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, 2015

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., respectfully submits the attached "2014 Child Maltreatment Fatality Report."

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.

We will also post this report on the CFRT web page on July 1. Thank you for accepting this report. Should you have any questions or concerns, please contact Melissa Wavelet at Melissa.Wavelet@state.co.us or 303-866-3941.

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
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Julie Krow, Office Director, Children Youth and Families, CDHS
Marc Mackert, Director, Administrative Review Division, CDHS
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Dee Martinez, Deputy Director of Enterprise Partnerships, CDHS
Jennifer Corrigan, Legislative Liaison, CDHS

2014 Child Maltreatment Fatality Report

COLORADO
Department of Human Services

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Executive Summary

The 2014 Colorado Department of Human Services Child Fatality Review Annual Report focuses on identifying commonalities and making recommendations for improvements in the Child Welfare system based on demographic information for 78 children in 67 substantiated fatal, near fatal, and egregious incidents. In order to determine trends related specifically to fatalities, information about 22 children from fatal incidents substantiated for child maltreatment in 2014 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.

From the group of 78 children in 67 substantiated fatal, near fatal, and egregious incidents occurring in 2014, 56 children in 45 incidents met statutory criteria for full review by the Child Fatality Review Team (CFRT). As outlined in statute, Colorado collects information on several different child and family characteristics across these different types of incidents.

Specific findings and recommendations are included in this report. Full CFRT reviews may not conclude in the same year when the incident occurred. Therefore, this report summarizes information from 26 incidents occurring in 2013 and 2014 that were fully reviewed by the CFRT and posted to the public notification website in 2014. Recommendations address the policy findings, systemic gaps and deficiencies identified during the CFRT review.

Child Characteristics. For fatalities in 2014, the most frequent race/ethnicity was White (59.1%), followed by Hispanic (22.7%). This is a change from 2013, were the most frequent race/ethnicity was Hispanic (34.8%) followed by White (30.4%). The most frequent race/ethnicity for all children in near fatal, and egregious incidents in 2014 was also White (43.6%). In Colorado, in 2014, boys accounted for 50% (11/22) of the substantiated child maltreatment fatalities. Boys were victims in approximately three-fourths of the near fatalities (71%) and of the egregious incidents (69%).

Family Characteristics. The majority (49/78) of all children who were victims in fatalities, near fatalities, and egregious incidents resided with two biological or adopted parents. Though income level and education level of legal caretakers is not routinely collected by counties, available information on services to families indicated that in 33 of the 45 (73.3%) fatal, near fatal, and egregious incidents that qualified for full CFRT review in 2014, the family was eligible for and received some level of supplemental benefits.

Other Family Stressors. Of the families involved in a child fatality substantiated for abuse or neglect, 31.8% (7/22) had some history of identified domestic violence. 31.8% (7/22) of these families experienced substance abuse issues, and for 22.7% (5/22) of the fatal incidents, there was a history of mental health treatment for at least one caregiver.

Prior Involvement with Child Protective Services. The number of fatalities where the family had prior history with child protective services has ranged from 35% to 82% over the past five years. In 2014, 81.8% (18/22) fatal incidents had prior involvement, ranging in intensity from one referral not accepted for assessment to involvement that included case services.

Perpetrator Relationship. As in 2013, the majority of all fatalities were committed by the victim's mother (59.1%; 13/22), and this is above national trends (27.2%). The second largest category of perpetrators of fatalities was fathers (8/22; 36.4%).

Findings and Recommendations. CFRT highlighted 85 systemic strengths across 26 reports from 2013 and 2014 reviewed by the CFRT and posted in 2014. The most commonly acknowledged systemic strength was collaboration between system entities. The CFRT also identified 61 systemic gaps and deficiencies across the child welfare system, and 229 policy findings. The most common issue identified was the current safety and risk assessment process. 182 recommendations resulting from systemic gaps, deficiencies, and policy findings 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, found on page 37.

Background

Colorado's Child Fatality Review Team (CFRT) process has undergone numerous changes since 2011. 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 child welfare system 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 (Colorado Revised Statutes § 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 the situation did not involve abuse or neglect, 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 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 SB 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. SB 13-255 also provided funding for two additional staff for the CFRT review process; bringing the total staff dedicated to this function to three. SB 13-255 became effective May 14, 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.

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, and then to a total of 122

in 2014. 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. These changes are reflected in Table 1. In 2014, some stability in numbers is illustrated, and as statute and definitions continue, consistency will allow for better trend analysis in the coming years. It is expected in 2015 that the capacity to report and analyze trends across near fatalities and egregious incidents will exist and be included in that year's annual report.

Table 1: Total statewide incidents reported over time and statutory change*

Year	Fatal Incidents	Near Fatal Incidents**	Egregious Incidents**	Total Incidents
2012	59	14	5	78
2013	55	21	35	115
2014	58	30	22	110

**Not all incidents met criteria for CFRT review.*
*** Near fatal and egregious incidents were not statutorily mandated for inclusion until April 12, 2012.*

Statute requires an annual report to the legislature on July 1 of each year that reflects aggregate information of incidents of egregious abuse or neglect, near fatalities or fatalities that occurred in the prior calendar year. This annual report focuses on several different subsets of information: all reported incidents, regardless of whether or not the incident was substantiated for abuse or neglect; incidents substantiated for abuse or neglect; incidents substantiated for abuse or neglect with prior involvement in the child welfare system; and fatal incidents substantiated for abuse and neglect.

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 the planned data integrity process for 2014, data was extracted on a quarterly basis 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 2014. This data integrity check identified nine incidents involving nine children who appeared as though their incident met the criteria for notification to the CDHS, but for which the CDHS did not receive notification from the county. All nine incidents met criteria for public notification. However, none of the nine incidents met criteria for full CFRT review, either because they were unsubstantiated for abuse and neglect, or the involved families did

not have prior history with departments of social services. 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 involved 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 2015, the ARD will continue this data integrity process to proactively correct data integrity issues, as well as to provide technical assistance to county departments.

Child Fatality Review Team Review Process and Timelines

Statute provides county departments 60 days from a qualifying fatal, near fatal, or egregious incident (those that appear to be a result of abuse and neglect with the necessary prior involvement) 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. Extensions are granted for 30 days each, with the ability to grant additional extensions as incidents require. The need for extensions impacts the total length of time needed to complete any individual review. For example, for all reports reviewed by the CFRT in 2014, 21 out of 54 incidents (38.9%) required at least one extension to obtain necessary information for the CFRT review. To date, 35 of the 45 qualifying incidents occurring in 2014 were afforded at least one extension, ranging from one extension to eight extensions.

Allegations that are substantiated and have either prior or current child welfare involvement require an in-depth case review. These incidents are referred to the Child Fatality Review Team (CFRT) process, which includes a full review of the incident, examination of families' prior involvements with the child welfare system, and recommendations around policy and practice considerations. See Table 2 for a comparison of incidents meeting criteria to be reviewed in 2012, 2013 and 2014.

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

Year	Children in Fatal Incidents	Children in Near Fatal Incidents*	Children in Egregious Incidents*	Total Children
2012	9	2	1	12
2013	8	10	25	43
2014	18	15	23	56

**Near fatal and egregious incidents were not statutorily mandated for inclusion until April 12, 2012.*

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.

Child Fatality Review Team Membership

A Child Fatality Review Team Retreat was scheduled and held on January 31, 2014. The purpose of the retreat was to:

- Present an overview of statutory requirements for reports,
- Provide a history of the evolution of the reports,
- Explain legislative changes that occurred in the past three years,
- Align team representation with statute, by discussing potential new appointments, requesting re-appointments, notifying appointing authorities of attendance, and balancing experience and background across existing members,
- Discuss workload management, in regard to holding reviews and meeting structure (for instance: when there are three or more reviews that need to be held during one month), and
- Discuss CFRT report content, multidisciplinary discussion process, and the decision making process in regard to how decisions by the multidisciplinary group are made.

Twenty-three attendees participated in the day long retreat. The agenda items were discussed and attendees made decisions regarding timeliness of notification of an incident to CDHS, internal report due dates, content of each CFRT report, membership, workload management, and structure of team discussion and decisions. The membership revisions are detailed in Appendix A, with the grayed-out months indicating an individual was not appointed for participation for that CFRT review meeting.

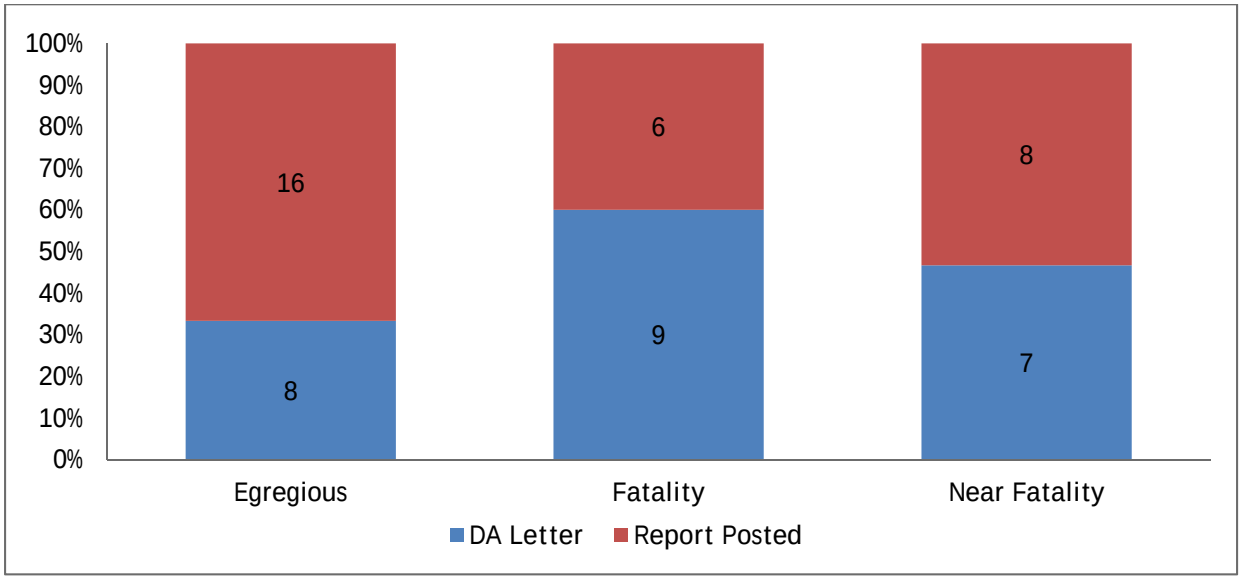
Incidents Reviewed in 2014

The information in this section reflects those incidents receiving a full review by the CFRT during the 2014 calendar year. Not all CFRT reports are completed within the calendar year when the incident occurred. Consequently, this section will also discuss the status of all pending CFRT reviews from 2014.

During the 12 month span from January 1, 2014 through December 31, 2014, the CFRT reviewed 54 incidents of fatal (15), near fatal (15) or egregious (24) child maltreatment. Please see Appendix A for a table showing attendance of the CFRT members across the review meetings. Each incident reviewed by the CFRT results in a written report that is typically posted to the CDHS public notification website (with confidential information redacted).

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 the applicable District Attorney prior to releasing the final non-confidential report when there is current, or likely, criminal investigation and/or prosecution. In these instances, CDHS requests District Attorneys to make known their preference for releasing or withholding the final non-confidential report. Chart 1 shows the posting status of all CFRT reports reviewed in 2014.

Chart 1: Report status of all incidents reviewed by the CFRT in 2014



In all 24 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 24 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. Further, the strengths, gaps and deficiencies, policy findings, and any recommendations in those reports would be included in the subsequent year's annual report.

At the time of this report's release, 78% (35/45) of CFRT reports are complete on incidents occurring in 2014, which is on track for timeliness according to statutory guidelines.

Colorado Department of Human Services and Department of Public Health and Environment Collaboration

The CDHS CFRT staff works closely with CDPHE's Child Fatality Prevention 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. This cross-reference of information happens on a continual basis and aids in data integrity and identification of all relevant incidents and children.

It is important to note that the CFPS uses different criteria to determine deaths they believe were caused by child maltreatment, or when child maltreatment 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.

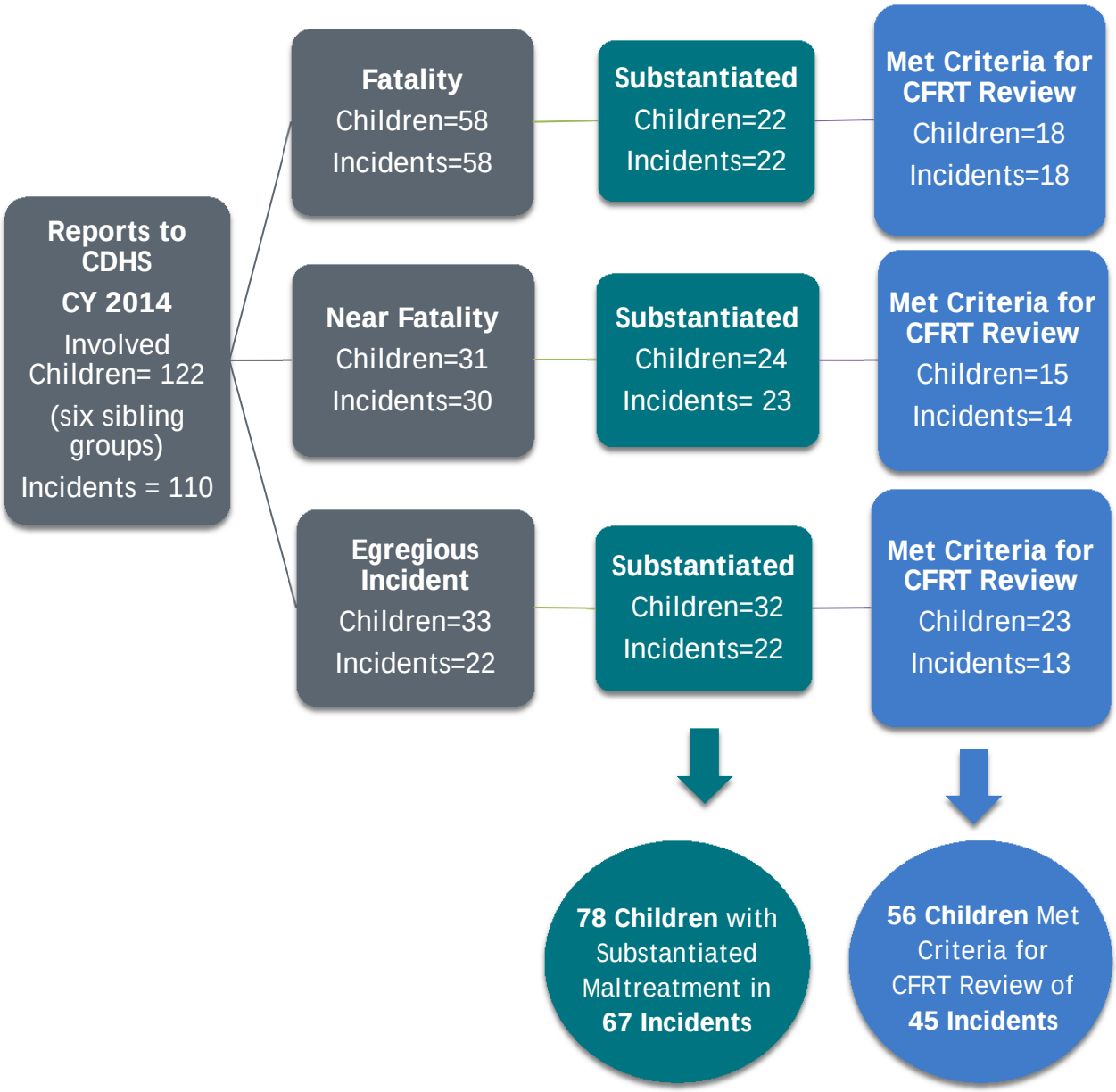
SB 13-255 requires that, as a result of collaboration, the two child fatality review teams make joint recommendations. These recommendations can be found on page 37 of this document, as well as in the CFPS Fiscal Year 2015 Annual Report. Updates and analysis of past recommendations follow the 2015 recommendations.

Overview of the 2014 Child Maltreatment Fatality, Near Fatality, and Egregious Incident Victims

As previously discussed, 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. Each incident may involve more than one child. In CY 2014, counties reported 110 incidents involving 122 children were suspected victims of fatal, near fatal, or egregious incident. Of the 122 children, 58 children experienced fatal incidents, 30 children were involved in near fatal incidents, and 33 children were victims of egregious incidents. After a thorough assessment of each child in each incident, 36 (62.1%) fatalities, 7 (20%) near fatalities and 1 (3%) egregious victims were found to be unsubstantiated for abuse or neglect, and therefore the incident was 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 2014, substantiated incidents included 78 children, 56 of whom had prior involvement with county departments of human services within the statutorily defined time period, thus indicating the need for full CFRT review. Figure 1 depicts the breakdown of the incidents reported in CY 2014. Appendix C contains a list of the counties by incident type.

Figure 1: Children involved in suspected and substantiated incidents of fatal, near fatal, and egregious child maltreatment in 2014



For purposes of this report, the majority of the analysis in the following section focuses on the 78 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). When available, comparisons are made across calendar years and to national data. Trends across years are only available for the fatal incidents, as this data has been collected for quite some time. Trends for near fatal and egregious incidents will be available for Colorado in 2015, given that statutory requirements remain unchanged. Table 3 provides an overview of the demographic characteristics of the 78 substantiated victims of incidents that occurred in CY 2014.

Table 3: Summary information of all 78 substantiated victims of child maltreatment fatalities, near fatalities, and egregious incidents

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Victim at Time of Incident	Less than one	8	36.4%	8	33.3%	9	28.1%
	One	3	13.6%	4	16.7%	4	12.5%
	Two	5	22.7%	6	25.0%	0	0.0%
	Three	2	9.1%	2	8.3%	1	3.1%
	Four	3	13.6%	0	0.0%	2	6.3%
	Five	0	0.0%	0	0.0%	3	9.4%
	Six	0	0.0%	1	4.2%	1	3.1%
	Seven	0	0.0%	2	8.3%	1	3.1%
	Eight	0	0.0%	0	0.0%	1	3.1%
	Eleven	0	0.0%	0	0.0%	1	3.1%
	Twelve	0	0.0%	0	0.0%	3	9.4%
	Thirteen	0	0.0%	1	4.2%	2	6.3%
	Fourteen	0	0.0%	0	0.0%	3	9.4%
	Sixteen	0	0.0%	0	0.0%	1	3.1%
	Eighteen	1	4.5%	0	0.0%	0	0.0%
Race/Ethnicity	African American	2	9.1%	2	8.3%	3	9.4%
	Asian	0	0.0%	0	0.0%	1	3.1%
	Hispanic	5	22.7%	8	33.3%	14	43.8%
	Multiracial	0	0.0%	1	4.2%	0	0.0%
	Unknown	2	9.1%	0	0.0%	6	18.8%
	White	13	59.1%	13	54.2%	8	25.0%
Gender	Female	11	50.0%	7	29.2%	11	34.4%
	Male	11	50.0%	17	70.8%	21	65.6%
Family Structure	Two Parents	12	54.5%	16	66.7%	21	65.6%
	Father	0	0.0%	0	0.0%	1	3.1%
	Father and Female Partner	1	4.5%	0	0.0%	0	0.0%
	Mother	1	4.5%	2	8.3%	2	6.3%
	Mother and Female Relative	0	0.0%	1	4.2%	0	0.0%
	Mother and Male Partner	6	27.3%	3	12.5%	3	9.4%
	Non-Relative Foster Care	1	4.5%	0	0.0%	4	12.5%
	Not in Household	0	0.0%	1	4.2%	1	3.1%
	Relative Foster Care	1	4.5%	0	0.0%	0	0.0%
	Two Relatives	0	0.0%	1	4.2%	0	0.0%
Incidents with Family Stressors*	Substance Abuse	7	31.8%	8	34.8%	6	27.3%
	Mental Health	5	22.7%	5	21.7%	7	31.8%
	Domestic Abuse	7	31.8%	8	34.8%	6	27.3%

**This is counted at the family/incident level.*

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 future 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 U.S. Department of Health and Human Services Administration for Children and Families annually publishes the Child Maltreatment[1] report, which provides the most current data available on key demographic characteristics of the children reported to the National Child Abuse and Neglect Data System (NCANDS) for deaths "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 the most recent national child maltreatment fatalities (FFY2013) to illustrate similarities and differences. At this time, national data is not available for near fatal or egregious incidents.

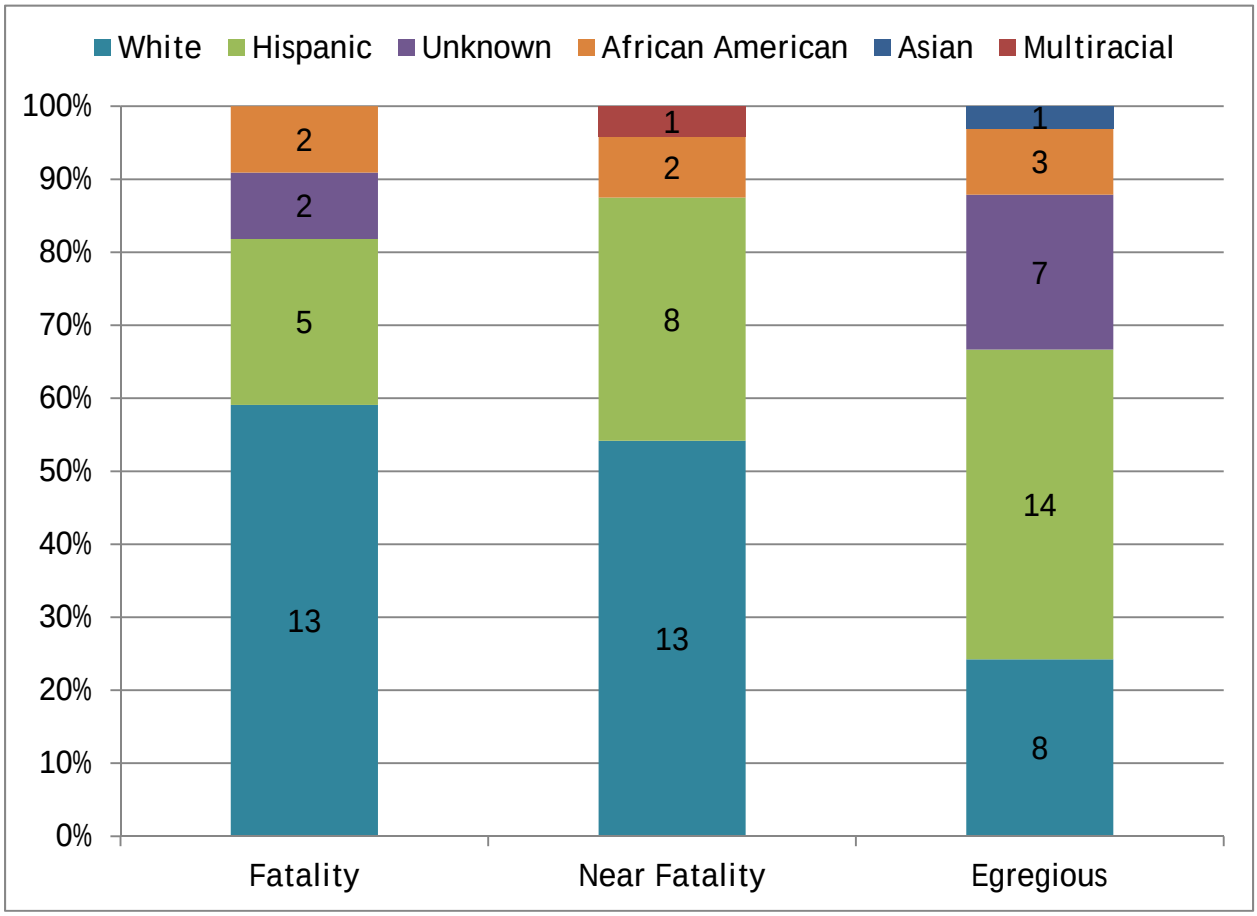
Race/Ethnicity

Nationally, 39.3% of child fatalities are White children, 33% are African American children, and 14.5% are Hispanic children.

Chart 3 displays the race/ethnicity for the 78 substantiated child maltreatment fatalities, near fatalities, and egregious incidents of children that occurred in Colorado in 2014. Race and ethnicity data from the 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%.

[1] US Department of Health and Human Services. (2014). Child maltreatment 2013. Retrieved from http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2013

Chart 3: Race/Ethnicity of 78 Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado for CY 2014



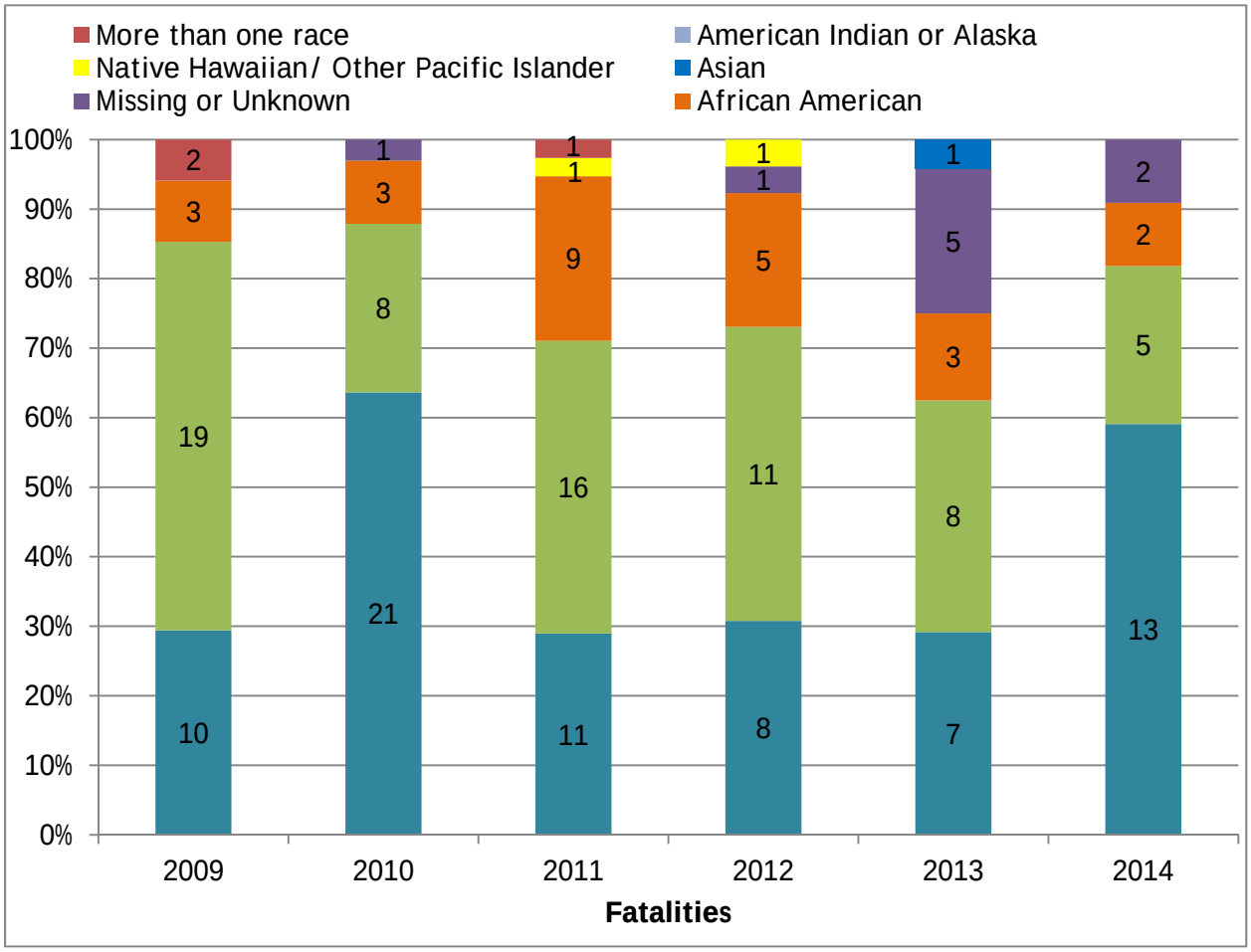
In analyzing data in this section, it is important to note how race was determined for this report. In the state automated child welfare information system, referred to as Trails in Colorado, race and ethnicity are captured as two separate variables. For the purposes of this report, these two variables 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, the child was considered Hispanic. This matches an approach 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 fatalities, the most frequent race/ethnicity was White (59.1%), followed by Hispanic (22.7%). This is a significant change from 2013, were the most frequency race/ethnicity was Hispanic (34.8%) followed by White (30.4%).

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 continued through 2013, with Hispanics comprising more than 34% of the child maltreatment fatalities. However, 2014 marks the end of a trend of Hispanic

being the most frequently reported race/ethnicity. Victims with White race/ethnicity now encompass more than half of the fatalities. This is a proportionate trend as White is forecasted to comprise 68.9% of Colorado's population in 2015 (Hispanic is forecasted to be 22.3% of Colorado's population in 2015). The percentage of White is expected to decrease over the next 25 years to approximately half of Colorado's population, and it will be important to watch those trends in comparison to fatality rates.

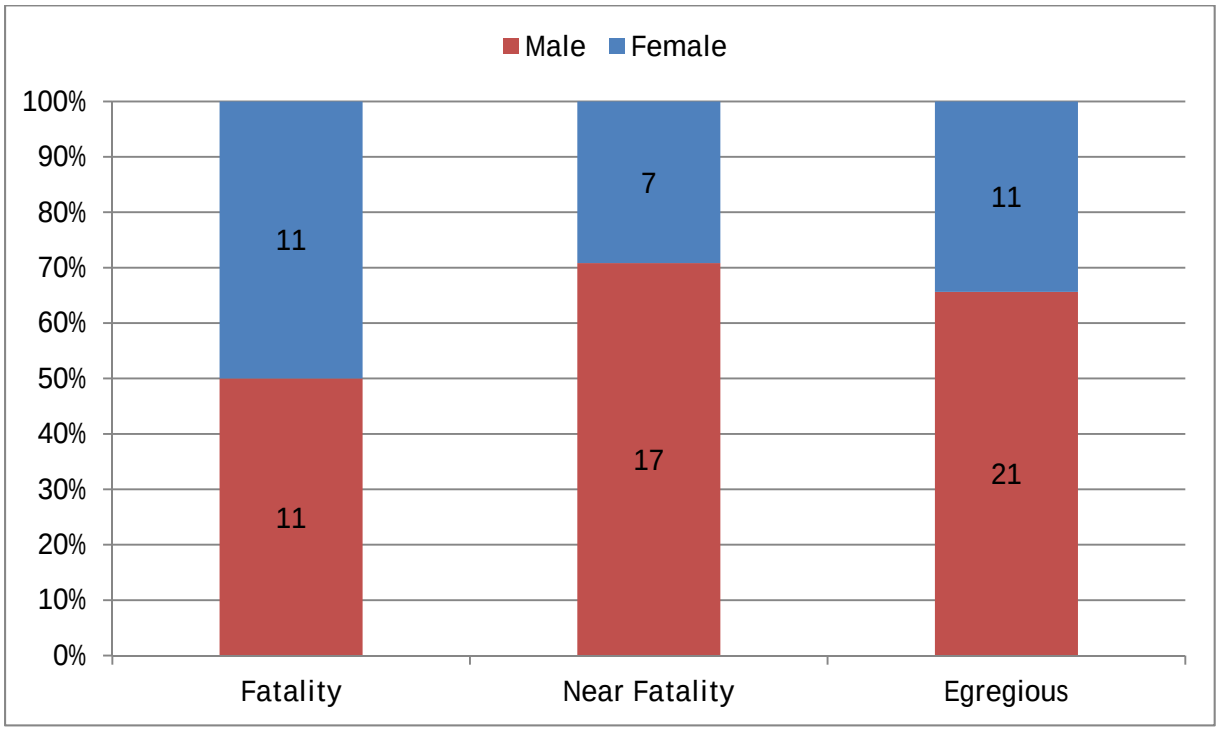
Chart 4: Race/ethnicity of victims in all substantiated child maltreatment fatalities in Colorado over the past seven calendar years



Gender

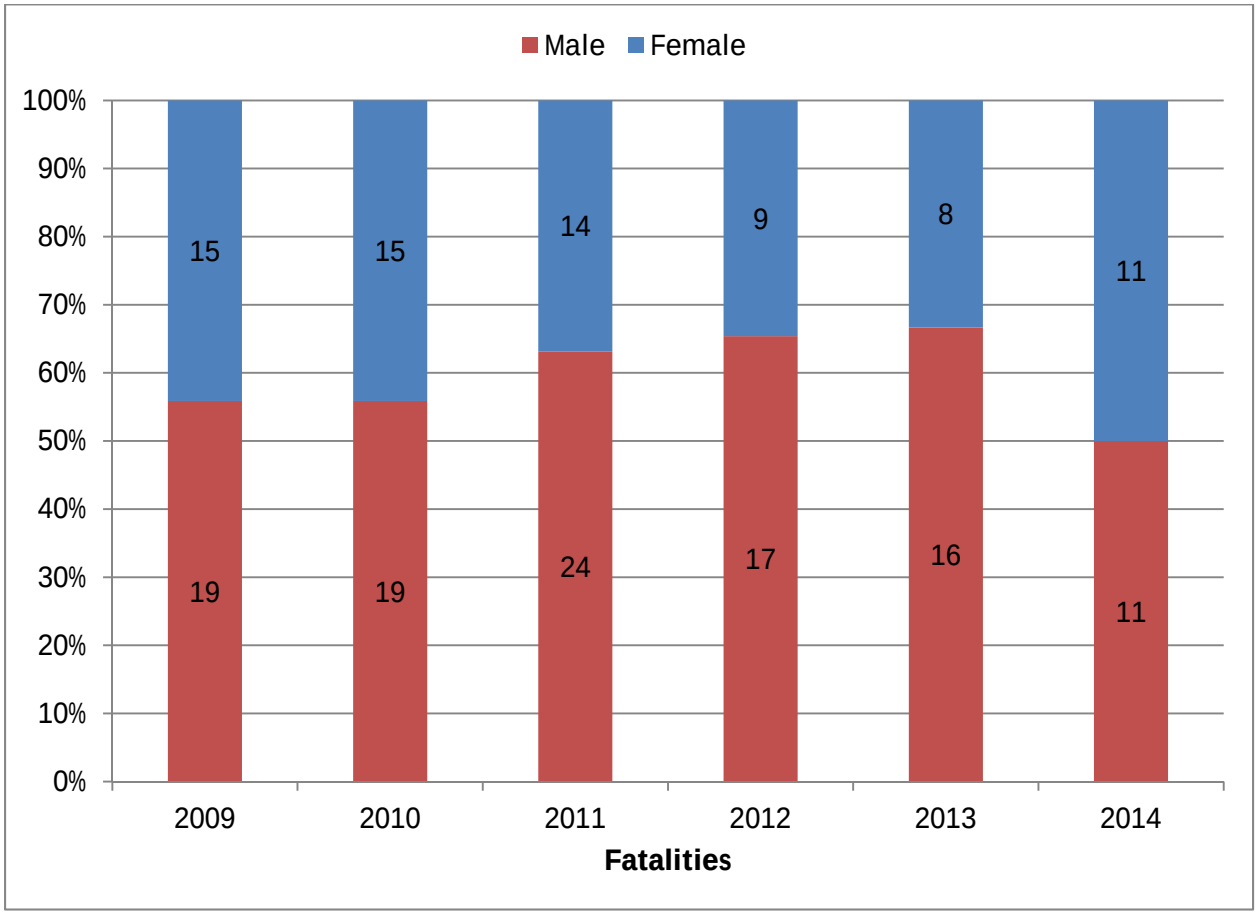
Chart 5 displays the breakdown in gender differences between types of incidents. Nationally, in FFY13, 58% of child maltreatment fatality victims were boys. In Colorado, in CY 2014, boys accounted for 50% (11/22) of the substantiated child maltreatment fatalities. Boys were victims of approximately three-fourths of the near fatalities (71%) and of the egregious incidents (69%). There are no federal comparison statistics for near fatal or egregious incidents.

Chart 5: Gender of 78 victims in substantiated child maltreatment fatalities, near fatalities, and egregious incidents in Colorado for CY 2014



In the recent past, Colorado mirrored national trends in regard to gender of child fatalities. In 2009, approximately 50% of child maltreatment fatalities involved boys. However, in 2011, the percentage of male victims increased to higher than 50%, with an all-time high in 2013 of 66.7%. In 2014, this trend in Colorado changed and became more aligned with the national percentage, with males accounting for 50% (11/22) of all fatalities (see Chart 6).

Chart 6: Gender of victims in all substantiated child maltreatment fatalities in Colorado over the past six calendar years



Age at Time of Incident

Historically, a child's age has been a key demographic factor associated with child maltreatment fatalities. National research has shown that in FFY13, victims of fatal child maltreatment tend to be younger, with approximately 81% of the child fatalities experienced by children age three or younger, and 46.5% being younger than one year old. Colorado's trends appear to closely follow the national trends. As displayed in Chart 7, approximately 36.4% (8/22) of the fatalities involved victims younger than one year old, and 81.1% (18/23) were three or younger. A similar pattern exists for the near fatalities, as 33.3% (8/24) of the victims were under the age of one, and 83.3% (20/24) were age three or under (see Chart 7).

The pattern of ages of children substantiated in egregious incidents did not exactly follow those of the fatal and near fatal victims. Approximately 28.1% (9/32) of the victims of egregious incidents were under the age of one, and 43.8% (15/32) of all egregious incident victims were aged three or younger. Ten of the 32 victims were ages 11 and older (31.4%), which is an increase over the past two years. In CY 2013, only four victims were over the age of 11; in CY 2012, two victims were over the age of 11.

Chart 7: Age of 78 victims in substantiated child maltreatment fatalities, near fatalities, and egregious incidents in CY 2014

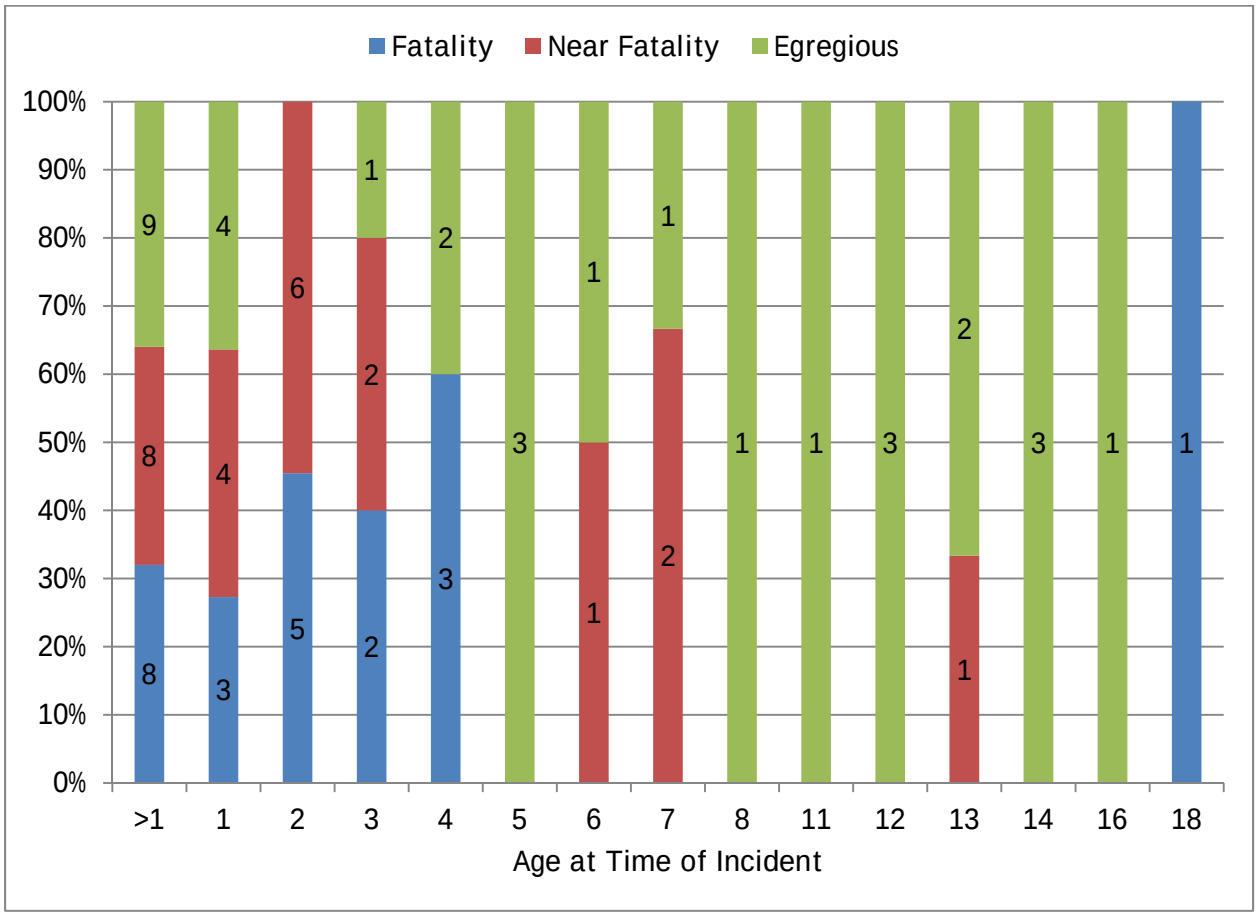
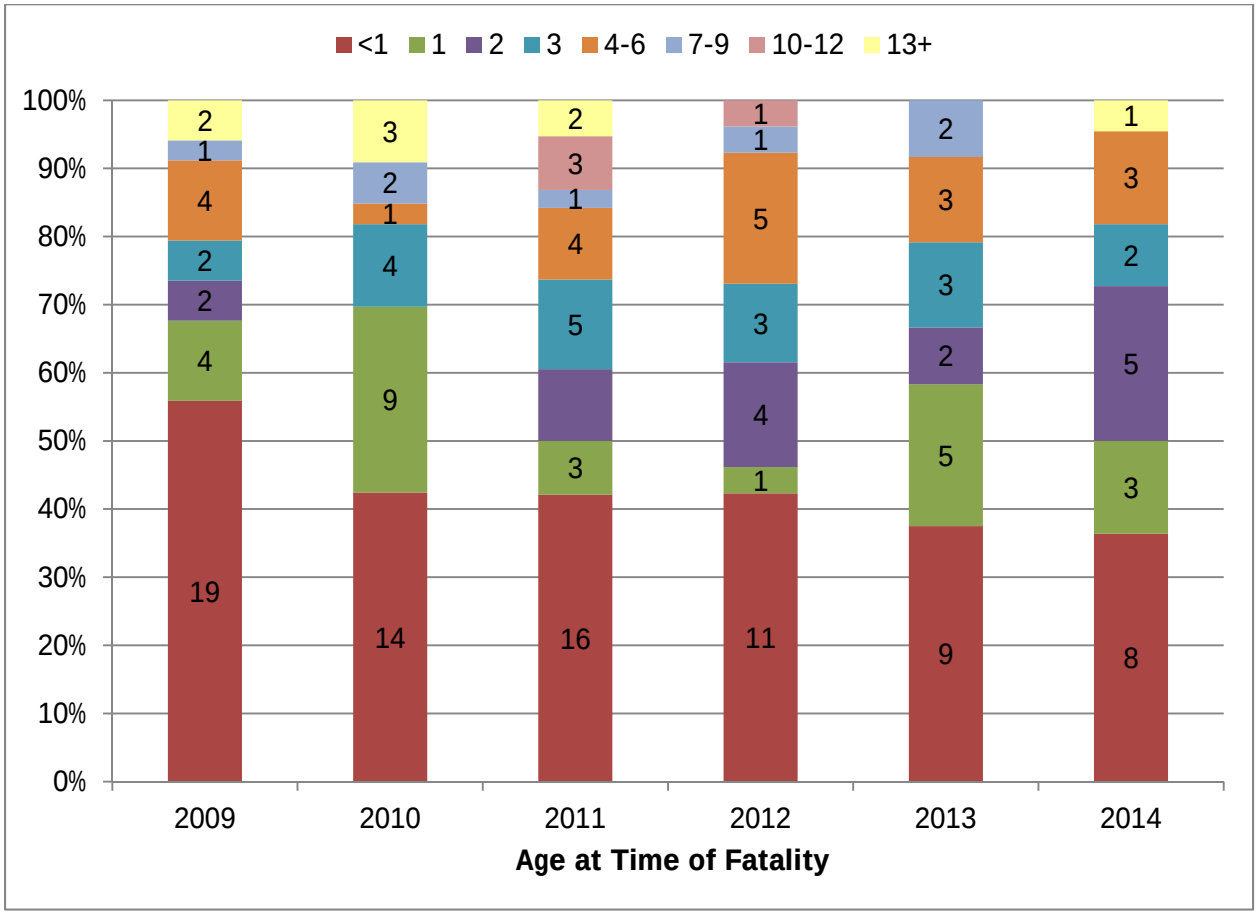


Chart 8 displays the trends in ages of victims in child maltreatment fatalities over the past six years. While it varies slightly over time, approximately 70% of children in fatal child maltreatment incidents are three years of age or younger. Total numbers of victims have changed throughout the years. In 2009, there 34 fatality victims; 33 in 2010, an all-time high with 38 in 2011, and then a decline from 2012 on – 26 in 2012, 24 in 2013 and 22 in 2014.

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. Each of these is discussed below, including data from fatalities, near fatal, and egregious incidents. Information on public assistance is at the family level of the legal caregiver(s), while information on the income and education are on the legal caregiver level. It is important to note there is often more than one legal caregiver per child, and the total number of applicable legal caregivers is 80.

Income and Education Level of Caregivers

In the changes made to the Colorado Revised Statute by SB 13-255, the income of, educational level of, and government assistance or services received by legal caregivers at the time of the incident became 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.

In CY 2014, information for 33 of the 45 (73.3%) reviewed incidents indicated that the family qualified for and received some level of supplemental benefits. Nationally, 25.8% of

caregivers involved in a child maltreatment fatality received public assistance. It is important to note that national figures on public assistance received by families of child maltreatment fatalities represent only 23 states and include only fatalities; Colorado's data includes near fatalities and egregious incidents. Types of benefits included Supplemental Nutrition Assistance Program (SNAP), Medicaid, Supplemental Security Income (SSI), Child Care Assistance Program (CCAP), Temporary Assistance for Needy Families (TANF), and Special Supplemental Nutrition Program- Women, Infants, Children (WIC). Medicaid, SNAP, WIC, and TANF were the most frequently utilized programs in this group.

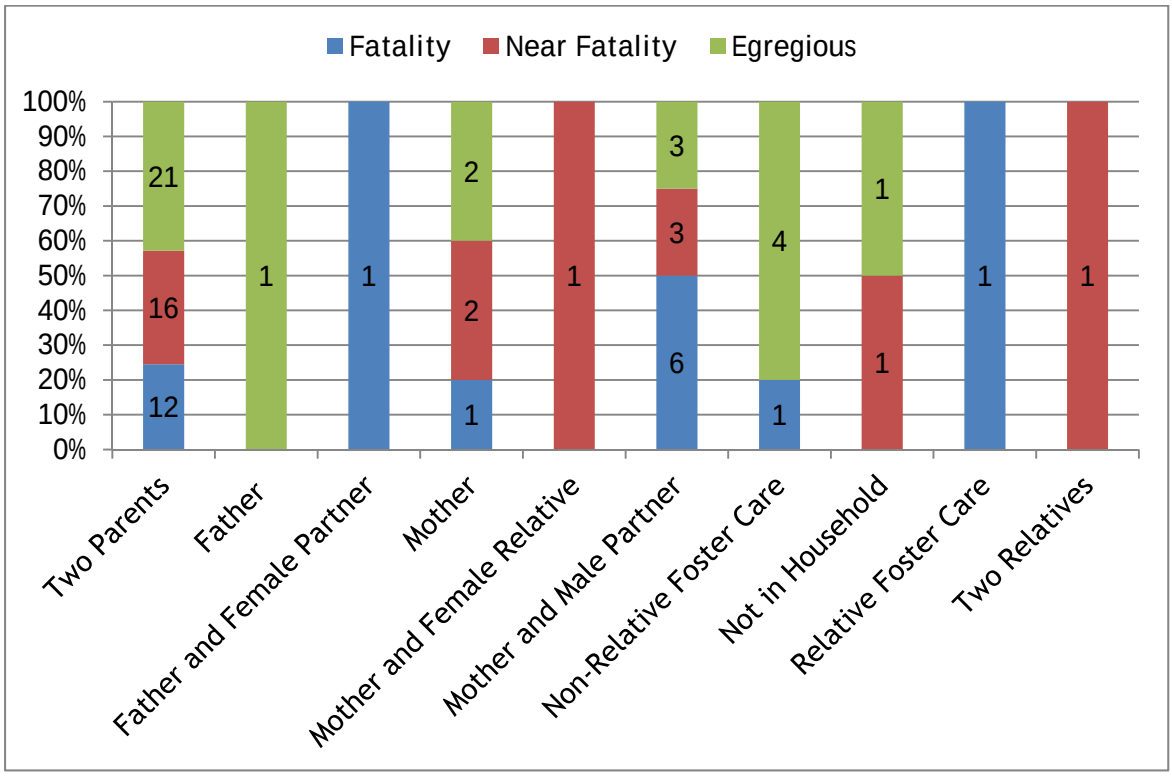
For the majority of the incidents reviewed, family income was unknown. For those caregivers for whom household income was reported (n=4), the mean income was $45,963.

Of the reported education levels for legal caregivers (n=26), the two most common were high school diploma/GED and less than high school HS diploma/GED.

Family Structure

Family composition is another factor potentially related to child maltreatment fatalities. As displayed in Chart 9, the majority (49/78) of all children in fatalities, near fatalities, and egregious incidents lived in families with two biological or adopted parents. In fact, 54.5% (12/22) of fatal incidents occurred for children in families with two biological or adopted parents. This family composition was also most likely for the children in egregious incidents and near fatalities, where 65.6% (21/32) of egregious occurred in a family with two biological or adopted parents and 66.7% (16/24) for near fatalities. This year, two children in two fatal incidents and four children in one egregious incident lived in substitute care settings, including non-relative foster care and relative foster care.

Chart 9: Family Structure of 78 victims of substantiated child maltreatment fatalities, near fatalities, and egregious incidents in 2014

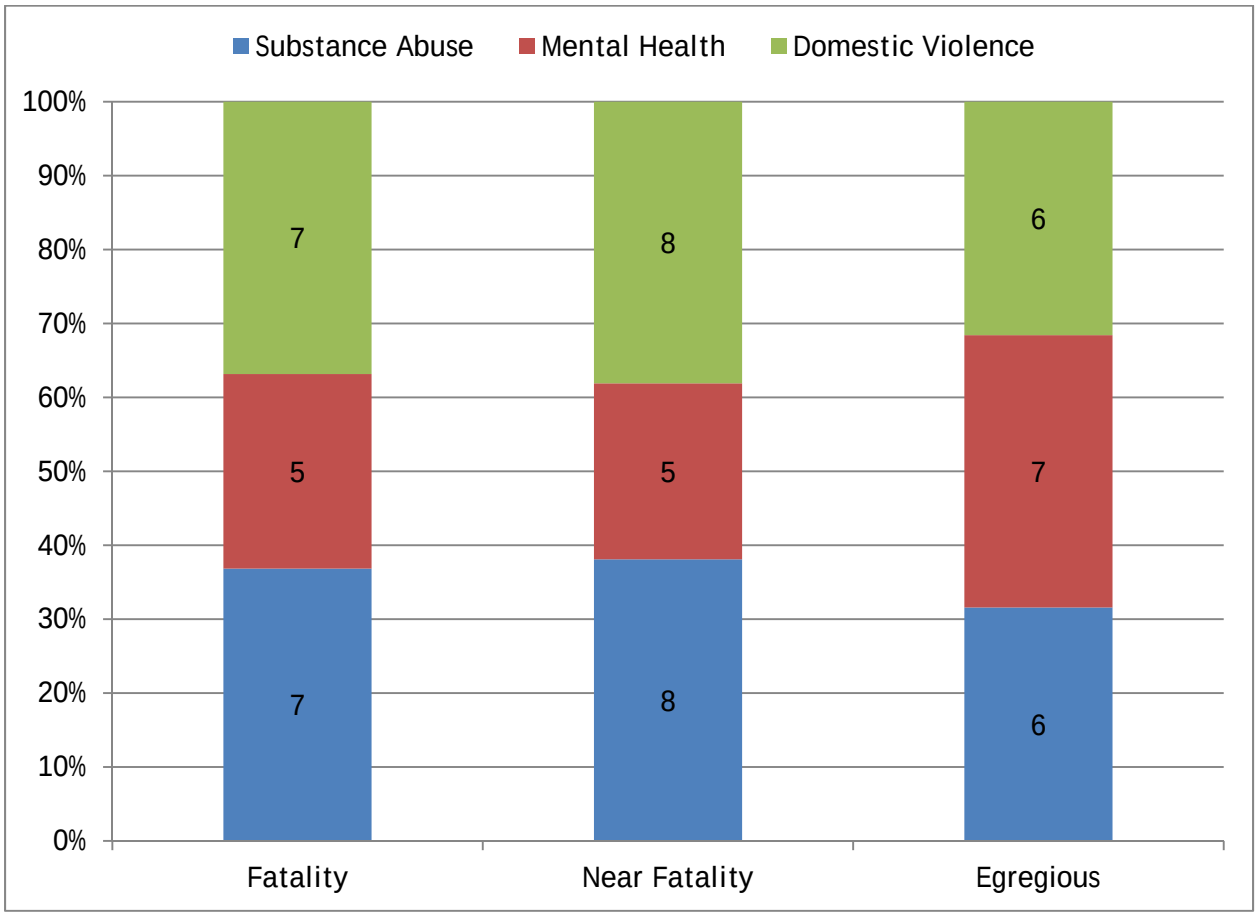


Other Family Stressors

Chart 10 identifies additional elements that were tracked in an effort to determine commonalities among the 78 children involved in fatalities, near fatalities, and egregious incidents from 2014. Nationally, 15.4% of child maltreatment fatalities involved domestic violence. This percentage is lower than in Colorado, as 31.8% (7/22) of the families involved in a child fatality had some history of identified domestic violence.

Within the families involved in child fatalities, 31.8% (7/22) of the families experienced substance abuse issues and for 22.7% (5/22) of the fatality incidents, there was a history of mental health treatment. More egregious incidents had families identified with mental health issues than in both fatal and near fatal incidents.

Chart 10: Other stressors in families of substantiated child maltreatment fatalities, near fatalities, and egregious incidents*



**This is counted at the family level and not present in all incidents.*

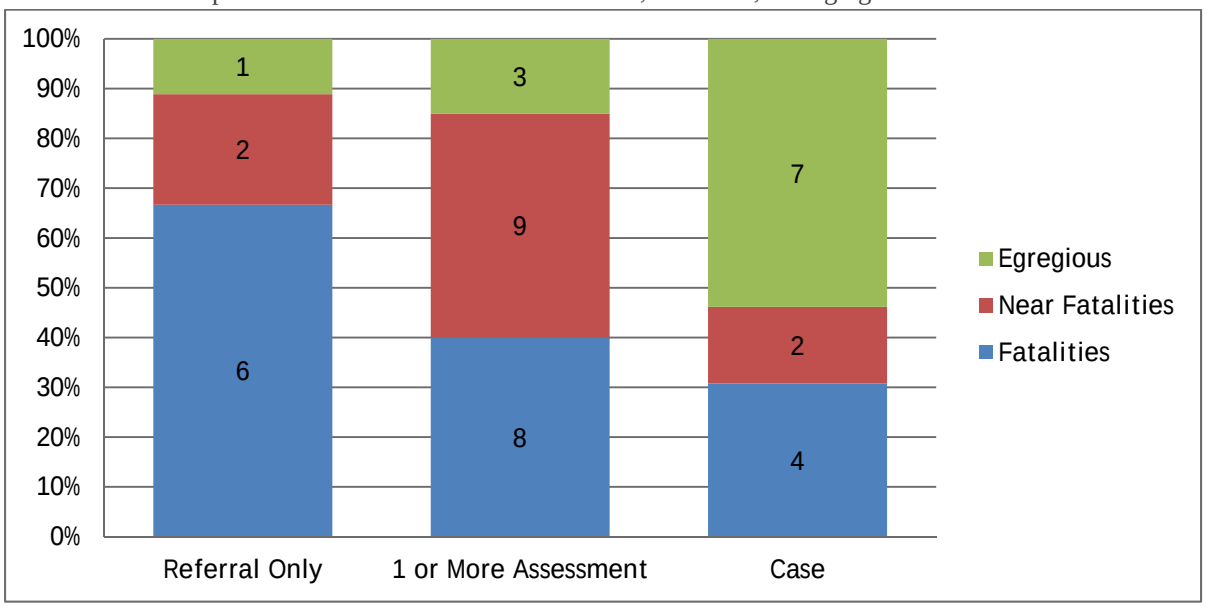
Prior Involvement

Nationally, in 2013, 3.1% of child fatalities involved families with prior CPS history within the past five years, and 11.6% received family preservation services. It is important to note national data varies for this measure based on state and local policy and reporting requirements to the Federal government. For the child maltreatment fatalities that occurred in Colorado during calendar years 2012 – 2014, approximately 35% to 82% of the families had prior child protection history as defined in statute. In 2014, 81.8% (18/22) of fatalities had prior history. This is a significant increase in the number of fatalities with prior history from 2013, as only nine incidents out of 24 had prior CPS 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 child welfare involvement was defined as a two year time period (2011) and a five year time period prior to 2011.

For the first time in this report, information related to the type and scope of prior involvement is available for analysis. Of note, most incidents where families had only one

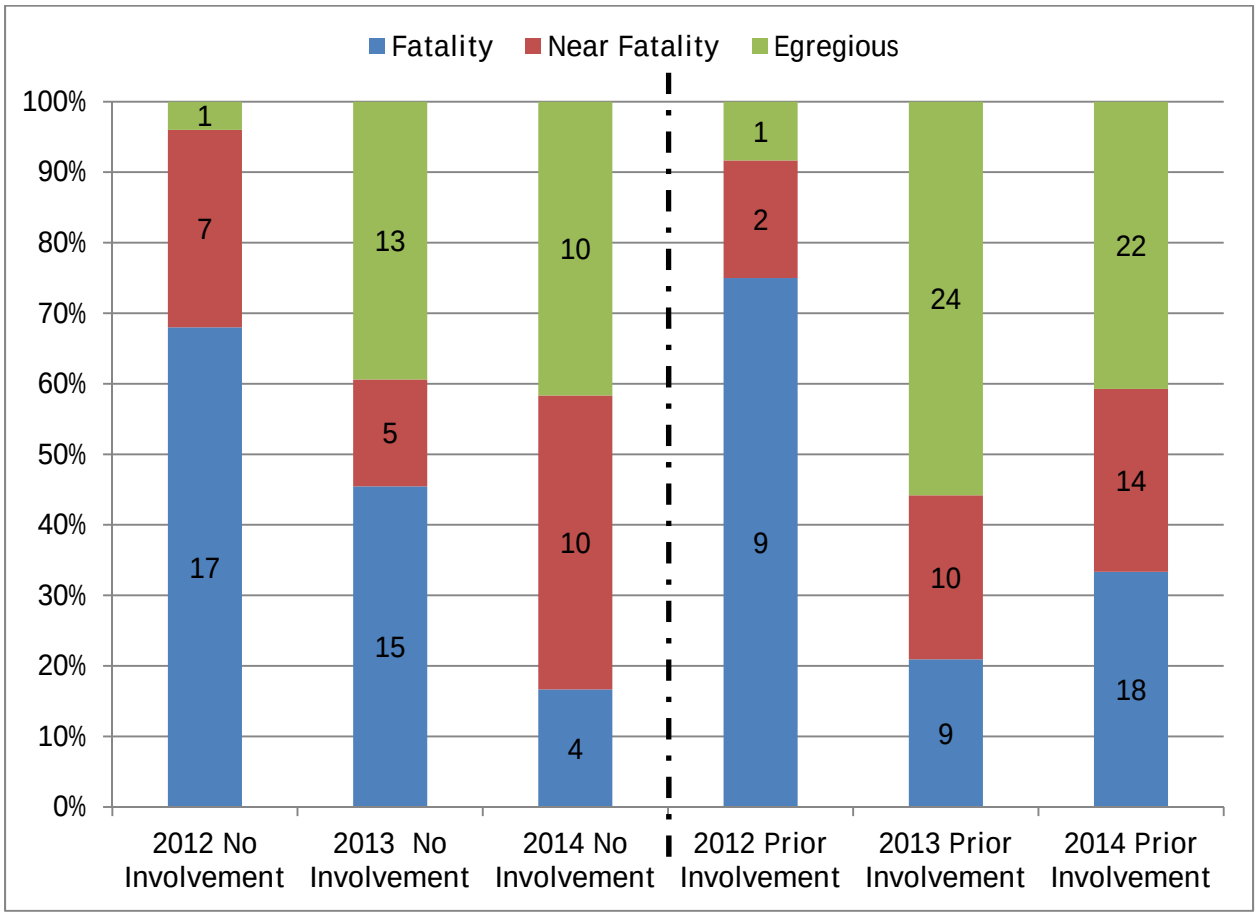
past screened out referral 66.7% (6/9) were child fatalities. Conversely, egregious incidents comprised the greatest number (53.8% or 7/13) of incidents where there was prior case history (meaning the involvement included services and a greater duration). This is illustrated in Chart 11.

Chart 11: Detail of prior involvement of families in 67 fatal, near fatal, and egregious incident of child maltreatment



In 2012, two of the near fatalities had prior involvement, and one egregious incident had prior involvement within the past two years. As the scope of prior involvement increased to an additional year in 2013, 10 of the near fatal incidents had history and 24 of the egregious incidents had history. A total of 45 children were reviewed in 2014, and the majority of incidents were fatalities (18/45; 40%). See Chart 12 for a comparison of the past three years of incidents with and without prior history.

Chart 12: Prior involvement of families in substantiated child maltreatment fatalities, near fatalities, and egregious incidents in Colorado from 2012-2014*



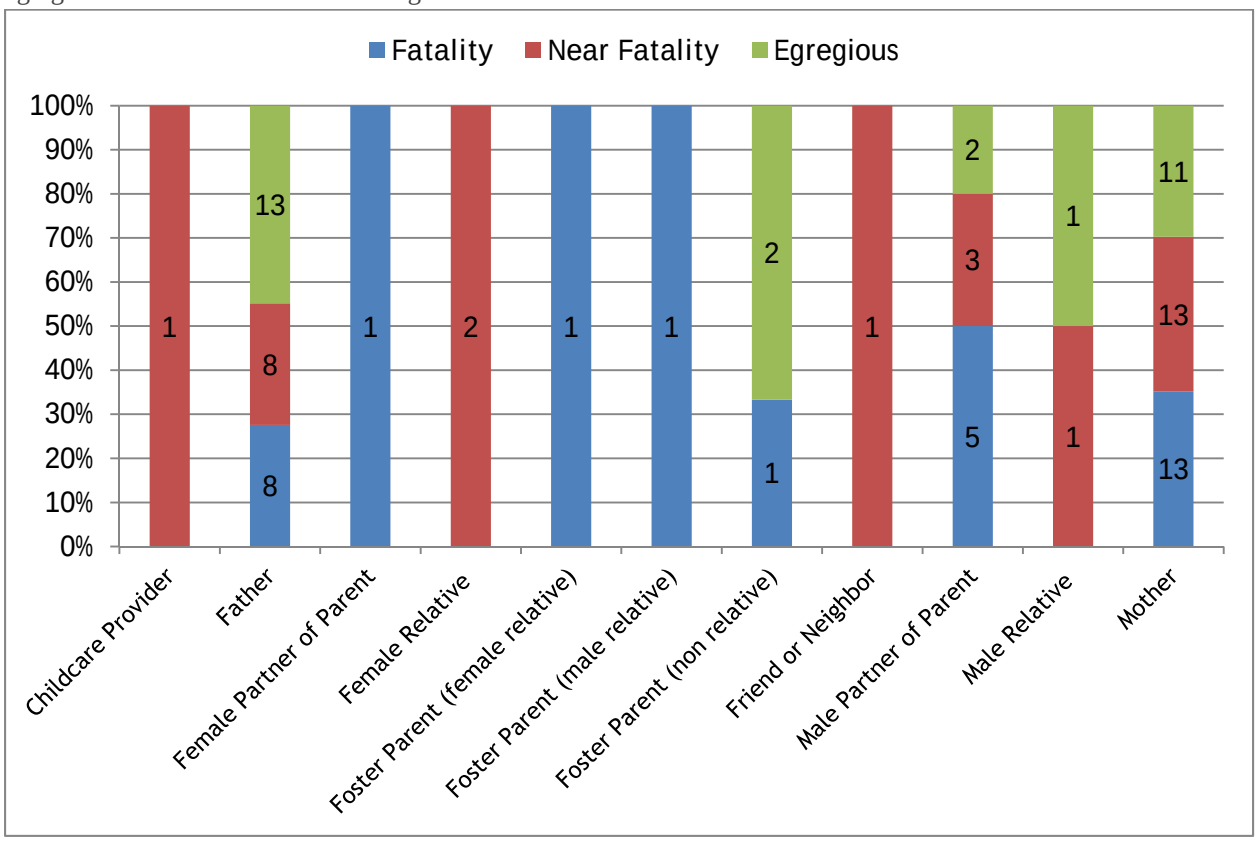
** As the statutory changes over the prior years have modified the population of incidents requiring review, and each has changed within each given calendar year, it limits the ability to interpret trends in the data. Further, any change in the final number of incidents in a given calendar year may be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

Perpetrator Relationship

Chart 13 displays the relationship between the perpetrator and to the victim between the perpetrators of the fatal, near fatal, or egregious incidents. As in 2013, the majority of all fatalities were committed by the victim's mother (59.1%; 13/22), and this is quite above national trends (27.2%). The second largest category of perpetrators of fatalities was fathers (8/22; 36.4%). For the near fatal incidents, mothers were also the most frequent perpetrators (13/24; 54.2%), and among the other 11 victims, the father was the perpetrator in eight incidents.

The perpetrators of egregious incidents were most frequently fathers (13/32), followed by the mother (11/32). Other notable categories of perpetrators of egregious incidents include non-relative foster parent (2/32) and male partner of parent (2/32).

Chart 13: Perpetrator relationship to 78 victims of substantiated child maltreatment fatalities, near fatalities, and egregious incidents in Colorado during CY 2014*



*More than one perpetrator exists for several incidents.

Summary of CFRT Review Findings and Recommendations

This section summarizes the findings and recommendations of the 26 Child Fatality/Near Fatality/Egregious Incident Case-Specific Executive Review Reports (hereafter referred to as CFRT reports) completed and posted to the CDHS public notification website since the completion of the 2013 CFRT Annual Report. This section does not include information from the 21 reports completed in 2014 where the District Attorney's office has requested non-disclosure, or from the 11 reports from 2013 that remain undisclosed. Each of the 26 CFRT reports contains an overview of systemic strengths identified by the CFRT, as well as systemic gaps and deficiencies identified in each particular report. The aggregate data from the 26 CFRT reports point to the strengths and gaps in the child welfare system surrounding fatalities, near fatalities, and egregious incidents.

Using the expertise provided by the CFRT multidisciplinary review, 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. Using county and state level quality assurance data, reviewers determined if policy findings were indicative of systemic issues within the individual county agency and/or the state child welfare system, and if so, produced one or more recommendations for system improvement.

This section first summarizes systemic strengths found by the CFRT in each of the 26 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 26 reports alongside resulting recommendations and progress.

Summary of Identified Systemic Strengths in the Delivery of Services to Children and/or Families

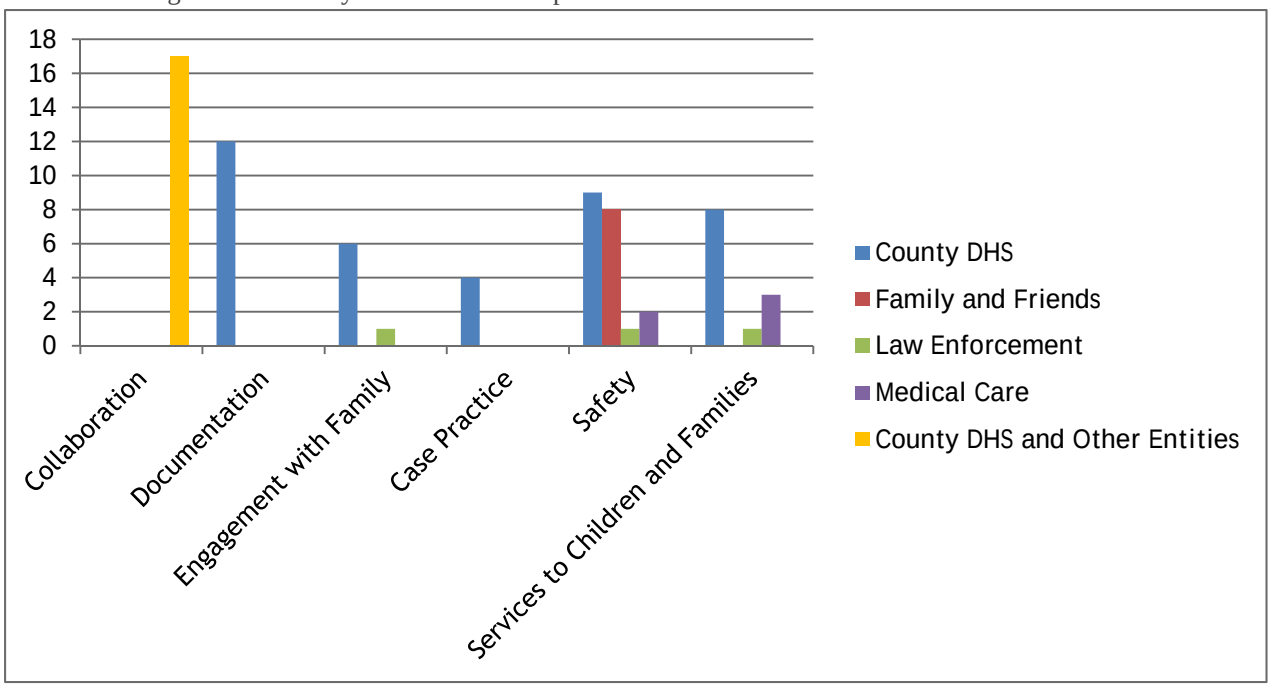
In the 26 fatal, near fatal, or egregious incidents of child maltreatment reviewed by the full Child Fatality Review Team and posted to the public notification website, the team noted 85 systemic strengths in the delivery of services to children and families. A qualitative analysis of the 85 systemic strengths indicated six main themes, exhibited by five separate systems. Items of systemic strength acknowledged by the team can be organized in the following categories: 1) Collaboration, 2) Documentation, 3) Engagement with Family, 4) Case Practice, 5) Safety, and 6) Services to Children and Families. The five systems most frequently mentioned are: 1) County Departments of Human Services (both alone and alongside other entities), 2) Community Providers, 3) Family and Friends, 4) Law Enforcement, and 5) Medical Providers. This report outlines each area of systemic strength and the involved entities or individuals. Chart 14 provides a summary of these systemic strengths.

Collaboration

The CFRT uses multi-disciplinary expertise to examine coordination and collaboration between various agencies as reflected in documents from multiple sources. The CFRT identified that at different times, collaboration between county offices and other professional entities was a systemic strength on 17 occasions in 15 reports. Most often,

collaboration occurring *after* the fatal, near fatal, or egregious incident was noted as a strength. Frequently, collaboration was noted between county departments and law enforcement. Medical providers were also indicated as important collaborative members of the child protection system, with the Children's Hospital of Colorado frequently mentioned as integral to some investigations and assessments of family situations surrounding fatal, near fatal, and egregious incidents.

Chart 14: Strengths identified by the CFRT review process



Documentation

Documentation by county departments of human services was indicated as a systemic strength on 12 occasions in 10 reports, with regard to casework in the fatal, near fatal and egregious incidents. Examples included historical information where pertinent information was clearly summarized to assist in current decision making, as well as documentation that led to criminal charges in some instances. Counties conduct internal reviews of all incidents which are brought before the CFRT. In four cases, the CFRT identified that the internal reviews were above expectations and particularly clearly written. These reports also provided additional transparency and critical analysis of practice.

Engagement of Family

On four occasions in four reports, it was noted that either county departments or law enforcement went above expectations to engage family members surrounding fatal, near fatal, and egregious incidents of child treatment. In one case, a county used a family engagement meeting to bring family members together to support the victim children. On another occasion, extended family was able to care for an injured child following the incident after the county carefully engaged and assisted in the organization of their extensive

involvement. On three occasions in three reports, the team noted commendable family engagement in involvement prior to the fatal, near fatal, or egregious incident.

Case Practice

In three reports, the CFRT identified caseworkers who excelled in service to children and families. One caseworker was described as "dedicated," and others were noted to have gone beyond basic duties to ensure safety and well-being for children in both prior involvement and following fatal, near fatal and egregious incidents.

Safety

The CFRT identified 20 instances in 14 reports where systems surrounding children and families provided excellent work in the promotion of child safety. Interestingly, this was the category where family, neighbors, and friends of children were most often mentioned as advocates or providers of child safety, whether by providing safety networks following incidents, or by making efforts to report safety concerns to county departments of human services. Similarly, the CFRT noted law enforcement and medical providers also worked to communicate about child safety with county departments, including identifying or recognizing signs of possible child abuse and neglect. County departments displayed good casework around communicating with families about the implications of marijuana use when parenting, and in one situation of domestic violence, were able to provide for child safety despite the complex environment.

Services to Children and Families

Finally, several services were noted as important to the needs of families and children both before and after fatal, near fatal, and egregious incidents. Specifically, trauma services were important in addressing the unique needs of trauma-exposed children. The State and Regional Team (START) at the Kempe Center for the Prevention and Treatment of Child Abuse was noted as an important service for both law enforcement and county departments. Using CAPTA funding, the DCW provides for this multi-disciplinary consultation team to review complex, multi-system cases of child maltreatment. In one incident, law enforcement called this team to consult on a case, which gave clear and precise direction to a county department. Finally, the quality of medical provided to children was noted as a systemic strength in two incidents.

Summary of Identified Systemic Gaps and Deficiencies in the Delivery of Services to Children and Families

In the 26 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 61 gaps and deficiencies in the delivery of services to children and families. While this represents an increase in identified systemic gaps and deficiencies, it is important to note that as CFRT membership stabilizes, a consistent team is better able to share and identify multi-systemic issues. This year the systemic gaps and deficiencies can be organized into five categories: 1) Safety and Risk Assessment Tools, 2) Extension Usage in Case Practice, 3) Domestic Violence Assessment and Services, 4) Mandatory Reporting, and 5) Unique Issues.

Each systemic gap and deficiency, whenever possible, corresponded with a recommendation to address the identified concern. Appendix C contains the recommendations resulting from these 26 incident reviews and information about their implementation status.

Safety and Risk Assessment Tools

A systemic deficiency identified by the CFRT in 18 reports was related to the Colorado Risk and Safety Assessment tools. The team noted that many policy findings were related to the inaccurate use of these tools. As will be discussed in the policy findings portion of this section, the CFRT noted 90 policy findings related to the use of the safety and risk assessments, spread across 22 of the 26 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 findings mentioned above, combined to form multiple recommendations in reports. In particular, the recommendations urged attention to training, evaluation and on-going continuous quality improvement of these tools.

The Division of Child Welfare began planned changes to the Colorado Risk and Safety Assessment tools in 2012. These changes are designed to positively impact performance in this area. It was expected the new Safety and Risk Assessment tools would be implemented state-wide in 2014. DCW is working on a phased implementation strategy, and implementation in each county will be based on criteria around performance of county practice. The implementation strategy will be finalized in 2015.

Extension Usage in Case Practice

In review of case specific county documentation, the CFRT noted a deficit in performance as related to the use of extensions in the timely closure of prior assessments and assessments of incidents. The rule related to extension usage, which was withdrawn in early 2015 as part of the concerns noted by the CFRT, is found in Figure 2.

Figure 2. 7.202.57 Conclusion of Investigation [Rev. eff. 3/2/13]

A. A High Risk Assessment shall be completed within thirty (30) calendar days of the date the referral was received, unless there are circumstances which have prevented this from occurring. Such circumstances shall be documented in the State automated case management system. 1. The caseworker shall request and document in the assessment extension window of the State automated case management system the primary reason(s) for the extension prior to the expiration of the thirty (30) day closure requirement, and Code of Colorado Regulations 30 2. The approving supervisor shall document within seven (7) calendar days in the assessment extension window of the State automated case management system the time limited extension(s) to the thirty (30) calendar days closure requirement including the rationale and the time frame for the extension(s).

The CFRT noted in seven incidents that extensions were not used correctly. As will be noted in the policy findings section, there were findings related to extensions and/or assessment

closure in 49 incidents, and various findings occurred in all 26 reports. This CFRT-identified gap combined with performance in this area across reports led to multiple recommendations, including the changes to rule in early 2015. As of January 1st, 2015, the use of extensions was removed from Volume VII and counties were given an additional 30 days to close assessment (for a total of 60 days). Figure 3 highlights the new rule. This change to rule will impact forthcoming policy findings.

Figure 3. 7.104.13 Conclusion of Assessment – Timing, Findings, Services [Eff. 1/1/15]

7.104.131 Timing [Eff. 1/1/15]

A. High Risk Assessments (HRA) or Traditional Response Assessment shall be completed within sixty (60) calendar days of the date the referral was received.

B. The initial assessment phase of a Family Assessment Response (FAR) shall be approved by the supervisor and closed within sixty (60) calendar days from the date the referral was received.

Domestic Violence Assessment and Services

The CFRT noted difficulty with assessment and service provision in four incidents where domestic violence occurred in prior involvement. In one case, the CFRT acknowledged the difficulty in communicating related to an assessment in situations where children and a caregiver may be staying at a domestic violence shelter. While shelter residents and circumstances are necessarily confidential, this can impede assessment and assurance of child safety.

The Commission to Eliminate Child Abuse and Neglect Fatalities (CECANF) held a public meeting in Denver on September 22-23, 2014, and several CDHS employees involved in the CFRT process in Colorado shared insights and lessons learned about the impact of domestic violence on child maltreatment fatalities, near fatalities, and egregious incidents. CHDS staff urged for more work related to ensuring that protective orders are in place for victims of domestic violence. Discussion of new child welfare rules that strengthen Colorado's rules around domestic violence occurred, and the Division of Child Welfare continues to collaborate with the Domestic Violence Program located within CDHS.

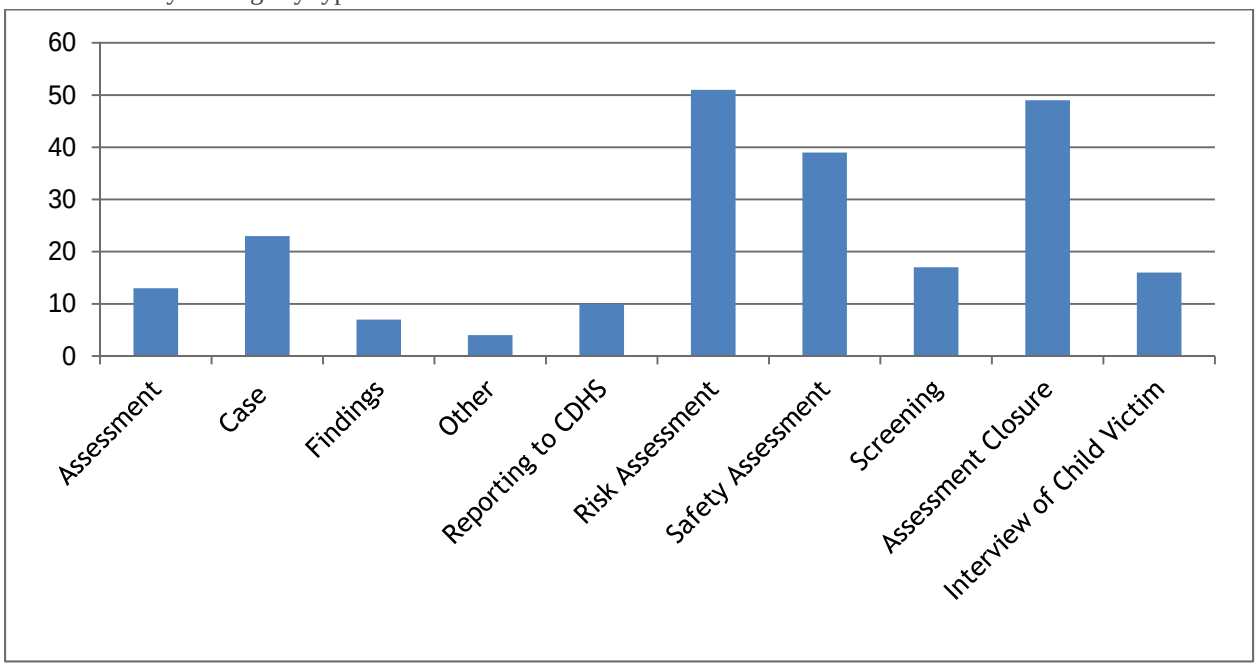
Unique Issues

The remaining half (32/61) of the gaps identified by the CFRT did not constitute overall trends across the 26 reports. However, each gap was uniquely addressed by a recommendation to a specific county or state department, or community partner. All subsequent recommendations, as well as the status of each recommendation, are found in Appendix C.

Summary of Policy Findings

The CFRT staff 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 staff identified areas of noncompliance with Volume VII and the Colorado Revised Statutes. The 229 policy findings (also referred to as 'policy violations' in some reports) from the 26 reports posted on the public notification site in 2014 comprise the next section of this report. The majority of policy findings can be categorized into ten categories: 1) Assessment, including thoroughness; 2) Case, including service planning and visits to children and families; 3) Findings of maltreatment, including both not meeting the threshold and not substantiating an allegation when information met criteria; 4) Other, including inadequate background checks of kinship providers; 5) Timely Reporting to CDHS of fatal, near fatal, and egregious incidents; 6) Risk Assessment; 7) Safety Assessment; 8) Screening of child maltreatment reports, including inaccurate screening out and screening in; 9) Timeliness of Assessment Closure, including the use of extensions; and 10) Timeliness to interviewing alleged victims of child maltreatment. The frequency by type of policy finding is contained in Chart 15.

Chart 15: Policy findings by type



Each policy finding represents an instance where caseworkers and/or county departments did not comply with specific statute or rule. However, there are limitations to interpreting policy findings in the aggregate across the varied history and circumstances of multiple incidents. For example, an individual policy finding related to the accuracy of the safety assessment tool may indicate that a caseworker selected an item on the tool that did not rise to the severity criteria outlined in rule, and this may or may not have adversely impacted overall decision making in the assessment. Similarly, policy findings related to screening represent referrals where the county incorrectly applied statute and rule, both for referrals that were

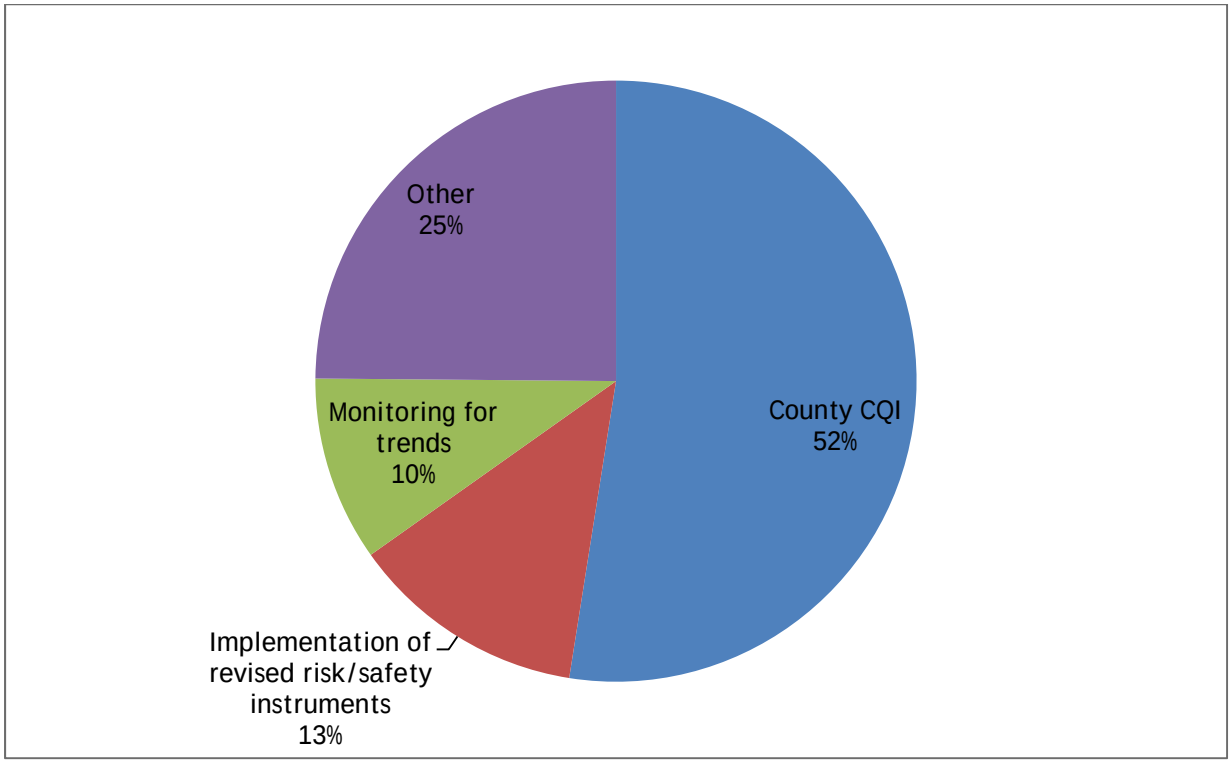
assigned for assessment *and* referrals that were not assigned for assessment. The findings also refer to the documented classification of referrals not assigned for assessment. Individual policy findings should not be directly correlated with the occurrence of fatal, near fatal, and egregious incidents, but rather present a snapshot of performance in county departments and can direct efforts toward continuous quality improvement.

Recognizing this, the CFRT examined each policy finding alongside current county practice and performance to determine whether the finding was indicative of current, systemic practices or issues in the agency. Using data gained from Screen Out, Assessment, In-Home, and 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. Other recommendations addressed issues related to the state level monitoring of services, or delivery of technical assistance. Specifically, the 229 policy findings in the 26 reports posted to the public website resulted in 119 recommendations for practice improvement for either county or state departments (some policy findings resulted in more than one recommendation). 69 policy findings were not indicative of specific practice concerns in the respective counties, and 56 were duplicate issues from the same CFRT report, and so supported the recommendation already included.

2014 Recommendations from Posted Reports

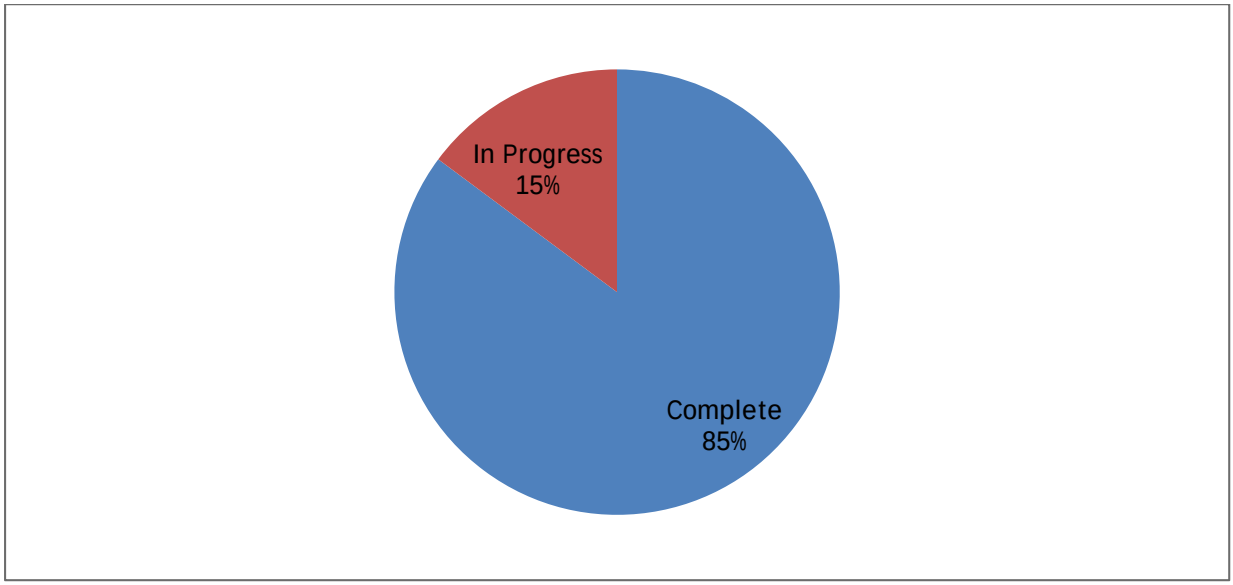
The CFRT developed a total of 182 recommendations from the 290 systemic gaps, deficiencies, and policy findings. There were 63 recommendations resulting from the 61 systemic gaps and deficiencies identified from the CFRT (two gaps resulted in more than one recommendation). 229 policy findings resulted in 119 recommendations. There is not a one-to-one ratio of policy findings to recommendations, because 69 policy findings were not indicative of current practice and performance in the respective counties, and 56 were duplicate issues from the same CFRT report, and so supported the recommendation already included. The 182 recommendations can be divided into four main areas, as illustrated in Chart 16: 1) County CQI to address barriers to performance and implement solutions; 2) Implementation and training on revised risk/safety tools to improve accuracy; 3) Monitoring for trends through the C-Stat and Administrative Review process; and 4) Other, including case-specific recommendations for practice, services, and technical assistance from DCW to county departments.

Chart 16. 182 recommendations resulting from gaps, deficiencies, and policy findings identified by the CFRT, by type



While several recommendations were reviewed in this report, the full texts of all 182 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 182 recommendations is 85% (155/182), as illustrated in Chart 17.

Chart 17: Status of 182 recommendations from all reports posted in 2014



CDPHE and CDHS Joint Recommendations to Prevent Child Maltreatment

#1. Policy Recommendation to Prevent Sudden Unexpected Infant Deaths
Modify Colorado Department of Human Services' rules regulating family foster care homes to better align with the American Academy of Pediatrics (AAP) infant safe sleep recommendations, including training for foster families regarding infant safe sleep.

The CFPS State Review Team reviews all infant deaths that occur suddenly and unexpectedly in sleep environments. Sleep-related infant deaths are also referred to as Sudden Unexpected Infant Deaths (SUIDs). SUIDs include sudden infant death syndrome (SIDS), accidental suffocation, positional asphyxia and overlays as well as deaths occurring in sleep environments that are due to undetermined causes. Between 2009 and 2013, there were 263 SUIDs that occurred in Colorado. There were 28 fewer SUIDs in 2013 compared to 2009, representing a 40.0 percent decrease in SUIDs during this time period.

The American Academy of Pediatrics (AAP) identifies several risk and protective factors for sleep-related infant deaths and endorses specific recommendations for safe infant sleeping environments.[2] Among the 263 SUIDs that occurred in Colorado from 2009-2013, common risk factors included not using a firm sleep surface (66.9 percent), the use of soft bedding such as pillows, blankets and crib bumpers (51.7 percent), placing the infant to sleep on his or her side or stomach (25.5 percent), and sleeping on the same surface with an adult or another child (often referred to as bed-sharing) (44.5 percent). Of the 263 SUIDs between 2009 and 2013 where there was data on the sleep environment, none met all nine AAP Level A recommendations. In order to reduce the risk of infant death from modifiable sleep-related factors, recommendations for infant safe sleep environments should be supported and followed in all settings where an infant may be placed to sleep, including foster care homes.

The Colorado Department of Human Services (CDHS) Office of Children, Youth and Families (CYF) is responsible for overseeing the *Rules Regulating Family Foster Care Homes* (7.708)[3] and the *Rules Regulating Child Placement Agencies* (7.710)[4]. Currently, the rules do not specifically require implementation of all the AAP recommendations for an infant safe sleep environment when an infant less than 1 year old is placed in a foster care home. In 2015, the Division of Child Care Licensing updated the *Rules Regulating Child Care Centers* to better align with the AAP recommendations for infant safe sleep and to require licensed child care centers and homes to establish infant safe sleep environments. In addition, the updated rules require that licensed child care providers participate in mandatory training about infant safe sleep. By modifying the *Rules Regulating Family Foster Care Homes* to better align with the AAP recommendations and to include a training component for infant safe sleep, all licensed

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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] Colorado Department of Human Services. (2012). *Rules regulating family foster care homes.* Retrieved from http://www.sos.state.co.us/pubs/CCR/CCRHome.html
[4] Colorado Department of Human Services. (2012). *Rules regulating child placement agencies.* Retrieved from http://www.sos.state.co.us/pubs/CCR/CCRHome.html

facilities in Colorado will have consistent infant safe sleep rules, and there is the potential to reduce the risk of sleep-related infant deaths in licensed facilities.

Pursuant to C.R.S. 25-20.5-407 (1) (i), the 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 recommendation to modify rules regulating family foster care homes to better align with the AAP recommendations for infant safe sleep.

#2. Policy Recommendation to Prevent Child Maltreatment
Support policies that impact the priorities of the Colorado Essentials for Childhood project: 1) increase family-friendly business practices across Colorado; 2) increase access to child care and after school care; 3) increase access to preschool and full-day kindergarten; and 4) improve social and emotional health of mothers, fathers, caregivers and children.

When conducting case-specific, multidisciplinary reviews of child fatalities that occur in Colorado, the CFPS State Review Team discusses whether any acts of omission or commission caused or contributed to the death, including child abuse and/or neglect. The team members are asked to collectively decide, using available information, if they believe that any human action or inaction caused and/or substantially contributed to the death of the child. This discussion is especially important because it provides information about any human behaviors that may be involved in the child's death. In addition, this information may be critical to the prevention of both intentional and unintentional deaths because the CFPS State Review Team makes this determination for every child fatality that is reviewed.

From 2009-2013, the CFPS State Review Team identified 220 fatalities where child maltreatment caused and/or contributed to the child's death. County departments of human services substantiated 153 (69.5 percent) of the 220 fatalities and 62 (40.5 percent) of the 153 met statutory criteria for review by the Colorado Department of Human Services (CDHS) Child Fatality Review Team. The remaining 67 (30.5 percent) of the 220 fatalities were identified as child maltreatment fatalities solely by the CFPS State Review Team using team judgment. These 67 fatalities were either not reported to county departments of human services or the incident did not meet the statutory definition for substantiated maltreatment.

Regardless of whether the child fatality was substantiated as child maltreatment by human services, it is critical for the CFPS to use a public health framework to identify and aggregate the circumstances involved in an array of child maltreatment deaths in order to develop child maltreatment prevention recommendations. The purpose of the CFPS is to interpret trends, common risk factors and multiple variables among all potential child maltreatment fatalities in order to develop strategies that will prevent the occurrence of abuse and neglect before it happens. This will impact a broad population of children in Colorado rather than targeting efforts only towards children at-risk of being maltreated or mitigating the effects of serious maltreatment that has already occurred.

The Essentials for Childhood (EfC) project is focused on preventing child maltreatment and other adverse childhood experiences. EfC supports a framework that creates safe, stable, nurturing relationships and environments for all children, which are essential to preventing child maltreatment and assuring that children reach their full potential. Safe, stable, nurturing relationships and environments can help to:

- Reduce the occurrence of child maltreatment and other adverse childhood experiences;
- Reduce the negative effects of child maltreatment and other adverse childhood experiences;
- Influence many physical, cognitive, emotional outcomes throughout a child's life;
- Reduce health disparities; and
- Have a cumulative impact on health.[5]

In 2013, Colorado was one of only five states to be awarded the EfC Cooperative Agreement from the Centers for Disease Control and Prevention. The Colorado EfC Collective Impact Team is a partnership of stakeholders with a commitment to a shared vision and common agenda. Utilizing a collective impact approach, partners will implement mutually reinforcing activities to create safe, stable, nurturing relationships and environments, and ultimately to reduce child maltreatment.

The Colorado EfC Collective Impact Team operates under the guiding principle that building safe, stable, nurturing relationships and environments:

- Requires a two-generation approach, targeting resources to children, as well as mothers, fathers and caregivers at the same time. Two-generation approaches in programs, policy and research put the entire family on a path to permanent economic security.
- Is the responsibility of all sectors in a community, including the business sector and policy makers.
- Requires that resources and opportunities be seamlessly integrated from conception to career.
- Requires changing social norms to value families, support and empower mothers and fathers, and honor the strengths found in different cultures.
- Begins with the inclusion of the family voice in decision making.

The common agenda priorities selected by the Colorado EfC Collective in order to fulfill the vision of a future where children and families thrive in the places where they live, learn, work and play include advancing policy and community approaches to:

1. Increase family-friendly business practices across Colorado
2. Increase access to child care and after school care
3. Increase access to preschool and full-day kindergarten
4. Improve social and emotional health of mothers, fathers, caregivers and children.

Each of these common agenda priorities includes policy recommendations at the organizational, regulatory or legislative level that build healthy families and communities. Policies in place at the community and state levels can help ensure children lead healthy and safe lives. Informing policies across multiple levels of the social ecology has the potential to improve the provision of safe, stable, nurturing relationships and environments in Colorado.

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[5] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention. (2014). *Essentials for childhood: Step to create safe, stable, nurturing relationships and environments.* Retrieved from http://www.cdc.gov/violenceprevention/pdf/essentials_for_childhood_framework.pdf

For each of the common agenda priorities, the following societal level strategies were selected to impact policy recommendations:

1. Increase family-friendly business practices across Colorado: 1) engage legislators and business leaders to support tax incentives for businesses that meet family-friendly criteria; 2) engage legislators and business leaders to increase Colorado's living wage covered by minimum wage; 3) engage legislators and business leaders to increase parents' abilities to take paid leave to care for children.
2. Increase access to child care and after school care: 1) engage investors in socially motivated investments that enhance access to childcare and after school care (Social impact bonds); 2) engage legislators, schools, and community decision makers and philanthropy in determining strategies to ensure the long-term financial sustainability of childcare and after school programs; 3) engage organizations, legislators and community decision makers in developing strategies to ensure high quality family, friend, and neighbor care.
3. Increase access to preschool and full-day kindergarten: 1) engage policymakers in long-term financially sustainable funding for free full day preschool and 2) engage policymakers in long-term financially sustainable funding for free full day kindergarten.
4. Advance policy and community approaches to improve social and emotional health of mothers, fathers, caregivers and children: 1) support policy, administrative, and regulatory changes needed to increase best practice behavioral health integration in all primary care and 2) address social norms around social/emotional wellness for children and parents (help seeking, parenting expectations, and health development).

During the 2015 legislative session, legislation was introduced to increase access to preschool and full-day kindergarten. Though this legislation did not pass, the introduction supports the work of the Colorado EfC Collective Impact Team and demonstrates commitment from Colorado policymakers that state-level policy is critical to building safe, stable, nurturing environments for healthy families and communities. By continuing to introduce legislation that supports the Colorado EfC common agenda priorities, Colorado legislators have the potential to promote relationships and environments that help children grow up to be healthy and productive citizens so that they, in turn, can build stronger and safer families and communities for their children.

Pursuant to C.R.S. 25-20.5-407 (1) (i), the 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 recommendation to support policies that impact the Essentials for Childhood common agenda priorities.

Analysis and Updates on Recommendations from Fiscal Year 2014 CFPS Annual Report

As part of the 2014 CFPS Annual Report, seven recommendations were made to policymakers to prevent child fatalities in Colorado. Colorado state agencies made significant progress towards accomplishing several of the recommendations. An analysis and summary of the CFPS State Review Team's recommendations from the previous year is described below.

#1. Modify child care licensing requirements and regulations regarding infant safe sleep to better align with American Academy of Pediatrics (AAP) safe sleep recommendations.

Following this recommendation in the 2014 annual report, the Infant Safe Sleep Partnership, a workgroup of CFPS, proposed language inclusive of the AAP infant safe sleep recommendations to the CDHS Office of Early Childhood Division of the Early Care and Learning to incorporate into the rules that regulate licensed child care centers and homes. In addition, members of the Infant Safe Sleep Partnership provided in-person expert testimony to the Colorado State Board of Human Services during rule-making hearings in January and February 2015. CDHS amended the rules to incorporate the language proposed by the Infant Safe Sleep Partnership regarding best practices for infant safe sleep environments. Effective April 1, 2015, approximately 6,000 licensed child care providers were required to adhere to the updated infant safe sleep rules.

#2. 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 purpose of the Colorado Department of Human Services 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. In Fiscal Year 2015, CDPHE contracted with the Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, which coordinates the Child Welfare Training System on behalf of the Colorado Department of Human Services, to develop a training curriculum for child welfare professionals to improve their knowledge and skills regarding infant safe sleep. The content for the training was completed in June 2015 and the training will be available to Colorado child welfare professionals in September 2015 at http://www.coloradocwts.com/. This training 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.

#3. 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.
The Colorado Department of Human Services continues to dedicate resources and efforts to implement Colorado's Child Welfare Plan, "Keeping Kids Safe and Families Healthy 2.0." In early 2015, CDHS launched a statewide hotline to facilitate reporting of suspected cases of child abuse and neglect, which was one of the components of the Child Welfare Plan. The hotline (1-844-CO-4-KIDS) operates out of a centralized location and is Colorado's first child-abuse hotline of its kind.

Appendix A: 2014 CFRT Attendance

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.*	**1/6/14**	**2/3/14**	**3/3/14**	**4/7/14**	**5/5/14**	**6/2/14**	**7/7/14**	**8/4/14**	**9/8/14**	**10/6/14**	**11/3/14**	**12/1/14**
Tiffany Flores, *CDHS, Child Protection Manager*	Yes	Yes										
Korey Elger, *Child Protection Ongoing Administrator* ***Initially attended without appointment, so attendance was paused to allow for appointment to be secured.*	Yes**	Yes**	No**	No**	No**	Yes	Yes	Yes	Yes			
Paige Rosemond, *CDHS, Child Protection Manager*										Yes	Yes	Yes
Brooke Ely-Milen, *Domestic Violence Program*	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes
Susan Nichols, *Administrative Review Division, Manager*	**No**	Yes	Yes	Yes	Yes	**No**	**No**	**No**	Yes	Yes	Yes	Yes
→**Backup:** Marc Mackert	**No**					**No**	Yes	Yes				
Sarah Hernandez, *CDPHE*	**No**	**No**	**No**									
Leah Emerick Anderson, *CDPHE, Child Fatality Prevention System Program*				Yes	**No**	**No**	Yes	Yes	No	No		

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.*	**1/6/14**	**2/3/14**	**3/3/14**	**4/7/14**	**5/5/14**	**6/2/14**	**7/7/14**	**8/4/14**	**9/8/14**	**10/6/14**	**11/3/14**	**12/1/14**
Giorgianna Venetis, *CDPHE, Essentials for Childhood Coordinator*											**No**	Yes
Colleen Kapsimalis, *CDPHE, Child Fatality Prevention System Program Manager*	Yes	Yes	**No**	Yes	Yes	**No**	Yes	Yes	**No**	Yes	Yes	Yes
Lew Gaiter, *Larimer County Commissioner*	By phone	By phone	**No**	Yes	**No**	**No**	Yes	**No**	**No**	By phone	**No**	**No**
Casey Tighe, *Jefferson County*	Yes	**No**	Yes	Yes	Yes	**No**	Yes	Yes	**No**	By phone	Yes	Yes
Dave Potts, *Chaffee County Commissioner*							Yes	**No**	**No**	**No**	**No**	**No**
Senator Jeanne Nicholson	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**
Representative Clarice Navarro	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**
Dennis Goodwin, *Office of Colorado's Child Protection Ombudsman*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Det. Amber Urban, *detective with Aurora Police Department*	Yes	**No**	**No**	Yes	**No**	**No**	**No**	**No**	**No**	Yes	**No**	**No**
→**Backup:Det. Ron Tanguma,**		Yes	**No**	Yes	**No**	**No**	**No**	**No**	**No**		**No**	**No**
Dr. Andrew Sirotnak, *Professor of Pediatrics, University of Colorado School of Medicine Director, Child Protection Team at Children's Hospital Colorado*	Yes	Yes	**No**	Yes	Yes	Yes	By phone	Yes	By phone	By phone	Yes	Yes

CFRT Member* *Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.	1/6/14	2/3/14	3/3/14	4/7/14	5/5/14	6/2/14	7/7/14	8/4/14	9/8/14	10/6/14	11/3/14	12/1/14
Barb Shaklee, *Director, Denver City Attorney Office*	By phone	Yes	Yes	By phone	**No**	Yes	Yes					
Stephanie Villafuerte, *Child Advocate and attorney for Rocky Mountain Children's Legal Center*	**No**	Yes	**No**	**No**	**No**	Yes	Yes	**No**	By phone	**No**	**No**	
Pam Wamhoff, *Family Advocacy Officer, Buckley Air Force Base*	Yes	**No**	Yes	Yes	**No**	Yes	**No**					
Sara Oliver, *Attorney General's Officer*	By phone	Yes	**No**	Yes								
Libbie McCarthy, *Attorney General's Officer*						By phone	Yes	Yes	Yes	Yes	Yes	Yes
Jill Gunderson, *CDHS Dispute Review Specialist*	Yes	**No**	Yes	Yes	Yes	Yes						
Sondra Ranum, *EQ Assistant Program Director*	Yes	**No**	Yes	By phone	**No**	By phone	**No**					
Michelle Sears-Ward, CDE, *Early Learning and School Readiness*								Yes	Yes	Yes	Yes	Yes
Pauline Hoekstra, *CDHS, Division of Child Welfare*	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes				
Jill Jordan, *CDHS PSSF Administrator*	Yes	Yes	Yes	Yes	Yes	**No**	**No**	Yes				
Kris Cowperthwaite, *Adams Department of Social Services*	Yes											
Lucy Sloan, *Adams Department of Social Services*	Yes											
Dan Makelky, *Douglas County Department of Human Services*	Yes	**No**	Yes	**No**	Yes	By phone	Yes	**No**	Yes	Yes	Yes	Yes

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.*	**1/6/14**	**2/3/14**	**3/3/14**	**4/7/14**	**5/5/14**	**6/2/14**	**7/7/14**	**8/4/14**	**9/8/14**	**10/6/14**	**11/3/14**	**12/1/14**
Sue McDonald, *Jefferson County Department of Human Services*	**No**	Yes	Yes	Yes	**No**	Yes						
Michelle Dossey, *Arapahoe County Department of Human Services*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**
Ginny Riley, *Larimer County Department of Human Services*	By phone	**No**	By phone	Yes								
Shirley Rhodus, *El Paso County Department of Human Services*	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Erin Hall, *Administrative Review Division*	**No**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Len Newman, *Administrative Review Division*						Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lisa Lied, *Administrative Review Division*	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes	Yes

Appendix B: 2012-2014 Incidents Qualified for CFRT Review by County and Type

County*	Fatal Incidents**			Near Fatal Incidents**			Egregious Incidents**					
	2012	2013	2014	2012	2013	2014	2012	2013	2014	2012 Total	2013 Total	2014 Total
Archuleta								1	1		1	1
Adams	2	2				1		3	2	2	5	3
Alamosa								1			1	
Arapahoe		1	1		2			1			4	1
Boulder		1	1		1						2	1
Clear Creek			1									1
Denver	1	1	4	1	3	3		7	3	2	11	10
Eagle	1									1		
El Paso	2	1	2		1	1	1		1	3	2	4
Fremont						1		1	2		1	3
Huerfano			1									1
Jefferson			2			4		2	1		2	7
Larimer			1					4			4	1
Logan	1		1							1		1
Mesa	1		1		1					1	1	1
Montezuma									1			1
Morgan			1		1	1					1	2
Otero				1		1				1		1
Phillips		1				2			1		1	
Pitkin									1			1
Pueblo	1		1		1			1		1	2	4
Routt			1									1
Weld		1									1	
Total	**9**	**8**	**18**	**2**	**10**	**14**	**1**	**21**	**13**	**12**	**39**	**45**

** Numbers represented above are indicative of the investigating county for the incident, not of all counties having prior involvement.*

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

Appendix C: Recommendations from 2014 Posted Reports

CFRT ID	Source	Recommendation	Status
13-040	Policy Finding	As of March 2014, Alamosa County is currently closing 80% of their assessments within 60 days. This number is below the statewide average for March 2014 of 89.5 %, though is also below the goal of 90.0%. a. It is recommended that Alamosa County employ a process in which barriers to the timely closure of assessments are identified and solutions to the identified barriers are implemented.	Complete
13-040	Policy Finding	It is recommended that DCW continue to engage with Alamosa County through the C-Stat process to monitor progress on this measure.	Complete
13-040	Policy Finding	It is recommended that the Division of Child Welfare (DCW) continue to monitor county performance regarding the accurate completion of the safety assessment and engage with Alamosa County as necessary to ensure improved performance in this area.	Complete
13-040	Policy Finding	For the month of March 2014, Alamosa County is interviewing the required parties within the assigned response time 89.3% of the time, which is slightly above the statewide average of 89%, and below the C-Stat goal of 90.0%. This data was derived from an exit cohort of assessments that were closed in the month of March 2014. This data includes two specific parameters: that the ROC note is coded as a "Face to Face" in the "Type/Location" box, and that the individual party is identified as a specific participant in the "Clients/Collaterals" window. Also, the C-Stat measure counts an attempt to contact a participant, even if the participant was not actually contacted. As part of routine quality assurance monitoring conducted by the Administrative Review Division (ARD), in a recent review of a generalizable random sample of assessments that were conducted during a period from 12/23/2012 to 6/23/2013, the county department saw the alleged victim within the response time 77.5% of the time. It should be noted that the ARD data is a representative sample of all assessments within the county that were opened in the six month review span, and that the ARD data has a 90% confidence interval. Also, the ARD data takes into account information documented in the "Comments/Summary" box, in addition to that in the "Type/Location" and "Clients/Collaterals" drop down box, in order to assess whether or not a participant was contacted within the response time. It is important to note that with the addition of rule 7.202.41 (A) (4) on of 3/2/2013, Volume VII now addresses reasonable efforts by the caseworker to see the child victim. As part of the aforementioned review of recent sample assessments, the department made reasonable efforts to see the victim of the allegation 82.5% of the time. According to the ARD data, specifically in regards to the rule addition, Alamosa County is performing at an average level. However, Alamosa County's performance in March 2014 is below the C-Stat goal of 90.0% timely response compliance. It is recommended that Alamosa County research the factors causing the gap between the C-Stat data and the ARD data to	Complete

CFRT ID	Source	Recommendation	Status
		determine their true performance, and implement measures to ensure high quality performance.	
13-040	Policy Finding	The policy finding related to timeliness of assessment closure reflects a current systemic practice issue for Rio Grande DSS. The report obtained from DCW is a C-Stat measure that is based on the standard 30 days, as well as an additional 30 days to allow for extension requests supported in Volume VII. The report measures the percentage of assessments closed within 60 days regardless of extension status. For the assessments closed between March 1 and March 31, 2014, the report shows Rio Grande DSS at 85.7% for High Risk Assessments. This number is below the statewide average for March 2014 of 89.5 % for High Risk Assessments, and is also below the goal of 90.0%. a. It is recommended that Rio Grande DSS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are enacted.	Complete
13-040	Policy Finding	It is recommended that DCW continue to monitor county performance regarding the timelines of assessment closure and engage with Rio Grande DSS as necessary to ensure improved performance in this area.	Complete
13-040	Policy Finding	The policy finding related to accurate completion of the Colorado Family Risk Assessment does reflect a systemic practice issue in ACHSD. In a recent review of a random sample of assessments that were conducted during a period from March 2, 2013 to September 3, 2013, ACHSD completed the risk assessment accurately in 71.2% of assessments. While this is above the statewide average of 59% for the same time span, it is recommended that ACHSD 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

CFRT ID	Source	Recommendation	Status
13-040	Policy Finding	The policy finding related to seeing the alleged victim within the assigned response time does reflect a systemic practice issue for Rio Grande DSS. . C-Stat data taken from assessments closed between March 1, 2014 and March 31, 2014, indicates that RGDDS saw the alleged victim within the assigned response time 33.3% of the time which is below the statewide data which indicates 89.6% 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 December 23, 2012 to June 23, 2013, showed the Rio Grande DSS at 54.2%. It is important to note that with the addition of rule 7.202.41 (A) (4) on 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 Rio Grande DSS made reasonable efforts to see the victim of the allegation 66.7% of the time. It is recommended that Rio Grande DSS monitor their performance on this measure to ensure improvement in order to meet the state goal of 90%.	Complete
13-040	Policy Finding	For High Risk Assessments opened by Rio Grande DSS between September 1, 2013 and February 28, 2014, 43.1% required an extension (i.e., were open longer than 30 days). Of those, 40 % had an extension request within 30 days. a. It is recommended that Rio Grande DSS 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.	Complete
13-040	Policy Finding	b. The statewide performance on the use of extensions from September 1, 2013 and February 28, 2014 was also low. Overall, 70.9% of referrals required an extension (opened beyond 30 days), and 40.4% 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.	Complete
13-040	CFRT	It is recommended that the Colorado Trails workload screen alert caseworkers even in other counties if new referrals and/or assessments are generated on a client involved in an open assessment and /or case. It is recommended that the alerts be generated by client ID numbers for the victim and the perpetrator.	Complete
13-040	CFRT	Colorado Department of Human Services, Division of Child Welfare (DCW) is to ensure that at least one person in each county has the restricted access profile.	Complete
13-040	CFRT	It is recommended that the Division of Child Welfare (DCW) 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.	Complete

CFRT ID	Source	Recommendation	Status
13-040	Policy Finding	The policy finding indicating that Alamosa County notified the Colorado Department of Human Services of the egregious incident four days late does reflect a systemic practice issue in this county department at the time of this referral. During calendar year 2012, Alamosa County provided timely notification to CDHS in 100% (1/1) of incidents. For calendar year 2013, this declined to 0.0% (0/1). It is recommended that Alamosa County consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	In Progress
13-040	Policy Finding	The policy finding that outlines inaccuracy of the safety assessment process for this Alamosa County referral does reflect a systemic practice issue in this 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 12/23/2012 to 6/23/2013, the county department completed the safety assessment process accurately, in accordance with Volume VII, 59.0% of the time, which is below the statewide average of 83.9% for roughly the same time period. It should be noted that specific to the 15 Standardized Safety Concerns of the Safety Assessment, Alamosa County completed this tab accurately 76.9% of the time for the same time period, compared to 93.4% accuracy on the 15 Standardized Safety Concerns statewide for roughly the same time period. a. It is recommended that Alamosa 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
13-040	Policy Finding	The policy finding related to the safety assessment does reflect a systemic practice issue in Rio Grande DSS. In a recent review of a random sample of assessments that were conducted during a period from December 23, 2012 to June 23, 2013, the Rio Grande DSS completed the safety assessment accurately in 83.3% of assessments, which is below the statewide average (not including Rio Grande) of 83.5% for the same time span. It is recommended that Rio Grande DSS 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
13-040	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Rio Grande DSS. In a recent review of a random sample of assessments that were conducted during a period from December 23, 2012 to June 23, 2013, the Rio Grande DSS completed the risk assessment accurately in 62.5% of assessments, which is above the statewide average (not including Rio Grande) of 56.7% for the same time span. It is recommended that Rio Grande DSS 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

CFRT ID	Source	Recommendation	Status
13-045	Policy Finding	The policy violations related to the Colorado Family Risk Assessment reflects a systemic practice issue for Adams CHSD. 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 September 26, 2012 to March 26, 2013, Adams CHSD completed the risk assessments accurately in 65% of assessments. This score fell from the previous review where 76% of assessments were completed accurately. It is recommended that the Division of Child Welfare (DCW), as implementation of these changes occurs, provide training and technical assistance to Adams CHSD in this area.	Complete
13-045	Policy Finding	The policy violation related to the Colorado Family Risk Assessment not being completed timely does not reflect a current systemic practice issue for Adams CHSD. 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 September 26, 2012 to March 26, 2013, Adams CHSD completed the risk assessments timely in 89% of assessments. There is no recommendation in this area.	Complete
13-045	Policy Finding	In regards to the policy violation related to the selected reason for not accepting the referral in Trails being inaccurate, it was previously requested that DCW have Trails remove the selection of "allegations to be assessed under a current open FAR." Upon further review this selection is still an option when screening out referrals. It is recommended that DCW address this with Trails and Adams CHSD	Complete
13-045	CFRT	It is recommended that Colorado Department of Human Service (CDHS) identify a mechanism for county DHS agencies to access information regarding parolees in a timely fashion to ensure child safety.	Complete
13-045	CFRT	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.	Complete
13-054	Policy Finding	For High Risk Assessments opened 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, 50.2 % had an extension request within 30 days. A. 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.	Complete

CFRT ID	Source	Recommendation	Status
13-054	Policy Finding	The statewide performance on the use of extensions between July 1, 2013–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.	Complete
13-054	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Arapahoe County DHS. In a recent review of a random sample of assessments that were conducted during a period from July 30, 2013 to January 30, 2014, the Arapahoe County DHS completed the risk assessment accurately in 69.8% of assessments, which is above the statewide average (not including Arapahoe County) of 63.8% for the same time span. It is recommended that Arapahoe County DHS 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
13-054	Policy Finding	The policy violations related to timeliness of assessment closure reflect a current systemic practice issue for Arapahoe County DHS. 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. 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

CFRT ID	Source	Recommendation	Status
13-054	Policy Finding	The policy finding related to seeing the alleged victim within the assigned response time does reflect a systemic practice issue for Arapahoe County DHS. According to the most recent C-Stat presentation for the month of December 2013, Arapahoe County DHS is interviewing the required parties within the assigned response time 84.3% of the time, which is below the previous months and is also below the C-Stat goal of 90.0%. 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 July 30, 2013 to January 30, 2014, showed the Arapahoe County DHS at 58.2%. It is important to note that with the addition of rule 7.202.41 (A) (4) on 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 Arapahoe County DHS made reasonable efforts to see the victim of the allegation 94.5% of the time. It is recommended that Arapahoe County DHS monitor their performance on this measure to ensure improvement in order to meet the state goal of 90%.	Complete
13-054	Policy Finding	For High Risk referrals received by Jefferson County between July 1, 2013 and December 31, 2013, 68.6% required an extension (i.e., were open longer than 30 days). This is slightly above the statewide average of 66.3% for the same time span. Of those requiring an extension, an extension was requested within 30 days of the opening of the referral 29% of the time. The statewide average during this time span was 45.3%. a. It is recommended that Jefferson 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.	Complete
13-054	CFRT	It is recommended that the Division of Child Welfare (DCW) 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.	Complete
13-054	CFRT	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.	Complete
13-054	Policy Finding	It is recommended that DCW 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.	In Progress
13-060	Policy Finding	At 45.3%, statewide performance on the use of extensions during assessments was low overall. 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.	Complete

CFRT ID	Source	Recommendation	Status
13-060	Policy Finding	The policy violation regarding the notification of the egregious abuse incident to CDHS does reflect a systemic practice issue in this county department at the time of this referral. During calendar year 2012, Pueblo DSS provided timely notification to CDHS in 100% (3/3) of incidents. For calendar year 2013, this declined to 50% (1/2). It is recommended that Pueblo DSS consider creating a more formal process for recognizing and reporting fatal, near fatal, and egregious incidents of child maltreatment to CDHS.	Complete
13-061	Policy Finding	As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from November 13, 2012 to May 13, 2013, the Pueblo DSS completed the safety assessment process accurately, in accordance with Volume VII, 91.3% of the time, which is above the statewide average of 84% for the same time period. While the policy violation does not reflect a larger systemic practice issue, it is recommended that Pueblo DSS supervisors closely monitor the performance of their staff on the safety assessment to ensure Pueblo DSS meets the C-Stat goal of 95%.	Complete
13-061	Policy Finding	The policy violation related to the Colorado Family Risk Assessment does reflect a systemic practice issue in Pueblo DSS. In a recent review of a random sample of assessments that were conducted during a period from November 13, 2012 to May 13, 2013, the Pueblo DSS completed the risk assessment accurately in 67.4% of assessments, which is above the statewide average of 58.3% for the same time span. It is recommended that Pueblo DSS 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
13-061	Policy Finding	The policy violation related to extensions is similar in nature to the violation related to timeliness of assessment closure. Based on additional data, this is reflective of a current systemic practice issue for Pueblo DSS. The C-Stat report, which measures the percentage of assessments closed within 60 days regardless of extension status, shows the Pueblo DSS at 76.4% for the month of October, 2013, with the statewide average at 86.2%. The C-Stat measure is based on the standard 30 days, as well as an additional 30 days to allow for extensions requests supported in Volume VII. a. It is recommended that Pueblo DSS employ a process in which barriers to the timeliness of assessment closures are identified and solutions to the identified barriers are implemented.	Complete
13-061	Policy Finding	It is recommended that DCW continue to monitor county performance regarding the timeliness of assessment closure and engage with Pueblo DSS as necessary to ensure improved performance in this area.	Complete

CFRT ID	Source	Recommendation	Status
13-061	Policy Finding	The policy finding related to the DDHS not reporting the egregious situation to CDHS within 24-hours of learning of the situation 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 64.7% (11 /17). It is recommended that: a. Denver County consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS;	Complete
13-061	CFRT	It is recommended that Pueblo DSS ensure they have an interpreter available at all times or on demand for the staff to utilize for the purposes of communicating with families who speak another language.	Complete
13-061	CFRT	It is recommended that Pueblo DSS caseworkers staff their cases when there are inconsistent explanations about when or how a child was injured and this leads to difficulty in accurately assessing the child's safety. It is recommended that Pueblo DSS document this supervision and staffing in the TRAILS system.	Complete
13-061	CFRT	It is recommended that all counties consult with their Division of Child Welfare liaison on cases that are of concern and see if the case is appropriate for a consult with START. The START coordinator can receive a call or email to start the process of a consultation from START. Once the coordinator receives a request for a consultation, a checklist for appropriate information will be sent to the most appropriate person to get the information needed for the consultation.	Complete
13-061	CFRT	It is recommended that the Division of Child Welfare (DCW) 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.	Complete
13-070	Policy Finding	The ARD should prioritize training for DDHS regarding the fatality review process to include specific guidance and further clarification on the definitions and reporting requirements regarding incidents of egregious harm and near fatalities.	Complete
13-070	Policy Finding	Policy violations related to the Colorado Family Risk Assessment are reflective of a systemic practice issue in DDHS. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from 4/8/2013 to 9/30/2013, the county department completed the risk assessment accurately, in accordance with Volume VII, 56.6% of the time, which is below the statewide average of 62.5% for roughly 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.	Complete

CFRT ID	Source	Recommendation	Status
13-070	Policy Finding	Based on the C-Stat data taken from assessments closed between 11/1/2013 and 11/30/2013, which was presented at the January 2013 C-Stat meeting, DDHS closed 88.9% of their assessments within 60 days. This number is above the statewide average for October 2013 of 84.2 %, and is slightly below the goal of 90.0%. a. It is recommended that DDHS employ a process in which barriers to the timely closure of assessments are identified and solutions to the identified barriers are implemented.	Complete
13-070	Policy Finding	It is recommended that DCW continue to engage with DDHS through the C-Stat process to monitor progress on this measure.	Complete
13-070	Policy Finding	The policy violation which reflects the EPCDHS not accurately documenting the reason that the referral was screened out is a systemic practice issue in this county department. As part of routine quality assurance monitoring, data from the "2013 Screen-Out Review" conducted 9/23/2013 to 9/27/2013 indicated that El Paso County accurately documented the county's reason for not accepting the referral 76.5% of the time, which was below the statewide average of 90.8%. It is recommended that El Paso County examine barriers to accurately identifying screen out reasons and implement solutions to improve in this area.	Complete
13-070	CFRT	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 (DCW) 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.	Complete
13-070	CFRT	To address the confusion that exists regarding the fatality review process and reporting requirements it is recommended that the Administrative Review Division (ARD) provide training to county DHS staff regarding the fatality review process to include specific guidance and further clarification on the definitions and reporting requirements regarding incidents of egregious harm and near fatalities.	Complete
13-070	CFRT	In regard to caseworkers' ability to assess the safety of children when parents have cognitive and/or developmental disabilities and identify resources in the community to support these parents, it is recommended that: a. DCW identify what training is currently being provided to caseworkers regarding assessing the safety of children when parents have cognitive and/or developmental disabilities;	Complete
13-070	CFRT	DDHS connect the parents on this case with a CCB advocate.	Complete
13-070	CFRT	DCW explore what community resources are available to support parents with cognitive and/or developmental disabilities across the state and provide that information to the County DHS agencies;	In Progress

CFRT ID	Source	Recommendation	Status
13-079	Policy Finding	The policy finding regarding inaccurate documentation of the safety concerns does reflect a systemic practice issue in Denver County. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from 4/8/2013 to 9/30/2013, the county department completed the safety assessment process accurately, in accordance with Volume VII, 71.7% of the time, which is below the statewide average (not including Denver) of 81.6% for roughly the same time span, and below the statewide goal of 95%. 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
13-079	CFRT	The CFRT indicated that the RED team protocol is being implemented across the state in the next six months and that through the roll-out process various trainings will happen. It is recommended that the Division of Child Welfare ensure that the RED team model includes a consistent process for situations where calling back the reporting party to gain information are needed to focus the team decision. After integrating in the model, if needed, DCW should ensure consistency across the state with the implementation and use of RED Teams.	Complete
13-085	Policy Finding	Policy violations related to the Colorado Family Risk Assessment are reflective of a systemic practice issue in DDHS. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from 4/8/2013 to 9/30/2013, the county department completed the risk assessment accurately, in accordance with Volume VII, 56.6% of the time, which is below the statewide average of 62.5% for roughly 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.	Complete
13-085	Policy Finding	The policy violation related to documentation of the child's kinship placement in the Family Services Plan is reflective of a systemic practice issue in DDHS. Data from the 2nd quarter of state fiscal year 2014 (10/1/13-12/31/13) indicates that documentation of the description of the type and appropriateness of the home/facility in which the child was placed was in accordance with Volume VII 85.7% of the time. It is recommended that DDHS employ a process to identify the barriers to documenting the type and appropriateness of the home/facility in which the child was placed and solutions to the barriers be implemented.	Complete

CFRT ID	Source	Recommendation	Status
13-085	Policy Finding	The policy violation related to addressing all parties in the Family Services Plan is reflective of a systemic practice issue in DDHS. Data from the 2 quarter of state fiscal year 2014 (10/1/13-12/31/13) indicates that all required parties are addressed in the Family Services Plan was in accordance with Volume VII 81.7% of the time. It is recommended that DDHS employ a process to identify the barriers to inclusion of the child's caregiver in the Family Service Plan and solutions to the barriers be implemented.	Complete
13-085	Policy Finding	Data from the 2nd quarter of state fiscal year 2014 (10/1/13-12/31/13) indicates that contact with the children in out of home placement is reflective of a systemic practice issue in Denver county. Agency personnel had contact with the child in 97.4% of all the months requiringcontact. Agency personnel had contact with the child every month 88.9% of the time.Statewide, during the same quarter, agency personnel had contact with the child in 98.2% of all months requiring contact and 91.3% every month. It is recommended that the county employ a process to identify the barriers to documentation of monthly contact with children in out of home placement and solutions to the barriers be implemented.	Complete
13-085	Policy Finding	Data from the 2nd quarter of state fiscal year 2014 (10/1/13-12/31/13) indicates that contact with the child's father/guardian/kin is documented in accordance with Volume VII 52.7% of the time. Please see recommendation #10 regarding frequency of contact with the child's mother/guardian/kin. It is recommended that Denver County employ a process to identify the barriers to documentation of monthly contact with the child's parents and solutions to the barriers be implemented.	Complete
13-085	Policy Finding	Based on the C-Stat data taken from assessments closed between December 2013 and February 2014, which was presented at the March 2014 C-Stat meeting, DDHS closed 86.9% of their assessments within 60 days in December 2013, 76.6% in January 2014, and 81.6% in February 2014. These numbers are below the goal of 90.0%. It is recommended that DDHS employ a process in which barriers to the timely closure of assessments are identified and solutions to the identified barriers are implemented.	Complete
13-085	Policy Finding	It is recommended that DCW continue to engage with DDHS through the C-Stat process to monitor progress on this measure.	Complete

CFRT ID	Source	Recommendation	Status
13-085	Policy Finding	Data from the Administrative Review Division "2013 Screen Out Review" indicated that for those referrals where it was appropriate to screen out the referral, Denver County accurately documented the reason for not accepting the assessment 85.7% of the time. Of all the referrals reviewed in the 2013 Screen Out Review, 90.9% of the referrals had the reasons for not accepting the referral for assessment appropriately documented. It is recommended that Denver County identify the barriers to documentation of accurate screen out reasons and solutions to the identified barriers are implemented.	Complete
13-085	Policy Finding	Based on the C-Stat data presented at the March 2014 C-Stat meeting, regarding assessments in October through December 2013, DDHS met the Volume VII criteria for timeliness of response in 91.3%, 89.8%, and 88.0% of the assessments, respectively. These numbers are below the goal of 90.0%. The policy finding related to making reasonable efforts to interview/observe the alleged victim within the assigned response time does reflect a systemic practice issue in DDHS. It is recommended that Denver County identify the barriers to interviewing/observing the alleged victim with the assigned response time and solutions to the barriers be implemented.	Complete
13-085	Policy Finding	Policy violations related to the Colorado Family Risk Assessment are reflective of a systemic practice issue in Jefferson County. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from 8/4/13 to 2/4/14, the county department completed the risk assessment accurately, in accordance with Volume VII, 56.6% of the time, which is below the statewide average (not including Jefferson) of 64% for roughly the same time span. It is recommended that Jefferson 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
13-085	Policy Finding	The policy violations regarding placement in kinship homes was identified in Denver County Department of Human Services' Internal Review report. It is recommended that DDHS develop and implement a process to ensure the completion of background checks prior to placement of children into kinship homes.	Complete
13-085	Policy Finding	For High Risk Assessments opened by Jefferson County DHS between September 1, 2013 – February 28, 2014, 68% required an extension (i.e., were open longer than 30 days). Of those, 35 % had an extension request within 30 days.A. It is recommended that Jefferson County DHS 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.	Complete

CFRT ID	Source	Recommendation	Status
13-085	CFRT	The Division of Child Welfare (DCW) should explore the need for more exhaustive background searches for kin-like providers, i.e., State-required fingerprint checks on all kin-like providers, if the kin-like providers will provide care to children longer then a certain amount of time.	Complete
13-085	CFRT	It is recommended that the Division of Child Welfare (DCW) 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.	Complete
13-085	Policy Finding	The policy violation identified in the child's out of home case and pertaining to the frequency of contact with the child's mother/guardian/kin is reflective of a systemic practice issue in Arapahoe County. In this case, there was a contact made February 11, 2014. At the time of the review by ARD this had not been entered into the case however that has been corrected. Data from the 2nd quarter of state fiscal year 2014 (10/1/13-12/31/13) indicates that contact with the child's mother/guardian/kin is documented in accordance with Volume VII 81.1% of the time. It is recommended that Arapahoe County employ a process to identify the barriers to documentation of monthly contact with the child's mother/guardian/kin and solutions to the barriers be implemented.	In Progress
13-087	Policy Finding	The statewide performance on the use of extensions between September 1, 2013–February 28, 2014 was also low. Overall, 70.9% of referrals required an extension (opened beyond 30 days), and 40.4% 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	Complete
13-087	Policy Finding	The policy finding related to the safety assessment does reflect a systemic practice issue in Jefferson County DHS. In a recent review of a random sample of assessments that were conducted during a period from August 4, 2013 to February 4, 2014, the Jefferson County DHS completed the safety assessment accurately in 83% of assessments, which is below the statewide average (not including Jefferson County) of 84.1% for the same time span. It is recommended that Jefferson County 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

CFRT ID	Source	Recommendation	Status
13-087	Policy Finding	The policy finding related to inaccurate completion of the Colorado Family Risk Assessment does reflect a systemic practice issue in Jefferson County DHS. In a recent review of a random sample of assessments that were conducted during a period from August 4, 2013 to February 4, 2014, Jefferson County DHS completed the risk assessment accurately in 56.6% of assessments. This is below the statewide average of 64% for the same time span. It is recommended that Jefferson County DHS 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
13-087	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a current systemic practice issue for Jefferson County DHS. 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. The April 2014 C-Stat report, which measures the percentage of assessments closed within 60 days regardless of extension status, shows Jefferson County DHS at 75.4% for High Risk Assessments for March 2014. This number is below the statewide average for March 2014 of 89.6 % for High Risk Assessments, and is also below the goal of 90.0%. 1) It is recommended that Jefferson 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
13-087	Policy Finding	It is recommended that DCW continue to monitor county performance regarding the timelines of assessment closure and engage with Jefferson County DHS as necessary to ensure improved performance in this area.	Complete
13-087	Policy Finding	For High Risk Assessments opened 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, 50.2 % had an extension request within 30 days. A. 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.	Complete
13-087	Policy Finding	The statewide performance on the use of extensions between July 1, 2013–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.	Complete

CFRT ID	Source	Recommendation	Status
13-087	Policy Finding	The policy finding that outlines inaccurate completion of the safety assessment process does reflect a systemic practice issue in Denver County. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from 4/8/2013 to 9/30/2013, the county department completed the safety assessment process accurately, in accordance with Volume VII, 71.7% of the time, which is below the statewide average (not including Denver) of 81.6% for the same time period. 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
13-087	CFRT	It is recommended that the Division of Child Welfare (DCW) begin the statewide implementation process to include training of all caseworkers and supervisor on 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.	Complete
13-089	Policy Finding	Policy violations related to the Colorado Family Risk Assessment are reflective of a systemic practice issue in Denver County. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from 4/8/2013 to 9/30/2013, the county department completed the risk assessment accurately, in accordance with Volume VII, 56.6% of the time, which is below the statewide average (not including Denver) of 62.5% 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.	Complete
13-089	Policy Finding	The policy violation regarding the completion of background checks for all persons 18 years of age or older prior to placement in a kinship home was identified in Denver County Department of Human Services' Internal Review report. It is recommended that DDHS develop and implement a process to ensure the completion of background checks prior to placement of children in kinship homes.	Complete

CFRT ID	Source	Recommendation	Status
13-089	Policy Finding	The policy violation related to documentation of the child's placement in the Family Services Plan is not reflective of a systemic practice issue in DDHS. Data from the 2nd quarter of state fiscal year 2014 (10/1/13-12/31/13) indicates that at the time of the out of home review, the child is placed in the most appropriate setting to meet his/her individual needs 99.6% of the time. In 99.3% of the out of home cases reviewed during the 2nd quarter of state fiscal year 2014, Denver County documented the type and appropriateness of the child's placement. At the time of this review, the child's placement with the child's father's ex-wife was not entered as a service authorization in Trails. It is recommended that Denver County enter a service authorization for the child's current kinship placement and document the appropriateness of the kinship home to meet the child's needs. In addition, it is recommended that the child's current living arrangement in the general information screen be updated to reflect his current placement with the child's father's ex-wife.	Complete
13-089	Policy Finding	The policy violation related to addressing all parties in the Family Services Plan (FSP) is not reflective of a systemic practice issue in DDHS. Data from the 2nd quarter of state fiscal year 2014 (10/1/13-12/31/13) indicates that all required parties are addressed in the Family Services Plan was in accordance with Volume VII 81.7% of the time in Denver County. This is not considerably different from the statewide level of compliance which is 81.5% for the same review period. As the Family Service Plan did not include the current caregiver at the time of this report, it is recommended that DDHS update the FSP to include this individual.	Complete
13-089	Policy Finding	Data from the Administrative Review Division "2013 Screen Out Review" indicated that for those referrals where it was appropriate to screen out the referral, Denver County accurately documented the reason for not accepting the assessment 85.7% of the time. Of all the referrals reviewed in the 2013 Screen Out Review, 90.9% of the referrals had the reasons for not accepting the referral for assessment appropriately documented. It is recommended that Denver County identify the barriers to documentation of accurate screen out reasons and solutions to the identified barriers are implemented.	Complete
13-089	Policy Finding	The policy finding related to seeing the alleged victim within the assigned response time does reflect a systemic practice issue for DDHS. According to the most recent C-Stat presentation for the month of April 2014, DDHS interviewed the alleged victims within the assigned response time 85.3% of the time, which is below the previous month's performance of 88% and below the C-Stat goal of 90%. 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 April 8, 2013 to September 30, 2013, showed DDHS at 87.3%. It is recommended that DDHS monitor their performance on this measure to ensure improvement in order to meet the state goal of 90%.	Complete

CFRT ID	Source	Recommendation	Status
13-089	CFRT	It is recommended that the Division of Child Welfare consider adding a component to the Child Welfare Training Academy that focuses on helping caseworkers talk with and provide information to caregivers on safe sleep environments.	Complete
13-090	Policy Finding	The policy finding related to the Colorado Safety Assessment Instrument 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 safety assessment accurately in 71.7% of assessments, which is below the statewide average (not including Denver) of 81.6% for approximately the same time period. It is recommended that DDHS 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
13-090	Policy Finding	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.	Complete
13-090	Policy Finding	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
13-090	Policy Finding	For High Risk Assessments opened by Larimer County between October 1, 2013- March 31, 2014, 71.6% required an extension (i.e., were open longer than 30 days). Of those, 43.7 % had an extension request within 30 days. a) It is recommended that Larimer 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.	Complete
13-090	CFRT	It is recommended that the Division of Child Welfare (DCW) begin the statewide training and 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.	Complete

CFRT ID	Source	Recommendation	Status
13-092	Policy Finding	The statewide performance on the use of extensions between October 1, 2013-March 31, 2014 was also low. Overall, 71.6% of referrals required an extension (opened beyond 30 days), and 38% 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.	Complete
13-092	Policy Finding	For High Risk referrals received by Otero County DHS between December 1, 2013-May 31, 2014, 55.4% required an extension (i. e., were open longer than 30 days). Of those, 14.6% had an extension request within 30 days. It is recommended that Otero County DHS 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.	Complete
13-092	CFRT	It was recommended that the mother needs to acknowledge the children were injured in the care of their father. Larimer County DHS has developed a more in-depth treatment plan for the mother which includes a psychological evaluation with a developmental assessment and a parent/child interactional to proceed with services designed to acknowledge safety concerns and build caregiver protective capacity for the mother. Larimer County DHS is seeking the recommendations from the evaluations and assessment to build caregiver protective capacity for the mother and building next steps in their treatment plan. For the mother involved in the egregious abuse incident, Cognitive Behavioral Therapy, which is a hands-on practical approach, is recommended. Treatment plans should be written in a specific, measurable, agreed upon, realistic and time limited (SMART) format. In using the SMART format, the caseworker will develop, with the family, the steps to build the desired behavioral change needed to create a safe environment for the child and/or caregiver protective capacity. The treatment plan will include specific measurements of the desired behavioral change, for example: while good attendance with a service provider is important, it is necessary for the treatment plan to articulate specific behavioral changes that the parent must demonstrate in order to achieve the objective. It is recommended that CDHS Division of Child Welfare provide further guidance on creating and using measurement of behavioral change in the treatment plan.	In Progress

CFRT ID	Source	Recommendation	Status
14-003	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Lincoln County DHS. In a recent review of a random sample of assessments that were conducted during a period from July 29, 2012 to January 29, 2013, the Lincoln County DHS completed the risk assessment accurately in 40% of assessments, which is below the statewide average (not including Lincoln County) of 57.6% for the similar time span. It is recommended that Lincoln County DHS 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
14-003	Policy Finding	For High Risk Assessments opened by Lincoln County DHS between December 1, 2013 and May 31, 2014, 58.3% required an extension (i.e., were open longer than 30 days). Of those, 0% had an extension request within 30 days. It is recommended that Lincoln County DHS 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.	Complete
14-003	Policy Finding	The policy violation related to the inaccurate completion of the safety assessment reflects a systemic practice issue in the DDHS. In a recent review of a random sample of assessments that were conducted during a period from April 8, 2013 through September 30, 2013, the DDHS completed the safety assessment accurately, in accordance with Volume VII, 71% of the time, which is below the statewide average (not including DDHS) of 81.6% for roughly the same time span. It is recommended that DDHS 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
14-003	CFRT	It is recommended that Otero County DHS substantiate neglect findings for injurious environment for all three caretakers (the mother, the father and the father's friend) of the baby.	In Progress
14-003	CFRT	It is recommended that Otero County DHS alert hospitals in Otero County and surrounding counties for this mother giving birth to the new baby.	Complete
14-003	CFRT	It is recommended that the Division of Child Welfare (DCW) 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.	Complete
14-003	CFRT	As the proper use of extensions during the assessment period may be related to the timely closure of assessments, it is recommended that the DCW begin including data on counties' use of extensions in the analysis and communications related to the C-Stat measure of timeliness of assessment closure.	Complete

CFRT ID	Source	Recommendation	Status
14-003	Policy Finding	The policy finding related to the safety assessment does reflect a systemic practice issue in Otero County DHS. In a recent review of a random sample of assessments that were conducted during a period from March 18, 2013 to September 18, 2013, the Otero County DHS completed the safety assessment accurately in 81.8% of assessments, which is slightly below the statewide average (not including Otero County) of 83.4% for the similar time span. It is recommended that Otero County 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.	In Progress
14-003	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Otero County DHS. In a recent review of a random sample of assessments that were conducted during a period from March 18, 2013 to September 18, 2013, the Otero County DHS completed the risk assessment accurately in 56.3% of assessments, which is slightly below the statewide average (not including Otero County) of 58.7% for the similar time span. It is recommended that Otero County DHS 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
14-003	Policy Finding	The policy finding related to seeing the alleged victim within the assigned response time may reflect a systemic practice issue for Lincoln County 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 July 29, 2012 to January 29, 2013, showed the Lincoln County DHS at 70%. It is important to note that with the addition of rule 7.202.41 (A) (4) on March 2, 2013, Volume VII now addresses reasonable efforts by the caseworker to see the child victim. During July 29, 2012 to January 29, 2013, the Lincoln County DHS made reasonable efforts to see the victim of the allegation 70% of the time. According to the most recent C-Stat data for January-March 2014, Lincoln County DHS is interviewing alleged victims within the assigned response time 90% of the time, and meets the C-Stat goal of 90.0%. It is recommended that Lincoln County DHS monitor their performance on this measure to maintain their most recent performance of 90%.	In Progress

CFRT ID	Source	Recommendation	Status
14-003	Policy Finding	The policy finding related to interviewing the person responsible for the abuse and/or neglect does not reflect a systemic practice issue for Lincoln County DHS. In a recent review of a random sample of assessments that were conducted during a period from March 18, 2013 to September 18, 2013, the Lincoln County DHS interviewed all required parties including person responsible for abuse and/or neglect in 90% of assessments, which is slightly above the statewide average (not including Lincoln County) of 87.2% for the similar time span. It is recommended that Lincoln County DHS monitor this in order to maintain their performance at 90%.	In Progress
14-003	Policy Finding	There is a lack of quantitative data related to entering information of abuse/or neglect into the State automated case management system. It is recommended that Otero County DHS look at the previous referrals to see if entering data timely appears to be an issue for Otero County. If it is an issue, employ a process in which barriers that prevent all referrals from being entered into the State automated case management system by the end of the business day are identified and solutions to the identified barriers are implemented.	In Progress
14-003	CFRT	The Division of Child Welfare should work with the Office of Information and Technology (OIT) to develop a scrolling alert in Trails to allow for improved communication among departments when there are significant concerns regarding an individual or family.	Complete
14-004	Policy Finding	The policy violation related to the Colorado Family Risk Assessment is reflective of a systemic practice issue in DDHS. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from April 8, 2013 through September 30, 2013, the county department completed the risk assessment accurately, in accordance with Volume VII, 56.6% of the time, which is below the statewide average of 62.5% (not including DDHS) for roughly 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.	Complete
14-004	Policy Finding	The policy violation related to the Colorado Family Risk Assessment is reflective of a systemic practice issue in ACHSD. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from September 18, 2013 and March 18, 2014, the county department completed the risk assessment accurately, in accordance with Volume VII, 43.4% of the time, which is below the statewide average of 62.5% (not including ACHSD) for roughly the same time span. It is recommended that ACHSD 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

CFRT ID	Source	Recommendation	Status
14-004	Policy Finding	For High Risk Assessments opened by Logan County between October 1, 2013 and March 31, 2014, 74.6% required an extension (i.e., were open longer than 30 days). Of those, 46.6% had an extension request within 30 days. A. It is recommended that Logan 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.	Complete
14-004	CFRT	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 (DCW) 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.	Complete
14-004	CFRT	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 secondary trauma providers as well as resources to provide education on secondary trauma prevention.	Complete
14-004	CFRT	In regards to the difficulties counties have in knowing exactly when to intervene at a higher level while providing voluntary services to a family, the CFRT recommends that the DCW discuss this issue with the Child Protection Task Group and explore whether or not additional guidance can be developed to assist counties when dealing with these types of situations.	In Progress
14-008	Policy Finding	The statewide performance on the use of extensions between October 1, 2013 and March 31, 2014 was also low. Overall, 71.6% of referrals required an extension (opened beyond 30 days), and 38% 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.	Complete
14-008	Policy Finding	The policy finding related to the safety assessment does reflect a systemic practice issue in Logan County. In a recent review of a random sample of assessments that were conducted during a period from June 16, 2013 to December 16, 2013, Logan County completed the safety assessment accurately in 88.6% of assessments, which is above the statewide average (not including Logan county) of 81.2% for the same time span. However, Logan County is below the state goal of 90%, so it is recommended that Logan 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

CFRT ID	Source	Recommendation	Status
14-008	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Jefferson County DCYF. In a recent review of a random sample of assessments that were conducted during a period from August 4, 2013 through February 5, 2014, the Jefferson County DCYF completed the risk assessment accurately in 56.6% of assessments, which is below the statewide average (not including Jefferson County) of 64.0% for the same time span. It is recommended that Jefferson County DCYF 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
14-008	CFRT	It is recommended that the Division of Child Welfare implement a process in determining how the parents' use of marijuana could impact the child's safety.	Complete
14-008	CFRT	It is recommended that the Division of Child Welfare explore whether there is a need to develop a rule in Volume VII on when a child is selected as "Participating as a Child" in the State automated case management system.	In Progress
14-008	Policy Finding	The policy finding related to monthly contact with the children does not reflect a systemic practice issue in Logan County. In a recent review of a random sample of In-Home Reviews that were conducted during a period from June 16, 2013 to December 16, 2013, Logan County completed required monthly contact with the child in 96.4% of the cases, which is above the statewide average (not including Logan County) of 95.2% for the same time span. The monthly contact with the caregiver/guardian/kin does reflect a systemic practice issue in Logan County. In a recent review of a random sample of In-Home Reviews that were conducted during a period from June 16, 2013 to December 16, 2013, Logan County completed required monthly contact with the caregiver/guardian/kin in 70% of the cases, which is above the statewide average (not including Logan county) of 63% for the same time span. It is recommended that Logan County employ a process in which barriers to the monthly contact with caregivers/guardian/kin are identified and solutions to the identified barriers are implemented.	Complete
14-008	Policy Finding	The policy finding related to Family Service Plan: 5A Review/Court report does reflect a systemic practice issue in Logan County. In a recent review of a random sample of In-Home Reviews that were conducted during a period from June 16, 2013 to December 16, 2013, Logan County completed required FSP: 5A in 78% of the cases, which is slightly above the statewide average (not including Logan County) of 77% for the same time span. It is recommended that Logan County employ a process in which barriers to the FSP: 5A Review/Court reports are identified and solutions to the identified barriers are implemented.	Complete

CFRT ID	Source	Recommendation	Status
14-012	Policy Finding	For High Risk Assessments opened by the DDHS between January 1, 2014 and June 30, 2014, 68% of those were open for 31 days or longer, requiring an extension. Of those, 39.8% of them received an extension within 30 days. It is recommended that the DDHS 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.	Complete
14-012	CFRT	It is recommended that the Division of Child Welfare (DCW) begin the statewide implementation process of the new risk assessment tool and that monitoring occur to determine if accuracy in the use of the tool increases as a result of its implementation.	Complete
14-012	CFRT	It was further recommended that Department of Child Welfare offer to provide mandated reporter training to BDC staff.	Complete
14-012	CFRT	The Jefferson County DCYF identified in their internal review that, "Supervisors should review the level of complexity of a referral when assigning to determine whether more than one caseworker should respond with a criminal investigation."	Complete
14-012	CFRT	Regarding the systemic gap of multiple law enforcement officers compared to one caseworker: a. The CFRT recommended that DCW determine a protocol to review the ability of counties to provide multiple caseworkers during critical incidents that co-occur with a law enforcement investigation. This was recommended to take place through the workload study.	In Progress
14-012	CFRT	The CFRT recommended that the Barbara Davis Center complete a Critical Incident Review regarding this particular situation and identify barriers to mandated reporting and solutions to those barriers.	Complete
14-019	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in the DDHS. In a recent review of a random sample of assessments that were conducted during a period from October 30, 2013 to April 30, 2014, the DDHS completed the risk assessment accurately in 50.9% of assessments, which is below the statewide average (not including the DDHS) of 61.0 % for approximately the same time span. It is recommended that the 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.	Complete

CFRT ID	Source	Recommendation	Status
14-019	Policy Finding	The policy findings related to not completing the Colorado Family Risk Assessment does reflect a systemic practice issue in the DDHS. In a recent review of a random sample of assessments that were conducted during a period from October 30, 2013 to April 30, 2014, the DDHS completed the risk assessment accurately in 50.9% of assessments, which is below the statewide average (not including the DDHS) of 61.0 % for approximately the same time span. It is recommended that the 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.	Complete
14-019	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Jefferson County DCYF. In a recent review of a random sample of assessments that were conducted during a period from August 4, 2013 through February 4, 2014, the Jefferson County DCYF completed the risk assessment accurately in 56.6% of assessments, which is below the statewide average (not including Jefferson County) of 64.0% for the same time span. It is recommended that Jefferson County DCYF 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
14-019	CFRT	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 (DCW) 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.	Complete
14-019	CFRT	It is recommended that the Division of Child Welfare (DCW) 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.	Complete
14-019	CFRT	As the proper use of extensions during the assessment period may be related to the timely closure of assessments, it is recommended that the DCW begin including data on counties' use of extensions in the analysis and communications related to the C-Stat measure of timeliness of assessment closure.	Complete
14-019	CFRT	DCW should explore the need for further guidance and/or regulation regarding which county is responsible for assessing child safety when a family has an open case (court and non-court involved) in one county but lives in another.	Complete

CFRT ID	Source	Recommendation	Status
14-019	CFRT	The Division of Child Welfare (DCW) should encourage county DHS agencies to develop Memorandums of Understanding (MOU) and/or protocol for working with all shelters in their respective counties to ensure the DHS' has access to children when there is concern for child abuse/neglect. The DCW and the Domestic Violence Program (DVP) should create a sample MOU and/or protocols and work with the counties and shelters, when needed, to complete this process.	In Progress
14-020	Policy Finding	The policy finding related to the inaccurate completion of the safety assessment does reflect a systemic practice issue in Jefferson County DCYF. In a recent review of a random sample of assessments that were conducted during a period from August 4, 2013 to February 4, 2014, the Jefferson County DCYF completed the safety assessment accurately in 83% of assessments, which is below the statewide average (not including Jefferson County DCYF) of 84.1% for the same time span. It is recommended that Jefferson 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
14-020	Policy Finding	For High Risk Assessments opened by Jefferson County DCYF between November, 2013 and April 30, 2014, 81.6% required an extension (i.e., were open longer than 30 days). Of those, 38% had an extension request within 30 days. It is recommended that Jefferson 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.	Complete
14-020	Policy Finding	The policy finding related to frequency of contact with the parents during the course of the case is a systemic issue for Jefferson County DCYF. In a recent review of a random sample of In-Home cases that were open during a period from August 4, 2013 through February 4, 2014, the Jefferson County DCYF completed monthly contacts with parents in 60% of cases, which is below the statewide average (not including Jefferson County) of 63% for the same time span. It is recommended that Jefferson County DCYF employ a process in which barriers to monthly contacts with parents are identified and solutions to the identified barriers are implemented.	Complete
14-020	Policy Finding	Fremont County had two incidents in 2012 which met criteria for reporting to the State. They reported both incidents timely. There was only this incident in 2013, which they did not report. However, the two incidents in 2012 were fatalities and this was the first egregious harm incident that Fremont County encountered. The CFRT recognizes the need for further clarification around the definition of "egregious harm." It is recommended that the Administrative Review Division (ARD) further clarify the definition and provide training to County staff around the State regarding the definition and reporting requirements for "fatal, near-fatal and egregious harm" incidents.	Complete

CFRT ID	Source	Recommendation	Status
14-020	CFRT	It is recommended that the Division of Child Welfare (DCW) 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.	Complete
14-020	CFRT	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.	Complete
14-021	Policy Finding	The policy finding related to reasonable efforts to interview the grandmother, an alleged perpetrator, does reflect a systemic practice issue for Fremont County 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 August 18, 2013 to February 18, 2014, showed the Fremont County DHS at 80.4%, which is below the statewide average (excluding Fremont County) of 89.7% for the same time span. It is recommended that Fremont County DHS monitor their performance on this measure to ensure improvement. Improvements can include utilizing the data ARD provides with each In-Home and Assessment Review and through County supervisors monitoring this practice during reviews of assessments.	Complete
14-021	CFRT	The CFRT recommended that Fremont County staff attend the Mandated Reporter Training along with St. Thomas More Hospital staff that is scheduled to occur in August, 2014. This recommendation came as an opportunity for Fremont County staff to further build a positive collaborative relationship with local hospitals to help the hospital staff understand the importance of the mandated reporting requirements.	Complete
14-021	CFRT	Fremont County should change the substantiation level to “egregious.”	Complete
14-021	Policy Finding	There is no data available regarding the policy finding related to the late receipt of the Internal Review report and supporting documentation. Routt County DHS did not have any reportable incidents in 2012. There were two reported fatalities in 2013 that did not meet criteria for a CFRT review as there was no prior DHS involvement for those incidents. Although this is the only incident that met CFRT review criteria in recent history, the ARD recommends that Routt County DHS employ a process in which barriers to the timely submission of required documents for a fatality are identified and solutions to the identified barriers are implemented.	In Progress

CFRT ID	Source	Recommendation	Status
14-024	Policy Finding	The policy finding related to inaccurate documentation of the safety concerns in the safety assessment does reflect a systemic practice issue in Dolores County DSS. In a recent review of a random sample of assessments that were conducted during a period from September 30, 2013 to March 30, 2014, the Dolores County DSS completed the safety assessment accurately in 75% of assessments, which is below the statewide average (not including Dolores County DSS) of 83.1% for the same time span. It is recommended that Dolores County DSS 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
14-024	CFRT	The CFRT recommended that the CDHS utilize the publicity campaign for the upcoming Statewide Child Abuse and Neglect Reporting Hotline to create a more positive view of the Department of Human Services in addition to the mandate of assessing allegations of child abuse and neglect.	Complete
14-041	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Dolores County DSS. In a recent review of a random sample of assessments that were conducted during a period from September 30, 2013 to March 30, 2014, the Dolores County DSS completed the risk assessment accurately in 75% of assessments, which is above the statewide average (not including Dolores County DSS) of 60.8% for the same time span. It is recommended that Dolores County DSS 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
14-041	Policy Finding	The DDHS should implement a process to ensure that individuals assigned to assess fatal, near fatal and egregious incidents do not have any prior involvement with the family.	Complete
14-041	CFRT	It is recommended that the Division of Child Welfare (DCW) 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.	Complete
14-041	CFRT	The CFRT recommended that DCW further clarify practice rules as it relates to the use of marijuana and its effect on parenting and child safety and risk.	Complete
14-041	Policy Finding	The policy finding related to monthly contact with the child in the out-of-home placement setting does reflect a systemic practice issue in Dolores County DSS. In the most recent Out-of-Home Administrative Review (April 1, 2013 to June 30, 2013), the Dolores County DSS completed monthly contact with the child in the correct setting in 50% of the cases, which is below the statewide average of 91% for the same time span. It is recommended that Dolores County employ a process in	In Progress

CFRT ID	Source	Recommendation	Status
		which barriers to the monthly contact with children in the correct setting are identified and solutions to the identified barriers are implemented.	
14-046	Policy Finding	The policy finding related to the inaccurate completion of the safety assessment instrument reflects a systemic practice issue in the DDHS. In a recent review of a random sample of assessments that were conducted during a period from April 8, 2014 to October 8, 2014, the DDHS completed the safety assessment accurately in 81.5 % of assessments, which is above the statewide average (not including the DDHS) of 77.3% for the same time span. It is recommended that DDHS employ a process in which barriers to the timeliness of the Colorado Safety Assessment tool are identified and solutions to the identified barriers are implemented. Additionally, the new Colorado Safety Assessment tool will be implemented by the State in 2015, and it is recommended that DDHS participate in the training and implementation of the new tool.	Complete
14-046	Policy Finding	The policy finding related to inaccurate documentation of the Colorado Family RiskAssessment tool does reflect a systemic practice issue in DDHS. In a recent review of arandom sample of assessments that were conducted during a period from April 8, 2014 toOctober 8, 2014, the DDHS completed the risk assessment tool accurately in 55.6% ofassessments, which is slightly below the statewide average (not including DDHS) of 59.3% forthe same time span. However, due to the level of performance on this measure, it isrecommended that DDHS employ a process in which barriers to the accurate completion of theColorado Family Risk Assessment tool are identified and solutions to the identified barriersare implemented. Additionally, the new Colorado Family Risk Assessment tool will beimplemented by the State in 2015, and it is recommended that DDHS participate in thetraining and implementation of the new tool.	Complete
14-046	Policy Finding	The policy finding related to the timeliness for the risk assessment tool does reflect a systemic practice issue in DDHS. In a recent review of a random sample of assessments that were conducted during a period from April 8, 2014 to October 8, 2014, the DDHS completed the risk assessment tool timely in 83.3% of assessments, which is below the statewide average (not including DDHS) of 91.4% for the same time span. It is recommended that DDHS employ a process in which barriers to the timeliness of the Colorado Family Risk Assessment tool are identified and solutions to the identified barriers are implemented. Additionally, the new Colorado Family Risk Assessment tool will be implemented by the State in 2015, and it is recommended that DDHS participate in the training and implementation of the new tool.	Complete

CFRT ID	Source	Recommendation	Status
14-046	Policy Finding	The policy finding related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Archuleta County DHS. In a recent review of a random sample of assessments that were conducted during a period from September 30, 2013 to March 30, 2014, the Archuleta County DHS completed the risk assessment accurately in 66.7% of assessments, which is above the statewide average (not including Archuleta County DHS) of 60.8% for the same time span. It is recommended that Archuleta County DHS 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. Additionally, the new Colorado Family Risk Assessment will be implemented by the State in 2015, and it is recommended that Archuleta County DHS participate in the training and implementation of the new tool.	Complete
14-046	CFRT	It is recommended that the DCW 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.	Complete
14-046	CFRT	The DDHS should reach out to the aunt and inquire about whether there are barriers keeping her from filing for legal custody of the children and assist her in overcoming those barriers if needed.	Complete
14-046	CFRT	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 that are received during the course of an open assessment to provide clarification on this area of practice.	Complete
14-046	Policy Finding	The policy finding related to seeing the alleged victim within the assigned response time reflects a systemic practice issue for the DDHS. 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 April 8, 2014 to October 8, 2014, showed the DDHS at 76.4% for interviewing/observing the alleged victims within the response time. The DDHS made reasonable efforts to interview/observe the victim 89.1% of the time. According to the most recent C-Stat presentation for the month of November 2014, the DDHS is interviewing the alleged victims within the assigned response time 84% of the time which is below the state goal of 90%. It is recommended that the DDHS monitor their performance on this measure to ensure improvement in order to meet the state goal of 90%.	In Progress

CFRT ID	Source	Recommendation	Status
14-050	Policy Finding	The policy finding related to the safety assessment tool does reflect a systemic practice issue in Archuleta County DHS. In a recent review of a random sample of assessments that were conducted during a period from September 30, 2013 to March 30, 2014, the Archuleta County DHS completed the safety assessment tool accurately in 75 % of assessments, which is below the statewide average (not including Archuleta County DHS) of 83.1% for the same time span. It is recommended that Archuleta County 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
14-050	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a current systemic practice issue for Alamosa County DHS. The C-Stat measure is based on the standard 30 days, as well as an additional 30 days to allow for extensions requests supported in Volume VII. The C-Stat data, which measures the percentage of assessments closed within 60 days regardless of extension status, shows Alamosa County DHS at 57.9% for High Risk Assessments for December, 2014. It is recommended that Alamosa 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
14-050	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in Fremont County DHS. In a recent review of a random sample of assessments that were conducted during a period from August 18, 2013 to February 18, 2014, the Fremont County DHS completed the risk assessment accurately in 74.4% of assessments, which is above the statewide average (not including Fremont County DHS) of 63.5% for the same time span. It is recommended that Fremont County DHS 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. Additionally, the new Colorado Family Risk Assessment tool will be implemented by the State in 2015, and it is recommended that Fremont County DHS participate in the training and implementation of the new tool.	Complete
14-050	CFRT	It is recommended that the DCW 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.	Complete

CFRT ID	Source	Recommendation	Status
14-050	Policy Finding	The policy findings related to not interviewing the sibling(s) or other children in the household does reflect a systemic practice issue in Archuleta County DHS. In a recent review of a random sample of assessments that were conducted during a period from September 30, 2013 to March 30, 2014, the Archuleta County DHS interviewed all required parties as part of the assessment 83.3% of the time, which is slightly below the statewide average (not including Archuleta County DHS) of 88.5% for the same time span. It is recommended that Archuleta County DHS monitor their performance on this measure to ensure improvement.	In Progress
14-050	Policy Finding	The policy finding related to not interviewing others who may have information regarding the alleged maltreatment during the assessment phase does reflect a systemic practice issue for Alamosa County DHS. In a recent review of a random sample of assessments that were conducted during a period from January 21, 2014 to July 21, 2014, the Alamosa County DHS interviewed all required parties as part of the assessment 87.8% of the time, which is slightly below the statewide average (not including Alamosa County DHS) of 88.1% for the same time span. It is recommended that Alamosa County DHS monitor their performance on this measure to ensure improvement.	In Progress
14-050	Policy Finding	The policy finding related to seeing the alleged victim within the assigned response time does reflect a systemic practice issue for Alamosa County DHS. According to the December C-Stat, which reviewed data for the month of November, 2014, Alamosa County DHS is interviewing the alleged victim within the assigned response time 88% of the time, which is below the statewide average of 90% and is also below the C-Stat goal of 90.0%. 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 January 21, 2014 to July 21, 2014 showed the Alamosa County DHS at 78.3% interviewing the alleged victim within the assigned response time. It is important to note that with the addition of rule 7.202.41 (A) (4) on 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 Alamosa County DHS made reasonable efforts to see the victim of the allegation 82.9% of the time. It is recommended that Alamosa County DHS monitor their performance on this measure to ensure improvement in order to meet the state goal of 90%.	In Progress
14-050	CFRT	It is recommended that all counties contact the Child Protection Team at CHC when there is conflicting medical information given on a case involving suspected child abuse. If local medical professionals refuse to comply with CHC recommendations, the county should notify CHC so that CHC can contact the local medical professionals personally.	In Progress

CFRT ID	Source	Recommendation	Status
14-051	Policy Finding	The policy finding regarding documentation supporting no required Safety Assessment does reflect a systemic practice issue for Fremont County DHS. In a recent review of a random sample of assessments that were conducted during a period from August 18, 2013 to February 18, 2014, Fremont County DHS had supporting documentation in 33.3% of assessments, which is below the statewide average of 80% for the same time span. It is recommended that Fremont County DHS employ a process in which barriers to support documentation are identified and solutions to the identified barriers are implemented. Additionally, the new Colorado Safety Assessment tool will be implemented by the State in 2015, and it is recommended that Fremont County DHS participate in the training and implementation of the new tool.	Complete
14-051	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool do reflect a systemic practice issue in EPCDHS. In a recent review of a random sample of assessments that were conducted during a period from March 17, 2014 to September 17, 2014, the EPCDHS completed the risk assessment tool accurately in 54.7% of assessments, which is below the statewide average (not including EPCDHS) of 59.2% for the same time span. It is recommended that EPCDHS employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment tool are identified and solutions to the identified barriers are implemented. Additionally, a new Colorado Family Risk Assessment tool will be implemented by the State in 2015, and it is recommended that EPCDHS participate in the training and implementation of the new tool.	Complete
14-051	CFRT	It is recommended that the DCW 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.	Complete
14-051	CFRT	Fremont County DHS met with law enforcement and Judicial Officers after this egregious abuse incident. Fremont County DHS has access to Judicial Officers after-hours at this time. There are no further recommendations for Fremont County. It is recommended that DCW continue working with all counties to develop a Memorandum of Understanding (MOU) between the county and the law enforcement agencies within that county.	Complete
14-059	Policy Finding	The policy finding related to the accurate completion of the safety assessment does reflect a systemic practice issue in FCDHS. In a recent review of a random sample of assessments that were conducted during a period from August 18, 2013 to February 18, 2014, the FCDHS completed the safety assessment accurately in 90.7% of assessments, which is above the statewide average (not including FCDHS) of 84.1 for the same time span. As FCDHS is performing below the 95% target for this measure, it is recommended that FCDHS employ a process in which barriers to the accurate completion of the safety assessment are identified and solutions to the	Complete

CFRT ID	Source	Recommendation	Status
		identified barriers are implemented.	
14-059	CFRT	It is recommended that the Division of Child Welfare (DCW) begin the statewide implementation process of the new Colorado Family Risk Assessment tool and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	Complete
14-059	CFRT	DCW should explore if there are needed changes to practice regarding how a caseworker should assess the protective capacity of the non-offending parent and make the determination whether the PRAN no longer has access to the children.	Complete
14-068	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in FCDHS. In a recent review of a random sample of assessments that were conducted during a period from August 18, 2013 to February 18, 2014, the FCDHS completed the risk assessment accurately in 74.4% of assessments, which is above the statewide average (not including FCDHS) of 63.5% for the same time span. Due to the level of performance in this area, it is recommended that FCDHS 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. Additionally, a new Colorado Family Risk Assessment will be implemented by the State in 2015, and it is recommended that FCDHS participate in the training and implementation of the new tool.	Complete
14-068	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in PCDSS. In a recent review of a random sample of assessments that were conducted during a period from May 4, 2014 to November 4, 2014, the PCDSS completed the risk assessment tool accurately in 74.5% of assessments, which is above the statewide average (not including PCDSS) of 57.8% for the same time span. Due to the level of performance on this measure, it is recommended that PCDSS employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment tool are identified and solutions to the identified barriers are implemented. Additionally, a new Colorado Family Risk assessment has been implemented by the State in 2015, and it is recommended that PCDSS continue to pilot/use this new tool.	Complete
14-068	CFRT	It is recommended that the Division of Child Welfare (DCW) begin the statewide implementation process of the new safety and risk assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	Complete

CFRT ID	Source	Recommendation	Status
14-068	CFRT	The CFRT identified that there is an opportunity to find out if a family has previously moved from another state by asking medical providers if there is medical history regarding the child in a different state, and then the caseworker can contact that state to determine past CPS involvement. It is recommended that information be added to the Colorado Child Welfare Training Academy regarding ways for caseworkers to determine past CPS history, including checking with medical providers.	Complete
14-079	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a current systemic practice issue for Alamosa County DHS. The February, 2015 C-Stat report, which measures the percentage of assessments closed within 60 days, shows Alamosa County at 60.9% which is below the statewide average of 80.2% for January, 2015. It is recommended that Alamosa County DHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete
14-079	CFRT	It is recommended that DCW continue the statewide implementation process of the new safety and risk assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	Complete
14-079	CFRT	The CFRT recommended that DCW offer more trainings for caseworkers specifically related to issues of domestic violence. Caseworkers should be trained to complete global assessments utilizing the timeframe allowed to completed assessments rather than determining safety solely on the day of the initial contact with the family. This will allow caseworkers to fully assess the cycle of domestic violence that may be present as well as the parent's protective capacity in light of domestic violence issues. Caseworkers can utilize community resources specializing in issues of domestic violence to educate the non-offending parent of resources available and improving protective capacity where there is a need for this. There are currently seven upcoming trainings related to issues of domestic violence provided by the Child Welfare Training Academy; six of those trainings are in the Denver Metro training region, and one is in the western training region. It is recommended that more training sessions are offered in the northeast and southeast regions so that the trainings are more easily accessible to caseworkers throughout the state.	Complete

CFRT ID	Source	Recommendation	Status
14-079	Policy Finding	The policy finding related to the assessment containing the required content does reflect a systemic practice issue for Alamosa County 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 January 21, 2014 to July 21, 2014, showed that Alamosa County DHS' assessments contained the required content 70% of the time, which is below the statewide average (not including Alamosa County DHS) of 86.4% for the same time span. It is recommended that Alamosa County DHS employ a process in which barriers to the accurate completion of the safety assessment tool are identified and solutions to the identified barriers are implemented.	In Progress
14-079	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in Alamosa County DHS. In a recent review of a random sample of assessments that were conducted during a period from January 21, 2014 to July 21, 2014, the Alamosa County DHS completed the risk assessment tool accurately in 67.5% of assessments, which is above the statewide average (not including Alamosa County DHS) of 59.4% for the same time span. Due to the level of performance on this measure, it is recommended that Alamosa County DHS employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment tool are identified and solutions to the identified barriers are implemented. Additionally, a new Colorado Family Risk assessment will be implemented by the State in 2015, and it is recommended that Alamosa County participate in the training and implementation of the new tool.	In Progress