COLORADO
Department of Human Services

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

The Honorable Kevin Lundberg
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, 2016

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

The Colorado Department of Human Services, in accordance with the statutory responsibility established through 26-1-139, C.R.S., submits the attached "2015 Child Maltreatment Fatality Report."

The statute requires that, "On or before July 1, 2014, and on or before each July 1 thereafter, an annual child fatality and near fatality review report, absent confidential information, summarizing the reviews required by subsection (5) of this section conducted by the team during the previous year," shall be developed and distributed to the Governor, the health and human services committee of the senate, and the health and environment committee of the house of representatives, or any successor committees.

Respectfully,

Reggie Bicha Executive Director

cc: Senator Larry Crowder, Vice Chair, Senate Health and Human Services
Representative Jonathan Singer, Vice Chair, House Public Health Care and Human Services
Representative Joann Ginal, Vice Chair, House Health, Insurance and the Environment
Senator Beth Martinez-Humenik
Senator Irene Aguilar
Senator Linda Newell
Representative Janet Buckner
Representative Kathleen Conti
Representative Jessie Danielson

Representative Justin Everett
Representative Janak Joshi
Representative Timothy Leonard
Representative Lois Landgraf
Representative Brittany Pettersen
Representative Dominick Moreno
Representative Max Tyler
Representative JoAnn Windholz
Representative J. Paul Brown
Representative Daneya Esgar
Representative Stephen Humphrey
Representative Gordon Klingenschmitt
Representative Susan Lontine
Representative Diane Mitsch Bush
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2015 Child Maltreatment Fatality Report

COLORADO
Department of Human Services

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Executive Summary

The 2015 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 information related to fatal, near fatal, and egregious incidents of child maltreatment. In order to determine trends related specifically to fatalities, information about 22 children involved in fatal incidents, substantiated for child maltreatment in 2015, is combined with data regarding all child maltreatment fatalities occurring in Colorado over the past five years, combined with national trend data.

As outlined in statute, Colorado collects information on several different child and family characteristics across the types of reviewed incidents. From the group of 69 children in 55 substantiated fatal, near fatal, and egregious incidents of child maltreatment occurring in 2015, 43 children in 34 incidents met statutory criteria for full review by the Child Fatality Review Team (CFRT).

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 27 incidents occurring in 2014 and 2015 that were reviewed by the CFRT and/or posted to the public notification website in 2015. Recommendations address the policy findings, and systemic gaps and deficiencies identified during the CFRT review.

Child Characteristics. For fatalities in 2015, the most frequent race/ethnicity was Hispanic (59.1%), followed by White (18.2%). This is a change from 2014, when the most frequent race/ethnicity was White (59.1%) followed by Hispanic (22.7%). The most frequent race/ethnicity for all children in fatal, near fatal, and egregious incidents of child maltreatment in 2015 was White (42%). In Colorado in 2015, males accounted for 59% (13/22) of the victims in substantiated child maltreatment fatalities. Males were victims in 87.5% of the near fatal incidents and 74.2% of the egregious incidents.

Family Characteristics. The most common family structure for children who were victims in fatal, near fatal, and egregious incidents of child maltreatment was a two parent household 36.2% (25/69). This was followed by those who resided with one (1) parent and one (1) unrelated caregiver at 34.7% (24/69). While income level and education level of legal caretakers is not routinely collected by counties, available information on services to families indicated that in 29 of the 36 (80.5%) fatal, near fatal, and egregious incidents reviewed by the CFRT in 2015, 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, 61.5% (8/13) had some history of identified domestic violence. Additionally, 61.5% (8/13) of families experienced substance abuse issues, and for 38.5% (5/13) 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 four

years. In 2015, 57.1% (12/21) fatal incidents had prior involvement, ranging in intensity from one referral not accepted for assessment to involvement that included case services.

Perpetrator Relationship. The victim's mother committed the fatality 40% of the time (12/30), which is above the national trend (28%). The second largest category of perpetrators of fatalities was the victim's father, at 33% (10/30).

Findings and Recommendations. The CFRT highlighted 68 systemic strengths across 27 reports from 2014 and 2015 reviewed by the CFRT and posted since the cutoff of inclusion in the 2014 CFRT Annual Report (4/29/2015) and the cutoff for inclusion in this report (3/31/2016). The most commonly acknowledged systemic strength was case practice by the county departments of human/social services. The CFRT also identified 60 systemic gaps and deficiencies across the child welfare system, and made 107 recommendations related to policy findings. The most common issue identified was the current safety and risk assessment process. There were 167 recommendations resulting from the systemic gaps, deficiencies, and policy findings. These can be found in Appendix C of this report. Appendix D contains updates on the status of 81 recommendations originally included in prior years' reports and were not completed at the time of completion of those reports. This report also includes joint recommendations with the Colorado Department of Public Health and Environment, found on page 39.

Background

Legislative History

Prior to 2011, the Colorado Department of Human Services (CDHS) had limited authority to conduct fatality reviews. Up until 2011, the CDHS conducted less formal reviews on fatalities when the child or family had previous involvement with Colorado's child welfare system in the five years prior to the incident. Since 2011, Colorado's Child Fatality Review Team (CFRT) process has undergone numerous legislative and program changes.

In 2011, House Bill (HB) 11-1181 provided the Colorado Department of Human Services (CDHS) statutory authority (Colorado Revised Statutes § 26-1-139) for the provision of a child fatality review process, and funded one staff position at the CDHS to conduct these reviews. The CFRT function was programmatically located within the Office of Children, Youth and Families' Division of Child Welfare. HB 11-1181 also established basic criteria for determining which incidents should be reviewed by the CFRT. The review criteria included incidents in which a child fatality occurred and the child or family had previous involvement with a county department within the two years prior to the fatality. The legislation also outlined exceptions to reviews if the previous involvement: a) did not involve abuse or neglect, b) occurred when the parent was seventeen years of age or younger and before he or she was the parent of the deceased child or, c) occurred with a different family composition and a different alleged perpetrator.

In 2012, Senate Bill (SB) 12-033 added the categories of near fatal and egregious incidents to the review responsibilities of the CFRT. It also added reporting and public disclosure requirements. This change aligned Colorado statute with federal requirements under the 1996 Child Abuse and Prevention Treatment Act (CAPTA) which mandates that states receiving federal CAPTA funds 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 was not fully determined until calendar year 2013.

In January of 2013, responsibility for managing the CFRT program was moved under the Administrative Review Division (ARD), located within the CDHS Office of Performance and Strategic Outcomes. Additionally, with the passing of SB 13-255 in 2013, legislative changes to the CFRT process occurred once again. Specifically, criteria for incidents 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 (noted above). These changes 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.

In 2014, SB 14-153 made small changes to the membership stipulations for the state legislative members of the Child Fatality Review Team. SB 14-153 made no changes to the CFRT processes, criteria for qualifying incidents, or incident reporting requirements.

Due to statutory changes over the prior years, which have modified the population of incidents requiring review, and given that changes have occurred within each given calendar year, there is limited ability to interpret trends in the data. Further, any change in the final number of incidents in a given calendar year may have been due to definitional changes rather than to changes in the number of actual incidents. For 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. The increase was likely due to increased awareness of the reporting requirements and procedures, changes to the definition of near fatal and egregious incidents, and the expanded definition and relevant time period of previous involvement. Since 2013 there have not been any significant statutory changes. Therefore, broad trends can now be considered for the past few calendar years.

Table 1 provides an overview of the overall number and type of incidents since 2012. As shown below, there are variances in the total number of types of incidents over the past four years, with 2015 displaying a decrease in all types of incidents when compared to 2014.

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	111
2014	60	30	22	112
2015	43	23	20	88^

**Not all incidents met criteria for CFRT review.*

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

^ Two of the 88 incidents reported were determined to not fit the definitions of fatal, near fatal, or egregious. While they are included in the total, they do not appear in the incident specific columns.

Statute requires an annual report to the legislature on July 1st of each year reflecting aggregate information with regard to fatal, near fatal, and egregious incidents of child maltreatment 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, incidents with reports finalized and posted since the completion of the prior year's annual report.

Identification and Reporting of Incidents

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

As part of the data integrity process for 2015, data was extracted on a quarterly basis from the Statewide Automated Child Welfare Information System (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. The data was then compared to the reports of incidents received from counties over the course of 2015. This data integrity check identified eight incidents involving nine children who appeared as though their incident met the criteria for notification to the CDHS, but for whom the CDHS did not receive notification from the county. All eight incidents met criteria for public notification. Only one of the eight incidents met criteria for full CFRT review. The other seven did not meet criteria either because they were unsubstantiated for abuse and neglect or the involved families did not have prior history with departments of human/social services (DHS). As part of the data integrity check, notice was sent to the county departments regarding the 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. The ARD will continue this data integrity process to proactively correct data integrity issues, and to provide technical assistance to county departments, as it continues to be a valuable and necessary part of the CFRT process.

Child Fatality Review Team Process and Timelines

Allegations that are substantiated and have either prior (within the previous three years) 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 involvement with the child welfare system, and recommendations around policy and practice considerations. Table 2 offers a comparison of incidents meeting criteria to be reviewed over the past four years. It is important to reiterate that as the statutory and definitional 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 past data.

Table 2: Number of incidents meeting statutory criteria to be reviewed by CFRT

Year	Fatal Incidents	Near Fatal Incidents*	Egregious Incidents*	Total Incidents
2012	9	2	1	12
2013	8	10	21	39
2014	18	14	13	45
2015	12	9	13	34

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

Statute allows county departments 60 days from a qualifying incident of fatal, near fatal, or egregious child maltreatment 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 at a time, with the ability to grant additional extensions as necessary. The need for extensions impacts the total length of time needed to complete any individual review. To date, 26 of the 34 (76.5%) qualifying incidents occurring in 2015 were afforded at least one extension, with the total number ranging from one to nine extensions.

Incidents Reviewed in 2015

As required by Volume 7 (25 CCR 2509-2), the CFRT must review all incidents within 30 days of the CDHS receiving all required and relevant reports and information critical to an effective fatality review. During 2015, the CFRT was able to review 36 incidents. It is important to note that not all incidents are able to be reviewed within the calendar year in which they occurred. As an example, of the 36 incidents reviewed during 2015, 15 of the incidents occurred in 2014 while the remaining 21 occurred in 2015. Overall, 62% (21/34) of the incidents that occurred in 2015 were reviewed in 2015.

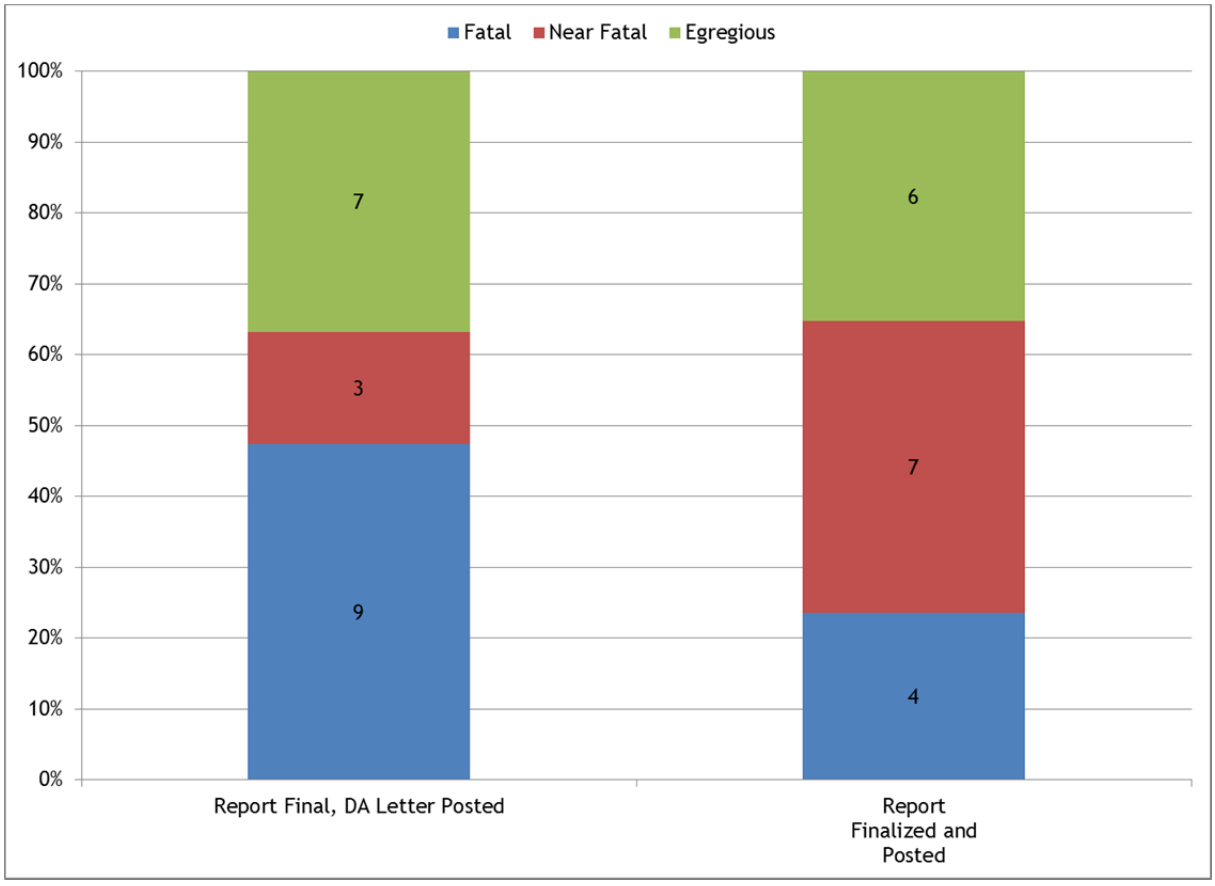
Completion and Posting of Case Specific Executive Summary Reports

Each incident reviewed by the CFRT results in a written report that is posted to the CDHS public notification website (with confidential information redacted). Specifically, statute requires that a case specific executive summary, absent confidential information, be posted on the CDHS website within seven (7) days of finalizing the confidential case-specific review report.

C.R.S. 26-1-139 (5) (j) (I) allows the CDHS to not release the final non-confidential case specific executive summary report if it is determined that doing so may jeopardize "any ongoing criminal investigation or prosecution or a defendant's right to a fair trial," or "any ongoing or future civil investigation or proceeding or the fairness of such proceeding." As such, the CFRT consults with applicable county and/or district attorneys prior to releasing the final non-confidential report when there is current, or likely, criminal or civil investigation and/or prosecution. In these instances, CDHS requests county and district attorneys to make known their preference for releasing or withholding the final non-confidential case specific executive summary report. When a determination is made not to post a case specific executive summary report, a copy of a letter from the county or district attorney in regards to that request is posted to the website. CDHS staff maintain contact with the county or district attorney to determine when the criminal or civil proceedings are completed and that releasing the report would no longer jeopardize the proceedings. At that time, CDHS requests a letter from the county or district attorney authorizing the release of the final non-confidential case executive summary report. The ARD then posts the report on the public notification webpage.

Chart 1 shows the posting status of all CFRT reports for incidents reviewed in 2015. Of the 36 incidents reviewed, final non-confidential case executive summary reports were posted for 17 of them. For the remaining 19 incidents reviewed, it was determined that releasing them could jeopardize criminal or civil proceedings and the reports were not posted. Throughout 2015, all incidents were reviewed and reports posted within the statutorily required timeframes.

Chart 1: Report status of all incidents reviewed by the CFRT in 2015



Child Fatality Review Team Membership and Attendance

As outlined in state statute, the Child Fatality Review Team is comprised of a variety of state and county department of human/social services staff, multidisciplinary members of the community, and external stakeholders. This includes personnel from the Colorado Department of Human Services, the Colorado Department of Public Health and Environment, law enforcement, medicine, and members from Colorado's General Assembly. The team meets monthly to review the circumstances surrounding incidents of egregious, near fatal, or fatal child maltreatment, including factors that contributed to the incident, and the services provided to the child, the child's family, and the perpetrator by the county department for any county with which the family has had prior involvement within the previous three years. The team also works to identify strengths and best practices of service delivery to the child

and the child's family, and when applicable, offers recommendations to improve policy and systemic factors. Team membership and attendance are detailed in Appendix A, with the grayed-out months indicating an individual was not appointed for participation for that CFRT review meeting.

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

The CDHS CFRT staff works closely with the Colorado Department of Public Health and Environment's (CDPHE) 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 members 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 than CDHS 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 39 of this document, as well as in the CFPS Fiscal Year 2015 Annual Report. Updates and analysis of past recommendations follow the 2015 recommendations.

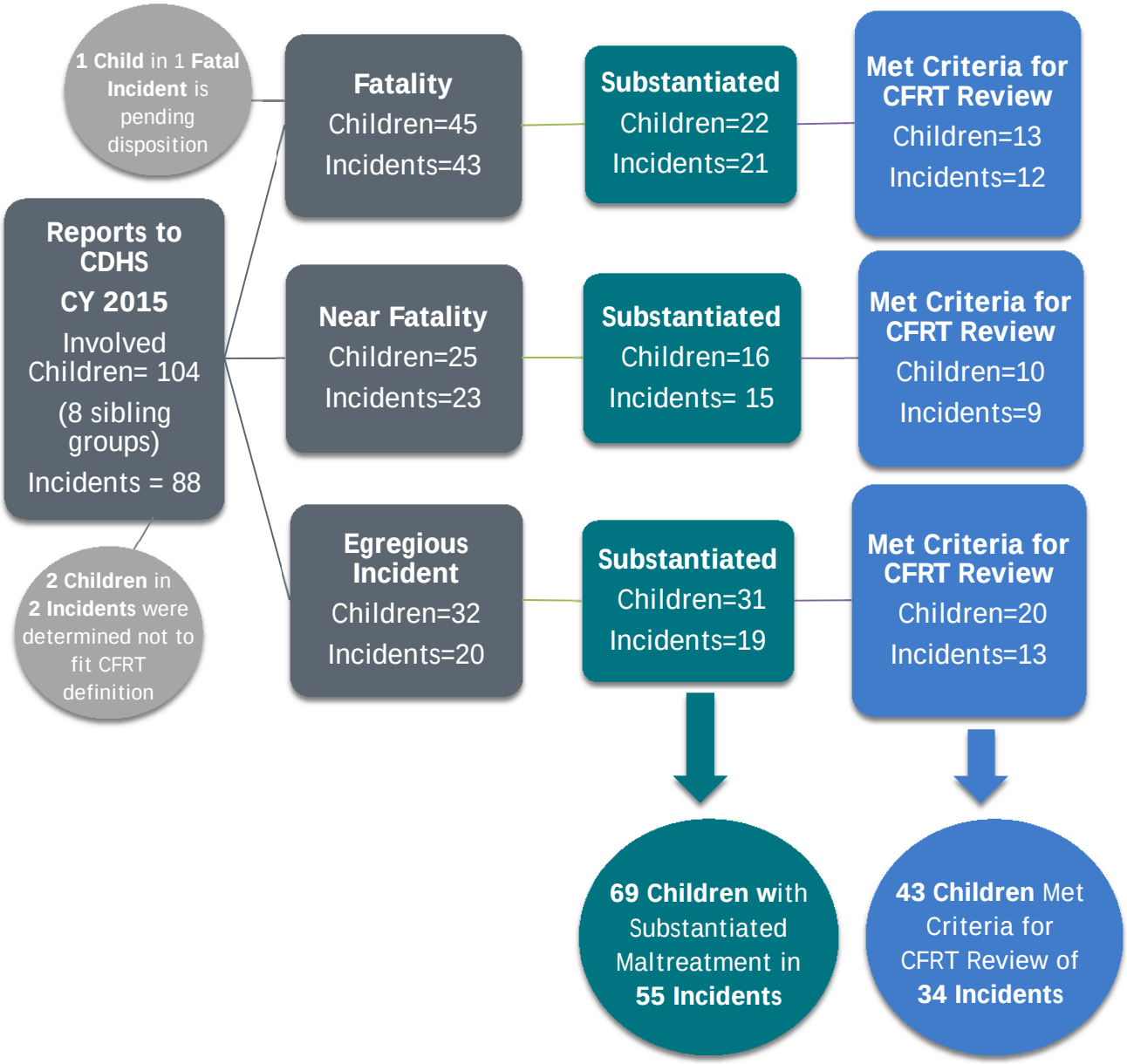
Overview of the 2015 Reports of Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment Victims

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 2015, counties reported 88 incidents involving 104 children who were suspected victims of fatal, near fatal, or egregious child maltreatment. Two children in two incidents were reported to the CFRT but later determined not to fit the definition. For the remaining 102 children, 45 children were associated with 43 fatal incidents, 25 children were associated with 23 near fatal incidents, and 32 children were associated with 20 egregious incidents.

Of those incidents with completed assessments (one fatal incident was pending disposition at the time of this report), 30 incidents regarding 32 children were found to be unsubstantiated for abuse or neglect. 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 2015, 55 substantiated incidents included 69 children, 43 of whom had prior involvement with DHS 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 2015. Appendix B 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 2015



For purposes of this report, the majority of the analysis in the following section focuses on the 69 substantiated victims of fatal, near fatal, and egregious incidents of child maltreatment reported to the CDHS or discovered through the data integrity check (described in the background section). When available, comparisons are made across calendar years and to national data. As this data has been collected for quite some time, trends for the fatal incidents are provided across several years. Table 3 provides an overview of the demographic characteristics of the 69 substantiated victims of incidents that occurred in CY 2015.

Table 3: Summary information of all 69 substantiated victims of child maltreatment fatalities, near fatalities, and egregious incidents in Colorado for CY 2015

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Victim at Time of Incident	Less than one	8	36.4%	6	37.5%	9	29.0%
	One	3	13.6%	1	6.3%	1	3.2%
	Two	5	22.7%	1	6.3%	3	9.7%
	Three	1	4.5%	2	12.5%	1	3.2%
	Four	2	9.1%	3	18.8%	1	3.2%
	Five	0	0.0%	0	0.0%	2	6.5%
	Six	0	0.0%	0	0.0%	3	9.7%
	Seven	0	0.0%	0	0.0%	3	9.7%
	Eight	0	0.0%	1	6.3%	0	0.0%
	Nine	1	4.5%	0	0.0%	1	3.2%
	Ten	1	4.5%	0	0.0%	0	0.0%
	Eleven	0	0.0%	1	6.3%	2	6.5%
	Twelve	0	0.0%	0	0.0%	2	6.5%
	Thirteen	0	0.0%	0	0.0%	2	6.5%
	Fourteen	0	0.0%	0	0.0%	0	0.0%
	Fifteen	0	0.0%	0	0.0%	1	3.2%
	Sixteen	0	0.0%	0	0.0%	0	0.0%
	Seventeen	1	4.5%	1	6.3%	0	0.0%
Race/Ethnicity	African American	3	13.6%	1	6.3%	5	16.1%
	Asian	0	0.0%	0	0.0%	0	0.0%
	Hispanic	13	59.1%	4	25.0%	7	22.6%
	Multiracial	1	4.5%	0	0.0%	4	12.9%
	Unknown	1	4.5%	0	0.0%	1	3.2%
	White	4	18.2%	11	68.8%	14	45.2%
Gender	Female	9	40.9%	2	12.5%	8	25.8%
	Male	13	59.1%	14	87.5%	23	74.2%
Family Structure	One parent	1	4.5%	2	12.5%	5	16.1%
	One parent and one related caregiver	1	4.5%	0	0.0%	2	6.5%
	One parent and one unrelated caregiver	7	31.8%	5	31.3%	12	38.7%
	Two parents	10	45.5%	6	37.5%	9	29.0%
	Two parents and relatives	0	0.0%	2	12.5%	3	9.7%
	One related caregiver	1	4.5%	0	0.0%	0	0.0%
	One parent and relatives	2	9.1%	0	0.0%	0	0.0%
	Residential Child Care Facility	0	0.0%	1	6.3%	0	0.0%

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 near fatal or egregious incidents of 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 (FFY 2014) to illustrate similarities and differences. National data is not available for near fatal or egregious incidents.

Race/Ethnicity

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[2].

Nationally, 43% of child fatalities are White children, 30.3% are African American children, and 15.1% are Hispanic children.

Race and ethnicity data from the 2010 Census data from the Colorado State Demography 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

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[1] US Department of Health and Human Services. (2015). Child maltreatment 2014. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/cm2014.pdf

[2] Gonzalez-Barrera, A. & Lopez, M. H. (June 2015). Is being Hispanic a matter of race, ethnicity or both? Retrieved from: http://www.pewresearch.org/fact-tank/2015/06/15/is-being-hispanic-a-matter-of-race-ethnicity-or-both/

the State Demographer estimated that by 2020, individuals of Hispanic origin will comprise 24.4% of Colorado's total population. The estimated population for those individuals identifying as White will decrease to 66.2%, while African American population will increase slightly to 4.3%.

Chart 3 displays the race/ethnicity for the 69 victims in the fatal, near fatal, and egregious incidents of child maltreatment that occurred in Colorado in 2015. While Hispanic (59%) was the most frequent race/ethnicity for children in fatal incidents of child maltreatment, White was the most frequent for children in near fatal incidents (69%) and children in egregious incidents (45%). Children of Hispanic race/ethnicity comprised 25% of near fatal victims and 23% of egregious victims. Trends for near fatal and egregious incidents more closely resemble the overall population trends for Colorado.

Chart 3: Race/Ethnicity of victims in all substantiated fatal, near fatal, and egregious incidents of child maltreatment in Colorado for CY 2015

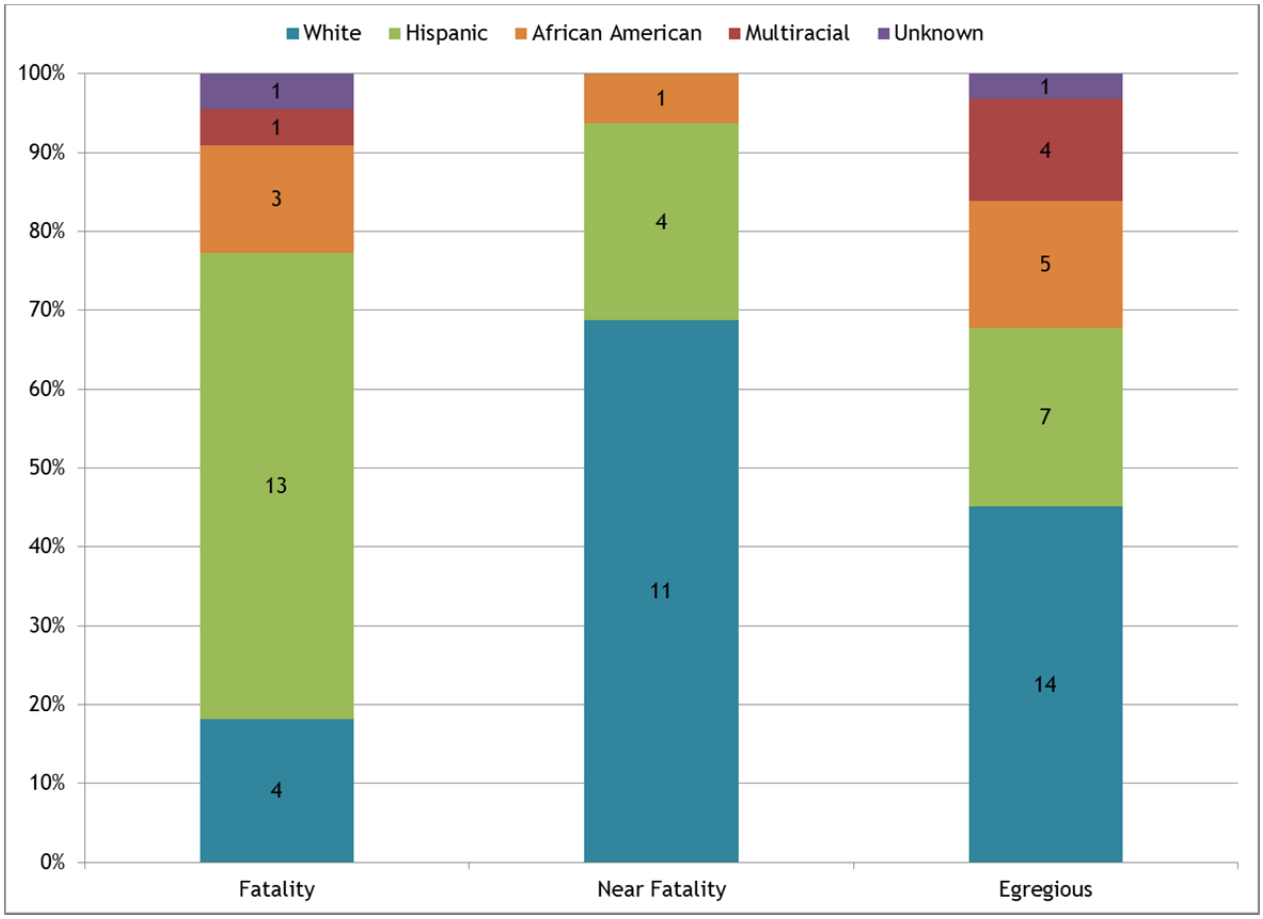
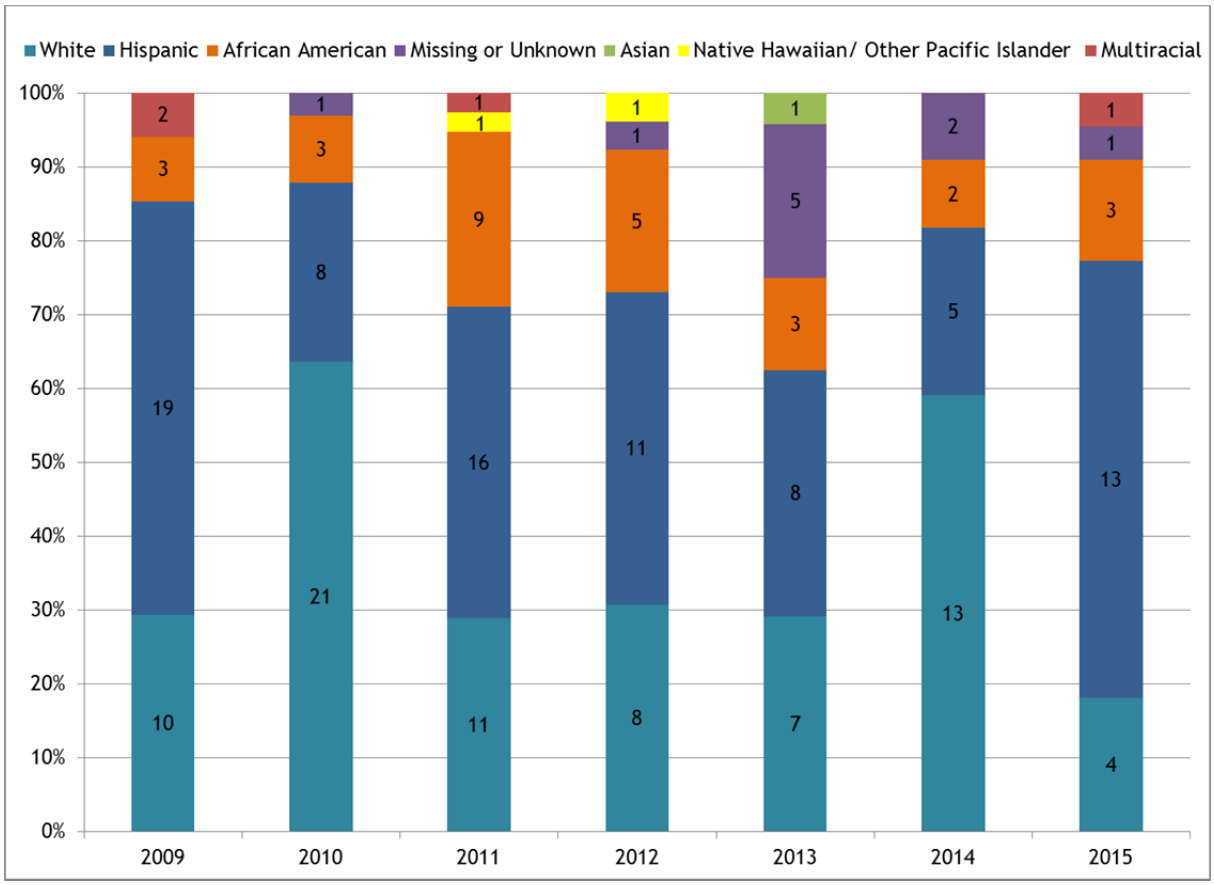


Chart 4 shows the race/ethnicity of all child maltreatment fatalities in Colorado over the past six years. For fatalities in CY 2015, the most frequent race/ethnicity was Hispanic (59.1%), followed by White (18.2%) and African American (13.6%). This is a significant change from 2014, where almost 60% of victims of child maltreatment fatalities were White (59.1%), followed by Hispanic (22.7%).

In calendar year (CY) 2009, Hispanic children 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. For CY 2014 victims identified as White encompassed more than half of the fatalities. However, CY 2015 marked a shift back to the pattern of Hispanic being the majority of victims. This is disproportionate to the population of Coloradans, as White comprised an estimated 68.9% of Colorado's population in 2015, while Hispanics are estimated to be 22.3% of Colorado's population. The percentage of White is expected to decrease over the next 25 years to approximately half of Colorado's population while the Hispanic population increases to 33%, and it will be important to watch those trends in comparison to fatality rates.

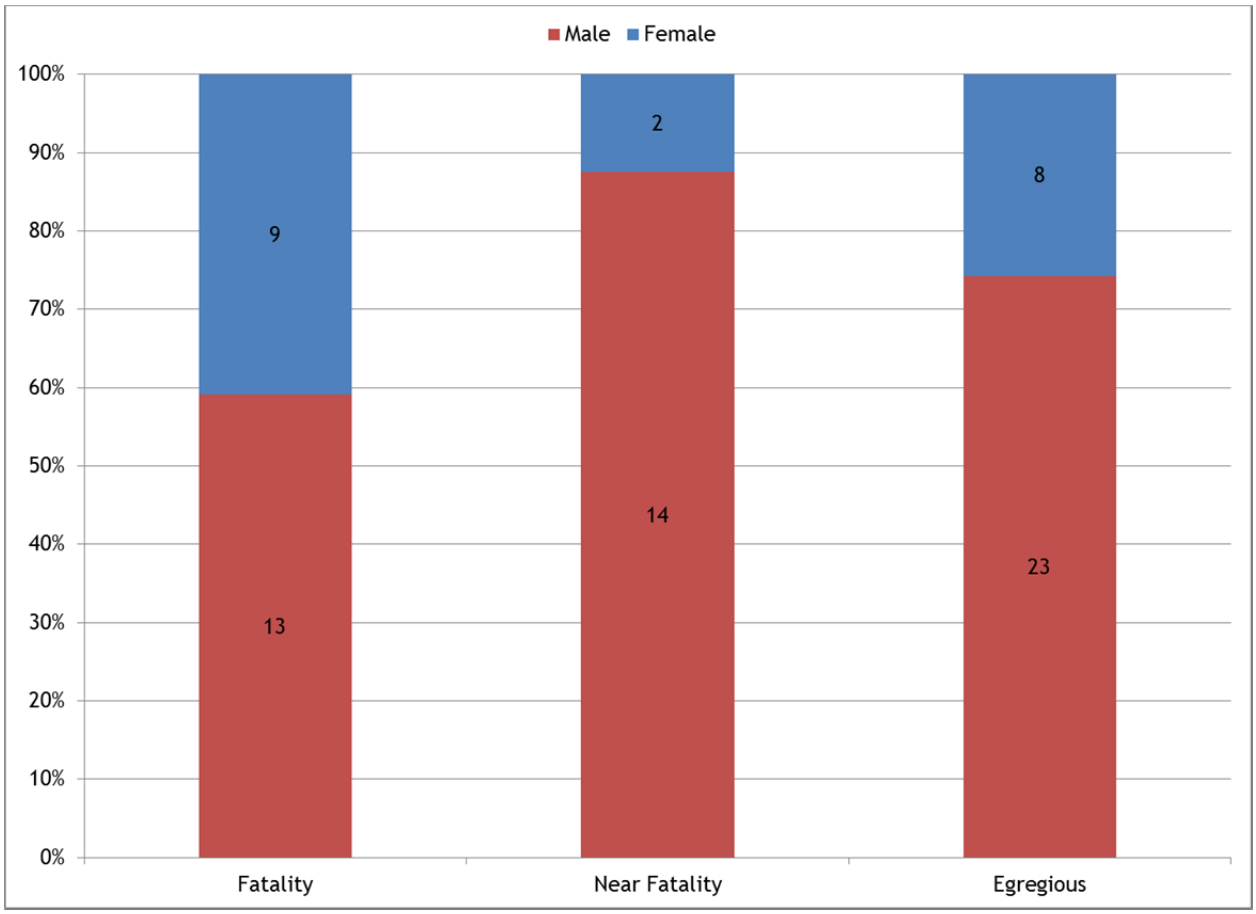
Chart 4: Race/ethnicity of victims in all substantiated child maltreatment fatalities in Colorado over the past seven calendar years



Sex of victim

Chart 5 displays the breakdown of differences in the sex of the victims by the type of incidents. Nationally, in FFY 2014, 58.3% of child maltreatment fatality victims were males. In Colorado, in CY 2015, males accounted for 59.1% (13/22) of the children in substantiated child maltreatment fatalities. Males were victims of almost all the near fatalities (87.5%; 14/16) and three-fourths of the egregious incidents (74.2%; 23/31). There are no federal comparison statistics for near fatal or egregious incidents.

Chart 5: Sex of 69 victims in substantiated child maltreatment fatalities, near fatalities, and egregious incidents in Colorado for CY 2015



In the recent past, Colorado mirrored national trends in regard to the sex of child fatality victims. In 2009 and 2010, approximately 56% of child maltreatment fatalities involved males. However, in 2011, the percentage of male victims increased to 63%, and then a high of 67% in 2013. In 2014, this trend in Colorado changed, with males accounting for 50% (11/22) of all fatalities. As demonstrated in Chart 6, for 2015 Colorado (59.1% male) is closely in-line with national trends (58.3% male) in regards to the sex of child maltreatment fatality victims.

Chart 6: Sex of victims in all substantiated child maltreatment fatality victims in Colorado over the past seven calendar years

Age at Time of Incident

Historically, a child's age has been a key demographic factor associated with child maltreatment fatalities. National data shows that in FFY 2014, victims of fatal child maltreatment incidents tend to be younger, with approximately 78% of the child fatalities experienced by children age three or younger, and 44.2% 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 77.3% (17/22) were three or younger. A similar pattern exists for the near fatalities, as 37.5% (6/16) of the victims were under the age of one, and 62.5% (10/16) 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. Twenty-nine percent (9/31) of the victims of egregious incidents were under the age of one, and 45.2% (14/31) of all egregious incident victims were aged three or younger. Seven of the 31 victims were ages 11 and older (22.6%), which is a decrease from the past year.

Chart 7: Age of 69 victims in substantiated child maltreatment fatalities, near fatalities, and egregious incidents in CY 2015

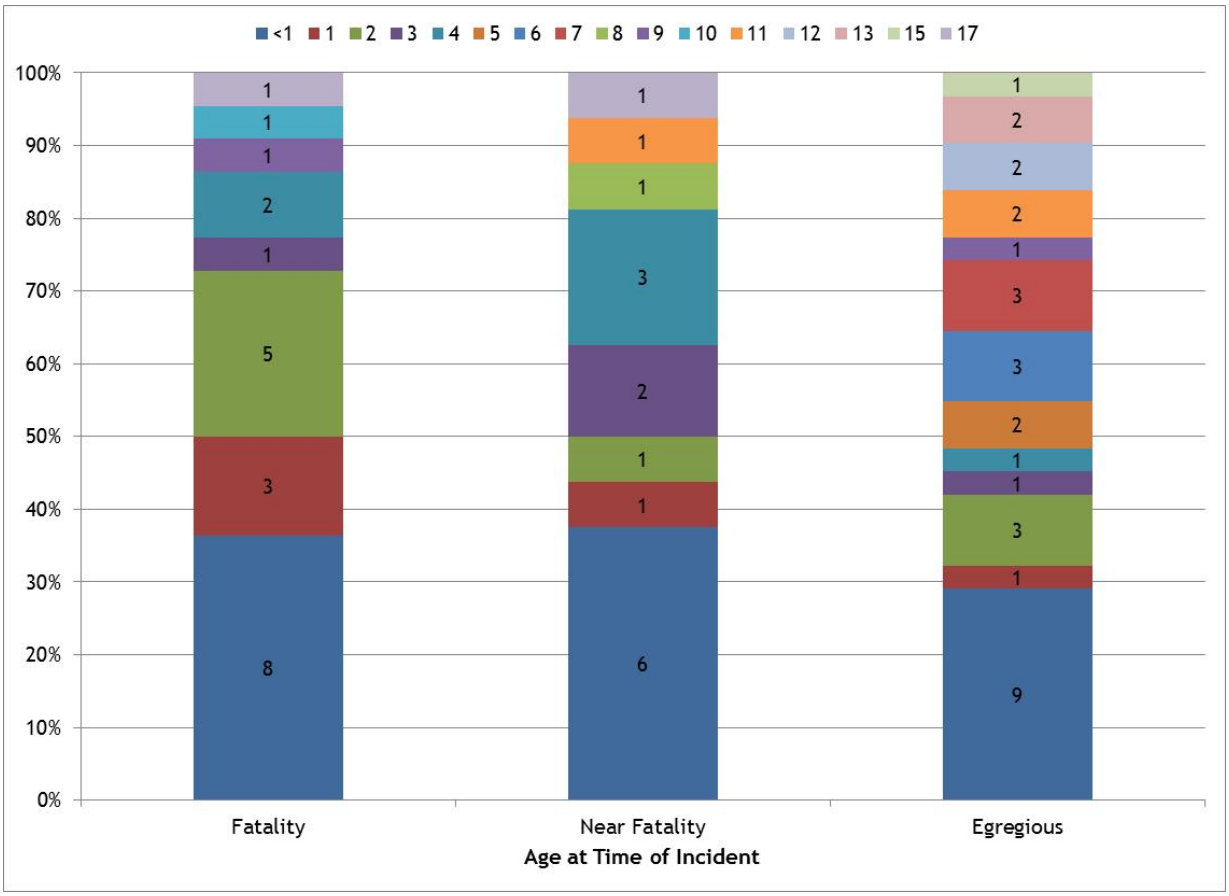
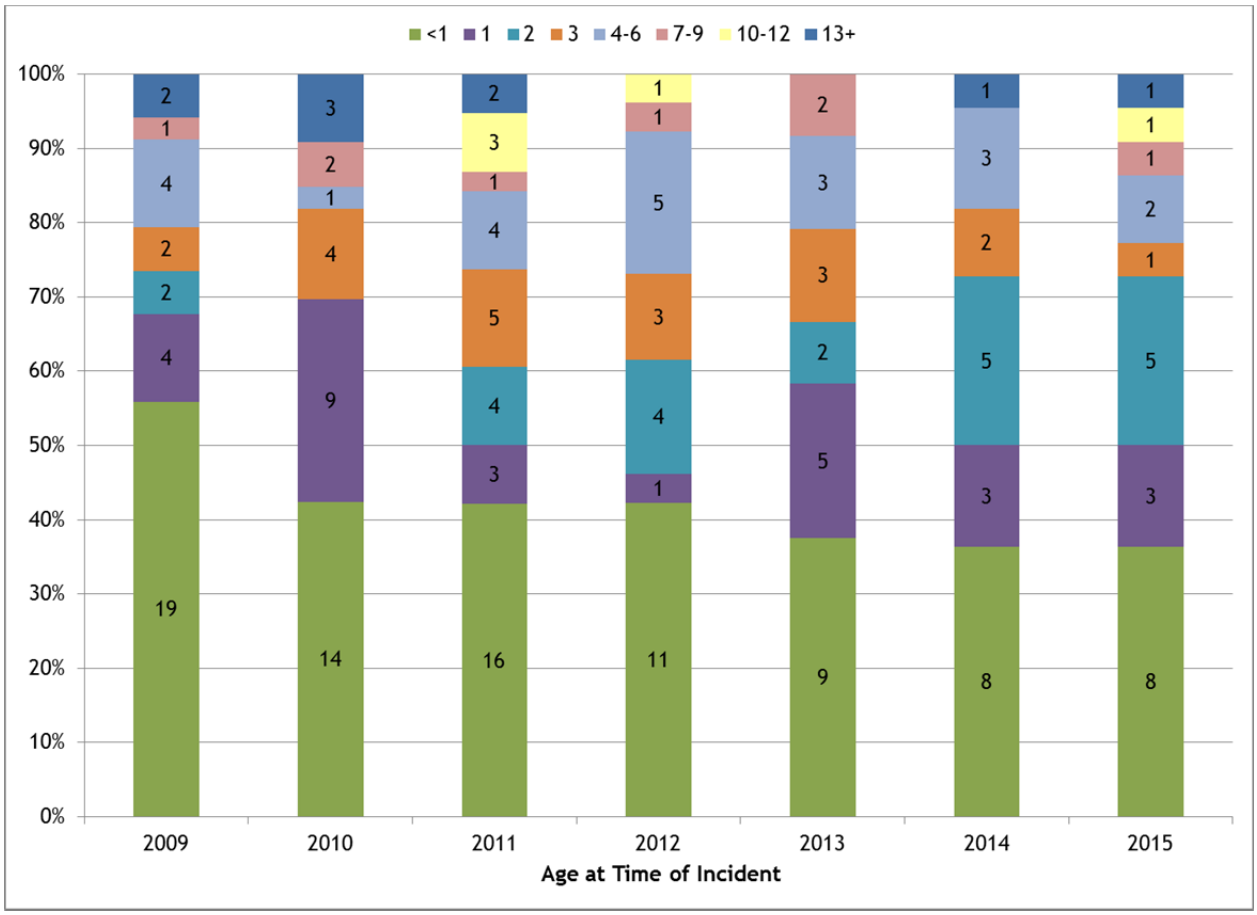


Chart 8 displays the trends in ages of victims in child maltreatment fatalities over the past six years. While it varies slightly over time, approximately 77% of children in fatal child maltreatment incidents are three years of age or younger.

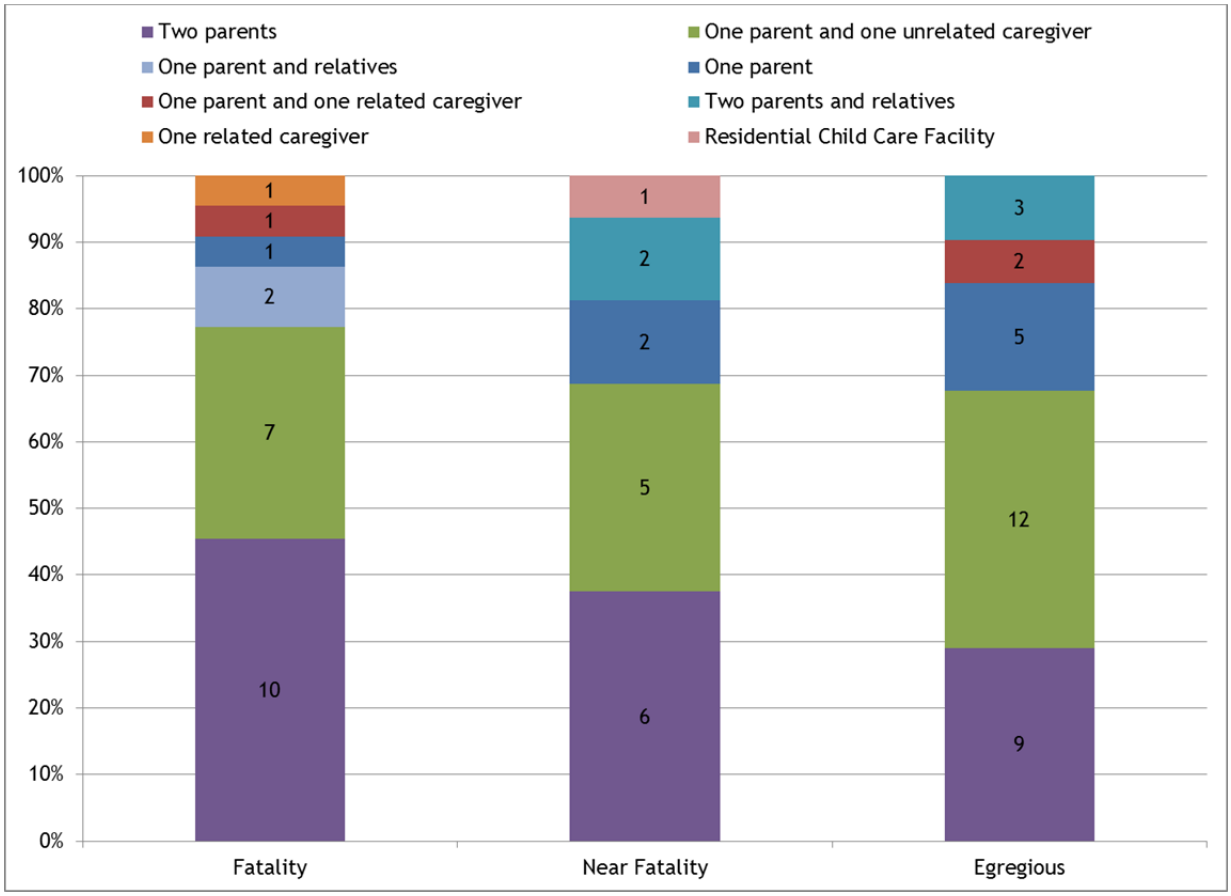
Chart 8: Age of victims in child maltreatment fatalities in Colorado over the past seven calendar years



Family Structure

Family composition is another factor potentially related to child maltreatment fatalities. As displayed in Chart 9, 36% (25/69) of all children in fatal, near fatal, and egregious incidents of child maltreatment lived in families with two parents. The second most common type of family structure across all substantiated incidents was one parent and one unrelated caregiver (34.8%; 24/69). In fact, 77.3% (17/22) of fatal incidents occurred for children in families with two parents or one parent and an unrelated caregiver. These two types of family composition were also most likely for the children in egregious incidents and near fatalities; 67.7% (21/31) of children in egregious incidents maltreatment and 68.8% (11/16) of children in near fatal incidents of child maltreatment. This year, one child in one incident was a victim of a near fatality in a Residential Child Care Facility.

Chart 9: Family Structure of 69 victims of substantiated child maltreatment fatalities, near fatalities, and egregious incidents in 2015



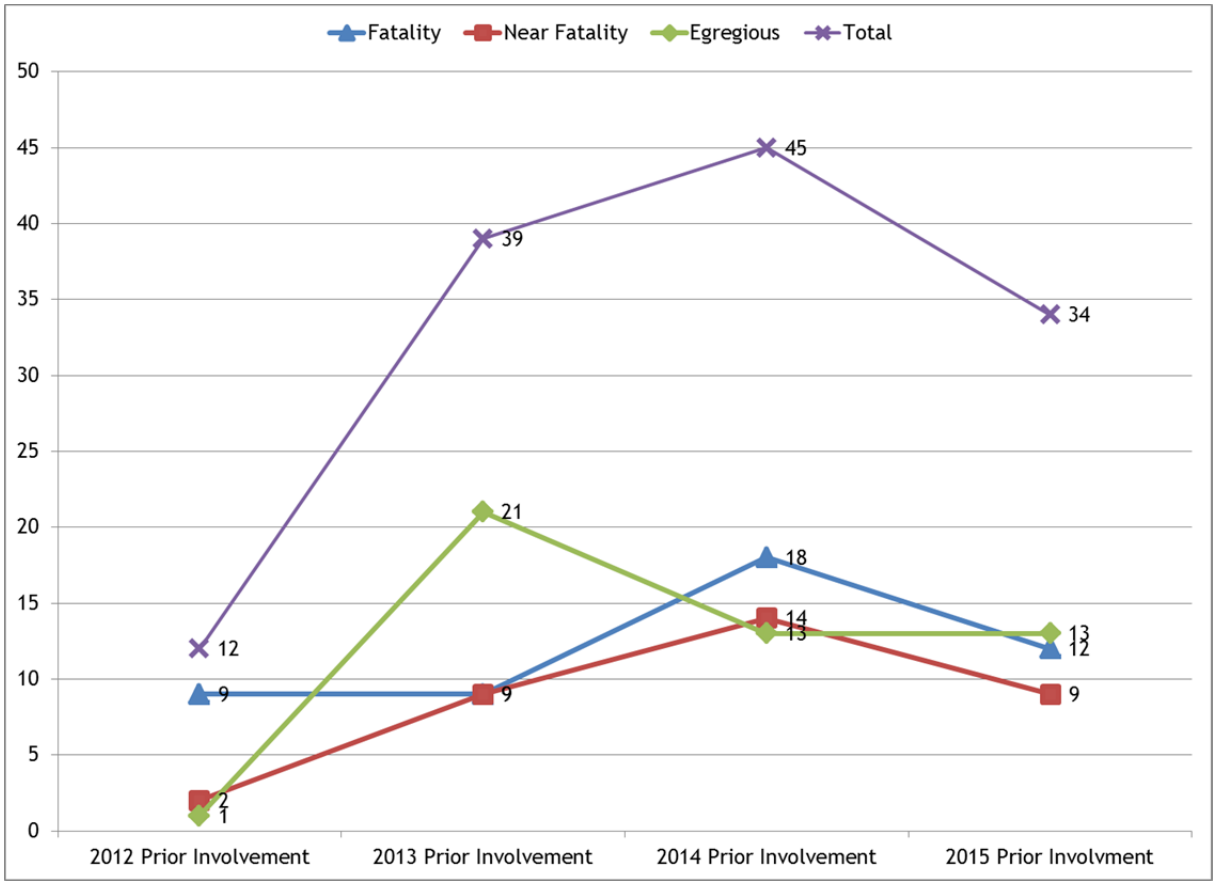
Prior Involvement

Nationally, in 2014, 1.8% of child fatalities involved families with prior out-of-home placement within the past five years, and 12.2% 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. According to current state statute, the CFRT is required to conduct a thorough review of fatal, near fatal, and egregious incidents of child maltreatment when there is prior history in the three years preceding the incident. Before the change to statute in 2013, prior child welfare involvement was defined as a two-year time period (2011).

For the child maltreatment fatalities that occurred in Colorado during calendar years 2012 – 2015, approximately 35% to 82% of the families had prior or current child protection history as defined in statute. In 2015, 12 of 21 (57.1%) families involved in fatal child maltreatment incidents had prior history and/or current involvement in the Child Protection System (CPS); in 2014, 81.8% (18/22) of fatalities had prior history and/or current involvement. This is a significant decrease in the number of fatalities in 2015 with prior history compared to those from 2014. The number of families with prior history and/or current involvement for both near fatalities and egregious incidents remained relatively stable from 2014 to 2015. Near

fatal incidents where families had prior history and/or current involvement remained stable at 60.9% (14/23) in 2014 and 60.0% (9/15) in 2015. Families involved in egregious child maltreatment incidents who had prior history and/or current involvement went from 59.1% (13/22) in 2014 to 68.4% (13/19) in 2015. Chart 10 details the trends in incidents with prior and/or current involvement for the past four calendar years.

Chart 10: Prior and/or current CPS involvement of families in substantiated child maltreatment fatalities, near fatalities, and egregious incidents in Colorado from 2012-2015*



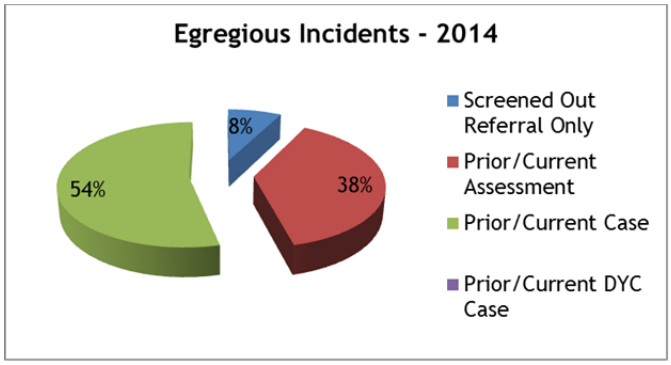
** As the statutory changes over the prior years have modified the population of incidents requiring review, and each has changed within each given calendar year, it limits the ability to interpret trends in the data. Further, any change in the final number of incidents in a given calendar year may be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

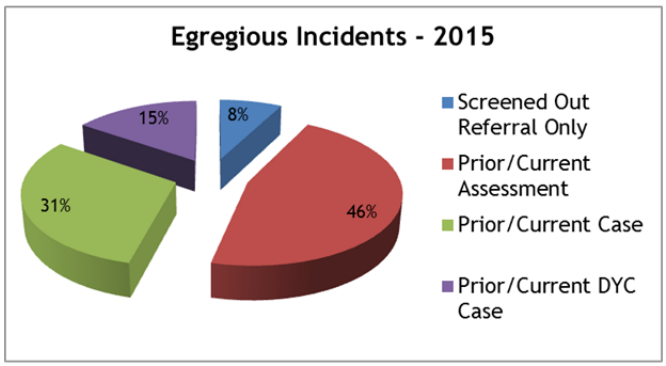
For the first time in 2014, information related to the type and scope of prior involvement was available for analysis, as illustrated in Chart 11 a-f. The same information is available for 2015, allowing for some basic comparisons. In determining the type and scope of prior involvement, this section follows the prior history to the furthest level of prior involvement the family had within the child protection system. For example, if a referral had been made regarding a family, and that referral was accepted for an assessment, the prior history will be counted only in the category for "Prior/Current Assessment." If the referral was not accepted for assessment, it would be counted in the "Prior/Current Referral" category. It should be noted that, for purposes of this report, if a child/family had prior or current involvement in

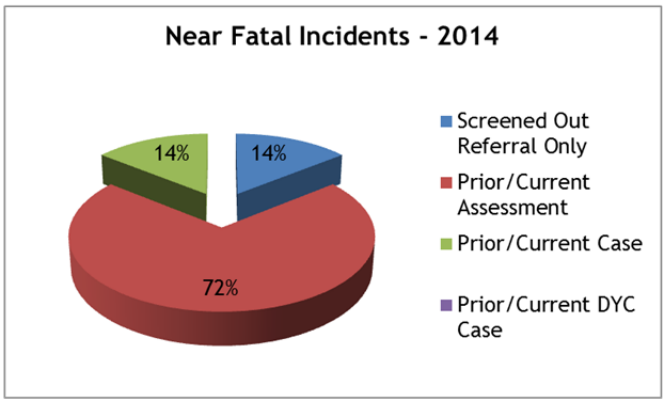
an open child welfare case and a prior or current involvement within the Division of Youth Corrections, that history was counted in both of those categories. This can result in a duplicate count for a family. While both of these describe a similar level of involvement (i.e., an open case), it can be helpful to distinguish between them. As an example, for CY 2015, there was one fatal and one near fatal incident where the prior involvement consisted of both child welfare and DYC involvement at the case level. As a result, the 2015 charts are based on 13 family involvements for fatalities (rather than 12), and 10 near fatal prior family involvements (rather than 9).

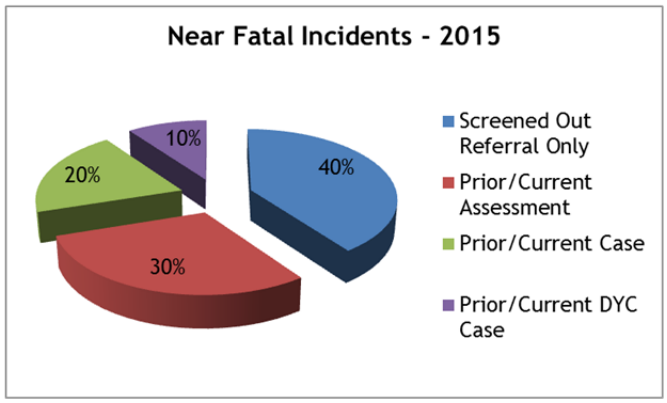
The most common type of prior history and/or current involvement for incidents occurring over the past two years was an assessment. The most frequent type of prior history and/or current involvement in fatal child maltreatment incidents in 2015 were assessments (5/13; 38.5%) and on-going cases (5/13; 38.5%). Conversely, near fatal incidents in 2015 comprised the greatest number (4/10; 40%) of incidents where the only prior history was a screened out referral, meaning the family was referred for a potential allegation of abuse or neglect but no abuse or neglect occurred.

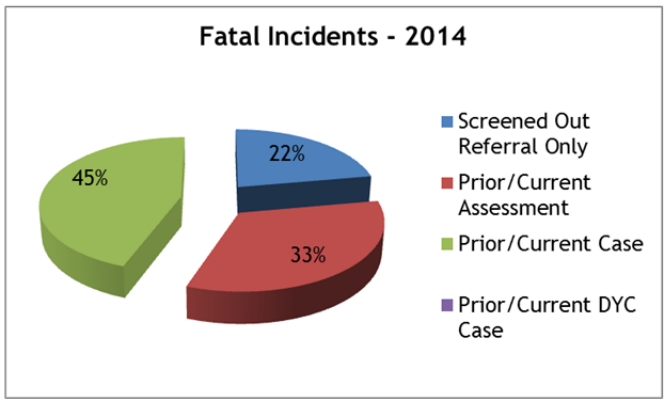
Chart 11a-f: Detail of prior involvement of families in fatal, near fatal, and egregious incidents of child maltreatment

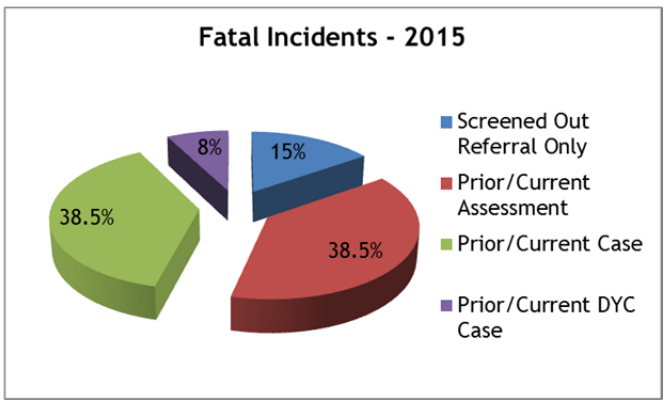












Perpetrator Relationship

Chart 12 displays the relationship between the perpetrator(s) and the victim(s) of fatal, near fatal, or egregious incidents of child maltreatment. It is important to note there can be more than one perpetrator per child and incident. In 2015, the most frequent perpetrator in fatal incidents was the victim's mother (12/30; 40%), and this is quite above national trends (28%). The second largest category of perpetrators of fatalities was fathers (10/30; 33.3%). For the near fatal incidents, mothers were also the most frequent perpetrators (8/18; 44.4%), and among the other 10 victims, the father was the perpetrator for four victims.

The perpetrators in egregious incidents were most frequently mothers (15/41; 36.6%), followed by the male partner of the parent (12/41; 29.3%) and the father (10/41; 24.4%). Across all types of incidents, five perpetrators were unknown, which means through assessment and investigation, a perpetrator of the incident was unable to be determined.

Chart 12: Perpetrator relationship to 69 victims of substantiated child maltreatment fatalities, near fatalities, and egregious incidents in Colorado during CY 2015*

More than one perpetrator exists for several children.

Family Characteristics

Several characteristics related to family dynamics appear to be generally associated with child maltreatment. Each of these is discussed below, including the data from fatal, near fatal, and egregious incidents reviewed by the CFRT in 2015. This information is only collected on the families where the incident meets the statutory criteria for review, which results in a more limited scope of analysis. 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.

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 the CFRT. This information continues to prove difficult to collect and report on, as it was not always part of the 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. For example, in 2015, there were 68 unique caregivers involved in incidents that were reviewed by the CFRT; income information was only known for 27 of these individuals (39.7%). Of those caregivers with known income information, the average income for caregivers involved in fatal incidents is approximately $21,214.56; $14,400 for near fatal incidents and $19,012.78 for egregious incidents.

Educational level was unknown for 54% (37/68) of the legal caregivers. Of the reported education levels for legal caregivers the most common across fatal, near fatal, and egregious incidents of child maltreatment was a high school diploma/GED. This accounted for 61% of the caregivers with a known educational attainment level. An additional 22.5% (7/31) had less than a high school diploma/GED.

Supplemental Public Benefits

In CY 2015, information for 29 of the 36 (80.5%) reviewed incidents indicated that the family qualified for and received some level of supplemental public benefits. According to the most recent available information, nationally, 25.8% of caregivers involved in a child maltreatment fatality received public benefits[3]. 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. The most frequently received supplemental benefit was Medicaid, received by 25 of the families. This was followed by Supplemental Nutrition Assistance Program (SNAP), which was received by 17 families. Other types of benefits received included, Supplemental Security Income (SSI),

[3] US Department of Health and Human Services. (2014). Child maltreatment 2013. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf

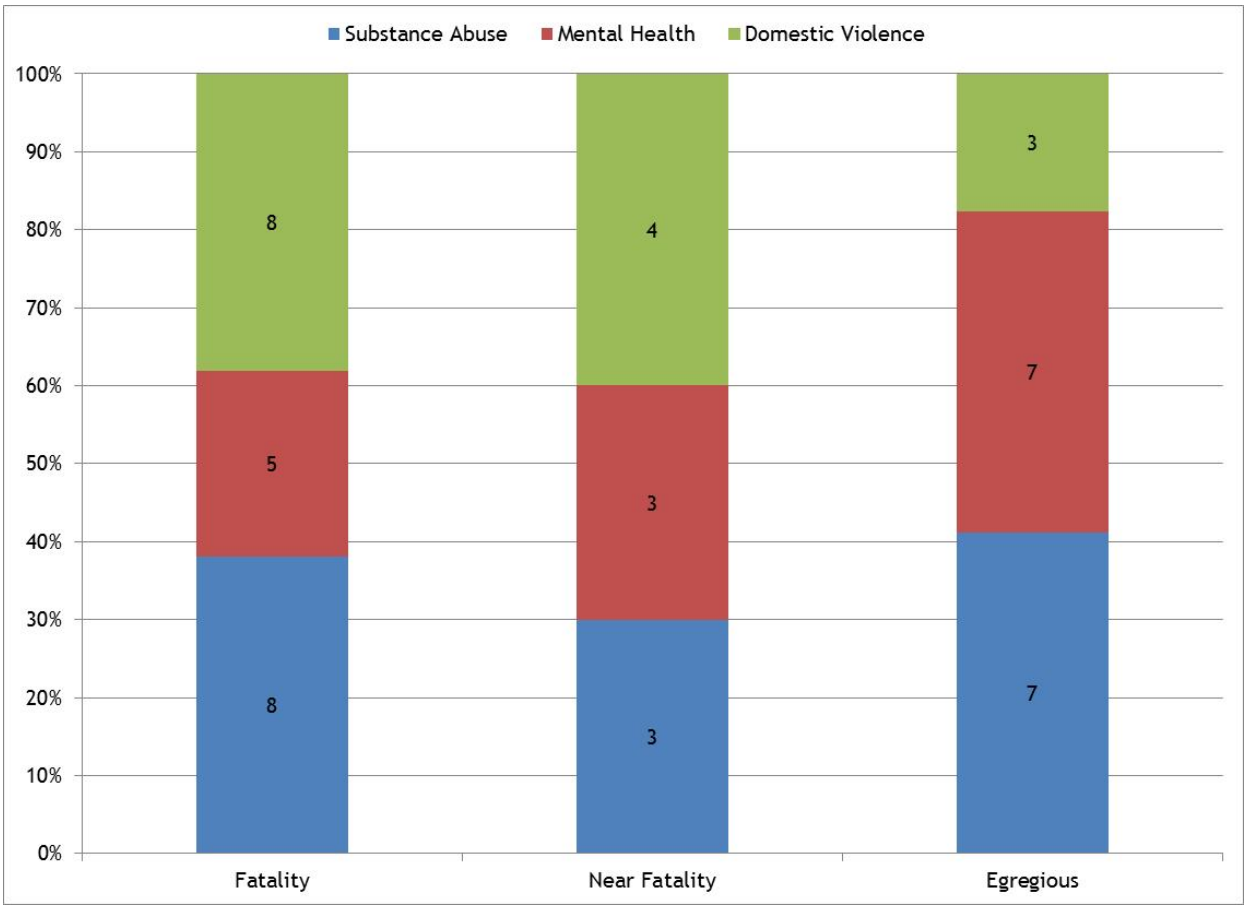
Temporary Assistance for Needy Families (TANF), and Special Supplemental Nutrition Program- Women, Infants, Children (WIC), Social Security Disability Insurance (SSDI), and Colorado Works.

Other Family Stressors

Chart 13 identifies additional elements that were tracked in an effort to determine commonalities among the families involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed in 2015. Nationally, 6.9% of child fatalities were associated with a caregiver who was known to abuse alcohol, while 17.9% of child fatalities had a caregiver who abused drugs. In Colorado, 61.5% (8/13) of the families involved in a fatal incident of child maltreatment reviewed by the CFRT in 2015 had some history of identified substance abuse.

Within the families involved in child fatalities, 61.5% (8/13) of the families experienced domestic violence issues and for 38.5% (5/13) 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 13: Other stressors in families of the child maltreatment fatalities, near fatalities, and egregious reviewed by the CFRT in 2015



Summary of CFRT Review Findings and Recommendations

This section summarizes the findings and recommendations of 27 non-confidential case-specific executive summary reports (hereafter referred to as reports). This includes 26 reports completed and posted to the CDHS public notification website after the date for inclusion in the 2014 CFRT Annual Report (4/30/2015) and prior to and including the end date for inclusion in this year's report (3/31/2016), and 1 report that met criteria for inclusion in the 2014 CFRT Annual Report, but was inadvertently left out. Each of the 27 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 27 reports point to the strengths and gaps in the child welfare system surrounding fatal, near fatal, and egregious incidents of child maltreatment.

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 7 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 27 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 27 reports alongside resulting recommendations and progress.

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

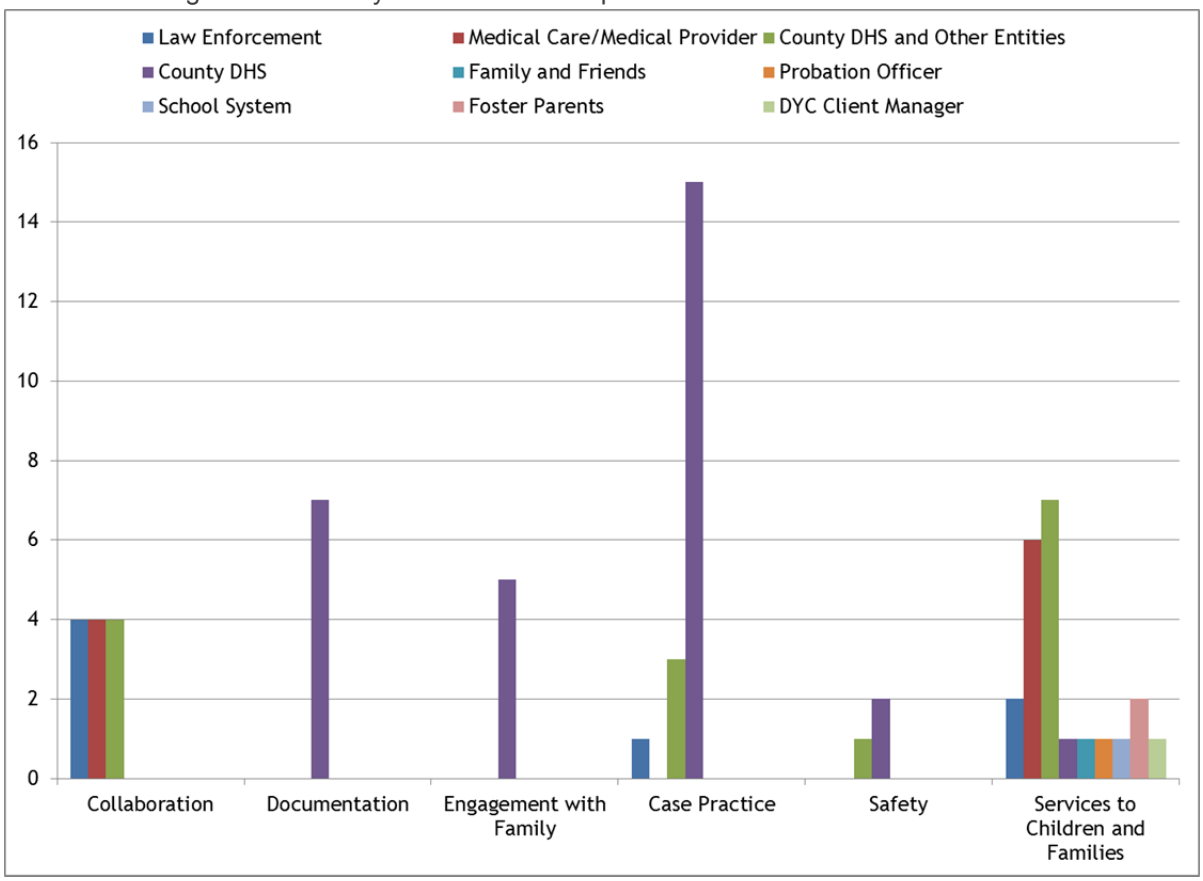
In the 27 fatal, near fatal, or egregious incidents of child maltreatment reviewed by the Child Fatality Review Team and posted to the public notification website, the team noted 68 systemic strengths in the delivery of services to children and families. A qualitative analysis of the 68 systemic strengths indicated six main themes. 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 three systems most frequently mentioned are: 1) County Departments of Human Services (both alone and alongside other entities), 2) Medical Providers, and 3) Law Enforcement. 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 12 occasions in 10 reports. Most often, collaboration occurring *after* the fatal, near fatal, or egregious incident was noted as a

strength. For example, county departments and law enforcement worked well together to investigate the circumstances around the incident. Medical providers were also indicated as important collaborative members in the assessment of the 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 seven occasions in six reports, with regard to casework in the fatal, near fatal and egregious incidents. Specifically, the CFRT noted that county departments of human/social services completed thorough internal reviews of the incidents and were transparent and forthcoming with information.

Engagement of Family

On five occasions, across five reports, it was noted that county departments worked diligently to engage and support family members surrounding fatal, near fatal, and egregious incidents of child maltreatment. In one case, a county involved extended family to support the mother and children after the incident, and coordinated extensive trauma treatment services for them. On another occasion, the county department was able to engage the mother and get her to work with the department.

Case Practice

The CFRT identified caseworkers who excelled in case practice to children and families 19 different times (across 13 reports) following fatal, near fatal and egregious incidents of child maltreatment. For example, caseworkers demonstrated strong practice skills by using a variety of methods to locate other children involved with the family when the children were hard to find. In another incident, the county worked with law enforcement to ensure translation services were available and located a cultural center to help better understand the culture of the family involved in the incident.

Safety

The CFRT identified three instances across three reports where systems surrounding children and families provided excellent work in the promotion of child safety. The CFRT noted the work of a county department of human/social services in sponsoring an educational campaign to promote Safe Sleep environments. County department of human/social services also worked diligently to ensure the safety of any children remaining in the home.

Services to Children and Families

Finally, service provision to children and families, both before and after fatal, near fatal, and egregious incidents of child maltreatment, was noted as a strength 22 times across 15 reports. In several different incidents, the county department of human/social services worked with other entities to help secure therapeutic services for the children and families, including trauma-specific treatment. In addition, partnerships with medical providers helped county department of human/social services explain the signs of child abuse to caretakers so they could better help the child. Finally, the quality of services provided to foster parents helped create stability and safety in two incidents.

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

In the 27 fatal, near fatal, or egregious child maltreatment incidents reviewed by the Child Fatality Review Team with case specific executive summary reports posted to the public notification website, the CFRT identified 60 gaps and deficiencies in the delivery of services to children and families. This number is almost the same as in 2014, reflecting a stable CFRT membership that is consistently able to share and identify multi-systemic issues. This year the systemic gaps and deficiencies can be organized into three main categories: 1) Safety and Risk Assessment Tools, 2) Changes Needed to County Practice or Policy, and 3) Other 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 27 incident reviews and information about their implementation status.

Safety and Risk Assessment Tools

A systemic deficiency identified by the CFRT in 25 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 40 policy findings related to the use of the safety and risk assessments, spread across 25 of the 27 reports. Statewide and county-specific data further supported this deficiency by continued 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 (DCW) began planning for changes to the Colorado Risk and Safety Assessment tools in 2012. These changes were designed to positively impact performance in this area. It was expected the new Safety and Risk Assessment tools would be implemented statewide in 2014. The DCW is working on a phased implementation strategy, and implementation in each county will be based on criteria around performance of county practice. To date, implementation has happened in 23 counties and full implementation across all 64 counties will be complete in 2017.

Changes Needed to County Practice or Policy

The CFRT noted particular county-specific issues with practice and state policy gaps in 10 of the 27 CFRT reports. Several recommendations centered on the county needing to complete a county internal review report of the fatal, near fatal, or egregious incident, as required in Volume 7, 7.106.121 (B) (2). As an example of an area to expand state child welfare policy, in one case the CFRT recommended that the DCW facilitate communication between counties to assist the smaller counties to have a county to contact for purposes of seeing the alleged victim within the assigned response time.

Unique Issues

The remaining half (26/60) 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, 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 regarding the assessment of the fatal, near fatal, and egregious incidents of child maltreatment 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 7 and the Colorado Revised Statutes.

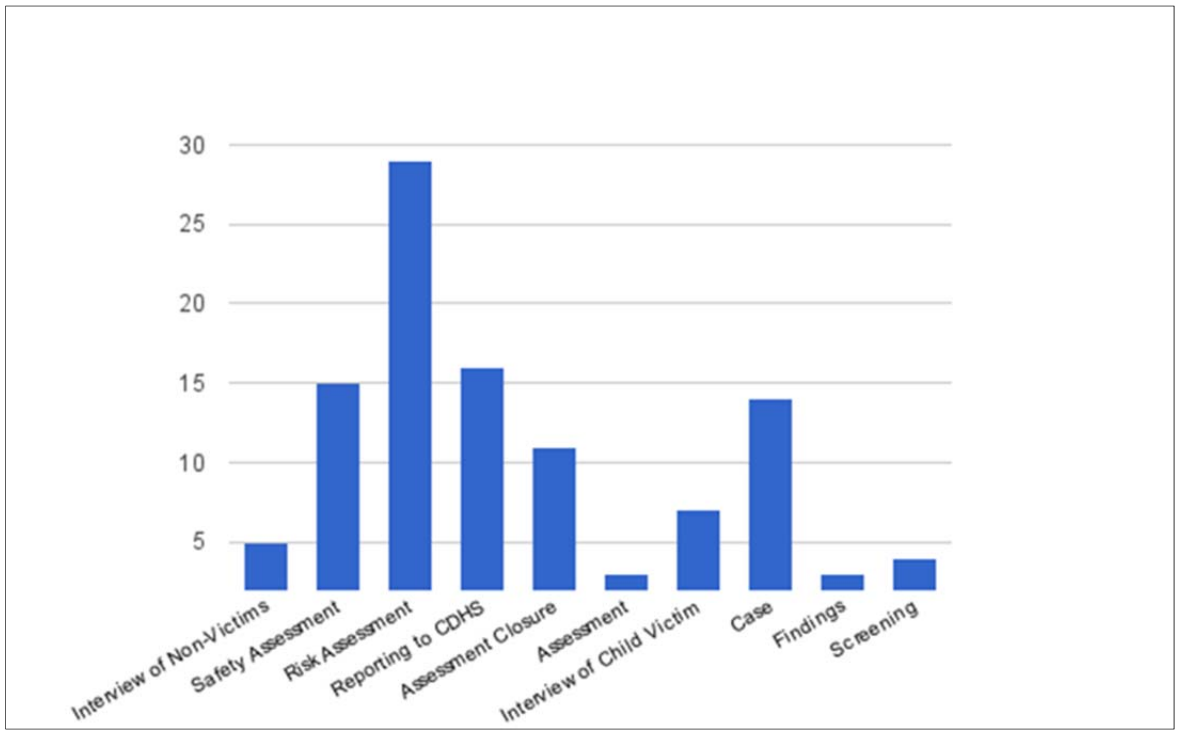
Each policy finding represents an instance where caseworkers and/or county departments did not comply with specific statute or rule. However, there are limitations to interpreting policy findings in the aggregate across the varied history and circumstances of multiple incidents. For example, an individual 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 staff 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 (including the use of the Results Oriented Management (ROM) system), determinations were made regarding the need for recommendations for improvement related to the policy findings.

There are 107 policy findings from the 27 reports posted between the cutoff for the last CFRT Annual Report (4/30/2015) and this year's report (3/31/2016) that resulted in recommendations. The majority of these 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) Timeliness to interviewing alleged victims of child maltreatment; 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 decisions; 9) Timeliness of Assessment Closure; and, 10) Interviewing alleged non-victims of child maltreatment. The frequency by type of policy finding is contained in Chart 15.

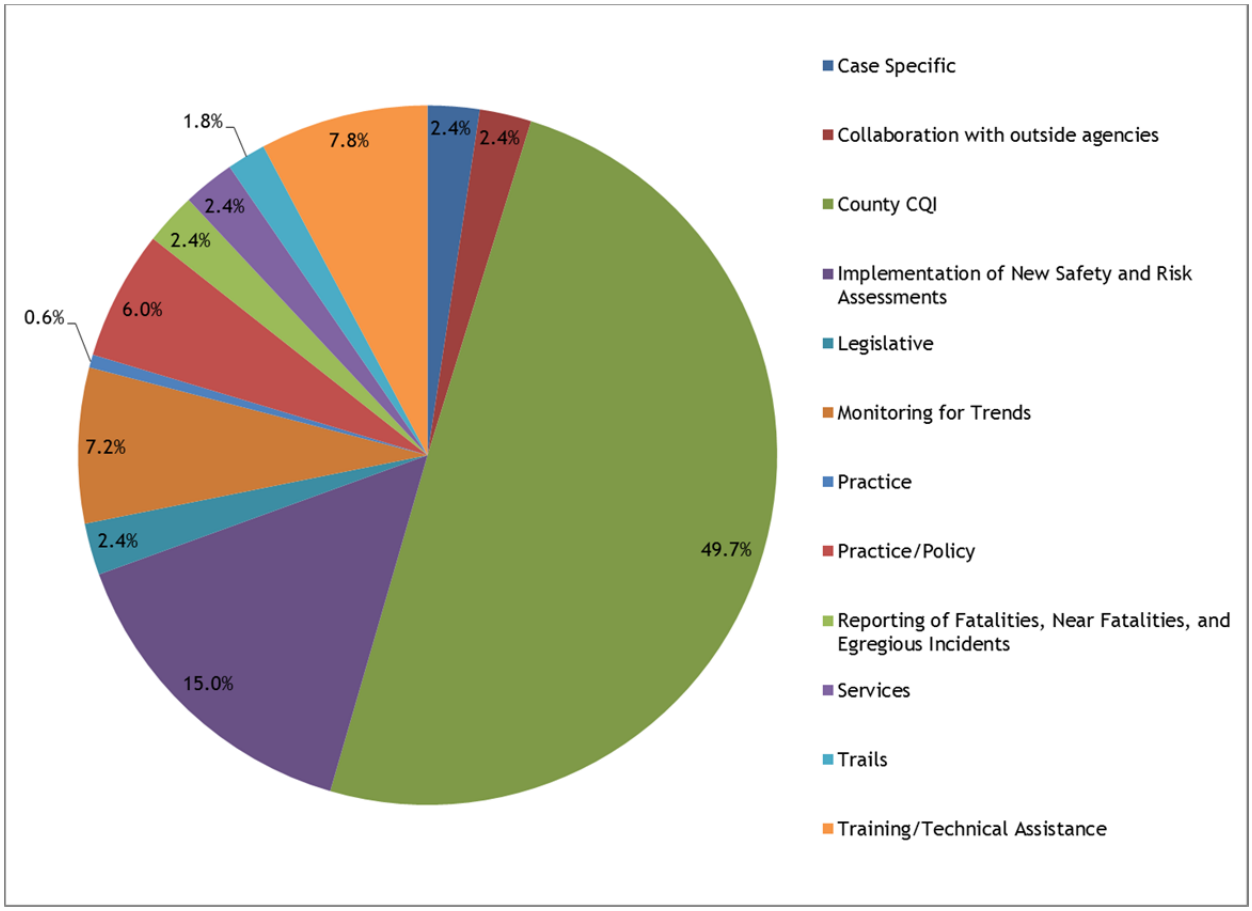
Chart 15: Policy findings by type



2015 Recommendations from Posted Reports

A total of 167 recommendations were made across the 27 posted reports. This included 60 related to systemic gaps and deficiencies and 107 related to policy findings. As illustrated in Chart 16, the top areas recommended are: 1) County CQI to address barriers to performance and implement solutions; 2) Implementation and training on revised risk/safety tools to improve accuracy; 3) Providing training and technical assistance from DCW to county departments; and, 4) Monitoring for trends through the C-Stat and Administrative Review process.

Chart 16. Focus of recommendations in the 27 reports posted between 5/1/2015 and 3/31/2016

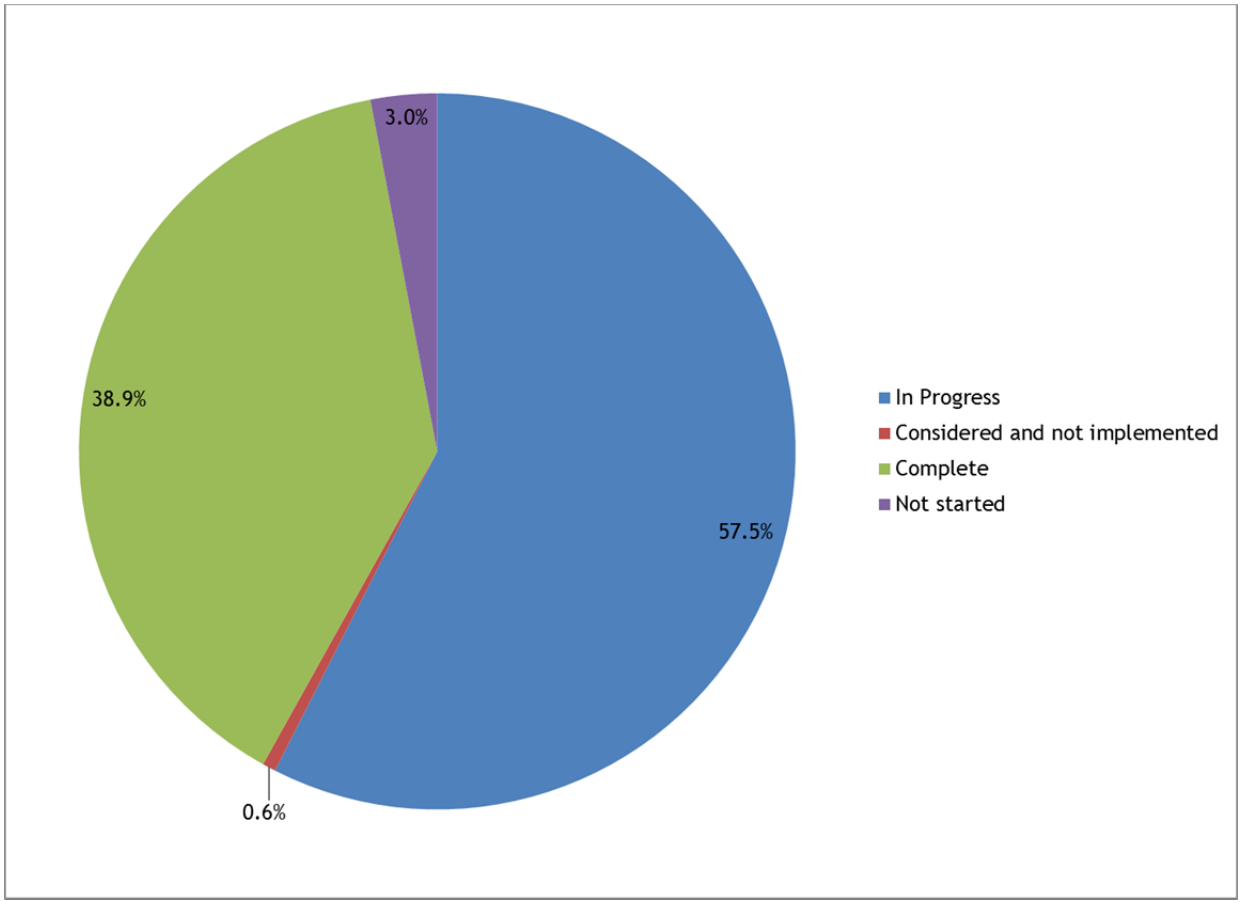


While several recommendations were reviewed in this report, the full texts of all 167 are contained in Appendix C. The status of progress on these recommendations is also presented. As illustrated in Chart 17, 38.9% of the recommendations have been completed while an additional 57.5% are in progress. For one recommendation, it was determined that it would not be implemented at this time. Specifically, the recommendation focused on enhancing the Colorado Trails system to alert caseworkers when a county staff member adds a client into demographics on a referral and/or assessment if that client is open in another Colorado Trails case/assessment/referral. This recommendation was discussed by the County Trails Users Group (CTUG) (an approved task group of the Policy Advisory Committee) and determined that the current alert system is not well utilized within the Trails system. Rather, CTUG

discussed prioritizing the creation of an enhanced notification system as part of the Trails modernization project.

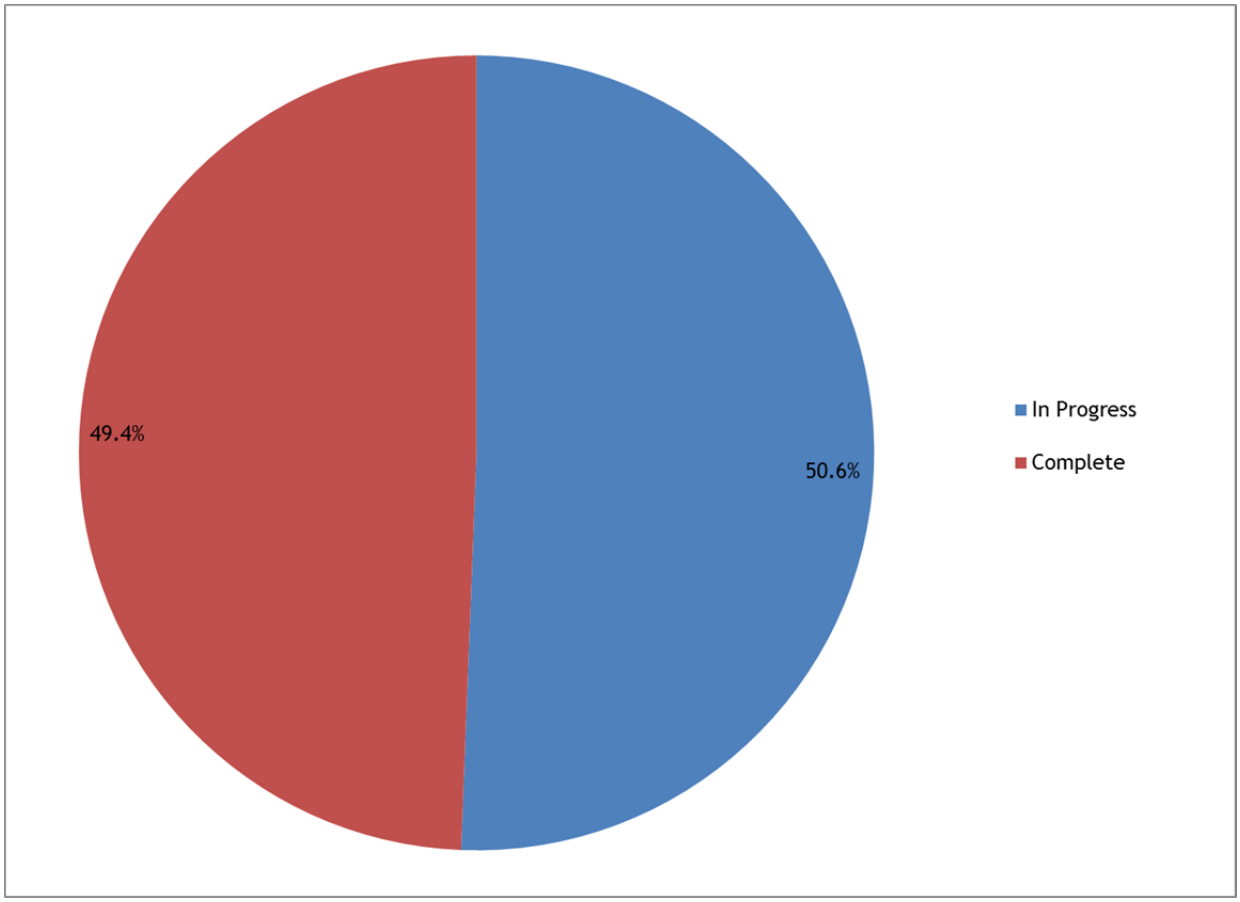
Adding recommendations to the tracking process is an ongoing process, so some small number of them will likely not be started at the time of each year's annual report if they were just finalized and/or added to the recommendation tracking process. This year, there were five recommendations that had not been started at the time of this report. All five of them were recently added to the tracking process.

Chart 17: Status of Recommendations for Reports Posted Between 5/1/2015 and 3/31/2016 (n=167)



An update on the implementation status of the 81 recommendations presented in the 2014 CFRT Annual Report that were not completed at that time are presented in Appendix D. Since the time of the last report, an additional 49.4% of the recommendations were completed. Almost all of the recommendations are either completed or in progress, as noted in Chart 18. Of the 41 recommendations in progress, 11 of them (27%) relate to the statewide implementation of the revised Safety and Risk Assessment tools. As discussed earlier, to date, implementation has happened in 23 counties and full implementation across all 64 counties will be complete in 2017.

Chart 18: Status of Recommendations Not Previously Completed From Reports Posted Prior to 5/1/2015 (n=81)



CDPHE and CDHS Joint Recommendations to Prevent Child Maltreatment

Strengthen policies and systems related to sharing child maltreatment data across local agencies in Colorado

One of the core components of the child welfare system is to make decisions based on the most accurate and current data possible. Sharing data electronically in real time can provide a more complete picture of family circumstances and have an immediate impact on improving child protection decision-making by state and local entities[4]. Although children and families often interact with multiple public agencies, such as local departments of human services, law enforcement agencies, hospitals and substance abuse treatment centers, these agencies do not always have access to data and information across agencies that would best serve children at risk for abuse or neglect fatalities.

Enhancing the ability of local agencies in Colorado to share data is a key component to prevent child abuse and neglect fatalities. Improving data sharing and analyses over time will strengthen prevention and intervention work by helping those who work with families (departments of human services, medical providers, law enforcement courts, and more) and families themselves make better decisions about child safety. One option to improve systems is to ensure access to the data in real-time and through electronic cross-notification among agencies. As a model for this work, Los Angeles County in California developed Electronic Suspected Child Abuse Report System (E-SCARS) to improve communication between law enforcement and child protective services agencies by sharing access to data across law enforcement agencies and departments of human services[4]. A similar approach could be considered by Colorado agencies in order to overcome data-sharing challenges such as high costs, confidentiality concerns and lack of collaboration. In doing so, improved communication and data sharing between agencies will enhance systematic responses to potential incidents of child maltreatment in Colorado. Most importantly, improved data will inform decisions regarding better policies and practices to prevention child maltreatment.

One way to strengthen practices related to sharing of child maltreatment data may be to create a data sharing profile as part of Colorado Trails modernization, which would require specific parameters to ensure confidentiality and minimize misuse. CDHS Division of Child Welfare is currently undergoing a modernization project and can consider this as part of its process.

Additionally, discussions during Child Fatality Review Team meetings consistently highlight the potential benefit of providing access for caseworkers to municipal court records and

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[4] Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). Within our reach: A national strategy to eliminate child abuse and neglect fatalities. Washington, DC: Government Printing Office.

medical databases. For example, caseworkers currently do not have access to municipal court records, which is a barrier to accessing information that could highlight issues frequently co-occurring with child maltreatment such as access to a caregiver's domestic violence history during current or prior relationships.

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 strengthen policies related to sharing child maltreatment data across local agencies in Colorado.

Appendix A: 2015 CFRT Attendance

CFRT Member* *Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.	1/5/15	2/2/15	3/2/15	4/6/15	5/4/15	6/1/15	7/6/15	8/3/15	9/14/15	10/5/15	11/2/15	12/7/15
Paige Rosemond, *CDHS, Child Protection Manager*	Yes	Yes	No	No	No	Yes	No	Yes	No	No		**No CFRT Meeting (no incidents ready for review)**
Lucinda Connelly, *CDHS, Child Protection Manager (appointed 10/20/2015)* ***Initially attended without appointment as backup.*								Yes**	Yes**	Yes**	Yes	
Backup: Korey Elger, *CDHS, Child Protection Ongoing Administrator (until 8/2015)*			Yes	Yes	Yes		Yes					
Brooke Ely-Milen, *Domestic Violence Program Director*	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Susan Nichols, *Administrative Review Division, Manager*	Yes	Yes	Yes	Yes	Yes	**No**	**No**	Yes	Yes	Yes	Yes	
Backup: Marc Mackert						**No**	**No**					
Colleen Kapsimalis, *CDPHE, Child Fatality Prevention System Program*	Yes	Yes	Yes	Yes	Yes	By phone	Yes	Yes	By phone	Yes	**No**	
Giorgianna Venetis, *CDPHE, Essentials for Childhood Coordinator*	**No**	**No**	**No**	**No**	**No**	By phone	Yes	**No**	Yes	**No**	By phone	
Lew Gaiter, *Larimer County Commissioner*	**No**	Yes	By phone	By phone	By phone	By phone	**No**	Yes	**No**	By phone	**No**	
Casey Tighe, *Jefferson County Commissioner*	Yes	By phone	Yes	Yes	Yes	**No**	Yes	Yes	**No**	Yes	**No**	
Dave Potts, *Chaffee County Commissioner*	Yes	Yes	Yes	Yes	Yes	Yes	By phone	**No**	**No**	Yes	Yes	
Senator Laura Woods *(active 08/11/2015)* ** *this position was vacant from January, 2015 to August, 2015*									**No**	**No**	Yes	

CFRT Member* *Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.	1/5/15	2/2/15	3/2/15	4/6/15	5/4/15	6/1/15	7/6/15	8/3/15	9/14/15	10/5/15	11/2/15	12/7/15
Representative Jonathan Singer *(active 8/19/2015) ** this position was vacant from January, 2015 to August, 2015*									No	Yes	Yes	**No CFRT Meeting (no incidents ready for review)**
Dennis Goodwin, *Office of Colorado's Child Protection Ombudsman*	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	
Det. Amber Urban, *Aurora Police Department (resigned 5/2015)*	No	No	No	No	No							
Backup: Det. Ron Tanguma	No	No	No	No	No							
Sgt. Brian Cotter, *Denver Police Department (appointed 10/5/2015)*										Yes	Yes	
Dr. Andrew Sirotnak, *Professor of Pediatrics, University of Colorado School of Medicine Director, Child Protection Team at Children's Hospital Colorado*	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	
Backup: Dr. Antonia Chiesa		No							Yes			
Leora Joseph, *Chief Deputy DA from the 18th Judicial District*	No	Yes	Yes	No	No	No	No	Yes	No	No	No	
Kathie Snell, MA, LPC, *Aurora Mental Health Center, Chief Operating Officer (appointed 11/2/2015)*											Yes	
Libbie McCarthy, *Attorney General's Officer*	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Michelle Sears-Ward, CDE, *Early Learning and School Readiness*	Yes	No	No	Yes	Yes	No	No	Yes	No	Yes	Yes	
Backup: Karen Thiel		No	Yes			Yes	Yes		No			
Vacant, *Rep. from the field of Child Advocacy (since 11/2014)*												
Dan Makelky, *Douglas County Department of Human Services*	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	

CFRT Member* *Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.	1/5/15	2/2/15	3/2/15	4/6/15	5/4/15	6/1/15	7/6/15	8/3/15	9/14/15	10/5/15	11/2/15	12/7/15
Backup: Ruby Richards/Nicole Becht						Yes	Yes					**No CFRT Meeting (no incidents ready for review)**
Michelle Dossey, *Arapahoe County Department of Human Services*	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes	Yes	
Backup: Michael DeGretto					Yes							
Shirley Rhodus, *El Paso County Department of Human Services*	By phone	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Erin Hall, *Administrative Review Division (resigned 8/2015)*	Yes	**No**	Yes	Yes	Yes	Yes	Yes	Yes				
Len Newman, *Administrative Review Division*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Lisa Lied, *Administrative Review Division*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	

Appendix B: 2012-2015 Incidents Qualified for CFRT Review by County and Type

County*	Fatal Incidents**				Near Fatal Incidents**				Egregious Incidents**							
	2012	2013	2014	2015	2012	2013	2014	2015	2012	2013	2014	2015	2012 Total	2013 Total	2014 Total	2015 Total
Archuleta										1	1			1	1	
Adams	2	2		2			1			3	2		2	5	3	2
Alamosa										1				1		
Arapahoe		2	1	1		1		1		1		2		4	1	4
Boulder		1	1			1		1						2	1	1
Clear Creek			1												1	
Denver	1	1	4	1	1	3	3	3		7	3	3	2	11	10	7
Eagle	1			1									1			1
El Paso	2	1	2			1	1	1	1		1	1	3	2	4	2
Fremont							1			1	2	1		1	3	1
Garfield				1												1
Huerfano			1												1	
Jefferson			2	2			4			2	1	3		2	7	5
La Plata								1								1
Larimer			1	1						4		2		4	1	3
Las Animas				1												1
Lincoln												1				1
Logan	1		1										1		1	
Mesa	1		1	1		1		1					1	1	1	2
Montezuma											1				1	
Morgan			1			1	1							1	2	
Otero					1		1						1		1	
Phillips		1												1		
Pitkin											1				1	
Pueblo	1		1			1	2	1		1	1		1	2	4	1
Routt			1												1	
Weld		1		1										1		1
Total	**9**	**9**	**18**	**12**	**2**	**9**	**14**	**9**	**1**	**21**	**13**	**13**	**12**	**39**	**45**	**34**

** 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 2015 Posted Reports

CFRT ID	Source	Recommendation	Status
15-002	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
15-002	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 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 July 3, 2014 to January 3, 2015, showed that Fremont County DHS interviewed all required parties 87 %, which is slightly below the statewide average (not including Fremont County DHS) of 87.9% for the same time span. It is recommended that Fremont County DHS monitor their performance on this measure to ensure improvement.	In Progress
15-002	Policy Finding	The Policy Finding related to the safety 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 July 3, 2014 to January 3, 2015, the Fremont County DHS completed the safety assessment tool accurately in 45.7% of assessments, which is slightly below the statewide average (not including Fremont County DHS) of 79.3% for the same time span. It is recommended that Fremont 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. Additionally, a new safety assessment tool is being implemented by the State in 2015, and it is recommended that Fremont County DHS participate in the training and implementation of the new tool.	In Progress
15-002	Policy Finding	The Policy Finding 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 July 3, 2014 to January 3, 2015, the Fremont County DHS completed the risk assessment accurately in 45.7% of assessments, which is below the statewide average (not including Fremont County DHS) of 60.2% 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.	In Progress

CFRT ID	Source	Recommendation	Status
15-006	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
15-006	CFRT	It is recommended that the Colorado Trails system be changed to alert caseworkers when a county staff member adds a client into demographics on a referral and/or assessment if that client is open in another Colorado Trails case/assessment/referral.	Considered and not implemented
15-006	CFRT	CFRT recommends that County Department of Humans Services comply with Volume VII, 7.106.121 (B) (2) in regards to the completion of County Internal Review Reports.	Complete
15-006	Policy Finding	The Policy Finding related to the timeliness of notification reflects a systemic practice issue for DDHS. From January 1, 2015 until August 28, 2015, DDHS provided timely notification to CDHS in 71.4% (5/7) of incidents. It is recommended that: a. DDHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete
15-006	Policy Finding	The Administrative Review Division (ARD) should prioritize training for DDHS casework 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
15-006	Policy Finding	The Policy Findings related to inaccurate documentation of the Colorado Family 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 September 14, 2014 to March 14, 2015, DDHS completed the risk assessment tool accurately in 43.6% of assessments, which is below the statewide average (not including the DDHS) of 57.5% for 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 tool are identified and solutions to the identified barriers are implemented. It is recommended that DDHS complete the new Colorado Family Risk Assessment Tool training in accordance with Volume VII 7.107.2	In Progress
15-006	Policy Finding	The Policy Finding related to timeliness of assessment closure does reflect a current systemic practice issue for Arapahoe County DHS. The September C-Stat report, which measures the percentage of assessments closed within 60 days, shows Arapahoe County DHS at 82.5% for August, 2015 which is below the statewide average of 88.1%. 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 implemented.	Complete

CFRT ID	Source	Recommendation	Status
15-006	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 Arapahoe 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 December 28, 2014 to June 28, 2015, showed that Arapahoe County DHS interviewed all required parties 60% of the time. It is recommended that Arapahoe County DHS monitor their performance on this measure to ensure improvement.	In Progress
15-006	Policy Finding	The Policy Finding related to the assessment containing the required content does reflect a systemic practice issue for Arapahoe 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 December 28, 2014 to June 28, 2015, showed that Arapahoe County DHS's assessments contained the required content 83.6% of the time, which is slightly below the statewide average (not including Arapahoe County DHS) of 84.7% for the same time span. It is recommended that Arapahoe County DHS monitor their performance on this measure to ensure improvement.	In Progress
15-007	CFRT	It is recommended that the Division of Child Welfare (DCW) continue 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.	In Progress
15-007	CFRT	In regards to the inaccurate documentation of severity levels by the DDHS, it is recommended that the DDHS make the following corrections in the state automated case management system so the severity levels accurately reflect the level of child maltreatment that occurred. a. The severity level of the allegation of intra-familial neglect; failure to protect against the mother as to the sibling be changed to a 'severe' severity level. b. The severity level of the allegation of intra-familial abuse; physical against the mother's boyfriend as to the child be changed to 'severe-near fatal.' c. The severity level of the allegation of intra-familial abuse; physical against the mother's boyfriend as to the sibling be changed to 'severe-egregious.'	Complete
15-007	Policy Finding	The Policy Finding related to the timeliness of notification reflects a systemic practice issue for DDHS. From January 1, 2015 until August 14, 2015, DDHS provided timely notification to CDHS in 60.0% (3/5) of incidents. It is recommended that: a. The DDHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete

CFRT ID	Source	Recommendation	Status
15-007	Policy Finding	The Administrative Review Division (ARD) should prioritize training for County casework 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.	In Progress
15-007	Policy Finding	The Policy Finding related to inaccurate documentation of the Colorado Family 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 September 14, 2014 to March 14, 2015, the DDHS completed the risk assessment tool accurately in 43.6% of assessments, which is below the statewide average (not including the DDHS) of 57.5% for 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 tool are identified and solutions to the identified barriers are implemented. It is recommended that DDHS complete the new Colorado Family Risk Assessment Tool training in accordance with Volume VII 7.107.1.	Complete
15-007	Policy Finding	The Policy Finding 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 October 8, 2014 to June 16, 2015, the PCDSS completed the Colorado Family Risk Assessment tool accurately in 63.9% of assessments, which is slightly above the statewide average (not including PCDSS) of 56.8% for the same time span. Due to the low level of performance, 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. PCDSS is currently a pilot county for the new Colorado Family Risk Assessment tool training and implementation and should continue efforts regarding the training and implementation of the new tool.	In Progress
15-022	CFRT	It is recommended that the Division of Child Welfare (DCW) continue 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.	In Progress
15-022	Policy Finding	The Policy Finding related to timeliness of assessment closure does reflect a current systemic practice issue for JCDCYF. The August C-Stat report, which measures the percentage of assessments closed within 60 days, showed JCDCYF at 79.3% for July, 2015 which is below the statewide average of 87.1%. It is recommended that JCDCYF implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete

CFRT ID	Source	Recommendation	Status
15-022	Policy Finding	The Policy Finding related to seeing the alleged victim within the assigned response time does not reflect a systemic practice issue for JCDCYF. According to the most recent C-Stat presentation for the month of August, which reflects data from July, 2015, JCDCYF is interviewing the alleged victim within the assigned response time 92.7% of the time which is above the state 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 August 1, 2014 to January 31, 2015, showed JCDCYF at 83.6% for observing/interviewing the alleged victim within the assigned response time and 92.7% for making reasonable efforts to observe/interview the alleged victim within the assigned response time. It is recommended that JCDCYF monitor their performance on this measure to ensure they maintain the State goal of 90%.	Complete
15-022	Policy Finding	The Policy Findings related to inaccurate documentation of the Colorado Family Risk Assessment tool do reflect a systemic practice issue in DDHS. In a recent review of a random sample of assessments that were conducted during a period from September 14, 2014 to March 14, 2015, DDHS completed the risk assessment tool accurately in 43.6% of assessments, which is below the statewide average (not including DDHS) of 57.5% 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 tool are identified and solutions to the identified barriers are implemented. It is also recommended that DDHS complete the new risk assessment tool training in accordance to Volume VII 7.107.1.	In Progress
15-022	Policy Finding	The Policy Finding related to all parties not being included in the Family Services Plan treatment plan does reflect a systemic practice issue for DDHS. In the most recent Out-of-Home Administrative Review, January 1, 2015 through March 31, 2015, DDHS included all required parties in the Family Services Plan treatment plan 58.9% of the time, which is below the statewide average of 78% for the same time span. It is recommended that DDHS employ a process in which the barriers to including all required parties in the treatment plan are identified and solutions to the identified barriers are implemented.	In Progress

CFRT ID	Source	Recommendation	Status
15-022	Policy Finding	The Policy Finding regarding including all services directed at areas of need identified through assessment in the Family Services Plan treatment plan does reflect a systemic practice issue for DDHS. In the most recent Out-of-Home Administrative Review, January 1, 2015 through March 31, 2015, DDHS included all services directed at identified areas of need in the Family Services Plan treatment plan 81.1% of the time, which is below the statewide average (excluding DDHS) of 88% for the same time span. It is recommended that DDHS employ a process in which the barriers to including all services directed at identified areas of need in the treatment plan are identified and solutions to the identified barriers are implemented.	In Progress
15-022	Policy Finding	The Policy Finding regarding the 90-Day review/Court report not being in Trails does reflect a systemic practice issue for DDHS. In the most recent Out-of-Home Administrative Review January 1, 2015 through March 31, 2015, DDHS completed the 90-Day review/Court report in Trails according to Volume 7 65.2% of the time, which is below the statewide average (excluding DDHS) of 71.6% for the same time span. It is recommended that DDHS employ a process in which the barriers to completing the 90-Day review/Court report in accordance with Volume 7 are identified and solutions to the identified barriers are implemented.	In Progress
15-032	CFRT	PCDSS should change the severity levels of the allegations to 'severe-near fatal.'	Complete
15-032	CFRT	DCW should explore the need for a policy or guidance related to entering allegations and findings in the state automated case management for each and every person suspected of abuse or neglect. DCW should provide it if it is determined that a policy or guidance is needed.	Complete
15-032	CFRT	It is recommended that PCDSS locate an infant mental health specialist to assess the interactions between the parents and the baby.	Complete
15-032	CFRT	It is recommended that the Colorado Child Welfare Training Academy offer annual regional trainings on the medical aspects of child abuse and neglect that is directed towards caseworkers who have already completed the new caseworker training series.	Complete
15-032	Policy Finding	The Policy Finding related to the timeliness of notification of the near fatal incident does reflect a systemic practice issue for PCDSS. From October 1, 2014 to October 1, 2015, PCDSS provided timely notification to CDHS in 50% (2/4) of incidents. It is recommended that PCDSS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete

CFRT ID	Source	Recommendation	Status
15-032	Policy Finding	The ARD should prioritize training for County casework 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.	In Progress
15-032	Policy Finding	The Policy Finding related to the overall finding not matching the definition does reflect a systemic practice issue for PCDSS. In a recent review of a random sample of assessments that were conducted during a period from December 8, 2014 through June 16, 2015, PCDSS substantiated the allegation accurately in 78.7% of assessments, which is below the statewide average (excluding PCDSS) of 92.6% for the same time span. a. It is recommended that PCDSS employ a process in which barriers to the accurate substantiation of allegations are identified and solutions to the identified barriers are implemented.	Complete
15-032	Policy Finding	The CFRT recommended that PCDSS enter a substantiated finding against an unknown PRAN for physical abuse against the baby.	Complete
15-038	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
15-038	CFRT	Regarding reviews of prior DYC involvement: It is recommended that C.R.S§ 26-1-139 be amended to specifically include review of current and prior DYC involvement for fatalities, near fatalities and egregious incidents in the same manner as the statute requires review of prior county human services involvement.	Not Started
15-038	CFRT	It is recommended that DYC develop policy to include the completion of an internal review and submission of the internal review report to CDHS when a youth with prior or current DYC commitment is involved in a fatality, near fatality, and/or egregious incident.	Not Started
15-038	Policy Finding	At the time of authoring this report, Mesa County DHS' most recent review of a random sample of assessments was completed using an instrument that did not include a review of their performance on the completion of RED Team framework; therefore, there is no data available to determine whether this is a systemic practice issue for Mesa County DHS. It is recommended that Mesa County DHS monitor their performance to ensure that they are completing the RED Team framework.	Complete

CFRT ID	Source	Recommendation	Status
15-038	Policy Finding	At the time of authoring this report, Mesa County DHS' most recent review of a random sample of assessments was completed using an instrument that did not include a review of their performance on accurate completion of the six assessment areas within the safety assessment tool; Therefore, there is no data available to determine whether this is a systemic practice issue for Mesa County DHS. It is recommended that Mesa County DHS monitor their performance to ensure that they completing the six assessment areas accurately.	In Progress
15-038	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool do reflect a systemic practice issue in Mesa County. In a recent review of a random sample of assessments that were conducted during a period from October 8, 2014 to June 1, 2015, Mesa County DHS completed the risk assessment tool accurately in 34% of assessments, which is below the statewide average (not including Mesa County) of 59.8% for the same time span. It is recommended that Mesa 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 is being implemented by the State, and it is recommended that Mesa County DHS participate in the training and implementation of the new tool.	In Progress
15-038	Policy Finding	At the time of authoring this report, Mesa County DHS' most recent review of a random sample of assessments was completed using an instrument that did not include a review of their performance on accurately reflecting individual allegations, perpetrators, victims, and findings in the findings window; therefore, there is no data available to determine whether this is a systemic practice issue for Mesa County DHS. It is recommended that Mesa County DHS monitor their performance to ensure that they are accurately reflecting individual allegations, perpetrators, victims, and findings in the findings window.	Complete

CFRT ID	Source	Recommendation	Status
15-038	Policy Finding	The policy finding related to seeing the alleged victim within the assigned response time does reflect a systemic practice issue for Mesa County DHS. According to the most recent C-Stat presentation for the month of October 2015, which reflect data from September 1-30, 2015, Mesa County DHS is interviewing the alleged victim within the assigned response time 94.4% of the time which is above the State 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 from October 8, 2014 through June 1, 2015, showed Mesa County DHS at 69.8% for observing/interviewing the alleged victim within the assigned response time and 84.9% for making reasonable efforts to observe/interview the alleged victim within the assigned response time. It is recommended that Mesa County DHS monitor their performance on this measure to ensure they maintain the State goal of 90%.	Complete
15-038	Policy Finding	The policy finding related to Family Service Plan: 3A Review/Court report does reflect a systemic practice issue in Mesa County. In a recent review of a random sample of In-Home Reviews that were conducted during a period from November 8, 2014 to June 1, 2015, Mesa County completed the required FSP: 3A according to Volume VII in 84% of the cases, which is below the statewide average (not including Mesa County) of 85% for the same time span. It is recommended that Mesa County employ a process in which barriers to the FSP: 3A Review/Court report are identified and solutions to the identified barriers are implemented.	In Progress
15-038	Policy Finding	The policy finding related to Family Service Plan: 5A Review/Court report does reflect a systemic practice issue in Mesa County. In a recent review of a random sample of In-Home Reviews that were conducted during a period from November 8, 2014 to June 1, 2015, Mesa County completed the required FSP: 5A according to Volume VII in 66% of the cases, which is below the statewide average (not including Mesa County) of 74% for the same time span. It is recommended that Mesa County employ a process in which barriers to the FSP: 5A Review/Court report are identified and solutions to the identified barriers are implemented.	In Progress

CFRT ID	Source	Recommendation	Status
15-038	Policy Finding	The policy finding related to monthly contact with the youth's mother does reflect a systemic practice issue in Mesa County. In a recent review of a random sample of In-Home Reviews that were conducted during a period from November 8, 2014 to June 1, 2015, Mesa County completed required monthly contact with the caregiver/guardians/kin in 34% of the cases, which is below the statewide average (not including Mesa County) of 65% for the same time span. It is recommended that Mesa 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.	In Progress
15-038	Policy Finding	The policy finding related to the quality of contact with the children/youth does reflect a systemic practice issue in Mesa County. In a recent review of a random sample of In-Home Reviews that were conducted during a period of November 8, 2014 to June 1, 2015, Mesa County completed a quality contact with the children/youth in 78% of the cases, which is below the statewide average (not including Mesa County) of 81% for the same time span. It is recommended that Mesa County employ a process in which barriers to the quality of contacts with children/youth are identified and solutions to the identified barriers are implemented.	In Progress
15-038	Policy Finding	The policy finding related to the safety assessment tool does reflect a systemic practice issue in Mesa County. In a recent review of a random sample of assessments that were conducted during a period from October 8, 2014 to June 1, 2015, Mesa County DHS completed the safety assessment tool accurately in 72% of assessments, which is below the statewide average (not including Mesa County) of 77.7% for the same time span. It is recommended that Mesa County 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. Additionally, a new safety assessment tool is being implemented by the State in 2017, and it is recommended that Mesa County DHS participate in the training and implementation of the new tool.	In Progress
14-014	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.	In Progress

CFRT ID	Source	Recommendation	Status
14-014	Policy Finding	For High Risk Assessments opened by the DDHS between October 1, 2013 and March 31, 2014, 67.9% required an extension (were open for 31 days or longer). Of those, 41.7 % had an extension request within 30 days. a. 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
14-014	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 (were open for 31 days or longer), 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
14-014	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, the DDHS interviewed the required parties within the assigned response time 87.6% of the time, which is higher than the previous month of 85.3% although still 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 the period of April 8, 2013 through September 30, 2013, showed the DDHS at 87.3%. It is recommended that the DDHS monitor their performance on this measure to ensure improvement in order to meet the state goal of 90%.	Complete
14-014	Policy Finding	The policy finding 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.	In Progress

CFRT ID	Source	Recommendation	Status
14-026	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.	In Progress
14-026	Policy Finding	The policy finding related to making reasonable efforts to see the alleged victim within the assigned response time does reflect a systemic practice issue for ACHSD. 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 September 18, 2013 to March 18, 2014, the ACHSD made reasonable efforts to see the victim of the allegation 78.2% of the time. It is recommended that ACHSD employ a process in which barriers to making reasonable efforts to see the alleged victims are identified and solutions to the identified barriers are implemented.	Complete
14-026	Policy Finding	The policy finding related to the safety 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 September 18, 2013 to March 18, 2014, the ACHSD completed the safety assessment in accordance with Volume VII 73.6% of assessments, which is below the statewide average (not including ACHSD) of 84.7% for the same time span. It is recommended that ACHSD 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
14-026	Policy Finding	The policy findings related to 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 September 18, 2013 to March 18, 2014, the ACHSD completed the risk assessment in accordance with Volume VII in 43.4% of assessments, which is below the statewide average (not including ACHSD) of 62.5% 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.	In Progress
14-032	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.	In Progress
14-032	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
14-032	Policy Finding	The policy finding related to the notification of the egregious abuse incident does reflect a systemic practice issue for DDHS. During the calendar year of 2013, DDHS provided timely notification to CDHS 64.7% (11 /17) of the time. At the time of the writing of this report, DDHS provided timely notifications to CDHS for 73.6% (14/19) of the incidents in the calendar year 2014. Administrative Review Division provided training to DDHS on May 29, 2014 and October 7, 2014. It is recommended that DDHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete
14-032	Policy Finding	The policy finding related to inaccurate documentation of the safety assessment process does reflect a systemic practice issue in DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period of October 30, 2013 to April 30, 2014, it was determined that the DDHS completed the safety assessment process accurately in 67.9% of assessments. The statewide average (excluding DDHS) during this time span was 82.5%. 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.	In Progress
14-032	Policy Finding	The policy finding related to the use of extensions does reflect a current systemic practice issue for DDHS. For High Risk Assessments opened by DDHS between January 1, 2014 to June 30, 2014, 68% required an extension (i.e., were open longer than 30 days). Of those, 39.8 % had an extension request within 30 days. It is recommended that 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
14-047	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.	In Progress
14-047	CFRT	It is recommended that the Division of Child Welfare facilitate communication between counties to assist the smaller counties to have a county to contact for purposes of seeing the alleged victim within the assigned response time.	In Progress

CFRT ID	Source	Recommendation	Status
14-047	Policy Finding	The policy finding related to seeing the alleged victim within the assigned response time does reflect a systemic practice issue for Morgan County DHS. According to the October C-Stat, which review data for the month of September 2014, Morgan County DHS is interviewing the alleged victim within the assigned response time 87.5% of the time, which is below the statewide average of 88.9% 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 June 16, 2013 to December 16, 2013 showed the Morgan County DHS at 81.6% 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 Morgan County DHS made reasonable efforts to see the victim of the allegation 89.5% of the time. It is recommended that Morgan County DHS examine their performance on this measure to ensure improvement in order to meet the state goal of 90%.	Complete
14-047	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Morgan County DHS. In a recent review of a random sample of assessments that were conducted during a period from June 16, 2013 to December 16, 2013, the Morgan County DHS completed the risk assessment accurately in 47.4% of assessments, which is below the statewide average (not including Morgan County DHS) of 64.8% for the same time span. It is recommended that Morgan 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
14-047	Policy Finding	The policy finding related to the safety assessment does reflect a systemic practice issue in Morgan County DHS. In a recent review of a random sample of assessments that were conducted during a period from June 16, 2013 to December 16, 2013, the Morgan County DHS completed the safety assessment accurately in 65.8% of assessments, which is below the statewide average (not including Morgan County DHS) of 81.2% for the same time span. It is recommended that Morgan County DHS employ a process in which barriers to the accurate completion of the Colorado Safety Assessment Instrument are identified and solutions to the identified barriers are implemented.	In Progress

CFRT ID	Source	Recommendation	Status
14-047	Policy Finding	The policy finding regarding all parties interviewed as part of the assessment, specifically other family members in the household, does reflect a systemic practice issue for Morgan County DHS. In a recent review of a random sample of assessments that were conducted during a period from June 16, 2013 to December 16, 2013, Morgan County DHS interviewed all required parties in 73.7% of assessments, which is below the statewide average of 86.9% for the same time span. It is recommended that Morgan County DHS employ a process in which barriers to interviewing all parties are identified and solutions to the identified barriers are implemented.	In Progress
14-048	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.	In Progress
14-048	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment 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 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 are identified and solutions to the identified barriers are implemented.	Complete
14-048	Policy Finding	The policy finding related to the safety assessment does 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 safety assessment accurately in 77.4% of assessments, which is slightly below the statewide average (not including EPCDHS) of 78.7% for the same time span. It is recommended that EPCDHS 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
14-048	Policy Finding	The policy finding regarding the assignment of incorrect response times does reflect a systemic practice issue for EPCDHS. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from March 17, 2014 to September 17, 2014, EPCDHS assigned the appropriate response time in accordance with Volume VII 88.9% of the time, which is below the statewide average of 95.1% for the same time span. It is recommended that EPCDHS employ a process in which barriers to the accurate assignment of the response time are identified and solutions to the identified barriers are implemented.	Complete
14-048	Policy Finding	The policy finding related to proper use of the Safety Plan does reflect a systemic practice issue in EPCDHS. In a recent review of a random sample of assessments (55) that were conducted during a period from March 17, 2014 to September 17, 2014, the EPCDHS completed the Safety Plan accurately in 0.0% (0/2) of assessments, which is below the statewide average (not including EPCDHS) of 40.0% for the same time span. It is recommended that EPCDHS employ a process in which barriers to the accurate completion of the Safety Plan are identified and solutions to the identified barriers are implemented.	Complete
14-058	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
14-058	CFRT	The CFRT recommended that CDHS continue working with all counties to develop a Memorandum of Understanding (MOU) between the county and the law enforcement agencies within that county to improve lines of communication between law enforcement and DHS agencies.	Complete
14-058	CFRT	It is recommended that DCW work with the Community Behavioral Health Division which manages the CDHS contracts with Community Mental Health Councils to identify more community options for substance abuse treatment.	In Progress
14-058	CFRT	It is recommended that CDHS consider options regarding adding a State Judicial or Parole representative to the CFRT.	In Progress

CFRT ID	Source	Recommendation	Status
14-058	Policy Finding	According to the most recent C-Stat presentation for the month of November, 2014, which reflects data from October, 2014, PCDSS is interviewing the alleged victim within the assigned response time 96.6% of the time which is above the state 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 May 4, 2014 through November 4, 2014, showed the PCDSS at 83.7% for observing/interviewing the alleged victim within the assigned response time and 89.8% for making reasonable efforts to observe/interview the alleged victim within the assigned response time. It is recommended that PCDSS monitor their performance on this measure to ensure they maintain the State goal of 90%.	Complete
14-058	Policy Finding	The policy findings related to incomplete 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. However, due to their 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 will be implemented by the State in 2015, and it is recommend that PCDSS participate in the training and implementation of the new tool.	In Progress
14-058	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 PCDSS. 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 May 4, 2014 to November 4, 2014, showed that PCDSS interviewed all required parties 87.2%, which is slightly below the statewide average (not including PCDSS) of 87.7% for the same time span. It is recommended that PCDSS monitor their performance on this measure to ensure improvement.	In Progress

CFRT ID	Source	Recommendation	Status
14-058	Policy Finding	There is a lack of quantitative data related to entering referrals of abuse or neglect into the State automated case management system. It is recommended that PCDSS look at previous referrals to determine if entering data timely appears to be an issue for PCDSS. If it is an issue, it is recommended that PCDSS employ a process in which barriers that prevent all referrals from being entered into the State automated case management system timely are identified and solutions to the identified barriers are implemented.	Complete
14-060	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
14-060	CFRT	DCW evaluate whether the current training being offered to caseworkers sufficiently addresses the assessment of safety of children, specific to neglect, when parents have cognitive and/or developmental disabilities or if additional training resources need to be identified.	Not Started
14-060	CFRT	DCW explore what community resources are available to support parents with cognitive and/or developmental disabilities across the state and make that information available to the County DHS agencies.	In Progress
14-060	Policy Finding	The policy finding related to inaccurate documentation of the safety assessment process does reflect a systemic practice issue in DDHS. 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 April 8, 2014 to October 8, 2014, it was determined that the DDHS completed the safety assessment process accurately in 81.5% of assessments. The statewide average (excluding DDHS) during this time span was 77.3%. It is recommended that DDHS continue to use the process in which DDHS is showing improvements in regards to completing the tool accurately, as evident by the data presented in the most recent assessment review provided to DDHS. Additionally, a new Colorado safety assessment tool is being implemented by the State in 2015, and it is recommended that DDHS participate in the training and implementation of the new tool.	In Progress

CFRT ID	Source	Recommendation	Status
14-060	Policy Finding	The policy finding related to inaccurate documentation of the Colorado Family Risk Assessment tool 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 April 8, 2014 to October 8, 2014, the DDHS completed the risk assessment tool accurately in 55.6% of assessments, which is slightly below the statewide average (not including the DDHS) of 59.3% for the same time span. However, due to the low level of performance on this measure, it is recommended that the DDHS 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, the new Colorado Family Risk Assessment tool is being implemented by the State in 2015, and it is recommended that the DDHS participate in the training and implementation of the new tool.	In Progress
14-073	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
14-073	CFRT	The CFRT recommended that the Child Protection Task Group (CPTG) develop a casework practice guide for managing non-court involved cases including a recommendation to counties that a family engagement meeting be held prior to closure of non-court involved cases.	Complete
14-073	Policy Finding	The policy finding related to the accurate completion of the safety assessment tool 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 3, 2014 to September 3, 2014, the ACHSD completed the safety assessment tool accurately in 90.4% of assessments, which is above the statewide average (not including ACHSD) of 80.8% for the same time span. However, the goal for accurate completion of the safety assessment tool is 95%. Therefore, it is recommended that ACHSD 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. Additionally, a new safety assessment tool is being implemented by the State in 2015, and it is recommended that ACHSD participate in the training and implementation of the new tool.	In Progress

CFRT ID	Source	Recommendation	Status
14-073	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool 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 3, 2014 to September 3, 2014, the ACHSD completed the risk assessment tool accurately in 63.5% of assessments, which is above the statewide average (not including ACHSD) of 60.6% for the same time span. Due to the low level of performance, it is recommended that ACHSD 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 is being implemented by the State in 2015, and it is recommended that ACHSD participate in the training and implementation of the new tool.	In Progress
14-073	Policy Finding	The policy finding related to monthly contact with the caregiver/guardian/kin does reflect a systemic practice issue in ACHSD. In a recent review of a random sample of In-Home Reviews that were conducted during a period from March 3, 2014 to September 3, 2014, ACHSD completed required monthly contact with the caregiver/guardian/kin in 73% of the cases, which is above the statewide average (not including ACHSD) of 63% for the same time span. However, due to the low level of performance on this measure, it is recommended that ACHSD 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
14-073	Policy Finding	The policy finding related to a parent not receiving the services that were identified as being needed through ongoing assessment does reflect a systemic practice issue in ACHSD. In a recent review of a random sample of In-Home Reviews that were conducted during a period from March 3, 2014 to September 3, 2014, the family received the services identified as being needed 84% of the time, which is below the statewide average (not including ACHSD) of 87%. It is recommended that ACHSD employ a process in which the barriers to ensuring the family received the services are identified and solutions to the identified barriers are implemented.	Complete
14-074	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress

CFRT ID	Source	Recommendation	Status
14-074	Policy Finding	The policy finding related to monthly contact with the mother does reflect a systemic practice issue in MCDHS. In the most recent Out-of-Home Administrative Review, in which there is data related to monthly contact with the mother (July 1, 2014 to September 30, 2014), the MCDHS completed required monthly contact with the mother in 66.3% of the cases, which is slightly above the statewide average (not including Mesa County) of 63.9% for the same time span. It is recommended that Mesa County employ a process in which barriers to the monthly contact with mothers are identified and solutions to the identified barriers are implemented.	In Progress
14-074	Policy Finding	The policy finding related to incomplete documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in MCDHS. In a recent review of a random sample of assessments that were conducted during a period from May 4, 2014 to November 4, 2014, MCDHS completed the risk assessment tool accurately in 42.3% of assessments, which is below the statewide average (not including Mesa County) of 58.9% for the same time span. It is recommended that MCDHS 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 MCDHS participate in the training and implementation of the new tool.	In Progress
14-085	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
14-085	CFRT	It is recommended that the CFRT write a letter to the Colorado Department of Corrections (DOC) Division of Adult Parole outlining concerns and proposed solutions regarding improving communication between DHS agencies and Parole.	Complete
14-085	CFRT	It is recommended that the CDHS continue to collaborate with the Colorado Department of Public Health and Environment (CDPHE) in their efforts regarding Safe Sleep education to community partners and include first responders.	In Progress
14-085	CFRT	It is recommended that Colorado State Legislators explore the feasibility of proposing new legislation to re-instate the exception for reviewing incidents where the past involvement “did not involve abuse and/or neglect.”	In Progress

CFRT ID	Source	Recommendation	Status
14-085	Policy Finding	The policy finding related to the safety assessment tool does reflect a systemic practice issue in JCDCYF. In a recent review of a random sample of assessments that were conducted during a period from February 14, 2014 to August 14, 2014, the JCDCYF completed the safety assessment tool accurately in 85.5 % of assessments, which is above the statewide average (not including JCDCYF) of 79.2 % for the same time span. The statewide goal for the accurate completion of the safety assessment tool is 95%. Therefore, it is recommended that JCDCYF 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. Additionally, a new safety assessment tool is being implemented by the State in 2015, and it is recommended that JCDCYF participate in the training and implementation of the new tool.	In Progress
14-085	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in JCDCYF. In a recent review of a random sample of assessments that were conducted during a period from February 14, 2014 to August 14, 2014, the JCDCYF completed the risk assessment tool accurately in 45.5% of assessments, which is below the statewide average (not including JCDCYF) of 61% for the same time span. It is recommended that JCDCYF 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 is being implemented by the State in 2015, and it is recommended that JCDCYF participate in the training and implementation of the new tool.	In Progress
14-086	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress

CFRT ID	Source	Recommendation	Status
14-086	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in Larimer County DHS. In a recent review of a random sample of assessments that were conducted during a period from July 3, 2014 to January 3, 2015, Larimer County DHS completed the risk assessment tool accurately in 56.6 % of assessments, which is below the statewide average (not including Larimer County DHS) of 60.3 % for the same time span. It is recommended that Larimer 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 tool is being implemented by the State in 2015, and it is recommended that Larimer County DHS participate in the training and implementation of the new tool.	In Progress
14-088	CFRT	It is recommended that the Division of Child Welfare (DCW) continue 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
14-088	CFRT	It is recommended that Colorado State Legislators explore the feasibility of proposing new legislation to re-instate the exception for reviewing incidents where the past involvement “did not involve abuse and/or neglect.”	In Progress
14-088	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool does 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 is being implemented by the State in 2015, and it is recommended that EPCDHS participate in the training and implementation of the new tool.	Complete
14-089	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
14-089	CFRT	It is recommended that Colorado Department of Human Services 24-hour monitoring team explore the possibility of developing a list of recommended trainings for foster parents.	In Progress

CFRT ID	Source	Recommendation	Status
14-089	CFRT	It is recommended that DCW work with Trails to develop a way for DHS staff to research foster families and gain a complete and accurate picture, ensuring educated decisions can be made around the placement for children.	In Progress
14-089	CFRT	DCW should explore how to handle situations where a county DHS agency decides to no longer place children in a foster home due to that county's concern about the foster family so that other counties can become aware of those concerns and make more educated decisions.	In Progress
14-089	Policy Finding	The policy finding 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 July 3, 2014 to January 3, 2015, the Fremont County DHS completed the risk assessment accurately in 45.7% of assessments, which is below the statewide average (not including Fremont County DHS) of 60.2% 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.	In Progress
14-089	Policy Finding	The policy finding related to monthly contact with the mother does reflect a systemic practice issue in Saguache County DSS. In the most recent Out-of-Home Administrative Review, in which there is data related to monthly contact with the mother (October 1, 2013 to December 31, 2013), the Saguache County DSS completed required monthly contact with the mother in 20% of the cases, which is below the statewide average (not including Saguache County DSS) of 71.6% for the same time span. It is recommended that Saguache County DSS employ a process in which barriers to the monthly contact with mothers are identified and solutions to the identified barriers are implemented	In Progress
14-089	Policy Finding	The policy finding related to monthly contact with the father does reflect a systemic practice issue in Chaffee County HHS. In the most recent Out-of-Home Administrative Review, in which there is data related to monthly contact with the father (July 1, 2014 to September 30, 2014), the Chaffee County HHS completed required monthly contact with the father in 0% of the cases, which is below the statewide average (not including Chaffee County HHS) of 53.9% for the same time span. It is recommended that Chaffee County HHS employ a process in which barriers to the monthly contact with fathers are identified and solutions to the identified barriers are implemented.	In Progress

CFRT ID	Source	Recommendation	Status
14-089	Policy Finding	The policy finding related to monthly contact with the father does reflect a systemic practice issue in Saguache County DSS. In the most recent Out-of-Home Administrative Review, in which there is data related to monthly contact with the father (October 1, 2013 to December 31, 2013), the Saguache County DSS completed required monthly contact with the mother/father in 0% of the cases, which is below statewide average (not including Saguache County DSS) of 57.1% for the same time span. It is recommended that Saguache County DSS employ a process in which barriers to the monthly contact with fathers are identified and solutions to the identified barriers are implemented.	In Progress
14-089	Policy Finding	The policy finding related to the assessment containing the required content does reflect a systemic practice issue for Chaffee County HHS. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of March 3, 2014 to September 3, 2014, showed that Chaffee County HHS's assessments contained the required content 76.2% of the time, which is below the statewide average (not including Chaffee County HHS) of 85.9% for the same time span. It is recommended that Chaffee County HHS monitor their performance on this measure to ensure improvement.	In Progress
14-089	Policy Finding	The Chaffee County HHS policy finding related to incomplete documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in Chaffee County HHS. In a recent review of a random sample of assessments that were conducted during a period from March 3, 2014 to September 3, 2014, Chaffee County HHS completed the risk assessment tool accurately in 52.4% of assessments, which is below the statewide average (not including Chaffee County HHS) of 59.1% for the same time span. It is recommended that Chaffee County HHS 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 Chaffee County HHS participate in the training and implementation of the new tool.	In Progress

CFRT ID	Source	Recommendation	Status
14-089	Policy Finding	The Saguache County DSS policy finding related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in Saguache County DSS. 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 Saguache County DSS completed the risk assessment tool accurately in 55.6% of assessments, which is below the statewide average (not including Saguache County DSS) of 59.4% for the same time span. It is recommended that Saguache County DSS 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 Saguache County DSS participate in the training and implementation of the new tool.	In Progress
14-089	Policy Finding	The Fremont County DHS policy finding related to seeing the alleged victim within the assigned response time does reflect a systemic practice issue for Fremont County DHS. According to the most recent C-Stat presentation for the month of May 2015 , which reflects data from April 2015, Fremont County DHS is interviewing the alleged victim within the assigned response time 88.2% of the time which is below the state 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 July 3, 2014 to January 3, 2015, showed Fremont County DHS at 69.6% for observing/interviewing the alleged victim within the assigned response time and 84.8% for making reasonable efforts to observe/interview the alleged victim within the assigned response time. It is recommended that Fremont County DHS monitor their performance on this measure to ensure they meet the State goal of 90%.	In Progress
14-096	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress

CFRT ID	Source	Recommendation	Status
14-096	Policy Finding	The policy finding related to incomplete documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in Pueblo County DSS. 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 Pueblo County DSS completed the risk assessment tool accurately in 74.5% of assessments, which is above the statewide average (not including Pueblo County DSS) of 57.8% for the same time span. However, due to their level of performance on this measure, it is recommended that Pueblo County DSS 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 is being implemented by the State in 2015, and it is recommended that Pueblo County DSS continue to participate in the training and implementation of the new tool.	In Progress
14-096	Policy Finding	The policy finding related to monthly contact with the parent does reflect a systemic practice issue in Pueblo County DSS. ARD Out of Home data from 1st Quarter State Fiscal Year (SFY) 2015 indicates Pueblo County DSS is 57.9% compliant with contacting the mother/guardian/kin in accordance with Volume VII which is slightly lower than the statewide average (not including Pueblo County DSS) of 64.4 % for the same time span. . It is recommended that Pueblo County DSS employ a process in which barriers to the monthly contact with parents/guardian/kin are identified and solutions to the identified barriers are implemented.	In Progress
14-100	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
14-100	CFRT	The CFRT recommended that they continue to support the efforts of the Colorado Department of Public Health and Environment (CDPHE) towards community Safe Sleep education. The CDPHE's Infant Safe Sleep Partnership should explore the need to include pharmacists as one of the targets for provider training on providing infant safe sleep education. Additionally, the Safe Sleep education webinar for caseworkers and other professionals is in the final stages of completion with an expected roll out date no later than December 31, 2015.	Complete

CFRT ID	Source	Recommendation	Status
14-100	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool do reflect a systemic practice issue in BCDHHS. In a recent review of a random sample of assessments that were conducted during a period from April 21, 2014 to October 21, 2014, the BCDHHS completed the risk assessment tool accurately in 61.5% of assessments, which is above the statewide average (not including BCDHHS) of 59.5% for the same time span. Due to the low level of performance on this measure, it is recommended that BCDHHS 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 is being implemented by the State in 2015, and it is recommended that BCDHHS participate in the training and implementation of the new tool.	In Progress
14-100	Policy Finding	The policy finding related to completing the safety assessment tool timely does reflect a systemic practice issue in BCDHHS. In a recent review of a random sample of assessments that were conducted during a period from April 21, 2014 to October 21, 2014, the BCDHHS completed the safety assessment tool accurately in 88.5% of assessments, which is above the statewide average (not including BCDHHS) of 77.5% for the same time span and below the C-Stat goal of 95%. It is recommended that BCDHHS employ a process in which barriers to the accurate completion of the safety assessment are identified and solutions to the identified barriers are implemented. Additionally, a new safety assessment tool is being implemented by the State in 2015, and it is recommended that BCDHHS participate in the training and implementation of the new tool.	In Progress
14-108	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress

CFRT ID	Source	Recommendation	Status
14-108	CFRT	The Administrative Review Division (ARD) authored a policy and research analysis of the definition of egregious incidents of child maltreatment. The policy analysis is to be used by State and County staff as a resource to provide additional guidance on how to determine if a specific incident of child maltreatment meets the criteria as an egregious incident of abuse and/or neglect. A Dear Director Letter was distributed to all county DHS directors in March 2015 containing the policy analysis for county DHS staff. It is recommended that the ARD continue to work with the Child Welfare Training System on developing curriculum for training based on the policy analysis. It is recommended that the ARD train County Department of Human Services 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.	In Progress
14-108	CFRT	CFRT recommends that Counties Department of Human Services comply with Volume VII, specifically 7.106.121 (B) (2) in regards to the Counties Internal Review Reports.	Complete
14-108	Policy Finding	The policy finding related to the timeliness of notification reflects a systemic practice issue for DDHS. From January 1, 2015 until August 28, 2015, DDHS provided timely notification to CDHS in 71.4% (5/7) of incidents. It is recommended that: a. DDHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS;	Complete
14-108	Policy Finding	The Administrative Review Division (ARD) should prioritize training for County casework 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.	In Progress

CFRT ID	Source	Recommendation	Status
14-108	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family 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 September 14, 2014 to March 14, 2015, DDHS completed the risk assessment tool accurately in 43.6% of assessments, which is below the statewide average (not including the DDHS) of 57.5% for 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 tool are identified and solutions to the identified barriers are implemented. It is recommended that DDHS complete the new Colorado Family Risk Assessment Tool training in accordance with Volume VII 7.107.1.	In Progress
14-108	Policy Finding	The policy finding related to the new abuse/neglect allegation from a reporter party that was not documented in the Trails system as a new referral/assessment does reflect a systemic practice issue for DDHS. It is recommended that DDHS participates in training on when to enter new referrals/assessments.	In Progress
13-055	CFRT	There are planned changes in the safety assessment that are scheduled to occur in 2014 that were designed to positively impact performance in this area. It is recommended that the Division of Child Welfare begin the statewide implementation process of the new safety assessment tool and that monitoring occur to determine if accuracy in the use of the tool increases as a result.	In Progress
13-055	CFRT	It was discussed at the CFRT meeting that Denver County no longer sends domestic violence resources to victims through the postal service. The Domestic Violence Practice Guide for Child Protection Services also addresses this in Practice Key #22. It is recommended that the Division of Child Welfare make efforts to disseminate the Guide to child protection workers.	Complete
13-055	Policy Finding	The policy finding that outlines inaccuracy 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 of 81.6% for the same time period. It should be noted that in regards to the accurate completion of the Caregiver Protective Capacity the county completed this accurately 94.3% of the time. It is recommended that Denver County employ a process in which barriers to the accurate completion of the Safety Assessment are identified and solutions to the identified barriers are implemented.	In Progress

CFRT ID	Source	Recommendation	Status
13-069	Policy Finding	The policy finding related to the DDHS not reporting the egregious incident 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 64.3% (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
13-069	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
13-073	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.	In Progress
13-073	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 additional secondary trauma providers as well as resources to provide education on secondary trauma prevention.	Complete
13-073	CFRT	It is recommended that the Division of Child Welfare consider the need for additional guidelines or procedures to follow when there is a significant disagreement between counties.	Complete
13-073	CFRT	The Division of Child Welfare should consider whether the guidance currently provided in statute regarding prospective harm as it applies to child protection cases is adequate or if further statutory or regulatory guidance is necessary.	Complete

CFRT ID	Source	Recommendation	Status
13-073	Policy Finding	The policy findings related to the lack of timely completion 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 DHS) 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.	In Progress
13-073	Policy Finding	For the policy findings related to Arapahoe County DHS requesting assessment extensions timely, 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. It is recommended that Arapahoe 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
13-073	Policy Finding	The statewide performance on the use of extensions between July 1, 2013 and December 31, 2013 was also low. Overall, 66.3% of referrals required an extension (opened beyond 30 days), and 45.3% of them had an extension requested within the 30 days. As the proper use of extensions during the assessment period may be related to the timely closure of assessments, it is recommended that the Division of Child Welfare begin including data on counties' use of extensions in the analysis and communications related to the C-Stat measure of timeliness of assessment closure.	Complete
13-073	Policy Finding	The policy finding related to timeliness of assessment closure does 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 April 2014 C-Stat report, which measures the percentage of assessments closed within 60 days regardless of extension status, shows Arapahoe County DHS at 61.3% 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%. 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
13-073	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.	Complete
13-073	Policy Finding	The policy finding related to the DDHS not reporting the near fatality of the sibling 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, DDHS 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:The DDHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS;	Complete
13-073	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
13-073	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.	In Progress
13-073	Policy Finding	The policy violation related to the inaccurate completion of 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.	In Progress

CFRT ID	Source	Recommendation	Status
13-073	Policy Finding	The policy finding related to the Arapahoe County DHS not reporting the near fatality of the sibling to CDHS within 24-hours of learning of the situation does reflect a systemic practice issue in Arapahoe County DHS at the time of this referral. During calendar year 2012, Arapahoe County DHS provided timely notification to CDHS in 50% (3/6) of incidents. For calendar year 2013, this increased to 72% (5/7). It is recommended that: Arapahoe County DHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete
13-073	Policy Finding	The ARD should prioritize training for Arapahoe County DHS 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
13-075	CFRT	There are planned changes in the risk assessment that are scheduled to occur in 2014 that were designed to positively impact performance in this area. It is recommended that the Division of Child Welfare begin the statewide implementation process of the new risk assessment tool and that monitoring occur to determine if accuracy in the use of the tool increases as a result of their implementation.	In Progress
13-075	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.	In Progress
13-081	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.	In Progress
13-081	CFRT	The CFRT acknowledges the complications DHS agencies are presented with by having to restrict the case record in Trails, while also needing that information. The CFRT recommends DCW explore ways to allow assigned caseworkers, their supervisors, and identified administrative staff access to the entire case record while having it restricted to others. DCW is to ensure that at least one person in each county has the restricted access profile.	Complete

CFRT ID	Source	Recommendation	Status
13-081	CFRT	DCW 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. DCW needs to identify a more practical way of supporting the counties. CFRT members from other counties recommended small counties partner with larger counties for support and direction.	Complete
13-081	CFRT	In regards to county and CDHS staff not understanding the Child Fatality Review Team process, and in particular, the statutory requirements regarding Initial Notification when fatalities, near-fatalities, and egregious incidents suspicious to have been caused by abuse or neglect, it is recommended that the Administrative Review Division provide training for county and CDHS staff regarding the Child Fatality Review Team process with specific guidance regarding the Initial Notification requirements.	In Progress
13-081	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
13-081	Policy Finding	The policy finding regarding the assignment of incorrect response times does reflect a systemic practice issue for Phillips County DSS. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from June 16, 2013 to December 16, 2013, Phillips County DSS assigned the appropriate response time in accordance with Volume VII 85.7% of the time. The statewide average (excluding Phillips County DSS) was 95.5% for the same time span. It is recommended that Phillips County DSS employ a process in which barriers to the accurate assignment of response times are identified and solutions to the identified barriers are implemented.	Not Started
13-081	Policy Finding	The policy finding related to inaccurate documentation of the safety assessment process does reflect a systemic practice issue in Phillips County DSS. As part of a routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period of June 16, 2013 to December 16, 2013, it was determined that the Phillips County DSS completed the safety assessment process accurately in 66.7% of assessments. The statewide average (excluding Phillips County DSS) during this time span was 81.2%. It is recommended that Phillips 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.	In Progress

CFRT ID	Source	Recommendation	Status
13-081	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Phillips County DSS. In a recent review of a random sample of assessments that were conducted during a period from June 16, 2013 to December 16, 2013, the Phillips County DSS completed the risk assessments accurately in 44.4% of assessments, which is below the statewide average (excluding Phillips County) of 64.8% for the same time span. It is recommended that Phillips 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.	In Progress
13-081	Policy Finding	For High Risk Assessments opened by Teller County DSS between November 1, 2013 to April 30, 2014, 82.3% required an extension (i.e., were open longer than 30 days). Of those, 4.6 % had an extension request within 30 days. 1) It is recommended that Teller County 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
13-081	Policy Finding	The statewide performance on the use of extensions between November 1, 2013 to April 30, 2014 was also low. Overall, 70.1% of referrals required an extension (opened beyond 30 days), and 40.8% 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 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
13-081	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Teller County DSS. In a recent review of a random sample of assessments that were conducted during a period from April 22, 2013 to October 22, 2013, the Teller County DSS completed the risk assessments accurately in 73.3% of assessments, which is above the statewide average (not including Teller County) of 62.5% for the same time span. It is recommended that Teller 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

CFRT ID	Source	Recommendation	Status
13-081	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in El Paso County DHS. In a recent review of a random sample of assessments that were conducted during a period from September 5, 2013 to March 5, 2014, the El Paso County DHS completed the risk assessments accurately in 49% of assessments, which is below the statewide average (not including El Paso County) of 63.3% for the same time span. It is recommended that El Paso 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
13-081	Policy Finding	The policy finding related to reasonable efforts to interview the mother, the alleged perpetrator, does reflect a systemic practice issue for Phillips County DSS. 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 June 16, 2013 to December 16, 2013, showed the Phillips County DSS at 77.8%, which is below the statewide average (not including Phillips County) of 86.9% for the same time span. It is recommended that Phillips County DSS monitor their performance on this measure to ensure improvement.	Not Started
13-081	Policy Finding	For High Risk Assessments opened by El Paso County DHS between November 1, 2013 to April 30, 2014, 71.3% required an extension (i.e., were open longer than 30 days). Of those, 41.1% had an extension request within 30 days. It is recommended that El Paso 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

Appendix D: Status Update for Recommendations from Previously Posted Reports

CFRT ID	Source	Recommendation	Status
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%.	Complete
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%.	Complete
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

CFRT ID	Source	Recommendation	Status
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	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	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
14-012	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
14-014	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.	In Progress

CFRT ID	Source	Recommendation	Status
14-014	Policy Finding	The policy finding 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.	In Progress
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
14-024	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.	Complete
14-026	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.	In Progress

CFRT ID	Source	Recommendation	Status
14-026	Policy Finding	The policy finding related to the safety 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 September 18, 2013 to March 18, 2014, the ACHSD completed the safety assessment in accordance with Volume VII 73.6% of assessments, which is below the statewide average (not including ACHSD) of 84.7% for the same time span. It is recommended that ACHSD 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
14-026	Policy Finding	The policy findings related to 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 September 18, 2013 to March 18, 2014, the ACHSD completed the risk assessment in accordance with Volume VII in 43.4% of assessments, which is below the statewide average (not including ACHSD) of 62.5% 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.	In Progress
14-032	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.	In Progress
14-032	Policy Finding	The policy finding related to the notification of the egregious abuse incident does reflect a systemic practice issue for DDHS. During the calendar year of 2013, DDHS provided timely notification to CDHS 64.7% (11 /17) of the time. At the time of the writing of this report, DDHS provided timely notifications to CDHS for 73.6% (14/19) of the incidents in the calendar year 2014. Administrative Review Division provided training to DDHS on May 29, 2014 and October 7, 2014. It is recommended that DDHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete

CFRT ID	Source	Recommendation	Status
14-032	Policy Finding	The policy finding related to inaccurate documentation of the safety assessment process does reflect a systemic practice issue in DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period of October 30, 2013 to April 30, 2014, it was determined that the DDHS completed the safety assessment process accurately in 67.9% of assessments. The statewide average (excluding DDHS) during this time span was 82.5%. 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.	In Progress
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 which barriers to the monthly contact with children in the correct setting are identified and solutions to the identified barriers are implemented.	In Progress
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%.	Complete

CFRT ID	Source	Recommendation	Status
14-047	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.	In Progress
14-047	CFRT	It is recommended that the Division of Child Welfare facilitate communication between counties to assist the smaller counties to have a county to contact for purposes of seeing the alleged victim within the assigned response time.	In Progress
14-047	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Morgan County DHS. In a recent review of a random sample of assessments that were conducted during a period from June 16, 2013 to December 16, 2013, the Morgan County DHS completed the risk assessment accurately in 47.4% of assessments, which is below the statewide average (not including Morgan County DHS) of 64.8% for the same time span. It is recommended that Morgan 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
14-047	Policy Finding	The policy finding related to the safety assessment does reflect a systemic practice issue in Morgan County DHS. In a recent review of a random sample of assessments that were conducted during a period from June 16, 2013 to December 16, 2013, the Morgan County DHS completed the safety assessment accurately in 65.8% of assessments, which is below the statewide average (not including Morgan County DHS) of 81.2% for the same time span. It is recommended that Morgan County DHS employ a process in which barriers to the accurate completion of the Colorado Safety Assessment Instrument are identified and solutions to the identified barriers are implemented.	In Progress

CFRT ID	Source	Recommendation	Status
14-047	Policy Finding	The policy finding regarding all parties interviewed as part of the assessment, specifically other family members in the household, does reflect a systemic practice issue for Morgan County DHS. In a recent review of a random sample of assessments that were conducted during a period from June 16, 2013 to December 16, 2013, Morgan County DHS interviewed all required parties in 73.7% of assessments, which is below the statewide average of 86.9% for the same time span. It is recommended that Morgan County DHS employ a process in which barriers to interviewing all parties are identified and solutions to the identified barriers are implemented.	In Progress
14-048	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.	In Progress
14-048	Policy Finding	The policy finding related to proper use of the Safety Plan does reflect a systemic practice issue in EPCDHS. In a recent review of a random sample of assessments (55) that were conducted during a period from March 17, 2014 to September 17, 2014, the EPCDHS completed the Safety Plan accurately in 0.0% (0/2) of assessments, which is below the statewide average (not including EPCDHS) of 40.0% for the same time span. It is recommended that EPCDHS employ a process in which barriers to the accurate completion of the Safety Plan are identified and solutions to the identified barriers are implemented.	Complete
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.	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.	Complete
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.	Complete

CFRT ID	Source	Recommendation	Status
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%.	Complete
14-058	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	In Progress
14-058	CFRT	The CFRT recommended that CDHS continue working with all counties to develop a Memorandum of Understanding (MOU) between the county and the law enforcement agencies within that county to improve lines of communication between law enforcement and DHS agencies.	Complete
14-058	CFRT	It is recommended that DCW work with the Community Behavioral Health Division which manages the CDHS contracts with Community Mental Health Councils to identify more community options for substance abuse treatment.	In Progress
14-058	CFRT	It is recommended that CDHS consider options regarding adding a State Judicial or Parole representative to the CFRT.	In Progress

CFRT ID	Source	Recommendation	Status
14-058	Policy Finding	The policy findings related to incomplete 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. However, due to their 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 will be implemented by the State in 2015, and it is recommend that PCDSS participate in the training and implementation of the new tool.	In Progress
14-058	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 PCDSS. 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 May 4, 2014 to November 4, 2014, showed that PCDSS interviewed all required parties 87.2%, which is slightly below the statewide average (not including PCDSS) of 87.7% for the same time span. It is recommended that PCDSS monitor their performance on this measure to ensure improvement.	In Progress
14-058	Policy Finding	There is a lack of quantitative data related to entering referrals of abuse or neglect into the State automated case management system. It is recommended that PCDSS look at previous referrals to determine if entering data timely appears to be an issue for PCDSS. If it is an issue, it is recommended that PCDSS employ a process in which barriers that prevent all referrals from being entered into the State automated case management system timely are identified and solutions to the identified barriers are implemented.	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
13-002	Policy Finding	2. The policy finding related to late assessment closure in Montrose County does not reflect current systemic practice in the county department. The C-Stat report, which measures the percentage of assessments closed within 60 days, shows the county department increasing from 54% in March of 2012 to 87% in July of 2013. It is recommended that the county continue engagement in the C-Stat process for continuous improvement on this measure in order to meet and/or exceed the goal of 90%.	Complete

CFRT ID	Source	Recommendation	Status
13-002	Policy Finding	3. The policy violation that reflects that the children were not contacted monthly, face-to-face, is not reflective of an area needing improvement for Montrose County. In the most current ARD Quality Assurance Review report, the data showed that the county is performing at 92% in this area. It is recommended that the county consider using the Trails report that tracks monthly, face-to-face contacts of children as a component of supervision to ensure continued or improved performance in this area.	Complete
13-002	Policy Finding	The policy violation related to completion of the Colorado Safety Assessment in Montrose County does not reflect a systemic practice issue in this county department. In a recent review of a random sample of assessments that were conducted during a period from 8/18/2012 to 3/18/2013, the county department completed the safety assessment accurately in 87% of assessments. Also of note are planned changes in the safety assessment that will occur in 2014 and may impact performance. It is recommended that DCW ensure that Montrose county receives the training prior to the implementation of the changes.	Complete
13-008	Policy Finding	The policy finding related to late assessment closure does not reflect current systemic practice in the county department. A recent C-Stat report, issued 7/19/2013, which measures the percentage of assessments closed within 60 days, shows the county department at 83%. The C-Stat measure is based on the standard 30 days, as well as an additional 30 days to allow for extension requests supported in Volume VII. It is recommended that the county continue engagement in the C-Stat process for continuous improvement on this measure in order to meet and/or exceed the goal of 90%.	Complete
13-008	Policy Finding	3. Policy violations related to the Colorado Family Risk Assessment do not reflect a systemic practice issue in this county department. In a recent, generalizable random sample, 83% of risk assessments were found by reviewers to have been completed accurately. Of note are changes in the Colorado Family Risk Assessment slated for spring, 2014. The changes will include clearer definitions of each item in the assessment as well as a coordinated training effort. It is recommended that DCW ensures that Arapahoe County staff receives this training prior to implementation of the new instrument.	Complete

CFRT ID	Source	Recommendation	Status
13-014	Policy Finding	4. The policy violations related to the Colorado Family Risk Assessment do not reflect a systemic practice issue in Arapahoe DHS. In a generalizable random sample from July 2013, data indicates Arapahoe DHS completed the risk assessment accurately in 83% of assessments, which is above the statewide average of 53% for the same time. As mentioned above in the summary of identified systemic gaps and deficiencies, there are planned changes in the Colorado Risk and Safety Assessment tools which are scheduled to occur in 2014 that were designed to positively impact performance in this area. It is recommended that the DCW, as implementation of these changes occurs, provide training and technical assistance to Arapahoe DHS in this area.	Complete
13-029	Policy Finding	The policy finding indicating that Denver County notified the Colorado Department of Human Services of the fatality six days late does reflect a systemic practice issue in this county department at the time of this referral. During calendar year 2012, Denver County provided timely notification to CDHS in 90% (9/10) of incidents. For calendar year 2013, this declined to 64% (9/14). It is recommended that Denver County consider creating a more formal process for recognizing and reporting fatal, near fatal, and egregious incidents of child maltreatment to CDHS.	Complete
13-038	Policy Finding	4. The policy violation related to timeliness of assessment closure reflects a current systemic practice issue for Boulder DHHS. The C-Stat report measure is based on the standard 30 days, as well as an additional 30 days to allow for extension requests supported in Volume VII. The C-Stat report, which measures the percentage of assessments closed within 60 days regardless of extension status shows Boulder County is currently closing 84.9% of their assessments on time as of the data for September 2013. This number is above the statewide average for September 2013 of 83.7 %, but below the goal of 90.0%. a. It is recommended that Boulder DHHS employ a process in which barriers to the timely closure of assessments are identified and solutions to the identified barriers are implemented.	Complete

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.	Complete
13-040	Policy Finding	3. 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.	Complete
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.	Complete

CFRT ID	Source	Recommendation	Status
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.	Complete
13-054	Policy Finding	2) 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.	Complete
13-055	CFRT	There are planned changes in the safety assessment that are scheduled to occur in 2014 that were designed to positively impact performance in this area. It is recommended that the Division of Child Welfare begin the statewide implementation process of the new safety assessment tool and that monitoring occur to determine if accuracy in the use of the tool increases as a result.	In Progress
13-055	Policy Finding	The policy finding that outlines inaccuracy 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 accourdance with Volume VII, 71.7% of the time, which is below the statewide average of 81.6% for the same time period. It should be noted that in regards to the accurate completion of the Caregiver Protective Capacity the county completed this accurately 94.3% of the time. It is recommended that Denver County employ a process in which barriers to the accurate completion of the Safety Assessment are identified and solutions to the identified barriers are implemented.	In Progress

CFRT ID	Source	Recommendation	Status
13-069	Policy Finding	The policy finding related to the DDHS not reporting the egregious incident 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 64.3% (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
13-069	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	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	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.	Complete
13-071	CFRT	There are planned changes in the safety assessment that are scheduled to occur in 2014 that were designed to positively impact performance in this area. It is recommended that the Division of Child Welfare begin the statewide implementation process of the revised safety assessment tool and that monitoring occur to determine if accuracy in the use of the tool increases as a result of its implementation.	In Progress

CFRT ID	Source	Recommendation	Status
13-071	Policy Finding	The policy finding related to inaccurate documentation of the safety assessment process reflects a systemic practice issue in EPCDHS. As part of a routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period of September 18, 2012 to March 18, 2013, it was determined that the EPCDHS completed the safety assessment process accurately in 81.5% of assessments. The statewide average during this time span was 83.8% with the statewide goal being 95%. It should be noted that in regards to the accurate completion of the Caregiver Protective Capacity the EPCDHS completed this accurately 98.1%. It is recommended that EPCDHS 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
13-073	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.	In Progress
13-073	Policy Finding	The policy findings related to the lack of timely completion 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 DHS) 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.	In Progress
13-073	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.	Complete

CFRT ID	Source	Recommendation	Status
13-073	Policy Finding	The policy finding related to the DDHS not reporting the near fatality of the sibling 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, DDHS 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 the DDHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete
13-073	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
13-073	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.	In Progress
13-073	Policy Finding	The policy violation related to the inaccurate completion of 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.	In Progress

CFRT ID	Source	Recommendation	Status
13-073	Policy Finding	The policy finding related to the Arapahoe County DHS not reporting the near fatality of the sibling to CDHS within 24-hours of learning of the situation does reflect a systemic practice issue in Arapahoe County DHS at the time of this referral. During calendar year 2012, Arapahoe County DHS provided timely notification to CDHS in 50% (3/6) of incidents. For calendar year 2013, this increased to 72% (5/7). It is recommended that Arapahoe County DHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	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

CFRT ID	Source	Recommendation	Status
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.	Complete
13-096	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.	In Progress

CFRT ID	Source	Recommendation	Status
13-096	CFRT	In regard to caseworkers' ability to assess the needs and safety of children who have significant cognitive and/or developmental disabilities and identify resources in the community to support these parents, it is recommended that: a. DCW explore what community resources are available to support parents with children who have significant cognitive and/or developmental disabilities across the state and provide that information to the County DHS agencies.	Complete
13-096	CFRT	In regard to caseworkers' ability to assess the needs and safety of children who have significant cognitive and/or developmental disabilities and identify resources in the community to support these parents, it is recommended that: b. The DDHS connect the youth and the sibling on this case with the CCB and explore services specific for the youth under the Children's Extensive Support (CES) waiver.	Complete
13-096	CFRT	In regard to caseworkers' ability to assess the needs and safety of children who have significant cognitive and/or developmental disabilities and identify resources in the community to support these parents, it is recommended that: c. The DDHS explore whether the youth and the sibling are eligible to receive Social Security Income (SSI) benefits, and if so, assist in applying for SSI benefits for the youth and the sibling.	Complete
13-096	Policy Finding	The policy finding related to the DDHS not reporting the egregious situation to CDHS within 24-hours of learning of the situation reflects a systemic practice issue in this county department at the time of this referral. During calendar year 2013, the DDHS provided timely notification to CDHS for 64.7% (11 /17) of incidents. To date in calendar year 2014, this declined to 50% (6 /12). It is recommended that the DDHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete

CFRT ID	Source	Recommendation	Status
13-096	Policy Finding	The policy finding regarding all required parties being interviewed as part of the assessment reflects a systemic practice issue for the DDHS. In a recent review of a random sample of assessments that were conducted during a period from April 8, 2013 to September 30, 2013, the DDHS interviewed all required parties 85.2% of the time, which is slightly below the statewide average (not including the DDHS) of 87.3% for approximately the same time period. It is recommended that the DDHS employ a process in which barriers to interviewing all required parties as part of the assessment are identified and solutions to the identified barriers are implemented.	Complete
13-096	Policy Finding	The policy finding related to the Colorado Safety Assessment does reflect a systemic practice issue for the DDHS. In a recent review of a random sample of assessments that were conducted during a period from April 8, 2013 to September 30, 2013, the DDHS completed the safety assessment accurately in 71.7% of assessments, which is below the statewide average (not including the DDHS) of 81.6% for approximately the same time period. It is recommended that the 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.	In Progress
13-096	Policy Finding	The policy finding related to inaccurate documentation of the Colorado Family Risk Assessment reflects a systemic practice issue for the DDHS. In a recent review of a random sample of assessments that were conducted during a period from April 8, 2013 to September 30, 2013, the 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 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.	In Progress
12-001	Incident Specific Report	The DCW should work with OIT to develop a scrolling alert in Trails to allow for improved communication among county departments when there are significant concerns regarding an individual or family. In addition to the functionality, the DCW should collaborate with county child welfare professionals to determine criteria for the use of such functionality.	Complete

CFRT ID	Source	Recommendation	Status
12-033	Incident Specific Report	Assessment tools should be created and used in Program Area 4: Youth in Conflict assessments/cases as they are in Program Area 5: Child Abuse and Neglect assessments/cases.	In Progress
12-033	Incident Specific Report	Training competencies should be developed for caseworkers that will be handling Program Area 4: Youth in Conflict assessments/cases.	In Progress
2012	Annual Report	Tracking egregious incidents of child maltreatment began in August 2012. While there is a small sample size to date, data reflects that egregious incidents are much more likely to occur with older youth. As supported within the case specific recommendations, this indicates the need for enhanced assessment of safety and risk for families and youth involved in Program Area 4: Youth in Conflict cases. Program Area 4: Youth in Conflict practice tends to focus on the behaviors of the youth. It is recommended that policy be modified to support the practice of conducting a broader assessment of familial strengths and needs specific to dealing with difficult behavior in youth. Specifically, tools and policy should be created supporting assessments of the family's needs for supportive services. These services may help parents develop increased coping skills and more appropriate responses to difficult behavior in their children.	In Progress