COLORADO
Department of Human Services

The Honorable Jared Polis
Governor of Colorado
135 State Capitol
Denver, CO 80203

June 28, 2019

Dear Governor Polis,

The Colorado Department of Human Services, in accordance with the statutory responsibility established through 26-1-139, C.R.S., submits the attached "2018 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,

M. Barnes

Michelle Barnes Executive Director

cc:
Senator Rhonda Fields, Chair Senate Health and Human Services Committee
Representative Jonathan Singer, Chair House Public Health Care and Human Services Committee
Representative Dafna Michaelson Jenet, Vice-Chair
Representative Yadira Caraveo
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Senator Jim Smallwood
Senator Faith Winter
Elizabeth Haskell, Committee Staff

Members of the Child Fatality Review Team
Members of the Colorado State Child Fatality Prevention Review Team
Jeremy Hill, Deputy Executive Director, Administrative Solutions, CDHS
Jerene Petersen, Deputy Executive Director of Community Partnerships, CDHS
Minna Castillo Cohen, Office Director, Children Youth and Families, CDHS
Rob Jakubowski, Division Director, Performance and Strategic Outcomes, CDHS
Marc Mackert, Director, Administrative Review Division, CDHS
Emily Hanson, Legislative Liaison, CDHS

2018 Child Maltreatment Fatality Annual Report

COLORADO
Division of Quality Assurance & Quality Improvement
Administrative Review Division

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Executive Summary

The 2018 Colorado Department of Human Services (CDHS) Child Fatality Review Annual Report focuses on data gathered from fatal, near fatal, and egregious incidents of child maltreatment that occurred in calendar year (CY) 2018. In CY 2018, there were 77 children involved in 71 substantiated fatal, near fatal, and egregious incidents of child maltreatment. The data provides an overview of the trends, characteristics and demographics of children and families involved with such incidents, and is presented in an effort to better understand and identify the factors associated with such incidents of abuse or neglect. From the group of 77 children in 71 substantiated fatal, near fatal, and egregious incidents of child maltreatment occurring in CY 2018, 41 children in 37 incidents met statutory criteria for a review by the CFRT.

The 2018 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. Through the years of reviewing incidents of fatal, near fatal, and egregious incidents of child maltreatment, we have learned that mitigating such incidents of child maltreatment is a community responsibility. The field of child welfare is often tasked with and represented as having the sole responsibility, and ability, to prevent such tragedies from occurring. While child welfare is responsible for intervening with families when there is an allegation of child abuse or neglect, and providing appropriate and necessary services to families in order to keep children safe, all systems and communities have a responsibility to help make families in our community healthier and more resilient.

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, some sections within this report also summarizes information from incidents which occurred in 2017 and 2018, and reviewed by the CFRT and/or posted to the public notification website in 2018.

Child Characteristics. 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. In Colorado, 30.6% (11/36) of the fatalities involved victims younger than one year old, and 66.7% (24/36) were three or younger.

A similar pattern of younger-aged victims exists for the near fatalities, as 42.1% (8/19) of the victims were under the age of one, and 68.4% (13/19) were age three or under (see Chart 7). The pattern of the age of victims of egregious incidents has followed its own trend within Colorado - the age of victims of egregious incidents were older than those victims most commonly associated with fatal and near fatal incidents of child maltreatment; however, in CY 2018, 63.6% of victims were three or younger.

For fatalities, near fatalities, and egregious incidents in 2018, most victims were White, and this closely resembles the race estimates for Colorado's overall population. For fatalities, most victims were White (41.6%), followed by Hispanic (30.5%). For near fatal incidents, the most victims were White (47.3%), and again, followed by Hispanic (31.6%). For egregious

incidents, most victims were White (33.3%), with the second most common race of victims being African American (22.7%).

In Colorado in 2018, males accounted for 55.6% of the children in substantiated child maltreatment fatalities. Males typically have a higher rate of child fatality by abuse and neglect; however, in Colorado, females surpassed male victims in CY 2016 and CY 2017.

Family Characteristics. In 2018, 40.3% (31/77) of all children in fatal, near fatal, and egregious incidents of child maltreatment lived in a household with two parents (see Chart 9). This family structure was also the most frequent for incidents occurring in 2015, 2016 and 2017. The second most common type of family structure across all substantiated incidents in 2018 was one parent and one unrelated caregiver at 27.3% (21/77). Approximately 41.7% (15/36) of fatal incidents occurred for children in families with two parents.

Prior Involvement with Child Protective Services. In 2018, the most common level of prior and/or current involvement with the child welfare system, for egregious, near fatal, and fatal incidents of child maltreatment, was a prior and/or current assessment. In 2018, 81.3% (13/16) of families involved with a fatal incident of child maltreatment had prior and/or current assessment. Near fatal incidents in 2018 fell in line with trends for prior and/or current involvement in fatal incidents of child maltreatment, with assessments as the most common level of prior and/or current involvement with the child welfare system (7/10; 70%). 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, was also a prior/current assessment (6/11; 54.5%), followed by a current/prior case (5/11; 45.5%).

Other Family Stressors. Of the families involved in a fatal child maltreatment incident, which met criteria for review by the CFRT, 31.6% (6/19) had some history of identified domestic violence. Additionally, 31.6% (6/19) of the families experienced substance abuse issues, and 36.8% (7/19) included a history of mental health treatment for at least one caregiver.

Perpetrator Relationship. A child's caregiver is most often the perpetrator of a fatal incident of child maltreatment and it usually involves one or two parents. National data trends mark the mother as the most common perpetrator of a fatal incident of child maltreatment. In Colorado, for CY 2018, the mother was the most common perpetrator in fatal, near fatal, and egregious incidents of child maltreatment. The father was the second most common perpetrator, and the third most common perpetrator was a partner of parent (male).

Findings and Recommendations. Across the 37 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 44 systemic strengths in the delivery of services to children and families. A total of 58 recommendations were made across the 37 reports posted between 4/1/2018 and 3/31/2019; this included 28 related to systemic gaps and deficiencies and 30 related to policy findings.

Background

Legislative History

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). 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 2013 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.

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.

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 seven years.

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	62^^^	25	20	108^^^^
2018	64	21	22	107

**Not all incidents reported 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.
^^^There were two additional fatalities, that occurred in 2017, but were not initially determined to be suspicious for abuse or neglect, and reported, until after the finalization of the 2017 Annual Report.
^^^^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.

Table 2 provides an overview of the overall number of substantiated incidents, by type, since 2012. The numbers reflect all fatal, near fatal, and egregious incidents that were determined to be the cause of abuse or neglect, regardless of whether or not there was prior child welfare history preceding the fatal, near fatal, and/or egregious incident of child maltreatment.

Table 2: Total Statewide Substantiated Incidents

Year	Fatal Incidents	Near Fatal Incidents**	Egregious Incidents**	Total Incidents
2012	26	9	2	37
2013	23	15	34	72
2014	23	22	23	68
2015	21	15	19	55
2016	35	20	16	71
2017	31	20	18	69
2018	34	18	19	71

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 2018. The data integrity checks identified 60 potential incidents. Of those incidents, five incidents involving five children met criteria for public notification. Two incidents, involving two 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.

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 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 3 offers a comparison of incidents meeting criteria for review over the past seven years. It is important to reiterate that as the statutory and definitional changes over the prior years (2012-2014) have modified the population of incidents requiring review, there are limitations to interpretation of trends in past data.

Table 3: 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	18^^^	13	9	41^^^^
2018	16	10	11	37

**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 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 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 fatal incident number is different from what was published in the 2017 Child Maltreatment Fatality Report as one incident was determined not to be substantiated at the fatal severity level; therefore lowering the overall total of fatal incidents that met criteria by one.
^^^^The total incident number for 2017 is different from what was published in the 2017 Child Maltreatment Fatality Report as one incident was determined not to be substantiated at the fatal severity level; therefore lowering the overall total of incidents that met criteria by one.

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, 28.9% (31/107) incidents that occurred in 2018 were afforded at least one extension, with the total number ranging from one to fifteen extensions.

Incidents Reviewed in 2018

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 2018, the CFRT was able to review 34 incidents. It is important to note not all incidents are reviewed within the calendar year in which they occurred.

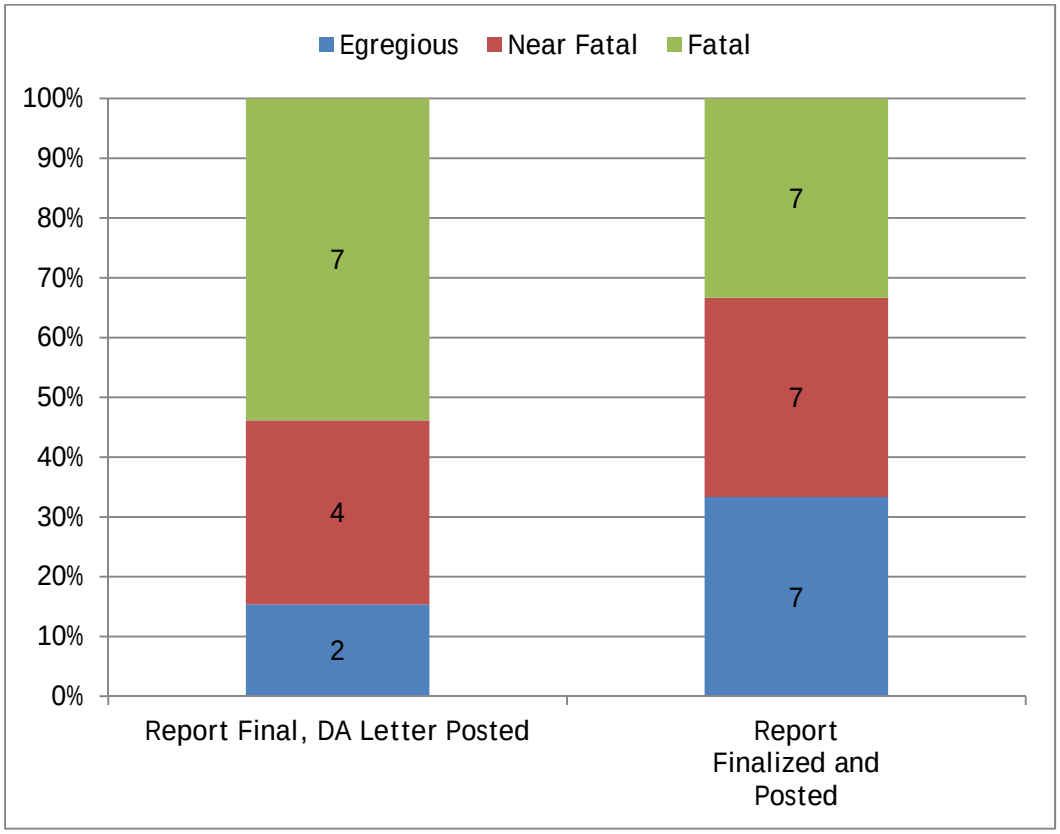
Completion and Posting of Case Specific Executive Summary Reports

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 2018. Of the 34 incidents reviewed, final non-confidential case executive summary reports were posted for 21 of them. For the remaining 13 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.

Chart 1: Report Status of all Incidents Reviewed by the CFRT in 2018.



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,

and CFRT staff are involved with and participate on CFPS workgroups and state review meetings. 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.

2018 Child Fatality Review Team Annual Retreat

In October of 2018, ARD hosted the fourth Annual Retreat. During the retreat, the CFRT reflected upon the previous year's reviews, and evaluated strengths and areas needing improvement in the review process. The CFRT reviewed recently published guidance from the National Center for Child Death Review and Prevention regarding criteria for child death reviews. Additionally, the CFRT explored a systems model approach for child death reviews and how this approach could serve as a framework for the CFRT meetings. 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 2017 reviews and incidents.

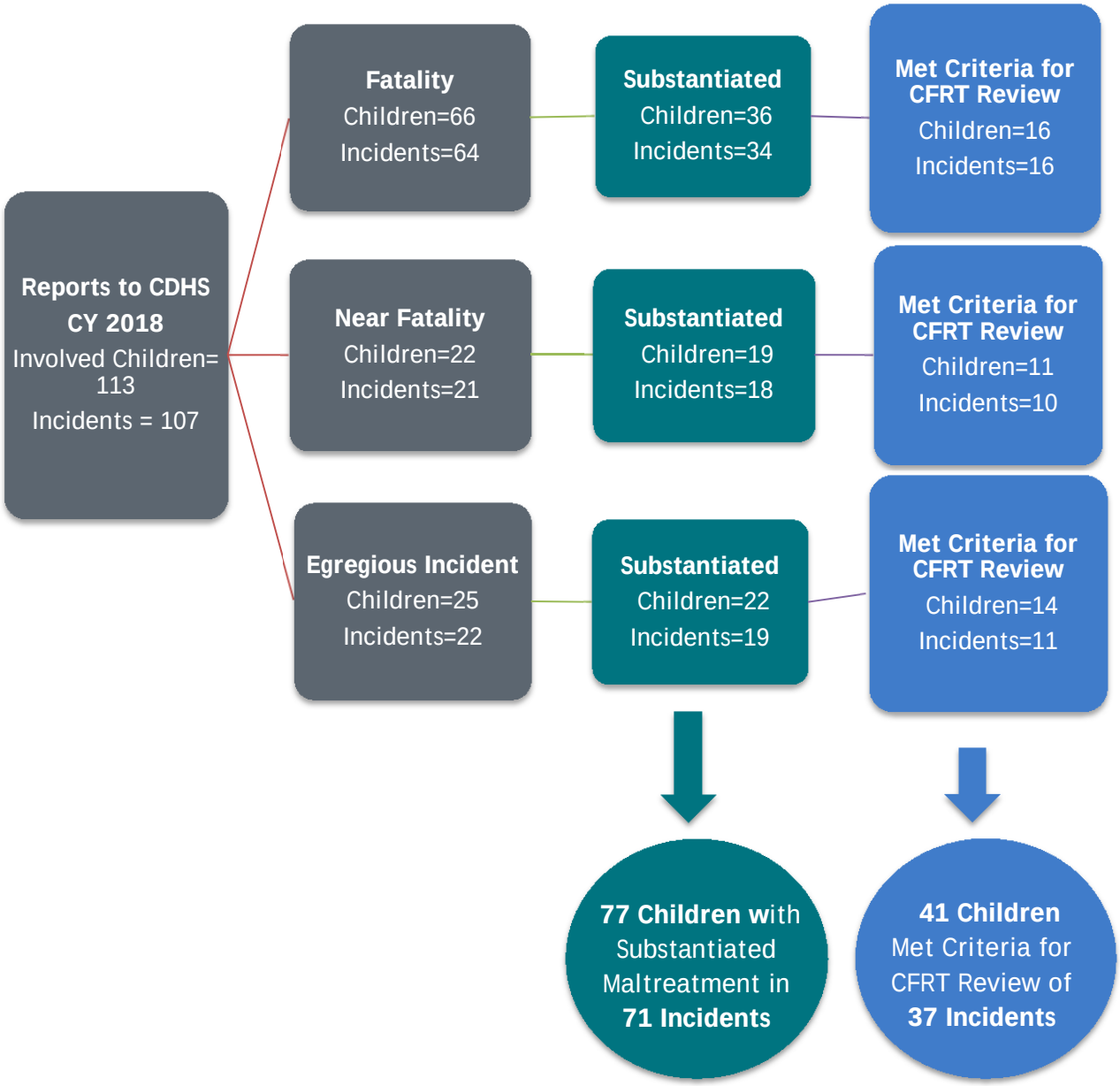
Overview of the 2018 Reports of Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment Victims

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 2018, counties reported 107 incidents involving 113 children who were suspected victims of fatal, near fatal, or egregious child maltreatment. Of the 113 children, 66 children were associated with 64 fatal incidents, 22 children were associated with 21 near fatal incidents, and 25 children were associated with 22 egregious incidents.

Upon completion of an assessment, DHS found that 36 incidents involving 36 children were 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 2018, 71 substantiated incidents included 77 children, 37 of which 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 2018. 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 2018



For purposes of this report, the majority of the analysis in the following section focuses on the 77 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 77 substantiated victims of incidents that occurred in CY 2018.

Table 4: Summary information of all 87 substantiated victims of child maltreatment fatalities, near fatalities, and egregious incidents in Colorado for CY 2018

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Victim at Time of Incident	Less than one	18	30.6%	10	42.1%	9	36.4%
	One	3	11.1%	3	5.3%	0	13.6%
	Two	6	16.7%	4	0.0%	2	9.1%
	Three	2	8.3%	4	21.1%	1	4.5%
	Four	2	5.6%	2	10.5%	1	4.5%
	Five	1	2.8%	1	5.3%	0	0.0%
	Six	0	0.0%	1	5.3%	0	0.0%
	Seven	2	5.6%	0	0.0%	0	0.0%
	Eight	3	8.3%	1	5.3%	0	0.0%
	Nine	2	5.6%	0	0.0%	0	0.0%
	Ten	0	0.0%	0	0.0%	0	0.0%
	Eleven	1	2.8%	0	0.0%	2	9.1%
	Twelve	0	0.0%	0	0.0%	2	9.1%
	Thirteen	0	0.0%	0	0.0%	1	4.5%
	Fourteen	1	2.8%	0	0.0%	0	0.0%
	Fifteen	0	0.0%	1	5.3%	0	0.0%
	Sixteen	0	0.0%	0	0.0%	2	9.1%
	Seventeen	0	0.0%	0	0.0%	0	0.0%
Race/Ethnicity	African American	3	8.3%	2	10.5%	6	27.3%
	White	15	41.7%	9	47.4%	7	31.8%
	Hispanic	11	30.6%	6	31.6%	4	18.2%
	Multiracial	4	11.1%	2	10.5%	3	13.6%
	Unknown	1	2.8%	0	0.0%	0	0.0%
Sex	Female	16	44.4%	13	68.4%	7	31.8%
	Male	20	55.6%	6	31.6%	15	68.2%
Family Structure	One parent	9	25.0%	2	10.5%	3	13.6%
	One parent and one related caregiver	0	0.0%	1	5.3%	0	0.0%
	One parent and one unrelated caregiver	8	22.2%	5	26.3%	8	36.4%
	Two parents	15	41.7%	8	42.1%	8	36.4%
	Two parents and relatives	1	2.8%	1	5.3%	1	4.5%
	One parent and relatives	3	8.3%	1	5.3%	2	9.1%
	One related caregiver	0	0.0%	1	5.3%	0	0.0%
Incidents with Additional Family Stressors*	Substance Abuse	4	28.6%	3	30.0%	6	31.6%
	Mental Health	5	35.7%	4	40.0%	7	36.8%
	Domestic Abuse	5	35.7%	3	30.0%	6	31.6%

**This is counted at the family level.*

Data and Demographics

Within the field of child welfare, studies have indicated a number of factors related to maltreatment, including 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." Nationally, for FFY17, 1,720 children were victims of fatal abuse and neglect. 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 2017) 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 case management 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. As an example, if a child's race/ethnicity was entered into Trails as White with Hispanic ethnicity, the child was considered Hispanic. This matches an approach proposed by the United States (US) Census Bureau. The US Census Bureau[2] estimated race and ethnicity data from population estimates for Colorado in 2018. The estimates indicated that Colorado's population in 2018 was 68.3% White (alone, not reporting another race/ethnicity), 21.5% Hispanic, and 4.5% Black or African American. The balance of the population estimates included ethnicities including American Indian, Asian, Native Hawaiian, Native American, etc.

For fatalities, near fatalities, and egregious incidents in 2018, most victims were White, and this closely resembles the race estimates for Colorado's overall population. For fatalities,

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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. (2019). Child maltreatment 2017. Available from https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment.

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

most victims were White (41.7%), then followed by Hispanic (30.6%). For near fatal incidents, most victims were White (47.3%), and again, followed by Hispanic (31.6%). For egregious incidents, most victims were White (36.4%), with the second most common race of victims being African American (22.7%). The following chart is a graphic depiction of race/ethnicity breakdown.

Chart 3: Race/Ethnicity of 77 victims in all Substantiated Fatal, Near fatal, and Egregious Incidents of Child Maltreatment in Colorado for CY 2018

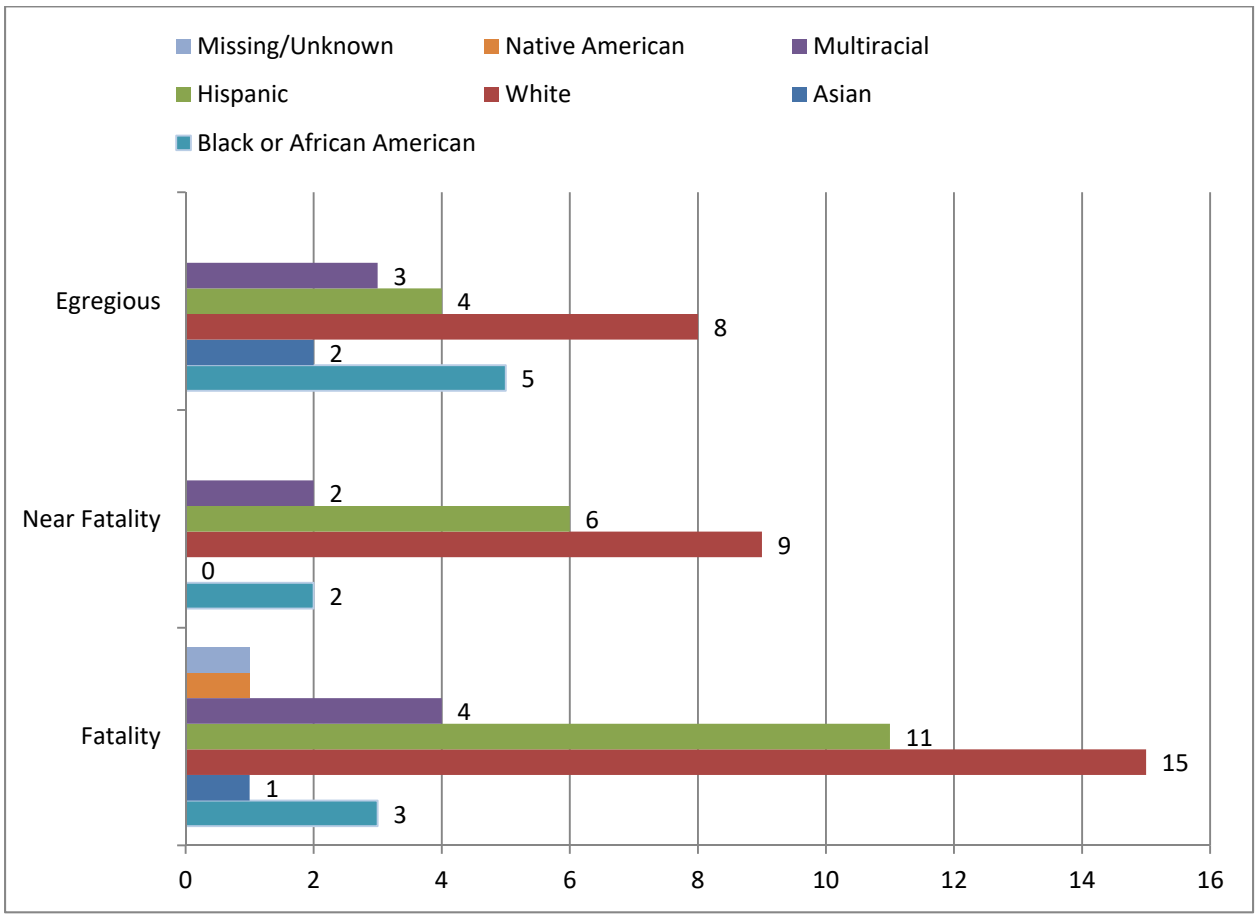
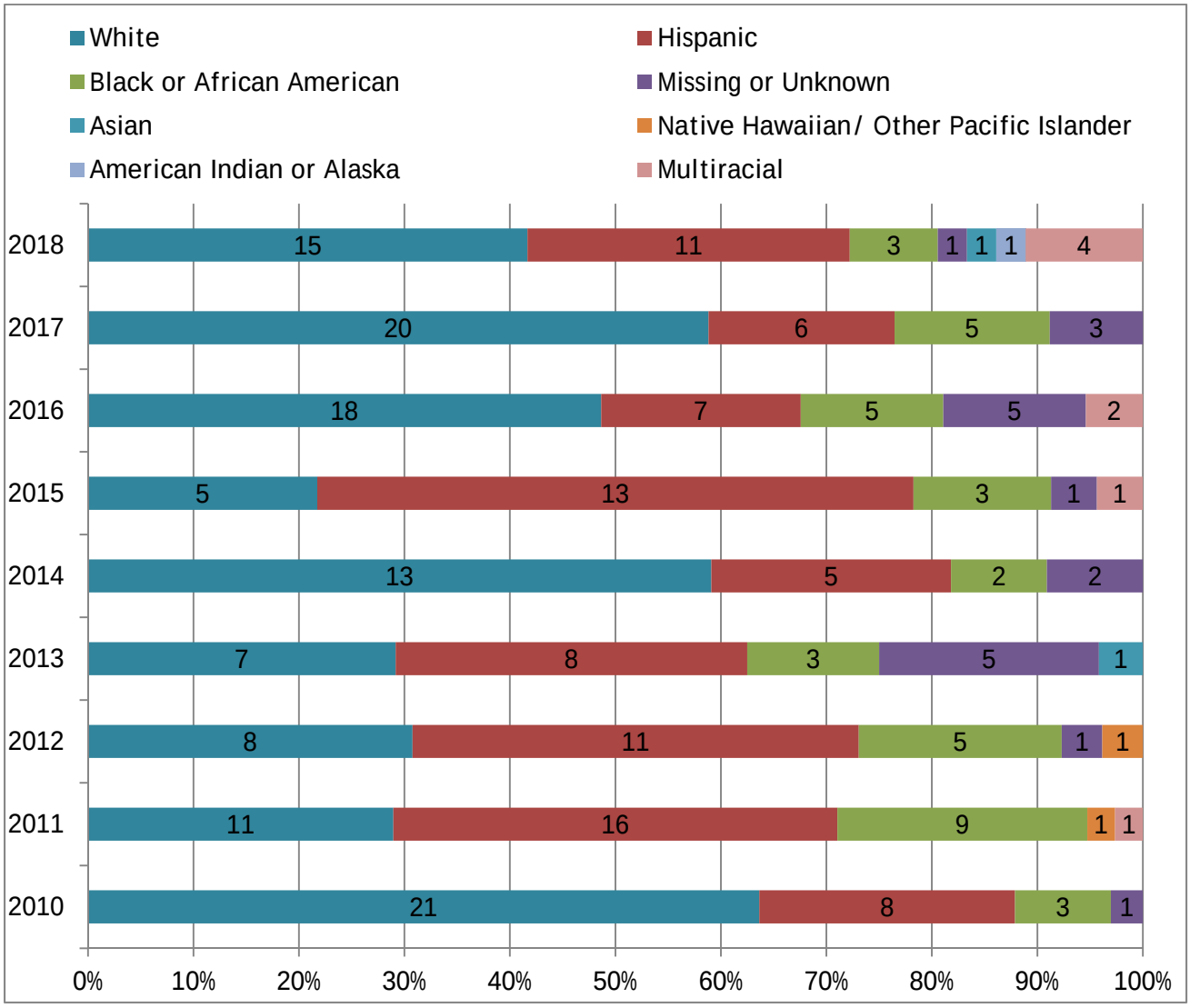


Chart 4 shows the trends related to the most common race/ethnicity of all child maltreatment fatalities in Colorado from 2010-2018. For Colorado's population trends, Hispanic child victims were disproportionality represented in fatal incidents during the years of 2011, 2012, 2013, and 2015. The chart depicts the three most common race/ethnicities of children involved in fatal incidents of abuse and neglect as being of either White, Hispanic, or African American race/ethnicity, which also mirrors national trends.

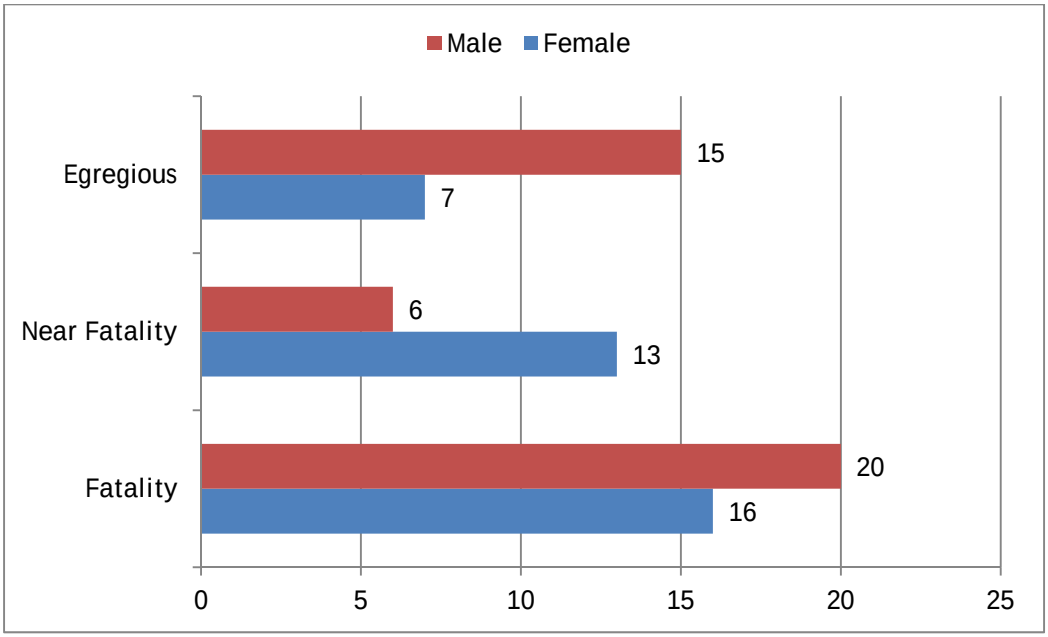
Chart 4: Race/ethnicity of Victims in all Substantiated Child Maltreatment Fatalities in Colorado over the Past Nine Calendar Years



Sex of victim

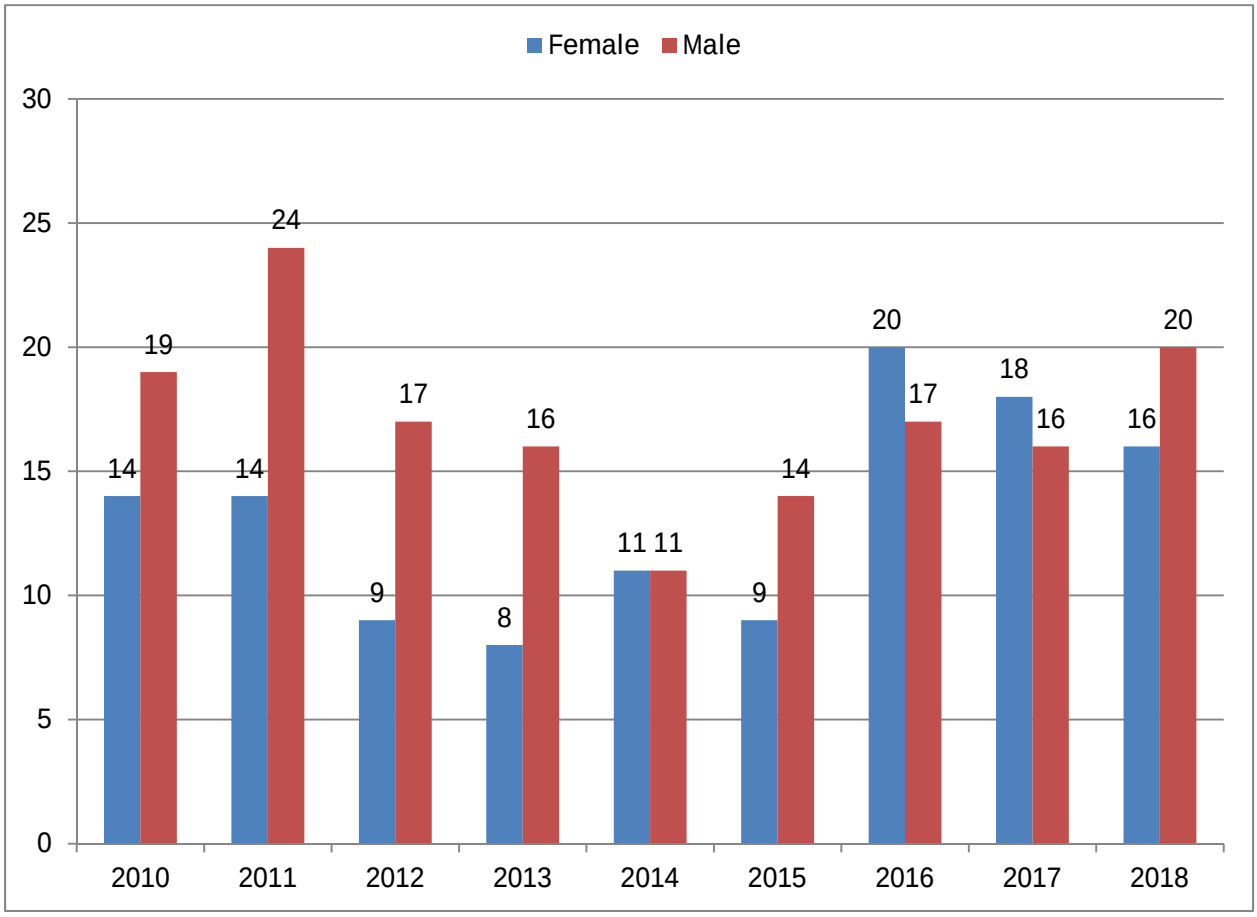
In Colorado in CY 2018, males accounted for 55.6% of the children in substantiated child maltreatment fatalities. Nationally, in FFY 2017, 57.9% of victims in child maltreatment fatalities were males. Chart 5 displays the breakdown of differences in the sex of the victims for the 77 victims involved in substantiated incidents of fatal, near fatal, and egregious incidents of abuse and neglect in CY 2018.

Chart 5: Sex of 77 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado for CY 2018



Males typically have a higher rate of child fatality by abuse and neglect; however, in Colorado, females surpassed male victims in CY 2016 and CY 2017. In 2018, males were the majority of victims in child maltreatment fatalities. Chart six demonstrates the trends of sex of victims involved in all substantiated child maltreatment fatalities in Colorado over the last nine years.

Chart 6: Sex of Victims in all Substantiated Child Maltreatment Fatalities in Colorado over the Past Nine 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 continues to show that victims of fatal child maltreatment incidents tend to be younger, as 49.6% were under the age of 1, and 71.8% of all victims of child fatalities were age three or younger. Colorado's trends appear to follow the national trends. As displayed in Chart 7, 30.6% (11/36) of the fatalities involved victims younger than one year old, and 66.7% (24/36) were three or younger.

A similar pattern of younger-aged victims exists for the near fatalities, as 42.1% (8/19) of the victims were under the age of one, and 68.4% (13/19) were age three or under (see Chart 7). The pattern of age of victims of egregious incidents has followed its own trend within Colorado- the age of victims of egregious incidents were older than those victims most commonly associated with fatal and near fatal incidents of child maltreatment; however, in CY 2018, 63.6% of victims were three or younger.

Chart 7: Age of 77 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2018

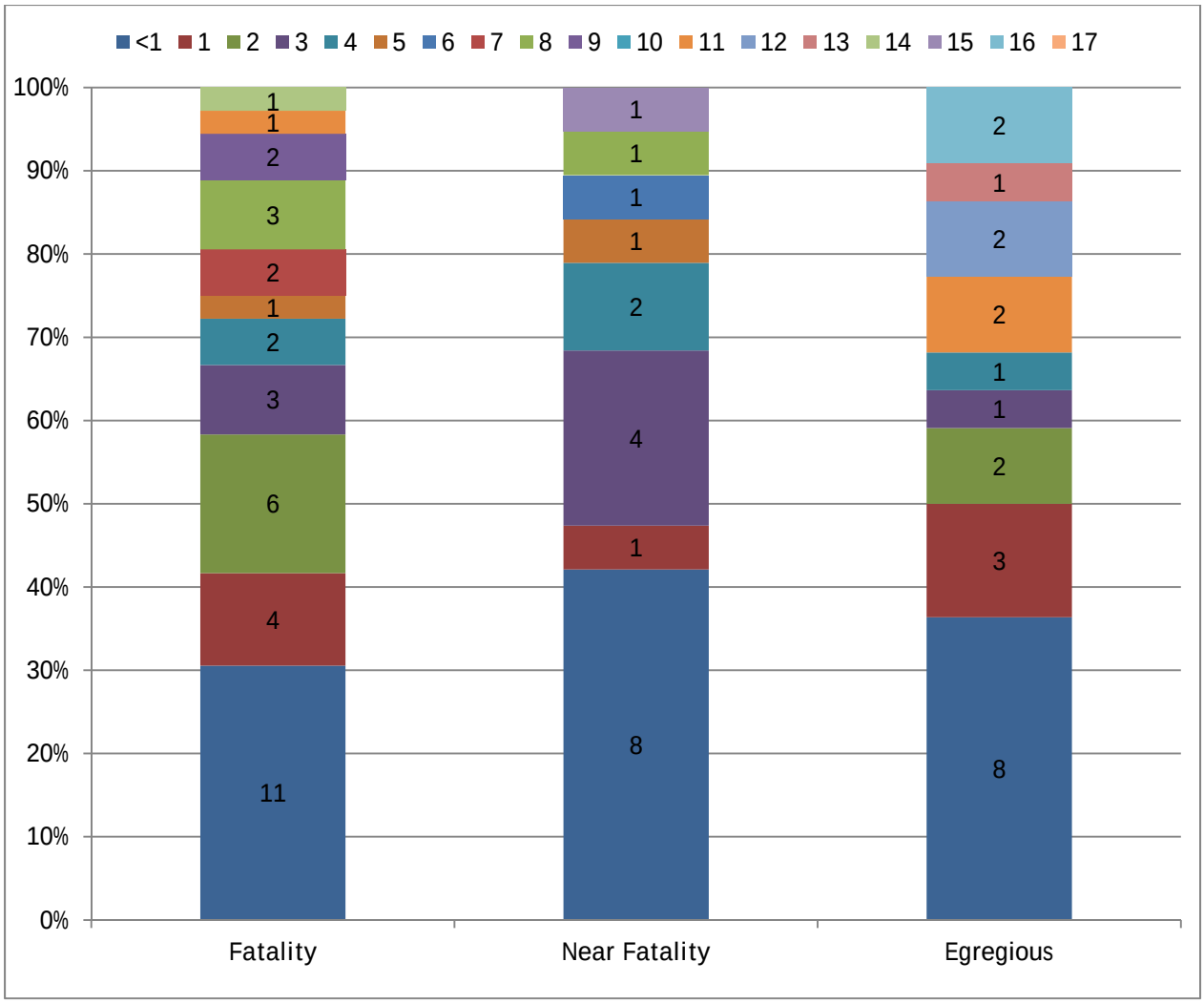
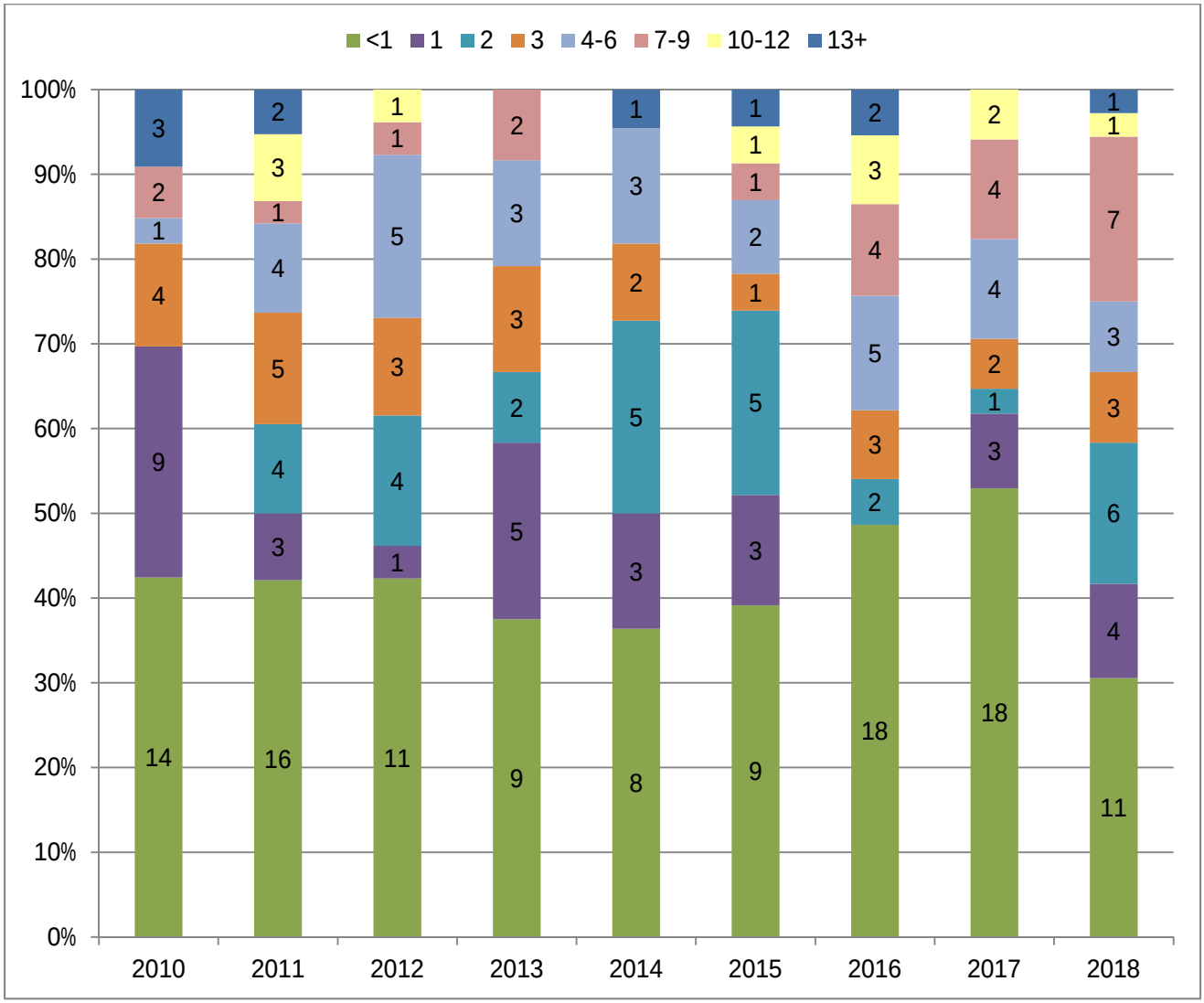


Chart 8 displays the trends in ages of victims in child maltreatment fatalities over the past nine calendar years. The data further depicts that children under the age of one year old are the most frequent victims of fatal child maltreatment.

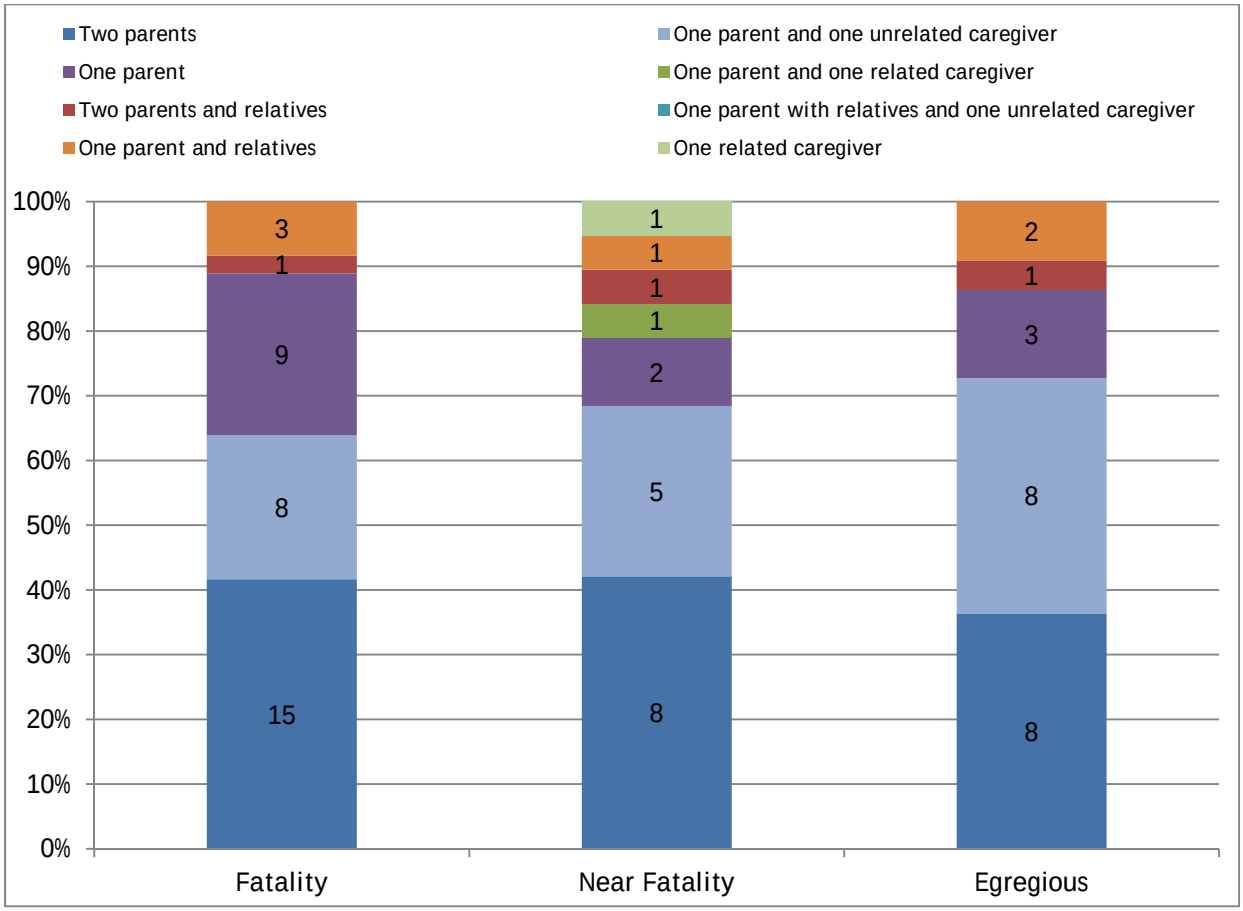
Chart 8: Age of Substantiated Victims in Child Maltreatment Fatalities in Colorado over the Past Nine Calendar Years



Family Structure

In 2018, 40.3% (31/77) of all children in fatal, near fatal, and egregious incidents of child maltreatment lived in a household with two parents (see Chart 9). This family structure was also the most frequent for incidents occurring in 2015, 2016 and 2017. The second most common type of family structure across all substantiated incidents in 2018 was one parent and one unrelated caregiver at 27.3% (21/77). Approximately 41.7% (15/36) of fatal incidents occurred for children in families with two parents.

Chart 9: Family Structure of 77 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in 2018



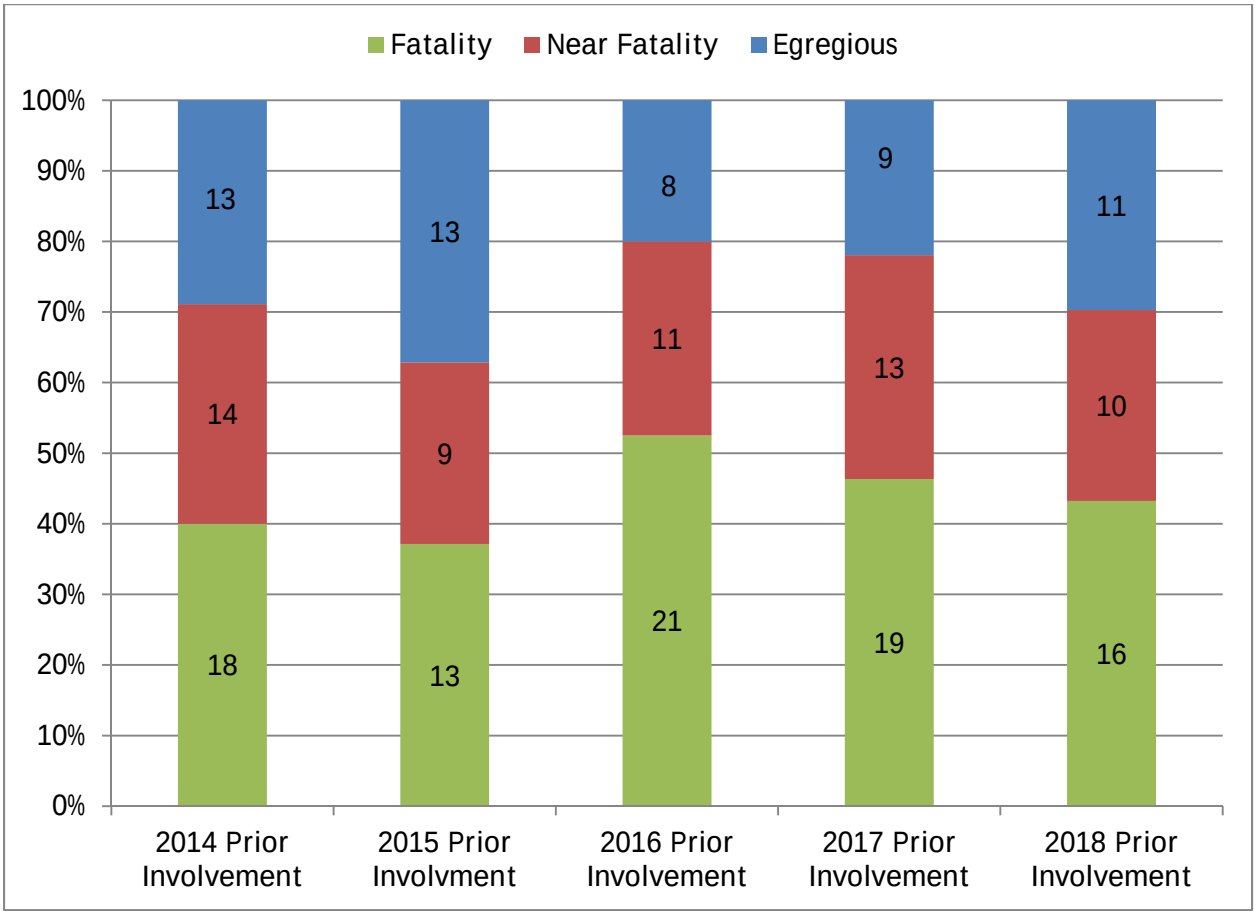
Prior Involvement

In CYs 2014-2018 the percentage of families in Colorado involved in a substantiated incident of fatal child maltreatment with prior involvement, within three years preceding the incident, has ranged between 35% and 82%. In 2018, 47.1% (16/34) of substantiated fatal child maltreatment incidents, the child, child's family, and/or alleged perpetrator had prior involvement with the child welfare system. In 2017, 61.3% (19/31) of fatal incidents substantiated for abuse or neglect had prior involvement with the child welfare system. In 2016, 60% (21/35) of families involved in substantiated fatal child maltreatment incidents had prior history and/or current involvement. In CY 2014, 82% of families involved in substantiated fatal incidents of child maltreatment had prior involvement within the last three years.

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, fluctuated from 60% (9/15) in 2015, to 55% (11/20) in 2016, rose to 65% (13/20) in 2017, and dropped down to 55.6% (10/18) in 2018. Families involved in egregious child maltreatment incidents who had prior history and/or current involvement went from 68.4% (13/19) in 2015 to 50% (8/16) in 2016, remained at 50% (9/18)

in 2017, and rose to 57.9% (11/19) in 2018. 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 2012-2018*



** As the statutory changes over the prior years have modified the population of incidents requiring review, it limits the ability to interpret trends in the data for CY 2012 and 2013.*

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 welfare 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.

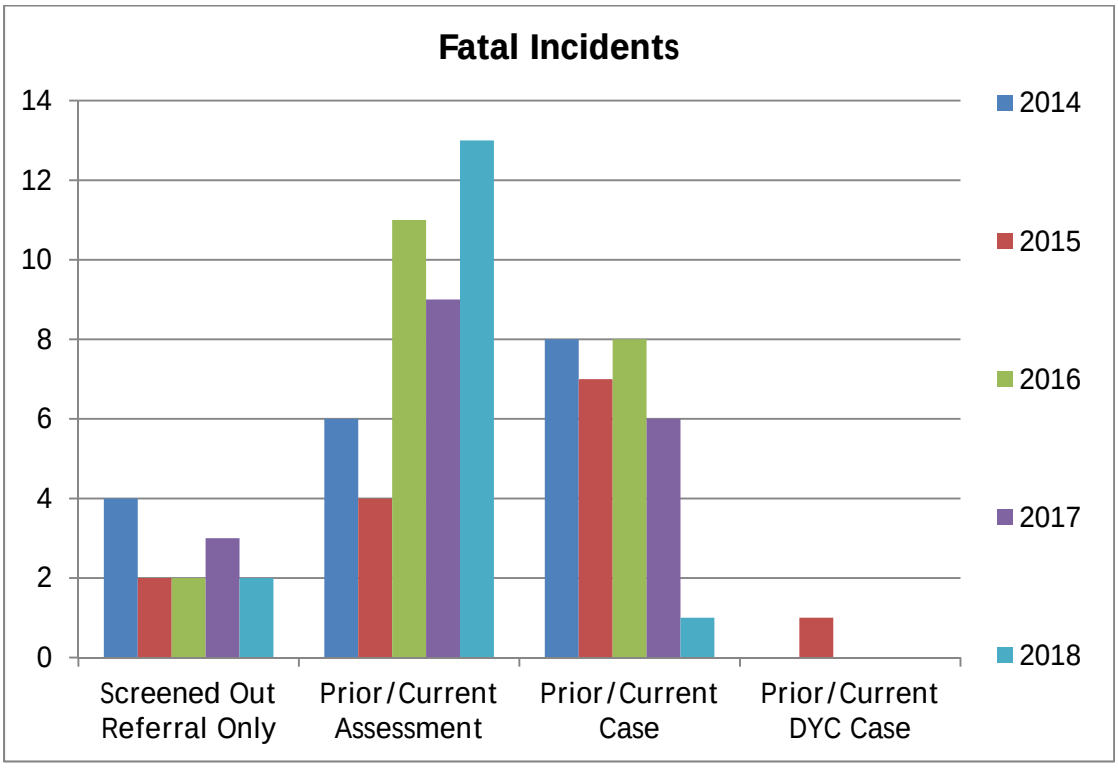
In 2018, the most common level of prior and/or current involvement with the child welfare system, for egregious, near fatal, and fatal incidents of child maltreatment, was a prior and/or current assessment.

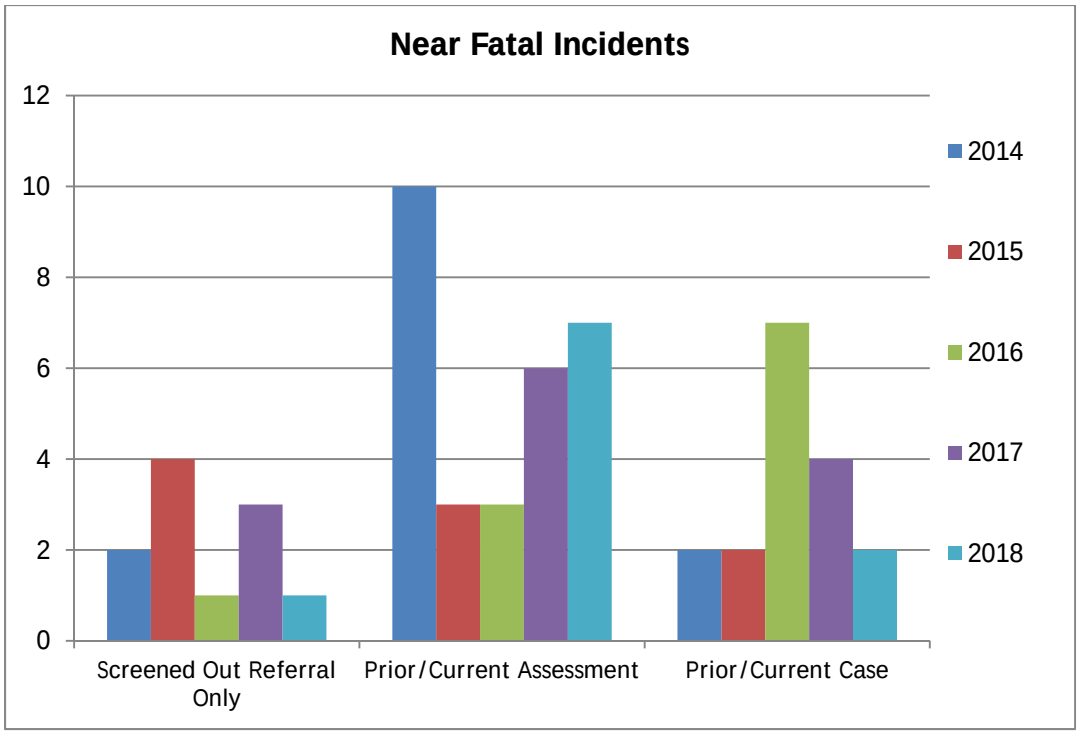
In 2018, 81.3% (13/16) of families involved with a fatal incident of child maltreatment had a prior and/or current assessment(s). This falls in line with trends noted in 2016 and 2017, where assessments were also the most common level of child welfare involvement in incidents of fatal child maltreatment. In 2015, case involvement was the most common level of prior history and/or current involvement for fatal incidents.

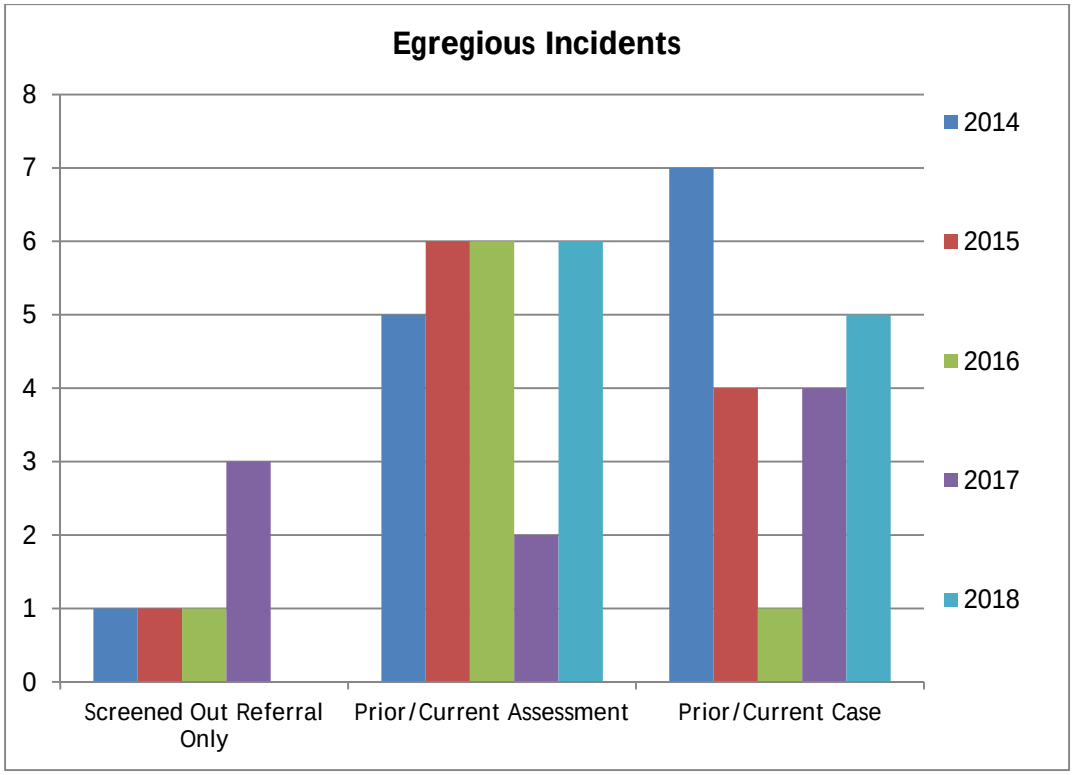
Near fatal incidents in 2018, fell in line with trends seen in 2017 and 2014 for prior and/or current involvement in fatal incidents of child maltreatment, with assessments as the most common level of prior and/or current involvement with the child welfare system (7/10; 70%). Conversely, in 2016, the 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%).

In 2018, 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, was also a prior/current assessment (6/11; 54.6%), followed by a current/prior case (5/11; 45.4%). This was a change from 2017 and 2014, where the most common level of prior and/or current involvement in a family's child welfare history associated with substantiated egregious incidents of abuse or neglect, were a prior and/or current case.

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




Near Fatal Incidents
12
10
8
6
4
2
0
2014
2015
2016
2017
2018
Screened Out Referral Only
Prior/Current Assessment
Prior/Current Case


Egregious Incidents
8
7
6
5
4
3
2
1
0
2014
2015
2016
2017
2018
Screened Out Referral Only
Prior/Current Assessment
Prior/Current Case

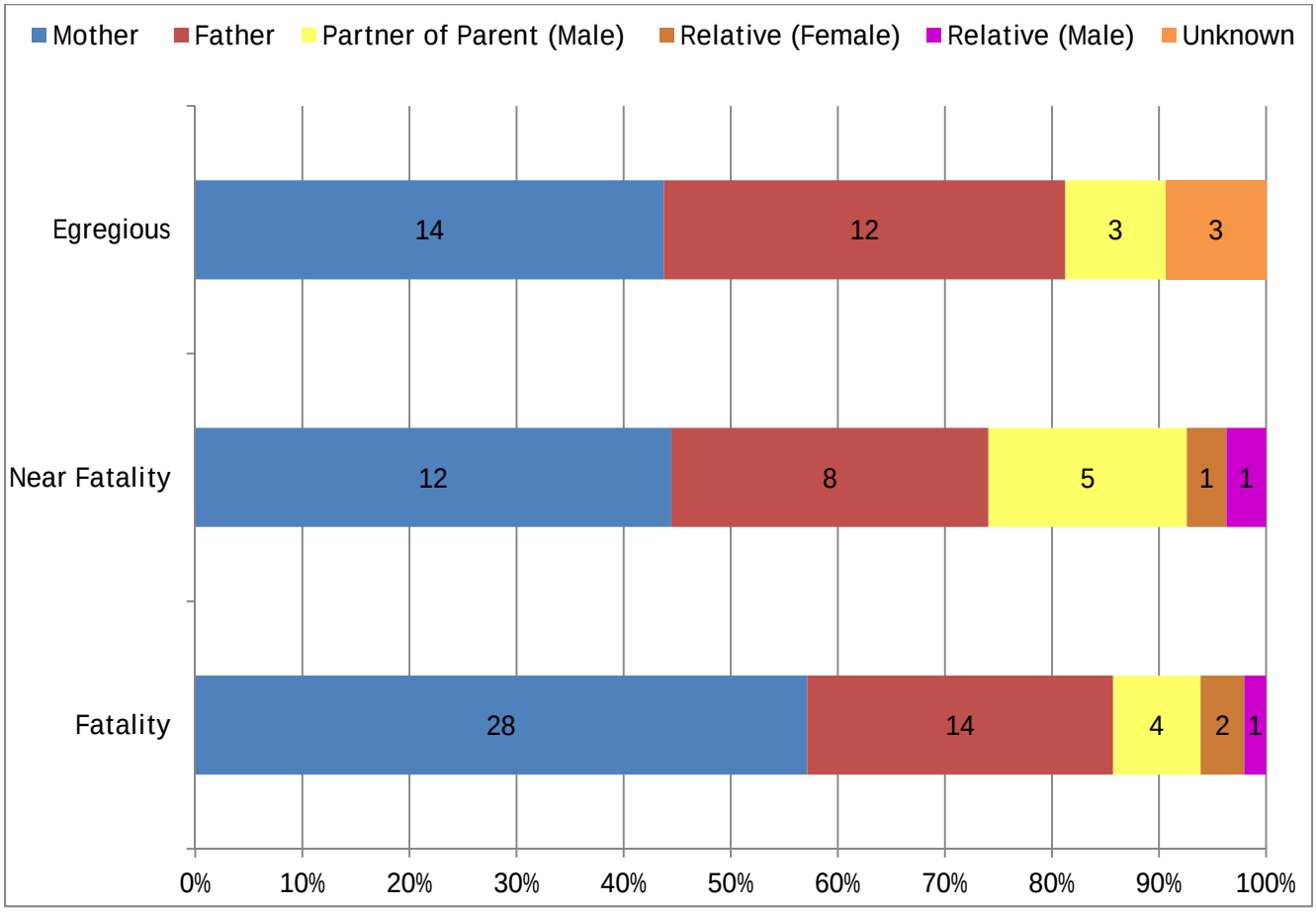
Perpetrator Relationship

A child's caregiver is most often the perpetrator of a fatal incident of child maltreatment, and it usually involves one or two parents. National data trends mark the mother as the most common perpetrator of a fatal incident of child maltreatment. In Colorado, for CY 2018, the mother was the most common perpetrator in fatal, near fatal, and egregious incidents of child maltreatment. The father was the second most common perpetrator, and the third most common perpetrator was a partner of parent (male). Chart 12 further 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 2018, mothers were the most common perpetrator 57.1% (28/49) across fatal incidents of child maltreatment. Fathers were identified as the second most common perpetrator at 28.6% (14/49). Across near fatal incidents, mothers were the perpetrator 44.4% (12/27) of the time, and 43.8% (14/32) of the time in egregious incidents of child maltreatment. Across all substantiated incidents in 2018, five 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 displays the relationship between the perpetrator(s) and the victim(s) of fatal, near fatal, or egregious incidents of child maltreatment.

Chart 12: Perpetrator Relationship to 77 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado during CY 2018*



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 2018 (34 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

Income and educational level of legal caregivers, as well as government assistance or services received by legal caregivers at the time of the incident, is required 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 61 unique caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed by the CFRT in 2018 (34 incidents); income information was only known for 16/61 of these individuals (26.2%). Of those caregivers with known income information, the average income for caregivers involved in fatal incidents is approximately $21,290, $15,600 for near fatal incidents, and $16,466 for egregious incidents.

Educational level was unknown for 39.3% (24/61) of the legal caregivers involved in fatal, near fatal, and/or egregious incidents of child maltreatment reviewed by the CFRT in 2018. The most common level of completed education of caregivers across fatal, near fatal, and egregious incidents of child maltreatment was a high school diploma. This accounted for 40.9% (25/61) of the caregivers with a known educational attainment level.

Supplemental Public Benefits

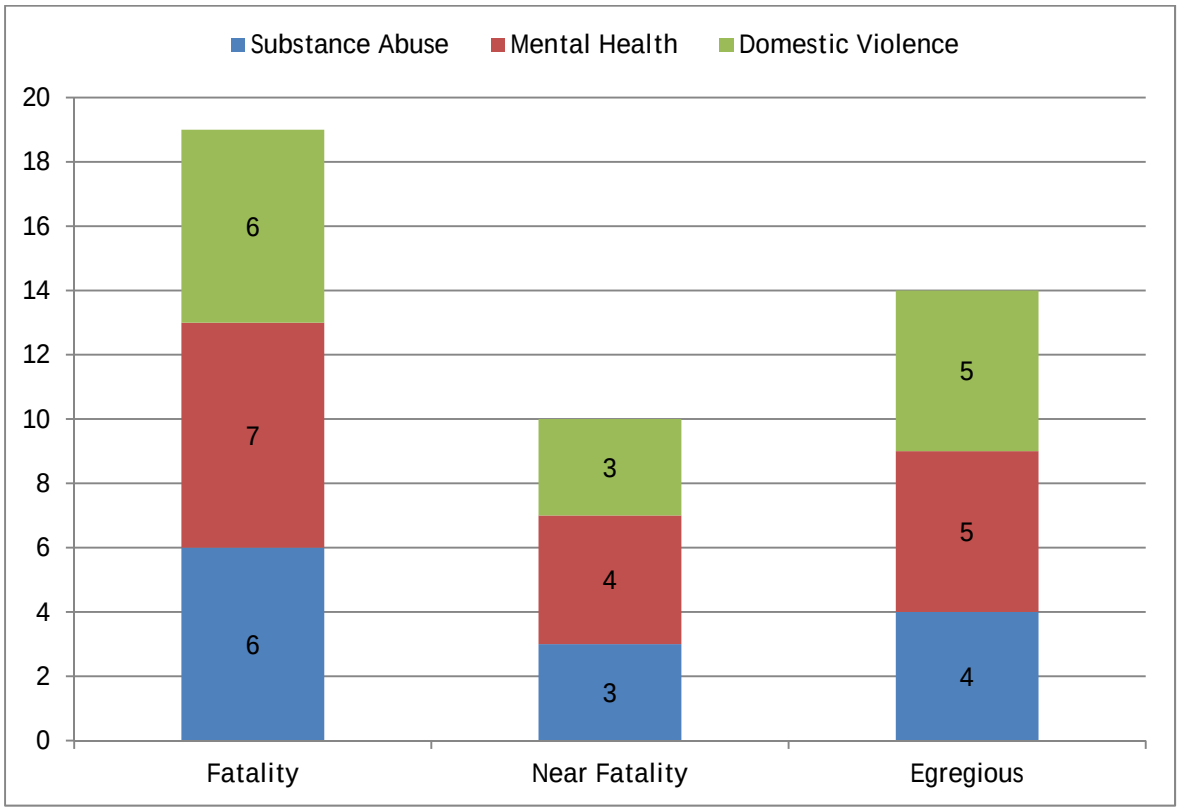
In CY 2018, information regarding supplemental public benefits were gathered for the 34 incidents of fatal, near fatal, and/or egregious child maltreatment reviewed by the CFRT. Information regarding supplemental public benefits is tracked by incident, rather than by the unique caregivers. Information collected indicated that the most frequently received supplemental benefit was Medicaid (26/34; 76.5%). In 16 of the 34 incidents reviewed (47.1%) 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), Housing Assistance, and Child Care Assistance Program (CCAP).

Other Family Stressors

Substance abuse, mental health, and domestic violence are often identified as stressors for caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment. There were 34 incidents reviewed by the CFRT in 2018; 14 fatal incidents, 11 near fatal incidents, and 9 egregious incidents. It is important to note that some incidents will not have any of the stressors identified during the review process, and others will have more than one identified. Of the families involved in a fatal child maltreatment incident, which met criteria for review by the CFRT, 42.9% (6/14) were identified to have had some history of identified domestic violence. Additionally, 50% (7/14) of families had some identified history of mental health issues. Chart 13 identifies stressors identified/associated with caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed in 2018.

Nationally, in FFY 2017, 6.1% of child fatalities were associated with a caregiver known to abuse alcohol, while 17.4% of child fatalities had a caregiver who abused drugs. Of the families involved in a fatal child maltreatment incident, which met criteria for review by the CFRT, 42.9% (6/14) of families had identified past or current substance abuse issues.

Chart 13: Other Stressors in Families of the Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents Reviewed by the CFRT in 2018



Summary of CFRT Review Findings and Recommendations

This section summarizes the findings and recommendations of 37 non-confidential case-specific executive summary reports (hereafter referred to as reports). This includes 37 reports completed and posted to the CDHS public notification website after the cut-off date for inclusion in the 2017 CFRT Annual Report (4/1/2018) and prior to and including the cut-off date for inclusion in this year's report (3/31/2019). Each of the 37 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 37 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 37 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 37 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 37 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 44 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) Engagement with Family, 3) Case Practice, 4) Safety, and 5) Services to Children and Families. The three systems most frequently mentioned were: 1) County Departments of Human Services (both alone and alongside other entities), 2) Medical Providers, and 3) Law Enforcement. Chart 14 provides a summary of these systemic strengths.

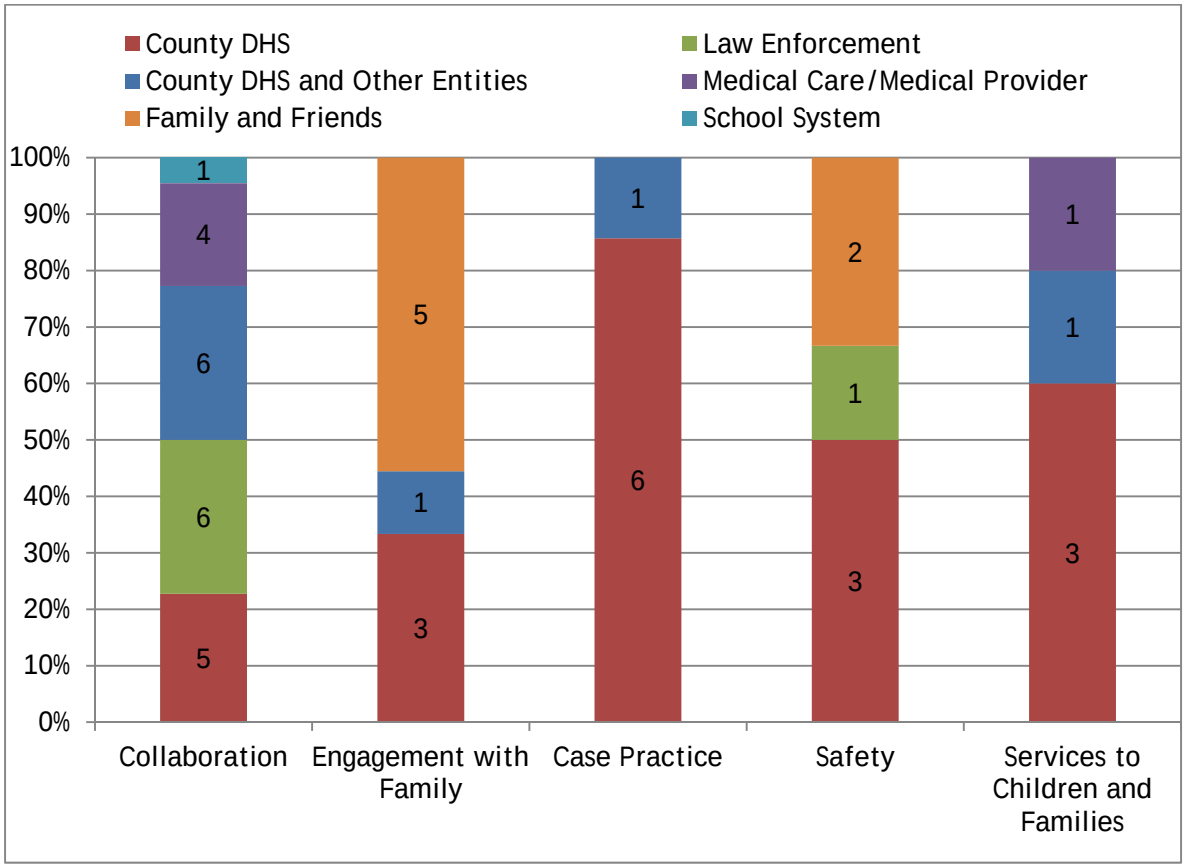
Collaboration

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 22 occasions across 19 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, law enforcement and medical providers, etc.) on 19 occasions. These collaborations often provided important information to the county child welfare professionals about the incident of child maltreatment, and helped to inform decisions regarding coordination of services and the outcome of the assessment.

Engagement of Family

Engagement of family members during the assessment was noted as a strength nine times across seven reports. County departments of human/social services were often recognized for engaging family members to find placements after an incident of egregious, near fatal, and/or fatal incident of child maltreatment and connecting families. This involved efforts to engage with parents after the incident occurred, ensure surviving sibling's safety, and finding relatives, instead of foster homes, for placement. 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.

Chart 14: Strengths Identified by the CFRT Review Process



Case Practice

The CFRT identified caseworkers who excelled in case practice seven different times (across three reports) following fatal, near fatal and egregious incidents of child maltreatment. Some examples of case practices that were identified as strengths included: the use of group supervision and conducting thorough internal reviews to identify strengths and areas needing improvement. 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 6 instances across five reports where systems surrounding children and families provided excellent work in the promotion of child safety. Oftentimes, DHS' efforts to assess, advocate for, and achieve safety for the victim and/or surviving siblings was notable.

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 nine times across five reports. Service provision often included services that were provided to the family as a result of the egregious, near fatal, and/or egregious incident of child maltreatment, which included

but were not limited to: medical evaluations, developmental assessments, referrals for therapeutic and/or trauma informed services, etc.

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

In the 37 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, 2018 and March 31, 2019, the CFRT identified 28 gaps and deficiencies in the delivery of services to children and families. Systemic gaps and deficiencies were organized into to the following categories: 1) Practice and/or Policy, 2) Training and Technical Assistance, 3) Implementation of Safety and Risk Assessment Tools, 4) Trails, and 5) 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 37 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 eight times across the 37 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 additional practice guidance regarding fatalities with no surviving siblings.

Safety and Risk Assessment Tools

A systemic deficiency identified by the CFRT, four times across the 37 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 37 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

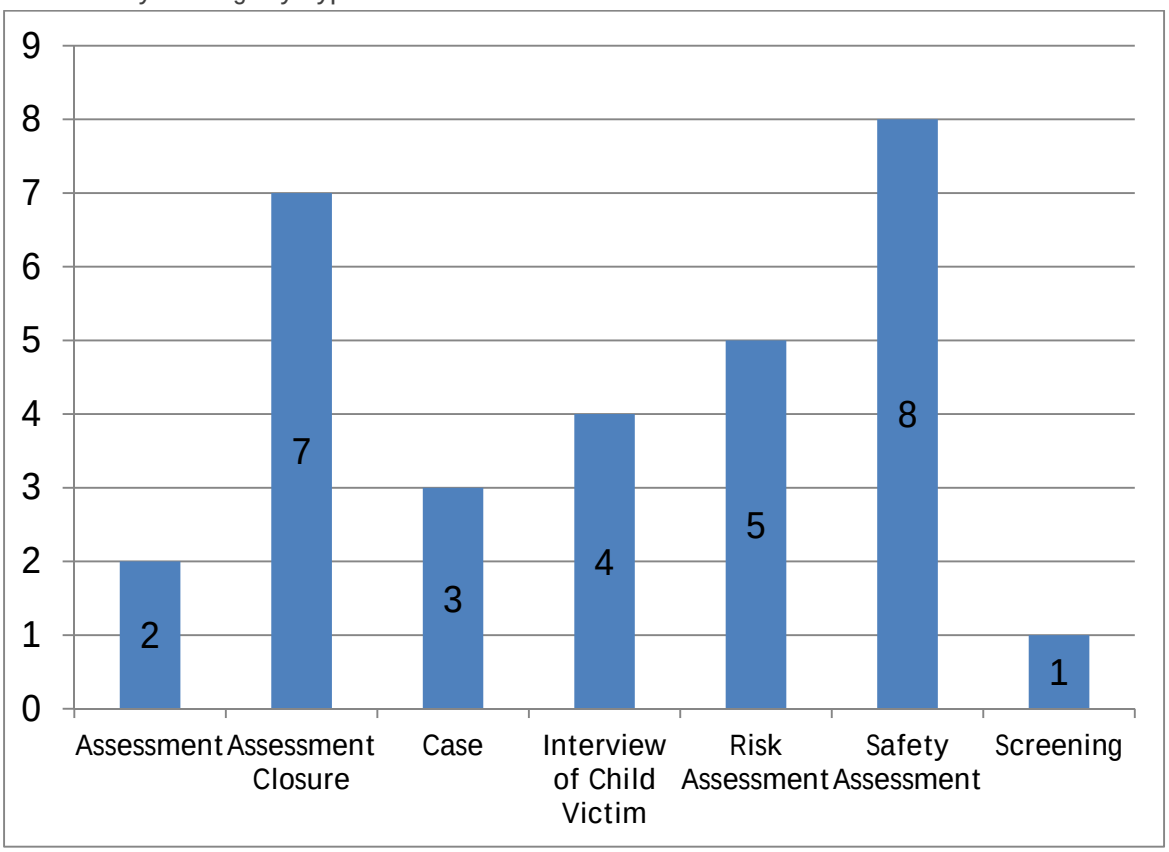
The CFRT staff methodically reviewed county agency documentation regarding the assessment of the fatal, near fatal, and egregious incidents of child maltreatment and prior involvement. In each review, the CFRT staff identified areas of noncompliance with Volume 7 and the Colorado Revised Statutes.

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 30 policy findings from 37 reports posted between the cutoff for the 2017 CFRT Annual Report (4/1/2018) and the 2018 Annual report (3/31/2019) that resulted in recommendations. The majority of these policy findings can be categorized into 7 areas of practice: 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) timeliness of interviewing or observing children alleged to have been abused and/or neglected, and 7) practice related to assessments of reports of child maltreatment. The frequency by type of policy finding is contained in Chart 15.

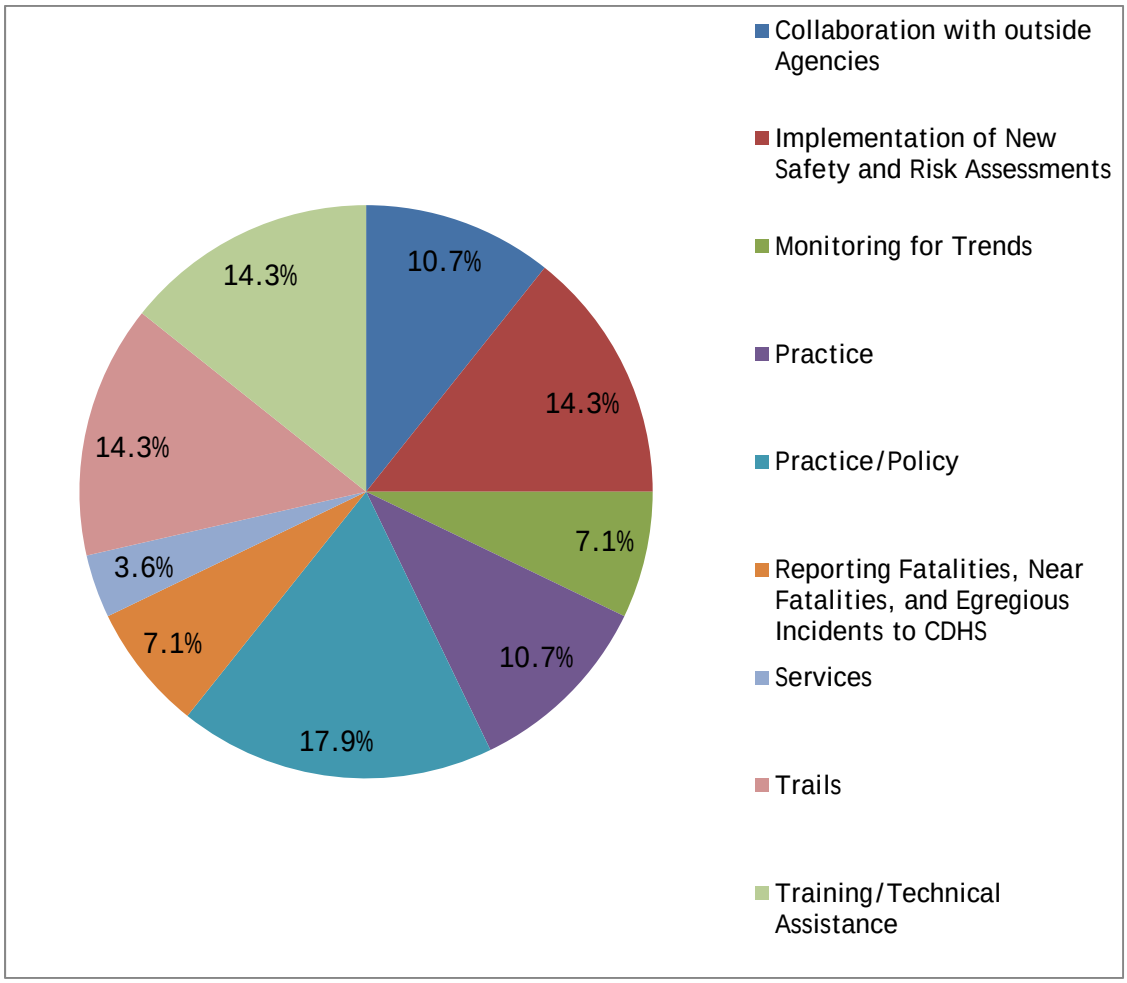
Chart 15: Policy Findings by Type



Recommendations from Posted Reports

A total of 58 recommendations were made across the 37 posted reports posted between 4/1/2018 and 3/31/2019. This included 28 related to systemic gaps and deficiencies and 30 related to policy findings. As illustrated in Chart 16, the top areas of recommendations are related to: 1) Policies or specific practices; 2) Training and technical assistance from DCW to county departments; 3) Safety and Risk Assessments; and 4)Trails.

Chart 16. Focus of Recommendations in the 37 Reports Posted Between 4/1/2018 and 3/31/2019



While several recommendations were reviewed in this report, the full texts of all 58 are contained in Appendix C, as well as the status of the progress on these recommendations. As illustrated in Chart 17, 74.5% of the recommendations have been completed, 15.5% are in progress, and 6.9% of 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 a small number of recommendations 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 tracking

spreadsheet. This year, 24.1% of the recommendations were not started at the time of this report.

Chart 17: Status of Recommendations(n=58) for Reports Posted Between 4/1/2018 and 3/31/2019

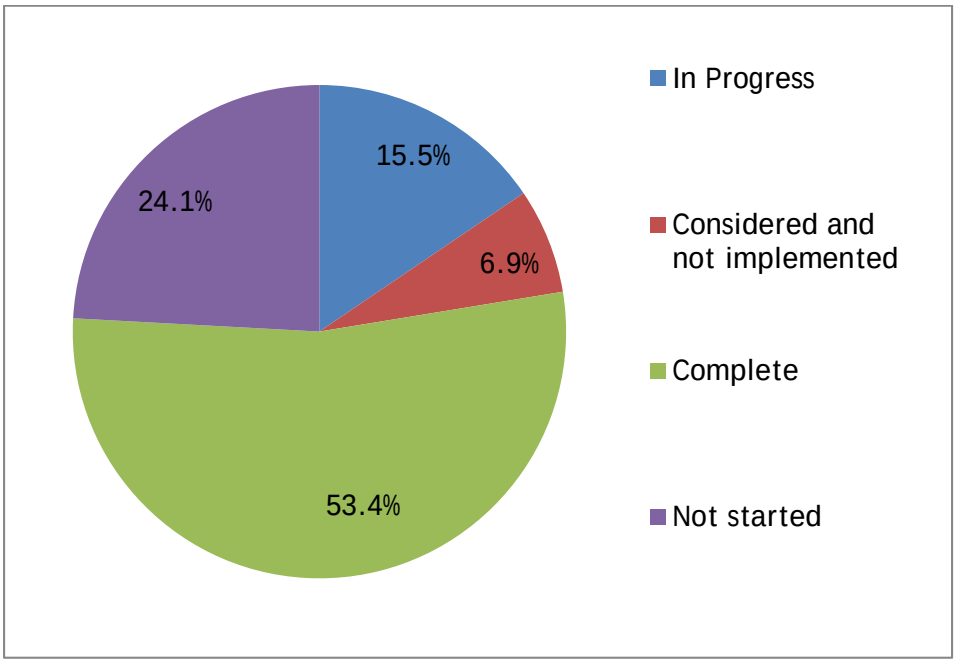
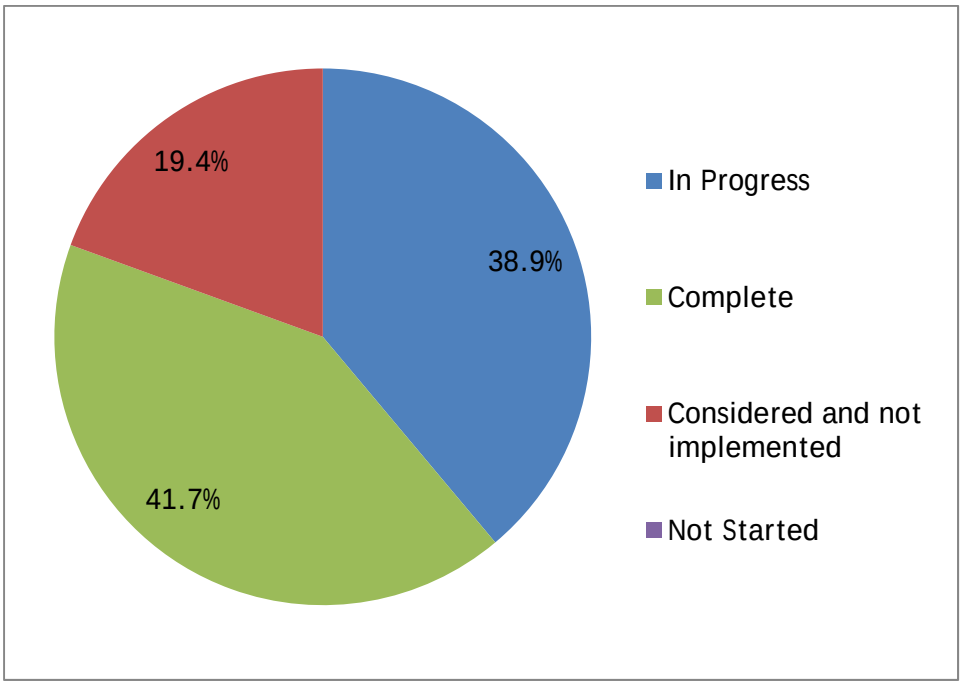


Chart 18: Status of Recommendations(n=36) Not Previously Completed From Reports Posted Prior to 4/1/2018



An update on the implementation status of the 36 recommendations presented in the 2017 CFRT Annual Report that were not completed at that time is presented in Appendix D.

Status of 2017 CFPS and CFRT Joint Recommendation

In 2017, the CFPS and CFRT made a joint recommendation regarding the need to raise awareness and provide education to child welfare providers and community agencies on safe firearm storage to prevent child deaths involving firearms. In an effort to implement the joint recommendation, CFPS and CFRT presented to several stakeholders including Child Abuse and Neglect Public Awareness Campaign and provided testimony to the Early Childhood School Readiness Legislative Committee in CY 2018. CFRT and CFPS also collaborated with Illuminate Colorado who secured funding to produce several safe storage briefs based on the joint recommendation outlining safe firearm storage to be shared with in-home service providers and families. Additionally, CDHS' Division of Child Welfare is working with the Child Welfare Training System to conduct a continuous quality improvement process to assess if and how firearm safety is currently covered by trainings offered in the system and where it could be incorporated.

CDPHE and CDHS Joint Recommendations to Prevent Child Maltreatment

Support policies that ensure access to quality, affordable child care, especially for infants and young children.

Pursuant to C.R.S. 25-20.5-407 (1) (i), the Child Fatality Prevention System (CFPS) State Review Team collaborates with the Colorado Department of Human Services (CDHS) Child Fatality Review Team (CFRT) to make joint recommendations for the prevention of child fatalities. In an effort to collaboratively identify a joint recommendation for the 2019 Legislative Report, CFRT and CFPS completed a methodical, joint review of the 79 fatal incidents from 2013 to 2017, which met the review criteria for both systems and identified trends associated with the circumstances surrounding these deaths. The joint review revealed that lack of access to quality, affordable child care is a contributing factor in these deaths.

The CDHS CFRT 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 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.

Child care is an important protective factor against family stress that can improve family functioning and prevent child maltreatment. Subsidized child care has been shown to decrease child maltreatment, including both abuse and neglect.[30] In families where caregivers experience less economic strain and decreased stress, child maltreatment is less likely to occur.[29] Quality child care often includes not only care, but also access to opportunities for early learning and education that impact infant and child development for children under 5 years old, encourages family engagement, and allows caregivers to work outside the home which contributes to family economic stability.[28]

Despite the demonstrated positive impact of child care, the high cost of child care in Colorado is a major barrier for families of all incomes, but it can be especially difficult for families with the lowest incomes to afford quality care. Child Care Aware of America estimates that in Colorado the annual cost of center-based child care is $14,950, and the annual cost of home-based child care is $10,522, while the annual cost of college tuition at a four-year college is $10,797.27. Married caregivers of 2 children living at the poverty line pay 110 percent of their household income for center-based child care in Colorado.[27]

During the 2019 legislative session, state policymakers committed to understanding and addressing lack of access to child care in Colorado by passing several bills. House Bill 19-1005 Early Childhood Educator Tax Credit establishes a refundable, annual tax credit for credentialed early childhood educators working at qualified facilities, and Senate Bill 19-063 requires the development of a strategic action plan to address the shortage of infant child care and family-home child care. House Bill 19-1262 State Funding For Full-day Kindergarten increases access to full-day kindergarten and ensures that caregivers are not charged

kindergarten tuition. House Bill 19-1013 Child Care Expenses Tax Credit Low-income Families, which extends existing tax credits for families earning less than $25,000 annually. Lastly, House Bill 19-1193 Behavioral Health Supports for High-Risk Families creates a pilot program to provide child care services to pregnant or parenting individuals seeking or participating in substance use disorder treatment.

Between 2013 and 2017, CFPS identified 223 child maltreatment deaths, which might have been prevented had quality, affordable child care been available to all families that needed it. State and local policymakers and organizations have an opportunity to further support strategies that ensure access to quality, affordable child care by:

- Increasing funding for child care assistance programs, specifically Colorado Child Care Assistance Program (CCCAP), to expand access to more families with infants and young children.
- Expanding enrollment in child care support subsidies through Colorado Works/Temporary Assistance to Needy Families (TANF) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that support families in working and being able to afford child care.[31]
- Passing policies that provide training and education to family, friend, and neighbor caregivers to increase quality of care in licensed-exempt settings, as some families may choose to use alternative care options because of the high cost of child care.
- Support participation by more social service programs in Colorado PEAK, the centralized system in Colorado where families can be screened and apply for a variety of economic supports, including assistance for medical care services, food and cash assistance, and early childhood programs.[32]
- Dedicate additional resources to support child care workforce development to increase the number of child care slots in Colorado and the quality of care provided by well-trained professionals.

Equity Considerations:

- Lack of affordable, quality child care, especially for infants and those under 5 years of age, disproportionately impacts families with the lowest incomes as they are not able to afford child care in our state, which may lead to increased familial stress, financially and emotionally, and may leave families with few options for who can care for their infants and young children.

For more information, view the CFPS child maltreatment data brief: www.cochildfatalityprevention.com/p/reports.html.

CITATIONS

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activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf

[30] Association of State and Territorial Health Officials (ASTHO). (n.d.). Essentials for childhood: Policy guide. Retrieved from http://www.astho.org/Prevention/Essentials-for-Childhood-Policy-Guide/

[31] Association of State and Territorial Health Officials (ASTHO). (n.d.). Essentials for childhood: Policy guide. Retrieved from http://www.astho.org/Prevention/Essentials-for-Childhood-Policy-Guide/

[32] Association of State and Territorial Health Officials (ASTHO). (n.d.). Essentials for childhood: Policy guide. Retrieved from http://www.astho.org/Prevention/Essentials-for-Childhood-Policy-Guide/

Appendix A: 2018 CFRT Attendance

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.*	**1.8.18**	**2.5.18**	**3.5.18**	**4.2.18**	**5.7.18**	**6.4.18**	**7.2.18**	**8.6.18**	**9.10.18**	**10.1.18**	**11.5.18**	**12.3.18**
Lucinda Connelly *CDHS, Child Protection Manager*	Yes	No Case Reviews Held	Yes	Yes	Yes	By phone	Yes	Yes	**No**	Yes	Yes	Yes
→**Backup:** Laura Solomon/Matt Holtman (eff. 10/1/2018)	---		---	---	---	---	---	---	**No**	---	---	---
Brooke Ely-Milen *CDHS, Domestic Violence Program Director*	Yes		Yes	Yes	Yes	**No**	By phone	Yes	By phone	Yes	Yes	**No**
Allison Gonzales *Administrative Review Division, Manager*	Yes		---	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Marc Mackert	---		Yes	---	---	---	---	---	---	---	---	---
Kate Jankovsky *CDPHE, Child Fatality Prevention System Coordinator*	Yes		Yes	By Phone	**No**	Yes	Yes	Yes	Yes	Yes	**No**	Yes
Christal Garcia *CDPHE, Violence and Injury Prevention*	Yes		Yes	**No**	Yes	Yes	Yes	Yes	**No**	Yes	**No**	Yes
Elizabeth "Betty" Donovan *Gilpin County DHS Director (CCI appointment)*	**No**											
Lora Thomas *Douglas County Commissioner(appointed 3/15/2018)*				Yes	Yes	**No**	Yes	Yes	**No**	By phone	By phone	Yes
Casey Tighe *Jefferson County Commissioner*	Yes		**No**	Yes	Yes	**No**	Yes	**No**	Yes	By phone	By phone	By phone
Dave Potts *Chaffee County Commissioner*	**No**		By phone	Yes	By phone	By phone	Yes	---	**No**	By phone	**No**	**No**
→**Backup:** Keith Baker			---	---	---	---	---	Yes	**No**	---	**No**	**No**
Senator Jim Smallwood *Senate Majority Leader appointment*			**No**	**No**	**No**	**No**	Yes	Yes	**No**	**No**	**No**	**No**
Representative Jonathan Singer *House of Representatives Majority Leader appointment*	By phone		By phone	By phone	**No**	Yes	Yes	**No**	**No**	**No**	By phone	**No**

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.*	**1.8.18**	**2.5.18**	**3.5.18**	**4.2.18**	**5.7.18**	**6.4.18**	**7.2.18**	**8.6.18**	**9.10.18**	**10.1.18**	**11.5.18**	**12.3.18**
Stephanie Villafuerte *Office of Colorado's Child Protection Ombudsman*	**No**	No Case Reviews Held	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**
→**Backup:** Sabrina Burbidge	**No**		**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**
Sgt. Brian Cotter *Denver Police Department*	**No**		By phone	By phone	Yes	**No**	**No**	**No**	**No**	By phone	**No**	Yes
Dr. Andrew Sirotnak *Professor of Pediatrics, University of Colorado School of Medicine Director, Child Protection Team at Children's Hospital Colorado*	Yes		Yes	By phone	Yes	**No**	Yes	**No**	By phone	Yes	**No**	Yes
→**Backup:** Dr. Antonia Chiesa	---		---	---	---	**No**	---	---	---	---	**No**	---
Amy Ferrin *Deputy District Attorney, 18th Judicial District*	By phone		**No**	Yes	Yes	By phone	**No**	Yes	By phone	Yes	By phone	Yes
Mara Kailin, PsyD *Aurora Mental Health Center, Director*	**No**		Yes	Yes	Yes	Yes	**No**	Yes	**No**	---	Yes	Yes
→**Backup:** Kathy Snell	**No**		---	---	---	---	**No**	---	**No**	Yes	---	---
Susan Colling *CO Division of Probation Services*	**No**		**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**		
Angel Weant *CO Division of Probation Services(appointed 10/25/2018*											**No**	**No**
→**Backup:** Dana Wilks	**No**		**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**	**No**
Don Moseley, *Ralston House Child Advocacy Center, Director*	**No**		Yes	Yes	By phone	**No**	Yes	Yes	**No**	Yes	**No**	**No**

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT.*	**1.8.18**	**2.5.18**	**3.5.18**	**4.2.18**	**5.7.18**	**6.4.18**	**7.2.18**	**8.6.18**	**9.10.18**	**10.1.18**	**11.5.18**	**12.3.18**
Dan Makelky, *Douglas County Department of Human Services*	---	No Case Reviews Held	---	---	---	---	---	---	---	---	---	---
→**Backup:** Ruby Richards/Nicole Becht	Yes		Yes	Yes	Yes	Yes	Yes	Yes	By phone	Yes	By phone	Yes
Michelle Dossey *Arapahoe County Department of Human Services*	Yes											
→**Backup:** Jessica Williamsen	**---**											
Angela Mead *Larimer County Human Services (appointed 3/20/2018)*				Yes	Yes	Yes	Yes	Yes	By phone	**No**	By phone	**No**
Shirley Rhodus *El Paso County Department of Human Services*	Yes											
Jill Calvert *El Paso County Department of Human Services*			Yes	Yes	**No**	**No**	Yes	Yes	By phone	---	---	By phone
→**Backup:** Krystal Grint			---	---	**No**	**No**	---	---	---	Yes	Yes	---
Cheryl Hyink *Administrative Review Division Staff*	Yes		Yes	**No**	Yes	Yes	Yes	**No**	Yes	Yes	Yes	Yes
James Martinez *Administrative Review Division Staff*	Yes		Yes									
Angela Myers *Administrative Review Division Staff*							Yes	Yes	Yes	Yes	Yes	Yes
Len Newman *Administrative Review Division Staff*	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	By phone	Yes	Yes
Libbie McCarthy *Attorney General's Office*	Yes		---	Yes	Yes	By phone	---	---	By phone	Yes	By phone	Yes
→**Backup:** Anita Schutte/Sarah Richelson	---		Yes	---	---	---	Yes	Yes	---	---	---	---

Appendix B: 2012-2018 Incidents Qualified for CFRT Review by County and Type

County*	Fatal Incidents							Near Fatal Incidents							Egregious Incidents													
	2012	2013	2014	2015	2016	2017	2018	2012	2013	2014	2015	2016	2017	2018	2012	2013	2014	2015	2016	2017	2018	2012 Total	2013 Total	2014 Total	2015 Total	2016 Total	2017 Total	2018 Total
Adams	2	2		2	1	2	2			1		3	1			3	2			1	1	2	5	3	2	4	4	3
Alamosa																1							1					
Arapahoe		2	1	1	4	1	2				1		2			1		2	1	1	2		3	1	4	5	4	4
Archuleta							1									1	1						1	1				1
Broomfield						1																					1	
Boulder		1	1						1		1	2									1		2	1	1	2		1
Chaffee						1																					1	
Clear Creek			1																					1				
Denver	1	1	4	1	1		2	1	3	3	3	1	1	2		7	3	3	3	3	4	2	11	10	7	5	4	8
Douglas					1	1							1						1							2	2	
Eagle	1			1																		1			1			
El Paso	2	1	2		4	4	4		1	1	1	1	5	2	1		1	1	1	1	1	3	2	4	2	6	10	7
Fremont										1						1	2	1			1		1	3	1			1
Garfield				1																					1			
Huerfano			1																					1				
Jefferson			2	2	2	3				4		1	1	1		2	1	3					2	7	5	3	4	1
La Plata					1		1				1		1	1						1					1	1	2	2
Larimer			1	1	1	3	1									4		2					4	1	3	1	3	1
Las Animas				1																					1			
Lincoln																		1							1			
Logan	1		1																			1		1				
Mesa	1		1	1	2		1		1		1			2								1	1	1	2	2		3
Moffat					1		1					1														2		1
Montezuma					1												1							1		1		
Montrose					1																					1		
Morgan			1						1	1		1								1			1	2		1	1	
Otero						1		1		1												1		1			1	
Park					1																					1		
Phillips		1																					1					
Pitkin																	1							1				
Pueblo	1		1				1		1	2	1	1				1	1			1		1	2	4	1	1	1	1
Rio Blanco														1														1
Routt			1										1						1					1		1	1	
San Miguel						1																					1	
Teller														1														1
Weld		1		1		1													1		1		1		1	1	1	1
Total	**9**	**9**	**18**	**12**	**21**	**19**	**16**	**2**	**8**	**14**	**9**	**11**	**13**	**10**	**1**	**21**	**13**	**13**	**8**	**9**	**11**	**12**	**38**	**45**	**34**	**40**	**41**	**37**

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

Appendix C: Recommendations from 2018 Posted Reports

CFRT ID	Recommendation Type	Recommendation	Status
18-012	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from September 17, 2017, to March 17, 2018, DDHS completed the Colorado Family Safety Assessment Tool when required 51.8% of the time, which is below the Ten Large County average (not including DDHS) of 79.6% for a comparable time span. It is recommended that DDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented.	In Progress
18-012	Policy Finding	Additionally, the policy finding related to the Colorado Family Safety Assessment Tool not being completed with all required individuals does reflect a systemic issue for DDHS. In a recent review of a generalizable random sample of assessments that were conducted during a period from September 17, 2017, to March 17, 2018, DDHS completed the Colorado Family Safety Assessment accurately with all required individuals in 69.6% of assessments, which is below the Ten Large County average (not including DDHS) of 89.5% for a comparable time span. It is recommended that DDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool with all required individuals are identified and solutions to the identified barriers are implemented.	In Progress
18-012	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from September 17, 2017, to March 17, 2018, DDHS completed the Colorado Family Safety Assessment Tool accurately 30.4% of the time, which is below the Ten Large County average (not including DDHS) of 35.2% for a comparable time span. It is recommended that DDHS employ a process in which barriers to accurately completing the Colorado Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	In Progress

18-012	Policy Finding	The policy finding related to the inaccurate completion of the Colorado Family Risk Assessment Tool does reflect a systemic issue for DDHS. In a recent review of a generalizable random sample of assessments that were conducted during a period from September 17, 2017, to March 17, 2018, DDHS completed the Colorado Family Risk Assessment Tool accurately in 39.3% of assessments, which is below the Ten Large County average (not including DDHS) of 50.9% for a comparable time span. It is recommended that DDHS employ a process in which barriers to accurately completing the Colorado Family Risk Assessment Tool are identified and solutions to the identified barriers are implemented.	In Progress
18-012	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for EPCDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the August 2018 C-Stat, EPCDHS's performance for May 2018 was 94.8% with a statewide goal of 95%. 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 23, 2017, to February 23, 2018, showed EPCDHS at 58.9% for observing/interviewing the alleged victim within the assigned response time, which is below the Ten Large County average (not including EPCDHS) of 71.4% for a comparable time span. EPCDHS made reasonable efforts to observe/interview alleged victims 85.7% of the time, which is below the Ten Large County average (not including EPCDHS) of 88.6% for a comparable time span. It is recommended that EPCDHS 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.	Not Started
18-013	CFRT	The CFRT recommended that there is a need for an alert in 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
18-013	Policy Finding	The Department has determined that the Trails Modernization has impacted performance data regarding interviewing/observing the alleged victim within the assigned response time in the Colorado Child Welfare Results Oriented Management (ROM) system, for June 2018. The Department suspended reporting out this data measure for the September 2018 C-Stat. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of December 16, 2017 to June 16, 2018, showed ACDHS at 67.9% for observing/interviewing the alleged victim within the assigned response time, which is below the Ten Large County average (not including ACDHS) of 70.5% for a comparable time span. It is recommended that ACDHS 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.	Not Started

18-016	CFRT	The CFRT recommended that the ARD and the Division of Child Welfare should convene a workgroup to analyze the risk factors from the cases reviewed by the CFRT in order to evaluate the responses needed from DHS and to make recommendations. The Colorado Revised Statutes, 26-1-139 (1) (c), states that one of the goals of the CFRT is "to identify and understand where improvements can be made in the delivery of child welfare services, and to develop recommendations for mitigation of the future incidents of egregious abuse or neglect against a child, near fatalities, or fatalities of a child due to abuse or neglect."	Not Started
18-016	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for ACHSD. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the July 2018 C-Stat, ACHSD's performance for May 2018 was 89.7%, with a statewide goal of 95%. It is recommended that ACHSD implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Not Started
18-043	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed when required does reflect a systemic practice issue for EPCDHS. 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 August 23, 2017 to February 23, 2018, EPCDHS completed the Colorado Family Safety Assessment Tool when required 69.1% of the time. It is recommended that EPCDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool when required are identified and solutions to the identified barriers are implemented.	Not Started
18-043	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for EPCDHS. 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 August 23, 2017 to February 23, 2018, EPCDHS completed the Colorado Family Safety Assessment Tool accurately 23.6% of the time. It is recommended that EPCDHS employ a process in which barriers to accurately completing the Colorado Family Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	Not Started

18-043	Policy Finding	The policy finding related to the assessment containing the required content does reflect a systemic practice issue for EPCDHS. 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 23, 2017 to February 23, 2018, showed that EPCDHS's assessments contained the required content 66.7% of the time, which is below the Ten Large County average (not including EPCDHS) of 81.7% for a comparable time span. It is recommended that EPCDHS 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.	Not Started
18-070	Policy Finding	The policy finding related to the Colorado Family Safety Assessment Tool not being completed accurately in accordance with Volume 7 does reflect a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period from September 17, 2017, to March 17, 2018, DDHS completed the Colorado Family Safety Assessment Tool accurately 30.4% of the time, which is below the Ten Large County average (not including DDHS) of 35% for a comparable time span. It is recommended that DDHS employ a process in which barriers to accurately completing the Colorado Family Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	Not Started
18-070	Policy Finding	The policy finding related to the Assessment Closure Summary not containing all required content does reflect a systemic practice issue in DDHS. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from September 17, 2017, to March 17, 2018, 50% of the Assessment Closure Summaries contained the required content. It is recommended that DDHS employ a process in which the barriers to documentation of all required content in the Assessment Closure Summary are identified and solutions to the barriers are implemented.	Not Started
17-006	CFRT	It is recommended that DCW provide formal guidance to county departments of human/social services on how to respond to reports of concern regarding a fatality which is suspicious for abuse or neglect when there are no surviving siblings.	Complete
17-006	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.	In Progress

17-034	CFRT	It was recommended that the ARD issue formal guidance to county departments of human or social services regarding notification requirements for fatal, near fatal, or egregious incidents which are suspicious for child abuse and/or neglect, specifically, when there are multiple children involved in one or more allegations at the fatal, near fatal, and/or egregious severity level. It should be noted that this recommendation was also made in a previous report; therefore, an Operational Memo (OM-OPSO-2017-0005) was issued on August 31, 2017, which provided the recommended formal guidance.	Complete
17-034	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for LPCDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the August 2017 C-Stat, LPCDHS's performance for June 2017, was 85.7%, with a statewide goal of 90%. It is recommended that LPCDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete
17-035	Policy Finding	The policy finding related to not engaging the mother's boyfriend in case planning does reflect a systemic practice issue for OCDHS. In the most recent Out-of-Home Administrative Review period from January 1, 2018, to March 31, 2018, OCDHS engaged the father in case planning 16.7% of the time. It is recommended that OCDHS employ a process in which the barriers to engaging fathers in case planning are identified and solutions to the identified barriers are implemented.	Not Started
17-064	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for Routt County DHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the January 2018 C-Stat, Routt County's performance for October 2017 was 84.6% with a statewide goal of 95%. It should be noted that the C-Stat statewide goal was increased from 90% to 95% in the month of November 2017. As part of a routine quality assurance monitoring, a review of a generalizable random sample of assessments that were conducted during a period of December 14, 2014 to June 14, 2015, showed Routt County DHS at 77.8% for observing/interviewing the alleged victim within the assigned response time. It is recommended that Routt County DHS 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
17-072	CFRT	The CFRT recommended that the ARD provide formal guidance regarding the definition and reporting requirements of near fatal incidents, which are suspicious for abuse and/or neglect.	Complete

17-072	CFRT	The CFRT recommend that the Division of Child Welfare (DCW) explore options for additional guidance to state rule in regard to information required to complete assessments, especially when there is an ongoing criminal investigation.	Considered and not implemented
17-072	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 January 2018 C-Stat, Arapahoe County DHS's performance for November 2017 was 88.8%, 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.	Complete
17-073	CFRT	The CFRT recommended that the ARD and the Division of Child Welfare should convene a workgroup to analyze the risk factors from the cases reviewed by the CFRT in order to evaluate the responses needed from DHS and to make recommendations. The Colorado Revised Statutes, 26-1-139 (1) (c), states that one of the goals of the CFRT is "to identify and understand where improvements can be made in the delivery of child welfare services, and to develop recommendations for mitigation of the future incidents of egregious abuse or neglect against a child, near fatalities, or fatalities of a child due to abuse or neglect."	Not Started
17-073	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 May 2018 C-Stat, Arapahoe County DHS's performance for March 2018, was 94.4%, 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.	Not Started
17-079	Policy Finding	The policy finding regarding the Family Services Plan review not meeting Volume 7 requirements does reflect a systemic practice issue for ACHSD. In the most recent Out-of-Home Administrative Review period from October 1, 2017, to December 31, 2017, ACHSD completed the Family Services Plan review in Trails according to Volume 7, 60.9% of the time, which is below the statewide average (excluding ACHSD) of 65.5% for the same time span. It is recommended that ACHSD employ a process in which the barriers to completing the Family Services Plan review in accordance with Volume 7 are identified and solutions to the identified barriers are implemented.	In Progress

17-079	CFRT	The CFRT recommended exploring the process for ending contact with a family leading up to and/or following a finalized adoption. One possible opportunity for change could be to decelerate the county's contact with the family rather than ceasing all contact upon the adoption's finalization. Additionally, the CFRT recommended exploring the possibility of better assessing an adoptive family's needs for services, both before and after an adoption.	Complete
17-079	CFRT	The CFRT recommended exploring the vetting process for kinship providers, such as in looking at how issues within a family are identified, discussed, and/or mitigated. It was also recommended to provide additional training to the providers who contract with counties to complete the home studies for foster and adoptive families. The additional training might help the providers better discern when foster and adoptive families are not being forthcoming and/or when they might need additional supports and services to maintain the children in their care.	Considered and not implemented
17-080	CFRT	The CFRT recommended that CDHS continue with efforts to recruit and maintain foster families throughout Colorado.	Complete
17-080	CFRT	The CFRT recommended for the Administrative Review Division to further explore and/or implement the process outlined in C.R.S. 26-1-139 (6) (e), which states, "For the purposes of participating in a specific case review, additional members may be appointed at the discretion of the members described in paragraphs (a) to (c) of this subsection (6) to represent agencies involved with the child or the child's family in the twelve months prior to the incident of egregious abuse or neglect against a child, a near fatality, or fatality." The CFRT discussed the benefits of having additional stakeholders as participants during the reviews for the applicable incidents.	In Progress
17-094	CFRT	The CFRT recommended that ACHSD provide internal training regarding treatment plan monitoring with respect to progress made and assessing for safety and risk during the course of ongoing cases.	Not Started
17-094	Policy Finding	The policy finding related to the frequency of monthly contact with the father does reflect a systemic practice issue in ACHSD. In a recent review of a generalizable sample of In-Home cases that were open during the period from September 27, 2017 to March 27, 2018, in all of the months requiring contact with the father, ACHSD agency staff had contact with the father in 63% of the months. It is recommended that ACHSD employ a process in which barriers to the monthly contact with fathers are identified and solutions to the identified barriers are implemented.	Not Started

16-047	CFRT	The CFRT recommended the addition of a critical alert component be added to the state automated case management system when an individual has been involved in a fatal, near fatal, or egregious incident of abuse or neglect. The critical alert component would allow for child welfare staff to be notified if a client identified in a new allegation of abuse or neglect has been involved in a previous fatal, near fatal, or egregious incident. This alert function will also help ensure child welfare staff have critical information to help make well-informed decisions about child safety and well-being.	In Progress
16-047	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
16-077	CFRT	The CFRT has made previous recommendations regarding the need for the Division of Child Welfare (DCW) to provide guidance and clarification in rule or practice regarding when a county department of human/ social services should intervene with a family when there are allegations about lack of school attendance (i.e., educational neglect). In review of this egregious incident, the CFRT has further identified the need for statute and Volume 7 to include educational neglect within in the definition of abuse and neglect.	Considered and not implemented
16-077	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 January 2017 C-Stat, DDHS's performance for November 2016, was 88.2% 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

16-077	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 2016 was 89.9% with a statewide goal of 90%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of 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
15-014	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	Complete
15-014	Policy Finding	The Policy Findings related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in Jefferson County. In a recent review of a random sample of assessments that were conducted during a period from August 1, 2014 to January 31, 2015, Jefferson County completed the risk assessment tool accurately in 50% of assessments, which is below the statewide average (not including Jefferson County) of 60.1% for the same time span. It is recommended that Jefferson County employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment tool are identified and solutions to the identified barriers are implemented. Additionally, a new Colorado Family Risk assessment will be implemented by the State in 2015, and it is recommended that Jefferson County participate in the training and implementation of the new tool.	Complete
15-033	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	Complete
15-033	CFRT	It is recommended that DCW explore with Trails to develop a way to track how many referrals have an allegation of marijuana use by caregivers.	Complete

15-033	Policy Finding	The policy finding related to the Colorado Family Risk Assessment tool not being completed in accordance with Volume VII does reflect a systemic practice issue in Garfield County DHS. In a recent review of a random sample of assessments that were conducted during a period from October 8, 2014 to June 1, 2015, the Garfield County DHS completed the risk assessment tool accurately in 30% of assessments, which is below the statewide average (not including Garfield County DHS) of 59.1% for the same time span. It is recommended that Garfield County DHS employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment tool are identified and solutions to the identified barriers are implemented.	Complete
15-033	Policy Finding	There is a lack of quantitative data related to entering new abuse/or neglect into the State automated case management system. It is recommended that Garfield County DHS review their practice of entering new abuse/ or neglect allegations into the State automated case management system (Trails) to determine if there is a systemic practice issue for Garfield County DHS. If it is an issue, employ a process in which barriers that prevent new abuse/ or neglect allegations documentation in the State automated case management system are identified and solutions to the identified barriers are implemented.	Complete
15-033	Policy Finding	The policy finding regarding the assignment of incorrect response times does reflect a systemic practice issue for Garfield 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 8, 2014 to June 1, 2015, Garfield County DHS assigned the appropriate response time in accordance with Volume VII 75.6% of the time, which is below the statewide average of 93.5% for the same time span. Of the 24.4%, not assigned appropriately, Garfield County DHS assigned 7 of the 10 referrals with an earlier response time than the referral necessitated. It is recommended that Garfield County DHS monitor their performance in this area to ensure correct response times are assigned.	Complete
14-038	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
14-038	CFRT	CFRT believes there is a need to clarify what constitutes a third party referral versus an institutional referral, as well as how to handle the referrals. For example, is there follow-up that needs to be documented in the state automated case management system (Trails) when a referral is sent to law enforcement? Do counties need to always create an intra-familial referral on the daycare provider's own children when there is an institutional referral? It is recommended that DCW clarify the definitions of these different referrals and how each of them need to be handled.	Complete

14-038	CFRT	A CFRT member researched and provided insight on child care options for families, parent resources, and how to search for licensed facilities. The information is located in these links: 1) Child care options- http://www.coloradoofficeofearlychildhood.com/#!ccrandr/c2217 2) Parent resources- http://www.coloradoofficeofearlychildhood.com/ 3) Search licensed facilities- http://www.colorado.gov/apps/jboss/cdhs/childcare/lookup/index.jsf A. It is recommended that DCW should disseminate the information to the Child Protection Task Group (CPTG). B. It is recommended that DCW partner with Division of Early Care and Learning on communication efforts around this information to the public.	Complete
14-038	Policy Finding	The Jefferson County DCYF policy finding related to the inaccurate completion of the safety assessment does reflect a systemic practice issue in Jefferson County DCYF. In a recent review of a random sample of assessments that were conducted during a period from February 14, 2014 to August 14, 2014, the Jefferson County DCYF completed the safety assessment accurately in 85.5% of assessments. While this is above the statewide average (not including Jefferson County DCYF) of 79.2% for the same time span, it remains below the state goal of 95%. It is recommended that Jefferson County employ a process in which barriers to the accurate completion of the Colorado Safety Assessment Instrument are identified and solutions to the identified barriers are implemented. Additionally, the new Colorado Family Safety Assessment Instrument will be implemented by the State in 2015, and it is recommended that Jefferson County DCYF participate in the training and implementation of the new tool.	Complete
14-038	Policy Finding	The Jefferson County DCYF policy finding related to the timeliness for the risk assessment does reflect a systemic practice issue in Jefferson County DCYF. In a recent review of a random sample of assessments that were conducted during a period from February 14, 2014 to August 14, 2014, the Jefferson County DCYF completed the risk assessment timely in 63.6% of assessments, which is below the statewide average (not including Jefferson County DCYF) of 68.9% for the same time span. It is recommended that Jefferson County employ a process in which barriers to the timeliness of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented. Additionally, the new Colorado Family Risk Assessment will be implemented by the State in 2015, and it is recommended that Jefferson County DCYF participate in the training and implementation of the new tool.	Complete

14-038	Policy Finding	The Jefferson County DCYF policy finding related to inaccurate documentation of the Colorado Family Risk Assessment does reflect a systemic practice issue in Jefferson County DCYF. In a recent review of a random sample of assessments that were conducted during a period from February 14, 2014 to August 14, 2014, the Jefferson County DCYF completed the risk assessment accurately in 45.5% of assessments, which is below the statewide average (not including Jefferson County) of 61% for the same time span. It is recommended that Jefferson County DCYF employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment are identified and solutions to the identified barriers are implemented. Additionally, the new Colorado Family Risk Assessment will be implemented by the State in 2015, and it is recommended that Jefferson County DCYF participate in the training and implementation of the new tool.	Complete
14-056	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk and safety assessment tools and that monitoring occur to determine if accuracy in the use of the tools increases as a result of their implementation.	Complete
14-056	CFRT	It is recommended that DCW work with State automated case management system (Trails) on the search function for names that are hyphened to make the search function more thorough, to include, but not limited to, the ability to search by Date of Birth (DOB) and enhanced the ability to search by name and address.	Complete
14-056	CFRT	It is recommended that the DCW through the Child Protection Task Group (CPTG) implement a process for supervisors to develop a process to randomly check on contacts made by their caseworkers.	Considered and not implemented
14-056	CFRT	It is recommended that DCW include a section in the Training Academy regarding the input of factual information in State automated case management system (Trails), and consequences for non-compliance with this law.	Complete
14-056	CFRT	Denver County Department of Human Services should receive training and technical assistance surrounding supervision of casework staff to include how to recognize concerning casework documentation and overall practice and work ethic (ie: cut and paste, limited detail in contact summaries, work attendance and overall performance).	Complete

14-056	CFRT	"To ensure best practice and accountability of all Human Services staff, Denver County Department of Human Services will implement policy and procedures related to supervision of casework practice to ensure that documentation of contacts and assessment steps are accurate. (i.e. spot checks to ensure contact is being made with clients, shadowing of caseworkers by supervisors, etc.)."	Complete
14-056	CFRT	"In addition, Denver County Department of Human Services should ensure that all staff responsible for the supervision and management of caseworkers is trained on the above policies and procedures implemented regarding review of casework practice."	Complete
14-056	Policy Finding	The policy finding related to inaccurate documentation of the safety assessment process does reflect a systemic practice issue in DDHS. As part of routine quality assurance monitoring, in a recent review of a generalizable random sample of assessments that were conducted during a period of April 8, 2014 to October 8, 2014, it was determined that the DDHS completed the safety assessment process accurately in 81.5% of assessments. The statewide average (excluding DDHS) during this time span was 77.3%. It is recommended that DDHS continue to use the process in which DDHS is showing improvements in regards to completing the tool accurately, as evident by the data presented in the most recent assessment review provided to DDHS. Additionally, a new Colorado safety assessment tool is being implemented by the State in 2015, and it is recommended that DDHS participate in the training and implementation of the new tool.	Complete

Appendix D: Status Update for Recommendations from Previously Posted Reports

CFRT ID	Recommendation Type	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
17-039	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
17-041	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.	Complete
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.	Considered and not implemented
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 information sharing and collaboration regarding joint investigations/assessments.	In Progress

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.	Complete
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.	In Progress
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.	In Progress
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
16-013	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.	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).	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
16-036	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.	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.	Complete

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.	Complete
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.	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.	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
15-011	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.	Considered and not implemented
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.	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.	Complete
15-038	CFRT	Regarding reviews of prior DYC involvement: It is recommended that C.R.S§ 26-1-139 be amended to specifically include review of current and prior DYC involvement for fatalities, near fatalities and egregious incidents in the same manner as the statute requires review of prior county human services involvement.	Considered and not implemented
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.	Considered and not implemented
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.	Complete

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.	Complete
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
15-042	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.	Complete
15-049	CFRT	The CFRT recommended that CDHS consider a change to Volume 7 and C.R.S. 26-1-139 to extend the due date for County Departments of Human Services' Internal Review Reports to be submitted to CDHS.	Complete
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.	Considered and not implemented

14-089	CFRT	It is recommended that DCW work with Trails to develop a way for DHS staff to research foster families and gain a complete and accurate picture, ensuring educated decisions can be made around the placement for children.	In Progress
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.	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. As supported within the case specific recommendations, this indicates the need for enhanced assessment of safety and risk for families and youth involved in Program Area 4: Youth in Conflict cases. Program Area 4: Youth in Conflict practice tends to focus on the behaviors of the youth. It is recommended that policy be modified to support the practice of conducting a broader assessment of familial strengths and needs specific to dealing with difficult behavior in youth. Specifically, tools and policy should be created supporting assessments of the family's needs for supportive services. These services may help parents develop increased coping skills and more appropriate responses to difficult behavior in their children.	In Progress
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)	Complete

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.	Complete