COLORADO
Department of Human Services

July 1, 2020

The Honorable Jared Polis
Governor, State of Colorado

The Honorable Jonathan Singer
Chair, Colorado House of Representatives Public Health Care and Human Services Committee

The Honorable Rhonda Fields
Chair, Colorado Senate Health and Human Services Committee

Ms. Kate Jankovsky
Manager, Colorado Department of Public Health and Environment's Child Fatality Prevention System

Governor Polis, Representative Singer, Senator Fields, and Ms. Jankovsky:

The Colorado Department of Human Services, in response to reporting requirements set forth in Section 26-1-139 (4), C.R.S., respectfully submits the attached annual child fatality and near fatality review report.

"The team shall...develop and distribute...on or before each July 1...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. The report must also include annual policy recommendations based on the collection of reviews required by subsection (5) of this section. The recommendations must address all systems involved with children and follow up on specific system recommendations from prior reports that address the strengths and weaknesses of child protection systems in Colorado."

Please see attached report for the response to this requirement. If you have any questions, please contact Kevin Neimond, Legislative Director at 303-620-6450.

Sincerely,

Michelle Barnes

Michelle Barnes
Executive Director, Colorado Department of Human Services

2019 Child Maltreatment Fatality Annual Report

COLORADO
Division of Quality Assurance & Quality Improvement
Administrative Review Division

This page intentionally left blank.

Executive Summary

The 2019 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) 2019. 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. When available, Colorado data from CY 2019 is presented along with national data for federal fiscal year (FFY) 2018. The report also highlights learnings and recommendations for improvements to the systems responsible for providing services to children and families in Colorado.

The CDHS CFRT currently operates under relevant criteria for excellence in child death reviews, as published by the National Center for Fatality Review and Prevention in 2018. Recent understandings have emerged on a national level that reviews should focus on system level changes and the CDHS CFRT has also come to understand the importance of adopting a systems model approach to case reviews; an approach that helps create a space to have vulnerable conversations with counties of human or social services about their practices and lessons learned from these tragedies, while keeping children and families at the center of the review. 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 communities healthier and more resilient.

In CY 2019, there were 73 children involved in 63 substantiated fatal, near fatal, and egregious incidents of child maltreatment. From the group of 73 children in 63 substantiated fatal, near fatal, and egregious incidents of child maltreatment occurring in CY 2019, 42 children in 37 incidents met statutory criteria for a review by the CFRT.

Child Characteristics. A child's age has been a key risk factor associated with child maltreatment fatalities, and research shows that younger children are the most vulnerable to child maltreatment. National data for FFY 2018 reflects victims of fatal child maltreatment incidents tend to be younger, as 46.6% were under the age of one, and 70.6% of all victims of child fatalities were age three or younger. Colorado's trends continue to mirror the national trends. As displayed in Chart 7, 52.9% (9/17) of the fatalities involved victims younger than one year old, and 70.6% (12/17) were three or younger.

A similar pattern of younger-aged victims exists for the near fatalities, as 43.5% (10/23) of the victims were under the age of one, and 78.3% (18/23) were age three or under. 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 and 2019, the majority of victims were three or younger. In CY 2019, 57.6% of victims were three or younger.

For fatalities, near fatalities, and egregious incidents in 2019, most victims were White, and this closely resembles the race estimates for Colorado's overall population. For fatalities, most victims were White (35.3%), followed by Hispanic (29.4%). For near fatal incidents, the majority of victims were White (52.2%), again followed by Hispanic (30.4%). For egregious incidents, most victims were White (36.4%), with the second most common race of victims being Hispanic (24.2%). In FFY 2018, it was noted that 87.3% of victims of child maltreatment fatalities are either White (40.1%), African American (32.8%), or Hispanic (14.4%).

Nationally, it is noted that males typically have a higher rate of child fatality by abuse and neglect. In FFY 2018, 57.6% of victims in child maltreatment fatalities were male; however, in Colorado, the number of female victims surpassed male victims in CY 2016, 2017, and 2019. In Colorado in CY 2019, females accounted for 70.6% of the children in substantiated child maltreatment fatalities.

Family Characteristics. In 2019, 38.4% (28/73) of all children in fatal, near fatal, and egregious incidents of child maltreatment lived in a household with two parents (see Chart 10). This family structure was also the most frequent for incidents occurring in 2015, 2016, 2017, and 2018. The second most common type of family structure across all substantiated incidents in 2019 was one parent and one unrelated caregiver, at 28.8% (21/73).

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 identify the mother as the most common perpetrator of fatal incidents of child maltreatment. In FFY 2018, it was noted that 80.3% of fatal incidents of child maltreatment involved one or both parents, sometimes acting alone and sometimes involving another person. In Colorado, for CY 2019, the mother was the most common perpetrator in fatal incidents of child maltreatment, and the father was the most common perpetrator of near fatal and egregious incidents of child maltreatment.

Prior Involvement with Child Protective Services. In 2019, of the families with prior involvement, 50% (5/10) of families involved with a fatal incident of child maltreatment had a prior and/or current case(s), which mirrored trends in 2014 and 2015. Conversely, in CYs 2016, 2017, and 2018, the most common level of prior involvement with the child welfare system was a prior and/or current assessment.

Near fatal incidents in 2019 fell in line with trends seen in 2014, 2017, and 2018 with assessments as the most common level of prior and/or current involvement with the child welfare system (7/11; 63.6%). 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 2019, the most common level of prior and/or current involvement with families involved with egregious incidents of child maltreatment was a prior and/or current assessment (12/16; 75%) which followed 2015, 2016, and 2018 trends. In 2014 and 2017, 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 was a prior and/or current case.

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 31 incidents reviewed by the CFRT in CY 2019; 11 fatal incidents, 7 near fatal incidents, and 13 egregious incidents. It is important to note that some incidents do not have any of the stressors identified during the review process, while others will have more than one stressor identified. Of the families involved in a fatal child maltreatment incident which met criteria for review by the CFRT, 45.4% (5/11) were identified to have a history of domestic violence and history of mental health issues. Additionally, 63.6% (7/11) of families had a history of substance abuse issues.

Findings and Recommendations. 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 in which the incident occurred. Therefore, some sections within this report also summarize information from incidents which occurred in 2015, 2016, 2017, 2018, and 2019, and reviewed by the CFRT and/or posted to the public notification website in 2019.

Of the 33 fatal, near fatal, or egregious child maltreatment incidents with case specific executive summary reports posted to the public notification website between April 1, 2019 and March 31, 2020, the CFRT identified 13 gaps and deficiencies in the delivery of services to children and families. Systemic gaps and deficiencies were organized into the following categories: 1) Practice and/or Policy, 2) Training and Technical Assistance, 3) Implementation of Safety and Risk Assessment Tools, 4) Legislative, and 5) Monitoring for Trends. Each systemic gap and deficiency, whenever possible, corresponded with a recommendation to address the identified concern. Appendix C contains the recommendations resulting from these 33 incident reviews, as well as information about their implementation status.

CFRT Learnings. This year's report features learnings from the CFRT, and draws upon the multidisciplinary team members' individual expertise and understanding of systems within the community when analyzing child welfare practice risks, and contributing factors that may have led to the tragedy. These learnings are presented in an effort to help the many systems that serve children and families better understand and identify the factors associated with such incidents of abuse or neglect. The following learnings are discussed further in the report: 1) Young children are vulnerable, and are the most common victims of fatal, near fatal, and egregious child maltreatment, 2) Violence is a predictor of future child maltreatment, 3) Families involved in fatal, near fatal, and egregious incidents of child maltreatment often have complex histories of stressors and trauma, and 4) There are many efforts and organizations that are striving to mitigate future incidents of child maltreatment, everyone

has a responsibility in prevention of child maltreatment, and a coordinated response is essential.

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 criteria for 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, the expanded definition and the 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 seven 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
2019	40	29	26	95

**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 result 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
2019	17	22	24	63

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 2019, 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 2019. The data integrity checks identified 53 potential incidents. Of those incidents, six incidents involving six children met criteria for public notification. One incident, involving one child, 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. After considering the 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 that 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 (2012-2013) 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
2019	10	11	16	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), 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, 38.9% (37/95) incidents that occurred in 2019 were afforded at least one extension, with the total number ranging from one to eleven extensions.

Incidents Reviewed in 2019

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 CY 2019, the CFRT was able to review 31 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

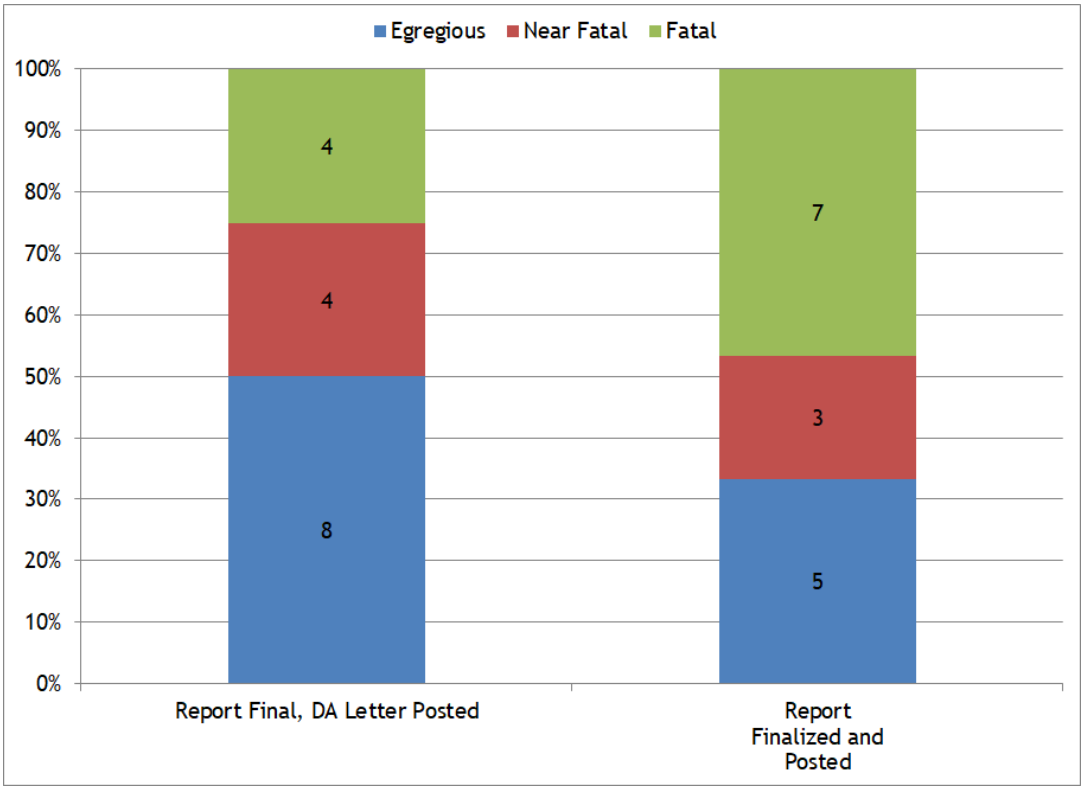
Each incident reviewed by the CFRT results in a written report that is posted to the CDHS public notification website (with confidential information redacted). Specifically, statute requires that a case-specific executive summary, absent confidential information, be posted on the CDHS website within seven (7) days of finalizing the confidential case-specific review report. In 2019, case-specific reports for fatal, near fatal, and/or egregious incidents reviewed by CFRT underwent changes in order to align with the review philosophy of a systems model approach.

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-specific 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 2019. Of the 31 incidents reviewed, final non-confidential case-specific executive summary reports were

posted for 15 of them. For the remaining 16 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 2019.



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 the CDHS, the Colorado Department of Public Health and Environment (CDPHE), mental health, law enforcement, district attorneys, county commissioners, county departments of human and/or social services, legislators, 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 in that CFRT review meeting.

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

The CDHS CFRT staff work 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 respective agency. The CFPS staff members at the CDPHE serve as the two state appointees from the CDPHE to the CDHS CFRT, and the CFRT staff are involved with and participate in 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 44 of this document.

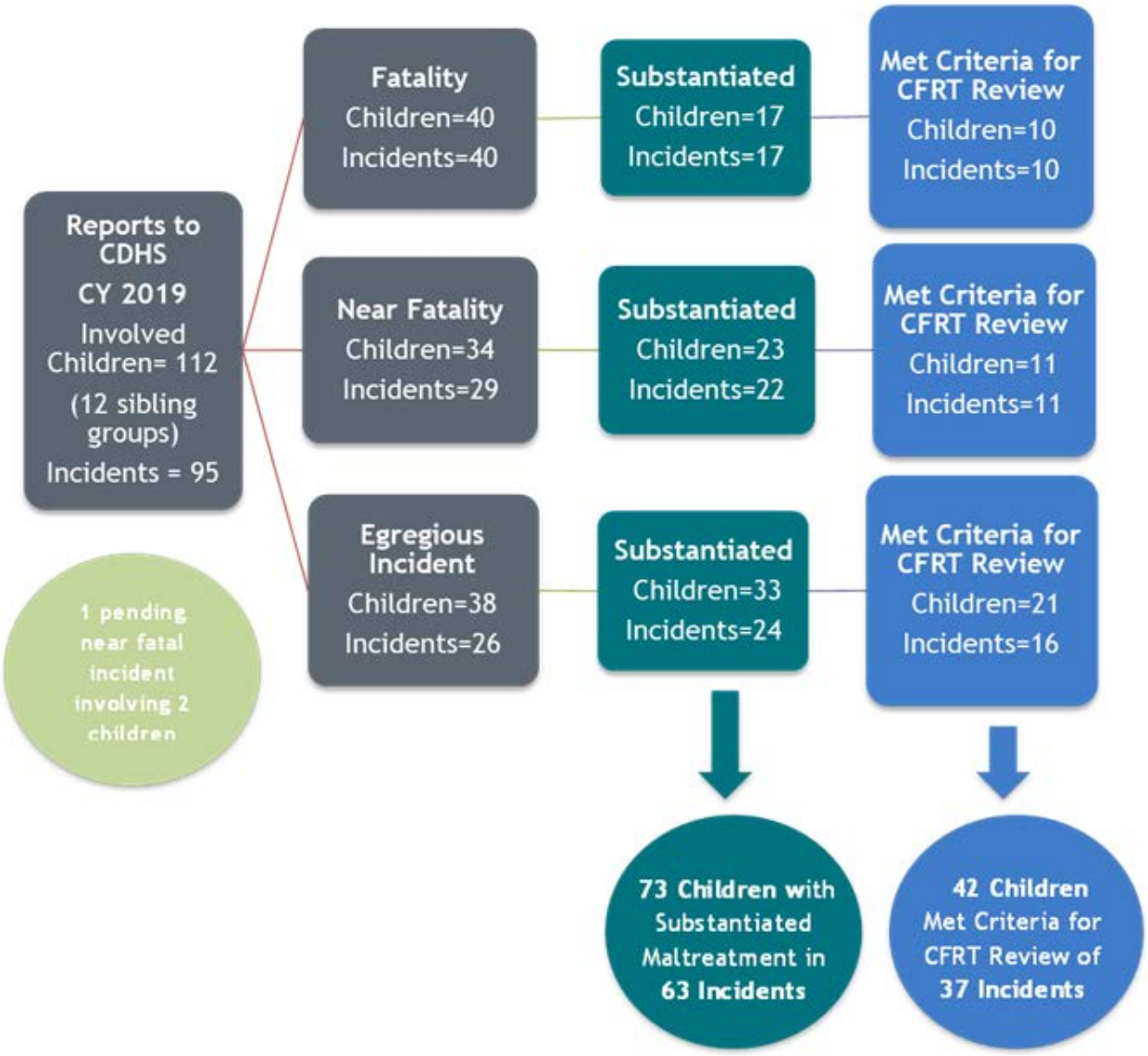
Overview of the 2019 Reports of Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment Victims

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 2019, counties reported 95 incidents involving 112 children who were suspected victims of fatal, near fatal, or egregious child maltreatment. Of the 112 children, 40 children were associated with 40 fatal incidents, 34 children were associated with 29 near fatal incidents, and 38 children were associated with 26 egregious incidents.

Upon completion of an assessment, DHS found that 32 incidents involving 39 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 2019, 63 substantiated incidents included 73 children, 37 of which had prior involvement with DHS within the statutorily defined time period of three years prior to the incident, thus indicating the need for review by the CFRT. Figure 1 depicts the breakdown of the incidents reported in CY 2019. 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 2019



For purposes of this report, the majority of the analysis in the following section focuses on the 73 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 4 provides an overview of the demographic characteristics of the 73 substantiated victims of incidents that occurred in CY 2019.

Table 4: Summary information of all 73 substantiated victims of child maltreatment fatalities, near fatalities, and egregious incidents in Colorado for CY 2019

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Victim at Time of Incident	Less than one	9	52.9%	10	43.5%	8	24.2%
	One	3	17.6%	4	17.4%	6	18.2%
	Two	0	0.0%	4	17.4%	3	9.1%
	Three	0	0.0%	0	0.0%	2	6.1%
	Four	0	0.0%	3	13.0%	1	3.0%
	Five	1	5.9%	1	4.3%	2	6.1%
	Six	0	0.0%	1	4.3%	0	0.0%
	Seven	0	0.0%	0	0.0%	1	3.0%
	Eight	0	0.0%	0	0.0%	0	0.0%
	Nine	1	5.9%	0	0.0%	1	3.0%
	Ten	2	11.8%	0	0.0%	2	6.1%
	Eleven	1	5.9%	0	0.0%	3	9.1%
	Twelve	0	0.0%	0	0.0%	2	6.1%
	Thirteen	0	0.0%	0	0.0%	0	0.0%
	Fourteen	0	0.0%	0	0.0%	2	6.1%
	Fifteen	0	0.0%	0	0.0%	0	0.0%
	Sixteen	0	0.0%	0	0.0%	0	0.0%
	Seventeen	0	0.0%	0	0.0%	0	0.0%
Race/Ethnicity	Black or African American	2	11.8%	2	8.7%	6	18.2%
	Asian	1	5.9%	0	0.0%	1	3.0%
	White	6	35.3%	12	52.2%	12	36.4%
	Hispanic	5	29.4%	7	30.4%	8	24.2%
	Multiracial	2	11.8%	2	8.7%	6	18.2%
	Native American	0	0.0%	0	0.0%	0	0.0%
	Missing/Unknown	1	5.9%	0	0.0%	0	0.0%
Sex	Female	12	70.6%	10	43.5%	14	42.4%
	Male	5	29.4%	13	56.5%	19	57.6%
Family Structure	One parent	3	17.6%	1	4.3%		0.0%
	One parent and one related caregiver	2	11.8%		0.0%	1	3.0%
	One parent and one unrelated caregiver	1	5.9%	6	26.1%	14	42.4%
	Two parents	6	35.3%	11	47.8%	11	33.3%
	Two parents and relatives	2	11.8%	2	8.7%	4	12.1%
	One parent and relatives	1	5.9%	1	4.3%	1	3.0%
	Foster Care		0.0%		0.0%	1	3.0%
	One unrelated caregiver		0.0%	2	8.7%		
	Two related caregivers	1	5.9%			1	3.0%
	One related caregiver and one unrelated caregiver	1	5.9%				
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 FFY18, 1,770 children were victims of fatal abuse or 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 2018) 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 comprehensive child welfare information system, referred to as Trails in Colorado, race and ethnicity/origin 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 was entered into Trails as White with Hispanic origin, 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 2019. The estimates indicated that Colorado's population in 2019 was 67.9% White (alone, not reporting another race/ethnicity), 21.7% Hispanic, and 4.6% Black or African American. The balance of the population estimates included ethnicities including American Indian, Asian, Native Hawaiian, Native American, etc.

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-datatechnology/statistics-research/child-maltreatment.

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

For fatalities, near fatalities, and egregious incidents in 2019, most victims were White, which closely resembles the race estimates for Colorado's overall population. For fatalities, most victims were White (35.3%), followed by Hispanic (29.4%). For near fatal incidents, just over half of the victims were White (52.2%), and followed by Hispanic (30.4%). For egregious incidents, most victims were White (36.4%), and the second most common race of victims being Hispanic (24.2%). Chart 2 is a graphic depiction of race/ethnicity breakdown.

Chart 2: Race/Ethnicity of 73 victims in all Substantiated Fatal, Near fatal, and Egregious Incidents of Child Maltreatment in Colorado for CY 2019

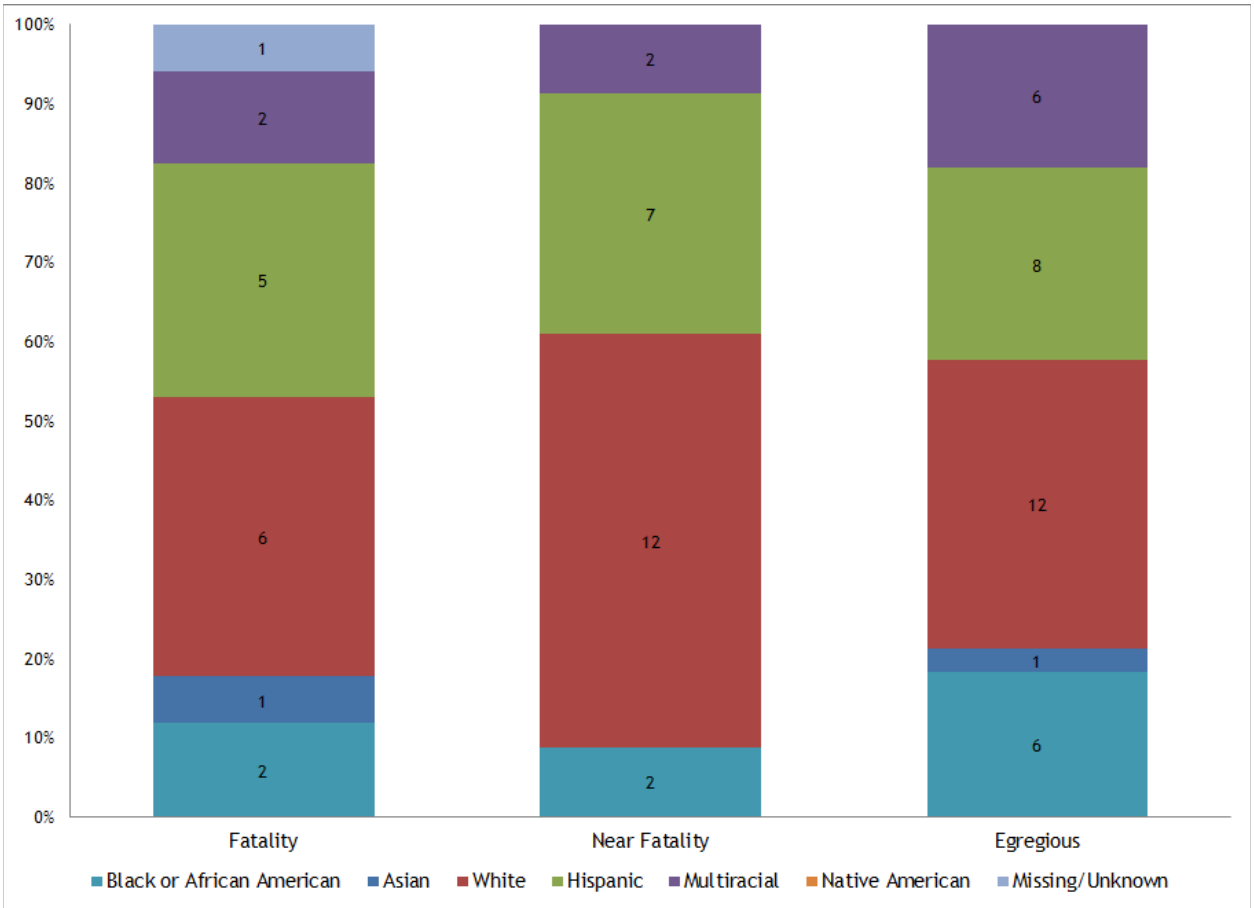
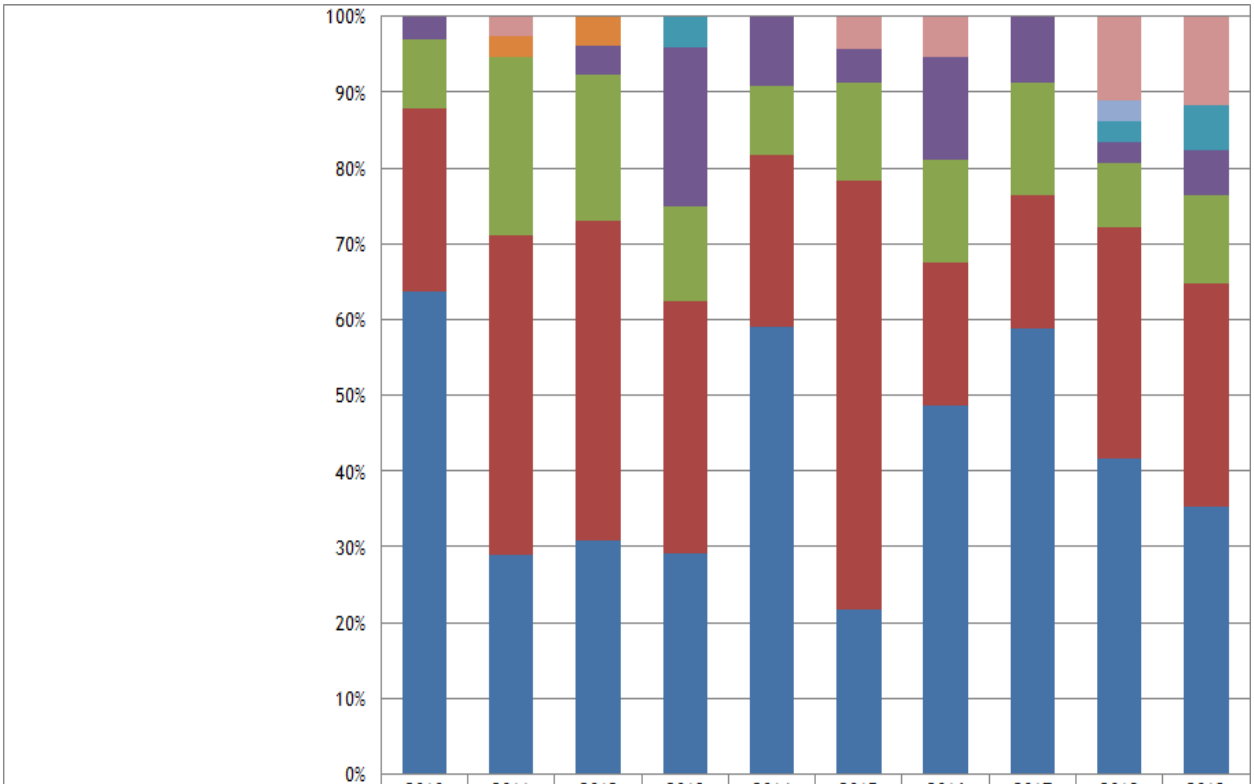


Chart 3 shows the trends related to the most common race/ethnicity of all child maltreatment fatalities in Colorado from 2010-2019. For Colorado's population trends, Hispanic child victims were disproportionately represented in fatal incidents during the years of 2011, 2012, 2013, and 2015. The chart depicts the three most common race/ethnicities of children involved in fatal incidents of abuse and neglect as being of White, Hispanic, or African American race/ethnicity or Multiracial, which also mirrors national trends.

Chart 3: Race/ethnicity of Victims in all Substantiated Child Maltreatment Fatalities in Colorado over the Past Ten Calendar Years



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Multiracial	0	1	0	0	0	1	2	0	4	2
American Indian or Alaska	0	0	0	0	0	0	0	0	1	0
Native Hawaiian/ Other Pacific Islander	0	1	1	0	0	0	0	0	0	0
Asian	0	0	0	1	0	0	0	0	1	1
Missing or Unknown	1	0	1	5	2	1	5	3	1	1
Black or African American	3	9	5	3	2	3	5	5	3	2
Hispanic	8	16	11	8	5	13	7	6	11	5
White	21	11	8	7	13	5	18	20	15	6

Sex of Victim

Nationally, it is noted that males typically have a higher rate of child fatality by abuse and neglect. In FFY 2018, 57.6% of victims in child maltreatment fatalities were males; however, in Colorado, females surpassed male victims in CY 2016, 2017, and 2019. In Colorado in CY 2019, females accounted for 70.6% of the children in substantiated child maltreatment fatalities. Chart 4 displays the breakdown of differences in the sex of the victims for the 73 victims involved in substantiated incidents of fatal, near fatal, and egregious incidents of abuse and neglect in CY 2019.

Chart 4: Sex of 73 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado for CY 2019

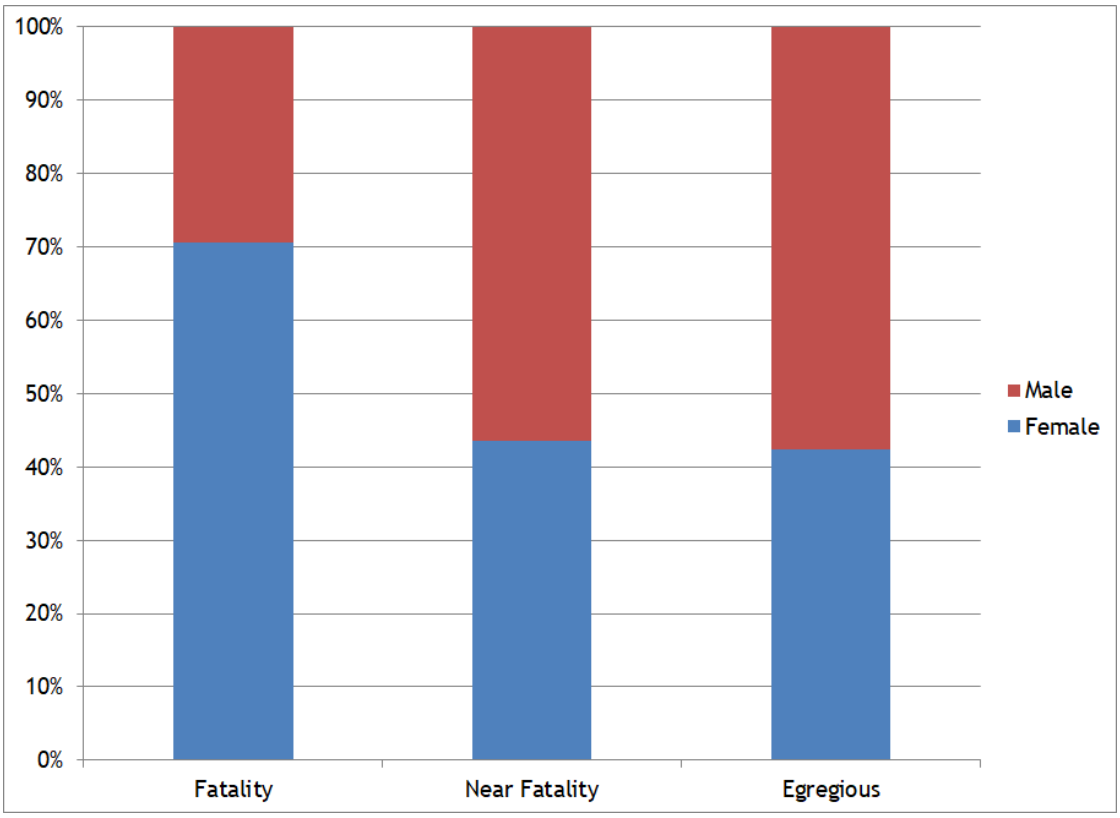
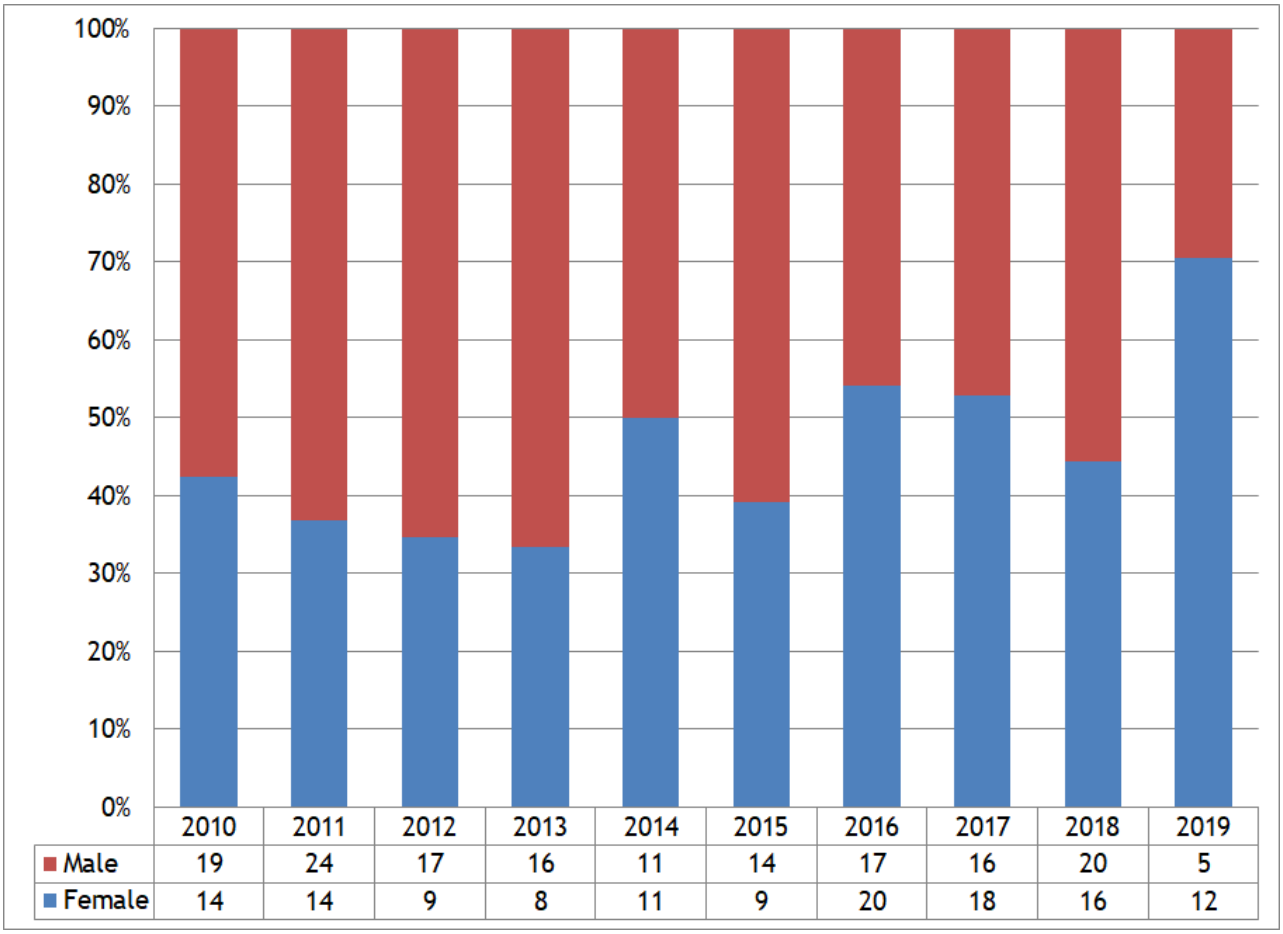


Chart 5 demonstrates the trends of sex of victims involved in all substantiated child maltreatment fatalities in Colorado over the last ten years.

Chart 5: Sex of Victims in all Substantiated Child Maltreatment Fatalities in Colorado over the Past Ten Years



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Male	19	24	17	16	11	14	17	16	20	5
Female	14	14	9	8	11	9	20	18	16	12

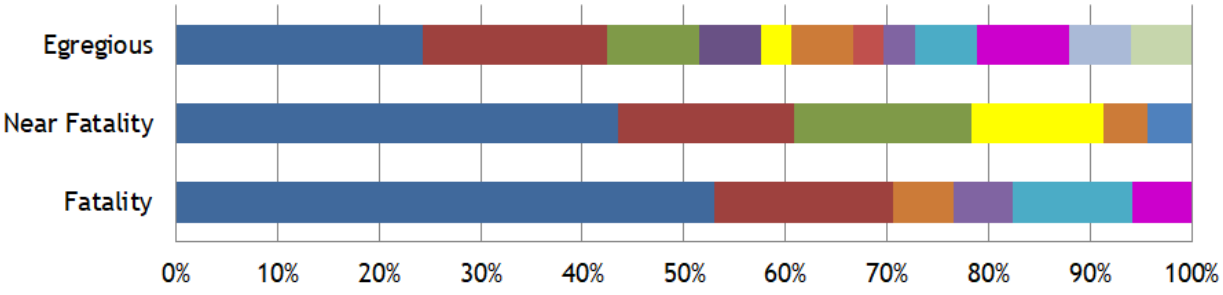
Age at Time of Incident

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 46.6% were under the age of one, and 70.6% of all victims of child fatalities were age three or younger. Colorado's trends continue to mirror the national trends. As displayed in Chart 6, 52.9% (9/17) of the fatalities involved victims younger than one year old, and 70.6% (12/17) were three or younger.

A similar pattern of younger-aged victims exists for the near fatalities, as 43.5% (10/23) of the victims were under the age of one, and 78.3% (18/23) were age three or under (see Chart 6). 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 and 2019, the majority of victims were three or younger. In CY 2019, 57.6% of victims were three or younger.

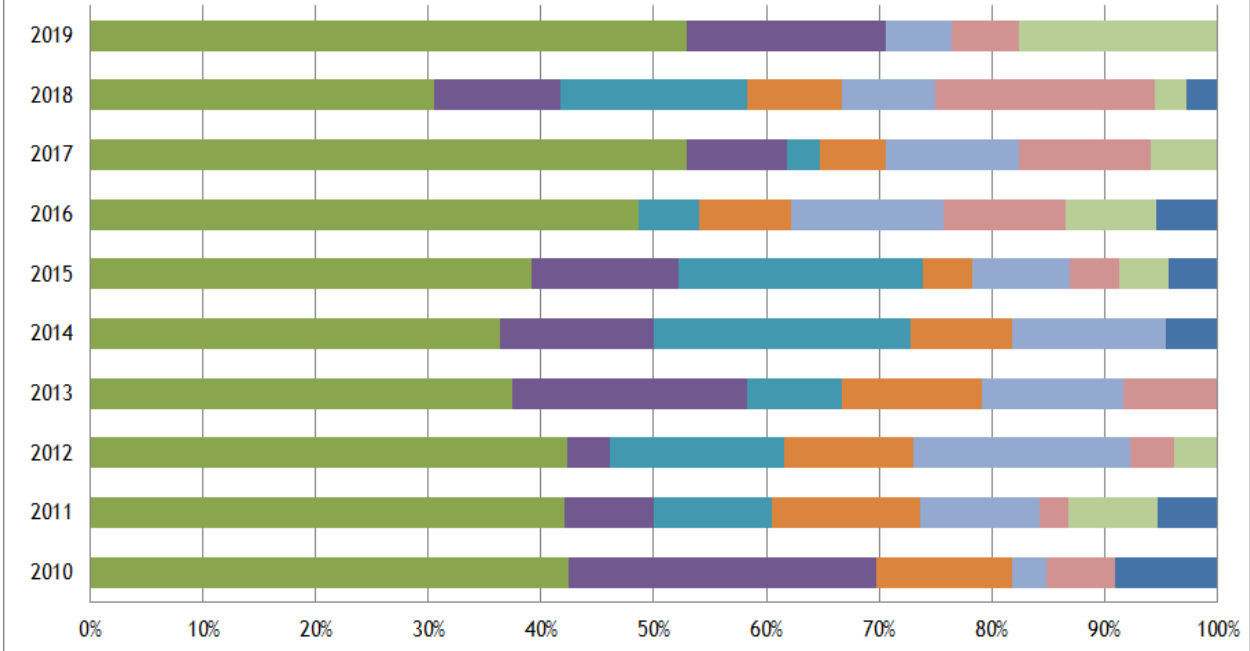
Chart 6: Age of 73 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2019



	Fatality	Near Fatality	Egregious
<1	9	10	8
1	3	4	6
2	0	4	3
3	0	0	2
4	0	3	1
5	1	1	2
6	0	1	0
7	0	0	1
8	0	0	0
9	1	0	1
10	2	0	2
11	1	0	3
12	0	0	2
13	0	0	0
14	0	0	2

Chart 7 displays the trends in ages of victims in child maltreatment fatalities over the past ten calendar years. The data further depicts that children under the age of one year old are the most frequent victims of fatal child maltreatment. Furthermore, when looking at victims age three or younger, this can range from approximately 58%-80% of all victims in child maltreatment fatalities. There is an opportunity to look at how our systems and our communities can help support the well-being and safety of this age group.

Chart 7: Age of Substantiated Victims in Child Maltreatment Fatalities in Colorado over the Past Ten Calendar Years



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
<1	14	16	11	9	8	9	18	18	11	9
1	9	3	1	5	3	3	0	3	4	3
2	0	4	4	2	5	5	2	1	6	0
3	4	5	3	3	2	1	3	2	3	0
4-6	1	4	5	3	3	2	5	4	3	1
7-9	2	1	1	2	0	1	4	4	7	1
10-12	0	3	1	0	0	1	3	2	1	3
13+	3	2	0	0	1	1	2	0	1	0

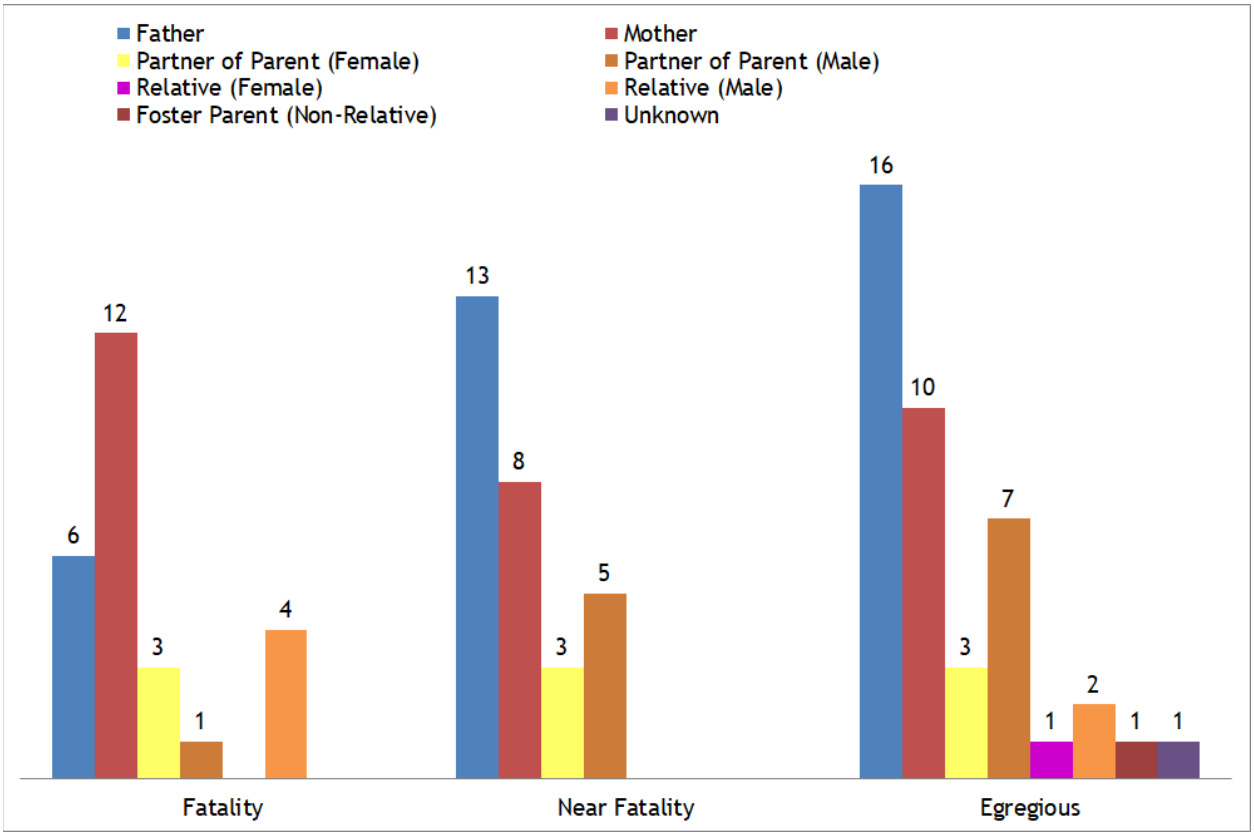
Perpetrator Relationship

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 indicate the mother as the most common perpetrator of a fatal incident of child maltreatment. In FFY 2018, it was noted that 80.3% of fatal incidents of child maltreatment involved one or both parents, sometimes acting alone and sometimes involving another person. In Colorado, for CY 2019, the mother was the most common perpetrator in fatal incidents of child maltreatment, while the most common perpetrator of near fatal and egregious incidents of child maltreatment was the father. Chart 8 further displays the relationship between the perpetrator(s) and the victim(s) of fatal, near fatal, and egregious incidents of child maltreatment. It is important to note there can be more than one perpetrator per child and incident.

In 2019, mothers were the most common perpetrator 46.2% (12/26) across fatal incidents of child maltreatment. Fathers were identified as the second most common perpetrator at 23.1% (6/26). Across near fatal and egregious incidents, fathers were the most common perpetrator

at 44.8% (13/29) and 39.0% (16/41) respectively. Across all substantiated incidents in 2019, one perpetrator was unknown in an egregious incident of child maltreatment, 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 8: Perpetrator Relationship to 73 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado during CY 2019

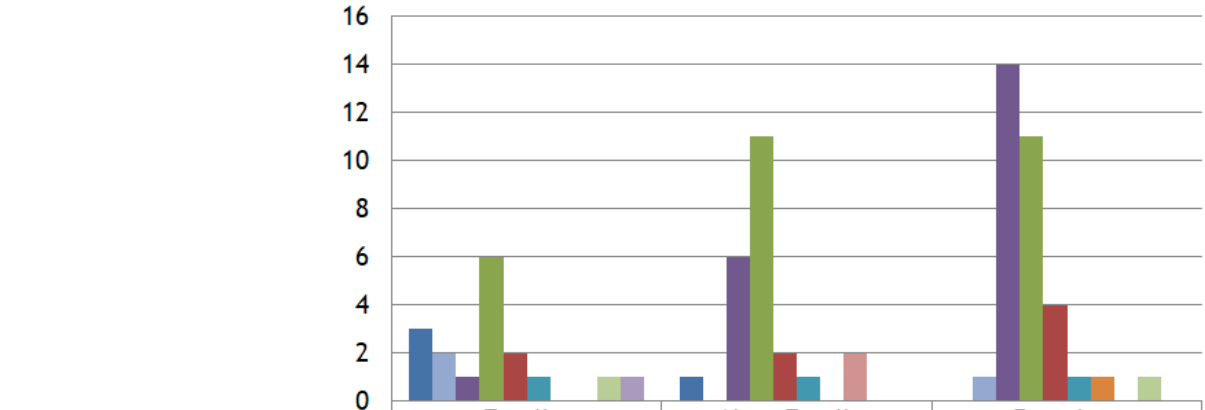


**More than one perpetrator exists for several children.*

Family Structure

In 2019, 38.4% (28/73) 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, 2017, and 2018. The second most common type of family structure across all substantiated fatal, near fatal, and egregious incidents in 2019 was one parent and one unrelated caregiver at 28.8% (21/73).

Chart 9: Family Structure of 73 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2019



	Fatality	Near Fatality	Egregious
One parent	3	1	0
One parent and one related caregiver	2	0	1
One parent and one unrelated caregiver	1	6	14
Two parents	6	11	11
Two parents and relatives	2	2	4
One parent and relatives	1	1	1
Foster Care	0	0	1
One unrelated caregiver	0	2	0
Two related caregivers	1	0	1
One related caregiver and one unrelated caregiver	1	0	0

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 2019 (31 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 Legal 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 51 unique caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed by the CFRT in 2019 (31 incidents); income information was only known for 9/51 of these individuals (17.6%). Of those caregivers with known income information, the average income for legal caregivers involved in fatal incidents is approximately $12,584, $23,333 for near fatal incidents, and $33,516 for egregious incidents.

Educational level was known for 78.4% (40/51) of the legal caregivers involved in fatal, near fatal, and/or egregious incidents of child maltreatment reviewed by the CFRT in 2019. The most common level of completed education of legal caregivers across fatal, near fatal, and egregious incidents of child maltreatment was a high school diploma. This accounted for 35.3% (18/51) of the legal caregivers with a known educational attainment level.

Supplemental Public Benefits

In CY 2019, information regarding supplemental public benefits were gathered for the 31 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 (21/31; 67.7%). In 14 of the 31 incidents reviewed (45.2%) 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), Special Supplemental Nutrition Program-Women, Infants, Children (WIC), Housing Assistance, and Child Care Assistance Program (CCAP).

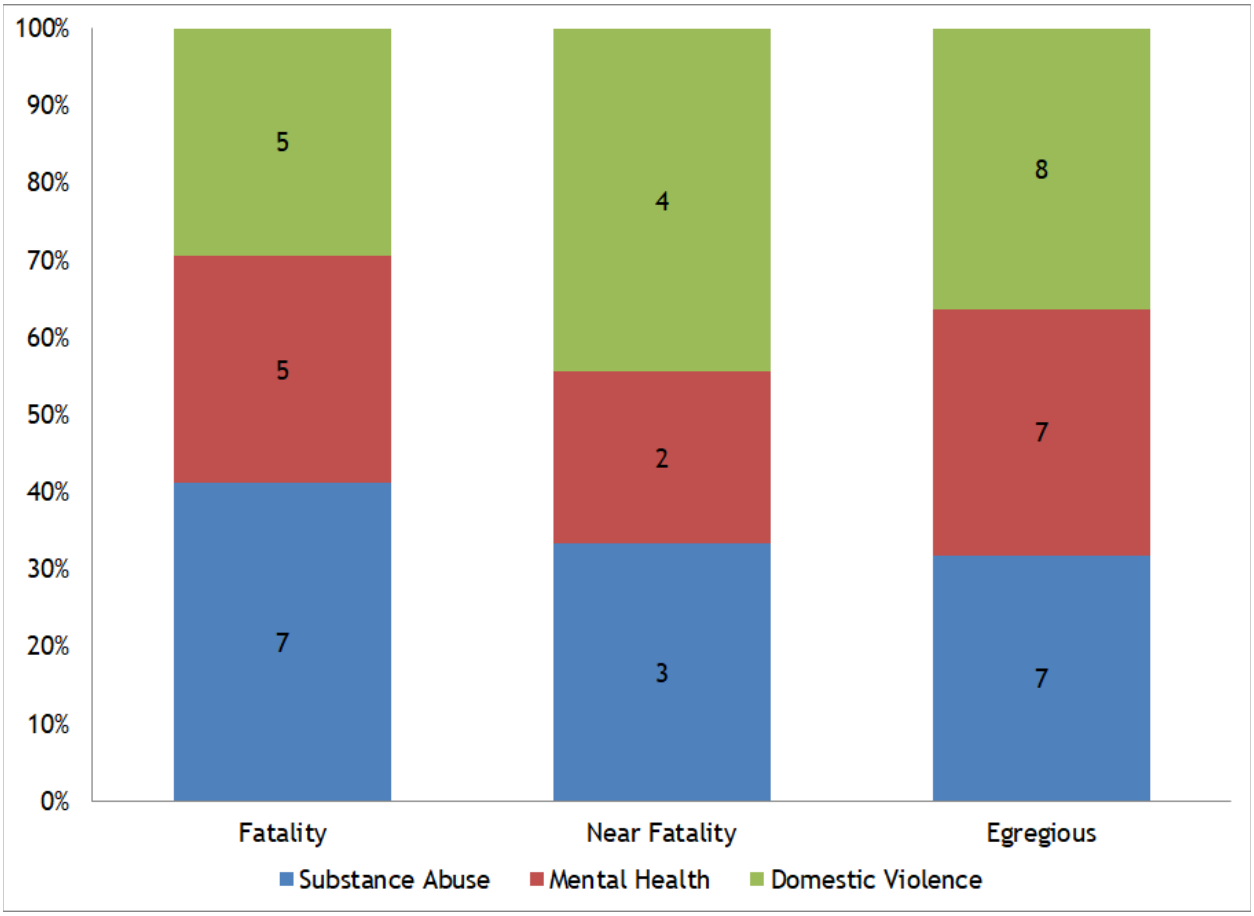
Other Family Stressors

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 31 incidents reviewed by the CFRT in 2019; 11 fatal incidents, 7 near fatal incidents, and 13 egregious incidents. It is important to note that some incidents will not have any of the stressors identified during the review process, while 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, 45.5% (5/11) were identified to have had some history of identified domestic violence and history of mental health issues.

Nationally, in FFY 2018, 5.9% of child fatalities were associated with a caregiver known to abuse alcohol, while 19.3% 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, 63.6% (7/11) of families had some identified history of substance abuse issues. Chart 10

identifies stressors identified/associated with caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed in 2019.

Chart 10: Other Stressors in Families of the Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents Reviewed by the CFRT in 2019



Prior Involvement

In CYs 2014 - 2019 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 2019, 58.8% (10/17) of substantiated fatal child maltreatment incidents, the child, child's family, and/or alleged perpetrator had prior involvement with the child welfare system. In 2018, 47.1% (16/34) of fatal incidents substantiated for abuse or neglect had prior involvement with the child welfare system.

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, who also had prior history and/or current involvement, has ranged from 55% - 65% between 2014 and 2018, and was 50.0% in 2019. Families involved in egregious child maltreatment incidents who had

prior history and/or current involvement followed a similar trend to near fatal incidents, ranging from 50.0% to 68.4% between 2014 and 2018, and was 48.5% in 2019. Chart 11 details the trends in incidents with prior and/or current involvement for the past six calendar years.

Chart 11: Prior and/or Current CPS Involvement of Families in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado from 2014-2019*

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 the type of prior and/or current involvement over the past six years is illustrated in Chart 12 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.

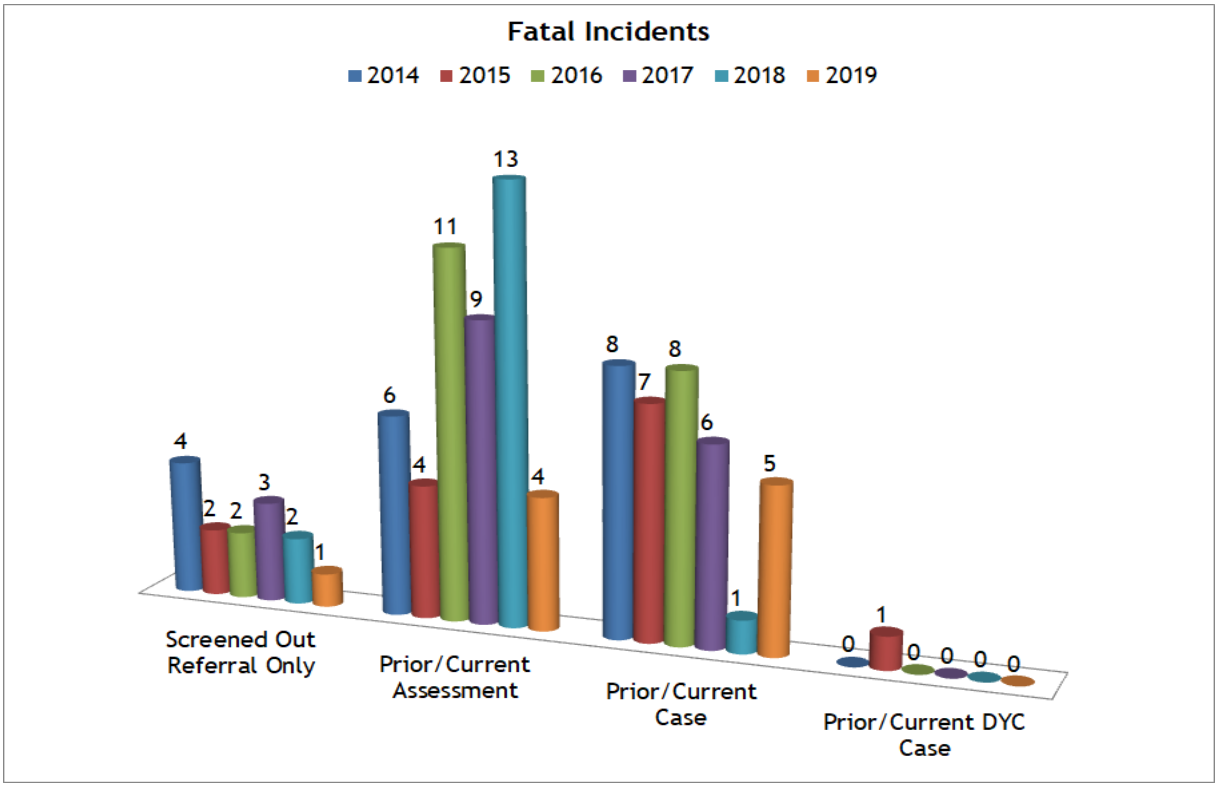
In 2019, for those families with prior involvement, 50.0% (5/10) of families involved with a fatal incident of child maltreatment had a prior and/or case(s), which mirrored trends in 2014

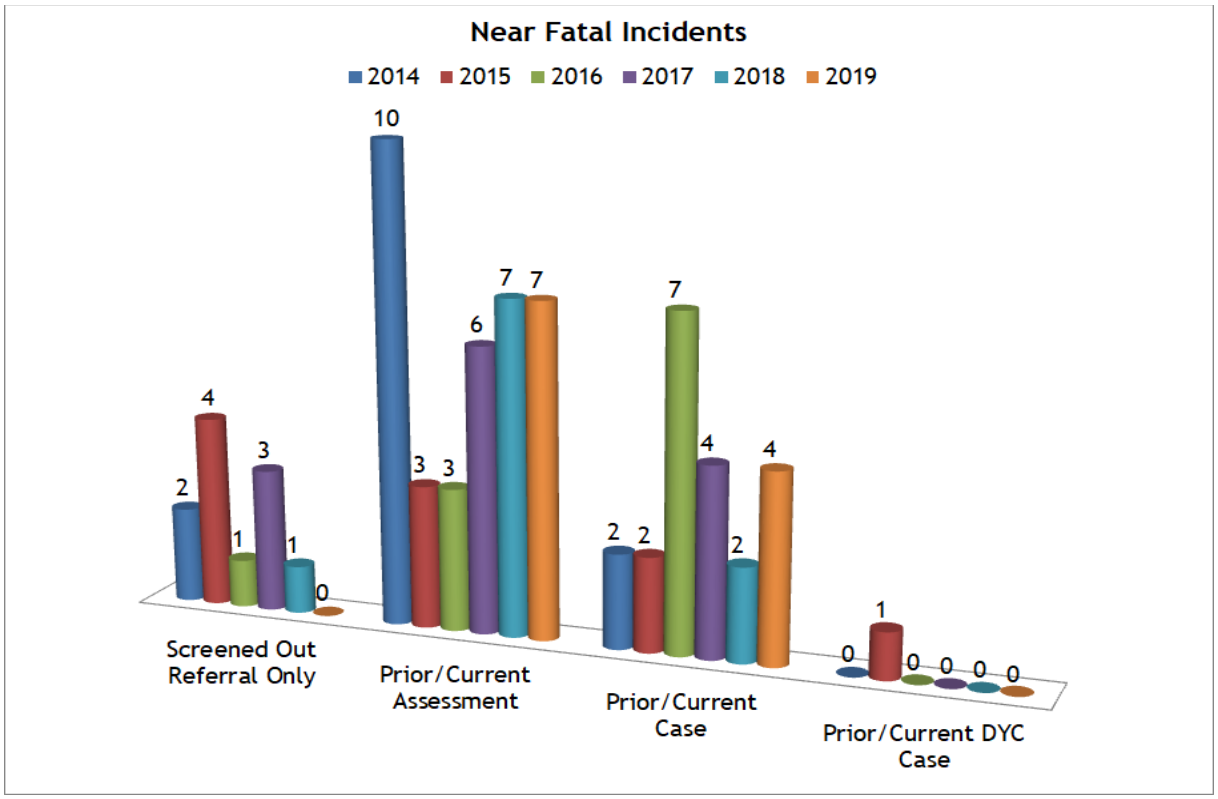
and 2015. Conversely, in CYs 2016, 2017, and 2018, the most common level of prior involvement with the child welfare system was a prior and/or current assessment.

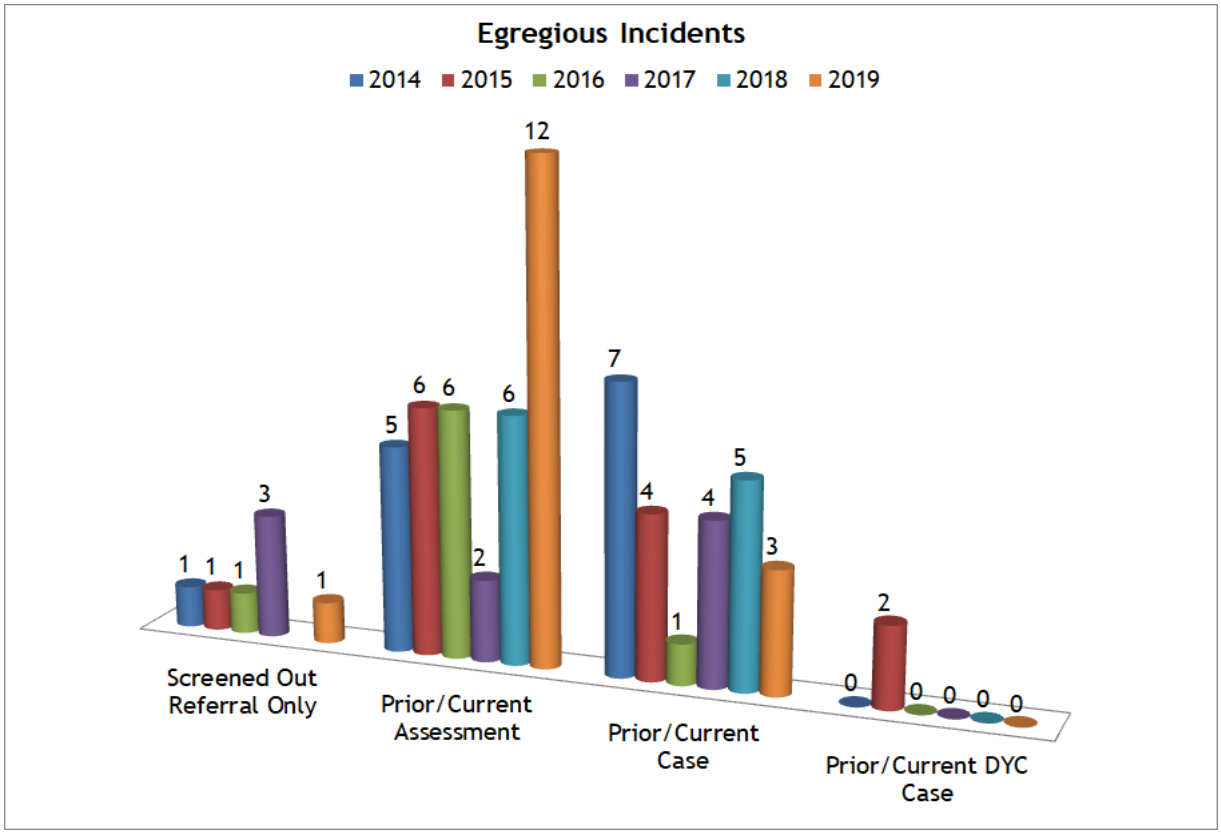
Near fatal incidents in 2019, fell in line with trends seen in 2014, 2017, and 2018 with assessments as the most common level of prior and/or current involvement with the child welfare system (7/11; 63.6%). Conversely, in 2016, the most common level of prior and/or current involvement for incidents of near fatal child maltreatment was a current and/or prior case (7/11; 63.6%).

In 2019, the most common level of prior and/or current involvement with families involved with egregious incidents of child maltreatment was a prior and/or current assessment (12/16; 75.0%) which followed 2015, 2016, and 2018 trends. In 2014 and 2017, 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, was a prior and/or current case.

Chart 12 a-c: Detail of Prior Involvement of Families in Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment




Near Fatal Incidents
2014
2015
2016
2017
2018
2019
2 4 1 3 1 0
10 3 3 6 7 7
2 2 7 4 2 4
0 1 0 0 0 0
Screened Out Referral Only
Prior/Current Assessment
Prior/Current Case
Prior/Current DYC Case


Egregious Incidents
2014
2015
2016
2017
2018
2019
1 1 1 3 1
5 6 6 2 6 12
7 4 1 4 5 3
0 2 0 0 0 0
Screened Out Referral Only
Prior/Current Assessment
Prior/Current Case
Prior/Current DYC Case

Summary of CFRT Review Findings and Recommendations

This section summarizes the findings and recommendations of 33 non-confidential case-specific executive summary reports (hereafter referred to as reports). This includes 33 reports completed and/or posted to the CDHS public notification website after the cut-off date for inclusion in the 2018 CFRT Annual Report (4/1/2019) and prior to and including the cut-off date for inclusion in this year's report (3/31/2020). Each of the 33 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 33 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 related to 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 33 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 33 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 33 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 40 systemic strengths in the delivery of services to children and families. Systemic strengths acknowledged by the team were organized into the following categories: 1) Collaboration, 2) Engagement with Family, 3) Case Practice, 4) Safety, 5) Services to Children and Families, and 6) Documentation. 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.

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 collaboration between county offices and other professional entities was a systemic strength on fourteen occasions across fourteen 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, family and friends of child(ren), and medical providers). 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 nine reports. County departments of human/social services were often recognized for engaging family members to find placements and connect families after an egregious, near fatal, and/or fatal incident of child maltreatment. This involved efforts to engage with parents after the incident occurred, ensuring the 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.

Case Practice

The CFRT identified caseworkers who excelled in case practice seven different times across six reports. Some examples of case practices that were identified as strengths included: thorough documentation of a family's history and utilization of a timeline in order to help organize information and identify themes and/or patterns of behavior, 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, services provided to the child and/or family prior to the fatal, near fatal, and/or egregious incident of child maltreatment, and caseworkers diligently working to find family to use as placement when necessary.

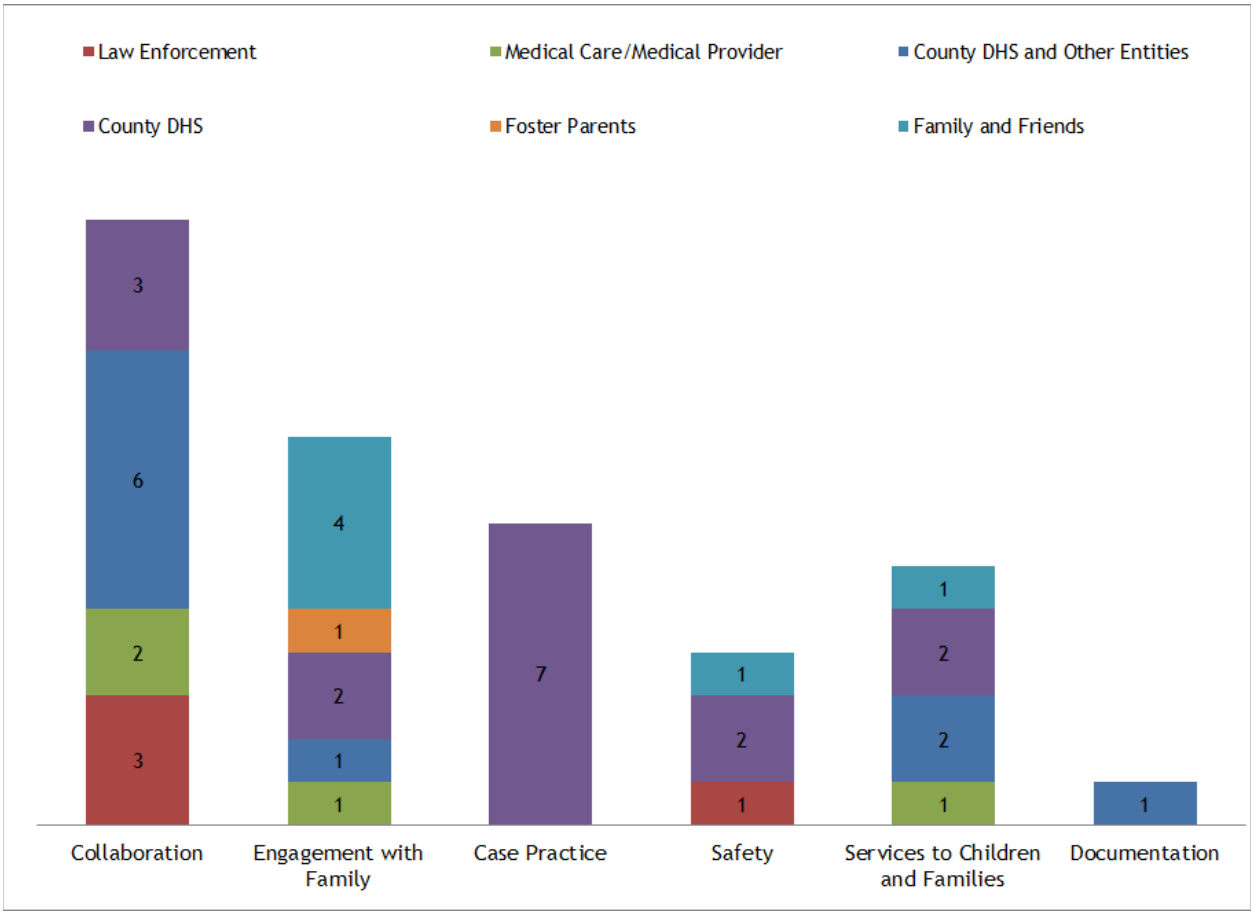
Safety

The CFRT identified four instances across four 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/or egregious incidents of child maltreatment, was noted as a strength six times across six 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, and placements with family members.

Chart 13: Systemic Strengths



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

In the 33 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, 2019 and March 31, 2020, the CFRT identified 13 gaps and deficiencies in the delivery of services to children and families. Systemic gaps and deficiencies were organized into the following categories: 1) Practice and/or Policy, 2) Training and Technical Assistance, 3) Implementation of Safety and Risk Assessment Tools, 4) Legislative, and 5) Monitoring for Trends. Each systemic gap and deficiency, whenever possible, corresponded with a recommendation to address the identified concern. Appendix C contains the recommendations resulting from these 33 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 five times across the 33 reports. Several of the recommendations indicated the need for the Division of Child Welfare (DCW) 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 assessment requirements when there are no surviving siblings. Another example was a recommendation related to the need for additional practice guidance regarding RED Team requirements.

Safety and Risk Assessment Tools

A systemic deficiency identified by the CFRT, two times across the 33 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 12 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, and has continued to provide training and technical assistance to county departments.

Unique Issues

The remaining gaps identified by the CFRT did not constitute overall trends across the 33 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

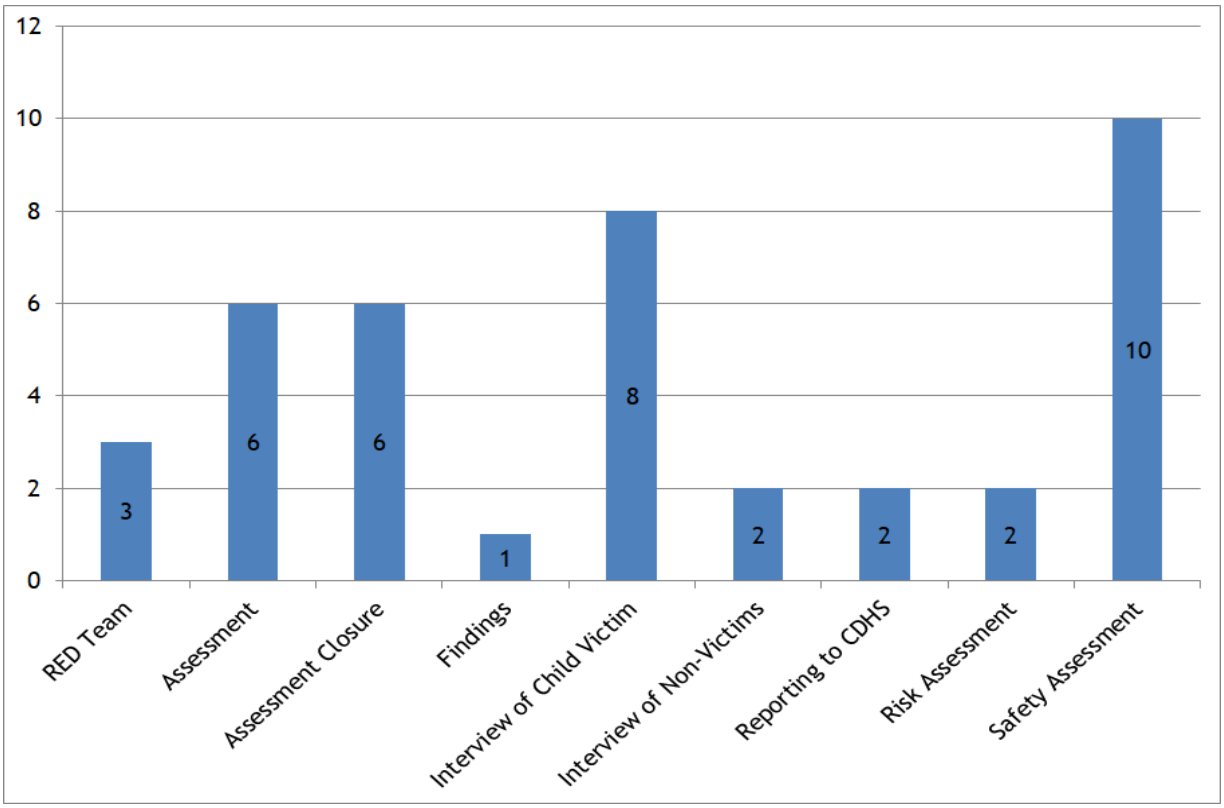
The CFRT staff methodically reviewed county agency documentation regarding the assessment of the fatal, near fatal, and egregious incidents of child maltreatment and prior involvement. In each review, the CFRT staff identified areas of noncompliance with Volume 7 and the Colorado Revised Statutes.

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 gathered from Screen Out, Assessment, In-Home, and Out-of-Home reviews conducted by the Administrative Review Division, and from administrative data gathered by 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 40 policy findings from 33 reports posted between the cutoff for the 2018 CFRT Annual Report (4/1/2019) and the 2019 Annual report (3/31/2020) and many resulted in recommendations. The majority of these policy findings can be categorized into 2 areas of practice: 1) assessment rules and procedures and 2) findings related to the requirement to report to CDHS within 24 hours of becoming suspicious of an incident of fatal, near fatal, and/or egregious child maltreatment. The frequency and specific type of policy finding is contained in Chart 14.

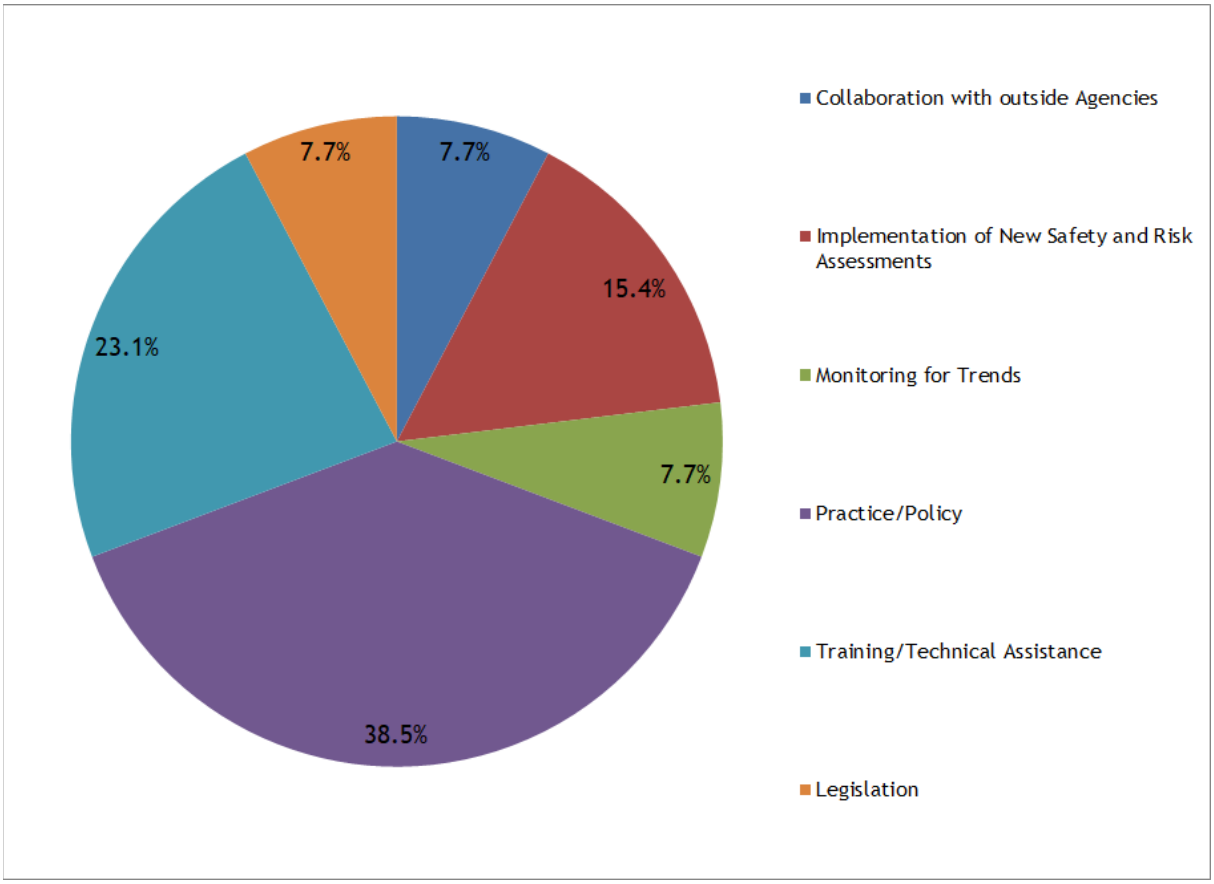
Chart 14: Policy Findings by Type



Recommendations from Posted Reports

A total of 53 recommendations were made across the 33 reports posted between 4/1/2019 and 3/31/2020. This included 13 related to systemic gaps and deficiencies and 40 related to policy findings. As illustrated in Chart 15, the top areas of recommendations are related to: 1) Policies or specific practices; 2) Training and technical assistance from DCW to county departments; and 3) Safety and Risk Assessments.

Chart 15. Focus of Recommendations in the 33 Reports Posted Between 4/1/2019 and 3/31/2020



While several recommendations were reviewed in this report, the full texts of all 53 are contained in Appendix C, as well as the status of the progress on these recommendations. As illustrated in Chart 16, 64.9% of the recommendations have been completed, 11.1% are in progress, and 7.4% have been 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 were recently added to the tracking spreadsheet. This year, 16.7% of the recommendations were not started at the time of this report.

Chart 16: Status of Recommendations(n=53) for Reports Posted Between 4/1/2019 and 3/31/2020

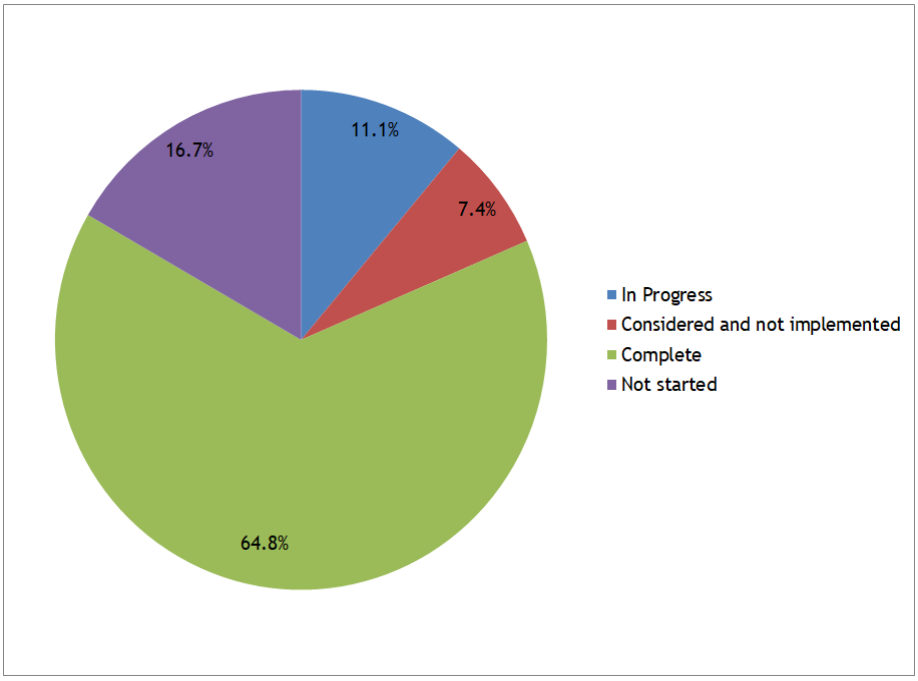
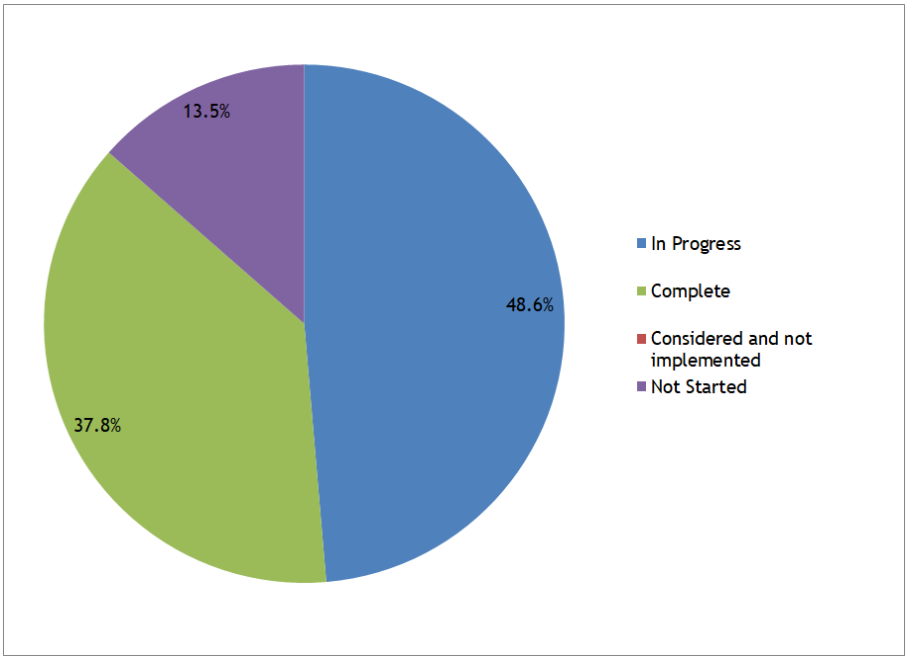


Chart 17: Status of Recommendations(n=37) Not Previously Completed From Reports Posted Prior to 4/1/2019



An update on the implementation status of the 37 recommendations presented in the 2018 CFRT Annual Report that were not completed at that time is presented in full detail Appendix D, as well as summarized in Chart 17 above.

Summary of CFRT Learnings

Learnings from the CFRT

The Colorado Department of Human Services Child Fatality Review Team (CDHS CFRT) was codified in 2011, and has since been conducting multidisciplinary reviews under the authority of Colorado Revised Statute 26-1-139. Through the years of reviewing incidents of fatal, near fatal, and egregious incidents of child maltreatment, we have established that mitigating such incidents of child maltreatment is a community responsibility. It is important to share learnings from such tragedies with the community and other professionals who are responsible for providing services to children and families, so we can continue to reflect on strategies that may help prevent future incidents of child maltreatment.

The CDHS Colorado Child Fatality Review Team currently operates under relevant criteria for excellence in child death reviews, as published by the National Center for Fatality Review and Prevention in 2018. Recent understandings have emerged on a national level that reviews should focus on system level changes and the CDHS CFRT has also come to understand the importance of adopting a systems model approach to case reviews. A systems model approach helps create a space to have vulnerable conversations with counties of human or social services about their practices and lessons learned from these tragedies, while keeping the child(ren) and families at the center of the review. The approach draws upon the multidisciplinary team members around the review table to use their individual expertise and understanding of systems within the community when analyzing the contributing factors and risks that may have led to the tragedy. The following learnings are presented in an effort to help the many systems that serve children and families better understand and identify the factors associated with such incidents of abuse or neglect.

Young children are vulnerable, and are the most common victims of fatal, near fatal, and egregious child maltreatment

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. Colorado and national data have continued to demonstrate the majority of victims are under the age of three. It is essential to connect families with young children to support and resources within their community. Affordable and available resources (home visiting programs, affordable and quality daycare, parenting support, food security, etc.) from the time of a child's birth is essential, and Colorado needs to ensure that service providers, community partners, medical professionals, etc. are playing an active role in assessing child safety and well-being.

Families involved in fatal, near fatal, and/or egregious incidents often have complex histories of trauma and stress

Reviews of fatal, near fatal, and egregious incidents of child maltreatment have shown that prior concerns which were reported to child welfare initially appeared as episodic events; however, timelines leading up to a fatal, near fatal, and egregious incident of child maltreatment share a different story; they often illustrate complex families systems and relationships, layers of stressors, trauma histories, extensive risk factors, patterns of abuse or neglect, and patterns of caregiver behaviors, etc. Child welfare needs to have adequate time and staffing in order to be able to sort through, assess, and provide effective services to children and families.

Violence is a predictor of future child maltreatment

Violence is a prevalent risk factor identified in the histories of the families involved in fatal, near fatal, and egregious incidents of child maltreatment, and research indicates that violence is a predictor of future maltreatment. Families' histories often involve domestic violence and it is evident that Colorado needs more resources for victims, and a system that holds perpetrators accountable for their actions.

Trust but verify

Whether a friend, family member, child welfare professional, teacher, medical professional, etc., it is important to trust but verify information received when a child's safety and/or well-being is in question. Since most incidents of child maltreatment occur at the hands of their caregivers, it is critical to verify information by using other sources of information and collateral contacts outside of the alleged perpetrator and household of the child(ren).

Child maltreatment is a public health and societal issue

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. These tragedies of child maltreatment should be considered a public health issue, and a coordinated and swift approach should be taken in an effort to try and mitigate future incidents of child maltreatment.

CDPHE and CDHS Joint Recommendations to Prevent Child Maltreatment

SUPPORT POLICIES THAT ENSURE ACCESS TO STABLE, QUALITY, AND 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 to prevent child fatalities. Based on the systematic review of cases reviewed by both systems, CFRT and CFPS jointly recommend supporting policies that ensure access to stable, quality, and affordable child care, especially for infants and young children.

This is a joint Colorado Department of Human Services (CDHS) Child Fatality Review Team and CFPS State Review Team recommendation. 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. CFRT identifies factors that may have led to the incident and assesses the sufficiency and quality of services provided to families and their prior involvement with the child welfare system. CFRT puts forth policy and practice recommendations based on identified strengths and systemic gaps and/or deficiencies that may help prevent future incidents of abuse or neglect. These recommendations also strengthen systems that deliver services to children and families.

This is the second year that CFRT and CFPS jointly put forward the recommendation to improve access to child care. In 2019, CFRT and CFPS completed a methodical, joint review of the 79 fatal incidents from 2013 to 2017 that met the review criteria for both systems. CFRT and CFPS then identified trends associated with the circumstances surrounding these deaths, which revealed that lack of access to stable, quality, and affordable child care was a contributing factor in 19% of the 62 deaths among infants and children under 5 years old. Since the need for quality, affordable child care has only increased in Colorado due to the COVID-19 pandemic, both systems continue to jointly support this recommendation. A recent

study of the impact of COVID-19 on child care estimates that 4.5 million child care slots could be lost due to the pandemic. The same analysis estimates that 55% of Colorado's child care slots could be lost, effectively doubling the need for licensed child care slots in the state.[68]

This recommendation is based on local team, CFPS State Review Team, and past CFPS recommendations impacts: child maltreatment deaths (abuse and neglect), sudden unexpected infant deaths (SUID), violent deaths (homicides, suicides and firearm deaths), unintentional injuries deaths (drowning, falls, fire, poisoning) and motor vehicle deaths.

Child care is an important factor to protect against family stress and is an evidence-based strategy to support families and prevent child maltreatment.[69, 70, 71] Subsidized child care has been shown to decrease child maltreatment, including both abuse and neglect.[72] Child maltreatment is less likely to occur when children are in families where caregivers have less economic strain and stress.[73] Additionally, child care encourages family engagement and allows caregivers to work outside the home, which contributes to family economic stability. Quality child care often includes early learning and education, which can positively impact infant and child development for children under 5 years old.[74]

While the health and social benefits of child care are well established, access to child care that is not only affordable, but also stable and of high quality, remains limited in Colorado. Many Colorado families are not able to afford child care, which may lead to increased financial and emotional stress and may force families to make decisions based on money, rather than what they think is best for their infants and young children. Child Care Aware of America estimates the annual cost of center-based child care in Colorado is $15,600 and $10,400 for home-based care. The annual cost of college tuition at a four-year college in Colorado is $11,140, which means that center-based child care costs exceed the costs of higher edcuation.[75]

Though the high cost of child care in Colorado is a major barrier for many families, the lack of stable, affordable, and quality child care, especially for infants and those under age 5, disproportionately impacts families with the lowest incomes, families living in rural communities, and Hispanic or Latino families. Married caregivers with two children living at the poverty line pay nearly 110% of their household income for center-based child care in Colorado.[76] Across the U.S., 60% of rural communities lack adequate child care resources to meet rural families' needs.[77] Additionally, nearly 60% of Hispanic or Latino families live in areas considered to be child care deserts.[78]

In addition to decreasing the economic burden on families across the state, increasing access to child care can also establish norms in Colorado that shift perceived responsibility of children and child care from a personal or individual family responsibility, to a shared

responsibility. Policymakers can play a role in increasing public support for policies supportive of children and families, such as child care.[79]

In response to the COVID-19 pandemic, the Emergency Child Care Collaborative began meeting in March 2020 to create an emergency child care system in Colorado. Initiated by Governor Polis, the Colorado Department of Human Services, and Gary Community Investments collaborate with various partners including early childhood providers, advocacy groups, school districts, and foundations. Funded through the federal Child Care and Development Funds (CCDF) and foundation funding, the public-private partnership extends free child care (a full tuition credit) for essential workers, including those working in health care, public safety, and other sectors identified in Updated Public Health Order 20-24 issued by the Colorado Department of Public Health and Environment.81 [80]

While emergency child care is essential during the pandemic, these supports are short-lived and are not able to fully address the larger child care gaps and needs in Colorado. State and local policymakers and organizations have an opportunity to further support strategies that ensure access to stable, quality, and affordable child care, such as those highlighted below.

Support implementation of Senate Bill 19-063: Infant and Family Child Care Action Plan.[81] The Infant and Family Child Care Action Plan includes several recommendations to increase availability of family child care homes and infant child care. Recommendations include providing financial, business, and professional support to prospective and existing family child care home providers and centers serving infants; increasing access to training and professional supports that enable infant care professionals and family child care providers to provide high-quality care; adding resources to the child care licensing process to increase support and training to providers and decrease time to obtain a background check; clarifying, coordinating, and resolving differences among state and local regulatory agencies to remove administrative and financial burdens, and assure safe environments for children in family child care homes; and examining how early education and other policies impact the availability of licensed infant care and family child care homes.

Supporting implementation of the Colorado Shines Brighter Strategic Plan.[82] The Colorado Shines Brighter Strategic Plan includes activities to maximize the number of high-quality early care and education options available to families, especially for families living in rural areas, families of infants and toddlers, and families of children with special needs. Activities include increasing the availability of affordable, convenient, and quality care, especially for infants and toddlers; providing more equitable and culturally relevant care; increasing inclusivity and access for children with special needs; continuing to invest in quality-enhancing professional development opportunities and workforce recruitment and retention across the early care and education (ECE) landscape; continuing to develop a diverse early childhood workforce; increasing knowledge and supports around child care licensing and offer essential business supports to child care providers; centralizing and increasing parent and caregiver access to early childhood information; increasing transition knowledge and associated supports by building relationships between families and early childhood professionals; expanding access to

early childhood mental health consultation; investing in rural outreach through micro-grants and other in-person and digital supports to increase the number of licensed and quality child care providers; integrating disparate data sources to improve Colorado's understanding of how programs and services interact to best serve and support children and families; and enhancing cross-sector collaboration to build data systems that support coordinated care and capture long-term outcomes

Increase funding and reduce systemic barriers for programs that provide concrete supports to families. There are several existing programs that provide concrete supports to families, but could benefit from modifications to reduce systemic barriers that keep families from accessing the programs. For example, Colorado families can access child care assistance programs, specifically the Colorado Child Care Assistance Program (CCCAP). However, some counties in the state require families applying for CCCAP to first seek child support from the non-custodial parent prior to being eligible for CCCAP, which limits access to the program. In addition, families in Colorado may be eligible for Colorado Works/Temporary Assistance to Needy Families (TANF), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the Supplemental Nutrition Assistance Program (SNAP). These programs support families in being able to afford child care.[83] While families can enroll in many of these benefits on Colorado PEAK, a centralized system where families can be screened and apply for a variety of economic supports, administering organizations can further minimize barriers and increase enrollment to these programs through additional online applications, less frequent re-enrollment requirements, not including child support payments in family income calculations, and expanding eligibility.

Support policies that provide training and education to family, friend, and neighbor caregivers. By passing policies that provide training and education to these caregivers, there will be the opportunity to increase the quality of care in licensed-exempt settings. This is important, as many families choose this care option because of the high cost of child care in licensed child care centers.

Increase access to care for families seeking substance misuse treatment. During the 2019 legislative session, state policymakers passed House Bill 19-1193, Behavioral Health Supports for High-Risk Families, which created a pilot program to provide child care services to pregnant or parenting individuals seeking or participating in substance use disorder treatment. Additional funding is needed to increase access to innovative child care resources like this program, especially for families experiencing high stress levels due to life events like seeking substance misuse treatment.

Dedicate additional resources to support child care workforce development. Further supporting child care workforce development in Colorado can increase the number of child care slots in Colorado and the quality of care provided by well-trained professionals. Current opportunities to develop the workforce include House Bill 19-1005, Early Childhood Educator Tax Credit, which established a refundable, annual tax credit for credentialed early childhood educators working at qualified facilities, and House Bill 19-1210, Local Government Minimum

Wage, which allowed local governments to establish their own minimum wage laws. County-level increases in the minimum wage may increase salaries for early childhood educators and child care providers and build towards paying the early childhood workforce a livable wage.

While Colorado policymakers, state agencies, and non-profit partners have made strides to increase access to quality, affordable, and stable child care for families in the state, the current and growing need for care far exceeds the supply. Given the impact of the COVID-19 pandemic on child care facilities and homes, policymakers can continue to support Colorado families and communities to become more resilient to global crises like the COVID-19 pandemic by supporting access to stable, quality, and affordable child care.

References

1. Jessen-Howard, S. and Workman, S. (2020, April 24). Coronavirus Pandemic Could Lead to Permanent Loss of Nearly 4.5 Million Child Care Slots. Center for American Progress. Retrieved from www.americanprogress.org/issues/early-childhood/news/2020/04/24/483817/coronavirus-pandemic-lead-permanent-loss-nearly-4-5-million-child-care-slots.
2. Association of State and Territorial Health Officials (ASTHO). (n.d.). Essentials for childhood: Policy guide. Retrieved from www.astho.org/Prevention/Essentials-for-Childhood-Policy-Guide.
3. Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L.K., & Alexander, S. P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
4. Executive Office of the President Council of Economic Advisers. (2016). Inequality in early childhood and effective public policy and effective public policy interventions. In Economic report of the president (Chapter 4). Retrieved from www.gpo.gov/fdsys/pkg/ERP-2016/pdf/ERP-2016-chapter4.pdf.
5. Association of State and Territorial Health Officials (ASTHO). (n.d.). Essentials for childhood: Policy guide. Retrieved from www.astho.org/Prevention/Essentials-for-Childhood-Policy-Guide.
6. Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
7. Executive Office of the President Council of Economic Advisers. (2016). Inequality in early childhood and effective public policy and effective public policy interventions. In Economic report of the president (Chapter 4). Retrieved from www.gpo.gov/fdsys/pkg/ERP-2016/pdf/ERP-2016-chapter4.pdf.
8. Child Care Aware of America. (2020). Price of Child Care in: Colorado. Retrieved from www.childcareaware.org/our-issues/research/the-us-and-the-high-price-of-child-care-2019/.
9. Child Care Aware of America. (2020). Price of Child Care in: Colorado. Retrieved from www.childcareaware.org/our-issues/research/the-us-and-the-high-price-of-child-care-2019/.
10. Malik, R., Hamm, K., Schochet, L., Novoa, C., Workman, S., and Jessen-Howard, S. (2018). America's Child Care Deserts in 2018. Center for American Progress. Retrieved from www.americanprogress.org/issues/early-childhood/reports/2018/12/06/461643/americas-child-care-deserts-2018/
11. Malik, R., Hamm, K., Schochet, L., Novoa, C., Workman, S., and Jessen-Howard, S. (2018). America's Child Care Deserts in 2018. Center for American Progress. Retrieved from www.americanprogress.org/issues/early-childhood/reports/2018/12/06/461643/americas-child-care-deserts-2018/.
12. Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
13. Emergency Child Care Collaborative, Frequently Asked Questions. (2020). Office of Early Childhood, Colorado Department of Human Services. Retrieved from coloradoofficeofearlychildhood.force.com/oec/OEC_Resources?p=Resources&s=Frequently-Asked-Questions-Emergency-Child-Care-Collaborative&lang=en.

14. Colorado Senate Bill 19-063 Infant and Family Child Care Action Plan: *A strategic action plan to address infant and family child care home shortages in Colorado*. (2019, December). Office of Early Childhood, Colorado Department of Human Services. Retrieved from coloradoofficeofearlychildhood.force.com/oec/OEC_Partners?p=Partners&s=SB63&lang=en.
15. *Colorado Shines Brighter, Opportunities for Colorado's Early Childhood System: Twelve Key Findings from the 2019 Birth through Five Needs Assessment*. (2020, January). Office of Early Childhood, Colorado Department of Human Services. Retrieved from coloradoofficeofearlychildhood.force.com/oec/OEC_Partners?p=Partners&s=Colorado-Shines-Brighter&lang=en.
16. Association of State and Territorial Health Officials (ASTHO). (n.d.). Essentials for childhood: Policy guide. Retrieved from www.astho.org/Prevention/Essentials-for-Childhood-Policy-Guide.

Appendix A: 2019 CFRT Attendance

	1.7.19	2.4.19	3.4.19	4.1.19	5.6.19	6.3.19	7.1.19	8.5.19	9.9.19	10.7.19	11.4.19	12.2.19
Lucinda Connelly *CDHS, Child Protection Manager*	Yes	Yes	Yes	Yes	By Phone	**No**	Yes	**No**	Yes	Yes	Yes	By Phone
→**Backup:** Korey Elger	---	---	---	---	---	---	---	**No**	---	---	---	---
Brooke Ely-Milen *CDHS, Domestic Violence Program Director*	Yes	Yes	Yes	Yes	By Phone	Yes	Yes	Yes	Yes	Yes	---	Yes
→**Backup:** Beth Collins											Yes	---
Allison Gonzales *Administrative Review Division, Manager*	Yes	Yes	Yes	Yes	---	Yes	Yes	Yes	Yes	---	Yes	Yes
→**Backup:** Marc Mackert	---	---	---	---	Yes	---	---	---	---	Yes	---	---
Kate Jankovsky *CDPHE, Child Fatality Prevention System Coordinator*	Yes	Yes	Yes	Yes	**No**	**No**	**No**	By Phone	Yes	By Phone	**By Phone**	By Phone
Christal Garcia *CDPHE, Violence and Injury Prevention*	Yes	Yes	**No**	Yes	**No**	**No**	Yes	**No**	Yes	Yes	**No**	**No**
Lora Thomas *Douglas County Commissioner*	**No**	**No**	**No**									
Angela Sneddon *Morgan County Human Services*											Yes	Yes
Casey Tighe *Jefferson County Commissioner*	**No**	**No**	**No**	Yes	Yes	Yes	Yes	By Phone	**No**	Yes	By Phone	By Phone
Marc Dettenrieder *Teller County Commissioner*			Yes	Yes	Yes	**No**	Yes	Yes	Yes	**No**	Yes	**No**
Senator Jim Smallwood *Senate Majority Leader appointment*	**No**	**No**	**No**	**No**	**No**	**No**	By phone	**No**	**No**	**No**	**No**	**No**
Representative Jonathan Singer *House of Representatives Majority Leader appointment*	**No**	**No**	**No**	**No**	By Phone	By phone	By Phone	By Phone	**No**	**No**	**No**	**No**
Sara Embrey *Office of Colorado's Child Protection Ombudsman*	---	**No**	Yes	Yes	By Phone	Yes	Yes	**No**	Yes	**---**	Yes	Yes
→**Backup:** Stephanie Villafuerte/Amanda Pennington	By Phone	**No**	---	---	---	---	---	**No**	Yes/AP	Yes/AP	---	---

	1.7.19	2.4.19	3.4.19	4.1.19	5.6.19	6.3.19	7.1.19	8.5.19	9.9.19	10.7.19	11.4.19	12.2.19
Sgt. Brian Cotter *Denver Police Department*	Yes	**No**	**No**	**No**	Yes	**No**	**No**	**No**	Yes	**No**	**No**	**No**
Dr. Andrew Sirotnak *Professor of Pediatrics, University of Colorado School of Medicine Director, Child Protection Team at Children's Hospital Colorado*	**No**	Yes	Yes	Yes	**No***	**No**	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Dr. Antonia Chiesa	**No**	---	---	---	**No**	---	---	---	---	---	---	---
Amy Ferrin *Deputy District Attorney, 18th Judicial District*	Yes	By Phone	**No**	By Phone	By Phone	Yes	Yes	By Phone	**No**	Yes	By Phone	**No**
Mara Kailin, PsyD *Aurora Mental Health Center, Director*	**No**	Yes	**No**	Yes	Yes	Yes	**No**	Yes	**No**	**No**	Yes	Yes
→**Backup:** Kathy Snell	**No**	---	**No**	---	---	---	**No**	---	**No**	**No**	---	---
Angel Weant *CO Division of Probation Services*	Yes	By Phone	By Phone	By Phone	By Phone	By Phone						
→**Backup:** Dana Wilks	---	---	---	---	---	---						
Don Moseley, *Ralston House Child Advocacy Center, Director*	By Phone	Yes	**No**	Yes	By Phone	**No**						
Dan Makelky, *Douglas County Department of Human Services*	---	---	---	---	---	---	---	---	---	---	---	---
→**Backup:** Ruby Richards/Nicole Adams	Yes/RR	Yes/NA	Yes/RR	Yes/RR	Yes/RR	By Phone/ NA	Yes/RR	By Phone/R R	Yes/NA	Yes/RR	By Phone/RR	Yes/NA
Angela Mead *Larimer County Human Services*	Yes	By Phone	By Phone	Yes	Yes	Yes	By Phone	By Phone	Yes	**No**	By Phone	Yes
Jill Calvert *El Paso County Department of Human Services*	---	---	By Phone	Yes	---	---	Yes	---	Yes	By Phone	**No**	Yes
→**Backup:** Krystal Grint/April Jenkins/Kris Reed	By Phone/KG	Yes/KG	By Phone/KG	Yes/KG	By Phone/KG	Yes/KG	---	By Phone/K R	---	---	**No**	---

	1.7.19	2.4.19	3.4.19	4.1.19	5.6.19	6.3.19	7.1.19	8.5.19	9.9.19	10.7.19	11.4.19	12.2.19
Cheryl Hyink *Administrative Review Division Staff*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Angela Myers *Administrative Review Division Staff*	Yes	Yes	By Phone	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Len Newman *Administrative Review Division Staff*	Yes	Yes	Yes	Yes	Yes	**No**	Yes	Yes				
Libbie McCarthy *Attorney General's Office*	**No**	---	---									
Sarah Richelson *Attorney General's Office*				---	Yes	Yes	Yes	Yes	---	Yes	---	Yes
Anita Schutte *Attorney General's Office*	**No**	Yes	Yes	Yes	---	---	---	---	Yes	---	Yes	---

Appendix B: 2012-2019 Incidents Qualified for CFRT Review by County and Type

County*	Fatal Incidents								Near Fatal Incidents								Egregious Incidents								2012 Total	2013 Total	2014 Total	2015 Total	2016 Total	2017 Total	2018 Total	2019 Total
	2012	2013	2014	2015	2016	2017	2018	2019	2012	2013	2014	2015	2016	2017	2018	2019	2012	2013	2014	2015	2016	2017	2018	2019								
Adams	2	2		2	1	2	2	1			1		3	1				3	2			1	1	2	2	5	3	2	4	4	3	3
Alamosa																		1								1						
Arapahoe		2	1	1	4	1	2	1				1		2		1		1		2	1	1	2	2		3	1	4	5	4	4	4
Archuleta							1											1	1							1	1				1	
Broomfield						1										1														1		1
Boulder		1	1					1		1		1	2			1							1	2		2	1	1	2		1	4
Chaffee						1																								1		
Clear Creek			1																								1					
Denver	1	1	4	1	1		2	1	1	3	3	3	1	1	2	1		7	3	3	3	3	4	7	2	11	10	7	5	4	8	9
Douglas					1	1		1						1							1			1					2	2		2
Eagle	1			1																					1			1				
El Paso	2	1	2		4	4	4	2		1	1	1	1	5	2	3	1		1	1	1	1	1	1	3	2	4	2	6	10	7	6
Fremont											1							1	2	1			1			1	3	1			1	
Garfield				1				1																				1				1
Huerfano			1																								1					
Jefferson			2	2	2	3					4		1	1	1	2		2	1	3						2	7	5	3	4	1	2
La Plata					1		1					1		1	1							1						1	1	2	2	
Larimer			1	1	1	3	1	1										4		2				1		4	1	3	1	3	1	2
Las Animas				1																								1				
Lincoln																				1								1				
Logan	1		1																						1		1					
Mesa	1		1	1	2		1	1		1		1			2	1									1	1	1	2	2		3	2
Moffat					1		1						1																2		1	
Montezuma					1														1								1		1			
Montrose					1																								1			
Morgan			1							1	1		1			1						1				1	2		1	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	**37**

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

Appendix C: Recommendations from 2019 Posted Reports

CFRT ID	Recommendation Type	Recommendation	Status
19-003	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for ACDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the June 2019 C-Stat, ACDHS's performance for April 2019 was 90.1 %, with a statewide goal of 95%. It is recommended that ACDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Not Started
19-003	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for ACDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the June 2019 C-Stat, ACDHS's performance for March 2019 was 81.6% 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 September 25, 2018-February 22, showed ACDHS at 54.5% for observing/interviewing the alleged victim within the assigned response time, which is above the Ten Large County average (not including ACDHS) of 67.9% for a comparable time span. It is recommended that ACDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete

19-003	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 ACDHS. 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 25, 2018-February 22, 2019, ACDHS completed the Colorado Family Safety Assessment Tool when required 56.4% of the time, which is below the Ten Large County average (not including ACDHS) of 63.1% for a comparable time span. It is recommended that ACDHS 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. Additionally, the policy finding related to the Colorado Family Safety Assessment Tool not being completed with all required individuals does not reflect a systemic issue for ACDHS. In a recent review of a generalizable random sample of assessments that were conducted during a period from September 25, 2018-February 22, 2019, ACDHS completed the current or impending danger section of the Colorado Family Safety Assessment with all required individuals in 80% of assessments, which is above the Ten Large County average (not including ACDHS) of 79.1% for a comparable time span. The Department encourages ACDHS to continue monitoring performance in this area of practice.	In Progress
19-003	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 ACDHS. 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 25, 2018-February 22, 2019, ACDHS completed the Colorado Family Safety Assessment Tool accurately 23.6% of the time, which is below the Ten Large County average (not including ACDHS) of 39.4% for a comparable time span. It is recommended that ACDHS 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	In Progress

19-009	CFRT	The CFRT recommended that the Administrative Review Division (ARD), with assistance from county departments of human or social services, ensure that Child Placement Agency (CPA) personnel are invited to reviews of fatal, near fatal, and egregious child maltreatment incidents when those incidents occur in foster homes licensed by CPAs.	In Progress
19-009	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for JCDCYFAP. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the August 2019 C-Stat, JCDCYFAP's performance for May 2019 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 July 11, 2018 through January 11, 2019, showed JCDCYFAP at 76.4% for observing/interviewing the alleged victim within the assigned response time, which is above the Ten Large County average (not including JCDCYFAP) of 66.5% for a comparable time span. It is recommended that JCDCYFAP 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
19-009	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 ACDHS. 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 July 29, 2018 through January 29, 2019, ACDHS completed the Colorado Family Safety Assessment Tool when required 56.4% of the time, which is below the Ten Large County average (not including ACDHS) of 63.1% for a comparable time span. It is recommended that ACDHS 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

19-027	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 September 2019 C-Stat, Arapahoe County DHS's performance for July 2019, was 83.2%, 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.	Complete
19-035	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 23, 2018, through March 23, 2019, DDHS completed the Colorado Family Safety Assessment Tool accurately 39.3% of the time, which is above the Ten Large County average (not including DDHS) of 34% 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

19-035	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for JCDCYFAP. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the September 2019 C-Stat, JCDCYFAP's performance for July 2019, was 90.7%, with a statewide goal of 95%. It is recommended that JCDCYFAP implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Not Started
19-035	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for JCDCYFAP. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the September 2019 C-Stat, JCDCYFAP's performance for June 2019, was 81.9% with a statewide goal of 95%. It is recommended that JCDCYFAP implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Not Started
18-044	CFRT	The CFRT formally recommended the need for accessible and affordable child care for all families. The CFRT recommended for CDHS to partner with the Colorado Department of Public Health and Environment (CDPHE) and the Office of Early Childhood (OEC) to determine the best action steps on how to work towards the recommendation of accessible and affordable child care for all families.	In Progress
18-044	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 February 2019 C-Stat, ACHSD's performance for December 2018, was 86.8%, 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.	Complete

18-044	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for ACHSD. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the February 2019 C-Stat, ACHSD's performance for November 2018, was 90.5% 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 February 25, 2018, to August 25, 2018, showed ACHSD at 54.5% for observing/interviewing the alleged victim within the assigned response time, which is below the Ten Large County average (not including ACHSD) of 69.4% for a comparable time span. It is recommended that ACHSD 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

18-044	Policy Finding	The policy finding related to making reasonable efforts to observe/interview the alleged victim does reflect a systemic practice issue for ACHSD. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of February 25, 2018, to August 25, 2018, showed ACHSD making reasonable efforts to observe/interview alleged victims 46.2% of the time, which is below the Ten Large County average (not including ACHSD) of 51.3% for a comparable time span. It is recommended that ACHSD 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

18-044	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 ACHSD. 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 February 25, 2018, to August 25, 2018, ACHSD completed the Colorado Family Safety Assessment Tool accurately 25.5% of the time, which is below the Ten Large County average (not including ACHSD) of 44.2% for a comparable time span. It is recommended that ACHSD 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.	Complete
18-044	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 ACHSD. 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 February 25, 2018, to August 25, 2018, ACHSD completed the Colorado Family Safety Assessment Tool when required 67.3% of the time, which is above the Ten Large County average (not including ACHSD) of 66.2% for a comparable time span. It is recommended that ACHSD 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.	Complete
18-044	Policy Finding	The policy finding related to all required parties being interviewed as part of the assessment does reflect a systemic practice issue for ACHSD. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of February 25, 2018, to August 25, 2018, showed that ACHSD interviewed all required parties 40.7% of the time, which is below the Ten Large County average (not including ACHSD) of 76.4% for a comparable time span. It is recommended that ACHSD employ a process in which barriers to interviewing all required parties as part of the assessment are identified and solutions to the identified barriers are implemented.	Complete

18-091	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for ACDHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the April 2019 C-Stat, ACHDS's performance for February 2019, was 91.7%, with a statewide goal of 95%. It is recommended that ACDHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Not Started
18-091	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 April 2019 C-Stat, DDHS's performance for January 2019, was 84.9% 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 March 30, 2018, through September 30, 2018, showed DDHS at 76.4% for observing/interviewing the alleged victim within the assigned response time, which is above the Ten Large County average (not including DDHS) of 68.5% for a comparable time span. 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.	Not Started
18-091	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 of March 30, 2018, through September 30, 2018, DDHS completed the Colorado Family Safety Assessment Tool when required 49.1% of the time, which is below the Ten Large County average (not including DDHS) of 67.4% 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.	Complete

18-091	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 of March 30, 2018, through September 30, 2018, DDHS completed the current or impending danger section of the Colorado Family Safety Assessment with all required individuals in 60% of assessments, which is below the Ten Large County average (not including DDHS) of 85.6% for a comparable time span. It is recommended that DDHS employ a process in which barriers to completing the Colorado Family Safety Assessment Tool with all required individuals are identified and solutions to the identified barriers are implemented.	Complete
18-091	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 of March 30, 2018, through September 30, 2018, DDHS completed the Colorado Family Safety Assessment Tool accurately 29.1% of the time, which is below the Ten Large County average (not including DDHS) of 43.8% 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.	Complete

17-037	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
17-037	Policy Finding	The policy finding related to the timeliness of notification of the fatality does reflect a systemic practice issue for LCHS. During the year time span from October 15, 2016 through October 15, 2017, LCHS provided timely notification to CDHS in 0% 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
17-060	Policy Finding	The policy finding related to the timeliness of notification of the egregious incident does reflect a systemic practice issue for Morgan County DHS. During the time span from November 27, 2016 through November 27, 2017, Morgan County DHS provided timely notification to CDHS in 0% of incidents. It is recommended that Morgan County DHS consider creating a more formal process for recognizing and reporting fatal, near fatal and egregious incidents of child maltreatment to CDHS.	Complete
17-060	Policy Finding	The policy finding related to timeliness of assessment closure does reflect a systemic practice issue for Morgan County DHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the November 2017 C-Stat, Morgan County DHS's performance for September 2017 was 80%, with a statewide goal of 95%. It is recommended that Morgan 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

17-060	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for Morgan County DHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the November 2017 C-Stat, Morgan County DHS's performance for August 2017 was 71.4% 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 11, 2015 through February 11, 2016, showed Morgan County DHS at 64.7% for observing/interviewing the alleged victim within the assigned response time. It is recommended that Morgan 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

17-108	Policy Finding	The policy finding related to the assessment containing the required content does reflect a systemic practice issue for El Paso 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 of August 25, 2018 through February 25, 2019, showed that El Paso County's assessments contained the required content 79.6% of the time, which is above the Ten Large County average (not including El Paso County) of 73% for a comparable time span. It is recommended that El Paso County employ a process in which barriers to documentation of 18 the assessment containing all required content are identified and solutions to the identified barriers are implemented	Complete
17-108	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 Boulder County. 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 October 28, 2018 through April 28, 2019, Boulder County completed the Colorado Family Safety Assessment Tool accurately 34.6% of the time, which is below the Ten Large County average (not including Boulder County of 34.7% for a comparable time span. It is recommended that Boulder County 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
17-108	Policy Finding	The policy finding related to the assessment containing the required content does reflect a systemic practice issue for Boulder 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 of October 28, 2018 through April 28, 2019, showed that Boulder County's assessments contained the required content 67.3% of the time, which is below the Ten Large County average (not including Boulder County) of 72.9% for a comparable time span. It is recommended that Boulder 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.	Not Started
16-002	CFRT	It is recommended that, through partnership with the Child Protection Team at the Kempe Center, the Medical Director for the Office of Children, Youth and Families (OCYF), and the Colorado	Complete

		Child Welfare Training Academy, curriculum related to serious childhood diseases and illness be added to the Medical Aspects of Child Maltreatment training.	
16-002	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 June 2016 C-Stat, Arapahoe County DHS' performance for April 2016 was 85.7% with a statewide goal of 90%. It is recommended that Arapahoe County DHS monitor their performance on this measure and determine any future needs for improvement.	Complete
16-002	Policy Finding	The policy finding related to the RED Team framework not being completed is a systemic practice issue for Arapahoe County DHS. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from June 15, 2015 to December 15, 2015, Arapahoe County DHS included all elements required in Volume 7, 42.6% of the time. New practice expectations for supervisor approval were created in response to the Office of the State Auditor (OSA) Child Welfare Performance Audit. Early reviews indicated the process for documenting supervisor approvals was not well known at the county level. In an effort to communicate the new expectations, DCW issued Operational Memo OM-CW-2015-0007. It should be noted that 41 assessments in the review were completed prior to the issuance of the Operational Memo. For the recent review of a random sample of assessments, supervisory approval was missing in 24 of the 48 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 80%. As this policy finding is related to not holding a RED Team as required by Volume 7, it should also be noted that during the random sample of assessments that were conducted during a period from June 15, 2015 to December 15, 2015, Arapahoe County DHS completed a RED Team as required by Volume 7, 89 % percent of the time. It is recommended that Arapahoe County DHS employ a process in which barriers to the completion of holding a RED Team and completing the RED Team framework as required by Volume 7 are identified and solutions to the identified barriers are implemented.	Complete

16-002	Policy Finding	The policy finding related to not accurately reflecting individual allegations, perpetrators, victims, and findings does reflect a systemic practice issue for Arapahoe County DHS. As part of a routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from June 15, 2015 to December 15, 2015, the individual allegations, perpetrators, victims, and findings were accurately reflected in the findings window, 81.3% of the time. It is recommended that Arapahoe County DHS monitor their performance on this measure and determine any future needs for improvement.	Complete
16-065	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 December 2016 C-Stat, Arapahoe County's performance for October 2016 was 80.5% with a statewide goal of 90%. It is recommended that Arapahoe County DHS implement a process in which barriers to the timeliness of assessment closure are identified and solutions to the identified barriers are implemented.	Complete
15-025	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
15-025	CFRT	It is recommended that DCW explore a Volume VII change regarding observing/interviewing alleged victims of egregious, near fatal, or fatality incidents, who are safe in the hospital within the assigned response time.	Complete
15-025	CFRT	It is recommended that DCW define type of allegations in Volume VII which correspond to those that are listed in Trails.	In Progress

15-025	Policy Finding	The policy finding related to seeing the alleged victim within the assigned response time does not reflect a systemic practice issue for Weld County DHS. According to the most recent C-Stat presentation for the month of October which reflected data from September, Weld County DHS is interviewing the alleged victim within the assigned response time 92.5 % of the time which is above the state goal of 90%. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of December 14, 2014 through June 14, 2015, showed Weld County DHS at 69.8% for observing/interviewing the alleged victim within the assigned response time and 88.7% for making reasonable efforts to observe/interview the alleged victim within the assigned response time. It is recommended that Weld County DHS employ a process in which barriers to observing/interviewing the alleged victim within the assigned response time are identified and solutions to the identified barriers are implemented.	Complete
15-025	Policy Finding	The policy finding related to the Colorado Safety Assessment Tool does reflect a systemic practice issue in Weld County DHS. In a recent review of a random sample of assessments that were conducted during a period from December 14, 2014 through June 14, 2015 Weld County DHS completed the Colorado Safety Assessment Tool accurately in 0% of assessments, which is below the statewide average (not including Weld County DHS) of 44.1% for the same time span. It is recommended that Weld County DHS employ a process in which barriers to the accurate completion of the Colorado Safety Assessment Tool are identified and solutions to the identified barriers are implemented.	Complete
15-025	Policy Finding	The policy findings related to inaccurate documentation of the Colorado Family Risk Assessment tool does reflect a systemic practice issue in Weld County DHS. In a recent review of a random sample of assessments that were conducted during a period from December 14, 2014 to June 14, 2015, Weld County DHS completed the Colorado Family Risk Assessment Tool accurately in 54.7% of assessments, which is above the statewide average (not including Weld County DHS) of 39.7% for the same time span. It is recommended that Weld 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

15-025	Policy Finding	The policy finding related to reasonable efforts to interview the alleged perpetrator, does reflect a systemic practice issue for Weld County DHS. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of December 14, 2014 to June 14, 2015, showed that Weld County DHS interviewed all required parties 66%, which is above the statewide average (not including Weld County DHS) of 52% for the same time span. It is recommended that Weld County DHS employ a process in which barriers to interview all required parties are identified and solutions to the identified barriers are implemented	Complete
15-026	CFRT	It is recommended that the Division of Child Welfare (DCW) continue the statewide implementation process of the new risk assessment tool and that monitoring occur to determine if accuracy in the use of the tool increases as a result of its implementation.	Complete
15-026	CFRT	The CFRT recommended that the Administrative Review Division track whether marijuana use was involved in all critical incidents reported as suspicious and substantiated for child abuse and/or neglect.	Considered and not implemented
15-026	CFRT	The CFRT recommended that more education regarding assessing for safety and the impact of marijuana use on parenting capacity is needed for community partners. DCW should explore developing and providing training to community partners to include assessing overall child safety and parenting capacity when marijuana use is involved. It should be noted that the Nurse Family Partnership program will be conducting a state and national review of this incident to determine any next steps or changes to their curriculum.	Considered and not implemented
15-026	Policy Finding	The Policy Findings related to not completing the Colorado Family Risk Assessment tool does reflect a systemic practice issue in Arapahoe County DHS. In a recent review of a random sample of assessments that were conducted during a period from December 28, 2014 to June 28, 2015, the Arapahoe County DHS completed the risk assessment tool accurately in 40% of assessments, which is below the statewide average (not including Arapahoe County DHS) of 57.2% for the same time span. It is recommended that Arapahoe County DHS employ a process in which barriers to the accurate completion of the Colorado Family Risk Assessment tool are identified and solutions to the identified barriers are implemented. It is also recommended that Arapahoe County DHS complete the	Complete

		new Colorado Family Risk Assessment tool training in accordance to Volume VII 7.107.1.	
15-041	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, and there are no surviving siblings.	Complete
15-048	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for Weld County DHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the April 2017 C-Stat, Weld County DHS's performance for January 2017 was 89.2% 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 June 9, 2016 through December 9, 2016, showed Weld County DHS at 83.3% for observing/interviewing the alleged victim within the assigned response time and 88.9% for making reasonable efforts to observe/interview the alleged victim within the assigned response time. It is recommended that Weld 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. It should be noted that the Division of Child Welfare (DCW) issued Policy Memo PM-CW-2016-0003 effective July 1, 2016, which stated, "During the assessment of a child fatality, near fatality or egregious incident, the caseworker shall not be expected to observe a deceased child or a child who is on life support or is in critical condition in a hospital environment." This assessment was completed prior to the issuance of the Policy Memo.	Complete
15-075	CFRT	It is recommended the CDHS Division of Child Welfare (DCW) assess whether they should identify additional exceptions to the current rule for referrals that require a RED Team.	Complete

15-075	CFRT	It is recommended that the DCW provide further training and guidance on completing RED Teams with extensive family Departments of Human Services history.	Complete
15-075	CFRT	It is recommended that DCW explore clarifying jurisdiction definitions and expectations around circumstances when assessments involve multiple counties.	Considered and not implemented
15-075	Policy Finding	The policy finding related to the RED Team framework not including all elements required by Volume 7 is a systemic practice issue for DDHS. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a period from March 2, 2015 to September 2, 2015, the DDHS included all elements required in Volume 7 4.1% of the time. New practice expectations for supervisor approval were created in response to the Office of the State Auditor (OSA) Child Welfare Performance Audit. Early reviews indicated the process for documenting supervisor approvals was not well known at the county level. In an effort to communicate the new expectations, DCW issued Operational Memo OM-CW-2015-0007 on October 15, 2015. It should be noted that all of the assessments in the recent review were completed prior to the issuance of the Operational Memo. For the recent review of a random sample of assessments, supervisory approval was missing in 29 of the 49 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 51% for DDHS. As this policy finding was related to not completing a RED Team when required, it is recommended that the DDHS employ a process in which barriers to the completion of the RED Team framework as required by Volume 7 are identified and solutions to the identified barriers are implemented.	Complete
15-075	Policy Finding	The policy finding related to the RED Team framework not including all elements required by Volume 7 is a systemic practice issue for Arapahoe County DHS. New practice expectations for supervisor approval were created in response to the OSA Child Welfare Performance Audit. Early reviews indicated the process for documenting supervisor approvals was not well known at the county level. In an effort to communicate the new expectations, DCW issued Operational Memo OM-CW-2015-0007 on October 15, 2015. It should be noted that the assessment in this review was completed before the issuance of the Operational Memo. As part of routine quality assurance monitoring, in a recent review of a random sample of assessments that were conducted during a	Complete

		period from June 15, 2015 to December 15, 2015, Arapahoe County DHS included all elements required in Volume 7 42.6% of the time. For the recent review of a random sample of assessments that were conducted during a period from June 15, 2015 to December 15, 2015, supervisory approval was missing in 24 of the 54 RED Team frameworks, which impacted the performance. Without considering supervisor approval, performance on the RED Team framework was at 80% for Arapahoe County DHS. It is recommended that Arapahoe County DHS employ a process in which barriers to the completion of the RED Team framework as required by Volume 7 are identified and solutions to the identified barriers are implemented.	

Appendix D: Status Update for Recommendations from Previously 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.	Complete
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.	Complete

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.	Complete
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.	Complete

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.	Complete
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."	In Progress

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.	Complete
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.	Complete

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.	Complete
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.	Complete

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 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

17-007	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
17-035	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.	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

17-050	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
17-071	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
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."	In Progress

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.	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.	Complete

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.	Complete
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
16-012	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

16-023	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.	Complete
16-036	Policy Finding	The policy finding regarding the 90-Day review/Court report not being documented in Trails does reflect a systemic practice issue for the Adams County HSD. In the most recent Out-of-Home Administrative Review data, 1st Quarter SFY17, Adams County HSD completed the 90-Day review/Court report in Trails according to Volume 7, 52.5% of the time, which is below the statewide average (excluding the Adams County HSD) of 65.9% for the same time span. It is recommended that Adams County HSD employ a process in which barriers to the FSP: 5A Review/Court report are identified and solutions to the identified barriers are implemented.	Complete

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
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
15-038	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
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

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