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 29, 2018

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 "2017 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 Alexander Winkle
Representative Brittany Pettersen
Representative Edie Hooten
Representative Dafna Michaelson Jenet
Representative Marc Catlin
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Representative Justin Everett
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2017 Child Maltreatment Fatality Report

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Executive Summary

The 2017 Colorado Department of Human Services Child Fatality Review Annual Report focuses on data gathered from fatal, near fatal, and egregious incidents of child maltreatment that occurred in 2017. The data provides an overview of the trends, characteristics and demographics of children and families involved with such incidents. The data is aggregated and presented in an effort to better understand and identify the factors associated with such incidents of abuse or neglect.

There is often a magnitude of contributing factors associated with child fatalities, near fatalities, and incidents of egregious abuse or neglect, which can make it difficult to understand why such incidents occur. Additionally, there can be significant emotions or reactions that come along with reviewing and evaluating the circumstances of fatal, near fatal, and egregious child maltreatment. Due to these complicating factors, it can be easy to go to a place of blame on others who are responsible for service delivery, so it is critical to keep in mind the intent of the reviews and remain objective. 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."

As outlined in statute, Colorado collects information on several different child and family characteristics across the types of incidents reviewed by the CDHS Child Fatality Review Team (CFRT). From the group of 87 children in 69 substantiated fatal, near fatal, and egregious incidents of child maltreatment occurring in 2017, 54 children in 41 incidents met statutory criteria for a review by the CFRT. In order to determine trends related specifically to fatalities, information about 34 children involved in fatal incidents, substantiated for child maltreatment in 2017, is compared to data regarding child maltreatment fatalities occurring in Colorado over the past six years.

The 2017 report also highlights recommendations for improvements of the child welfare system, as well as other systems that are responsible for providing services to children and families in Colorado. Specific findings, strengths, and gaps/deficiencies identified through the CFRT reviews are also included in this report. Please note, CFRT reviews may not conclude in the same year when the incident occurred. Therefore, this report summarizes information from incidents occurring in 2015, 2016, and 2017 reviewed by the CFRT and/or posted to the public notification website in 2017.

Child Characteristics. For fatalities, near fatalities, and egregious incidents in 2017, most victims were either White or Hispanic. For fatalities, most victims were of White ethnicity (58.8%), followed by Hispanic (17.6%). The most frequent race/ethnicity for victims of near fatal incidents was White (35.0%) and Hispanic (35.0%). For egregious incidents, the most frequent ethnicity of victims was Hispanic (33.3%). This is a change from 2016, where the most frequent ethnicity for children involved in fatal, near fatal, and egregious incidents of

child maltreatment was White. In Colorado in 2017, females accounted for 52.9 % (18/34) of the victims in substantiated child maltreatment fatalities. This was the second consecutive year the number of female victims surpassed the number of male victims in child maltreatment fatalities in Colorado. Males accounted for 60.0% (12/20) of the victims involved in near fatal incidents and 57.6% (19/33) of the victims involved in egregious incidents.

Family Characteristics. In 2017, 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 48.3% (42/87). While income level and education level of legal caretakers is not consistently collected by counties, information available indicated that in 20 of the 45 incidents reviewed (44.4%) families were receiving Supplemental Nutrition Assistance Program (SNAP) benefits. The most frequently received supplemental public benefit was Medicaid 55.5% (25/45).

Prior Involvement with Child Protective Services. The number of fatalities where the family had prior history with child protective services has ranged between 35% to 82% over the past five years. In 2017, 61.3% (19/31) of fatal incidents substantiated for abuse or neglect, had prior involvement, six of which had current involvement with the child welfare system at the time of the incident. The prior involvement included different levels of child welfare intervention, ranging from one referral not accepted for assessment to prior involvement that included case services.

Other Family Stressors. Of the families involved in a fatal child maltreatment incident which met criteria for review by the CFRT, 36.8% (7/19) had some history of identified domestic violence. Additionally, 42.1% (8/19) of the families experienced substance abuse issues, and 21.1% (7/19) included a history of mental health treatment for at least one caregiver.

Perpetrator Relationship. In 2017, fathers were the most common perpetrator in fatal incidents of child maltreatment 30.4% (14/46). This is above national trends for FFY 2016, which represented fathers as perpetrators in 16.8 % of fatal incidents of child maltreatment. This is also a shift from Colorado's trends seen over the past several years, where mothers were most commonly identified as perpetrators in fatal incidents of child maltreatment.

Findings and Recommendations. The CFRT highlighted 92 systemic strengths across 32 reports reviewed by the CFRT and posted since the cutoff of inclusion in the 2016 CFRT Annual Report (3/31/2017) and the cutoff for inclusion in this report (3/31/2018). The most commonly acknowledged systemic strength was collaboration between the county departments of human/social services and other community entities. The CFRT also identified systemic gaps and deficiencies and 78 related to policy findings, across the 32 reports. The most common issue identified was improving County Continuous Quality Improvement (CQI) processes to address barriers to performance and implement solutions. There were 133 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 publication of those reports. This report also includes joint recommendations with the Colorado Department of Public Health and Environment, found on page 43.

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 (DCW). HB 11-1181 also established criteria for determining which incidents would 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 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 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, specifically between 2011-2013, which modified the population of incidents requiring review, there was limited ability to interpret trends in the data. Any change in the final number of incidents between 2012 and 2014 may have been due to definitional changes rather than to changes in the number of actual incidents. For example, 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. The increase was likely due to increased awareness of the reporting requirements and procedures 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 several 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 six years, with 2017 displaying a decrease in fatal incidents since 2016, the same number of near fatal incidents, and a slight increase 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^^
2017	60	25	20	106^^^

**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 2015 were determined to not fit the definitions of fatal, near fatal, or egregious abuse or neglect. While they are included in the total, they do not appear in the incident specific columns.
^^Two of the reported incidents reported in 2016 were determined to not fit the definitions of fatal, near fatal, or egregious abuse or neglect. While they are included in the total they do not appear in the incident specific columns.
^^^ One reported incident in 2017 was determined to not fit the definitions of fatal, near fatal, or egregious abuse or neglect. While this incident is included in the total, it does not appear in the incident specific columns.

Statute requires an annual report to the legislature, on or before 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 2017, data was extracted on a quarterly basis from the state automated case management 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 number of reported incidents received from counties over the course of CY 2017. The data integrity checks identified 73 potential incidents. Of those incidents, 7 incidents involving 8 children met criteria for public notification. Three incidents, involving 3 children, met criteria for a review by CFRT. The ARD will continue this data integrity process and will provide technical assistance to county departments as necessary, as it continues to be a valuable and necessary part of the CFRT process.

Child Fatality Review Team Process and Timelines

The Child Fatality Review Team reviews incidents of fatal, near fatal, or egregious abuse or neglect determined to be a result of child maltreatment, when the child or family had previous of involvement with the child welfare system within the last three years. The process includes a review of the incident, identification of contributing factors that may have led to the incident, the quality and sufficiency of service delivery from state and local agencies, and the families' prior involvement with the child welfare system. As a result of identified strengths, as well as systemic gaps and/or deficiencies, recommendations are put forth regarding policy and practice considerations that may help prevent future incidents of fatal, near fatal, or egregious abuse or neglect, and/or strengthen the systems which provide direct service delivery to children and families. Table 2 offers a comparison of incidents meeting criteria for review over the past six 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, there are limitations to interpretation of 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
2017	19	13	9	41

**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.*
^The fatal incidents number is different from what was originally published in the 2015 Child Maltreatment Fatality Report as one child in one fatal incident was pending disposition at the time the 2015 report was finalized.
^^The total incident number is different from what was originally published in 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 requires that county departments provide the CDHS with all relevant information and reports to inform the CFRT's review, within 60 days of becoming aware of an incident, which was determined to be the result of fatal, near fatal or egregious abuse or neglect. Please note that county departments only need to submit such documentation if the incident meets the aforementioned statutory criteria to be reviewed by CFRT. 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, 60.9% (64/105) incidents that occurred in 2017 were afforded at least one extension, with the total number ranging from one to nine extensions.

Incidents Reviewed in 2017

As required by Volume 7 (25 CCR 2509-2), the CFRT must review all incidents within 45 business days of the CDHS receiving all required and relevant reports and information necessary to complete a review. During 2017, the CFRT was able to review 45 incidents. It is important to note not all incidents are reviewed within the calendar year in which they occurred. As an example, of the 45 incidents reviewed during 2017, four of the incidents occurred in 2015, 19 occurred in 2016, and 22 occurred in 2017. Approximately half (22/41) of the qualifying incidents that occurred in 2017, were reviewed in 2017.

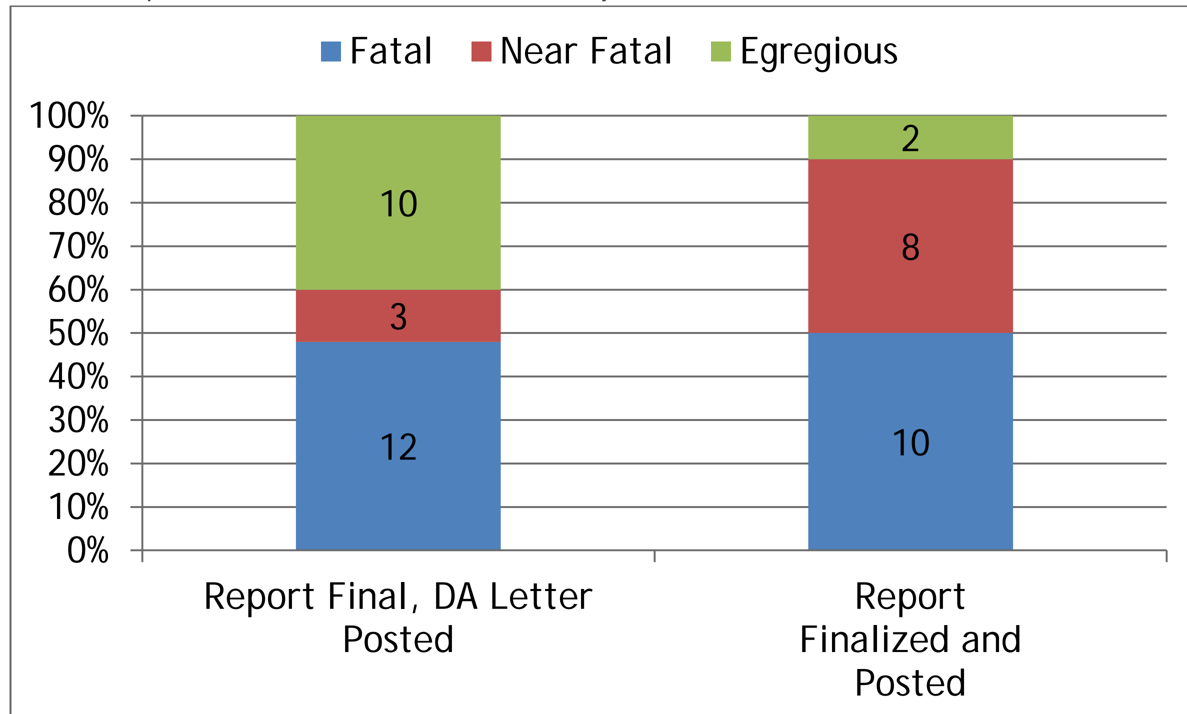
Completion and Posting of Case Specific Executive Summary Reports

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, or likely will be, a 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 in lieu of the case specific executive summary report. CDHS staff maintain contact with the county or district attorney to determine when the criminal or civil proceedings are completed and release of 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 case specific executive summary report on the public notification webpage.

Chart 1 shows the posting status of all CFRT reports for incidents reviewed in 2017. Of the 45 incidents reviewed, final non-confidential case executive summary reports were posted for 20 of them. For the remaining 25 incidents reviewed, it was determined that releasing the final non-confidential report could jeopardize criminal or civil proceedings and a letter from the district attorney or county department was posted in lieu of the report. Throughout 2017, all incidents were reviewed and reports posted within the statutorily required timeframes.

Chart 1: Report Status of all Incidents Reviewed by the CFRT in 2017.



Child Fatality Review Team Membership and Attendance

The Child Fatality Review Team is a multidisciplinary team of up to twenty members, as outlined in C.R.S. 26-1-139. Representation includes, but is not limited to: members from CDHS, Colorado Department of Public Health and Environment (CDPHE), mental health, law enforcement, district attorneys, county commissioners, county departments of human and/or social services, legislature, and many more critical disciplines responsible for representing and/or providing services to the children and families of Colorado. Additionally, there are three full time ARD staff members who are dedicated to the review process. The team meets monthly to review incidents of egregious, near fatal, or fatal child maltreatment when the child or family has also had prior involvement with the child welfare system within three years prior to the incidents. 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 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. 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.

2017 Child Fatality Review Team Outreach and Education: Promoting an Understanding of Why Such Incidents of Child Maltreatment Occur

C.R.S. 26-1-139 highlights the need to promote a better understanding of the causes of each incident of egregious , near fatal, and/or fatal abuse or neglect. In an effort to promote such an understanding, there were several opportunities over the 2017 calendar year in which data and trends associated with such incidents of abuse or neglect were shared with various stakeholders and community partners. These efforts also included moving forward recommendations for systems outside of child welfare, as it has been acknowledged by the CFRT that mitigating future incidents of child maltreatment is a community responsibility.

Prevention Steering Committee and Colorado Children's Trust Fund

The Prevention Steering Committee and Colorado Children's Trust Fund Board began holding joint quarterly meetings in 2016. The group's overall goal is the prevention of child abuse and neglect. During a November 2017 meeting, 2016 CFRT recommendations, as well as 2016 aggregate data were presented in an effort to collaborate and share information related to trends, stressors, contributing factors, and lessons learned from the CFRT reviews.

Department of Regulatory Affairs Recommendation

Over the last several years, the CFRT has identified a potential systemic gap related to service delivery from the medical community when there have been signs of abuse or neglect that went unidentified by medical professionals, within days or weeks leading up to a fatal incident of child maltreatment. Additionally, through a 2017 review of a child maltreatment fatality, Jefferson County Department of Human Services (Jefferson County) identified a similar case-specific gap associated with a fatal child maltreatment incident. In the case-specific incident, the child was seen by a medical provider two days prior to the incident of fatal child maltreatment. The child was diagnosed with "flu like symptoms" and subsequently sent home. Information reviewed indicated there were signs of abuse and neglect during the medical visit, which were not identified by the medical provider and/or reported to the county department. As a result of this incident, it was recommended that CDHS work in collaboration with Department of Regulatory Agencies (DORA) and other entities to discuss the need for training and education surrounding the screening, identification, and reporting requirements regarding child abuse and neglect, and to ensure children are receiving full exams at all medical appointments, in order to help assess for possible signs of abuse and neglect.

As a result of the case-specific recommendation made by Jefferson County, as well as the potential systemic gap previously identified by the CFRT, the ARD Manager whom oversees the CFRT, spoke with the Colorado Medical Board on February 15, 2018, in order to seek help from the medical community in mitigating future incidents of fatal child maltreatment. Since collaborating with DORA and the Medical Board, additional efforts are underway in order to ensure the medical community has easy access and information about the statewide child abuse and neglect hotline, and there is an increase in education and awareness regarding identification of child abuse and/ or neglect. These efforts include, but are not limited to:

- Collaborating with representatives from the Colorado Hospital Association, Children's Hospital, and the Kempe Center in order to plan, develop, and distribute additional information and training regarding proper screening and identification of signs of abuse and neglect during medical contacts/visits with children and families.
- Establishing partnerships within the medical community and promoting awareness regarding child abuse and neglect and Hotline reporting procedures and information.
- Promoting the Colorado Child Abuse and Neglect Hotline number to ensure it is visibly posted in hospitals and emergency room departments.

Child Welfare Training System

The ARD collaborated with the Colorado Child Welfare Training System (CWTS), county departments of human/social services staff, and the Kempe Center in the development of a training designed to support child welfare supervisory practice in an effort to prevent serious harm to children. The training course was designed around lessons learned from a child fatality review, a social ecological model which can help assist supervisors in assessing for families' risk and protective factors, and several additional tools that can help support supervisors during supervision with child welfare caseworkers through organizing and analyzing complex child welfare history.

2017 Child Fatality Review Team Annual Retreat

In an effort to continue to enhance the CFRT process and ensure that the CFRT is meeting the statutory requirements, ARD hosted the third Annual Retreat in June of 2017. During the retreat, the CFRT focused on reviewing the goals, duties and statutory requirements set forth by statute.

The second half of the retreat was open to county department staff participation and ARD staff provided an overview of the aggregate data collected from 2016 reviews and incidents.

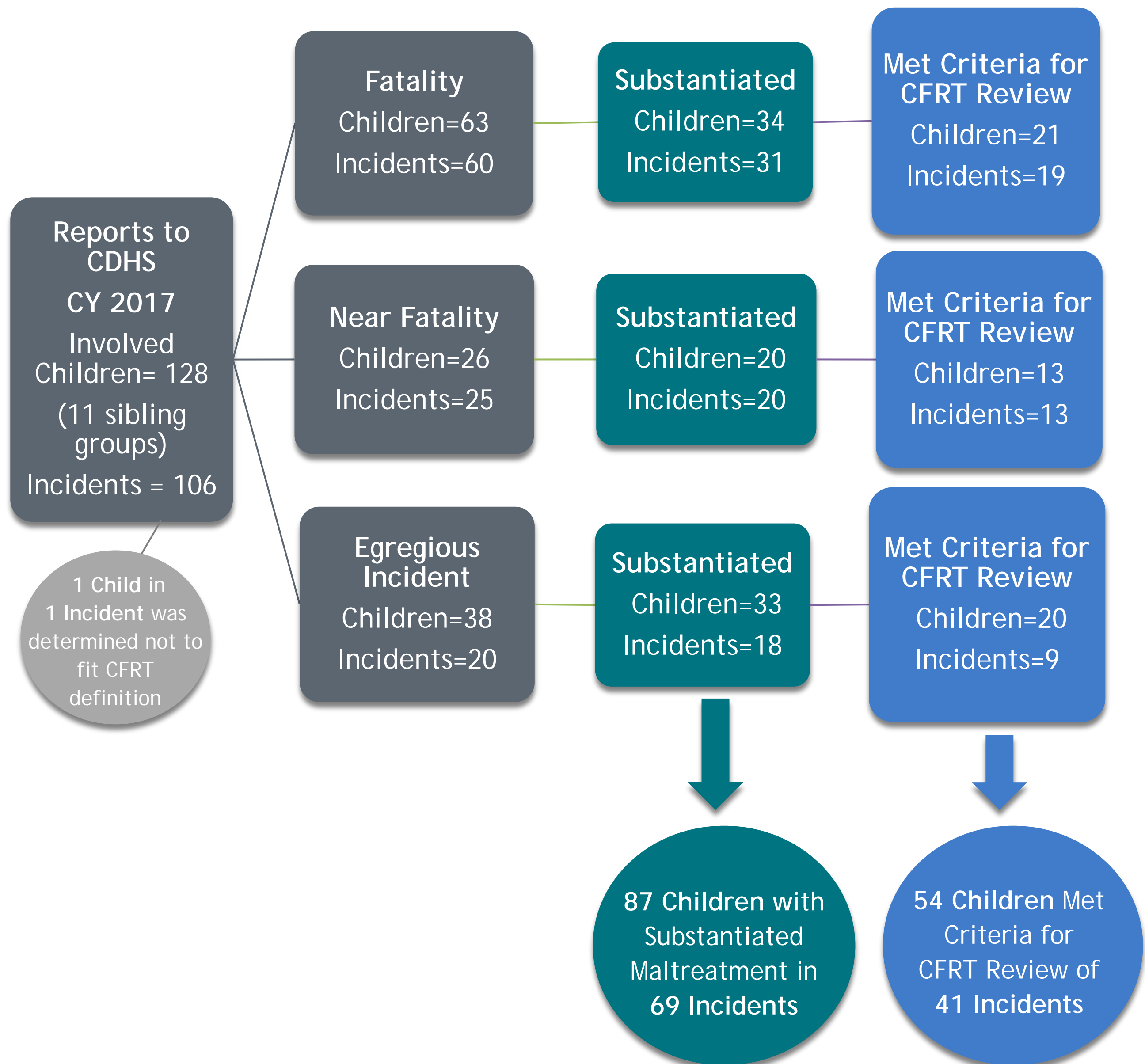
Overview of the 2017 Reports of Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment Victims

As previously discussed, all county departments of human/social services (DHS) are required to report all egregious incidents, near fatalities, and fatalities suspicious for child abuse and neglect to the state department (ARD). Each incident may involve more than one child. In CY 2017, counties reported 106 incidents involving 128 children who were suspected victims of fatal, near fatal, or egregious child maltreatment. One child in 1 incident was reported, but later determined not to fit the definitions and/or criteria. For the remaining 127 children, 63 children were associated with 60 fatal incidents, 26 children were associated with 25 near fatal incidents, and 38 children were associated with 20 egregious incidents.

Of those incidents where county departments completed assessments, 36 incidents involving 40 children were found to be unsubstantiated for abuse or neglect. Therefore, these incidents were determined not to be the result of child maltreatment, and were not reviewed by the CFRT. Incidents deemed substantiated are considered to be the result of child maltreatment and there is a “Founded” disposition against the person(s) responsible for the abuse or neglect. In CY 2017, 69 substantiated incidents included 87 children, 54 of whom had prior involvement with DHS within the statutorily defined time period, thus indicating the need for review by the CFRT.

Figure 1 depicts the breakdown of the incidents reported in CY 2017. 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 2017



For purposes of this report, the majority of the analysis in the following section focuses on the 87 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, trends for the fatal incidents are provided across several years. Table 3 provides an overview of the demographic characteristics of the 87 substantiated victims of incidents that occurred in CY 2017.

Table 3: Summary information of all 87 substantiated victims of child maltreatment fatalities, near fatalities, and egregious incidents in Colorado for CY 2017

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Victim at Time of Incident	Less than one	18	52.9%	10	50.0%	9	27.3%
	One	3	8.8%	3	15.0%	0	0.0%
	Two	1	2.9%	4	20.0%	2	6.1%
	Three	2	5.9%	1	5.0%	3	9.1%
	Four	2	5.9%	0	0.0%	2	6.1%
	Five	2	5.9%	0	0.0%	1	3.0%
	Six	0	0.0%	2	10.0%	1	3.0%
	Seven	3	8.8%	0	0.0%	1	3.0%
	Eight	1	2.9%	0	0.0%	0	0.0%
	Nine	0	0.0%	0	0.0%	1	3.0%
	Ten	2	5.9%	0	0.0%	5	15.2%
	Eleven	0	0.0%	0	0.0%	0	0.0%
	Twelve	0	0.0%	0	0.0%	2	6.1%
	Thirteen	0	0.0%	0	0.0%	1	3.0%
	Fourteen	0	0.0%	0	0.0%	2	6.1%
	Fifteen	0	0.0%	0	0.0%	0	0.0%
	Sixteen	0	0.0%	0	0.0%	1	3.0%
	Seventeen	0	0.0%	0	0.0%	2	6.1%
Race/Ethnicity	African American	5	14.7%	5	25.0%	6	18.2%
	White	20	58.8%	7	35.0%	7	21.2%
	Hispanic	6	17.6%	7	35.0%	11	33.3%
	Multiracial	0	0.0%	1	5.0%	9	27.3%
	Unknown	3	8.8%	0	0.0%	0	0.0%
Sex	Female	18	52.9%	8	40.0%	14	42.4%
	Male	16	47.1%	12	60.0%	19	57.6%
Family Structure	One parent	4	11.8%	2	10.0%	6	18.2%
	One parent and one related caregiver	1	2.9%	5	25.0%	0	0.0%
	One parent and one unrelated caregiver	4	11.8%	0	0.0%	2	6.1%
	Two parents	16	47.1%	10	50.0%	16	48.5%
	Two parents and relatives	3	8.8%	1	5.0%	7	21.2%
	One legal caregiver with relatives and one unrelated caregiver	1	2.9%	0	0.0%	1	3.0%
	One parent and relatives	4	11.8%	0	0.0%	1	3.0%
	Residential Child Care Facility	0	0.0%	0	0.0%	0	0.0%
	Foster Care	1	2.9%	2	10.0%	0	0.0%
Incidents with Additional Family Stressors*	Substance Abuse	8	42.1%	2	33.3%	1	7.7%
	Mental Health	4	21.1%	2	33.3%	5	38.5%
	Domestic Abuse	7	36.8%	2	33.3%	7	53.8%

**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 but not limited to: child characteristics, family characteristics, stressors 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 there has been little research 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 Child Maltreatment[1] report is published annually and 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 2016) 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's ethnicity 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 FFY16, 87.4% of child fatalities were White (45.1%), African American (28.5%), and Hispanic (13.8%). The US Census Bureau[3] estimated race and ethnicity data from

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[1] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2018). Child maltreatment 2016. Available from https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment.

[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/

[3] https://www.census.gov/quickfacts/CO

population estimates for Colorado in 2017. The estimates indicated that Colorado's population in 2017 was 68.6% White (alone, not reporting another race/ethnicity), 21.3% Hispanic, and 4.5% Black or African American. The balance of the population estimates included ethnicities including American Indian, Asian, Native American, etc.

For fatalities, near fatalities, and egregious incidents in 2017, most victims were of one of two ethnicities, White or Hispanic. For fatalities, most victims were of White ethnicity (58.8%), followed by Hispanic (17.6%). The most frequent race/ethnicity for victims of near fatal incidents was equally White (35.0%) and Hispanic (35.0%). For egregious incidents, the most frequent ethnicity of victims was Hispanic (33.3%). This is a slight change from 2016, where the most frequent ethnicity for children involved in fatal, near fatal, and egregious incidents of child maltreatment was White. Trends for fatal events most closely resemble the overall population trends for Colorado, while the trends for near fatal and egregious incidents differ, as Hispanic children are disproportionality represented in the egregious and near fatal incidents. The following chart is a graphic depiction of race/ethnicity breakdown.

Chart 3: Race/Ethnicity of 87 victims in all Substantiated Fatal, Near fatal, and Egregious Incidents of Child Maltreatment in Colorado for CY 2017

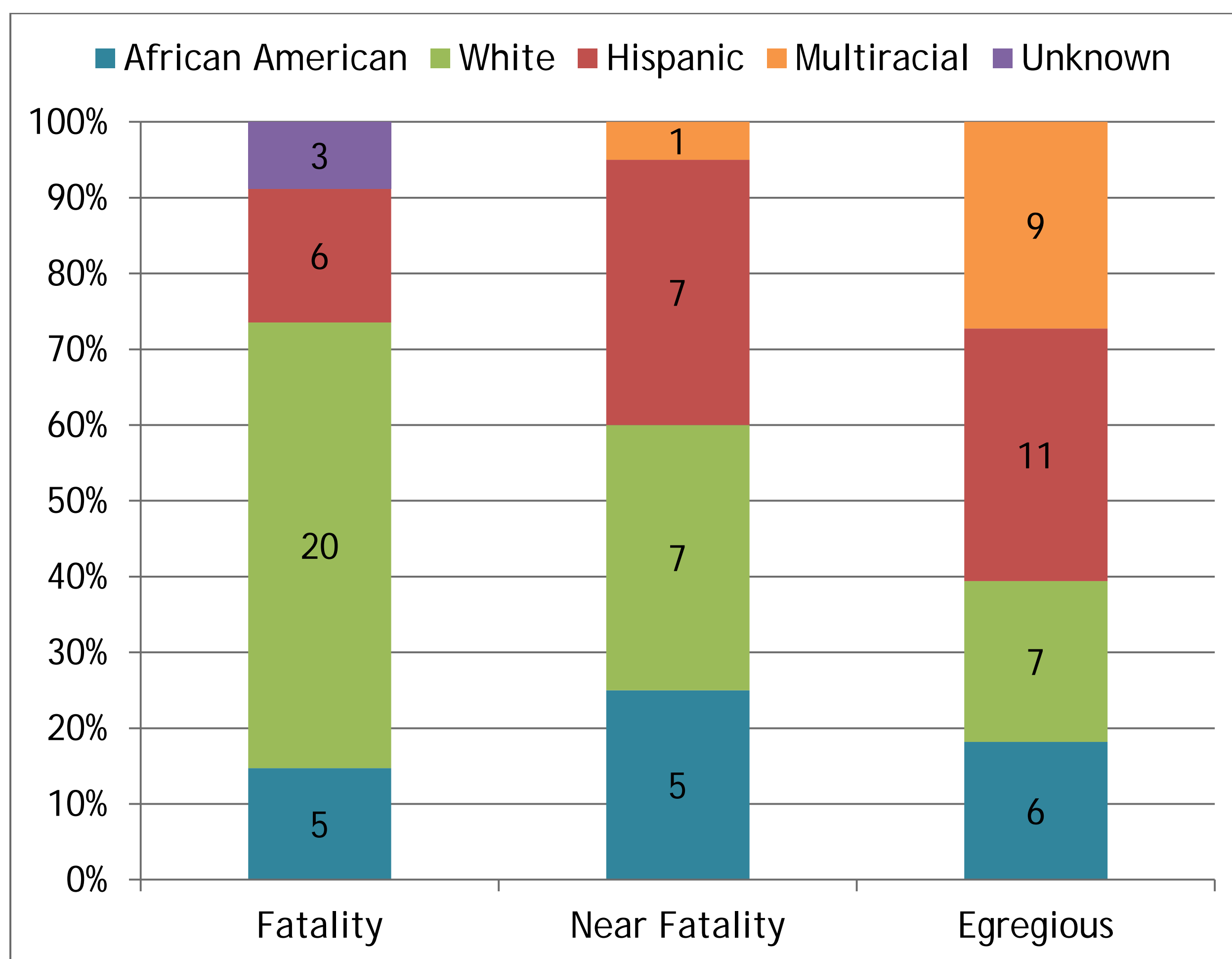
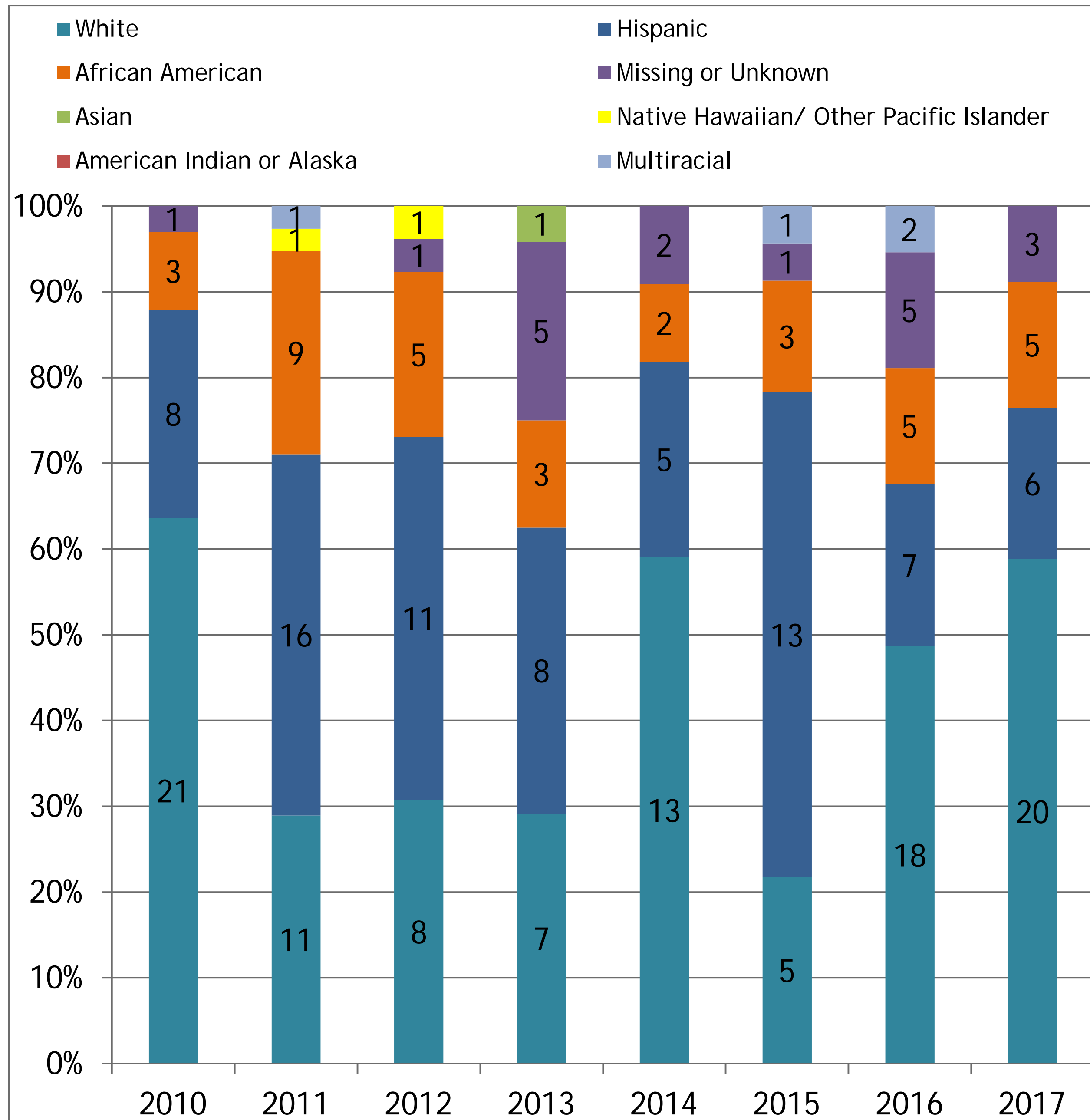


Chart 4 shows the race/ethnicity of all child maltreatment fatalities in Colorado from 2017-2010. For fatalities in CY 2017, the most frequent race/ethnicity was White (58.8%), which fell in line with 2016 trends. However, this has been a significant change from 2015, where the majority of victims involved in child maltreatment fatalities were Hispanic.

Chart 4: Race/ethnicity of Victims in all Substantiated Child Maltreatment Fatalities in Colorado over the Past Eight Calendar Years

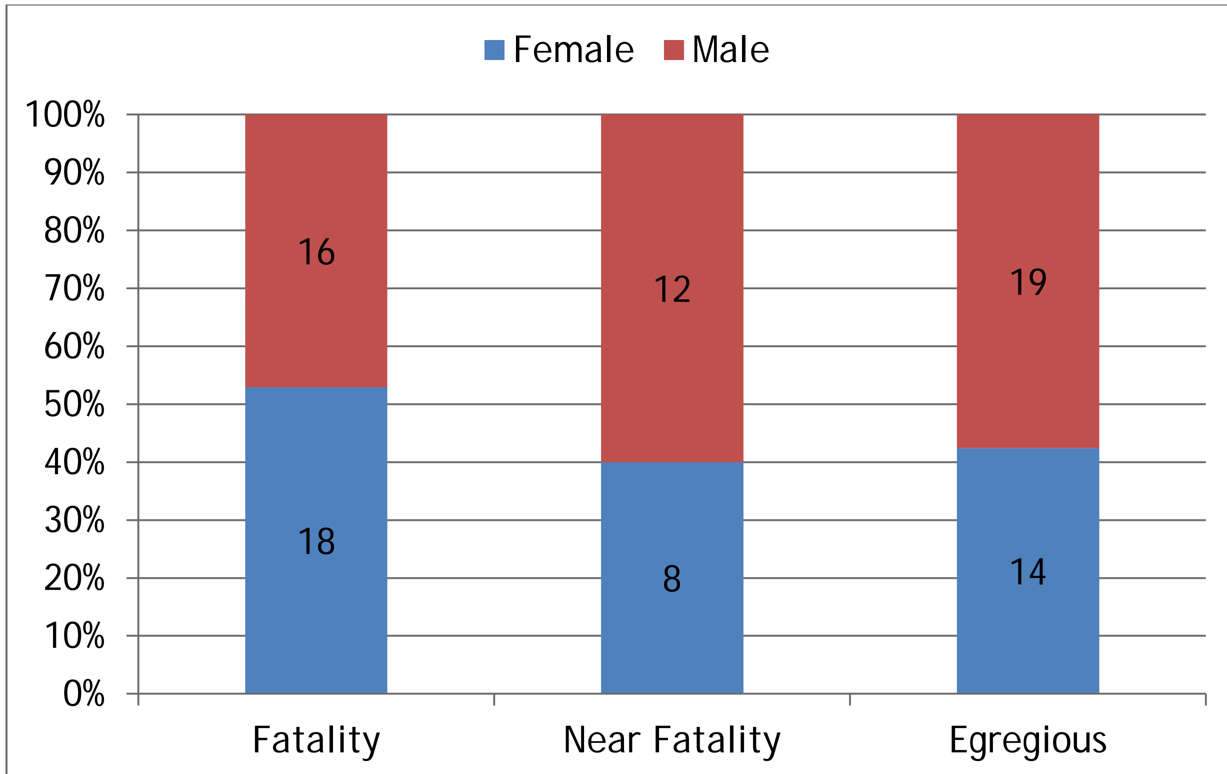


Sex of victim

Chart 5 displays the breakdown of differences in the sex of the victims for the 87 victims involved in substantiated incidents of fatal, near fatal, and egregious incidents of abuse and

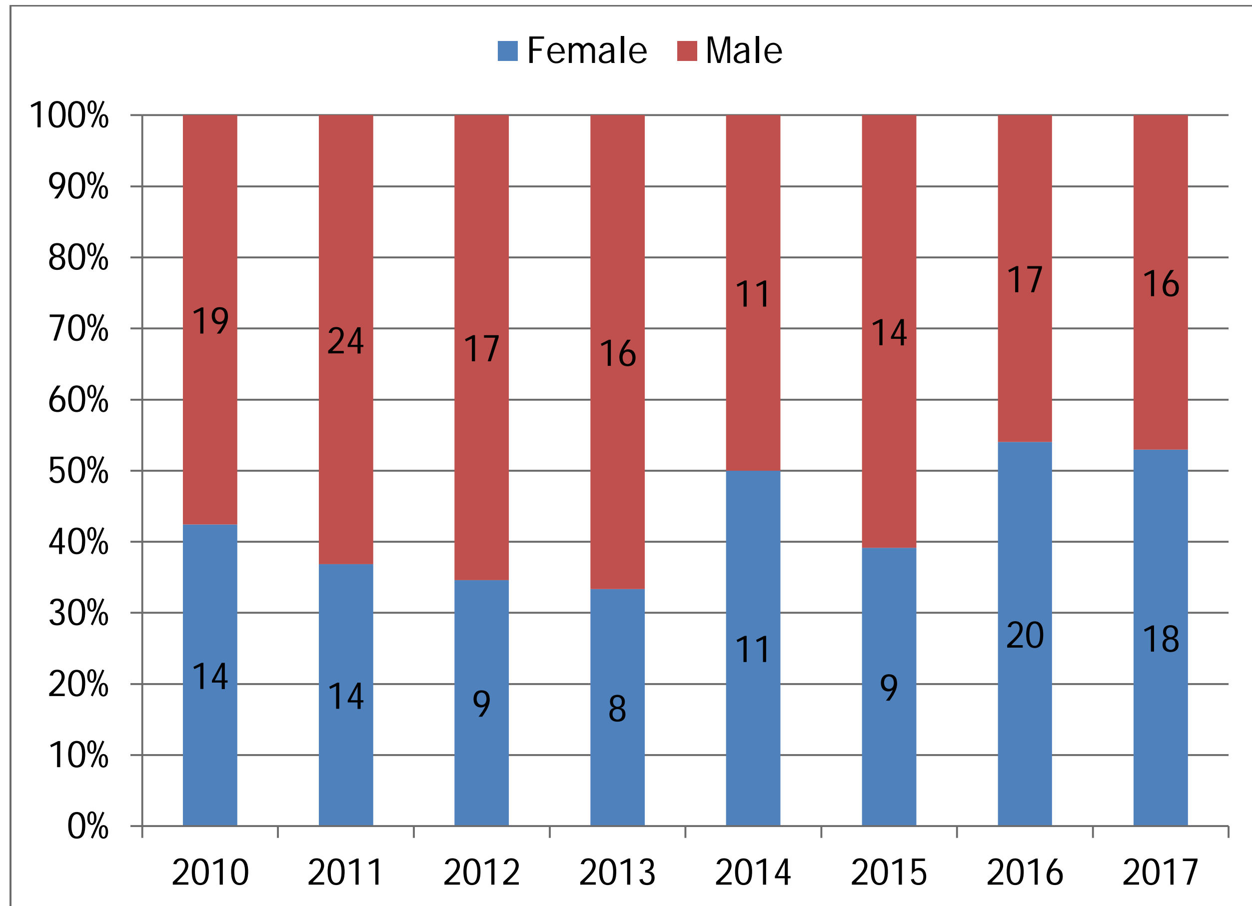
neglect in CY 2017. In Colorado, in CY 2017, males accounted for 47% of the children in substantiated child maltreatment fatalities. Males were victims in 60 % of near fatalities, and over half of the egregious incidents (57.6%). Nationally, in FFY 2016, 58.6% of victims in child maltreatment fatalities were males, a four-percentage-point increase from FFY 2015. There are no federal comparison statistics for near fatal or egregious incidents.

Chart 5: Sex of 87 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado for CY 2017



In the recent past, Colorado mirrored national trends with 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. However, as demonstrated in Chart 6, female victims surpassed male victims in CY 2016 and CY 2017. In 2016, female victims accounted for 54% of all substantiated fatalities in Colorado, and in 2017, the percentage slightly decreased to 52.9%.

Chart 6: Sex of Victims in all Substantiated Child Maltreatment Fatalities in Colorado over the Past Seven Calendar Years



Age at Time of Incident

A child's age has been a key risk factor associated with child maltreatment fatalities, and research continues to show that younger children are the most vulnerable to child maltreatment. National data shows that in FFY 2016, victims of fatal child maltreatment incidents tend to be younger, with 70% of all child fatalities experienced by children age three or younger, and 44.4% were under the age of 1. Colorado's trends appear to follow the national trends. As displayed in Chart 7, 52.9% (18/34) of the fatalities involved victims younger than one year old, and 70.6% (24/34) were three or younger.

A similar pattern of younger-aged victims exists for the near fatalities, as 50% (10/20) of the victims were under the age of one, and 90% (18/20) were age three or under (see Chart 7). The pattern of ages of children substantiated in egregious incidents did not exactly follow those of the fatal and near fatal victims, and has followed its own trend within Colorado – victims of egregious incidents tend to be older. The data also reflects that 27.3% (9/33) of the victims of egregious incidents were under the age of one, and 42.4% (14/33) were aged three or younger. Approximately 57% (19/33) of victims of egregious incidents were aged four or older, and 42.1% (16/38) were aged ten or older.

Chart 7: Age of 87 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2017

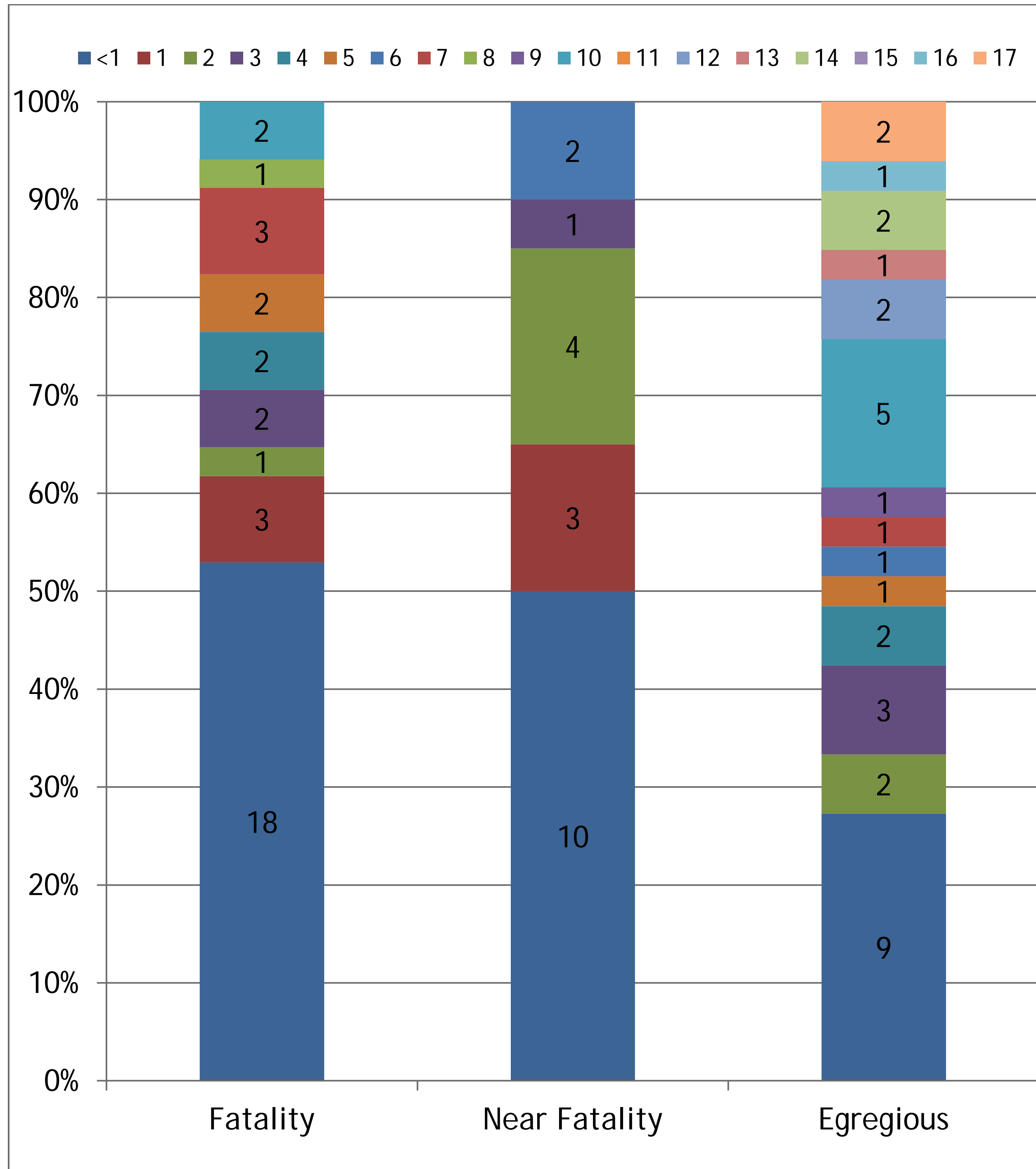
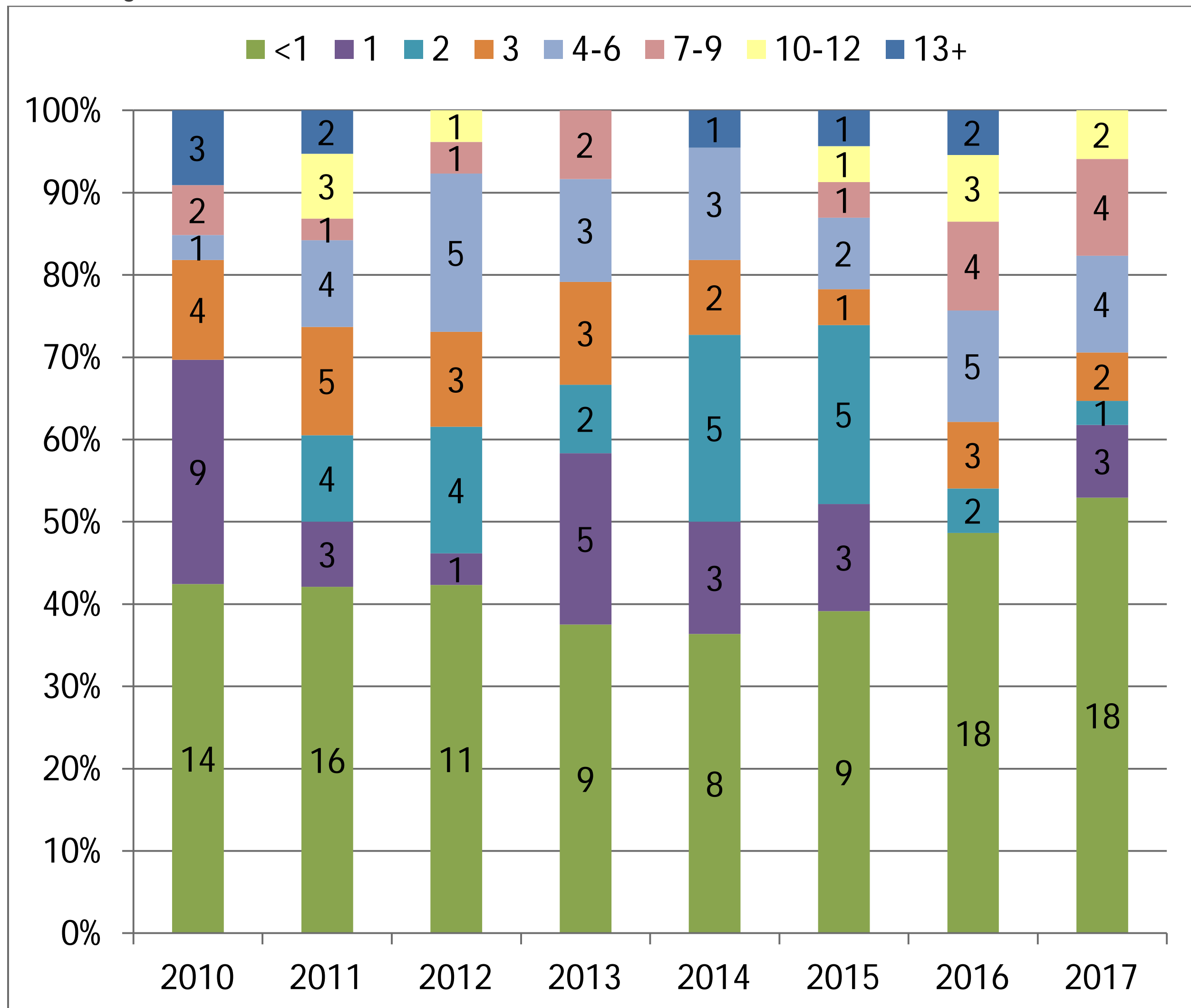


Chart 8 displays the trends in ages of victims in child maltreatment fatalities over the past seven calendar years. The data further depicts that children under the age of one year old are the most frequent victims of fatal child maltreatment.

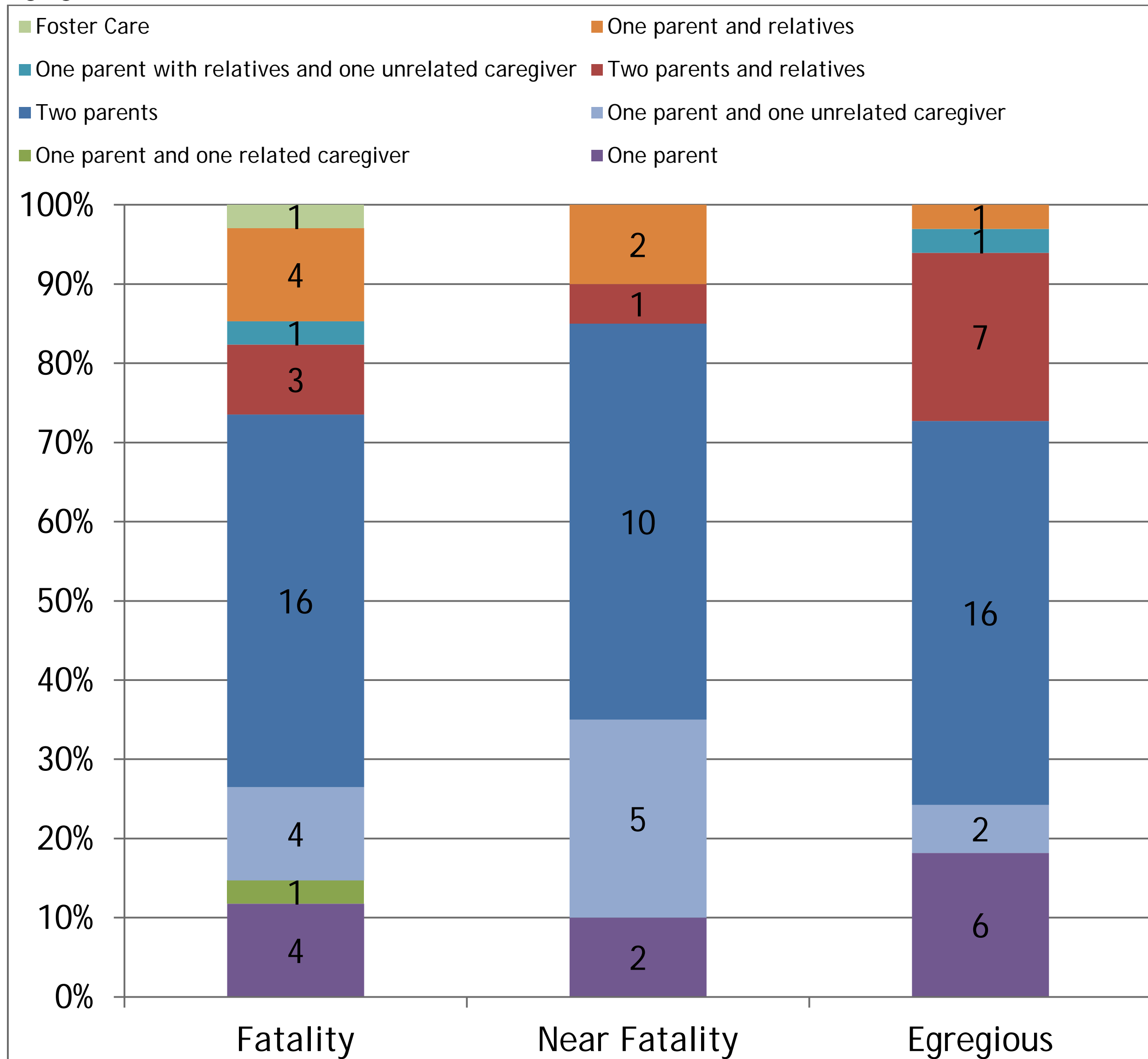
Chart 8: Age of Victims in Child Maltreatment Fatalities in Colorado over the Past Seven Calendar Years



Family Structure

In 2017, as displayed in Chart 9, 48.3% (42/87) of all children in fatal, near fatal, and egregious incidents of child maltreatment lived in a household with two parents. This family structure was also the most frequent for incidents occurring in 2015 and 2016. The second most common type of family structure across all substantiated incidents in 2017 was one parent 13.8% (12/87). Approximately 47% (16/34) of fatal incidents occurred for children in families with two parents. The family structures of one parent, one parent and one unrelated caregiver, and one parent and relatives, were equally represented as the second most common type of family structure for children involved in fatal incidents of child maltreatment for 2017.

Chart 9: Family Structure of 87 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in 2017



Prior Involvement

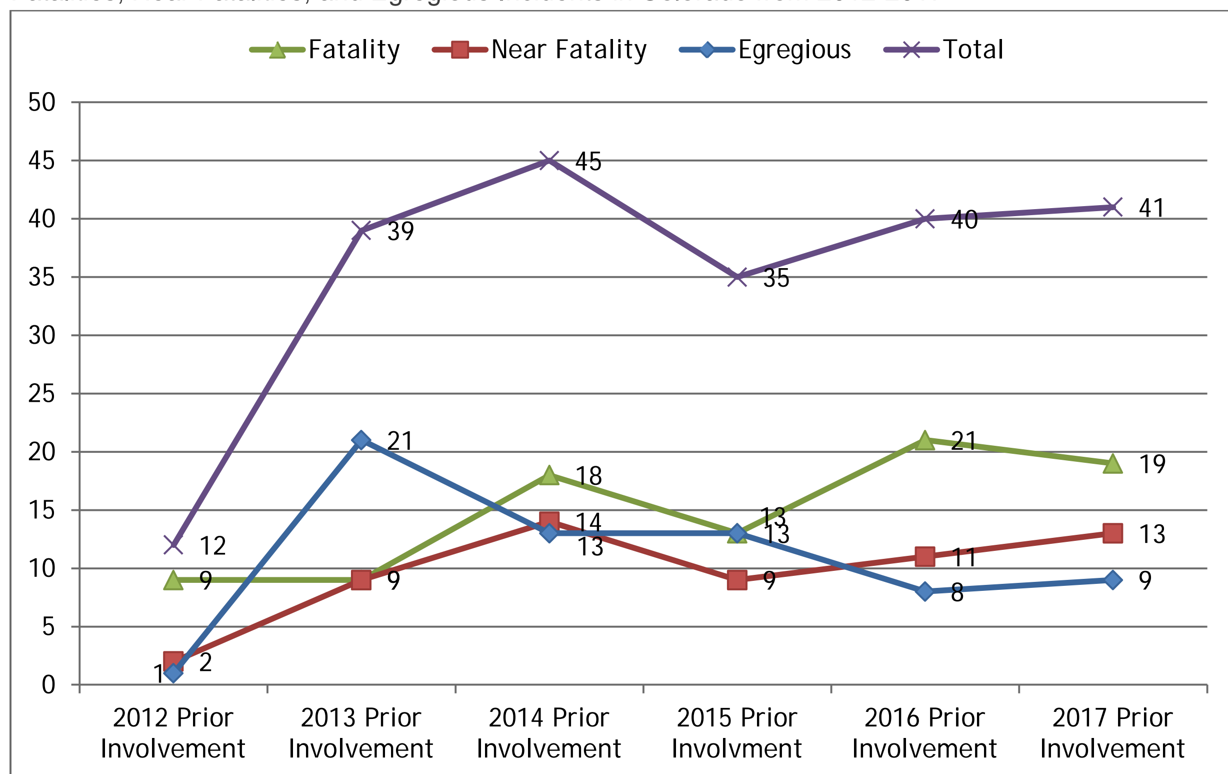
Nationally, in 2016, 2.4% of child fatalities involved families with prior out-of-home placement within the past five years, and 10.4% received family preservation services. It is important to note national data varies for this measure based on state and local policy and reporting requirements to the 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 within 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).

Over the calendar years from 2012-2017, the percentage of families involved in substantiated incidents of fatal child maltreatment with prior involvement in Colorado has ranged between

35% and 82%. The last three calendar years have represented similar percentages, with a marked decrease since 2014, where 82% of families involved in substantiated fatal incidents of child maltreatment had prior involvement within the last three years. In 2017, 61.3% (19/31) of fatal incidents substantiated for abuse or neglect had prior involvement with the child welfare system. In six of these incidents (6/19), families had current involvement with the child welfare system at the time of the incident. This is similar to 2016, where 21 of 35 (60%) families involved in substantiated fatal child maltreatment incidents had prior history and/or current involvement. In 2015, 13 of 22 (59.1%) of families involved in fatal child maltreatment incidents had prior history and/or current involvement.

The number of families with prior history and/or current involvement for near fatalities and egregious incidents substantiated for child maltreatment has varied throughout the years. The percentage of families involved in near fatal incidents of child maltreatment, whom also had prior history and/or current involvement with the child welfare system within three years prior to the incident, fluctuated from 60.0% (9/15) in 2015, to 55% (11/20) in 2016, and rose to 65% (13/20) in 2017. 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, and remained at 50% (9/18) in 2017. Chart 10 details the trends in incidents with prior and/or current involvement for the past six 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 2012-2017*



** 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.

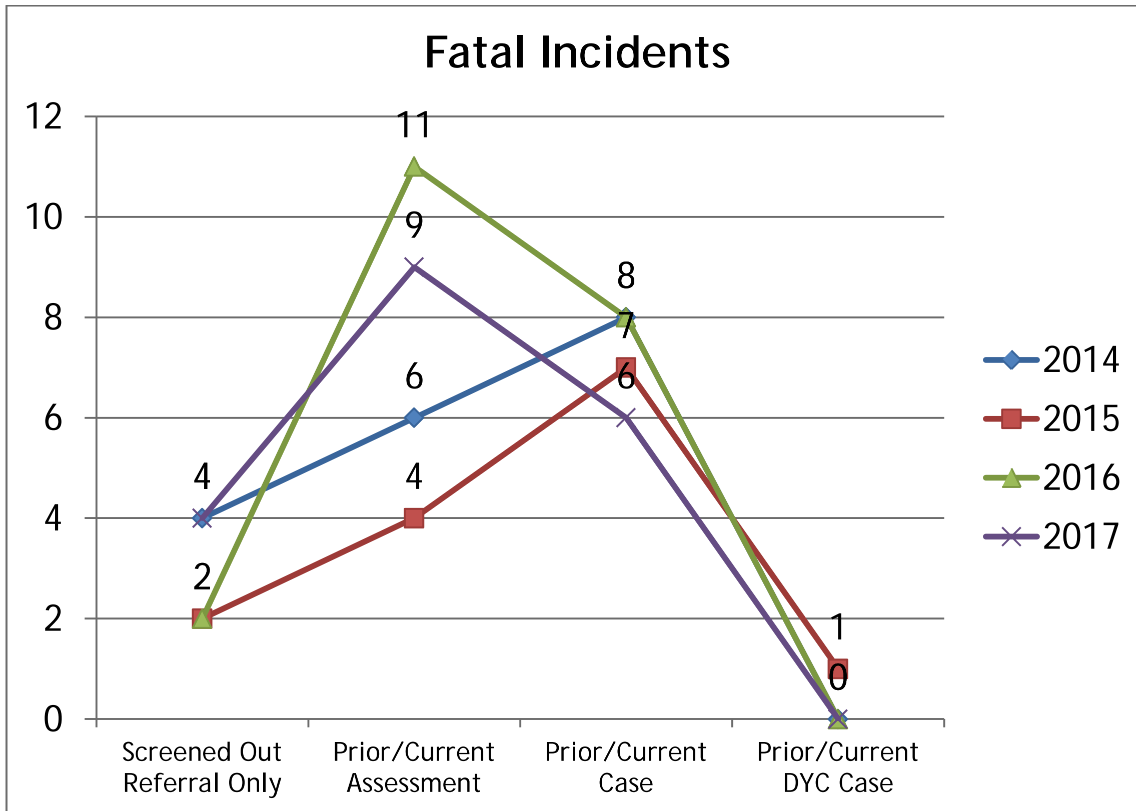
Since 2014, given the statutory stability around the scope and definition of prior involvement, information related to prior involvement is available for analysis. Trends related to prior and/or current involvement over the past three years is illustrated in Chart 11 a-c. In determining the type and scope of prior involvement, this section follows the prior history to the furthest level of prior involvement/intervention the family had within the child protection system. For example, if a county department of human/social services received a referral regarding a family, and that referral was accepted for 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.

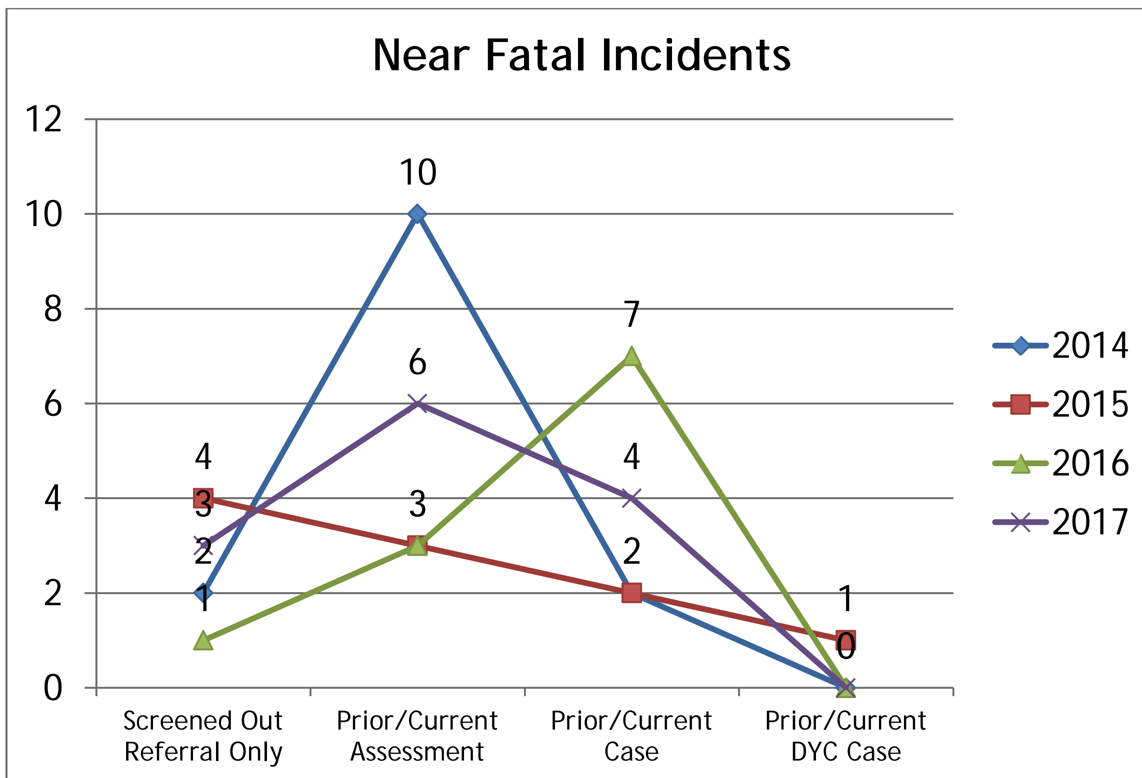
It should be noted for purposes of this report, if a child/family had prior or current involvement in an open child welfare case and a prior or current involvement within the Division of Youth Services, that history was counted in both of those categories. This can result in a duplicate count for a family. 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 DYS 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).There was not prior DYS involvement noted for incidents reviewed by CFRT in CYs 2016 and 2017.

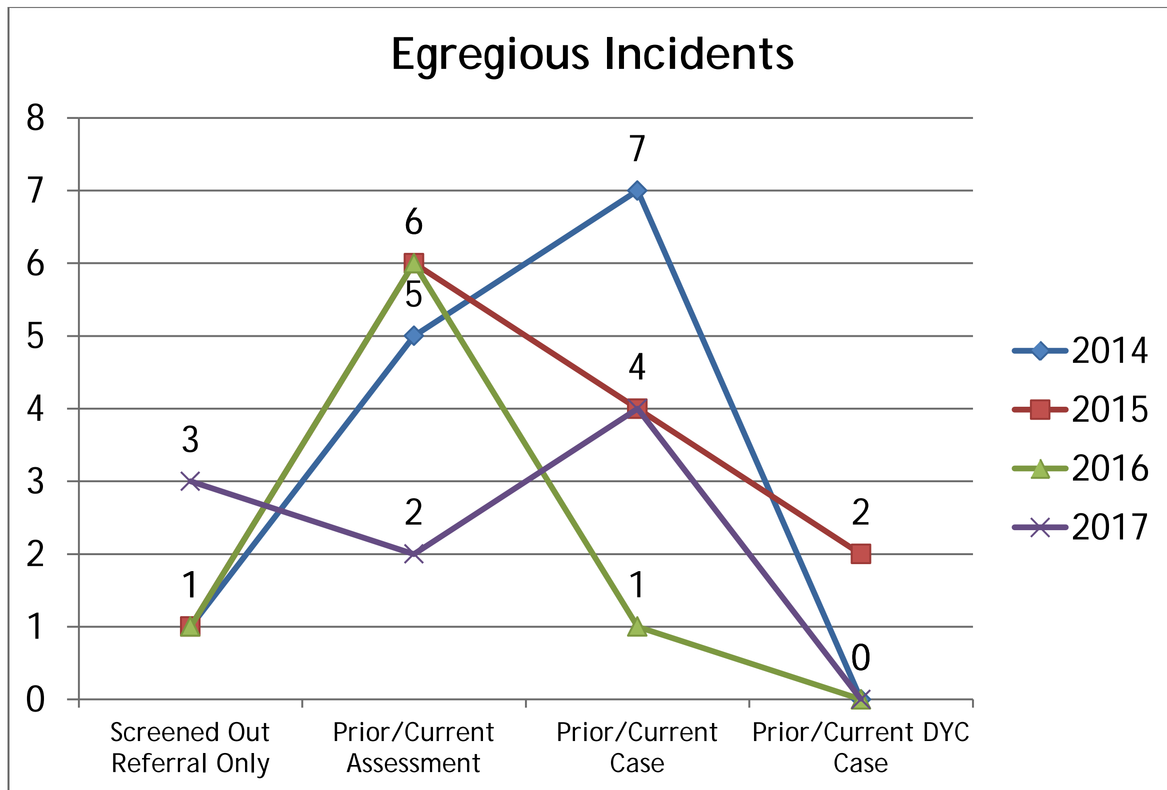
In 2017, for fatal incidents substantiated for child maltreatment, the most common level of prior and/or current involvement with the child welfare system was a prior and/or current assessment (9/19; 47.4%). This falls in line with trends noted in 2016, where assessments were also the most common level of child welfare involvement in incidents of fatal child maltreatment (11/21; 52.4%). In 2015, on-going case prior history and/or current involvement was the most common level of prior history and/or current involvement for fatal incidents.

Near fatal incidents in 2017, fell in line with trends for prior and/or current involvement seen in fatal incidents of child maltreatment, with assessments as the most common level of prior and/or current involvement with the child welfare system (6/13; 46.1%). Conversely, in 2016, the most common level of prior and/or current involvement for incidents of near fatal child maltreatment was a current and/or prior case (7/11; 63.6%).

Chart 11a-c: Detail of Prior Involvement of Families in Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment







In 2017, the most common level of prior and/or current involvement in a families child welfare history associated with substantiated egregious incidents of abuse or neglect, were a prior and/or current case (4/9; 44.4%). This resembled a trend noted in 2014 where a prior and/or current case was the most common prior involvement; however, this was a change from 2015 and 2016, where assessments were the most common level of prior involvement.

Perpetrator Relationship

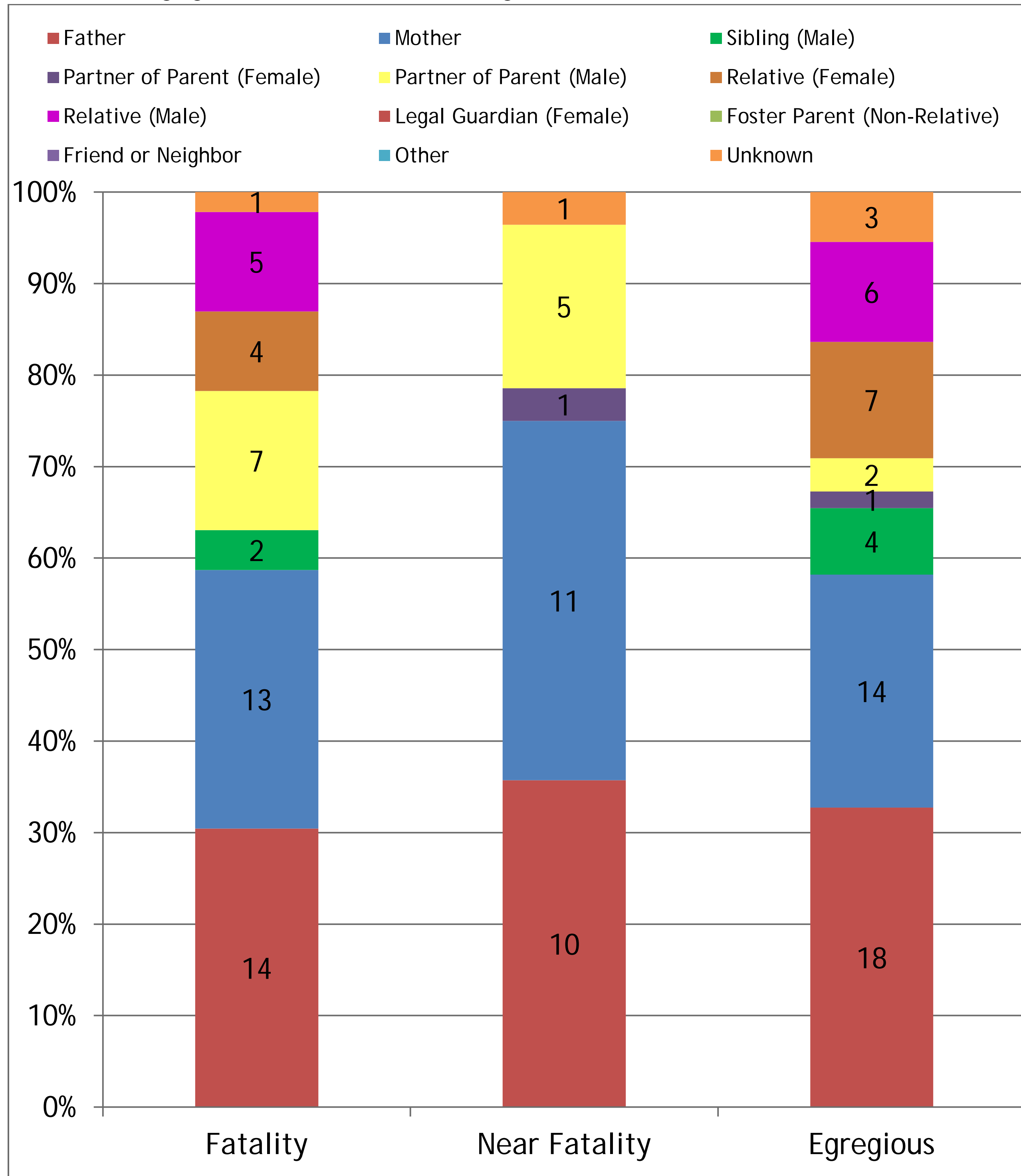
Chart 12 displays the relationship between the perpetrator(s) and the victim(s) of fatal, near fatal, or egregious incidents of child maltreatment. It is important to note there can be more than one perpetrator per child and incident. In 2017, fathers were the most common perpetrator in fatal incidents of child maltreatment (14/46; 30.4%). This is quite above national trends for FFY 2016, which represented fathers as perpetrators in 16.8 % of fatal incidents of child maltreatment.

In Colorado for CY 2017, mothers were identified as the second most common perpetrator (13/46; 28.3%) involved in fatal incidents of child maltreatment. This is a shift from the last several years, where the victim's mother has been the most common perpetrator associated with fatal incidents of child maltreatment. Nationally, mothers are also the most commonly associated perpetrator in incidents of fatal child maltreatment.

For near fatal incidents of child maltreatment in 2017, mothers were the most common perpetrators (11/28; 39.3%) and the father was the second most common perpetrator (10/28; 35.7%). The perpetrators in egregious incidents were most frequently fathers (18/55; 32.7%), and mothers were the second most frequent (14/55; 25.5%). With all incidents, four

perpetrators were unknown (three in an egregious incident, one in a near fatal incident, and one in a fatal incident), which means through assessment and investigation it was determined that abuse or neglect had occurred and a perpetrator of the incident was unable to be determined.

Chart 12: Perpetrator Relationship to 87 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado during CY 2017*



*More than one perpetrator exists for several children.

Family Characteristics

Collecting and analyzing characteristics associated with families involved in incidents of fatal, near fatal, and/or egregious child maltreatment, can help the child welfare system and community better identify and understand risk factors, stressors, and contributing factors associated with such incidents. Income, education, public benefits, and stressors are outlined in the next sections of this report and includes data from fatal, near fatal, and egregious incidents reviewed by the CFRT in 2017 (45 incidents). Since this information is only collected for families when the incident of fatal, near fatal, or egregious child maltreatment meets the statutory criteria for review, the scope of analysis is limited. 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

Changes made to the Colorado Revised Statute as a result of SB 13-255, required the income and educational level of legal caregivers, as well as government assistance or services received by legal caregivers at the time of the incident, to be included in the final confidential case-specific executive summary for those incidents of fatal, near fatal, and egregious child maltreatment that met criteria for review by the CFRT. This information continues to prove difficult to collect and report on, as it was not always part of the available documentation from county departments of human/social services. Income and education level of caregivers are not variables consistently collected during child protection assessments. For example, there were 86 unique caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed by the CFRT in 2017 (45 incidents); income information was only known for 19 of these individuals (22.1%). Of those caregivers with known income information, the average income for caregivers involved in fatal incidents is approximately $14,360.57, $16,000.00 for near fatal incidents, and $13,868.57 for egregious incidents.

Educational level was unknown for 62.8% (54/86) of the legal caregivers involved in fatal, near fatal, and/or egregious incidents of child maltreatment reviewed by the CFRT in 2017. Similar to 2016 statistics, of the reported education levels for legal caregivers the two most common levels 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 59.3% (51/86) of the caregivers with a known educational attainment level.

Supplemental Public Benefits

In CY 2017, information regarding supplemental public benefits was also tracked and gathered for the 45 incidents of fatal, near fatal, and/or egregious child maltreatment reviewed by the CFRT. Information regarding supplemental public benefits is tracked by incident, rather than by the unique caregivers. Information collected indicated that the most frequently received supplemental benefit was Medicaid (25/45; 55.5%). In 20 of the 45 incidents reviewed (44.4%) families were receiving Supplemental Nutrition Assistance Program (SNAP) benefits. Other types of benefits received included, Supplemental Security Income (SSI), Temporary

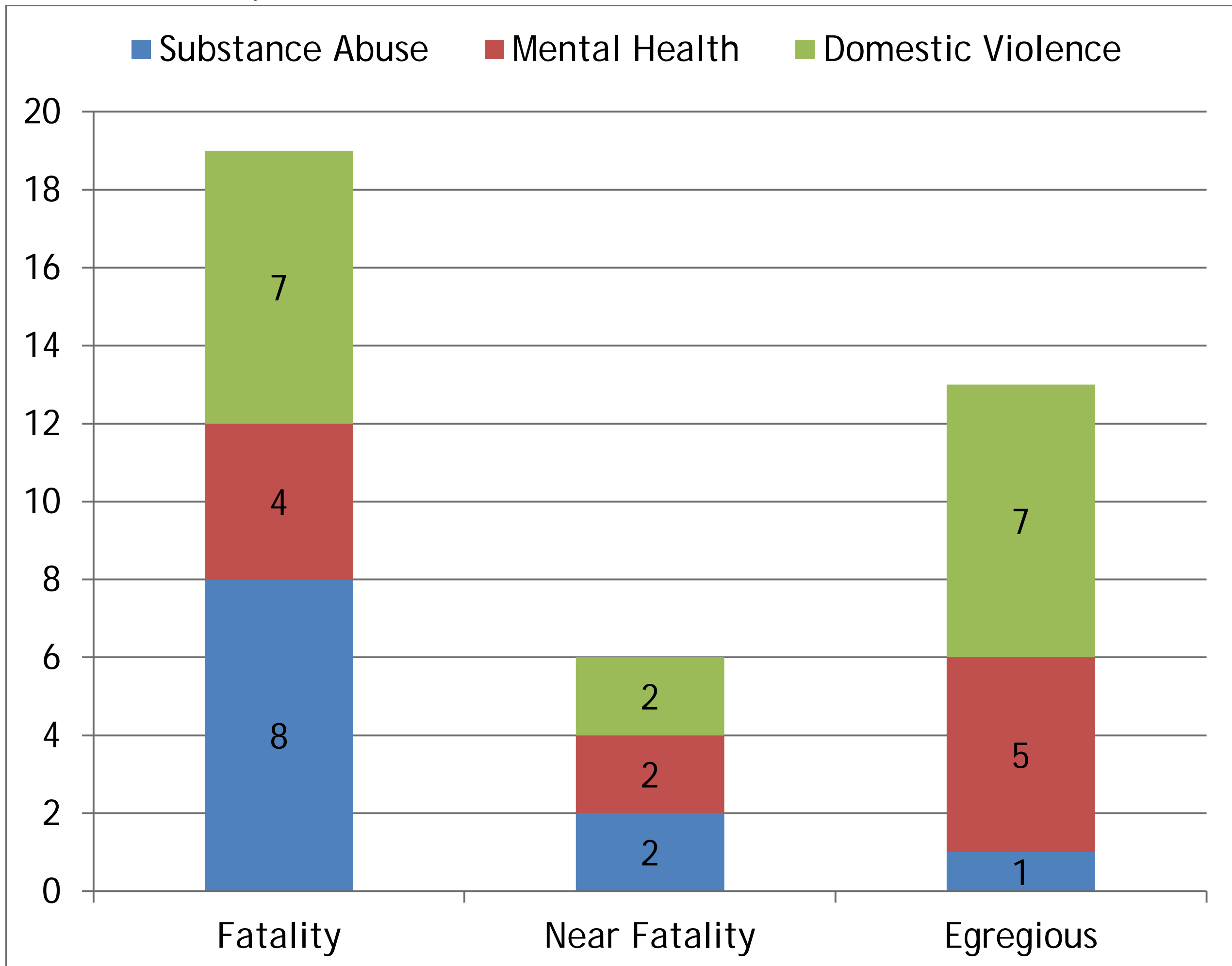
Assistance for Needy Families (TANF), and Special Supplemental Nutrition Program- Women, Infants, Children (WIC), Child Care Assistance Program (CCAP) and Colorado Works services.

Other Family Stressors

Chart 13 identifies stressors identified/associated with caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed in 2017. Of the families involved in a fatal child maltreatment incident which met criteria for review by the CFRT, 36.8% (7/19) had some history of identified domestic violence. Additionally, 42.1% (8/19) of the families experienced substance abuse issues, and for 21.1% (4/19) there was a history of mental health treatment for at least one caregiver.

Nationally, in FFY 2016, 5.7% of child fatalities were associated with a caregiver known to abuse alcohol, while 15.1% of child fatalities had a caregiver who abused drugs. In Colorado, 42.1% (8/19) of the families involved in a fatal incident of child maltreatment in 2017, which met criteria for review by the CFRT, had some current and/or identified history of substance abuse.

Chart 13: Other Stressors in Families of the Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents Reviewed by the CFRT in 2017



Summary of CFRT Review Findings and Recommendations

This section summarizes the findings and recommendations of 32 non-confidential case-specific executive summary reports (hereafter referred to as reports). This includes 32 reports completed and posted to the CDHS public notification website after the cut-off date for inclusion in the 2016 CFRT Annual Report (3/31/2017) and prior to and including the cut-off date for inclusion in this year's report (3/31/2018). Each of the 32 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 32 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 multi-disciplinary 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 32 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 32 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

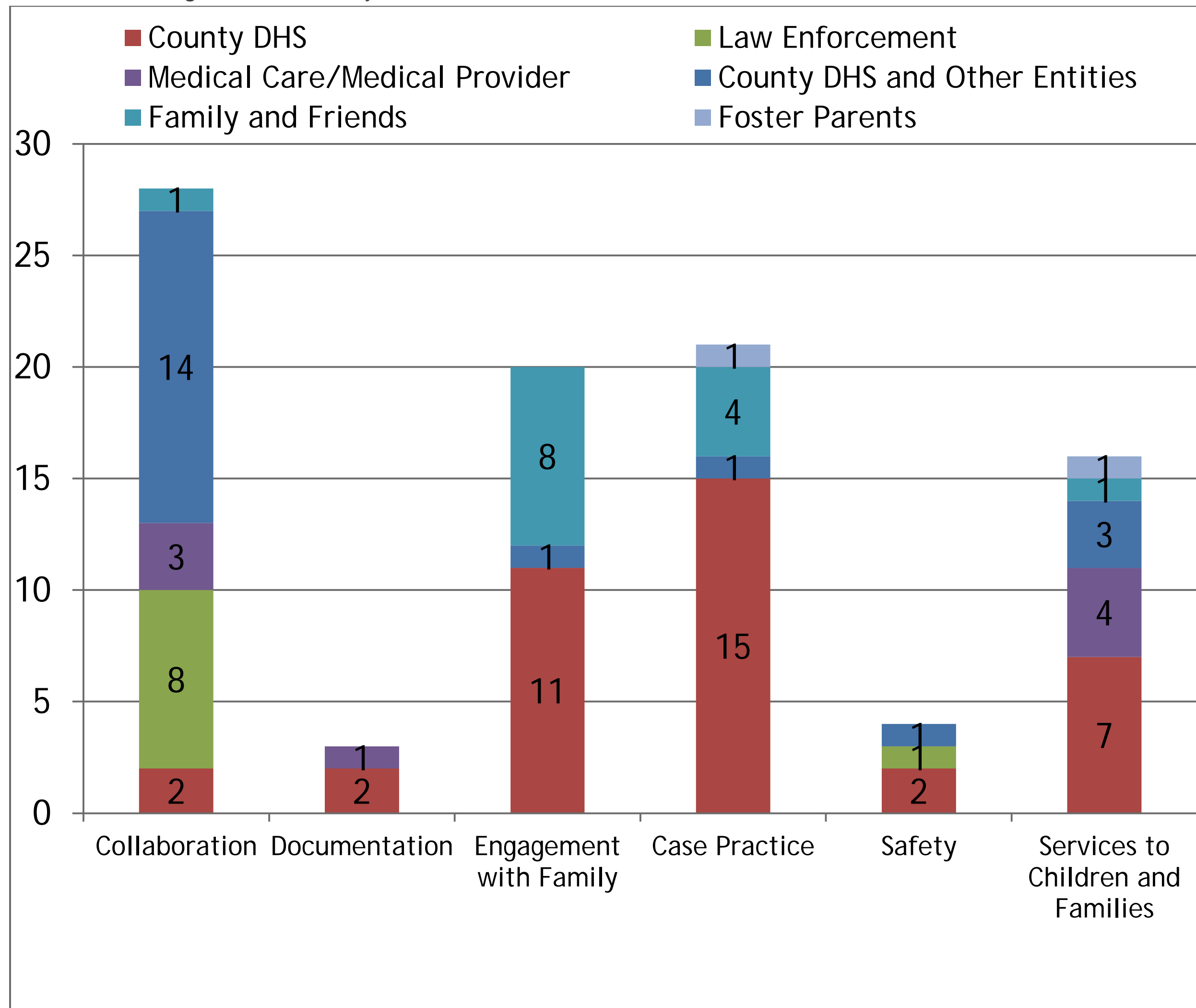
Across the 32 fatal, near fatal, or egregious incidents of child maltreatment reviewed by the Child Fatality Review Team and posted to the public notification website, the team noted 92 systemic strengths in the delivery of services to children and families. Items of systemic strength acknowledged by 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 28 occasions across 22 reports. Most often, collaboration which occurred *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.) on 14 occasions. Similarly, county departments and law enforcement worked well together to investigate the circumstances surrounding the incident of fatal, near fatal, or egregious child maltreatment, eight of the 32 reports. Strong collaboration between county departments of human/social services was identified in 2 of the reports. Medical providers were also indicated as important collaborative members in the assessment of the fatal, near fatal, and egregious incidents in three reports. These collaborations often provide important information to the county child welfare professionals about the incident of child maltreatment, and help inform decisions regarding the outcome of the assessment.

Chart 14: Strengths Identified by the CFRT Review Process



Documentation

Documentation by county departments of human/social services was indicated as a systemic strength on three occasions, across three reports. Specifically, the CFRT noted that county departments of human/social services completed thorough internal reviews of the incident

and prior involvement. Additionally, in one report, the CFRT identified a strength related to an autopsy report, and identified that having a thorough and well-written autopsy report can be beneficial to law enforcement and the district attorney's office with regards to the prosecution of an offender of fatal, near fatal, and/or egregious abuse or neglect.

Engagement of Family

On 11 occasions, across 18 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 occurred, ensure surviving sibling's safety, and finding relatives for placement. In one report, it was noted that during the assessment of the incident, due to the strong rapport the caseworker was able to develop with the children and family, the children felt more comfortable during the interview process. 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 future safety and permanency of the children. On 8 occasions, the county department of human/social services was noted to engage family and friends during the incident assessment. In several of these noted strengths, the engagement with family and friends helped ensure placement with relatives, and involved families' support systems in case planning. Lastly, it should be noted that one report identified positive engagement of other systems (e.g. home visiting program) that helped provide families additional parenting support.

Case Practice

The CFRT identified caseworkers who excelled in case practice to children and families 15 different times (across 17 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 timely and thorough manner that then informed safety intervention decisions. At times, this also included thorough collaboration between multiple caseworkers. Lastly, the CFRT identified the use of timelines and thorough reviews of a family's child welfare history as strengths related to case practice. A thorough analysis of risks, strengths, and prior child welfare involvement can help inform decisions regarding child safety, future risk of maltreatment and necessary interventions.

Safety

The CFRT identified 4 instances across 4 reports where systems surrounding children and families provided excellent work in the promotion of child safety. In 3 of the 4 instances, the CFRT noted 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.

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 16 times across 14

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. Four 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 32 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, 2017 and March 31, 2018, the CFRT identified 55 gaps and deficiencies in the delivery of services to children and families. Systemic gaps and deficiencies were organized into four main categories: 1) Practice and/or Policy, 2) Training and Technical Assistance, 3) Implementation of Safety and Risk Assessment Tools, and 4) 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 32 incident reviews, as well as information about their implementation status.

Practice or Policy

The CFRT noted particular county-specific issues with practice and state policy 20 times across the 32 reports. Several of the recommendations indicated the need for the Division of Child Welfare to provide additional guidance, or to establish protocol for various rules and/or policies outlined in Volume 7. An example included the need for DCW to provide additional guidance to county departments of human/social services regarding the circumstances when the county cannot locate a family. Another example was a recommendation related to the need for establishing a protocol for case closure, as it pertains to additional database checks (background checks, court records, etc.).

Safety and Risk Assessment Tools

A systemic deficiency identified by the CFRT, 6 times across the 32 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 13 policy findings related to the use of the safety and risk assessments. 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 Colorado Family Safety and Risk Assessment Tools in January 2017.

Unique Issues

The remaining gaps identified by the CFRT did not constitute overall trends across the 32 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

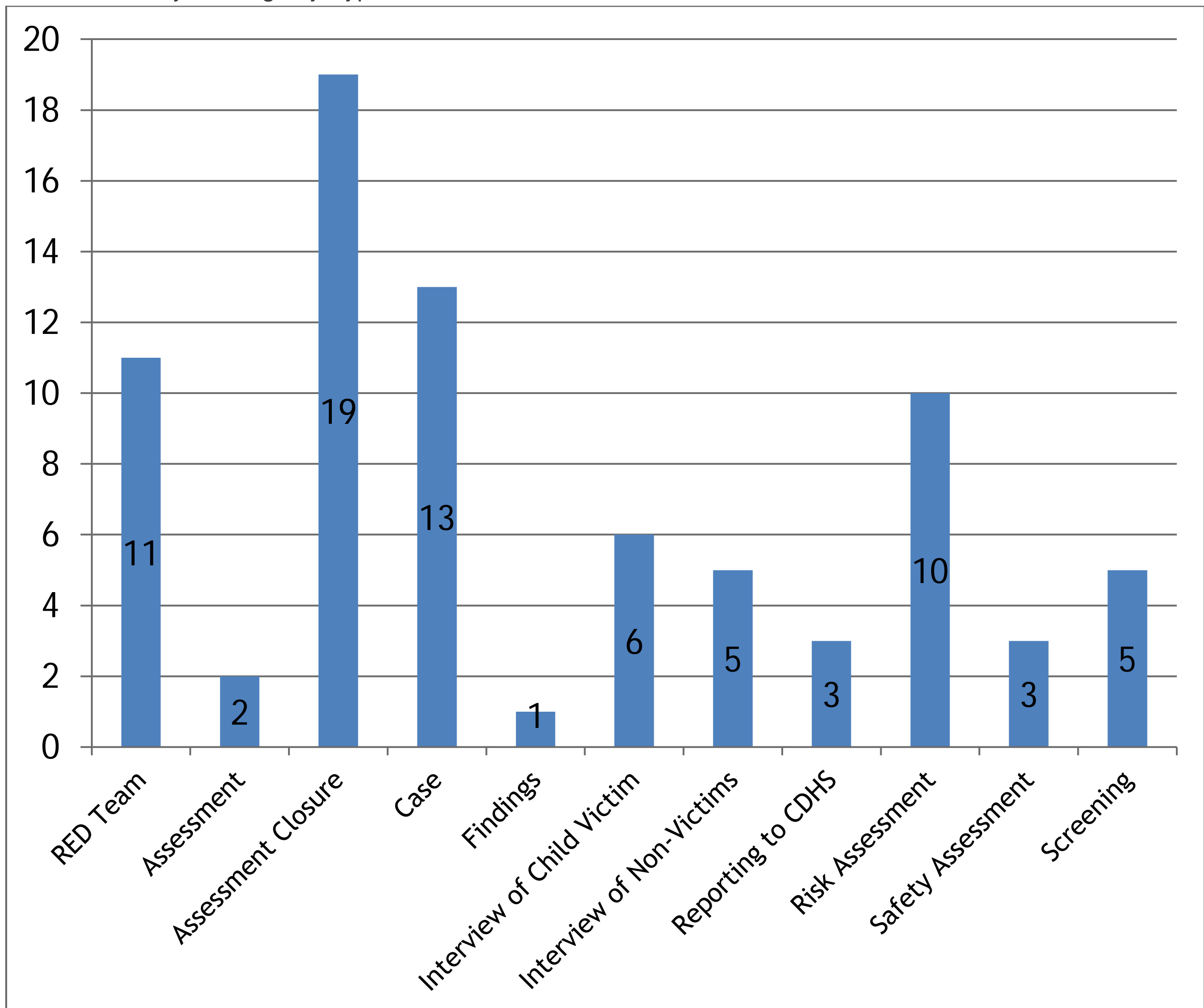
The CFRT staff methodically reviewed county agency documentation regarding the assessment of the fatal, near fatal, and egregious incidents of child maltreatment and prior involvement. In each review, the CFRT staff identified areas of noncompliance with Volume 7 and the Colorado Revised Statutes.

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 were 78 policy findings from 32 reports posted between the cutoff for the 2016 CFRT Annual Report (3/31/2017) and the 2017 Annual report (3/31/2018) 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.

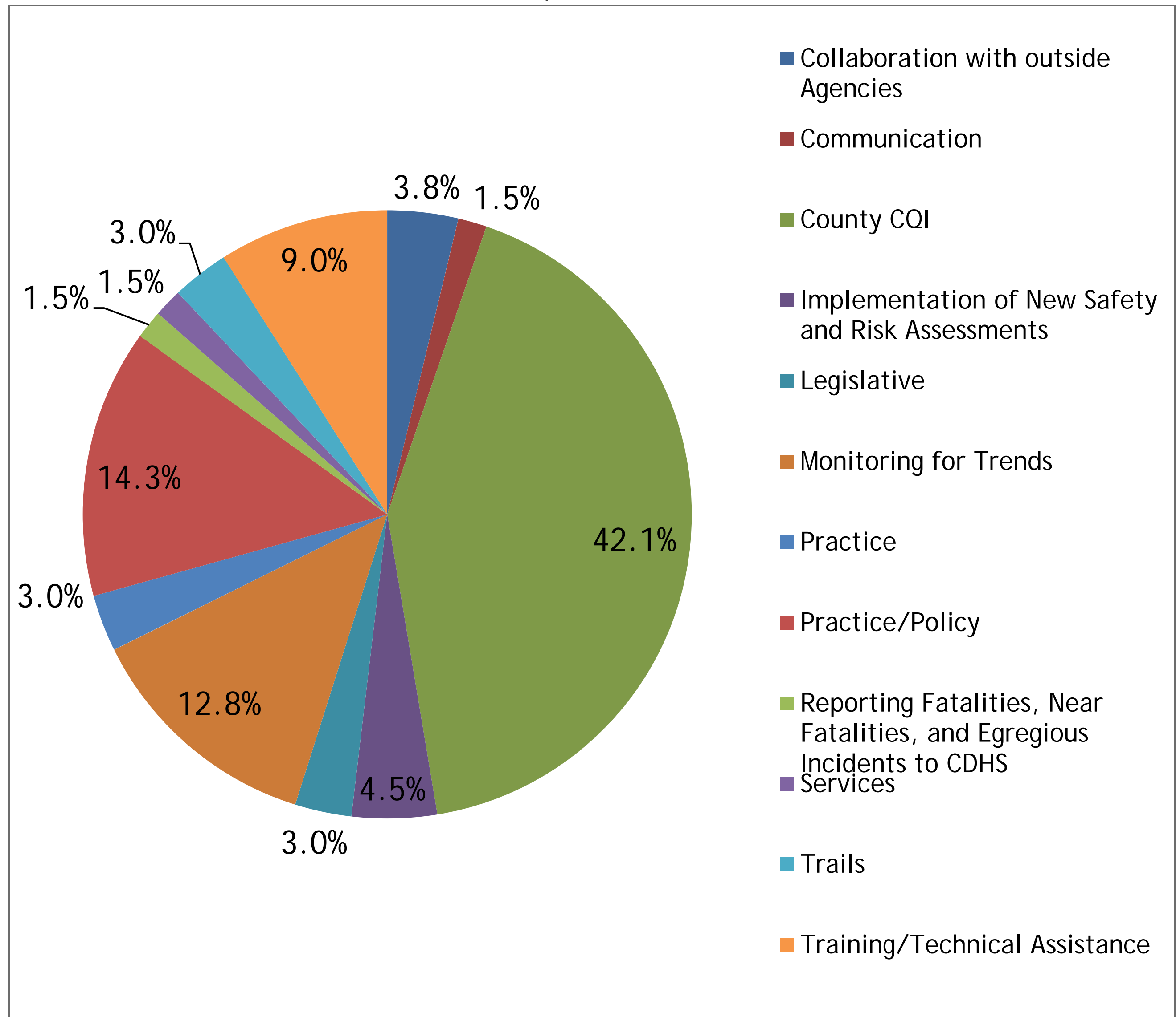
Chart 15: Policy Findings by Type



Recommendations from Posted Reports

A total of 133 recommendations were made across the 32 posted reports. This included 55 related to systemic gaps and deficiencies and 78 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) providing training and technical assistance from DCW to county departments; 5) implementation and training on revised risk/safety tools to improve accuracy.

Chart 16. Focus of Recommendations in the 32 Reports Posted Between 4/1/2017 and 3/31/2018

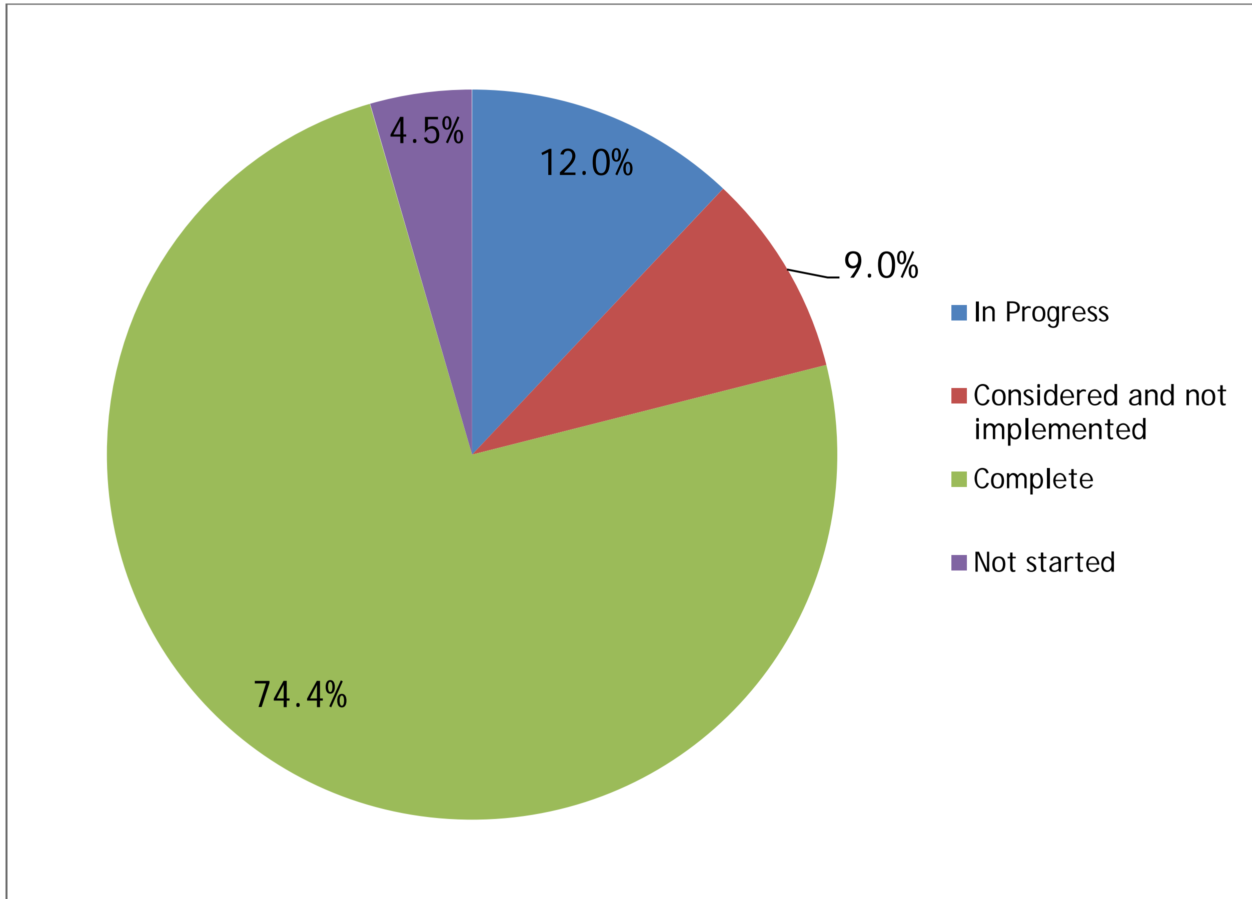


While several recommendations were reviewed in this report, the full texts of all 133 are contained in Appendix C, as well as the status of the progress on these recommendations. As illustrated in Chart 17, 74.4% of the recommendations have been completed while an additional 12.0% are in progress. For 4.9% of recommendations, the recommendations were

considered and not implemented. 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.

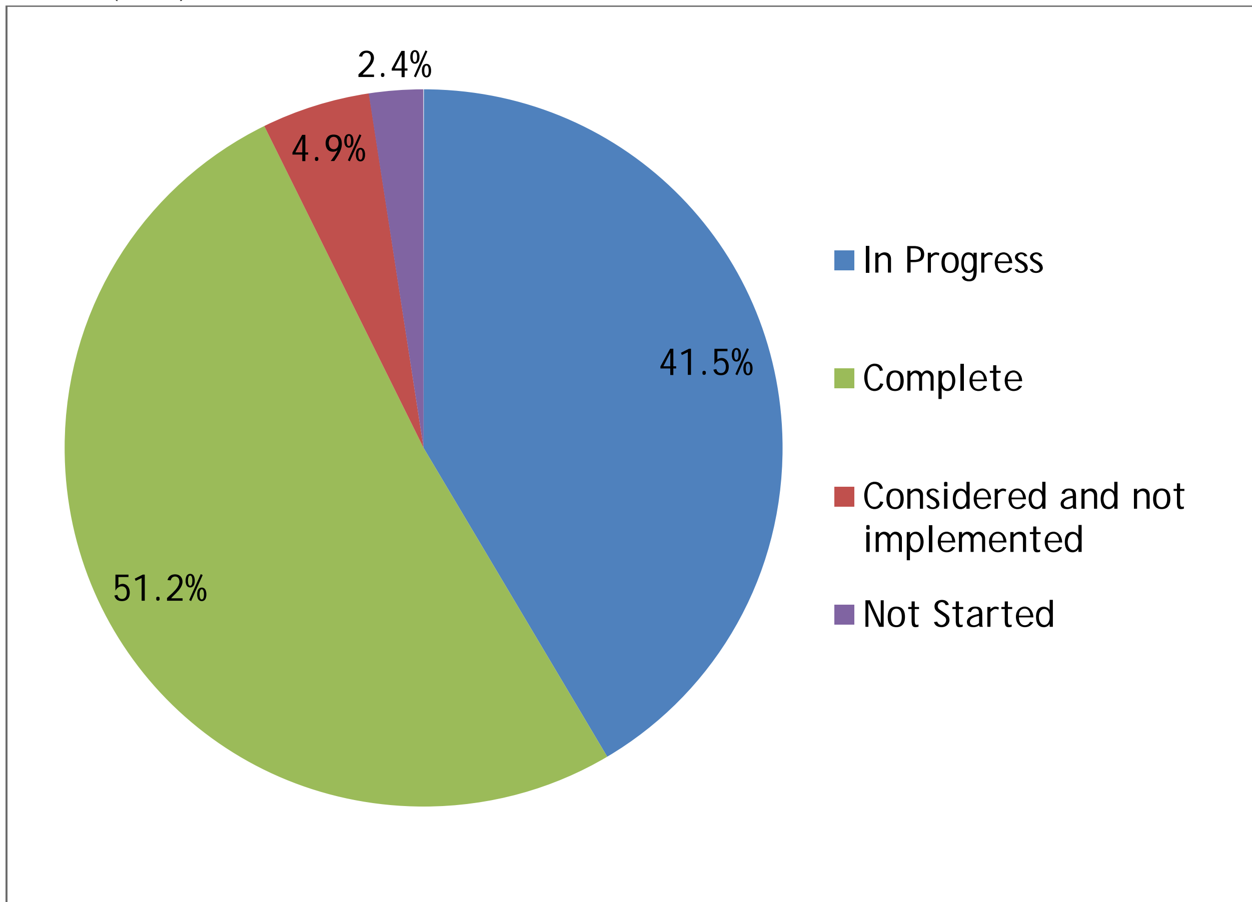
Adding recommendations to the tracking spreadsheet is an ongoing process, so some small number of them will not be started at the time of each year's annual report if the reports were just finalized and the recommendations recently added to the recommendation tracking process. This year, 4.5% of the recommendations were not started at the time of this report.

Chart 17: Status of Recommendations for Reports Posted Between 4/1/2017 and 3/31/2018 (n=133)



An update on the implementation status of the 41 recommendations presented in the 2016 CFRT Annual Report that were not completed at that time is presented in Appendix D. Since the time of the last report, an additional 51.2% of the recommendations have been completed.

Chart 18: Status of Recommendations Not Previously Completed From Reports Posted Prior to 4/1/2017(n=41)



CDPHE and CDHS Joint Recommendations to Prevent Child Maltreatment

Raise awareness and provide education to child welfare providers and community agencies on firearm safety and appropriate storage to prevent future incidents of fatal child maltreatment involving firearms.

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 (CFRT) to make joint recommendations for the prevention of child fatalities due to child maltreatment. In an effort to collaborate to identify a joint recommendation for the 2018 Legislative Report, CFRT and CDPHE completed a methodical, joint review of twenty-one fatal incidents of abuse and neglect from 2016 that were reviewed by both the CFPS and CFRT. Incidents were reviewed to identify themes and trends associated with the cause of death and surrounding circumstances of the fatal child maltreatment. The analysis revealed the most prevalent contributing factor was fatal child maltreatment by firearm among cases shared by CDHS and CFPS.

From 2012 to 2016, CFPS identified 140 deaths occurring to persons under the age of 18 where firearms were the means. Of these 140 firearms-related deaths, the majority were youth suicide deaths (66.4 percent, n=93), followed by homicides (29.3 percent, n=41), inclusive of child maltreatment deaths and other assaults. The majority of these weapons were owned by biological parents (42.9 percent, n=60), the child themselves (6.4 percent, n=9), or a stepparent (5.0 percent, n=7), while information on weapon ownership was missing in 20.7 percent (n=29) of deaths reviewed. Data on firearm storage circumstances from these deaths indicates that only 13.6 percent (n=19) of these firearms were stored locked and 15.0 percent (n=21) were stored unloaded. Whether these weapons were stored securely and unloaded was missing or unknown for 35.0 percent (n=49) and 54.3 percent (n=76) of these deaths.

Based on the CFPS data and the joint analysis of shared cases, both CFRT and CFPS endorse the recommendation to raise awareness and provide education to child welfare providers and community agencies on firearm safety and appropriate storage to prevent future incidents of fatal child maltreatment involving firearms. The following efforts will be pursued by CDPHE and CFRT as a result of this joint recommendation:

- Explore a partnership with the Child Welfare Training System to provide additional training to child welfare professionals on data associated with fatal child maltreatment and raise awareness of assessing for child access to weapons during child protection assessments.

- Provide information to prevention programs (i.e CCR, SafeCare, and home visiting programs) in an effort to educate and raise awareness regarding the importance of firearm safety and appropriate storage of weapons when there are children in the home.

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.

Appendix A: 2017 CFRT Attendance

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.*	1.9.17	2.6.17	3.6.17	4.3.17	5.1.17	6.5.17	7.10.17	8.7.17	9.11.17	10.2.17	11.6.17	12.4.17
Lucinda Wayland Connelly *CDHS, Child Protection Manager*	Yes	Yes	By phone	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes
→**Backup:** Laura Solomon	---	---	---	---	---	---	No	---	---	---	No	---
Brooke Ely-Milen *CDHS, Domestic Violence Program Director*	Yes	Yes	Yes	Yes	Yes	Yes	By phone	No	By phone	Yes	No	Yes
Allison Gonzales *Administrative Review Division, Manager*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	---	Yes	Yes	Yes
→**Backup:** Marc Mackert	---	Yes	---	---	---	---	---	---	Yes	---	---	Yes
Colleen Kapsimalis *CDPHE, Child Fatality Prevention System Program*	No	Yes	By phone									
Kate Jankovsky *CDPHE, Child Fatality Prevention System Coordinator* (appointed April 19, 2017)					No	No	Yes	Yes	No	Yes	Yes	Yes
Giorgianna Venetis *CDPHE, Essentials for Childhood Coordinator* (resigned August 30, 2017)	By phone	No	No	No	No	Yes	No	No				
Christal Garcia *CDPHE, Violence and Injury Prevention* (appointed November 16, 2017)												No
Elizabeth "Betty" Donovan *Gilpin County DHS Director (CCI appointment)*	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes	Yes
Casey Tighe *Jefferson County Commissioner*	Yes	Yes	No	Yes	By phone	No	Yes	No	Yes	Yes	Yes	Yes
Dave Potts *Chaffee County Commissioner*	By phone	Yes	Yes	Yes	Yes	Yes	No	No	No	By phone	Yes	Yes
Senator Jim Smallwood *Senate Majority Leader appointment*		No	No	No	No	No	No	No	No	No	Yes	No
Representative Jonathan Singer *House of Representatives Majority Leader appointment*	By phone	By phone	By phone	By phone	No	No	By phone	By phone	No	No	No	Yes

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.*	1.9.17	2.6.17	3.6.17	4.3.17	5.1.17	6.5.17	7.10.17	8.7.17	9.11.17	10.2.17	11.6.17	12.4.17
Melissa Vigil *Office of Colorado's Child Protection Ombudsman*	By phone	Yes	By phone	No	---	---	---	---	No	---	---	---
→**Backup:** Stephanie Villafuerte/Sabrina Burbidge (Stephanie appointed 11/27/2017)	---	---	---	No	By phone	Yes	By phone	By phone	No	By phone	By phone	By phone
Sgt. Brian Cotter *Denver Police Department*	No	No	By phone	Yes	No	Yes	No	Yes	No	No	Yes	No
Dr. Andrew Sirotnak *Professor of Pediatrics, University of Colorado School of Medicine Director, Child Protection Team at Children's Hospital Colorado*	No	By phone	Yes	By phone	Yes	No	By phone	By phone	No	By phone	Yes	No
→**Backup:** Dr. Antonia Chiesa	No	---	---	---	---	---	---	---	No	---	---	No
Leora Joseph *Chief Deputy District Attorney, 18th Judicial District* (resigned February 24, 2017)	No	No										
Amy Ferrin *Deputy District Attorney, 18th Judicial District* (appointed June 13, 2017)							Yes	By phone	No	Yes	By phone	Yes
Kathie Snell, MA, LPC *Aurora Mental Health Center, Chief Operating Officer*	Yes	Yes	No	No	Yes	Yes	No	No	---	---	Yes	Yes
→**Backup:** Mara Kailin	---	---	No	No	---	---	No	No	Yes	Yes	---	---
Susan Colling *CO Division of Probation Services, Juvenile Probation Specialist* (appointed February 24, 2017)			---	Yes	No	No	No	Yes	No	No	No	No
→**Backup:** Dana Wilks			Yes	---	No	No	No	---	No	No	No	No
Don Moseley, *Ralston House Child Advocacy Center, Director*	Yes	No	By phone	Yes	By phone	By phone	No	Yes	Yes	By phone	No	By phone
Dan Makelky, *Douglas County Department of Human Services*	---	---	Yes	---	Yes	---	---	---	---	---	---	No
→**Backup:** Ruby Richards/Nicole Becht	Yes	Yes	---	Yes	---	Yes	Yes	Yes	Yes	Yes	Yes	No

Dan Makelky, *Douglas County Department of Human Services*	---	---	Yes	---	Yes	---	---	---	---	---	---	No
Michelle Dossey *Arapahoe County Department of Human Services*	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	---
→**Backup:** Jessica Williamsen (effective October 2, 2017)	No	---	---	---	---	---	No	---	---	---	---	Yes
Shirley Rhodus *El Paso County Department of Human Services*	Yes	Yes	Yes	Yes	---	Yes	By phone	Yes	Yes	Yes	Yes	Yes
→**Backup:** Marian Percy	---	---	---	---	Yes	---	---	---	---	---	---	---
Cheryl Hyink *Administrative Review Division Staff*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Lisa Lied *Administrative Review Division Staff*	No											
James Martinez *Administrative Review Division Staff*			Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Len Newman *Administrative Review Division Staff*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Libbie McCarthy *Attorney General's Office*	Yes	---	Yes	---	---	---	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Anita Icenogle/Sarah Richelson	---	Yes	---	Yes	Yes	Yes	---	---	---	---	---	---

Appendix B: 2012-2017 Incidents Qualified for CFRT Review by County and Type

County*	Fatal Incidents						Near Fatal Incidents						Egregious Incidents						2012 Total	2013 Total	2014 Total	2015 Total	2016 Total	2017 Total
	2012	2013	2014	2015	2016	2017	2012	2013	2014	2015	2016	2017	2012	2013	2014	2015	2016	2017						
Archuleta														1	1					1	1			
Adams	2	2		2	1	2			1		3	1		3	2			1	2	5	3	2	6	4
Alamosa														1						1				
Arapahoe		2	1	1	4	1				1		2		1		2	1	1		3	1	4	2	4
Broomfield						1																		1
Boulder		1	1					1		1	2									2	1	1	2	
Chaffee						1																		1
Clear Creek			1																		1			
Denver	1	1	4	1	1		1	3	3	3	1	1		7	3	3	3	3	2	11	10	7	4	4
Douglas					1	1						1					1						1	2
Eagle	1			1															1			1		
El Paso	2	1	2		4	4		1	1	1	1	5	1		1	1	1	1	3	2	4	2	6	10
Fremont									1					1	2	1				1	3	1		
Garfield				1																		1		
Huerfano			1																		1			
Jefferson			2	2	2	3			4		1	1		2	1	3				2	7	5	4	4
La Plata					1					1		1						1				1	1	2
Larimer			1	1	1	3								4		2				4	1	3	3	3
Las Animas				1																		1		
Lincoln																1						1		
Logan	1		1																1		1			
Mesa	1		1	1	2			1		1									1	1	1	2	0	
Moffat					1						1												1	
Montezuma					1										1						1		0	
Montrose					1																		0	
Morgan			1					1	1		1							1		1	2		2	1
Otero						1	1		1										1		1			1
Park					1																		0	
Phillips		1																		1				
Pitkin															1						1			
Pueblo	1		1					1	2	1	1			1	1			1	1	2	4	1	2	1
San Miguel						1																		1
Routt			1									1					1				1		0	1
Weld		1		1		1											1			1		1	1	1
Total	9	9	18	12	21	19	2	8	14	9	11	13	1	21	13	13	8	9	12	38	45	34	35	41

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

Appendix C: Recommendations from 2017 Posted Reports

CFRT ID	Source	Recommendation	Status
17-007	CFRT	The State CFRT noted that there was an opportunity to explore rules around egregious, near fatality, and fatality assessments in regard to a previously assigned caseworker completing an assessment on an egregious, near fatality or fatality assessment.	In Progress
17-010	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 May 2017 C-Stat, DDHS's performance for March 2017, was 87.5% 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
17-039	CFRT	The CFRT recommended that the Division of Child Welfare (DCW) provide formal guidance regarding what counties should do when they have accepted a referral for assessment and then are unable to locate the family.	In Progress
17-039	CFRT	The CFRT recommended that a task-group involving staff from county departments of human/social services and law enforcement agencies develop protocol for creating a strong working relationship/communication among the agencies to facilitate better information sharing and collaboration regarding joint investigations/assessments.	In Progress
17-039	CFRT	The CFRT recommended that the Administrative Review Division's Steering Committee should consider proposing a change to the rules in Volume 7 to look at the time frames for when the internal review report has to be submitted.	Complete
17-041	CFRT	The CFRT recommended that the Administrative Review Division's Steering Committee should consider proposing a change to the rules in Volume 7 to look at the time frames for when the internal review report has to be submitted.	Complete
17-041	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 November 2017 C-Stat, Arapahoe County DHS's performance for September 2017, was 89.8% with a statewide goal of 95%. 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. It should be noted that the C-Stat statewide goal was increased from 90% to 95% in the month of November 2017.	Not Started
17-050	CFRT	It was recommended that changes to law enforcement legislation should be explored regarding mandating drug testing for any child fatality, which is suspicious for abuse or neglect.	Not Started
17-050	CFRT	It is recommended that a task-group involving staff from county departments of human/social services and law enforcement agencies develop protocol for creating a strong working relationship/communication among the agencies to facilitate better	In Progress

		information sharing and collaboration regarding joint investigations/assessments.	
17-052	Policy Finding	The policy finding related to the timeliness of notification of the fatal incident does reflect a systemic practice issue for LCHS. During the year time span from December 31, 2016, through December 31, 2017, LCHS provided timely notification to CDHS in 33.3% of incidents. It is recommended that LCHS consider creating a more formal process for recognizing and reporting fatal, near fatal, and egregious incidents of child maltreatment to CDHS.	In Progress
17-071	CFRT	It is recommended that a task-group involving staff from county departments of human/social services and law enforcement agencies develop protocol for creating a strong working relationship/communication among the agencies to facilitate better information sharing and collaboration regarding joint investigations/assessments.	Not Started
17-071	CFRT	The CFRT recommended that the Division of Child Welfare (DCW) provide formal guidance regarding what counties should do when they have accepted a referral for assessment and then are unable to locate the family.	Not Started
16-012	CFRT	It is recommended that the Colorado Child Protection Ombudsman explore having all of the Colorado municipalities report their criminal data/records to the Colorado State Courts- Data Access program.	Complete
16-012	CFRT	It is recommended that there be a discussion between County Trails User Group (CTUG) and CFRT members regarding an alert in the state automated case management system (Trails) that notifies Departments of Human Services agencies that have open cases/assessments/ referrals when a mutual client is added to another case/assessment/ referral.	In Progress
16-012	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a current systemic practice issue for Arapahoe County DHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the May, 2016 C-Stat, Arapahoe County DHS performance for March, 2016 was 85% with a statewide goal of 90%. It is recommended that Arapahoe County DHS monitor their performance on this measure to ensure they reach the statewide goal of 90%.	Complete

16-012	Policy Finding	The policy finding related to the RED Team framework not completed as required by Volume 7 is a systemic practice issue for Arapahoe 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 15, 2015 to December 15, 2015, Arapahoe County DHS included all elements required in Volume 7 42.6% 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 after the issuance of the Operational Memo. For the recent review of a random sample of assessments, supervisory approval was missing in 24 of the 54 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 80% for Arapahoe 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 15, 2015 to December 15, 2015, Arapahoe County DHS completed a RED Team as required by Volume 7, 89 % percent of the time. It is recommended that Arapahoe 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.	Complete
16-012	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. 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 March 2, 2015 to September 2, 2015, DDHS included all elements required in Volume 7, 4% of the time. 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 accurate completion of the RED Team framework as required by Volume 7 are identified and solutions to the identified barriers are implemented.	Complete

16-012	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, Douglas County DHS included all elements required in Volume 7, 31% of the time. For the recent review of a random sample of assessments, supervisory approval was missing in 14 of the 42 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 64% for Douglas County DHS. It is recommended that 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.	Complete
16-013	Policy Finding	The policy finding related to the overall finding not matching the definition, does not reflect a systemic practice issue for Montrose County DHHS. As part of routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period from October 22, 2013 to April 22, 2014, showed that Montrose County DHHS documented an accurate overall finding, 88.9 % which is below the statewide average (not including Montrose County DHHS) of 93.5 %, for the same time span. It is recommended that Montrose County DHHS monitor their performance in this area and determine any future needs for improvement.	In Progress
16-016	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 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 August 23, 2015 to February 23, 2016, ACHSD included all elements required in Volume 7, 62% 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 21assessments in this review were completed prior to the issuance of the Operational Memo. For the recent review of a random sample of assessments, supervisory approval was missing in 19 of the 50 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 100% for ACHSD. 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.	Complete

16-018	CFRT	The CFRT identified a need for child welfare caseworkers to have access to additional databases (i.e. municipal court records, NCIC, and CCIC), in order to have additional information to assist in making well-informed decisions around child safety and well-being. It is recommended that this need be further discussed and explored by Child Welfare Sub Policy Advisory Committee (Sub-PAC).	In Progress
16-018	CFRT	The CFRT recommended that the Division of Child Welfare and OIT explore expanding the rights or privileges of "Restricted Access" in the state's automated management system (Trails) in order to ensure county department of human or social services staff always have access to necessary and pertinent information.	Complete
16-018	CFRT	The CFRT discussed a need for establishing a protocol for case closure, as it pertains to additional database checks (background checks, court records etc.) It was determined that this recommendation should be further explored through conversations with Sub-PAC.	Complete
16-018	Policy Finding	The policy finding related to Pueblo County DSS not completing a RED Team framework as required by Volume 7 reflects a systemic practice issue for Pueblo County DSS. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from April 2, 2015 to October 2, 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 29 of the required RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 75% for Pueblo County DSS. As this policy finding was related to not completing a RED Team as required by Volume 7, it is recommended that Pueblo County DSS employ a process in which any 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
16-023	CFRT	It is recommended that DCW, in collaboration with stakeholders and county departments of human services, develop an additional assessment tool, which specifically addresses the unique risk factors for children ages 0-5, and provide guidance for county departments of human services on the use of this tool prior to case closure.	Considered and not implemented
16-023	CFRT	It is recommended that DCW explore adding an option or requirement for follow-up with families after case closure and/or achievement of permanency, specifically for children ages 0-5, in an effort to mitigate future incidents of child maltreatment.	Considered and not implemented

16-023	CFRT	It is recommended that DCW provide standardized practice expectations to county departments of human services related to requesting and providing courtesy supervision.	Considered and not implemented
16-023	Policy Finding	The policy finding regarding the 90-Day review/Court Report not being in Trails does reflect a systemic practice issue for Prowers County DSS. In the most recent Out-of-Home Administrative Review data for First Quarter SFY (July 1, 2016 through September 30, 2016), Prowers County DSS completed the 90-Day review/Court Report in Trails according to Volume 7, 16.7% of the time, which is below the statewide average (excluding Prowers County DSS) of 65.3% for the same time span. It is recommended that Prowers County DSS employ a process in which the barriers to completing the 90-Day review/Court report in accordance with Volume 7 are identified and solutions to the identified barriers are implemented.	In Progress
16-023	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 Mesa 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 October 5, 2015 to April 5, 2016, Mesa County DHS included all elements required in Volume 7, 56.5% of the time. Supervisory approval was missing in 13 of the 46 RED Team frameworks, which impacted the performance. 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 five assessments in this review were completed prior to the issuance of the Operational Memo. Without considering supervisor approval, performance on the RED Team framework was at 80%. It is recommended that Mesa 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.	Complete
16-049	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 April 2017 C-Stat, Arapahoe County DHS's performance for February 2017 was 88.9% 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

16-049	Policy Finding	The policy finding related to the RED Team framework not being completed when required by Volume 7 is a systemic practice issue for Arapahoe County DHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from June 25, 2016, to December 25, 2016, the assessments included all elements required in Volume 7, 40% of the time, which is below the Ten Large county average of 80.9% for the same time span. As this policy finding is related to not completing a RED Team framework when required by Volume 7, it should also be noted that Arapahoe County DHS completed a RED Team framework when required by Volume 7, 93.3% percent of the time, which is below the Ten Large county average of 97.5% for the same time span. It is recommended that Arapahoe County DHS employ a process in which barriers to the completion of holding a RED Team and completing the RED Team framework when required by Volume 7 are identified and solutions to the identified barriers are implemented.	Complete
16-056	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned 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 January 2017 C-Stat, DDHS's performance for October 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 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
16-078	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 March 2017 C-Stat, DDHS's performance for January 2017 was 88.9 % 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

16-078	Policy Finding	The policy findings related to interviewing/observing the alleged victim within the assigned response time do reflect a systemic practice issue for DDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the March 2017 C-Stat, DDHS's performance for December 2016 was 88.3%, 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 through 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
16-078	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for JCDCYF. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the March 2017 C-Stat, JCDCYF's performance for January 2017 was 87.7 % with a statewide goal of 90%. 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
16-090	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for EPCDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the March 2017 C-Stat, EPCDHS's performance for January 2017 was 85.4% with a statewide goal of 90%. It is recommended that EPCDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete
16-094	Policy Finding	The policy finding related to the timeliness of notification of the fatal incident does reflect a systemic practice issue for the County DSS. During calendar year 2016, the County DSS provided timely notification to CDHS in 0% of incidents. It is recommended that the County DSS consider creating a more formal process for recognizing and reporting fatal, near fatal, and egregious incidents of child maltreatment to CDHS.	In Progress
16-094	Policy Finding	The policy finding related to the quality of the monthly contacts with children does reflect a systemic practice issue in the County DSS. In a recent review of a generalizable random sample of In-Home cases that were open during a period from September 17, 2015 to May 17, 2015, the County DSS completed quality monthly contacts with the child in 54% of the cases. It is recommended that the County DSS employ a process in which barriers to the quality monthly contacts with children are identified and solutions to the identified barriers are implemented.	Not Started

16-094	Policy Finding	The policy finding related to all parties not being included in the Family Services Plan treatment plan does reflect a systemic practice issue for the County DSS. In a recent review of a generalizable random sample of In-Home cases that were open during a period from September 17, 2015 to May 17, 2015, the County DSS included all required parties in the Family Services Plan treatment plan 29% of the time. It is recommended that the County DSS employ a process in which the barriers to including all required parties in the treatment plan are identified and solutions to the identified barriers are implemented.	Not Started
16-102	CFRT	It is recommended that the processes related to IART, specific to review findings, feedback, and or recommendations be reviewed and/or restructured in order to ensure necessary and relevant information from the review is communicated back to the appropriate county department of human and/or social services staff. Having an effective feedback loop and quality assurance process is critical and necessary to ensure children/youth's safety and well-being in institutional settings.	In Progress
16-102	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 Arapahoe County DHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from June 25, 2016 to December 25, 2016, Arapahoe County DHS included all RED Team elements required in Volume 7, 40% of the time, which is below the statewide average (not including Arapahoe County) of 80.9% for the same time span. It should be noted, 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 Arapahoe County DHS employ a process in which barriers to including all required elements of the RED Team are identified and solutions to the identified barriers are implemented.	Complete
16-105	CFRT	It is recommended that DCW provide formal guidance to county departments of human/social services regarding practice expectations concerning requirement for responding to reports of concern regarding a fatality, which is suspicious for abuse or neglect, and there are no surviving siblings.	In Progress

16-105	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for EPCDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the April 2017 C-Stat, EPCDHS's performance for February 2017 was 88.6% with a statewide goal of 90%. It is recommended that EPCDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete
15-011	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
15-011	CFRT	Regarding reviews of prior DYC involvement: - It is recommended that 26-1-139 be amended to specifically include current and prior DYC involvement for fatalities, near fatalities and egregious incidents equally as the statute requires prior county human services involvement.	In Progress
15-011	CFRT	It is recommended that DYC develop policy to include the completion of an internal review and submission of the internal review report when a youth with prior or current DYC commitment is involved in incidents of fatalities, near fatalities, and/or egregious events.	In Progress
15-011	Policy Finding	The Policy Findings related to inaccurate documentation of the Colorado Family Risk Assessment tool 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 December 28, 2014 to June 28, 2015, Arapahoe County DHS completed the risk assessment tool accurately in 40% of assessments, which is below the statewide average (not including Arapahoe County DHS) of 57.2% 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 tool are identified and solutions to the identified barriers are implemented. It is also recommended that Arapahoe County DHS complete the new risk assessment tool training when it becomes available.	Complete
15-011	Policy Finding	Arapahoe County DHS should review their practice to determine if there is a systemic practice issue for assigning fatal, near fatal and egregious incidents to caseworkers who do not have prior involvement with the family. If a systemic issue is identified, Arapahoe County DHS should implement a process to ensure that individuals assigned to assess fatal, near fatal and egregious incidents do not have any prior involvement with the family.	Complete
15-011	Policy Finding	The Policy Finding related to timeliness of assessment closure does reflect a current systemic practice issue for Arapahoe County DHS. The August C-Stat report, which measures the percentage of assessments closed within sixty days, shows Arapahoe County DHS at 67.3% for High Risk Assessments for June, 2015, which is below the statewide average of 87.1% and below the C-Stat 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

15-011	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 from December 28, 2014 to June 28, 2015, showed that Arapahoe County DHS interviewed all required parties 60% of the time, which is below the statewide average (not including Arapahoe County DHS) of 86.7% for the same time span. It is recommended that Arapahoe County DHS monitor their performance on this measure to ensure others who may have information regarding the alleged maltreatment are interviewed.	Complete
15-011	Policy Finding	The Policy Finding related to the inaccurate 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 December 28, 2014 to June 28, 2015, Arapahoe County completed the Safety Plan accurately in 40% of assessments, which is below the statewide average (not including Arapahoe County DHS) of 52.7% for the same time span. 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. It is recommended that Arapahoe County DHS complete the new safety assessment tool training when it becomes available.	Complete
15-019	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 implement	Complete
15-019	CFRT	It is recommended that DCW explore jurisdiction definitions and expectations around circumstances where assessments involve multiple counties.	Considered and not implemented
15-019	CFRT	It is recommended that county invite involved law enforcement and district attorneys to the CFRT meetings for their specific case.	Complete
15-019	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 Adams County Human Services Department 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 22, 2014 to April 21, 2015, showed that Adams County Human Services Department interviewed all required parties 83.6%, which is below the statewide average (not including Adams County Human Services Department) of 89.2% for the same time span. It is recommended that Adams County Human Services Department monitor their performance on this measure to ensure improvement.	Complete

15-019	Policy Finding	The Policy Finding related to the safety assessment tool does reflect a systemic practice issue in Adams County Human Services Department. In a recent review of a random sample of assessments that were conducted during a period from August 22, 2014 to April 21, 2015, Adams County Human Services Department completed the safety assessment accurately in 86.8% of assessments, which is above the statewide average (not including Adams County Human Services Department) of 77.9% for the same time span and below the C-Stat goal of 95%. It is recommended that Adams County Human Services Department 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 recommended that Adams County Human Services Department complete the new safety assessment tool training in accordance to Volume VII 7.107.1.	Complete
15-019	Policy Finding	The Policy Findings related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in Adams County Human Services Department. In a recent review of a random sample of assessments that were conducted during a period from August 22, 2014 to April 21, 2015, Adams County Human Services Department completed the risk assessment tool accurately in 66% of assessments, which is above the statewide average (not including Adams County Human Services Department) of 58.8% for the same time span. Due to the low level of performance on this measure, it is recommended that Adams County Human Services Department 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 Adams County Human Services Department complete the new Colorado Family Risk Assessment tool training in accordance to Volume VII 7.107.1.	Complete
15-019	Policy Finding	The Policy Finding related to seeing the alleged victim within the assigned response time does reflect a systemic practice issue for Adams County Human Services Department. According to the most recent C-Stat presentation for the month of July, which reflects data from June, Adams County Human Services Department is interviewing the alleged victim within the assigned response time 85.7% 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 August 22, 2014 through April 21, 2015, showed Adams County Human Services Department at 67.3% for observing/interviewing the alleged victim within the assigned response time and 83.6% for making reasonable efforts to observe/interview the alleged victim within the assigned response time. It is recommended that Adams County Human Services Department monitor their performance on this measure to ensure they maintain the State goal of 90%.	Complete
15-027	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

15-027	CFRT	It is recommended that DCW work with the Child Welfare Training Academy on specific training of caseworkers on documentation about abuse/neglect when law enforcement has an ongoing investigation.	Complete
15-027	CFRT	It is recommended that CDHS, Administrative Review Division provide training to County Department of Human Services regarding the definition and assessment of near fatal incidents.	Complete
15-027	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 cases to be opened from one assessment when such a split is warranted.	Complete
15-027	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 August 1, 2014 to March 31, 2015, EPCDHS assigned the appropriate response time in accordance with Volume VII 85.2% of the time, which is below the statewide average of 95% for the same time span. It is recommended that EPCDHS monitor their performance on this measure to ensure improvement.	Complete
15-027	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 August 1, 2014 to March 31, 2015, EPCDHS completed the risk assessment tool accurately in 50.9% of assessments, which is below the statewide average (not including EPCDHS) of 59.1% 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, and it is recommended that EPCDHS participate in the training and implementation of the new tool.	Complete
15-042	CFRT	It is recommended that the CDHS DVP explore the expansion of community-based domestic violence services in Lincoln County.	Considered and not implemented
15-042	Policy Finding	Through the CFRT review process, it was determined that there was a lack of clarity, agreement, and understanding between Douglas County DHS and Lincoln County DHS regarding the initial response to the July 18, 2015 referral. This resulted in the policy finding related to the children not being interviewed within the assigned response time. It is recommended that Lincoln County DHS and Douglas County DHS have further discussions internally and jointly regarding the factors that contributed to the lack of clarity around the initial response. Based on the information learned from these discussions, Douglas County DHS and Lincoln County DHS will each employ a process in which the barriers to timely response as outlined in 7.104.1 (B) (1) are identified and solutions to the identified barriers are implemented.	Complete

15-042	Policy Finding	Through the CFRT review process, it was determined that there was a lack of clarity, agreement, and understanding between Douglas County DHS and Lincoln County DHS regarding the initial response to the July 18, 2015 referral. This resulted in the policy finding related to the children not being interviewed within the assigned response time. It is recommended that Lincoln County DHS and Douglas County DHS have further discussions internally and jointly regarding the factors that contributed to the lack of clarity around the initial response. Based on the information learned from these discussions, Douglas County DHS and Lincoln County DHS will each employ a process in which the barriers to timely response as outlined in 7.104.1 (B) (1) are identified and solutions to the identified barriers are implemented.	Complete
15-042	Policy Finding	There is a lack of quantitative data to support if the assignment of caseworkers on fatal, near fatal and egregious maltreatment incidents to caseworkers who do not have prior involvement with the family is a systemic practice issue in Lincoln County DHS. Lincoln County DHS should review their practice to determine if there is a systemic practice issue for assigning fatal, near fatal and egregious incidents to caseworkers who do not have prior involvement with the family. If a systemic issue is identified, Lincoln County DHS should implement a process to ensure that individuals assigned to assess fatal, near fatal and egregious incidents do not have any prior involvement with the family.	In Progress
15-042	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 Lincoln 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 November 14, 2014 to May 14, 2015, Lincoln County included all 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. It should be noted that the assessment/referral in this review were completed prior to the issuance of the Operational Memo. For the recent review of a random sample of assessments, documentation of supervisory approval was missing in 10 of the 10 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 20%. It is recommended that Lincoln County 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
15-059	CFRT	It is recommended that the Division of Child Welfare (DCW) define what constitutes a conflict of interest case and establish a protocol when there is a conflict of interest case.	Considered and not implemented
15-059	CFRT	It is recommended the DCW assess whether they should identify additional exceptions to the current rule for referrals that require a RED team.	Complete

15-059	CFRT	It is recommended that the DCW provide further training and guidance on RED teams with extensive family history with DHS.	Complete
15-059	CFRT	It is recommended that DCW work with the Child Welfare Training Academy to provide training around gathering information from collaterals and use of the information provided to make informed decisions rather than relying solely on a child(ren)'s disclosure.	Considered and not implemented
15-059	CFRT	It is recommended DCW work with the Child Welfare Training Academy to better assist caseworkers in assessing for child maltreatment through better interviewing skills while continuing to engage the family.	Complete
15-059	CFRT	It is recommended that DCW develop a handout to provide to families regarding potential consequences of what could happen when the media becomes involved.	Considered and not implemented
15-059	CFRT	Additionally, DCW and the Attorney General's office should look into the privacy rights of Child Abuse victims getting the same protection as rape victims regarding media coverage.	Considered and not implemented
15-059	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 required FSP: 5A in 64% of the cases, which is slightly 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 Reports are identified and solutions to the identified barriers are implemented	Complete
15-059	Policy Finding	The policy finding related to selecting the inaccurate reason for not accepting the referral for assessment does reflect a systemic practice issue in DDHS. During the 2014 Administrative Review Screen-Out Review which was conducted between September 22 and September 26, 2014 and included screened-out referrals from February, 2014 through July, 2014, the DDHS selected the correct reason for not accepting a referral for assessment 80.4% of the time which is below the estimated statewide performance of 82.4%. It is recommended that DDHS monitor their performance with the accurate selection of the screen-out reason.	Complete
15-065	CFRT	The CFRT recommended that the Child Protection Task Group (CPTG) develop a workgroup to review and determine the need for further guidance and clarification regarding the Internal Review process, including timing and expectations.	Complete
15-088	CFRT	The CFRT recommended that DCW work with the Child Welfare Training Academy to determine specific requirements or guidelines regarding the forty-hours of mandatory training a caseworker must obtain on an annual basis for their caseworker certification.	Considered and not implemented
15-088	CFRT	DCW should further define "educational neglect" in Volume 7 to better assist county departments of social services in making assigning decisions for referrals alleging educational neglect.	In Progress
15-088	CFRT	It is recommended that DCW, the CDHS Domestic Violence Program (DVP) and the Child Welfare Training Academy develop and implement Phase II of the domestic violence training across the state to caseworkers.	Complete
15-088	CFRT	It is recommended that DCW and the DVP consider adding a specialized domestic violence expert certification for caseworkers.	Considered and not implemented

15-088	CFRT	It is recommended that DCW consider adding domestic violence as one of the required training subject matters for annual caseworker certification.	Considered and not implemented
15-088	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, DDHS 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 in October 2015. It should be noted that all of the assessments in the recent review were 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
15-088	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for DDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provides the basis for C-Stat data, DDHS' performance for January 2016 was 88.3% 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 2, 2015 to September 2, 2015, showed DDHS at 72.7% 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 DDHS monitor their performance on this measure to ensure they reach the State goal of 90%.	Complete
15-088	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 provides the basis for C-Stat data, Arapahoe County DHS' performance for February 2016 was 89.6% with a statewide goal of 90%. It is recommended that Arapahoe County DHS monitor their performance to ensure they reach the statewide goal of 90%.	Complete

15-088	Policy Finding	The policy finding related to the assessment containing the required content does not 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 June 15, 2015 to December 15, 2015, showed that Arapahoe County DHS' assessments contained the required content 81.8% of the time. It is recommended that Arapahoe County DHS monitor their performance on this measure and determine any future needs for improvement.	Complete
15-088	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 Arapahoe 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 prior to 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 15, 2015 to December 2, 2015, Arapahoe County DHS included all elements required in Volume 7 42.6% of the time. For the recent review of a random sample of assessments that were conducted during a period from June 15, 2015 to December 15, 2015, supervisory approval was missing in 24 of the 54 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 80% for Arapahoe County DHS. As this policy finding was related to not completing a RED Team when required, it is recommended that Arapahoe 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.	Complete
14-052	CFRT	It is recommended that DCW continue working with all counties to develop a Memorandum of Understanding (MOU) between the county and the law enforcement agencies within that county to manage issues of communication in times of crisis, background checks and family pets. ECDHHS worked with the law enforcement in their area to educate them to notify DHHS when law enforcement removes and places children.	Complete
14-052	CFRT	It is recommended that the ARD update the Fatality Review Website to include a section specifically for county staff regarding the CFRT process.	Complete
14-052	Policy Finding	The policy finding related to reasonable efforts to interview the younger cousin and spouse does reflect a systemic practice issue for ECDHHS. 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 26 2013 to December 26, 2013, showed that ECDHHS interviewed all required parties 82.9% of the time, which is below the statewide average (not including ECDHHS) of 86.1% for the same time span. It is recommended that ECDHHS monitor their performance on this measure to ensure improvement.	Complete

14-052	Policy Finding	The policy finding related to reasonable efforts to interview the younger cousin and spouse does reflect a systemic practice issue for PCDHHS. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of October 24, 2013 to April 24, 2014, showed that PCDHHS interviewed all required parties 76.5% of the time, which is below the statewide average (not including PCDHHS) of 89.3% for the same time span. It is recommended that PCDHHS monitor their performance on this measure to ensure improvement.	Complete
14-054	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
14-054	CFRT	The DCW should explore developing a training to help caseworkers learn how to search, review and create historical timelines. Having a good understanding of the family's history and correlating it with what is happening with the family in the present will better inform our understanding of and the decisions we make around the safety and risk concerns of all of the children and all parents involved.	Complete
14-054	Policy Finding	The policy finding related to the timeliness for the risk assessment tool does reflect a systemic practice issue in DDHS. In a recent review of a random sample of assessments that were conducted during a period from April 8, 2014 to October 8, 2014, DDHS completed the risk assessment tool timely in 83.3% of assessments, which is below the statewide average (not including DDHS) of 91.4% for the same time span. It is recommended that DDHS employ a process in which barriers to the timeliness of the Colorado Family Risk Assessment tool are identified and solutions to the identified barriers are implemented. Additionally, the new Colorado Family Risk Assessment tool will be implemented by the State in 2015, and it is recommended that DDHS participate in the training and implementation of the new tool.	Complete
14-054	Policy Finding	The policy finding related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in DDHS. In a recent review of a random sample of assessments that were conducted during a period from April 8, 2014 to October 8, 2014, DDHS completed the risk assessment tool accurately in 55.6% of assessments, which is slightly below the statewide average (not including DDHS) of 59.3% 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. Additionally, the new Colorado Family Risk Assessment tool will be implemented by the State in 2015, and it is recommended that DDHS participate in the training and implementation of the new tool.	Complete

14-054	Policy Finding	The policy finding related to the timeliness for 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 April 8, 2014 to October 8, 2014, DDHS completed the safety assessment tool timely in 87% of assessments, which is below the statewide average (not including DDHS) of 92.4% for the same time span. It is recommended that DDHS employ a process in which barriers to the timeliness of the Colorado Safety Assessment tool are identified and solutions to the identified barriers are implemented. Additionally, the new Colorado Safety Assessment tool will be implemented by the State in 2015, and it is recommended that DDHS participate in the training and implementation of the new tool.	Complete
14-054	Policy Finding	The policy finding 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 slightly 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, the new Colorado Family Risk Assessment tool 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
14-054	Policy Finding	The policy finding related to inaccurate documentation of the Colorado Family Risk Assessment tool 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 January 27, 2014 to July 27, 2014, the Arapahoe County DHS completed the risk assessment tool accurately in 68.5% of assessments, which is above the statewide average (not including Arapahoe County DHS) of 59% 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 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 Arapahoe County DHS participate in the training and implementation of the new tool.	Complete
14-054	Policy Finding	The policy finding related to FAR service phase does reflect a systemic practice issue in Arapahoe County DHS. During the month of November 2014, Arapahoe County DHS completed 88.7% of the FAR Assessments within 60 days. The statewide performance for the same time frame was 90.3%. a. It is recommended that Arapahoe County DHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are enacted.	Complete

14-054	Policy Finding	b. It is recommended that DCW continue to monitor county performance regarding the timelines of assessment closure and engage with Arapahoe County DHS as necessary to ensure improved performance in this area.	Complete
14-054	Policy Finding	Currently, there is no mechanism in Trails by which to measure county compliance in regards to whether or not referrals are correctly transferred between the receiving county and the responsible county. It is important to note rule 7.202.4 was changed as of March 2, 2013 to include a timeframe in which the referral must be entered into Trails and transferred to the responsible county. Rule regarding the transfer of referrals between counties is now 7.202.4 (I) rather than 7.202.4 (G) and states the following, "If a county department receiving a referral determines that another county has responsibility, the receiving county department shall forward the referral to the responsible county department as soon as possible, but no longer than eight (8) hours of determining responsibility, by entering the referral into the State automated case management system. The receiving county department shall make personal contact with the responsible county to verify receipt of the referral." It is recommended that the DCW identify a mechanism by which to measure compliance with the new policy regarding the transfer of referrals.	Complete
14-070	CFRT	It is recommended that DCW explore a Volume 7 change regarding observing/interviewing alleged victims of egregious or near fatal incidents, who are safe in the hospital, within the assigned response time.	Complete
14-070	Policy Finding	The policy finding related to timeliness of assessment closure does not reflect a current systemic practice issue for PCDSS. The January 2016 C-Stat report, which measures the percentage of assessments closed within 60 days, shows PCDSS at 88.9% for November 2015. It is recommended that PCDSS monitor their performance on this measure to ensure reaching or exceeding the state goal of 90%.	Complete
14-070	Policy Finding	The policy finding related to not entering a new allegation as a referral does reflect a systemic practice issue in PCDSS. In a recent review of Out-of-Home Reviews that were conducted during a period from July 1, 2015 to September 30, 2015, PCDSS entered new allegations as a referral 81.3% of the time, which is below the statewide average, not including PCDSS of 97.4%. It is recommended that PCDSS monitor their progress on this measure to ensure improvement.	Complete
14-070	Policy Finding	At the time of authoring this report, PCDSS's most recent review of Out-of-Home cases was completed using an instrument that did not include the policy finding related to a parent not receiving the services that were identified as being needed through ongoing assessment. Therefore, there is no data available to support whether this is a systemic practice issue for PCDSS. It is recommended that PCDSS monitor their performance on this measure to ensure that they are providing services that were identified as being needed through ongoing assessment.	Complete

14-070	Policy Finding	The policy finding related to not addressing all on-site inspection non-compliance issues does reflect a systemic issue for PCDSS. In a recent review conducted February 23-25, 2016 of the initial certification of licensed foster homes in PCDSS shows that PCDSS addressed all on-site inspection non-compliance issues 75% of the time. It is recommended that PCDSS monitor their progress on this measure to ensure improvement.	Complete
14-070	Policy Finding	The policy finding related to meeting the SAFE home study interview requirements does reflect a systemic issue for PCDSS. A recent review conducted February 23-25, 2016 of the initial certification of licensed foster homes in PCDSS shows that PCDSS met the SAFE home study interview requirements 64% of the time. It is recommended that PCDSS implement a process in which barriers to meeting SAFE home study interview requirements are identified and solutions to the identified barriers are implemented.	Complete
14-070	Policy Finding	The policy finding related to the SAFE home study not containing the required content for the background of the family for provider one does reflect a systemic issue for PCDSS. A recent review conducted February 23-25, 2016 of the initial certification of licensed foster homes in PCDSS shows that PCDSS' SAFE home study contained the required content for the background of the family for provider one 50% of the time. It is recommended that PCDSS implement a process in which barriers to the SAFE home study containing the required content for the background of the family for provider one are identified and solutions to the identified barriers are implemented.	Complete
14-070	Policy Finding	The policy finding related to the SAFE home study not containing the required content for the background of the family for provider two does reflect a systemic issue for PCDSS. A recent review conducted February 23-25, 2016 of the initial certification of licensed foster homes in PCDSS shows that PCDSS' SAFE home study contained the required content for the background of the family for provider two 60% of the time. It is recommended that PCDSS implement a process in which barriers to the SAFE home study containing the required content for the background of the family for provider two are identified and solutions to the identified barriers are implemented.	Complete
14-080	CFRT	CFRT recommends all emergency doctors complete a mandatory reporter training and child maltreatment training in order for them to identify signs of child abuse. It is recommended that the Division of Child Welfare (DCW) consult with the Child Protection Team (CPT) at Children's Hospital of Colorado (CHC) to ensure the emergency doctors statewide are trained or are aware of being able to consult the CPT at CHC.	Complete
14-080	CFRT	The CFRT recommended that the CDHS utilize the publicity campaign for the Statewide Child Abuse and Neglect Reporting Hotline to also advertise the new Mandatory Reporter Training, which is available to the public.	Complete
14-080	CFRT	In January 2015, the DCW acquired additional secondary trauma training and consultation services that all counties can access, which include two voluntary pilot opportunities for more intensive secondary trauma training and consultation. The CFRT recommended that DCW explore the possibility of adding the secondary trauma pilot program being utilized in Jefferson County DCYF to the resources available to counties.	Complete

13-033	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 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
13-033	Policy Finding	The policy finding indicating that Adams County notified the Colorado Department of Human Services of the egregious incident four days late does reflect a systemic practice issue in this county department at the time of this referral. During calendar year 2013, Adams County provided timely notification to CDHS in 12.5% (1/8) of incidents. It is recommended that Adams County create a more formal process for recognizing and reporting fatal, near fatal, and egregious incidents of child maltreatment to CDHS within twenty-four hours of the incident.	Complete
13-033	Policy Finding	The policy violation related to accurate completion of the Colorado Family Risk Assessment in Adams County does reflect a systemic practice issue in this county department. In a recent review of a random sample of assessments that were conducted during a period from 9/26/2012 to 3/26/2013, the county department completed the risk assessment accurately in 64.8% of assessments. While this is above the statewide average of 56.9% for the same time span, it is recommended that Adams County employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented.	Complete
13-033	Policy Finding	As part of ongoing quality improvement, Adams County has implemented a process to ensure that referrals which have been assigned as a "callback" or for "further information gathering" are addressed by the receiving screening supervisor to review the information and determine disposition. As part of routine quality assurance monitoring, data from the "2012 Screen-Out Review" conducted 9/24/2012 to 9/28/2012 indicated that Adams County appropriately screened out referrals 90.0% of the time. It is recommended that Adams County consult data from the "2013 Screen-Out Review," when the data is finalized, to determine if barriers to accurately screening out referrals need to be examined and solutions need to be implemented.	Complete
13-033	Policy Finding	The policy violation related to timeliness of assessment closure reflects a current systemic practice issue for Denver County. 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 Denver County is currently closing 87.6% of their assessments on time. This number is above the statewide average for September 2013 of 83.7%, but is also below the statewide goal of 90.0%. It is recommended that Denver County employ a process in which barriers to the timely closure of assessments are identified and solutions to the identified barriers are implemented.	Complete

13-033	Policy Finding	It is recommended that DCW continue to engage with Denver County through the C-Stat process to monitor progress on this measure.	Complete
13-033	Policy Finding	The policy violation related to accurate completion of the Colorado Family Risk Assessment in Denver County does reflect a systemic practice issue in this county department. In a recent review of a random sample of assessments that were conducted during a period from 10/10/2012 to 4/10/2013, the county department completed the risk assessment accurately in 41.8% of assessments, which is below the statewide average of 60.9% for the same time span. It is recommended that Denver County employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented.	Complete
13-044	CFRT	It is recommended that the Division of Child Welfare (DCW) begin to offer training to county staff related to trauma-informed therapy for families dealing with domestic violence issues, which would include training regarding the familial dynamics associated with trauma and domestic violence. It was noted that the Domestic Violence Management Board (DVMB) could offer potential trainings for case work staff through the CDHS training site, or that this could be addressed in the training academy. It is suggested that DCW investigate implementing trauma-based assessments in all counties, and that DCW reach out to counties who are already using these assessments to help develop statewide implementation	Complete
13-044	CFRT	It is recommended that the Division of Child Welfare (DCW) begin to address and write rules and statute for PA4 referrals and cases, taking into account empirical evidence and best practice.	Complete
13-044	CFRT	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
13-044	Policy Finding	The policy violation regarding the Pueblo County case worker not making monthly contact with the maternal grandmother of the children does reflect a systemic practice issue in this county department. In a recent review of a random sample of in home cases that were open for services between 11/13/2012 and 5/13/2013, the county department made contact with the caregiver/guardian/kin according to Volume VII requirements 73.0% of the time. While this is above the statewide average of 56.0% for roughly the same time span, this is an Area for Improvement. It is recommended that Pueblo County employ a process in which barriers to monthly contacts with parents and caregivers are identified and solutions to the identified barriers are implemented.	Complete
13-044	Policy Finding	Based on the most recent C-Stat data for October 2013, Pueblo County is currently closing 76.4% of their assessments within 60 days. This number is below the statewide average for October 2013 of 86.2 %, and is also below the goal of 90.0%. It is recommended that Pueblo County employ a process in which barriers to the timely closure of assessments are identified and solutions to the identified barriers are implemented.	Complete
13-044	Policy Finding	It is recommended that DCW continue to engage with Pueblo County through the C-Stat process to monitor progress on this measure.	Complete

13-044	Policy Finding	For High Risk referrals received by Jefferson County between July 1, 2013 and December 31, 2013, 68.6% required an extension (i.e., were open longer than 30 days). This is slightly above the statewide average of 66.3% for the same time span. Of those requiring an extension, an extension was requested within 30 days of the opening of the referral 29% of the time. The statewide average during this time span was 45.3%. It is recommended that Jefferson County employ a process in which barriers to the timely use of extensions for assessments needing to be open longer than 30 days are identified and solutions to the barriers are implemented.	Complete
13-044	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
13-044	Policy Finding	The policy violation related to accurate completion of the Colorado Family Risk Assessment in Jefferson County does reflect a systemic practice issue in this county department and statewide. In a recent review of a random sample of assessments that were conducted during a period from 2/21/2013 to 8/21/2013, the county department completed the risk assessment accurately in 82.1% of assessments, which is above the statewide average of 60.7% for the same time span. However, this is still an Area for Improvement. It is recommended that Jefferson County employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented.	Complete
13-044	Policy Finding	The policy violation related to the Jefferson County Department of Human Services not making contacts with all of the child's caregivers per Volume VII requirements does reflect a systemic practice issue in this county department. In a recent review of a random sample of in-home cases that were open between 2/21/2013 and 8/21/2013, the county department made contact with all of the required caregivers according to Volume VII requirement 64.0% of the time, which is above the statewide average of 53.0% for roughly the same time span. The quality of contacts with the mother/guardian/kin was sufficient to address issues pertaining to the safety, permanency, and well-being of the child and to promote achievement of case goals 88.0% of the time for in-home cases open between 2/21/2013 and 8/21/2013 in Jefferson County. The quality of contacts with the father/guardian/kin was sufficient to meet these goals 78.0% of the time for the same sample of in-home cases. It should be noted that Jefferson County had an agreement with Garfield County indicating that Garfield County would provide courtesy supervision for the child and caregivers on alternating months. It is recommended that Jefferson County employ a process in which barriers to the frequency of contact with all caregivers per Volume VII requirements are identified and solutions to the identified barriers are implemented.	Complete

13-044	Policy Finding	It is recommended that the DCW continue to monitor county performance regarding the frequency of contact with all caregivers and engage with Jefferson County as necessary to ensure improved performance in this area.	Complete
13-044	Policy Finding	As overall state performance for the frequency of contact with caregivers was low (53%), it is recommended that DCW examine policy and practice related to this area, implementing any changes deemed necessary for improvement.	Complete

Appendix D: Status Update for Recommendations from Previously Posted Reports

CFRT ID	Source	Recommendation	Status
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."	Complete
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.	Complete
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.	In Progress
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

16-028	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 DDHS. 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 September 26, 2015 to March 26, 2016, the DDHS included all elements required in Volume 7, 58% of the time. For the recent review of a random sample of assessments, supervisory approval was missing in 13 of the 50 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 84% for the DDHS. It is recommended that the DDHS 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.	Complete
16-028	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 Arapahoe 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 15, 2015 to December 15, 2015, the Arapahoe County DHS included all elements required in Volume 7, 42.6% of the time. For the recent review of a random sample of assessments, supervisory approval was missing in 24 of the 54 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 80% for the Arapahoe County DHS. It is recommended that the Arapahoe 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.	Complete

16-028	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 JCDCYF. 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 July 31, 2015 to January 31, 2016, the JCDCYF included all elements required in Volume 7, 64 % of the time. For the recent review of a random sample of assessments, supervisory approval was missing in 13 of the 55 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 78% for JCDCYF. It is recommended that JCDCYF 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.	Complete
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.	Complete

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.	Complete
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
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.	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.	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
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.	Considered and not implemented
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

15-038	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.	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
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
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
15-049	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.	In Progress

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.	Complete
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.	Considered and not implemented
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.	Complete
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.	Complete
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.	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.	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.	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.	Complete
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.	Complete
14-089	CFRT	It is recommended that DCW work with Trails to develop a way for DHS staff to research foster families and gain a complete and accurate picture, ensuring educated decisions can be made around the placement for children.	In Progress
14-089	CFRT	DCW should explore how to handle situations where a county DHS agency decides to no longer place children in a foster home due to that county's concern about the foster family so that other counties can become aware of those concerns and make more educated decisions.	In Progress
14-089	Policy Finding	The policy finding related to 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	Complete

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.	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.	Complete
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
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. Assupported 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. ProgramArea 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 andneeds 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 helpparents develop increased coping skills and more appropriate responses to difficult behavior in their children.	In Progress
15-038	Policy Finding	DYC Policy re: 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