to explore avenues through which to function independently of CDHS. The Ombudsman Office staff supported the introduction of Senate Bill 14-201. The program has grown and evolved since its inception in 2011. The Ombudsman Office has established itself as a viable, sustainable voice for the citizens of Colorado and a collaborator for better child protection practice. Senate Bill 14-201 will look at the Ombudsman Office and determine how and where it can be most effective in improving the outcomes for children and families.

This bill reestablishes an advisory work group to assist the general assembly and the governor in reviewing the current structure of the ombudsman program, and developing a plan for the program's autonomy and accountability. The advisory group will meet no later than August 1, 2014, and will include up to fifteen members appointed by the general assembly, the chief justice of the Colorado Supreme Court, and the governor. The current acting ombudsman will be included in the work group as a non-voting member. The work group's duties are as follows:

- Reconcile the recommendations made in the detailed plan by the original ombudsman program work group in 2010 with the way the ombudsman program is currently structured and functions, and make appropriate recommendations concerning the program's autonomy and accountability.
- Identify concrete steps for establishing autonomy and accountability of the ombudsman program.
- Make recommendations concerning the most effective utilization of the ombudsman program to further child protection efforts in Colorado.

The bill requires the advisory group to present its recommendations by December 1, 2014. The expectation is that any statutory changes recommended by the advisory work group would be considered during the 2015 legislative session.

Special Projects Pursued by the Ombudsman Office in Year 3

The Ombudsman Office pursued two special projects during Year 3.

- **Special Project I: Facilitation of Adoption Stakeholder and CDHS Meetings**
- **Special Project II: Facilitation of Grievance Process Roundtable**

Summary and Conclusion of Special Project I: Facilitation of Adoption Stakeholder and CDHS Meetings

During Year 1 of the ombudsman program, the Ombudsman Office identified adoption subsidies and related topics surrounding adoptions from the child protection system as an area that was to be monitored by the Ombudsman Office based on multiple contacts to the Ombudsman Office. The Ombudsman Office received concerns from Colorado Coalition of Adoptive Families (COCAF) regarding adoption subsidies and post-adoption services statewide. Among the concerns was an interest in exploring the differences in adoption subsidies from county to county. In addition, adoptive parents had varying levels of understanding about adoption subsidies and their ability to negotiate, and expressed interest in gaining more information about navigating the adoption process in the best interest of the children and their specific needs and challenges. Beginning in Year 1, the Ombudsman Office conducted research concerning the adoption subsidy process in Colorado and found that Colorado counties have the ability to negotiate adoption subsidy rates based on several variables.

Beginning at the conclusion of Year 1 and reaching into Year 2, the Ombudsman Office reached out to COCAF and the Division of Children, Youth and Families to begin a dialogue concerning the issues raised to the Ombudsman Office. The Ombudsman Office facilitated an initial meeting between adoption stakeholders and CDHS staff in November 2012 and facilitated a follow up meeting between these parties in April 2013. (Documents from these meetings can be found in the Appendix of the Year 2 Annual Report). Throughout Year 3, the Ombudsman Office has continued attempts to facilitate future meetings between the parties to continue the dialogue on the issues that were raised in Year 1. Both parties are in full agreement with the continuation of dialogue related to all topics around adoption and are committed to ensuring that families adopting from the child protection system and children being adopted are getting their needs met in the best possible way, in accordance with state and federal law.

Although the Ombudsman Office continues to receive adoptive-related complaints, the initial issues instigating this special project in Year 1, and the Ombudsman Office's commitment to facilitate meetings between parties, have been mediated and resolved. The Ombudsman Office understands that the need for dialogue between the stakeholders and CDHS will need to continue in an effort to educate current and potential adoptive families on the laws and guidelines surrounding adoption subsidies. However, the Ombudsman Office believes the relationship between the parties is strong enough that there is no need for future facilitation by the Ombudsman Office. Therefore, the Ombudsman Office will be closing out this special

project, successfully meeting the specified goals. The Ombudsman Office will continue to offer support, guidance and suggestions in adoption arena when necessary.

Summary and Conclusion of Special Project II: Facilitation of Grievance Process Roundtable

In 2010, Senate Bill 10-171 established the Ombudsman Office. Through the creation of the Ombudsman Office, specific special projects were assigned to it. One of those special projects required the Ombudsman Office to review existing child welfare complaint mechanisms used across Colorado and provide improvement recommendations for streamlining the grievance process. The Child Welfare Action Committee further charged the Ombudsman Office with examining the “creation of a statewide grievance policy that is transparent, accountable, and accessible by children and families within the child protection system.”

During Year 1, the Ombudsman Office began examining statewide grievance processes across Colorado. Research included a literature review regarding best practice measures and guidelines concerning complaint resolution processes nationally. Further, the Ombudsman Office conducted a survey of Colorado county human services directors regarding methods, policies and procedures by which their departments handle incoming child welfare complaints. (Results of this survey can be found in the Year 1 Annual Report.) The Ombudsman Office contracted with the Center for Policy Research to conduct interviews with various county representatives about the following: the county’s formal complaint process; reactions to the CDHS complaint process; duplication of complaint efforts; time frames the counties attempt to follow in resolving complaints; case volume; outcomes; and any best practices within the agency. (Further details of these interviews, including best practices can be found in Year 1 Annual Report.)

During Year 2 of the program, the Ombudsman Office facilitated a grievance roundtable discussion inviting Colorado counties, CDHS, and other stakeholders to share individual grievance processes and explore ways to streamline processes and decrease duplication. During this time, the participating agencies offered presentations regarding their complaint/grievance processes, as well as materials used to gather and report on grievance procedures. These materials were made available to all child welfare stakeholders for use as a reference or template when reviewing and structuring their county’s grievance process. (A complete report on this roundtable, as well as copies of materials presented can be found in the Year 2 Annual Report.)

Year 3 began with a change of leadership within the Ombudsman Office. During this year, the new ombudsman reviewed the prior years’ work on the charge originating out of the Child Welfare Action Committee. This review examined county director survey results from Year 1, as well as the interview summaries with county department staff, and the minutes and documents from the grievance round table in Year 2. The ombudsman also reviewed literature and available research on the topic of grievance and/or complaint resolution processes to

determine any recommendations for streamlining the process for Colorado children and families. At the conclusion of this review, the ombudsman found that Colorado citizens have access to the following methods for filing a grievance regarding their interactions with a local and/or state child protection entity:

- The CDHS Division of Child Welfare has an internal process for handling complaints that is easily accessible on the public-facing CDHS web page;
- The CDHS Division of Youth Corrections has an internal process for handling complaints;
- Colorado counties have internal processes by which concerned individuals may file complaints, including requesting meetings with the caseworker's direct supervisor, manager and county director;
- Citizen review panels (CRPs) review grievances concerning the conduct of county human services department personnel.

Citizens of Colorado also have access to other various professional entities to file grievances if the party is not an employee of a county or state human services department. These include:

- The Office of Child Representative (OCR) charged with overseeing complaints regarding state-paid guardians ad litem, child and family investigators who are attorneys, or child welfare attorneys under contract with the OCR;
- Court Appointed Special Advocates (CASA) volunteers appointed by the court to serve as independent advocates for families and children's best interests;
- Colorado Department of Regulatory Agencies and Board of Psychologist Examiners investigating complaints about mental health professionals;
- The Colorado Commission on Judicial Discipline that monitors the judiciary conduct in the state;
- The Colorado Commission on Judicial Performance that evaluates judges and their ability to perform their duties; and
- The Supreme Court Office of Attorney Regulation Counsel that investigates allegations against attorneys, magistrates, and municipal court judges.

The creation and charge of the Ombudsman Office is to "provide families, mandatory reporters, state and county employees, other employees who work with children and families, and concerned citizens an alternative place to voice their concerns about the response to children in the child welfare system without fear of reprisals." Over the past three years, the Ombudsman Office has remained Colorado's independent entity to review such complaints. Therefore, the Ombudsman Office finds, through the Year 3 review and work completed in Years 1 and 2 of this program, that the grievance processes listed above, along with the ombudsman process, are sufficient and meeting the needs of the citizens of Colorado. The Ombudsman Office further finds that the creation of the Ombudsman Office provides a

statewide grievance process that is transparent, accountable and accessible by children and families within the child protection system, as charged by the Child Welfare Action Committee.

The Ombudsman Office has concluded the work on this charge outlined in Senate Bill 10-171 and respectfully requests that this charge be viewed as complete. The Ombudsman Office will continue to monitor the need for further work or research to be done on the grievance processes in Colorado should the need become apparent through the day-to-day work and outreach of the Ombudsman Office.

References

Colorado Child Protection Ombudsman Program Work Group. (2010). *Detailed Plan for the Establishment and Operation of the Child Protection Ombudsman Program*. Denver, CO

Colorado Department of Human Services. (2009). *Second Interim Report of the Governor's Child Welfare Action Committee*. Denver, CO

Colorado Revised Statutes, Sections 19-3.3-101 to 109. (2010). Retrieved July 24, 2013 from:
http://www.state.co.us/gov_dir/leg_dir/olls/sl2010a/sl_225.pdf.

Office of Colorado's Child Protection Ombudsman. (2012). *2011-2012 Annual Report*. Aurora, CO

Office of Colorado's Child Protection Ombudsman. (2013). *2012-2013 Annual Report*.
Aurora, CO

Colorado Office of the State Auditor. (2014). *Department of Human Services Child Protection Ombudsman Program Performance Audit*.
Denver, CO

Colorado General Assembly. (2014). *Senate Bill 14-201*
Denver, CO

Appendix A:
Colorado Senate Bill 14-201



NOTE: This bill has been prepared for the signatures of the appropriate legislative officers and the Governor. To determine whether the Governor has signed the bill or taken other action on it, please consult the legislative status sheet, the legislative history, or the Session Laws.



SENATE BILL 14-201

BY SENATOR(S) Newell, Aguilar, Carroll, Guzman, Kefalas, Lambert, Lundberg, Nicholson, Steadman, Todd, Crowder, Heath, Herpin, Hill, Jones, Kerr, Rivera, Schwartz, Tochtrop, Zenzinger;
also REPRESENTATIVE(S) Singer, May, Melton, Becker, Exum, Fields, Ginal, Kraft-Tharp, Labuda, Lee, McCann, Rosenthal, Ryden, Schafer, Tyler, Williams, Young.

CONCERNING REESTABLISHING A CHILD PROTECTION OMBUDSMAN
ADVISORY WORK GROUP TO DEVELOP A PLAN FOR ACCOUNTABLE
AUTONOMY FOR THE CHILD PROTECTION OMBUDSMAN PROGRAM.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **repeal and reenact, with amendments**, 19-3.3-105 as follows:

19-3.3-105. Advisory work group - development of plan for autonomy and accountability - repeal. (1) WITHIN SIXTY DAYS AFTER MAY 14, 2014, THE GOVERNOR, PRESIDENT OF THE SENATE, AND SPEAKER OF THE HOUSE OF REPRESENTATIVES SHALL APPOINT MEMBERS TO A VOLUNTARY ADVISORY WORK GROUP, REFERRED TO IN THIS ARTICLE AS THE "WORK GROUP". THE GOVERNOR, PRESIDENT OF THE SENATE, SPEAKER OF THE HOUSE OF REPRESENTATIVES, AND CHIEF JUSTICE SHALL SELECT

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

MEMBERS TO THE WORK GROUP PURSUANT TO SUBSECTION (2) OF THIS SECTION. MEMBERSHIP MUST CONSIST OF PERSONS WITH EXPERTISE IN ISSUES RELATING TO THE PUBLICLY FUNDED CHILD PROTECTION SYSTEM AND AN INTEREST IN ASSISTING AND ADVISING THE GENERAL ASSEMBLY AND GOVERNOR WITH RESPECT TO THE DEVELOPMENT OF A PLAN FOR AUTONOMY AND ACCOUNTABILITY OF THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN, REFERRED TO IN THIS ARTICLE AS THE "PLAN".

(2) (a) (I) THE PRESIDENT OF THE SENATE, IN CONSULTATION WITH THE SENATE MINORITY LEADER, SHALL SELECT TWO MEMBERS OF THE PUBLIC TO SERVE ON THE WORK GROUP.

(II) THE SPEAKER OF THE HOUSE OF REPRESENTATIVES, IN CONSULTATION WITH THE HOUSE MINORITY LEADER, SHALL SELECT TWO MEMBERS OF THE PUBLIC TO SERVE ON THE WORK GROUP.

(b) THE CHIEF JUSTICE SHALL SELECT ONE MEMBER FROM THE JUDICIAL DEPARTMENT TO SERVE ON THE WORK GROUP.

(c) THE GOVERNOR SHALL SELECT THE REMAINING MEMBERS. THE WORK GROUP MUST INCLUDE REPRESENTATIVES FROM COUNTY DEPARTMENTS, COUNTY ATTORNEYS, COUNTY COMMISSIONERS, MANDATORY REPORTERS, PRIVATE SERVICE PROVIDERS, PERSONS OR FAMILY MEMBERS OF PERSONS WHO HAVE HAD PRIOR INVOLVEMENT AS CHILDREN WITH THE CHILD WELFARE SYSTEM, CHILD PROTECTION ADVOCATES, THE OFFICE OF THE CHILD'S REPRESENTATIVE, FOSTER PARENTS, AND LAW ENFORCEMENT AGENCIES. THE GOVERNOR SHALL APPOINT THE ACTING CHILD PROTECTION OMBUDSMAN TO THE WORK GROUP AS A NONVOTING MEMBER.

(d) THE TOTAL MEMBERSHIP OF THE WORK GROUP MUST NOT EXCEED FIFTEEN MEMBERS, NOT INCLUDING THE CHILD PROTECTION OMBUDSMAN.

(e) THE GOVERNOR SHALL ESTABLISH A PROCESS BY WHICH PERSONS INTERESTED IN PARTICIPATING IN THE WORK GROUP MAY SUBMIT LETTERS OF INTEREST TO THE GOVERNOR. POTENTIAL MEMBERS OF THE WORK GROUP SHALL ADVISE THE GOVERNOR OF ANY CONFLICTS OF INTEREST THAT THEY MAY HAVE WITH RESPECT TO PARTICIPATING IN THE WORK GROUP.

(f) THE MEMBERSHIP OF THE WORK GROUP MUST, TO THE EXTENT PRACTICABLE, INCLUDE PERSONS FROM THROUGHOUT THE STATE AND REFLECT THE ETHNIC DIVERSITY OF THE STATE.

(g) MEMBERS OF THE WORK GROUP, INCLUDING LEGISLATIVE MEMBERS, SHALL PARTICIPATE IN THE WORK GROUP WITHOUT COMPENSATION OR REIMBURSEMENT OF EXPENSES.

(3) THE WORK GROUP MUST CONVENE ON OR BEFORE AUGUST 1, 2014, AND MAY CONVENE WITHOUT ALL MEMBERS PRESENT AND MAY ORGANIZE SUBCOMMITTEES CONSISTING OF WORK GROUP MEMBERS AND ANY OTHER PERSONS INVITED TO PARTICIPATE BY THE WORK GROUP. THE WORK GROUP MAY CONSULT WITH THE STATE AUDITOR OR HIS OR HER DESIGNEE, THE OFFICE OF LEGISLATIVE LEGAL SERVICES, THE OFFICE OF LEGISLATIVE COUNCIL, OR OTHER NONPROFIT ORGANIZATIONS AS IS PERTINENT TO THE DUTIES OF THE WORK GROUP.

(4) THE DUTIES OF THE WORK GROUP INCLUDE:

(a) TO RECONCILE THE RECOMMENDATIONS IN THE DETAILED PLAN PREPARED BY THE ADVISORY WORK GROUP CREATED IN 2010 AND THE MANNER IN WHICH THE CHILD PROTECTION OMBUDSMAN PROGRAM WAS SUBSEQUENTLY STRUCTURED AND FUNCTIONED BASED ON THOSE RECOMMENDATIONS AND TO MAKE NEW RECOMMENDATIONS AS APPROPRIATE CONCERNING THE AUTONOMY AND ACCOUNTABILITY OF THE PROGRAM;

(b) TO IDENTIFY CONCRETE STEPS FOR AUTONOMY AND ACCOUNTABILITY OF THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN; AND

(c) TO MAKE RECOMMENDATIONS CONCERNING THE MOST EFFECTIVE UTILIZATION OF THE OFFICE OF THE CHILD PROTECTION OMBUDSMAN TO FURTHER CHILD PROTECTION EFFORTS IN COLORADO.

(5) ON OR BEFORE DECEMBER 1, 2014, THE WORK GROUP SHALL COMPLETE A WRITTEN PLAN FOR AN AUTONOMOUS AND ACCOUNTABLE OFFICE OF THE CHILD PROTECTION OMBUDSMAN. UPON COMPLETION OF THE PLAN, THE WORK GROUP SHALL PROVIDE A COPY OF THE PLAN TO THE HEALTH AND HUMAN SERVICES COMMITTEE OF THE SENATE AND THE PUBLIC

HEALTH CARE AND HUMAN SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES, OR ANY SUCCESSOR COMMITTEES, THE GOVERNOR, AND THE EXECUTIVE DIRECTOR, WHO SHALL POST THE PLAN ON THE STATE DEPARTMENT'S WEB SITE.

(6) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2016.

SECTION 2. In Colorado Revised Statutes, 19-3.3-102, **amend** (2) (a) as follows:

19-3.3-102. Child protection ombudsman program - independence of office - administrative rules. (2) (a) The head of the child protection ombudsman program shall be known as the child protection ombudsman, referred to in this article as the "ombudsman". The program shall be operated by a full-time, qualified ombudsman with the professional designations and qualifications determined appropriate by the executive director. ~~after consultation with the work group created pursuant to section 19-3.3-105.~~

SECTION 3. In Colorado Revised Statutes, 19-3.3-103, **amend** (1) introductory portion and (2) introductory portion as follows:

19-3.3-103. Child protection ombudsman program - powers and duties - access to information - confidentiality - testimony. (1) ~~In addition to any other duties specified in the detailed plan for the program developed pursuant to section 19-3.3-105,~~ The ombudsman ~~shall have~~ HAS the following duties, AT A MINIMUM:

(2) ~~In addition to any other duties specified in the detailed plan for the program developed pursuant to section 19-3.3-105,~~ The ombudsman ~~shall have~~ HAS the following powers, AT A MINIMUM:

SECTION 4. In Colorado Revised Statutes, 19-3.3-106, **amend** (1) (a) as follows:

19-3.3-106. Award of contract. (1) (a) Subject to the provisions of subsection (2) of this section, ~~within thirty days after completion of the detailed plan pursuant to section 19-3.3-105,~~ the executive director, in accordance with the "Procurement Code", articles 101 to 112 of title 24, C.R.S., shall issue the request for proposals for the administration of the

program. The proposal submission period, the review of submissions, and the award of the contract shall be completed within sixty days after the issuance of the request for proposals.

SECTION 5. In Colorado Revised Statutes, **amend** 19-3.3-109 as follows:

19-3.3-109. Review by the state auditor's office. The state auditor shall conduct or cause to be conducted a performance and fiscal audit of the program at the beginning of the third year of operation of the program. ~~or pursuant to the time frame recommended in the detailed plan developed pursuant to section 19-3.3-105, whichever date is sooner.~~ Thereafter, at the discretion of the legislative audit committee, the state auditor shall conduct or cause to be conducted a performance and fiscal audit of the program.

SECTION 6. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Morgan Carroll
PRESIDENT OF
THE SENATE

Mark Ferrandino
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Cindi L. Markwell
SECRETARY OF
THE SENATE

Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED _____

John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

Appendix B: Detailed Data Runs



Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2013-2014*							
County	Number of Contacts	Nature of Contacts (n=401)		Ombudsman Response to Contacts (n=401)		Disposition of Resolved Contacts (n=397)	
		Nature	Number	Response	Number	Result	Number
Adams	26	Case/Ongoing	7	Inquiry Review	9 17	Affirmed Agency/Caseworker Actions Closed Lack of Information Duplicate Referral Resource Referral	15 1 2 8
		Contact/Visitation	1				
		Intake/Assessment	6				
		Lack of Response	1				
		Non-Complaint	9				
		Placement	1				
		Services	1				
Alamosa	4	Intake/Assessment	1	Inquiry Review	3 1	Affirmed Agency/Caseworker Actions Resource Referral	1 3
		Non-Complaint	3				
Arapahoe	49	Case Ongoing	9	Inquiry Review	18 31	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions, with Recommendations Closed, per Complainant Closed Lack of Information Declined to Investigate Duplicate Referral Resource Referral	28 1 1 1 1 1 5 12
		Contact/Visitation	1				
		Intake/Assessment	8				
		Lack of Response	5				
		Non-Complaint	14				
		Permanency	2				
		Placement	8				
		Removal of Children	1				
Services	1						
Archuleta	0						
Baca	0						
Bent	0						
Boulder	10	Case Ongoing	2	Inquiry Review	6 4	Affirmed Agency/Caseworker Actions Closed, per Complainant Closed, Lack of Information Resource Referral	4 1 1 4
		Child Safety, Health, and Well Being	1				
		Intake/Assessment	1				
		Non-Complaint	6				

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2013-2014*							
County	Number of Contacts	Nature of Contacts (n=401)		Ombudsman Response to Contacts (n=401)		Disposition of Resolved Contacts (n=397)	
		Nature	Number	Response	Number	Result	Number
Broomfield	8	Case/Ongoing Intake/Assessment Non-Complaint	1 3 4	Inquiry Review	4 4	Affirmed Agency/Caseworker Actions Closed, Lack of Information Resource Referral	4 2 2
Chaffee	0						
Cheyenne	0						
Clear Creek	0						
Conejos	1	Contact/Visitation	1	Review	1	Affirmed Agency/Caseworker Actions	1
Costilla	3	Case/Ongoing Intake/Assessment Lack of Response	1 1 1	Inquiry Review	1 2	Agency/Caseworker Non- Compliance with Policy or Law Duplicate Referral	2 1
Crowley	1	Non-Complaint	1	Inquiry	1	Resource Referral	1
Custer	0						
Delta	2	Case/Ongoing Non-Complaint	1 1	Inquiry Review	1 1	Affirmed Agency or Caseworker Actions, with Recommendations Resource Referral	1 1
Denver	19	Case/Ongoing Contact/Visitation Intake/Assessment Lack of Response Non-Complaint Placement	3 2 2 2 9 1	Inquiry Review	10 9	Affirmed Agency/Caseworker Actions Agency/Caseworker Non- Compliance with Policy or Law Duplicate Referral Resource Referral	8 1 1 9
Dolores	2	Case Ongoing Placement	1 1	Review	2	Affirmed Agency/Caseworker Actions Agency/Caseworker Non- Compliance with Policy or Law	1 1

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2013-2014*							
County	Number of Contacts	Nature of Contacts (n=401)		Ombudsman Response to Contacts (n=401)		Disposition of Resolved Contacts (n=397)	
		Nature	Number	Response	Number	Result	Number
Douglas	10	Intake/Assessment Lack of Response Non-Complaint Placement	6 1 2 1	Inquiry Review	3 7	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions, with Recommendations Agency/Caseworker Non- Compliance with Policy or Law Duplicate Referral Resource Referral	4 1 2 1 2
Eagle	3	Case/Ongoing Non-Complaint Placement	1 1 1	Inquiry Review	1 2	Affirmed Agency/Caseworker Actions Resource Referral	1 1 1
Elbert	1	Non-Complaint	1	Inquiry	1	Resource Referral	1
El Paso	43	Case/Ongoing Child Safety, Health, and Well Being Intake/Assessment Lack of Response Non-Complaint Placement	7 1 10 5 15 5	Inquiry Review	18 25	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions, with Recommendations Closed, per Complainant Closed, Lack of Information Resource Referral	21 1 1 2 7 11
Fremont	5	Case/Ongoing Contact/Visitation Intake/Assessment Placement	2 1 1 1	Review	5	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions, with Recommendations	4 1 1
Garfield	1	Case/Ongoing	1	Review	1	Affirmed Agency/Caseworker Actions	1
Gilpin	0						
Grand	0						

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2013-2014*							
County	Number of Contacts	Nature of Contacts (n=401)		Ombudsman Response to Contacts (n=401)		Disposition of Resolved Contacts (n=397)	
		Nature	Number	Response	Number	Result	Number
Gunnison	1	Intake/Assessment	1	Review	1	Affirmed Agency/Caseworker Actions	1
Hinsdale	0						
Huerfano	6	Case/Ongoing Non-Complaint	1 5	Inquiry Review	5 1	Affirmed Agency/Caseworker Actions Closed, Lack of Information Resource Referral	1 2 3
Jackson	4	Case/Ongoing Non-Complaint	1 3	Inquiry Review	3 1	Agency/Caseworker Non-Compliance with Policy or Law Closed per Complainant Closed, Lack of Information Resource Referral	1 1 1 1
Jefferson	26	Case/Ongoing Child Safety, Health, and Well-Being Intake/Assessment Lack of Response Non-Complaint Placement	6 1 5 3 9 2	Inquiry Review	10 16	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions, with Recommendations Agency/Caseworker Non-Compliance with Policy or Law Closed per Complainant Declined to Investigate Deviation from Best Practice Standards Resource Referral	9 4 1 1 1 1 9
Kiowa	0						
Kit Carson	2	Intake/Assessment Non-Complaint	1 1	Inquiry Review	1 1	Affirmed Agency/Caseworker Actions Closed, Lack of Information	1 1
Lake	0						

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2013-2014*							
County	Number of Contacts	Nature of Contacts (n=401)		Ombudsman Response to Contacts (n=401)		Disposition of Resolved Contacts (n=397)	
		Nature	Number	Response	Number	Result	Number
La Plata	3	Intake/Assessment Non-Complaint	2 1	Inquiry Review	1 2	Affirmed Agency/Caseworker Actions Resource Referral	2 1
Larimer	17	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint Placement	2 6 3 4 2	Inquiry Review	8 9	Affirmed Agency/Caseworker Actions Duplicate Referral Resource Referral	9 4 4
Las Animas	1	Placement	1	Review	1		
Lincoln	0						
Logan	9	Case/Ongoing Intake/Assessment Placement	4 1 4	Inquiry Review	1 8	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions, with Recommendations Duplicate Referral	7 1 1
Mesa	9	Case/Ongoing Intake/Assessment Non-Complaint Placement	3 2 1 3	Inquiry Review	1 8	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions, with Recommendations Agency/Caseworker Non- Compliance with Policy or Law Resource Referral	6 1 1 1
Mineral	0						
Moffat	3	Contact/Visitation Non-Complaint	1 2	Inquiry Review	2 1	Closed per Complainant Resource Referral	1 2
Montezuma	1	Intake/Assessment	1	Review	1	Affirmed Agency/Caseworker Actions	1

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2013-2014*							
County	Number of Contacts	Nature of Contacts (n=401)		Ombudsman Response to Contacts (n=401)		Disposition of Resolved Contacts (n=397)	
		Nature	Number	Response	Number	Result	Number
Montrose	3	Intake/Assessment Lack of Response Non-Complaint	1 1 1	Inquiry Review	1 2	Affirmed Agency/Caseworker Actions Affirmed Agency or Caseworker Actions, with Recommendations Closed, Lack of Information	1 1 1
Morgan	2	Lack of Response Non-Complaint	1 1	Inquiry Review	1 1	Affirmed Agency/Caseworker Actions Closed, Lack of Information	1 1
Otero	0						
Ouray	0						
Park	1	Permanency	1	Inquiry	1	Closed per Complainant	1
Phillips	0						
Pitkin	0						
Prowers	1	Case/Ongoing	1	Review	1	Affirmed Agency/Caseworker Actions	1
Pueblo	14	Case/Ongoing Intake/Assessment Lack of Response Non-Complaint Placement	1 7 1 3 2	Inquiry Investigation Review	4 1 9	Affirmed Agency/Caseworker Actions Agency/Caseworker Non- Compliance with Policy or Law Closed per Complainant Closed, Lack of Information Resource Referral	8 1 1 1 2
Rio Blanco	3	Case/Ongoing Placement	1 2	Inquiry Review	1 2	Affirmed Agency/Caseworker Actions Duplicate Referral	2 1
Rio Grande	1	Lack of Response	1	Review	1	Affirmed Agency/Caseworker Actions	1
Routt	0						
Saguache	0						
San Juan	0						

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2013-2014*							
County	Number of Contacts	Nature of Contacts (n=401)		Ombudsman Response to Contacts (n=401)		Disposition of Resolved Contacts (n=397)	
		Nature	Number	Response	Number	Result	Number
San Miguel	0						
Sedgwick	0						
Southern Ute	1	Intake Assessment	1	Inquiry	1	Resource Referral	1
Statewide	1	Non-Complaint	1	Inquiry	1	Resource Referral	1
Summit	1	Non-Complaint	1	Inquiry	1	Resource Referral	1
Teller	0						
Washington	0						
Weld	13	Case/Ongoing	3	Inquiry	5	Affirmed	6
		Intake Assessment	2	Review	8	Agency/Caseworker Actions	1
		Lack of Response	2			Agency/Caseworker Non-Compliance with Policy or Law	2
		Non-Complaint	5			Closed, Lack of Information	1
		Placement	1			Duplicate Referral	3
Yuma	1	Non-Complaint	1	Inquiry	1	Resource Referral	1
Colorado Department of Human Services	0						
Department of Youth Corrections	0						
Unknown**	89	Child, Safety, Health, and Well-Being	1	Inquiry	89	Closed, Lack of Information	23
		Non-Complaint	87			Declined to Investigate	5
		Resource/Information	1			Resource Referral	61

Number and Nature of Contacts, Ombudsman Responses, and Results of Inquiries, Reviews, and Investigations, by County for Fiscal Year 2013-2014*							
County	Number of Contacts	Nature of Contacts (n=401)		Ombudsman Response to Contacts (n=401)		Disposition of Resolved Contacts (n=397)	
		Nature	Number	Response	Number	Result	Number
Total	401	Case/Ongoing	59	Inquiry	214	Affirmed	150
		Child Safety, Health, & Well-Being	4	Investigation	1	Agency/Caseworker Actions	12
		Contact/Visitation	7	Review	186	Affirmed Agency or Caseworker Actions, with Recommendations	11
		Intake/Assessment	69			Agency/Caseworker Non-Compliance with Policy or Law	9
		Lack of Response	27			Closed, per Complainant	44
		Non-Complaint	192			Closed, Lack of Information	7
		Permanency	3			Declined to Investigate	1
		Placement	36			Deviation from Best Practice Standards	17
		Removal of Children	1			Duplicate Referral	146
		Resource/Information	1			Resource Referral	
		Services	2				
* OCCPO recognizes that the number of calls per county may or may not be indicative of systemic issues within that county, and may be attributable to awareness of OCCPO in that particular location or some other variables yet to be identified. As OCCPO continues to collect data in the next year or two, the trends should become clearer as to frequency of calls per county.							
** Callers with an unknown county include those needing help with systems navigation or looking for other, general information.							

Appendix C:
Ombudsman Investigative Reports
Executive Summaries



June 2, 2014

Investigative Report

Senate Bill 10-171

The Office of the Colorado Child Protection Ombudsman was established through Senate Bill 10-171 to “improve accountability and transparency in the child protection system and to promote better outcomes for children and families involved in the child protection system.”

Case # 10157 Adams County

(303) 864-5111

www.protectcoloradochildren.org

Executive Summary

The child was placed with a relative and her roommate in July 2010. Adams County Human Services had protective supervision of the child and his siblings for approximately ten months before Allocation of Parental Rights was granted to his caregiver and the Dependency and Neglect case was closed. During those ten months, things appeared to be going well at the caregiver's home and no safety concerns were identified.

In September 2011, a report was received by Adams County Human Services regarding physical abuse. All three children were interviewed and reported the caregiver used physical discipline. The children reported they did not fear their caregivers and appeared happy and settled. No disclosures were made regarding abuse or neglect by the children. Any policy issues identified by the Office of the Colorado Child Protection Ombudsman did not impact the children's well-being and safety.

A report was received in January 2012 by Adams County Human Services regarding the child having a broken arm and numerous bruises. The worker interviewed all three children and the children did not report any abuse or neglect. The caseworker required the caretakers to have the child seen by medical professionals to rule out abuse concerns. The first doctor did not feel comfortable making a determination whether the injuries were concerning for abuse. The family was referred to Children's Hospital where the child was seen by four different doctors and questioned about concerns of abuse. The child did not make an outcry and doctors believed the explanation of injuries were plausible. The investigation was closed with no further action.

Commerce City Police Department was contacted to complete a welfare check on February 7, 2012. Two officers responded to the address but no one was home. One of the officers contacted Adams County Human Services. The officer reported the caseworker indicated the child had been seen the day before at Children's Hospital and had been cleared of possible child abuse. It appears this may have been a miscommunication as the child had been seen a month before in the Children's Hospital Emergency Room.

The child was seen at the Community Reach Center for alleged behavioral issues at the request of the caregiver on February 6 and 10, 2012. The therapist reported not having any concerns about the child's safety in his caregiver's custody. On February 13, 2012, the day before the child was found unconscious at his home, he had a cast removed from his arm. The medical staff at the orthopedic clinic reported no indication of abuse at the time of the appointment and did not notice any concerning bruises or marks that made them question the child's safety.

Our investigation into the death of the child revealed that the actions or inactions of the Adams County Human Services Department and the Commerce City Police Department did not appear to contribute to the death of the child. The overall casework and services provided to the family were sufficient to ensure the safety of the children. However, we did find that improvements can be made to practice, response, communication and collaboration in future child protection investigations. We have also learned that these agencies are actively taking steps to improve their communication, response and practice.

ALLEGATIONS

The Office of the Colorado Child Protection Ombudsman (OCCPO) initiated an investigation on May 7, 2012 into the response of Adams County Human Services in the weeks and months prior to the death of the child. The inquiry into the child's death was based on the media coverage of allegations by the extended family that Adams County Human Services and Commerce City Police Department did not respond timely or adequately to the family's concerns the child was being abused and/or neglected.

INVESTIGATIVE OVERVIEW

OCCPO reviewed Colorado Department of Human Services' documentation to determine if Adams County Human Services complied with policy and procedures outlined in the Colorado Children's Code and Volume Seven of the Colorado Department of Human Services' Rules and Regulations upon receiving any reports of concern regarding the family or involvement with the family during the course of an investigation or open child welfare case. The OCCPO conducted reviews of collateral contacts with medical professionals and law enforcement to determine if the actions of the professionals in anyway contributed the fatality of the child. The OCCPO's investigation in to these allegations could not be concluded until the completion of all associated criminal proceeding. The caregiver was found Guilty at trial by a jury of Criminally Negligent Child Abuse Resulting in Serious Bodily Injury on May 28, 2013. On August 2, 2013, she was sentenced to eight years in the Department of Corrections and three years parole.

During the course of the investigation OCCPO reviewed the following information:

- Colorado Trails, the database utilized by all Colorado county social service offices
- Colorado Courts Database
- Adam's County District Attorney's Office case files. The review of these records included medical records, police reports and contacts, review of evidence, and Colorado Department of Human Services documentation.
- Adams County Human Services case files
- Commerce City Police Department reports and 911 call logs for the child's residence
- Adams County Internal review report
- Colorado Department of Human Services Child Fatality Non-Confidential Case-Specific Executive Review Report
- OCCPO meeting with Adams County Human Services Administrator on January 27, 2014.

Prior involvement with Human Services

In June 2010, Adams County Human Services received a report regarding the children. A Dependency and Neglect case was initiated with this family after an investigation discovered child protection concerns. The children were removed from their mother's custody and temporary legal custody of the child was granted to his caregiver. Adam County Human Services maintained protective supervision of the child for approximately ten months. No child protection concerns were documented during the time Adams County Human Services was monitoring the child and his caregiver. The Courts granted an Allocation of Parental Rights of the child to the caregiver on May 18, 2011.

A report was received by Adams County Human Services on September 23, 2011. The report regarded an older sibling reporting her caregiver hit the child causing him to hit his head. The reporting party also expressed concern for the older sibling as she was having an extreme reaction of fear when she would receive consequences at school. The reporting party had witnessed interactions between the older sibling and caregiver and caregiver's roommate that were disproportionate to the offense. Adams County Human Services assigned the referral as a three day response but the intake worker responded the same day. Based on no disclosures of abuse by the children, no additional services were provided.

A report was received by Adams County Human Services on January 5, 2012. The report was regarding the child having a broken arm and numerous bruises in various places and stages of healing. The intake worker responded and spoke immediately to the child outside the presence of the alleged perpetrators before speaking with anyone else. The worker took photographs of the child's injuries. The caseworker checked out by medical professionals. The 2012 and the doctor did not feel comfortable caseworker required the caretakers to have Room at Children's Hospital. The caseworker of concerns of child abuse. The child was seen perps and questioned about abuse outside the child did not make an outcry and the doctors

The worker took photo-directed the caretakers to have the child child was seen by a doctor on January 6, making a determination of abuse. The the child checked out in the Emergency informed the Emergency Room Physician by four doctors who are child abuse ex-presence of the alleged perpetrators. The concluded the explanations of injuries were plausible. The investigation was concluded and no additional services were provided due to lack of disclosure by the children or concern of abuse by medical professionals.



A report was received by Adams County Human Services on February 14, 2012. The reporting party indicated that the child was taken to Children's Hospital after allegedly falling off a chair in the home. The child had noticeable injuries that were not consistent with the caregiver's account of events. A child abuse investigation was initiated and conducted as well as a criminal investigation by the Commerce City Police Department. The siblings were taken into protective custody and placed in foster care on February 14, 2012. Adams County Human Services' caseworkers were thorough in their documentation of this investigation.

Recommendations

Based upon the findings during the investigation, the Office of the Colorado Child Protection suggests the following recommendations to improve practice among child protection agencies...

1. Increase training for child protection caseworkers, medical professionals, and law enforcement to better understand and recognize Posttraumatic Stress Disorder in abused children and Battered Children's Syndrome.
2. Improve the relationship between law enforcement and child protection agencies to effectively work together to ensure safety of children in the community.
3. Increase agency standards for documentation to include every contact with family members and collaterals to include names, agencies, and contact information.

Agency Response

We acknowledge receipt of your report and will consider the recommendations.

July 21, 2014

Investigative Report

Senate Bill 10-171

The Office of the Colorado Child Protection Ombudsman was established through Senate Bill 10-171 to “improve accountability and transparency in the child protection system and to promote better outcomes for children and families involved in the child protection system.”

Case # 10133 Montezuma County

(303) 864-5111

www.protectcoloradochildren.org

Executive Summary

Child came to the attention of the Department on November 1, 2011 after a report was filed that she had been taken to the emergency room via ambulance after what was initially reported as a strangulation at home. The report indicated that Child had a heartbeat when the ambulance left the family residence and that the child was being treated at the hospital. Although the child's family was known to the Montezuma County Department of Human Services, and Caregiver had an open child welfare case with the MCDHS, Child was not involved in the open case and no referrals of abuse and/or neglect had been made to the Department concerning her safety and well-being prior to November 1, 2011.

At the time of Child's death, Caregiver was working on an open child welfare case with Montezuma County Department of Human Services. During the pendency of the open case, the caregiver's gave birth to Child. In the open case on Caregiver's oldest child, caseworkers documented that they had voluntarily met with the caregivers and had offered them referrals to parenting classes after Child was born. Caseworkers also noted that Child was seen often by Department staff and appeared to be doing well in her parent's care. There was no indication that can be found in case documentation that would have warranted Montezuma County Department of Human Services to open a child welfare investigation or case on Child.

Our investigation revealed that the actions or inactions of Montezuma County Department of Human Services did not appear to contribute to the death of Child. The OCCPO found it to be a strength of MCDHS to provide voluntary support and services to this young mother and her infant without the presence of any safety concerns. The investigation did find that improvements can be made to practice and that Montezuma County Department of Human Services would benefit from technical assistance and/or training for their staff. Our office recommends that this training be focused on Volume VII rules surrounding when a referral should be opened as an assessment for investigation, with particular training surrounding the investigation of child fatalities.

The Complaint:

On April 30, 2012, the OCCPO received a complaint concerning the death of Child. Specifically, the complaint questioned whether the Montezuma County Department of Human Services (“the County”) responded appropriately to her family prior to her death. The complaint alleged that Caregiver previously had a child (Sibling) removed from her, after the child sustained significant physical injuries while in her care and the care of the child’s father. Further, the complainant was concerned that the County had not adequately assessed the death of Child, or Caregiver’s responsibility concerning the death, yet was recommending return of Caregiver’s older (previously removed) child to her care.

Decision to Investigate:

The OCCPO opened a review into the complaint on April 30, 2012. According to the TRAILS database, the County did not assign the referral concerning Child’s death for investigation when they received the report (approval date 11/4/11); therefore, there was no documentation in the TRAILS database concerning Child’s fatality. On May 7, 2012 the OCCPO notified Dennis Story, Director of Montezuma County Department of Human Services and Executive Director Reggie Bicha of the Colorado Department of Human Services that an investigation had been opened concerning Sibling and Child. Sibling and Child’s investigations were blended as the historical information regarding the family would aid in the OCCPO’s review of the complaint concerning the County’s lack of involvement with Child prior to her death. Further, Child’s death and the subsequent information that could have been gathered through a thorough investigation by MCDHS may have provided valuable insight into the position Montezuma County Department of Human Services had regarding their desire to return Sibling to his mother’s care.

After further review of the case and complaint concerning Sibling, the OCCPO made the determination that the Montezuma County Department of Human Services did not violate rule or law as it related to the handling of Sibling’s case. There was a significant delay in Sibling’s permanency due to multiple appeals filed by many parties in this case; however, Sibling remained in his placement and was ultimately adopted by the providers that had been caring for him since September 2008. On May 1, 2014, after extensive review of all records available to the OCCPO, the Ombudsman reversed the 2012 decision to proceed with an investigation into the portion of the complaint related to Sibling. During this review of documentation, the OCCPO found that the facts and actions of MCDHS in this case were in line with Volume VII and the Colorado Children’s Code and that recommendations for practice improvements would best be handled through a Review of County Practice with Recommendations which includes a written summation to the Montezuma County Department of Human Services Director, Dennis Story.

INVESTIGATIVE OVERVIEW:

OCCPO reviewed Colorado Department of Human Services' documentation to determine if Montezuma County Department of Human Services complied with policy and procedures outlined in the Colorado Children's Code and Volume VII of the Colorado Department of Human Services' Rules and Regulations upon receiving any reports of concern regarding the welfare of Child or involvement with the family during the course of an investigation or open child welfare case. The OCCPO's investigation into the allegations outlined above could not be concluded until all criminal and other court proceedings involving Child and Sibling were completed. The criminal proceedings concerning Child's death were concluded on September 25, 2012. The Child's caregiver plead guilty to manslaughter and received a 90 day jail sentence and four years probation. The appellate process and subsequent adoption proceedings of Sibling were concluded in February 2014.

During the course of the investigation, OCCOP reviewed the following information:

- Colorado TRAILS, the database utilized by all Colorado county social services agencies
- Colorado Courts Database
- Records obtained from the District Attorney's Office of the Twenty-Second Judicial District, including court filings and documentation, as well as the investigative reports completed by local law enforcement.
- Montezuma County Department of Human Services case files
- Medical records and law enforcement reports from the Serious Bodily Injury case involving Sibling .
- Montezuma County Department of Human Services Internal Fatality Review Report
- OCCPO meeting with Montezuma County Department of Human Services staff and Director.

Volume VII outlines the rules for investigations of allegations of abuse and/or neglect. Volume VII clearly states that all reports of physical injury consistent with child abuse and/or neglect should be thoroughly assessed by the appropriate county department. Specifically, 12 C.C.R. 2509-3 § 7.202.4(G)(1) states:

"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."

Further, all child abuse and neglect fatalities should be assessed in accordance with Volume VII § 7.202.75 when the following requirements are met:

“The county department shall investigate child fatalities in intrafamilial and institutional settings in those cases in which:

- A. There is reason to know or suspect that abuse/or neglect caused or contributed to the child’s death.
- B. The death is not explained or cause of death is unknown at the time of the child’s death.
- C. The history given about the child’s death is at variance with the degree or type of injury and subsequent death.”

Based on these responsibilities, the County should have opened an assessment into the physical abuse and subsequent death of Child, concerning her caregivers. In doing so, the County would have been able to make an independent assessment into all parties involvement into the abuse and/or neglect, as well as the fatality of Child.

By failing to investigate the report of abuse and/or neglect received on November 1, 2011, and the subsequent death of Child resulting from abuse and/or neglect, the County violated rules set forth in Volume VII.

Prior involvement with Human Services:

Child had no prior involvement with the Department of Human Services. Caregiver’s caseworker was aware of her birth and offered recommendations for community resources to the family; however, there was no prior open assessments or cases involving Child.

Recommendations:

1. Montezuma County Department of Human Services should receive training and/or technical assistance concerning the investigations of child fatalities. All child fatalities, as they relate to abuse and/or neglect, should be thoroughly investigated by the appropriate county departments because the information gathered during fatality investigations may provide important information, which may be utilized in the future if the family becomes involved with the child protection system again.
2. Montezuma County Department of Human Services should also receive additional training and support around Volume VII rule concerning the investigation of all reports of abuse and neglect and subsequent documentation of these assessments in the TRAILS database. This support and training should include rule surrounding the investigation of fatal incidents of child abuse and neglect.
3. When completing an internal review, the County Department should ensure that all information contained in the review is complete and accurate. During the review of Montezuma County's Internal Review document, information was found to be incomplete and in some instances inaccurate. For example, the Internal Review states that OCCPO staff participated in the internal review process which is inaccurate. OCCPO staff visited the Montezuma County Office and reviewed the file privately within the County building and in May 2012, had a telephone conference with the County Director and the Caseworker to ask clarifying questions regarding documentation gathered. This was not identified as an internal review of the fatality with the OCCPO and fell far outside the Volume VII guidelines of 60 days post fatality for an internal review. (7.202.77) Further, the OCCPO found that pertinent information in the historical summarizations was missing and would have been pertinent to the Child Fatality Review Process, that may help inform and improve future practice.

July 21, 2014

County Response

Senate Bill 10-171

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Case # 10133

Montezuma County

(303) 864-5111

www.protectcoloradochildren.org

MONTEZUMA COUNTY DEPARTMENT OF SOCIAL SERVICES
RESPONSE TO OMBUDSMAN INVESTIGATIVE REPORT CASE #

CASE # 10133

June 30, 2014

The Executive Summary in this matter is to the point and recommendations are appropriate. We appreciate that the investigation confirmed that neither the department's actions nor inactions contributed to the death of Child. The department appreciates the recommendations for ongoing technical assistance and training for staff.

After a complaint on about April 30, 2012; The Office of Colorado's Child Protection Ombudsman (OCCPO) began an investigation concerning this department's response to the November 1, 2011 death of Child. In part, but specifically; "the complainant was concerned that the County had not adequately assessed the death of Child, or Caregiver's responsibility concerning the death, yet was recommending the return of Caregiver's older (previously removed) child to her care". The connection of the fatal abuse of Child and the department's recommendation that Caregiver's previously removed child be returned to her care lingered in the OCCPO investigation. This was despite the fact that OCCPO determined that the Montezuma County Department of Social Services "did not violate rule or law as it related to handling of case." Certain conclusions were then made.

To establish some historical context, OCCPO opened in May 2011. This child suffered fatal child abuse November 1, 2011 which was then investigated by OCCPO within its first year of existence.

OCCPO then examines the county department's response per VOL VII regulations and initially cites the county being non-compliant with 7.202.4(G)(1) as it failed to assign the fatal abuse of Child for an investigation. That particular regulation was revised 7-1-12. The department is not able to determine what the regulation stated at the time of the 11-1-11 child abuse fatality. In spite of the regulation stating at 7.702.4(G)(1) "The county department shall assign a referral for assessment and investigation if it: (1) Contains specific allegations ..." The State Department of Human Services has launched within the past year an "Enhanced Screening" tool which better determines how referrals are screened for an investigation and assessment. Clearly all referrals are not and have not been assigned for assessment and investigation. As an aside, the department welcomes this practice, has been trained for using the tool and adopted the application of Enhanced Screening and RED Team.

Regardless, the 11-1-11 child abuse fatality would have been assigned for an investigation had there been a surviving sibling in the household. It was not assigned because there was not a surviving sibling in the home. The parental rights of Caregiver to that surviving half-sibling had been terminated. Although that termination of parental rights was on appeal, Caregiver had absolutely no access to that child per court order.

OCCPO cites the department as being non-compliant with 7.202.75 as the county “should have opened an assessment into the physical abuse and subsequent death of Child, concerning her parents”. It is at this juncture when parsing words becomes relevant to the county’s response.

It is stated in the Policy and Practice Findings as part of the OCCPO investigation: “The Referral Reason is documented as ‘Fatality’ however, based on the above summary the child was not deceased. Based on the information provided by the reporting party, the referral reason should have been Physical Abuse (severe) and should have been assigned for investigation by Montezuma County”. In the above summary, the department arrives at the hospital emergency room on 11-1-11 at about 9 AM based upon concerns of a relative made to the department that the child was found strangled earlier in the morning. A brief period of time elapsed between the child suffering abuse just hours before, being taken to the ER by ambulance with an EMT reported heartbeat, and then pronounced dead at the ER. The county disagrees that based on this short period of time the referral should have been assigned as physical abuse. The allegation was strangulation neither identified as intentional or accidental. The final conclusion after the autopsy and law enforcement investigation was not strangulation but blunt force head injury.

At the time of this fatal child abuse, The Colorado Children’s Code states at 19-3-305 “**Required report of postmortem investigation.** (1) Any person who is required by section 19-3-304 to report known or suspected child abuse or neglect who has reasonable cause to suspect that a child died as a result of abuse or neglect shall report such fact immediately to a local law enforcement agency and to the appropriate medical examiner. The local law enforcement agency and the medical examiner shall accept such report for investigation and shall report their findings to the local enforcement agency, the district attorney, and the county department. (2) The county department shall forward a copy of such report to the state department of human services”.

The director for the department confirmed through 11-1-11 phone contact with the appropriate law enforcement agency that they were on scene investigating circumstances surrounding the death of this child. After confirming there were no surviving siblings in the home to assess their safety and need for protection, the department did not open the referral for an investigation. The referral was timely entered into the Trails system.

It should be noted that it is in the mutual culture of this department and law enforcement to jointly investigate allegations of child abuse and neglect. The culture has thrived over the preceding 25 years. That culture necessarily meant that joint law enforcement and social services investigations occurred regarding previous allegations of child abuse to the above mentioned surviving sibling while in the care of Child’s mother. If law enforcement needed our assistance, they would have requested such. If the department had information relevant to the fatality investigation it would have been offered.

Also in the Policy and Practice Findings, OCCPO disagrees with the county not conducting an investigation because Child was deceased and there were no surviving siblings in the Caregiver’s home. And it is correctly noted that 7.202.75 does not exempt the county department from conducting a fatality investigation if there are no surviving siblings.

The report goes on to cite the county for being non-compliant with 7.202.76. That concern is amplified as being significant. The portion of 7.202.76 quoted in part appears to be taken from that regulation as revised 10-1-12. That appears to be the case since the part quoted begins “Assessment shall be coordinated with law enforcement”

The language in 7.202.76 which appears to have been in effect 11-1-11 had been last revised 11-1-98. Important to the department’s response, and admittedly a parsing of words, is the fact that the then regulation at 7.202.76 (B) begins “Investigations shall be coordinated with law enforcement”

At the risk of being redundant, there was no surviving sibling in the household to assess the safety of. The department deferred to law enforcement’s investigation. For reasons more apparent than not to those of us providing child welfare services in Colorado, the child welfare system came under criticism at about the time of this fatality or just before. Legislation was passed and regulations revised. That would include the nuance of a regulation noting investigation procedures in 11-1-98 referring to an investigation and later when revised 10-1-12 replacing “investigation” with “assessment”. That shift reflects practice in the field.

In terms of coordinating with law enforcement, the investigation was sealed and the department deferred to law enforcement’s lead in the criminal investigation. In the initial discussion with law enforcement confirming that an investigation was underway, part of that discussion would have been at least a mention that the county had prior involvement with the mother of the child. In a small jurisdiction such as ours, prior involvement of the family with law enforcement and/or child protective services would have been know across agency lines. However, the department concedes that such coordination and discussion was not documented in the Trails data base.

Continuing with coordinating with law enforcement, it would not have been prudent for the department to argue the investigation being sealed demand investigation information to confirm abuse/neglect in and enter such finding in an automated system (regardless of a time frame). Without that information, a preponderance of evidence was not available to confirm abuse/neglect. Sending such confirmation to the alleged perpetrators within the 60 day time period triggers due process and could deflect the conclusion of a criminal investigation and successful prosecution of the crime. Once an admission was made in court and announced to the public, the department confirmed fatal child abuse and notified the child’s father of that finding. The investigation material did not attribute any responsibility to the child’s mother.

And finally the lingering association of this fatal abuse and the separate case terminating Caregiver’s parental rights to a surviving sibling remain apparent in the Investigative Report to the very end. That termination of parental rights was on appeal filed by attorneys for both parents. The department joined the appeal regarding the mother. That appeal generally regarded procedural and constitutional arguments. Had the appeal overturned the termination of her parental rights, information contained in the independent criminal investigation would have contributed significant sway into whatever position the department would have taken.

Respectfully,

Dennis A. Story, Director

Appendix D:
CDHS Investigative Recommendations Charts



REPORT	RECOMMENDATION (S)	STATUS AS OF 8/2014	Due Date
2011-2012 (Year 1)	1. The Department of Human Services should provide training to workers involved in child protection to more accurately identify substance use:	1. The issue of substance abuse is already addressed in the New Worker Training Academy, and also in in-service training. Caseworkers are trained to assess substance use and the affects on a child. The in-service training focuses on how to see behaviors and effectively work with a family who is struggling with substance abuse issues.	COMPLETE
	A) The signs, indicators, and characteristics of substance use, the inherent risks of substance use to children, and how substance use impacts family dynamics and child safety.	A) This information is covered in the New Worker Training Academy and in in-service training. There are indicators that are taught, as well as effects on children and family dynamics. The entire curriculum is currently being reviewed and the reviewers will ensure that this pertinent information remains present in the training. **The curriculum which covers substance abuse is complete. CDHS will contact Mimi and provide OCCPO with a copy of the curriculum related to substance abuse issues	COMPLETE **Mimi to provide OCCPO with curriculum updates
	B) Drug testing, new drugs/substances being used and manufactured, and updates on the effects of substance use on the safety of children.	B) This will be addressed with the new curriculum and will continue to be offered in in-service trainings. **The curriculum which covers substance abuse issues is complete and CDHS will provide OCCPO with a copy.	COMPLETE ** Mimi to provide OCCPO with updates
2011-2012	2. The Department of Human Services should provide training to caseworkers, supervisors, and any other staff that may approve work or supervise staff around the use of the safety assessment tool, the utilization of safety plans, and the risk assessment tool, as specified in CDHS policy, Volume VII, 7.202.53 and 7.202.54.	2. Training is set to be completed regarding the new safety and risk assessment tools for late Fall 2014. The training through the Child Welfare Academy will address consistency and definitions. If through this process, individual county concerns are identified, CDW will complete county-specific coaching and technical assistance	Aug-14
	A) CDHS should provide an annual mandatory testing process for all staff that would utilize these tools or supervise workers utilizing the tools in order to make sure staff have a functional understanding of the tools and they are being used accurately and appropriately.	A) ARD provides a review of safety assessment accuracy of completion, CQI process and targeting training.	
2011-2012	3. The Department of Human Services should adopt policy that mandates the frequency and documentation of supervision of caseworkers and any staff responsible for intake/assessments by supervisors during assessments.	3. Training is set to be completed regarding the new safety and risk assessment tools for late Fall 2014. This training includes specific training for supervisors. The supervisor training academy also emphasizes the need to provide supervision. Although it does not mandate the frequency, it addresses the importance of documentation.	Oct-14
	A) This would require supervisors to review all relevant information in the assessment file prior to approving assessment closure.	A) This is being addressed in the front end Rule rewrite of child protection.	Oct-14
2011-2012	4. The Department of Human Services should have County DHS partner and collaborate with neighboring county DHS agencies when there are staffing issues or issues that arise with workers going on leave or having family emergencies.	4. CDHS has implemented a process by creating a list of county certified (retired) staff that are available when counties experience staffing shortage.	COMPLETE
2011-2012	5. The Department of Human Services will develop policy around case contacts documentation in TRAILS to include completion of Face to Face contacts with children and parents within 30 days of contact, and collateral contacts and other pertinent case contacts within 45 days of contact. The CDHS will provide training as needed to County child protection staff.	5. This is currently being addressed in the Rule rewrite and will be followed up with training.	Oct-14
	A) CDHS should tighten time frames (7.002.1) in an effort to eliminate gaps in pertinent information for CDHS and other county departments that may encounter families currently working within the system.	A) This is currently being addressed in the Rule rewrite and will be followed up with training.	Jan-14
2011-2012	6. The Department of Human Services should develop policy and provide training and direction to County Departments on how to proceed with assessments and cases when issues are present in multiple program areas (PA 4 and PA 5).	6. This was presented to the child protection task group and the group reported that any safety concern regardless of a child's age should be addressed as long as it meets the definition of safety concerns as outlined in the tool. CDHS, with the addition of the Pathways to Success grant, is working to create a youth assessment tool.	Oct-15

Color/Tab Legend
Agree
Partially Agree
Disagree

REPORT	RECOMMENDATION (S)	STATUS AS OF 8/2014	Due Date
2012-2013 (Year 2)	1. The Department of Human Services should implement additional trainings or safeguards of the current process until the new safety and risk tools become available.	1. Current practice is for ARD to review accuracy of completion of safety assessments, which is in turn reviewed at CSTAT. CDHS (county liaison) would follow up with counties in need of training or technical assistance.	COMPLETE*
2012-2013	2. The Department of Human Services should provide training regarding mandatory reporting of child abuse. Specifically an independent online discipline-specific mandatory reporter training for medical personnel, clergy, law enforcement, educators, and child care providers.	2. This web based training for mandatory reporters is being refined and made available online to participants through the public facing CDHS web page and will again be pushed in the public awareness campaign. Kempe Center has completed the training and the system has been developed to provide the participant with a certificate, as well as the database will track who is taking the training. OCCPO agrees to place this link on their website, publish it in the quarterly newsletter and market to stakeholders as able.	Apr-14
2012-2013	3. The Department of Human Services should provide information for child welfare professionals and other stakeholders around educating clients about system navigation, decision-making, and expectations.	3. Some counties currently use Parent Handbooks and some DR counties use FAR pamphlets for the families they are working with. This could potentially be addressed in public awareness campaign efforts (i.e. making statewide applicable Parent Handbook available on our website). Further exploration of what is currently on the web is needed. CDHS will also make this information available on their public facing webpage due to launch April 2014.	Apr-14
2012-2013	4. The Department of Human Services should establish a process to handle reports of threats of retribution, by county and by worker, to monitor for trends.	4. Complaint process (online instructions), Citizen Review Panels in each county, and monthly OCCPO meetings.	COMPLETE*
2012-2013	5. The Department of Human Services should provide a variety of trainings that are updated and accessible to all geographic regions of the state.	5. Four Regional training sites and Kempe as new contractor for Training Academy. Advanced in-service training is going to be made available within each region. CDHS is waiting for response from counties/regions of their specific training needs for advanced caseworkers.	COMPLETE
2012-2013	6. The Department of Human Services should review policy related to consistent adoption subsidy negotiations by county and provide consistent post-adoption services and supports for families.	6. Gretchen Russo and Connie Vigil met with Deborah Cave and Colleen Tarket from Colorado Coalition of Adoption on February 3, 2014 and are waiting for more material to be given back to them. CDHS is continuing to collect and review policies. OCCPO will be making outreach to Colorado Coalition of Adoption for futher follow up.	Sep-14
2012-2013	7. The Department of Human Services should assist counties in identifying effective practices of Child Protection Team (CPT), while also assisting counties in maximizing effectiveness of time and effort spent preparing for and participating in CPTs.	7. Blake Jones, a national expert, met with DCW for consultation on Child Protection Teams and the use of citizen review panels in Colorado. DCW Child Protection staff are developing a plan for Child Protection Teams and the use of citizen review panels in Colorado.	Sep-14
2012-2013	8. The Department of Human Services should develop a process and policy to monitor the issues of after hour response to Law Enforcement Agencies for county action, inaction, and compliance with law in situations involving arrests and decisions about child care and custody.	8. Each county is to have an agreement outlining the responsibility and working relationship between the county department and LEA. 8. A tracking sheet has been started by CDHS that includes information of county agreements with law enforcement. CDHS has completed a MOU with Colorado State Patrol. CDHS will develop policy around tracking current MOU's, as well as issues with MOU compliance and ensuring that MOU's are updated regularly. A copy of the Colorado State Patrol agreement was given to OCCPO at the April 22, 2014 meeting. CDHS is now utilizing a tracking form to monitor all MOU agreements between counties and law enforcement agencies. DCW is also mantaining a copy of these agreements.	Oct-14

Color/Tab Legend
Agree
Partially Agree
Disagree

* CURRENT PRACTICE

RECOMMENDATION (S)	STATUS AS OF 08/2014	Due Date
1. The Colorado Department of Human Services should review its policies and practices surrounding the writing of, review of, and supervision surrounding Child Fatality/Near Fatality/Egregious Incident Non-Confidential Case-Specific Executive Review Reports to ensure that documentation is accurate and all policy and/or law violations are identified and clearly documented.	As statute indicates the intent of the CFRT process is to identify systemic strengths and gaps, the CDHS agrees that policies laws relevant to the specific incident and prior history should be considered as part of the reviews. This includes identifying strengths as well as gaps. The ARD has initiated work with the CFRT to enhance these efforts.	Complete
2. When writing a Child Fatality/Near Fatality/Egregious Incident Non-Confidential Case-Specific Executive Review Report, the Colorado Department of Human Services should not summarize information located within county referrals and/or assessments, as well as other pertinent documents utilized in the review; rather, it should use the specific language that is written in those reports.	Due to the large amount of documentation reviewed, summarization must occur in the final report. The CDHS agrees that specific language should be included and quoted to the extent that it is necessary in supporting findings of strengths or gaps included in the reports. The ARD follows this practice currently in authoring the reports.	Agree and Complete
3. When writing a CDHS Child Fatality/Near Fatality/Egregious Incident Non-Confidential Case- Specific Executive Review Report, the Colorado Department of Human Services should indicate the date the report was released publicly on Page 1 of the report.	Current Practice	Complete
4. When documenting the County Internal Review information, the Colorado Department of Human Services should identify the specific name of the county completing the internal review, along with the date of the review, information discussed within the internal review, and recommendations and/or changes in county policy or practice the reviewing county identified.	The CDHS agrees that the County Internal Review report should be identified as part of the information reviewed by the CFRT. The CDHS also agrees that, as relevant to CFRT findings, information from the County Internal Review reports may be included in the final CFRT report.	Agree and Complete
5. The Colorado Department of Human Services should not bring a fatality review before the Child Fatality Review Team prior to obtaining all necessary reports related to the fatality.	Current Practice	Complete
6. The CFRT should thoroughly review cases in accordance with the Colorado Children's Code to identify any violations of law.	As statute indicates the intent of the CFRT process is to identify systemic strengths and gaps, the CDHS agrees that policies laws relevant to the specific incident and prior history should be considered as part of the reviews. This includes identifying strengths as well as gaps. The ARD has initiated work with the CFRT to enhance these efforts.	Complete
7. When writing a Child Fatality/Near Fatality/Egregious Incident Non-Confidential Case-Specific Executive Review Report, the Colorado Department of Human Services should review the assessment specific to the investigation of the fatality for policy and/or practice violations, as well as to identify gaps in services that may have assisted the family.	Current practice is to identify lessons learned	Complete
8. The Colorado Department of Human Services should develop a policy addressing actions that should be taken by a county department when assessments of a family indicate "High Risk," in an effort to intervene with the family prior to abuse and/or neglect occurring.	Marc Winokur is looking at this	
9. The Colorado Department of Human Services should review all child fatalities related to abuse and/or neglect, regardless of whether the family has prior history with child protective services. If the family had prior history with child protective services in any county department, CDHS should review all prior history as a part of the Child Fatality Review process. Review prior history of the immediate family and current caregivers involved with the child.	Current statute does not provide for the review of all child fatalities, regardless of whether the family had prior history. Statute specifically restricts reviews to egregious, near fatal, and fatal incidents of child maltreatment where families had prior involvement in the previous three years. For incidents meeting these criteria, the CDHS does have processes in place for consideration and review of prior history. The ARD has initiated efforts to collaborate with the CFRT members to determine the best approach for reviewing prior history in order to inform findings and recommendations.	Complete
10. The Colorado Department of Human Services should consult with an outside or independent entity to conduct a review of CDHS Child Fatality/Near Fatality/Egregious Incident non-Confidential Case-Specific Executive Review Reports over the past two years.	Statute guiding the contents of the final reports changed each year for the past three years. The CDHS has committed to maintaining ongoing efforts to enhancing the reviews and reports to best comply with and meet the legislative intent of the CFRT process.	
11. The Colorado Department of Human Services should devise a plan to address recommendations made by the Child Fatality Review Team (CFRT) within 30 days of CFRT making any recommendations.	Will develop a tracking mechanism. Systemic and programmatic changes go to DSW.	
12. Upon completion of the Colorado Department of Human Services' Plan (as identified in Section V(F) of the CDHS Report), CDHS should present that plan to the Child Fatality Review Team (CFRT) for approval, and then to the public by posting it on the CDHS webpage.	DSW and ARD have a tracking spreadsheet. Systemic and Programmatic recommendations are presented as a part of the CFRT report.	Agree and Complete

Color/Tab Legend
Agree
Partially Agree
Disagree