STATE OF COLORADO

Colorado Department of Human Services
people who help people

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John W. Hickenlooper
Governor

Reggie Bicha
Executive Director

April 30, 2013

The Honorable John Hickenlooper
Governor of Colorado
136 State Capitol
Denver, CO 80203

The Honorable Irene Aguilar
Chair, Senate Health and Human Services Committee
201 East Colfax Avenue
Denver, Colorado 80203

The Honorable Dianne Primavera
Chair, House Public Health Care & Human Services Committee
201 East Colfax Avenue
Denver, Colorado 80203

The Honorable Beth McCann
Chair, House Health, Insurance & Environment Committee
201 East Colfax Avenue
Denver, Colorado 80203

Dear Governor Hickenlooper, Senator Aguilar, Representative Primavera and Representative McCann:

The Colorado Department of Human Services, in accordance with the statutory responsibility established through 26-1-139, C.R.S., submits the attached "Child Maltreatment Fatality Report 2012." The statute requires that, "On or before April 30, 2013, and each April 30 thereafter, an annual child fatality and near fatality review report, absent confidential information, summarizing the reviews required by subsection (5) of this section conducted by the team during the previous year," shall be developed and distributed to the Governor, the health and human services committee of the senate, and the health and environment committee of the house of representatives, or any successor committees.

Respectfully,

Reggie Bicha
Executive Director

cc: Senator Linda Newell, Vice Chair, Health and Human Services
Senator Larry Crowder, Health and Human Services
Senator John Kefalas, Health and Human Services
Senator Kevin Lundberg, Health and Human Services
Senator Jeanne Nicholson, Health and Human Services
Senator Ellen Roberts, Health and Human Services
Representative Dave Young, Vice Chair, Public Health Care & Human Services
Representative Kathleen Conti, Public Health Care & Human Services
Representative Justin Everett, Public Health Care & Human Services
Representative Janak Joshi, Public Health Care & Human Services
Representative Lois Landgraf, Public Health Care & Human Services
Representative Jenise May, Public Health Care & Human Services
Representative Beth McCann, Public Health Care & Human Services
Representative Sue Schafer, Public Health Care & Human Services
Representative Jonathan Singer, Public Health Care & Human Services
Representative Amy Stephens, Public Health Care & Human Services
Representative Max Tyler, Public Health Care & Human Services
Representative Jim Wilson, Public Health Care & Human Services
Representative Sue Schafer, Vice Chair, Health, Insurance & Environment Committee
Representative Kathleen Conti, Health, Insurance & Environment Committee
Representative Rhonda Fields, Health, Insurance & Environment Committee
Representative Joann Ginal, Health, Insurance & Environment Committee
Representative Steve Humphrey, Health, Insurance & Environment Committee
Representative Janak Joshi, Health, Insurance & Environment Committee
Representative Dianne Primavera, Health, Insurance & Environment Committee
Representative Amy Stephens, Health, Insurance & Environment Committee
Representative Spencer Swalm, Health, Insurance & Environment Committee
Representative Dave Young, Health, Insurance & Environment Committee
Members of the Colorado State Child Fatality Prevention Review Team
Julie Krow, Office Director, Children Youth and Families, CDHS
Marc Mackert, Director, Administrative Review Division, CDHS
Jay Morein, Office Director, Performance and Strategic Outcomes, CDHS
Dee Martinez, Deputy Director of Enterprise Partnerships, CDHS
Sarah Sills, Legislative Liaison, CDHS

Child Maltreatment Fatality Review Report 2012

April 30, 2013

Colorado Department of Human Services
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Contents

Executive Summary

The 2012 Colorado Department of Human Services Child Fatality Review Report focuses on identifying commonalities and making recommendations for improvements in the Child Welfare system based the findings from 37 substantiated child maltreatment fatalities, near fatalities, and egregious incidents that occurred in 2012. This includes demographic information from all 37 incidents, and more specific recommendations made as a result of the nine fatalities, two near fatalities, and one egregious event reviewed by the Child Fatality Review Team (CFRT).

In order to determine systemic issues, information from these 37 cases is combined with data regarding all child maltreatment fatalities occurring in Colorado over the past five years, as well as data at a national level and from research conducted within the child welfare field. Findings are categorized across four major areas and summarized by each category. Recommendations are also provided that address the issues discovered by the CFRT as well as those uncovered in the completion of this report.

Child Characteristics

The majority of child maltreatment fatality, near fatality, and egregious incident victims in Colorado in Calendar Year 2012 were White (38%) with a large percentage claiming Hispanic ethnicity (35%). More than two-thirds of the victims were male (68%). Approximately 65% of victims of an egregious, near fatal, or fatal child maltreatment incident in Colorado were age two or under, with approximately 87% of the victims being under the age of five.

Parent Characteristics

At the time of the child's death, the majority of the mothers and fathers were between the ages of 20 and 24, although the percentage of this category for mothers is significantly higher than fathers. Almost 50% of the mothers were under the age of 24 at the time of the child's death.

Environmental/Situational Characteristics

Several environmental/situational characteristics have been identified as having a relationship to child maltreatment fatalities. These characteristics include birth order, the number of children and adults in the household, family mobility and family composition. Information on these particular characteristics were not collected on the families and victims of child maltreatment fatalities, or on the egregious incidents or the near fatalities for 2012. Information on these characteristics will be gathered beginning in 2013.

Information on additional family stressors were available and found to be involved in a substantial portion of the cases, including substance abuse (30%), domestic violence (41%), and mental health (35%).

Policy Findings

The average number of Volume VII policy violations is one per report. It should be noted that two of the reports did not have any policy violations. Given that the reports cover any county involvement over the past two years, there is an even lower rate of policy violations per county involvement, indicating strong child welfare practice overall.

Recommendations

This report concludes with a list of recommendations intended to address many of the issues identified. Specifically, the list is broken into recommendations provided by the CFRT during the case specific reviews as well as recommendations occurring as a result of the larger analysis contained in this report. Many of these recommendations are at the county-level, and require collaboration between CDHS, the county, and county partners (e.g. law enforcement and mental health providers). Two recommendations have already been implemented via CDHS' C-Stat process: the monitoring of the proper use of extensions in assessments, and the accurate completion of the safety and risk assessments. Public health/awareness recommendations include the implementation of evidence-based prevention programs, such as Nurse-Family Partnership, a community response program and SafeCare, that may help reduce the likelihood of child maltreatment overall. Data collection recommendations include Trails modifications and concentrated efforts to collect data across fatalities, near fatalities, and egregious incidents.

Conclusion

The Colorado Department of Human Services intends for this report to help to better inform the Child Welfare practice, and the public, with the intent of reducing child fatalities resulting from maltreatment. As the recommendations are implemented, it is the Department's intent to keep the public informed of the progress being made.

Background

Approximately four children are fatally abused or neglected in the United States each day. During Federal Fiscal Year (FFY) 2011 there were approximately 3.4 million referrals made nationwide alleging maltreatment towards roughly 6.2 million children. In Colorado, county departments of human/social services received 81,734 referrals in State Fiscal Year (SFY) 2012.

Prior to 2011, the Colorado Child Fatality Prevention Act addressed Colorado's two Child Fatality Review processes in the State, with the majority of the statutory authority in the Act assigned to the Colorado Department of Public Health and Environment (CDPHE). The Child Fatality Prevention Act assigned limited statutory authority for the provision of a child fatality review process to the Colorado Department of Human Services (CDHS).

During the 2011 legislative session, House Bill 11-1181 was adopted, codifying the CDHS' Child Fatality Review Team (CFRT) and providing statutory authority through section 26-1-139 of the Colorado Revised Statutes. The statute outlines the objectives and duties of the county departments, CDHS, and the CFRT regarding reporting procedures and the fatality review process, and defines the structure and membership of the CFRT.

In 2012, Senate Bill 12-033 was adopted, amending statute to require the addition of a review by the CFRT of both near fatalities and egregious incidents of abuse or neglect, and public disclosure of non-confidential information. An incident of egregious abuse or neglect is defined as "an incident of suspected abuse or neglect involving significant violence, torture, use of cruel restraints, or other similar, aggravated circumstances." Near fatality incidents are defined as "a case in which a physician determines that a child is in serious, critical, or life-threatening condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment." The change in statute brought Colorado in line with the federal requirements under the 1996 Child Abuse and Prevention Treatment Act (CAPTA), which mandates any state receiving CAPTA funds to adopt "provisions which allow for public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality", 42 U.S.C. 5106 § a(b)(2)(A)(x). The change in statute enables the CFRT to gain a better understanding of the causes, trends, and system responses to child maltreatment; to develop recommendations in policy, practice and systemic changes to improve the overall health, safety, and well-being of children in Colorado; and to mitigate future child fatalities.

Beginning August 1, 2012, all County Departments of Human/Social Services (DHS) began reporting egregious incidents, near fatalities, and fatalities suspicious for child abuse and neglect to CDHS, within 24-hours of becoming aware of the incident. Within three days of being notified by the county, CDHS posts public notifications on its website, indicating that information regarding a qualifying incident was received; whether or not the child was living in their home or in an out of home placement; whether or not the case will be reviewed by the CFRT; and the child's age and gender.

The CDHS works closely with CDPHE's Injury and Violence Prevention Unit Manager to ensure each child fatality is tracked and evaluated. CDPHE reviews every child fatality in the state and has its own process for evaluating trends and emerging patterns. CDHS and CDPHE have a collaborative relationship in regards to the two review processes. Each review process serves a different purpose and each process is fully supported by the alternate agency. The Child Fatality Prevention System (CFPS) chair is one of the two state appointees from CDPHE to the CDHS CFRT. The CFRT chair is one of the two state appointees from CDHS to the CFPS. In addition to providing the CFPS staff with access to Trails, CDHS provides CFPS with information (county DHS, medical, police, and coroner reports) gathered by CDHS during its review of each reported child fatality, regardless of whether or not the fatality was substantiated for child maltreatment. Reciprocally,

CFPS notifies CDHS when a child abuse and neglect (CAN) fatality of a Colorado resident is identified that does not appear to have been reported to any DHS agency.

The CFRT conducts in-depth case reviews of incidents of egregious child abuse or neglect, near fatalities, or fatalities within 30 days of receiving the necessary documentation from the county DHS when the following criteria are met:

1. The incident was substantiated for fatal or severe abuse or neglect; and
2. The child or family had previous involvement with a county DHS in Colorado within two years prior to the incident.

A case-specific review report is written within 30 days of the CFRT review. Once the report is completed, county DHS representatives have 30 days to review the report and submit written comments. CDHS has another 30 days following the receipt of written comments from the county DHS to finalize the report. The Case-Specific Executive Summary Report, absent confidential information, is posted on the CDHS website within seven days of finalizing the report. The flowchart in Appendix A depicts the entire review process timeline.

Statute further requires that, on or before April 30, 2013, and by each April 30th thereafter, CDHS shall prepare an Annual Child Fatality and Near Fatality Review Report, absent confidential information, summarizing the reviews conducted by the team during the previous year. The report is to be transmitted to the Governor, appropriate legislative committees, the Colorado State Child Fatality Prevention Review Team, and made available to the public on the CDHS website.

Given the amount of time required, and statutorily authorized, to complete the review process and to draft reports, incidents of fatal, near fatal, and egregious child maltreatment in the last few months of one calendar year are likely to be reviewed by the team the following year. Due to this, there will be a 'carry over' effect each year.

Overall, the CFRT reviewed 20 child maltreatment fatalities, near fatalities, or egregious incidents in CY 2012. Eleven of the reviews were completed on fatalities that took place in 2011. Of these 11, reports have been finalized on 9. The other two are currently being finalized. While there were a total of 12 incidents during CY 2012, only 9 were reviewed by the team during the calendar year. Due to the incidents occurring late in 2012, the remaining three will be reviewed by the CFRT during 2013. Further, of the nine reviews of 2012 incidents that were completed, full reports have been finalized for seven. At the time of this report, the other two reports were awaiting additional information and review.

Objectives of the Annual Report

As intended per legislative declaration and statute, this report has the following objectives:

- To understand the causes of the reviewed incidents of egregious abuse or neglect against a child, near fatalities, and fatalities;
- To identify any gaps or deficiencies that may exist in the delivery of services to children and their families by public agencies responsible for mitigating child abuse, neglect, or death;
- To make recommendations for changes to laws, rules, and policies directed at child welfare practice that will support improved outcomes for Colorado's child welfare system.

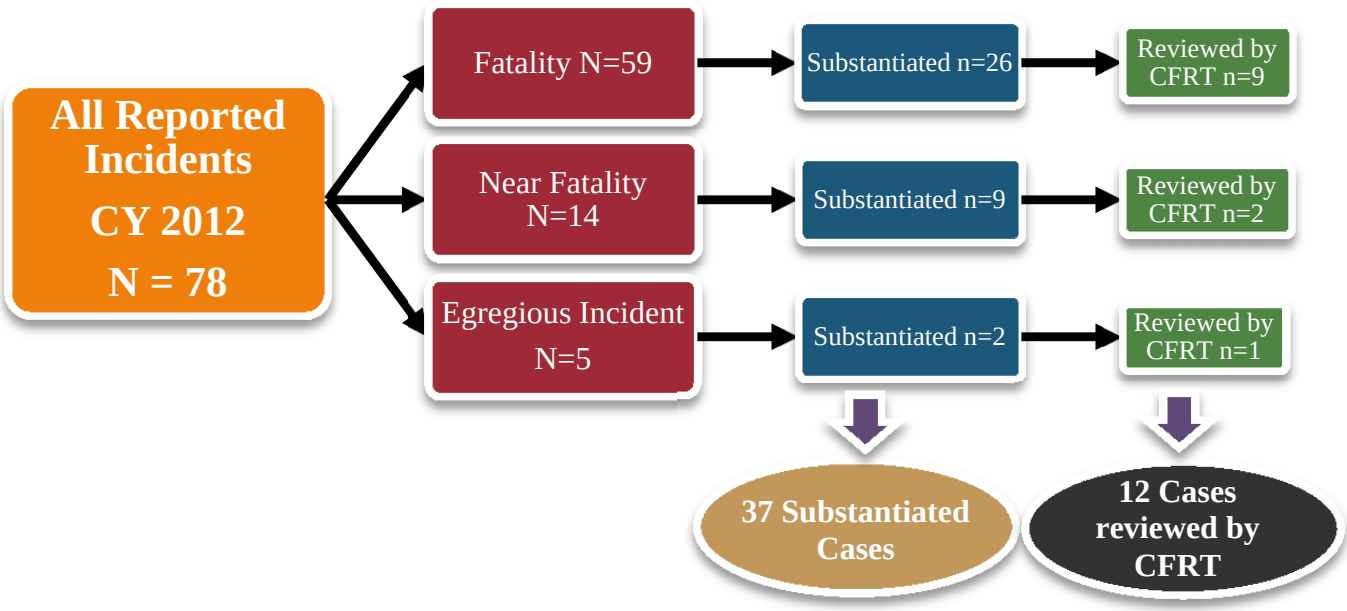
Overview of the 2012 Child Maltreatment Fatality, Near Fatality, and Egregious Incident Victims

All County Departments of Human/Social Services (DHS) must report to CDHS all egregious incidents, near fatalities, and fatalities suspicious for child abuse and neglect. In CY 2012, it was reported that 78 children were victims of a suspected egregious incident, a near fatality, or a fatality as a result of child maltreatment. Of the 78 child victims, 59 incidents were fatalities, 14 were near fatal incidents, and five incidents were egregious. After a thorough assessment of each incident, 56% of fatalities, 36% of near fatalities, and 60% of egregious incidents were found to be unsubstantiated for abuse or neglect, and therefore were not considered to be a result of child maltreatment.

The cases deemed substantiated are therefore the result of child maltreatment and there is a "Founded" disposition against the person responsible for the abuse. In CY 2012, 37 cases were substantiated and, of these cases, 12 had prior involvement with county departments of human services within two years of the substantiated incident.

The cases that are substantiated and have the prior involvement required for an in-depth case review are referred to the Child Review Fatality Team (CFRT) process, which includes a full review of the incident and recommendations around policy and practice considerations. In CY 2012, 12 cases were reviewed by the CFRT: 9 fatality cases; 2 near fatality cases; and 1 egregious incident. Each case reviewed by the team produces a written report that is posted to the CDHS website (with confidential information redacted).

The flowchart below depicts the breakdown of the incidents reported in CY 2012. Appendix B contains a list of the counties where the family resided and the date of incident, by incident type.



For purposes of this report, the majority of the analysis focuses on the 37 substantiated cases of child maltreatment fatalities, near fatalities, and egregious incidents reported to CDHS. Table 1 provides an overview of the demographic characteristics of the 37 substantiated incidents that occurred in CY 2012.

Table 1: Summary Information of all 37 Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents from Calendar Year 2012

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Child at Incident	Less than one year	10	38.5%	6	66.7%	0	0.0%
	2	6	23.1%	2	22.2%	0	0.0%
	3	3	11.5%	0	0.0%	0	0.0%
	4	3	11.5%	0	0.0%	0	0.0%
	5	2	7.7%	0	0.0%	0	0.0%
	7	1	3.8%	0	0.0%	0	0.0%
	11	1	3.8%	0	0.0%	0	0.0%
	14	0	0.0%	1	11.1%	0	0.0%
	15	0	0.0%	0	0.0%	1	50.0%
	16	0	0.0%	0	0.0%	1	50.0%
Race/Ethnicity	White	8	30.8%	5	55.6%	1	50.0%
	Hispanic	11	42.3%	2	22.2%	0	0.0%
	African American	5	19.2%	1	11.1%	1	50.0%
	Asian	0	3.8%	1	0.0%	0	0.0%
	Pacific Islander	1	0.0%	0	11.1%	0	0.0%
	Unknown	1	3.8%	0	0.0%	0	0.0%
Gender	Male	17	65.4%	6	66.7%	2	100.0%
	Female	9	34.6%	3	33.3%	0	0.0%
Family Structure	Two Parent Home	13	50.0%	7	77.8%	0	0.0%
	Single Female	10	38.5%	2	22.2%	1	50.0%
	Single Male	1	3.8%	0	0.0%	1	50.0%
	Divorced Parents	1	3.8%	0	0.0%	0	0.0%
	Foster Care	1	3.8%	0	0.0%	0	0.0%
Additional Family Stressors	Substance Abuse	9	34.6%	1	11.1%	1	50.0%
	Mental Health	8	30.8%	3	33.3%	2	100.0%
	Domestic Violence	10	38.5%	5	55.6%	0	0.0%

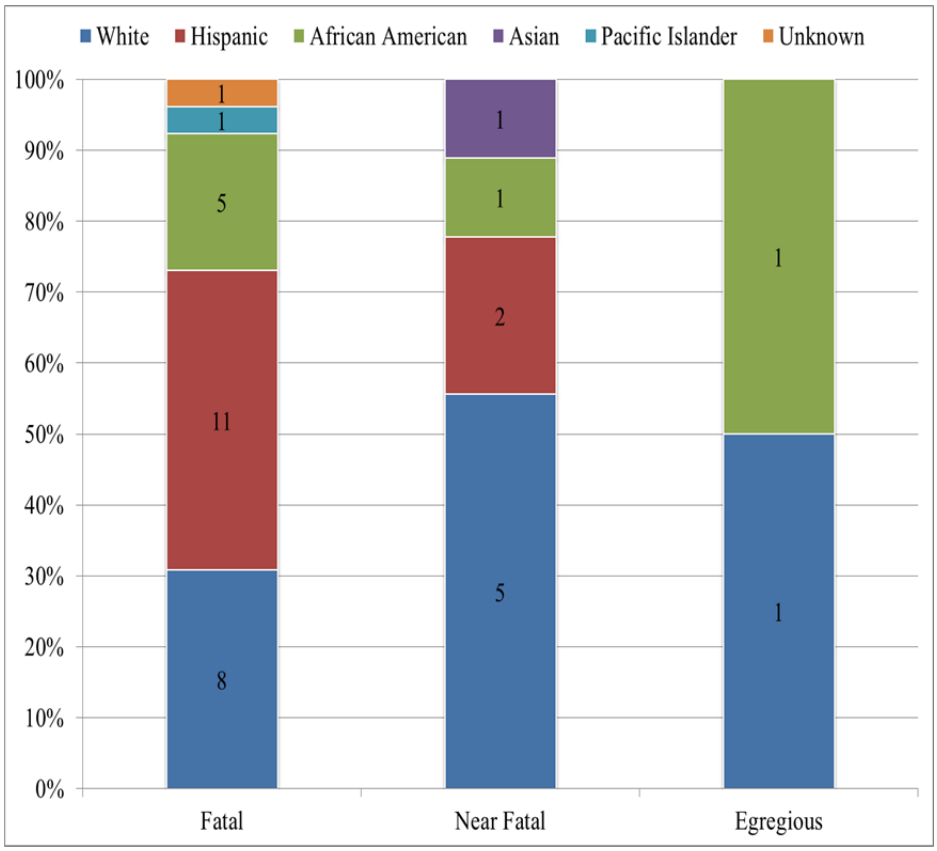
Data and Demographics

Within the field of child welfare, studies have indicated a number of factors related to maltreatment, including: 1) child characteristics; 2) parent characteristics; and 3) environmental/situational characteristics. While fatalities may share certain characteristics that can be used as indicators of risk factors, there is no one profile that will allow child protection workers to identify either perpetrators or children who will become victims. Little research has been conducted on incidents of near fatalities and egregious abuse or neglect.

Child Characteristics

The Child Maltreatment 2011 publication (published annually by the United States Department of Health and Human Services Administration for Children and Families), the most current data available, provides aggregate information on key demographic characteristics of the children reported to the National Child Abuse and Neglect Data System (NCANDS) whose death was "caused by an injury resulting from abuse or neglect, or where abuse or neglect was a contributing factor." The determination of when abuse or neglect is considered a contributing factor is left to each individual state. Comparing demographics of the children reported nationally to those of fatalities occurring in Colorado is used to identify similarities with, and differences from, national trends. National data is not available for near fatal or egregious incidents.

Chart 1: Race/Ethnicity of 37 Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado for CY 2012



Race/Ethnicity

Nationally, 41% of child fatalities are White, 28% are African American, and 18% are Hispanic.

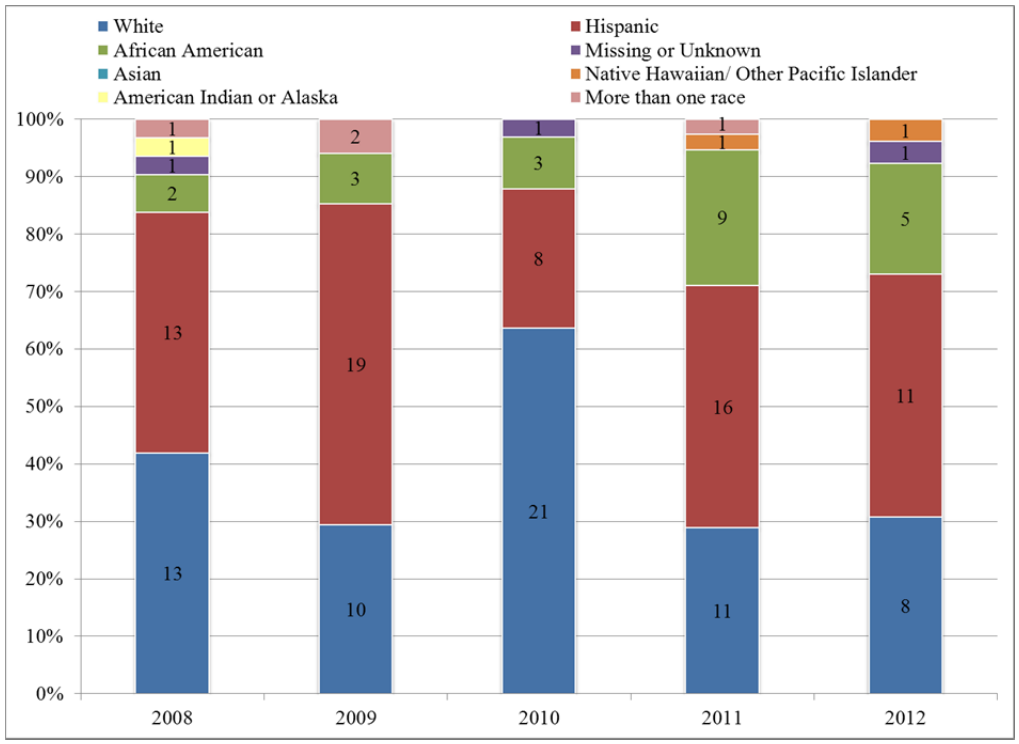
Chart 1 displays the race/ethnicity for the 37 substantiated child maltreatment fatalities, near fatalities, and egregious incidents that occurred in Colorado in 2012. For fatalities, the most frequent race/ethnicity was Hispanic (42%) followed by White (31%).

Race and ethnicity data from the Colorado State Demographers Office indicate that in 2010, 71% of Colorado's population was White and 4% was African American. Approximately 20% of the population is of Hispanic or Latino origin.

Chart 2 shows the race/ethnicity of all child maltreatment fatalities in Colorado over the past five years. For calendar years 2008 and 2009, the racial/ethnic composition of Colorado's child maltreatment fatality victims matched national trends. White children had the highest occurrence of fatalities or were equal to the

occurrence rate of Hispanic victims. In CY 2009, Hispanic children, for the first time, had the greatest share of fatalities in Colorado. This trend has continued in 2012, with Hispanics comprising more than 42% of the child maltreatment fatalities. Unlike the national child fatality characteristics, African American children represent the third highest group of fatalities in Colorado. This analysis does not represent rates of abuse within given race/ethnicity, but just race/ethnicity as a percentage of all fatalities reported in the given calendar year.

Chart 2: Race of Victims in All Child Maltreatment Fatalities in Colorado over the Past Five Calendar Years



Gender

Nationally, in FFY 2011, 59% of child maltreatment fatality victims were boys. In Colorado, in CY 2012, boys accounted for 65.4% of the substantiated child maltreatment fatalities. Boys also were victims of two-thirds of the near fatalities, and both of the egregious incidents.

In the recent past, Colorado mirrored national trends, in regard to gender of child fatalities. Prior to 2008, the general majority of the victims in child maltreatment fatalities were female. In 2008, the trend reversed, and boys became the slight majority. In the past two calendar years, boys accounted for more than 60% of the victims (see Chart 3). In 2012, boys accounted for 65% of the victims of child maltreatment fatalities. This percentage has been on the rise since 2008 (see Chart 4).

Chart 3: Gender of Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2012

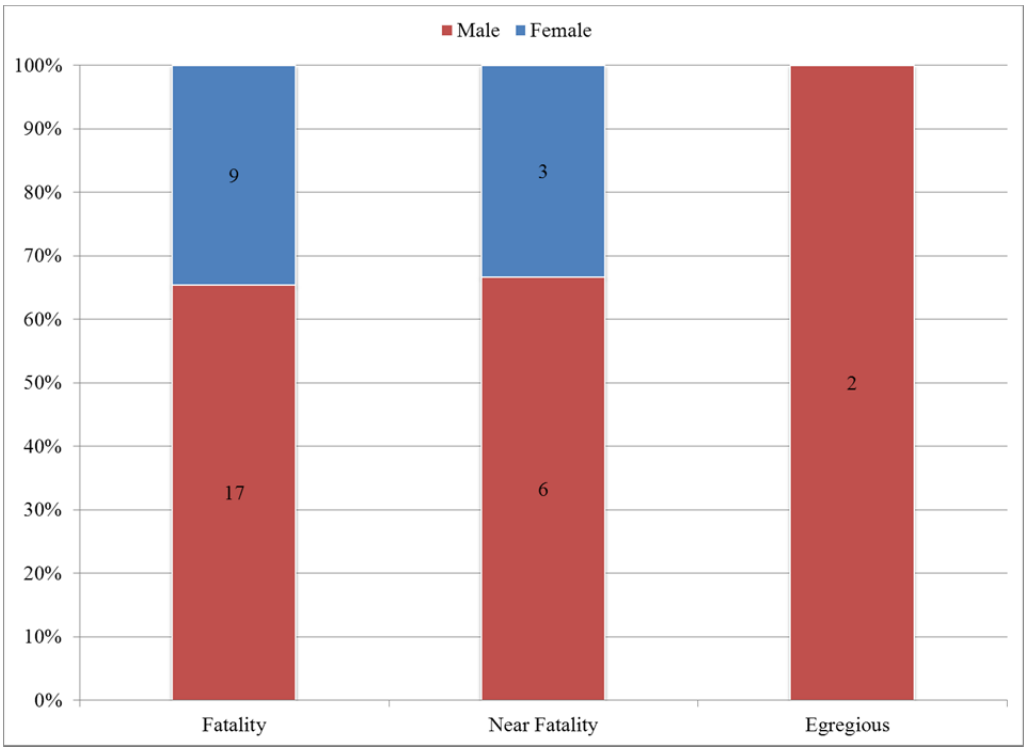
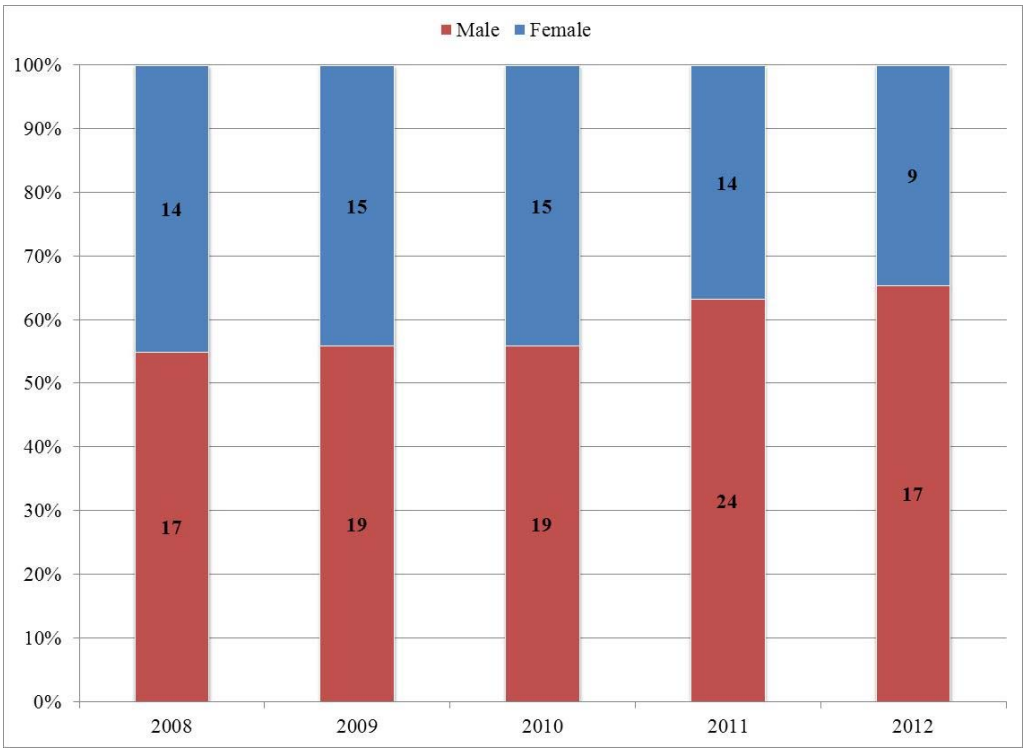


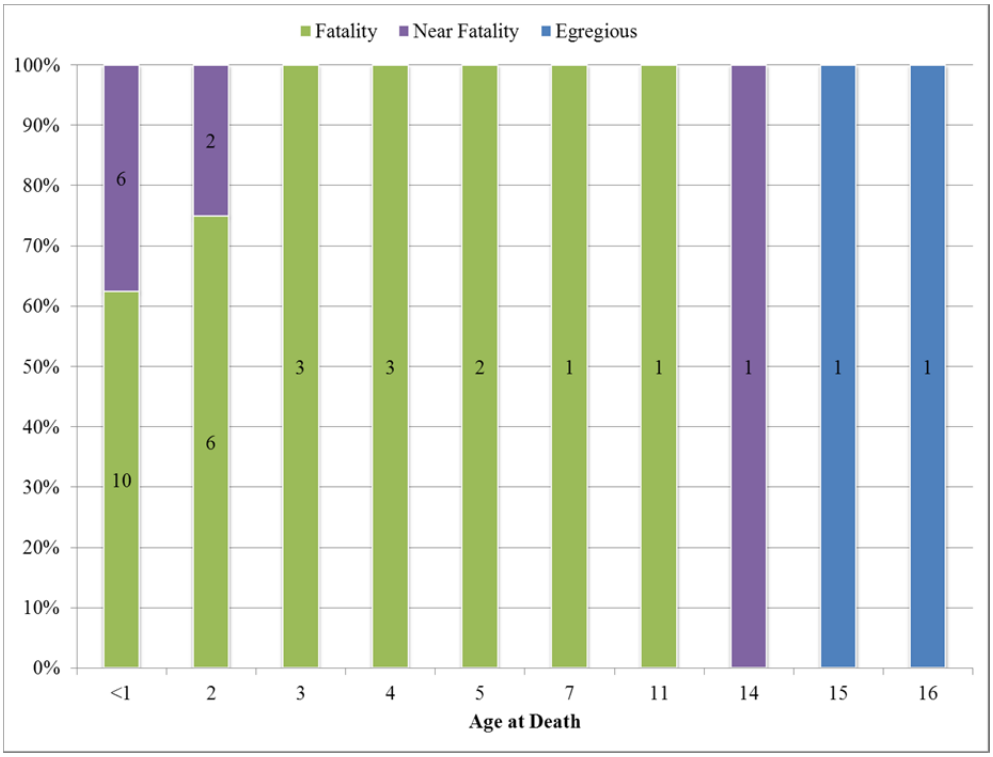
Chart 4: Gender of Victims in All Child Maltreatment Fatalities in Colorado over the Past Five Calendar Years



Age at Time of Fatality

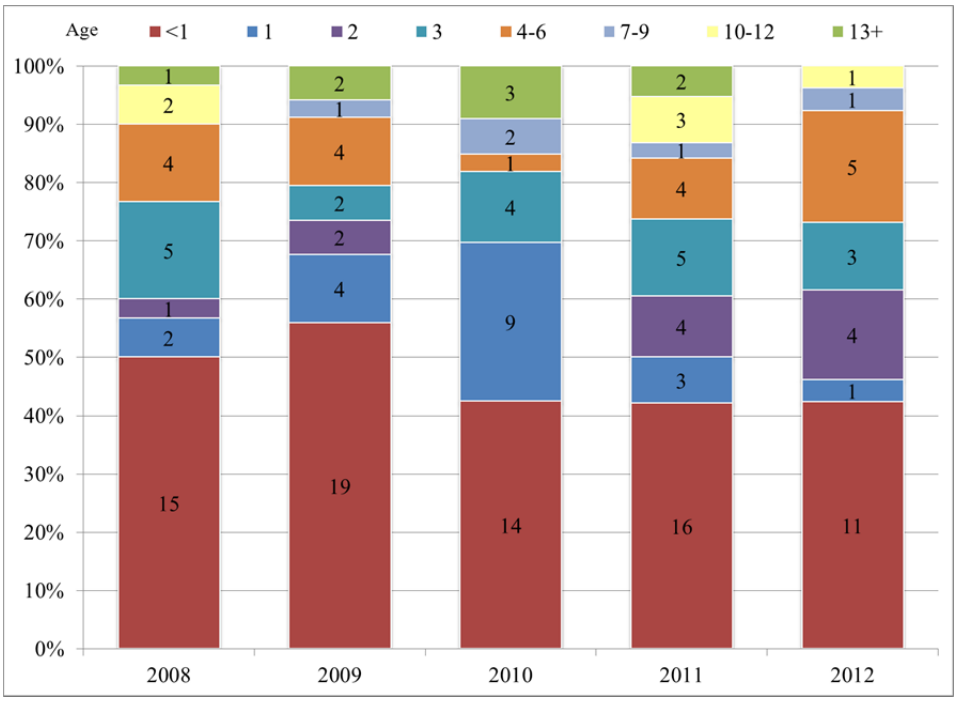
Fatalities due to maltreatment are the second leading cause of death for children under the age of five. National research has shown that victims of fatal child maltreatment tend to be younger, with approximately 90% of the child fatalities experienced by children age five or younger, and 42% being infants. Colorado's trends appear to closely follow the national trends. As displayed in Chart 5, approximately 50% of the fatalities involved infants, almost 75% were three or younger, and the vast majority (92%) were five or younger. A similar pattern exists for the near fatalities, as 67% of the victims were under the age of one, and 89% were age two or under. The two victims of egregious incidents were both teenagers, and approximately four years older than the oldest fatality victim.

Chart 5: Age of Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2012



The child's age has historically been a key demographic factor associated with child maltreatment fatalities. Each year since 2008, the highest number of fatalities has involved infants as victims, ranging from 42% to 56% of all child maltreatment fatalities in any given year (see Chart 6). Over the same time period, nearly 90% of victims of child fatalities were five years or younger, with little variance from year to year. The majority of near fatality victims are also younger; in CY 2012, almost 90% of the children were age two or under. In contrast, both of the victims of substantiated egregious abuse were teenagers.

Chart 6: Age of Victims in Child Maltreatment Fatalities in Colorado over the Past Five Calendar Years



Family Characteristics

Several characteristics related to family dynamics appear to be generally associated with child maltreatment fatalities. Each of these is discussed below.

Age of Parents

It has been found that parents of abuse/neglect fatality victims tend to be in their late teens or early twenties, with a large percentage becoming parents around the age of 20, regardless of whether or not they are the perpetrator. According to data from the Colorado Department of Public Health and Environment, in 2011 35% of all births in Colorado were to mothers 24 years of age or younger.

In recent years, detailed information about the parent characteristics for the children who experience a serious maltreatment incident has not been consistently recorded. While some of the parent characteristics are recorded in Trails, incomplete records and complex family dynamics make it difficult to conduct an accurate analysis for the 37 substantiated cases in 2012. For example, the father at birth may not be the person in the father role at the time of death. However, for the past five calendar years, consistent and accurate data is available for many of the mothers and fathers of victims of child maltreatment fatalities (N=161). Charts 7a and 7b illustrate the age of mothers (n=156) and fathers (n=129) at the time of death of the victim, for all maltreatment fatalities that occurred between 2008 and 2012. Mothers and fathers that were either not identified, deceased, or otherwise not known were not included in this analysis.

Chart 7a: Age of Mother at Time of Child's Death, Child Maltreatment Fatalities, 2008-2012

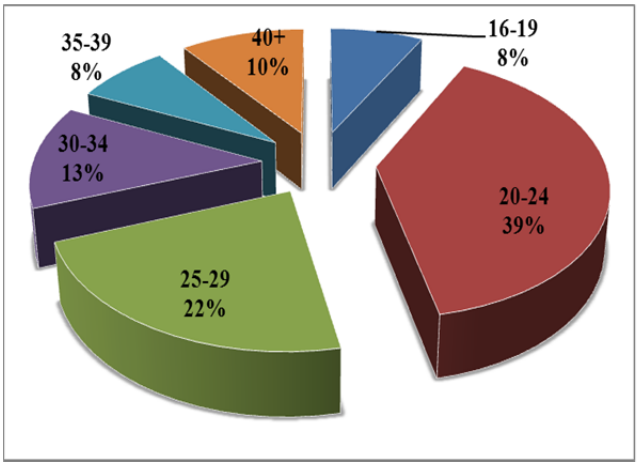
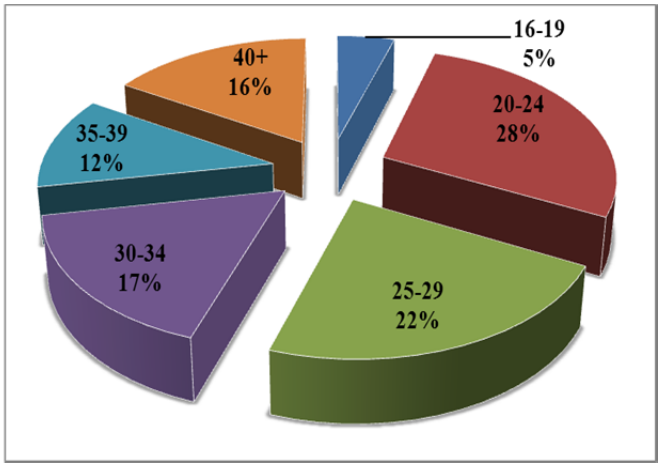


Chart 7b: Age of Father at Time of Child's Death, Child Maltreatment Fatalities, 2008-2012

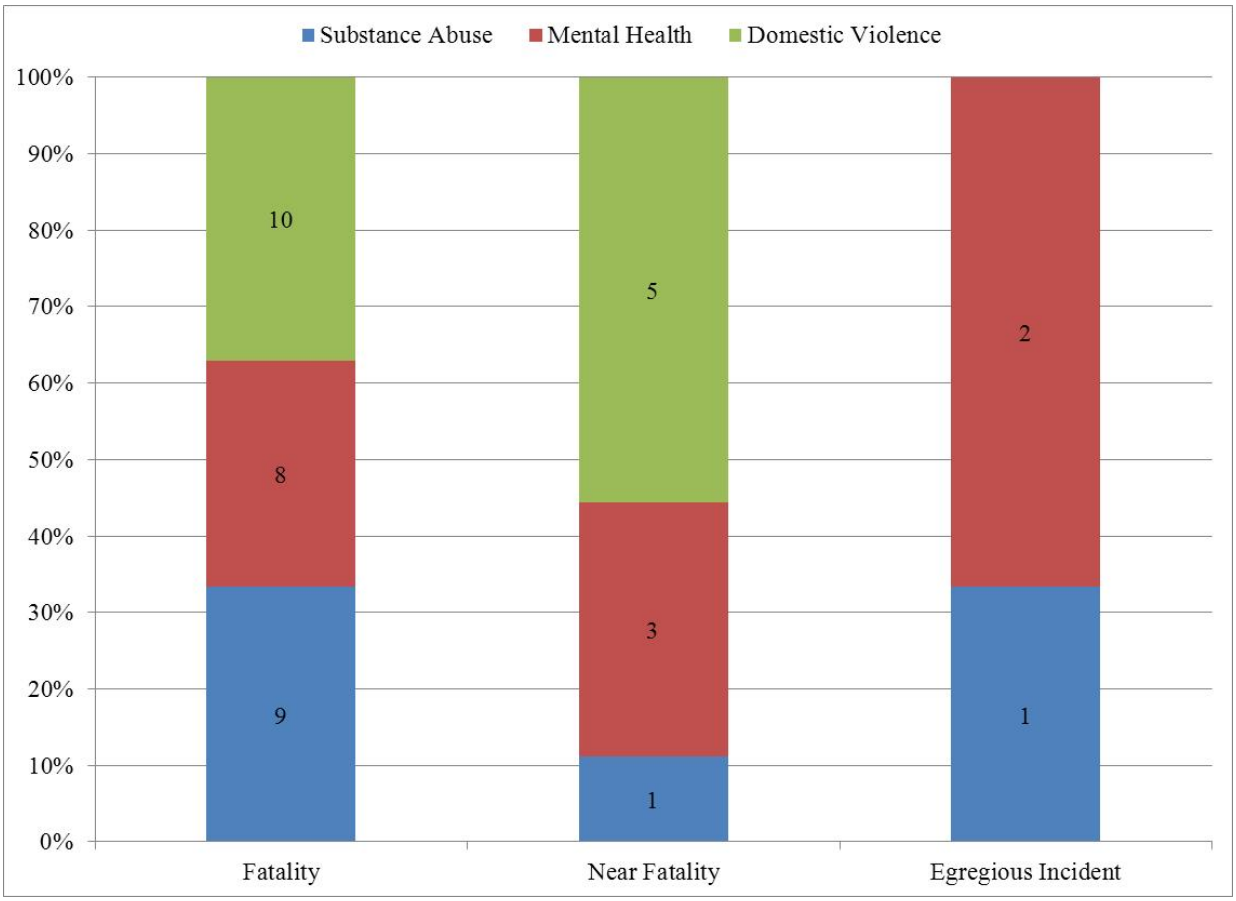


As illustrated above, at the time of the child's death, the majority of the mothers and fathers were between the ages of 20 and 24, although the percentage of this category for mothers is significantly higher than for the fathers. Almost 50% of the mothers were under the age of 24 at the time of death, a trend similar to the national data and research literature. Overall, the age of parents in Colorado at the time of birth and death, closely resembles what has been found in the literature in that they were young when the fatality occurred.

Other Family Stressors

Chart 8 identifies additional elements that were tracked in an effort to determine commonalities among the 37 fatalities, near fatalities, and egregious incidents from 2012. Nationally, 5.7% of child maltreatment fatalities involved alcohol abuse as a risk factor, while 16.7% involved domestic violence, and 12.8% involved drug abuse. In Colorado, almost 41% of the families had some history of identified domestic violence, while 30% experienced substance abuse issues. Additionally, in 35% of the substantiated cases, there was a history of mental health issues.

Chart 8: Other Family Stressors in 37 Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents*



*Some cases involved co-occurring stressors

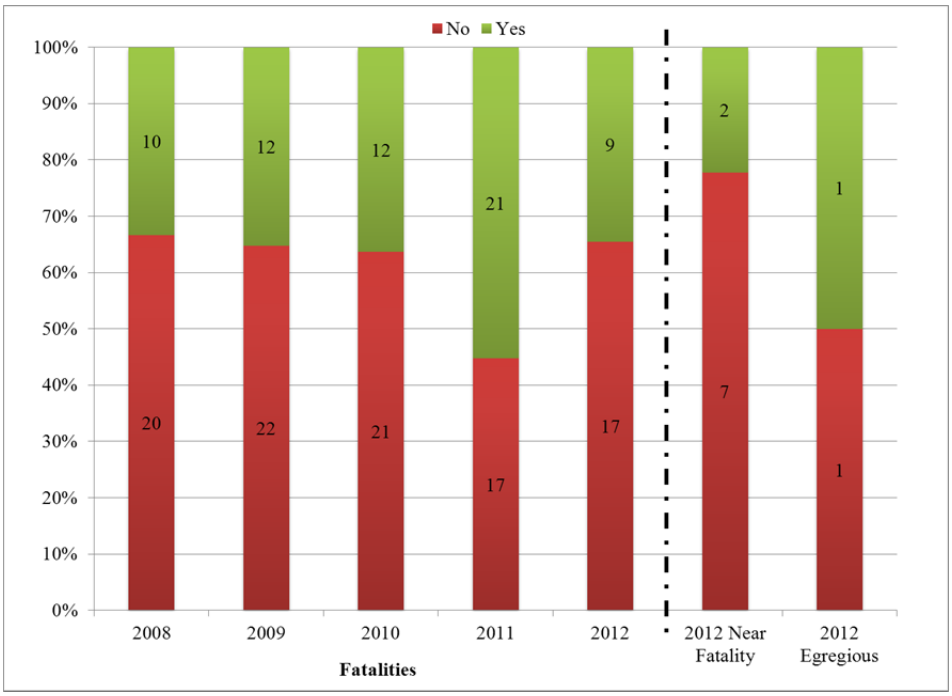
Prior Involvement

Studies indicate that anywhere from 21% to 29% of families who experienced a maltreatment fatality had prior contact with Child Protection Service (CPS) agencies.

For the child maltreatment fatalities that occurred in Colorado during the past five calendar years (2008 – 2012), between 35% to 55% of the families had prior child protection history, with 2012 having the lowest percent over the five years. According to current state statute, the Child Fatality Review Team is required to conduct a thorough review of child fatalities when there is prior history in the two years preceding the incident. Before the change in statute in 2012, prior history was defined to be a five year time period

For the near fatalities and egregious incidents, only 2 cases and 1 case, respectively, had prior history.

Chart 9: Prior History of Victims in All Child Maltreatment Fatalities in Colorado over the Past Five Calendar Years



Environmental/Situational Characteristics

This section identifies some of the relevant environmental and situational characteristics associated with child maltreatment fatalities. While information on these particular characteristics have not previously been collected on the Colorado families and victims of child maltreatment fatalities, or on the egregious incidents or near fatalities, they will be gathered for future analysis, as research shows these characteristics can impact child maltreatment fatalities:

- Birth Order
- Number of Children and Adults in Household
- Mobility
- Family Composition

Child Fatality Review Team Findings

This section of the report will focus on specific strengths, gaps, and recommendations identified through reviews conducted by the CFRT during CY 2012. This will include some fatalities that actually occurred during CY 2011, and the majority of those that occurred during CY 2012. This section of the report is based on the reports of the 16 incidents from 2011 and 2012 that were reviewed and finalized during CY 2012.

Strengths

Through the analysis of the 16 egregious, near fatal, or fatal child maltreatment incidents that were reviewed by the full Child Fatality Review Team, four areas were identified as strengths across multiple reviews.

- **Communication and Collaboration**

Local county departments of human/social services were generally found to have communicated and collaborated effectively with other county departments of human/social services, as well as with collateral agencies, to assess the safety of children. Examples of this included:

- During assessments conducted prior to fatalities, county departments made significant efforts to seek medical opinions from primary care physicians, hospital staff physicians, and experts on child abuse and neglect injuries at the Kempe Center on the nature of the physical injuries. These opinions were used to help inform decisions regarding whether or not abuse was likely occurring.
- County departments effectively collaborated with local law enforcement to locate endangered children, and coroners to help determine circumstances surrounding the fatality. These efforts also assisted in locating surviving siblings who were living with other caregivers so that their safety could be assessed and managed. This included efforts across multiple counties and law enforcement jurisdictions.

For the first time in over a decade of reviews related to child maltreatment fatalities, communication and collaboration among counties, as well as between county departments and external partners, was noted as a strength across several reviews.

- **Assessing Safety of Surviving Siblings**

In several reviews, the CFRT identified that county departments made significant efforts to locate and assess the safety of surviving siblings who were not living with the alleged perpetrator at the time of the incident.

- **Quality of Documentation**

CFRT members noted the overall high quality of the documentation related to the previous involvement that county departments had with the families. As counties are required to consider prior involvement in determining the appropriate level of engagement with families (e.g., whether to open a case, intensity and appropriateness of services, etc.), it's critical to have sufficiently detailed documentation available. It allows county departments to make well informed decisions regarding appropriate level of engagement on future referrals.

- **Engagement of Family Members**

Several of the reviews and reports identified that caseworkers were able to successfully engage and build a rapport with caregivers. This directly impacted the quality of information the caseworkers were able to gather and subsequently have available to determine and manage safety for children.

Gaps and Deficiencies

- **Communication and Collaboration**

While communication and collaboration between county departments of human/social services, and between county departments and collateral agencies, has greatly improved and was noted as a strength, the CFRT also identified specific areas where continued improvements should be made.

- Functionality of the Trails system was specifically identified as a barrier to communication in two areas:
  - There is currently no functionality that would allow counties to associate critical alerts to specific clients. For example, several of the cases reviewed by the CFRT involved significant efforts to locate families with high mobility (i.e., a history of moves between counties). Each time a county receives a call requesting or providing information regarding a child or family, a large volume of information in Trails must be reviewed in order to identify if there are significant concerns for child safety. The CFRT believes it would be beneficial if Trails had a function where a county could associate specific information that would immediately display across a scrolling banner whenever a child welfare professional searches the system for an individual who has been associated to that alert. For families that child welfare professionals are having a difficult time locating, this suggested Trails enhancement could assist other counties in knowing when a family has a higher level of risk and may, as a consequence, require a faster response time, or a more collaborative approach to assessing safety.
  - Trails does not currently have functionality allowing the tracking of requests for information about a client. Trails was designed to initiate a record with a referral regarding allegations of abuse and/or neglect. However, county departments often receive phone calls requesting or providing information about families that do not meet the definition of a referral. If there is not currently an open assessment or case with a family, there is no functionality that would allow for these calls to be logged and associated with families. Having this type of information available, should a referral be received in the future, may help inform appropriate decisions about potential response levels by child protective services.
- Earlier it was noted that child welfare professionals diligently sought opinions from medical professionals to help inform if presenting injuries were consistent with causes identified by caregivers, or were more likely related to abuse or neglect. However, in several instances the medical professionals were either hesitant or unable to provide conclusive statements to this effect. Reasons for this ranged from concerns of possible litigation, to lack of recognizing signs of abuse, to the lack of certainty of the causes of injuries (e.g., broken bones or bruising due to falling at a playground versus physical abuse). Child welfare professionals often rely heavily on the opinion of medical professionals in determining if past abuse has occurred, which in turn is used to determine likelihood of future harm. When medical professionals are reluctant to provide definitive statements, it adds to the difficulty child welfare professionals have in accurately predicting levels of risk for future harm to children and subsequently in differentiating appropriate levels of engagement and intervention on their behalf.

- On occasions, law enforcement did not collaborate with a county department in conducting interviews of surviving siblings or delayed notifying a county department of an allegation. This hindered the ability of the county department to immediately begin determining and planning for the short term safety of the children as well as longer term future risk of harm. Given that this collaboration with law enforcement was identified as a strength in several other cases reviewed, this appears to be a jurisdiction specific concern.

- **Lack of Community Centered Resources**

In one case, a lack of mental health providers available within the community caused delays and barriers to the caregiver being able to receive timely services to address identified mental health needs.

- **Safety Assessment and Planning**

  - When a safety concern is identified, and it is determined that there is not a caregiver with protective capacity in the home to manage safety, county departments must either place a child into out-of-home care or complete a Safety Plan to manage safety for the child. In instances of out-of-home placements, Volume VII also requires that a re-assessment for safety be completed prior to returning a child to his/her home. However, for instances where a Safety Plan is used to manage safety on in-home cases, there are no guidelines for effectively determining when the Safety Plan is no longer necessary.
  - As will be discussed later under the Policy Findings, in a number of cases, the Safety and Risk Assessment tools were completed inaccurately. As these tools are designed to help inform decisions around managing immediate safety, need for services, and case closure, their accurate completion and use is critical.
  - Currently there are no requirements or formal tools available for guiding practice through a global assessment of family needs on Program Area 4: Youth in Conflict cases. The CFRT identified that this may lead to situations where services primarily focus on youth behaviors while not addressing the caregivers' need for services. As a result, caregivers may not receive assistance in learning different skills and interactional behaviors that can help a family remain together while maintaining safety for the youth and caregiver.

Policy Findings

In examining practice related to any current (i.e., at the time of the incident) or previous involvement by county departments, the CFRT process identified instances in which Volume VII policies were not followed. The following section summarizes these findings.

- The average number of Volume VII policy violations was one per report. It should be noted that two of the seven reports did not have any policy violations. Further, considering that the reports cover any county involvement over the past two years, this means that numerous assessments and cases were reviewed over the course of the seven reports. Thus, there is an even lower rate of policy violations per county involvement, indicating strong child welfare practice overall. The CFRT team carefully considers each policy violation or area of concern and may make recommendations to a county department or the DCW based on those areas. The following section discusses any recommendations made as a result of such consideration.

CFRT Case Specific Recommendations and Actions Taken

Recommendations were made towards addressing identified systemic gaps, policy violations, and/or practice concerns. The following section summarizes the 2012 recommendations. It also provides a description of the status on the implementation of each recommendation.

- The DCW should work with the Office of Information Technology (OIT) to develop a scrolling alert in Trails to allow for improved communication among county departments when there are significant concerns regarding an individual or family. In addition to the functionality, the DCW should collaborate with county child welfare professionals to determine criteria for the use of such functionality.

  Status: The report containing this recommendation was finalized in December of 2012. This functionality was discussed with Trails (OIT) staff and a decision was made to include it as part of the larger assessment project that will be required due to the revision of Colorado's Safety and Risk Assessment tools. This process was previously authorized under the Child Welfare Sub-Policy Advisory Committee (PAC) Policy Number 11CW009. This project is scheduled for completion in the fall of 2013.

- The DCW should review Volume VII rules and the state automated case management system, Trails, to determine how information from calls to the Department that are not referrals for child abuse or neglect shall be recorded.

  Status: The report containing this recommendation was finalized in December of 2012. A review and discussion of this topic is on the agenda for the May 13, 2013 meeting of the Child Protection Task Group.

- The Division of Child Welfare should continue to monitor the proper use of extensions for assessments and the accurate completion of the safety and risk assessments.

  Status: The report containing this recommendation was finalized in December of 2012. The Department of Human Services currently monitors both of these areas through existing continuous quality improvement initiatives. The CDHS, through implementation of the C-Stat process, monitors performance of both of these measures monthly. State Child Protection staff provide training and technical assistance to county departments on both the timeliness and accuracy of assessment completion.

- Adams County Department of Human Services should work to improve the working relationship with the Commerce City Police Department.

  Status: The report containing this recommendation was finalized in December of 2012. The Adams County Department of Human Services created an action plan to contact all law enforcement jurisdictions they collaborate with in order to enhance relationships and create ongoing strategies for future collaborative efforts.

- The Colorado Department of Human Services, Division of Child Welfare, should utilize the Child Protection Task Group, comprised of county and state child protection experts, to determine if the difficulties identified in accessing mental health services are a systemic problem across the state.

  Status: The report containing this recommendation was finalized in April of 2013. The Child Protection Task Group will begin consideration of this issue during the May 13, 2013 meeting.

- The Colorado Department of Human Services, Division of Child Welfare, should recommend a change to policy requiring re-assessment of safety when concluding the use of a safety plan.

  Status: The report containing this recommendation was finalized in April of 2013. The Child Welfare Sub-PAC, through Policy Number 11CW009, had previously authorized a workgroup of state child welfare professionals to examine and update Colorado's Safety and Risk Assessment tools. As a result of this recommendation, the workgroup has been asked to consider appropriate methods for assessing and documenting successful resolution of safety concerns and effectively ending a safety plan. The implementation of the new tools is projected to take place in the fall of 2013.

- Adams County Department of Human Services should work with its contracted mental health providers to improve the timeliness of notification of client specific issues. Adams County should pursue agreement from the two contract mental health providers that their agencies will immediately advise the referring and/or assigned caseworkers via email (or through a technology system) of client status (missed appointments, closed case, etc.); all Adams County child welfare staff and the CDHS will be informed upon finalization of this process.

  Status: The report containing this recommendation was finalized in April of 2013. The Adams County Department of Human Services created an information sharing procedure that they now use with all of their mental health providers. The procedure addresses specific information to be shared, as well as timelines for sharing such information.

- Adams County Department of Human Services should include the mental health provider, as appropriate when child safety remains an issue in decision making and case planning discussions regarding mutual clients, as appropriate, and when child safety remains an issue.

  Status: The report containing this recommendation was finalized in April of 2013. Adams County Department of Social Services has discussed the importance of including mental health providers' input when making informed case planning decisions, as applicable within each case.

- The Colorado Department of Human Services, Division of Child Welfare, should assist Mesa County Department of Human Services in developing and hosting a training for its local medical community on the identification, assessment, treatment, and reporting of suspected child abuse and/or neglect.

  Status: The report containing this recommendation was finalized in January of 2013. The Division of Child Welfare collaborated with Mesa County Department of Human Services to examine data related to reporting parties to determine if there were differences in Mesa County's reporting parties as compared to other large counties. No differences were noted. Mesa County then worked with their community and hospital liaisons to schedule trainings to be provided on May 7 and 8, 2013.

- Eagle County Department of Health and Human Services should provide training to the local community service providers on how to recognize child abuse and/or neglect and the requirements of mandatory reporting. The Colorado Department of Human Services, Division of Child Welfare, will assist in this effort as needed.

  Status: The report containing this recommendation was finalized in April of 2013. The Eagle County Department of Health and Human Services (ECDHHS) has a significant community engagement effort currently under way. The efforts include making approximately 25 contacts per quarter with the community. The ECDHHS initiated this effort in January of 2013, has revised the reporting presentation being used as a result of early engagement efforts, and have additional meetings scheduled.

- The Colorado Department of Human Services, Division of Child Welfare, should improve Colorado's Risk Assessment tool and the relevant instructions and provide training and coaching to caseworkers and supervisors on how to complete the tool, and use it to guide decision making and case planning.

  Status: The report containing this recommendation was finalized in April of 2013. The Child Welfare Sub-PAC, through Policy Number 11CW009, had previously authorized a workgroup of state child welfare professionals to examine and update the Safety and Risk Assessment tools. The workgroup examined Risk Assessment tools being used in several states and then partnered with the Social Work Research Center at Colorado State University to conduct research leading to the creation of a revised tool for in Colorado. This included improving definitions used and more clear instructions guiding child welfare professionals through the accurate use of the tool. Initial research reports indicated the tool has strong reliability and validity, and several pilots of the instrument have already occurred with front line caseworkers. The tool is projected to be finalized in the fall of 2013. Once the tool has been finalized, training and coaching for caseworkers and supervisors will occur.

- The Colorado Department of Human Services, Division of Child Welfare, should provide coaching and technical assistance to the Denver County Department of Human Services on the accurate completion of the risk assessment tool, and using the tool to guide decision making and case planning.

  Status: The report containing this recommendation was finalized in April of 2013. The Child Welfare Sub-PAC, through Policy Number 11CW009, had previously authorized a workgroup of state child welfare professionals to examine and update the Safety and Risk Assessment tools. As the current tools are close to being updated and enhanced, the DCW will work with Denver County Department of Human Services to provide training and coaching on the new tools once they are finalized. The tools are projected to be finalized in the fall of 2013.

- The workgroup formed to improve the Colorado Safety and Risk Assessment tools should address the need to clarify in policy when services shall be offered to a family, based on its risk assessment score, and what documentation may be necessary, if services are not going to be provided.

  Status: The report containing this recommendation was finalized in April of 2013. The Child Welfare Sub-PAC, through Policy Number 11CW009, had previously authorized a workgroup of state child welfare professionals to examine and update the Safety and Risk Assessment tools. As part of this project, the group will make recommendations to the Child Welfare Sub-PAC on how risk scores should best be used to inform case and service provision decisions, and rules will be promulgated as needed.

- Assessment tools should be created and used in Program Area 4: Youth in Conflict assessments/cases as they are in Program Area 5: Child Abuse and Neglect assessments/cases.

  Status: The report containing this recommendation was finalized in April of 2013. The Child Welfare Sub-PAC, through Policy Number 11CW009, had previously authorized a workgroup of state child welfare professionals to examine and update the Safety and Risk Assessment tools. This is projected for completion in the fall of 2013. Upon completion of the tools for Program Area 5: Child Abuse and Neglect, the workgroup will begin a process to research the efficacy of creating similar tools for the Program Area 4: Youth in Conflict population.

- Training competencies should be developed for caseworkers that will be handling Program Area 4: Youth in Conflict assessments/cases.

  <u>Status</u>: The report containing this recommendation was finalized in April of 2013. The Child Welfare Sub-PAC, through Policy Number 11CW009, had previously authorized a workgroup of state child welfare professionals to examine and update the Safety and Risk Assessment tools. This is projected for completion in the fall of 2013. Upon completion of the tools for Program Area 5: Child Abuse and Neglect, the workgroup will begin a process to research the efficacy of creating similar tools for the Program Area 4: Youth in Conflict population. Upon completion of any new tool, training competencies will be created and training provided to caseworkers providing services to both Program Area 5: Child Abuse and Neglect and Program Area 4: Youth in Conflict cases.

- The Colorado Department of Human Services, Division of Child Welfare will submit a policy submittal request to the Child Welfare Sub-PAC requesting the creation of a workgroup to address the need for family assessment tools in Program Area 4: Youth in Conflict assessments and cases.

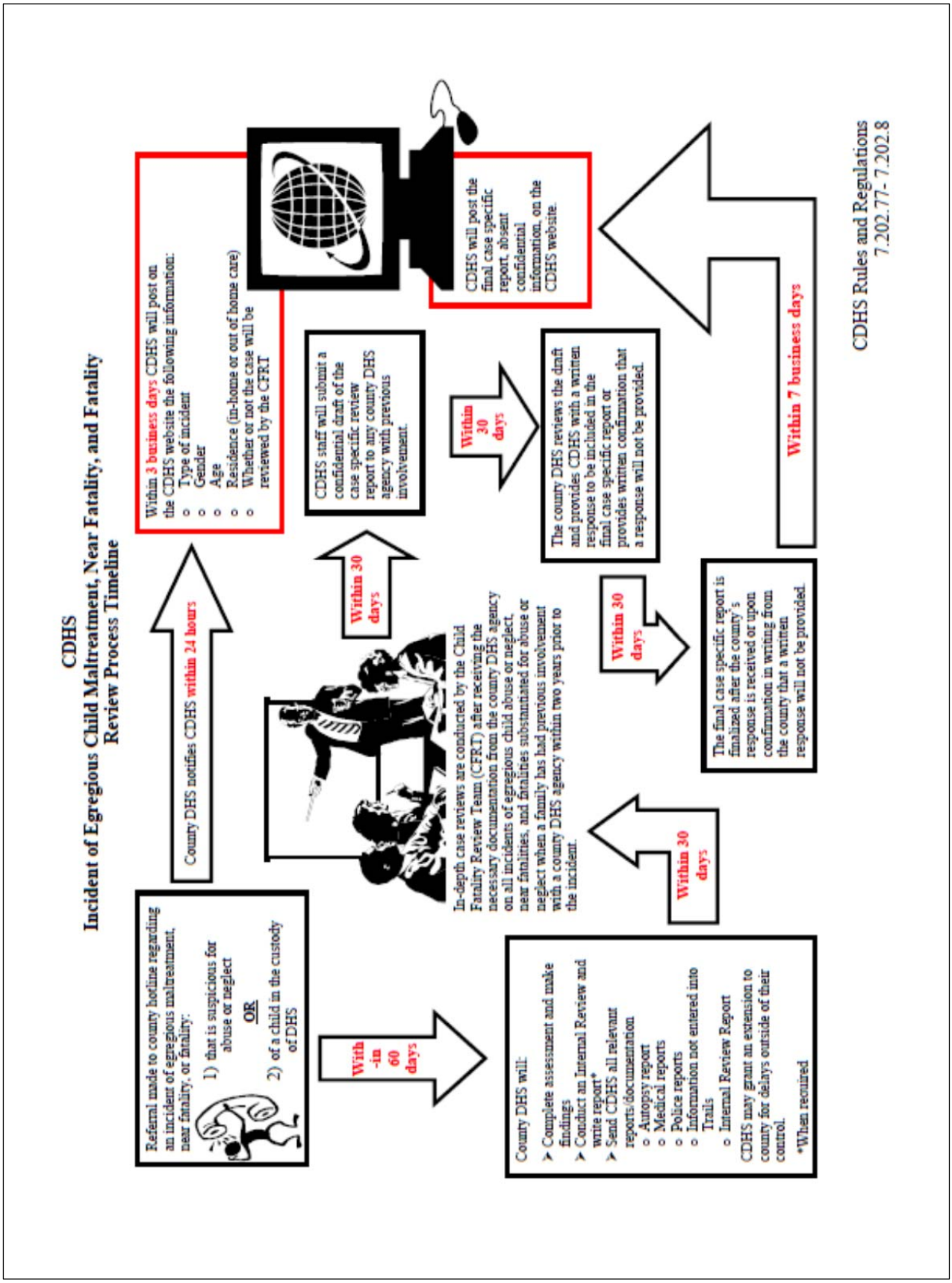
  <u>Status</u>: The report containing this recommendation was finalized in April of 2013. The Child Welfare Sub-PAC, through Policy Number 11CW009, had previously authorized a workgroup of state child welfare professionals to examine and update the Safety and Risk Assessment tools. Responsibility for this recommendation has been assigned to this existing workgroup.

The Colorado Department of Human Services will continue to track each of the recommendations through to implementation.

Recommendations And Action Steps

- Overall, the data indicate that abuse and neglect related to fatalities occurs a vast majority of the time in younger children in Colorado. Additionally, it tends to occur with younger parents, specifically younger mothers. Based on these findings, prevention opportunities should be sought specific to these populations. Examples of evidence based programs that may help reduce the likelihood of child maltreatment overall for this population include the Nurse-Family Partnership, Safe Care and Community Response Programs. Funding to expand these programs in Colorado has been included in the FY 2013-14 Long Bill.
- Tracking egregious incidents of child maltreatment began in August 2012. While there is a small sample size to date, data reflects that egregious incidents are much more likely to occur with older youth. As supported within the case specific recommendations, this indicates the need for enhanced assessment of safety and risk for families and youth involved in Program Area 4: Youth in Conflict cases. Program Area 4: Youth in Conflict practice tends to focus on the behaviors of the youth. It is recommended that policy be modified to support the practice of conducting a broader assessment of familial strengths and needs specific to dealing with difficult behavior in youth. Specifically, tools and policy should be created supporting assessments of the family's needs for supportive services. These services may help parents develop increased coping skills and more appropriate responses to difficult behavior in their children.
- Given the relevance of parent characteristics in relation to fatality rates (e.g., age of parents at birth and death of the child, family composition, etc.) these variables should be collected in the future, with greater detail shown describing the roles and relationships within each family. Parent characteristics data should also be collected for the egregious incidents and the near fatalities, which will allow for trend analysis in the future.
- In Colorado, almost 41% of the families involved in the egregious, near fatal, or fatal incidents of child maltreatment had some history of identified domestic violence. The child protection system is required to coordinate with the behavioral health and physical health systems to mitigate these issues as part of ensuring a child's safety. Current work is being done to help inform county departments of human services about the impact of domestic violence on child protective services practice. The forthcoming "Domestic Violence Practice Guide for Child Protection Services" is a comprehensive practice guide created to enhance knowledge and practice in child welfare cases with identified domestic violence. As the guide is finalized, the document should be widely distributed to child welfare professionals throughout Colorado, with trainings offered across the state specific to this topic.
- A review of the child welfare literature suggests different variables that may be informative towards child maltreatment prevention efforts. However, Colorado has not consistently captured data on these variables within the CFRT process. In order to better inform future Annual Reports, the CFRT should collect the following information for all egregious, near fatal, and fatal incidents of child maltreatment:
    (a) Birth Order
    (b) Number of Children and Adults in Household
    (c) Transiency of families
    (d) Family Composition
- As new research and data becomes available to the department around child fatalities, near fatalities, and egregious incidents, the Administrative Review Division should review any new and relevant research to identify additional variables for data collection and analysis. Any new information learned should be applied to future review and analysis of fatal, near fatal, and egregious incidents of child maltreatment.
- Trails should be modified to allow for incidents to be coded as "Near Fatality" or "Egregious" Incidents. This modification will allow data to be extracted based on the type of incident.

Appendix A: CFRT Timeline



Appendix B: Date of Incidents by County and Type

County	Fatal	Near Fatal	Egregious
Adams	2/17/12, 1/1/12*		
Denver	6/28/12	12/14/12	
Eagle	6/6/12		
El Paso	4/15/12, 9/1/12		9/21/12
Logan	1/1/12*		
Mesa	4/11/12		
Otero		12/31/12	
Pueblo	10/15/12**		
Total	9	2	1

* Actual date of incident is unknown

** This was initially reported as a Near Fatal incident and changed to Fatal upon the child's death.

Appendix C: Colorado Revised Statute C.R.S. 26-1-139

TITLE 26. HUMAN SERVICES CODE
ARTICLE 1.DEPARTMENT OF HUMAN SERVICES
PART 1. GENERAL PROVISIONS

C.R.S. 26-1-139 (2012)

26-1-139. Child fatality and near fatality prevention - legislative declaration - process - department of human services child fatality review team - reporting - rules

(1) The general assembly hereby finds and declares that:

(a) It is of the utmost importance and a community responsibility to mitigate the incidents of egregious abuse or neglect, near deaths, or deaths of children in the state due to abuse or neglect. Professionals from disparate disciplines share responsibilities for the safety and well-being of children as well as expertise that can promote that safety and well-being. Multidisciplinary reviews of the incidents of egregious abuse or neglect, near deaths, or deaths of children due to abuse or neglect can lead to a better understanding of the causes of such tragedies and, more importantly, methods of mitigating future incidents of egregious abuse or neglect, near deaths, or deaths.

(b) There is a need for agency transparency and accountability to the public regarding an incident of egregious abuse or neglect against a child, a near fatality, or a child fatality that involves a suspicion of abuse or neglect when the child or family has had previous involvement with the state or county that was directly related to the incident.

(c) There is a need for a multidisciplinary team to conduct in-depth case reviews after an incident of egregious abuse or neglect against a child, a near fatality, or a child fatality that involves a suspicion of abuse or neglect and when the child or family has had previous involvement, that was directly related to the incident of egregious abuse or neglect against a child, near fatality, or fatality, with a county department within two years prior to the incident. The multidisciplinary review would complement that of the review conducted by the Colorado state child fatality prevention review team in the department of public health and environment pursuant to article 20.5 of title 25, C.R.S. The goal of the multidisciplinary review shall not be to affix blame, but rather to improve understanding of why the incidents of egregious abuse or neglect against a child, near fatalities, or fatalities occur and develop recommendations for mitigation of future incidents of egregious abuse or neglect against a child, near fatalities, or fatalities.

(d) It is the intent of the general assembly to codify the department of human services child fatality review team as well as modify certain aspects of its processes to promote an understanding of the causes of each child's death or near death incident due to abuse or neglect, identify systemic deficiencies in the delivery of services and supports to children and families, and recommend changes to help mitigate future incidents of egregious abuse or neglect against a child, near fatalities, or child deaths.

(e) It is further the intent of the general assembly to comply with the federal "Child Abuse Prevention and Treatment Act", 42 U.S.C. sec. 5101 et seq., which requires states to allow for public disclosure of the findings or information about a case of child abuse or neglect that resulted in a child fatality or near fatality.

(2) As used in this section, unless the context otherwise requires:

(a) "Incident of egregious abuse or neglect" means an incident of suspected abuse or neglect involving significant violence, torture, use of cruel restraints, or other similar, aggravated circumstances that may be further defined in rules promulgated by the state department pursuant to this section.

(b) "Near fatality" means a case in which a physician determines that a child is in serious, critical, or life-threatening condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment.

(c) "Previous involvement" means a situation in which the county department has received a referral, responded to a report, opened an assessment, provided services, or opened a case in the Colorado TRAILS system; except that the following situations shall not be considered to be "previous involvement":

(I) The situation did not involve abuse or neglect;

(II) The situation occurred when the parent was seventeen years of age or younger and before he or she was the parent of the deceased child; or

(III) The situation occurred with a different family composition and a different alleged perpetrator.

(d) "Suspicious fatality or near fatality" means a fatality or near fatality that is more likely than not to have been caused by abuse or neglect.

(e) "Team" means the department of human services child fatality review team established in rules promulgated pursuant to section 26-1-111 and codified pursuant to subsection (3) of this section.

(3) There is hereby established in the state department the department of human services child fatality review team. The team shall have the following objectives:

(a) To assess the records of each case in which a suspicious incident of egregious abuse or neglect against a child, near fatality, or child fatality occurred and the child or family had previous involvement with a county department that was directly related to the incident of egregious abuse or neglect against a child, near fatality, or fatality within two years prior to the incident of egregious abuse or neglect against a child, near fatality, or fatality;

(b) To understand the causes of the reviewed incidents of egregious abuse or neglect against a child, near fatalities, or child fatalities;

(c) To identify any gaps or deficiencies that may exist in the delivery of services to children and their families by public agencies that are designed to mitigate future child abuse, neglect, or death; and

(d) To make recommendations for changes to laws, rules, and policies that will support the safe and healthy development of Colorado's children.

(4) The team shall have the following duties:

(a) To review the circumstances around the incident of egregious abuse or neglect against a child, near fatality, or child fatality;

(b) To review the services provided to the child, the child's family, and the perpetrator by the county department for any county with which the family has had previous involvement that was directly related to the incident of egregious abuse or neglect against a child, near fatality, or fatality in the two years prior to the

incident of egregious abuse or neglect against a child, near fatality, or fatality;

(c) To review records and interview individuals, as deemed necessary and not otherwise prohibited by law, involved with or having knowledge of the facts of the incident of egregious abuse or neglect against a child, near fatality, or fatality, including but not limited to all other state and local agencies having previous involvement with the child or family that was directly related to the incident of egregious abuse or neglect against a child, near fatality, or fatality within two years prior to the incident of egregious abuse or neglect against a child, near fatality, or fatality;

(d) To review the county department's compliance with statutes, regulations, and relevant policies and procedures that are directly related to the incident of egregious abuse or neglect against a child, near fatality, or fatality;

(e) To identify strengths and best practices of service delivery to the child and the child's family;

(f) To identify factors that may have contributed to conditions leading to the incident of egregious abuse or neglect against a child, near fatality, or fatality, including, but not limited to, lack of or unsafe housing, family and social supports, educational life, physical health, emotional and psychological health, and other safety, crisis, and cultural or ethnic issues;

(g) To review supports and services provided to siblings, family members, and agency staff after the incident of egregious abuse or neglect against a child, near fatality, or fatality;

(h) To identify the quality and sufficiency of coordination between state and local agencies;

(i) To develop and distribute the following reports, the content of which shall be determined by rules promulgated by the state department pursuant to subsection (7) of this section:

(I) On or before April 30, 2013, and each April 30 thereafter, an annual child fatality and near fatality review report, absent confidential information, summarizing the reviews required by subsection (5) of this section conducted by the team during the previous year. The team shall post the annual child fatality and near fatality review report on the state department's web site and distribute it to the Colorado state child fatality prevention review team established in the department of public health and environment pursuant to section 25-20.5-406, C.R.S., the governor, the health and human services committee of the senate, and the health and environment committee of the house of representatives, or any successor committees. The annual child fatality and near fatality review report shall be prepared within existing resources.

(II) The final confidential, case-specific review report required pursuant to subsection (5) of this section for each child fatality, near fatality, or incident of egregious abuse or neglect. The final confidential, case-specific review report shall be submitted to the Colorado state child fatality prevention review team established in the department of public health and environment pursuant to section 25-20.5-406, C.R.S.

(III) A case-specific executive summary, absent confidential information, of each incident of egregious abuse or neglect against a child, near fatality, or child fatality reviewed. The team shall post the case-specific executive summary on the state department's web site.

(5) (a) Each county department shall report to the state department any suspicious incident of egregious abuse or neglect against a child, near fatality, or fatality of a child within twenty-four hours of the incident of egregious abuse or neglect against a child, near fatality, or fatality. If the county department has had previous involvement that was directly related to the incident of egregious abuse or neglect against a child, near

fatality, or child fatality within two years prior to the incident of egregious abuse or neglect against a child, near fatality, or fatality, the county department shall provide the state department with all relevant reports and documentation regarding its previous involvement with the child within sixty calendar days after the incident of egregious abuse or neglect against a child, near fatality, or fatality. The state department may grant, at its discretion, an extension to a county department for delays outside of the county department's control regarding the receipt of all relevant reports and information critical to an effective review, including but not limited to the final autopsy and law enforcement reports, until such documents can be made available for review by the team.

(b) Within three business days after receiving the information provided under paragraph (a) of this subsection (5), the department shall disclose to the public that information has been received, whether the department is conducting a review of the incident, whether the child was in his or her own home or in foster care, as defined in section 19-1-103 (51.3), C.R.S., and the child's gender and age. The department may disclose the scope of the review.

(c) The team shall complete its review of each incident of egregious abuse or neglect, near fatality, or fatality, draft a confidential, case-specific review report and submit the draft report to any county department with previous involvement within thirty calendar days after the review team meeting. Any county department with previous involvement shall have thirty calendar days after the completion of the draft confidential, case-specific review report to review the draft confidential, case-specific review report and provide a written response to be included in the final confidential, case-specific review report. A confidential, case-specific review report shall be finalized and submitted pursuant to paragraph (e) of this subsection (5) no more than thirty calendar days after the county department's response is received by the team or upon confirmation in writing from the county department that a written response will not be provided.

(d) The proceedings, records, opinions, and deliberations of the department of human services child fatality review team shall be privileged and shall not be subject to discovery, subpoena, or introduction into evidence in any civil action in any manner that would directly or indirectly identify specific persons or cases reviewed by the state department or county department. Nothing in this paragraph (d) shall be construed to restrict or limit the right to discover or use in any civil action any evidence that is discoverable independent of the proceedings of the department of human services child fatality review team.

(e) The final confidential, case-specific review report shall be provided to the executive director, the director for any county or community agency referenced in the report, the county commissioners of any county department with previous involvement, the legislative members of the team appointed pursuant to paragraph (f) of subsection (6) of this section, and the department of public health and environment.

(f) The state department shall post on its web site, within seven business days after the report's finalization, a case-specific executive summary of the final confidential, case-specific review report, absent confidential information as described in paragraph (i) of this subsection (5), of each incident of egregious abuse or neglect against a child, near fatality, or child fatality reviewed pursuant to this section.

(g) The case-specific executive summary for a child who was in his or her own home at the time of the incident shall include:

(I) The age and gender of the child and a description of the child's family;

(II) A statement of whether any child welfare services, as defined in section 26-5-101 (3), were being provided to the child, any member of the child's family, or the person suspected of the abuse or neglect;

(III) The date of the last contact between the agency providing any child welfare service and the child, the child's family, or the person suspected of the abuse or neglect; and

(IV) Any other information required by rules promulgated by the state department pursuant to subsection (7) of this section.

(h) The case-specific executive summary for a child who was in foster care, as defined in section 19-1-103 (51.3), C.R.S., at the time of the incident shall include:

(I) The age, gender, and race or ethnicity of the child;

(II) A description of the foster care placement;

(III) The licensing history of the foster care placement; and

(IV) Any other information required by rules promulgated by the state department pursuant to subsection (7) of this section.

(i) The case-specific executive summary or other release or disclosure of information pursuant to this section shall not include:

(I) Any information that would reveal the identity of the child who is the subject of the executive summary, any member of the child's family, any member of the child's household who is a child, or any caregiver of the child;

(II) Any information that would reveal the identity of the person suspected of the abuse or neglect or any employee of any agency that provided child welfare services, as defined in section 26-5-101 (3), to the child or that participated in the investigation of the incident of fatality, near fatality, or egregious abuse or neglect;

(III) Any information that would reveal the identity of a reporter or of any other person who provides information relating to the incident of fatality, near fatality, or egregious abuse or neglect;

(IV) Any information which, if disclosed, would not be in the best interests of the child who is the subject of the report, any member of the child's family, any member of the child's household who is a child, or any caregiver of the child, as determined by the state department in consultation with the county that reported the incident of fatality, near fatality, or egregious abuse or neglect and the district attorney of the county in which the incident occurred, and after balancing the interests of the child, family, household member, or caregiver in avoiding the stigma that might result from disclosure against the interest of the public in obtaining the information.

(V) Any information for which disclosure is not authorized by state law or rule or federal law or regulation.

(j) The state department may not release the case-specific executive summary if the state department, in consultation with the county, determines that making the executive summary available would jeopardize any of the following:

(I) Any ongoing criminal investigation or prosecution or a defendant's right to a fair trial; or

(II) Any ongoing or future civil investigation or proceeding or the fairness of such proceeding.

(k) If at any point in the review process it is determined that the incident of egregious abuse or neglect against a child, near fatality, or fatality is not the result of abuse or neglect, the review shall cease.

(l) The state department or any county department may release to the public any information at any time to correct any inaccurate information reported in the news media, so long as the information released by the state department or county department is not explicitly in conflict with federal law.

(6) The team consists of up to twenty members, appointed on or before September 30, 2011, as follows:

(a) Three members from the state department, appointed by the executive director;

(b) Two members from the department of public health and environment, appointed by the executive director of said department;

(c) Three members representing county departments, appointed by a statewide organization representing county commissioners;

(d) At least eight additional multidisciplinary members, to be appointed by the members described in paragraphs (a) to (c) of this subsection (6), including but not limited to representatives from the office of the child protection ombudsman and from the fields of child protection, physical medicine, mental health, education, law enforcement, district attorneys, child advocacy, and any others as deemed appropriate;

(e) For the purposes of participating in a specific case review, additional members may be appointed at the discretion of the members described in paragraphs (a) to (c) of this subsection (6) to represent agencies involved with the child or the child's family in the twelve months prior to the incident of egregious abuse or neglect against a child, a near fatality, or fatality; and

(f) One member from the health and environment committee of the house of representatives or any successor committee, to be appointed by the speaker of the house of representatives, and one member from the health and human services committee of the senate or any successor committee, to be appointed by the president of the senate. The members appointed pursuant to this paragraph (f) are nonvoting members and are not required to be present at any meeting of the team.

(7) The state department shall promulgate additional rules, as necessary, for the implementation of this section, including but not limited to the confidentiality of information in incidents of egregious abuse or neglect against a child, near fatalities, or child fatalities.

HISTORY: Source: L. 2011: Entire section added, (HB 11-1181), ch. 120, p. 375, § 1, effective April 20.L. 2012: Entire section amended, (SB 12-033), ch. 91, p. 295, § 1, effective April 12.