COLORADO
Department of Human Services

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

The Honorable Jim Smallwood
Chair, Senate Health and Human Services Committee
201 East Colfax Avenue
Denver, CO 80203

The Honorable Jonathan Singer
Chair, House Public Health Care and Human Services Committee
201 East Colfax Avenue
Denver, CO 80203

The Honorable Joann Ginal
Chair, House Health, Insurance, and Environment Committee
201 East Colfax Avenue
Denver, CO 80203

June 30, 2017

Dear Governor Hickenlooper, Representative Smallwood, Representative Singer, and Representative Ginal:

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 Beth Martinez Humenik, Vice Chair, Senate Health and Human Services Committee
Representative Jessie Danielson, Vice Chair, House Public Health Care and Human Services Committee
Representative Daneya Esgar, Vice Chair, House Health, Insurance, and Environment Committee
Senator Larry Crowder
Senator Irene Aguilar
Senator John Kefalas
Representative Dan Pabon
Representative Brittany Pettersen
Representative Edie Hooten
Representative Dafna Michaelson Jenet
Representative Marc Catlin
Representative Larry Liston
Representative Justin Everett
Representative Kimmi Lewis
Representative Janet Buckner

Representative Susan Lontine
Representative. Dominque Jackson
Representative Chris Kennedy
Representative. Susan Beckman
Representative Phil Covarrubias
Representative Stephen Humphrey
Representative Lois Landgraf
Representative Kim Ransom
Members of the Child Fatality Review Team
Members of the Colorado State Child Fatality Review Prevention Review Team
Robert Werthwein, Office Director, Children Youth and Families, CDHS
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Melissa Wavelet, Office Director, Performance and Strategic Outcomes, CDHS
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2016 Child Maltreatment Fatality Report

COLORADO
Department of Human Services

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Executive Summary

The 2016 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 37 children involved in fatal incidents, substantiated for child maltreatment in 2016, 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 97 children in 71 substantiated fatal, near fatal, and egregious incidents of child maltreatment occurring in 2016, 57 children in 40 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 32 incidents occurring in 2014, 2015, and 2016 that were reviewed by the CFRT and/or posted to the public notification website in 2016. Recommendations address the policy findings, and systemic gaps and deficiencies identified during the CFRT review.

Child Characteristics. For fatalities in 2016, the most frequent race/ethnicity was White (48.6%), followed by Hispanic (18.9%). This is a change from 2015, when the most frequent race/ethnicity was Hispanic (59.1%) followed by White (18.2%). The most frequent race/ethnicity for all children in fatal, near fatal, and egregious incidents of child maltreatment in 2015 was White (41.2%). In Colorado in 2016, females accounted for 54% (20/37) of the victims in substantiated child maltreatment fatalities. This was the first year the number of female victims surpassed the number of male victims in child maltreatment fatalities. Males were victims in 68.2% of the near fatal incidents and 47.4% 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 39.2% (38/97). This was followed by those who resided with simply one (1) parent at 26.8%(26/97). While income level and education level of legal caretakers is not routinely collected by counties, available information on services to families indicated that in 100% of the fatal, near fatal, and egregious incidents reviewed by the CFRT in 2016, the family was eligible for and received some level of supplemental benefits.

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 2016, 21 of 35 (60%) of fatal incidents had prior involvement, ranging in intensity from one referral not accepted for assessment to involvement that included case services.

Other Family Stressors. Of the families involved in a child fatality substantiated for abuse or neglect, 42.9% (9/21) had some history of identified domestic violence. Additionally, 47.6% (10/21) of families experienced substance abuse issues, and for 33.3% (7/21) of the fatal incidents, there was a history of mental health treatment for at least one caregiver.

Perpetrator Relationship. The victim's mother committed the fatality 53.8% of the time (28/52), which is above the national trend (28%). The second largest category of perpetrators of fatalities was the victim's father, at 26.9% (14/52).

Findings and Recommendations. The CFRT highlighted 99 systemic strengths across 44 reports from 2014, 2015, and 2016 reviewed by the CFRT and posted since the cutoff of inclusion in the 2015 CFRT Annual Report (3/31/2016) and the cutoff for inclusion in this report (3/31/2017). The most commonly acknowledged systemic strength was collaboration between the county departments of human/social services and other community entities. The CFRT also identified 45 systemic gaps and deficiencies across the child welfare system, and made 86 recommendations related to policy findings. The most common issue identified was improving County Continuous Quality Improvement (CQI) processes to address barriers to performance and implement solutions. There were 131 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 161 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 some trends in the data. 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 five years, with 2016 displaying an increase in fatal and near fatal incidents since 2015, and a slight decrease in egregious incidents.

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^
2016	71	25	17	115^

**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 reported incidents reported in both 2015 and 2016 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. County departments have worked diligently to comply with this requirement.

As part of the data integrity process for 2016, 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 2016. The data integrity checks identified 66 children who appeared as though they experienced an incident that may have required notification to the CDHS, but for whom the CDHS did not receive notification. Of these, there were seven incidents involving eight of the children that met criteria for public notification. None of the incidents met criteria for a full CFRT review either because they were unsubstantiated for abuse and/or neglect, or the involved families did not have prior history with departments of human/social services. 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 reviewed through 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 for review 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	13^	9	13	35^
2016	21	11	8	40

**There was a change in state statute from 2012 to 2013 that increased the time span for prior involvement from two years to three years.*

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

^This number is different from the 2015 Child Maltreatment Fatality Report as one child in one fatal incident was pending disposition at the time the 2015 report was finalized.

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 affects the total length of time needed to complete any individual review. To date, 45 of the 115 (39.1%) incidents occurring in 2016 were afforded at least one extension, with the total number ranging from one to nine extensions.

Incidents Reviewed in 2016

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 2016, the CFRT was able to review 32 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 32 incidents reviewed during 2016, one of the incidents occurred in 2014, 10 occurred in 2015, and the remaining 21 occurred in 2016. Overall, 52.5% (21/40) of the incidents that occurred in 2016 were reviewed in 2016.

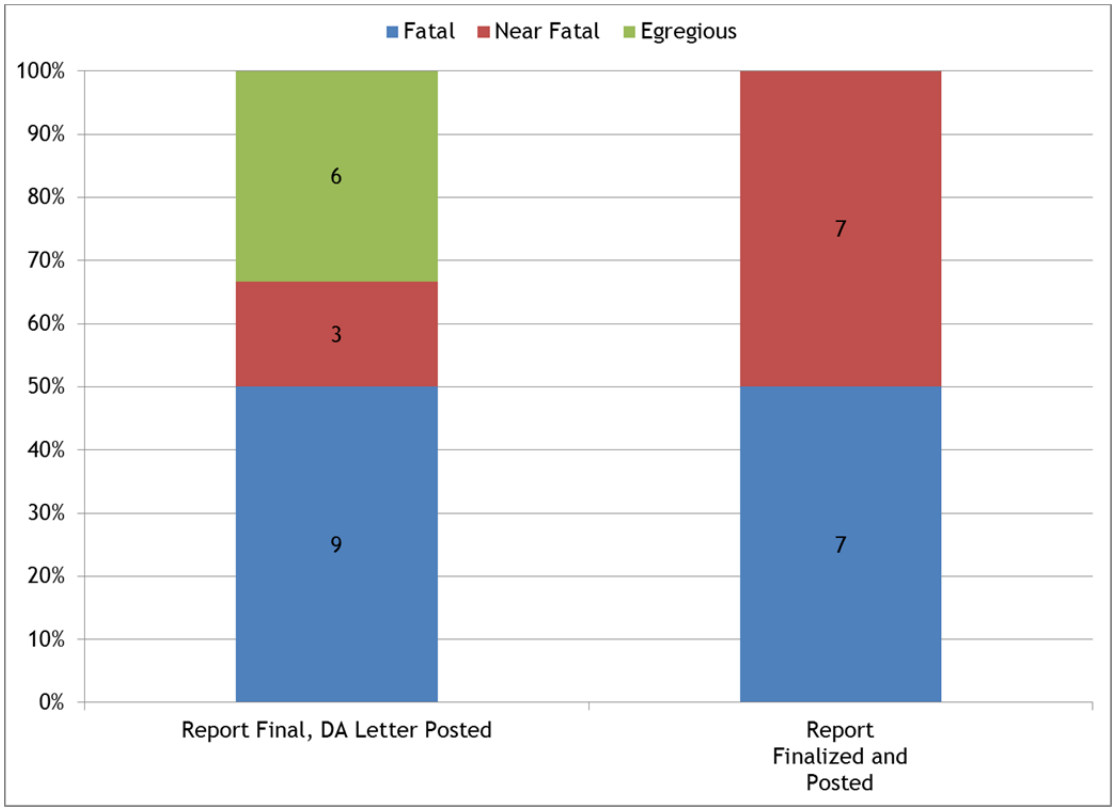
Completion and Posting of Case Specific Executive Summary Reports

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 2016. Of the 32 incidents reviewed, final non-confidential case executive summary reports were posted for 14 of them. For the remaining 18 incidents reviewed, it was determined that releasing them could jeopardize criminal or civil proceedings and the reports were not posted. Throughout 2016, all incidents were reviewed and reports posted within the statutorily required timeframes.

Chart 1: Report status of all incidents reviewed by the CFRT in 2016



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 participates on 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 2016 Annual Report.

Changes made to the Child Welfare System as a Result of CFRT Recommendations

This section of the report is intended to highlight the changes that were made to child welfare policy in Colorado, as a result of recommendations made by the CFRT. C.R.S. 26-1-139 (1)(c) states, "The goal of the multidisciplinary review shall not be to affix blame, but rather to improve understanding of why the incidents of egregious abuse or neglect against a child, near fatalities, or fatalities of a child due to abuse or neglect occur, to identify and understand where improvements can be made in the delivery of child welfare services and to develop recommendations for mitigation of future incidents of egregious abuse or neglect against a child, near fatalities, or fatalities of a child due to abuse or neglect.

In 2016, a recommendation was made by the CFRT that the CDHS - Division of Child Welfare (DCW) consider a change to rule which would provide an exception to the requirement for caseworkers to observe/interview alleged victims of fatalities. As a result of the recommendation, DCW determined a caseworker's observation of a deceased child or a child undergoing medical interventions did not contribute to the quality of information in a child fatality, near fatality, or egregious assessment, and an exception to rule was added for these circumstances. The intended outcome of this practice change is to reduce the effects of secondary trauma on caseworkers so caseworkers can continue to serve children and families in Colorado.

In 2014, the CFRT recommended that county department staff be present in person or via teleconference to present their case at the monthly CFRT meetings. Throughout the CFRT review process, it was determined an integral piece of completing a thorough and effective State Child Fatality Review includes having county departments who have assessed the egregious, near fatal or fatal incident, as well as county departments who have had prior history with the child and/or family within the last three years, present at the review. The ARD put forth Volume 7 rule revisions as a result of this recommendation, and the rules were approved at State Board's second hearing on May 5, 2017. The revised rules go into effect July 1, 2017. The policy change will help ensure the CFRT can complete thorough and effective reviews, which will assist the CFRT in accomplishing its goals as set forth in statute.

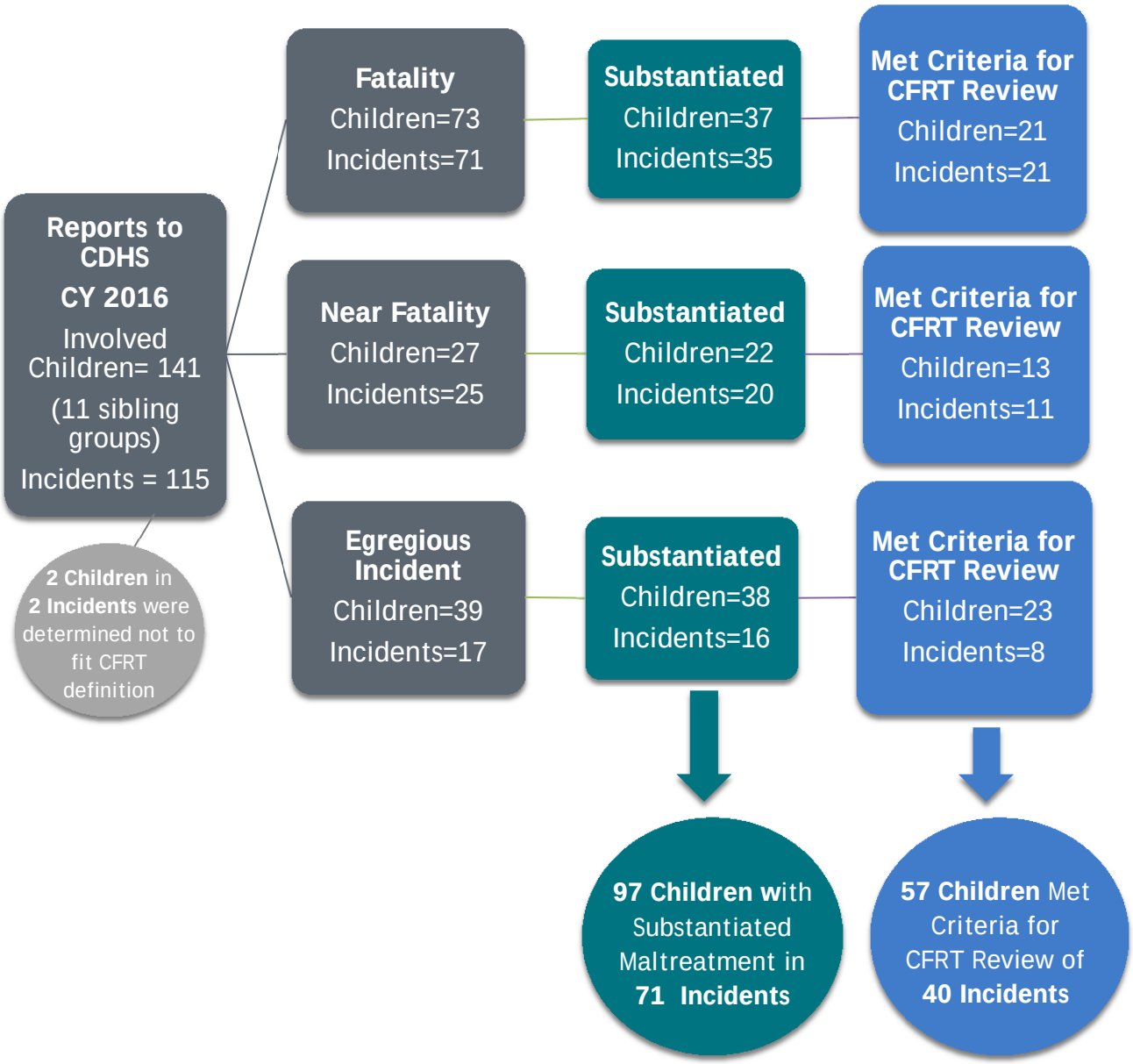
Overview of the 2016 Reports of Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment Victims

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 2016, counties reported 115 incidents involving 141 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 139 children, 73 children were associated with 71 fatal incidents, 27 children were associated with 25 near fatal incidents, and 39 children were associated with 17 egregious incidents.

Of those incidents with completed assessments, 42 incidents regarding 42 children were found to be unsubstantiated for abuse or neglect. Therefore, these incidents were not considered 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 2016, 71 substantiated incidents included 97 children, 57 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 2016. 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 2016



For purposes of this report, the majority of the analysis in the following section focuses on the 97 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 97 substantiated victims of incidents that occurred in CY 2016.

Table 3: Summary information of all 97 substantiated victims of child maltreatment fatalities, near fatalities, and egregious incidents in Colorado for CY 2016

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Victim at Time of Incident	Less than one	18	48.6%	12	54.5%	6	15.8%
	One	0	0.0%	2	9.1%	2	5.3%
	Two	2	5.4%	3	13.6%	1	2.6%
	Three	3	8.1%	2	9.1%	1	2.6%
	Four	1	2.7%	0	0.0%	3	7.9%
	Five	2	5.4%	0	0.0%	1	2.6%
	Six	2	5.4%	0	0.0%	3	7.9%
	Seven	1	2.7%	1	4.5%	2	5.3%
	Eight	2	5.4%	0	0.0%	3	7.9%
	Nine	1	2.7%	1	4.5%	2	5.3%
	Ten	2	5.4%	0	0.0%	5	13.2%
	Eleven	1	2.7%	0	0.0%	0	0.0%
	Twelve	0	0.0%	0	0.0%	3	7.9%
	Thirteen	0	0.0%	0	0.0%	1	2.6%
	Fourteen	1	2.7%	0	0.0%	2	5.3%
	Fifteen	0	0.0%	0	0.0%	1	2.6%
	Sixteen	1	2.7%	0	0.0%	0	0.0%
	Seventeen	0	0.0%	1	4.5%	2	5.3%
Race/Ethnicity	African American	5	13.5%	2	9.1%	3	7.9%
	White	18	48.6%	9	40.9%	13	34.2%
	Hispanic	7	18.9%	9	40.9%	22	57.9%
	Multiracial	2	5.4%	2	9.1%	0	0.0%
	Unknown	5	13.5%	0	0.0%	0	0.0%
Sex	Female	20	54.1%	7	31.8%	20	52.6%
	Male	17	45.9%	15	68.2%	18	47.4%
Family Structure	One parent	10	27.0%	7	31.8%	9	23.7%
	One parent and one related caregiver	1	2.7%	0	0.0%	8	21.1%
	One parent and one unrelated caregiver	6	16.2%	1	4.5%	0	0.0%
	Two parents	15	40.5%	9	40.9%	14	36.8%
	Two parents and relatives	1	2.7%	1	4.5%	4	10.5%
	One related caregiver and one unrelated caregiver	1	2.7%	2	9.1%	0	0.0%
	One parent and relatives	3	8.1%	0	0.0%	3	7.9%
	Residential Child Care Facility	0	0.0%	0	0.0%	0	0.0%
	Foster Care	0	0.0%	2	9.1%	0	0.0%
Incidents with Additional Family Stressors*	Substance Abuse	10	38.5%	3	42.9%	2	22.2%
	Mental Health	7	26.9%	0	0.0%	2	22.2%
	Domestic Abuse	9	34.6%	4	57.1%	5	55.6%

**This is counted at the family level.*

Data and Demographics

Within the field of child welfare, studies have indicated a number of factors related to maltreatment, including: child characteristics, family characteristics, and other complicating factors. While fatalities may share certain characteristics that can be used as indicators of risk factors, there is no one profile that will allow child protection workers to identify either future perpetrators or children who will become victims. Please note that little research has been conducted on 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 2015) 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, for FFY15, 42.3% of child fatalities are White children, 30.6% are African American children, and 14.5% 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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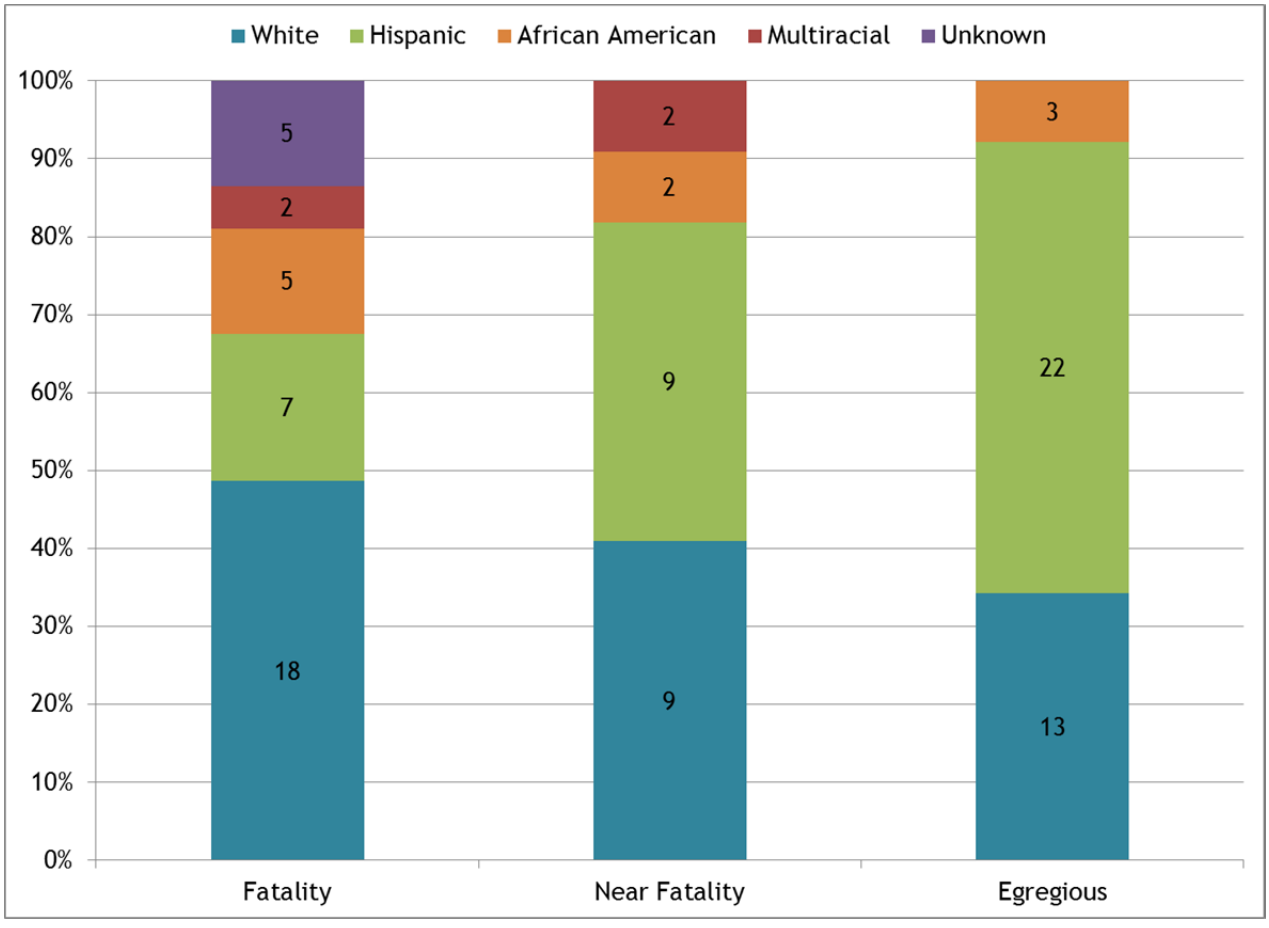
[1] US Department of Health and Human Services. (2017). Child maltreatment 2015. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/cm2015.pdf

[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[3] estimated that by 2020, individuals of Hispanic origin will comprise 24.3% of Colorado's total population. The estimated population for those individuals identifying as White will decrease to 66.5%, while African American population will increase slightly to 4.2%.

Chart 3 displays the race/ethnicity for the 97 victims in the fatal, near fatal, and egregious incidents of child maltreatment that occurred in Colorado in 2016. While White (48.7%) was the most frequent race/ethnicity for children in fatal incidents of child maltreatment, Hispanic was the most frequent for children in egregious incidents (57.9%). Both White and Hispanic children made up a respective 40.9% of the near fatal incidents. Trends for fatal events most closely resemble the overall population trends for Colorado, while the trends for near fatal and egregious incidents differ from Colorado population trends. Hispanic children are disproportionality represented in the egregious and near fatal incidents.

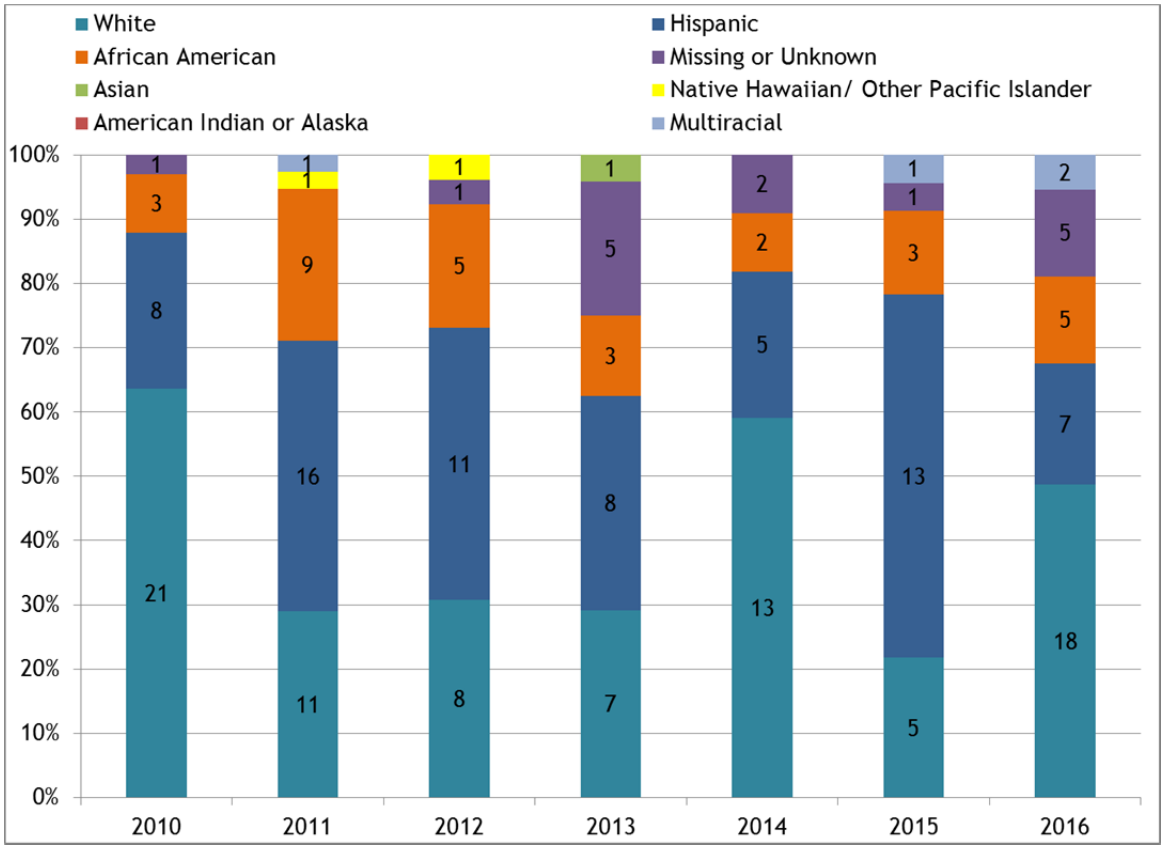
Chart 3: Race/Ethnicity of 97 victims in all substantiated fatal, near fatal, and egregious incidents of child maltreatment in Colorado for CY 2016



[3] https://demography.dola.colorado.gov/population/

Chart 4 shows the race/ethnicity of all child maltreatment fatalities in Colorado over the past six years. For fatalities in CY 2016, the most frequent race/ethnicity was White (48.7%), followed by Hispanic (18.9%) and African American (13.5%). This is a significant change from 2015, where the majority of child victims were Hispanic. However, the 2016 trends fall in line with trends from 2014 and 2010, and in other years (2011-2013), the share of White and Hispanic child victims were less disparate.

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

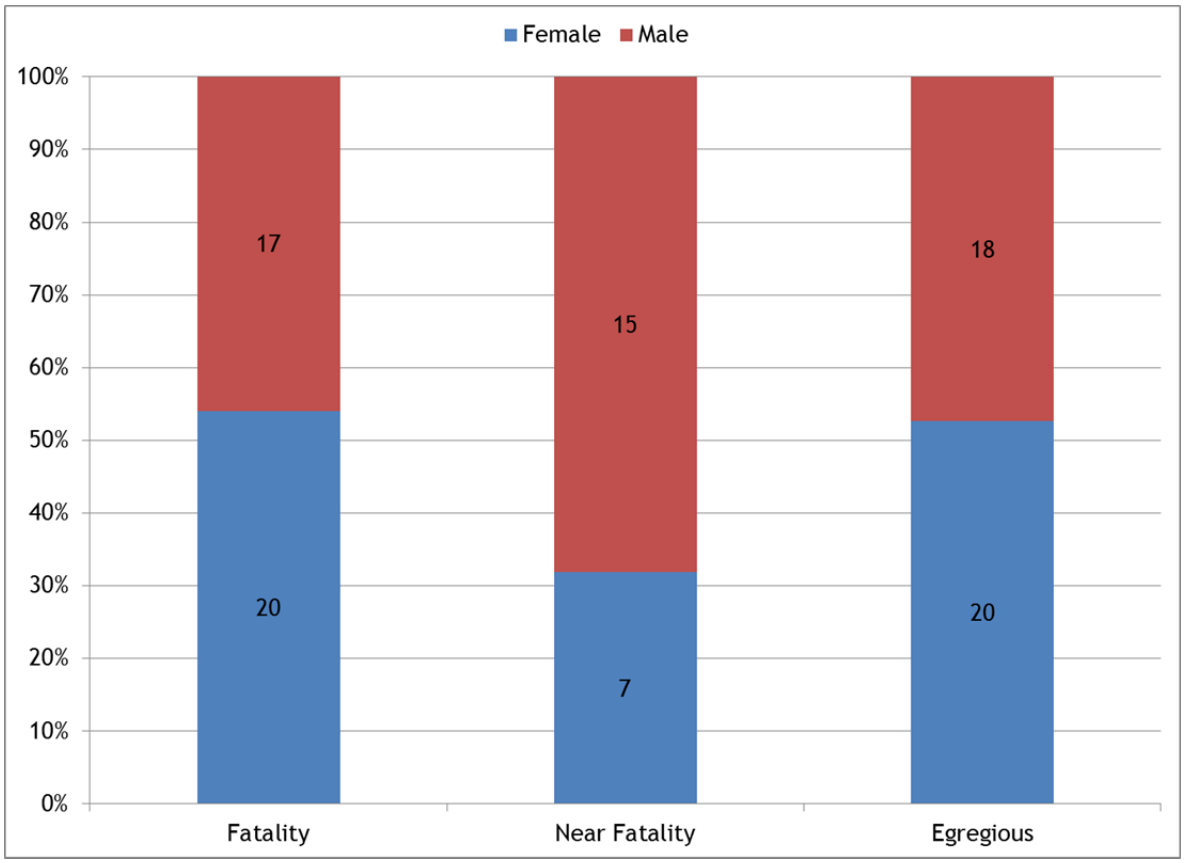


As mentioned above, CY 2016 marked a shift back to the pattern of Whites being the majority of victims. This year's data is more proportionate to the population of Coloradans, as White comprised a 69% of Colorado's population in 2015, while Hispanics are 22.3% of Colorado's population. The percentage 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%. It will be important to watch those trends in comparison to fatality rates. To date, there has been no discernable pattern to the racial/ethnic make-up of the child fatality victims.

Sex of victim

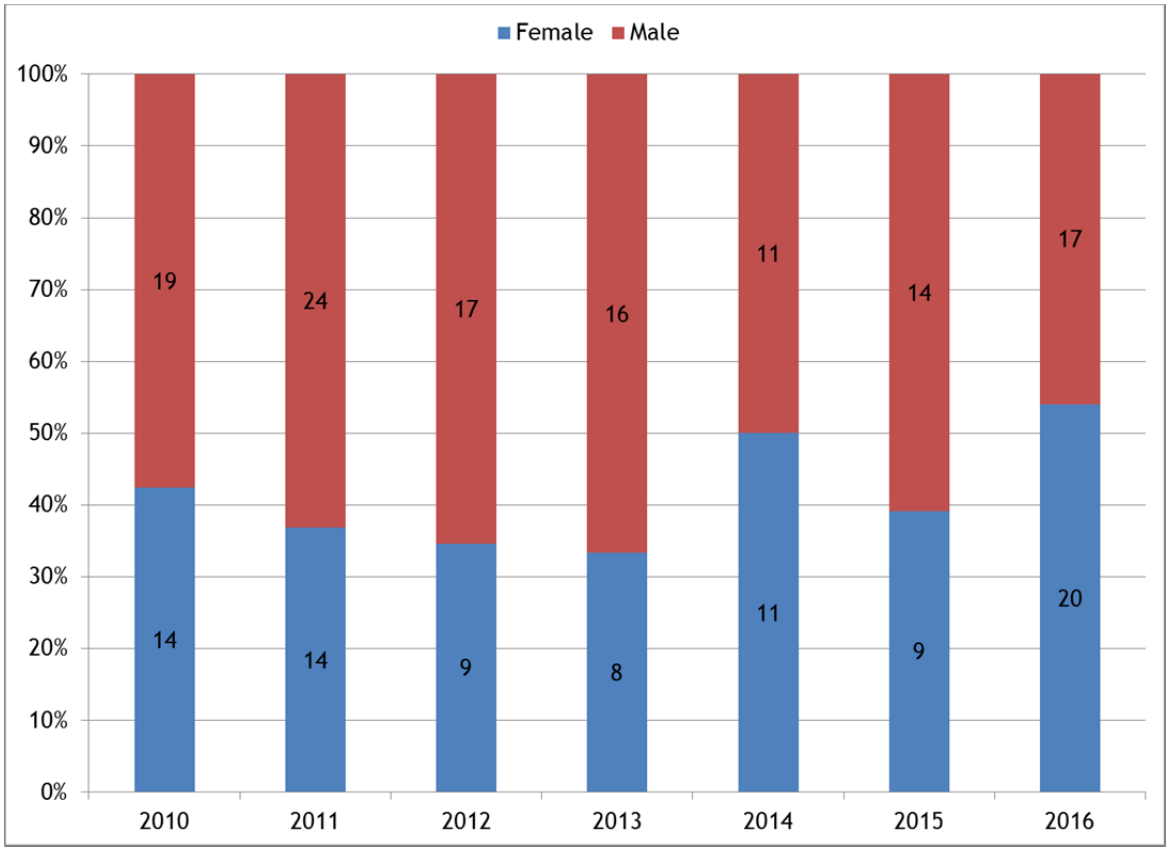
Chart 5 displays the breakdown of differences in the sex of the victims by the type of incidents. Nationally, in FFY 2015, 54.6% of child maltreatment fatality victims were males, almost a four-percentage-point difference from FFY 2014. In Colorado, in CY 2016, males accounted for 45.9% of the children in substantiated child maltreatment fatalities. Males were victims of more than two-thirds of the near fatalities (68.2%) and just under half of the egregious incidents (47.4%). There are no federal comparison statistics for near fatal or egregious incidents.

Chart 5: Sex of 97 victims in substantiated child maltreatment fatalities, near fatalities, and egregious incidents in Colorado for CY 2016



In the recent past, Colorado mirrored national trends in regard to the sex of child fatality victims – males were the highest percentage of victims. In 2010, approximately 56% of child maltreatment fatalities involved males, increasing to 63% in 2011 and then reaching a high of 67% in 2013. Percentage of male victims saw a small decrease in 2014, with males accounting for 50% of all fatalities, and this number rose once again in 2015 Colorado to 60.9% male. As demonstrated in Chart 6, CY 2016 is the first year the percentage of female victims surpasses male victims.

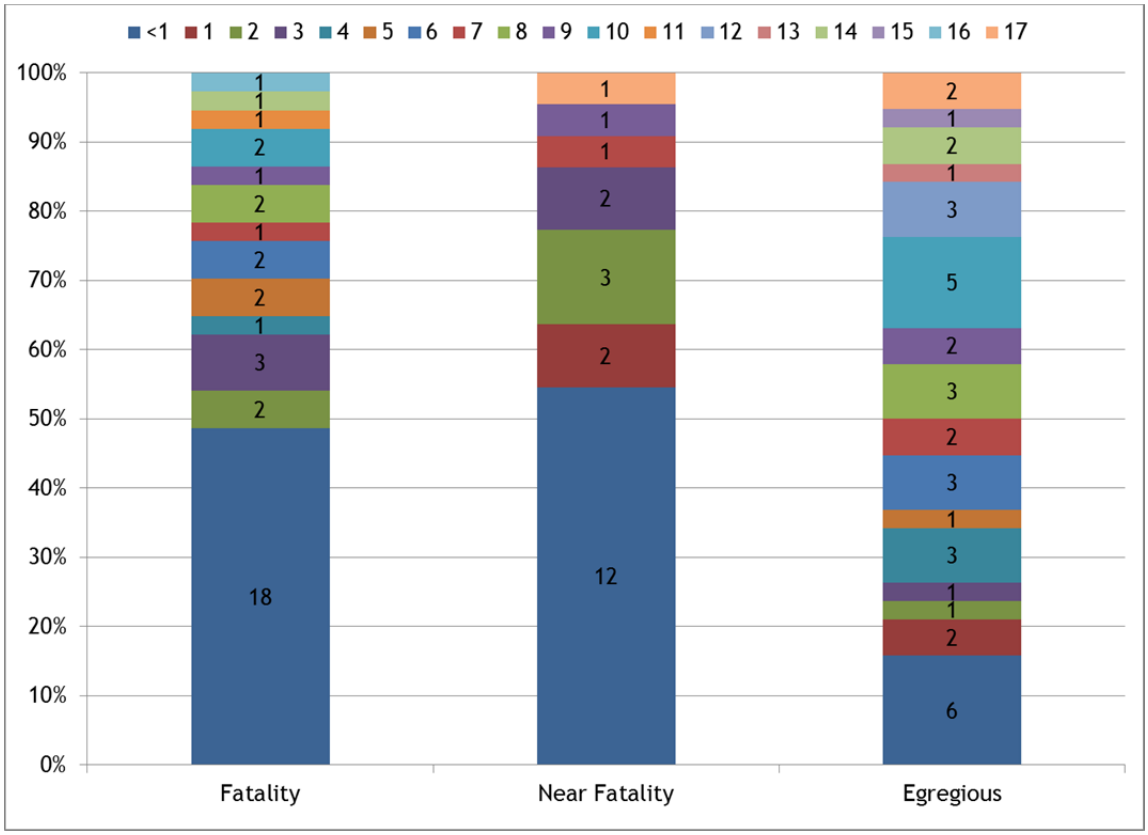
Chart 6: Sex of victims in all substantiated child maltreatment fatality victims in Colorado over the past seven calendar years



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 2015, victims of fatal child maltreatment incidents tend to be younger, with approximately 74.8% of the child fatalities experienced by children age three or younger, and 49.4% being younger than one year old. Colorado's trends appear to closely follow the national trends. As displayed in Chart 7, approximately 48.6% (18/37) of the fatalities involved victims younger than one year old, and 62.2% (23/37) were three or younger. A similar pattern of younger-aged victims exists for the near fatalities, as 54.5% (12/22) of the victims were under the age of one, and 86.4% (19/22) were age three or under (see Chart 7).

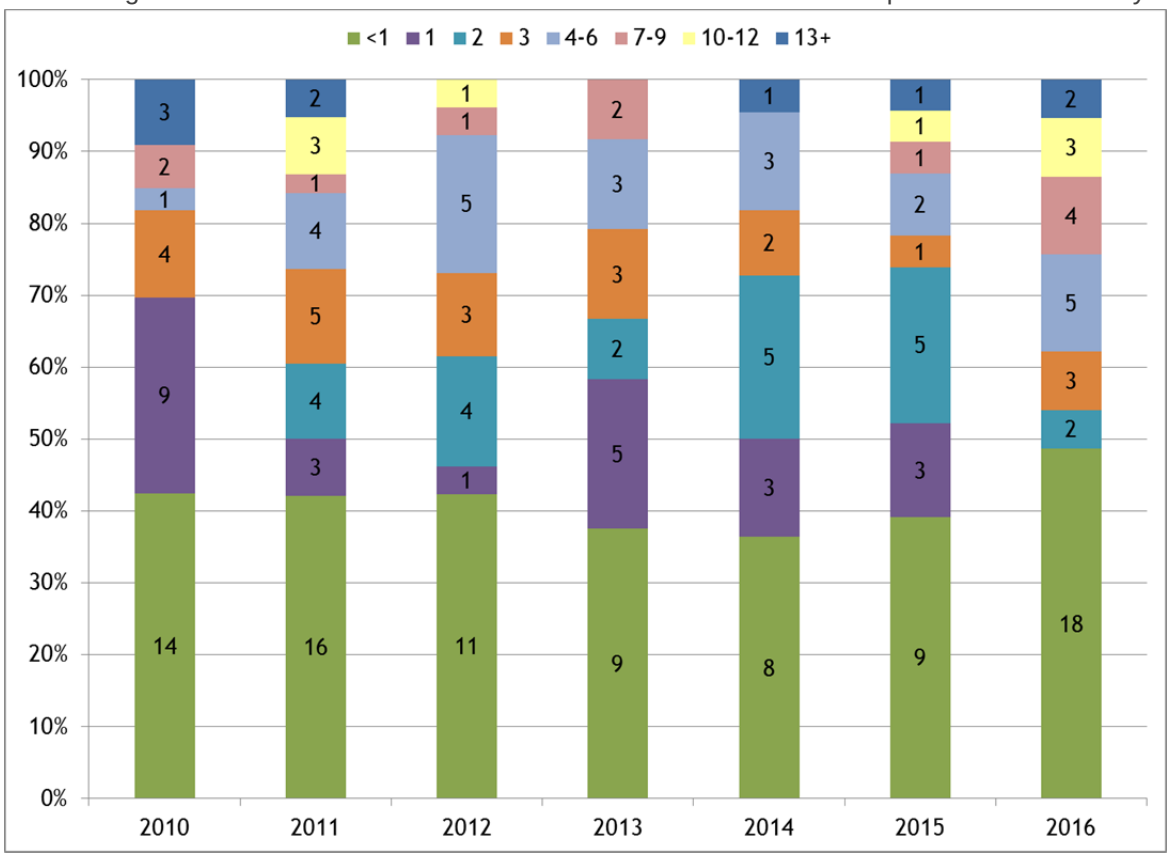
Chart 7: Age of 97 victims in substantiated child maltreatment fatalities, near fatalities, and egregious incidents in CY 2016



The pattern of ages of children substantiated in egregious incidents did not exactly follow those of the fatal and near fatal victims, and has followed its own trend within Colorado – victims of egregious incidents tend to be older. Approximately 16% (6/38) of the victims of egregious incidents were under the age of one, and only 26.3% (10/38) of all egregious incident victims were aged three or younger. Seventy-four percent of the 38 victims of egregious incidents were aged four or older, and 36.8% (14/38) were aged ten or older.

Chart 8 displays the trends in ages of victims in child maltreatment fatalities over the past six years. While it varies slightly over time, and is at its lowest percentage in 2016, over time approximately 75% of children in fatal child maltreatment incidents are three years of age or younger.

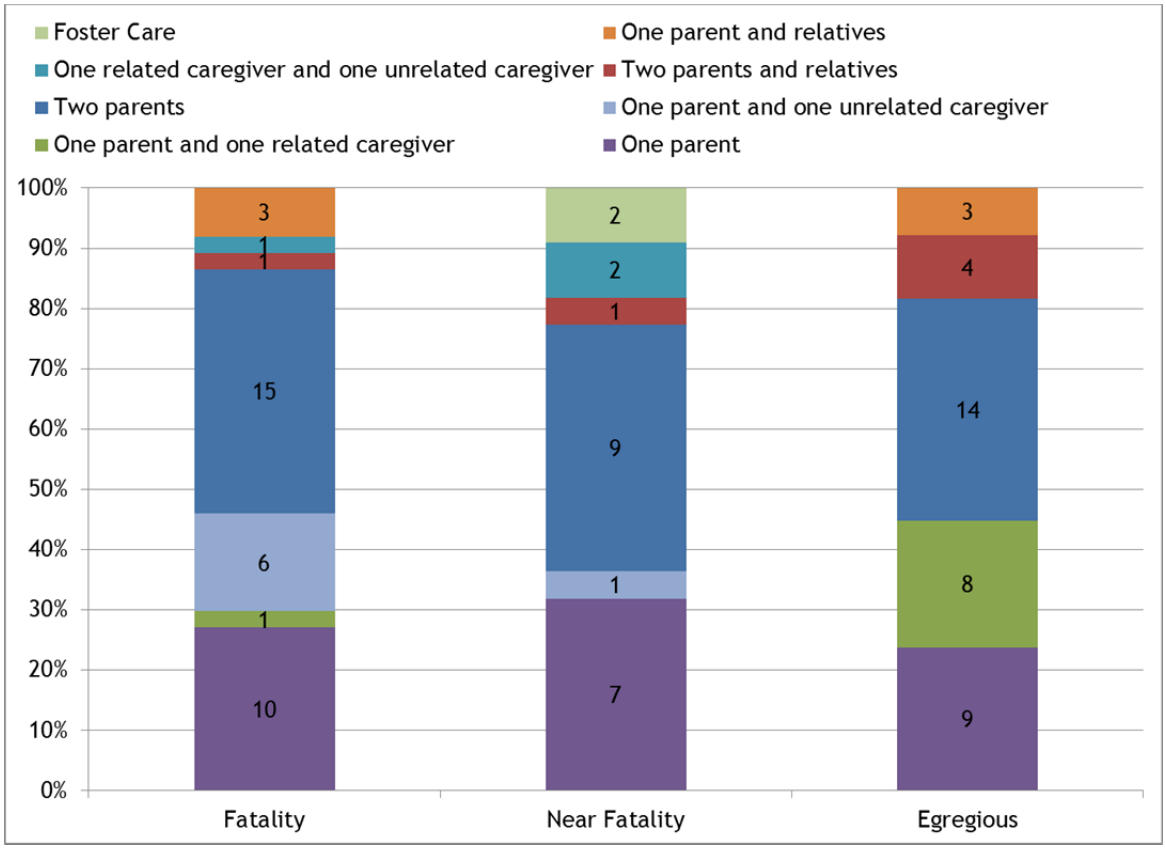
Chart 8: Age of victims in child maltreatment fatalities in Colorado over the past seven calendar years



Family Structure

Family composition is another factor potentially related to child maltreatment fatalities. As displayed in Chart 9, 39.2% (38/97) of all children in fatal, near fatal, and egregious incidents of child maltreatment lived in families with two parents. This family composition was also the most frequent for incidents occurring in 2015. The second most common type of family structure across all substantiated incidents was one parent (26.8%; 26/97). Approximately 68% (25/37) of fatal incidents occurred for children in families with two parents or simply one parent. These two types of family composition were also most likely for the children in egregious incidents and near fatalities; 60.5% (23/38) of children in egregious incidents maltreatment and 72.7% (16/22) of children in near fatal incidents of child maltreatment. These results are slightly different from 2015, where the second most common type of family structure was one parent and one unrelated caregiver.

Chart 9: Family Structure of 97 victims of substantiated child maltreatment fatalities, near fatalities, and egregious incidents in 2016



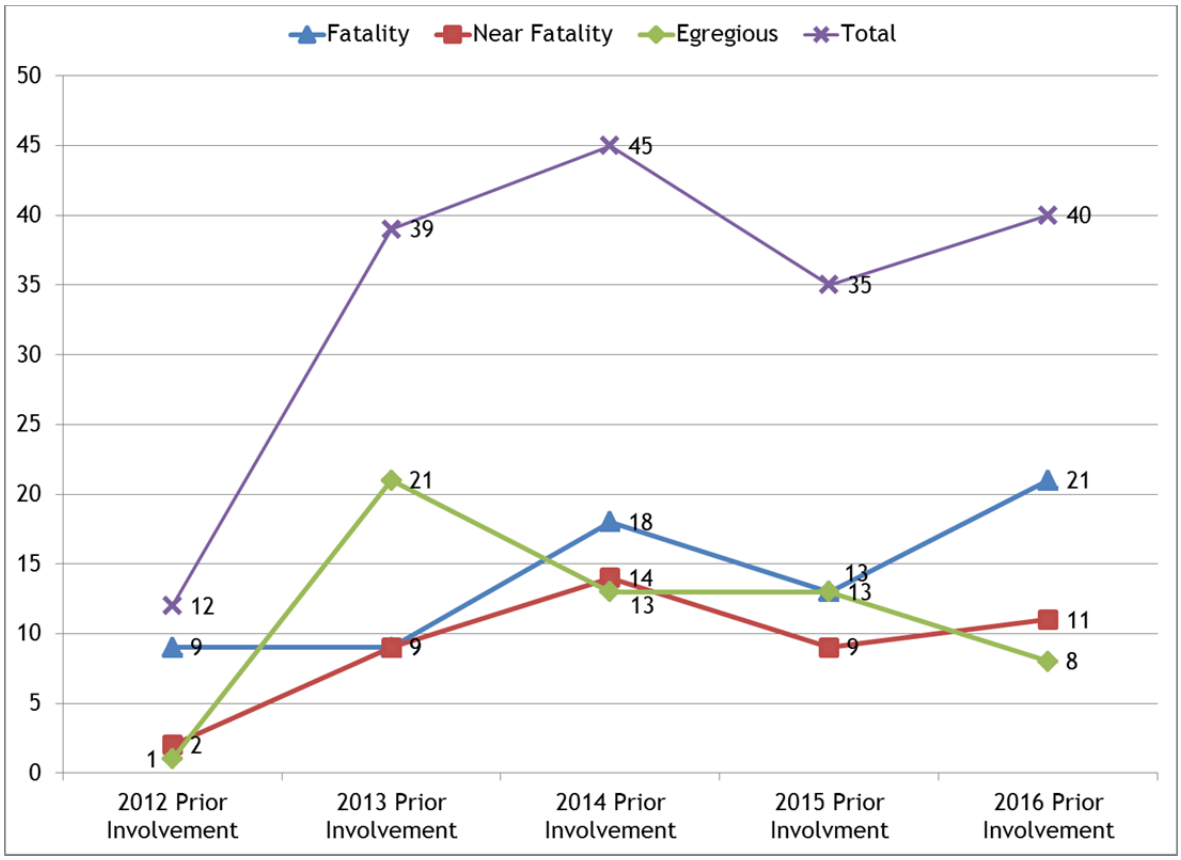
Prior Involvement

Nationally, in 2015, 2.3% of child fatalities involved families with prior out-of-home placement within the past five years, and 12% 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 – 2016, approximately 35% to 82% of the families had prior or current child protection history as defined in statute. In 2016, 21 of 35 (60%) families involved in fatal child maltreatment incidents had prior history and/or current involvement in the Child Protection System (CPS); in 2015, 13 of 22 (59.1%) of families involved in fatal child maltreatment incidents had prior history and/or current involvement. The percent of fatalities with prior history remained stable from 2015 to 2106, and remain lower than 2014, where 82% of families involved in fatal incidents had prior and/or current CPS involvement.

The number of families with prior history and/or current involvement for both near fatalities and egregious incidents saw some change from 2015 to 2016. Near fatal incidents where families had prior history and/or current involvement remained stable at 60.0% (9/15) in 2015 and 55% (11/20) in 2016. Families involved in egregious child maltreatment incidents who had prior history and/or current involvement decreased from 68.4% (13/19) in 2015 to 50% (8/16) in 2016. Chart 10 details the trends in incidents with prior and/or current involvement for the past five 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 2012-2016*



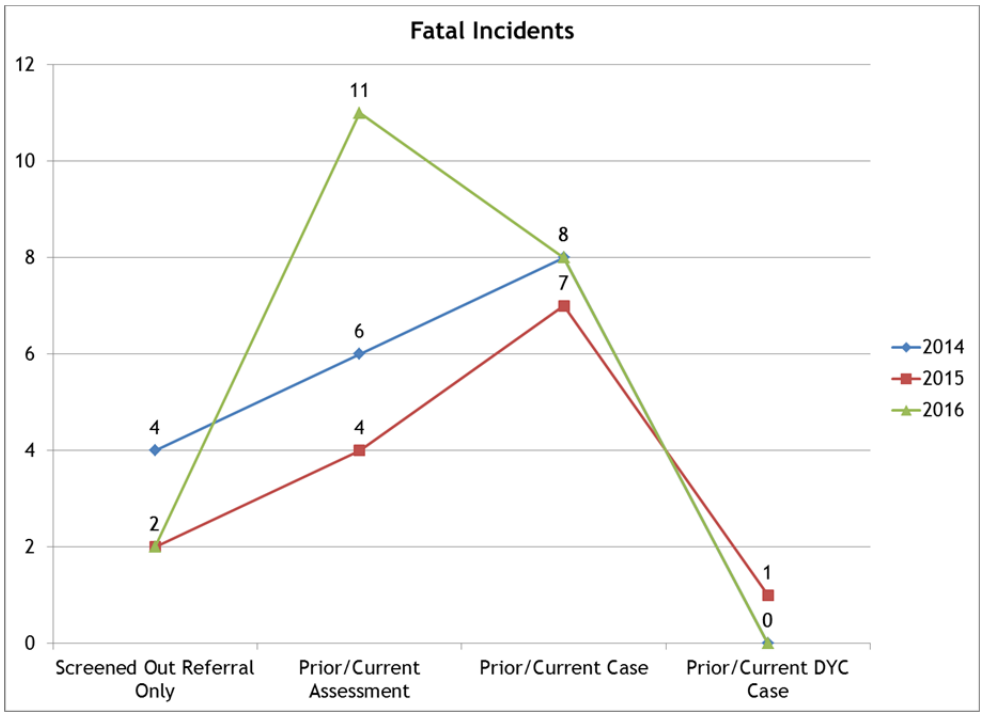
** As the statutory changes over the prior years have modified the population of incidents requiring review, and each has changed within each given calendar year, it limits the ability to interpret trends in the data. Further, any change in the final number of incidents in a given calendar year may be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

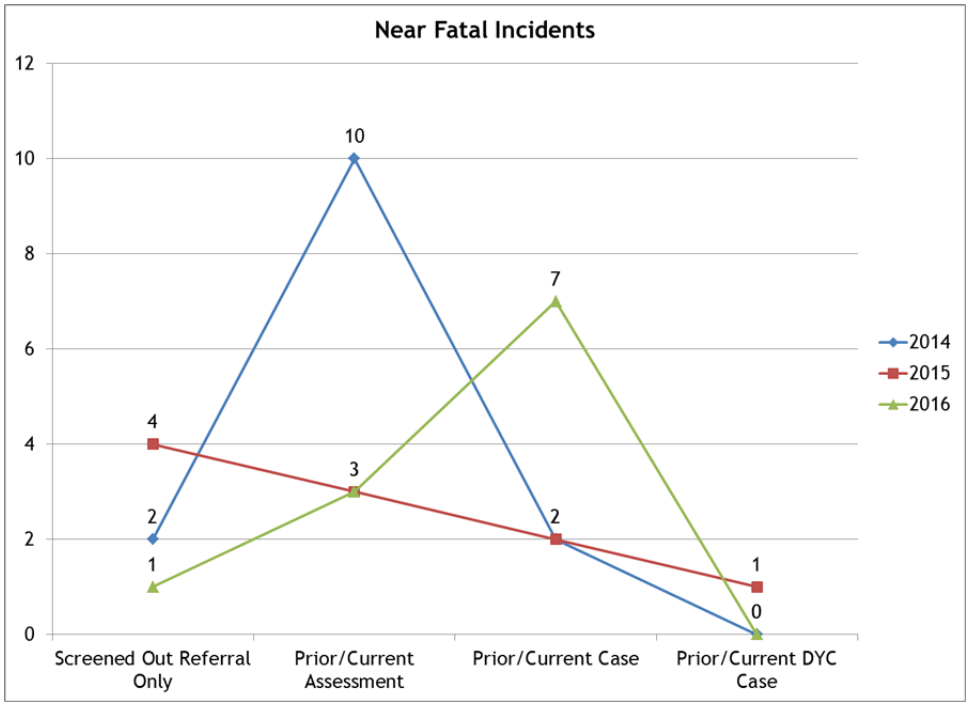
Since 2014, information related to the type and scope of prior involvement was available for analysis. The trends for types of prior involvement over the past three years is illustrated in Chart 11 a-c. In determining the type and scope of prior involvement, this section follows the prior history to 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 a child welfare assessment, the prior history will be counted only in the category for "Prior/Current Assessment." If the referral was not accepted for assessment,

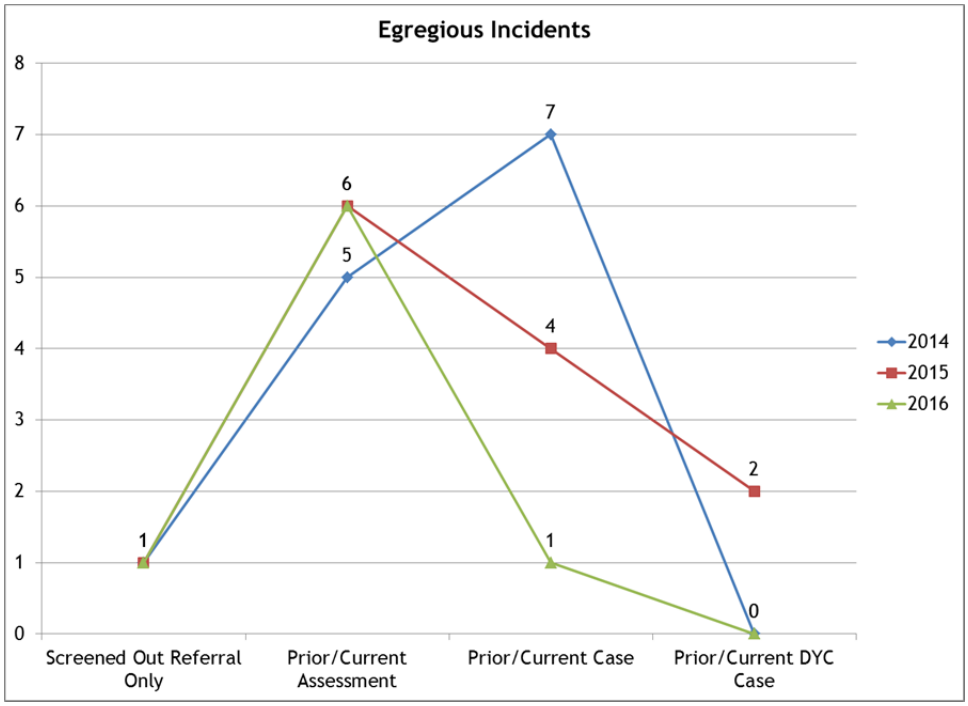
it would be counted in the "Prior/Current Referral" category. It should be noted that, for purposes of this report, if a child/family had prior or current involvement in an open child welfare case and a prior or current involvement within the Division of Youth Corrections, that history was counted in 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 numbers are based on 13 family involvements for fatalities (rather than 12), and 10 near fatal prior family involvements (rather than 9). In 2016, no family had history with the DYC system.

The most frequent type of prior history and/or current involvement in fatal child maltreatment incidents in 2016 were child welfare assessments (11/21; 52.4%). In 2015, on-going case prior history and/or current involvement was the most common type of prior history and/or current involvement for fatal incidents; involvement in an on-going cases was the second most common type of history in 2016 (8/21; 38.1%). Conversely, near fatal incidents in 2016 comprised the greatest number (7/11; 63.6%) of incidents where the highest level of history was a case, meaning the family was part of on-going child protection services.

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




Near Fatal Incidents
12
10
8
6
4
2
0
10
7
4
3
2
2
1
1
0
Screened Out Referral Only
Prior/Current Assessment
Prior/Current Case
Prior/Current DYC Case
2014
2015
2016

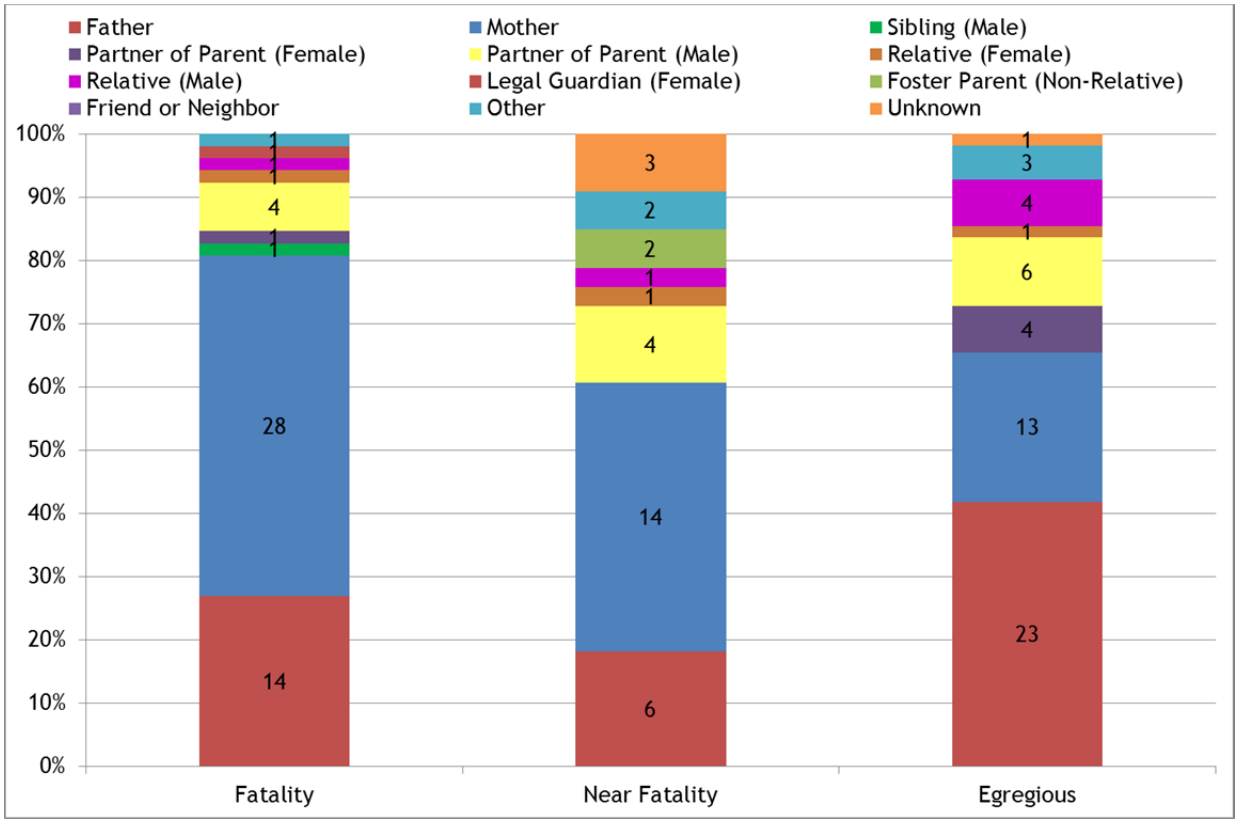

Egregious Incidents
8
7
6
5
4
3
2
1
0
7
6
5
4
2
1
1
0
Screened Out Referral Only
Prior/Current Assessment
Prior/Current Case
Prior/Current DYC Case
2014
2015
2016

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 2016, the most frequent perpetrator in fatal incidents was the victim's mother (28/52; 53.9%), and this is quite above national trends (26.7%), though mothers are the most frequent perpetrators of fatalities nationally. The second largest category of perpetrators of fatalities was fathers (14/52; 26.9%). For the near fatal incidents, mothers were also the most frequent perpetrators (14/33; 42.4%), and the father was the perpetrator for six victims.

The perpetrators in egregious incidents were most frequently fathers (23/55; 41.8%), which is opposite of fatal and near fatal incidents. Mothers were the second most frequent (13/55; 23.6%). Across all three types of incidents, the third most common perpetrator was the male partner of a parent. With all incidents, four perpetrators were unknown (one in an egregious incident and three in near fatal incidents), which means through assessment and investigation, a perpetrator of the incident was unable to be determined.

Chart 12: Perpetrator relationship to 97 victims of substantiated child maltreatment fatalities, near fatalities, and egregious incidents in Colorado during CY 2016*



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 2016. 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 the immediate safety of children. For example, in 2016, there were 61 unique caregivers involved in incidents that were reviewed by the CFRT; income information was only known for 22 of these individuals (36.1%). Of those caregivers with known income information, the average income for caregivers involved in fatal incidents is approximately $16,186.80; $15,121.17 for near fatal incidents and $3,600 for egregious incidents.

Educational level was unknown for 45.9% (28/61) of the legal caregivers. Of the reported education levels for legal caregivers the two most common across fatal, near fatal, and egregious incidents of child maltreatment was a high school diploma/GED and less than a high school diploma/GED. This accounted for 84.9% (28/33) of the caregivers with a known educational attainment level. An additional 15.2% (5/33) had an associates/vocational degree or higher

Supplemental Public Benefits

In CY 2016, information for 100% (32/32) of the 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[4]. 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 22 of the families. This was followed by Supplemental Nutrition Assistance Program (SNAP), which was received

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

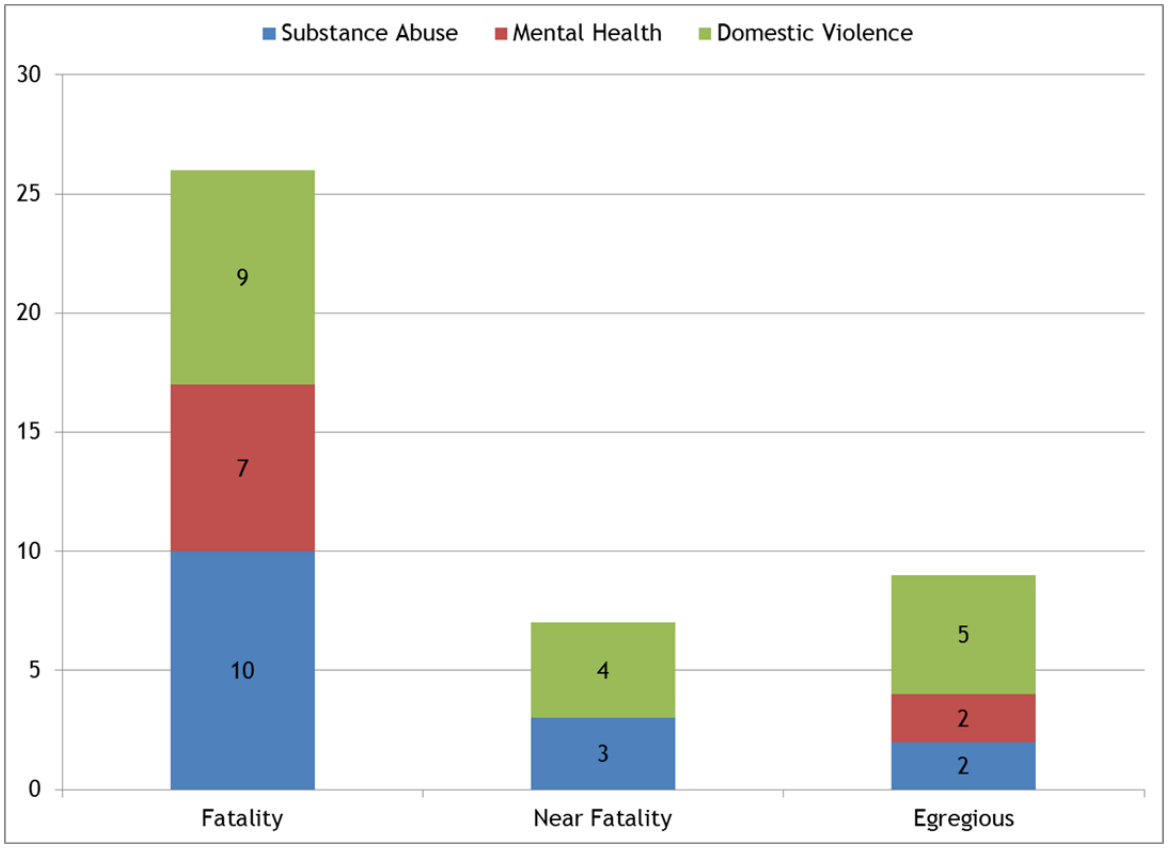
by 15 families. Other types of benefits received included, Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), and Special Supplemental Nutrition Program- Women, Infants, Children (WIC), Social Security Insurance (SSI), Child Health Plan Plus (CHP+) and housing assistance.

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 2016. Nationally, 6.9% of child fatalities were associated with a caregiver who was known to abuse alcohol, while 18.1% of child fatalities had a caregiver who abused drugs. In Colorado, 47.6% (10/21) of the families involved in a fatal incident of child maltreatment reviewed by the CFRT in 2016 had some history of identified substance abuse.

Within the families involved in child fatalities, 42.9% (9/21) of the families experienced domestic violence issues and for 33.3% (7/21) of the fatality incidents there was a history of mental health treatment. Of the information known for near fatal and egregious incidents, 36.4% (4/11) and 62.5% (5/8) families were impacted by domestic violence, respectively.

Chart 13: Other stressors in families of the child maltreatment fatalities, near fatalities, and egregious reviewed by the CFRT in 2016



Summary of CFRT Review Findings and Recommendations

This section summarizes the findings and recommendations of 44 non-confidential case-specific executive summary reports (hereafter referred to as reports). This includes 44 reports completed and posted to the CDHS public notification website after the date for inclusion in the 2015 CFRT Annual Report (3/31/2016) and prior to and including the end date for inclusion in this year's report (3/31/2017). Each of the 44 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 44 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 that 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 involvement and the involvement regarding the incident itself. 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 across the 44 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 44 reports that resulted in a recommendation, alongside resulting recommendations and progress.

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

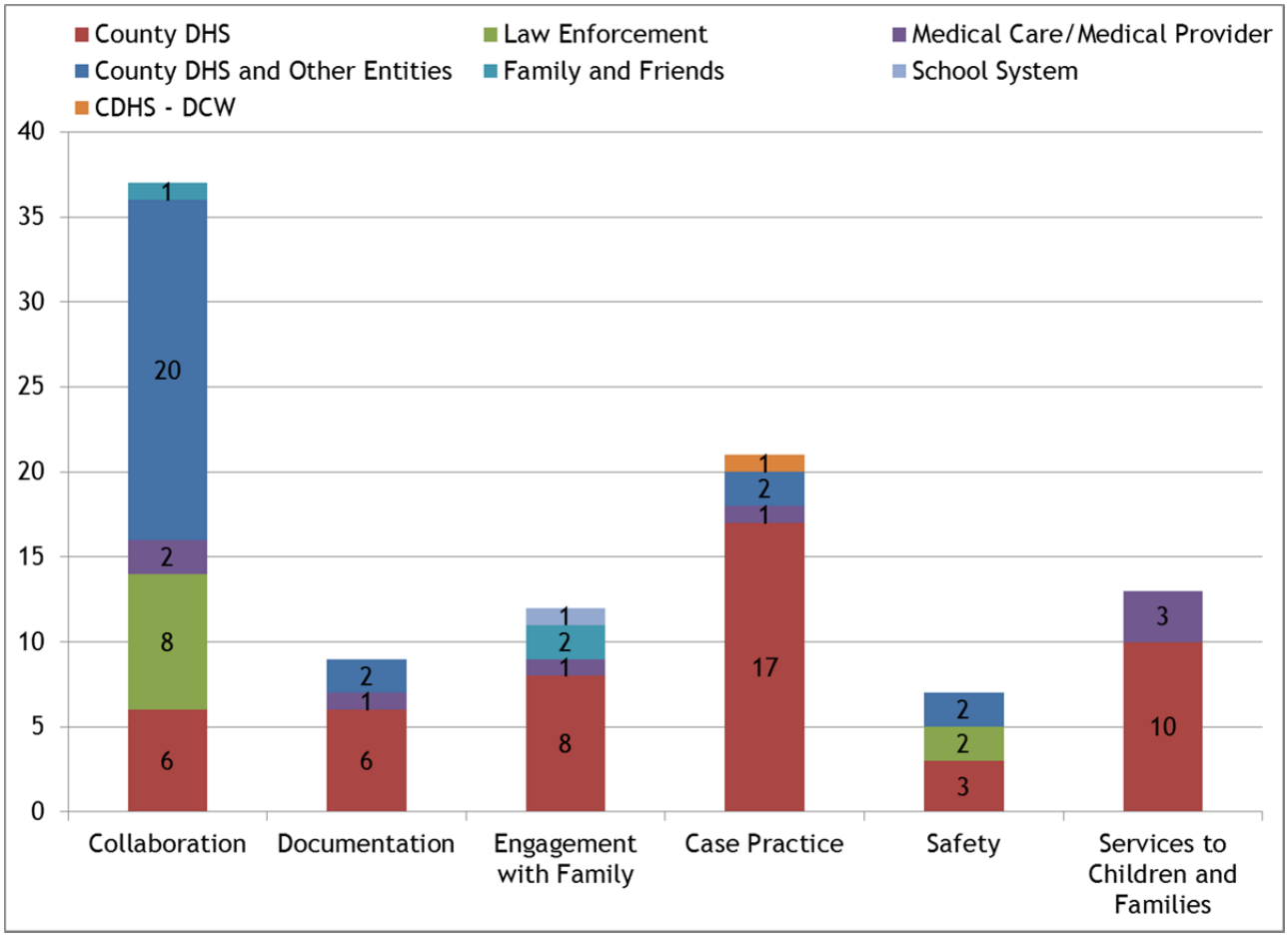
Across the 44 fatal, near fatal, or egregious incidents of child maltreatment reviewed by the Child Fatality Review Team and posted to the public notification website, the team noted 99 systemic strengths in the delivery of services to children and families. Items of systemic strength acknowledged by the team were organized across 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 37 occasions in 29 reports. Most often, collaboration occurring *after* the fatal, near fatal, or egregious incident was noted as a

strength. For example, county departments collaborated well with other agencies (e.g., another state's department of human services, local community agencies, etc.) after 20 incidents. Similarly, county departments and law enforcement worked well together to investigate the circumstances around the incident in the assessment of eight of the incidents. Strong collaboration between county departments of human/social services was identified in the reports of six incidents. Medical providers were also indicated as important collaborative members in the assessment of the fatal, near fatal, and egregious incidents, engaging with county departments in a positive manner on two different incidents. These collaborations are often provide important information to the county child welfare professionals that is critical in helping to inform the outcome of assessments in order to ensure the ongoing safety of children.

Chart 14: Strengths identified by the CFRT review process



Documentation

Documentation by county departments of human services was indicated as a systemic strength on nine occasions in eight 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. Additionally, the CFRT identified that the documentation of

county departments of human services' assessment of the incidents was thorough; supporting their finding of abuse and/or neglect and helping other professionals understand the full context of the incident, the assessment, and any service delivery to the children and families.

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. This involved efforts to engage with parents after the incident in order to support reunification, gather information that is more complete during the assessment of the incident, and to better assess interactions between parents and children. In one report, it was noted that, during the assessment of the incident, the children requested to work with a caseworker who had assisted them during a prior involvement. Due to the strength of the relationship, and the trust the children had in the caseworker, the children felt comfortable disclosing the extent of maltreatment they had endured over the past years. Several of the strengths noted the ability of caseworkers to positively engage with families during the assessment of the fatal, near fatal, or egregious incident in order to better assess safety and risk concerns, mitigate concerns, and plan for the longer safety and permanency of the children. Lastly, it should be noted that two reports identified positive engagement of families by other systems (e.g., medical professionals and schools) that helped families have a better understanding of the concerns for children as well as helping to monitor and protect the safety of children.

Case Practice

The CFRT identified caseworkers who excelled in case practice to children and families 21 different times (across 18 reports) following fatal, near fatal and egregious incidents of child maltreatment. During the assessment of several incidents, counties utilized a team approach to gathering information. This allowed them to quickly gather information from other professionals across multiple locations (e.g., law enforcement and medical professionals) in a more timely and thorough manner that then informed safety intervention decisions. At times, this also included thorough collaboration between after-hours workers and the worker assigned to the assessment. Lastly, the CFRT identified the use of a timeline to chart out the history of prior involvement with families as a practice that helps counties more thoroughly understand potential risks and strengths existing within the family and better inform decisions based on that analysis.

Safety

The CFRT identified seven instances across seven 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 to get an order to produce children when a parent was uncooperative during an assessment. Several times, the CFRT identified the thoroughness of county departments of human/social services in assessing the safety of other children in the family as part of their assessment of the fatal, near fatal, or egregious incident of child maltreatment. Two reports acknowledged the work other professionals (e.g., law enforcement) in recognizing situations that required intervention and either directly

intervening and/or making an appropriate referral to a county department of human/social services.

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 13 times across 11 reports. Examples included findings regarding the overall appropriateness of services provided to the families. This included services that were trauma informed and specific to domestic violence. Two reports also referenced strengths regarding decisions to seek medical evaluations and thoroughness of medical evaluations in providing information regarding the extent and nature of injuries, etc.

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

In the 44 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 between April 1, 2016 and March 31, 2017, the CFRT identified 45 gaps and deficiencies in the delivery of services to children and families. Systemic gaps and deficiencies were organized into three main categories: 1) Changes to Practice or Policy, 2) Implementation of New Safety and Risk Assessment Tools, 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 44 incident reviews and information about their implementation status.

Changes Needed to County Practice or Policy

The CFRT noted particular county-specific issues with practice and state policy gaps 19 times across the 44 CFRT reports. Several of the recommendations indicated the need for rule revisions. An example included changes to the requirement that caseworkers need to interview or observe a child fatally injured due to mistreatment. The team identified that caseworkers ultimately rely on information from the medical professionals and do not gain unique information from the observation, but do experience secondary trauma because of the requirement to observe the deceased child. The CFRT team believed that changing the requirement would not detrimentally affect the assessment and but would reduce the stress and trauma experienced by caseworkers. Another example was a recommendation related to clarifying rule and statute in regards to needing to assign a referral for assessment when there are not surviving siblings after a fatal incident of abuse and/or neglect.

Safety and Risk Assessment Tools

A systemic deficiency identified by the CFRT 12 times across the 44 reports involved the Colorado Risk and Safety Assessment tools. The team noted many policy findings related to the inaccurate use of these tools. As will be discussed in the policy findings portion of this section, the CFRT noted 29 policy findings related to the use of the safety and risk assessments, spread across 13 of the 44 reports. Specific to this gap, the CFRT continued to support the implementation of the new safety and risk assessment tools.

The Division of Child Welfare completed the phased roll out of the safety and risk assessment tools in January 2017.

Unique Issues

The remaining 14 gaps identified by the CFRT did not constitute overall trends across the 44 reports. However, the gaps had a related recommendation made to a specific county, state department, or community partner. Appendix C contains a list of the recommendations, as well as the status of each recommendation.

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. In each review, the CFRT staff identified areas of noncompliance with Volume 7 and the Colorado Revised Statutes.

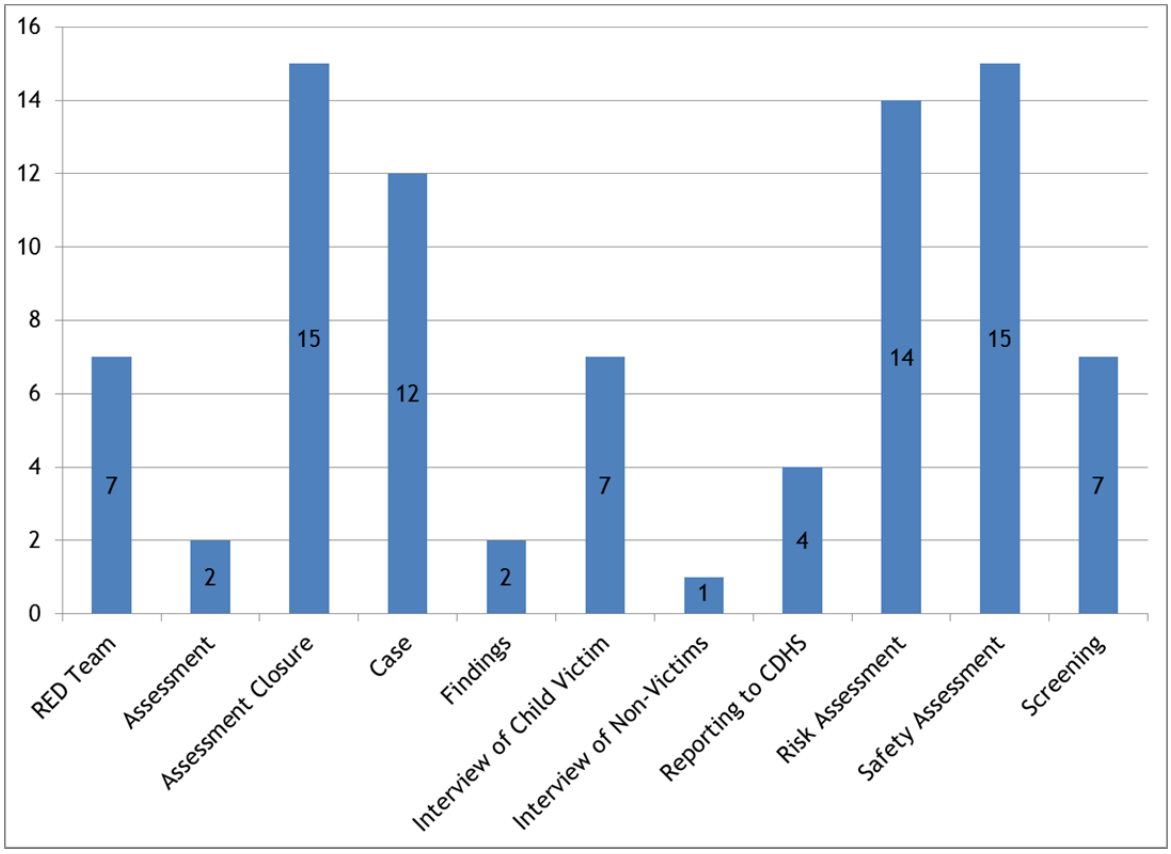
Each policy finding represents an instance where caseworkers and/or county departments did not comply with specific statute or rule. However, there are limitations to interpreting policy findings in the aggregate across the varied history and circumstances of multiple incidents. For example, an individual 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 86 policy findings from the 44 reports posted between the cutoff for the last CFRT Annual Report (3/31/2016) and this year's report (3/31/2017) that resulted in recommendations. The majority of these policy findings can be categorized into 11 categories: 1) assessments closing within required timeframes; 2) accuracy of the safety assessment tool; 3) accuracy in the use of the risk assessment tool; 4) findings related to the management of an ongoing case; 5) screening decisions; 6) implementation of the RED Team process; 7) timeliness of interviewing or observing children alleged to have been abused

and/or neglected; 8) timely reporting of fatal, near fatal, or egregious incidents of child maltreatment to the CDHS; 9) practice related to assessments of reports of child maltreatment, 10) accuracy of findings of abuse and neglect allegations; and 11) interviewing non-victims as part of an assessment . The frequency by type of policy finding is contained in Chart 15.

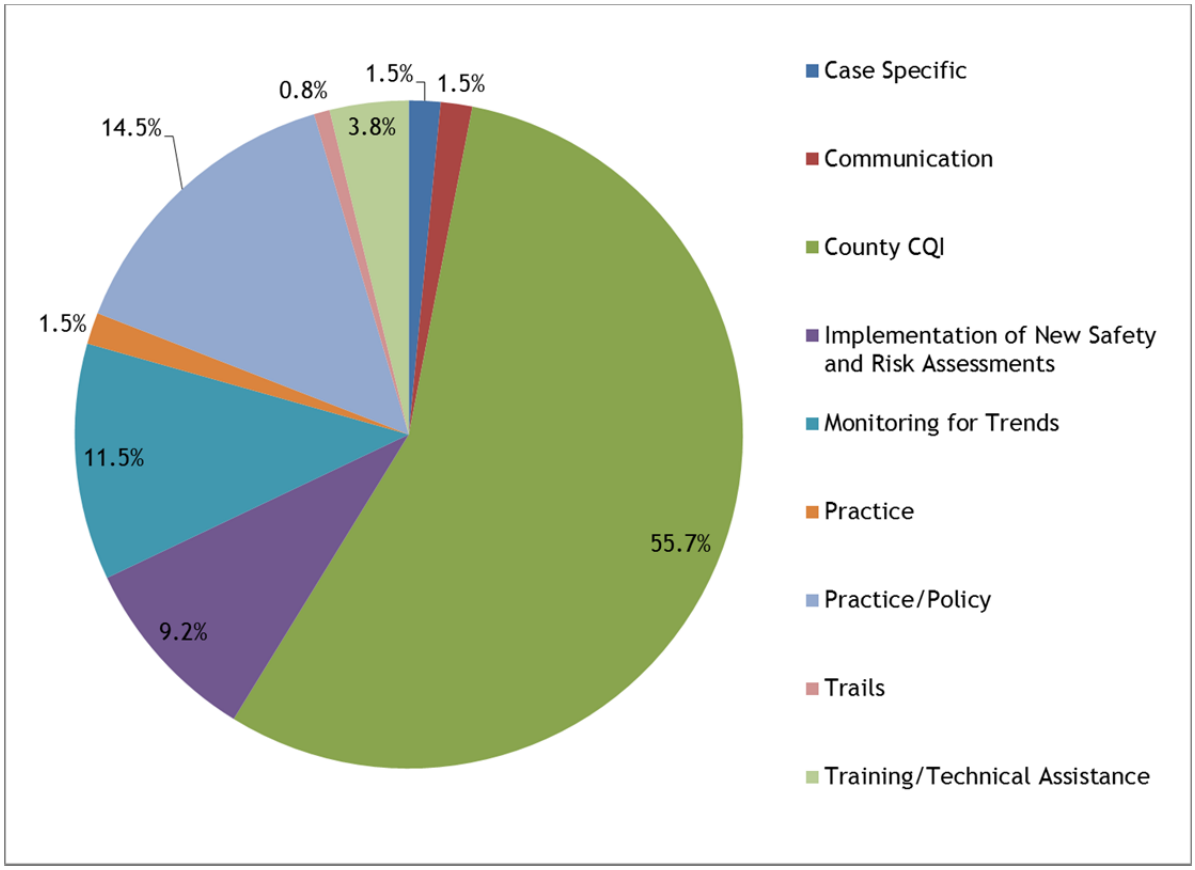
Chart 15: Policy findings by type



Recommendations from Posted Reports

A total of 131 recommendations were made across the 44 posted reports. This included 45 related to systemic gaps and deficiencies and 86 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) changes in policy or specific practices; 3) county monitoring of performance to actively track the status of compliance with practice expectations; 4) implementation and training on revised risk/safety tools to improve accuracy; 5) providing training and technical assistance from DCW to county departments.

Chart 16. Focus of recommendations in the 27 reports posted between 4/1/2016 and 3/31/2017

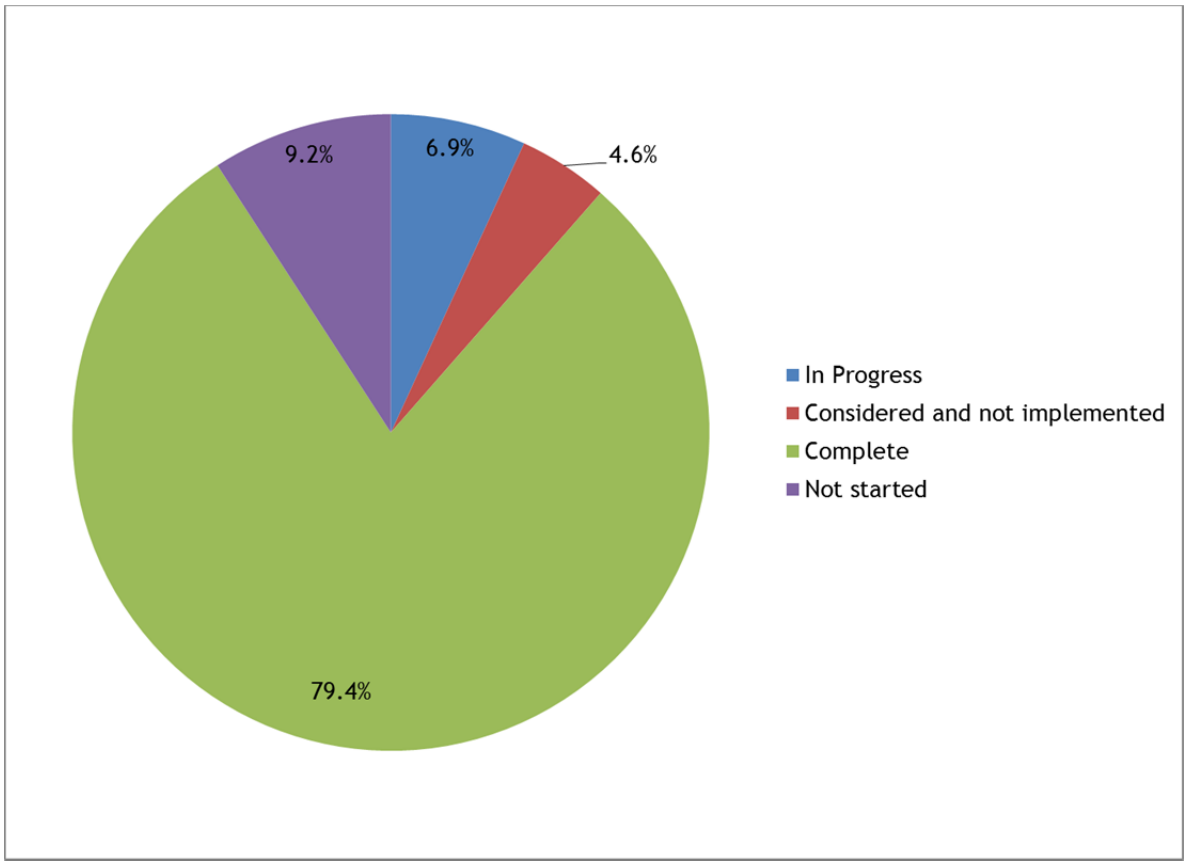


While several recommendations were reviewed in this report, the full texts of all 131 are contained in Appendix C, as well as the status of progress on these recommendations. As illustrated in Chart 17, 79.4% of the recommendations have been completed while an additional 6.9% are in progress. For six recommendations, it was determined that they either would not, or could not, be implemented at this time. Reasons for not implementing the recommendations included a determination that policy and practice expectations were sufficient, or that the recommendation was outside of the jurisdiction of the Division of Child Welfare.

Adding recommendations to the tracking process is an ongoing endeavor, so some small number of them will not be started at the time of each year's annual report if the reports were just finalized and the recommendations recently added to the recommendation tracking

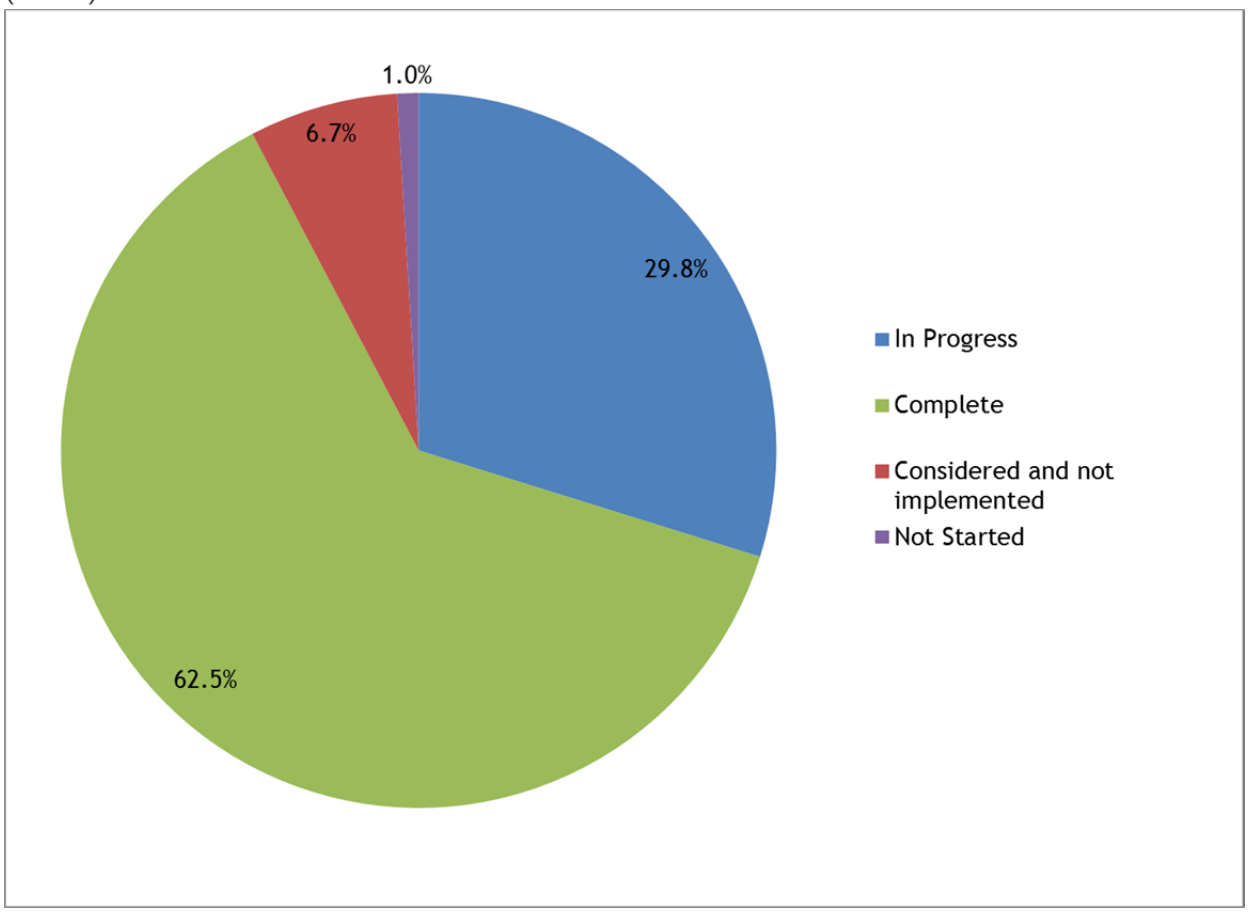
process. This year, there were 12 recommendations not started at the time of this report. Of these, five of them were recently (i.e., within seven months of the cutoff date for updates to be included in this report) added to the tracking process.

Chart 17: Status of Recommendations for Reports Posted Between 4/1/2016 and 3/31/2017 (n=131)



An update on the implementation status of the 104 recommendations presented in the 2015 CFRT Annual Report that were not completed at that time is presented in Appendix D. Since the time of the last report, an additional 62.5% of the recommendations were completed. The implementation of the new safety and risk assessment tools were responsible for a substantial portion of the completed recommendations. Almost all of the recommendations are either completed or in progress (29.8%), as noted in Chart 18.

Chart 18: Status of Recommendations Not Previously Completed From Reports Posted Prior to 4/1/2015 (n=104)



CDPHE and CDHS Joint Recommendations to Prevent Child Maltreatment

Strengthen practices related to sharing child maltreatment data across local agencies in Colorado.

Pursuant to C.R.S. 25-20.5-407 (1) (i), the Child Fatality Prevention System (CFPS) State Review Team is required to collaborate with the Colorado Department of Human Services (CDHS) Child Fatality Review Team to make joint recommendations for the prevention of child fatalities due to child maltreatment. Both teams endorse the recommendation to strengthen policies related to sharing child maltreatment data across local agencies in Colorado. Most importantly, improved data will inform decisions regarding better policies and practices to prevent child maltreatment. In addition, per statute, CFPS reconciled child maltreatment data from both systems. More information can be found in the child maltreatment data brief: http://www.cochildfatalityprevention.com/p/reports.html.

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.[5] 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 of preventing 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 others) and families themselves to 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.

Current efforts are underway to better understand other state models of this work, such as California's Los Angeles County Electronic Suspected Child Abuse Report System (E-SCARS). This system is designed to improve communication between law enforcement and child

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[5] 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.

protective services agencies by sharing access to data across agencies.[6] Colorado agencies could consider a similar approach in order to overcome data-sharing challenges such as high costs, confidentiality concerns and lack of collaboration. Additionally, one way to strengthen practices related to sharing of child maltreatment data may be to create a data-sharing profile in Colorado Trails, which would require specific parameters to ensure confidentiality and minimize misuse. Colorado Trails modernization is in development within the Colorado Department of Human Services (CDHS) Division of Child Welfare and exploration will continue to determine if resources will support a data-sharing profile. Discussions during local CFPS team and State Review Team meetings also consistently highlight the potential benefit of providing access for caseworkers to municipal court records and 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. An assessment of barriers, current laws and existing electronic systems will be a part of ongoing research to strengthen practices related to data-sharing across agencies.

Current work on this project includes a needs assessment of several Denver metro area CFPS teams regarding information sharing, background research on other state processes to share information and key informant interviews with partners at various state and local agencies. Additionally, efforts to coordinate various statewide projects to increase information sharing related to child maltreatment will begin during summer 2017 with an in-person convening of interested agencies and partners, including Colorado Department of Human Services, Child Protection Ombudsman of Colorado, and Colorado Department of Public Health and Environment.

[6] Ibid.

Appendix A: 2016 CFRT Attendance

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.*	**1/4/16**	**2/1/16**	**3/7/16**	**4/4/16**	**5/2/16**	**6/6/16**	**7/11/16**	**8/1/16**	**9/12/16**	**10/3/16**	**11/7/16**	**12/5/16**
Lucinda Connelly, *CDHS, Child Protection Manager*	Yes	By Phone	Yes	Yes	Yes	Yes	By Phone	Yes	Yes	Yes	Yes	Yes
→**Backup:** Korey Elger												
Brooke Ely-Milen, *CDHS, Domestic Violence Program Director*	Yes	By Phone	By Phone	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes	**No**
Susan Nichols, *Administrative Review Division, Manager (resigned 3/23/2016)*	Yes	Yes	Yes									
Allison Gonzales, *Administrative Review Division, Manager (appointed 8/1/2016- attended as a staff member prior to 8/1/2016)*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Marc Mackert *(appointed 3/18/2016 – 8/1/2016)*			Yes	Yes	Yes	Yes	Yes					
Colleen Kapsimalis, *CDPHE, Child Fatality Prevention System Program*	Yes	**No**	Yes	**No**	**No**	Yes	**No**	Yes	**No**	By Phone	Yes	**No**
Giorgianna Venetis, *CDPHE, Essentials for Childhood Coordinator*	**No**	By Phone	**No**	**No**	**No**	**No**	**No**	**No**	**No**	Yes	**No**	Yes
Lew Gaiter, *Larimer County Commissioner (resigned 2/1/2016)*	**No**											
Elizabeth "Betty" Donovan, *Gilpin County DHS Director (CCI appointment)*									Yes	By Phone	**No**	Yes
Casey Tighe, *Jefferson County Commissioner*	Yes	By Phone	Yes	Yes	Yes	**No**	Yes	Yes	By Phone	**No**	Yes	**No**

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.*	**1/4/16**	**2/1/16**	**3/7/16**	**4/4/16**	**5/2/16**	**6/6/16**	**7/11/16**	**8/1/16**	**9/12/16**	**10/3/16**	**11/7/16**	**12/5/16**
Dave Potts, *Chaffee County Commissioner*	Yes	By Phone	By Phone	Yes	By Phone	Yes	**No**	Yes	**No**	Yes	**No**	Yes
Senator Laura Woods	Yes	**No**	**No**	**No**	**No**	Yes	By Phone	Yes	**No**	**No**	**No**	**No**
Representative Jonathan Singer	Yes	By Phone	By Phone	**No**	By Phone	Yes	**No**	Yes	Yes	Yes	By Phone	**No**
Stephanie Villafuerte, *Office of Colorado's Child Protection Ombudsman*	**No**	By Phone	**No**	Yes	By Phone	By Phone	**No**	**No**	**No**	**No**	**No**	**No**
→**Backup:** Melissa Vigil											Yes	Yes
Sgt. Brian Cotter, *Denver Police Department*	Yes	By Phone	Yes	**No**	Yes	**No**	Yes	**No**	By Phone	**No**	By Phone	By Phone
Dr. Andrew Sirotnak, *Professor of Pediatrics, University of Colorado School of Medicine Director, Child Protection Team at Children's Hospital Colorado*	Yes	By Phone	Yes	**No**	**No**	Yes	**No**	Yes	Yes	**No**	Yes	Yes
→**Backup:** Dr. Antonia Chiesa				**No**	No		**No**			**No**		
Leora Joseph, *Chief Deputy District Attorney, 18th Judicial District*	**No**	Yes	Yes	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	Yes
Kathie Snell, MA, LPC, *Aurora Mental Health Center, Chief Operating Officer*	Yes	Yes	**No**	Yes	Yes	Yes	**No**	**No**	**No**	Yes	Yes	Yes
Michelle Sears-Ward, CDE, *Early Learning and School Readiness (resigned 3/28/2016)*	Yes	**No**	**No**									
→**Backup:** Karen Thiel		**No**	**No**									
Don Moseley, *Ralston House Child Advocacy Center, Director (appointed 3/18/2016)*				Yes	By Phone	Yes	Yes	Yes	By Phone	Yes	**No**	By Phone

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.*	**1/4/16**	**2/1/16**	**3/7/16**	**4/4/16**	**5/2/16**	**6/6/16**	**7/11/16**	**8/1/16**	**9/12/16**	**10/3/16**	**11/7/16**	**12/5/16**
Dan Makelky, *Douglas County Department of Human Services*	Yes	Yes	Yes	By Phone	**No**	**No**	Yes	Yes	**No**	**No**	**No**	**No**
→**Backup:** Ruby Richards/Nicole Becht					Yes	Yes			Yes	**No**	Yes	Yes
Michelle Dossey, *Arapahoe County Department of Human Services*	**No**	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes
→**Backup:** Michael DeGretto	**No**						Yes					
Shirley Rhodus, *El Paso County Department of Human Services*	Yes	By Phone	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Len Newman, *Administrative Review Division*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**No**	**No**	Yes	Yes	Yes
Lisa Lied, *Administrative Review Division*	Yes	Yes	**No**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Libbie McCarthy, *Attorney General's Office*	Yes	By Phone	Yes	Yes	Yes	Yes	**No**	**No**	By Phone	**No**	Yes	Yes
→**Backup:** Anita Icenogle						Yes	Yes	Yes		Yes		

Appendix B: 2012-2016 Incidents Qualified for CFRT Review by County and Type

County*	Fatal Incidents**					Near Fatal Incidents**					Egregious Incidents**									
	2012	2013	2014	2015	2016	2012	2013	2014	2015	2016	2012	2013	2014	2015	2016	2012 Total	2013 Total	2014 Total	2015 Total	2016 Total
Archuleta												1	1				1	1		
Adams	2	2		2	1			1		3		3	2			2	5	3	2	4
Alamosa												1					1			
Arapahoe		2	1	1	4		1		1			1		2	1		4	1	4	5
Boulder		1	1				1		1	2							2	1	1	2
Clear Creek			1															1		
Denver	1	1	4	1	1	1	3	3	3	1		7	3	3	3	2	11	10	7	5
Douglas					1										1					2
Eagle	1			1												1			1	
El Paso	2	1	2		4		1	1	1	1	1		1	1	1	3	2	4	2	6
Fremont								1				1	2	1			1	3	1	
Garfield				1															1	
Huerfano			1															1		
Jefferson			2	2	2			4		1		2	1	3			2	7	5	3
La Plata					1				1										1	1
Larimer			1	1	1							4		2			4	1	3	1
Las Animas				1															1	
Lincoln														1					1	
Logan	1		1													1		1		
Mesa	1		1	1	2		1		1							1	1	1	2	2
Moffat					1					1										2
Montezuma					1								1					1		1
Montrose					1															1
Morgan			1				1	1		1							1	2		1
Otero						1		1								1		1		
Park					1															1
Phillips		1															1			
Pitkin													1					1		
Pueblo	1		1				1	2	1	1		1	1			1	2	4	1	1
Routt			1												1			1		1
Weld		1		1											1		1		1	1
Total	**9**	**9**	**18**	**12**	**21**	**2**	**9**	**14**	**9**	**11**	**1**	**21**	**13**	**13**	**8**	**12**	**39**	**45**	**34**	**40**

** 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 four-year period.*

Appendix C: Recommendations from 2016 Posted Reports

CFRT ID	Source	Recommendation	Status
16-009	CFRT	The CFRT recommended that the DCW consider a change to Volume 7 to provide an exception to the requirement for caseworkers to observe/interview alleged victims of fatalities.	Complete
16-009	CFRT	The CFRT recommended that the DCW explore clarifying in Volume 7 the definition of "same day" related to an "immediate and/or same day response time."	In Progress
16-009	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for EPCDHS. It should be noted that the Division of Child Welfare (DCW) issued Policy Memo PM-CW-2016-0003 effective July 1, 2016, which stated, "During the assessment of a child fatality, near fatality or egregious incident, the caseworker shall not be expected to observe a deceased child or a child who is on life support or is in critical condition in a hospital environment." This assessment was completed prior to the issuance of the Policy Memo. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provides the basis for C-Stat data, EPCDHS' performance for February 2016 was 89.9% with a statewide 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 26, 2015 through February 26, 2016, showed EPCDHS at 53.6% for observing/interviewing the alleged victim within the assigned response time and 71.4% for making reasonable efforts to observe/interview the alleged victim within the assigned response time. It is recommended that EPCDHS monitor their performance on this measure and determine any future needs for improvement.	Complete

CFRT ID	Source	Recommendation	Status
16-009	Policy Finding	The policy finding related to the RED Team framework not being completed is 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 August 26, 2015 through February 26, 2016, EPCDHS included all elements required in Volume 7, 45.3% of the time. New practice expectations for supervisor approval were created in response to the Office of the State Auditor (OSA) Child Welfare Performance Audit. Early reviews indicated the process for documenting supervisor approvals was not well known at the county level. In an effort to communicate the new expectations, DCW issued Operational Memo OM-CW-2015-0007. It should be noted that the assessment in this review was completed prior to the issuance of the Operational Memo. For the recent review of a random sample of assessments, supervisory approval was missing in 11 of the 53 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 66%. As this policy finding was related to not completing a RED Team when required, it is recommended that EPCDHS employ a process in which barriers to the completion of the RED Team framework as required by Volume 7 are identified and solutions to the identified barriers are implemented.	Not Started
16-009	Policy Finding	The policy finding related to the overall finding not matching the definition, does not 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 August 26, 2015 through February 26, 2016, 87.5% of the assessments' overall findings matched the definition in Volume 7. It is recommended that EPCDHS monitor their performance on this measure and determine any future needs for improvement.	Not Started
16-019	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for DDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the December 2016 C-Stat, DDHS's performance for October, 2016 was 89.4%, with a statewide goal of 90%. It is recommended that DDHS 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
16-019	Policy Finding	The policy finding related to neither interviewing the alleged victim within the assigned response time, nor making reasonable efforts to interview the alleged victim within the response time, does reflect a systemic practice issue for DDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the December 2016 C-Stat, DDHS's performance for October, 2016 was 87.3%, with a statewide 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 March 17, 2016 to September 17, 2016, showed DDHS at 75% for observing/interviewing the alleged victim within the assigned response time and 87.5% for making reasonable efforts to observe/interview the alleged victim within the assigned response time. It is recommended that DDHS employ a process in which barriers to observing/interviewing the alleged victim within the response time are identified and solutions to the identified barriers are implemented.	Complete
16-027	CFRT	It is recommended that the CDHS Division of Child Welfare explore adding a reason referrals require no further action to the Volume 7.103.5 addressing when there are no surviving siblings, as a county has the ability in the state automated case management system (Trails) to substantiate the allegation of abuse and/or neglect at the referral stage based on the law enforcement investigation, without conducting an independent child welfare assessment.	In Progress

CFRT ID	Source	Recommendation	Status
16-032	Policy Finding	The policy finding related to the RED Team framework not including all elements required by Volume 7 is a systemic practice issue for Douglas County DHS. New practice expectations for supervisor approval were created in response to the OSA Child Welfare Performance Audit. Early reviews indicated the process for documenting supervisor approvals was not well known at the county level. In an effort to communicate the new expectations, DCW issued Operational Memo OM-CW-2015-0007 on October 15, 2015. It should be noted that the assessment in this review was completed before the issuance of the Operational Memo. 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 29, 2015 to December 29, 2015, the Douglas County DHS included all elements required in Volume 7, 31% of the time. Supervisory approval was missing in 15 of the 42 RED Team frameworks reviewed, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 64% for the Douglas County DHS. It is recommended that the Douglas County DHS employ a process in which barriers to the accurate completion of the RED Team framework as required by Volume 7 are identified and solutions to the identified barriers are implemented.	Not Started

CFRT ID	Source	Recommendation	Status
16-032	Policy Finding	The policy finding related to RED Team not being completed as required by Volume 7 is a systemic practice issue for Douglas County DHS. 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 29, 2015 to December 29, 2015, the Douglas County DHS included all elements required in Volume 7, 31% of the time. New practice expectations for supervisor approval were created in response to the OSA Child Welfare Performance Audit. Early reviews indicated the process for documenting supervisor approvals was not well known at the county level. In an effort to communicate the new expectations, DCW issued Operational Memo OM-CW-2015-0007 on October 15, 2015. It should be noted that the assessment in this review was completed before the issuance of the Operational Memo. For the recent review of a random sample of assessments, supervisory approval was missing in 15 of the 42 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 64% for the Douglas County DHS. As this policy finding is related to not holding a RED Team as required by Volume 7, it should also be noted that during the random sample of assessments that were conducted during a period from June 29, 2015 to December 29, 2015, Douglas County DHS completed a RED Team as required by Volume 7, 67% percent of the time. It is recommended that the Douglas County DHS employ a process in which barriers to the completion of the RED Team framework as required by Volume 7 are identified and solutions to the identified barriers are implemented.	Not Started
16-033	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for Adams County HSD According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the October 2016 C-Stat, Adams County's performance for August 2016 was 87.1% with a statewide goal of 90%. It is recommended that Adams County HSD implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Not Started
16-033	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for Arapahoe County DHS According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the October 2016 C-Stat, Arapahoe County's performance for August 2016 was 88.5% with a statewide goal of 90%. 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
16-036	Policy Finding	The policy finding regarding the 90-Day review/Court report not being documented in Trails does reflect a systemic practice issue for the Adams County HSD. In the most recent Out-of-Home Administrative Review data, 1st Quarter SFY17, Adams County HSD completed the 90-Day review/Court report in Trails according to Volume 7, 52.5% of the time, which is below the statewide average (excluding the Adams County HSD) of 65.9% for the same time span. It is recommended that Adams County HSD employ a process in which barriers to the FSP: 5A Review/Court report are identified and solutions to the identified barriers are implemented.	Not Started
16-036	Policy Finding	The policy finding related to the RED Team framework not including all elements required by Volume 7 is a systemic practice issue for the Adams County HSD. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from August 23, 2015 to February 23, 2016, the Adams County HSD included all elements required in Volume 7, 62% of the time. Supervisory approval was missing in 19 of the 50 RED Team frameworks, which impacted the performance. New practice expectations for supervisor approval were created in response to the OSA Child Welfare Performance Audit. Early reviews indicated the process for documenting supervisor approvals was not well known at the county level. In an effort to communicate the new expectations, DCW issued Operational Memo OM-CW-2015-0007 on October 15, 2015. It should be noted that 21 referrals in this review were received prior the issuance of the Operational Memo. Without considering supervisor approval, performance on the RED Team framework was at 96% for the Adams County HSD. It is recommended that the Adams County HSD employ a process in which barriers to the accurate completion of the RED Team framework as required by Volume 7 are identified and solutions to the identified barriers are implemented.	Not Started

CFRT ID	Source	Recommendation	Status
16-061	Policy Finding	The policy finding related to the RED Team framework not including all elements required by Volume 7 is 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 February 29, 2016 to August 29, 2016, EPCDHS included all elements required in Volume 7 60% of the time. Furthermore, after statewide implementation of the RED Team process, feedback from county departments and state staff was gathered during continuous quality improvement workshops. In response to the feedback, DCW issued Policy Memo PM-CW-2016-0005 (effective November 21, 2016) in an effort to provide further guidance and instruction related to the RED Team process which included, but was not limited to, required documentation in the state automated case management system (Trails). It was determined: "Documentation in the RED Team framework shall include, but not be limited to: Reason for referral (documented in the Reason for Referral; Danger/Harm narrative box); Justification for decision (documented in the Next Steps narrative box); and Next Steps (documented in the Next Steps narrative box)." This RED Team framework was completed prior to the issuance of this Policy Memo. It is recommended that EPCDHS employ a process in which barriers to the completion of the RED Team framework as required by Volume 7 are identified and solutions to the identified barriers are implemented.	Not Started
15-012	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
15-012	CFRT	It is recommended that the Child Protection Task Group (CPTG) determine the best course to disseminate information to caseworkers regarding daycare regulations and how to recognize and report persons operating unlicensed daycares.	Considered and not implemented
15-012	CFRT	It is recommended that LPCDHS explore their practice and use of their CPT as "advisory only" as outlined in CRS 19-1-103 (22).	Complete

CFRT ID	Source	Recommendation	Status
15-012	Policy Finding	The Policy Finding related to the inaccurate use of a Safety Plan does reflect a systemic issue for LPCDHS. In a review of a random sample of assessments that were conducted during a period from September 30, 2013 to March 30, 2014, the LPCDHS did not have any Safety Plans which were reviewed. The statewide average for accurately completing the Safety Plan is 51.1%. It is recommended that LPCDHS review data from the most recent ARD review (May 2015) when it becomes available, and employ a process in which barriers to the accurate use of a Safety Plan are identified and solutions to the identified barriers are implemented, if necessary. Additionally, a new safety assessment tool is being implemented by the State, and it is recommended that LPCDHS participate in the training and implementation of the new tool.	Complete
15-012	Policy Finding	The Policy Finding related to completing the safety assessment tool accurately (which includes timeliness) does reflect a systemic practice issue in LPCDHS. In a review of a random sample of assessments that were conducted during a period from September 30, 2013 to March 30, 2014, the LPCDHS completed the safety assessment tool accurately, in 85.0% of assessments, which is above the statewide average (not including LPCDHS) of 83.1% for the same time span, but below the goal of 95%. It is recommended that LPCDHS 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, and it is recommended that LPCDHS participate in the training and implementation of the new tool.	Complete
15-012	Policy Finding	The Policy Findings related to not completing the Colorado Family Risk Assessment tool accurately (which includes timeliness) does reflect a systemic practice issue in LPCDHS. 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 LPCDHS completed the risk assessment accurately in 79.5% of assessments, which is above the statewide average (not including LPCDHS) of 60.8% for the same time span. However, due to the level of performance on this measure, it is recommended that LPCDHS 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 LPCDHS participate in the training and implementation of the new tool.	Complete

CFRT ID	Source	Recommendation	Status
15-012	Policy Finding	The Policy Finding related to timeliness of assessment closure does reflect a current systemic practice issue for MCDSS. 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 July 2015 C-Stat report, which measures the percentage of assessments closed within 60 days regardless of extension status, shows MCDSS at 45.5% for High Risk Assessments. The statewide performance for this same time period is 86.5%. It is recommended that MCDSS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete
15-012	Policy Finding	The Policy Finding related to completing the safety assessment tool accurately (which includes timeliness) does reflect a systemic practice issue in MCDSS. 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 MCDSS completed the safety assessment tool accurately in 86.1% of assessments, which is above the statewide average (not including MCDSS) of 83.2% for the same time span. However, the measure is below the goal of 95%. It is recommended that MCDSS 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 MCDSS participate in the training and implementation of the new tool.	Complete
15-021	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
15-021	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 January 1, 2015 through July 1, 2015, Larimer County DHS completed the Colorado Family Risk Assessment Tool accurately in 62.3% of assessments, which is above the statewide average (not including Larimer County DHS) of 43.1% 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.	Complete

CFRT ID	Source	Recommendation	Status
15-021	Policy Finding	The policy finding related to completing the Colorado Safety Assessment tool timely 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 January 1, 2015 through July 1, 2015, Larimer County DHS completed the Colorado Safety Assessment tool accurately in 86.8% of assessments, which is above the statewide average (not including Larimer County DHS) of 43.5% 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 Safety Assessment tool are identified and solutions to the identified barriers are implemented.	Complete
15-024	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
15-024	CFRT	It is recommended that DCW explore providing training and guidance on how they can help supervisors and caseworkers outline and analyze the global view of the family's history to better understand patterns of maltreatment.	Complete
15-024	CFRT	DCW should explore clarification in rule or practice guidance regarding when a county department of human services should intervene with a family when the allegation is about lack of school attendance.	Considered and not implemented
15-024	CFRT	DCW should take a look at jurisdiction for IA assessments and determine if it should change or remain the same. "Arapahoe County DHS recommends that consideration be made to have institutional investigations completed by the State rather than at the county level for two primary reasons; 1. Institutional investigations are considered third party. Third party investigations are not within the scope of responsibility otherwise for county departments of child protection. 2. The governing and licensing entity responsible for child care institutions are the State, therefore the investigating party should be the State."	Considered and not implemented
15-024	CFRT	DCW should explore a rule change to allow an additional response time in situations where additional victims are identified after the original response time lapses.	In Progress

CFRT ID	Source	Recommendation	Status
15-024	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a current systemic practice issue for JCDCYF. The October 2015 C-Stat report, which measures the percentage of assessments closed within 60 days, showed JCDCYF at 87.7% for September 2015 which is below the statewide average of 89.1%. 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
15-024	Policy Finding	The policy finding related to the Colorado Family Risk Assessment tool not being completed in accordance with Volume VII 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 January 15, 2015 to July 15, 2015, JCDCYF completed the risk assessment tool accurately in 61.8% of assessments, which is above the statewide average (not including JCDCYF) of 43.1% for the same time span. Due to the low level of performance, 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. It is also recommended that JCDCYF complete the training on the new Colorado Family Risk Assessment tool when it becomes available.	Complete
15-024	Policy Finding	The policy finding related to the RED Team framework not including all elements required by Volume VII is a systemic practice issue for JCDCYF. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from January 15, 2015 to July 15, 2015, JCDCYF included all elements required in Volume VII 0% of the time, which is below the statewide average (not including JCDCYF) of 10.7% for the same time span. New practice expectations for supervisor approval were created in response to the OSA Child Welfare Performance Audit. Early reviews indicated the process for documenting supervisor approvals was not well known at the county level. In an effort to communicate the new expectations, DCW issued Operational Memo OM-CW-2015-0007. It should be noted that the assessment in this review was completed prior to the issuance of the Operational Memo. For the recent review of a random sample of assessments, supervisory approval was missing in 47 of the 50 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 66% for JCDCYF and 49.7% statewide. It is recommended that JCDCYF employ a process in which barriers to the completion of the RED Team framework as required by Volume VII are identified and solutions to the identified barriers are implemented.	Complete

CFRT ID	Source	Recommendation	Status
15-024	Policy Finding	The policy finding related to documentation of the type and appropriateness of the youngest sibling's placement is a systemic practice issue for DDHS. In the most recent Out-of-Home Administrative Review (July 1, 2015 until September 30, 2015), DDHS documented placement information in accordance with Volume VII, 79.7% of the time, which is below the statewide average (excluding DDHS) of 85.6% for the same time period. It is recommended that DDHS employ a process in which the barriers to documenting the placement information in accordance with Volume VII are identified and solutions to the identified barriers are implemented.	Complete
15-024	Policy Finding	The policy finding regarding the 90-Day review/Court report not meeting Volume VII requirements does reflect a systemic practice issue for DDHS. In the most recent Out-of-Home Administrative Review (July 1, 2015 until September 30, 2015), DDHS completed the 90-Day review/Court report in Trails according to Volume VII, 75.2% of the time, which is above the statewide average (excluding DDHS) of 66.6% for the same time span. It is recommended that DDHS monitor their progress on this measure to ensure improvement.	Complete
15-024	Policy Finding	The policy finding regarding contact with children for the purpose of assessing child safety and well-being is a systemic practice issue for DDHS. In the most recent Out-of-Home Administrative Review (July 1, 2015 until September 30, 2015), DDHS documented the required content from contacts with children in accordance with Volume VII, 77.3% of the time, which is slightly above the statewide average (excluding DDHS) of 76.8% for the same time span. It is recommended that DDHS monitor their progress on this measure to ensure improvement.	Complete
15-024	Policy Finding	The policy finding regarding contact with the mother for the purpose of assessing parent progress on the treatment plan and parent progress toward permanency is a systemic practice issue for DDHS. In the most recent Out-of-Home Administrative Review (July 1, 2015 until September 30, 2015), DDHS documented the content of contact with the mother in accordance with Volume 7, 87.5% of the time, which is above the statewide average (excluding Denver County) of 82.2% for the same time span. It is recommended that DDHS monitor their progress on this measure to ensure improvement.	Complete

CFRT ID	Source	Recommendation	Status
15-024	Policy Finding	The policy finding related to the accurate completion of the safety assessment tool, which includes timeliness, does reflect a systemic practice issue in Adams County HSD. In a recent review of a random sample of assessments that were conducted during a period from February 16, 2015 to August 16, 2015, Adams County HSD completed the safety assessment tool accurately in 56.4% of assessments, which is above the statewide average (not including Adams County HSD) of 50.8% for the same time span. However, due to the low level of performance, it is recommended that Adams County HSD 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. It is also recommended that Adams County HSD complete the training on the new Colorado Safety Assessment tool when it becomes available.	Complete
15-024	Policy Finding	The policy finding related to the Colorado Family Risk Assessment tool not being completed in accordance with Volume VII does reflect a systemic practice issue for Adams County HSD. In a recent review of a random sample of assessments that were conducted during a period from February 16, 2015 to August 16, 2015, Adams County HSD completed the risk assessment tool accurately in 50.9% of assessments, which is above the statewide average (not including Adams County HSD) of 46.1% for the same time span. However, due to the low level of performance, it is recommended that Adams County HSD 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 Adams County HSD complete the training on the new Colorado Family Risk Assessment tool when it becomes available.	Complete

CFRT ID	Source	Recommendation	Status
15-024	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for Adams County HSD. According to the October, 2015 C-Stat presentation for the month of September 2015, Adams County HSD is interviewing/observing the alleged victim within the assigned response time 90.3% of the time, which is above 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 completed during a period of February 16, 2015 to August 16, 2015, showed Adams County HSD at 60%. 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 Adams County HSD made reasonable efforts to see the victim of the allegation 87.3% of the time. It is recommended that Adams County HSD monitor their performance on this measure to ensure improvement in order to maintain the state goal of 90%.	Complete
15-024	Policy Finding	The policy finding related to the overall finding not matching the definition does reflect a systemic practice issue for DDHS. In a recent review of a random sample of assessments that were conducted during a period from March 2, 2015 through September 2, 2015, DDHS' overall finding matched the definition in 85.5% of assessments, which is below the statewide average (excluding DDHS) of 88.6% for the same time span. It is recommended that DDHS monitor their performance on this measure to ensure improvement.	Complete
15-024	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 March 2, 2015 through September 2, 2015, DDHS completed the risk assessment tool accurately in 56.4% of assessments, which is above the statewide average (not including DDHS) of 46.7% 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 completed the training on the new Colorado Family Risk Assessment tool when it becomes available.	Complete

CFRT ID	Source	Recommendation	Status
15-024	Policy Finding	The policy finding regarding the assignment of incorrect response times does reflect a systemic practice issue for 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 March 2, 2015 through September 2, 2015, DDHS assigned the appropriate response time in accordance with Volume VII 88.9% of the time, which is slightly below the statewide average of 90.1% for the same time span. It is recommended that DDHS monitor their performance on this measure to ensure improvement.	Complete
15-024	Policy Finding	The policy finding related to monthly contact with the maternal grandmother does reflect a systemic practice issue in DDHS. In a recent review of a random sample of In-Home Reviews that were conducted during a period from April 2, 2015 to November 1, 2015, DDHS completed required monthly contact with the caregiver/guardian/kin in 62% of the cases, which is above the statewide average (not including DDHS) of 59% for the same time span. It is recommended that DDHS 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
15-024	Policy Finding	The policy finding related to not completing the treatment plan in Trails does reflect a systemic practice issue for DDHS. In a recent review of a random sample of In-Home Reviews that were conducted during a period from April 2, 2015 to November 1, 2015, DDHS completed the required FSP: 3A in 64% of the cases, which is below the statewide average (not including DDHS) of 82% for the same time span. It is recommended that DDHS employ a process in which barriers to the FSP: 3A: Treatment Plan are identified and solutions to the identified barriers are implemented.	Complete
15-024	Policy Finding	The policy finding related to Family Service Plan: 5A Review/Court report does reflect a systemic practice issue in DDHS. In a recent review of a random sample of In-Home Reviews that were conducted during a period from April 2, 2015 to November 1, 2015, DDHS completed the required FSP: 5A in 64% of the cases, which is above the statewide average (not including DDHS) of 63% for the same time span. It is recommended that DDHS employ a process in which barriers to the FSP: 5A Review/Court report are identified and solutions to the identified barriers are implemented.	Complete

CFRT ID	Source	Recommendation	Status
15-024	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a current systemic practice issue for DDHS. The October 2015 C-Stat report, which measures the percentage of assessments closed within 60 days regardless of extension status, shows DDHS at 85.9% for High Risk Assessments for September 2015. The statewide average is 89.1%. It is recommended that DDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete
15-024	Policy Finding	The policy finding related to the safety 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 March 2, 2015 through September 2, 2015, DDHS completed the safety assessment tool accurately in 67.3% of assessments, which is above the statewide average (not including DDHS) of 51.2% for the same time span. It is recommended that DDHS 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 it is recommended that DDHS completed the training and implementation of the new safety assessment tool when it becomes available.	Complete
15-024	Policy Finding	The policy finding related to seeing the alleged victim within the assigned response time does reflect a systemic practice issue for Arapahoe County DHS. According to the most recent C-Stat presentation for the month of October 2015, which reflects data from September 2015, Arapahoe County DHS is interviewing the alleged victim within the assigned response time 86.5% 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 December 28, 2014 through June 28, 2015, showed Arapahoe County DHS at 49.1% for observing/interviewing the alleged victim within the assigned response time and 70.9% for making reasonable efforts to observe/interview the alleged victim within the assigned response time. It is recommended that Arapahoe County DHS employ a process in which the barriers to the timeliness of initial response with the alleged victim(s) is identified and solutions to the identified barriers are implemented.	Not Started

CFRT ID	Source	Recommendation	Status
15-024	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for JCDCYF. According to the most recent C-Stat presentation for the month of October 2015, which reflects data from September 2015, JCDCYF is interviewing the alleged victim within the assigned response time 86.9% 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 January 15, 2015 to July 15, 2015, showed JCDCYF at 76.4% for observing/interviewing the alleged victim within the assigned response time and 89.1% 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 improvement to reach the state goal of 90%.	Complete
15-024	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 January 15, 2015 to July 15, 2015, JCDCYF completed the safety assessment tool accurately, which includes timeliness in 83.6% of assessments, which is above the statewide average (not including JCDCYF) of 43.8% for the same time span. It is recommended that JCDCYF monitor their performance on this measure to ensure improvement. It is also recommended that JCDCYF complete the training on the new Colorado Safety Assessment tool when it becomes available.	In Progress
15-030	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. Additionally, it is recommended that DCW continue to provide consistent guidance regarding the use of the new tools.	Complete
15-030	CFRT	It is recommended that DCW implement a procedure for oversight/check-ins to counties when they are newly implementing DR.	Complete
15-030	Policy Finding	Eagle County DHHS is one of three pilot counties for the new Colorado Family Risk Assessment tool. Eagle County DHHS should continue to work with DCW to ensure accurate and timely completion of the Colorado Family Risk Assessment tool.	Complete
15-030	Policy Finding	Eagle County DHHS is one of three pilot counties for the new Colorado Family Safety Assessment tool. Eagle County DHHS should continue to work with DCW to ensure accurate and timely completion of the Colorado Family Safety Assessment tool.	Complete

CFRT ID	Source	Recommendation	Status
15-031	Policy Finding	The policy finding related to the RED Team framework not including all elements required by Volume VII is a systemic practice issue for JCDCYF. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from January 15, 2015 to July 15, 2015, JCDCYF included all elements required in Volume VII 0% of the time, which is below the statewide average (not including JCDCYF) of 10.7% for the same time span. New practice expectations for supervisor approval were created in response to the OSA Child Welfare Performance Audit. Early reviews indicated the process for documenting supervisor approvals was not well known at the county level. In an effort to communicate the new expectations, DCW issued Operational Memo OM-CW-2015-0007. It should be noted that the assessment in this review was completed prior to the issuance of the Operational Memo. For the recent review of a random sample of assessments, supervisory approval was missing in 47 of the 50 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 66% for JCDCYF and 49.7% statewide. It is recommended that JCDCYF employ a process in which barriers to the completion of the RED Team framework as required by Volume VII are identified and solutions to the identified barriers are implemented.	Complete
15-037	Policy Finding	The policy finding related to timeliness of assessment closure does/does not reflect a current systemic practice issue for Arapahoe County DHS. The October 2015 C-Stat report, which measures the percentage of assessments closed within 60 days, showed Arapahoe County DHS at 79.6% for September 2015, which is below the statewide average of 89.1%. 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
15-037	Policy Finding	The policy finding related to the Colorado Family Risk Assessment tool not being completed in accordance with Volume VII does reflect a systemic practice issue in Arapahoe County. In a recent review of a random sample of assessments that were conducted during a period December 28, 2014 to June 28, 2015, Arapahoe County completed the risk assessment tool accurately in 40% of assessments, which is below the statewide average (not including Arapahoe County) of 41.3% for the same time span. It is recommended that Arapahoe County 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 Arapahoe DHS complete the training on the new Colorado Family Risk Assessment tool when it becomes available.	Complete

CFRT ID	Source	Recommendation	Status
15-037	Policy Finding	The policy finding related to the assessment containing the required content does reflect a systemic practice issue for Arapahoe County. 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 December 28, 2014 to June 28, 2015, showed that Arapahoe County's assessments contained the required content 83.6% of the time, which is above the statewide average (not including Arapahoe County) of 70.6% for the same time span. It is recommended that Arapahoe County employ a process in which barriers to documentation of the assessment containing all required content are identified and solutions to the identified barriers are implemented.	In Progress
15-047	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
15-047	CFRT	It is recommended that DCW revise rule to better determine when referrals should be assigned High Risk Assessments (HRA) or Family Assessment Response (FAR).	Considered and not implemented
15-047	Policy Finding	The policy finding related to the Colorado Family Risk Assessment tool not being completed in accordance with Volume VII does reflect a systemic practice issue in Mesa County DHS. In a recent review of a random sample of assessments that were conducted during a period from October 8, 2014 to June 1, 2015, the Mesa County DHS completed the risk assessment tool accurately in 34% of assessments, which is below the statewide average (not including Mesa County DHS) of 59.8% for the same time span. It is important to note that Volume 7.107.2 [eff. 1/1/15] established "a transition period for completion of training and access to the new Colorado Family Risk Assessment Tool in the state automated case management system." As of the completion of this assessment, the training to access the new Colorado Family Risk Assessment Tool is not available; therefore, the former version of rule applies to this violation. 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.	Complete

CFRT ID	Source	Recommendation	Status
15-047	Policy Finding	The policy finding related to the Colorado Safety Assessment tool does reflect a systemic practice issue in Mesa County DHS. 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 Colorado Safety Assessment tool accurately in 72% of assessments, which is below the statewide average (not including Mesa County DHS) of 77.7% 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 Safety Assessment tool are identified and solutions to the identified barriers are implemented. It is also recommended that Mesa County DHS completed the training on the new Colorado Safety Assessment tool when it becomes available.	Complete
15-049	CFRT	The CFRT recommended that CDHS consider a change to Volume 7 and C.R.S. 26-1-139 to extend the due date for County Departments of Human Services' Internal Review Reports to be submitted to CDHS.	Not Started
15-085	CFRT	It is recommended that Las Animas County DHS ensure that families in the community are aware of child care assistance and providers.	Considered and not implemented
15-085	CFRT	It is recommended that Las Animas County DHS talk with the sawmill owner and outreach to the community about water safety.	Considered and not implemented
15-085	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a current systemic practice issue for Las Animas County DHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provides the basis for C-Stat data, Las Animas County DHS performance for December, 2015 was 33% with a statewide goal of 90%. It is recommended that Las Animas County DHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Not Started
15-086	CFRT	The DCW should consider developing protocol related to how county departments of human or social services respond to courtesy interview requests. The courtesy interview protocol should include, but not be limited to: requests from outside state departments of human and social services, as well as, county to county requests within the State of Colorado.	In Progress
15-086	CFRT	The ARD and the DCW should establish review protocol and guidelines for when incidents of egregious, near fatal and/or fatal abuse or neglect occur in Colorado, but the family or child does not have established residency in the State.	In Progress

CFRT ID	Source	Recommendation	Status
15-086	Policy Finding	The policy finding related to the timeliness of notification of the fatal incident does reflect a systemic practice issue for DDHS. During calendar year 2015, DDHS provided timely notification to CDHS in 77.8% (14/18) of incidents. It is recommended that DDHS evaluate their process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS as required by Volume 7. Furthermore, it is recommended that DDHS identify any barriers preventing the completion of timely notifications, and then employ a process in which solutions to the identified barriers are implemented.	Complete
15-086	Policy Finding	The policy finding related to the RED Team framework not including all elements required by Volume 7 is a systemic practice issue for 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 March 2, 2015 to September 2, 2015, the RED Team framework included all elements required in Volume 7, 4.1% of the time. New practice expectations for supervisor approval were created in response to the Office of the State Auditor (OSA) Child Welfare Performance Audit. Early reviews indicated the process for documenting supervisor approvals was not well known at the county level. In an effort to communicate the new expectations, DCW issued Operational Memo OM-CW-2015-0007 on October 15, 2015. It should be noted that the assessment in this review was completed prior to the issuance of the Operational Memo. For the recent review of a random sample of assessments, supervisory approval was missing in 29 of the 49 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 51% for DDHS. It is recommended that DDHS employ a process in which barriers to the completion of the RED Team framework, as required by Volume 7, are identified and solutions to the identified barriers are implemented.	Complete

CFRT ID	Source	Recommendation	Status
15-086	Policy Finding	The policy finding related to ACHSD not completing a RED Team framework as required by Volume 7 reflects a systemic practice issue for ACHSD. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from February 16, 2015 to August 16, 2015, the RED Team framework included all required elements required in Volume 7, 0% of the time. New practice expectations for supervisor approval were created in response to the Office of the State Auditor (OSA) Child Welfare Performance Audit. Early reviews indicated the process for documenting supervisor approvals was not well known at the county level. In an effort to communicate the new expectations, DCW issued Operational Memo OM-CW-2015-0007 on October 15, 2015. It should be noted that the assessment in this review was completed prior to the issuance of the Operational Memo. For the recent review of a random sample of assessments, supervisory approval was missing in 45 of the 47 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 95.7 % for ACHSD. As this policy finding was related to ACHSD not completing a RED Team as required by Volume 7, it is recommended that ACHSD employ a process in which barriers to the completion of the RED Team framework as required by Volume 7 are identified and solutions to the identified barriers are implemented.	In Progress
14-028	CFRT	It is recommended that the Division of Child Welfare (DCW) begin the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	Complete
14-028	CFRT	As the proper use of extensions during the assessment period may be related to the timely closure of assessments, it is recommended that the Division of Child Welfare begin including data on counties' use of extensions in the analysis and communications related to the C-Stat measure of timeliness of assessment closure.	Complete
14-028	CFRT	It is recommended that Morgan County DHS ensure that the sibling participates in the Juvenile Fire Setting Program @ Children's Hospital of Colorado. On August 5, 2014, the CDHS Administrative Review Division emailed Morgan County DHS the information and contact information about the Juvenile Fire Setting Program @ Children's Hospital of Colorado.	Complete

CFRT ID	Source	Recommendation	Status
14-028	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 August C-Stat documentation for the month of May 2014, Morgan County DHS is interviewing the alleged victim within the assigned response time 85.7% of the time, which is 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%. 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 monitor their performance on this measure to ensure improvement in order to meet the state goal of 90%.	Complete
14-028	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) 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 safety assessment are identified and solutions to the identified barriers are implemented.	Complete
14-028	Policy Finding	For High Risk Assessments opened by Morgan County DHS between December 1, 2013 and May 31, 2014, 51.9% required an extension (i.e., were open longer than 30 days). Of those, 38.2 % had an extension request within 30 days. It is recommended that Morgan County DHS employ a process in which barriers to the timely use of extensions for assessments needing to be open longer than 30 days are identified and solutions to the barriers are implemented.	Complete
14-033	CFRT	It is recommended that the Division of Child Welfare (DCW) begin the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	Complete
14-033	CFRT	As the proper use of extensions during the assessment period may be related to the timely closure of assessments, it is recommended that the Division of Child Welfare begin including data on counties' use of extensions in the analysis and communications related to the C-Stat measure of timeliness of assessment closure.	Complete

CFRT ID	Source	Recommendation	Status
14-033	CFRT	Law enforcement spoke with CCHHS and recognized that the fatality assessment should have been a joint investigation. CDHS, Division of Child Welfare is working with all counties to develop, as well as train law enforcement officers and caseworkers on joint investigations and get copies of all Memorandum of Understanding's (MOU) between the county and law enforcement agencies within that county.	Complete
14-033	Policy Finding	For the policy finding related to the timeliness of notification of the near fatal incident there is no documentation as this is the first incident involving CCHHS. It is recommended that CCHHS employ a process in which barriers to the timeliness of notifications for fatalities, near fatalities and egregious incidents are identified and solutions to the barriers are implemented.	Complete
14-033	Policy Finding	The policy finding related to the use of extensions does reflect a current systemic practice issue for CCHHS. For High Risk Assessments opened by CCHHS between March 1, 2014 and August 31, 2014, 63.6% required an extension (i.e., were open longer than 30 days). Of those, 4.8 % had an extension request within 30 days. It is recommended that CCHHS 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
14-033	Policy Finding	The policy finding related to the safety assessment does reflect a systemic practice issue in CCHHS. In a recent review of a random sample of assessments that were conducted during a period from December 15, 2013 to June 15, 2014, the CCHHS completed the safety assessment accurately in 77.3% of assessments, which is below the statewide average (not including CCHHS) of 80.7% for the same time span. It is recommended that CCHHS employ a process in which barriers to the accurate completion of the safety assessment are identified and solutions to the identified barriers are implemented	Complete
14-033	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in CCHHS. In a recent review of a random sample of assessments that were conducted during a period from December 15, 2013 to June 15, 2014, the CCHHS completed the risk assessment accurately in 31.8% of assessments, which is below the statewide average (not including CCHHS) of 59.5% for the same time span. It is recommended that CCHHS employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented.	Complete

CFRT ID	Source	Recommendation	Status
14-033	Policy Finding	The policy finding related to the timeliness for the safety assessment does reflect a systemic practice issue in CCHHS. In a recent review of a random sample of assessments that were conducted during a period from December 15, 2013 to June 15, 2014, the CCHHS completed the safety assessment timely in 86.3% of assessments, which is below the statewide average (not including CCHHS) of 91% for the same time span. It is recommended that CCHHS employ a process in which barriers to the accurate completion of the safety assessment are identified and solutions to the identified barriers are implemented.	Complete
14-033	Policy Finding	The policy finding related to seeing the alleged victim within the assigned response time does reflect a systemic practice issue for CCHHS. According to the October C-Stat, for the month of September 2014, CCHHS is interviewing the alleged victim within the assigned response time 66.7% 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 December 15, 2013 to June 15, 2014, showed the CCHHS at 86.4%. 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 CCHHS made reasonable efforts to see the victim of the allegation 86.4% of the time. It is recommended that CCHHS examine their performance on this measure to ensure improvement in order to meet the state goal of 90%.	Complete
14-033	Policy Finding	The policy finding regarding all parties interviewed as part of the assessment, specifically other siblings in the household, does reflect a systemic practice issue for CCHHS. In a recent review of a random sample of assessments that were conducted during a period from December 15, 2013 to June 15, 2014, CCHHS interviewed all required parties in 81.8% of assessments, which is below the statewide average of 88.5% for the same time span. It is recommended that CCHHS employ a process in which barriers to interviewing all parties are identified and solutions to the identified barriers are implemented.	Complete

CFRT ID	Source	Recommendation	Status
14-033	Policy Finding	The policy finding related to monthly contact with the children does reflect a systemic practice issue in CCHHS. In a recent review of a random sample of In-Home Reviews that were conducted during a period from December 15, 2013 to June 15, 2014, CCHHS completed required monthly contact with the child in 83.3% of the cases, which is below the statewide average (not including CCHHS) of 94.7% for the same time span. It is recommended that CCHHS employ a process in which barriers to the monthly contact with children are identified and solutions to the identified barriers are implemented.	Complete
14-033	Policy Finding	The policy finding related to the Family Service Plan there is no documentation reflecting CCHHS performance in the timeliness of Family Service Plans. It is recommended that CCHHS employs a process in which barriers to the timeliness of Family Service Plans are identified and solutions to the identified barriers are implemented.	Complete
14-033	Policy Finding	The policy finding related to Family Service Plan: 5A Review/Court report does reflect a systemic practice issue in CCHHS. In a recent review of a random sample of In-Home Reviews that were conducted during a period from December 15, 2013 to June 15, 2014, CCHHS completed required FSP: 5A in 0% of the cases, which is below the statewide average (not including CCHHS) of 80% for the same time span. It is recommended that CCHHS employ a process in which barriers to the FSP: 5A Review/Court reports are identified and solutions to the identified barriers are implemented.	Complete
14-034	CFRT	It is recommended that the Division of Child Welfare (DCW) begin the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	Complete
14-034	CFRT	As the proper use of extensions during the assessment period may be related to the timely closure of assessments, it is recommended that the Division of Child Welfare begin including data on counties' use of extensions in the analysis and communications related to the C-Stat measure of timeliness of assessment closure.	Complete
14-034	CFRT	The CFRT recommended that DCW consider adding language in rule that would ensure all counties are utilizing additional methods of locating families and potentially adding into rule a checklist of potential databases or other means of record searches to locate families.	Complete
14-034	CFRT	The CFRT recommended that Child Protection Task Group (CPTG) look at informing practice and steps that caseworkers should take while waiting for a secondary test when a newborn tests positive at birth for substances.	Complete

CFRT ID	Source	Recommendation	Status
14-034	Policy Finding	The policy finding related to the safety assessment does reflect a systemic practice issue in Jefferson County DCYF. In a recent review of a random sample of assessments that were conducted during a period from August 4, 2013 to February 4, 2014, the Jefferson County DCYF completed the safety assessment accurately in 83.0% of assessments, which is below the statewide average (not including Jefferson County DCYF) of 84.1% for the same time span and below the state goal of 95%. It is recommended that Jefferson County DCYF employ a process to ensure that casework and supervisory staff members understand how to utilize the safety assessment and on which household the assessment is to be completed. It should be noted that in the new Safety Assessment instrument scheduled to roll out from DCW, there is a place for the caseworker to identify the household on which the assessment is completed.	Complete
14-034	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Jefferson County DCYF. In a recent review of a random sample of assessments that were conducted during a period from August 4, 2013 through February 4, 2014, the Jefferson County DCYF completed the risk assessment accurately in 56.6% of assessments, which is below the statewide average (not including Jefferson County) of 64.0% for the same time span. It is recommended that Jefferson County DCYF employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented.	Complete
14-034	Policy Finding	The policy finding related to extensions does reflect a systemic practice issue in Jefferson County DCYF. For High Risk Assessments opened by Jefferson County DCYF between November, 2013 and April 30, 2014, 81.6% required an extension (i.e., were open longer than 30 days). Of those, 38% had an extension request within 30 days. It is recommended that Jefferson County employ a process in which barriers to the timely use of extensions for assessments needing to be open longer than 30 days are identified and solutions to the barriers are implemented.	Complete
14-042	CFRT	It is recommended that the Division of Child Welfare (DCW) begin the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	Complete
14-042	CFRT	It is recommended that the DCW explore the need for further guidance to counties on what to do when the county has an open assessment and another referral/assessment comes into the county, regarding the same family.	Complete

CFRT ID	Source	Recommendation	Status
14-042	CFRT	CFRT recommends that county staff be present in person or via teleconference to present their case at the monthly CFRT meetings.	Complete
14-042	Policy Finding	The policy finding related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in Adams County HSD. 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 Adams County HSD completed the risk assessment tool accurately in 63.5% of assessments, which is slightly above the statewide average (not including Adams County) of 60.6% for the same time span. However, due to the level of performance on this measure, it is recommended that Adams County HSD 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 will be implemented by the State in 2015, and it is recommended that Adams County HSD participate in the training and implementation of the new tool.	Complete
14-057	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
14-057	CFRT	It is recommended that DCW work with Trails staff to determine if an update could be implemented in the Trails system to allow two or more cases to be opened from one assessment when such split is warranted.	Complete
14-057	CFRT	It is recommended that the Child Protection Task Group (CPTG) assess whether there should be further clarification around how contacts can be documented when a county DHS completes a courtesy visit for another county. It was suggested that the county caseworker completing the courtesy visit could be added as a secondary caseworker in Trails so that the caseworker can document directly into Trails, but the county who received the referral maintains responsibility until such time that the responsibility is formally transferred to the other county.	Complete

CFRT ID	Source	Recommendation	Status
14-057	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in HCDSS. In a recent review of a random sample of assessments that were conducted during a period from August 4, 2013 to February 4, 2014, the HCDSS completed the risk assessment tool accurately in 76.7% of assessments, which is above the statewide average (not including HCDSS) of 62.5% for the same time span. However, due to the low level of performance on this measure, it is recommended that HCDSS 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 HCDSS participate in the training and implementation of the new tool.	Complete
14-057	Policy Finding	The policy finding regarding the assignment of incorrect response times does reflect a systemic practice issue for HCDSS. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from August 4, 2013 to February 4, 2014, HCDSS assigned the appropriate response time in accordance with Volume VII 73.1% of the time, which is below the statewide average of 95.5% for the same time span. It is recommended that HCDSS employ a process by which the barriers to the incorrect assignment of the response time are identified and solutions to the identified barriers are implemented.	Complete
14-057	Policy Finding	The policy finding related to monthly contact with the parents does reflect a systemic practice issue in HCDSS. In a recent review of a random sample of In-Home Reviews that were conducted during a period from August 4, 2013 to February 4, 2014, HCDSS completed required monthly contact with the caregiver/guardian/kin in 70.0% of the cases, which is above the statewide average (not including HCDSS) of 63.0% for the same time span. Due to the low level of performance on this measure, it is recommended that HCDSS employ a process in which barriers to the monthly contact with parents are identified and solutions to the identified barriers are implemented.	Complete

CFRT ID	Source	Recommendation	Status
14-057	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. However, due to the level of performance on this measure, 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 will be implemented by the State in 2015, and it is recommended that ACHSD participate in the training and implementation of the new tool.	Complete
14-065	CFRT	CFRT recommended that daycare centers participate in the mandatory reporter training; however, the CDHS licensing states that child care centers are only required to sign a documentation that states the direct care providers understand that they are mandatory reporters. Daycare centers provide topic-specific annual trainings, but not related to child abuse/neglect. It is recommended that CDHS licensing require daycare providers to complete an annual training related to child abuse/neglect and mandated reporting.	Complete
14-065	Policy Finding	The policy finding related to the incorrect use of a Safety Plan does reflect a systemic issue for Arapahoe County DHS. In a recent review of a random sample of assessments that were conducted during a period from January 27, 2014 to July 27, 2014, the Arapahoe County DHS completed the Safety Plan accurately in 66.7% of assessments, which is above the statewide average (not including Arapahoe County DHS) of 40.3% for the same time span. However, due to the level of performance on this measure, it is recommended that Arapahoe County DHS employ a process in which barriers to the accurate implementation of the Safety Plan are identified and solutions to the identified barriers are implemented.	Complete
14-065	Policy Finding	The policy finding related to notification to the DECL on the institutional assessment has no data. It is recommended that Arapahoe County DHS employ a process in which barriers to the notification of institutional assessments are identified and solutions to the identified barriers are implemented.	Not Started
14-087	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

CFRT ID	Source	Recommendation	Status
14-087	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.	In Progress
14-087	Policy Finding	The policy finding related to the timeliness of notification of the egregious incident reflects a systemic practice issue for JCDCYF. From January 1, 2015 to June 11, 2015, JCDCYF provided timely notification to CDHS for 75% (3/4) of incidents. It is recommended that: a. The JCDCYF create a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete
14-087	Policy Finding	The Administrative Review Division (ARD) should prioritize training for JCDCYF's child protection staff regarding the fatality, near fatality and egregious incident review process to include specific guidance and further clarification on the definitions and reporting requirements regarding incidents of egregious harm, near fatalities, and fatalities.	Complete
14-087	Policy Finding	The policy finding related to the Safety Assessment tool reflects a systemic practice issue in JCDCYF. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from August 1, 2014 to January 31, 2015, JCDCYF completed the safety assessment accurately, which includes timeliness, 79.6% of the time, which is slightly above the statewide average of 77.7% for approximately the same time span and below the C-stat goal of 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.	Complete

CFRT ID	Source	Recommendation	Status
14-087	Policy Finding	The policy violation related to timely completion of the Colorado Family Risk Assessment tool, which is measured along with accuracy, does reflect a systemic practice issue for JCDCYF. In a recent review of a random sample of assessments that were conducted during a period from August 1, 2014 to January 31, 2015, JCDCYF completed the risk assessment tool accurately 50% of the time, which is below the statewide average of 60.1% for approximately 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.	Complete
13-072	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 it's implementation.	Complete
13-072	CFRT	The CFRT recommended that the Division of Child Welfare research outreach efforts that may help to inform medical professionals of the warning signs and potential varied presentations of child physical abuse.	Complete
13-072	CFRT	The CFRT recommended that the law enforcement professionals who are investigating this egregious incident be contacted by LDHS in order to offer assistance in the prosecution of the alleged perpetrator. By contacting these individuals it may become clear that there is an underlying motive for the process of attempting to charge the alleged perpetrator and the LDHS may be able to offer potential assistance in efforts by law enforcement.	Complete
13-072	CFRT	The CFRT indicated that the Children's Code describes various reasons for the court to file a Dependency and Neglect case, as well as to take custody of a child. It was stated that further training of judicial officers could be warranted if the issue of not consulting the Children's Code related to filing of a child welfare case continues. It is also recommended that staff from LDHS reach out to the Larimer County attorney to invite the individual to their quarterly meetings which are open to all county attorneys to discuss the application of the Children's Code to various cases.	Complete

CFRT ID	Source	Recommendation	Status
13-072	Policy Finding	The policy violation which reflects the LDHS not accurately documenting the reason that the referral was screened out is a systemic practice issue in this county department. As part of routine quality assurance monitoring, data from the "2013 Screen-Out Review," conducted 9/23/2013 to 9/27/2013, indicated that Larimer County accurately documented the county's reason for not accepting the referral 85.5% of the time, which is lower than the statewide average of 89.2%. It is recommended that Larimer County employ a process in which barriers to the accurate documentation of the reason that a referral is screened out are identified and solutions to the identified barriers are implemented.	Complete
13-072	Policy Finding	It is recommended that the Division of Child Welfare (DCW) monitor county performance regarding accurate documentation of the reason a referral is screened out and engage as necessary to ensure improved performance in this area.	Complete
13-072	Policy Finding	For High Risk referrals received by Larimer County DHS between July 1, 2013 and December 31, 2013, 70.5% required an extension (i.e., were open longer than 30 days). This is slightly above the statewide average of 66.3% for the same time span. Of those requiring an extension, an extension was requested within 30 days of the opening of the referral 50.8% of the time. The statewide average during this time span was 45.3%. It is recommended that Larimer 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
13-072	Policy Finding	At 45.3%, statewide performance on the use of extensions during assessments was low overall. As the proper use of extensions during the assessment period may be related to the timely closure of assessments, it is recommended that the Division of Child Welfare begin including data on counties' use of extensions in the analysis and communications related to the C-Stat measure of timeliness of assessment closure.	Complete
13-084	CFRT	It is recommended that the Division of Child Welfare (DCW) examine Volume VII at 7.202.55 and clarify which, if not all, aspects of the High Risk Assessment protocols are required in an Institutional Abuse and/or Neglect Assessment.	Complete

CFRT ID	Source	Recommendation	Status
13-084	Policy Finding	The policy violation related to seeing the alleged victim within the assigned response time does not reflect a systemic practice issue for Larimer County DHS. According to the most recent C-Stat presentation of March 2014, for the month of December of 2013, Larimer County DHS was interviewing the required parties within the assigned response time 87.5% of the time, which is below the previous month's and is also below the C-Stat goal of 90%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of February 8, 2013 to August 8, 2013, showed Larimer County DHS at 83.9% for FAR Assessments and 72.7% for High Risk Assessments, which is above the statewide of 75.5% and below the statewide average of 75% respectively. It is important to note that with the addition of rule 7.202.41 (A) (4) of March 2, 2013, Volume VII now addresses reasonable efforts by the caseworker to see the child victim. During the same time span as above, the Larimer County DHS made reasonable efforts to see the victim of the allegation 96.8% of the time for FAR Assessments and 90.9% of the time for High Risk Assessments, which is above the statewide of 91.8% and 87.3% respectively. It is recommended that Larimer County DHS monitor the performance of their staff on this measure to ensure continued performance at or above the state goal of 90%.	Complete
13-084	Policy Finding	For High Risk Assessment (HRA) referrals received by Larimer County DHS between July 1, 2013 and December 31, 2013, 70.5% required an extension (i.e., were open longer than 30 days). This is slightly above the statewide average of 66.3% for the same time span. Of those requiring an extension, an extension was requested within 30 days of the opening of the referral 50.8% of the time. The statewide average during this time span was 45.3%. It is recommended that Larimer 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
13-084	Policy Finding	At 45.3%, statewide performance on the use of extensions during assessments was low overall. As the proper use of extensions during the assessment period may be related to the timely closure of assessments, it is recommended that the Division of Child Welfare begin including data on counties' use of extensions in the analysis and communications related to the C-Stat measure of timeliness of assessment closure.	Complete

Appendix D: Status Update for Recommendations from Previously Posted Reports

CFRT ID	Source	Recommendation	Status
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
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
13-038	Policy Finding	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%. 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
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.	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.	Complete

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.	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.	Complete
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.	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.	Complete

CFRT ID	Source	Recommendation	Status
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.	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.	Complete
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.	Complete
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.	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
13-096	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.	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.	Complete
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.	Complete
14-004	CFRT	There are planned changes in the safety and risk assessments that are scheduled to occur in 2014 that were designed to positively impact performance in this area. It is recommended that the Division of Child Welfare (DCW) begin the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	Complete
14-004	CFRT	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.	Complete

CFRT ID	Source	Recommendation	Status
14-008	CFRT	It is recommended that the Division of Child Welfare explore whether there is a need to develop a rule in Volume VII on when a child is selected as "Participating as a Child" in the State automated case management system.	In Progress
14-008	Policy Finding	The policy finding related to the safety assessment does reflect a systemic practice issue in Logan County. In a recent review of a random sample of assessments that were conducted during a period from June 16, 2013 to December 16, 2013, Logan County completed the safety assessment accurately in 88.6% of assessments, which is above the statewide average (not including Logan county) of 81.2% for the same time span. However, Logan County is below the state goal of 90%, so it is recommended that Logan County employ a process in which barriers to the accurate completion of the safety assessment are identified and solutions to the identified barriers are implemented.	Complete
14-012	CFRT	It is recommended that the Division of Child Welfare (DCW) begin the statewide implementation process of the new risk assessment tool and that monitoring occur to determine if accuracy in the use of the tool increases as a result of its implementation.	Complete
14-012	CFRT	Regarding the systemic gap of multiple law enforcement officers compared to one caseworker, 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.	Considered and not implemented
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.	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.	Complete

CFRT ID	Source	Recommendation	Status
14-019	CFRT	The Division of Child Welfare (DCW) should encourage county DHS agencies to develop Memorandums of Understanding (MOU) and/or protocol for working with all shelters in their respective counties to ensure the DHS' has access to children when there is concern for child abuse/neglect. The DCW and the Domestic Violence Program (DVP) should create a sample MOU and/or protocols and work with the counties and shelters, when needed, to complete this process.	Considered and not implemented
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.	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.	Complete
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.	Complete
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.	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.	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.	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.	Complete
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.	Complete

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.	Complete
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
14-058	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.	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.	Considered and not implemented
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
14-060	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.	Complete
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.	In Progress
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.	Considered and not implemented

CFRT ID	Source	Recommendation	Status
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.	Complete
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.	Complete
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.	Complete

CFRT ID	Source	Recommendation	Status
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.	Complete
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.	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.	Complete
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

CFRT ID	Source	Recommendation	Status
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.	Complete
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.	Complete
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.	Complete

CFRT ID	Source	Recommendation	Status
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."	Considered and not implemented
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.	Complete
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.	Complete
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.	Complete

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.	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."	Considered and not implemented
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.	Complete
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.	Considered and not implemented
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

CFRT ID	Source	Recommendation	Status
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.	Complete
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.	Complete

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.	Complete
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.	Complete
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

CFRT ID	Source	Recommendation	Status
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.	Complete
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.	Complete
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.	Complete
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

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.	Complete
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.	Complete
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
15-006	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.	Complete
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.	In Progress

CFRT ID	Source	Recommendation	Status
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	Complete
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.	Complete
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.	Complete

CFRT ID	Source	Recommendation	Status
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.	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.	Complete
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	Policy Finding	DYC Policy regarding pass request: Uphold expectations for the transition process to include specific safety plans for each individual pass, identify responsibility for the custodian of the pass, and correct approval on all temporary release paperwork (taken from Near Fatality Review Panel Report)	In Progress
15-038	Policy Finding	The policy finding related to documentation of the Independent Living Plan (ILP) in the Discrete Case Plan does not reflect a systemic practice issue for the Western Region DYC. As part of a routine quality assurance monitoring, a recent review of generalizable random sample of cases that were conducted during a period of July 1, 2015 to September 30, 2015, showed that the Western Region DYC documented accurately in the Discrete Case Plan 80% of the time. It is recommended that the Western Region DYC monitor their performance on this measure to ensure accurate documentation of the ILP in the Discrete Case Plan.	In Progress
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.	In Progress

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	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.	Complete