COLORADO
Department of Human Services

July 1, 2021

The Honorable Jared Polis
Governor, State of Colorado

The Honorable Dafna Michaelson Jenet
Chair, Colorado General Assembly House Public and Behavioral Health and Human Services Committee

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

Governor Polis, Representative Michaelson Jenet, and Senator Fields:

The Colorado Department of Human Services, in response to reporting requirements set forth in Section26-1-139 C.R.S., respectfully submits the attached Child Maltreatment Fatality Review Report.

> *"(4)(i) To develop and distribute the following reports, the content of which shall be determined by rules promulgated by the state department pursuant to subsection (7) of this section: (I) On or before July 1, 2014, and on or before each July 1 thereafter, an annual child fatality and near fatality review report, absent confidential information, summarizing the reviews required by subsection (5) of this section conducted by the team during the previous year. 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. The team shall post the annual child fatality and near fatality review report on the state department's website and distribute it to the Colorado state child fatality prevention review team established in the department of public health and environment pursuant to section 25-20.5-406, C.R.S., the governor, the health and human services committee of the senate, and the public health care and human services committee of the house of representatives, or any successor committees.*

If you have any questions, please contact Kevin Neimond, CDHS' Policy and Legislative Director, at 303-620-6450.

Sincerely,

Jeremy Hill
Deputy Executive Director, Administrative Solutions

2020 Child Maltreatment Fatality Annual Report

COLORADO
Division of Quality Assurance & Quality Improvement
Administrative Review Division

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Executive Summary

The 2020 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) 2020. This year was unique, as the world was faced with a global pandemic due to the infectious coronavirus disease, COVID-19. All of us were impacted in one form or another by the pandemic. The impact of the pandemic is difficult to quantify, and we cannot draw a direct causal connection to child maltreatment, but it's important to note that families and children experienced increased stressors due to changes in daily routines, stay-at-home orders, illness, school closures, loss of childcare, unemployment, isolation, and more - some individuals and families were impacted more than others.

The 2020 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 2020 is presented along with national data for federal fiscal year (FFY) 2019. The report also highlights learnings and recommendations for improvements to the systems responsible for providing services to children and families in Colorado.

The CDHS Child Fatality Review Team (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 2020, there were 98 children involved in 84 substantiated fatal, near fatal, and egregious incidents of child maltreatment. From the group of 98 children in 84 substantiated fatal, near fatal, and egregious incidents of child maltreatment occurring in CY 2020, 62 children in 52 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 continues to show that younger children are the most vulnerable to child maltreatment. Younger children rely solely on their caregivers to meet their needs and have little to no ability to self-protect from maltreatment. National data continue to show that victims of fatal child maltreatment incidents tend to be younger, as 45.4% were under the age of one, and 70.3% of all victims of child fatalities were age three or younger. Colorado's trends continue to mirror the national trends as 39.3% (11/28) of the

fatalities involved victims younger than one year old, and 71.4% (20/28) were three or younger.

A similar pattern of younger-aged victims exists for the near fatalities, as 69% (20/29) of the victims were under the age of one, and 86.2% (25/29) 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, 2019, and 2020, the majority of victims were three or younger. In CY 2020, 53.7% (22/41) of victims were three or younger.

Nationally, it is noted that males typically have a higher rate of child fatality by abuse and neglect. In FFY 2019, 58.3% of victims in child maltreatment fatalities were males; Colorado data showed that 67.8% of victims in substantiated child maltreatment fatalities were males. Colorado trends have varied over the years, specifically when females surpassed male victims in CY 2016, 2017, and 2019.

For fatalities, near fatalities, and egregious incidents in 2020, most victims were White, which closely resembles the race estimates for Colorado's overall population. For fatalities, the majority of the victims were White (53.6%), followed by Hispanic (21.4%). For near fatal incidents, most victims were White (48.3%), followed by multiracial (20.7%). For egregious incidents, most victims were White (41.5%), followed by Hispanic (29.3%). Chart 2 is a graphic depiction of race/ethnicity breakdown.

Family Characteristics. In 2020, 45.9% (45/98) of all children in fatal, near fatal, and egregious incidents of child maltreatment lived in a household with two parents. This family structure was also the most frequent for incidents occurring in 2015, 2016, 2017, 2018, and 2019. The second most common type of family structure across all substantiated fatal, and near fatal incidents in 2020 was one parent at 19.3% (11/57). The second most common type of family structure across egregious incidents was two parents and relatives at 19.5% (8/41).

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 continuously indicates the mother as the most common perpetrator of a fatal incident of child maltreatment. In FFY 2019, it was noted that nearly 80% of fatal incidents of child maltreatment involved one or both parents, sometimes acting alone and sometimes involving another person. For 2020, in Colorado, mothers were the most common perpetrator across fatal and near fatal incidents of child maltreatment at 43.9% (18/41) and 51.2% (21/41) respectively. Fathers were identified as the second most common perpetrator for fatal and near fatal incidents of child maltreatment at 26.8% (11/41) and 31.7% (13/41). Across egregious incidents, fathers were the most common perpetrator at 45.6% (26/57).

Prior Involvement with Child Protective Services. In CYs 2014 - 2020 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 2020, 75.0% of substantiated fatal child maltreatment incidents, the child, child's family, and/or alleged perpetrator had prior involvement with the child welfare system. This is an increase from 2019, with only 58.8% of fatal incidents substantiated for abuse or neglect had prior involvement with the child welfare system. In 2020, the most common type of prior involvement for families involved in fatal, near fatal, and egregious incidents of child maltreatment was a current and/or prior assessment.

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 36 incidents reviewed by the CFRT in 2020: 12 fatal incidents, 14 near fatal incidents, and 10 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 fatal child maltreatment incidents which met criteria for review by the CFRT, 33.3% (4/12) had a history of identified mental health issues, and 16.7% (2/12) were identified to have had some history of domestic violence.

Nationally, in FFY 2019, 5.8% of child fatalities were associated with a caregiver known to abuse alcohol, while 19.4% of child fatalities had a caregiver who abused drugs. Of the fatal child maltreatment incidents reviewed, which met criteria for review by the CFRT, 66.7% (8/12) of the incidents reviewed had some identified caregiver history of substance abuse issues. Chart 10 further identifies stressors identified/associated with caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed in 2020.

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 prior to 2020 and reviewed by the CFRT and/or posted to the public notification website in 2020.

A total of 22 recommendations were made across the 24 reports posted between 4/1/2020 and 3/31/2021. This included 10 related to systemic gaps and deficiencies and 12 related to policy findings. The top areas of recommendations are related to: 1) Safety and Risk Assessments; 2) County Continuous Quality Improvement; 3) Collaboration with outside agencies; 4) Legislation; 5) Communication; and 6) Training and Technical Assistance

CFRT Recommendation Steering Committee. In 2020, a Steering Committee was formed, with a vision to ensure each CFRT recommendation is prioritized, acted upon, and implemented in a timely manner to address known systemic gaps and prevent future child deaths. The Committee is responsible for providing high level strategic direction for each CFRT recommendation, and oversees and supports implementation of recommendations. The relevant group to review and act on CFRT recommendations will vary and will often involve participants from multiple offices, agencies or sectors. The current committee has 11 members from four different CDHS offices, two county departments, and a representative from the Colorado Department of Public Health and Environment's Child Maltreatment Prevention Unit. Representation from CDHS includes the Office of Children Youth and

Families, the Office of Behavioral Health, the Administrative Review Division, the Office of Early Childhood, and Community Partnerships.

CFRT Learnings. This year's report also 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 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.

Internal Review Guide. County internal reviews are required when there has been an incident of fatal, near fatal, or egregious child maltreatment, and the county holds current or prior involvement within three years of the incident. County departments had previously requested that guidance for internal reviews be developed in collaboration with the Administrative Review Division (ARD) staff that support the CDHS CFRT process. From February through October of 2020, a group of county department child protection managers and Administrative Review Division staff came together on four different occasions in order to develop guidance for county departments to utilize when faced with having to engage in the challenging and critical work of an internal review.

The guide is intended to be a resource, not a mandate, and may evolve as we continue to learn how to best review and analyze these tragic incidents of child maltreatment. The purpose of a county department review is multifaceted. When a child is a victim of fatal, near fatal, or egregious child maltreatment, county departments reflect upon past service delivery and analyze the contributing factors and risks that may have led to the tragedy. The guidance is presented in an effort to assist county departments through the review process, and to better understand and identify the factors associated with such incidents of abuse or neglect.

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 eight 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
2020	59	34	30	123

**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
2020	28	28	28	84

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 2020 data were extracted on a quarterly basis from the comprehensive child welfare information system (Trails) for any assessment with an egregious, near fatal, or fatal allegation of child maltreatment. Additionally, data were pulled for any child with a date of death entered into Trails. The data were then compared to the number of reported incidents received from counties over the course of CY 2020. The data integrity checks identified 34 potential incidents. Of those incidents, six incidents involving six children met criteria for public notification. 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, and 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	40^^^^
2018	16	10	11	37
2019	10	11	16	37
2020	21	14	17	52

**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, 43.9% (54/123) of incidents that occurred in 2020 were afforded at least one extension, with the total number ranging from one to sixteen extensions. The average number of extensions afforded per report is 5.7.

Incidents Reviewed in 2020

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 2020, the CFRT was able to review 36 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

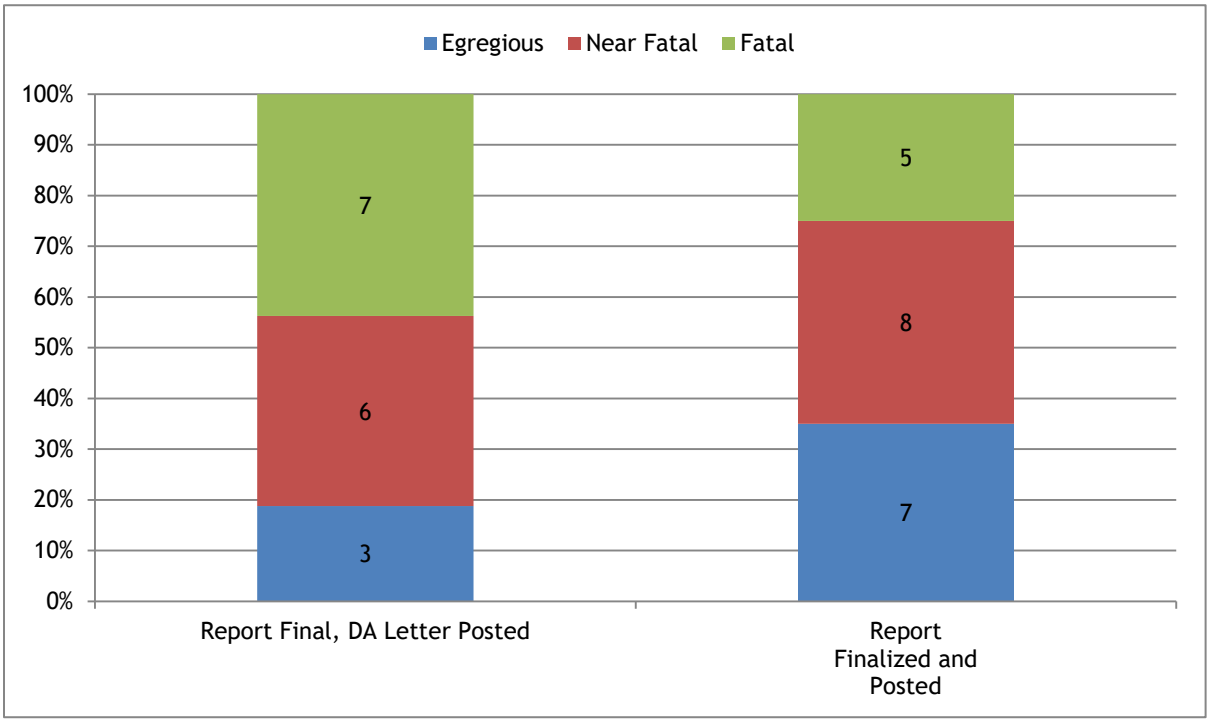
Each incident reviewed by the CFRT results in a written report that is posted to the CDHS public notification website (with confidential information redacted). Specifically, statute requires that a case-specific executive summary, absent confidential information, be posted on the CDHS website within seven (7) days of finalizing the confidential case-specific review report. In 2019, case-specific reports for fatal, near fatal, and 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 2020. Of the 36 incidents reviewed, final non-confidential case-specific executive summary reports were posted for 20 of them. For 16 of the 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 2020.



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), field of 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 previous involvement with the child welfare system within three years prior to the incident. 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.

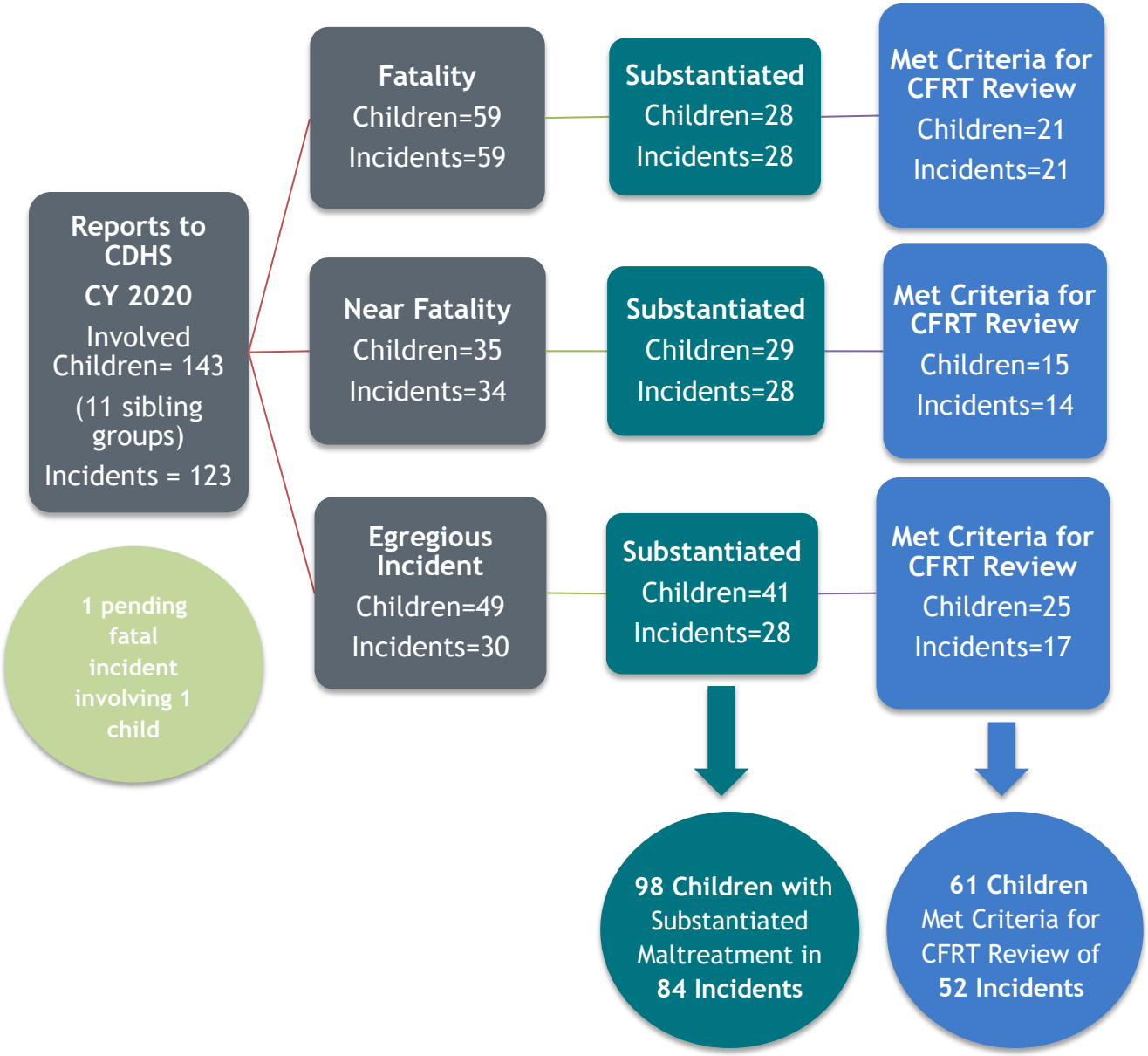
Overview of the 2020 Reports of Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment Victims

As previously discussed, 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 2020, counties reported 123 incidents involving 143 children who were suspected victims of fatal, near fatal, or egregious child maltreatment. Of the 143 children, 59 children were associated with 59 fatal incidents, 35 children were associated with 34 near fatal incidents, and 49 children were associated with 30 egregious incidents.

Upon completion of an assessment, DHS found that 38 incidents involving 44 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. At the time of authoring this report, there is one pending incident involving one child that does not yet have a finding associated.

In CY 2020, 84 substantiated incidents included 98 children, 52 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 2020. 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 2020



For purposes of this report, the majority of the analysis in the following section focuses on the 98 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 have been collected, trends for the fatal incidents are provided across several years. Table 4 provides an overview of the demographic characteristics of the 98 substantiated victims of incidents that occurred in CY 2020.

Table 4: Summary information of all 98 substantiated victims of child maltreatment fatalities, near fatalities, and egregious incidents in Colorado for CY 2020

Characteristic	Detail	Fatal	%	Near Fatal	%	Egregious	%
Age of Victim at Time of Incident	Less than one	11	39.3%	20	69.0%	18	43.9%
	One	4	14.3%	3	10.3%	2	4.9%
	Two	1	3.6%	1	3.4%	2	4.9%
	Three	4	14.3%	1	3.4%	0	0.0%
	Four	0	0.0%	1	3.4%	3	7.3%
	Five	1	3.6%	1	3.4%	0	0.0%
	Six	1	3.6%	0	0.0%	0	0.0%
	Seven	0	0.0%	0	0.0%	2	4.9%
	Eight	0	0.0%	0	0.0%	1	2.4%
	Nine	1	3.6%	0	0.0%	2	4.9%
	Ten	1	3.6%	0	0.0%	1	2.4%
	Eleven	3	10.7%	0	0.0%	2	4.9%
	Twelve	0	0.0%	0	0.0%	3	7.3%
	Thirteen	0	0.0%	0	0.0%	1	2.4%
	Fourteen	0	0.0%	0	0.0%	2	4.9%
	Fifteen	0	0.0%	0	0.0%	0	0.0%
	Sixteen	0	0.0%	2	6.9%	1	2.4%
	Seventeen	1	3.6%	0	0.0%	1	2.4%
Race/Ethnicity	Black or African American	4	14.3%	4	13.8%	7	17.1%
	Asian	0	0.0%	0	0.0%	0	0.0%
	White	15	53.6%	14	48.3%	17	41.5%
	Hispanic	6	21.4%	5	17.2%	12	29.3%
	Multiracial	3	10.7%	6	20.7%	3	7.3%
	Native Hawaiian/ Other Pacific Islander	0	0.0%	0	0.0%	1	2.4%
	Native American	0	0.0%	0	0.0%	0	0.0%
	Missing/Unknown	0	0.0%	0	0.0%	1	2.4%
Sex	Female	9	32.1%	18	62.1%	19	46.3%
	Male	19	67.9%	11	37.9%	22	53.7%
Family Structure	One parent	6	21.4%	5	17.2%	4	9.8%
	One parent and one related caregiver	1	3.6%	1	3.4%	1	2.4%
	One parent and one unrelated caregiver	4	14.3%	1	3.4%	7	17.1%
	Two parents	12	42.9%	13	44.8%	20	48.8%
	Two parents and relatives	0	0.0%	3	10.3%	8	19.5%
	One parent and relatives	3	10.7%	2	6.9%	1	2.4%
	Foster Care	1	3.6%	2	6.9%	0	0.0%
	One unrelated caregiver	0	0.0%	0	0.0%	0	0.0%
	One related caregiver	0	0.0%	1	3.4%	0	0.0%
	One related caregiver and one unrelated caregiver	1	3.6%	0	0.0%	0	0.0%
	One legal caregiver with relatives and one unrelated caregiver	0	5.9%	0	0.0%	0	0.0%
Incidents with Additional Family Stressors*	Substance Abuse	8	57.1%	11	44.0%	8	42.1%
	Mental Health	4	28.6%	5	20.0%	3	15.8%
	Domestic Abuse	2	14.3%	9	36.0%	8	42.1%

**This is counted at the family level for incidents which met criteria for review, and were reviewed in CY 2020.*

Data and Demographics

Within the field of child welfare, there is a large body of research regarding a number of risk factors related to maltreatment, including but not limited to: inappropriate expectations of children, lack of parenting knowledge and child developmental stages, substance abuse, domestic violence, past history of abuse, financial stress, mental health issues, 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 minimal 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 FFY19, 1,840 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 2019) 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 (U.S.) Census Bureau. The U.S. Census Bureau[2] estimated race and ethnicity data from population estimates for Colorado in 2019, the latest year of finalized census data. 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 the following ethnicities: 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. (2021). Child Maltreatment 2019. Available from https://www.acf.hhs.gov/cb/research-data-technology/ statistics-research/child-maltreatment.

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

For fatalities, near fatalities, and egregious incidents in 2020, most victims were White, which closely resembles the race estimates for Colorado's overall population. For fatalities, the majority of the victims were White (53.6%), followed by Hispanic (21.4%). For near fatal incidents, most victims were White (48.3%), followed by multiracial (20.7%). For egregious incidents, most victims were White (41.5%), followed by Hispanic (29.3%). Chart 2 is a graphic depiction of race/ethnicity breakdown.

Chart 2: Race/Ethnicity of 98 victims in all Substantiated Fatal, Near Fatal, and Egregious Incidents of Child Maltreatment in Colorado for CY 2020

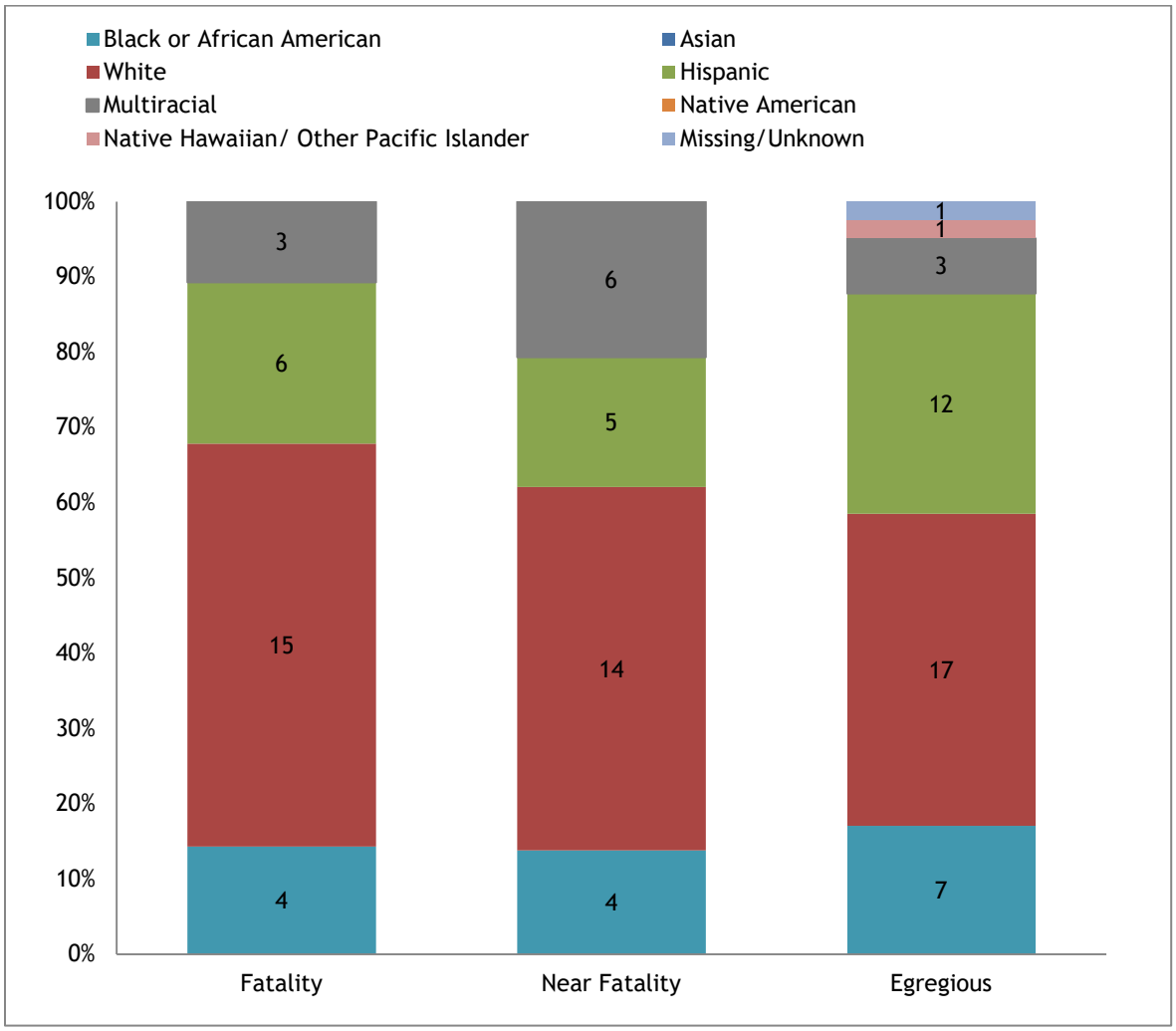
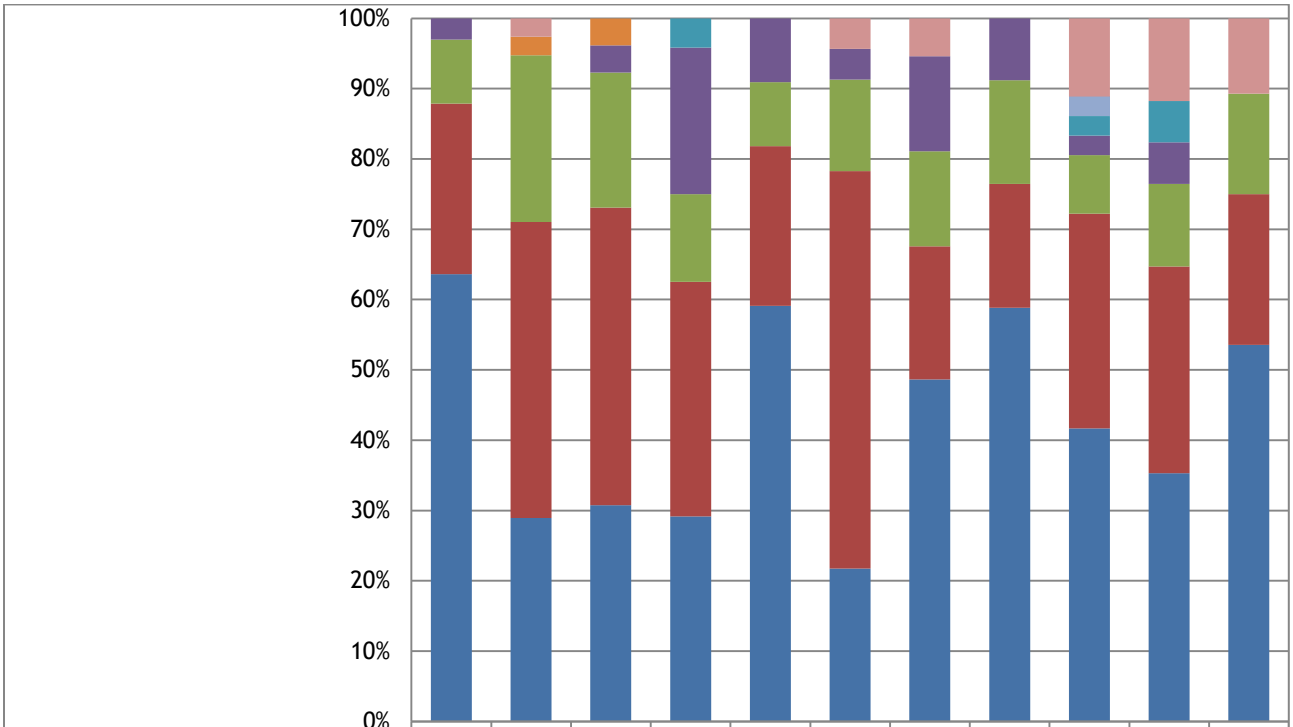


Chart 3 shows the trends related to the most common race/ethnicity of all child maltreatment fatalities in Colorado from 2010-2020. For Colorado's population trends, Hispanic child victims were disproportionately represented in fatal incidents during the years of 2011, 2012, 2013, and 2015. The chart 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 Eleven Calendar Years



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Multiracial	0	1	0	0	0	1	2	0	4	2	3
American Indian or Alaska	0	0	0	0	0	0	0	0	1	0	0
Native Hawaiian/ Other Pacific Islander	0	1	1	0	0	0	0	0	0	0	0
Asian	0	0	0	1	0	0	0	0	1	1	0
Missing or Unknown	1	0	1	5	2	1	5	3	1	1	0
Black or African American	3	9	5	3	2	3	5	5	3	2	4
Hispanic	8	16	11	8	5	13	7	6	11	5	6
White	21	11	8	7	13	5	18	20	15	6	15

Sex of Victim

Nationally, it is noted that males typically have a higher rate of child fatality by abuse and neglect. In FFY 2019, 58.3% of victims in child maltreatment fatalities were males; Colorado data showed that 67.8% of victims in substantiated child maltreatment fatalities were males. Colorado trends have varied over the years, specifically when females surpassed male victims in CY 2016, 2017, and 2019. Chart 4 displays the breakdown of differences in the sex of the

victims for the 98 victims involved in substantiated incidents of fatal, near fatal, and egregious incidents of abuse and neglect in CY 2020.

Chart 4: Sex of 98 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado for CY 2020

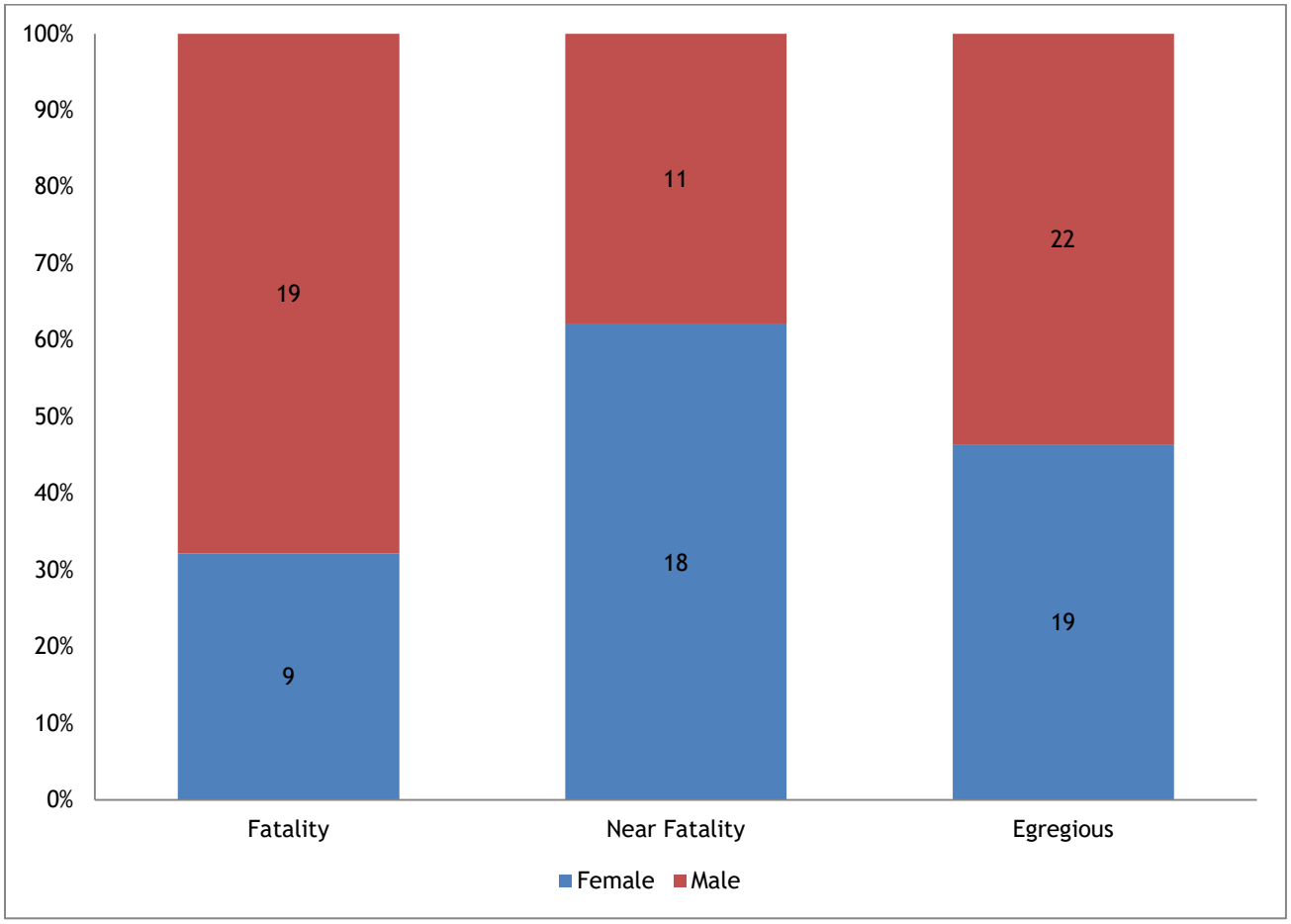
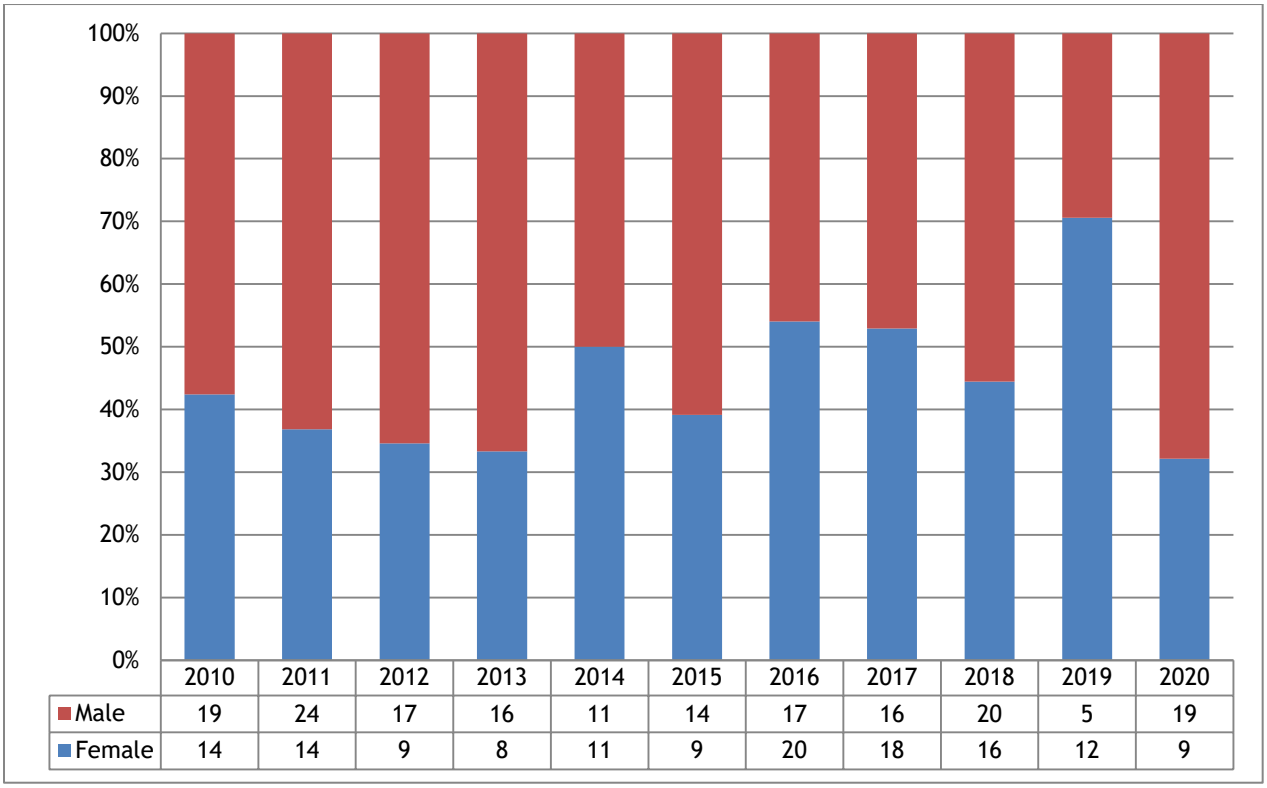


Chart 5 demonstrates the trends of sex of victims involved in all substantiated child maltreatment fatalities in Colorado over the last eleven years.

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



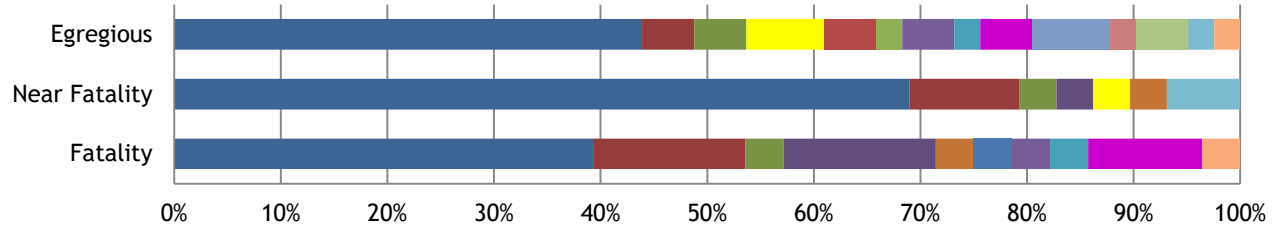
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Male	19	24	17	16	11	14	17	16	20	5	19
Female	14	14	9	8	11	9	20	18	16	12	9

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. Younger children rely solely on their caregivers to meet their needs and have little to no ability to self-protect from maltreatment. National data continues to show that victims of fatal child maltreatment incidents tend to be younger, as 45.4% were under the age of one, and 70.3% of all victims were age three or younger. Colorado's trends continue to mirror the national trends. As displayed in Chart 6, 39.3% (11/28) of the fatalities involved victims younger than one year old, and 71.4% (20/28) were three or younger.

A similar pattern of younger-aged victims exists for the near fatalities, as 69% (20/29) of the victims were under the age of one, and 86.2% (25/29) 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, 2019, and 2020, the majority of victims were three or younger. In CY 2020, 53.7% (22/41) of victims were three or younger.

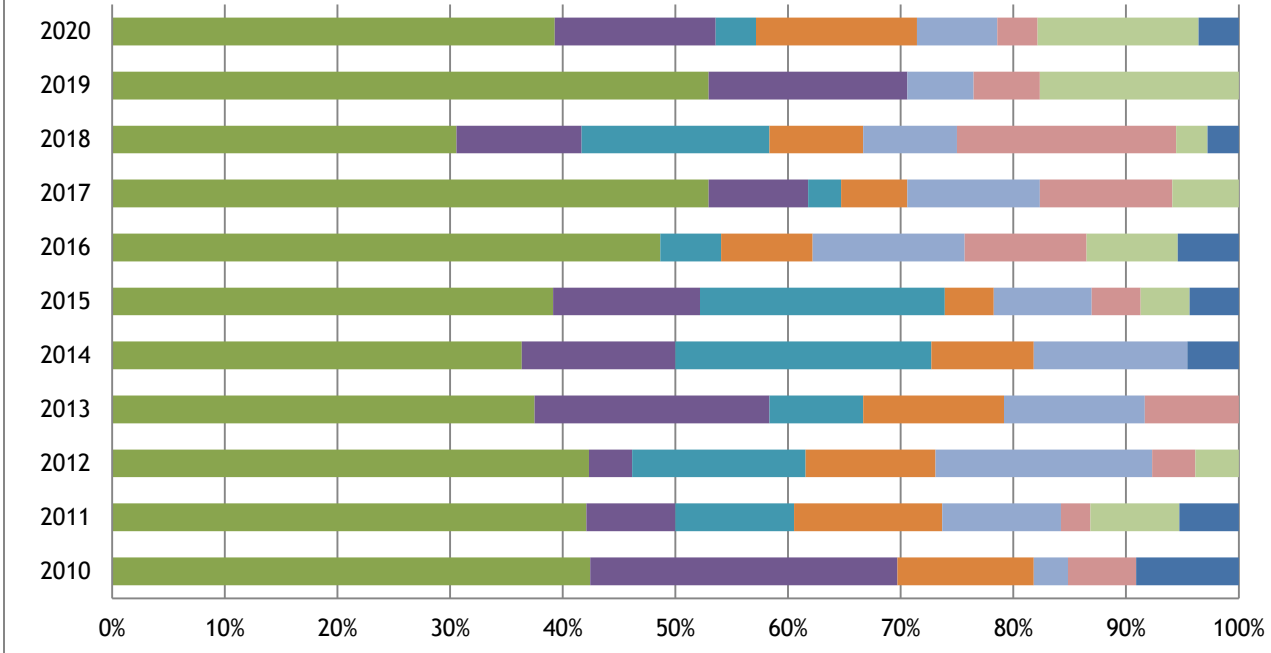
Chart 6: Age of 98 Victims in Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2020



	Fatality	Near Fatality	Egregious
<1	11	20	18
1	4	3	2
2	1	1	2
3	4	1	0
4	0	1	3
5	1	1	0
6	1	0	0
7	0	0	2
8	0	0	1
9	1	0	2
10	1	0	1
11	3	0	2
12	0	0	3
13	0	0	1
14	0	0	2
15	0	0	0
16	0	2	1
17	1	0	1

Chart 7 displays the trends in ages of victims in child maltreatment fatalities over the past eleven 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%-86% of all victims in child maltreatment fatalities. There continues to be 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 Eleven Calendar Years



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
<1	14	16	11	9	8	9	18	18	11	9	11
1	9	3	1	5	3	3	0	3	4	3	4
2	0	4	4	2	5	5	2	1	6	0	1
3	4	5	3	3	2	1	3	2	3	0	4
4-6	1	4	5	3	3	2	5	4	3	1	2
7-9	2	1	1	2	0	1	4	4	7	1	1
10-12	0	3	1	0	0	1	3	2	1	3	4
13+	3	2	0	0	1	1	2	0	1	0	1

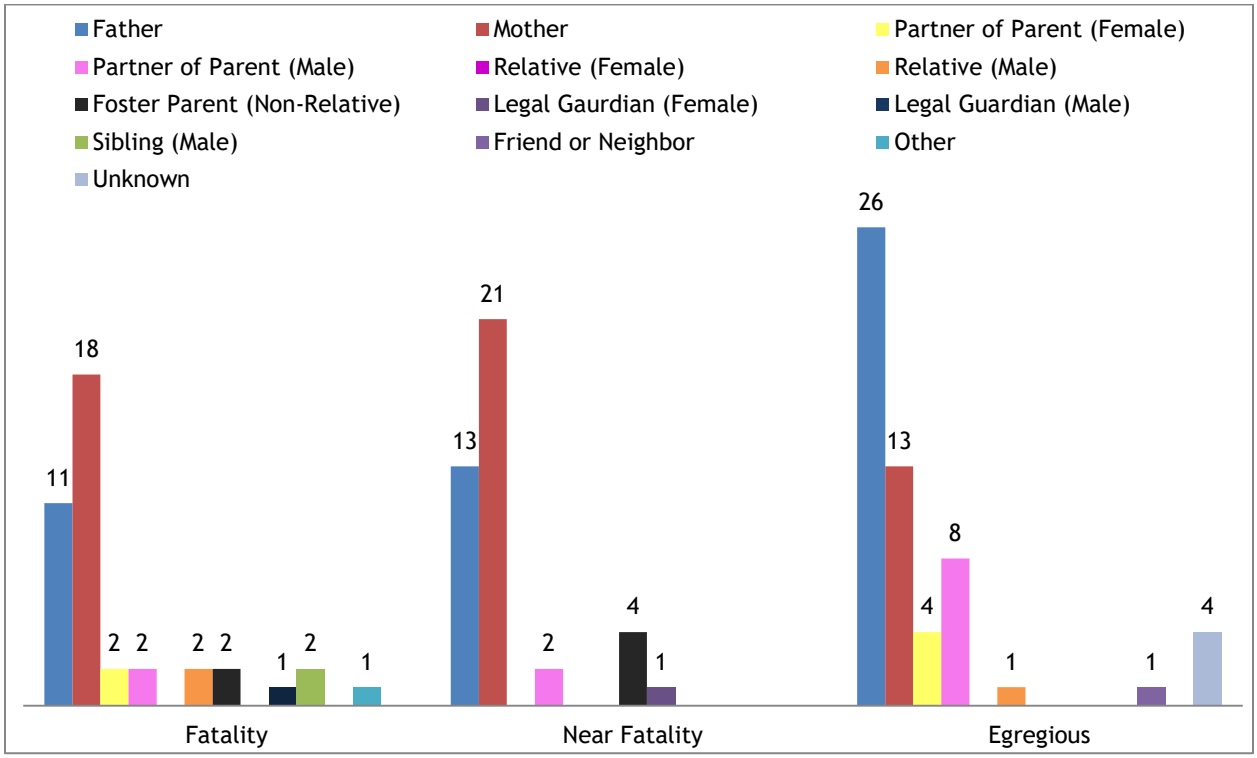
Perpetrator Relationship

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 continuously indicates the mother as the most common perpetrator of a fatal incident of child maltreatment. In FFY 2019, it was noted that nearly 80% of fatal incidents of child maltreatment involved one or both parents, sometimes acting alone and sometimes involving another person. For 2020, in Colorado, mothers were the most common perpetrator across fatal and near fatal incidents of child maltreatment at 43.9% (18/41) and 51.2% (21/41) respectively. Fathers were identified as the second most common perpetrator for fatal and near fatal incidents of child maltreatment at

26.8% (11/41) and 31.7% (13/41). Across egregious incidents, fathers were the most common perpetrator at 45.6% (26/57).

For all substantiated incidents in 2020, four perpetrators were unknown in egregious incidents 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 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.

Chart 8: Perpetrator Relationship to 98 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in Colorado during CY 2020

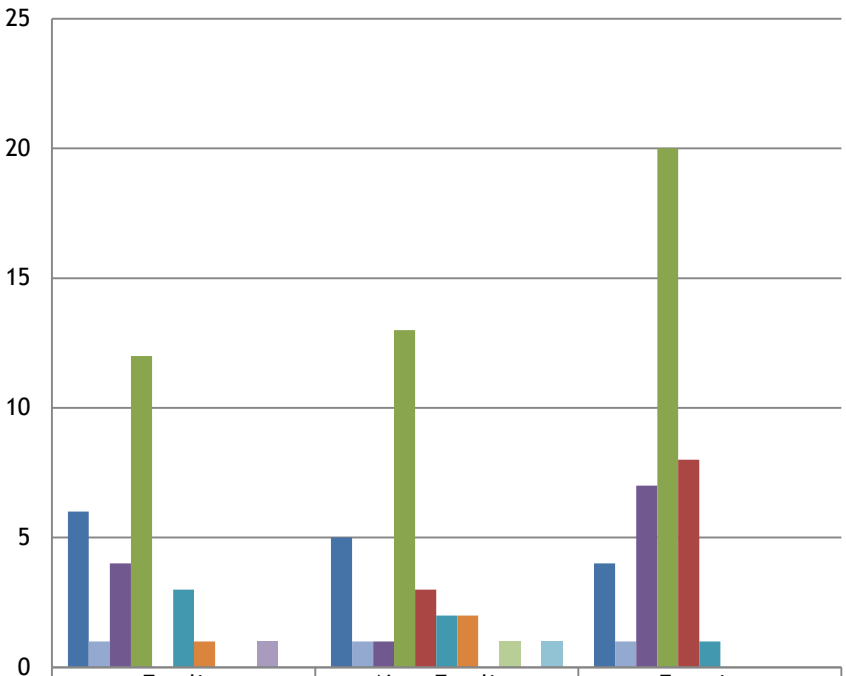


**More than one perpetrator exists for several children.*

Family Structure

In 2020, 45.9% (45/98) 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, 2018, and 2019. The second most common type of family structure across all substantiated fatal and near fatal incidents in 2020, was one parent at 21.4% (6/28) and 17.2% (5/29) respectively. The second most common type of family structure across egregious incidents was two parents and relatives at 19.5% (8/41).

Chart 9: Family Structure of 98 Victims of Substantiated Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents in CY 2020



	Fatality	Near Fatality	Egregious
One parent	6	5	4
One parent and one related caregiver	1	1	1
One parent and one unrelated caregiver	4	1	7
Two parents	12	13	20
Two parents and relatives	0	3	8
One parent and relatives	3	2	1
Foster Care	1	2	0
One unrelated caregiver	0	0	0
One related caregiver	0	1	0
One related caregiver and one unrelated caregiver	1	0	0
One legal caregiver with relatives and one unrelated caregiver	0	1	0

Family Characteristics

Collecting and analyzing characteristics associated with families involved in incidents of fatal, near fatal, and 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 2020 (36 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 education 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 meet criteria for review by the CFRT. This information continues to prove difficult to collect and report on, as it is 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 65 unique caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed by the CFRT in 2020 (36 incidents); income information was only known for 10/65 of these individuals (15.4%). Of those caregivers with known income information, the average income for legal caregivers involved in fatal incidents is approximately $1,500, $17,986 for near fatal incidents, and $25,498 for egregious incidents.

Educational level was known for 50.8% (33/65) of the legal caregivers involved in fatal, near fatal, and/or egregious incidents of child maltreatment reviewed by the CFRT in 2020. 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 38.5% (25/65) of the legal caregivers with a known educational attainment level.

Supplemental Public Benefits

In CY 2020, information regarding supplemental public benefits were gathered for the 36 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 (17/36; 47.2%). In 16 of the 36 incidents reviewed, 44.4% of 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).

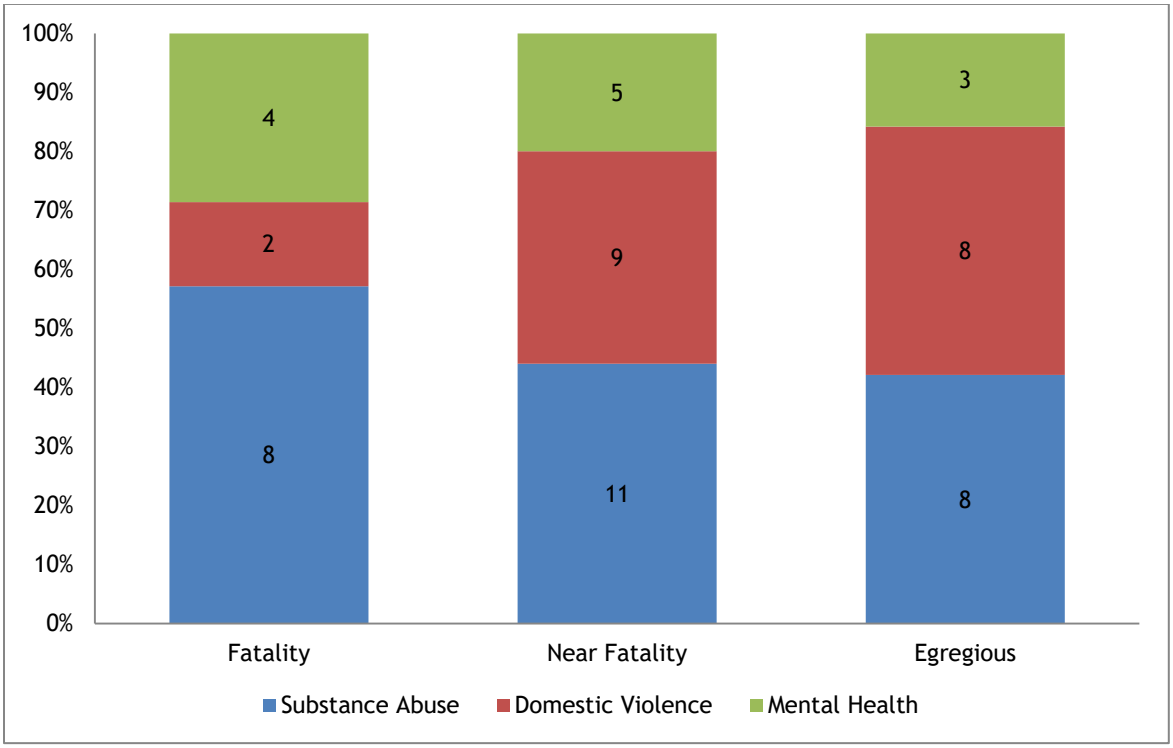
Other Family Stressors

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 36 incidents reviewed by the CFRT in 2020; 12 fatal incidents, 14 near fatal incidents,

and 10 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 fatal child maltreatment incidents which met criteria for review by the CFRT, 33.3% (4/12) had a history of identified mental health issues, and 16.7% (2/12) were identified to have had some history of domestic violence.

Nationally, in FFY 2019, 5.8% of child fatalities were associated with a caregiver known to abuse alcohol, while 19.4% of child fatalities had a caregiver who abused drugs. Of the fatal child maltreatment incidents reviewed, which met criteria for review by the CFRT, 66.7% (8/12) of the incidents reviewed had some identified caregiver history of substance abuse issues. Chart 10 further identifies stressors identified/associated with caregivers involved in fatal, near fatal, and egregious incidents of child maltreatment reviewed in 2020.

Chart 10: Other Stressors in Families of the Child Maltreatment Fatalities, Near Fatalities, and Egregious Incidents Reviewed by the CFRT in 2020



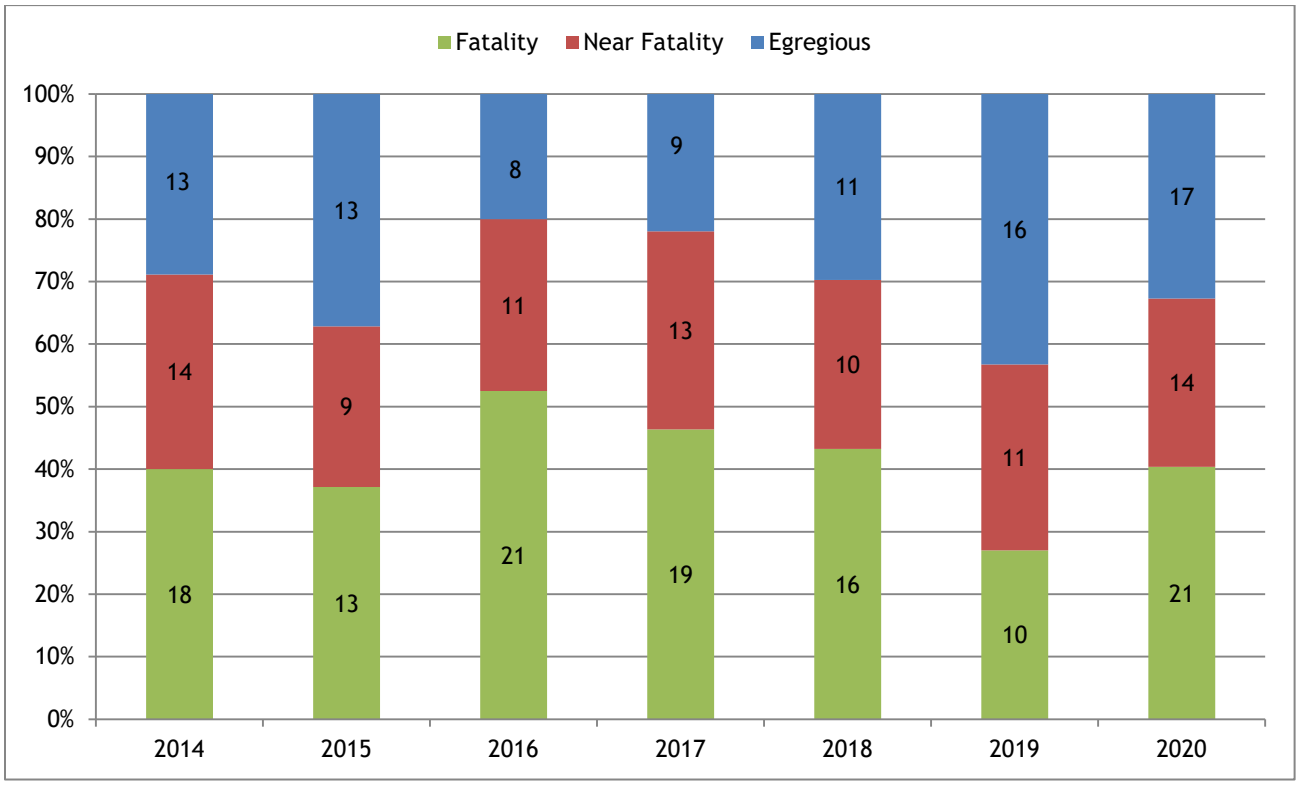
Prior Involvement

In CYs 2014 - 2020 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 2020, 75.0% of substantiated fatal child maltreatment incidents, the child, child's family, and/or alleged perpetrator had prior involvement with the child welfare system. This is an increase from 2019, with only 58.8% of

fatal incidents substantiated for abuse or neglect had prior involvement with the child welfare system. The most common type of prior involvement for all three incident types was a prior and/or current assessment.

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 2019, and was 50.0% in 2019 and in 2020. 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 48.5% to 68.4% between 2014 and 2019, and was 60.7% in 2020. 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 2014-2020*



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 seven years is illustrated in Charts 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

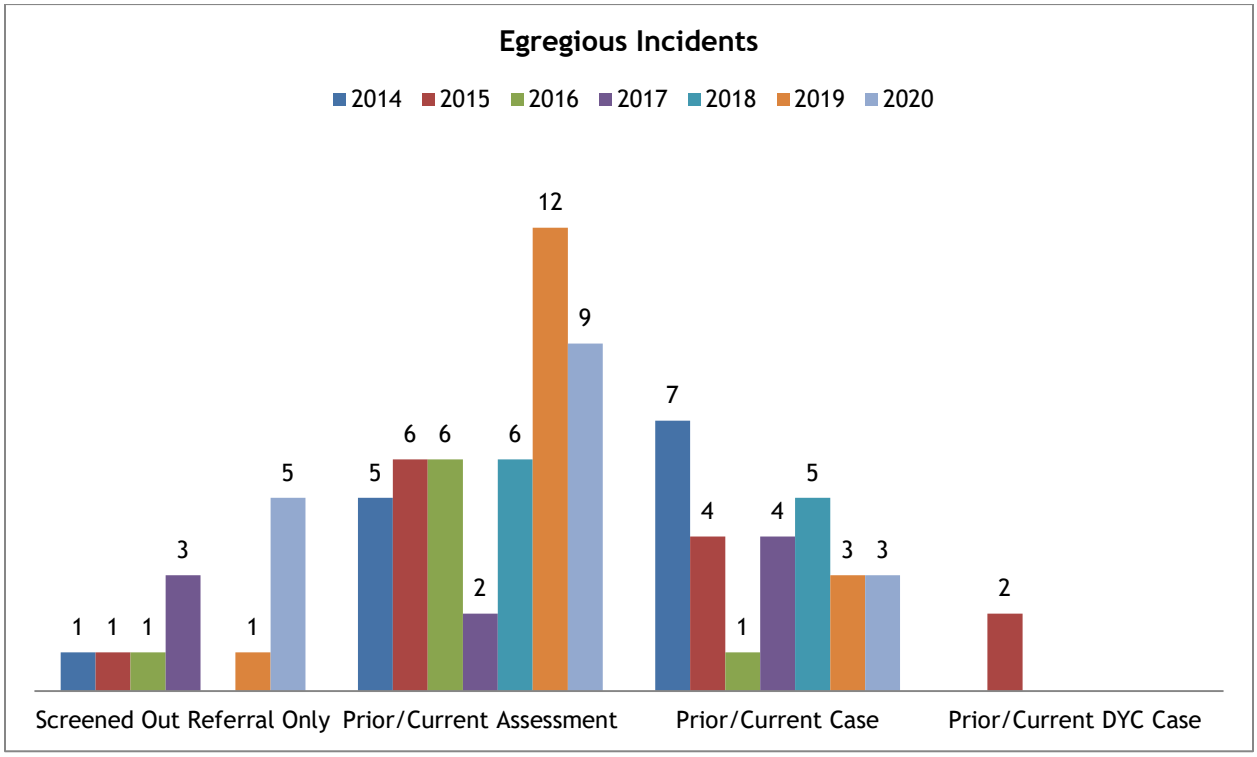
counted only in the category for “Prior/Current Assessment.” If the referral was not accepted for assessment, it would be counted in the “Prior/Current Referral” category.

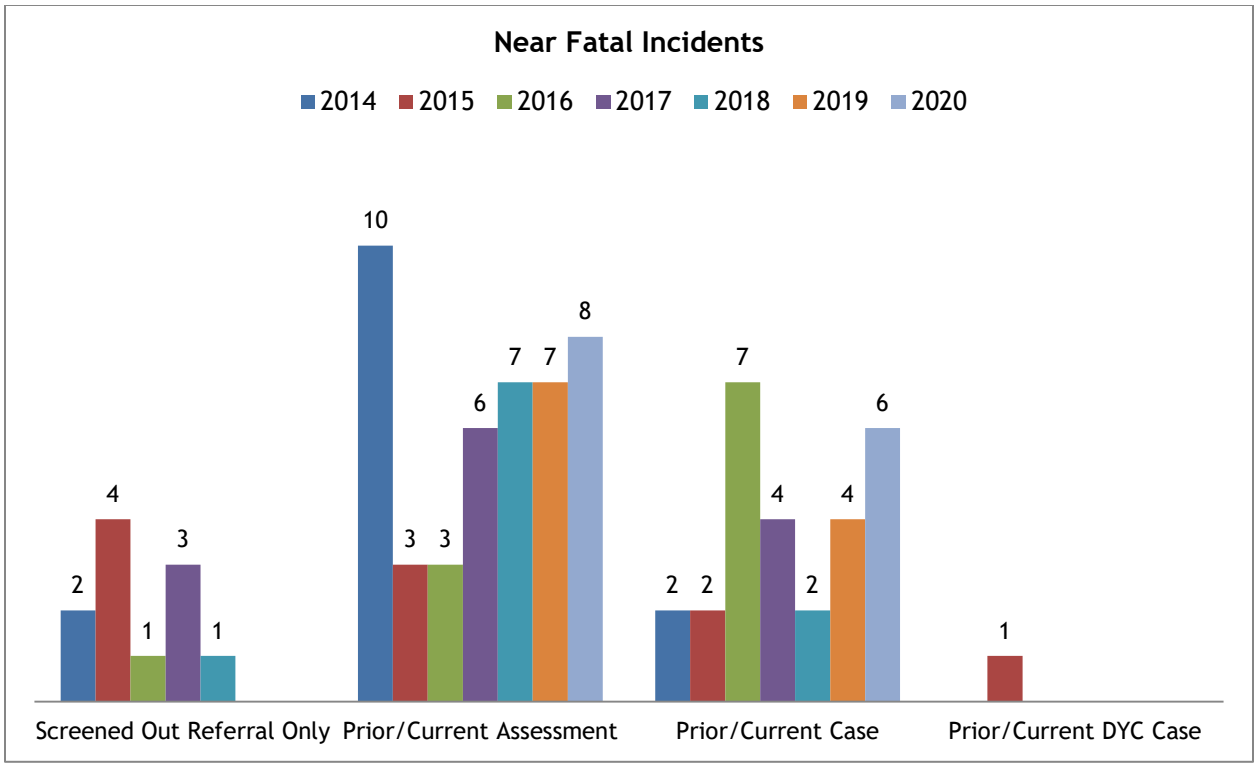
In 2020, for those families with prior involvement, 28.6% (6/21) of families involved with a fatal incident of child maltreatment had a prior and/or current case(s), which was lower than trends in 2014, 2015, and 2019. In 2020, the most common level of prior involvement with the child welfare system was a prior and/or current assessment. This mirrored trends in CYs 2016, 2017, and 2018.

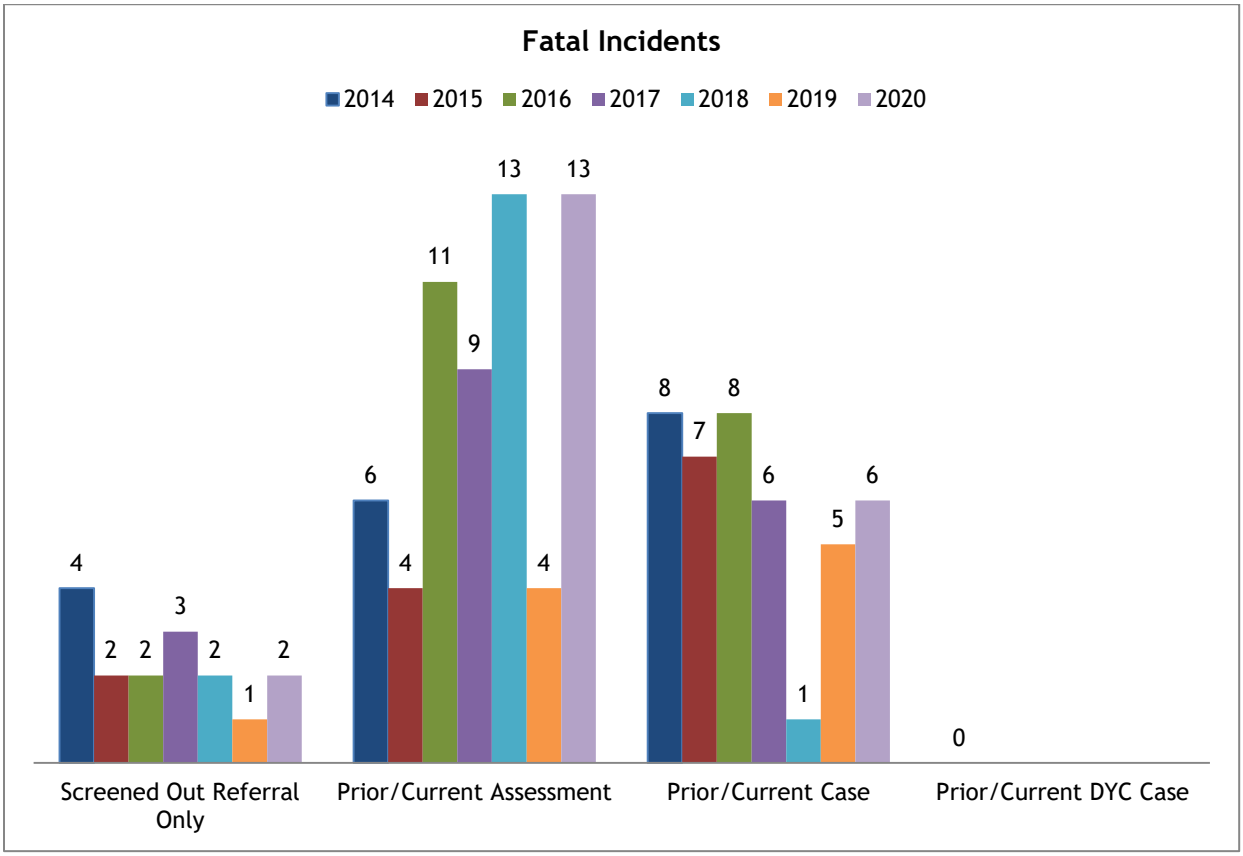
Near fatal incidents in 2020 fell in line with trends seen in 2014, 2017, 2018, and 2019, with assessments as the most common level of prior and/or current involvement with the child welfare system (8/14; 57.1%). Conversely, in 2016, the most common level of prior and/or current involvement for incidents of near fatal child maltreatment was a current and/or prior case (7/11; 63.6%).

In 2020, 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 (9/17; 52.9%) which followed 2015, 2016, 2018, and 2019 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
2020
2
4
1
3
1
10
3
3
6
7
7
8
2
2
7
4
2
4
6
1
Screened Out Referral Only
Prior/Current Assessment
Prior/Current Case
Prior/Current DYC Case


Fatal Incidents
2014
2015
2016
2017
2018
2019
2020
4
2
2
3
2
1
2
6
4
11
9
13
4
13
8
7
8
6
1
5
6
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 24 non-confidential case-specific executive summary reports (hereafter referred to as reports). This includes 24 reports completed and/or posted to the CDHS public notification website after the cut-off date for inclusion in the 2019 CFRT Annual Report (4/1/2020) and prior to and including the cut-off date for inclusion in this year's report (3/31/2021). Each of the 24 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 24 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.

This section first summarizes systemic strengths found by the CFRT across the 24 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 24 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 24 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 47 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, and 5) Services to Children and Families. The three systems most frequently mentioned were: 1) County Departments of Human Services (both alone and alongside other entities), 2) Medical Providers, and 3) Family and Friends.

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 13 occasions across 13 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 12 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 19 different times across 15 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

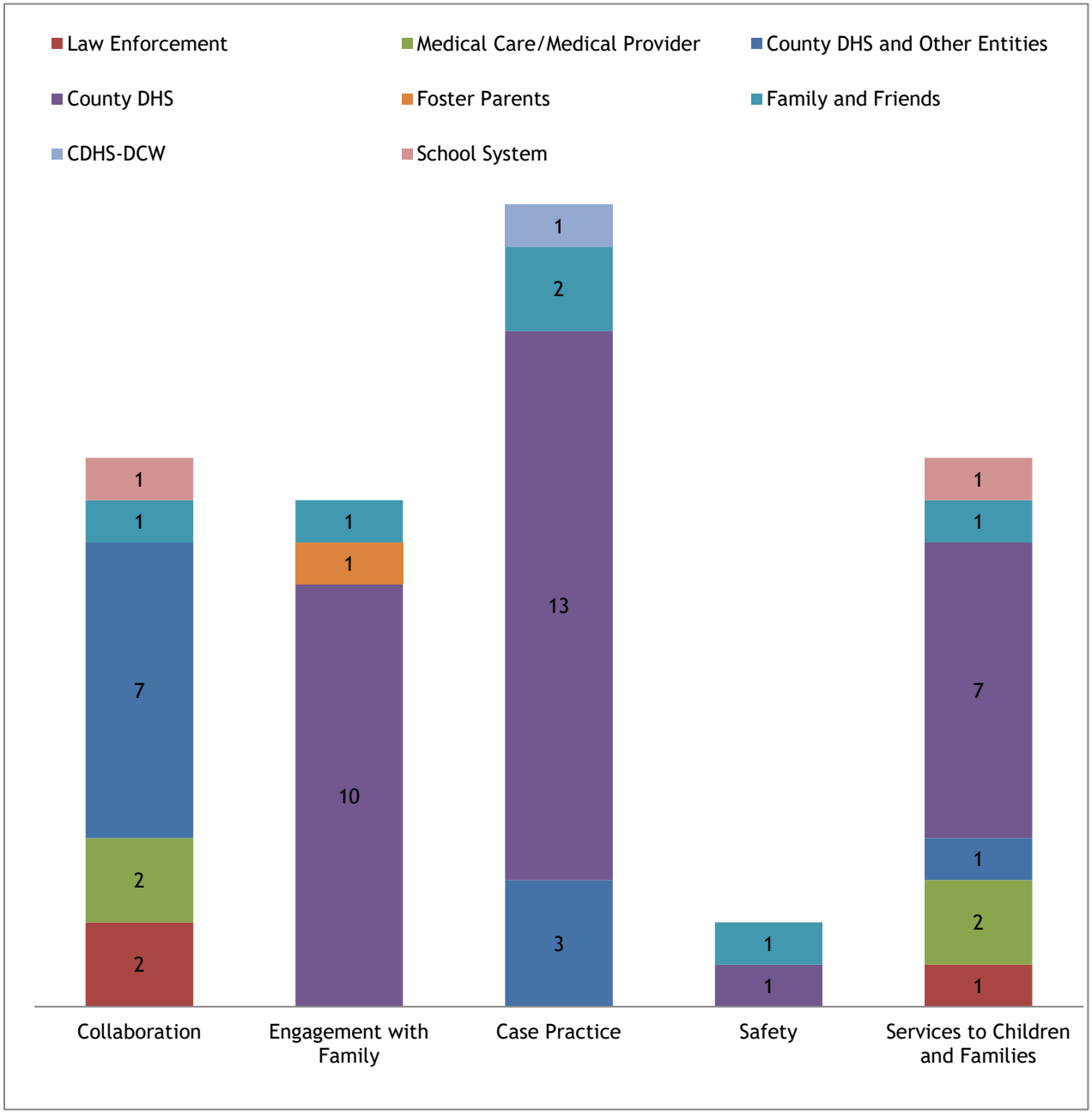
The CFRT identified two instances across two reports where systems surrounding children and families provided excellent work in the promotion of child safety. Oftentimes, efforts to assess, advocate for, and achieve safety for the victim and/or surviving siblings was notable.

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 13 times across 13 reports. Service provision often included services that were provided to the family as a result

of the fatal, near fatal, and/or egregious incident of child maltreatment, which included but 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 24 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, 2020 and March 31, 2021, the CFRT identified 10 gaps and deficiencies in the delivery of services to children and families, and issued corresponding recommendations. Systemic gaps and deficiencies were organized into the following categories: 1) Practice and/or Policy; 2) Legislation; 3) Collaboration with Outside Agencies; 4) Communication; 5) Training and Technical Assistance; and 6) 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 24 incident reviews, as well as information about their implementation status.

Collaboration

The CFRT identified a systemic gap/deficiency around collaboration between law enforcement and county departments of human and/or social services two times across the 24 reports. The CFRT recommended a continuation of a previous recommendation related to creating a stronger working relationship and improving communication between departments of human and/or social services and law enforcement.

Legislative

The CFRT identified two systemic gaps that resulted in legislative recommendations. In one, the CFRT recommended proposing and supporting a legislative change for domestic violence and parental alienation to be included in the Colorado Children's Code definitions of abuse and neglect. In the other, the recommendation for legislation was related to legislative changes that would enhance and streamline the cooperation between county departments of human/social services and law enforcement in order to make those professional relationships more consistent and reciprocal across the state. The CFRT recommended exploring the possibility of creating a more defined legislative statement regarding the relationship between county departments of human/social services and law enforcement, which would also provide further guidance on what information could be shared between them to assist with their respective assessments and investigations.

Unique Issues

The remaining gaps identified by the CFRT did not constitute overall trends across the 24 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.

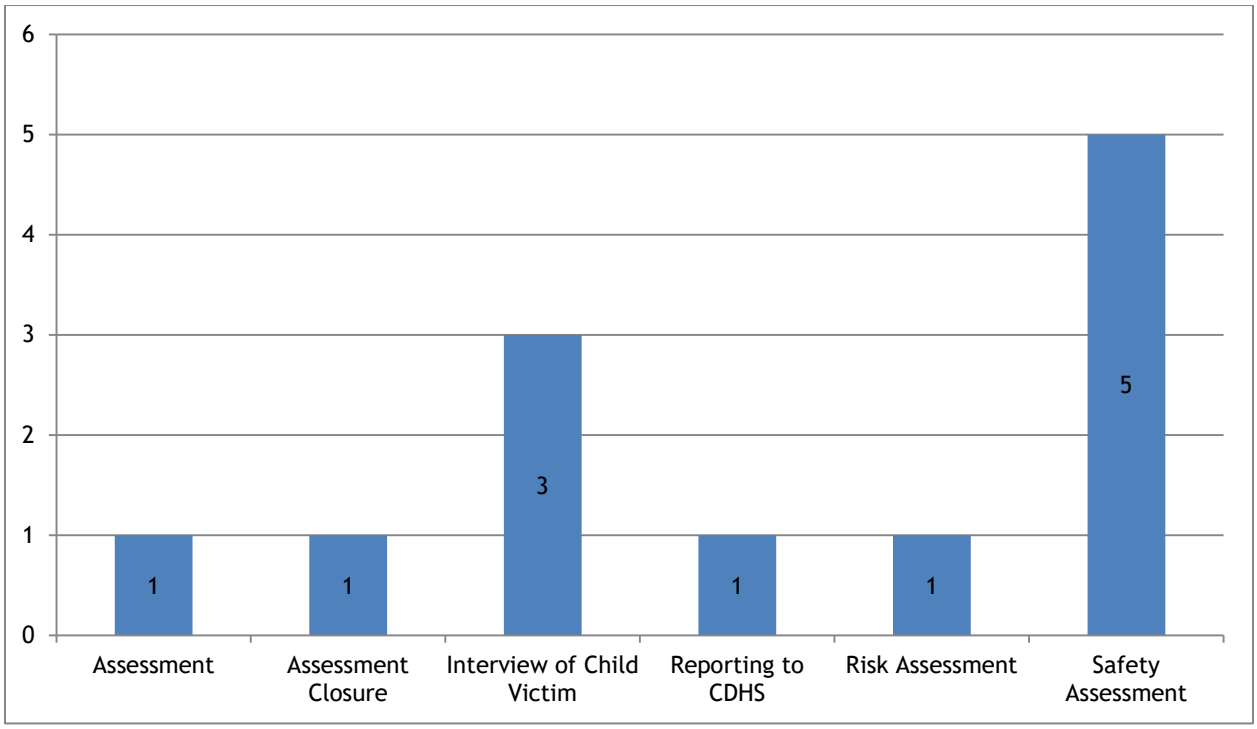
Summary of Policy Findings

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.

There were 12 policy findings, with associated recommendations, from 24 reports posted between the cutoff for the 2019 CFRT Annual Report (4/1/2020) and the 2020 Annual report (3/31/2021).The majority of these policy findings can be categorized in one main area of practice: 1) assessment rules and procedures.

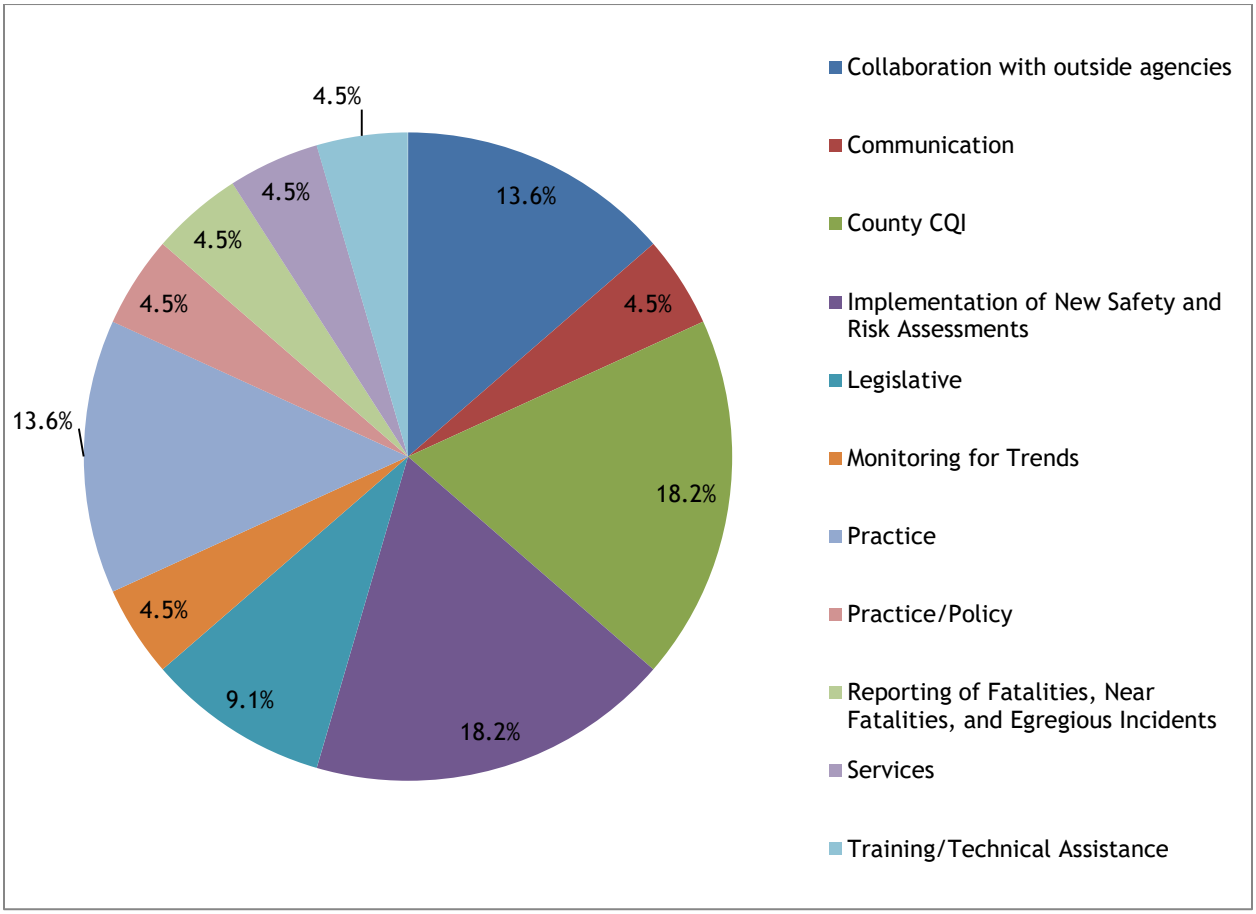
Chart 14: Policy Findings by Type



Recommendations from Posted Reports

A total of 22 recommendations were made across the 24 reports posted between 4/1/2020 and 3/31/2021. This included 10 related to systemic gaps and deficiencies and 12 related to policy findings. As illustrated in Chart 15, the top areas of recommendations are related to: 1) Safety and Risk Assessments; 2) County Continuous Quality Improvement; 3) Collaboration with outside agencies; and 4) Training and Technical Assistance

Chart 15. Focus of Recommendations in the 24 Reports Posted Between 4/1/2020 and 3/31/2021



While several recommendations were reviewed in this report, the full texts of all 22 are contained in Appendix C, as well as the status of the progress on these recommendations. As illustrated in Chart 16, 36.4% of the recommendations have been completed, 22.7% are in progress, and 4.5% 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 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, 36.4% of the recommendations were not started at the time of this report.

Chart 16: Status of Recommendations(n=22) for Reports Posted Between 4/1/2020 and 3/31/2021

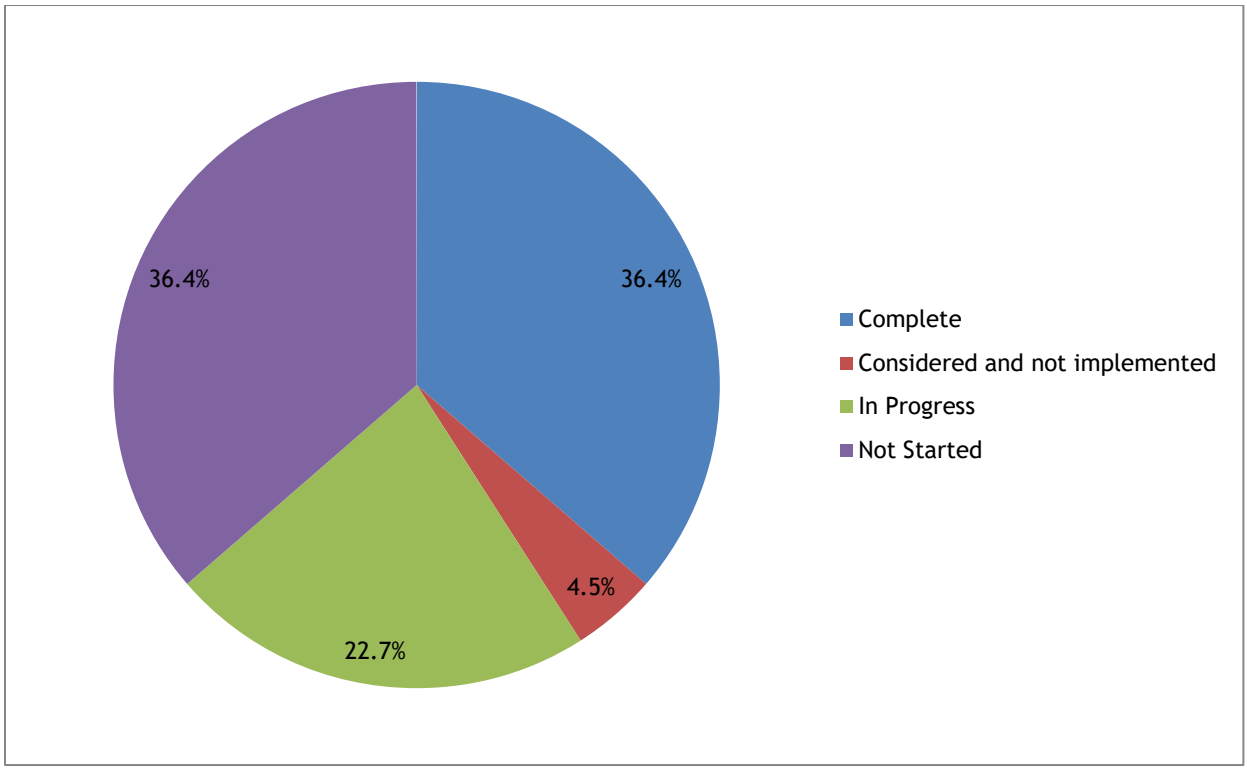
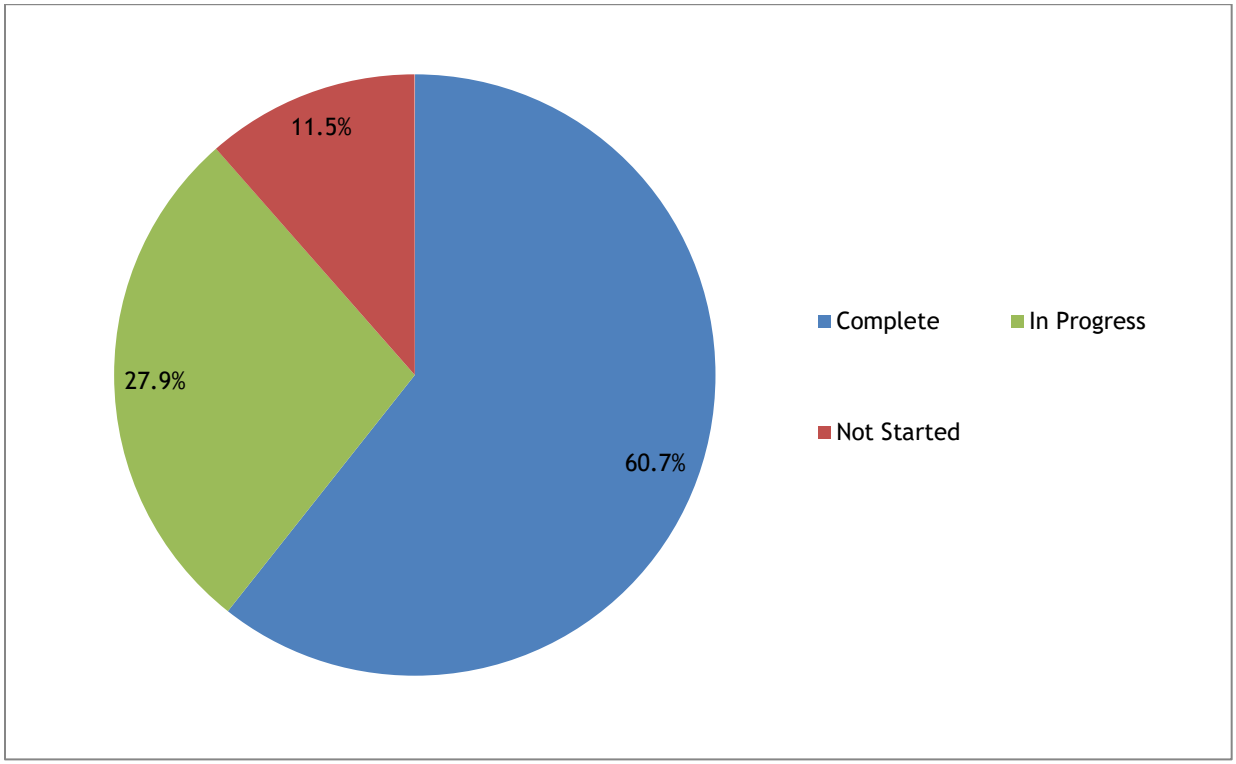


Chart 17: Status of Recommendations(n=61) Not Previously Completed From Reports Posted Prior to 4/1/2020



An update on the implementation status of the 61 recommendations presented in the 2019 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.

CFRT Recommendation Steering Committee

In 2020, a Steering Committee was formed, with a vision to ensure each CFRT recommendation is prioritized, acted upon, and implemented in a timely manner to address known systemic gaps and prevent future child deaths. The Committee is responsible for providing high level strategic direction for each CFRT recommendation, and oversees and supports implementation of recommendations. The relevant group to review and act on CFRT recommendations will vary and will often involve participants from multiple offices, agencies or sectors. The current committee has 11 members from four different CDHS offices as well as two counties, and a representative from the Colorado Department of Public Health and Environment Child Maltreatment Prevention Unit. Representation from CDHS includes the Office of Children Youth and Families, the Office of Behavioral Health, the Administrative Review Division, the Office of Early Childhood, and Community Partnerships.

Systemic recommendations vary greatly in terms of the named systems, scope and intensity. CFRT has maintained a running list of recommendations issued and their status. Based on a history of CFRT reviews and recommendations, it is clear that the underlying contributing factors of child deaths often go beyond the scope of child welfare, and even human services. Implementing recommendations does not live with any one office within CDHS -- preventing child deaths and promoting child and family well-being is ALL of our responsibilities. The purpose of the Committee is to ensure that the recommendations are not just issued by the CFRT, but also prioritized and implemented in a timely manner.

The first meeting of the newly formed Child Fatality Review Team (CFRT) Recommendation Steering Committee was held in September 2020, and members started reviewing recommendations and assigning impact and effort scores to determine prioritization efforts. Overall, it was clear that while several CFRT recommendations remain in progress, a good deal of work is already underway through existing initiatives and pending legislation. The Committee continues to demonstrate that getting the right people together to share information and expertise across disciplines improves the Department’s effectiveness and efficiency in tackling improvements to systemic gaps.

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 continue 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 family 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.

COLORADO CHILD FATALITY PREVENTION SYSTEM

EVIDENCE-INFORMED HOME VISITATION

SUPPORT POLICIES THAT EXPAND ACCESS TO COMMUNITY-BASED HOME VISITING PROGRAMS FOR ALL FAMILIES WITH 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 expand access to community-based home visiting programs for all families with 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.

Children get off to a better, healthier start when caregivers and parents have the supports and the skills needed to raise them. Community-based home visiting programs are family support and service delivery programs that take place in a location that is convenient and comfortable for the family, including the family home or a neutral location such as a park or library. Participation in these programs is voluntary and families may choose to opt-out whenever they want. Home visitors may be trained nurses, social workers, child development specialists, and trained community members. Visits vary by model, from a focus on linking pregnant women with prenatal care, to promoting strong parent-child attachment, or coaching parents on learning activities that foster their child's development and supporting

parents' role as their child's first and most important teacher. Home visitors evaluate a family's needs and provide tailored services. The exact services and topics vary based on the specific home visiting program and may include teaching parenting skills and modeling effective techniques; promoting early learning in the home, providing information and guidance on a wide range of topics including breastfeeding, infant safe sleep, injury prevention, home safety, child health, and nutrition; conducting screenings and providing referrals to address postpartum depression, substance use, and family violence; and linking families to available resources and services related to basic needs, housing, child care, food assistance, employment, and insurance.

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

Home visiting programs contribute to positive health outcomes. These programs improve child health and development; school readiness; parenting skills; caregiver health; increased high school graduation rates for mothers; and family income, employment, and economic self-sufficiency. They also reduce family violence or crime and child maltreatment. Home visiting programs help families by connecting them with services and referrals.[1] Between 2015 and 2019, CFPS identified 237 cases where child maltreatment either directly caused or contributed to the death of an infant, child, or youth in Colorado. The rates of child maltreatment deaths were significantly higher for infants and children ages 0-4 compared to older populations. Given the many ways that the COVID-19 pandemic has stressed families, from school and child care closures, to job loss, to health concerns, home visitation services that provide compassionate, responsive support are more important than ever.

Community-based home visiting programs support the Strengthening Families' Protective Factors Framework.[2] Strengthening Families is an approach to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect. The goal is to engage families, programs, and communities in building five factors, which can protect children and youth from child maltreatment: parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and social and emotional competence. In 2019, home visiting programs in Colorado served more than 8,198 families. However, the National Home Visiting Resource Center estimates that an additional 310,900 pregnant caregivers and families with 393,000 infants and children in Colorado would benefit from participation in an evidence-informed home visiting program.[3]

There is not a single county in Colorado that has home visiting programs to meet the overall needs of families in the county. Families may be eligible for home visiting services, but oftentimes they are not aware of these services or of the different choices of programs available in their community.[4] Additionally, there may not be enough home visiting services in

a community to meet the need. The Nurse-Family Partnership, which serves first time, low-income mothers in all 64 counties in Colorado, may be the only home visiting program in a county, especially in rural counties. Thus, there is great opportunity to add to the service array, so that all families who would benefit from home visiting and who desire it may have that option.

To support families effectively, home visitors need to establish trusting relationships with families. While existing programs attempt to meet the needs of each family, families report that there are significant gaps in being able to access services that reflect the family's language and culture.[5] Having access to home visitors who belong to their communities, speak their language, and understand their culture can encourage families from vulnerable communities to participate in home visitation programs. For example, Promotores de Salud are community health workers who address the needs of Latinx communities. Promotores have been shown to improve maternal and child health by increasing breastfeeding, children's immunization rates, promoting better nutrition, and helping families reduce barriers to health care.[6, 7, 8] A program currently offered in Colorado that considers a family's language and culture is Home Instruction for Parents of Preschool Youngsters (HIPPY). However, more models could adopt this approach and use community health workers, including Promotores, to support families and improve health outcomes for vulnerable populations.

Given the importance of home visiting programs in meeting Colorado families' needs and helping families thrive, state and local policymakers can support strategies to expand home visitation such as those highlighted below:

Prioritize funding of home visitation services. Policymakers can support the expansion of home visitation by making funding decisions that expand and diversify investments in home visitation, exploring existing tax and fee structures, prioritizing the expansion and reauthorization of Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program funding, and aligning COVID-19 stimulus funds with home visiting efforts. Additionally, enacting policies that require health insurance reimbursement of home visitation is essential to expanding these programs. Also, Colorado's planned implementation of the federal Family First Prevention Services Act (2016), also known as Family First, allows the state to use federal child welfare funding to fund prevention services including home visiting to support families and prevent out-of-home placements for children. The Colorado Department of Human Services has identified several home visiting models that, with additional state efforts, will fully align with the requirements to receive Family First funding.[9]

Support the Home Visiting Investment Plan. In May 2021, the Home Visiting Investment Task Force finalized recommendations that, when fully funded and implemented, will provide home visitation to a minimum of 1,700 additional families, representing a 20% increase.[10] The task force, which was approved in 2020 by Colorado's Early Childhood Leadership Commission, includes home visiting programs, state and county agencies, child development specialists, family resource centers, early childhood councils, philanthropy, and families. The recommendations outlined in the Home Visiting Investment Plan call for increased funding,

innovation, workforce development, outreach, marketing efforts, and partnerships through coalition building to expand Colorado's home visiting capacity. The plan's recommendations also support health equity by prioritizing family participation, expanding access to culturally and linguistically appropriate services, and recruiting and training a diverse home visiting workforce. The full Home Visiting Investment Plan, including detailed recommendations, can be found on the Early Childhood Leadership Commission website: http://www.earlychildhoodcolorado.org/working-groups.

Expand broadband internet access. By promoting the expansion of broadband internet access across the state, policymakers can support virtual home visitation and improve access to families. While virtual home visits may not work for every family, the virtual delivery method can give families access to a greater range of services, including home visiting services that reflect a family's cultural and linguistic needs. A recent study examined the impact of one evidence-based home visiting mode, SafeCare, shifting from home to virtual program delivery due to the COVID-19 pandemic.[11] The majority of SafeCare providers reported that families remained engaged in the program and made progress on the program's target skills. However, many families faced challenges due to limitations of technology, internet access, and data plans. Recent American Rescue Plan Act emergency funding to the MIECHV Program may help provide some families with technology to participate in virtual home visits.[12] However, the expansion of broadband internet access remains essential to ensure more Colorado families have access to virtual home visitation options. Please see the Broadband Internet Access recommendation for more information.

Community-based, evidence-informed home visiting is an effective way to help Colorado families thrive and prevent child deaths. Given the substantial federal investment in home visiting through the American Rescue Plan Act and Family First, among state efforts to improve home visiting service provision in Colorado, state policymakers have an opportunity to meaningfully expand these important supports and serve even more Colorado families who would benefit from in-home and virtual support.

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Appendix A: 2020 CFRT Attendance

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.*	**1.6.20**	**2.3.20 (ended early due to snow)**	**2.18.20**	**3.2.20**	**4.6.20 (virtual)**	**5.4.20 (virtual)**	**6.1.20 (virtual)**	**7.6.20 (virtual)**	**8.3.20 (virtual)**	**9.14.20 (virtual)**	**10.6.20 (virtual)**	**11.2.20 (virtual)**	**12.7.20 (virtual)**
Lucinda Connelly *CDHS, Child Protection Manager*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Korey Elger	---	---	---	---	---	---	---	---	---	---	---	---	---
Brooke Ely-Milen *CDHS, Domestic Violence Program Director*	---	By Phone	No	Yes	Yes	Yes	Yes	Yes	---	Yes	Yes	Yes	
→**Backup:** Beth Collins	Yes	---	No	---	---	---	---	---	Yes	---	---	---	
Beth Collins *CDHS, Domestic Violence Program Specialist*													Yes
Allison Gonzales *Administrative Review Division, Manager*	Yes	Yes	Yes	---	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Marc Mackert	---	---	---	Yes	---	---	---	---	---	---	---	---	---
Kate Jankovsky *CDPHE, Child Fatality Prevention System Coordinator*	By Phone	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Christal Garcia *CDPHE, Violence and Injury Prevention*	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Angela Sneddon *Morgan County Human Services*	Yes	By Phone	No	By Phone	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Casey Tighe *Jefferson County Commissioner*	By Phone	By Phone	No	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Marc Dettenrieder *Teller County Commissioner*	No	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.*	**1.6.20**	**2.3.20 (ended early due to snow)**	**2.18.20**	**3.2.20**	**4.6.20 (virtual)**	**5.4.20 (virtual)**	**6.1.20 (virtual)**	**7.6.20 (virtual)**	**8.3.20 (virtual)**	**9.14.20 (virtual)**	**10.6.20 (virtual)**	**11.2.20 (virtual)**	**12.7.20 (virtual)**
Senator Jim Smallwood *Senate Majority Leader appointment*	No	No	No	No	No	No	No	No	No	No	No	No	No
Representative Jonathan Singer *House of Representatives Majority Leader appointment*	No	No	No	No	No	No	No	No	Yes	Yes	Yes	No	Yes
Sara Embrey *Office of Colorado's Child Protection Ombudsman*	Yes	Yes	Yes										
Claire Hooker *Office of Colorado's Child Protection Ombudsman*			Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Amanda Pennington	---	---	---	---	---	---	---	---	---	---	---	---	---
Sgt. Brian Cotter *Denver Police Department*	Yes	No	No	Yes	Yes	Yes	No	No	Yes	No	No	No	Yes
Dr. Andrew Sirotnak *Professor of Pediatrics, University of Colorado School of Medicine Director, Child Protection Team at Children's Hospital Colorado*	Yes	By Phone	By Phone	No	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
→**Backup:** Dr. Antonia Chiesa	---	---	---	---	---	---	---	---	---	---	---	---	---
Amy Ferrin *Deputy District Attorney, 18th Judicial District*	By Phone	Yes	No	Yes	Yes								
Allyson Baber *Chief Deputy District Attorney, 17th Judicial District*											Yes	---	Yes
→**Backup:** Shelby Conney											---	Yes	---
Mara Kailin, PsyD *Aurora Mental Health Center, Director*	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes
→**Backup:** Kathy Snell	---	---	No	---	---	No	---	---	---	No	---	---	---
Jenny Bender, *Executive Director of Colorado CASA*					Yes	Yes	No	No	Yes	Yes	No	Yes	Yes

CFRT Member* **Grayed-out months indicate an individual was not appointed for participation at the time of the CFRT meeting.*	**1.6.20**	**2.3.20 (ended early due to snow)**	**2.18.20**	**3.2.20**	**4.6.20 (virtual)**	**5.4.20 (virtual)**	**6.1.20 (virtual)**	**7.6.20 (virtual)**	**8.3.20 (virtual)**	**9.14.20 (virtual)**	**10.6.20 (virtual)**	**11.2.20 (virtual)**	**12.7.20 (virtual)**
Lea Bernstein-Holmes, *Mental Health Coordinator, Sheridan School District*						Yes	Yes	Yes	Yes	**No**	Yes	Yes	Yes
Dan Makelky, *Douglas County Department of Human Services*	---	Yes	---	---	**No**	---	**No**	---	**No**	---	**No**	---	---
→**Backup:** Ruby Richards/Nicole Adams	Yes/ NA	Yes/RR NA	Yes/RR	Yes/ RR	**No**	Yes/RR	**No**	Yes	**No**	Yes/RR	**No**	Yes/NA	Yes/RR
Angela Mead *Larimer County Human Services*	Yes	By Phone	Yes	Yes	Yes	Yes	Yes	Yes	**No**	Yes	**No**	Yes	Yes
Jill Calvert *El Paso County Department of Human Services*	Yes	By Phone	By Phone	Yes	**No**	By Phone	---	Yes	---	Yes	Yes	Yes	Yes
→**Backup:** April Jenkins/Kris Reed	---	---	---	---	**No**	---	Yes/KR	---	Yes/KR	---	---	**---**	---
Cheryl Hyink *Administrative Review Division Staff*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Angela Myers *Administrative Review Division Staff*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Nada Pavlovich *Administrative Review Division Staff*		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Sarah Richelson *Attorney General's Office*	---	Yes	Yes	---	Yes	---	Yes	---	Yes	---	Yes	---	Yes
Anita Schutte *Attorney General's Office*	Yes	---	---	Yes	---	Yes	---	---	---	---	---	---	---
Bianca Miyata *Attorney General's Office*						By Phone	Yes	Yes	---	Yes	---	Yes	---

Appendix B: 2012-2020 Incidents Qualified for CFRT Review by County and Type

Fatal Incidents									Near Fatal Incidents									Egregious Incidents																
2012	2013	2014	2015	2016	2017	2018	2019	2020	2012	2013	2014	2015	2016	2017	2018	2019	2020	2012	2013	2014	2015	2016	2017	2018	2019	2020	2012 Total	2013 Total	2014 Total	2015 Total	2016 Total	2017 Total	2018 Total	2019 Total	2020 Total
2	2		2	1	2	2	1	1			1		3	1					3	2			1	1	2	1	2	5	3	2	4	4	3	3	2
																			1									1							
	2	1	1	4	1	2	1					1		2		1	2		1		2	1	1	2	2	1		3	1	4	5	4	4	4	3
						1													1	1								1	1				1		
					1											1																	1		1	
	1	1					1			1		1	2			1									1	2			2	1	1	2		1	4	
					1																											1			
		1																											1						
1	1	4	1	1		2	1	6	1	3	3	3	1	1	2	1	2		7	3	3	3	3	4	7	5	2	11	10	7	5	4	8	9	13
				1	1		1								1							1			1					2	2		2	
1			1																								1			1					
																										1									1
2	1	2		4	4	4	2	7		1	1	1	1	5	2	3	4	1		1	1	1	1	1	1	5	3	2	4	2	6	10	7	6	16
											1								1	2	1			1		1		1	3	1			1		1
			1				1																						1					1	
		1																											1						
		2	2	2	3			3			4		1	1	1	2	3	3	2	1	3					2		2	7	5	3	4	1	2	8
				1		1						1		1	1								1							1	1	2	2		
		1	1	1	3	1	1												4		2				1			4	1	3	1	3	1	2	
			1																											1					
																					1									1					
1		1																									1		1						
1		1	1	2		1	1			1		1			2	1										1	1	1	1	2	2		3	2	1
				1		1							1																		2		1		
				1																1									1		1				
				1																											1				
1		1						1		1	1						1							1				1	2		1	1		1	1
					1				1		1																1		1			1			
	1																											1						
																	1																		1
																				1									1					
1		1				1		2		1	2	1	1						1	1			1				1	2	4	1	1	1	1		2
														1																			1		
		1												1								1							1		1	1			
								1																										1	
					1										1																		1		
	1		1		1												2					1		1			1		1	1	1	1		2
10	9	18	12	21	19	16	10	21	2	8	14	9	11	13	10	11	14	4	21	13	13	8	9	11	16	17	12	38	45	34	40	41	37	37	52

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

Appendix C: Recommendations from 2020 Posted Reports

CFRT ID	Recommendation Type	Recommendation	Status
20-008	CFRT	The CFRT made a formal recommendation to explore recruitment, training, and retention efforts in Colorado to assist in expanding the number of appropriate and available foster homes across the state for the LGBTQ children and youth who are in need of out-of-home care.	In Progress
20-034	CFRT	The CFRT identified a need for the expansion of substance abuse treatment and services in our communities to help support pregnant mothers, who have past and current substance abuse history.	Not Started
19-030	CFRT	The CFRT recommended the need to explore the current training/curriculum for kinship and foster families to ensure they are receiving information about caring for children with trauma histories and self-harming behaviors in order to ensure the kinship and foster families are as prepared as possible and able to safely meet the children's needs. Likewise, the team recommended for the same exploration into the training/curriculum for caseworkers to ensure they are able to make safe and appropriate decisions regarding placement for children.	In Progress
19-063	CFRT	The CFRT recommended a continuation of a previous recommendation related to creating a stronger working relationship and communication between DHS and law enforcement. It was recommended that additional training be considered for law enforcement officers in how to communicate their concerns to DHS when law enforcement responds to a call and there are older children/adolescents present.	In Progress
19-074	CFRT	The CFRT recommended the development of a workgroup that can review domestic violence cases in Colorado to see if there are better ways to work with perpetrators and victims in order to prevent further lethal outcomes for children and families.	In Progress
19-074	CFRT	The CFRT recommended creating dual track court systems for families involved in multiple court actions (i.e. domestic relations, criminal, and civil). This would allow for professionals to collaborate and coordinate services, case management, and participation/compliance with the families involved.	Not Started
19-074	CFRT	The CFRT recommended proposing and supporting a legislative change for domestic violence and parental alienation to be included in the Colorado Children's Code definitions of abuse and neglect.	Complete

18-026	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
18-026	Policy Finding	The policy finding related to the inaccurate completion of the Colorado Family Risk Assessment Tool does reflect a systemic issue for EPCDHS. 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 Risk Assessment Tool accurately in 40% of assessments. It is recommended that EPCDHS 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
18-095	Policy Finding	The policy finding related to the timeliness of notification of the near fatal incident does reflect a systemic practice issue for Rio Blanco County DHHS. During the year time span from May 12, 2018, through May 13, 2019, Rio Blanco County DHHS provided timely notification to CDHS in 0% of incidents. It should be noted that Rio Blanco County DHHS only had this one incident that met criteria for notification to CDHS during this review span. It is recommended that Rio Blanco County DHHS consider creating a more formal process for recognizing and reporting fatal, near fatal, and egregious incidents of child maltreatment to CDHS.	Complete

18-095	Policy Finding	The policy finding related to interviewing/observing the alleged victim within the assigned response time does reflect a systemic practice issue for Mesa County DHS. According to the Colorado Child Welfare Results Oriented Management (ROM) system, which provided data for the April 2019 C-Stat, Mesa County DHS's performance for January 2019, was 91.7% 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 April 12, 2018, through October 13, 2018, showed Mesa County DHS at 67.3% for observing/interviewing the alleged victim within the assigned response time, which is below the Ten Large County average (not including Mesa County DHS) of 69.9% for a comparable time span. It is recommended that Mesa 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.	Not Started
18-104	CFRT	The CFRT formally recommended for legislative changes to be made that would enhance and streamline the cooperation between county departments of human/social services and law enforcement in order to make those professional relationships more consistent and reciprocal across the state. The CFRT recommended exploring the possibility of creating a more defined legislative statement regarding the relationship between county departments of human/social services and law enforcement, which would also provide further guidance on what information could be shared between them to assist with their respective assessments and investigations.	Not Started
18-104	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

18-104	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 July 29, 2018, to January 29, 2019, showed ACDHS at 47.4% for observing/interviewing the alleged victim within the assigned response time, which is below the Ten Large County average (not including ACDHS) of 67.9% 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
18-104	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 July 29, 2018, to January 29, 2019, ACDHS completed the Colorado Family Safety Assessment Tool accurately 31.6% 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.	Not Started
18-104	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, to January 29, 2019, ACDHS completed the Colorado Family Safety Assessment Tool when required 57.9% 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.	Not Started

18-104	Policy Finding	The policy finding related to the assessment containing the required content does reflect a systemic practice issue for ACDHS. As part of a routine quality assurance monitoring, a recent review of a generalizable random sample of assessments that were conducted during a period of July 29, 2018, to January 29, 2019, showed that ACDHS's assessments contained the required content 60.5% of the time, which is below the Ten Large County average (not including ACDHS) of 79.2% for a comparable time span. It is recommended that ACDHS employ a process in which barriers to documentation of the assessment containing all required content are identified and solutions to the identified barriers are implemented.	Not Started
18-104	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 June 2019 C-Stat, DDHS's performance for March 2019, was 87.4% 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 March 30, 2018, to 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. DDHS made reasonable efforts to observe/interview alleged victims 87.3% of the time, which is below the Ten Large County average (not including DDHS) of 88.8% 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.	Complete
18-104	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 March 30, 2018, to 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

18-104	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 March 30, 2018, to 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
17-077	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
17-077	CFRT	It is recommended that DCW explore the potential for a process for exceptions that counties could submit to CDHS in order to keep an assessment open past 60 days, or re-open an assessment to make changes in Trails.	Considered and not implemented

Appendix D: Status Update for Recommendations from Previously Posted Reports

CFRT ID	Recommendation Type	Recommendation	Status
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.	Complete
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.	Complete
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 below 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	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.	Complete
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.	Complete
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.	Complete
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
18-016	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
18-044	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
18-070	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

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 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 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
17-006	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.	Complete
17-035	Policy Finding	The policy finding related to not engaging the mother's boyfriend in case planning does reflect a systemic practice issue for OCDHS. In the most recent Out-of-Home Administrative Review period from January 1, 2018, to March 31, 2018, OCDHS engaged the father in case planning 16.7% of the time. It is recommended that OCDHS employ a process in which the barriers to engaging fathers in case planning are identified and solutions to the identified barriers are implemented.	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.	Complete
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.	Complete
17-073	CFRT	The CFRT recommended that the ARD and the Division of Child Welfare should convene a workgroup to analyze the risk factors from the cases reviewed by the CFRT in order to evaluate the responses needed from DHS and to make recommendations. The Colorado Revised Statutes, 26-1-139 (1) (c), states that one of the goals of the CFRT is "to identify and understand where improvements can be made in the delivery of child welfare services, and to develop recommendations for mitigation of the future incidents of egregious abuse or neglect against a child, near fatalities, or fatalities of a child due to abuse or neglect."	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.	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 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
16-012	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
15-025	CFRT	It is recommended that DCW define type of allegations in Volume VII which correspond to those that are listed in Trails.	In Progress
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.	Complete

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.	Complete