COLORADO
Department of Human Services

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

July 1, 2014

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 2013."

The statute requires that, "On or before July 1, 2014, and each July 1 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 Owen Hill, 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 Joann Ginal, Public Health Care and Human Services
Representative Janak Joshi, Public Health Care & Human Services
Representative Lois Landgraf, 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 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 Lois Landgraf, Health, Insurance & Environment Committee
Representative Frank McNulty, Health, Insurance & Environment Committee
Representative Dianne Primavera, Health, Insurance & Environment Committee
Representative Jonathan Singer, Health, Insurance & Environment Committee
Representative Spencer Swalm, Health, Insurance & Environment Committee
Senator Jeannie Nicholson, Member of the Child Fatality Review Team
Representative Clarisse Navarro, Member of the Child Fatality Review Team
Members of the Child Fatality Review Team
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
Melissa Wavelet, Office Director, Performance and Strategic Outcomes, CDHS
Dee Martinez, Deputy Director of Enterprise Partnerships, CDHS
Jennifer Corrigan, Legislative Liaison, CDHS

2013 Child Maltreatment Fatality Review Report

COLORADO
Department of Human Services

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EXECUTIVE SUMMARY

The 2013 Colorado Department of Human Services Child Fatality Review Report focuses on identifying commonalities and making recommendations for improvements in the Child Welfare system based on the information from 76 substantiated child maltreatment fatalities, near fatalities, and egregious incidents that occurred in 2013. This report includes demographic information for the children in the 76 substantiated incidents, and more specific recommendations made as a result of the 15 incidents fully reviewed by the Child Fatality Review Team (CFRT) and posted to the public website.

In order to determine systemic issues, information about children from 23 substantiated fatalities 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. Recommendations are provided that address the policy findings, gaps, and deficits identified during the CFRT process.

Child Characteristics

The majority of child maltreatment fatality, near fatality, and egregious incident victims in Colorado in Calendar Year 2013 were White (46%), closely followed by Hispanic (29%). Two-thirds of the victims were male (67%). 39% of children in these incidents were age one or younger. 86% were age five or younger.

Family Characteristics

The enactment of HB 13-255 required more detailed information about family characteristics. Though income level and education level of legal caretakers proved difficult to gather, information on services to families indicated that in 24 incidents fully reviewed by the CFRT team under the new statute, 16 families received some type of supplemental benefit, with Medicaid and the Supplemental Nutrition Assistance Program (SNAP) being the most common programs. Family structure was also gathered in 2013, based on recommendation from the 2012 report. 48% of fatal incidents occurred in families with two biological parents. Likewise, 66% of egregious incidents occurred to children in families with two biological parents.

Other Family Stressors

Information on additional family stressors was available and these characteristics were found in a substantial portion of cases, including substance abuse (20%), domestic violence (38%), and mental health (32%). Prior history was examined and compared to the past years.

Prior History with Child Protective Services

The number of fatalities where the family has prior history with child protective services has ranged from 35% to 55% over the past 5 years. In 2013, 35% of fatal incidents had prior involvement.

Perpetrator Relationship

New analysis for 2013 about perpetrator type found fathers acting alone were the most common perpetrator in all substantiated incidents (25%).

Review Findings and Recommendations

The CFRT highlighted 45 systemic strengths across 15 reports completed and posted in 2013. The most commonly acknowledged asset was child welfare practice. The CFRT also identified 30 systemic gaps and deficits across the child welfare system, which resulted in recommendations for county agencies and CDHS. Similarly, in the 15 reports, 87 policy findings were noted in prior history and current involvement, with the majority of these (37%) directed to the safety and risk assessment. 66 recommendations resulting from gaps, deficits, and policy findings that were indicative of areas for practice and system improvement are contained in Appendix C of this report.

This report also includes joint recommendations with the Colorado Department of Public Health and Environment and the follow-up status of 13 outstanding recommendations from the 2012 annual report.

BACKGROUND

Colorado's Child Fatality Review Team (CFRT) process has undergone numerous changes between 2011 and 2013. Prior to 2011, the Colorado Department of Human Services (CDHS) had limited authority to conduct fatality reviews. Up until 2011, the CDHS was conducting reviews on fatalities where the child or family had previous involvement with the family in the prior five years in a less formal manner.

In 2011, House Bill (HB) 11-1181 provided the Colorado Department of Human Services with statutory authority (26-1-139) for the provision of a child fatality review process, and funded the CDHS for one staff position to conduct these reviews. HB 11-1181 also established basic criteria for when incidents should be reviewed by the CFRT. These included incidents in which a child fatality occurred and the child or family had previous involvement with a county department in the two years prior to the fatality. It also outlined that previous involvement did not include when:

1. The situation did not involve abuse or neglect;
2. 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
3. The situation occurred with a different family composition and a different alleged perpetrator.

In 2012, Senate Bill (SB) 12-033 added the review of near fatal and egregious incidents to the responsibilities of the CFRT. It also included reporting and public disclosure requirements. This aligned Colorado statute with federal requirements under the 1996 Child Abuse and Prevention Treatment Act (CAPTA) which mandates states 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)). As SB 12-033 became effective April 12, 2012, any impact of adding egregious and near fatal incidents to the total number of incidents requiring review would not be fully determined until calendar year 2013.

With the passing of HB 13-255, legislative changes to the CFRT process occurred again in 2013. Specifically, criteria for qualifying for a full review by the CFRT were changed. This included lengthening the time considered for previous involvement from two years to three years, and removing the exceptions related to previous involvement (listed above). These changes effectively expanded the population of incidents requiring a CFRT review. HB 13-255 also provided funding for two additional staff for the CFRT review process; bringing the total staff dedicated to this function to three. HB 13-255 became effective May 14, 2013, so the full impact of expanding the range of incidents to be reviewed may not be seen until 2014.

As the statutory changes over the prior years have modified the population of incidents requiring review, and each has changed within each given calendar year, it limits the ability to interpret trends in the data. Further, any change in the final number of incidents in a given calendar year may be due to definitional changes rather than to changes in the number of actual incidents.

As an example, a total of 78 children were reported as alleged victims of a fatal, near fatal or egregious child maltreatment incident during calendar year 2012. This increased to a total of 116 children reported as alleged victims during calendar year 2013. This increase is likely due to the increased awareness of the reporting requirements and procedures as well as the definition of near fatal and egregious incidents in conjunction with the expanded definition of previous involvement and the extension from two to three years. Overall, for calendar year 2012 there were five egregious and fourteen near fatal incidents reported. This increased to 35 egregious incidents involving 39 children and 21 near fatal incidents involving 21

children in calendar year 2013. The total number of incidents that required a CFRT review increased from 12 to 39. These changes are reflected in Table 1. Going forward, stability in the statute and definitions will allow for better trend analysis.

Table 1: Incidents Reported Over Time and Statutory Change

Year	Fatal Incidents	Near Fatal Incidents	Egregious Incidents	Total Children
2012	59	14	5	78
2013	55	21	35	116

REVIEW PROCESS AND TIMELINES

HB 13-255 also changed the required reporting date for the CFRT Annual Report, moving it back from April 30th of each year to July 1st. As a result, this section will discuss incidents reviewed from May 1, 2013 through June 30, 2014. Reviews completed prior to May 1, 2013 were discussed in the 2012 CFRT Annual Report.

During this 14 month span, the CFRT reviewed 43 incidents of fatal (11), near fatal (12) or egregious (20) child maltreatment. Of these, three incidents occurred in 2012. Because they occurred late in the year, the review itself occurred in the next calendar year. Of the 39 incidents that occurred during calendar year 2013, 14 of them were reviewed within 2013, while the remaining 24 were reviewed in calendar year 2014. The final two incidents reviewed occurred early in calendar year 2014. Please see Appendix A for a table showing attendance of the CFRT members across the review meetings.

Statute provides county departments 60 days from a qualifying incident to provide the CDHS with information necessary to inform the review. Because some of this information comes from other agencies (e.g., law enforcement, coroners, etc.), statute also provides the CDHS with the authority to provide extensions to county departments to allow time to gather necessary information that is outside their direct control. The need for extensions impacts the total length of time needed to complete any individual review.

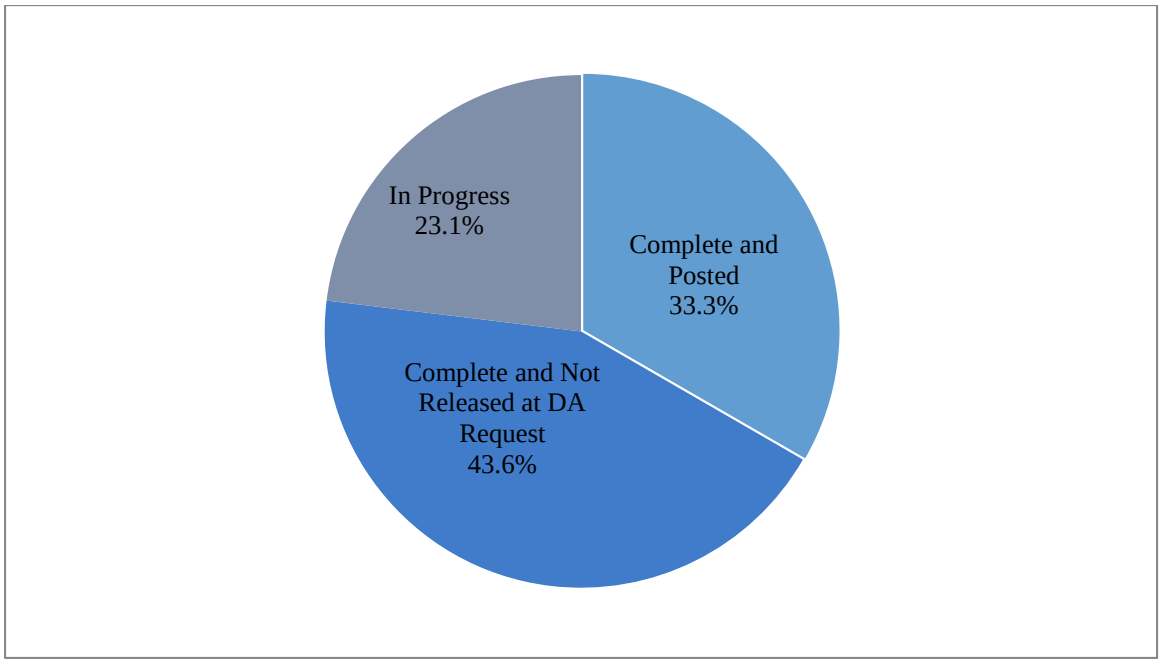
As an example, of the 39 incidents in 2013 that required a review, 27 of them were provided at least one extension. For those that required an extension, the total number of extensions provided ranged from a low of one to a high of five. Overall, a total of 62 extensions were provided to these 27 incidents; equaling an average of 2 extensions per incident that required an extension. Because each extension is granted in 30 day increments, this effectively means that for many of the incidents, all information needed by the review team may not be available until approximately four months after the incident occurred. Providing time to scan and distribute the material to team members so they have time to read and prepare for the actual CFRT discussion means that incidents may not be reviewed until five months after the incident.

Once the CFRT members review an incident, statute provides clear timelines and steps for finalizing both the confidential and non-confidential versions of the report, and posting the non-confidential version on the appropriate Department web page. For many reports associated with 2011 and 2012 incidents, these timelines were not met. In addition to the two additional staff provided through SB 13-255, the responsibility for overseeing the CFRT function moved from the Division of Child Welfare to the Administrative Review Division (ARD) (January of 2013) and changes were implemented to track and assure timeliness. Reports are now being completed within the statutorily required timeframes.

Chart 1 shows the current status of 2013 reports. At time of this report, reviews for 30 of the 39 incidents that occurred in calendar year 2013 have been completed. For 13 of them, a final non-confidential report

has been posted on the Administrative Review Division's web page. For the remaining 17 the final non-confidential report has not been posted or released. Reports for the final 9 incidents are in progress.

Chart 1: 2013 Report Status



C.R.S. 26-1-139 (5) (j) (I) allows the CDHS to not release the final non-confidential report if it may jeopardize "any ongoing criminal investigation or prosecution or a defendant's right to a fair trial". As such, the ARD consults with District Attorney's prior to releasing the final non-confidential report when there is current, or likely, criminal investigation and/or prosecution. In these instances, the Department requests District Attorneys to make known their preference for releasing or withholding the final non-confidential report. In all 17 incidents where a report has not been released, it is because the District Attorney has requested it be withheld so as not to impact investigations and/or prosecutions. For these 17 incidents, a copy of the formal request from the District Attorney is posted on the web page in place of the report. The ARD maintains contact with each District Attorney, requesting a letter authorizing release of the final non-confidential report at the conclusion of the investigation/prosecution. At that time, the ARD would post and release the report.

IDENTIFICATION AND REPORTING OF INCIDENTS

Statute requires that county departments provide notification to the CDHS of any suspicious incident of egregious abuse or neglect, near fatality, or fatality of a child due to abuse or neglect within 24 hours of becoming aware of the incident. Over the years of legislative changes in the definition of these applicable populations, county departments have worked diligently to comply with this requirement.

As part of analyzing data in preparation for this Annual Report, data was extracted from Trails for any assessment with an egregious, near fatal or fatal allegation of child maltreatment. Additionally, data was pulled for any child with a date of death entered into Trails. This data was then compared to the reports of incidents received from counties over the course of 2013. This data integrity check identified 14 incidents

involving 14 children that appeared as though they met the criteria for notification to the CDHS, but for which the CDHS did not receive notification from the county.

Two of these incidents involved child maltreatment allegations substantiated at an egregious severity level. As such, notification should have been sent to the CDHS and subsequently posted on the public notification web page. However, as there was no prior involvement with either of the families, they would not have required a review by the CFRT.

The remaining 12 incidents involved fatal incidents that were assigned for assessment by a county department. Upon assignment, thereby meeting the definition of suspicious incident fatality, notification should have been sent to the CDHS and subsequently posted on the public notification web page. It is important to note that none of the 12 incidents were substantiated, meaning it was determined that the death was not due to child maltreatment. As such, none would have met criteria for a CFRT review.

As part of the data integrity check, notice was sent to the county departments regarding the above incidents and the incidents were added to the public notification web page. Discussions with counties revealed potential confusion over the specific notification requirements and processes. This helped identify the need for better information and training around the requirements and processes for county staff. During 2014, the ARD will work to create and disseminate this information to relevant county staff.

COLORADO DEPARTMENT OF HUMAN SERVICES AND DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT COLLABORATION

The CDHS CFRT staff works closely with CDPHE's Child Fatality Prevent System (CFPS) team to consider data from each system and make joint recommendations based upon these findings. Each review process serves a different purpose and each process is fully supported by the alternate agency. The CFPS staff members at CDPHE serve as the two state appointees from CDPHE to the CDHS CFRT. A CFRT staff person from the ARD is one of the six 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.

It is important to note that the CFPS uses different criteria to determine deaths they believe child maltreatment caused or contributed to the death. In their Fiscal Year 2014 Annual Report, the CDPHE provides the following description:

> Although Colorado's Children's Code (C.R.S. 19-1-103 (1)) and legal definitions of child abuse and child neglect serve as guidance for the review team, the final decision on whether to record an act of omission or commission is based on available information and professional judgments made by the multidisciplinary CFPS State Review Team. This team includes representatives from departments of human services. The decision to document an act of omission or commission as child abuse or child neglect does not have legal ramifications. The determination is subjective opinion on the part of the CFPS State Review Team and does not trigger any prosecution or action on the part of departments of human services. As such, fatalities classified as child maltreatment by the CFPS State Review Team will not be reflective of official counts of abuse or neglect fatality reported by the Colorado Department of Human Service (CDHS). Additionally, some of these fatalities do not meet the criteria for review by the CDHS Child Fatality Review Team. This is because they were

deaths of children with no known prior history of child maltreatment within the three years prior to the fatality and deaths of children for whom child maltreatment was not the direct cause of death. Or, they were deaths of children who were unknown to the department of human services system.

HB 13-255 requires that, as a result of collaboration, the two child fatality review teams make joint recommendations. These recommendations can be found on Page 27 of this document, as well as in the CFPS Fiscal Year 2014 Annual Report.

OVERVIEW OF THE 2013 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 2013, counties reported that 116 children were victims of a suspected egregious incident, a near fatality, or a fatality as a result of child maltreatment, for a total of 111 reported incidents. Of the 116 children, 56 children experienced fatal incidents, 21 children were involved in near fatal incidents, and 39 children were victims of egregious incidents. After a thorough assessment of each child in each incident, 33 (58.9%) fatalities, 6 (28.6%) near fatalities and 1 (2.5%) egregious incident were found to be unsubstantiated for abuse or neglect, and therefore were not considered to be a result of child maltreatment.

Incidents deemed substantiated are considered the result of child maltreatment and there is a "Founded" disposition against the person(s) responsible for the abuse or neglect. In CY 2013, substantiated incidents included 76 children, 43 of whom had prior involvement with county departments of human services within the statutorily defined time period.

The cases that are substantiated and have the prior involvement required for an in-depth case review are referred to the Child Fatality Review Team (CFRT) process, which includes a full review of the incident and recommendations around policy and practice considerations. See Table 2 for a comparison of children whose incident met criteria to be reviewed in 2012 and 2013. Each incident reviewed by the team results in a written report that is posted to the CDHS website (with confidential information redacted).

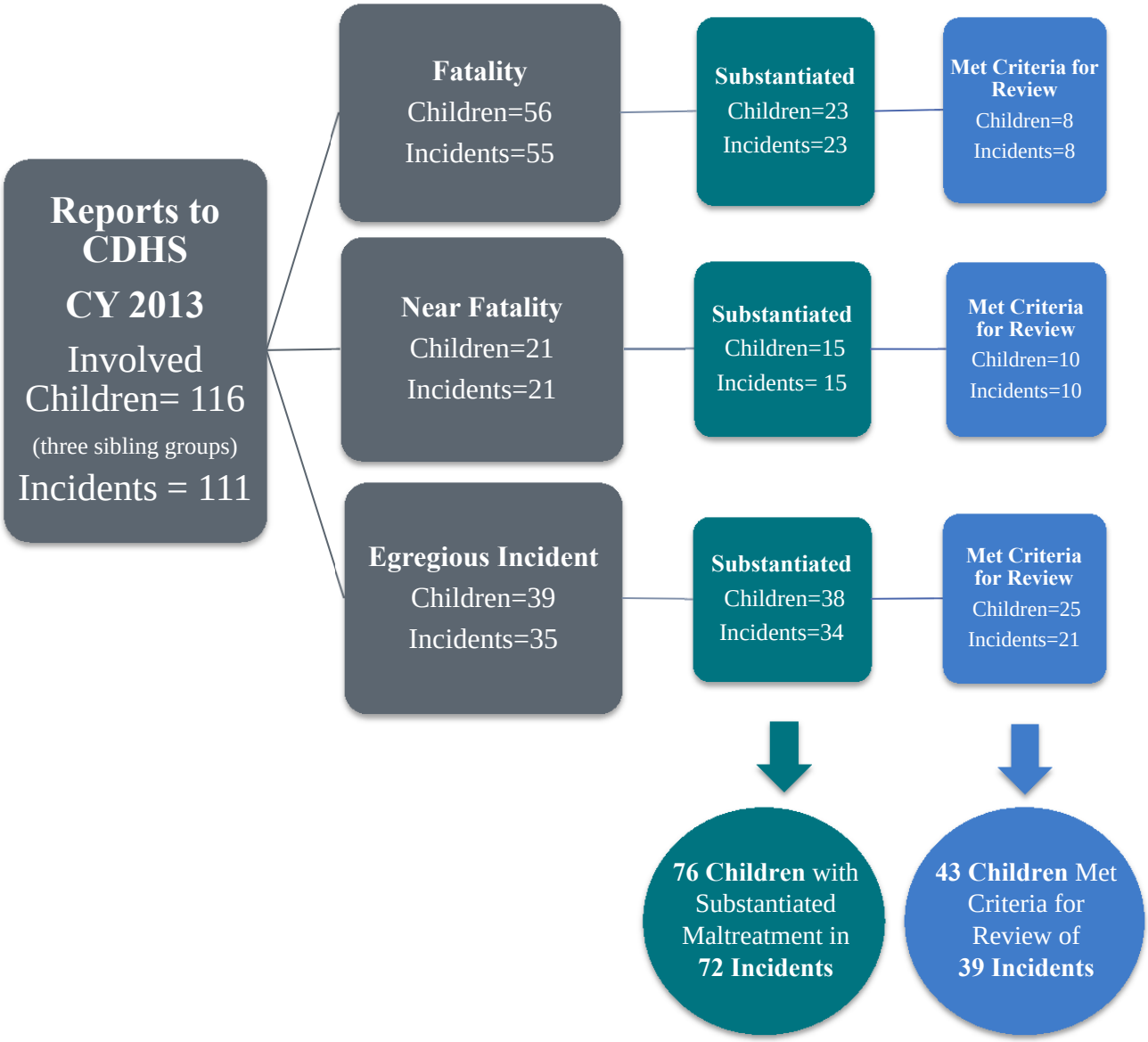
It is important to reiterate that as the statutory changes over the prior years have modified the population of incidents requiring review, and each has changed within each given calendar year, it limits the ability to interpret trends in the data. Further, any change in the final number of incidents in a given calendar year may be due to definitional changes rather than to changes in the number of actual incidents.

Table 2: Number of children whose incident met criteria to be reviewed by CFRT

Year	Fatal Incidents	Near Fatal Incidents	Egregious Incidents	Total Children
2012	9	2	1	12
2013	8	10	25	43

Chart 2 depicts the breakdown of the incidents reported in CY 2013. Appendix B contains a list of the counties and dates of each incident by incident type.

Chart 2: 2013 Children Involved in Suspected and Substantiated Incidents of Fatal, Near Fatal, and Egregious Child Maltreatment



For purposes of this report, the majority of the analysis in the following section focuses on the 76 substantiated victims of child maltreatment fatalities, near fatalities, and egregious incidents reported to the CDHS and discovered through the data integrity check (described in the background section). Table 3 provides an overview of the demographic characteristics of the 76 substantiated victims of incidents that occurred in CY 2013.

Table 3: Summary Information of all 76 Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incident Victims from Calendar Year 2013

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Victim at Time of Incident	Less than one year	9	39.1%	6	40.0%	15	39.5%
	One	5	21.7%	3	20.0%	4	10.5%
	Two	1	4.3%	2	13.3%	3	7.9%
	Four	1	4.3%	2	13.3%	1	2.6%
	Five	2	8.7%	1	6.7%	3	7.9%
	Six		0.0%		0.0%	2	5.3%
	Seven	1	4.3%		0.0%	2	5.3%
	Nine	1	4.3%		0.0%	1	2.6%
	Three	3	13.0%	1	6.7%	3	7.9%
	Thirteen		0.0%		0.0%	2	5.3%
	Fifteen		0.0%		0.0%	1	2.6%
	Sixteen		0.0%		0.0%	1	2.6%
Race/Ethnicity	African American	2	8.70%	3	20.00%	3	7.89%
	Asian	1	4.35%		0.00%		0.00%
	Hispanic	8	34.78%	4	26.67%	10	26.32%
	Multiracial		0.00%	1	6.67%	4	10.53%
	White	7	30.43%	7	46.67%	21	55.26%
	Unknown	5	21.74%		0.00%		0.00%
Gender	Female	7	30.4%	3	20.0%	15	39.5%
	Male	16	69.6%	12	80.0%	23	60.5%
Family Structure	One bio parent and one unrelated caregiver	5	21.7%	3	20.0%	6	15.8%
	One bio parent	4	17.4%	3	20.0%	4	10.5%
	Two bio parents	11	47.8%	3	20.0%	25	65.8%
	One unrelated caregiver		0.0%		0.0%	1	2.6%
	One related caregiver		0.0%	1	6.7%		0.0%
	Two related caregivers	1	4.3%	2	13.3%	2	5.3%
	One related caregiver and one unrelated caregiver	1	4.3%		0.0%		0.0%
	Daycare/Foster Care	1	4.3%	3	20.0%		0.0%
Incidents with Additional Family Stressors	Substance Abuse	2	8.7%	2	13.3%	11	28.9%
	Mental Health	4	17.4%	3	20.0%	17	44.7%
	Domestic Abuse	4	17.4%	8	53.3%	17	44.7%

DATA AND DEMOGRAPHICS

Within the field of child welfare, studies have indicated a number of factors related to maltreatment, including: child characteristics, family characteristics, and other complicating factors. 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. Please note that little research has been conducted on incidents of near fatalities and egregious abuse or neglect.

CHILD CHARACTERISTICS

The Child Maltreatment 2012 publication (published annually by the United States Department of Health and Human Services Administration for Children and Families), provides the most current data available 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. Throughout this section, demographic data from Colorado child maltreatment fatalities will be compared to national child maltreatment fatalities to illustrate similarities and differences. Please note, national data is not available for near fatal or egregious incidents.

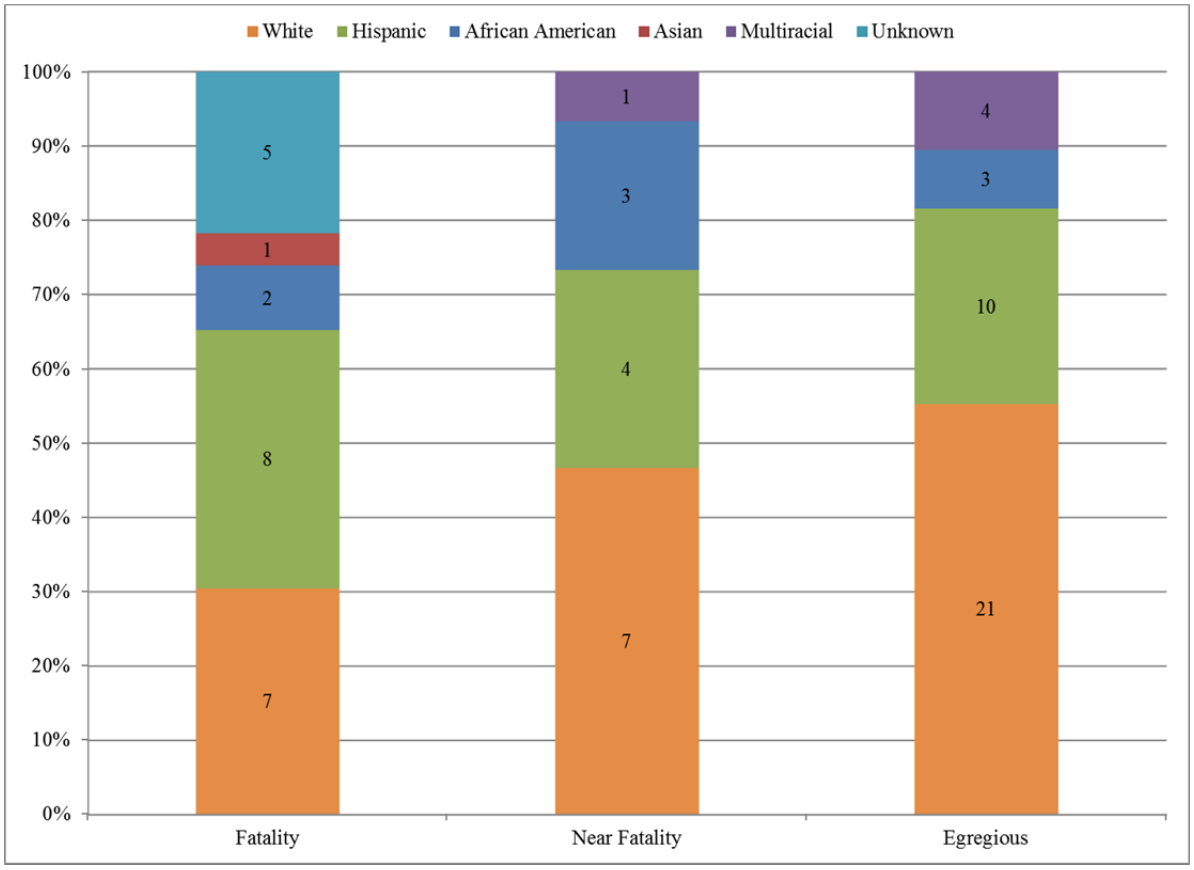
RACE/ETHNICITY

Nationally, 38.3% of child fatalities are White children, 31.9% are African American children, and 15.3% are Hispanic children.

Chart 3 displays the race/ethnicity for the 76 substantiated child maltreatment fatalities, near fatalities, and egregious incidents that occurred in Colorado in 2013. For fatalities, the most frequent race/ethnicity was Hispanic (34.8%) followed by White (30.4%).

Race and ethnicity 2010 Census data from the Colorado State Demographers Office indicate that 71.1% of Colorado's population was White and 4.1% was African American. Approximately 20.6% of the population is of Hispanic or Latino origin. Population forecasts by the State Demographer estimate by 2015, individuals of Hispanic origin will comprise 22.5% of Colorado's total population. The estimated population for those individuals identifying as White will decrease to 68.7%, while African American population will increase slightly to 4.2%.

Chart 3: Race/Ethnicity of 76 Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado for CY 2013

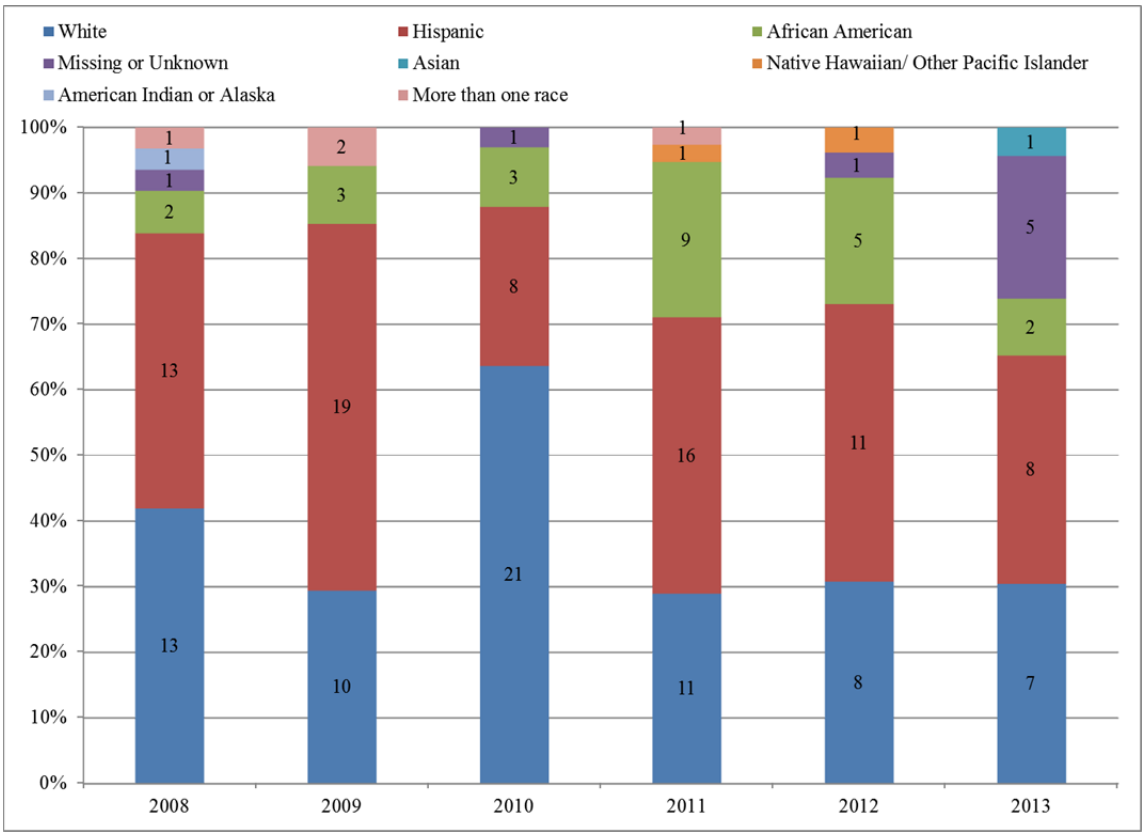


In analyzing data in this section, it is important to note how race was determined for this report. In Trails, race and ethnicity are captured as two separate variables. For the purposes of this report, these were combined into one overall variable. To do so, Hispanic ethnicity was treated as its own race. As an example, if a child was entered into Trails as White with Hispanic Ethnicity, this was mapped to Hispanic. This matches an approach being proposed by the Census Bureau and currently taken by other child welfare researchers.

Chart 4 shows the race/ethnicity of all child maltreatment fatalities in Colorado over the past six 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. With the exception of 2010, this trend has continued through 2013, with Hispanics comprising more than 34% of the child maltreatment fatalities. It is worth noting that, for 2013, there is a higher than normal number of children where a race was not entered into Trails, likely impacting the overall percentage of each race for this year.

Unlike the national child fatality characteristics, African American children represent the third highest group of fatalities in Colorado. However, this appears to match Colorado's demographics, where there is a higher percentage of individuals with Hispanic/Latino origin. This analysis does not represent rates of abuse or neglect within a given race/ethnicity, but just race/ethnicity as a percentage of all fatalities reported in the given calendar year.

Chart 4: Race of Victims in All Substantiated Child Maltreatment Fatalities in Colorado over the Past Six Calendar Years



GENDER

Nationally, in FFY 2012, 57.6% of child maltreatment fatality victims were boys. In Colorado, in CY 2013, boys accounted for 69.6% (16/23) of the substantiated child maltreatment fatalities. Boys also were victims of four-fifths of the near fatalities, and approximately two-thirds of the egregious incidents. There are no federal comparison statistics for near fatal or egregious incidents. Chart 5 displays the breakdown in gender differences between types of incidents.

In the recent past, Colorado mirrored national trends in regard to gender of child fatalities. In 2008, approximately 50% of child maltreatment fatalities involved boys. In Colorado, this trend continued to grow, with boys accounting for 69.6 % of the victims of child maltreatment fatalities in 2013. This percentage has been on the rise since 2008 (see Chart 6).

Chart 5: Gender of 76 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2013

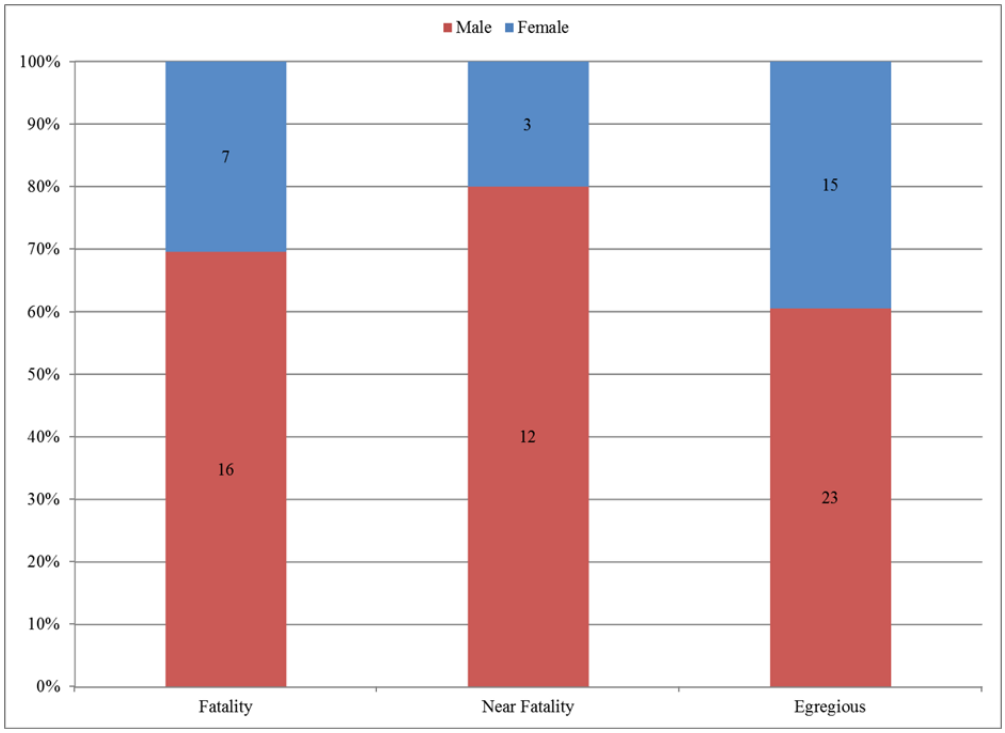
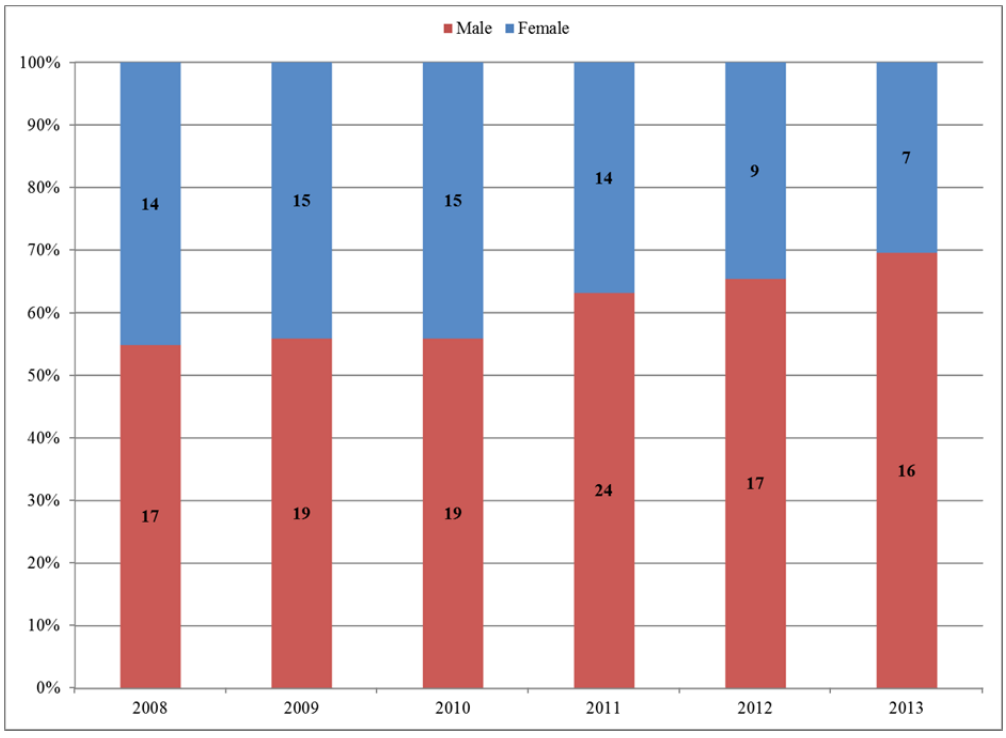


Chart 6: Gender of Victims in All Substantiated Child Maltreatment Fatalities in Colorado over the Past Six Calendar Years



AGE AT TIME OF INCIDENT

A child's age has historically been a key demographic factor associated with child maltreatment fatalities. National research has shown that victims of fatal child maltreatment tend to be younger, with approximately 70.3% of the child fatalities experienced by children age three or younger, and 44.4% being younger than one year old. Colorado's trends appear to closely follow the national trends. As displayed in Chart 7, approximately 39% (9/23) of the fatalities involved victims younger than one year old, and 78% (18/23) were three or younger. A similar pattern exists for the near fatalities, as 40% (6/15) of the victims were under the age of one, and 80% (12/15) were age three or under (see Chart 7). As the number of egregious incidents reviewed by the team increased in 2013, the pattern of ages of the victims closely mirrored those of the fatal and near fatal victims. Approximately 40% (15/38) of the victims of egregious incidents were under the age of one, and 60% (23/38) of all egregious incident victims were aged three or younger.

Chart 7: Age of 76 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2013

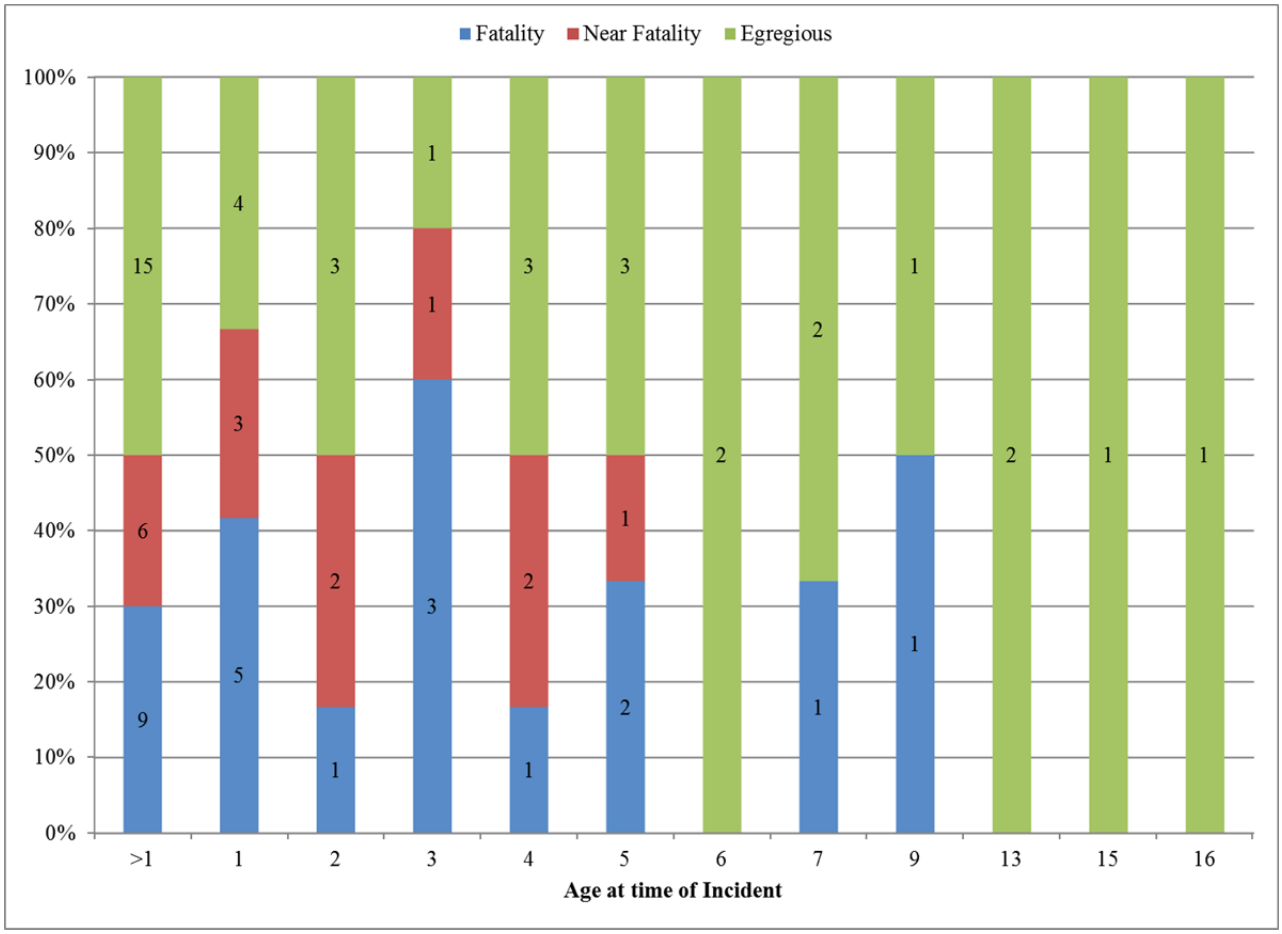
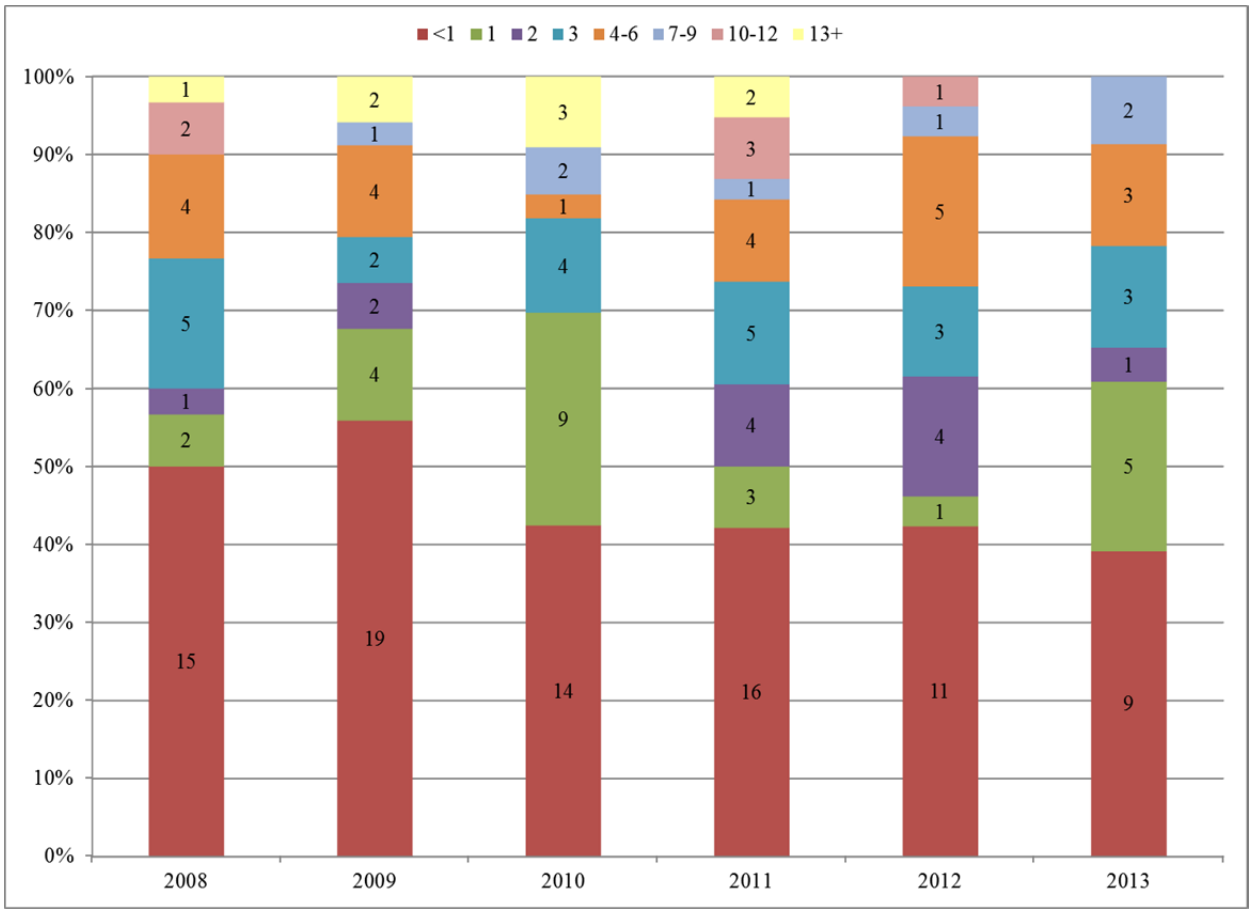


Chart 8 displays the trends in victim ages across the past six years. While it varies slightly over time, approximately 70% of children in fatal child maltreatment incidents are three years of age or younger.

Chart 8: Age of Victims in Child Maltreatment Fatalities in Colorado over the Past Six 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, including data from fatalities, near fatal, and egregious incident reports.

INCOME AND EDUCATION LEVEL OF CAREGIVERS

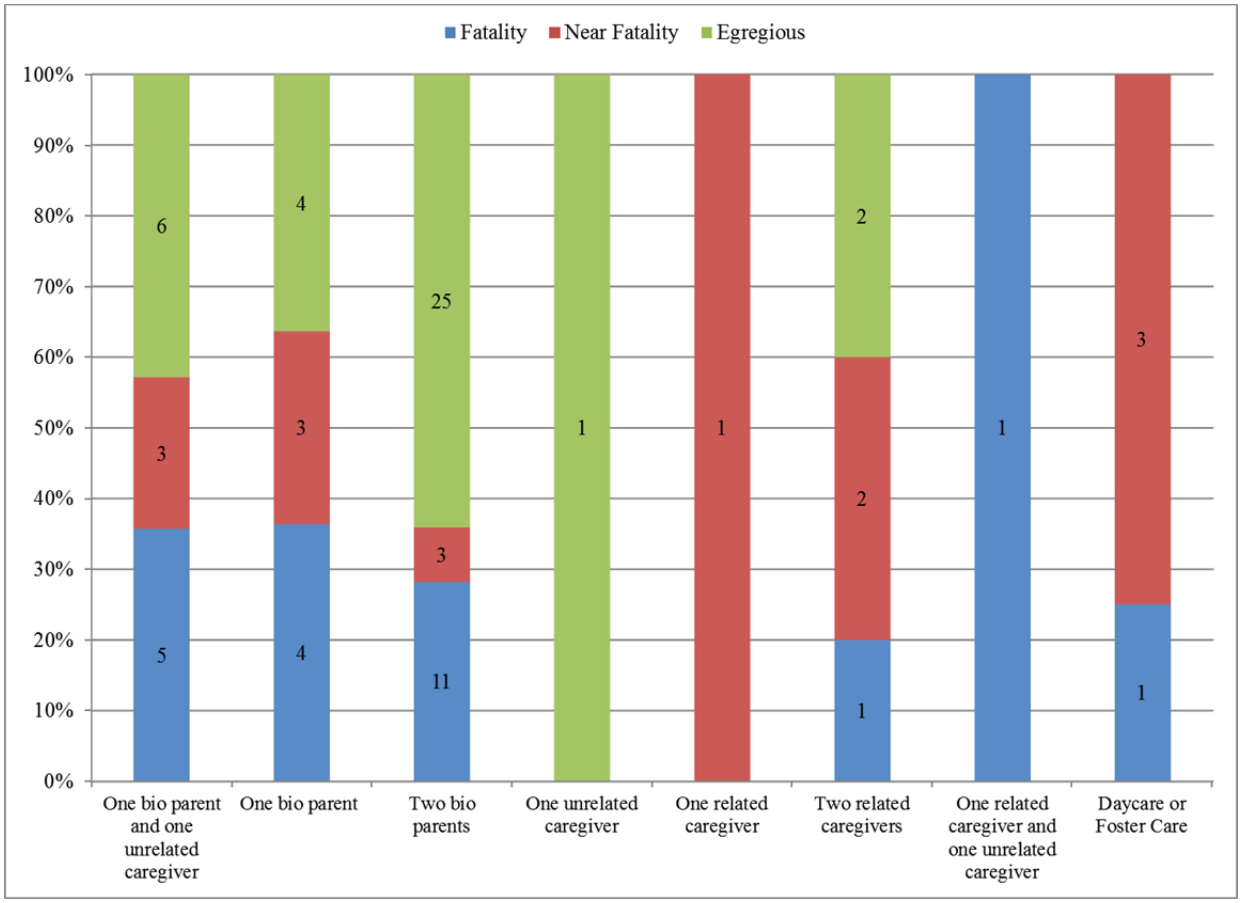
In the changes made to the Colorado Revised Statute by HB 13-255, income, educational level, and service involvement of legal caregivers at the time of the incident as a reporting expectation for confidential, case-specific reports reviewed by CDHS. This information proved difficult to collect and report on, as it was not always part of available documentation. Income and education level of caregivers are not variables routinely collected during child protection assessments, as assessments are more focused on determining immediate safety of children. This information is not available for those reports where a full review was not conducted. Out of 24 reports fully completed after the enactment of HB 13-255, six reports included information about income and/or education levels. In those six reports, legal caretakers most commonly were

unemployed and had less than a high school diploma or GED. Two reports had income reported, both of which were under $8,000 per year, which is well below the Federal poverty level for a household, regardless of family size. 16 of the 24 reports indicated that the family qualified for and received some level of supplemental benefits, including Supplemental Nutrition Assistance Program (SNAP), Medicaid, Supplemental Security Income (SSI), Child Care Assistance Program (CCAP), and Special Supplemental Nutrition Program- Women, Infants, Children (WIC). Medicaid and SNAP were the most frequently utilized programs in this group.

FAMILY STRUCTURE

Family composition is another factor potentially related to child maltreatment fatalities. As displayed in Chart 9, the majority (39/76) of all fatalities, near fatalities, and egregious incidents took place in families with two biological parents of the victim. In fact, 50% (11/23) of fatal incidents occurred for children in families with two biological parents. This family composition was also most likely for the children in egregious incidents, where 66% (25/38) occurred in a family with two biological parents. This compares to 48% (11/23) for fatalities, and 20% (3/15) for near fatalities. This year, four incidents occurred in substitute care settings, including daycare and foster care.

Chart 9: Family Structure of 76 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious in 2013

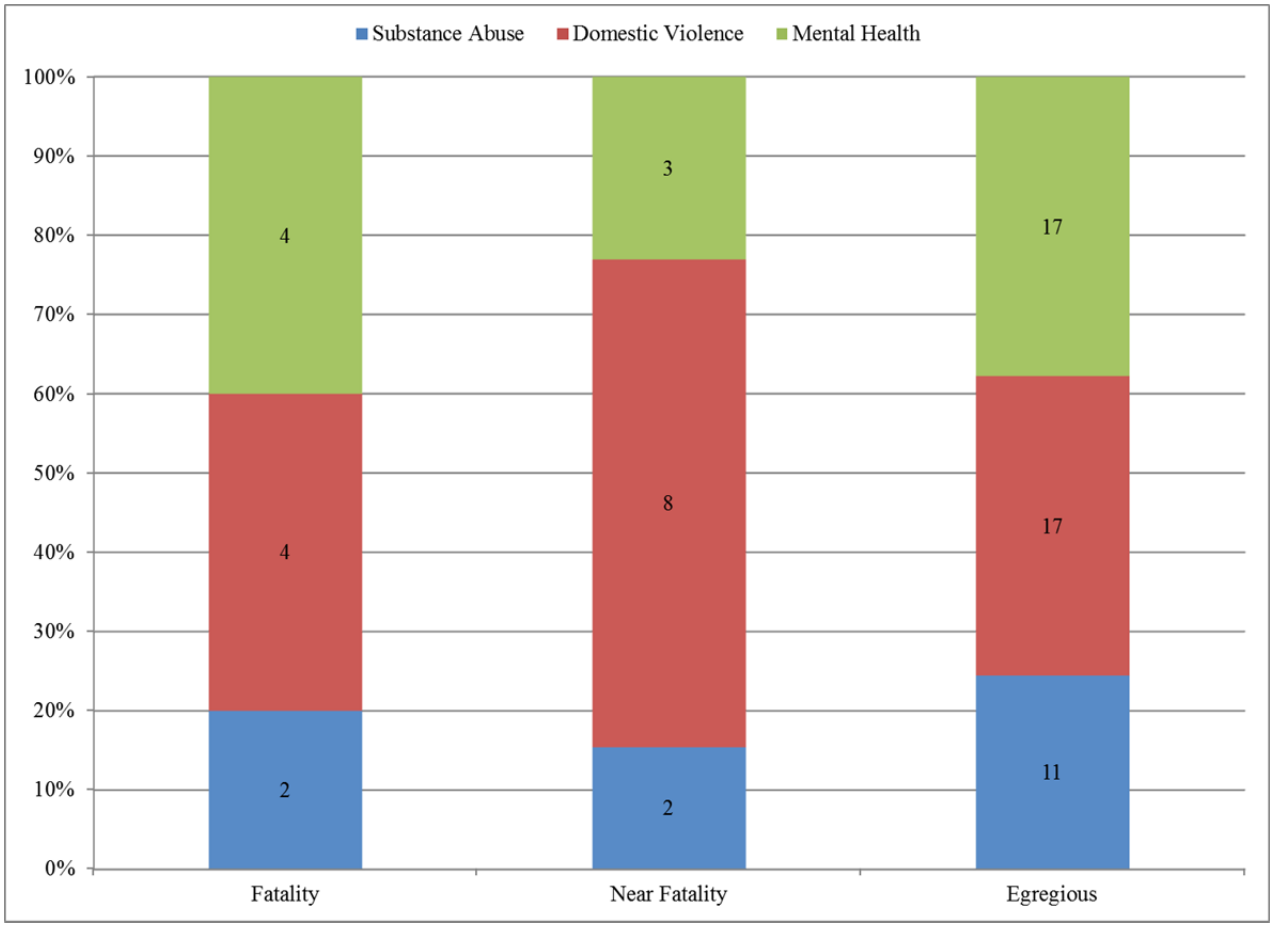


OTHER FAMILY STRESSORS

Chart 10 identifies additional elements that were tracked in an effort to determine commonalities among the children in the 76 fatalities, near fatalities, and egregious incidents from 2013. Nationally, 6.3% of child maltreatment fatalities involved alcohol abuse as a risk factor, while 20.1% involved domestic violence, and 17.3% involved drug abuse. These percentages were matched closely in Colorado, as 8.7% (2/23) of the families also experienced substance abuse issues and 17.4% (4/23) of the families involved in a child fatality had some history of identified domestic violence. Additionally, in 17.4% (4/23) of the fatality incidents, there was a history of mental health treatment.

More near fatal and egregious incidents involved domestic violence than fatalities, 53.3% (8/15) and 44.7% (17/38) respectively. This aligns with the high prevalence of incidents occurring in a family composition with two caregivers. While 50% of incidents occurred in a family comprised of two biological parents, another 20% occurred in a family with one biological parent and one unrelated caregiver. In addition, in almost 45% of the substantiated egregious incidents, there was a history of mental health issues for any caregiver at the time of the incident. At this time there is no national data to compare to these percentages.

Chart 10: Other Family Stressors in Families of 76 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents*



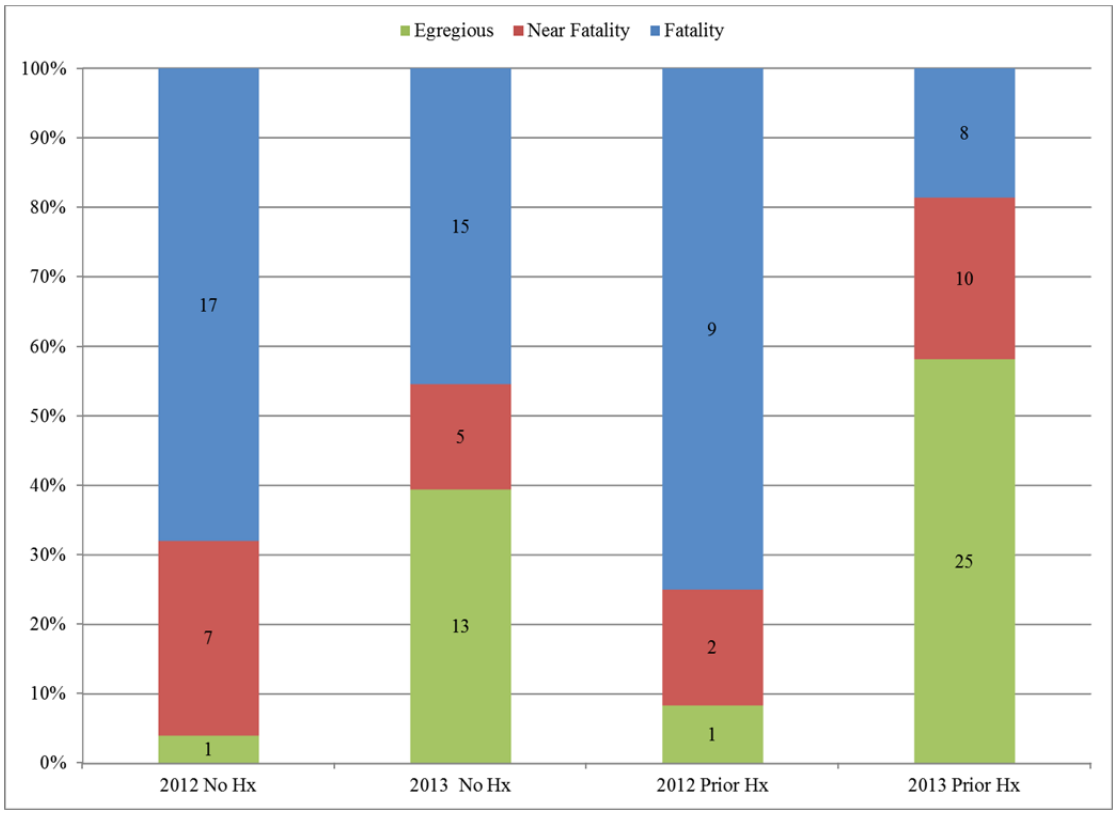
*Some incidents involved co-occurring stressors, whereas not all families involved in these incidents experienced these stressors.

PRIOR INVOLVEMENT

Nationally, in 2012, 8.5% of child fatalities involved families with prior CPS history within the past five years. For the child maltreatment fatalities that occurred in Colorado during calendar years 2008 – 2013, approximately 35% to 55% of the families had prior child protection history. In 2013, 34.8% (8/23) of fatalities had prior history. According to current state statute, the Child Fatality Review Team is required to conduct a thorough review of child fatalities, near fatalities, and egregious incidents when there is prior history in the three years preceding the incident. Before the change in statute in 2013, prior history was defined as a two year time period (2011) and a five year time period prior to 2011.

In 2012, two of the near fatalities had prior history, and only one egregious incident had prior history within the past two years. As the scope of prior history increased to an additional year in 2013, more incidents in 2013 required a review by the Child Fatality Team. A total of 43 children were reviewed in 2013, and more than half of the children were victims of egregious incidents (59%). Among families with prior history, there were eight more children with near fatal findings reviewed, and one less victim of a fatal incident reviewed in 2013 compared to 2012. See Chart 11 for a comparison of the past two years.

Chart 11: Prior History of Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado from 2012-2013*



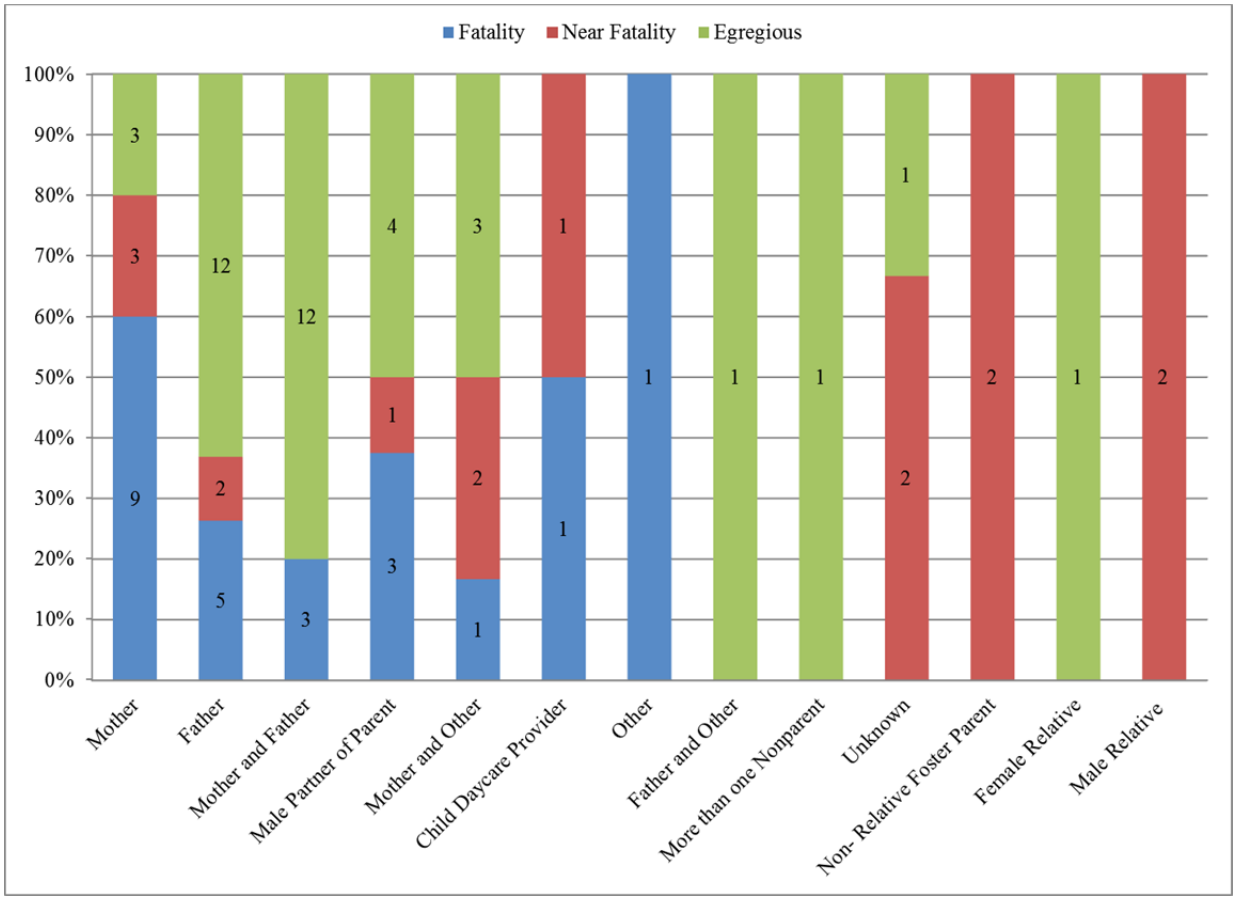
* As the statutory changes over the prior years have modified the population of incidents requiring review, and each has changed within each given calendar year, it limits the ability to interpret trends in the data. Further, any change in the final number of incidents in a given calendar year may be due to definitional changes rather than to changes in the number of actual incidents.

PERPETRATOR RELATIONSHIP

Chart 12 displays the different relationship to the victim between the perpetrators of the fatal, near fatal, or egregious incidents. The majority of all fatalities were committed by the victim's mother (39.1%, 9/23), is slightly above national trends (27.1%). The second largest category of perpetrators of fatalities was fathers (5/23). For the near fatal incidents, mothers acting alone were also the most frequent perpetrators (3/15), although among the other 13 victims, the relationships of the perpetrator varied from a male relative to a day care provider.

The perpetrators of egregious incidents were most frequently fathers acting alone (12/38), followed exactly by mother and father together (12/38). Other notable categories of perpetrators of egregious incidents include male partner of parent (4/38), mother (3/38), and mother acting with another person (3/38).

Chart 12: Perpetrator Relationship to 76 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado during CY 2013



SUMMARY OF REVIEW FINDINGS AND RECOMMENDATIONS

This section summarizes the findings and recommendations of the fifteen incident reports posted since the 2012 Annual Report. This section does not include information from the seventeen reports where the District Attorney's office has requested non-disclosure. Each of the fifteen reports contains an overview of systemic strengths identified by the CFRT, as well as systemic gaps and deficiencies for that particular report. The aggregate data from the fifteen reports point to the strengths and gaps in the child welfare system surrounding fatalities, near fatalities, and egregious incidents.

Using the expertise contained in the CFRT, members identified gaps and deficiencies, which ultimately resulted in recommendations to strengthen the child welfare system. Reviewers identified policy findings based on Volume VII and Colorado Revised Statutes. Each report contained a review of both past and current involvement. If policy findings were indicative of systemic issues within the individual county agency or the state child welfare system, recommendations also resulted.

This section first summarizes systemic strengths found by the CFRT in each of the fifteen reports. Then, the section provides an overview of systemic gaps and deficiencies as well as any corresponding recommendations and progress. This section also summarizes policy findings from the 15 reports alongside resulting recommendations and progress. This section also presents the joint recommendations made in collaboration with the Colorado Department of Public Health and Environment's Child Fatality Prevention System. This section concludes with recommendations and progress from earlier 2012 reports and the 2012 Annual Report.

SUMMARY OF IDENTIFIED SYSTEMIC STRENGTHS IN THE DELIVERY OF SERVICES TO CHILDREN AND/OR FAMILIES

In the 15 fatal, near fatal, or egregious incident reports of child maltreatment reviewed by the full Child Fatality Review Team and posted to the public notification website, strengths in the delivery of services to children and families were noted in 45 items. Items of strength acknowledged by the team can be organized in the following categories: 1) Assessment and Documentation by County Agencies, 2) Child Welfare Practice, 3) Collaboration between Agencies, and 4) Services Available to Children, Families, and County Agencies.

ASSESSMENT AND DOCUMENTATION BY COUNTY AGENCIES

The CFRT identified exemplary assessment and documentation on 13 separate items. In particular, the team identified in eight items that documentation in case files supported decisions following the incident in thorough detail. The team also recognized counties when it was clear that caseworkers conducted global assessments to preserve or maintain child safety following an incident. On four items, the team acknowledged prior assessments conducted by county agencies. Specifically, many items mentioned global assessment practices as strengths in the assessment process, with focus on more than just the alleged incident, but also on the surrounding circumstances.

CHILD WELFARE PRACTICE

General casework by county agencies was noted as a strength in 15 items. Regarding prior involvement, the CFRT acknowledged caseworkers for engagement with families, proactive services related to assessed risk of child maltreatment, and cultural sensitivity with families. Following the incident that precipitated the review, the CFRT noted, after reviewing documentation, that caseworkers were engaging with families in a culturally sensitive way, and actively pursued the support of extended family as well as absent parents. One county exhibited both supportive supervision to a caseworker following an incident as well as multiple team meetings to support and assist the caseworker in decision making throughout the assessment. The team also noted one county's thorough and detailed internal review of the incident and their prior involvement with the family.

COLLABORATION BETWEEN VARIOUS AGENCIES

The CFRT uses multi-disciplinary expertise to examine coordination and collaboration between various agencies as reflected in documents from multiple sources. Following the incident of maltreatment under review, the CFRT highlighted six items that exemplified collaboration between agencies to provide a thorough, coordinated response to fatalities, near fatalities, and egregious incidents of child maltreatment. Law enforcement's response and collaboration with county agencies was noted in two items, where the joint investigation led to better assessment and more streamlined services to families and children. Three items listed in the Assessment area also credited collaboration with law enforcement by casework staff as integral to the quality of the assessment. Interstate communication between child protection service entities was noted in two items as a strength. The CFRT highlighted the child protection team (CPT) at Children's Hospital as an important resource for assessment by county agencies in cases of severe child maltreatment. Finally, the CFRT noted that one case detailed strong coordination between two counties in a joint assessment and response to an incident.

SERVICES AVAILABLE TO CHILDREN, FAMILIES, AND COUNTY AGENCIES

The CFRT examines the services available to families and county agencies during prior involvement and surrounding the incident under review. The CFRT noted 11 occasions of strong service delivery by county agencies. In one case, prior involvement with the agency included a past foster family for the children who maintained supportive interaction with the parents and children after reunification. Specific community services were named on two occasions, to emphasize prior case successes with families. In services provided after the incident, the CFRT noted family meetings, parent-child interactional assessments, supervised visitation, victim's assistance programming, and facilitated family support were integral in working with families after near fatal, fatal, or egregious incidents. One item noted the importance of secondary trauma support for caseworkers who have been closely involved in these types of incidents.

SUMMARY OF IDENTIFIED SYSTEMIC GAPS AND DEFICIENCIES IN THE DELIVERY OF SERVICES TO CHILDREN AND FAMILIES

In the 15 fatal, near fatal or egregious child maltreatment incidents reviewed by the full Child Fatality Review Team and posted to the public notification website, the CFRT identified 30 gaps and deficiencies in the delivery of services to children and families. The gaps and deficiencies can be organized into five categories: 1) Safety and Risk Assessment Tools, 2) Policy, 3) Collaboration between Agencies, 4) Systemic Practice, and 5) Case Specific Practice. Each gap and deficiency, whenever possible, corresponds with a recommendation to address the identified concern. Appendix C contains the recommendations resulting from these 15 incident reviews and information about their implementation status.

SAFETY AND RISK ASSESSMENT TOOLS

A systemic deficiency identified by the CFRT on six occasions was related to the Colorado Risk and Safety Assessment tools. The team noted that many policy violations were related to the accurate use of these tools. As will be discussed in the policy findings portion of this section, the CFRT noted 32 policy findings related to the use of the safety and risk assessments, spread across 13 of the 15 reports. Statewide and county-specific data further supported this deficiency by illustrating overarching performance difficulties and inability to meet the statewide goal for accuracy on these tools. This CFRT-identified gap, along with policy violations mentioned above, combined to form multiple recommendations in reports. In particular, the recommendations urged attention to training, evaluation and on-going continuous quality improvement. The Division of Child Welfare has announced planned changes to the Colorado Risk and Safety Assessment tools, which are scheduled to be implemented in winter 2014 and are designed to positively impact performance in this area. The Colorado Risk and Safety Assessment tool implementation plan includes the following activities:

- Field Testing in counties varying in size and geographical location;
- Revision of Rule;
- Statewide training; and
- Modification to Trails.
- County departments will not have access to the new tools in Trails until individual staff complete the training.

POLICY

The CFRT noted two separate items that concerned policies on domestic violence. First, the CFRT highlighted that current Colorado statute and administrative rule does not specifically address domestic violence in the presence of children in the definition of child abuse and neglect. The item further stated that according to a report entitled, "Child Witnesses to Domestic Violence" by the Administration for Children and Families, 23 States and Puerto Rico currently address the issue of children who witness domestic violence in state statute (2013). Of note are the aggregate data from 2013 reports, where domestic violence was a risk factor in 39.7% of all fatalities, near fatalities, and egregious incidents substantiated for maltreatment. The recommendation related to this policy gap is for the Division of Child Welfare to team with the Domestic Violence Program to explore and identify policy changes.

The second policy deficiency identified by the CFRT pertains to firearm possession by those convicted of domestic violence. The case specific report noted: "C.R.S. 13-14-105.5 Civil Protection Orders - Prohibition on Possessing or Purchasing a Firearm was enacted after House Bill 13-1259 and signed by the governor on May 14, 2013, establishing an effective date of July 1, 2013. This statute indicates that if the court subjects a person to a domestic abuse protection order, the court, as part of such order, shall order

the person to: Refrain from possessing or purchasing any firearm or ammunition for the duration of the order; and relinquish, for the duration of the order, any firearm or ammunition in the respondent's immediate possession or control or subject to the respondent's immediate possession or control."

C.R.S.13-14-105.5 outlines the timeframes in which such person is required to relinquish any firearms (no longer than 72 hours after being served with the court order) and ammunition (no longer than five days after being served with the court order) and indicates that not more than three business days after the relinquishment, proof of relinquishment is to be filed with the court. The statute further indicates that failure to file proof of relinquishment or failure to do so in a timely manner constitutes a violation of the protection order and the "court shall issue a warrant for the respondent's arrest." The CFRT noted that in their review of documentation pertaining to a case where a convicted domestic violence offender committed gun violence in front of the children, there was no indication the father relinquished his firearms and/or filed proof of relinquishment with the court. The recommendation from this case is related to implementation of a policy that has already been enacted. The recommendation included education and technical assistance by the Domestic Violence Program for the District Court.

Unrelated to domestic violence, the CFRT identified one other policy deficiency. The CFRT noted there does not seem to be consistent practice on how new allegations of child maltreatment are handled in open assessments or cases. This item resulted in a recommendation that the Child Protection Task Group explore clarification and policy change if needed to improve consistency across the state.

COLLABORATION BETWEEN AGENCIES

The CFRT noted five items pertaining to difficulty in collaboration and/or communication between agencies. Two of the five pertained to the challenges in effectively conducting interstate work with child protective services. These two items resulted in a recommendation that state staff assist county staff in interstate cases to advocate for information exchange and release. The other three items were concerning collaboration between DHS and the court, other community agencies, and the family's extended safety network. These items resulted in two county specific recommendations developed to address these gaps.

SYSTEMIC PRACTICE

The CFRT noted five gaps or deficiencies in systemic practice based on review of the fifteen reports: 1) the entry of substantiated findings of child maltreatment when the perpetrator is unknown; 2) the need for additional secondary trauma support for caseworker exposed to critical cases; 3) inconsistent documentation of reasons for not accepting an assessment; 4) difficulty with the requirement that critical cases be restricted to a small number of authorized users, particularly given that counties do not consistently maintain workers who have this authorization; and 5) inconsistent use of Criminal Background Information (CBI) checks on potential caregivers for children. All five of these gaps and deficiencies resulted in recommendations to be systemically addressed by the Division of Child Welfare.

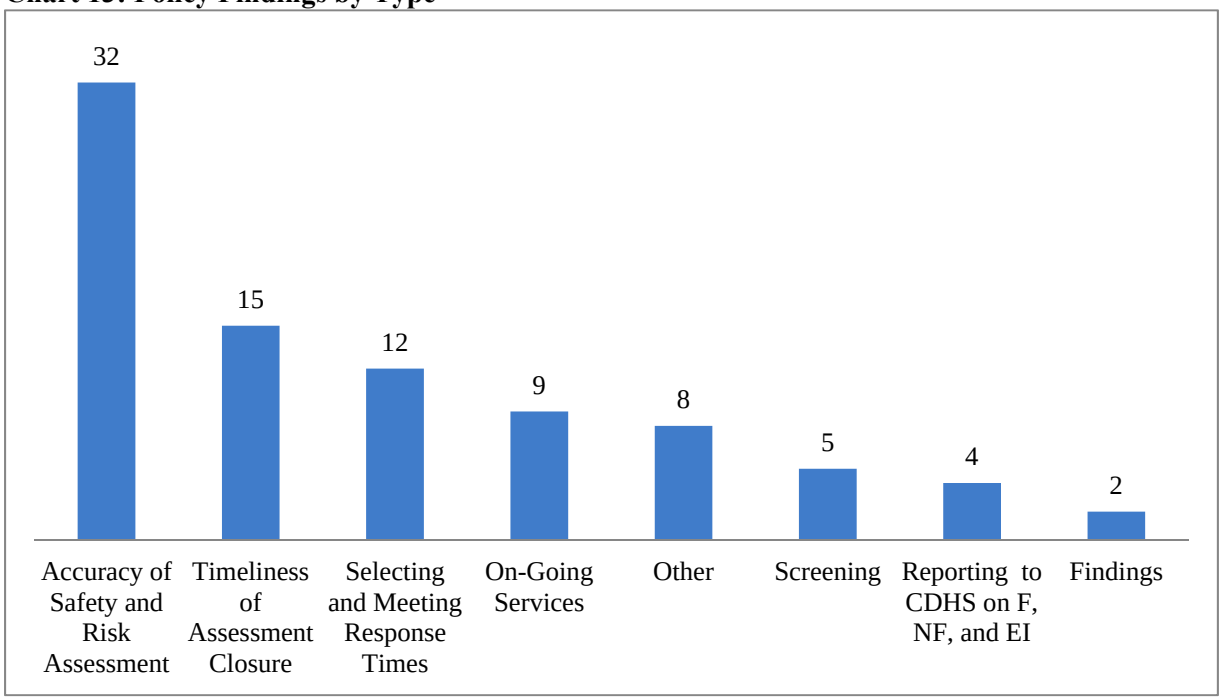
CASE SPECIFIC PRACTICE

The remaining 11 gaps and deficiencies were case specific, in that the CFRT identified individual instances of practice by the county that could be improved. In some of these cases, the CFRT recommended corrections to existing documentation or county level continuous quality improvement (CQI) to address identified concerns. These items were generally varied, including lack of engagement with absent parents, difficulty with custody resolution, deficiencies in assessment, and inadequate documentation support agency decision making.

SUMMARY OF POLICY FINDINGS

The CFRT methodically reviewed county agency documentation of fatalities, near fatalities, and egregious incidents, service delivery after the incident, and prior involvement (13-255, effective May 14, 2013, changed the length of prior involvement from two years to three years). In each review, the CFRT identified areas of noncompliance with Volume VII and the Colorado Revised Statutes. The 87 findings from the fifteen reports posted on the public notification site comprise the next section of this report. The majority of policy findings can be categorized into eight categories: 1) Accuracy of Safety and Risk Assessment, 2) Timeliness of Assessment Closure, 3) Selecting and Meeting Response Times, 4) Screening, 5) Reporting to CDHS on Fatalities, Near Fatalities, and Egregious Incidents, 6) Case Services, 7) Findings, and 8) Other. Chart 13 shows a count of policy findings by type.

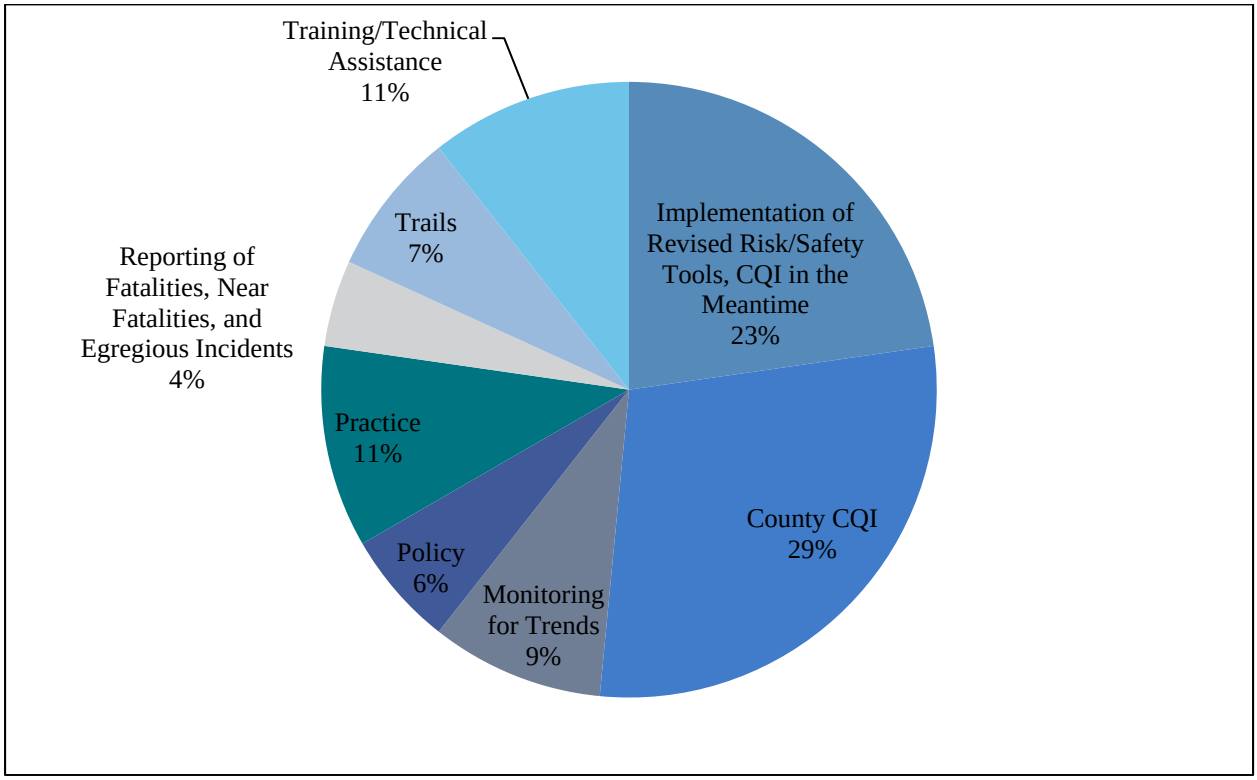
Chart 13: Policy Findings by Type



For the majority of policy findings, the CFRT examined current county practice to determine whether the finding was indicative of systemic practices in the agency. Using data gained from Screen Out, Assessment, In-Home, Out-of-Home reviews conducted by the Administrative Review Division, or from administrative data gained from the Division of Child Welfare as part of the C-Stat process, counties were determined to either not have recommendations related to the policy finding, or the CFRT recommended county continuous quality improvement (CQI) processes. CQI includes identifying barriers to performance and implementation of solutions to improve practice.

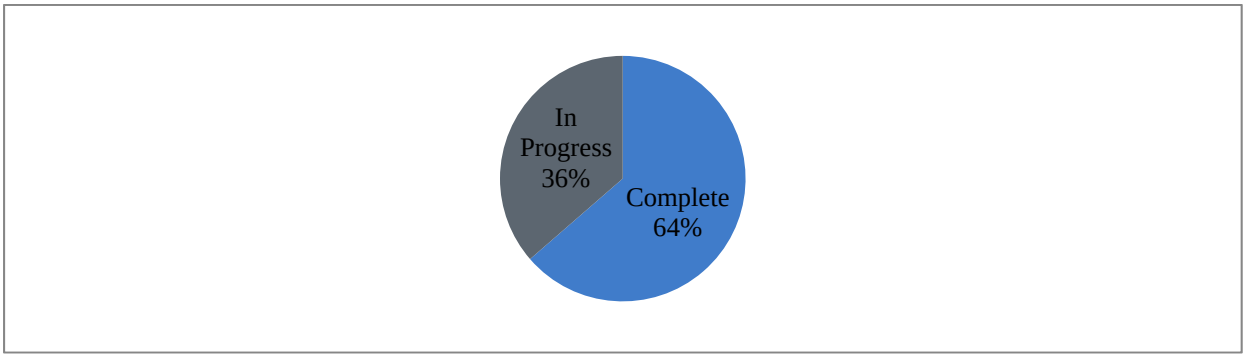
The CFRT developed recommendations from gaps, deficiencies, and policy findings in the fifteen reports published in 14 months since the last review. The 66 total recommendations can be divided into eight main areas, as illustrated in Chart 14: 1) County CQI; 2) Implementation of revised risk/safety tools, CQI in the meantime; 3) Training/Technical Assistance; 4) Practice; 5) Monitoring for Trends; 6) Trails; 7) Policy; and 8) Reporting of Fatalities, Near Fatalities, and Egregious Incidents.

Chart 14: Types of Recommendations by Type (N=66)



While several recommendations were reviewed in this report, the full texts of all 66 are contained in Appendix C. The status of progress on these recommendations is also presented. Current status on completion by the assigned agency for the 67 recommendations is illustrated in Chart 15.

Chart 15: Status of 66 Recommendations from 2013 Posted Reports



JOINT RECOMMENDATIONS TO PREVENT CHILD MALTREATMENT

Pursuant to C.R.S. 25-20.5-407 (1) (i), the Child Fatality Prevention System (CFPS) State Review Team is required to collaborate with the Colorado Department of Human Services (CDHS) Child Fatality Review Team to make joint recommendations for the prevention of child fatalities due to child maltreatment. Both teams endorse the recommendations outlined below.

Incorporate infant safe sleep education and how to address safety concerns related to infant safe sleep practices as part of the Colorado Department of Human Services Child Welfare Training System for child welfare professionals.

The CFPS reviews all infant deaths that occur in sleep environments. Sleep-related infant deaths are also referred to as Sudden Unexpected Infant Deaths (SUID). SUID cases include Sudden Infant Death Syndrome (SIDS), accidental suffocation, positional asphyxia, overlays, as well as deaths occurring in sleep environments that are from undetermined causes. Child maltreatment also contributes to some SUID fatalities. For example, an intoxicated caregiver who chooses to share a bed with an infant may inadvertently roll-over on top of the infant causing the child to suffocate. Of the 284 SUID fatalities that occurred between 2008 and 2012, child maltreatment caused or contributed to 24 of the fatalities, as determined by the CFPS State Review Team. Sixteen of the 24 fatalities were substantiated by county departments of human services. Nine of the 16 fatalities were reviewed by the CDHS Child Fatality Review Team because the fatality was determined to be the result of child maltreatment and the child or family had involvement with a county Department of Human Services prior to the fatality. As such, both the CFPS State Review Team and the CDHS Child Fatality Review Team endorse the recommendation for CDHS to incorporate infant safe sleep education and how to address safety concerns related to infant sleep practices as part of the CDHS Child Welfare Training System for child welfare professionals. In order to reduce the risk of infant death from known sleep-related causes, safe sleep environments should be supported in all settings, including the home, where an infant may be placed to sleep.

The purpose of the CDHS Child Welfare Training System is to provide strength-based, family-centered training programs for child welfare professionals by delivering specialized courses for caseworkers, supervisors, case service aides, foster parents and other child and family-serving personnel.[1] The Child Welfare Training System is working closely with the CDPHE and the Infant Safe Sleep Partnership to develop recommendations around training that best meet the needs of Colorado families and child welfare professionals. This will improve the ability of child welfare professionals to provide information to parents and other caregivers about infant sleep related risks and how to ensure safe sleeping environments.

Child welfare professionals, including caseworkers, case service aides and other child and family-serving personnel, have significant opportunities to interact with families they serve. Their duties involve direct observation of families in their home environments. They are in a unique position to provide information on sleep safety to parents and caregivers of infants and parents-to-be. In addition, child welfare professionals can take action to encourage parents and caregivers to take the steps necessary to provide safe sleeping conditions for the children in their care based on the American Academy of Pediatrics (AAP)

[1] Colorado Department of Human Services. (2014). *Colorado child welfare training system*. Retrieved from http://www.coloradocwts.com/about

recommendations for safe infant sleeping environments to reduce risk factors and increase protective factors for sleep-related infant deaths.[2]

Continue to provide dedicated resources for the implementation of Colorado's Child Welfare Plan, "Keeping Kids Safe and Families Healthy 2.0," to make prevention programs for families with young children available in every county in Colorado.

From 2008-2012, the CFPS State Review Team identified 230 fatalities where child maltreatment caused and/or contributed to the death. County Departments of Human Services substantiated 158 (68.7 percent) of these 230 fatalities for maltreatment and 63 (39.9 percent) of the 158 met statutory criteria for CDHS Child Fatality Review Team review. Seventy-two (31.3 percent) of the 230 fatalities were identified as child maltreatment fatalities solely by the CFPS State Review Team using team judgment. These 72 fatalities were either not reported to county Departments of Human Services (17 fatalities) or the incident did not meet the statutory definition for substantiated maltreatment (55 fatalities).

Prevention programs that promote healthy interactions and support successful parenting through education, resource referral, basic health services and family self-sufficiency have the potential to improve the quality of the child's home environment and the child's well-being. Therefore, prevention programs may decrease the risk for child maltreatment. The intent is to work with families to prevent involvement in the child welfare system when a family is at-risk. Based on scientific evidence, the promotion of safe, stable, nurturing relationships and environments is strategic in that, if done successfully, they can influence a broad range of health outcomes as well as increase the ability of children, and the adults they become, to successfully participate in life opportunities, including education, employment and family and societal relations.[3] Safe, stable and nurturing environments minimize risk factors and maximize the protective factors that reduce vulnerability to child maltreatment.

In 2013, CDHS introduced the second phase of Colorado's Child Welfare Plan called "Keeping Kids Safe and Families Healthy 2.0," which emphasizes prevention services to support families before they become part of the child welfare system.[4] Prevention services support families with basic issues such as unemployment and poverty, which can place a family at risk for abuse and neglect. CDHS plans to provide additional services that can help families address a broad range of socio-economic, educational, cultural and health factors that impact their stability and safety. The programs currently being implemented include: SafeCare, Nurse-Family Partnership and Colorado Community Response.

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[2] Task Force on Sudden Infant Death Syndrome. (2011). SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleep environment. *Pediatrics, 128*(5), e1341-e1367. doi: 10.1542/peds.2011-2285

[3] Centers for Disease Control and Prevention National Center for Injury Prevention and Control. (2014, January 29). *Strategic direction for the child maltreatment prevention: Preventing child maltreatment through the promotion of safe, stable, and nurturing relationships between children and caregivers*. Retrieved from http://www.cdc.gov/violenceprevention/overview/strategicdirections.html

Schofield, T. J., Lee, R. D., & Merrick, M. T. (2013). Safe, stable, nurturing relationships as a moderator of intergenerational continuity of child maltreatment: A meta-analysis. *Journal of Adolescent Health, 53*(4 Suppl), S32-S38. doi: 10.1016/j.jadohealth.2013.05.004

[4] Colorado Department of Human Services. (2014). *Child welfare 2.0.* Retrieved from http://www.colorado.gov/cs/Satellite/CDHS-Main/CBON/1251639305644

SafeCare is a structured, evidence-based,[5] in-home visitation program providing direct skills training to high-risk parents and children ages 0-5 and has been shown to reduce child maltreatment among families with a history for maltreatment or with risk factors for maltreatment.[6] SafeCare focuses on preventing child abuse and neglect and improving positive parenting. The services offered include child behavior management, planned activities training, home safety training and child health care skills, all designed to stabilize families and prevent child maltreatment. The National SafeCare Training and Research Center provides support and certification of SafeCare trainers nationally. The Kempe Center for the Prevention and Treatment of Child Abuse is a certified SafeCare trainer in Colorado and is responsible for the expansion sites funded by Colorado's Child Welfare Plan 2.0. SafeCare in Colorado was originally funded by the Administration for Children and Families as an Evidence-Based Home Visitation grant awarded to the Colorado Judicial Department and the Kempe Center, serving families in Denver County for four years. In September 2013, the program, as part of Colorado's Child Welfare Plan 2.0, has expanded to include four provider agencies, partnering with their county child welfare departments.

The Nurse-Family Partnership is an evidence-based home visitation program[7] designed for first-time, low-income mothers and their children ages 0-2 and includes one-on-one home visits by a trained public health registered nurse.[8] Currently, the Nurse-Family Partnership is offered in 60 of 64 Colorado counties, with plans to bring services to scale over the next five years through the Nurse Home Visitor Program at the Office of Early Childhood, funded under the state's Tobacco Master Settlement fund. In addition, CDHS proposes a bridge between the Nurse-Family Partnership nurses and county caseworkers to help ensure that first-time mothers-to-be have access to county-provided assistance programs.

Colorado Community Response (CCR) is a promising practice for preventing child maltreatment and strengthening family functioning by increasing a family's protective capacities. The CCR pilot program was created in July 2013 and is currently in the implementation phase with the program evaluation scheduled to launch in November 2014. Components of a community response program include case management, home visits, collaborative goal-setting and family engagement, direct services and resource referrals, financial decision-making assistance, coaching and flexible spending accounts. CCR is a public-private partnership that will serve families that have been reported to county child protective agencies, but are either "screened out" or closed after initial assessment. In Colorado, approximately 55 percent of child welfare referrals were "screened out" following a child maltreatment report. These families are generally not served through the child welfare system because the referral did not contain specific allegations of "known" or "suspected" abuse or neglect as defined in law, did not provide sufficient information to locate the alleged victim or pertained to victims who were 18 and older. However, these families are still at high-risk for re-referral to the child welfare system and future incidences of child maltreatment.[9] Researchers and policy makers have long identified lack of economic security as the leading risk factor for child abuse and neglect. The effect of poverty on the likelihood of child maltreatment has been found to be independent of features commonly associated with poverty including poor mental health, substance abuse, and reduced education.[10] CCR

[5] U.S. Department of Health and Human Services Administration for Children & Families. (2013, August). *Home visiting evidence of effectiveness: Project 12-Ways/SafeCare.* Retrieved from http://homvee.acf.hhs.gov/document.aspx?sid=18&rid=1&mid=1

[6] Georgia State University School of Public Health. (2014). *National SafeCare training and research center*. Retrieved from http://safecare.publichealth.gsu.edu/

[7] U.S. Department of Health and Human Services Administration for Children & Families. (2013, July). *Home visiting evidence of effectiveness: Nurse-family partnership (NFP).* Retrieved from http://homvee.acf.hhs.gov/document.aspx?sid=14&rid=1&mid=1

[8] Nurse-Family Partnership. (2011). *Nurse-family partnership.* Retrieved from http://www.nursefamilypartnership.org/

[9] Colorado Department of Human Services. (2013). *Office of early childhood: Colorado community response.* Retrieved from http://www.coloradoofficeofearlychildhood.com/#!colorado-community-response/c1ul5

[10] Cancian, M., Shook Slack, K., & Youn Yang, M. (2010). The effect of family income on risk of child maltreatment. *Institute for Research on Poverty.* Retrieved from http://www.irp.wisc.edu/publications/dps/pdfs/dp138510.pdf

program administrators anticipate a large portion of program referrals will be related to risk factors for child maltreatment that are partially indicative of families' economic struggles. This strategy has the potential to provide prevention services and increase the availability of community support to a higher number of families and fill a critical gap in Colorado's child maltreatment prevention continuum.

In addition to these three programs, the CFPS State Review Team endorses the expansion of other evidence-based home visitation models that are currently operating in the state in order for home visitation programs to be implemented in every county in Colorado. CDHS Office of Early Childhood oversees Parents as Teachers, Home Instruction for Parents of Preschool Youngsters (HIPPY) and Healthy Steps as part of the federal Maternal, Infant and Early Childhood Home Visiting (MIECV) Program.

Parents as Teachers[11] is an evidence-based program,[12] which serves parents and children ages 0-5 years and provides parents with child development knowledge, parenting support and early detection of developmental delays and health issues. The outcomes of Parents as Teachers include prevention of child abuse and neglect and increasing children's school readiness. Colorado currently has eight Parents as Teachers sites serving five counties under the MIECV Program as well as programs in 30 additional counties that operate with local and state funding support.

Home Instruction for Parents of Preschool Youngsters (HIPPY)[13] is an evidence-based program[14] that aims to promote preschoolers' school readiness and support parents as their children's first teacher by providing instruction in the home, which strengthen protective factors to reduce child maltreatment. The program model is designed for parents who lack confidence in their ability to prepare their children for school, including parents with past negative school experiences or limited financial resources. Colorado currently has four HIPPY sites serving five counties through the MIECV Program as well as sites in two additional counties through the Colorado Parent and Child Foundation.

Healthy Steps[15] is an evidence-based program[16] that is delivered in the context of pediatric primary care well-child visits and is augmented with home visits during the first three years of a child's life. The program is co-sponsored by the American Academy of Pediatrics (AAP) and supports the physical, emotional and intellectual development of the child by enhancing the relationship between health care professionals and parents. Currently, Healthy Steps is offered in three counties with expansions underway in three additional counties through the MIECHV Program.

Currently, the number of children served by home visitation programs in Colorado is estimated at 6,500 based on contracts supported through the Office of Early Childhood through the Nurse Home Visitor Program and the MIECHV Program. The expansion of home visitation programs has the potential to reach a greater number of families in Colorado and improve health and development outcomes for at-risk children. Securing resources to sustain multiple home visiting programs is a public health approach to positive outcomes for Colorado children and their parents.

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[11] http://www.parentsasteachers.org/

[12] U.S. Department of Health and Human Services Administration for Children & Families. (2013, July). *Home visiting evidence of effectiveness: Parents as teachers (PAT).* Retrieved from http://homvee.acf.hhs.gov/document.aspx?sid=16&rid=1&mid=1

[13] HIPPY USA. (2014). *HIPPYUSA: Home instruction for parents of preschool youngsters.* Retrieved from http://www.hippyusa.org/index.php

[14] U.S. Department of Health and Human Services Administration for Children & Families. (2013, May). *Home visiting evidence of effectiveness: Home instruction for parents of preschool youngsters (HIPPY).* Retrieved from http://homvee.acf.hhs.gov/document.aspx?sid=13&rid=1&mid=1

[15] Healthy Steps for Young People. (2014). *Healthy steps for young people.* Retrieved from http://healthysteps.org/

[16] U.S. Department of Health and Human Services Administration for Children & Families. (2011, July). *Home visiting evidence of effectiveness: Healthy steps.* Retrieved from http://homvee.acf.hhs.gov/document.aspx?sid=12&rid=1&mid=1

FOLLOW-UP ON STATUS OF 2012 RECOMMENDATIONS

In 2011, House Bill 11-1181 codified the CFRT process. Since that time, the reporting process has continued to evolve and improvements have been made. Reports completed for the 2011 fatalities did not contain specific recommendations. Beginning in 2012, the CFRT made recommendations toward addressing identified systemic gaps, policy violations, or practice concerns. The following section summarizes the recommendations included in the 2012 Annual Report as well as the status of these recommendations. This summary does not include the three recommendations that were complete as of the 2012 report, but rather reflects those that were in progress during the 2013 reporting period.

1) 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: **In progress.** 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-PAC Policy Number 11CW009. This project has been rescheduled for completion in the fall of 2014.*

2) 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: **In progress.** The report containing this recommendation was finalized in December of 2012. A review and discussion of this topic was held on the May 13th, 2013 meeting of the Child Protection Task Group. The DCW also has progressed on plans for a statewide hotline that will include a process for recording individual reports of child maltreatment. Requirements for recording these calls are included in a rule revision scheduled for an effective date of January 1, 2015.*

3) 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: **In progress.** 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. Data for measurement of the timeliness of assessment completion is analyzed directly from Trails. Data regarding the accurate completion of the safety assessment comes from reviews of assessments conducted by the Administrative Review Division (ARD). State Child Protection Staff provide training and technical assistance to county departments on both the timeliness and accuracy of assessment completion.*

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

*Status: **Complete.***

5) 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: **In progress.** The report containing this recommendation was finalized in April of 2013. In progress and near completion, the Division of Child Welfare is working with HCPF to compose a letter to counties regarding the accessibility of mental health services.*

6) 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: **In progress.** 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 2014. Requirements related to re-assessment of safety at the conclusion of a safety plan are included in a rule revision scheduled for an effective date of January 1, 2015.*

7) 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: **Complete.** 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 held training for health care providers in the summer of 2013.*

8) 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: **In progress.** 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 use 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 implemented in the fall of 2014.*

9) 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: **In progress.** 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 2014.

10) 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: **In progress.** 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 Policy Advisory Committee on how risk scores should best be used to inform case and service provision decisions. Rule revisions adding additional guidance are included in a rule revision scheduled for an effective date of January 1, 2015.*

11) 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: **In progress.** 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 2014. Upon completion of these tools, the workgroup will begin a process to research the efficacy of creating similar tools for the Program Area 4: Youth in Conflict population. This is on hold pending implementation of Safety and Risk Assessment tool and rule revision for Program Area 5: Child Abuse and Neglect assessments/cases. This recommendation is a deliverable for the federal "Pathways to Success" grant. To complete the task, youth voice and other practice experts will be included on the discussion. This project is projected to be complete by September 2015.*

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

*Status: **In progress.** 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 implementation in the fall of 2014. Upon implementation of these tools, 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 Program Area 4: Youth in Conflict cases. This recommendation is a deliverable for the federal "Pathways to Success" grant. To complete the task, youth voice and other practice experts will be included on the discussion. This project is projected to be complete by September 2015.*

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

*Status: **In progress.** 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 and is projected to begin in the winter of 2014 following the assessment tools being implemented for the Program Area 5: Abuse and/or Neglect population. This recommendation is a deliverable for the federal "Pathways to Success" grant. To complete the task, youth voice and other practice experts will be included on the discussion. This project is projected to be complete by September 2015.

APPENDIX A: CFRT ATTENDANCE

Role	CFRT Member	1/7/13	2/4/13	3/4/13	4/1/13	5/6/13	6/3/13	7/1/13	8/5/13	9/9/13	10/7/13	11/4/13	12/2/13
CDHS Appointees (3): 26-1-139 6(a)	**Tiffany Flores,** *CDHS, Child Protection Manager (Appointed 7/15/2013) (Ruby Richards 1/2013-3/13 Alisa Marlatt 4/13 to 7/13)*	Yes	Yes	Yes	No CFRT (No cases ready to review)	Yes	Yes	No	No	No	Yes (Didn't sign signin b/c late)	Yes	No
	Brooke Ely-Milen, *Domestic Violence Program (Appointed 10/21/2013) (Ruth Glenn 1/2013-10/2013)*	Yes	Yes	Yes		No	No	No	No	No	No	Yes	Yes
	Susan Nichols, *Administrative Review Division, Manager*	n/a	n/a	n/a		Yes	Yes	Yes	No	Yes	Yes	Yes	No
	→**Backup:** Marc Mackert	Yes	Yes	Yes									
CDPHE Appointees (2): 26-1-139 6(b)	**Sarah Hernandez,** *CDPHE (Appointed 12/2013) (Lindsey Myers, 1/2013-12/2013)*	Yes	Yes	Yes		Yes	No	No	Yes	Yes	No	By phone	Yes
	Colleen Kapsimalis, *CDPHE (Appointed 12/2013) (Scott Bates 1/2013-12/2013)*	No	Yes	Yes		Yes	No	Yes	Yes	No	No	No	Yes
CCI Appointees (3): 26-1-139 6(c)	**Lew Gaiter**, *Larimer County Commissioner*	By phone	No	By phone		Yes	By phone	By phone	Yes	Yes	No	No	No
	Casey Tighe, *Jefferson County (appointed 8/30/13)* **David Foy,** *Washington County (1/2013 – 4/2013)*	No	Yes	No						Yes	No	No	Yes
	Vacant **(**Del Schwab**,** *Elbert County Commissioner to 1/2013)*	No											

Role	CFRT Member	1/7/13	2/4/13	3/4/13	4/1/13	5/6/13	6/3/13	7/1/13	8/5/13	9/9/13	10/7/13	11/4/13	12/2/13
Senate Appointee (1): 26-1-139 6(f)	**Senator Jeanne Nicholson** *(Active 7/18/2013)* **Senator Joyce Foster** (*1/2013 – 7/2013)*	No	No	No	No CFRT (No cases ready to review)	No	No	No	No	No	No	No	No
House Appointee (1): 26-1-139 6(f)	**Representative Clarice Navarro,** *(Active 7/15/2013)* **Representative Jonathan Singer** (*1/2013 – 7/2013*)	No	No	No		No	Yes	By phone	No	No	No	No	No
Team Appointees (at least 8): 26-1-139 6(d)	**Dennis Goodwin,** *Office of Colorado's Child Protection Ombudsman (start 7/2013)* ***Becky Updike*** *(1/2013 - 5/2013)* ***Sabrina Byrnes*** *(6/2013)*	No	Yes	Yes		No	No	Yes	Yes	No	Yes	Yes	Yes
	Det. Amber Urban, *detective with Aurora Police Department*	Yes	Yes	No		Yes	Yes	Yes	Yes	No	No	No	No
	Det. Ron Tanguma, *detective with Aurora Police Department*	No	Yes	Yes		No	Yes	No	Yes	No	Yes	No	No
	Dr. Andrew Sirotnak, *Professor of Pediatrics, University of Colorado School of Medicine Director, Child Protection Team at Children's Hospital Colorado*	No	No	No		Yes	No	No	Yes	Yes	Yes	Yes	No
	Barb Shaklee, *Director, Denver City Attorney Office*	Yes	Yes	Yes		Yes	Yes	Yes	No	By phone	No	No	By phone
	Stephanie Villafuerte, *Child Advocate and attorney for Rocky Mountain Children's Legal Center*	Yes	Yes	No		Yes	No	No	No	No	No	No	By phone
	Pam Wamhoff, *Family Advocacy Officer, Buckley Air Force Base*	Yes	Yes	No		Yes	Yes	Yes	Yes	No	No	No	Yes
	Sara Oliver, *Attorney General's Officer*	Yes	Yes	No		No	Yes	Yes	Yes	Yes	By phone	By phone	Yes

Role	CFRT Member	1/7/13	2/4/13	3/4/13	4/1/13	5/6/13	6/3/13	7/1/13	8/5/13	9/9/13	10/7/13	11/4/13	12/2/13
Team Appointees (at least 8): 26-1-139 6(d)	**Jill Gunderson,** *Dispute Review Specialist*	Yes	Yes	Yes	No CFRT (No cases ready to review)	No	Yes	No	Yes	Yes	Yes	Yes	Yes
	Sondra Ranum, *EQ Assistant Program Director*					Yes	No	No	Yes	By phone	Yes	Yes	Yes
	Pauline Hoekstra, *CDHS, Division of Child Welfare*	Yes	No	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	Jill Jordan, *CDHS PSSF Administrator*	Yes	Yes	Yes		Yes	No	No	No	No	No	Yes	Yes
	Connie Fixsen, *CDHS Prevention Specialist*	Yes	Yes	Yes		Yes	Yes	Yes	No	No	No	No	No
County Representatives:	**Kris Cowperthwaite,** *Adams Department of Social Services*	No	No	Yes		Yes	Yes	Yes	Yes	Yes	No	No	Yes
	Lucy Sloan, *Adams Department of Social Services*	Yes	No	Yes		Yes	By phone	No	Yes	Yes	No	By phone	Yes
	Dan Makelky, *Douglas County Department of Human Services*	Yes	No	No		Yes	Yes	No	Yes	No	Yes	Yes	Yes
	→**Backup:** Nicole Becht	Yes	Yes										
	Sue McDonald, *Jefferson County Department of Human Services*	Yes	Yes	Yes		No	No	Yes	No	Yes	Yes	Yes	Yes
	Michelle Dossey, *Arapahoe County Department of Human Services*	Yes	Yes	Yes		Yes	No	Yes	Yes	Yes	No	Yes	Yes
	→**Backup:** Josie Berry						Yes						
	Ginny Riley, *Larimer County Department of Human Services*	Yes	Yes	By phone		Yes	Yes	No	Yes	Yes	Yes	By phone	No
	Shirley Rhodus, *El Paso County Department of Human Services*	Yes	Yes	Yes		Yes	Yes	No	Yes	Yes	Yes	Yes	Yes

Role	CFRT Member	1/7/13	2/4/13	3/4/13	4/1/13	5/6/13	6/3/13	7/1/13	8/5/13	9/9/13	10/7/13	11/4/13	12/2/13
ARD Staff	**Erin Hall,** *Administrative Review Division, Child Fatality Review Team Facilitator*	Yes	Yes	Yes	No CFRT (No cases ready to review)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ARD Staff	**Eric Hoskins,** *Administrative Review Division (started in position 10/2013)*										Yes	Yes	Yes
ARD Staff	**Lisa Lied,** *Administrative Review Division (started in position 9/2013)*									Yes	Yes	Yes	Yes

APPENDIX B: 2012-2013 INCIDENTS QUALIFIED FOR REVIEW BY COUNTY AND TYPE

County	Fatal Incidents		Near Fatal Incidents		Egregious Incidents			
	2013	2012	2013	2012	2013	2012	2013 Total	2012 Total
Archuleta					1		1	
Adams	2	2			3		5	2
Alamosa					1		1	
Arapahoe	1		2		1		4	
Boulder	1		1				2	
Denver	1	1	3	1	7		11	2
Eagle		1						1
El Paso	1	2	1			1	2	3
Fremont					1		1	
Jefferson					2		2	
Larimer					4		4	
Logan		1						1
Mesa		1	1				1	1
Morgan			1				1	
Otero				1				1
Phillips	1						1	
Pueblo		1	1		1		2	1
Weld	1						1	
Total	**8**	**9**	**10**	**2**	**21**	**1**	**39**	**12**

*Numbers represented above are indicative of the investigating county for the incident. For example, in 2013 15 of 39 total incidents, at least one and as many as three other counties had history reviewed as part of the CFRT process.

**Trend analysis is not yet possible based on year to year comparisons; statutory change occurred related to history length and reporting of near fatal egregious incidents during this two year period.

APPENDIX C: RECOMMENDATIONS FROM 2013 POSTED REPORTS

Recommendations are presented in the order released on the public-facing website, with the most recent recommendations (posted in May, 2014) toward the end of this Appendix.

	Type	Recommendation	Status
1.	Practice	In this review, the caseworkers in latter assessments made effort to engage in an interstate manner. It is recommended that when working with families that have history and or current involvement in another state, that efforts are made from the first point of contact to ascertain information related to prior involvement, service receipt, and concerns noted. CDHS program staff can assist with advocacy as needed if difficulties arise when communicating with other state jurisdictions.	Complete
2.	Policy	It is recommended that the Division of Child Welfare examine and/or develop a statewide policy for handling new, screened out or screened in referrals during the course of an open assessment to provide clarification on this area of practice.	Complete
3.	Training and Technical Assistance	It is recommended that the provider of the Colorado child welfare training academy consult the Domestic Violence Practice Guide for Child Protective Services (2013), available on-line at http://www.colorado.gov/cs/Satellite/CDHS-ChildYouthFam/CBON/1251588267351, to develop training for new workers on casework in situations where domestic violence is a pivotal factor.	Complete
4.	Policy	It is recommended that the Division of Child Welfare provide clarification of 7.202.57(E)(1) and explore whether the rule is sufficient to ensure adequate communication with non-custodial parents.	In Progress
5.	Reporting of Fatalities, Near Fatalities, and Egregious Incidents	The Colorado Department of Human Services report on this fatality review was overdue to the responding county department. There were recent legislative changes that impact the Child Fatality Review Team and the reporting process. One of these changes included approval for additional FTE in the Colorado Department of Human Services to assist in timely completion of future reviews. Following hire, the recommendation for this team is to utilize continuous quality improvement to develop an efficient system for the review and reporting of child fatalities, near fatalities, and egregious incidents. It is recommended that this occur to address this concern.	Complete

	Type	Recommendation	Status
6.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	Policy violations related to the Colorado Family Risk Assessment reflect a systemic practice issue in this county department. In a recent review of a generalizable random sample of assessments that were conducted during a period from 9/18/2012 to 3/18/2013, the county department completed the risk assessment accurately in 71% of assessments. Though an improvement from county performance in a 2010 review, where the risk assessment was completed accurately 64% of the time, continued focus in this area is recommended. It is important to highlight, however, that the performance of El Paso County exceeded that of the rest of the state during a similar review period, where 59% of risk assessments were completed accurately. Also of note are planned changes in the safety and risk assessment that will occur in 2014 and may impact performance. In particular, there will be a place in the new tool where CDHS allows for the designation of primary and secondary caregivers in the risk assessment.	In Progress
7.	Trails	Similar to #2 in the systemic gaps noted by the Child Fatality Review Team, this policy finding should be included as part of strategies and policies for when new reports are received on currently open assessments. The selection chosen in error is no longer available in Trails. It is recommended that El Paso County submit a request for an analyst fix to change the not accepted for assessment reason to the accurate option.	Complete
8.	County Continuous Quality Improvement	The policy findings related to late assessment closure do not reflect current systemic practice in the county department. The C-Stat report, which measures the percentage of assessments closed within 60 days regardless of extension status, shows the county department increasing from 67% in March of 2012 to 88% in April of 2013. The C-Stat measure is based on the standard 30 days, as well as an additional 30 days to allow for extension requests supported in Volume VII. It is recommended that the county continue engagement in the C-Stat process for continuous improvement on this measure in order to meet and/or exceed the goal of 90%.	Complete
9.	County Continuous Quality Improvement	The policy violation that reflects a child not seen within the required response time is reflective of an area needing improvement in this county department. C-Stat reports from March 2012 administrative data and April 2013 administrative data show a decline in county department performance from 87% to 80% during this span. It is important to note that rule 7.202.14(4) has recently changed as of 3/2/2013 to include reasonable efforts by the caseworker to see the child victim. This policy violation would not have applied in this case under the new rule. The above administrative data does not count reasonable efforts. However, the review data from a generalizable random sample of all assessments during a period from 9/18/2012 to 3/18/2013 indicates that the county department made reasonable efforts to interview/observe the alleged victim within the assigned response time in 88% of cases.	Complete

	Type	Recommendation	Status
10.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	The policy finding that outlines inaccuracy of the safety assessment process does not reflect systemic practice in the county department. A recent review of a generalizable random sample of assessments that were conducted during a period from 9/18/2012 to 3/18/2013 shows that the county department completed the safety assessment process accurately in 82% of assessments. This is significant improvement from county performance in a 2010 review, where the safety assessment process was found to have been completed accurately 37% of the time. Again, planned changes in the safety and risk assessment will occur in 2014 that may impact accuracy of completion performance.	In Progress
11.	Reporting of Fatalities, Near Fatalities, and Egregious Incidents	The Colorado Department of Human Services report on this fatality review was overdue to the responding county department. There were recent legislative changes that impact the Child Fatality Review Team and the reporting process. One of these changes included approval for additional FTE in the Colorado Department of Human Services to assist in timely completion of future reviews. Following hire, the recommendation for this team is to utilize continuous quality improvement to develop an efficient system for the review and reporting of child fatalities, near fatalities, and egregious incidents.	Complete
12.	County Continuous Quality Improvement	The policy finding related to late assessment closure in Denver County does not reflect current systemic practice in the county department. The C-Stat report, which measures the percentage of assessments closed within 60 days, shows the county department is currently at 87% assessment closure within 60 days, based on data collected from January 1, 2013 to June 30, 3013. The C-Stat measure is based on the standard 30 days, as well as an additional 30 days to allow for extension requests supported in Volume VII. It is recommended that the county continue engagement in the C-Stat process for continuous improvement on this measure in order to meet and/or exceed the goal of 90%.	Complete
13.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	The policy violation that reflects that the 15 safety concerns were not accurately selected is not reflective of an area needing improvement for the Denver Department of Human Services. In the most current Administrative Review Division Quality Assurance Review report, the data showed that the county is performing above the "area needing improvement" threshold. Despite the inaccurate documentation, the child's safety was not adversely impacted as the county acted to preserve the children's safety as evidenced by filing a Dependency and Neglect petition and placing the children in out-of-home care. Changes in the safety assessment are tentatively scheduled to occur in spring of 2014. This process includes enhanced definitions of the safety concerns, and training, designed to improve statewide performance on accurate assessment of safety. It is recommended that the implementation of the revised tool include an evaluation component to ensure its effective use in identifying and addressing safety concerns.	In Progress

	Type	Recommendation	Status
14.	Practice	The policy violations that reflect a finding was not made when needed is not reflective of an area needing improvement for the Denver Department of Human Services. Administrative Review Division data specifically measures the overall finding of assessments and the accuracy of selecting the correct finding. In the most current Administrative Review Division Quality Assurance Review report, the data showed that the county is performing above the "area needing improvement" threshold. It is recommended that the Denver Department of Human Services change the second finding in the referral to reflect the abuse/neglect type of Physical Abuse, unknown perpetrator, versus Medical neglect, unknown perpetrator.	Complete
15.	Training and Technical Assistance	The policy violation that reflects that the parent was not contacted monthly is reflective of an area needing improvement for the Denver Department of Human Services. In the most current Administrative Review Division Quality Assurance Review report, the data showed that the county is performing below 70% in this area. At the request of Denver Department of Human Services Administrators, a meeting was held with the Administrative Review Division on 7/23/2013 to discuss performance regarding parental contacts. The Administrative Review Division is scheduled to conduct a training specific to contacts with parents with the Denver Department of Human Services casework and supervisor staff on October 14, 2013.	Complete
16.	County Continuous Quality Improvement	It is recommended that Denver County supervisors continue to review contacts with parents and ensure that parents are contacted, at least monthly to discuss case dynamics and that the content of the note covers the parents enhanced capacity to provide safety for the child.	Complete
17.	Trails	The Division of Child Welfare is currently working with the County Trails Users Group to develop a report in Trails for supervisors and caseworkers to use in monitoring monthly contacts with parents. Upon completion of the report, it is recommended that the Division of Child Welfare ensure county staff are trained on its use in monitoring contact with parents.	Complete
18.	County Continuous Quality Improvement	The team recommends engagement with absent parents and supported the increased diligent search efforts that Mesa County was focusing on at the time of the review.	Complete
19.	Training and Technical Assistance	The policy violation that reflects that the parent was not contacted monthly is reflective of an area needing improvement for Montrose County. In the most current Administrative Review Division Quality Assurance Review report, the data showed that the county is performing below 70% in this area. It is recommended that supervisors begin reviewing contacts with parents and ensure that parents are contacted, at least monthly to discuss case dynamics and that the content of the note covers the parents enhanced capacity to provide safety for the child. The Division of Child Welfare is currently working with the County Trails Users Group to develop a report in Trails for supervisors and caseworkers to use in monitoring monthly contacts with parents. Upon completion of the report, it is recommended that the Division of Child Welfare ensure all county staff are trained on its use in monitoring contact with parents.	Complete

	Type	Recommendation	Status
20.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	The policy violation related to completion of the Colorado Family Risk Assessment in Montrose County does reflect a systemic practice issue in this county department. In a recent review of a random sample of assessments that were conducted during a period from 8/18/2012 to 3/18/2013, the county department completed the risk assessment accurately in 54% of assessments. Of note are planned changes in the risk assessment that will occur in 2014 and may also impact performance. It is recommended that the Division of Child Welfare complete technical assistance with Montrose County in this area, and prioritize them for training when the new tools are implemented.	In Progress
21.	Training and Technical Assistance	The policy violation related to completion of the Colorado Family Risk Assessment in Mesa County does reflect a systemic practice issue in this county department. In a recent review of a random sample of assessments that were conducted during a period from 11/7/2012 to 3/7/2013, the county department completed the risk assessment accurately in 49% of assessments. Of note are planned changes in the risk assessment that will occur in 2014 and may also impact performance. It is recommended that the Division of Child Welfare complete technical assistance with Mesa County in this area, and prioritize them for training when the new tools are implemented.	In Progress
22.	Training and Technical Assistance	The team also recommended that the Division of Child Welfare (Division of Child Welfare) alert the Court Improvement Program in writing that new judges should receive training on the differences between assessments in custody cases compared to those conducted in situations of alleged maltreatment. If assistance is needed, Division of Child Welfare should provide technical assistance for any curriculum development related to this issue.	Complete
23.	Training and Technical Assistance	The team recommends that Division of Child Welfare designate a program staff member to assist counties in advocating for or clarifying information needed from other states. The team recommends communicating this designation to county staff statewide.	Complete

	Type	Recommendation	Status
24.	Trails	The CFRT recognized how the inclusion of "Additional information" and "Duplicate referral" in the Trails Not Accepted for Assessment Reason pick list without further clarification as to the distinction, could prove to be confusing. The CFRT believes it's important to note rule 7.202.4(H) was changed as of March 2, 2013 and now includes the following nine reasons (all contain further clarification); 1) When the current allegations have previously been assessed and determined to be unfounded; 2) Refer to other state social/human services department; 3) Referral does not meet criteria of abuse or neglect as defined in statutes and regulations; 4) Referral lacks sufficient information to locate child/family; 5) Referral is duplicative of a previous referral (if so, associate with the duplicate referral in the State's automated case management system); 6) Alleged perpetrator in referral is third (3rd) party, as defined in statutes and regulations, county department shall refer to law enforcement; 7) Referral information contains allegations of past incident of abuse/neglect – no current allegation of abuse or neglect. 8) Client/family refused services not court ordered for assessment (applicable for Program Area 4 only); or, 9) Other (requires documented explanation in the State's automated case management system). The CFRT recommends the Division of Child Welfare (Division of Child Welfare) ensures the Not Accepted for Assessment Reason pick list be changed to reflect the new policy change.	Complete
25.	Trails	The CFRT acknowledges the complications DHS agencies are presented with having to restrict the case record in Trails while having an immediate need for that information. The CFRT recommends Division of Child Welfare explore ways to allow assigned caseworkers, their supervisors, and identified administrative staff access to the entire case record while having it restricted.	In Progress
26.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	It is recommended that the Division of Child Welfare begin the statewide implementation process of the new Colorado Risk and Safety Assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
27.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	Policy violations related to the Colorado Family Risk Assessment is reflective of a systemic practice issue in DDHS. In a recent review of a random sample of assessments that were conducted during a period from 9/18/2012 to 3/18/2013, the county department completed the risk assessment accurately in 41.8% of assessments, which is below the statewide average of 9.8% for the same time span. It is recommended that DDHS employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented.	In Progress

	Type	Recommendation	Status
28.	Trails	Currently, there is no mechanism in Trails by which to measure county compliance in regards to whether or not referrals are correctly transferred between the receiving county and the responsible county. It is important to note rule 7.202.4 was changed as of March 2, 2013 to include a timeframe in which the referral must be entered into Trails and transferred to the responsible county. Rule regarding the transfer of referrals between counties is now 7.202.4 (I) rather than 7.202.4 (G) and states the following, "If a county department receiving a referral determines that another county has responsibility, the receiving county department shall forward the referral to the responsible county department as soon as possible, but no longer than eight (8) hours of determining responsibility, by entering the referral into the State automated case management system. The receiving county department shall make personal contact with the responsible county to verify receipt of the referral." It is recommended that CDHS, Division of Child Welfare identify a mechanism by which to measure compliance with the new policy regarding the transfer of referrals. Additionally, it is recommended that Division of Child Welfare provide further clarification regarding jurisdictional issues and the roles/responsibilities of the receiving and the responsible county when transferring a referral between counties.	In Progress
29.	Policy	The Colorado Department of Human Services, Division of Child Welfare should explore whether statutory changes need to be made to C.R.S. 19-1-103(1)(a) regarding the definition of child abuse or neglect to specifically include the occurrence of DV in the presence of, or perceived by, the child.	In Progress
30.	Monitoring for Trends	The policy violation that reflects the alleged victim not being seen within the required response time is not reflective of an area needing improvement for Larimer DHS. Data on FAR assessments from reviews that took place in March 2012 and March 2013 show a decline in county department performance from 91% to 88% during this span and an increase on High-Risk Assessments from 90% to 95%. It is important to note, however, that rule 7.202.14(4) has recently changed as of March 2, 2013 to include reasonable efforts by the caseworker to see the child victim. The above administrative data does not count reasonable efforts. However, the review data from a random sample of all assessments during a period from 8/27/2012 to 2/27/2013 indicates that the county department made reasonable efforts to interview/observe the alleged victim within the assigned response time in 100% of cases. It is recommended that CDHS, Division of Child Welfare review data in regards to this policy violation to identify if there is a trend occurring whereby alleged victims are not being seen within the required response time at a higher rate in FAR assessments than High-Risk assessments.	Complete

	Type	Recommendation	Status
31.	Monitoring for Trends	The policy violation regarding no interviews being conducted with the mother, father, and half-sibling does not reflect current, systemic practice in Larimer DHS. Administrative Review Division data from a March 2012 assessment review in Larimer DHS indicates all required parties were interviewed as part of the investigation in 96% of the FAR assessments and 93% of High-Risk assessments. The data from the assessment review in March 2013 indicates all required parties were interviewed in 94% of FAR assessments and 90% of High-Risk assessments. The data reflects a slight decrease from 2012 to 2013. It is recommended that CDHS, Division of Child Welfare continue to monitor Larimer DHS' data in this area to ensure the county's performance in this area does not continue to decline.	Complete
32.	Practice	Current policy indicates that county departments shall assign a referral for assessment when the referral contains specific allegations of known or suspected abuse or neglect. When a county has an open assessment and another referral, with new allegations of abuse/neglect, is received by the county, the county is required to complete two assessments despite the fact they are investigating the allegations in both referrals simultaneously. The CFRT recognizes this may be duplicative in nature and questions whether there may be a way to streamline the investigation of the different allegations into one assessment. It is recommended that CDHS, Division of Child Welfare explore alternative ways (in practice and Trails) for counties to streamline the investigation of allegations from multiple referrals into one assessment and the implications of that process to policy.	In Progress
33.	County Continuous Quality Improvement	In determining risk of future maltreatment and informing decision making related to further involvement by the child protection system, it is important that thorough assessments are conducted and documented in a manner that supports such decision making. It is recommended that EPCDHS take steps to ensure that future assessments appropriately consider and reconcile prior history with current reports and observations related to safety and risk of future maltreatment, and document such efforts within the assessment in Trails.	Complete
34.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	It is recommended that the Division of Child Welfare begin the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
35.	Reporting of Fatalities, Near Fatalities, and Egregious Incidents	The policy finding indicating that Denver County notified the Colorado Department of Human Services of the fatality six days late does reflect a systemic practice issue in this county department at the time of this referral. During calendar year 2012, Denver County provided timely notification to CDHS in 90% (9/10) of incidents. For calendar year 2013, this declined to 64% (9/14). It is recommended that Denver County consider creating a more formal process for recognizing and reporting fatal, near fatal, and egregious incidents of child maltreatment to CDHS.	Complete

	Type	Recommendation	Status
36.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	The policy finding that outlines inaccuracy of the safety assessment process does reflect a systemic practice issue in Denver County department. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from 10/10/2012 to 4/10/2013, the county department completed the safety assessment process accurately, in accordance with Volume VII, 81.5% of the time. It is recommended that Denver County employ a process in which barriers to the accurate completion of the safety assessment are identified and solutions to the identified barriers are implemented.	Complete
37.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	The policy violation related to accurate completion of the Colorado Family Risk Assessment in Denver County does reflect a systemic practice issue in this county department. In a recent review of a random sample of assessments that were conducted during a period from 10/10/2012 to 4/10/2013, the county department completed the risk assessment accurately in 41.8% of assessments. It is recommended that Denver County employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented.	Complete
38.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	The policy violation related to accuracy of the Colorado Family Risk Assessment in El Paso County does reflect a systemic practice issue in this county department. In a recent review of a generalizable random sample of assessments that were conducted during a period from 9/18/2012 to 3/18/2013, the county department completed the risk assessment accurately in 70.9% of assessments. Though an improvement from county performance in a review from April 2012, when the risk assessment was completed accurately 50% of the time, and from a review in October 2012, when the risk assessment was completed accurately 61.5% of the time, continued focus in this area is recommended. It is important to highlight, however, that the performance of El Paso County exceeded that of the rest of the state during a similar review period, when 59% of risk assessments were completed accurately. It is recommended that El Paso County employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented.	Complete
39.	Assessment	While the fact the caseworker did not inform the alleged perpetrator of the allegation of abuse or afford him an opportunity to respond was identified as a policy violation of 19-3-308 (3)(a), it should be noted that rule contradicts what statute says. Current rule regarding informing perpetrators of the allegations (7.202.52 (D)) states, "As a part of the assessment, reasonable efforts shall be made to: 1. Interview any person(s) alleged as responsible for the abuse or neglect. 2. Advise the person(s) alleged as responsible for the abuse or neglect or the referral. 3. Give the person(s) alleged as responsible for the abuse or neglect an opportunity to respond to the allegations. It is recommended that CDHS, Division of Child Welfare explore the need for aligning rule, statute, and practice so they are all congruent.	Complete

	Type	Recommendation	Status
40.	County Continuous Quality Improvement	4. The policy violation related to timeliness of assessment closure reflects a current systemic practice issue for Boulder DHHS. The C-Stat report measure is based on the standard 30 days, as well as an additional 30 days to allow for extension requests supported in Volume VII. The C-Stat report, which measures the percentage of assessments closed within 60 days regardless of extension status shows Boulder County is currently closing 84.9% of their assessments on time as of the data for September 2013. This number is above the statewide average for September 2013 of 83.7 %, but below the goal of 90.0%. a. It is recommended that Boulder DHHS employ a process in which barriers to the timely closure of assessments are identified and solutions to the identified barriers are implemented.	Complete
41.	Monitoring for Trends	b. It is recommended that Division of Child Welfare continue to engage with Boulder DHHS and monitor progress on this measure.	Complete
42.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	There are planned changes in the safety assessment that are scheduled to occur in 2014 that were designed to positively impact performance in this area. It is recommended that the Division of Child Welfare begin the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
43.	County Continuous Quality Improvement	The policy findings related to the timeliness of assessment closure reflects a current systemic issue for Archuleta DHS. The C-Stat report, which measures the percentage of assessments closed within 60 days regardless of extension, shows the Archuleta DHS at 76.0% with the statewide average being 84.2%. The C-Stat measure is based on the standard 30 days, as well as an additional 30 days to allow for extension requests supported in Volume VII. a. It is recommended that Archuleta DHS employ a process in which barriers to the timeliness of assessment closures are identified and solutions to the identified barriers are implemented.	Complete
44.	Monitoring for Trends	b. It is recommended that the Division of Child Welfare (Division of Child Welfare) continue to monitor county performance regarding the timeliness of assessment closure and engage with Archuleta DHS as necessary to ensure improved performance in this area.	Complete
45.	County Continuous Quality Improvement	The policy finding related to the appropriateness of the assigned response time, as defined by Volume VII, reflects a systemic practice issue for Archuleta DHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period of October 3, 2012 to April 3, 2013, Archuleta DHS assigned an appropriate response time in 71.4% of assessments. The statewide average during this time span was 95.3%. It is recommended that Archuleta DHS examine their practice and decision making related to appropriate response times and request technical assistance from the Division of Child Welfare should they determine necessary.	Complete

	Type	Recommendation	Status
46.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	The policy finding related to inaccurate documentation of the safety assessment process reflects a systemic practice issue in Archuleta DHS. As part of a routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period of October 3, 2012 to April 3, 2013, it was determined that the Archuleta DHS completed the safety assessment process accurately in 50% of assessments. The statewide average during this time span was 84.4%. It is recommended that Archuleta DHS employ a process in which barriers to the accurate completion of the safety assessment are identified and solutions to the identified barriers are implemented.	Complete
47.	County Continuous Quality Improvement	The policy finding related to no face-to-face observation of the one-year-old sibling within the assigned response time reflects a systemic practice issue for Archuleta DHS. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of October 3, 2012 to April 3, 2013, showed the Archuleta DHS at 62.5%. It is important to note that with the addition of rule 7.202.41 (A) (4) on of March 2, 2013, Volume VII now addresses reasonable efforts by the caseworker to see the child victim. During the same time span as above, the Archuleta DHS made reasonable efforts to see the victim of the allegation 68.8% of the time. It is recommended that Archuleta DHS monitor the performance of their staff on this measure to ensure improvement in order to meet the state goal of 90%.	Complete
48.	County Continuous Quality Improvement	The policy finding related to required parties interviewed as part of the assessment reflects a systemic practice issue for Archuleta DHS. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of October 3, 2012 to April 3, 2013, showed the Archuleta DHS at 56.3%. This is below the statewide average of 85%. It is recommended that Archuleta DHS employ a process in which barriers to interviewing required parties are identified and solutions to the identified barriers are implemented.	Complete
49.	County Continuous Quality Improvement	The policy finding related to the 90-day review does reflect a systemic practice issue for Archuleta DHS. Out of Home Review data from the 1st Quarter SFY 2014 indicates Archuleta DHS is 20% compliant with 90-day reviews. It is recommended that Archuleta DHS employ a process in which barriers to 90-day reviews are identified and solutions to the identified barriers are implemented.	Complete
50.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	There are planned changes in the safety and risk assessments that are scheduled to occur in 2014 that were designed to positively impact performance in this area. It is recommended that the Division of Child Welfare begin the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress

	Type	Recommendation	Status
51.	County Continuous Quality Improvement	The policy finding that outlines inaccuracy of the safety assessment process does reflect a systemic practice issue in Morgan County. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from 6/18/2012 to 12/18/2012, the county department completed the safety assessment process accurately, in accordance with Volume VII, 81.6% of the time, which is slightly below the statewide average of 82.7% for the same time period. It should be noted that in regards to the accurate completion of the Safety Intervention Analysis tab on the Safety Plan, the county completed this accurately 100% of the time in the sample of assessments that were reviewed, which is above the statewide average of 98.9% for roughly the same time period. Though the county performed well specific to completing the Safety Intervention Analysis tab, the county's performance related to the completion of the safety assessment is an area for improvement. It is recommended that Morgan County employ a process in which barriers to the accurate completion of the safety assessment are identified and solutions to the identified barriers are implemented.	In Progress
52.	County Continuous Quality Improvement	The policy violation related to the accurate completion of the Colorado Family Risk Assessment in Morgan County does reflect a systemic practice issue in this county department. In a recent review of a generalizable random sample of assessments that were conducted during a period from 6/18/2012 to 12/18/2012, the county department completed the risk assessment accurately in 26.3% of assessments, which is below the statewide average of 60.2% for the same time span. It is recommended that Morgan County employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented.	In Progress
53.	County Continuous Quality Improvement	As part of routine quality assurance monitoring, a generalizable random sample of 1,542 referrals that were screened out between March 1, 2012 and August 31, 2012 across the state were reviewed as part of the "2012 Screen-Out Review." This review, conducted from 9/24/2012 to 9/28/2012, indicated that Yuma County appropriately screened out referrals 95.5% of the time. It is recommended that Yuma County consult data from the "2013 Screen-Out Review," when the data is finalized, to determine if practice remains at the same high quality on this area.	In Progress
54.	Practice	It is recommended that the Division of Child Welfare (Division of Child Welfare) look at a systemic way at managing the resources of the cost of the CBI or find other databases to search criminal information on clients or kinship options for placement.	Complete

	Type	Recommendation	Status
55.	County Continuous Quality Improvement	The policy violations related to timeliness of assessment closure reflects a current systemic practice issue for Arapahoe County DHS. The C-Stat measure is based on the standard Review Division 30 days, as well as an additional 30 days to allow for extension requests supported in Volume VII. The February 2014 C-Stat report, which measures the percentage of assessments closed within 60 days regardless of extension status, shows Arapahoe County DHS at 66.7% for High Risk Assessments for January 2014. This number is below the statewide average for January 2014 of 80.1 % for High Risk Assessments, and is also below the goal of 90.0%. 1) It is recommended that Arapahoe County DHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are enacted.	Complete
56.	Monitoring for Trends	2) It is recommended that Division of Child Welfare continue to monitor county performance regarding the timelines of assessment closure and engage with Arapahoe County DHS as necessary to ensure improved performance in this area.	Complete
57.	County Continuous Quality Improvement	B. For High Risk referrals received by Arapahoe County between July 1, 2013 and December 31, 2013, 75% required an extension (i.e., were open longer than 30 days). Of those, 50% had an extension request within 30 days. 1) It is recommended that Arapahoe County employ a process in which barriers to the timely use of extensions for assessments needing to be open longer than 30 days are identified and solutions to the barriers are implemented.	In Progress
58.	Monitoring for Trends	2) The statewide performance on the use of extensions between July 1, 2013 and December 31, 2013 was also low. Overall, 66.3% of referrals required an extension (opened beyond 30 days), and 45.3% of them had an extension requested within the 30 days. As the proper use of extensions during the assessment period may be related to the timely closure of assessments, it is recommended that the Division of Child Welfare begin including data on counties' use of extensions in the analysis and communications related to the C-Stat measure of timeliness of assessment closure.	In Progress

	Type	Recommendation	Status
59.	County Continuous Quality Improvement	The policy violation related to seeing the alleged victim within the assigned response time reflects a systemic practice issue for ACHSD. C-Stat data taken from assessments closed between August, 1, 2013 and August 31, 2013, which was presented at the November 2013 C-Stat meeting, indicates that ACHSD saw the alleged victim within the assigned response time 90% of the time which is slightly above the statewide data which indicates 88.6% of the time the alleged victim within the assigned response time. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of March 2, 2013 to September 3, 2013, showed the ACHSD at 61.8%. It is important to note that with the addition of rule 7.202.41 (A) (4) on of March 2, 2013, Volume VII now addresses reasonable efforts by the caseworker to see the child victim. During the same time span as above, the ACHSD made reasonable efforts to see the victim of the allegation 81.8% of the time. It is recommended that ACHSD monitor the performance of their staff on this measure to ensure improvement in order to meet the state goal of 90%.	In Progress
60.	Practice	The Division of Child Welfare should explore the resources currently provided with Federal funding through the Child Abuse Prevention and Treatment Act (CAPTA) and explore the need for more additional secondary trauma providers as well as resources to provide education on secondary trauma prevention.	Complete
61.	Policy	The Domestic Violence Program (DVP) should contact the District Court that granted the Permanent Civil Protection Order in this case and request that the court research whether or not the father filed proof of relinquishment of his firearms with the court, and if not, whether or not a warrant was issued for the father's arrest. If the father did not file proof of relinquishment of his firearms and a warrant wasn't issued pursuant C.R.S. 13-14-105.5 Civil Protection Orders - Prohibition on Possessing or Purchasing a Firearm, the DVP should encourage the court to explore ways to implement the new legislations, such as a system of tracking Domestic Abuse Protection Orders (described in 18 U.S.C. §922 (d)(8) or (g)(8)) when there is an indication in the court record that a person subjected to a domestic abuse protection order has a firearm and/or ammunition.	In Progress

	Type	Recommendation	Status
62.	County Continuous Quality Improvement	The policy violation related to seeing the alleged victim within the assigned response time reflects a systemic practice issue for ACHSD. C-Stat data taken from assessments closed between 8/1/2013 and 8/31/2013, which was presented at the November 2013 C-Stat meeting, indicates that ACHSD saw the alleged victim within the assigned response time 90% of the time which is slightly above the statewide data which indicates 88.7% of the time the alleged victim is seen within the assigned response time. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of March 2, 2013 to September 3, 2013, showed the ACHSD see the alleged victim within the assigned response time 61.8%. For the same time period, the statewide data indicates 76% compliance with this rule. It is important to note that with the addition of rule 7.202.41 (A) (4) on of March 2, 2013, Volume VII now addresses reasonable efforts by the caseworker to see the child victim. During the same time span as above, the ACHSD made reasonable efforts to see the victim of the allegation 81.8% of the time. It is recommended that ACHSD monitor the performance of their staff on this measure to ensure improvement in order to meet the state goal of 90%.	Complete
63.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	There are planned changes in the safety assessment that are scheduled to occur in 2014 that were designed to positively impact performance in this area. It is recommended that the Division of Child Welfare begin the statewide implementation process of the new safety assessment tool and that monitoring occur to determine if accuracy in the use of the tool increases as a result of their implementation.	In Progress
64.	Practice	It is recommended that efforts be made to contact the adoptive parents of the half-sibling of the father of the 19-month-old victim to advise them that they are likely legally responsible for the half-sibling of the father of the 19-month-old victim. Documentation indicated that a law enforcement officer in Louisiana made contact with the half-sibling of the father of the 19-month-old victim as part of a welfare check and the half-sibling refused to speak with the police officer. It is further recommended that the county social services department in Louisiana be contacted to help assess the appropriateness of the placement for the half-sibling.	Complete
65.	Implementation of Revised Risk/Safety Tools, CQI in the Meantime	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Denver County. In a recent review of a random sample of assessments that were conducted during a period from April 8, 2013 to September 30, 2013, DDHS completed the risk assessment accurately in 56.6% of assessments, which is below the statewide average (not including Denver County) of 62.5% for approximately the same time period. It is recommended that DDHS employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented.	In Progress

	Type	Recommendation	Status
66.	Technical Assistance	The policy finding related to timeliness of closure of FAR assessment does reflect a current systemic practice issue for JCDHS. The April 2014 Timeliness of Assessment Closure report, which measures the percentage of FAR assessments closed within 60 days, shows JCDHS at 68.5% for March 2014. This number is below the statewide average for March 2014 of 74.8 % for FAR assessments and the state goal of 90%. It is recommended that The Division of Child Welfare provide technical assistance to JCDHS on policy and rule associated with closing FAR assessments in a timely manner.	Complete