NAVIGATE INVESTIGATE ILLUMINATE REFORM

OFFICE OF COLORADO'S

CHILD PROTECTION OMBUDSMAN

ANNUAL REPORT FISCAL YEAR 2016-2017

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From the Ombudsman

September 1, 2017

The past year has been a busy one for the Office of Colorado's Child Protection Ombudsman (CPO). For the past 12 months, our office has engaged in a rigorous building process. As a new state agency, we embarked upon a long journey with our advisory board and stakeholders to develop operating systems that allow us to do the work that was envisioned by the Colorado State Legislature — namely, creating a safer, more effective child protection system for all Colorado children.

As such, we have spent substantial time developing a robust strategic plan and implementing it. Our statute requires us to make recommendations, including *systemic changes*, to improve the safety of and promote better outcomes for children and families receiving child protection services in Colorado. It also requires us to educate citizens and stakeholders concerning child maltreatment and the role of the community in strengthening families and keeping children safe.

To this end, we developed a number of new systems and resources that allow our agency to begin handling large systemic cases while maintaining a high level of service for citizens seeking one-on-one assistance. In Fiscal Year 2016-2017 we were able to hire an additional child protection systems analyst as well as secure assistance for ongoing research. These additional resources will allow the CPO to investigate more systemic issues affecting the child protection system.

In addition, we completed the CPO's new *Case Practices and Operating Procedures*, that outline how we handle a complaint from beginning to end. These policies describe our jurisdiction, the complaint process, the roles of parties during an investigation and under what circumstances final case recommendations are issued.

We also developed a clear public reporting process. Our new reporting policy describes, in exact detail, what information will be communicated to the public and when. The goal of these initiatives is to ensure that our agency is not only accountable to the public but also transparent. These initiatives will create consistent and clear communication about what we learn during the course of our work regarding the strengths and weaknesses of our child protection system.

Lastly, we created a robust communication process that begins with an enhanced website. In July of this year, we launched a new website that contains far greater information than ever before. On this new site, you will find a list of our pending investigations, a complete archive of our investigative reports, as well as a list of the CPO's recommendations. We have also added a new feature called CPO Impact. On this page you will be able to track all of our work on behalf of children, including what legislation we are following and audio recordings of our testimony in the Colorado Legislature.

In summary, the past year was full of hard work. We remain steadfast in our goal to expand the range of services that we offer to the public, children and families so that we can prevent child abuse and neglect, improve outcomes and create a safer, more transparent child protection system for all Colorado children.

Sincerely,

Stephanie Villafuerte

Child Protection Ombudsman

Introduction

The Office of Colorado's Child Protection Ombudsman (CPO) was designed to bring change through utility. During its six years in operation, the CPO has had to be agile.

The charge of studying and improving an ever-evolving system requires ingenuity and thoughtfulness. During its first five years, the CPO brought about change on an individual level. Primarily working with individual families and improving practices one agency, employee or rule at a time. This level of service is vital. It ensures that families and stakeholders have a confidential and effective outlet to air their grievances about the child protection system.

During the past year, however, we reexamined our practices and our statute. The result was two-fold. Through this analysis the CPO created a more efficient process for providing individual families services. For the first time in the CPO's history, citizens are now connected directly with investigators when they file their complaint. Streamlining this intake process has decreased the amount of time between when a complaint is filed and an investigation is completed. This improvement was crucial as the CPO also realized that more resources and time must be spent in fulfilling a second component of our statute – investigating systemic issues within the child protection system and issuing recommendations for change. This report will detail the CPO's efforts during Fiscal Year 2016-2017 to position itself in a place where more time and resources are dedicated to the study of systemic issues within the child protection system and issuing recommendations. Similar to its first five years, the CPO's sixth year was full of thoughtful discussions and innovative thinking. With a new, streamlined process and improved tools the CPO is ready to elevate its services to a new level, and as such deliver change to more citizens and stakeholders.

> ***"As a county practitioner, it can be frustrating to feel as if we are scrutinized from multiple sources, but the reality is that the Child Protection Ombudsman's office is one of the few outside entities that has an understanding about what we are trying to accomplish and shares the same overall child protection philosophy. It is, at times, actually reassuring to know that families or other professionals may call and have a different, impartial voice be able to explain that our actions were in accordance with rule or statute. Despite our best efforts, we may be seen as explaining away poor performance when things do not go as some of those we serve would want things to go.***
>
> ***Being able to let people we work with know that there is an entity that they can access completely unaffiliated with us that will either support what we have done or provide us with documentation that shows where we may have done something incorrectly actually can help us to provide better service. The Child Protection Ombudsman can provide an essential function to us in ensuring that we, as counties, deliver quality services."***
>
> **County Human Service Partner**

CPO Vision

Ensuring safety for Colorado's children today and envisioning a stronger child protection system for the future.

Agency Overview

Background

The CPO was born out of tragedy. In 2007, the deaths of 12 children known to Colorado child protection services sparked an outcry by the public. Citizens demanded greater oversight, accountability and transparency of the child protection system in Colorado. The public demanded to know more about how the systems charged with protecting Colorado's children were keeping them safe and working to prevent such tragedies in the future.

Senate Bill 10-171 established the office in 2010 and five years later the legislature determined the CPO needed independence from the entities it was designed to review. So, on June 2, 2015, Senate Bill 15-204, *Concerning the Independent Functioning of the Office of the Child Protection Ombudsman*, was signed into law. This legislation positioned the CPO as an independent state agency. As an independent agency, the CPO is charged with studying and investigating Colorado's child protection system, which is comprised of "any public agency or any provider that receives public moneys that may adversely affect the safety, permanency, or well-being of the child." See C.R.S. 19-3.3-103(1)(a)(I)(A).

The concept of an ombudsman dates back hundreds of years and is designed to provide citizens with an independent, unbiased and trusted intermediary between the public and an organization. In a similar fashion, the CPO works to provide a clear channel between the citizens of Colorado and the agencies and providers tasked with protecting children. Using those standards, the CPO serves the public by independently gathering information, investigating complaints and providing recommendations to child protection agencies and providers.

To ensure the accountability and transparency of the CPO and the Ombudsman, the legislature also created the Child Protection Ombudsman Board (CPO Board) in 2015. The CPO Board was the first of its kind in the nation. By law, the CPO Board is required to oversee the Ombudsman's performance and act as an advisory body on strategic direction and financial oversight of the CPO.

The CPO is now housed within the Colorado State Judicial Branch and is located at the Ralph L. Carr Judicial Center in Denver. Colorado's current Child Protection Ombudsman, Stephanie Villafuerte, was appointed in December 2015 by the CPO Board. Ombudsman Villafuerte took office in January 2016.

Mission

The Office of Colorado's Child Protection Ombudsman works to improve the safety, permanency and well-being of Colorado's children by investigating complaints, delivering recommendations and driving systemic reform in the child protection system.

Role of the CPO

By design, the CPO serves as an independent, neutral problem solver that helps citizens navigate a complex child protection system in an expert and timely manner. The CPO has independent access to child protection records that are not otherwise available to the public. This allows the CPO to objectively review and investigate complaints, deliver recommendations and drive systemic reform through research and education. Through objective study the CPO works to improve the delivery of services to children and families within the child protection system.

Responsibilities of the CPO

The CPO was established pursuant to C.R.S. 19-3.3-101. In addition to providing all citizens free and confidential services, the CPO provides citizens and stakeholders four primary services.

NAVIGATE – The CPO helps citizens navigate the child protection system and directs them towards needed services and resources. Citizens often contact the CPO with questions about how a child protection agency/provider functions or which system provides a certain service. If the CPO determines that a citizen's inquiry does not contain a complaint alleging violations by an agency/provider, the CPO will help resolve their question by providing either systems navigation or a resource referral.

INVESTIGATE – The CPO objectively researches and investigates concerns about the delivery of services to children and families within the child protection system. If the CPO determines that a complaint about an agency/provider within the child protection system includes allegations that rules or laws were violated in the delivery of services to children, the CPO will open an investigation. During an investigation CPO staff will conduct a comprehensive, independent study of relevant facts, records and witness statements. The CPO's investigations may include a single agency/provider or multiple systems impacting multiple families in Colorado.

ILLUMINATE – The CPO's work illuminates the strengths and weaknesses within the child protection system that are directly impacting the safety, permanency and well-being of children and families. By publicly releasing investigation reports, violations and data, the CPO provides citizens and stakeholders with the information necessary to maintain a transparent and accountable child protection system.

REFORM – The CPO will make recommendations to the public, child protection agencies/providers, the General Assembly and the Governor that help reform and improve outcomes for children and families.

CPO Staff

Currently, the CPO is comprised of five full-time employees and two part-time employees. The CPO also launched its internship program during Fiscal Year 2016-2017. A graduate student from the University of Colorado Denver joined the CPO staff for 11 months while she completed her capstone project.

The skills, passions and experiences of each CPO employee creates one of the most unique perspectives and approaches for studying the child protection system.

- **Stephanie Villafuerte, Child Protection Ombudsman**
  Ms. Villafuerte has over 26 years of experience dedicated to the legal and public policy fields in the area of child maltreatment. She has worked extensively in state and federal court, the legislature and as the executive director of a statewide, nonprofit agency dedicated to serving children. In a variety of roles, Ms. Villafuerte has worked to solve the myriad of needs of Colorado's abused and neglected children. Ms. Villafuerte took office in January 2016.

- **Sabrina Burbidge, Deputy Ombudsman**
  Ms. Burbidge has been working in the areas of public and private child welfare for 23 years. Ms. Burbidge has worked within Colorado's child protection system as a caseworker, supervisor and trainer for caseworkers and foster parents. She has served as a subject matter expert at the state legislature and has offered training on child welfare specific issues both nationally and internationally. Ms. Burbidge joined the CPO in January 2012.

- **Jordan Steffen, Communications and Policy Director**
  Ms. Steffen worked in the field of journalism, researching and analyzing public policy, law and rule as it related to child welfare for six years. Ms. Steffen has spent extensive time researching long-standing state policies and practices for preventing child abuse and neglect, and has reported extensively on the child protection system. Ms. Steffen joined the CPO in July 2016.

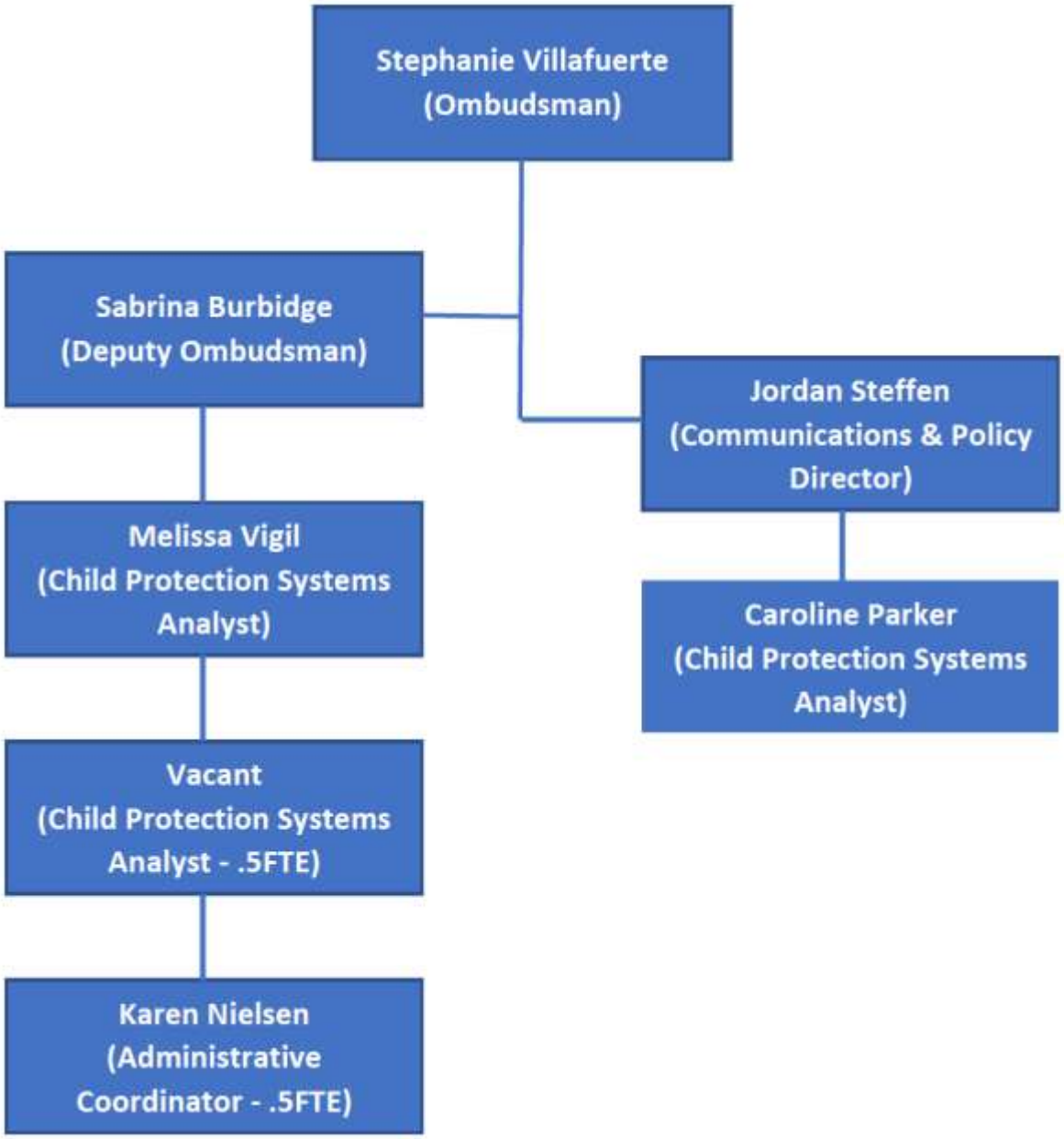
- **Melissa Vigil, Child Protection Systems Analyst**
  Ms. Vigil has served as a caseworker and lead child protection intake worker within Colorado's public child welfare system for eight years. She has extensive experience providing crisis intervention services, as well as investigating allegations of abuse and neglect, with a specialty in sexual abuse investigations. Ms. Vigil also has her Master's Degree in criminology, as well as experience within the criminal justice system and local police departments. Ms. Vigil joined the CPO in May 2016.

- **Caroline Parker, Child Protection Systems Analyst**
  Ms. Parker has worked with legislatures across the country to advance policies that protect children and families at the state level. Her expertise also extends into areas including family economic policy and Title IX compliance on university campuses. Most recently, Ms. Parker worked in South Africa developing extra-curricular programs for at-risk high school students. Ms. Parker joined the CPO in August 2017.

- **Karen Nielsen, Administrative Coordinator**
  Ms. Nielsen worked with families within the child welfare system, assisting them with their substance abuse treatment needs for 24 years. She has been a member of various committees within the child protection system addressing needs for treatment services, as well as offering strategies to build a more collaborative system. Ms. Nielsen joined the CPO in March 2013.

Staff Flow Chart

The CPO is comprised of five full-time employees; Ombudsman, Deputy Ombudsman, Communications and Policy Director and two and a half Child Protection Systems Analyst. The position of Administrative Coordinator is a part-time position. The CPO will fill the second part-time position of Child Protection Systems Analyst during the fall of 2017.



CPO Jurisdiction

The CPO receives "complaints concerning child protection services made by, or on behalf of, a child relating to any action, inaction, or decision of any public agency or any provider that receives public moneys that may adversely affect the safety, permanency, or well-being of a child. The Ombudsman may, independently and impartially, investigate and seek resolution of such complaints, which resolution may include but need not be limited to, referring a complaint to the state department or appropriate agency or entity and making a recommendation for action relating to a complaint." See C.R.S. 19-3.3-103(1)(a)(I)(A).

Some examples of agencies/providers the CPO has jurisdiction to review include: human service agencies, youth corrections, law enforcement, educators, medical professionals and treatment providers.

Pursuant to C.R.S. 19-3.3-101 to 110, the CPO does not have the authority to:

- Investigate allegations of abuse and/or neglect.
- Interfere or intervene in any criminal or civil court proceeding.
- Review or investigate complaints related to judges, magistrates, attorneys or guardians ad litem.
- Overturn any court order.
- Mandate the reversal of an agency/provider decision.
- Offer legal advice.

CPO Board

To ensure the accountability and transparency of the CPO and the Ombudsman, the legislature also created the CPO Board in 2015. The CPO Board was the first of its kind in the nation. By law, the CPO Board is required to oversee the Ombudsman's performance and act as an advisory body on strategic direction and financial oversight of the CPO.

CPO Board Members	
Chief Justice Appointments • Hon. Kenneth Plotz, Board Chair • Simone Jones, Board Vice Chair • Hon. Charles Greenacre • Pax Moultrie **Governor Appointments** • Dee Martinez • Karen Beye • Constance Lee Linn • Vacant	**Senate President Appointment** • Victoria Shuler **Senate Minority Leader Appointment** • Peg Rudden **Speaker of the House Appointments** • Vacant **House Minority Leader Appointment** • Kyle Forti

Our Work

Ombudsmen operate throughout the world, specializing in everything from health care to labor relations. In addition to responding to citizens' concerns, the ombudsman's role has historically been designed to drive systemic change through impartial collaboration, data driven analysis and education. They research and investigate problems and provide education to the public and stakeholders on ways to solve them. The ombudsman's effectiveness does not reside in an ability to mandate compliance. Instead, it drives reform by illuminating problems within an agency and creates detailed recommendations for reform.

As a specialty, child protection ombudsman offices have evolved over the past three decades. There are approximately 33 child protection ombudsman offices in the United States – Colorado being one of the newest. All of these agencies vary in structure, scope and responsibility.

In Colorado, the CPO serves citizens by helping them navigate the child protection system, investigating their complaints, illuminating issues within the child protection system and providing recommendations to reform systems. To maintain its impartiality – and in keeping with statute – the CPO will independently collect information, records and/or documents from an agency/provider when investigating a complaint. If applicable, the CPO will publicly release a report detailing its findings and recommendations.

CPO Case Practices

The CPO previously employed a three-phase system with two different tracks involving varying degrees of inquiry. During the past fiscal year, the CPO dedicated a substantial amount of time to improving and creating more efficient procedures for handling complaints and completing investigations. Those efforts resulted in a streamlined process. Now, all cases move through the same track, resulting in the CPO being able to efficiently handle less complicated cases and devote more time to complex issues.

The CPO's revised *Case Practices and Operating Procedures* were fully implemented on July 1, 2017. Several of the new policies were put into practice prior to that date. The CPO's procedure for handling a case is detailed below. (A complete copy of the CPO's *Case Practices and Operating Procedures* is located in **Appendix A**.)

INTAKE
All inquiries the CPO receives from contacts are subject to the same intake process. During that process, the CPO will gather information from the contact and determine which CPO service is most appropriate. If the CPO determines that a resource referral/systems navigation is the appropriate service, the CPO will provide the contact with information to help resolve their question. The CPO will open an investigation if it determines that the inquiry is within the jurisdiction of the CPO and alleges an action or inaction by an agency/provider that may have resulted in violation of policy and/or law during the delivery of services to children within the child protection system.

INVESTIGATION

The CPO will launch an investigation if a complaint alleges that:

- An agency/provider violated policy and/or law in the delivery of services to children and families or;
- The complaint indicates an absences of policy and/or law within the child protection system.

During an investigation, the CPO staff will complete a comprehensive, independent study of relevant facts, records and witnesses' statements. The CPO staff will study all records collected and may contact the agency/provider involved in the investigation and/or schedule a site visit to analyze any on-site records as well as conduct interviews of agency/provider staff.

FINDINGS AND RECOMMENDATIONS

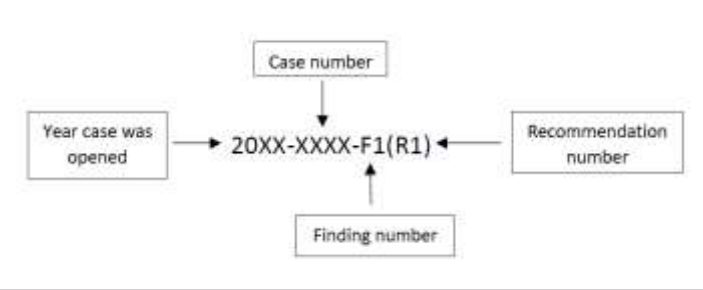
At the conclusion of an investigation, the CPO staff will reach one or more of the following findings:

- Affirmed Agency/Provider Actions
- Affirmed Agency/Provider Actions with Recommendations
- Identification of Practice Concerns
- Absence of Policy
- Absence of Law
- Agency/Provider Non-Compliance with Policy
- Agency/Provider Non-Compliance with Law

*Definitions for each of these findings may be found in the CPO's *Case Practices and Operating Procedures*, located in **Appendix A**.

The CPO will issue recommendations pursuant to C.R.S. §19-3.3-103(2)(e), which mandates the CPO to, "recommend to the general assembly, the executive director, and any appropriate agency or entity statutory, budgetary, regulatory and administrative changes, including systemic changes, to improve the safety of and promote better outcomes for children and families receiving child protection services in Colorado."

Each recommendation – a suggestion or proposal to improve the child protection system – will be a result of a specific finding. Multiple recommendations can be associated with the same finding. Each recommendation will be assigned a unique identification number to help stakeholders and citizens track the recommendation throughout the report and on the CPO's website.

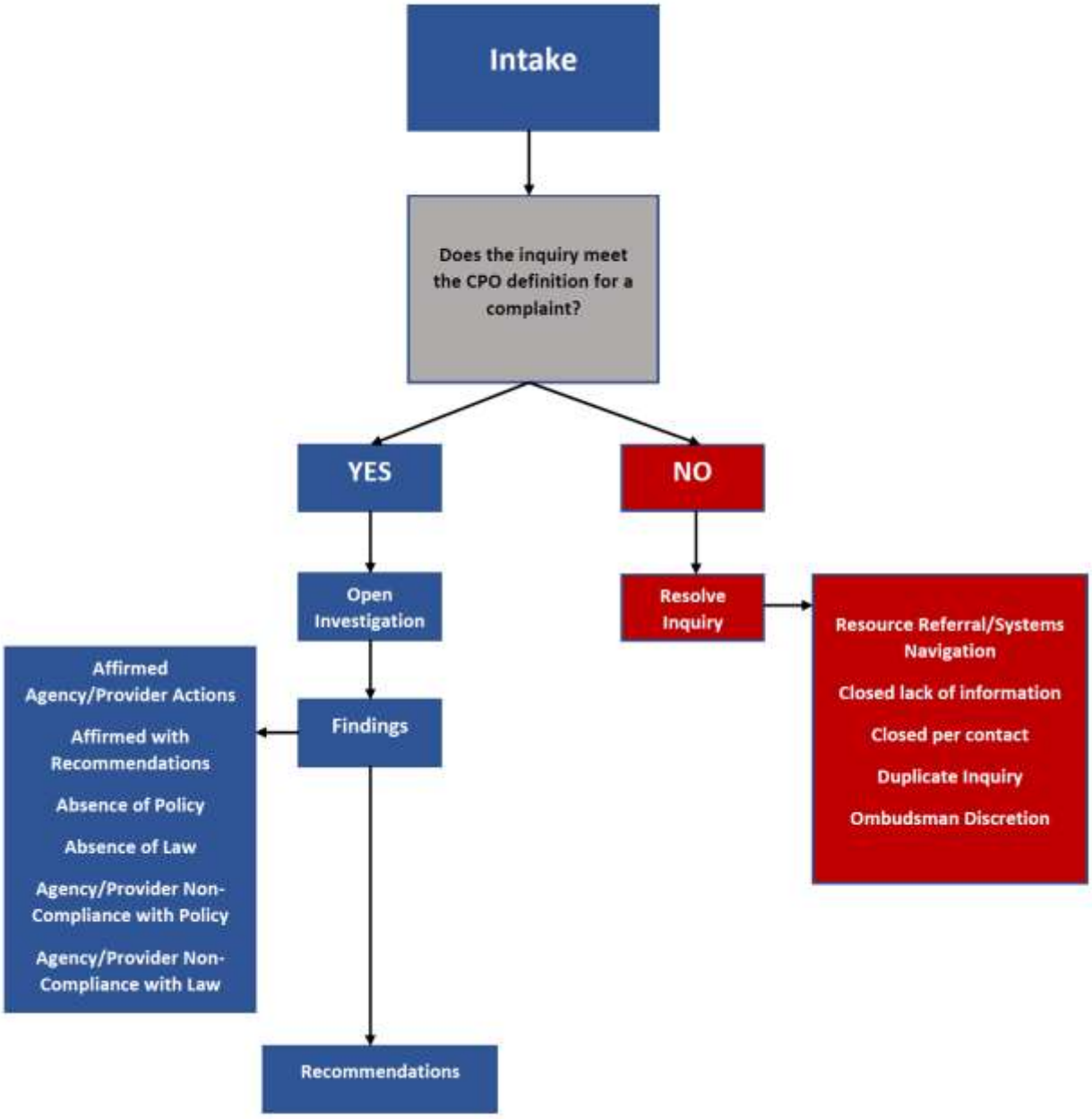


Example of CPO Recommendation ID

The CPO will produce and release an investigation report – which includes recommendations – when it makes any finding other than Affirmed Agency/Provider Actions. Agency/providers will have an opportunity to respond to the findings and recommendations prior to the report being released.

Process Flow Chart

Each contact the CPO receives is evaluated using the process below.



Fiscal Year 2016-2017 Recap

Citizens' Concerns

During the past three fiscal years, the CPO has seen a steady increase in the number of cases involving agencies/providers within the Division of Youth Services (DYS), juvenile justice and mental health systems. The number of cases involving systems outside of child welfare was four times higher during Fiscal Year 2016-2017, compared to the previous fiscal year. Some examples of those complaints include allegations that children with developmental disabilities do not have fair access to mental health services. One complainant was concerned that a police officer mishandled an alleged incident of child abuse, while a different citizen filed a complaint alleging excessive force was being used in a DYS facility. These cases have highlighted the CPO's need to continue expanding its expertise so it may more efficiently handle increasingly diverse complaints.

Additionally, the CPO also experienced an increase in the complexity of cases involving child welfare services. Contacts concerning county child welfare departments continue to account for the majority of contacts the CPO receives – about 86 percent during Fiscal Year 2016-2017. During the past fiscal year, these cases involved a complaint alleging a lack of due process for families when county departments determine there is inconclusive evidence to support whether child abuse occurred. In a different investigation, the CPO requested a third-party review of a county department's handling of a report of suspected of sexual abuse. The CPO has established an expertise in handling complaints involving child welfare services. Still, due to the consistent demand for such services from the CPO, the agency will expand its staff in the coming months to ensure there is adequate staff to handle more diverse complaints.

Highlights

The past fiscal year marked the CPO's first complete fiscal year as an independent state agency. During that year, the CPO not only refined its understanding of the demand for services and the resources necessary to efficiently serve citizens, it also realized the full potential of the agency and the work required to create meaningful change within the child protection system. To meet that demand and fulfill that potential, the CPO dedicated countless hours, discussions and resources toward becoming a more efficient, transparent and impactful agency. Some of the highlights from Fiscal Year 2016-2017 are detailed below.

Systemic Work

The CPO received 577 contacts during Fiscal Year 2016-2017. While the high demand for one-on-one services continues, so does the necessity for the CPO to tackle complex, systemic issues facing the child protection system. In August 2017, the CPO opened its first systemic investigation after it received a complaint alleging inconsistent negotiations and determinations of adoption assistance across Colorado. To date, staff have dedicated hundreds of hours, contacted dozens of agencies and reviewed thousands of pages of documents as part of this investigation. The findings and recommendations that will be made in this investigation have the potential to greatly improve the delivery of services to multiple families by multiple agencies. The CPO expects to release its final report and recommendations before the end of the calendar year.

As the CPO continues to expand its expertise and study of the child protection system, it also continues to identify additional systemic issues affecting the delivery of services to children and families. The CPO has implemented policies developed during Fiscal Year 2016-2017 to facilitate more systemic investigations. These polices will ensure the CPO is able to collaborate with stakeholders and complete independent research to identify concerns both central and peripheral to the child protection system.

Streamlined Process

During Fiscal Year 2016-2017, the CPO implemented several practices designed to increase the efficiency in which the CPO handles cases. One of the most predominant changes in practice created a direct connection between citizens and investigators. Previously, the CPO would direct all contacts to an intake manager. The intake manager would take down information from the contact and then assign the information to one of the CPO's investigators. The CPO eliminated this step by directly connecting citizens and stakeholders with investigators when they file their complaint. This allows investigators to collect necessary information sooner and decreases the amount of time cases remain in the queue. Below are some additional examples of practices the CPO has implemented to improve efficiency.

Case Practices – One of the CPO's biggest achievements in the past fiscal year was the completion of its *Case Practices and Operating Procedures*. CPO staff dedicated months to analyzing past procedures and identifying the improvements necessary for the CPO to move forward with impactful change. The CPO's *Case Practices and Operating Procedures* provide guidance for everything from case management to grievance polices. The CPO procedures were designed to mimic best practice standards set by the International Ombudsman Association, the United States Ombudsman Association and the American Bar Association.

Some examples of improvements include:

- Streamlining procedures for receiving inquiries and complaints about the child protection system.
- Creating clear deadlines and expectations for the agencies/providers the CPO is investigating.
- Standardizing reporting formats, including templates for finalized reports and briefings.

Second Child Protection Systems Analyst – In November 2016, the Colorado General Assembly's Joint Budget Committee (JBC) approved the CPO's request for funds to hire an additional Child Protection Systems Analyst. The CPO filled the position in July 2017. The second Child Protection Systems Analyst will help expand the CPO's expertise beyond the child welfare system, including systems such as the DYS, and help handle cases in other areas as well.

New Case Management System – During Fiscal Year 2016-2017, the CPO designed a new web-based case management system. From start to finish, the new system has improved how the CPO manages, tracks and analyzes its cases. Data entry has become more intuitive, staff have

more versatility in the way they log case updates and reports more accurately and efficiently reflect CPO data. The new case management system launched on July 3, 2017.

Outreach and Education

The CPO is statutorily required to educate citizens and stakeholders "concerning child maltreatment and the role of the community in strengthening families and keeping children safe." See C.R.S. 19-3.3-103(2)(c). During the past fiscal year, the CPO worked to identify ways to become more accessible to the public and improve the transparency of its work.

New Website – During Fiscal Year 2016-2017, the CPO performed a complete overhaul of its website. Functions that were counterintuitive were removed. Information that was buried was brought to the front of the website and clearly organized, including the CPO's investigation reports, mandated reports and recommendations. New functions include a page that allows visitors to track the CPO's work at the legislature and learn about outreach campaigns. The website was designed to serve citizens and to inform the public with up-to-date information about the CPO and issues facing the child protection system. The new website is a place for citizens and stakeholders to engage in the process of reforming and improving the child protection system.

Public Reporting – While revising its *Case Practices and Operating Procedures*, the CPO created public reporting procedures to increase and standardize communications with stakeholders and citizens. These procedures were designed to hold the CPO accountable to the public and ensure transparency of the CPO's work.

Public reporting practices the CPO implemented include:

- **Public Notifications:** After the CPO opens an investigation, a public notification of that investigation is posted on the "Pending Cases" page of the CPO's website. The notification includes: the case number, service area, area of concern, date the investigation was opened and the status of the investigation. This practice allows stakeholders and citizens to track the investigation and ensures the CPO completes investigations within the required timeframes.
- **Investigative Briefings:** If, through its preliminary research, the CPO determines an investigation requires additional study, time and resources, the CPO will release an investigative briefing. The investigative briefing will outline why additional research is necessary, how the investigation will proceed and provide an estimated completion date. Investigative briefings will be posted on the "Investigative Briefings" page of the CPO's website.
- **Investigation Reports:** The CPO provides the public and stakeholders any recommendations it makes to an agency/provider. The CPO does so by publicly releasing its investigation reports. The CPO considers any agency/provider's response and – if appropriate based on the information provided – revises its findings and recommendations prior to publicly releasing its investigation

report. All investigation reports are posted to the "Investigation Reports" page on the CPO's website.

- **Reporting Templates:** To ensure stakeholders and the public have clear expectations concerning the CPO's work, the CPO created standardized reporting templates. These templates are used for all public reporting and serve as clear guidelines for staff while writing investigative briefings and investigation reports. They also provide agency/providers clear instructions about how to respond to CPO findings.

Outreach Efforts – To ensure the CPO is meeting its mandate to educate citizens and stakeholders about the CPO's work and issues within the child protection system, staff dedicated a substantial amount of time performing outreach across the state during the past fiscal year. CPO staff met with a wide variety of stakeholders – including child welfare directors and staff, judicial employees and advocates – during group meetings and in one-on-one settings. A list containing additional outreach and education initiatives by the CPO is located in **Appendix B**. Some examples of the CPO's outreach include:

- A two-day tour of the agencies and staff that comprise the child protection system in the Seventh Judicial District (which incorporates Gunnison, Montrose, Delta, Hinsdale, Ouray and San Miguel counties). During this tour, CPO staff met with child welfare workers, judges, law enforcement and members of the legal community who work within the child protection system. In addition to learning about the area, the CPO also provided stakeholders with information about the CPO's services.
- To mark the first year of the CPO serving as an independent state agency, the CPO hosted an open house in January 2017. About 50 members of the child protection community – including the Colorado Department of Human Services (CDHS), county human service departments, the CDHS's Administrative Review department, legislators and the child protection legal community – attended.
- The Ombudsman and Deputy Ombudsman provided testimony during the past legislative session. They spoke during committee hearings on multiple pieces of legislation. The Deputy Ombudsman also gave a presentation at the legislature regarding drug endangered children and how to assess their safety.
- On June 21, 2017, the CPO held its inaugural out-of-town board meeting. The CPO used the meeting as an opportunity to host an informational lunch at the Morgan County Combined Courts. The CPO heard from stakeholders from surrounding county human services departments, the 13th Judicial District Attorney's Office, guardians ad litem and judicial staff about issues affecting child protection in northeast Colorado and what role the CPO may play in creating change.

Communications and Policy Director – In November 2016, the JBC approved the CPO's request for funds to turn the position of Communications and Policy Director into a full-time position. The position was originally created as a part-time role, but during Fiscal Year 2016-

2017 it became apparent that a full-time staff member was necessary. The full-time position will be instrumental in ensuring that the CPO's new public reporting policies and outreach campaigns are implemented properly and administered efficiently.

Office Growth

Fiscal Year 2016-2017 also marked substantial internal growth for the CPO. In August 2016, the CPO moved into its permanent office space at the Ralph Carr Judicial Center in Denver. Staff quickly settled into the space, which was designed to allow for additional growth. Vacant space was quickly filled as the CPO launched its internship program and retained a contract research assistant.

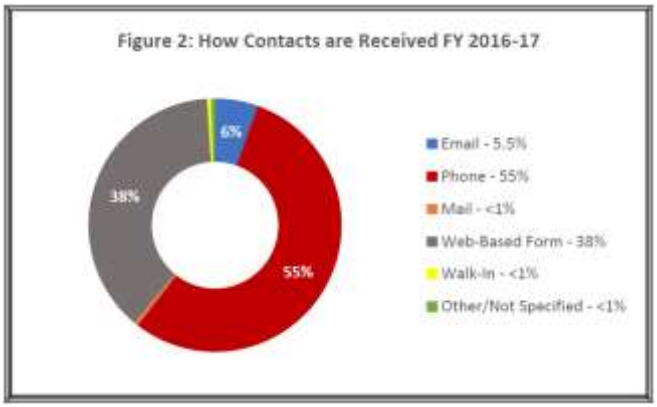
The CPO worked with the Attorney General's Office to finalize the CPO Board bylaws, grievance policies, document retention policies and fiscal policies. Written evaluations for staff were created and the first staff evaluations were completed during fall 2016. The CPO Board also drafted, finalized and utilized the written evaluation for the Ombudsman.

In December 2016, the CPO held its second annual staff retreat. During the two-day, in-house retreat, staff discussed strategies for advancing the agency and streamlining processes. Many of these discussions served as catalysts for the programs implemented during the past fiscal year, including the completion of the *Case Practices and Operating Procedures*, website redesign and new case management system.

By the Numbers

CPO Data Analysis

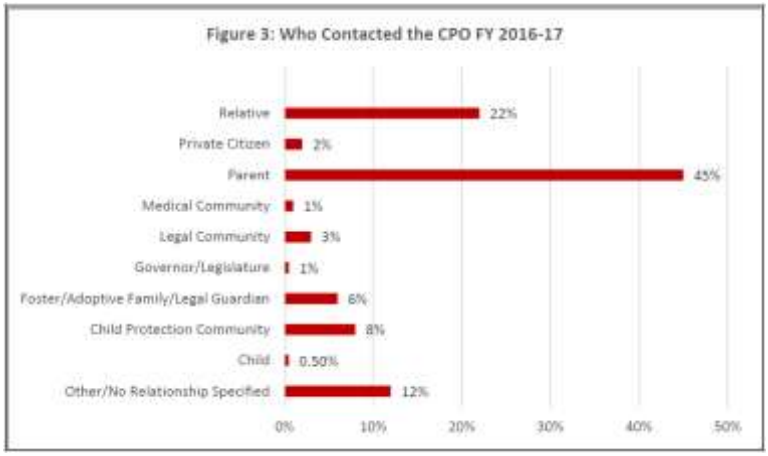
In order to continue effectively serving Colorado's citizens, the CPO collects data on how its services are being used by the public. During Fiscal Year 2016-2017 the CPO received 577 contacts. This is consistent with the number of contacts received during the previous fiscal year – 580 – and represents a 327 percent increase compared to its first year of operations. (See Figure 1) A chart detailing the contacts received during the past fiscal year is located in **Appendix C**.



How Contacts are Received

The CPO tracks how it receives contacts from citizens in an effort to ensure that it is accessible to all members of the public. The two most used methods for contacting the CPO were by phone and by using the online complaint form. Unlike previous years, the CPO saw a 3 percent decrease in the number of contacts filed via telephone and a 7 percent increase in the number of contacts it received via the online complaint form. (See Figure 2)

Who Contacted the CPO



Since its inception, the citizens who contacted the CPO have largely been comprised of biological relatives of children receiving services from the child protection system. That trend continued during Fiscal Year 2016-2017. About 67 percent of the citizens who contacted the CPO during the past fiscal year were biological parents or grandparents concerned about an agency/provider's actions or inactions in providing services to children. The CPO has identified foster and adoptive parents, kinship placements, children and juveniles, mandated reporters and the child protection legal community as groups of individuals it would like to provide more services to. During the past fiscal year, contacts from these groups made up about 15 percent of the CPO's total contacts. (See Figure 3)

Budget

The CPO's total appropriation for Fiscal Year 2016-2017 was $614,458.

Figure 7: FY 2016-17 Budget Allocations	
Expenditure	**Cost**
Legal Services	$22,812
Personnel Services	$461,479
General Operating Fund	$130,167
TOTAL BUDGET ALLOCATION FOR FY 2016-17	**$614,458**

The internal budget of the CPO functions within the following categorical breakdowns:

- **Legal Services:** Expenses related to the utilization of the Attorney General's Office, such as CPO Board development, CORA requests, legal establishment of the CPO's operating and fiscal policies.
- **Personnel Services**: Expenses associated with salaries and benefit packages for employees.

- **General Operating Fund**: General expenses related to the day-to-day functioning of the CPO.

The increase in funds from Fiscal Year 2016-2017 to Fiscal Year 2017-2018 represent a 27 percent increase. Figure 8 depicts the total appropriations for each fiscal year the CPO has been in operation, as well as the funds the JBC allotted the CPO for Fiscal Year 2017-2018. (See Figure 8)

Figure 8: Office of Child Protection Ombudsman Yearly Appropriations						
FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
$343,000	$343,000	$343,000	$504,250	$484,762*	$614,458	$782,421

*The reduction in funds between Fiscal Year 2014-2015 and Fiscal Year 2015-2016 was a result of CPO becoming an independent agency.

Investigation Reports and Recommendations

Since its inception, the CPO has issued 219 recommendations to agencies/providers. Recommendations are one of the most critical services the CPO provides the public, as they help to improve the child protection system on all levels. To date, the CPO has issued recommendations for improvement to county child welfare departments, the CDHS, mental health providers, hospitals and law enforcement. In all but one recorded instance, recommendations sent to the county child welfare departments have been acknowledged.

The majority of recommendations issued by the CPO during Fiscal Year 2016-2017 involved additional or ongoing training for county child welfare department staff and supervisors. This trend is consistent with the recommendations the CPO issued during the previous fiscal year. Some training recommendations include providing staff guidance on state rules and state laws regarding when county child welfare departments are required to assign a caseworker to assess reports of child abuse or neglect. Additional examples include a recommendation that a county child welfare department supervisor provide a caseworker with training on accurately documenting their cases, and a recommendation that staff be trained on rules dictating how often they have face-to-face contact with children who are placed outside of their homes.

The CPO also issued recommendations that a county child welfare department review its internal polices for notifying caseworkers, guardians ad litem and parents when a report of child abuse is made in a case. At the time of this annual report's submission, the CPO had issued 13 recommendations in three completed investigation reports. (Complete copies of these investigation reports may be found in **Appendix D**.) Prior to the close of Fiscal Year 2016-2017, the CPO opened five additional investigations involving four agencies/providers. The CPO expects those investigation reports and additional recommendations to be completed by the end of September 2017.

During the past fiscal year, the CPO developed policies to more consistently and efficiently communicate its recommendations with citizens and stakeholders. Those policies have since been implemented. One of the practices implemented is housing all of the CPO's recommendations in a central location on the CPO's website. This page allows visitors to quickly look up recommendations by year and agency, as well as track the recommendation back to the investigation it was developed from. The CPO now assigns a

unique identification number to each recommendation, which allows the CPO and the public to analyze whether there are any trends developing.

Moving Forward

During the past fiscal year, the CPO focused a substantial amount of attention and effort establishing strong practices. The CPO has now fully implemented these practices. To ensure those practices position the CPO in a place where it has the necessary resources and processes to handle large systemic cases, while maintaining a high quality of services for citizens seeking one-on-one assistance, the CPO has developed the three goals listed below. As is required under the State Measurement for Accountable, Responsive and Transparent Government Reports Act (See C.R.S. 2-7-204), the CPO submitted its Fiscal Year 2017-2018 Performance Plan on June 21, 2017. The following goals were developed using the guidelines of the SMART Act and are designed to ensure the CPO is moving toward improvement on a continual basis. A complete copy of the CPO's Performance Plan is available on the "Informational Reports" page of the CPO's website.

Outreach and Education

The CPO will work to improve communication methods and increase outreach campaigns to better educate and engage citizens and stakeholders about issues facing the child protection system. To ensure the CPO is meeting its mandate of educating citizens and stakeholders, it will create more consistent, timely and informative methods of communicating the CPO's work. This includes issuing quarterly reports and improving communication with legislators concerning issues the CPO has identified within the child protection system. The CPO will also work to expand its outreach efforts by increasing its engagement with rural communities and improving accessibility for Spanish-speaking communities.

Efficiency

During Fiscal Year 2017-2018, the CPO will use new practices that ensure the CPO manages its caseload efficiently and effectively, allotting staff the necessary time and resources to investigate systemic concerns. One of the ways the CPO will increase the amount of time it dedicates to systemic cases, without lessening the quality of service provided to individuals, is utilizing data to identify trends in the child protection system to launch investigations sooner.

Systemic Reform

The CPO will increase the expertise and resources needed to investigate and research systemic issues within the child protection system. In addition to streamlining its processes, the CPO will expand its expertise and resources to ensure the CPO is fulfilling its mandated charge of investigating systemic issues and driving reform across the child protection system. Additionally, the CPO is developing a system to improve how the agency tracks and analyzes its recommendations to agencies/providers.

Conclusion

The CPO serves a unique and vital role in improving and bolstering the systems designed to keep Colorado children and families safe. However, as this agency continues moving forward, there is always room to improve and expand our own processes and services. Protecting children is an ever-evolving charge, and one the CPO does not take lightly. The CPO recognizes and appreciates that it is one of many entities dedicated to improving the lives of children and the systems that protect them. As this agency continues its work, it will continue searching for new ways to work with and serve stakeholders, legislators and citizens working toward the same goal. We look forward to working with members of the child protection community and with citizens, to ensure a stronger protection system for the future.

The CPO respectfully submits this report to the Governor, Chief Justice, CPO Board and the General Assembly, as is required under C.R.S. 19-3.3-108.

Appendix A

CHILD PROTECTION OMBUDSMAN of COLORADO

Office of Colorado's Child Protection Ombudsman

CASE PRACTICES AND OPERATING PROCEDURES

Stephanie Villafuerte, Child Protection Ombudsman

Effective July 1, 2017
Last Reviewed May 1, 2017
Next Review May 1, 2018

Table of Contents

Definitions

The terms and phrases listed below will be used throughout this document to help explain the Office of Colorado's Child Protection Ombudsman's (CPO) case practices and operating procedures.

Absence of Law
An investigation will conclude with this finding if the CPO identifies deficits in law governing the functions of an agency/provider within the child protection system.

Absence of Policy
An investigation will conclude with this finding if the CPO identifies deficits in policy governing the functions of an agency/provider within the child protection system.

Affirmed Agency/Provider Actions:
This finding means the CPO found no policy and/or law compliance violations by an agency/provider as they relate to the complaint.

Affirmed Agency/Provider Actions with Recommendations:
This finding indicates that the agency/provider did not violate policy and/or law, but the CPO determines there are areas of practice that could be improved upon to ensure the highest level of service delivery to a child or family. In this instance, the CPO will make recommendations to the agency/provider.

Agency/Provider:
Any public agency/provider within the child protection system that "*receives public moneys*" and is responsible for providing services that impact the "*safety, permanency, or well-being of the child.*" *See* C.R.S. §19-3.3-103(1)(a)(I)(A).

Agency/Provider Non-Compliance with Law:
This finding indicates that the agency/provider failed to follow state and/or federal child protection law.

Agency/Provider Non-Compliance with Policy:
This finding indicates that the agency/provider failed to follow policies regulating their practice in delivering services within the child protection system.

CMS (Case Management System):
The CPO maintains an internal case management system. This database includes all records related to the CPO's handling of citizens' inquires and investigations.

Case Number:
Every inquiry received by the CPO will be assigned a unique identifying number in the CMS. Citizens may use the identifying number to locate case information on the CPO website.

Child Protection System:
Per Colorado Revised Statute §19-3.3-103(1)(a)(I)(A), Colorado's child protection system is comprised of *"any public agency or any provider that receives public moneys that may adversely affect the safety, permanency, or well-being of the child."*

Closed Lack of Information:
This finding indicates that the contact did not provide the CPO with sufficient information to proceed.

Closed Per Contact:
This finding is issued when a contact withdraws their inquiry and requests that the CPO take no further action.

Complaint:
An alleged action or inaction by an agency/provider that may have resulted in violation of policy and/or law in the delivery of services to children and families within the child protection system.

Complainant:
Any individual alleging an action and/or inaction by an agency/provider that may have resulted in violation of policy and/or law in the delivery of services to children and families within the child protection system.

Contact:
Any individual who engages the CPO with an inquiry about the child protection system. A contact becomes a complainant if the CPO determines their inquiry meets the definition of a complaint.

CPO (Office of Colorado's Child Protection Ombudsman):
The Office of Colorado's Child Protection Ombudsman will be referred to as the CPO. The CPO denotes the agency as a whole and does not refer to an individual employee.

Duplicate Inquiry:
If a contact makes repeated inquires to the CPO and the CPO has previously resolved the inquiry or investigation, the CPO will issue this finding and close the inquiry without further services.

Evidence:
The available body of facts or information that support the CPO's finding(s) in an investigation.

Finding:
A determination made by the CPO at the conclusion of an inquiry or investigation.

Identification of Practice Concerns:
This finding indicates that the CPO identified practice(s) within an agency/provider's handling of a case which negatively affect the delivery of services to children and families. These concerns do not violate policy and/or laws.

Inquiry:
A concern or question about the child protection system.

Intake:
All inquires the CPO receives from contacts will be subject to an intake process. During that process the CPO will gather information from the contact and determine which CPO service will be most beneficial in addressing their concern or question.

Investigation:
A comprehensive, independent study of relevant facts, records and witnesses' statements will be initiated after the CPO receives a complaint alleging that an agency/provider has violated policy and/or law in the delivery of services to children and families within the child protection system.

Investigative Briefing:
When the CPO identifies an investigation that requires additional study, time and resources, the CPO will release a report outlining why additional research is necessary, how the investigation will proceed and an estimated completion date. **(See Policy 6.102 Investigative Briefing)**.

Investigation Report:
If, at the conclusion of the investigation, the CPO makes any finding **other than** *affirming the actions of the agency/provider* the CPO will complete and release a report. Details about the investigation report may be found in **Policy 6.200** .

Ombudsman:
The term Ombudsman refers to the head of the CPO who is responsible for the implementation and execution of these practices and procedures.

Ombudsman Discretion:
The Ombudsman, or his/her designee, has the authority to determine what service, if any, will be provided to a contact. The reasons for declination of services by the Ombudsman will be documented in the CPO case management system.

Recommendation:
A suggestion or proposal, "*to improve the safety of and promote better outcomes for children and families receiving child protection services in Colorado." See* C.R.S. §19-3.3-103(2)(e).

Resource Referral/System Navigation:
Services provided to a contact during the CPO's intake process that provides them with information to help resolve their questions or concerns regarding the child protection system.

Staffing:
A comprehensive analysis by the CPO staff in which details of an inquiry are presented. During this process the Ombudsman, or his/her designee, will assess any action needed and assign appropriate staff to the case. If the CPO does not open an investigation, staff will not be assigned.

Introduction

This document outlines general operating policies and procedures to guide the operations of the *Office of Colorado's Child Protection Ombudsman* (CPO).

In writing its procedures, the CPO completed a thorough study of policies and procedures practiced by child protection ombudsmen across the country and the world. CPO procedures were designed to mimic best practice standards set by the International Ombudsman Association, the United States Ombudsman Association and the American Bar Association.

These case practices and operating procedures have been developed to ensure that the *Ombudsman* is able to execute the functions and responsibilities of the CPO as mandated in statute.

1.000 Contacting the Office of Colorado's Child Protection Ombudsman

The business hours of the CPO are 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding state holidays.

The CPO can be contacted in the following ways:

Mail: Office of Colorado's Child Protection Ombudsman
1300 Broadway, Suite 430
Denver, Colorado 80203

Email: Info@coloradocpo.org

Phone: 720-625-8640

Online Complaint Form: www.coloradocpo.org

Upon receipt of an email, letter or telephone message, CPO staff will respond within two business days.

In person appointments: Due to security restrictions at the Ralph L. Carr Judicial Center, the CPO is unable to meet with *complainants* in person.

1.100 Role of the Ombudsman

By design, the *Office of Colorado's Child Protection Ombudsman* (CPO) serves as an independent, neutral problem solver that helps citizens navigate a complex child protection system in an expert and timely manner. The *Ombudsman* has independent access to child protection records that are not otherwise available to the public. This allows the CPO to objectively review and investigate *complaints*, deliver *recommendations* and drive systemic reform through research and education. Through objective study the CPO works to improve the delivery of services to children and families within the *child protection system*.

1.200 Responsibilities of the CPO

The CPO was established pursuant to C.R.S. §19-3.3-101. The CPO's primary duties include:

- Provide citizens free and confidential services.
- Help citizens navigate the *child protection system* and direct them towards needed services and resources.
- Objectively research and investigate concerns about the delivery of services to children and families within the *child protection system*.
- Illuminate the strengths and weaknesses within the *child protection system* that are directly impacting the safety, permanency and well-being of children and families.
- Make *recommendations* to the public, child protection *agencies/providers*, the General Assembly and the Governor that help reform and improve outcomes for children and families.

1.300 CPO Jurisdiction

The CPO receives "*complaints concerning child protection services made by, or on behalf of, a child relating to any action, inaction, or decision of any public agency or any provider that receives public moneys that may adversely affect the safety, permanency, or well-being of a child. The ombudsman may, independently and impartially, investigate and seek resolution of such complaints, which resolution may include, but need not be limited to, referring a complaint to the state department or appropriate agency or entity and making a recommendation for action relating to a complaint." See* C.R.S. §19-3.3-103(1)(a)(I)(A).

Examples of *agency/providers* the CPO has jurisdiction to review include: human services agencies, youth corrections, law enforcement, educators, medical professionals and treatment providers.

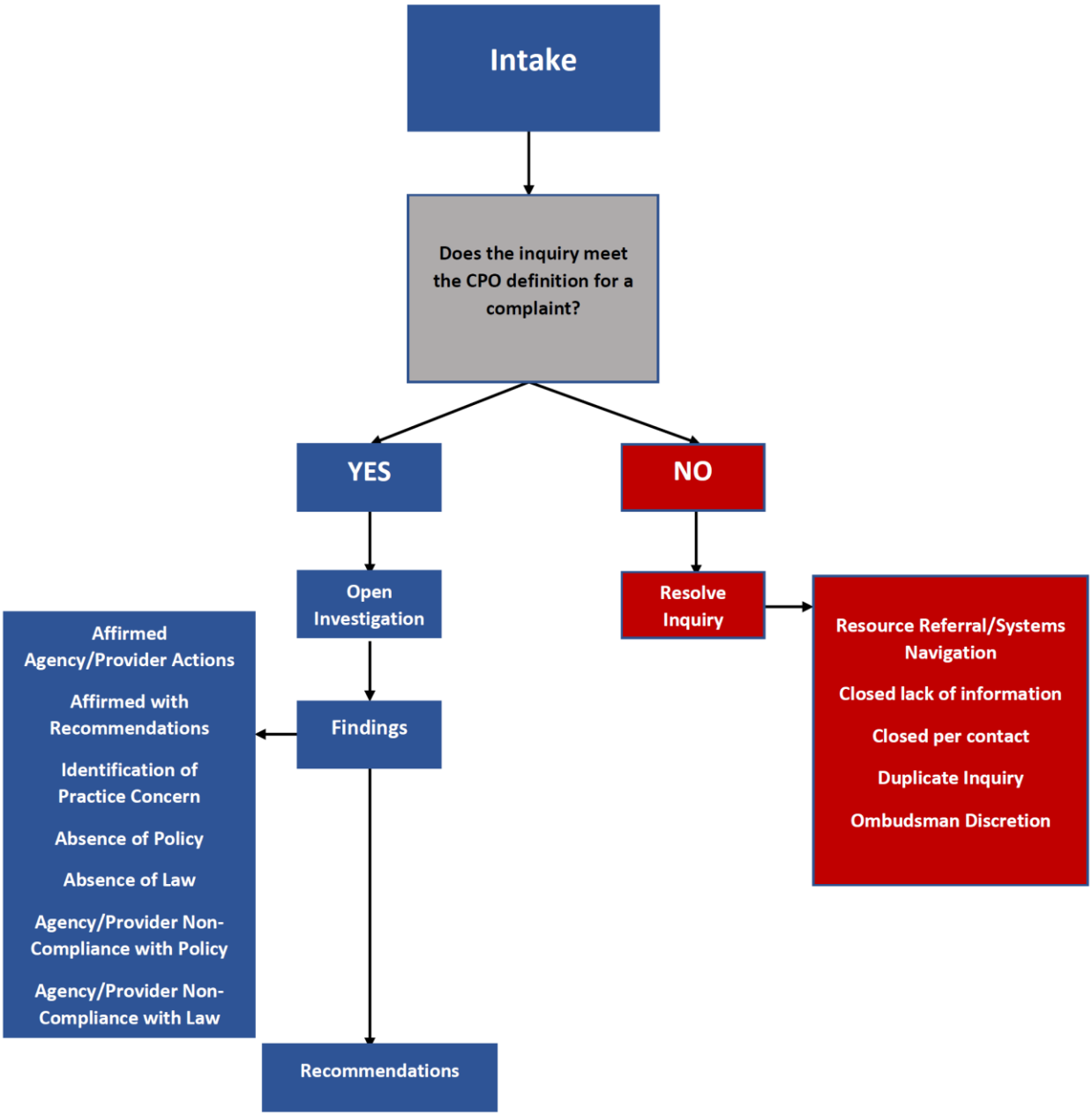
Pursuant to C.R.S. §19-3.3-101 to 110, the CPO does not have the authority to:

- Investigate allegations of abuse and/or neglect.
- Interfere or intervene in any criminal or civil court proceeding.
- Review or investigate *complaints* related to judges, magistrates, attorneys or guardians ad litem.

- Overturn any court order.
- Mandate the reversal of an agency/provider decision.
- Offer legal advice.

1.400 CPO Complaint Process

This chart may be used as a reference for **Policies 2.000 through 5.000**, which detail case process and resolution.



2.000 Intake

All *inquiries* the CPO receives from *contacts* will be subject to an *intake* process. During that process, the CPO will gather information from the *contact* and determine which CPO service is most appropriate. All information will be entered into the CMS.

Per the discretion of the *Ombudsman*, or his/her designee, assignment of *inquiries* will be prioritized based on the individual circumstances of the *inquiry*.

At the conclusion of the *intake* process, if the CPO determines that a *resource referral/systems navigation* is the appropriate service, the CPO will provide the *contact* with information to help resolve their question or *inquiry* regarding the *child protection system*. The CPO will document the *resource referral/system navigation* in the CMS.

The CPO may conclude the *intake* process without providing a *resource referral/service navigation* or *investigation* for one of the following reasons:

- Lack of information from the *contact*
- The *contact* withdraws their *inquiry*
- *Duplicate inquiry*
- *Ombudsman discretion*

At the conclusion of the *intake* process, if the CPO determines that the information provided by the *contact* is within the jurisdiction of the CPO and the *inquiry* meets the definition of a *complaint* an *investigation* will be initiated.

3.000 Investigation

The CPO will initiate a comprehensive, independent study of relevant facts, records and witnesses' statements when issues raised in a *complaint* involve allegations that:

- An *agency/provider* violated policy and/or law in the delivery of services to children and families and/or;
- The CPO identifies an absence of policy and/or law within the *child protection system*.
- The CPO identifies practice(s) within an agency/provider's handling of a case which negatively affect the delivery of services to children and families. These concerns do not violate policy and/or laws.

The *Ombudsman* or his/her designee will assign CPO staff members to the *investigation.* Staff assignments will be entered into the CMS and approved by the *Ombudsman* or his/her designee.

The CPO will provide the *complainant* with written notification that:

- A*n investigation* has been opened.

- The name and contact information of the CPO staff member(s) assigned to the *investigation.*
- The estimated length of the *investigation.* **(See Policy 3.200 Investigation Length)**

The CPO will notify the *agency/provider* that:

- An *investigation* has been opened.
- Public notification of the *investigation* will be posted to the CPO website. **(See Policy 6.101 Public Notification)**

The *complainant* will also be encouraged to keep the CPO informed of any new information that may affect the *investigation*.

To maintain its impartiality – and in keeping with statute – the CPO will independently collect information, records and/or documents from an *agency/provider* when reviewing and/or investigating a *complaint*. *"In investigating a complaint, the ombudsman shall have the authority to request and review any information, records, or documents, including records of third parties, that the ombudsman deems necessary to conduct a thorough and independent review of a complaint so long as either the state department or a county department would be entitled to access or receive such information, records, or documents." See* C.R.S. §19-3.3-103(1)(a)(II)(A). The CPO will incur reasonable expenses to photocopy relevant records.

The assigned CPO staff members will conduct a comprehensive and independent study of all records collected and may contact the *agency/provider* involved in the *investigation* and/or schedule a site visit to analyze any on-site records, as well as conduct interviews of *agency/provider* staff.

To ensure the integrity of the *investigation*, CPO staff members will submit all questions to the *agency/provider* involved in the *investigation* in writing via email. The CPO will require any response provided by an *agency/provider* to be submitted in writing via email.

All documents received from an *agency/provider*, or supplied by the *complainant*, will be scanned and electronically stored within the CMS.

At the conclusion of an *investigation*, the CPO may issue *recommendations* to the *agency/provider.* **(See Policy 7.102 Recommendations)**

3.100 Role of Agency/Provider During Investigation

An *agency/provider* involved in an *investigation* may expect the following:

- The CPO will submit all requests for information, documents or records to the *agency/provider* in writing via email. The CPO will require any response provided by an *agency/provider* to be submitted in writing via email.

- Prior to releasing its *investigation report* – including *recommendations* and *findings* – the *agency/provider* will be:
    - Provided a copy of the CPO's *investigation report* prior to its public release.
    - Given **10 business days** to respond to any CPO *findings* and/or *recommendations*. All *agency/provider's* response must be submitted in writing via email.
    - Advised that the CPO's *findings*, *recommendations* and the *agency/provider's* response will be made public through the release of its *investigation reports*. **(See Policy 6.200 Investigation Report)**

- The CPO will consider any *agency/provider's* response and – if appropriate based on the information provided – revise its *findings* and *recommendations* prior to publicly releasing its *investigation report*.

3.200 Investigation Length

It is the goal of the CPO to provide a timely response to all *investigations.* The length of time for an *investigation* to be completed will vary depending on internal CPO resources, the complexity of the issues, the length of time for outside reports to be obtained and, in some instances, for criminal or civil legal proceedings to be completed.

Investigations are generally completed within **60 business days** from the staffing date. Any delay outside of the above timeframes will be documented in the CMS and approved by the *Ombudsman*. The *complainant* and any relevant *agency/provider* will also be provided with written notification of any delay and expected completion date.

3.300 Investigation Conclusions

At the conclusion of an *investigation*, the CPO staff will reach one or more of the following *findings* **(See Definitions):**

- Affirmed Agency/Provider Actions
- Affirmed Agency/Provider Actions with Recommendations
- Identification of Practice Concerns
- Absence of Policy
- Absence of Law
- Agency/Provider Non-Compliance with Law
- Agency/Provider Non-Compliance with Policy

If the CPO affirms an *agency/provider's* actions, the CPO will provide the *complainant* a written summary of the CPO's *findings*. In instances where the *complainant* is the legal guardian or custodian, the CPO will provide an explanation of the facts which led to the decision made by the CPO. In instances where the *complainant* is not the legal guardian and/or custodian, limited information will be provided due to state and federal confidentiality laws pursuant to C.R.S. §19-3.3-103(III)(3). **(See Policy 12.000 Confidentiality)**

The CPO will produce and release an *investigation report* – to include *recommendations* – when a finding is made other than *Affirmed Agency/Provider Actions*. **(See Policy 6.200 Investigation Reports)**

If the CPO issues an *investigation report*, the *complainant* will be provided with a copy.

The *Ombudsman* may terminate an *investigation* at any time if the information presented no longer meets the criteria for an *investigation* as defined in **Policy 3.000**. This action will be documented in the CMS. If an *investigation* is terminated, a written explanation for the decision will be provided to the *complainant*, *agency/provider*, and all other relevant parties.

4.000 CPO Document Requests to Outside Agencies or Providers

Pursuant to C.R.S. §19-3.3-103(a)(II)(A), *"In investigating a complaint, the ombudsman shall have the authority to request and review any information, records, or documents, including records of third parties, that the ombudsman deems necessary to conduct a thorough and independent review of a complaint so long as either the state department or a county department would be entitled to access or receive such information, records, or documents."* When requesting records from an outside entity or agency, the CPO staff will submit a written request for records to the agency or entity that clearly defines the records needed.

If the CPO requests access to records, the CPO will submit a written request.

The CPO staff will limit their request for records to those that are related to the *complaint* or relevant to the circumstance surrounding the *complaint* which is under *investigation*. The CPO will also incur reasonable costs for the photocopying of all files.

5.000 CPO Recommendations

The CPO will issue *recommendations* pursuant to C.R.S. §19-3.3-103(2)(e), which mandates the CPO to, "*recommend to the general assembly, the executive director, and any appropriate agency or entity statutory, budgetary, regulatory and administrative changes, including systemic changes, to improve the safety of and promote better outcomes for children and families receiving child protection services in Colorado.*"

6.000 Public Reporting

The CPO will provide citizens with clear and consistent reports detailing the CPO's *findings* and *recommendations* to *agencies/providers* within the *child protection system*. **Policies 6.000 through 7.102** detail the CPO's practice of releasing information. Below is a reference chart for the CPO's public reporting.

CPO PROCESS	CPO ACTION	PUBLIC REPORTING	TYPE
INTAKE	The CPO resolves the inquiry.	**YES**	**CPO Dashboard** (See Policy 7.101)
INVESTIGATION	CPO opens an investigation.	**YES**	**Public Notification** (See Policy 6.101)
	The CPO identifies an investigation that requires additional study, time and resources.	**YES**	**Investigative Briefing** (See Policy 6.102)
FINDINGS	Affirmed Agency/Provider Actions	**YES**	**CPO Dashboard** (See Policy 7.101)
	• Affirmed with Recommendations • Identification of Practice Concerns • Absence of Policy • Absence of Law • Agency/Provider Non-Compliance with Policy • Agency/Provider Non-Compliance with Law	**YES**	**Investigation Report** (See Policy 6.200) **CPO Dashboard** (See Policy 7.101)

6.100 Case Announcements

To hold the CPO accountable to the public and ensure transparency of the CPO's work, the CPO will make information concerning all pending *investigations* available to the public through its website.

The CPO will communicate information about pending *investigations* in two ways:

- Public Notifications
- *Investigative Briefings*

6.101 Public Notifications

After the CPO opens an *investigation*, a public notification of that *investigation* will be posted on the "Pending Cases" page of the CPO's website. Each *investigation* will be identified on the "Pending Cases" page by a unique *case number*.

Each public notification will include:

- The *case number*
- Service Area
    - Human Services

    - Law Enforcement
    - Mental Health
    - Division of Youth Services
    - Judicial
    - Community Agencies
    - Other
- Area of concern
    - Sufficiency of Response
    - Assessment of Needed Services
    - Service Delivery
    - Other
- Status
- Date the CPO opened the *investigation*

Below is an example of a public notification:

Case Number	Service Area	Area of Concern	Status	Date Investigation Opened
2017-XXXX	Example Service Area	Example of Area of Concern	Example Status	X/XX/2017

Once the CPO completes the *investigation*, the status on the public notification will be changed from "Ongoing" to "Completed." After the status is changed to "Completed," the public notification will remain on the "Pending Cases" page on the CPO's website for 10 business days. If the CPO issues *recommendations* at the conclusion of an *investigation*, the *investigation report* will be posted on the "Investigation Reports" page of the CPO website.

6.102 Investigative Briefing

If, through its preliminary research, the CPO determines an *investigation* requires additional study, time and resources, the CPO will release an *investigative briefing* outlining why additional research is necessary, how the *investigation* will proceed and an estimated completion date. The *investigative briefing* is designed to act as a mechanism to hold the CPO accountable to the public and ensure transparency of the CPO's work. The *investigative briefing* will outline why an *investigation* is warranted, how the *investigation* will proceed and an estimated completion date.

The *investigative briefing* will be completed and released no more than **60 business days** after the *investigation* was staffed.

Each *investigative briefing* will include:

- *Case number*
- Service Area

- Summary of the *complaint*
- Summary of preliminary research
- Summary of the CPO's decision to open an *investigation*
- Next steps by the CPO
- Estimated length of the *investigation* and reasoning

Investigative briefings will be posted on the "Investigative Briefings" page of the CPO's website. A link to the *investigative briefing* will also be posted with the corresponding case on the "Pending Cases" page.

If the CPO determines it will not be able to meet the timeline set forth in the *investigative briefing*, the CPO will produce and release an updated *investigative briefing* explaining the reasons for the delay and will provide a new estimated date for completion.

Once an *investigation* is completed, the *investigative briefing* will be included in the appendix of the final *investigation report*.

6.200 Investigation Reports

In meeting its statutory requirements to *"improve accountability and transparency in the child protection system and promote better outcomes for children and families involved in the child protection system,"* as stated in C.R.S. §19-3.3-101(2)(a), the CPO will provide the public and stakeholders any *recommendations* it makes to an *agency/provider*. The CPO will do so by publicly releasing its *investigation reports*.

In absence of a finding of *affirmed agency/provider's actions*, the CPO will complete and publicly release an *investigation report.*

If the CPO issues *findings* and *recommendations* to an *agency/provider*, a copy of the CPO's *investigation report* will be provided to the *agency/provider* prior to the report's public release. The a*gency/provider* will have **10 business days** to respond to any CPO findings and/or *recommendations*. All *agency/provider's* responses must be submitted in writing via email. Any response provided to the CPO will be included in the *investigation report*.

The CPO will consider any *agency/provider's* response and – if appropriate based on the information provided – revise its *findings* and *recommendations* prior to publicly releasing its *investigation report*.

Each *investigation report* will include:

- Executive Summary
- Relevant *agency/provider*
- Summary of the *complaint*
- *Investigation* summary
- Conclusion
- Findings and *Recommendations*

- *Recommendation* summary
- *Agency/Provider* Response

All *investigation reports* will be posted to the "Investigation Reports" page on the CPO's website.

In determining the release of any information, the "*ombudsman, employees of the office and any persons acting on behalf of the office shall comply with all state and federal confidentiality laws that govern the state department or a county department with respect to the treatment of confidential information or records and the disclosure of such information and records*," as stated in C.R.S. §19-3.3-103(3). These laws include, but are not limited to, the Colorado Children's Code, CAPTA, HIPPA and FERPA.

7.000 Data Collection

The CPO records all actions taken during the life of a case in the CMS.

7.100 CPO Dashboard

The CPO will maintain an interactive "Dashboard" page on its website. The "Dashboard" will serve as an information portal for stakeholders and citizens. Users will have the ability to search and sort CPO data. Data sets and *recommendations* will be updated monthly.

7.101 Monthly Updates

Using data documented in the CMS, the CPO will update the "Dashboard" during the first week of every month.

At a minimum, the "Dashboard" will include monthly updates of the following:

- Number of *inquiries* received
- Number of *resource referrals/system navigations* provided
- Number of *complaints* identified by the CPO
- Number of *investigations* opened
- Number of *investigations* closed
- Summary of dispositions for each closed *investigation*
    - Any CPO *findings* of *affirmed agency/provider actions*
    - Any CPO *findings* of policy and/or law violations and the corresponding *agency/provider*
    - Any CPO absence of law and/or policy identified by the CPO

7.102 Recommendations

The CPO's website will also include a running list of all CPO *recommendations*. The list will be updated during the first week of every month.

Each *recommendation* listed will include:

- *Case number*
- *Recommendation* tracking number
- Date the CPO issued the *recommendation*
- Full-text of the CPO's *recommendation*
- *Agency/provider* that received the *recommendation*
- *Agency/provider's* response (if applicable)

Below is an example of a *recommendation* on the "Recommendations" page:

Case Number	Recommendation Number	Date Issued	Agency/Provider	Recommendation	Agency/Provider Response
2017-XXXX	2017-XXXX-F1(R1)	XX/XX/2017	Example Agency/Provider	Full text of recommendation.	Agree/Disagree/ Partially Agree

In determining the release of any information, the "*ombudsman, employees of the office and any persons acting on behalf of the office shall comply with all state and federal confidentiality laws that govern the state department or a county department with respect to the treatment of confidential information or records and the disclosure of such information and records*," as stated in C.R.S. §19-3.3-103(3). These laws include, but are not limited to, the Colorado Children's Code, CAPTA, HIPPA and FERPA.

8.000 CPO Informational Reports

To ensure the CPO is effectively meeting its mandate to *"educate the public concerning child maltreatment and the role of the community in strengthening families and keeping children safe,"* as stated in C.R.S. §19-3.3-103(2)(c), the CPO must provide citizens with a consistent and timely flow of information about issues within the *child protection system* and the overall functioning of the CPO.

The CPO will do this through the scheduled release of the following informational reports:

- Annual Report: Per C.R.S. §19-3.3-108, will be submitted on September 1 of every year.
- State Measurement for Accountable, Responsive and Transparent (SMART) Government Act: Per C.R.S. §2-7-201 to 207.
- Quarterly Reports

Each report will be released and posted on the "Informational Reports" page of the CPO's website.

9.000 Open Meetings Laws

All CPO board meetings are open to the public pursuant to C.R.S. §24-6-401 to 402.

10.000 Colorado Open Records Act (CORA)

The CPO is committed to transparency. The CPO is subject to the CORA (C.R.S. §24-72- 201 to 206) and in accordance with the provisions outlined in C.R.S. § 19-3.3-103(1)(a)(I)(B). In adhering to this Act, the CPO will comply with all state and federal confidentiality laws with respect to the treatment of confidential information or records and the disclosure of such information and records.

10.100 Procedures for Handling Record Requests

All records requests submitted to the CPO by mail, courier or email shall be immediately provided to the *Ombudsman*. The *Ombudsman* will approve all responses to the CORA except in extraordinary circumstances he/she will authorize a designee.

The CPO will accept only records requests made in writing or electronically via email. Records request made via social media shall not be accepted and must be resubmitted. Record requests or requestors that cite the Freedom of Information Act (FOIA) will be treated as though they were made pursuant to the CORA.

When responding to a records request, the CPO shall make every effort to respond within three business days, as is required by C.R.S §24-72-203(3)(b). A request is received the day an email or letter containing the request is opened. The three-business day response time begins the first business day following receipt of the request. A request received after noon on any day the CPO is officially closed will be considered received as of the following business day.

No employee of the CPO may modify, redact or omit any records they are required to provide, pursuant to this policy, to the *Ombudsman* or his or her designee handling the request. Staff should never assume a document is exempt and should always consult the *Ombudsman* before making a final determination. Redactions and decisions about whether a record falls under an exemption to the CORA will be made by the *Ombudsman* in consultation with the Colorado Attorney General's Office.

When feasible, the CPO will endeavor to provide electronic copies of files to requestors if such alternative is significantly less burdensome to provide than paper copies. When responsive records cannot be easily or cost effectively provided electronically to a requestor, the CPO will work with the requestor to schedule a time to inspect the records in person. The CPO is open from 8 a.m. to 5 p.m., Monday through Friday, except state holidays. The *Ombudsman* may

grant exceptions where the CPO, requestor or the records produced require special accommodations.

When a requestor (either an individual or organization) has an overdue balance for completing a prior request to the CPO, work on a new CORA request will not begin until the overdue bill is paid in full.

10.200 Fees

When a request requires the production of more than 25 pages of documents or more than one hour of staff time to locate or produce the records, the CPO will charge the requestor for all copying expenses and for staff time in accordance with C.R.S. §24-72-205(5)(a) and applicable law.

Any cost charged to a requestor shall not exceed the actual cost of producing the records, in accordance with C.R.S. §24-72-205(5)(a) and applicable law.

For requests where the CPO anticipates more than 25 pages will be produced and/or more than one hour of staff time will be consumed, the CPO will provide a requestor with advance notice and an estimate of compliance costs. Such costs must be paid in full before the production of records unless alternative arrangements have been made through the *Ombudsman*.

10.300 Production of Documents

When the number of pages produced in response to a records request exceeds 25 pages, the CPO will charge $0.25 per page for all documents copied.

When researching the location of a document, retrieving or producing records consumes more than one hour of staff time, the CPO shall charge $20 an hour for all staff time. An hourly rate not to exceed $30 an hour when specialized document production or specialized skills are required to fully comply with a records request. In extraordinary circumstance, the use of a third-party contractor may be necessary and will be discussed with the requestor in advance.

By policy of the CPO, the requestor shall also be charged $30 an hour for time spent by an attorney engaged in the practice of law directly related to a records request, including but not limited to, the review of documents for privilege or other exemptions to production; document redaction; creation of documents that articulate the privileged nature of the requested documents or conducting CORA related legal research.

Payment is due within 30 calendar days of the invoice date. Past due amounts will be referred to collections.

10.400 Format of Records Produced

The CORA guarantees that "*all public records shall be open for inspection by any person at reasonable times, except as provided in this part 2 or as otherwise specifically provided by law*,"

as stated in C.R.S. §24-72-201. The CORA does not guarantee access to public records in a specific format. When the production or review of records in a specific format would interfere with the regular discharge of duties of the CPO and staff, in accordance with C.R.S. §24-72-203(1)(a), or levy an undue burden upon the CPO, the *Ombudsman* will determine the appropriate format for the records to be produced. The CPO may require that members of the public only be allowed to review copies of documents when the custodian of records determines that allowing access to originals could interfere with the regular discharge of duties of the CPO, its staff or the production of original records could jeopardize the condition of the records.

10.500 CPO Contact for CORA Requests

For details on how to file a CORA request, please visit www.coloradocpo.org. Additionally, anyone seeking information may call the CPO at 720-625-8640 and ask to speak with the Communications and Policy Director.

11.000 Legal Advice

The CPO does not provide legal advice to *contacts* or *complainants*.

12.000 Confidentiality

Complainants must acknowledge electronically, through the web-based complaint form, or verbally with CPO staff, their understanding of the CPO's confidentiality policy. The *complainant*'s acknowledgement of the CPO confidentiality policy will be documented in the CMS.

Pursuant to C.R.S. §19-3.3-103 (1)(a)(I)(B) the CPO treats all *complaints* as confidential, including the *"identities of complainants and individuals from whom information is acquired; except that disclosures may be permitted if the Ombudsman deems it necessary to enable the Ombudsman to perform his/her duties and to support any recommendations resulting from an investigation."*

Further, C.R.S. §19-3.3-103(3) states that *"the Ombudsman, employees of the office, and any persons acting on behalf of the office shall comply with all state and federal confidentiality laws that govern the state department or a county department with respect to the treatment of confidential information or records and the disclosure of such information and records."* These laws include, but are not limited to, the Colorado Children's Code, CAPTA, HIPPA and FERPA.

The CPO will release identifying information to the proper authorities for anyone that makes any statements of credible harm to themselves or to someone else.

13.000 Mandatory Reporting

CPO staff members are required under C.R.S. §19-3-304 to report known or suspected child abuse and/or neglect. CPO staff will inform the *Ombudsman* or his/her designee prior to reporting alleged abuse and/or neglect, unless doing so would place a child or adult at risk of harm. CPO staff shall immediately, upon receiving such information, report or cause a report to be made to the county department, local law enforcement or through the Colorado's statewide child abuse reporting hotline (1-844-CO4-KIDS).

14.000 Conflict of Interest

Staff must have the ability to act independently and impartially in order to perform the duties necessitated by their position. Staff must be above reproach in all relationships and must not maintain any appearance of a conflict of interest. The CPO has a conflict of interest policy within the personnel manual. Each staff member must certify annually that they have reviewed the policy and have no conflicts of interest that would impair their ability to carry out their duties.

15.000 Filing a Grievance

Should a *complainant* believe that any staff member performed their duties in an unsatisfactory manner, the *complainant* is entitled to file a written grievance with the *Ombudsman*. (**See Appendix A: Grievance Policies**)

Should a *complainant* believe that the *Ombudsman* performed his/her duties in an unsatisfactory manner, the *complainant* is entitled to file a written grievance with the CPO Board. **(See Appendix A: Grievance Policies)**

16.000 Legislative Involvement

The CPO will work to provide the General Assembly with thoughtful insight and comprehensive research concerning issues within the *child protection system*. Through its research, *investigations* and engagement with stakeholders and citizens, the CPO will provide legislators with *recommendations* concerning *"statutory, budgetary, regulatory and administrative changes, including systemic changes, to improve the safety of and promote better outcomes for children and families receiving child protection services in Colorado." See* C.R.S. §19-3.3-103(2)(e).

APPENDIX A: Grievance Policies

Complaints Regarding CPO Staff Member Performance

Should a complainant to the Office of Colorado's Child Protection Ombudsman (CPO) be dissatisfied with the performance of a CPO staff member during the course of their involvement with the CPO, the complainant may file a grievance with the Ombudsman. In order to do so, the complainant must submit their detailed concerns in writing to the Ombudsman.

Grievances should be addressed to the Ombudsman and can be mailed to:

> Office of Colorado's Child Protection Ombudsman
> Attn: Complaint Regarding CPO Staff Member Performance
> 1300 Broadway, Suite 430
> Denver, Colorado 80203

Once received, the Ombudsman will thoroughly review the grievance and take the following steps to ensure resolution:

1. Review the written grievance and speak with the complainant should more information be necessary.
2. Meet with staff associated with the grievance.
3. Review the work completed by CPO staff.
4. Provide written feedback to the complainant regarding the findings of the grievance review and any plan necessary to resolve the complainant's concerns.

THE COLORADO CHILD PROTECTION OMBUDSMAN BOARD

PUBLIC COMPLAINT PROCESS

ARTICLE I: AUTHORITY

Section 19-3.3-102(3)(a)(IV), C.R.S., requires the Colorado Child Protection Ombudsman Board (the "Board") to develop a public complaint process related to the Child Protection Ombudsman (the "Ombudsman").

ARTICLE II: GENERAL GUIDELINES

Before filing a complaint, the following general guidelines should be considered:

1. The public complaint process addressed in this policy is only intended to address performance-related issues with the Ombudsman. Specifically, this policy addresses whether the Ombudsman acted ethically or complied with agency procedures.

2. The public complaint process addressed in this policy is not intended to appeal the outcome or result of a case submitted to the Office of the Child Protection Ombudsman (the "Office").

ARTICLE III: PROCEDURES

Section 3.1 Procedure for Filing a Complaint.

Any person who has a complaint against the Ombudsman related to his or her performance, and who cannot resolve the issue through discussion directly with the Ombudsman, may file a complaint with the Board. The following procedures must be followed for submission of a public complaint:

1. The complaint must be in writing, and must include the name, address and telephone number of the person submitting the complaint.

2. The complaint shall set forth, as precisely as reasonably possible, the nature of the complaint and the efforts, if any, to resolve the complaint.

3. The complaint must be submitted with the following designated attention to the below address:

   Office of the Colorado Child Protection Ombudsman
   ATTN: PUBLIC COMPLAINT CONCERNING OMBUDSMAN
   Ralph L. Carr Judicial Building
   1300 Broadway, Suite 430
   Denver, Colorado 80203

4. Once received, the Office of the Child Protection Ombudsman Staff ("Office") shall immediately forward the public complaint unopened to the Board Chair.

Section 3.2 Procedure for Resolution of Public Complaint.

Once a complaint is filed against the Ombudsman and received by the Board Chair, the following procedures address resolution of the matter:

1. The Chair or his or her designee will review the public complaint and determine, in his or her discretion, whether additional information is necessary from the individual. The Board Chair or designee shall send to the individual within thirty days an acknowledgment that the complaint was received.

2. The Chair or his or her designee shall notify the Ombudsman within the same thirty days that a complaint needs to be addressed at the next regularly scheduled meeting so the topic may be placed on the Board's agenda.

3. The public complaint will be distributed to the Board members in advance of the next regularly scheduled meeting for their review.

4. At the meeting, the Board shall discuss the complaint in public, unless the contents of the complaint addresses personnel issues related to the Ombudsman or the Chair, in his or her discretion, determines that the issue may cause potential embarrassment to the individual complainant.

5. If the complaint must be discussed in Executive Session, the Board Chair will call for a motion to enter into Executive Session.

6. In order to resolve the complaint, the Board may need to discuss the complaint with the Ombudsman or obtain additional information.

7. Following the Board's discussion concerning the grievance, whether in public or in Executive Session, the Board shall in public session and by majority vote determine what, if any action, should be taken in response to the complaint. The Board, as delegated to the Chair, shall provide a written response to the complainant notifying the complainant and the Ombudsman of the Board's determination.

8. The complaint shall be resolved as expeditiously as resources allow.

ARTICLE IV: AMENDMENTS

Section 4.1 Procedures.

This Public Complaint Process may be amended or repealed, in whole or in part, by a majority vote at any publicly noticed meeting of the Board and shall be effective upon adoption or amendment.

Section 4.2 Distribution.

The Chair, as may be delegated to the Ombudsman, shall provide a copy of the latest version of this Public Complaint Process to all new Board members upon their appointment, and to any other person who requests a copy. The latest version of the Public Complaint Process shall be made available to the public via the Office website.

Section 4.3 History.

Adopted and effective by the Board on July 13, 2017.

CHILD PROTECTION OMBUDSMAN BOARD:

KENNETH PLOTZ
Board Chair

SIMONE JONES
Board Vice-Chair

Appendix B

Fiscal Year 2016-2017 Outreach Events and Presentations

July 2016

- July 11, 2016: Presented at the Colorado Juvenile Judges Training Institute
- July 20, 2016: Denver Juvenile Court En Banc meeting

August 2016

- August 1, 2016: Two-day Outreach Campaign in the Seventh Judicial District
- August 22, 2016: Court Appointed Special Advocates Board of Directors and Regional Directors Meeting

September 2016

- September 9, 2016: Presented at the Colorado Human Services Directors Association Regional meeting, Pitkin County
- September 10, 2016: Presented at the Court Appointed Special Advocates Conference
- September 12, 2016: Presented at the Colorado State Judicial Conference
- September 13, 2016: Presented at the Office of the Respondent Parent's Counsel Conference
- September 13, 2016: Presented at the Office of the Child's Representative Conference
- September 19, 2016: Launched an outreach campaign with the 17th Judicial District

October 2016

- October 13, 2016: Presentation at the 17th Judicial District Employee Meeting
- October 25, 2016: Presentation at the Colorado Foster Parent Association Conference

December 2016

- December 9, 2016: Presentation at the CDHS' Child Welfare Executive Leadership Council
- December 12, 2016: Presented to the CPO's Fiscal Year 2017-2018 Budget Request to the JBC
- December 14, 2016: Presented to the Adams County Court Improvement Team

January 2017

- January 3, 2017: State Measurement for Accountable, Responsive and Transparent Act Presentation to Joint Judiciary Committees
- January 18, 2017: Presentation to the Court Appointed Special Advocate Legacy Program
- January 21, 2017: Presentation to the Court Appointed Special Advocate Arapahoe County

April 2017

- April 13, 2017: Presentation to the Colorado Human Services Director's Association
- April 17, 2017: Presentation to Colorado Department of Human Services Adoption Steering Committee
- April 17: Deputy Ombudsman Presentation to the Colorado Legislature Children's Caucus
- April 25, 2017: Deputy Ombudsman Testimony in the Colorado Legislature on HB 17-1283
- April 27, 2017: Attended the Colorado Child Maltreatment Prevention Framework for Action Meeting

- April 28, 2017: Ombudsman Presentation at the 20th Judicial District Attorney's Office

June 2017

- June 21, 2017: CPO Presentation at Fort Morgan Courthouse, Multi-Disciplinary Meeting

Appendix C

CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts by Agency
Fiscal Year
June 2017

County	Number of Complaints	Nature	Result	Open
Adams	44	Case / Ongoing (17) Foster Care/Adoption/Kinship (1) Inquiry (6) Intake / Assessment (12) Lack of Response (8)	Affirmed Agency Actions (26) Closed Lack of Information (2) Closed per Complainant (2) Resource Referral/System Navigation (4)	10
Alamosa	3	Case / Ongoing (2) Inquiry (1)	Affirmed Agency Actions (2) Resource Referral/System Navigation (1)	0
Arapahoe	41	Case / Ongoing (12) Foster Care/Adoption/Kinship (1) Inquiry (10) Intake / Assessment (11) Lack of Response (7)	Affirmed Agency Actions (23) Closed Lack of Information (2) Closed Per Complainant (2) Declined/Duplicate Report (2) Resource Referral/System Navigation (6)	6
Archuleta	1	Lack of Response (1)	Closed Per Complainant (1)	0
Baca	0	0	0	0
Bent	2	Case / Ongoing (1) Intake / Assessment (1)	Affirmed Agency Actions (2)	0
Boulder	11	Case / Ongoing (3) Inquiry (6) Intake / Assessment (1) Lack of Response (1)	Affirmed Agency Actions (3) Closed Lack of Information (1) Resource Referral/System Navigation (5)	2
Broomfield	12	Case / Ongoing (5) Intake / Assessment (6) Lack of Response (1)	Affirmed Agency Actions (9) Closed Lack of Information (1) Declined/Duplicate Report (1)	1
Chaffee	2	Intake / Assessment (2)	Affirmed Agency Actions (1) Resource Referral/System Navigation (1)	0
Cheyenne	1	Case/Ongoing (1)	0	1
Clear Creek	0	0	0	0
Conejos	1	Intake/Assessment (1)	0	1
Costilla	0	0	0	0
Crowley	1	Intake / Assessment (1)	0	1
Custer	0	0	0	0
Delta	9	Case / Ongoing (2) Intake / Assessment (5) Lack of Response (2)	Affirmed Agency Actions (5) Closed Lack of Information (1)	3

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CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts by Agency
Fiscal Year
June 2017

County	Number of Complaints	Nature	Result	Open
Denver	61	Case / Ongoing (15) Foster Care / Adoption / Kinship (2) Inquiry (22) Intake / Assessment (15) Lack of Response (7)	Affirmed Agency Actions (29) Closed Lack of Information (8) Closed Per Complainant (3) Resource Referral/System Navigation (14)	7
Dolores	0	0	0	0
Douglas	10	Case / Ongoing (4) Inquiry (3) Intake / Assessment (3)	Affirmed Agency Actions (5) Resource Referral/System Navigation (3)	2
Eagle	3	Case / Ongoing (1) Intake/Assessment (2)	Affirmed Agency Actions (2)	1
El Paso	49	Case / Ongoing (16) Inquiry (15) Intake / Assessment (16) Lack of Response (2)	Affirmed Agency Actions (20) Closed Lack of Information (6) Declined/Duplicate Report (2) Resource Referral/System Navigation (13)	8
Elbert	3	Case / Ongoing (2) Lack of Response (1)	Affirmed Agency Actions (2)	1
Fremont	8	Case / Ongoing (3) Inquiry (1) Intake / Assessment (2) Lack of Response (2)	Affirmed Agency Actions (4)	4
Garfield	6	Case/Ongoing (1) Inquiry (2) Intake/Assessment (2) Lack of Response (1)	Closed Lack of Information (1) Resource Referral/System Navigation (2)	3
Gilpin	0	0	0	0
Grand	2	Intake / Assessment (1) Lack of Response (1)	Affirmed Agency Actions (2)	0
Gunnison	1	Lack of Response (1)	0	1
Hinsdale	0	0	0	0
Huerfano	3	Case/Ongoing (1) Intake / Assessment (2)	Affirmed Agency Actions (1) Declined/Duplicate Report (1)	1
Jackson	2	Lack of Response (2)	Affirmed Agency Actions (1) Closed Lack of Information (1)	0

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CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts by Agency
Fiscal Year
June 2017

County	Number of Complaints	Nature	Result	Open
Jefferson	50	Case / Ongoing (26) Inquiry (4) Intake / Assessment (11) Lack of Response (9)	Affirmed Agency Actions (33) Closed Lack of Information (1) Closed Per Complainant (1) Declined/Duplicate Report (1) Resource Referral/System Navigation (3)	11
Kiowa	2	Inquiry (1) Intake/Assessment (1)	Affirmed Agency Actions (1)	1
Kit Carson	5	Case / Ongoing (2) Lack of Response (3)	Affirmed Agency Actions (2) Closed Lack of Information (1)	2
La Plata	3	Inquiry (2) Lack of Response (1)	Affirmed Agency Actions (1) Resource Referral/System Navigation (2)	0
Lake	1	Intake / Assessment (1)	Affirmed Agency Actions (1)	0
Larimer	31	Case / Ongoing (9) Inquiry (6) Intake / Assessment (8) Lack of Response (8)	Affirmed Agency Actions (21) Closed Lack of Information (4) Declined/Duplicate Report (1) Resource Referral/System Navigation (1)	4
Las Animas	3	Inquiry (1) Intake/Assessment (2)	Affirmed Agency Actions (2) Closed Lack of Information (1)	0
Lincoln	2	Inquiry (1) Intake / Assessment (1)	Affirmed Agency Actions (1) Resource Referral/System Navigation (1)	0
Logan	2	Case/Ongoing (1) Intake / Assessment (1)	Affirmed Agency Actions (1)	1
Mesa	30	Case / Ongoing (14) Inquiry (4) Intake / Assessment (9) Lack of Response (3)	Affirmed Agency Actions (22) Closed Lack of Information (2) Declined/Duplicate Report (1) Resource Referral/Systems Navigation (2)	3
Mineral	0	0	0	0
Moffat	1	Lack of Response (1)	Affirmed Agency Actions (1)	0
Montezuma	3	Inquiry (1) Intake / Assessment (2)	Affirmed Agency Actions (1) Resource Referral/System Navigation (1)	1
Montrose	10	Case / Ongoing (5) Intake / Assessment (4) Lack of Response (1)	Affirmed Agency Actions (7)	3
Morgan	2	Case / Ongoing (1) Mandated Reporting (1)	Affirmed Agency Actions (1)	1

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CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts by Agency
Fiscal Year
June 2017

County	Number of Complaints	Nature	Result	Open
Otero	4	Case/Ongoing (2) Inquiry (2)	Affirmed Agency Action (2) Resource Referral/System Navigation (2)	0
Ouray	0	0	0	0
Park	4	Case/Ongoing (1) Foster Care/Adoption/Kinship (1) Inquiry (1) Intake / Assessment (1)	Closed Lack of Information (1) Closed Per Complainant (1)	2
Phillips	0	0	0	0
Pitkin	0	0	0	0
Prowers	1	Lack of Response (1)	Affirmed Agency Actions (1)	0
Pueblo	17	Case / Ongoing (4) Foster Care / Adoption / Kinship (3) Inquiry (1) Intake / Assessment (4) Lack of Response (5)	Affirmed Agency Actions (10) Closed Per Complainant (1) Resource Referral/System Navigation (1)	5
Rio Blanco	7	Case / Ongoing (2) Inquiry (3) Intake / Assessment (2)	Affirmed Agency Actions (3) Closed Lack of Information (2) Resource Referral/System Navigation (1)	1
Rio Grande	0	0	0	0
Routt	5	Case/Ongoing (1) Inquiry (1) Intake / Assessment (2) Lack of Response (1)	Affirmed Agency Actions (3) Declined/Duplicate Report (1)	1
Saguache	0	0	0	0
San Juan	0	0	0	0
San Miguel	0	0	0	0
Sedgwick	1	Intake / Assessment (1)	Affirmed Agency Actions (1)	0
Southern Ute Tribe	0	0	0	0
Summit	0	0	0	0
Teller	2	Inquiry (1) Intake/Assessment (1)	Affirmed Agency Actions (1) Closed Lack of Information (1)	0
Ute Mountain Ute Tribe	0	0	0	0
Washington	3	Case / Ongoing (2) Inquiry (1)	Affirmed Agency Actions (2) Resource Referral/System Navigation (1)	0

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CHILD PROTECTION OMBUDSMAN of COLORADO

Overview of Ombudsman Contacts by Agency
Fiscal Year
June 2017

County	Number of Complaints	Nature	Result	Open
Weld	31	Case / Ongoing (8) Inquiry (9) Intake / Assessment (11) Lack of Response (3)	Affirmed Agency Actions (11) Closed Lack of Information (3) Closed Per Complainant (1) Resource Referral/System Navigation (8)	8
Yuma	2	Case / Ongoing (1) Mandated Reporting (1)	Affirmed Agency Actions (1) Closed Lack of Information (1)	0
Total	498	Case/Ongoing (165) Foster Care / Adoption / Kinship (8) Inquiry (105) Intake/Assessment (145) Lack of Response (73) Mandated Reporting (2)	Affirmed Agency Actions (267) Closed Lack of Information (40) Closed Per Complainant (12) Declined/Duplicate Report (10) Resource Referral/System Navigation (72)	97

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Appendix D

CHILD PROTECTION OMBUDSMAN of COLORADO
1300 Broadway, Suite 430
Denver, CO 80203
720-625-8640

July 19, 2016

Chris Kline
Adams County Department of Human Services
7190 Colorado Boulevard
Commerce City, CO 80022

RE: Ombudsman Complaint Regarding TRAILS Case ID: [redacted]

Dear Mr. Kline,

I am writing in reference to the complaint filed with Colorado's Child Protection Ombudsman Office (CPO) concerning TRAILS Case ID: [redacted]. The complainant contacted our Office with concerns that the child was not being seen by the caseworker in the child's placement on a monthly basis. The complainant was also concerned that there was overall poor communication between the placement provider and the ongoing caseworker. Finally, the complainant expressed concern that there was a delay in the child being referred for mental health services. The Office of Colorado's Child Protection Ombudsman opened the complaint for review on April 4, 2016.

The CPO carefully reviewed the complaint, including the documentation in the TRAILS database. During the course of reviewing the complaint, concerns regarding the frequency of face to face contacts with the child in the placement providers home were noted. The CPO reached out to Adams County Department of Human Services (ACDHS) via email on April 25, 2016 and subsequently received a response on April 27, 2016. All of this information was taken under careful consideration throughout the review process.

I. Violations of Volume VII

During the review of the complaint, the CCPO found the following violation of Volume VII related to TRAILS Case ID: 1800055.

A. Volume VII, 7.202.1(F) PROVISION OF ONGOING CHILD PROTECTION SERVICES (CPS) [Eff. 1/1/15]

Monthly Contact: The primary purpose for case contacts shall be to assure child safety and well-being and move the case toward achieving identified treatment goals. *Documentation in the state automated case management system of at least one monthly contact* shall summarize progress toward these goals. In child protection cases in which the children or youth remain in the home and in child

protection cases in which the children or youth are placed out of the home, the county department shall have face-to-face and telephone contact with the children or youth and parents and relevant collateral contacts as often as needed (while meeting the minimum expectations below) to reasonably attempt to assure the safety, permanency and well-being of the children.

The child was placed into the initial placement provider's home in August 2015. In reviewing TRAILS, there was not face to face contact, in the provider's home, documented for September, November or December 2015. The child was moved to a new placement in January 2016. The child was observed on the date of placement; however, there was no face to face contacts with the child in the provider's home in March and May 2016. The CPO would note that a foster care review was completed by the Colorado Department of Human Services, Administrative Review Division on February 8, 2016 and noted that documentation of face to face contacts for September and November 2015 could not be located in the file.

B. Agency Response to Policy Violations

The CPO brought this to the attention of ACDHS who advised on April 27, 2016 that there was acknowledgement that there were missing visits and that expectations have been clearly outlined for the caseworker on compliance with monthly face to face contacts with a child in his or her placement. In a follow up email from May 12, 2016, the CPO was advised that no formal performance improvement plan has been implemented with the worker at this time.

C. Remaining Concerns and Agency Response

The CPO was advised by the complainant that there has been a delay in obtaining mental health services for the child in care. The CPO discussed this with ACDHS and was advised on April 27, 2016 that there had been some confusion regarding the paperwork for the child's treatment. ACDHS reported that all forms had been signed and sent to the treatment provider. In a follow up email on May 12, 2016, ACDHS advised that the child had been receiving mental health services through a school based therapist while awaiting the referral to Aurora Mental Health to be processed. CPO confirmed on July 12, 2016 that mental health services for the child began with Aurora Mental Health in June 2016.

Finally, the CPO was advised that there was poor communication between the caseworker and the placement provider. On April 27, 2016, ACDHS acknowledged that the relationship between the placement provider and the caseworker was not the most productive working relationship. In a follow up email on May 12, 2016, ACDHS advised they were making attempts to reach out to the placement provider to schedule a meeting to determine next steps to improve the worker-foster parent relationship in an effort to support meeting the child's needs.

II. CPO Conclusion

The CPO will be closing out this review as "Agency/Caseworker Non-Compliance with Policy and Law" and offers the following recommendations:

A. Continued/Ongoing training for caseworkers on Volume VII requirements surrounding frequency of face to face contacts with children in out of home care.

B. Administrative/Supervisory training on the use of findings from Administrative Review Division reports in supervision to ensure correction of compliance findings and ongoing compliance with Volume VII.

The CPO is appreciative of the openness of Adams County's Department of Human Services throughout this review process and recognizes all of the hard work that the Department is doing to ensure that children of Adams County receive the best possible care and services to help them thrive. The CPO requests that ACDHS respond to this notification in writing with a detailed plan, including timeframes, for which ACDHS will follow through with the above recommendations, as well as an update on work being done with the caseworker involved to ensure ongoing compliance with face to face contacts per Volume VII. Thank you for your time and attention to this matter and please contact this office with any questions you have regarding the review of this complaint.

With Regards,

Sabrina Burbidge
Deputy Ombudsman

Approved:

Stephanie Villafuerte
Ombudsman

CHILD PROTECTION OMBUDSMAN of COLORADO
1300 Broadway, Suite 430
Denver, CO 80203
720-625-8640

August 17, 2016

Don Mares
Denver Department of Human Services
1200 Federal Boulevard
Denver, Colorado 80204

RE: Ombudsman Complaint Regarding Assessment ID: [redacted]

Dear Mr. Mares,

I am writing in reference to the complaint filed with the Office of Colorado's Child Protection Ombudsman (CPO) concerning TRAILS Assessment ID: [redacted]. The CPO opened the complaint for review on April 29, 2016. A summary of our review and findings are outlined below.

I. Originating Complaint Summary

The CPO received a complaint concerning TRAILS Assessment ID: [redacted]. The complainant reported that there had been a report regarding alleged Institutional Neglect/Lack of Supervision made to the Denver Department of Human Services (DDHS) on March 29, 2016 and it had not been assigned for assessment. The CPO opened the complaint for review on April 29, 2016.

II. CPO Review Process

The CPO carefully reviewed the complaint, including the referral made to DDHS on March 29, 2016, as well as Volume VII rule and the Colorado Children's Code. The CPO also reviewed the TRAILS cases of both children involved in the referral, specifically the case contacts in each, to verify if the children's caseworkers, guardian ad litems, parents and/or legal custodians had been notified of the allegations in the Institutional Abuse/Neglect referral.

On June 7, 2016, the CPO contacted DDHS with the following two concerns that were noted during the course of the review:

- The referral was not assigned for institutional investigation concerning a lack of staff supervision. Please explain the reason for the screen out, as there are no notes in TRAILS reflecting RED Team or decision making steps on this referral.

- Was notification provided to the caseworkers of the children involved in the referral that a report had been made concerning children on their caseload? Please reply, including any reason for the decision and the agency process when an institutional report is made and the children have open child welfare cases.

On June 9, 2016, the CPO received a response from DDHS. DDHS stated that after further review and analysis of Referral ID: [redacted], the DDHS had made the decision to assign the referral for further investigation. DDHS also advised that the DDHS will be notifying caseworkers or custodians of the two children involved. Further, DDHS stated that DDHS was reviewing and improving on their agency's policy regarding notification of caseworkers and custodians of such incidents when not specifically required by Volume VII rule.

On June 17, DDHS provided the CPO a copy of DDHS' Institutional Abuse Screening and Investigation Process (Appendix A).

The referral was assigned for assessment by a caseworker on June 9, 2016 with the investigation noted as beginning on June 13, 2016. On July 21, 2016, DDHS completed their investigation into the allegations of Institutional Neglect. In review, DDHS completed a thorough investigation into the allegations; however, there is no documentation within the assessment, or either child's ongoing cases, that demonstrates that DDHS contacted either the parents, caseworkers, Guardian ad litems, or legal custodians of the children involved in the investigation.

III. Identified Violations of Volume VII

7.103.6(A)(1)(2)(3) Criteria for Assigning a Referral for Assessment

"County departments shall assign a referral for assessment if it:

1. Contains specific allegations of known or suspected abuse and/or neglect as defined in 7.000.2;
2. Provides sufficient information to locate the alleged victim; and,
3. Identifies a victim under the age of eighteen (18)"

7.104.24(A)(1) Notice

"The licensing authority or certifying unit shall be notified that a referral concerning abuse and/or neglect has been received within one (1) working day after receipt of the referral."

7.104.15(B)(1) Notice

"Regardless of the outcome of the assessment and as allowable by law, county departments shall notify:

1. The parent(s), guardians(s), custodian(s), or caregiver(s) of the alleged victim child(ren) of the outcome of the assessments. Non-custodial parent(s) shall also be notified of the outcomes of the assessments unless is not in the best interests of the child(ren)."

IV. Conclusion

After completing a review into the complaint filed with the CPO on April 29, 2016, the CPO concludes this review as Agency Non-Compliance with Policy (Volume VII). The CPO makes the following recommendations for DDHS:

1. Training for all participants involved in RED Team, and/or supervisors reviewing institutional reports, regarding the requirements to assign allegations of Institutional Abuse and/or Neglect, as well as the required time frames for investigation.

2. Training for all supervisors, administrators and staff involved in Institutional Abuse and/or Neglect assignments and investigations regarding DDHS Institutional Abuse Screening and Investigation Process.

3. DDHS continue to review and revise their internal policies regarding notification of caseworkers, Guardian ad litems, parents and legal custodians when an allegation of abuse and/or neglect is made regarding a child in out of home care.

4. DDHS immediately notify the caseworkers of the children involved in this assessment to notify them of the allegations made in the initial report, as well as the outcome of the investigation.

Recommendations are designed to improve overall service delivery and practice within your county and for the families you serve. The CPO request written confirmation of DDHS receipt of this letter and documentation of any plan developed to address the recommendations made herein. The CPO will document such feedback and/or plan for tracking purposes and will release the recommendations and feedback in the annual report released each September.

Thank you for your time and attention to this matter and please contact this office with any questions you have regarding the review of this complaint.

With Regards,

Sabrina Burbidge

Sabrina Burbidge
Deputy Ombudsman

Approved:

Stephanie Villafuerte

Stephanie Villafuerte
Ombudsman

Appendix A

DDHS Institutional Abuse Screening and Investigation Process

- Allegations of institutional abuse will be reviewed by a screening team of one Intake Supervisor and one designated Administrator within one working day.
- The screening team will review history of concerns regarding the facility and any involved children to inform decision making. The review shall be documented in the automated case management system. The Supervisor is to ensure the review and the documentation have occurred.
- The screening team will utilize Volume 7 (7.202.5) and the Children's Code within our screening decisions and investigations.
- The screening team will determine response time of any assigned institutional assessment based on Volume 7 regulations, including documenting the appropriate exception why the identified victim child was not observed within the prescribed timeframe.
- The screening team and assigned Caseworker will identify other involved persons including licensing and guardians and notify them timely.
- There will be one Supervisor overseeing all institutional abuse investigations.
- There will be one identified Caseworker for all institutional abuse investigations as workload permits.
    - There will be identified staff to be utilized if necessary due to workload or leave issues.

CHILD PROTECTION
OMBUDSMAN
of COLORADO

Office of Colorado's Child Protection Ombudsman

INVESTIGATION REPORT

Case 2016-2243

Stephanie Villafuerte

Child Protection Ombudsman

June 30, 2017

Introduction

By design, the Office of Colorado's Child Protection Ombudsman (CPO) serves as an independent, neutral problem solver that helps citizens navigate a complex child protection system in an expert and timely manner. The Ombudsman has independent access to child protection records that are not otherwise available to the public. This allows the CPO to objectively review and investigate complaints, deliver recommendations and drive systemic reform through research and education. Through objective study the CPO works to improve the delivery of services to children and families within the child protection system.

Jurisdiction

The CPO receives *"complaints concerning child protection services made by, or on behalf of, a child relating to any action, inaction, or decision of any public agency or any provider that receives public moneys that may adversely affect the safety, permanency, or well-being of a child. The ombudsman may, independently and impartially, investigate and seek resolution of such complaints, which resolution may include, but need not be limited to, referring a complaint to the state department or appropriate agency or entity and making a recommendation for action relating to a complaint." See* C.R.S. §19-3.3-103(1)(a)(I)(A).

Pursuant to C.R.S. §19-3.3-101 to 110, the CPO does not have the authority to:

- Investigate allegations of abuse and/or neglect.
- Interfere or intervene in any criminal or civil court proceeding.
- Review or investigate complaints related to judges, magistrates, attorneys or guardians ad litem.
- Overturn any court order.
- Mandate the reversal of an agency/provider decision.
- Offer legal advice.

Public Disclosure

In meeting its statutory requirements to *"improve accountability and transparency in the child protection system and promote better outcomes for children and families involved in the child protection system,"* as stated in C.R.S. §19-3.3-101(2)(a), the CPO will provide the public and stakeholders any recommendations it makes to an agency/provider. The CPO will do so by publicly releasing its investigation reports.

Impartiality

To maintain its impartiality – and in keeping with statute – the CPO will independently collect information, records and/or documents from an agency/provider when reviewing and/or investigating a complaint. *"In investigating a complaint, the ombudsman shall have the authority to request and review any information, records, or documents, including records of third parties, that the ombudsman deems necessary to conduct a thorough and independent review of a complaint so long as either the state department or a county department would be entitled to access or receive such information, records, or documents." See* C.R.S. §19-3.3-103(1)(a)(II)(A).

How To Read This Report

The CPO has designed its investigative reports to provide citizens and stakeholders clear and concise information concerning the investigations in which the CPO issues recommendations.

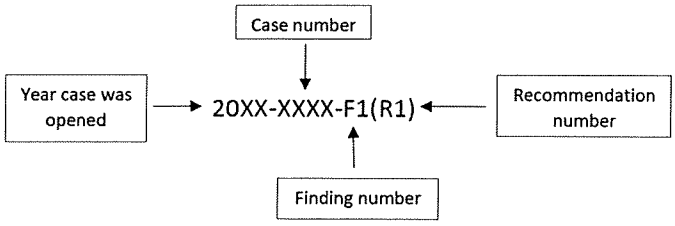
Each report will include an executive summary, relevant agency/provider, summary of the complaint, investigation summary, conclusion as well as the CPO's findings and recommendations. Below is a list of terms and brief explanations to serve as a reference while reading this report.

Findings

At the conclusion of each investigation, the CPO will issue one or more of the following **findings**:

1. **Absence of Law**: An investigation will conclude with this finding if the CPO identifies deficits in the law governing the functions of an agency/provider within the child protection system.
2. **Absence of Policy**: An investigation will conclude with this findings if the CPO identifies deficits in policy governing the functions of an agency/provider within the child protection system.
3. **Affirmed Agency/Provider Actions**: This finding means the CPO found no policy and/or law compliance violations by an agency/provider as they relate to the complaint.
4. **Affirmed Agency/Provider Actions with Recommendations**: This finding indicates that the agency/provider did not violate policy and/or law, but the CPO determines there are areas of practice that could be improved upon to ensure the highest level of service delivery to a child or family. In this instance, the CPO will make recommendations to the agency/provider.
5. **Agency/Provider Non-Compliance with Law**: This finding indicates that the agency/provider failed to follow state and/or federal child protection law.
6. **Agency/Provider Non-Compliance with Policy**: This finding indicates that the agency/provider failed to follow policies regulating their practice in delivering services within the child protection system.
7. **Identification of Practice Concerns**: This finding indicates that the CPO identified practice(s) within an agency/provider's handling of a case which negatively affect the delivery of services to children and families. These concerns do not violate policy and/or laws.

Recommendations



Each recommendation – a suggestion or proposal to improve the child protection system – will be a result of a specific finding. Multiple recommendations can be associated with the same finding. Each recommendation will be assigned a unique identification number to help stakeholders and citizens track the recommendation throughout the report and on the CPO's website.

Case: 2016-2243

I. Executive Summary

On December 7, 2016, the Office of Colorado's Child Protection Ombudsman (CPO) received a complaint regarding a 2-year-old girl (C.H.) residing in Pueblo County. The complainant was concerned that C.H. had been diagnosed with anal genital warts, which was stated by the complainant to be unusual for a child C.H.'s age and could be indicative of sexual abuse.

The complainant reported to the CPO that a child abuse report was made to Pueblo County Department of Social Services (PCDSS) on November 23, 2016 concerning possible sexual abuse. As is required by Volume VII, the PCDSS did not take the referral to a RED Team meeting to determine the appropriate level of response, nor did PCDSS assign a caseworker to assess the allegations made in the report.

On December 12, 2016, the CPO opened a case in this matter. Initial review of the case by the CPO revealed that the PCDSS declined to assess the report of possible sexual abuse because the PCDSS determined that C.H. contracted the anal genital warts at birth. The PCDSS reported to the CPO that this determination was based on information gathered during interactions with the father through the PCDSS' open child welfare case with the family. The PCDSS stated that C.H.'s mother had an outbreak of Human Papillomavirus (HPV) at the time of C.H.'s birth causing C.H. to contract the virus. The CPO, however, also learned that the PCDSS made this determination before obtaining and reviewing birth and medical records for C.H. or her mother that would confirm either the mother's diagnosis and outbreak of HPV at birth, as well as the transmission to C.H.

Due to ongoing concerns for C.H.'s safety, the CPO requested on two separate occasions that PCDSS assign a caseworker to fully assess the allegations of sexual abuse on C.H. The PCDSS did not complete an assessment for either request.

Upon conclusion of its investigation, the CPO identified three violations of Volume VII and two violations of the Colorado Children's Code involving PCDSS' handling of the two reports of alleged sexual abuse on C.H. The CPO issued six recommendations to PCDSS. The compliance violations and recommendations are summarized the table below.

Agency/Provider	CPO Finding	CPO Recommendation	Agency/Provider Response
Pueblo County Department of Social Services	Non-Compliance with Policy (See page 12)	2016-2243-F1(R1) (See page 13)	Partially Agree
Pueblo County Department of Social Services	Non-Compliance with Policy (See page 13)	2016-2243-F2(R1) (See page 13)	Partially Agree
Pueblo County Department of Social Services	Non-Compliance with Policy (See page 13)	2016-2243-F2(R2) (See page 13)	Agree
Pueblo County Department of Social Services	Non-Compliance with Policy (See page 13)	2016-2243-F3(R1) (See page 13)	Partially Agree
Pueblo County Department of Social Services	Non-Compliance with Law (See page 14)	2016-2243-F4(R1) (See page 14)	Agree
Pueblo County Department of Social Services	Non-Compliance with Law (See page 14)	2016-2243-F5(R1) (See page 14)	Partially Agree
Pueblo County Department of Social Services	Practice Concern (See page 14)	2016-2243-F6(R1) (See page 14)	Agree

II. Relevant Agency/Provider(s)

The agency/provider(s) were given an opportunity to participate and provide information during the CPO's investigation. The agency/provider(s)' response to the CPO's findings or recommendations may be found throughout this report. The agency/provider(s)' complete responses are found in Appendix A.

Agency/Providers Involved:

A. Pueblo County Department of Social Services

III. Summary of the Complaint

Complaint Received: 12/07/2016	Case Opened: 12/12/2016

The CPO received a complaint expressing concern for how the Pueblo County Department of Social Services (PCDSS) handled a report of sexual abuse allegations involving a two-year-old girl (C.H.). The complainant reported that C.H. was seen in a medical clinic on November 23, 2016 and was diagnosed with anal genital warts. The complainant reported that a referral had been made to the Colorado Child Abuse and Neglect Hotline (TRAILS Referral ID: [redacted]) outlining the diagnosis on C.H. and stating that this diagnosis was likely indicative of sexual abuse in a child this age. The complainant followed up approximately one week later with PCDSS and was advised that the report had not been assigned for further investigation by a caseworker.

The complainant expressed additional concerns that the father of C.H. was not receiving adequate support and guidance from PCDSS related to the concerns of sexual abuse.

IV. Investigation Summary

Due to significant concerns for C.H.'s safety, and the lack of response by PCDSS to address these concerns, the CPO opened a formal investigation on March 22, 2017.

The CPO investigation involved the following:

- Review of the TRAILS database
- Review of medical records
- Review of the Pueblo Police Department report
- Review of the Pueblo Child Advocacy Center Report
- Interviews of the complainant
- Communication with PCDSS staff
- Participation in a Child Abuse and Neglect Expert Staffing (CANES)
- Consultation with medical professionals

The CPO further utilized the following rules and laws during its investigation:

- Volume VII (Child Welfare Policy)
- Colorado Children's Code (Colorado State Law)

While the CPO analysis included all areas of the PCDSS' handling of this case, preliminary and ongoing research by the CPO led the CPO to focus on three main areas of concern:

1. Whether the PCDSS's initial handling of the November 23, 2016 report of sexual abuse was in accordance with Volume VII.
2. Whether the PCDSS had complete and accurate information when it made the decision to not open an assessment regarding the allegations of sexual abuse on C.H.
3. Incomplete and, at times, inaccurate documentation in this case.

A summary of the CPO's analysis of each of those areas is outlined below. For the purposes of this report, the child involved in the abuse allegation will be referred to as C.H., and her younger sibling will be referred to as L.H.

November 23, 2016 Report of Possible Sex Abuse

On November 23, 2016, the PCDSS received a report regarding a 2-year-old girl with anal genital warts. The CPO reviewed the report as it was documented in TRAILS. (TRAILS Referral ID: [redacted]) The mandatory reporter who called the hotline informed the caseworker that C.H.'s father was concerned about the "skin tags" on his daughter's anus and sought medical treatment. C.H.'s father informed medical staff that C.H. and her siblings were recently placed in his care due to their mother's drug use. At the clinic, it was determined that the "skin tags" were in fact anal genital warts.

The caseworker taking the report from the mandatory reporter inquired if C.H. contracted the condition from the mother during child birth.

> *"Caller said it was more likely that C.H. was sexually abused. Caller said father expressed concerns about maternal grandfather in the past but did not state concerns about sexual abuse. Caller is going to report to police and see if they want a forensic exam."*[1]

Upon review of the report in TRAILS, the CPO discovered that the hotline caseworker who accepted the report, gave the report to an ongoing caseworker. Giving the report to an ongoing caseworker – instead of an intake caseworker – prevented the report from being considered at a RED Team meeting. During a RED Team meeting, supervisors and staff review the report and determine whether the case will be assigned to a caseworker for assessment, and, if assigned, how quickly a caseworker must respond. Under Volume VII 7.1.03.4(A), all reports of possible sex abuse are to discussed at a RED Team meeting.

The report made on November 23, 2016 in this case was screened out the same day, without being discussed at a RED Team meeting. PCDSS entered the following note into the TRAILS database as its reasoning for not assigning a caseworker to assess the allegations of sexual abuse:

> *"No information available from reporter of abuse and neglect as defined in law."*[2]

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[1] Notes documented in TRAILS Referral ID: [redacted]

[2] "Reason Not Accepted for Assessment," noted in TRAILS ID: [redacted]

The CPO inquired about PCDSS' decision to screen out the report.[3] PCDSS responded to the CPO's inquiry in an email stating that *"genital warts in and of themselves are not an indicator of sexual abuse, and therefore there was not an actual allegation of sexual abuse."*[4]

PCDSS stated that staff have *"been trained in the Medical Aspects of Child Maltreatment offered by the Child Welfare Training System, that this is the case."* The caseworker appropriately followed up with the father and referred the father to a community resource that could provide an informed opinion, according to the PCDSS. (This meeting between the father and caseworker is detailed further on page 11.) When asked about the decision not to present the report at a RED Team meeting, the PCDSS stated that, *"our interpretation is that RED Team is not required if there is not an actual allegation of abuse or neglect."*

Corroboration

The CPO reviewed the case in TRAILS to determine what medical records, birth records or other documentation were obtained by the caseworker to corroborate the father's claim that C.H.'s anal genital warts were contracted at birth. There was no documentation in TRAILS indicating that the caseworker contacted the detective or the Pueblo Child Advocacy Center to corroborate the father's claims. The case file also lacked any additional documentation that could have verified the claims. At the time this statement was made – one month after the November 2016 report – the PCDSS had not assessed the report of possible sexual abuse. There was no documentation in TRAILS indicating that either the Pueblo Child Advocacy Center nor the Pueblo Police Department had provided documentation confirming whether the mother experienced an HPV outbreak at the time of C.H.'s birth.

Additionally, the CPO review of the case file in TRAILS revealed that the caseworker did not complete a new safety assessment of the home after the report was made on November 23, 2016. Under Volume VII 7.107.11(H), caseworkers overseeing ongoing cases are required to complete a new Colorado Safety Assessment tool any time there are situations that "might pose a new or renewed threat to child safety."[5]

The CPO asked the PCDSS about the lack of documentation and whether the caseworker had, in fact, met with law enforcement, medical professionals or collected pertinent medical documents that would confirm C.H.'s genital warts were the result of her mother having an outbreak of HPV during C.H.'s birth.

The PCDSS responded to the CPO's inquiry on the same day. The PCDSS stated:

> *"PCDSS has requested medical and birth records in regards to the children, and the assigned caseworker will enter this information in the case file once it has been received. Although the caseworker has received conclusive information from law enforcement and the Child Advocacy Center indicating that C.H. was not a victim of sexual abuse and concerning how C.H. contracted genital warts, the assigned caseworker has not provided*

[3] CPO inquiry emailed to PCDSS on February 14, 2017
[4] PCDSS emailed response to CPO inquiry received on February 14, 2017
[5] See Volume VII 7.107.11(H)

full and complete documentation of her follow up discussions and receipt of subsequent reports in the TRAILS record."[6]

While the CPO recognized the PCDSS' ongoing efforts to obtain documentation in the case, it also remained extremely concerned for C.H.'s safety. The PCDSS' response indicated that the PCDSS was seeking critical information in the case, but it also confirmed that the PCDSS made its determination that C.H.'s anal genital warts were contracted from her mother, prior to obtaining the medical and birth records needed to confirm how C.H. contracted the virus.

First Request for Assessment

Given the compliance issues identified regarding the PCDSS failure to assign the November 23, 2016 referral for further assessment, as well as lack of corroborating medical information to support PCDSS' assertion that C.H. contracted the herpes virus at birth, the CPO determined that concerns for C.H.'s immediate safety needed to be addressed. On February 22, 2017, the CPO alerted the PCDSS, with its concerns regarding this case and requested that a RED Team meeting be held immediately to review the report of sexual abuse and determine the appropriate level of response to the allegations.

The PCDSS entered a new report into the TRAILS database based on the CPO's ongoing concerns for sexual abuse. The PCDSS confirmed that the new report would be presented at a RED Team meeting on February 24, 2017. The CPO verified this through an independent review of the report in TRAILS. The report was presented at a RED Team meeting. The report was screened out and not assigned to a caseworker for assessment.

Second Request for Assessment

On March 14, 2017, the CPO provided the PCDSS with a revised letter[7] outlining the conclusion of its initial review of the case, policy and law violations identified by the CPO and a list of eight recommendations. Two of the recommendations and responses from the PCDSS are highlighted below. The complete letter can be found in Appendix C.

> **CPO Recommendation 7:** PCDSS to obtain, verify and document medical records for mother, father, [C.H.] and [L.H.] to confirm if mother potentially had a documented outbreak of genital warts at the time of delivery, if in fact, [C.H.] contracted genital warts at birth, and any ER documentation that would verify [C.H.] had been seen at the hospital in recent months prior to the report being filed with PCDSS.
>
> PCDSS response for Recommendation Seven:
>
> *"PCDSS agrees with this recommendation with respect to C.H. and the mother. PCDSS has obtained information from the hospitals in which the mother and C.H. were*

[6] PCDSS emailed response to CPO inquiry received on February 22, 2017

[7] The CPO revised three of its eight recommendations after considering the responses submitted by the PCDSS on March 9, 2017. A letter reflecting the revisions was delivered to the PCDSS on March 14, 2017.

examined at following the birth and delivery of [C.H.]. These records are now filed in the case record. PCDSS does not agree that the father's records need to be reviewed unless there is a need demonstrated by the records of C.H."

CPO Recommendation 8: If there has been no assessment into the concerns, then it is advised that the PCDSS open an assessment immediately into the allegations of sexual abuse, assess C.H.'s safety and the risk for future victimization.

PCDSS response for Recommendation Eight:

"PCDSS does not agree with this recommendation, as this has been looked into by the local Child Advocacy Center and law enforcement and there are no concerns that require follow up that have been identified to us."

Request for Multi-Disciplinary Assessment

The CPO reviewed PCDSS' response to the recommendations. The responses did not resolve the issues raised by the CPO leaving the CPO with continued concern for C.H.'s safety. Therefore, on March 16, 2017, the CPO requested the PCDSS provide the following information:

1. Copies of the exam completed at the Pueblo Child Advocacy Center and any follow-up exams.
2. Copies of the Pueblo Police Department's report.
3. Documentation of the caseworker's contact with the Pueblo Child Advocacy Center as was reported to have occurred.
4. Medical records for C.H. and her mother from the time of C.H.'s birth.

On March 20, 2017, the CPO received the following documentation from the PCDSS:

1. Discharge summary from C.H.'s delivery
2. Pueblo Child Advocacy Center's Sex Assault Nurse Examiner (SANE) report, follow up report and supporting documentation
3. Pueblo Police Department Report
4. Emergency Room Records for C.H. from May 2014
5. Segmented medical records and discharge summary from C.H.'s hospitalization in June 2014
6. Report of Contact note entered March 16, 2017, detailing the caseworker's attempt to contact the Pueblo Child Advocacy Center to determine whether labs were ordered for C.H.
7. Report of Contact note entered March 20, 2017 which stated the caseworker had received C.H.'s medical records and placed them, along with a 718-page report (on disc) in the case file

The CPO conducted a thorough review of the information provided by the PCDSS. That review intensified the CPO's concerns for C.H.'s immediate safety. The CPO found almost two dozen facts that when, considered as a whole, should have prompted PCDSS to conduct an assessment. (A complete list of those facts in Appendix D, pages 2 to 4.)

The documents also bolstered the evidence supporting the CPO's findings of policy and law violations on the part of PCDSS. (Those violations are detailed in Section VI.)

Given the ongoing concerns for C.H.'s safety and the PCDSS' refusal to complete an assessment, the CPO sought assistance from the Colorado Department of Human Services, Division of Children, Youth and Families (CDHS-DCYF), on March 22, 2107. Specifically, the CPO requested that the CDHS-DCYF:

1. Ensure that a thorough assessment into the concerns of sexual abuse be completed.
2. Ensure that the case is staffed through a multi-disciplinary team at the Kempe Center for the purposes of the following:
    a. Review of systemic lapses that may have occurred during the handling of the specific allegations surrounding sexual abuse.
    b. Recommendations for any necessary medical follow up for C.H.
3. Ensure the CPO is advised of the completion of these recommendations and any subsequent findings.

After the CPO contacted the CDHS-DCYF, staff were instructed to begin a review of the concerns raised by the CPO. Further, the CDHS-DCYF assisted in the arranging of a multi-disciplinary staffing to review all of the medical documentation to determine any necessary next steps to ensure the health, safety and well-being of C.H.

CANES Consultation

On March 30, 2017, PCDSS notified the CPO that the case had been scheduled for a Child Abuse and Neglect Expert Staffing (CANES). The CANES consultation was coordinated by Illuminate Colorado.

The following individuals participated in the CANES consultation on April 19, 2017:

1. Jade Woodard, Executive Director, Illuminate Colorado
2. Dr. Kathi Wells, MD, FAAP, Child Abuse Pediatrician, Denver Health and Children's Hospital Colorado, Medical Director, Denver Health Clinic at the Family Crisis Center
3. Rapunzel Fuller, Child Welfare Program Administrator, PCDSS
4. Lee Hodge, Child Welfare Program Administrator, PCDSS
5. Korey Elger, Ongoing Child Welfare Administrator, CDHS
6. Stephanie Villafuerte, Child Protection Ombudsman
7. Sabrina Burbidge, Deputy Ombudsman

The CANES Report was released on April 19, 2017. According to the report, C.H. was delivered via cesarean section due to prolonged rupture of membranes (10 hours) and likely contracted the Herpes Simplex Virus (HSV) at that time. It is important to note that HSV is different from Human Papillomavirus (HPV), also known as genital warts.

The report stated:

> *"There is no medical documentation that* [C.H.] *contracted Human Papillomavirus (HPV), also known as genital warts, at birth. It is possible that* [C.H.] *did contract HPV at birth. It*

is also possible that it was contracted through sexual abuse or through non-abusive contact such as diaper changing by a caregiver with HPV/warts.

A child under 5 years of age with anogenital warts/condyloma acuminatum/HPV falls in the category of 'suspicious' for sexual abuse, but not diagnostic or highly suspicions, as there are other forms of transmission. Genital or anal condyloma acumination (manifestation of HPV) in the absence of other indicators of abuse is classified as 'finding with no expert consensus on interpretation with respect to sexual contact or trauma,' though it is noted that lesions appearing for the first time in a child older than 5 years may be more likely to be the result of sexual transmission.

Standard medical practice in cases with a child under 5 with HPV is to test for other possible sexually transmitted infections and report to child welfare for future investigation beyond that which can be done by a healthcare provider."[8]

A complete copy of the report may be found in Appendix E.

The CANES review found that there is no medical documentation confirming that C.H. contracted HPV from her mother at the time of C.H.'s birth. Thus, the PCDSS had inadequate information when the report was screened out by the department on November 23, 2016. Additionally, the CANES review found that C.H. may have contracted the virus at birth, through sexual abuse or non-abusive contact. Without the ability to definitively rule out sexual abuse, the PCDSS should have assigned a caseworker to assess the report of possible abuse.

Documentation

Throughout the investigation, the CPO also reviewed C.H.'s family history in TRAILS. During its review the CPO found the family had an open child welfare case with the PCDSS at the time the November 23, 2016 report of sexual abuse (TRAILS ID: [redacted]). The PCDSS opened the case on October 3, 2016 after C.H. and L.H.'s sibling was born and tested positive for opiates. Notes in that case also revealed the mother received no prenatal care during her pregnancy with C.H. and L.H.'s younger sibling. PCDSS was granted protective supervision of C.H. and her siblings. The children's father maintained custody and the children were placed in his care.

This information became pertinent in the CPO's investigation as it was later discovered a note entered by the caseworker incorrectly identified which child was diagnosed with anal genital warts and was possibly the victim of sexual abuse. One example of such errors was made by the PCDSS caseworker on November 29, 2016.

C.H.'s younger sibling was 1-year-old when the report of possible sexual abuse was made on November 23, 2016.

[8] Child Abuse & Neglect Expert Staffing (CANES) report, page 2

Case notes detailed a caseworker's visit with the family on November 29, 2016. (This was a scheduled visit related to the open case, and not a response to the allegation of abuse made on November 23, 2016.) During the visit, the caseworker spoke with the children's father about L.H. having genital warts.

> The case note states that the father, *"let this worker know about the concerns with* [L.H.]*'s bottom. Father took her to the doctor because he was concerned about the skin tags. Father was told that* [L.H.] *has genital warts and that they can only appear due to a sexual encounter. He was advised to follow-up with the Child Advocacy Center. Father said he and mother had taken* [L.H.] *to the doctor and the ER in the recent months and were continuously told there was nothing to worry about."*[9]

The notes indicated that the caseworker told the father she would follow-up on his concerns. There is no documentation in TRAILS of the caseworker doing so.

The following month, on December 19, 2016, the caseworker completed a home visit at the family's residence. (Again, this visit was in relation to the family's ongoing case, not an assessment of the report of possible abuse and/or neglect made on November 23, 2016.) According to case notes in TRAILS, the father again expressed concerns about C.H.'s genital warts.

> The notes state that, *"There is a concern with* [C.H.] *having genital warts which father thought were skin tags. Father followed up with what he needed to do and it was determined that the genital warts were an accidental cause from birth and the* [Pueblo Police Department] *detective and Child Advocacy Center have closed the case. Father said they have to wait 6 months to see if they go away. If they get worse during that time, then they will need to be frozen off."*[10]

On February 15, 2017, PCDSS added a note clarifying information in the case notes.

> The clarifying note stated that, *"the note stating [L.H.] had genital warts was incorrect and the child with genital warts was [C.H.]. [L.H.] never had genital warts."*[11]

By cross referencing information in TRAILS and the report filed on November 23, 2016, the CPO determine that the caseworker identified the wrong child as the subject of the report in their case note dated November 29, 2016.

In response to the CPO's inquiry about this discrepancy, the PCDSS reiterated that the decision to screen out the November 2016 report was correct and that C.H. is the only child in the household displaying symptoms of genital warts.[12]

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[9] Notes documented in TRAILS ID: [redacted]
[10] Notes documented in TRAILS ID: [redacted]
[11] Notes documented in TRAILS ID: [redacted]
[12] PCDSS emailed response to CPO inquiry received on February 22, 2017

The PCDSS added that, *"the assigned caseworker mistakenly referenced the name of as* [L.H]. *instead of* [C.H.] *in her face-to-face contact entry dated November 29, 2016, when documenting her conversation with the father who shared concerns about the child's bottom and genital warts. There was no sexual abuse concerns reported to the Department about* [L.H.]."[13]

V. Conclusion

In conclusion, the CPO found that the PCDSS, failed to comply with Volume VII and the Colorado Children's Code when making a determination to assign referrals of abuse and/or neglect for further assessment by a caseworker.

This report concludes the investigation into the complaint concerning the PCDSS with a finding of Agency Non-Compliance with Policy and Agency Non-Compliance with Law.

VI. Findings and Recommendations

At the conclusion of an investigation, the CPO may make findings that the agency/provider was not compliant with policy and/or was not compliant with law and will offer recommendations to the agency/provider for improvement of service delivery. If the CPO finds no violations of policy and/or law, the CPO may affirm the actions of the agency/provider.

The CPO maintains the discretion to issue recommendations at the conclusion of any case. The CPO cannot reverse or overturn decisions made by the agency/provider or court orders, as a result of an investigation.

Any agency/provider involved in a case will be provided a copy of the investigation prior to the report's public release. Agencies will have 10 business days to respond to any CPO findings and/or recommendations. All agency/provider's responses must be submitted in writing. Any response provided to the CPO will be included in the case report.

The CPO will consider any agency/provider response and, if necessary, revise its findings and recommendations prior to publicly releasing its case report.

Pueblo County Department of Human Services

1 Non-Compliant with Policy

Volume VII: 7.103.4(A), RED Teams

All referrals of abuse and neglect made to a county department of human services are required to be reviewed during a RED Team meeting. The report that was made to the PCDSS on November 23, 2016 – TRAILS ID: [redacted] – should have been discussed at a

[13] PCDSS emailed response to CPO inquiry received on February 22, 2017

RED team meeting. Instead, the report was screened out and not assigned to a caseworker for assessment. This delayed a proper assessment of C.H.'s safety.

RECOMMENDATION (ID – 2016-2243-F1(R1)): PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding the implementation and utilization of the RED Team framework in reviewing referrals.

2	Non-Compliant with Policy

Volume VII: 7.103.6(A)(1)(2)(3), Criteria for Assessing a Referral for Assessment

The referral received by PCDSS on February 22, 2017 – TRAILS ID: [redacted] – met the criteria for assessment. While the PCDSS was not in possession of all critical information, it did possess enough information to show that the report of suspected sexual assault met the criteria for assessment. Failing to assign the report for assessment potentially left C.H. in an unsafe environment.

RECOMMENDATION (ID – 2016-2243-F2(R1)): PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding the criteria to assign a referral for assessment if a referral contains specific allegations of known or suspected abuse and/or neglect.

RECOMMENDATION (ID – 2016-2243-F2(R2)): PCDSS to ensure all recommendations made in the CANES Consultation Report are adhered to and the CPO is provided with confirmation of their completion.

3	Non-Compliant with Policy

Volume VII: 7.107.11(H), Parameters for use of the Colorado Safety Assessment Tool

The PCDSS failed to follow policy when its caseworker did not complete a new safety assessment tool in an ongoing case – TRAILS ID: [redacted] – following the report of possible sexual abuse. Failing to do so resulted in the PCDSS leaving the sibling group in a home that had not been properly assessed for safety concerns.

RECOMMENDATION (ID – 2016-2243-F3(R1)): PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding when the Colorado Safety Assessment Tool is required under Volume VII.

4	Non-Compliant with Law

Colorado Revised Statute: 19-3-308(1)(a), Action upon report of intrafamilial, institutional, or third-part abuse (immediate response).

The PCDSS violated C.R.S. 19-3-308(1)(a) when they did not assign the report received on November 23, 2016 for assessment by a caseworker. Failing to assign the report for assessment potentially left C.H. in an unsafe environment.

RECOMMENDATION (ID – 2016-2243-F4(R1)): PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding the response requirements within the Colorado Children's Code relating to reports of child abuse and/or neglect.

5	Non-Compliant with Law

Colorado Revised Statute: 19-3-308(1.5)(a), Action upon report of intrafamilial, institutional, or third party abuse (assessment).

The PCDSS violated C.R.S. 19-3-308(1)(a) when they did not assign the report received on November 23, 2016 for assessment by a caseworker. Failing to assign the report for assessment potentially left C.H. in an unsafe environment.

RECOMMENDATION (ID – 2016-2243-F5(R1)): PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding the response requirements within the Colorado Children's Code relating to reports of child abuse and/or neglect.

6	Practice Concern

The PCDSS caseworker, on three occasions, referenced the wrong child in her documentation of the sexual abuse concerns in the TRAILS database. The inaccuracy of this documentation brings into question the credibility of the documentation throughout the ongoing child protection case.

RECOMMENDATION (ID – 2016-2243-F6(R1)): PCDSS offer continuing education to the caseworker involved in this case regarding accurate documentation of interactions in the TRAILS database.

VII. Recommendation Summary

Pursuant to C.R.S. §19-3.3-103(2)(e) the CPO has the authority to "recommend to the general assembly, the executive director, and any appropriate agency or entity statutory, budgetary, regulatory, and administrative changes, including systemic changes, to improve the safety of and promote better outcomes for children and families receiving child protection services in Colorado."

While the CPO does not have authority to mandate compliance with its recommendations, all recommendations issued by the CPO are provided to the agency/provider's supervising entity and to citizens through public reports.

Recommendation ID	CPO Finding	Agency/Provider Response	Agree/Disagree
2016-2243-F1(R1)	Finding One: Non-Compliant w/ Policy	Yes	Partially Agree
2016-2243-F2(R1)	Finding Two: Non-Compliant w/ Policy	Yes	Partially Agree
2016-2243-F2(R2)	Finding Two: Non-Compliant w/ Policy	Yes	Agree
2016-2243-F3(R1)	Finding Three: Non-Compliant w/ Policy	Yes	Partially Agree
2016-2243-F4(R1)	Finding Four: Non-Compliant w/ Law	Yes	Agree
2016-2243-F5(R1)	Finding Five: Non-Compliant w/ Law	Yes	Partially Agree
2016-2243-F6(R1)	Finding Six: Practice Concern	Yes	Agree

A complete copy of the PCDSS' response may be found in Appendix A.

The CPO is appreciative of the openness of the PCDSS throughout this investigative process and recognizes all of the hard work that the Department is doing to ensure that children of Pueblo County receive the best possible care and services to help them thrive.

With Regards,

Melissa Vigil
Child Protection Systems Analyst

Sabrina Burbidge
Deputy Ombudsman

Approved:

Stephanie Villafuerte
Ombudsman

APPENDIX A

Agency/Provider Response

Any agency/provider involved in a case will be provided a copy of the investigation report prior to the report's public release. Agencies will have 10 business days to respond to any CPO findings and/or recommendations. All agency/provider's responses must be submitted in writing. Any response provided to the CPO will be included in the case report.

The CPO will consider any agency/provider response and, if necessary, revise its findings and recommendations prior to publicly releasing its case report.

The CPO provided a copy of this investigation report to the agency/provider listed in Section II of this report on June 30, 2017. The agency/provider submitted their written responses on July 14, 2017

Recommendation ID	CPO Finding	Agency/Provider
2016-2243-F1(R1)	Non-Compliant w/ Policy	Partially Agree
CPO Recommendation: PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding the implementation and utilization of the RED Team framework in reviewing referrals.		
PCDSS Response: PCDSS will work with CDHS to try to obtain training to offer to caseworkers and supervisors in Pueblo County.		

Recommendation ID	CPO Finding	Agency/Provider
2016-2243-F2(R1)	Non-Compliant w/ Policy	Partially Agree
CPO Recommendation: PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding the criteria to assign a referral for assessment if a referral contains specific allegations of known or suspected abuse and/or neglect.		
PCDSS Response: PCDSS does not believe that the decision to assign was the issue – the definition of abuse/neglect was the issue. However, PCDSS will work with CDHS to try to obtain training to offer to caseworkers and supervisors in Pueblo County.		

Recommendation ID	CPO Finding	Agency/Provider
2016-2243-F2(R2)	Non-Compliant w/ Policy	Agree
CPO Recommendation: PCDSS to ensure all recommendations made in the CANES Consultation Report are adhered to and the CPO is provided with confirmation of their completion.		
PCDSS Response: The Caseworker Manager reports that all recommendations on the CANES Consultation Report have been completed.		

Recommendation ID	CPO Finding	Agency/Provider
2016-2243-F3(R1)	Non-Compliant w/ Policy	Partially Agree
CPO Recommendation: PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding when the Colorado Safety Assessment Tool is required under Volume VII.		
PCDSS Response: PCDSS will work with CDHS to try to obtain training to offer to caseworkers and supervisors in Pueblo County.		

Recommendation ID	CPO Finding	Agency/Provider
2016-2243-F4(R1)	Non-Compliant w/ Law	Agree
CPO Recommendation: PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding the response requirements within the Colorado Children's Code relating to reports of child abuse and/or neglect.		
PCDSS Response: PCDSS will work with CDHS to try to obtain training to offer to caseworkers and supervisors in Pueblo County.		

Recommendation ID	CPO Finding	Agency/Provider
2016-2243-F5(R1)	Non-Compliant w/ Law	Partially Agree
CPO Recommendation: PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding the response requirements within the Colorado Children's Code relating to reports of child abuse and/or neglect.		
PCDSS Response: PCDSS will work with CDHS to try to obtain training to offer to caseworkers and supervisors in Pueblo County.		

Recommendation ID	CPO Finding	Agency/Provider
2016-2243-F6(R1)	Practice Concern	Agree
CPO Recommendation: PCDSS offer continuing education to the caseworker involved in this case regarding accurate documentation of interactions in the TRAILS database.		
PCDSS Response: PCDSS will offer training and support on accurate documentation to the caseworker involved in this case.		

APPENDIX B

CHILD PROTECTION OMBUDSMAN of COLORADO

February 24, 2017

Tim Hart, Director
Pueblo County Department of Social Services
201 West 8th Street
Pueblo, Colorado 81003
[redacted]

RE: Ombudsman Complaint Regarding Referral ID: [redacted]

Dear Mr. Hart,

I am writing in reference to the complaint filed with the Office of Colorado's Child Protection Ombudsman (CPO) concerning TRAILS Referral ID: [redacted]. The CPO opened the complaint for review on December 7, 2016. A summary of our review and findings are outlined below.

I. Originating Complaint Summary

The CPO received a complaint concerning TRAILS Referral ID: [redacted]. The complainant stated that there had been a report regarding alleged Sexual Abuse made to the Pueblo County Department of Social Services (PCDSS) on November 23, 2016 and it had not been assigned for assessment. The CPO opened the complaint for review on December 7, 2016.

II. CPO Review Process

The CPO carefully reviewed the complaint, including the referral made to PCDSS on November 23, 2016, as well as Volume VII rule and the Colorado Children's Code. The CPO also reviewed the TRAILS assessments and cases of the child involved in the referral.

Upon review of TRAILS Referral ID: [redacted] to PCDSS, caseworker notes reflect a telephone call with a mandated reporter. The caseworker wrote:

"[redacted] was seen 15 minutes ago and had no information other than she examined the child and believes child may have been sexually abused. She said father told her he got

custody of the children about a month ago due to mother's drug use. Father did not make any allegations of sex abuse. He brought child in to be examined for what he thought was skin tags on [redacted]'s bottom. Caller states [redacted] does not have skin tags. Caller said child has genital warts around her anus which is caused by sexual abuse. Worker asked if the warts could be from mother, if mother had genital warts when the child was born. Caller said it was more likely that child was sexually abused. Caller said father expressed concerns about maternal grandfather in the past but did not state concerns about sexual abuse. Caller is going to report to police and see if they want a forensic exam."

CPO reviewed TRAILS Referral ID: [redacted] and found it to be screened out on November 23, 2016 without Red Team. PCDSS's reason for not accepting the referral for assessment indicated *"no information available from reporter of abuse and neglect as defined in law."*

CPO reviewed all TRAILS history pertaining to the family and found TRAILS Case ID: [redacted] to be currently open with PCDSS. The case opened on October 3, 2016 because baby [redacted] was born drug exposed, testing positive for opiates and mother did not receive any prenatal care. On October 12, 2016, a Dependency & Neglect (D&N) Petition was filed and PCDSS was granted protective supervision of [redacted], [redacted], [redacted] and Luis with custody remaining with father. PCDSS was granted legal custody of [redacted] and she was placed in kinship care with the father of [redacted].

Notes within TRAILS Case: [redacted] indicate the caseworker briefly spoke with the father on November 29 and December 19, 2016 about the genital warts. Client contact details within the case confirmed that [redacted] was almost 2 ½ years old and [redacted] was 1 ½ years old at the time the case opened with PCDSS.

On November 29, 2016, the caseworker completed a home visit at the family residence. Notes reflect that the ongoing caseworker briefly spoke with father about '[redacted]' having genital warts. The case note stated:

"... father let this worker know about the concerns with [redacted]'s bottom. Father took her to the doctor because he was concerned about the skin tags. Father was told that [redacted] has genital warts and that can only appear due to a sexual encounter. He was advised to follow-up with the Child Advocacy Center. Father said he and mother had taken [redacted] to the doctor and the ER in the recent months and were continuously told there was nothing to worry about."

The caseworker indicated that she would follow-up thereafter but notes did not reflect any follow up by the caseworker occurred.

On December 19, 2016, the caseworker completed a home visit at the family residence and TRAILS reflects a conversation between the caseworker and the father which stated there was a concern regarding [redacted] having genital warts. The note stated:

> *"There is a concern with [redacted] having genital warts which father thought were skin tags. Father followed up with what he needed to do and it was determined that the genital warts were an accidental cause from birth and the Detective and Child Advocacy Center have closed the case. Father said they have to wait 6 months to see if they go away. If they get worse during that time, then they will need to be frozen off."*

Due to lack of documentation, there is no way to corroborate that the caseworker had a conversation or obtained records from any medical provider, the Detective or Child Advocacy Center verifying that an investigation occurred or verifying how the child contracted genital warts. The documentation only suggests that the information gained about the genital warts was from father; therefore, there is no way to ensure safety concerns had been addressed.

Further, a review of the TRAILS Case ID: [redacted] documentation revealed that the Colorado Safety Assessment tool was not completed at the time of the new sexual abuse allegations in accordance with Volume VII which requires the tool to be completed in situations that might pose a new or renewed threat to child safety.

On February 14, 2017, the CPO contacted PCDSS with the following requests for information:

1. Please advise as to why the referral was screened out and Red Team was not utilized.

2. The initial screened out referral referenced concerns regarding [redacted] only. Please advise if there were concerns for both children displaying the symptoms of the disease and concerns for possible sexual abuse.

3. If it was determined that the disease was contracted accidentally at birth, did mother's hospital records reflect an outbreak at the time the child(ren) were

born? Was her medical history reviewed by the caseworker? Where has this information been documented in the case?

On February 14, 2017, the CPO received a response from PCDSS, [redacted], in reference to the first question only. [redacted] reported after further review and analysis of Referral ID: [redacted], PCDSS noted:

> *"...genital warts in and of themselves are not an indicator of sexual abuse, and therefore there was no actual allegation of sexual abuse. We have been trained, in the Medical Aspects of Child Maltreatment offered by the Child Welfare Training System, that this is the case."*

[redacted] also advised:

> *"...in the absence of other reasons for the supposition of child abuse, the referral was screened out and the worker appropriately followed up the concern with the parent of the child, along with a referral to an appropriate community resource that could provide an informed opinion."*

Further, [redacted] stated that *"our interpretation is that Red Team is not required if there is not an actual allegation of abuse or neglect."*

On February 15, 2017, PCDSS added a note to TRAILS Case ID: [redacted] clarifying the note from December 19, 2016. The worker notated:

> *"...the note stating [redacted] had genital warts was incorrect and the child with genital warts was Leticia. [redacted] never had genital warts."*

On February 21, 2017, due to the discrepancies of which child had genital warts, CPO reviewed the TRAILS Hotline ID: [redacted]. The entire recording was not captured as it was answered by the crisis unit. The recorded call reflects that the mandated reporter called and stated:

> *"I am needing to make a report and speak with a supervisor because I have a 2 ½ year old here with warts all around her anus."*

By cross-referencing the age details provided by the mandated reporter and client information in TRAILS, CPO believes the TRAILS Referral and Hotline call confirm the

concerns are related to [redacted] as the alleged victim because [redacted] is 2 ½ years old. Based on case documentation from November 29, December 19, February 15 and the referral dated November 23, the CPO became concerned about inconsistencies in documentation by the caseworker regarding the identification of the children and who was the alleged victim.

On February 22, 2017, the CPO advised PCDSS [redacted] of the CPO's concerns regarding the inaccurate documentation and that the allegations of Sexual Abuse had not been investigated or properly addressed within the referral or the open child welfare case. Due to concerns for the vulnerability of the child and the unaddressed allegations of sexual abuse, the CPO requested that an immediate assessment of the Sexual Abuse allegations occur.

On February 22, 2017, the CPO received a response from PCDSS, [redacted] in reference to the second and third questions in the CPO February 14, 2017 request. [redacted] reported that after gathering all the important facts and details concerning the referral, the case records and after a conference with the assigned caseworker and supervisor:

> *"...the initial screened out referral referenced concerns regarding [redacted] are correct and [redacted] is the only child in the household displaying symptoms of genital warts. However, the assigned caseworker mistakenly referenced the name of the child, as "[redacted]" instead of "[redacted]" in her face to face contact entry dated November 29, 2016, when documenting her conversation with the father who shared concerns about the child's bottom and genital warts. There were no sexual abuse concerns reported to the Department about the child [redacted]."*

[redacted] also reported:

> *"PCDSS has requested medical and birth records in regards to the children, and the assigned caseworker will enter this information in the case file once it has been received. Although the caseworker has received conclusive information from law enforcement and the Child Advocacy Center indicating that the child, [redacted] was not a victim of Sexual Abuse and concerning how the child contracted genital warts, the assigned caseworker has not provided full and complete documentation of her follow up discussions and receipt of subsequent reports in the TRAILS record."*

Additionally, [redacted] said *"in regards to your request for this referral to be reopened and assigned for assessment, [redacted] and I have discussed the matter and will enter a new*

referral on February 23, 2017 concerning Sexual Abuse allegations, which will be RED teamed on February 24, 2017."

On February 23, 2017, the CPO confirmed that in fact, a new referral had been generated by PCDSS and entered into the database under TRAILS Referral ID: [redacted]

III. Identified Violation of Volume VII Rule

The following violations were noted relating to the lack of response to the original referral concerning allegations of Sexual Abuse:

7.103.4(A) Red Teams
"County departments shall develop and implement a process utilizing the RED Team framework to review referrals and determine response times. The RED Team process shall be utilized for all referrals."

7.103.6(A)(1)(2)(3) Criteria for Assigning a Referral for Assessment
"County departments shall assign a referral for assessment if it:
1. Contains specific allegations of known or suspected abuse and/or neglect as defined in Section 7.000.2;
2. Provides sufficient information to locate the alleged victim; and,
3. Identifies a victim under the age of eighteen (18)."

7.107.11(H) Parameters for Use of the Colorado Safety Assessment Tool
"The Colorado Family Safety Assessment shall be completed:
H. Whenever there is a significant change in family circumstances or situations that might pose a new or renewed threat to child safety."

IV. Identified Violations of Colorado Children's Code

The following violations were noted relating to the lack of response to the original referral concerning allegations of Sexual Abuse:

19-3-308(1)(a). Action upon report of intrafamilial, institutional, or third-party abuse – investigations – child protection team - rules.
"The county department shall respond immediately upon receipt of any report of a known or suspected incident of intrafamilial abuse or neglect to assess the abuse involved and the appropriate response to the report. The assessment shall be in accordance with rules adopted by the state board of social services to determine the

risk of harm to such child and the appropriate response to such risks. Appropriate responses shall include, but are not limited to, screening reports that do not require further investigation, providing appropriate intervention services, pursuing reports that require further investigation, and conducting immediate investigations. The immediate concern of any assessment or investigation shall be the protection of the child, and, where possible, the preservation of the family unit."

19-3-308(1.5)(a). Action upon report of intrafamilial, institutional, or third-party abuse – investigations – child protection team - rules.
"Upon referral to the county department, the county department shall assess the possibility of abuse or neglect."

V. Conclusion

After completing a review into the complaint filed with the CPO on December 7, 2016, the CPO concludes this review as Agency Non-Compliance with Policy (Volume VII) and Agency Non-Compliance with Law (Colorado Children's Code). The CPO makes the following recommendations for PCDSS:

1. Training for all caseworkers and supervisors regarding implementation and utilization of the RED Team framework in reviewing referrals.

2. Training for all caseworkers and supervisors regarding the criteria to assign a referral for assessment if a referral contains specific allegations of known or suspected abuse and/or neglect.

3. Training for all caseworkers and supervisors regarding when the Colorado Safety Assessment Tool is required under Volume VII rule.

4. PCDSS to make appropriate corrections to the TRAILS Case to accurately reflect throughout case notes which child was diagnosed with genital warts.

5. PCDSS to verify and document Department's communications with law enforcement in determining whether or not maltreatment of the child occurred resulting in [redacted] contacting genital warts from Sexual Abuse.

6. PCDSS to verify and document whether or not the child was interviewed and forensically examined at the Child Advocacy Center, the outcome of the interview

and why the case with the Advocacy Center closed.

7. PCDSS to obtain, verify and document medical records for mother, father, [redacted] and [redacted] to confirm if mother potentially had a documented outbreak of genital warts at the time of delivery, if in fact, the child contracted genital warts at birth, and any ER documentation that would verify the child had been seen at the hospital in recent months prior to the report being filed with PCDSS.

8. If there has been no assessment into the concerns, then it is advised that PCDSS open an assessment immediately into the allegations of Sexual Abuse, assess the child's safety and the risk for future victimization.

Recommendations are designed to improve overall service delivery and practice within your county and for the families you serve. The CPO request PCDSS confirm receipt of this letter and provide documentation of any plan developed to address the recommendations made herein. The CPO requests that any response by the PCDSS be provided in writing within 14 calendar days from the date of receipt of this letter. The CPO will document such feedback and/or plan for tracking purposes and will release the recommendations and feedback in accordance with the CPO public report release policy.

Thank you for your time and attention to this matter and please contact this office with any questions you have regarding the review of this complaint.

With Regards,

Melissa Vigil

Melissa Vigil
Child Protection Systems Analyst

Approved:

Stephanie Villafuerte

Stephanie Villafuerte
Ombudsman

APPENDIX C

CHILD PROTECTION OMBUDSMAN of COLORADO

March 14, 2017

Tim Hart, Director
Pueblo County Department of Social Services
201 West 8th Street
Pueblo, Colorado 81003
[redacted]

RE: Ombudsman Complaint Regarding Referral ID: [redacted]

Dear Mr. Hart,

I am writing in reference to the complaint filed with the Office of Colorado's Child Protection Ombudsman (CPO) concerning TRAILS Referral ID: [redacted]. The CPO opened the complaint for review on December 7, 2016. A summary of our review and findings are outlined below.

I. Originating Complaint Summary

The CPO received a complaint concerning TRAILS Referral ID: [redacted]. The complainant stated that there had been a report regarding alleged Sexual Abuse made to the Pueblo County Department of Social Services (PCDSS) on November 23, 2016 and it had not been assigned for assessment. The CPO opened the complaint for review on December 7, 2016.

II. CPO Review Process

The CPO carefully reviewed the complaint, including the referral made to PCDSS on November 23, 2016, as well as Volume VII rule and the Colorado Children's Code. The CPO also reviewed the TRAILS assessments and cases of the child involved in the referral.

Upon review of TRAILS Referral ID: [redacted] to PCDSS, caseworker notes reflect a telephone call with a mandated reporter. The caseworker wrote:

"[redacted] was seen 15 minutes ago and had no information other than she examined the child and believes child may have been sexually abused. She said father told her he got

custody of the children about a month ago due to mother's drug use. Father did not make any allegations of sex abuse. He brought child in to be examined for what he thought was skin tags on [redacted]'s bottom. Caller states [redacted] does not have skin tags. Caller said child has genital warts around her anus which is caused by sexual abuse. Worker asked if the warts could be from mother, if mother had genital warts when the child was born. Caller said it was more likely that child was sexually abused. Caller said father expressed concerns about maternal grandfather in the past but did not state concerns about sexual abuse. Caller is going to report to police and see if they want a forensic exam."

CPO reviewed TRAILS Referral ID [redacted] and found it to be screened out on November 23, 2016 without Red Team. PCDSS's reason for not accepting the referral for assessment indicated *"no information available from reporter of abuse and neglect as defined in law."*

CPO reviewed all TRAILS history pertaining to the family and found TRAILS Case ID: [redacted] to be currently open with PCDSS. The case opened on October 3, 2016 because baby [redacted] was born drug exposed, testing positive for opiates and mother did not receive any prenatal care. On October 12, 2016, a Dependency & Neglect (D&N) Petition was filed and PCDSS was granted protective supervision of [redacted], [redacted], [redacted] and [redacted] with custody remaining with father. PCDSS was granted legal custody of [redacted] and she was placed in kinship care with the father of [redacted]

Notes within TRAILS Case: [redacted] indicate the caseworker briefly spoke with the father on November 29 and December 19, 2016 about the genital warts. Client contact details within the case confirmed that [redacted] was almost 2 ½ years old and [redacted] was 1 ½ years old at the time the case opened with PCDSS.

On November 29, 2016, the caseworker completed a home visit at the family residence. Notes reflect that the ongoing caseworker briefly spoke with father about '[redacted]' having genital warts. The case note stated:

"... father let this worker know about the concerns with [redacted]'s bottom. Father took her to the doctor because he was concerned about the skin tags. Father was told that [redacted] has genital warts and that can only appear due to a sexual encounter. He was advised to follow-up with the Child Advocacy Center. Father said he and mother had taken [redacted] to the doctor and the ER in the recent months and were continuously told there was nothing to worry about."

The caseworker indicated that she would follow-up thereafter but notes did not reflect any follow up by the caseworker occurred.

On December 19, 2016, the caseworker completed a home visit at the family residence and TRAILS reflects a conversation between the caseworker and the father which stated there was a concern regarding [redacted] having genital warts. The note stated:

> *"There is a concern with [redacted] having genital warts which father thought were skin tags. Father followed up with what he needed to do and it was determined that the genital warts were an accidental cause from birth and the Detective and Child Advocacy Center have closed the case. Father said they have to wait 6 months to see if they go away. If they get worse during that time, then they will need to be frozen off."*

Due to lack of documentation, there is no way to corroborate that the caseworker had a conversation or obtained records from any medical provider, the Detective or Child Advocacy Center verifying that an investigation occurred or verifying how the child contracted genital warts. The documentation only suggests that the information gained about the genital warts was from father; therefore, there is no way to ensure safety concerns had been addressed.

Further, a review of the TRAILS Case ID:[redacted] documentation revealed that the Colorado Safety Assessment tool was not completed at the time of the new sexual abuse allegations in accordance with Volume VII which requires the tool to be completed in situations that might pose a new or renewed threat to child safety.

On February 14, 2017, the CPO contacted PCDSS with the following requests for information:

1. Please advise as to why the referral was screened out and Red Team was not utilized.

2. The initial screened out referral referenced concerns regarding [redacted] only. Please advise if there were concerns for both children displaying the symptoms of the disease and concerns for possible sexual abuse.

3. If it was determined that the disease was contracted accidentally at birth, did mother's hospital records reflect an outbreak at the time the child(ren) were

born? Was her medical history reviewed by the caseworker? Where has this information been documented in the case?

On February 14, 2017, the CPO received a response from PCDSS, [redacted] in reference to the first question only. [redacted] reported after further review and analysis of Referral ID: [redacted] PCDSS noted:

"...genital warts in and of themselves are not an indicator of sexual abuse, and therefore there was no actual allegation of sexual abuse. We have been trained, in the Medical Aspects of Child Maltreatment offered by the Child Welfare Training System, that this is the case."

[redacted] also advised:

"...in the absence of other reasons for the supposition of child abuse, the referral was screened out and the worker appropriately followed up the concern with the parent of the child, along with a referral to an appropriate community resource that could provide an informed opinion."

Further, [redacted] stated that *"our interpretation is that Red Team is not required if there is not an actual allegation of abuse or neglect."*

On February 15, 2017, PCDSS added a note to TRAILS Case ID: [redacted] clarifying the note from December 19, 2016. The worker notated:

"...the note stating [redacted] had genital warts was incorrect and the child with genital warts was [redacted] never had genital warts."

On February 21, 2017, due to the discrepancies of which child had genital warts, CPO reviewed the TRAILS Hotline ID: [redacted] The entire recording was not captured as it was answered by the crisis unit. The recorded call reflects that the mandated reporter called and stated:

"I am needing to make a report and speak with a supervisor because I have a 2 ½ year old here with warts all around her anus."

By cross-referencing the age details provided by the mandated reporter and client information in TRAILS, CPO believes the TRAILS Referral and Hotline call confirm the

concerns are related to [redacted] as the alleged victim because [redacted] is 2 ½ years old. Based on case documentation from November 29, December 19, February 15 and the referral dated November 23, the CPO became concerned about inconsistencies in documentation by the caseworker regarding the identification of the children and who was the alleged victim.

On February 22, 2017, the CPO advised PCDSS [redacted] of the CPO's concerns regarding the inaccurate documentation and that the allegations of Sexual Abuse had not been investigated or properly addressed within the referral or the open child welfare case. Due to concerns for the vulnerability of the child and the unaddressed allegations of sexual abuse, the CPO requested that an immediate assessment of the Sexual Abuse allegations occur.

On February 22, 2017, the CPO received a response from PCDSS, [redacted] in reference to the second and third questions in the CPO February 14, 2017 request. [redacted] reported that after gathering all the important facts and details concerning the referral, the case records and after a conference with the assigned caseworker and supervisor:

> *"...the initial screened out referral referenced concerns regarding [redacted] are correct and [redacted] is the only child in the household displaying symptoms of genital warts. However, the assigned caseworker mistakenly referenced the name of the child, as "[redacted]" instead of "[redacted]" in her face to face contact entry dated November 29, 2016, when documenting her conversation with the father who shared concerns about the child's bottom and genital warts. There were no sexual abuse concerns reported to the Department about the child [redacted]."*

[redacted] also reported:

> *"PCDSS has requested medical and birth records in regards to the children, and the assigned caseworker will enter this information in the case file once it has been received. Although the caseworker has received conclusive information from law enforcement and the Child Advocacy Center indicating that the child, [redacted] was not a victim of Sexual Abuse and concerning how the child contracted genital warts, the assigned caseworker has not provided full and complete documentation of her follow up discussions and receipt of subsequent reports in the TRAILS record."*

Additionally, [redacted] said *"in regards to your request for this referral to be reopened and assigned for assessment, [redacted] and I have discussed the matter and will enter a new*

referral on February 23, 2017 concerning Sexual Abuse allegations, which will be RED teamed on February 24, 2017."

On February 23, 2017, the CPO confirmed that in fact, a new referral had been generated by PCDSS and entered into the database under TRAILS Referral ID: [redacted]

III. Identified Violation of Volume VII Rule

The following violations were noted relating to the lack of response to the original referral concerning allegations of Sexual Abuse:

7.103.4(A) Red Teams
"County departments shall develop and implement a process utilizing the RED Team framework to review referrals and determine response times. The RED Team process shall be utilized for all referrals."

7.103.6(A)(1)(2)(3) Criteria for Assigning a Referral for Assessment
"County departments shall assign a referral for assessment if it:
1. Contains specific allegations of known or suspected abuse and/or neglect as defined in Section 7.000.2;
2. Provides sufficient information to locate the alleged victim; and,
3. Identifies a victim under the age of eighteen (18)."

7.107.11(H) Parameters for Use of the Colorado Safety Assessment Tool
"The Colorado Family Safety Assessment shall be completed:
H. Whenever there is a significant change in family circumstances or situations that might pose a new or renewed threat to child safety."

IV. Identified Violations of Colorado Children's Code

The following violations were noted relating to the lack of response to the original referral concerning allegations of Sexual Abuse:

19-3-308(1)(a). Action upon report of intrafamilial, institutional, or third-party abuse – investigations – child protection team - rules.
"The county department shall respond immediately upon receipt of any report of a known or suspected incident of intrafamilial abuse or neglect to assess the abuse involved and the appropriate response to the report. The assessment shall be in accordance with rules adopted by the state board of social services to determine the

risk of harm to such child and the appropriate response to such risks. Appropriate responses shall include, but are not limited to, screening reports that do not require further investigation, providing appropriate intervention services, pursuing reports that require further investigation, and conducting immediate investigations. The immediate concern of any assessment or investigation shall be the protection of the child, and, where possible, the preservation of the family unit."

19-3-308(1.5)(a). Action upon report of intrafamilial, institutional, or third-party abuse – investigations – child protection team - rules.
"Upon referral to the county department, the county department shall assess the possibility of abuse or neglect."

V. Conclusion

After completing a review into the complaint filed with the CPO on December 7, 2016, the CPO concludes this review as Agency Non-Compliance with Policy (Volume VII) and Agency Non-Compliance with Law (Colorado Children's Code). The CPO makes the following recommendations for PCDSS:

1. PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding the implementation and utilization of the RED Team framework in reviewing referrals.

2. PCDSS offer refresher training for the caseworkers and supervisors involved at this decision point on TRAILS Referral ID: [redacted] regarding the criteria to assign a referral for assessment if a referral contains specific allegations of known or suspected abuse and/or neglect.

3. PCDSS offer refresher training for the caseworkers and supervisors involved in the assessment of safety on TRAILS Case ID: [redacted] regarding when the Colorado Safety Assessment Tool is required under Volume VII rule.

4. PCDSS to make appropriate corrections to the TRAILS Case to accurately reflect throughout case notes which child was diagnosed with genital warts.

5. PCDSS to verify and document Department's communications with law enforcement in determining whether or not maltreatment of the child occurred resulting in [redacted] contacting genital warts from Sexual Abuse.

6. PCDSS to verify and document whether or not the child was interviewed and forensically examined at the Child Advocacy Center, the outcome of the interview and why the case with the Advocacy Center closed.

7. PCDSS to obtain, verify and document medical records for mother, father, [redacted] and [redacted] to confirm if mother potentially had a documented outbreak of genital warts at the time of delivery, if in fact, the child contracted genital warts at birth, and any ER documentation that would verify the child had been seen at the hospital in recent months prior to the report being filed with PCDSS.

8. If there has been no assessment into the concerns, then it is advised that PCDSS open an assessment immediately into the allegations of Sexual Abuse, assess the child's safety and the risk for future victimization.

Recommendations are designed to improve overall service delivery and practice within your county and for the families you serve. The CPO request PCDSS confirm receipt of this letter and provide documentation of any plan developed to address the recommendations made herein. The CPO requests that any response by the PCDSS be provided in writing within 14 calendar days from the date of receipt of this letter. The CPO will document such feedback and/or plan for tracking purposes and will release the recommendations and feedback in accordance with the CPO public report release policy.

Thank you for your time and attention to this matter and please contact this office with any questions you have regarding the review of this complaint.

With Regards,

Melissa Vigil

Melissa Vigil
Child Protection Systems Analyst

Approved:

Stephanie Villafuerte

Stephanie Villafuerte
Ombudsman

APPENDIX D

CHILD PROTECTION OMBUDSMAN of COLORADO

March 22, 2017

Tim Hart, Director
Pueblo County Department of Social Services
201 West 8th Street
Pueblo, Colorado 81003

[redacted]

RE: Ombudsman Complaint Regarding Referral ID: [redacted]

Dear Mr. Hart,

I am writing to follow up regarding the Office of Colorado's Child Protection Ombudsman's (CPO) review of a complaint received concerning TRAILS Referral ID: [redacted]. The CPO opened the original complaint for review on December 7, 2016. The complaint was open due to a lack of response by Pueblo County Department of Social Services (PCDSS) to allegations of sexual abuse concerning [redacted] ([redacted]). During the course of its review, the CPO made a number of compliance findings and recommendations. A letter outlining those findings and recommendations was sent to PCDSS on February 24, 2017. (See Appendix A) PCDSS submitted a written response to the CPO findings and recommendations on March 9, 2017. (See Appendix B)

After considering PCDSS' response, the CPO emailed a revised letter of disposition to PCDSS on March 14, 2017. (See Appendix C). The CPO, however, remains concerned about [redacted]'s safety and PCDSS' continued assertion that medical records confirm that the anal genital warts on [redacted] are due to her mother having a documented outbreak of the herpes simplex virus at the time of [redacted]'s birth. Additionally, the CPO is troubled by PCDSS' documentation of this case in TRAILS, its analysis of critical information and PCDSS' refusal to assess the allegations in [redacted]'s case.

After reviewing PCDSS' response, submitted on March 9, 2017, and its corresponding information in the TRAILS database, the CPO found the documentation to be unclear and not helpful in resolving the concerns. Therefore, on March 16, 2017, the CPO requested the PCDSS provide the following additional information:

1. Copies of the exam completed at the Pueblo Child Advocacy Center and any follow up exams.
2. Copies of the police report.

3. Documentation of the caseworker's contact with the Pueblo Child Advocacy Center as was reported to have occurred in the PCDSS March 9, 2017 response.
4. Medical records on [redacted] and her mother from the time of [redacted]'s birth.

On March 20, 2017, the CPO received the following documentation from PCDSS:

1. Discharge Summary from [redacted]'s delivery.
2. Pueblo Child Advocacy Center's Sex Assault Nurse Examiner (SANE) report, follow up report and supporting documentation.
3. Pueblo Police Department Report 16-[redacted]
4. Emergency Room Records for [redacted] from May 2014.
5. Segmented medical records and discharge summary from [redacted]'s hospitalization June 2014.
6. Report of Contact note entered March 16, 2017, detailing the caseworker's attempt to contact the Pueblo Child Advocacy Center to determine whether labs were ordered for [redacted].
7. Report of Contact note entered March 20, 2017 which stated the caseworker had received [redacted]'s medical records and placed them, along with a 718-page report (on disc) in the case file.

The CPO conducted a thorough review of the information provided by PCDSS and following the review the CPO's concerns have intensified regarding the child's immediate safety. At the conclusion of its review, the CPO found almost two dozen facts that when considered as a whole, should have prompted PCDSS to conduct an assessment. Below is a list of those facts and the corresponding documents they were obtained from.

Discharge Summary from [redacted]'s Delivery:

- [redacted] was delivered by caesarian section due to the mother not dilating in a timely manner.
- The only diagnoses made for [redacted] at the time of discharge were the mother's lack of prenatal care (total of six visits), delivery by caesarian section, heart murmur and intrauterine drug exposure.
- [redacted] was discharged to her mother's care with no noted complications and no required follow up outside of her normal pediatric appointments.

Emergency Room Records for [redacted] from May 2014:

- [redacted] was seen in the emergency room at 6-days-old for hyperthermia, scalp lesions consistent with the herpes simplex virus and sepsis evaluation. [redacted] was admitted on May 27, 2014 and discharged May 30, 2014 pending lab results.
- The only complication noted for her mother's pregnancy, labor or delivery was limited prenatal care.

- The mother told emergency room staff she did not have a history of the herpes virus, genital herpes or herpes labialis.

Discharge Summary for Hospitalization (June 1 to June 23, 2014):

- [redacted] was positive for:
  - Meningitis, herpes simplex
  - Sepsis due to herpes simplex
  - Herpes simplex virus
- [redacted] was hospitalized for 21 days to receive intravenous antiviral therapy.

Pueblo Child Advocacy Center SANE Report, Follow Up and Supporting Documentation:

- [redacted] was referred to the Pueblo Child Advocacy Center by Pueblo Community Health Center regarding genital warts questioning sexual abuse and/or assault.
- Father reported that [redacted] was hospitalized for 1.5 months after her birth for complications at birth related to mother's herpes virus.
- Father reported that mother tested positive for HPV at the time of delivery.
- Father reported numerous times that the mother had herpes at the time of delivery.
- Physical assessment showed a total of five areas of "healed scarring" on [redacted]'s upper thigh and ankle.
- Diagnosed with anal genital warts present on anus and the right inner buttocks.
- SANE nurse wrote that the *"Mother had HPV when child was born, child was at Memorial Hospital for 1.5 mos. after birth related to this complication per Father's report."*
- Recommendations that [redacted] have continued follow-up with her primary care physician, including genital assessments.

Pueblo Police Department Report 16-[redacted]:

- Father stated [redacted] had been seen three to four months prior to this report for what doctors determined were "skin tags" on her anus. This information was reported to father from mother.
- Father stated that due to the mother's drug use the children had been in other houses.
- Father stated that [redacted] was born and tested positive for herpes.
- Father reported that [redacted]'s mother had HPV when she gave birth to [redacted] and that it was passed to [redacted] during child birth causing her to be hospitalized at Memorial Hospital for a month and a half.
- SANE nurse wrote to law enforcement that *"warts are a virus which are often passed through means other than sexual and that warts have less than a 23% of*

being passed through sexual encounters."

- SANE nurse reported that [redacted]'s mother had HPV which was passed to [redacted] at birth and *"most likely had genital warts virus as well which did not exacerbate in [redacted] until now."*

At the conclusion of the review of all documentation in TRAILS and the documentation provided by the PCDSS, the CPO remains gravely concerned that the allegations of sexual abuse have not been thoroughly assessed.

The CPO found that the documentation (listed above) that PCDSS relied upon to screen out Referral ID: [redacted] should have resulted in an assessment and screening out the referral was a violation of policy and law. Specifically, the following information demonstrates why the PCDSS should have opened an assessment into the alleged sexual abuse:

- There are no medical records that provide support for the statements that [redacted]'s mother had a herpes outbreak or HPV at the time of the child's birth.
- There is no consideration for how the virus, if active at time of delivery, would have spread to [redacted] given she was delivered by caesarian section.
- Law enforcement and the Child Advocacy Center made their determinations that [redacted] did not suffer sexual abuse based on incorrect and/or unverified information provided to them by the father.
- No independent assessment was completed by any party to ensure that the information father was providing concerning the mother's medical history was accurate.
- Law enforcement and PCDSS did not investigate the report from the SANE nurse indicating that multiple areas of scarring were found on [redacted]'s upper thigh and ankle during her SANE exam.
- There is no documentation in TRAILS that indicates that PCDSS has confirmed that [redacted] has received the follow-up medical care recommended by the SANE nurse in the December 8, 2016 exam report. These recommendations included following up with the SANE primary care physician (PCP) and continued PCP follow up to include genital assessments.

The CPO remains convinced that [redacted] remains in a situation that is potentially unsafe and PCDSS has refused to complete a thorough assessment of her safety. Due to the urgency of concerns for [redacted]'s safety, the CPO is seeking assistance from the Colorado Department of Human Services – Division of Child Welfare (CDHS-DCW), as the supervising entity for PCDSS, for the following:

1. Ensure that a thorough assessment into the concerns of sexual abuse be completed.

2. Ensure that the case is staffed through a multi-disciplinary team at the Kempe Center for the purpose of the following:

a. Review of systemic lapses that may have occurred during the handling of the specific allegations surrounding sexual abuse.
b. Recommendations for any necessary medical follow up care for [redacted]

3. Ensure the CPO is advised of the completion of these recommendations and any subsequent findings.

The CPO has opened an investigation into the actions of PCDSS as they relate to [redacted]'s case. The CPO will continue gather information and monitor the case. A case report detailing its findings will be forthcoming.

Sincerely,

Stephanie Villafuerte
Child Protection Ombudsman

Sabrina Burbidge
Deputy Ombudsman

APPENDIX E

Child Abuse & Neglect Expert Staffing (CANES)
Coordinated by Illuminate Colorado

Requesting Agency: Pueblo County Department of Human Services

Date of Consult: 4/19/2017

CANES Team in Attendance:

- Jade Woodard, Executive Director, Illuminate Colorado
- Dr. Kathi Wells, MD, FAAP, Child Abuse Pediatrician, Denver Health and Children's Hospital Colorado, Medical Director, Denver Health Clinic at the Family Crisis Center

Attendees:

- Rapunzel Fuller, Child Welfare Program Administrator, Pueblo County DSS
- Lee Hodge, Child Welfare Program Administrator, Pueblo County DSS
- Korey Elger, Ongoing Child Welfare Administrator, Division of Child Welfare, CDHS
- Stephanie Villafuerte, Child Protection Ombudsman
- Sabrina Burbidge, Deputy Ombudsman

Purpose of CANES Consultation:

According to the CANES request, Pueblo County DHS requested consultation regarding:

- Increased understanding and explanation of medical records, specifically whether or not there are indications of sexual abuse

Structure of Consultation:

The CANES team, along with the invited experts and attendees, utilized a Records Review & Small Group Consultation model to focus on drafting considerations and recommendations for Pueblo County DHS in moving forward with management of this case.

Considerations:

- The Office of the Child Protection Ombudsman received a complaint, and subsequently opened an investigation, based on a concern from a mandatory reporter related to concerns that C. was at high risk for sexual abuse and that the allegation had not been fully investigated by Pueblo County DSS.
- C. was seen by a SANE nurse at the Pueblo Child Advocacy Center. SANE's findings state "no injuries noted consistent with physical or sexual abuse."

- Father reported to Pueblo Officer Benjamin Muniz on 11/23/16 that at the beginning of the year, he and mother had noticed growths on C. and that 3-4 months prior they had taken her to Parkview Emergency Room in Pueblo West where they were told by a doctor not to worry because she was so young. Father told Officer Muniz that mother told him that the doctor told her that the lesions were skin tags (although he did not hear the doctor state this). Additionally, father reported to the SANE examiner, Bobbie Hall that the lesions had been present since C. was about 1 year old and that he and mother had gotten them "checked out" but that they had been flaring up the past three months while he had been caring for her. No medical records were provided at the time of the consult to confirm this statement.
- Medical records clearly document that C. contracted Herpes Simplex Virus (HSV) at birth, suffered Herpes Encephalitis and Sepsis at 4 days old, and was hospitalized for over a month at that time. C. was delivered via cesarean section due to prolonged rupture of membranes (10 hours) and likely contracted the HSV during that time period.
- There is no medical documentation that C. contracted Human Papillomavirus (HPV), also know as genital warts, at birth. It is possible that C. did contract HPV at birth. It is also possible that is was contracted through sexual abuse or through non-abusive contact such as diaper changing by a caregiver with HPV/warts.
- A child under 5 years of age with anogenital warts/condyloma acuminatum/HPV falls in the category of "suspicious" for sexual abuse, but not diagnostic or highly suspicious, as there are other forms of transmission. Genital or anal condyloma acuminatum (manifestation of HPV) in the absence of other indicators of abuse is classified as a "finding with no expert consensus on interpretation with respect to sexual contact or trauma", though it is noted that lesions appearing for the first time in a child older than 5 years may be more likely to be the result of sexual transmission. See resources.
- Standard medical practice in cases with a child under 5 with HPV is to test for other possible sexually transmitted infections and report to child welfare for future investigation beyond that which can be done by a healthcare provider.
- Medical records review in this case cannot definitively state one way or another if the HPV is the result of sexual abuse.
- Other than the physical manifestation of the HPV, there are no other indications of sexual abuse known at this time.

Recommendations:

- Pursue care from a dermatologist for care and treatment of the HPV.

- Test C. for other possible sexually transmitted infections such as HIV, Hepatitis B, Hepatitis C, Syphilis, by blood test. If she is noted to have vaginal discharge that can also be cultured for gonorrhea or chlamydia but none was noted during the SANE examination.
- C. needs to be cared for by a provider that is aware of these concerns and able to watch for additional symptoms in the future. If other sores or vaginal discharge is present in the future re-evaluation should occur. Medical providers also need to be aware of possibility of disclosure in the future as C. becomes more verbal.
- Educate father on care of HPV including hygiene and medical follow up. Recommendations for father include to monitor and discourage C. from scratching the HPV, encourage vigilant hand-washing by C. and caregivers that help with diapering and toileting. Dermatologist will be able to provide additional recommendations for care and to prevent spreading to other children in the home, as well as address concerns of the correlation with cervical cancer.
- Any additional indicators of child sexual abuse are very concerning and may change the medical finding.

Resources:

- Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused (Attached)

Mini-Review

Updated Guidelines for the Medical Assessment and Care of Children Who May Have Been Sexually Abused

Joyce A. Adams MD [1,*], Nancy D. Kellogg MD [2], Karen J. Farst MD [3], Nancy S. Harper MD [4], Vincent J. Palusci MD, MS [5], Lori D. Frasier MD [6], Carolyn J. Levitt MD [7], Robert A. Shapiro MD [8], Rebecca L. Moles MD [9], Suzanne P. Starling MD [10]

[1] *Department of Pediatrics, University of California, Davis Medical Center, Sacramento, California*
[2] *Department of Pediatrics, University of Texas Health Science Center at San Antonio, San Antonio, Texas*
[3] *Department of Pediatrics, University of Arkansas for Medical Sciences, Arkansas Children's Hospital, Little Rock, Arkansas*
[4] *Department of Pediatrics, University of Minnesota; University of Minnesota Masonic Children's Hospital, Minneapolis, Minnesota*
[5] *Department of Pediatrics, New York University School of Medicine, New York, New York*
[6] *Department of Pediatrics, Penn State Milton S. Hershey Children's Hospital, Hershey, Pennsylvania*
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A B S T R A C T

The medical evaluation is an important part of the clinical and legal process when child sexual abuse is suspected. Practitioners who examine children need to be up to date on current recommendations regarding when, how, and by whom these evaluations should be conducted, as well as how the medical findings should be interpreted. A previously published article on guidelines for medical care for sexually abused children has been widely used by physicians, nurses, and nurse practitioners to inform practice guidelines in this field. Since 2007, when the article was published, new research has suggested changes in some of the guidelines and in the table that lists medical and laboratory findings in children evaluated for suspected sexual abuse and suggests how these findings should be interpreted with respect to sexual abuse. A group of specialists in child abuse pediatrics met in person and via online communication from 2011 through 2014 to review published research as well as recommendations from the Centers for Disease Control and Prevention and the American Academy of Pediatrics and to reach consensus on if and how the guidelines and approach to interpretation table should be updated. The revisions are based, when possible, on data from well-designed, unbiased studies published in high-ranking, peer-reviewed, scientific journals that were reviewed and vetted by the authors. When such studies were not available, recommendations were based on expert consensus.
Key Words: Child sexual abuse, Differential diagnosis, Sexually transmitted infections, Expert opinion, Medical history taking, Peer review, Expert testimony

Introduction

A set of guidelines and recommendations, published in 2007,[1] were developed using a process of consensus development after a review of the medical literature available at the time regarding the medical evaluation and interpretation of medical and laboratory findings in children brought for examination for suspected sexual abuse. This report presents updated guidelines, developed after a review of recently published research and recommendations from the Centers for Disease Control and Prevention (CDC)[2] and the American Academy of Pediatrics (AAP).[3] The authors searched the medical literature to identify well-designed, unbiased studies published in high-ranking journals that addressed the topic of medical evaluation of suspected child sexual abuse and the interpretation of medical findings. The group reached consensus on the revision of the 2007 guidelines, based on literature critique and review.

Medical History

An accurate and complete history is essential in making the medical diagnosis and determining appropriate treatment of child abuse.[4] The history includes physical symptoms, emotional/behavioral symptoms, and information about the abuse needed to assess and manage suspected victims of abuse. Obtaining details about the abuse is typically coordinated with a multidisciplinary team and may be obtained by a forensic interviewer or a medical professional. Due to differences in purpose and approach, the medical history may differ, yet complement, the forensic interview. For example, a medical history identifying physical symptoms of painful urination may be directly related to a recent episode of sexual abuse and provide additional information of forensic significance.[5]

The authors indicate no conflicts of interest. The authors received financial support from the Midwest Regional Children's Advocacy Center, Office of Juvenile Justice and Delinquency Prevention (DOJ) by grant number 2013-CI-FX-K001.
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http://dx.doi.org/10.1016/j.jpag.2015.01.007

Table 1
Examination Techniques

Genital Examination, Prepubertal Child		Anal Examination, Prepubertal Child	
Examination Positions	Supine Frog-leg or Lithotomy Prone Knee-chest (PKC)	Examination Positions (In Order of Preference)	Supine Knee-chest PKC Lateral Decubitus
Examination technique	Labial separation and traction PKC with gluteal lift Speculum examinations not indicated unless child sedated	Examination technique	Buttock separation PKC with gluteal lift
Confirmatory technique	Floating hymen with water or saline PKC with gluteal lift	Confirmatory technique	Reassess after bowel movement, ambulating, or alternate position
Genital Examination, Pubertal Child		**Anal Examination, Pubertal Child**	
Examination positions	Supine lithotomy PKC with gluteal lift	Examination positions	Supine knee-chest PKC Lateral decubitus
Examination technique	Labial separation and traction Speculum examination can be done if Tanner 3 or greater	Examination technique	Lateral buttock separation Gluteal lift in PKC
Confirmatory technique	Trace hymenal rim with cotton tip swab Foley catheter[58] PKC with gluteal lift	Confirmatory technique	Reassess after bowel movement, ambulating, or alternate position

The process of obtaining the history from the child and nonoffending caregiver also provides an opportunity to assess fears or concerns related to the abuse[4] and to stress the importance of engaging in evidence-based trauma-focused mental health therapy. A recent study found that trauma symptoms in children were highly associated with the degree of self-blame the child felt about the abuse incident(s), an issue that can be addressed during the medical evaluation.[6] This can also be an opportunity to assess whether the caregiver is supportive and protective of the child through the disclosure process. At the conclusion of the examination, the medical provider should explain to the caregivers the significance of physical findings, if any, and that a normal examination does not exclude abuse.

Table 2
Timing of Medical Examinations

Indications for *emergency* evaluation[13,59]
- Medical, psychological, or safety concerns such as acute pain or bleeding, suicidal ideation, or suspected human trafficking
- Alleged assault that may have occurred within the previous 72 hours (or other state-mandated time interval) necessitating collection of trace evidence for later forensic analysis
- Need for emergency contraception
- Need for postexposure prophylaxis (PEP) for STIs including human immunodeficiency virus (HIV)

Indications for *urgent* evaluation
- Suspected or reported sexual contact occurring within the previous 2 weeks, without emergency medical, psychological, or safety needs identified

Indications for *nonurgent* evaluation
- Disclosure of abuse by child, sexualized behaviors, sexual abuse suspected by a multidisciplinary team, or family concern for sexual abuse, but contact occurred more than 2 weeks prior without emergency medical, psychological, or safety needs identified

Indications for *follow-up* evaluation
- Findings on the initial examination are unclear or questionable necessitating reevaluation
- Further testing for STIs not identified or treated during the initial examination
- Documentation of healing/resolution of acute findings
- Confirmation of initial examination findings, when initial examination was performed by an examiner who had conducted fewer than 100 of such evaluations

Examination

All children who are suspected victims of child sexual abuse should be offered an examination performed by a medical provider with specialized training in sexual abuse evaluation (Table 1). The urgency of the medical evaluation can be prioritized as emergency, urgent, or nonurgent (Table 2). An emergency evaluation should be done without delay, and urgent and nonurgent evaluations should be done within 1 to 7 days. Some children will benefit from follow-up examinations with a specialized provider to reassess findings and conduct further testing,[7] particularly if acute injury or sexually transmitted infection (STI) is suspected (Table 2).

Previous versions of the guidelines suggested changing the "72-hour rule" for evidence collection in prepubertal children to the "24-hour rule."[8] Subsequent studies have confirmed that DNA is predominantly recovered when examinations of prepubertal children are conducted less than 24 hours from the time of the assault.[9,10] Research on the use of DNA amplification in sexual assault is limited in young children, but Y-chromosome specific DNA has been recovered in young female victims presenting 24 hours after assault.[11,12] Importantly, the presence of significant physical findings does not predict recovery of foreign DNA and should not be the basis for collecting forensic evidence.[10] Additionally, DNA can still be recovered following genital wiping after the event.[12]

At this time, forensic evidence collection is recommended for sexual contact that may have resulted in the exchange of biologic material within 24 hours in prepubertal children and within 72 hours in adolescents.[13] Some young children will still benefit from evidence collection beyond 24 hours,[13] especially in areas where DNA amplification is performed as part of crime lab analysis. Some

jurisdictions have expanded the evidence collection window on adolescent and adult sexual assault to 5 to 7 days because sperm may be recovered from the cervix more than 72 hours after an assault.[14] Collection of clothing, bedding, or other household items that may harbor potential trace evidence can occur at a later time and is not the role of the medical provider. Clinicians should become familiar with regional resources and recommendations regarding collection of evidence.

Documentation

The medical record should include history, physical examination, and laboratory findings.[15] The results and interpretation of the medical evaluation should be summarized carefully with unambiguous language that can be understood by nonmedical professionals.[16] Photodocumentation is recommended as a standard of care,[15] especially for examinations with positive findings, because abnormal examination findings are rare. Diagnostic-quality still images or videos allow for expert review for quality assurance, teaching, and legal proceedings[17]; however, photographs never substitute for detailed written descriptions of the examination findings.

Testing for STIs

Culture of potentially infected sites has traditionally been the diagnostic gold standard for cases of possible sexual abuse/assault.[18,19] Culture is costly and limited by low sensitivity, especially in the identification of *Chlamydia* infection (as low as 20% sensitive in prepubertal girls).[20] Nucleic acid amplification testing (NAAT) has been in use for years in the sexually active adolescent and adult populations due to its higher sensitivity (100% by transcription mediated amplification),[20] ability to collect a sample noninvasively, ability to test for both *Neisseria gonorrheae* and *Chlamydia trachomatis* with 1 sample, and its lower cost compared with culture. The US Food and Drug Administration has not approved the commercially available NAATs for use in prepubertal children, because the low prevalence of STIs in this population (<5 %)[20] compared with adolescents and adults makes it difficult to perform large randomized controlled trials for validation. However, their use has been studied in this population,[20] and the CDC discusses their use in the 2010 Sexually Transmitted Diseases Treatment Guideline: "NAATs can be used as an alternative to culture with vaginal specimens or urine from girls whereas culture remains the preferred method for urethral specimens or urine from boys and for extra-genital specimens for all children."[2] Black et al[20] performed a multisite study comparing genital culture to NAAT in prepubertal and postpubertal children being evaluated for sexual abuse, which serves as the foundation for the CDC's recommendations on this topic. Even though there boys were included in the study population (51/536), none of the boys tested positive for an STI and extragenital site comparison testing was not included. Therefore, the CDC recommendations for NAATs for STIs in young children are limited to recommendations on genital testing in girls.

In 2014, the CDC removed its recommendation for *routine* additional testing when a NAAT is positive for *C trachomatis*; however, there is still a recommendation to consider retesting with an alternate target for *N gonorrhoeae* and for "consultation with an expert" when using NAATs in cases of child sexual abuse evaluation.[21] When NAATs are used to diagnose infection in prepubertal children or older children and the result could have significance in legal proceedings, confirmatory testing should be performed to exclude a possible false-positive result.[20,22,23]

Although the CDC still recommends culture for nongenital sites, many practitioners find it difficult to access cultures. NAATs have been evaluated in adult studies for pharyngeal[24,25] and anorectal[26,27] infections. NAATs (especially strand displacement amplification [SDA] and transcription mediated amplification [TMA]) have been found to have superior sensitivity to detecting infection at these sites compared with culture and specificity rates that are well within the range of acceptable for clinical practice. The practitioner must be familiar with the validation and confirmation practices of the laboratory processing specimens from their patients. If NAATs are used for testing in young children and the results could have forensic significance, the practitioner should develop a strategy for confirmatory testing, because the low prevalence of infection in this population lowers the positive predictive value of the result.

Culture by using Diamond's or InPouch TV© media remains the most specific method of diagnosing *Trichomonas vaginalis*.[28] When identified by wet mount examination, there is a potential to misidentify nonpathogenic intestinal species of *Trichomonas* (such as *T hominis*) due to morphologic similarities[23] and the possibility of fecal cross-contamination. Additionally, the wet mount is estimated to be only 50% sensitive in detecting trichomonads. Rapid testing is now available by nucleic acid probe hybridization and TMA, but there have been no published studies regarding the use of these techniques for detecting *T vaginalis* in children. While these tests may offer more rapid turnaround and higher sensitivity than culture, confirmatory testing should be considered in cases where the result could have forensic significance and the population has a low prevalence of infection (eg, young children). At present, NAAT for *T vaginalis* is limited to TMA. However, several research polymerase chain reaction tests are being studied that show greater sensitivity compared with wet mount or culture.[23]

Interpretation of Findings

See Table 3. Additions to the guidelines table since the prior version are noted in bold, including a section on conditions that often are erroneously attributed to sexual abuse trauma.[29] Several deletions also were made. Flattened anal folds were removed from "findings commonly caused by medical conditions other than trauma or sexual contact" because no studies have addressed the association of flattened anal folds with sexual contact. The language "anal dilatation to less than 2 centimeters" was removed since the significance of anal dilation of a certain size is

Table 3
The 2015 Approach to Interpretation of Medical Findings in Suspected Child Sexual Abuse

Findings Documented in Newborns or Commonly Seen in Nonabused Children*
Normal Variants
1. Normal variations in appearance of the hymen
a. Annular: Hymenal tissue present all around the vaginal opening including at the 12 o'clock location
b. Crescentic hymen: hymenal tissue is absent at some point above the 3 to 9 o'clock locations
c. Imperforate hymen: hymen with no opening
d. Microperforate hymen: hymen with one or more small openings
e. Septate hymen: hymen with one or more septae across the opening
f. Redundant hymen: hymen with multiple flaps, folding over each other
g. Hymen with tag of tissue on the rim
h. Hymen with mounds or bumps on the rim at any location
i. **Any notch or cleft of the hymen (regardless of depth) above the 3 and 9 o'clock locations**
j. **Superficial notches of the hymen at or below the 3 and 9 o'clock locations**
k. Smooth posterior rim of hymen that appears to be relatively narrow along the entire rim
2. Periurethral or vestibular band(s)
3. Intravaginal ridge(s) or column(s)
4. External ridge on the hymen
5. Linea vestibularis (midline avascular area)
6. Diastasis ani (smooth area)
7. Perianal skin tag(s)
8. Hyperpigmentation of the skin of labia minora or perianal tissues in children of color
9. Dilation of the urethral opening
Findings commonly caused by medical conditions other than trauma or sexual contact†
10. Erythema of the genital tissues
11. Increased vascularity of vestibule and hymen
12. Labial adhesion
13. Friability of the posterior fourchette
14. Vaginal discharge
15. **Molluscum contagiosum**
16. Anal fissure(s)
17. Venous congestion or venous pooling in the perianal area
18. Anal dilatation in children with predisposing conditions, such as current symptoms or history of constipation and/or encopresis, or children who are sedated, under anesthesia or with impaired neuromuscular tone for other reasons, such as post-mortem
Conditions mistaken for abuse
19. Urethral prolapse
20. Lichen sclerosus et atrophicus
21. Vulvar ulcer(s)
22. Erythema, inflammation, and fissuring of the perianal or vulvar tissues due to infection with bacteria, fungus, viruses, parasites, or other infections that are not sexually transmitted
23. Failure of midline fusion, also called perineal groove
24. Rectal prolapse
25. **Visualization of the pectinate/dentate line at the juncture of the anoderm and rectal mucosa**
26. **Partial dilatation of the external anal sphincter, with the internal sphincter closed, causing the appearance of deep creases in the perianal skin**
27. **Red/purple discoloration of the genital structures (including the hymen) from lividity post-mortem, confirmed by histological analysis.**
Findings With No Expert Consensus on Interpretation With Respect to Sexual Contact or Trauma‡
28. Complete anal dilatation with relaxation of both the internal and external anal sphincters, in the absence of other predisposing factors such as constipation, encopresis, sedation, anesthesia, and neuromuscular conditions
29. **Notch or cleft in the hymen rim, at or below the 3 or 9 o'clock location, which is deeper than a superficial notch and may extend nearly to the base of the hymen, but is not a complete transsection. Complete clefts/transsections at 3 or 9 o'clock are also findings with no expert consensus in interpretation.**
30. Genital or anal condyloma acuminatum in the absence of other indicators of abuse; **lesions appearing for the first time in a child older than 5 years may be more likely to be the result of sexual transmission**[33]
31. Herpes type 1 or 2, confirmed by culture or PCR testing, in the genital or anal area of a child with no other indicators of sexual abuse[22]

(continued)

Table 3 (*continued*)

Findings Caused by Trauma and/or Sexual Contact§
Acute trauma to external genital/anal tissues, which could be accidental or inflicted
32. Acute laceration(s) or bruising of labia, penis, scrotum, perianal tissues, or perineum
33. Acute laceration of the posterior fourchette or vestibule, not involving the hymen
Residual (healing) injuries to external genital/anal tissues (These rare findings are difficult to diagnose unless an acute injury was previously documented at the same location.)
34. Perianal scar
35. Scar of posterior fourchette or fossa
Injuries indicative of acute or healed trauma to the genital/anal tissues
36. Bruising, petechiae, or abrasions on the hymen
37. Acute laceration of the hymen, of any depth; partial or complete
38. **Vaginal laceration**
39. **Perianal laceration with exposure of tissues below the dermis**
40. **Healed hymenal transection/complete hymen cleft- a defect in the hymen between 4 o'clock and 8 o'clock that extends to the base of the hymen, with no hymenal tissue discernible at that location.**
41. A defect in the posterior (inferior) half of the hymen wider than a transection with an absence of hymenal tissue extending to the base of the hymen.
Infections transmitted by sexual contact, unless there is evidence of perinatal transmission or clearly, reasonably and independently documented but rare nonsexual transmission
42. Genital, rectal or pharyngeal *Neisseria gonorrheae* infection
43. Syphilis
44. Genital or rectal *Chlamydia trachomatis* infection
45. *Trichomonas vaginalis* infection
46. HIV, if transmission by blood transfusion has been ruled out
Diagnostic of sexual contact
46. Pregnancy
47. Semen identified in forensic specimens taken directly from a child's body

This table lists medical and laboratory findings; however, most children who are evaluated for suspected sexual abuse will not have physical signs of injury or infection. The child's description of what happened and report of specific symptoms in relationship to the events described are both essential parts of a full medical evaluation. **Items in bold type have been added or revised in this updated version of the table.**

* These findings are normal and are unrelated to a child's disclosure of sexual abuse.

† These findings require that a differential diagnosis be considered, as each may have several different causes.

‡ These physical and laboratory findings may support a child's disclosure of sexual abuse, if one is given, but should be interpreted with caution if the child gives no disclosure. Physical findings (numbers 28 and 29) should be confirmed using additional examination positions and/or techniques. Additional information, such as mother's gynecologic history or child's history of oral lesions may clarify likelihood of sexual transmission for children with condyloma or herpes. After complete assessment, a report to Child Protective Services may be indicated in some cases. Photographs or video recordings of these findings should be evaluated and confirmed by an expert in sexual abuse evaluation to ensure accurate diagnosis.

§ These findings support a disclosure of sexual abuse and are highly suggestive of abuse even in the absence of a disclosure, unless a timely and plausible description of accidental injury is provided by the child and/or caretaker. Physical findings (items 32 through 41) should be confirmed using additional examination positions and/or techniques. Diagnoses of the sexually transmitted infections must be confirmed by additional testing to avoid assigning significance to possible false positive screening test results. Photographs or video recordings of these findings should be evaluated and confirmed by an expert in sexual abuse evaluation to ensure accurate diagnosis.

unknown. Anal dilation is a dynamic sign and measuring maximum anal dilation during the examination is difficult. Earlier studies on measurement using photographs[30,31] used different techniques, so results cannot be compared. One recent study reports reflex anal dilation in 36% of sexually abused children when examined in the lateral position with buttock separation for 30 seconds.[32] In

another study, total anal dilation occurred in 12% of the suspected abuse group and was significantly associated with reported anal penetration, after controlling for examination position and presence of anal symptoms.[33] Further research is needed to assess the significance of anal findings with respect to abuse and the impact of examination positions, techniques, and other factors on the frequency of these findings.

The "Indeterminate" category has been relabeled as "No Consensus" regarding the significance of a particular examination finding for sexual abuse. The term "Indeterminate" was often misinterpreted by clinicians to mean case information is insufficient or inadequate.[34] The lack of expert consensus does not mean that there is no scientific evidence regarding the findings in this category. These findings have been associated with sexual abuse in some studies in which study populations were too small, whereas other studies have documented the finding in a nonabused population or have not found an association with sexual abuse.

One examination finding that is listed under the "No Consensus" heading is a notch in the inferior rim of the hymen that may extend nearly to the base of the hymen. This finding has some support as being associated with sexual abuse,[35,36] but there is currently no consensus among experts as to the level of certainty that the finding is due to trauma. One challenge in interpreting the significance of a deep notch is defining it. Previously, a deep notch was defined as a notch that extended through more than 50% of the width of the hymen.[36] However, in clinical practice it is virtually impossible to measure or estimate the percentage of the hymenal width through which a notch extends. This finding must be differentiated from other variations such as a scalloped edge of hymen or a narrow section of the hymen rim adjacent to a mound. Even if a notch in the inferior rim of the hymen clearly extends nearly to the base of the hymen, the expert panel did not reach consensus that it should be considered clear evidence of prior injury.

Providers

The provision of medical care to child sexual abuse victims has become increasingly specialized. In December 2013, there were 324 diplomates of the American Board of Pediatrics with subspecialty certification in Child Abuse Pediatrics (CAP).[37] Additionally, the International Association of Forensic Nurses (IAFN) has established guidelines for the specialized training of pediatric sexual assault nurse examiners (SANE-P) in the care of the child victims of sexual assault,[38] which include a competency-based clinical preceptorship with an experienced provider.

Medical evaluations should be performed by a qualified provider with experience in child sexual abuse. These professionals may include child abuse pediatricians, SANE-Ps, or physicians and mid-level practitioners with advanced training in child abuse evaluation. The medical provider, regardless of degree, should have formal education and training in the medical evaluation of child sexual abuse. Medical providers need to be familiar with guidelines and recommendations on the medical evaluation of children available from the American Academy of Pediatrics (AAP)[3] and on the identification and treatment of STIs.[2]

Qualified medical providers need to maintain currency of practice through continuing education and peer review. Photodocumentation is recommended by the AAP,[3] National Children's Alliance (NCA),[15] and IAFN.[38] Medical peer review involves participation in expert review of photodocumented findings, particularly those thought to be abnormal or indicative of sexual abuse. Medical providers who perform higher numbers of child sexual abuse examinations,[39] read current medical literature, and regularly review cases with an expert demonstrate greater diagnostic accuracy in child sexual abuse evaluations.[40]

All medical programs evaluating victims of child sexual abuse, including programs that use nurse examiners or SANEs, benefit from the supervision and guidance of a qualified medical director who demonstrates competency and currency of practice in the evaluation of child sexual abuse. A medical director is necessary to develop protocols and delegated orders, formulate medical diagnoses, and provide medical treatment plans and prescriptions.

Expert Review of Examination Findings

The purpose of peer review in any medical context is the improvement of quality of care for patients. Standardization of medical processes is designed to reduce variability, improve care, reduce mortality and morbidity, and decrease costs. The cost of misdiagnosis can be both financial, in the case of expensive medical procedures, and societal, if child abuse is inaccurately diagnosed based on an examiner's misinterpretation of physical findings. Those in image-based specialties such as radiology and pathology have studied interrater reliability issues and have proposed methodology for improvement.[41–43]

While the child's history remains the most important piece of evidence in child sexual abuse evaluations, physical findings resulting from sexual abuse, when present, are important in the investigative and legal arenas. Examiners must critically evaluate findings in the context of the known medical literature. Many studies suggest that inexperienced examiners are far more influenced by the history than are more experienced examiners in assessing examination findings.[44] These studies also show that an experienced examiner provides more consistent and objective interpretation of examination findings.[40,44,45] Although it is not clear at what level of experience an examiner becomes an expert, it is certainly through training, clinical experience, knowledge of the current literature, continuing education, and engagement in review or oversight of cases. One study demonstrated that variability in interpretation of such findings appears to be linked to level of training, profession, experience, and knowledge of the literature.[46]

Clinicians without sexual abuse expertise can access expert consultation remotely. One example is myCaseReview, a secure Web-based telehealth product in which medical providers submit images for review by a medical panel of board-certified CAP experts (http://www.mrcac.org/medical-academy/mycasereview/). Other telehealth and telemedicine applications are available commercially

Table 4
Recommendations for Providers

- Obtain a medical history from the child/adolescent patient for the purpose of diagnosis and treatment
- Develop skills in the use of examination positions and techniques for the best assessment of anogenital findings
- Know the differential diagnosis of entities confused with sexual abuse, to avoid an incorrect diagnosis
- Remain current in the state of the art and science of child sexual abuse medical evaluation and treatment
- Obtain high-quality, interpretable photodocumentation of examination findings
- Develop a peer review system to have all abnormal cases reviewed by an expert provider
- Teach multidisciplinary teams that all children benefit from a medical evaluation by a qualified provider
- Provide court testimony that is objective, fact-based, educational, and clear for medical and nonmedical audiences

that can provide secure HIPAA-compliant case review.[46–48] The use of such programs satisfies the requirements of the National Children's Alliance (NCA) but may not go far enough in providing comprehensive assessment of the quality of examinations. Feedback to examiners, followed by documented improvement against shared baselines, is the backbone of an iterative process for continuous quality improvement in the field.

Court Testimony

Providing expert medical testimony requires a thoughtful, thorough approach and knowledge of court proceedings that often is outside the realm of standard medical practice.[49,50] The AAP has a policy on Guidelines for Expert Witness Testimony,[51] and other medical specialties have published guidelines as well.[52–56] The role of the expert medical provider in courtroom proceedings is as an educator to the judge and jury, explaining why and how the evaluation was completed, providing details of the examination, and providing expert opinion on the significance of any examination findings. Since a majority of sexual abuse victims have normal genital examinations,[36,57] a common theme in testimony is the explanation of the findings and that a physical examination alone does not prove or disprove that sexual abuse occurred.

Table 5
Suggested Research Questions

- What is the role of the medical history in the forensic investigation of child sexual abuse?
- With new forensic evidence analyses available, should the timing of forensic collection change for children or adolescents?
- Can NAATs be used for extragenital site testing for gonorrhea and chlamydia in children and/or adolescents?
- Can NAATs be used to detect *Trichomonas* or herpes in children and adolescents?
- Should NAATs be used for routine screening in prepubertal boys?
- What is the significance of findings listed in the "No Expert Consensus" category with regards to likelihood of sexual contact/abuse?
- How do examination position and techniques and/or anal symptoms affect anal findings?
- Can deep notches be readily differentiated from complete transsections in photographs and/or videos?

Conclusion

The recommendations in these revised guidelines incorporate current research and practice guidelines for clinicians who evaluate children and adolescents for suspected sexual abuse (Table 4). During the revisions of these guidelines, several areas of focus for additional research were identified (Table 5). In addition, several terms are clarified, components of the Interpretation Table have been reorganized, and recommendations for improving overall quality of care have been elaborated. While the Interpretation Table remains an important component of this evolving treatise, the importance of the child's history in the diagnosis of sexual abuse cannot be overstated. Similarly, the patient's medical and mental health needs must be prioritized during the medical assessment. The provider has a key role in gathering the medical history, evaluating the medical and mental health needs of the child, and educating families, multidisciplinary partners, judges, and jurors in the appropriate assessment, interpretation of findings, and management of sexually abused children and adolescents.

Acknowledgments

The authors thank Tim Kutz, MD, Mark Hudson, MD, and Deborah Lowen, MD, for their contribution to the consensus document. We also are grateful to Jane Braun, MA, and Kori Stephens, MPH, of the Midwest Regional Children's Advocacy Center for their financial and administrative support of this project.

The authors would like to add a special dedication to our friend and collaborator, Rich Kaplan, MD, who was instrumental in getting us together and keeping the process going.

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